Beyond the Treatment Wars

Why Matching the Right Care to the Right Patient Matters in Chronic Pain

EtioLinks White Paper

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Executive Summary

Chronic pain treatment remains characterised by persistent debate. Different schools of thought emphasise structural correction, exercise rehabilitation, psychological therapy, nervous system retraining, medication management, procedural intervention, or multidisciplinary care. Each approach has evidence supporting benefit in some patients, yet no single model consistently resolves the broad population burden of chronic pain. [1,2]

This has often been interpreted as evidence that chronic pain is inherently resistant to treatment, or that available therapies are inadequate. A more plausible interpretation is that chronic pain is heterogeneous, while treatment selection frequently remains insufficiently individualised.

Patients who share the same diagnosis may differ substantially in the processes maintaining their symptoms, their readiness for change, their contextual constraints, and the stage of illness at which they present. Under these conditions, effective

therapies can appear ineffective when delivered to poorly matched populations, at the wrong time, or in the wrong sequence.

This paper argues that the future of chronic pain care may depend less on discovering one universally superior treatment, and more on choosing existing treatments more intelligently. Moving beyond treatment wars requires a shift from therapy allegiance toward precision pathway thinking: identifying what is maintaining symptoms, aligning first-line care accordingly, and adapting decisions over time.

1. The Chronic Pain Treatment Debate

Few fields in healthcare generate as much treatment disagreement as chronic pain. Debates continue regarding the relative importance of tissue pathology, biomechanics, deconditioning, fear avoidance, trauma, central sensitisation, psychological distress, lifestyle factors, and social determinants. Parallel disagreements exist regarding the best response to these contributors.

Some clinicians prioritise exercise rehabilitation and graded loading. Others emphasise cognitive and behavioural approaches. Others focus on emotional processing, pain reprocessing, medication management, interventional procedures, or multidisciplinary programmes. In practice, many clinicians use hybrids of these models, yet often without a consistent framework for deciding which patient requires which emphasis. [1,3]

This creates a fragmented landscape in which patients may receive markedly different recommendations depending on whom they consult. It also contributes to professional polarisation, where therapeutic schools are sometimes defended as if one approach must prevail over all others.

Yet the persistence of these debates may reflect a flawed question. The issue may not be which treatment is best in general, but which treatment is best for a particular patient, at a particular time, and in a particular sequence.

2. Why Evidence Often Appears Conflicting

Clinical trials and systematic reviews frequently report modest average effects across many chronic pain interventions. [2,4] This has led some observers to conclude that most treatments offer limited benefit. However, average effects in heterogeneous populations may obscure meaningful subgroup responses.

It has long been recognised that chronic pain populations are heterogeneous, with meaningful differences across biomedical, psychological, and behavioural dimensions that may shape treatment response. [5]

Two patients with chronic low back pain may share a diagnostic label while differing substantially in what is sustaining symptoms. One may present with persistent danger interpretation and movement avoidance. Another may be characterised by sleep disruption and physiological overload. Another may show emotional suppression, unresolved stress, or trauma-related activation. Another may function through rigid self-control, perfectionism, and repeated overexertion. These patients may all meet criteria for the same diagnosis, yet respond differently to the same intervention.

When heterogeneous populations are grouped together, interventions that help a meaningful subgroup may appear only modestly effective overall. Conversely, treatments may be generalised beyond their optimal indications because they perform reasonably well on average.

The challenge may therefore lie less in treatment efficacy alone, and more in treatment allocation.

3. When Good Treatments Look Like Failures

Many apparently unsuccessful treatments fail not because the therapy itself lacks value, but because the fit between patient and intervention is poor.

Graduated exposure and movement-based rehabilitation may be highly effective where fear, avoidance, and danger learning are prominent, yet may be poorly tolerated in patients whose physiological system is already overwhelmed by exhaustion, poor sleep, or high autonomic arousal. [6]

Education and reassurance may reduce symptoms in patients whose pain is strongly linked to misinterpretation of threat, yet may be insufficient where unresolved emotional conflict, grief, or relational trauma remain active drivers. [7]

Structured cognitive strategies may benefit some patients, yet in others may reinforce excessive self-monitoring, control efforts, or perfectionistic coping patterns that are already contributing to persistence.

Exercise may restore function in many patients, yet aggressive loading introduced without pacing, confidence, or regulation may worsen flare cycles in others.

These examples illustrate an important principle: poor fit can masquerade as treatment failure.

4. The Missing Variable in Chronic Pain Care

Modern healthcare invests heavily in determining whether treatments work, yet comparatively less attention is given to determining for whom they are most likely to work, when they should be introduced, and what may reduce their effectiveness.

This gap is especially costly in chronic pain, where presentations are multidetermined and treatment pathways often involve multiple providers over time. Without structured reasoning, therapy selection may be driven by clinician preference, local availability, referral habit, or whichever modality is encountered first.

Such pathways can create unnecessary delay, repeated failed interventions, and growing patient scepticism. They may also fuel professional conflict, as each discipline

encounters the subset of patients most likely to reach them and may infer broad superiority from partial experience.

A more mature model would treat allocation as central rather than secondary.

5. Why Sequencing Matters

Even an appropriate treatment may fail if introduced at the wrong stage. Timing and sequence are often under-recognised determinants of outcome.

A patient with marked physiological arousal and sleep disruption may first require restoration of basic regulation before engaging effectively in exposure-based rehabilitation. A patient with severe fear of movement may need confidence and safety learning before loading intensity increases. A patient whose symptoms are closely linked to emotional inhibition may require sufficient stability and trust before emotionally focused work becomes tolerable.

In other cases, excessive delay may itself become harmful. Waiting too long to reintroduce movement, challenge fearful beliefs, or address reinforcing patterns may allow disability to consolidate.

Sequencing therefore matters alongside selection. Chronic pain care is not only about choosing the right intervention, but about choosing the right next intervention.

6. Toward Precision Pathways in Chronic Pain

A precision pathway approach begins with identifying the dominant processes most likely maintaining symptoms at that point in time, while also considering factors that may influence pacing, engagement, and risk.

This does not require reduction of complex human experience to a single category. Rather, it requires structured reasoning that distinguishes likely drivers, recognises interacting influences, and prioritises high-leverage opportunities for change.

Such an approach is compatible with multidisciplinary care, but improves how multidisciplinary resources are deployed. Instead of asking every discipline to do everything for every patient, it allows more targeted and sequenced use of available expertise.

This may improve outcomes while reducing unnecessary treatment burden.

7. The Role of Clinical Decision Support

Human judgement remains central in chronic pain care, yet complexity, time pressure, and fragmented information make consistent reasoning difficult. Clinical decision support can help by organising relevant data, highlighting likely maintaining processes, identifying risks of mismatch, and suggesting more coherent next steps. [8]

Its role is not to replace clinical expertise or prescribe rigid protocols. Rather, it is to augment reasoning in conditions where variability is high and pathways matter.

PainMAP was conceived within this context: as a structured reasoning framework intended to support better matching, better sequencing, and earlier alignment of care.

8. Conclusion

The future of chronic pain care may not be decided by which therapeutic school wins the debate. It may be decided by whether the field moves beyond that debate altogether.

Many current conflicts reflect an understandable but limited search for the best treatment in general. Chronic pain is more likely to require the best treatment for this patient, in this context, at this time.

Existing therapies already contain substantial value. The next breakthrough in chronic pain may not be a new therapy, but better decisions about existing ones.

That is the path beyond the treatment wars.

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