Conventional and complementary approaches to chronic widespread pain and its comorbidities

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ABSTRACT
The concept of comorbidities as a challenge for healthcare systems has recently been given increasing attention in leading medical journals. Many patients suffering from chronic pain, especially those who are older or poorer, have more than one pathology (multimorbidity) or more than one set of manifestation of one pathology (comorbidity). These patients present a difficult problem in industrialised societies, with services that are highly specialised and compartmentalised. Systematic reviews of interventions for patients of this kind do not mention acupuncture. Acupuncturists claim that their treatment promotes general well-being and can help with multiple symptoms, but evidence for this claim is currently lacking. Longitudinal research with prospective data collection regarding the effect on morbidity burden is needed.

WHY DOES IT MATTER?
The concept of comorbidities has recently attracted considerable attention.1–6 The difficulties faced by highly specialised and industrialised healthcare systems in dealing with comorbidities are well-known and hotly debated. It is challenging to coordinate the healthcare required for addressing multiple affected organ systems. Protagonists of acupuncture may speculate that this is an ideal opportunity to showcase the effectiveness of a therapy which claims to address several organ systems at once. Acupuncturists claim that their treatment promotes general well-being and can help with multiple symptoms, but evidence for this claim is currently lacking. Longitudinal research with prospective data collection regarding the effect on morbidity burden is needed.

Western medical tradition harbours concepts of adaptive processes which may take a turn for the worse and become maladaptive.7 Exposure to prolonged distress has effects on both physiological and mental health. Genetic vulnerabilities in conjunction with adverse environmental factors are said to generate central sensitisation and psychological depression.8 Each medical specialism has a heading for ‘functional disorders’ to accommodate the manifestations of generalising pain disorders. The predicament of dealing with this group of conditions as isolated phenomena within their specialism is well-known.9

The concept of an accumulation of discrete disease entities in one person is alien to Eastern medical thinking. ‘Comorbidities’ do not exist in a Traditional Chinese medicine framework. In theory, acupuncture—as a somatosensory stimulation therapy enacted in a therapeutic ritual—is an ideal tool for ‘killing many birds with one stone’. However, there are very few data to support this theory-based claim. Is acupuncture the longed-for magic formula that will facilitate adaptive responses in dysregulated organisms? A therapy which enhances adaptive physiological processes ought to demonstrate positive outcomes.10

Chronic pain poses problems in its multiple relationships: relationships between internal organs as in viscerovisceral convergence; between internal organs and the musculature as in viscero-somatic convergence; and relationships between episodic and chronic presentations as in headache and musculoskeletal pain. Anxiety, depression and anger, as affective components of the pain experience, go hand in hand with pain but may be treated as comorbidities by separate specialists. This has consequences for the delivery of treatment. It places the management of these conditions in an awkward borderland between pathophysiology and psychology: services for physical health from people who touch the patient look after bodies; services for mental health from people who do not touch the patient look after—what? Heads? Minds? Brains?

Clinical practice is informed by guidelines which themselves are guided by
The research is based on reductionist models which neither represent the bodily situation of the patient (many diseases in one body) nor the configuration of the services dealing with this situation (many people, many organisations). The relationships between the organs of the body are not adequately matched by the relationships between the specialists who treat these organs. Medical authorities spanning 2000 years of history, from Huang Di to William Osler, have repeated the call to treat the person not the disease. However, the contemporary organisation of healthcare labour compartmentalises this approach to ‘Medical Humanities’ in medical education, or to disciplines like primary care or palliative care which rely heavily on the meaning patients give to their conditions. ‘We are shaped by our diagnoses, but we are not reduced to them’, writes Charles Rosenberg.

WHAT ARE COMORBIDITIES?
How are diseases categorised? Taxonomy relates to the way conditions are named (nosology) to their presumed relationships with each other. The definitions of diseases change over time and culture. Valderas et al define comorbidity as the occurrence of one or more related conditions in an individual with any given condition. Multimorbidity can be seen as the occurrence of unrelated diseases. Episodic intermittent illnesses such as widespread musculoskeletal pain or depression are also considered by some as chronic conditions. However, at present such categorisation has very few consequences either for long-term management strategies for the affected individuals or for service provision by healthcare organisations (Figure 1).

Kernick categorises multimorbidity and complexity according to their effect on healthcare management. The social setting plays an important rule. Using a systemic model, he groups situations into ‘ordered’, ‘transitional’ and ‘unordered’, the latter with a subdivision into complex or chaotic relationship patterns. Order multimorbidities can be addressed with protocollised template-driven care. This work can safely be carried out by minimally trained practitioners. This is not the case in the transitional or unordered domains. Working in these areas requires a capacity for contextual understanding and interpersonal trust. Trust in continuing relationships is repeatedly seen as the most important feature of care by patients. Trust can also be seen as a method to reduce the challenge of complexity.

