Reflexión

CONSIDERATIONS FOR THE IMPLEMENTATION OF A NON-PHARMACOLOGICAL, PATIENT-CENTERED APPROACH TO CHRONIC NON-ONCOLOGICAL PAIN TREATMENT IN THE UK AND CHILE

CONSIDERACIONES PARA LA IMPLEMENTACIÓN DE UN ENFOQUE NO FARMACOLÓGICO CENTRADO EN EL PACIENTE PARA EL TRATAMIENTO DEL DOLOR CRÓNICO NO ONCOLÓGICO EN EL REINO UNIDO Y CHILE

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ABSTRACT
Non-oncological chronic pain imposes a significant global burden, and its prevalence is increasing. The World Health Organisation and UK National Institute for Health and Care Excellence promote patient-centered care as an effective approach to treating chronic non-oncological pain. This approach improves long term health outcomes by identifying root causes which impact these conditions, within the framework of the biopsychosocial care model. Within Chile and the United Kingdom, patients advocate for pharmacological interventions, however Centres for Disease Control and Prevention emphasise a preference for non-pharmacological management strategies. As the UK healthcare system actively seeks to reduce reliance on pharmacological treatment modalities, using alternative interventions, Chilean healthcare has also begun to regenerate its approaches to treatment. The objective of this paper is to reflect upon the implementation of these strategies to gain insights into their potential for driving change.
Key words: Patient-centered care, Biopsychosocial model, Chronic pain, Interventions, Complementary therapeutic methods.

RESUMEN
El dolor crónico no oncológico supone una importante carga a nivel mundial y su prevalencia va en aumento. La Organización Mundial de la Salud y el National Institute for Health and Care Excellence de Reino Unido promueven la atención centrada en el paciente para tratar el dolor crónico no oncológico. Este enfoque mejora los resultados de salud a largo plazo mediante la identificación de las causas fundamentales que repercuten en estas afecciones, en el marco del modelo de atención biopsicosocial. En Chile y el Reino Unido, los pacientes se inclinan por las intervenciones farmacológicas, sin embargo, los Centros para el Control y la Prevención de Enfermedades promueven estrategias de gestión no farmacológicas. Mientras el sistema sanitario de Reino Unido busca activamente reducir la dependencia de las modalidades de tratamiento farmacológico, utilizando intervenciones alternativas, el sistema de salud chileno también ha comenzado a revisar sus enfoques de tratamiento. El objetivo de este documento es reflexionar sobre la implementación de estas estrategias para comprender su potencial para impulsar el cambio.
Palabras claves: Atención dirigida al paciente, Modelos biopsicosociales, Dolor crónico, Intervenciones, Métodos terapéuticos complementarios.

INTRODUCCIÓN

Chronic non-oncological pain and its associated co-morbidities influence population productivity and employment, disproportionately affecting those of a lower socioeconomic level[1]. This significantly impacts quality adjusted life years, often leading to long term disability, which places a substantial strain on public healthcare systems both in the United Kingdom (UK) and in Chile. In the UK, up to 46% of the adult population suffer from chronic non-oncological pain. Comparatively, in Chile, studies indicate it affects approximately 32%. A substantial portion receive pharmacological treatment[2-4]. While painkillers are commonly utilized to manage chronic non-oncological pain, it is essential to consider potential risks associated with their long-term use[4-6]. Despite patient preferences, healthcare providers must exercise caution due to the lack of high-quality evidence supporting their effectiveness for chronic non-oncological, pain; particularly idiopathic. Non-pharmacological interventions provide an alternative approach that does not involve medication use[3,6]. They consider lifestyle modifications and utilise physical interventions, alternative/ complementary treatment modalities and behavioural therapies to manage health conditions[3,4,7].

As a chiropractic student I work within a student clinic which provides free or significantly discounted care, this facilitates access for individuals who might ordinarily be unable to engage with this care modality, chiropractors mostly operate within the private healthcare system. Patients' access can often be limited to their time at the university, with international students being particularly affected. Consequently, obtaining a clearer comprehension of how chronic non-oncological pain guidelines are implemented

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internationally is important[2]. Additionally, reflecting upon how the delivery of patient-centered, non-pharmacological treatment could be accomplished in a restricted time frame aids in professional development[4].

