

## Enough is enough:

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## **Enough is enough: Time for change in pain education?**

Each year the International Association for the Study of Pain (IASP) runs a campaign to bring attention to an aspect of pain management. This year the Global Year is for Excellence in Pain Education (see: <https://www.iasp-pain.org/GlobalYear>). The aim of the year is to bridge the gap between knowledge and practice. There are some useful factsheets available on the website to help promote excellence in pain education including: Current Status of Pain Education and Implementation Challenges; Pain Curriculum Design Models and Implementation Approaches; and Pain Education Assessment and Evaluation Strategies.

The need to ensure knowledge is used in practice is not unique to education about pain management; it is something that echoes throughout education-land. Academics and clinicians alike spend much of their time wondering why evidence is not translated into practice. Last year we ran a workshop at the RCN International Research Conference to explore nurses' priorities for research into pain education. Michelle Briggs (University of Manchester) worked with us to set the scene by outlining the evidence in respect of the current standing of pain education for health professionals in the UK, the influence of policy on pain education, and the challenge of curriculum design and assessment. In a nutshell we presented a well-researched but predictable narrative that demonstrated how years of research, pedagogical innovation, guidelines, and passion were not improving practice. The long and short of it? We believe we are getting better at the education side, we have more tools at our disposal in clinical practice, nurses are better educated than ever at the start of their careers, but we are still not getting it right for the patient. This results in patients of all ages continuing to experience unnecessary unrelieved pain (Twycross & Finley 2013; Meissner *et al.* 2015).

In our workshop we asked participants to address some key issues we felt might help us identify, through research, a way forward. Firstly, we had determined by our preparatory

work that much of the research about the impact of pain education was focused on the short-term impact of an educational intervention. (We have also highlighted this in one of our EBN Blogs – see: <http://blogs.bmj.com/ebn/2017/04/30/do-we-need-to-rethink-how-we-educate-healthcare-professionals-about-pain-management/>.) We felt, quite strongly, that demonstrating short-term knowledge gain was not helpful when it is long-term behavioural change that is needed. The workshop participants agreed and during the subsequent discussions identified strategies to help address this. The need for the patient, and patient-related outcomes, to be central to any evaluation of educational interventions was the dominant theme in this discussion. Evaluation of the impact of educational interventions needs to be authentic – in other words it needs to measure what is important in the real world. Knowledge is only one side of the equation; the other side is whether having (theoretical) knowledge leads to effective (evidence based) behaviour in nurses. The participants suggested that an ideal evaluation strategy would be one in which a 360-degree view of educational impact was gathered. This would include outcomes such as completed pain scores that are clearly correlated with documented pain management strategies such as analgesia administration, national pain audit data, patient and nurse interviews and focus groups, and observation of behaviour using video. Limited follow-up in many studies also received criticism, with the group voicing the desire to see sustainable change, and therefore long-term evaluation of the impact of interventions.

The next part of our discussion focused on educational interventions. Participants were clear that we needed to use pedagogically sound approaches to improve pain management in practice. The main theme that emerged from this discussion was the need for interventions to allow students and staff to learn and practice their new knowledge and skills in realistic environments. There is a place for lectures and classroom learning but we also need to consider using simulation and role play. Teaching should also include the voices of patients through the use of case studies and having service-users speaking to and discussing pain management with students in the classroom. We also need to provide opportunities for

reflection and placements with pain experts and role models. There are myriad ways to achieve this and many electronic resources available when a 'live' patient cannot be. Pain education, we felt, needs to be embedded throughout the curriculum and owned by everyone in clinical practice. One of the key ideas in this discussion was the ability for the learner to practice the application of theory in real world settings with all the competing priorities and conflicts that interfere with good intentions to manage pain effectively.

The final part of our discussion focussed on the assessment of pain knowledge and skills. We agreed that an increase in (theoretical) knowledge was an intended outcome of education. However, the ability to use knowledge in practice should be the focus of assessment strategies. Participants felt there was a need to have practice-based assessments in which learners' ability to apply new knowledge is tested in realistic settings. Objective Structured Clinical Examinations (OSCE) were one of the favourite strategies identified. To help students develop confidence and intention to make use of newly acquired knowledge and skills the group felt that peer- and self-assessment were helpful tools. This lifelong learning skill was a way of encouraging continuous professional development to minimise learners' focusing on simply passing each assessment (i.e. to get your degree/masters or another qualification) rather than on changing behaviours and challenging non-evidence based practices. For this to happen, the learner needs to be able to see the benefit to themselves and the patient of increased knowledge and skills. The third component of a triangulation of assessment was the difference seen in practice, measured by pain audit activity. While this is less attributable to the individual it is one of the most important outcomes of pain education.

In this Global Year for Excellence in Pain Education the British Pain Society's Pain Education Special Interest Group (see: <https://www.britishpainsociety.org/pain-education-special-interest-group/>) will be publishing guidance on implementing a core curriculum for pre-registration pain education. This document will give a British perspective on the recently

revised IASP core curricula (available to IASP members only unfortunately) as well as integrate important principles from professional guidance such as the RCN Pain Knowledge and Skills Framework (see: <https://www.rcn.org.uk/professional-development/publications/pub-004984>).

There is an appetite to improve pain management *via* clinician- and patient-empowerment. There isn't a one-size fits all approach, but it is probably time we mandated excellence in pain knowledge and skill as a fundamental outcome of professional education. The draft pre-registration nurse education standards from the UK Nursing and Midwifery Council give pain very little attention (although this is an improvement on the 2010 standards). It is up to us to keep the pressure on, particularly in the Global Year for Excellence in Pain Education, and find a way to move this agenda forward.

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