INTERNATIONAL JOURNAL OF HEALTH PROFESSIONS
Volume 11, Issue 1, 2024, Pages 174–185, ISSN 2296-990X, DOI: 10.2478/ijhp-2024-0013

People with Chronic Pain in Switzerland: Patients' and Health Professionals' Perspective on Potentials of Outpatient Health Care

Menschen mit chronischen Schmerzen in der Schweiz: Perspektive von Patient:innen und Gesundheitsfachkräften zu Potenzialen der ambulanten Gesundheitsversorgung

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Received 30 August 2024, accepted 3 December 2024

Abstract

Introduction: Chronic pain is a complex social and health challenge, as it represents a life-changing burden. In outpatient healthcare, where clear structures and guidelines for interprofessional collaboration (IPC) are lacking, people with chronic pain (PWCP) and health professionals (HPs) encounter barriers. This study aims to identify the needs of PWCPs in the Swiss outpatient healthcare system and to compare these needs with the views of HPs.
Method: The study employed a two-phase qualitative research design. Phase one was a secondary analysis of seven narrative semi-structured individual interviews with PWCPs, while phase two involved transcribing and inductively analyzing three individual interviews and three focus group discussions with HPs.
Results: Inhibiting and promoting factors were categorized into five themes at the individual, social, and political levels from both perspectives. IPC was central to HPs, including physiotherapy, whereas PWCP focused on interpersonal aspects for successful treatment.
Conclusion: Complex clinical pictures with biopsychosocial effects require interdisciplinary approaches to meet the needs and requirements of PWCP and HPs and to achieve patient-centered treatment goals.

Abstract

Einleitung: Chronische Schmerzen zeigen sich als komplexe gesellschaftliche Gesundheitsherausforderung, da sie meist eine lebensverändernde Belastung darstellen. In der ambulanten Gesundheitsversorgung, wo klare Strukturen und Handlungsrichtlinien für interprofessionelle Zusammenarbeit (IPC) fehlen, stossen Menschen mit chronischen Schmerzen (MmcS) und Health Professionals (HPs) auf Hürden. Ziel in dieser Arbeit ist es, die Bedürfnisse der MmcS im ambulanten schweizerischen Gesundheitssystem aufzuzeigen und mit der Sicht der HPs in Bezug zu setzen.
Methodik: Basierend auf einem zweiphasigen qualitativen Forschungsdesign wurde in Phase eins eine Sekundäranalyse zu sieben narrativen semistrukturierten Einzelinterviews (EIs) mit MmcS inhaltsanalytisch ausgewertet. In Phase zwei wurden drei EIs und drei Fokusgruppengespräche mit HPs transkribiert und induktiv inhaltsanalytisch ausgewertet.
Resultate: Hemmende und fördernde Faktoren wurden auf individueller, gesellschaftlicher und politischer Ebene aus beiden Perspektiven zu fünf Themen kategorisiert. Die IPC war zentral für die HPs inklusive der Physiotherapie, wobei MmcS für eine gelungene Behandlung zwischenmenschliche Aspekte ins Zentrum rückten.
Schlussfolgerung: Komplexe Krankheitsbilder mit biopsychosozialen Auswirkungen verlangen nach komplexen, interdisziplinären Versorgungsansätzen, um den Bedürfnissen und Anforderungen aus Sicht von MmcS als HP gerecht werden zu können und um patient:innenzentrierte Behandlungsziele erreichen zu können.

Keywords

Chronic pain – Swiss outpatient healthcare system – Health professionals – DIPEx – Qualitative research – Interprofessionality

Keywords

Chronischer Schmerz – Ambulantes Schweizer Gesundheitssystem – Health Professionals – DIPEx – Qualitative Forschung – Interprofessionalität

INTRODUCTION

Chronic pain is a multifaceted health issue that profoundly impacts individuals, healthcare professionals (HPs), society, and the healthcare system. Chronic pain affects all aspects of life, including social relationships, economic security, and quality of life. The significant life changes caused by chronic pain require resources at both individual and societal levels to cope with the situation, as the affected person's ability to contribute socially is altered. Approximately 10%–40% of the global population is affected (Cohen et al., 2021).

In Switzerland, direct and indirect healthcare costs due to chronic pain are currently underreported (Das Schweizer Parlament, 2022). According to the Bern Pain Center, initial estimates on chronic pain go up to 10 billion Swiss francs (Schmerzzentrum Bern, 2023), with the 2007 cost estimates being 4.3–5.8 billion (Oggier, 25.07.2007).

According to the International Association for the Study of Pain (IASP), chronic pain is defined as a subjective painful sensation lasting more than three months (Treede et al., 2015). Since 2020, chronic pain has been an independent diagnosis in the newly introduced ICD 11 (Treede, 2021). However, the nationwide implementation of the International Classification of Diseases ICD 11 in Switzerland is still in progress (Swiss Pain Society, 2022). Physical, psychological, and social factors influence pain processing (Cohen et al., 2021), making interprofessional collaboration (IPC) essential due to the biopsychosocial model (Baker et al., 2010). IPC involves patient-centered, goal-oriented coordination of HPs with diverse backgrounds who learn from one another to address complex situations creatively and collaboratively (Meier et al., 2022).

Despite recognizing the importance of IPC at the national level and implementing strategies in training (Bundesamt für Gesundheit, 2020; Ulrich et al., 2020), Switzerland lags behind other countries in transforming its healthcare system to be more interprofessional. Particularly in outpatient care, the lack of organizational structures to support IPC results in reliance on the individual commitment of HPs (Benz et al., 2011; Weiss et al., 2022). Meier et al. (2022) emphasized the need for patient-centered care within IPC, where patients are included as equal members of the healthcare team to make joint decisions (Berchtold et al., 2020; Bundesamt für Gesundheit, 2020).