The aim of this commentary is to reflect on the implementation of non-pharmacological guidelines in the UK and Chile[1,3]. This is relevant to ensure optimal treatment outcomes, foster patient trust and pinpoint areas that may need additional support. By doing this healthcare providers can better equip patients with the tools they need to actively participate in their treatment, self-manage, and minimise future health risks[3,4].

Chronic non-oncological pain is non-cancerous intermittent or persistent pain lasting more than three months[1,4]. It can originate from various musculoskeletal disorders including arthritis, migraine headaches, diabetic neuropathy and be influenced by psychosocial factors[3,7,8]. Disorders can also be idiopathic or non-specific including fibromyalgia, idiopathic neuropathy and chronic regional pain syndrome[3,5,8,9]. In both Chile and the UK, non-pharmacological, patient-centered, interventions are recognised as valuable strategies for improving the quality of life of individuals with chronic non-oncological pain, these strategies have been incorporated into treatment guidelines[1,3,7]. Patient-centered care is an approach to care which prioritises individual's needs, values and preferences. It fosters a collaborative healthcare provider-patient relationship, tailoring treatment to align with the patient's unique circumstances[4,6]. This empowers patients to actively participate in care decisions and focuses on partnership, communication, self-management, health promotion and patient education[3,4]. It has been found to improve patient satisfaction, quality of care and health outcomes[7]. Patient-centered care encompasses the biopsychosocial model. This model demonstrates a holistic approach to healthcare which considers biological, psychological and social factors and their influence on health and wellbeing[2,6]. It acknowledges that complex interactions between these determine and individual's health and influence their subjective experience of pain[4]. Chilean and UK guidelines align closely, however UK guidelines can be contingent, depending on which trust patients receive care from[1]. The implementation of these guidelines presents challenges pertaining to barriers to care, treatment adherence, patient comprehension, shared decision making, psychosocial factors, treatment agreements, funding and a requirement of additional training amongst healthcare providers[4].

DEVELOPMENT

The World Health Organisation (WHO) acknowledges chronic non-oncological pain as a distinct entity[1], categorising it as both a primary and secondary disease within the International Classification of Diseases (ICD-11). The adoption of appropriate coding is expected to facilitate access to comprehensive multimodal care for all chronic pain patients, supporting precise epidemiological research and the development of health policies regarding chronic non-oncological pain. This includes the allocation of adequate treatment financing. Access to non-pharmacological treatment, in the public healthcare system, requires referral from a primary healthcare physician in both Chile and the UK. Although referrals can be made if the pain is secondary to a recognised pathology, within Chilean healthcare chronic non-oncological pain is generally viewed as a symptom and not a disease, creating a barrier to care. However, the enactment of Law No. 21.531, concerning fibromyalgia and chronic non-oncological pain, demonstrates that advancements are ongoing[9].