THE MAKING OF ‘COMORBIDITIES’: A SOCIAL-CONSTRUCTIONIST VIEW ON THE DIVISION OF MEDICAL WORK IN HEALTH SERVICES
Could ‘comorbit’ be an artefact generated by the need for a disease label in order to obtain medical services? Could the emergence of comorbidities be an epiphenomenon of the division of labour in the health industry? Disease labels are the currency for regulating access to medical services or subspecialisms. They legitimise the delivery of healthcare by certain groups of practitioners. Disease labels are also used to generate demand for medical services. Comorbidity creates a dilemma for the coordination of healthcare if several disease labels are attached to one case. The problem arises as a result of the increasing subspecialisation of medical knowledge and the consequent fragmentation of health services. Recent policy reports and articles call for us to create stable relationships with patients whose bodily envelope contains too many diseases, making it difficult to coordinate the work that needs to be done.

COMPLEXITY AND CONTINUITY OF CARE: RELATIONSHIPS AND INFORMATION
Maria Giamberardino states “complexity is the rule in the comorbid pain patient, not only for diagnosis, but also for management, which necessarily needs to be thorough and integrated among disciplines. In an era of super-specialisation where there is a risk of treating diseases specifically and separately, we must acknowledge the essential role of a unifying clinician who can sum up and coordinate all the specialist interventions for a pain patient.” The work of unifying,
coordinating, making sense, negotiating and listening is highly skilled labour.\textsuperscript{26} It needs psychological flexibility, health systems literacy, high information-processing skills and, last but not least, kudos and status. This statement blends in with the call by Mercer\textit{et al} to spend more time with patients in the deep end of social adversity.\textsuperscript{27} Haggerty, in a recent \textit{BMJ} editorial, is more explicit, allocating the role of the main coordinator to be ‘the provider with the most comprehensive knowledge, typically the general practitioner or the family doctor … What matters for continuity is that the designation and the role of the coordinating person should be visible to the patient and to others in the system.’\textsuperscript{28} Continuity of care is hampered, exposing the vulnerabilities of people with multimorbidities who are often elderly or not well-resourced. Good communication and sharing of information are needed.\textsuperscript{29} Good care needs trust between the clinician and patient, and trust between clinicians is needed to make care transitions useful.\textsuperscript{30} However, sensitive biographical information (eg, the disclosure of intimate partner violence) or, in other words, the patient’s narrative is not a value-free dataset to cut and paste from one organisation to another or from one relationship to another.\textsuperscript{31} Care coordination is therefore much more than time spent with the patient. It is also time spent for the patient and on behalf of the patient, which often involves the skilful work of dealing with the dynamics of incompatible information systems.

\textbf{THE POSITION OF ACUPUNCTURE AND THE ACUPUNCTURIST}

Where do acupuncture as a therapy and acupuncturists as therapists fit in the scenario? The situation becomes delicate at this point. Acupuncture may be delivered by high ranking or highly paid healthcare practitioners alongside their usual activities. It may be delivered by hands-on practitioners opportunistically or in specifically dedicated sessions. It may be employed as a personal out-of-pocket add-on therapy or as a third party-funded intervention. It can be enacted as a clinical procedure or as an act of interpersonal care. The price for needling intervention varies between £450 for a first episode of specialist care in a hospital environment and £25 for a nurse delivering the service in primary care. Acupuncture ‘comes in so many shapes and forms that it becomes almost impossible to take the presence of transdermal therapeutic needling as the common denominator for such a wide range of multidimensional interventions. It is therefore important to look at the other contextual effects influencing interaction and outcome. However, the enacted ritual of interpersonal healing involving touch and talk is a common characteristic for acupuncture in all its service manifestations.\textsuperscript{32} \textsuperscript{33}