Most current studies focus either on the perspective of HPs or people with chronic pain (PWCP) (Al-Qadi et al., 2021; Berchtold et al., 2020; Weiss et al., 2022). Although isolated studies have combined deficits in the quality of care provided by specific professions with the perspective of PWCP (Michel et al., 2009), they often fail to address the IPC aspect. This study aims to bridge this research gap by exploring various aspects of inhibiting or promoting factors in the outpatient treatment of PWCP. The research question guiding this study is this:

What needs and concerns do PWCPs express regarding outpatient healthcare in Switzerland, including physiotherapy?

This study focuses on identifying potential improvements at different levels of outpatient healthcare in Switzerland. By comparing the perspectives of PWCPs and HPs on IPC, this qualitative research proposes initial solutions for enhancing outpatient healthcare.

METHOD

Research Design

A qualitative research design was chosen to gain insights into individual experiences and uncover the multifaceted dynamics of chronic pain (Ohlbrecht, 2019).

This study is connected to the *Database of Individual Patients' Experiences* (DIPEx) Switzerland project (www.dipex.ch), which focuses on the patient perspective (see Fig. 1). DIPEx International conducts studies in 14 countries using narrative interviews to systematically capture, evaluate, and make the experiences of individuals affected by various diseases accessible through online excerpts (IBHM, 2019). The procedure for data collection and processing is defined by the international network (www.dipexinternational.org) through a manual. This approach enables the capture of a transnational understanding of chronic diseases.

Samples and DIPEx transcripts

The seven transcripts used to analyze the PWCP perspective came from German-language, semi-structured narrative interviews from the Swiss DIPEx project module "chronic pain." Using a generalist guide developed specifically for the DIPEx project, three different interviewers conducted the interviews. All participants agreed to the interview and gave their permission for further data analysis. The interviews were based on the 2016 Declaration of Helsinki (World Medical Association, 2013). Demographic characteristics are shown in Table 1.

The underlying clinical picture was derived from the transcripts and not confirmed as a clear diagnosis comparable to a doctor's letter. However, the composition of the clinical pictures represents the population described in the literature (see Table 2). It fulfills the criteria for chronic pain formulated by ISAP (Treede et al., 2015), defined as inclusion criteria. In one interview, the pain duration was described as "for several years," while in the others it could be deduced.

Three online focus group (FG) discussions via Zoom or MS teams with 4–5 HPs from different healthcare

Table 1: Sociodemographic characteristics of participants.

Variable		PWCP (n=7)	HPs (n=10)
Gender	Male	2	3
	Female	5	7
Age group	< 30	0	3
	30-39	0	1
	40-49	4	3
	50-59	2	2
	>60	1	1
Place of residence	Zurich	5	4
	Aargau	1	1
	Zug/ Lucerne	0	3
	Berne/Solothurn	1	2
Highest education	Tertiary	5	7
	Secondary	2	3
Nationality	Switzerland	1	*n/a
	Other	6	*n/a
Occupation	Yes	6	10
	No	1	0

Table 2: Clinical picture and interview duration of the DIPEx transcripts of the PWCP in the study's first phase.

PWCP (n=7)	Clinical picture	Pain experience in years	Interview duration in minutes
Interview 1, PWCP	Neuropathic pain due to back injury	*n/a	88
Interview 2, PWCP	Rheumatoid arthritis	45	89
Interview 3, PWCP	Tumor resection	10	49
Interview 4, PWCP	Whiplash	1	79
Interview 5, PWCP	Fibromyalgia	5	85
Interview 6, PWCP	Neurogenic pain due to back surgery	20	106
Interview 7, PWCP	Migraine	20	91

professions were planned for the second analysis. The inclusion criteria for the HPs were more than two years of treatment experience in the outpatient healthcare sector with regular contact with PWCP and more than 50% of the workload of patients. HPs from the basic insurance sector (BIS), supplementary insurance sector (SIS), and the area of individual health services (IHS) were included to meet the requirements of the IPC in outpatient care. Working in hospitals and day clinics specializing in chronic pain were defined as exclusion criteria, because they have organizational structures for IPC regulation that are lacking in the outpatient setting (Weiss et al., 2022). A semi-structured guide was created for the data collection of the FGs and individual interviews (IIs), which was shaped by the initial results of the secondary analysis of the PWCP transcripts (see Appendix 1). The interviews aimed to compare the views of the PWCP with those of the HPs to obtain as multifaceted a representation of the topic as possible (Zwick & Schröter, 2012). The study supervisor reviewed the guidelines. One pilot FG was conducted to test the guidelines.

Recruitment

In an initial recruitment phase between October 2022 and January 2023, approximately 50 HPs specializing in chronic pain in Switzerland were contacted via an internet search and the researchers' existing network. Three rejections were received due to lack of time; otherwise, no feedback was received. Four HPs were recruited through the researchers' outpatient practice network. Due to the limited response rates, it was decided in consultation with the principal investigator to allow smaller groups for the focus groups and to conduct additional individual online interviews. In the second step, 15 HPs were contacted via LinkedIn from February to April 2023. Seven participants responded. This resulted in three FGs and two IIs. One FG with three participants was not included due to a technical malfunction. One HP from this FG agreed to participate in a 10–15-minute addendum. This II was included in the analysis material. Supplementary 10 HPs were contacted in June and August 2023. One more FG with two HPs was conducted; see Table 3.