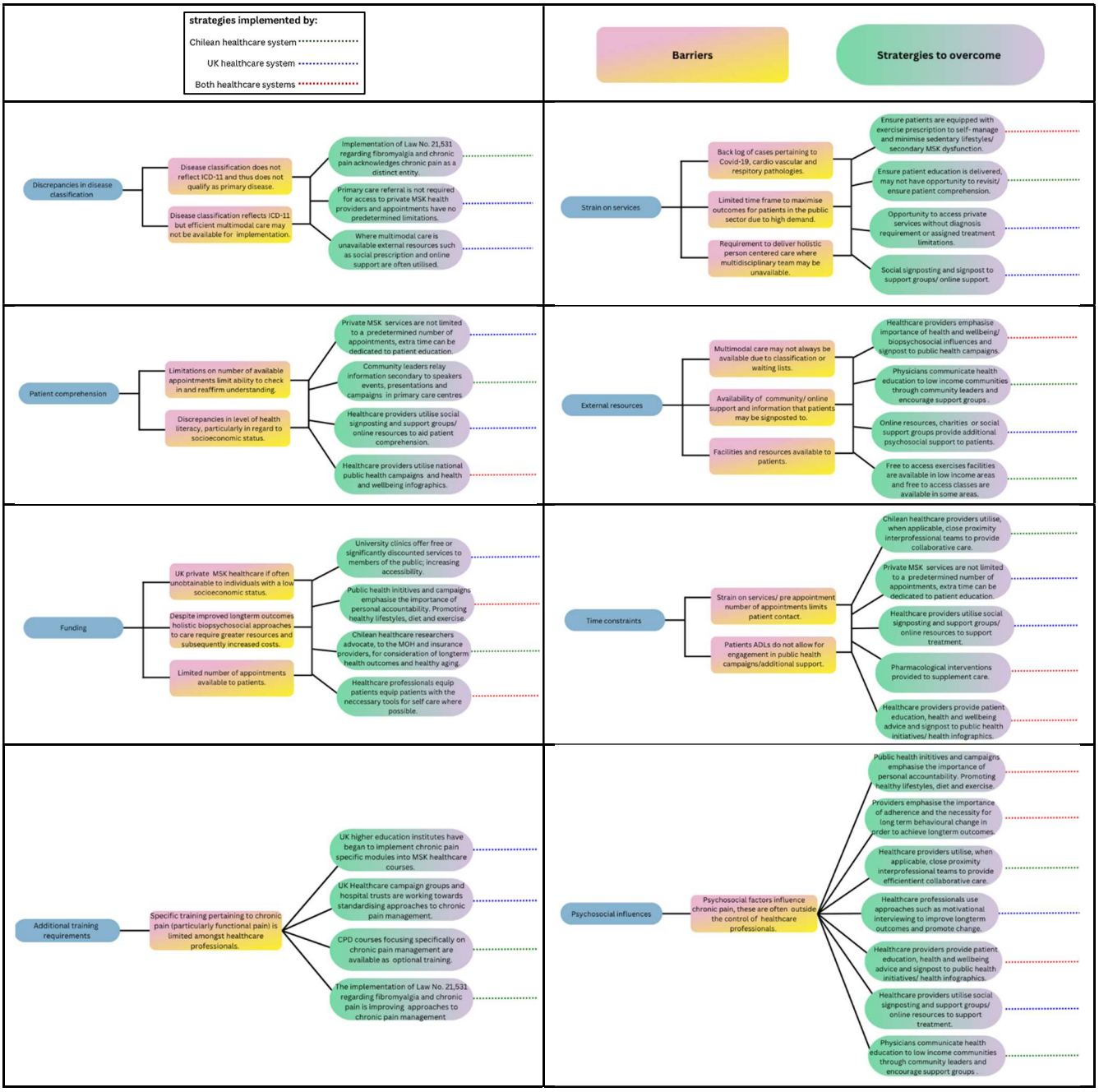
Primary care centres in Chile leverage multidisciplinary teams to enhance patient care, this contrasts UK primary healthcare, where interprofessional communication usually occurs via letters and emails. Multidisciplinary teams in Chile often work in close proximity, within the same facility, allowing for improved communications and efficiency. Continued multimodal care, throughout chronic non-oncological pain treatment, relies on the presence of comorbidities. Guidelines in Chile and the UK endorse that the interplay between psychological comorbidities and chronic pain highlights the importance of holistic, patient centered, strategies to enhance health outcomes[3,4]. The WHO[1] and National Institute for Health and Care Excellence (NICE) recognise psychological disorders to be conditions that can be categorised as diseases and comorbidities[7], but this acknowledgement does not translate to the Chilean public healthcare system. By addressing all three dimensions within the biopsychosocial model treatment can produce a comprehensive and personalised care pathway[4].

