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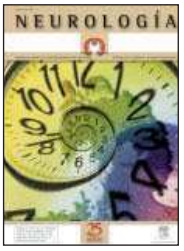

EDITORIAL

Efficiency of specialist clinics. On the article "Assessment of the efficiency of the clinical management of neuropathic pain in specialist clinics compared to general clinics in neurology health care units in Spain"

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Abstract
With reference to the article "Assessment of the efficiency of the clinical management of neuropathic pain in specialist clinics compared to general clinics in neurology health care units in Spain" by Matias-Guiu et al., a reflection is made on the methodological and operational difficulties of working with results in health, quality of life or costs in something so subjective as pain, and its impact on daily life. It then highlights the importance of the decision to establish a specialist clinic or other type of specific care team for neuropathic pain, adding another level of care. Some points are given for the analysis of that decision.
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PALABRAS CLAVE
Dolor neuropático;
Resultados de investigaciones;
Gestión del dolor;
Medición de los resultados del tratamiento del dolor

Eficiencia de las consultas especializadas. A propósito del trabajo "Evaluación de la eficiencia del manejo clínico del dolor neuropático en consultas especializadas frente a consultas generales en unidades asistenciales de neurología en España"

Resumen
A propósito del trabajo "Evaluación de la eficiencia del manejo clínico del dolor neuropático en consultas especializadas frente a consultas generales en unidades asistenciales de neurología en España" de Matías-Guiu et al, se hace una reflexión sobre las dificultades metodológicas y operativas de trabajar con resultados en salud, calidad de vida o costes en un tema tan subjetivo como es el dolor y su impacto en la vida diaria. A continuación se destaca la importancia de la decisión de establecer una consulta monográfica u otro tipo de dispositivo asistencial específico para el dolor neuropático, incorporando un nivel más a la asistencia. Se dan algunas claves para el análisis de esa decisión.
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The article "Evaluation of the efficiency of clinical management of neuropathic pain in specialized consultations versus general consultations in neurology care units in Spain", by Matias-Guiu et al.[1], is innovative and courageous in raising the study of the efficiency of intervention as its primary objective and, moreover, does so in a subject as difficult as pain. Its reading is very interesting and we believe it deserves some comment and reflection.

As the authors acknowledge, the study has some limitations due to the number of cases, its retrospective nature or the difficult homogeneity of the samples and interventions in both groups. However, this study gives us the opportunity to open a debate on very important issues:

1. The methodological and operational difficulties involved in working with results in health, quality of life or costs in a matter as subjective as pain, and its impact on everyday life.
2. The analysis of the decision to establish a specialist clinic or another type of specific care team for neuropathic pain, incorporating one more level of care, which is (or should be) a prime organisational decision in a service.

The first question raised highlights the difficulty of measuring costs and outcomes multidimensionally, using validated scales that reflect the experience of pain (subjective) and its interference in patient welfare and daily activities (largely subjective) and individual performance (mediated by each patient's circumstances; for example, depending on employment status or family support, etc.).

Costs are approached by distinguishing direct and indirect costs, the latter being calculated according to the social approach or "bottom up" approach. This entails assigning as indirect costs the activities the patient has to stop doing and the income forgone by the impairment represented by the disease, with the difficulty of delimiting which concepts should be included and how measuring them is made operational[2,3]. In this sense, the article in question raises an outlook that should be a reference and used as a comparison for those made in future. It therefore represents an important methodological contribution.

In addition, there is an effort to evaluate aspects of care very relevant to the patient in this situation, such as accessibility, delay in assessment and treatment, and satisfaction with the doctor. We do not believe that in a specialist pain clinic these two issues can be considered to be independent. Accessibility - defined as the possibility for patients with neuropathic pain to obtain care without undue delay when required - is not just an objective, but may itself be part of the treatment and influence the results. Having a prompt appointment with a trusted doctor can avoid, to a large degree, anxiety and self-medication and may even have a placebo effect[4]. In a specialist clinic or unit, delay in care is related to how it is linked with the other levels of care. This brings us to a second reflection, which should be expressed and thought about before considering the implementation of a specialist clinic or unit at our centres: the need for it and the importance of managing referrals between levels of care.

We wish to clarify that we are not talking here about two specific situations, which lead to two affirmations on our part. The first is that the pain units at our centres should be truly multidisciplinary and include a neurologist[5]. The second is that directing cases to neurostimulation and, in general, to neurosurgical procedures for pain should be carried out by super-specialised neurologists. In highly specialised clinics or units, the key to efficiency is correctly selecting and monitoring cases (as in epilepsy surgery or movement disorders).

Leaving aside these two situations that need a specialised consultation, the question is whether the specialist clinic or unit being considered is necessary; that is, does it add enough value to the existing situation to justify its implementation, what is the opportunity-cost involved and is there not a more efficient way to meet this need?

At least two alternatives can be considered to improve the care of neuropathic pain or any other disease: *a*) improving management by the general neurologist, including training and organisational improvements, and *b*) stratifying the offer, setting up care steps with criteria for referral between them, in which the lower step would be the general physician and the higher, a specialist clinic or a multidisciplinary pain unit where the neurologist is present. These two approaches are not mutually exclusive. Indeed, it will always be necessary for certain cases (the "simpler" ones) to be seen in the general consultation and for referrals to the specialist to be chosen. The selection of arriving cases is always the key to the smooth running of a specialist clinic. If the general neurologist does not have adequate training or if the referral criteria are not well established, then care, testing and treatment will become doubled. There will be a selection of cases at the highest-level consultation, sliding towards physician interests (cases that are attractive from the point of view of research, teaching, recommendations, medical staff and relatives, etc.) and not towards patient needs. The highest level consultations, in the public and private sectors, are attended by patients with a higher economic and cultural level rather than by those who need it most, as would be expected. This has been demonstrated by our own experience as well as in the literature on usage studies in our own country and other developed ones[6,7].

When the quality of care provided and the costs are equal, opening a specific clinic can be justified. This should be based on non-care benefits (teaching, research), for which it is also necessary to be very clear about the criteria for referral in both directions (case selection). Research often requires achieving homogeneity of care and a sufficient volume of cases, which leads us to the following conclusion: they must be few, have a sufficient case mix and have a clear area of referral.

In summary, we believe that neuropathic pain units should be proposed, as long as they are few in number, with a clear referral area, for selected cases, having protocols and criteria for referral to specialists and care levels, are a focus of research, training, management and monitoring of the quality of care for this disease in the area in question, and that communication with doctors who can refer patients and with patients themselves is organised, guaranteeing accessibility. To improve access, it may be interesting to

use information technology or an associated nursing clinic to reinforce monitoring and training in patient self-care. With these considerations, we are talking about very complex units; to ensure their structure, procedures and results are suitable, they should be reputable units based on explicit criteria developed by experts. In this issue, scientific societies have the opportunity and the duty to be protagonists.

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