Data analysis

In the first analytical step, the perspective of the affected PWCP was analyzed using the thematic content analysis of Clarke and Braun (2013) and was inductively analyzed and categorized regarding the research question as part of a secondary analysis. The identified categories were extracted from the generalist DIPEx transcripts and summarized into overarching themes from the PWCP perspective. In the second step, six interview recordings of the FGs and IIs from the HP perspective were simplified using MAXQDA according to Dresing and Pehl (2018) and analyzed identically as in phase one. A peer debriefing was conducted to ensure validity. The study by Hollederer and Wildner (2015), which was found through a relevant literature search on the topic of *needs* and *health ethics aspects* in various databases (Google Scholar, PubMed, CINHAL), served as a template for the structural framework concept of the macro, meso, and micro levels, into which the content-analytical topics were deductively classified (see Fig. 1).

Table 3: Composition and duration of the FGs and IIs of the interviews with the HPs in the second phase.

HPs (n=10)	Professional group	Professional experience in years	% Proportion of treatments with PWCP	Interview duration in minutes
Interview 8	Physiotherapy Physiotherapy Physiotherapy	7 2 2	30 20 30	59
Interview 9	Physiotherapy	*4.5*	*30*	50
Interview 10	Physiotherapy Psychology/Hypnosis	33 18	15 60	60
Interview 11	Hypnosis	20	50	57
Interview 12	Traditional Chinese Medicine	23	50	10
Interview 13	Occupational therapy Naturopathy	*N/A 4	*n.a. 30	59

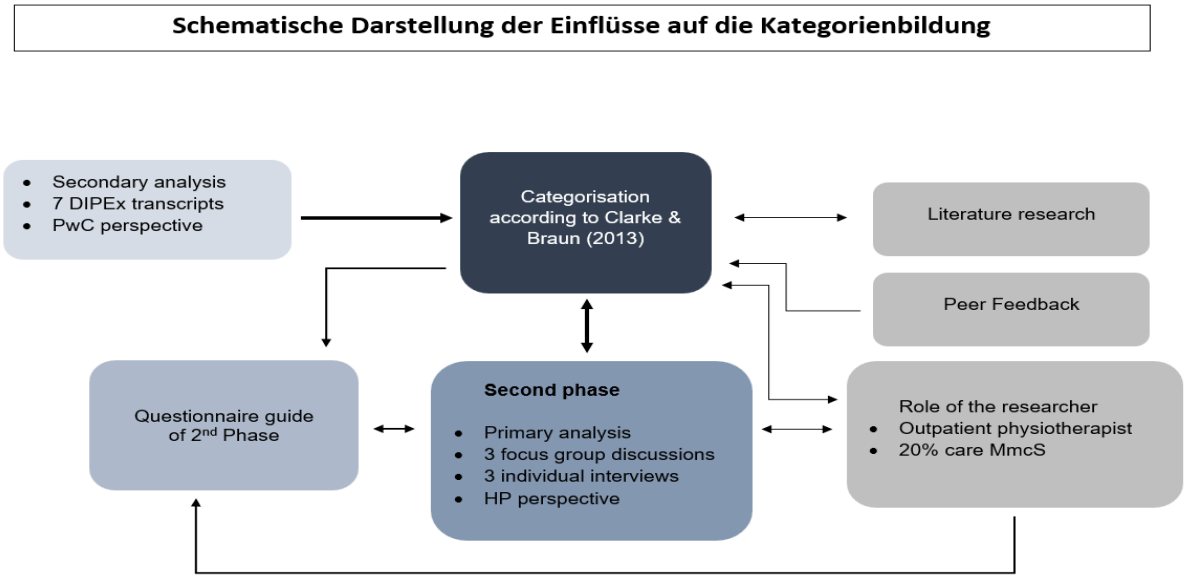

Figure 1: Influences on thematic categorization, including the researchers' influence due to their profession as physiotherapists.

Superordinate topics relating to the healthcare system were assigned to the macro level. Topics relating to the network of outpatient HPs were assigned to the meso level, and topics associated with HP–PWCP interactions were assigned to the micro level.

The quality of the present study is determined by the data triangulation and the investigator triangulation. The DIPEX interviews were conducted by different interviewers, thus balancing out subjective influences (Flick, 2014).

Ethical considerations

This study explores the needs of PWCP concerning healthcare and the derivation of initial solutions. According to the Cantonal Ethics Committee, studies with respondents using a qualitative research design are not subject to ethical–legal assessment and receive a declaration of nonresponsibility (Kantonale Ethikkommission Zürich, w.D). The project is linked as a subproject (nested project) to the Swiss DIPEx study, which has received nationwide ethical approval (BASEC Req. 2018-00050, CEBES internal Ethics Review Board IBHM UZH). In both surveys, the study objective, content, voluntariness, and anonymization were explained to the participants using a study information sheet. Written and verbal consent was obtained for data collection and processing.

Data protection

The data protection of the DIPEx project is guaranteed by internal data management guidelines for quality assurance. This regulates the anonymization of participants and data management. The researchers must sign a confidentiality agreement that prohibits the disclosure of personal data.