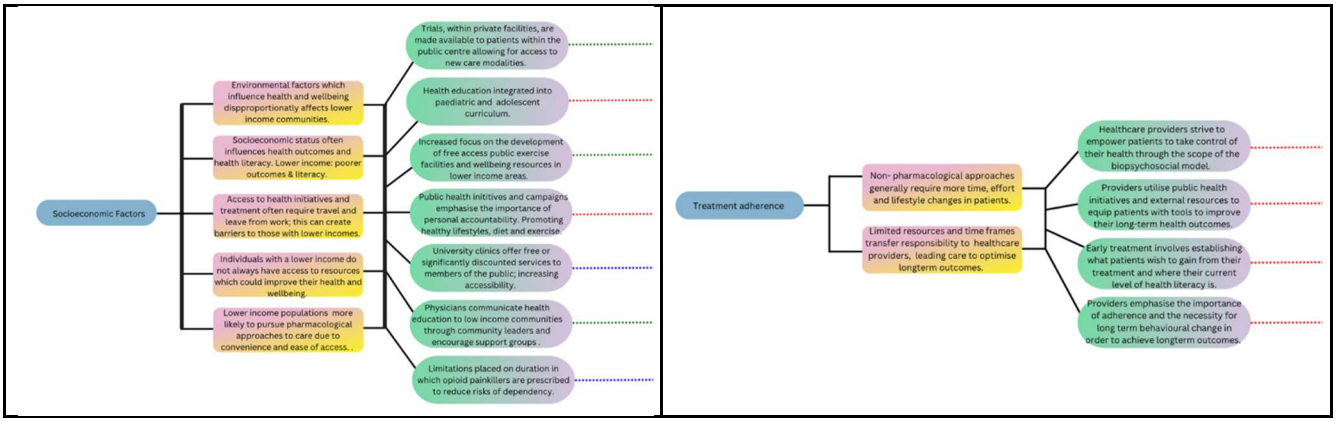
Pain education, even in the absence of a multimodal team, can increase the patient-centric nature of the treatment[3,4]. Helping patients to understand their pain, particularly if it is functional, can assist them in comprehending why a biopsychosocial approach is necessary. This can act as a catalyst for enabling patients to formulate a self-care plan and take a more active role in their treatment[4]. Sharing knowledge with patients can also help them understand that pharmacological interventions may not be the best choice and encourage them to be more receptive to embracing alternative approaches[3,7]. Pain neuroscience research indicates that pain is multifactorial and, in chronic non-oncological pain, does always not signify harm[3,8]. Ensuring that patients understand this concept is important. Fear avoidance often leads to increased inactivity which can exacerbate chronic

pain symptoms. It also increases an individual's likelihood of developing conditions such as osteoporosis and sarcopenia later in life, these can escalate the risk of fractures, falls and functional damage[1]. Some university healthcare programmes, within the UK, incorporate pain modules into their curriculums. Professionals in Chile report that they would find additional education to be beneficial but relay difficulties in assessing how well patients comprehend the information provided. Kinesiologists and rehab facilities face high demand. With many patients waiting and a fixed number of appointments per patient, it is difficult to allocate time to those who could use additional support in understanding their condition and developing self-care plans. Care plans are set by the patient's physician and often do not allow for deviation. Resources and education are primarily provided on an individual basis and public awareness remains low[4]. UK practitioners often overcome this constraint by signposting patients to peer/community-based care or by providing additional resources they can take away to aid their learning and help them develop their self-care strategies[4].

The graph below illustrates barriers faced in the non-pharmacological treatment of chronic non-oncological pain treatment in the UK and Chile. It highlights strategies in which healthcare systems strive to implement guidelines (Table 1).

Table 1. Strategies to overcome barriers to guideline implementation.





CONCLUSION

The objective of this paper was to reflect upon the implementation of a patient centered non-pharmacological approach to treating chronic non-oncological pain, in the UK and Chile[1,3]. This process has provided insights into possible reasons why, in the treatment of chronic non-oncological pain, patient preference often involves pharmacological interventions[4,5]. They do not encounter the challenges or resource requirements associated with non-pharmacological interventions. This approach, however, is not an ideal long-term solution[5]. As a healthcare student, reflecting on the implementation of guidelines[3] has highlighted that delivery can vary and outcomes can be influenced by several factors related to both the patient and the healthcare provider. These factors may sometimes be within our control and other times not. Awareness enables us to address and overcome constraints. By learning from positive experiences, we can grow and improve as healthcare professionals, gaining new skills and insights that enhance our ability to support patients and implement guidelines effectively in a holistic patient centered manner.

Future research could benefit from gathering information from the patient's perspective. This would help to identify perceived barriers to care and offer a better understanding of what additional support patients may require, and if there are specific areas where additional support is in most need of development.

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