\textbf{THE CHALLENGE OF MEASURING OUTCOMES: FROM SURROGATES TO PATIENT-RELATED OUTCOME MEASURES (PROMS)}

In contemporary medicine, acupuncture as needling therapy is only part of a multicomponent intervention. Depending on the skill mix of the practitioner and the profile of the organisation, the other components of the treatment may be empathic attention, support in behavioural change strategies, exercise therapy and so forth. Each intervention is part of a bigger intervention, like a set of Russian dolls. It is delivered as a component of a complex intervention which, in itself, treats a sub-problem of a person with more than one disease label or medical condition—that is, a patient with comorbidities. It is therefore difficult to attribute the effects of acupuncture to anything other than the index condition for which outcomes are collected. Wide variations in the individual relevance of certain condition-specific measurements of outcome plus the need to be inclusive and patient-specific make it difficult to collect meaningful information about the effects of acupuncture therapy, particularly if measurements have to be in a format that enables further statistical modelling. Practitioners of acupuncture claim that features such as sleep or general well-being improve as a collateral effect of the ritualised somatosensory stimulation therapy. Qualitative studies have gathered information from patients about the experience of being treated with acupuncture, an experience which includes much more than the needling effect itself.\textsuperscript{34}–\textsuperscript{36} The lack of quantitative data to support the claim that acupuncture does indeed have effects on the comorbidity burden may be a result of the absence of research trials that systematically gather data about outcomes in different organ systems over a meaningful period of time. The search for patient-generated outcome parameters led to the development of flexible questionnaires which allow patient-generated outcome criteria.\textsuperscript{37} Research has just been commissioned to develop robust outcome tools for musculoskeletal patient-related outcome measures (M-PROMs).\textsuperscript{38} Positive patient experiences in hard-to-reach groups with low socioeconomic status are reported.\textsuperscript{39} Metasyntheses of qualitative studies strengthen the position of the patients’ experience.\textsuperscript{40} Tension exists between individual minimally significant change and the set criteria for the (cost-)effectiveness of an intervention.\textsuperscript{41} Such tension reflects the differing interests of the stakeholders in third party-funded therapeutic relationships. Anecdotal reports and case reports frequently mention a reduction in drug consumption and polypharmacy, but too little is known to allow this claim to be validated with robust data. A recent Cochrane report about interventions to improve outcomes for patients with comorbidities does not include acupuncture as a possible intervention.\textsuperscript{42} Approaches geared towards reducing polypharmacy...
did not include acupuncture. A trial investigating the effects of five-element acupuncture on patients with mainly chronic pain and ‘medically unexplained symptoms’ reported improvements in subjective well-being and, on some occasions, lifestyle changes of participants, but no change in healthcare utilisation or quality of life measures.

HOLDING WORK: CO-CREATING HEALTH OR FOSTERING DEPENDENCE?

In conclusion, we see a contrast between the abundance of claims resulting from many years of delivering acupuncture in various therapeutic settings and the paucity of robust quantifiable information to support these claims. In order to establish whether acupuncture is a useful intervention for addressing comorbidities, studies of longer duration and with a different focus are needed. Comorbidities are considered to be long-term conditions. For acupuncture to become an effective part of treatment strategies addressing the comorbidity burden within the constraints of limited health budgets, studies would be needed to investigate the effectiveness and cost-effectiveness of interpersonal healing work alongside standard interventions in the management of interdependent chronic conditions associated with pain. This would categorise adaptive work, such as somatosensory stimulation, as part of maintenance treatment. Such research is in an early phase. Similar considerations take place under the rubric of ‘co-creating health’ in the field of self-management, which moves away from one-off interventions to supported self-management. describes the role of serial encounters in the ‘ultra-brief, ultra-long’ relationship between clinician and patient as a crucial part of generalist care in his landmark discussion paper on ‘Blue sky research’. Another consequence of a ‘Blue sky’ approach is to investigate the role of longstanding therapeutic relationships with a hands-on component. Very little is known about their combined effectiveness and the role of the relationship in itself to promote recovery or the ability to live with chronic illness.

Attachment theory provides a framework for the link between relationship styles and health. In a way all this raises the question whether the concept of ‘jollying along’ as a supportive, holding a relationship in situations such as chronic pain, could be reframed. Holding work, characterised as ‘affective management of people with longstanding chronic illness, especially mild-to-moderate depression and anxiety’, has been recognised as a substantial part of primary care. Acupuncture may also have a place in this concept. An acupuncturist in this context describes a person and a professional who engages with somatic and psychological aspects alike. This attention to interations of the body/mind environment to inform the treatment is already written down in the classic textbook on Chinese medicine, Neijing Suwen. The big question for resource allocation and health service planning is whether to build on multiskilled practitioners or on multidisciplinary teams in the community. Most clinical guidelines refer to the latter service model. The advantage of working with single practitioners with ‘extended scope’ is that it reduces fragmentation. The advantage of working with multidisciplinary teams is that greater specialist knowledge is available. Currently there are mental health workers such as Improved Access to Psychological Therapies (IAPT)/well-being practitioners trained in dealing with chronic pain as part of their competencies. Within physiotherapy, subspecialisation in chronic pain has been happening for some time. Again the question arises of where, in modern medical teamwork, acupuncture has its place? This can be the question for regulated healthcare practitioners on where to fit this added treatment component into their specified job description or it can be the question of where to add the acupuncturist as a complementing care professional. Is it about acupuncture or acupuncturists, the method, the professional role or the practitioner? Interpersonal healing rituals are part of any medical culture and are also present in biomedical encounters. Is it about deliberately adding the effects of healing rituals to enhance other treatment effects? Can acupuncture be part of chronic disease management, particularly in the context of pain disability?

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