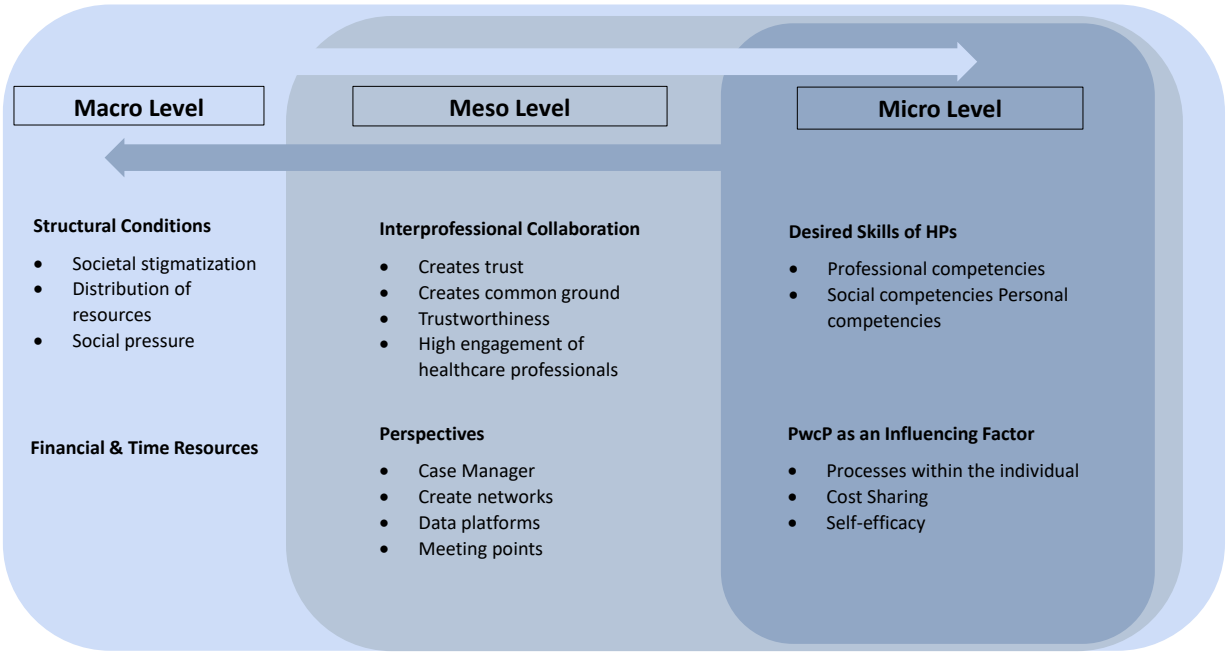

Figure 2: Macro, meso, and micro levels in Swiss outpatient healthcare from HP and PWCP perspectives.

The same security methods were used for the second survey.

RESULTS

The thematic content analysis revealed five main themes from four perspectives (see Fig. 2) that identified both inhibiting and promoting factors affecting chronic pain care in the outpatient healthcare system. The analysis showed that political, social, intrapersonal, and interpersonal factors influence the concerns and needs of PWCP as well as the scope of action of the HPs.

The analyzed inhibiting and promoting factors were divided into the healthcare system levels (see Fig. 2) and provided a basis for deriving the potential for outpatient care, as the levels influence each other. The influence of the higher level on the lower levels was perceived more clearly by the HPs than by the PWCP.

> Healthcare as it is at the moment is making people ill. Turning it back is difficult. Nevertheless, as a therapist, you have to be prepared to jump over your own shadow and try to change the system from within. If we don't do that, just massage and say: "Yes, we're trying." Then we won't get anywhere. It takes a lot of proactive therapists who try to network. We therapists need to have the self-confidence to talk to doctors. (Interview 10, HPs, pos. 42)

The following chapters intensively discuss the individual levels and their interrelationships.

Macro-level analysis

Two main categories were identified at this level: the structural conditions with which the HPs and PWCP have to come to terms, as well as the financial and time resources that influence their respective decisions and perceptions. The category of *social stigmatization* was assigned to the thematic area of structural conditions. The PWCPs and HPs reported that the psychological level, in particular, leads to stigmatization in the case of chronic pain. The PWCPs reported that they did not feel taken seriously due to psychological factors. However, one person reported the importance of these psychological triggers, as the psyche played a role for them due to their long illness.

In addition, *social stigmatization* was identifiable with the perception of illness behavior. In the DIPEx interviews, PWCP reported that certain behaviors were expected by insurance agencies, individual HPs, and the social environment. If they continued to work and participate in social life, their illness was denied by their environment, as pain is not visible to others from the outside.

> I: Have you personally experienced prejudice?
> N: That they don't understand if you take the elevator, or that you don't swim or ride a bike. They said you have to move more. You have to motivate yourself and then you'll be fine. [...] But it's difficult to fix that. [...] Now the additional blood tests are available, so you can search. The fact that health insurance doesn't pay for it because it's not the standard should

be opened up because it could help other people too. [...] I think it's a shame that conventional medicine has paragraphs, and you don't go left and right. (Interview 5, PWCP, pos. 115–118)

Text passages on stigmatization are closely related in terms of content to coding for the category of social competence in the topic area of HP skills at the micro level. Furthermore, the text passages on stigmatization in some interviews coincide with the categories in the topic area of *financial and time resources*.

In the category of social pressure, the categories of *hierarchy* and *providing evidence to payers* were included. The above interview passage shows that the health insurance company pays for certain standards. In the interviews, the HPs and PWCPs reported on the standardized presentation of evidence to the health insurance company. Some of those affected reported that this evidence was too restrictive and had a sanctioning effect if they tried to continue their lives in pain.

The analysis of the HPs' interviews revealed that the hierarchical structure at the macro level impacted IPC at the meso level. The HPs noted that chronic pain is rarely diagnosed and that relevant diagnoses are often excluded from prescriptions, with biomechanical diagnoses such as neck pain being more commonly documented. One FG discussed the difficulty of addressing the issue of diagnosis with the medical professions, as they were above them due to the hierarchy. This has a significant impact on the macro level of *financial and time resources*. Passages were identified that show that inadequate diagnosis leads to recurring examinations, which results in a prolonged course of treatment for PWCPs. In the interviews, the HPs talked about changes in examination techniques and approaches, as well as reduced financial reimbursements by the BIS. This results in a time limit for physiotherapists for economic reasons. One physiotherapist described the situation as follows:

> If chronic pain was on the diagnosis, the diagnosis would be different. I imagine it's like dizziness, where we have a different way of diagnosing. And that would be what saves us time. (Interview 8, HPs, pos. 37)

In the analysis, a comparison could be made concerning the time resources of BIS and SIS/IHS. The HPs from the SIS/IHS reported more time resources than the HPs from the BIS. The subcategories in the time resource often coincided with the subcategories of social competence in the skills area of the HPs at the micro level. For example, the PWCPs reported that they felt taken more seriously, that they were seen more as individuals, and that the treatment was patient-centered. They felt that they were examined more closely with more therapy time.

Meso-level analysis

Three main categories were identified at the meso level. Transcript analysis based on the HP perspective revealed a lack of networks and structures in the area of IPC in outpatient care. Individual text passages about the IPC were identified in the DIPEx interviews with the PWCPs.

Promoting factors of the IPC

The IPC is considered by all HPs to be a crucial factor in the effective treatment of chronic pain. It promotes trust in PWCP treatment and common ground between HPs, which in turn strengthens trust. These advantages can lead to joint treatment planning that is individually tailored to the goals and needs of those affected. One participant from an FG summarized this as follows:

> We are all equal. The hierarchy is flat. We need all the skills for the people and hypnosis can also help, for example, to improve the mindset. We need to work together much more than saying: "If this doesn't work, the next person in line will." It's not about the line, it's about the patient's needs. To gather strength, specifically directed and individualized. (Interview 10, HPs, pos. 54)

Inhibiting factors of the IPC

The issues of *trustworthiness* and *commitment* were identified as inhibiting factors.

The HPs reported that IPCs require a high level of commitment because they work in separate locations. Currently, no structures support collaboration, as seen in inpatient care, and financial compensation is lacking for time spent on activities such as phone calls or meetings.

> Communication is difficult plus it's not paid for in physiotherapy. That makes it even more difficult. I could sit here for two hours a day and send emails, but the effort is relatively high for the fact that the return is not great at the moment. (Interview 9, HP, pos. 39)

The analysis showed that effective communication is essential for IPC to work, requiring HPs to rely on each other. However, the interviews revealed mutual prejudices among HPs that complicated IPC. In particular, SIS/IHS HPs face prejudices from BIS HPs against their professional group.

> I still work in a practice with two or three doctors. One is from the old school. He makes fun of me when I talk about hypnosis. [...] and what I see is that our training in the medical world is becoming more and

> more specific, [...] GPs are broader, but specialists are extreme. Their small area and that's it. (Interview 11, HP, pos. 38)

As illustrated in this passage, the medical profession is also subject to prejudice. Both PWCPs and HPs described the medical profession as having too little time and a tendency to focus solely on biological parameters, which hinder care within a comprehensive biopsychosocial model. This highlights the need for IPC to address the expressed needs from the PWCP perspective.

Perspectives

Beyond physical proximity, joint meetings, and the creation of networks, most HPs require one person to take the lead in joint coordination. Case managers should maintain an overview of the treatment and collaboratively plan the next steps in the treatment pathway with the treating HPs and PWCPs. One PWCP in the DIPEx transcripts mentioned positive experiences with this model. Furthermore, one HP requested that a shared data network be created so that previous testing and diagnoses were not lost, thereby simplifying PWCP identification in the early stages. One HP, who works in a large practice with different professions, reported a high level of interprofessional reliability due to increased communicative exchange because of physical proximity and regular meeting points, such as team meetings. The present study showed that IPC can also be promoted through virtual spaces. The two FGs with multiple professions reported more positive interactions than the FG and II with a single profession.

> We are all working for the patient, but there is no structure. We had a meeting with the university last week with the doctors. [...] They went to different places to see how interprofessional work works. It came out that intensive care units or neurological rehabilitation, where you can build this up wonderfully, where the exchange takes place. [...] In the chronic area, where everyone is treated on an outpatient basis, we have no structures that organize interprofessional work. There is a round table because it is not possible in the setting. That's not pleasant from the patient's point of view. You have to decide for yourself what you believe and how you bring the different images together so that you get a whole picture that contributes to the positive. (Interview 8, HPs, pos. 42)

Micro-level analysis

The micro level comprises personal needs and barriers to healthcare for chronic pain at both the PWCP and HP levels. At the micro level, six main categories were identified for the two perspectives, which are interrelated – with each other, and with the macro and meso levels (see Figs. 2 & 3).

Self-efficacy

Self-efficacy is a desirable goal in chronic pain treatment from both the PWCP and HP perspectives. Building an understanding of the disease during its course is essential. By understanding their illness, PWCPs have more influence on their pain and learn techniques for self-regulation. More initiative and more responsibility for one's health were seen as promoting factors in the texts. Categories from the macro and meso levels, such as incorrect diagnosis, disagreement between professions, and too much biomechanical thinking, were perceived by the HPs and PWCPs as inhibiting factors on self-efficacy. In some places, the PWCPs reported that their self-efficacy was inhibited because HPs assumed that they were simulating their disease state, chronic pain. They had to actively defend themselves against HPs or make a change in the care team.

Cost sharing

The PWCPs reported that financial decisions influenced treatment choice. As a result of macro-level *evidence management vis-à-vis payers*, which is perceived as too strict by the PWCPs, treatment options are restricted. Therapies from the SIS and IHS must, in some cases, be financed independently. The PWCP's financial decisions are always weighed against treatment benefits.

> The question is how much have I thrown out of the window and how much has been used. I can afford it. [...] I don't know what it would be like if I hadn't done it at all. (Interview 3, PWCP, pos. 74-76)

The HPs explained that financial participation in healthcare promotes greater self-responsibility and thus greater self-efficacy among PWID.

Processes in the individual

The interviewees described the course of health as a process. Depending on the phase of PWCP, factors can be identified that either promote or inhibit therapy. Trust in the other person and the hope of finding an explanation for the symptoms or achieving relief are promoting factors. The DIPEx transcripts revealed that PWCPs isolate themselves, become resigned to their state of health, and lose their zest for life.

Numerous therapies and examinations lead to therapy fatigue and frustration over time, which have an inhibiting effect on therapy. The category of *dealing with the other*

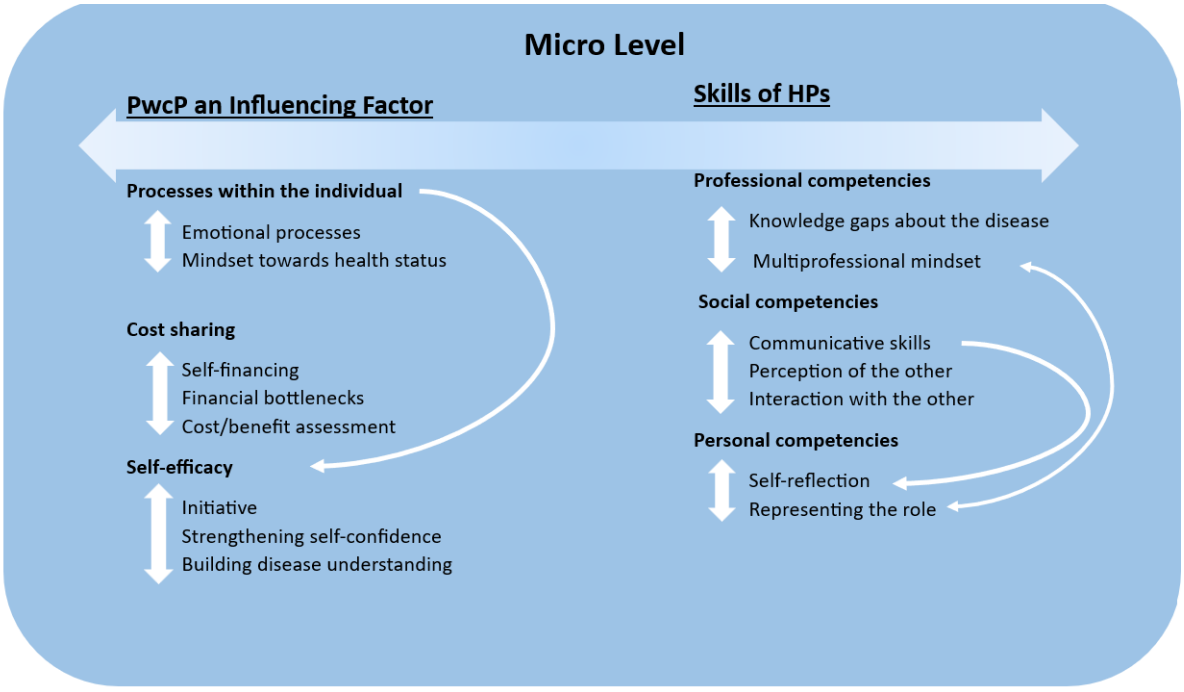

Figure 3: Micro level: Inter- and intra-personal relationships to PWCP concerns and needs.

person and *perception of the other person* in the topic of *social skills of HPs* is closely related to the processes in the individual. For example, HPs and PWCPs reported that the latter felt mistreated when their treatment was not adapted to their internal processes.

The time and energy resources of the PWCPs are described as limited, with the majority being used for therapy and work. Some PWCPs reported that social withdrawal is a strategy and thus part of their self-efficacy. By consciously choosing social contacts and events, energy resources can be better organized. Other passages show that this limitation of social contact has a negative impact on their environment and psychological state.

> HP: Many are isolated and no longer feel that they are taken seriously. That someone listens to them and is there for them. That's good on a psychological level.
> I: What do you think are the reasons that they are isolated?
> HP: Because they are ashamed of their complaints and don't want to talk about them, or that everyone asks: "Hey, why do you still have crutches?" [...] Not having to explain yourself when you're alone at home. (Interview 9 HP, pos. 86-90)

Professional competence

In the area of professional competence, the categories of *interprofessional mindset* and *knowledge gaps were* identified. The category of interprofessional mindset includes passages that emphasize working across different topics and knowing when to refer a person to another professional. In the PWCP DIPEx transcripts, HPs are not expected to treat every condition. Instead, PWCPs expect HPs to offer assistance in taking further steps in their treatment. This category is closely linked to dealing with others through social skills and communication.

> Meet people where they are. That sounds simple, but the more specialized people are, the more difficult it becomes. So, I think that's important. With autoimmune polyarthritis, the psyche is also important. (Interview 2, PWCP, pos. 90)

In the interviews, physiotherapists expressed differing opinions on how extensively a specialist should cover all areas of the biopsychosocial model. They reported that communication and coaching were insufficiently taught in their basic training, resulting in certain aspects of the biopsychosocial model being addressed only through further training or self-study. The analysis also showed that regarding the clinical picture of chronic pain,

knowledge about the standard procedure (anamnesis, examination) and the application of the biopsychosocial model was insufficient. The HPs mentioned that colleagues who feel insecure often take refuge in the biomechanical model. The correct diagnosis of chronic pain according to ICD 11 does not yet work properly. This, in turn, has an impact on their financial and time resources at the macro level.

Social competence

Both HPs and PWCPs consider the social skills of HPs to be a key component of treatment. The topics of *perceiving the other person*, *dealing with the other person*, and *communication* were identified.
The categories of *communication* and *dealing with the other person* are closely related. The HPs and PWCPs reported that the latter felt taken seriously and acknowledged when the appropriate words were used. Establishing a connection with the category of *self-reflection* was also possible.

> Communication is important in the therapeutic relationship. We know that this makes a big difference to the success of therapy. It is even more important for chronic pain patients because they often have the feeling that they are not being taken seriously or are being left alone. (Interview 9, HP, pos. 96)

Two FGs discussed the importance of communication in chronic pain treatment and the fact that quality is limited by language barriers. Essential aspects of treatment, such as agreeing on goals and providing information about pain, which were frequently discussed in the interviews, cannot be communicated satisfactorily as a result. However, these aspects are closely linked to self-efficacy.
The category of *dealing with the other person* focuses on treating each other with mutual respect, believing what is said, and acknowledging the situation. At the macro level, the social stigmatization that the PWCPs have to deal with is recognizable. These stigmas concern the psychological level and society's perception of one's behavior in the face of pain and findings that cannot be clearly objectified. To achieve this, HPs must open up to PWCPs and engage with them without adhering to their usual treatment patterns. Two HPs reported that being affected by chronic pain enabled them to gain a deeper understanding of the situation. PWCPs expect to be seen as individuals rather than being treated according to a standardized grid system. Here in particular, a discrepancy is perceived in the medical professions, whereby the PWCPs assume that this arises due to the requirements and specifications of the health insurance company and the time pressure at a macro level.

> Starting with the computer on the table when you come to him, and he looks at the computer first. If you experience it differently, you notice that it just makes a difference. Then some exceptions don't do that. You like going to them because they look at you first. (Interview 2, PWCP, pos. 37)

HPs want to meet on an equal footing and wish for an open and honest approach. From HP's viewpoints, clarifying the assignment, defining their competencies, and clarifying their expectations have a positive effect on their dealings with the other person. They say that honest and open communication is essential at the beginning, as the pressure on the HPs can be reduced and the PWCPs gain more self-determination by consciously deciding on the therapy. In some places, the PWCPs were dropped because the HPs had reached their limits, as no further referral, or evaluation, or action meeting existed. This markedly deviates from what PWCPs and HPs hoped for in the interviews concerning treatment.
Social skills are particularly influenced by time resources from the macro level. For example, both HPs and PWCPs mentioned that the latter felt more valued when more time was given to them. The comparisons in the interviews also clearly show that more time is taken for individual PWCP in the SIS area than in the BIS area.

> I'm currently working in two different practices. In one, I can organize my therapy time myself [...] In the other, it's a three-quarter-hour rhythm and I have to do everything that comes up somehow. Just this small difference makes a difference in time management. How can I meet the other person? How much space I can give something or how firmly I have the feeling in the conversation, in the process, that I have to structure it so that I get somewhere in this time. (Interview 13, HPs, pos. 72-73)

Personal competence

The personal competence that HPs should demonstrate is about the ability to self-reflect and be able to represent one's role model. These two components are required for honest and open communication. In addition, understanding their role is essential for HPs to be aware of what they can offer therapeutically and where their limits lie.

> What you do with the basic training is to some extent a question of interpretation. It depends on what

kind of team you meet. What tools do you need in everyday practice and in which direction you will develop once you have completed your training? That's a difficulty, but also a great opportunity, which I appreciate about my profession. [...] I can lean out when I know where my strengths lie. Where do I have to redirect, where do I have to set boundaries, where is it no longer professional? (Interview 13, HPs, *pos. 85)*

DISCUSSION

This study aimed to identify PWCP needs and concerns in the Swiss outpatient healthcare system and compare them with HP perspectives in the context of IPC. Suggestions from various perspectives are presented to highlight potential improvements in the quality of care. Based on the present results, an initial overview of the situation regarding the outpatient treatment of PWCP in Switzerland is provided, and fields of action are identified at various levels, including social, political, interprofessional, intrapersonal, and interpersonal aspects.

Overarching *social structures* as well as *financial and time resources* influence the decisions and perceptions of HPs and PWCPs. The need for IPC proved to be more important for HPs than for PWCPs. The needs of the PWCPs focus on the *skills of the HPs*, whereby a major part of the required concerns was directed at social skills, specifically *communication*, *dealing with the other person*, and *perceiving the other person*. The identified topics were categorized into the macro, meso, and micro levels of the Swiss healthcare system, allowing initial correlations between the levels and the present study to be identified.

A current example from outpatient physiotherapy will be used to illustrate these connections between the macro, meso, and micro levels of Swiss healthcare. The Federal Council's new proposal, which sets a time limit for physiotherapy sessions (Bundesrat, 2023), leads to differentiated tariff sessions of 45 minutes for "complex" and 30 minutes for "simple" cases, depending on the medical diagnosis. ICD 11 was published by the World Health Organization (WHO) in 2020 but is not yet mandatory in Switzerland (Swiss Pain Society, 2022). The inaccurate differential diagnosis of chronic pain was identified in the results as an untapped potential that could be used to save time and financial resources and reduce the previously unremunerated commitment of HPs.

Weiss et al. (2022) demonstrated that a high level of commitment is required from HPs in the outpatient sector for IPC and that organizational structures are necessary. Despite the official recognition and support of the role of IPCs by the federal government (Bundesamt für Gesundheit, 2020; Fedlex, 2023), the federal bill on physiotherapy intervention reveals a contradiction in that it is aimed at simplified reductions in healthcare cost growth (Bundesrat, 2023). Such a bill would further increase the existing strong commitment to physiotherapy in PWCP care, as financial and time resources are limited at a national level and implemented in an oversimplified manner.

However, the results of IPC are not the only findings that align with scientific studies from Switzerland. A study conducted by the Federal Office of Public Health (FOPH) found similar results regarding the skills of HPs (Berchtold et al., 2020), wherein the patients identified "holism," "sympathy/empathy," "transparency and comprehensibility," and "interface management" as key topics they demand. The importance of social and personal skills also played a role at the national level. In 2020, for example, these were defined as part of the Federal Health Professions Act (Fedlex, 2023) for Swiss universities.

Another essential point in the study was that the PWCPs themselves act as an influencing factor in their care. Kieselbach et al. (2023) already identified a dynamic process within PWCP in the course of the disease history and claimed that a different prioritization in PWCP care arises depending on the temporal course of the disease. This can be supported by the available results, which provide evidence that incorrect prioritization can set PWCP back in the course of their health. In particular, self-efficacy, which is an essential component of the health competence of PWCPs, influences the state of health (Careum, 2021). The *Health Literacy Survey Switzerland 2019–2021* showed that self-management skills are limited in people with poor health, low social status, a financially precarious situation, younger age groups, and little social support in Switzerland. This correlation can also be found in the present results regarding factors influencing PWCP care.

Core communication skills are essential prerequisites for conveying health-related information, which in turn determines health literacy. The present study demonstrated the importance of communication in relation to understanding illness and self-competence, corroborating the findings of Careum (2021) on health literacy.

Thus, this study acts as an essential link to show the different levels and aspects of outpatient care for PWCPs. The comparison of different perspectives and the inclusion of clinical pictures relevant to chronic pain is a strength of this qualitative study, as it enables a meta-perspective on the complex topic and care situation of chronic pain in Switzerland.

LIMITATIONS

The perspective of the surveyed PWCPs is broadly diversified regarding their healthcare needs and accurately

reflects the population with chronic pain. In contrast, the HP perspective is predominantly represented by the professional physiotherapy group, as other professional groups were less successfully recruited for the survey. One possible reason for this recruitment imbalance could be the physiotherapeutic background of the researchers involved in this interdisciplinary topic. Another reason is the lack of time for those invited to participate in the survey, as indicated by the feedback. This lack of time due to an already increased commitment can be substantiated with the present results. The situation in the medical profession could only be inferred indirectly from the perceptions of the participating HPs and PWCPs. In a further step, the viewpoint of the medical professions would be essential, especially as they are confronted with sometimes negative experiences on the part of the PWCPs, including prejudices. The perspective of the medical professionals would be highly relevant for the result completeness, and concerning the complex requirements of patient-centered care.

The FGs, some of which included only two HPs, could only partially reflect the symbioses between different healthcare professions. Larger groups are necessary to make precise statements about the interactions between HPs in an outpatient IPC setting. A further limitation lies in the everyday and generalist survey of the mostly narrative DIPEx-IIs from the PWCP perspective. This limitation meant that not all relevant aspects of outpatient care were covered in depth. However, the study demonstrated that the IPC has so far occupied little space in the lifeworld of PWCPs, whereas interpersonal issues are more relevant. Notably, Berchtold et al. (2020) indicated that PWCPs notice a lack of IPC. The impact of IPC on PWCP care in the outpatient setting has not been sufficiently clarified. The results indicate that further studies are needed to explicitly examine the structuring of IPC at the outpatient care level in the Swiss healthcare system.

CONCLUSION

The area of chronic pain is a complex construct that, depending on the approach taken, offers different options for potentials in outpatient healthcare. The psychosocial aspect of treatment appears to be an essential building block for trust and cooperation with the other person. The biopsychosocial model is well established in science, training, and among HPs, particularly concerning chronic pain. However, its implementation in outpatient healthcare remains limited, partly due to the lack of differential diagnostics. Untapped potential remains regarding IPC, both in organizational structures and in possible time and financial compensation models. The communicative skills of HPs are essential in PWCP healthcare, both for IPC and for promoting health literacy among PWCPs (Careum, 2021).

CONFLICTS OF INTEREST

None.

ACKNOWLEDGMENTS

Our thanks to the PWCPs and HPs who took the time to share their views on the healthcare sector. Our thanks also go to the Digital Health Design Living Lab (DHD LL) as part of the structural development of inter-institutional collaborations based on the Zurich digitization initiative. Furthermore, we would like to express our gratitude to the Digital Health Design Living Lab (DHD LL) for their contribution to the structural development of inter-institutional collaborations based on the Zurich Digitization Initiative.

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