THE BRITISH PAIN SOCIETY

Opinion

Education as part of wider health policy and improvement strategies

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Summary points

1. The majority of people living with persistent pain will receive treatment for the pain from non-specialists in pain management who may not have received the necessary training to deliver high-quality care.
2. There is now a wide range of learning platforms and packages available, but these may struggle to reach beyond those with a specialist interest. Addressing this will require action at both local and national levels to prioritise training in pain management.
3. Although education may improve knowledge, changing behaviour will require a wider change in clinical culture, including changing public and clinical attitudes and ensuring that the NHS recognises, prioritises and rewards high-quality pain management.

Keywords

Pain, models educational, policy-making, program evaluation

The last half-century has brought extraordinary advances in our understanding – and ability to treat – people's pain. These scientific and therapeutic advances, however, have not necessarily had the wider impact that they could have. The publication of the Chief Medical Officer's 2008 Annual Report chapter on chronic pain¹ drew focus to this gap.

In seeking to improve health outcomes, the call for better education for clinicians has become a well-rehearsed battle cry. We know the tiny number of formal hours' teaching provided that are dedicated to pain education.² Yet our education colleagues tell us that the curriculum is full and if we want to petition we should join the queue outside the dean's door. Resources have never been more constrained. What will we ask for?

Pain education for clinicians must be seen in the wider context of healthcare delivery across the NHS. Most people with pain will be treated by clinicians who have not trained as specialists in pain management. This is critical in making the case for broad curricular

inclusion. There can be no clinical specialty where the basics of pain management are not relevant. For successful change to this extent, action is required at both the national and local level. Nationally, there must be clarity and broad agreement about the aspects of pain management that should be included in different curricula at different levels. An example for this way of working at postgraduate level was the recent review of public health content of postgraduate curricula at the Royal College of Physicians jointly with the Faculty of Public Health. The impetus of the first National Pain

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Summit for England may help to create unity of purpose for those who approve, set and monitor curricula at national level.

However, embedding pain in training curricula is not something that can be solved solely by calling for change at a national level. To achieve this, the current policy environment driven by localism requires local clinical and educational champions for pain education to work directly with their local health schools and deaneries. One approach is for local pain education champions to work to create dedicated teaching time on pain in the formal curriculum. A more challenging – but perhaps more effective strategy – will be to ensure that high-quality pain medicine is taught by those delivering all parts of the curriculum, including both formal and bedside teaching. This approach fits better with modern problem-based learning curricula, reinforces the message that pain management is a universally required skill, and may be the best way to tackle the ‘full curriculum’ problem. However, the success of this approach requires building strong alliances with those non-specialists in pain medicine who will teach it, developing the commitment and skills to deliver this content across the curriculum.

At the national level there has been some initial progress. Countries within the UK have been driving the pain agenda with the publication of the England Chief Medical Officer’s 2008 Annual Report, cited above, the appointment of a National Lead Clinician for Chronic Pain in Scotland³ and the establishment of an education subgroup to consider chronic pain education, and the publication of mandatory chronic pain directives in Wales with accompanying Map of Medicine Pathways.⁴ While the need for education features prominently in all of these approaches, progress has been slow and mechanisms to effect change are absent or largely uncoordinated. The situation is different for specialist doctors, other specialist non-medical clinicians and generalists of all types.

In terms of specialist medical education, since its foundation in 2007, the Faculty of Pain Medicine⁵ at the Royal College of Anaesthetists has created a dedicated national curriculum for the training of doctors specialising in pain medicine. Specialist training for anaesthetists with an interest in pain now involves two years’ dedicated training in pain medicine with one of these years focusing on chronic pain. Although a number of professional groups have broadly supported the educational agenda by forming pain interest groups – for example, the Royal College of Nursing, the Royal College of Pharmacists and the Pain Physiotherapy Association – these groups have not yet embarked on dedicated specialist education as undertaken by the Faculty of Pain Medicine.

Non-specialist and non-medical health professionals can already enhance their own knowledge and skills in pain medicine by enrolling on one of the eight or so MSc courses in pain management available in the UK. There is no common set of curriculum or minimum standards for these courses, and they are not mandatory, unless sought as essential criteria by individual employers in job specifications for pain specialists. The first multiprofessional MSc in pain management was launched by Cardiff University in 1996 and this was followed by a number of other such courses in Leicester, Edinburgh, Keele, King’s College London, Birmingham and Belfast.

For those with a particular interest in a specialist pain management course, but who do not want to enrol on a Master’s level programme, e-learning has opened up multiple possibilities; for instance, a 12-week e-learning foundation in pain management for primary and community care is offered by a higher educational institution.⁶ These short courses focus on improving early assessment and management of pain, and it is the intention to build on this initiative to provide a wider range of pain education.

Another e-resource for interest groups is www.pain-communitycentre.org, hosted by Cardiff University. This website provides quick, easy-to-access, free education to both specialist and non-specialist practitioners. Information is available in small aliquots, and fits with a just-in-time learning approach. Practitioners can indicate their time available for study and the site will generate a suggested list of presentations (podcasts, videos, written texts) to fit. Users can state their learning preferences and be directed to acute or chronic pain education, specialist or primary situations and pharmacological or non-pharmacological approaches. Modules are accredited for continued professional education points. For the committed learner, this is a flexible and comprehensive resource. However, arguably, resources such as this reach those who need it the least.

At a more general level, therefore, to address the global deficit in pain knowledge and skills, the Pain Education Special Interest Group of the British Pain Society has begun developing guidelines for generic undergraduate training. Due to be released in 2012, these will provide curriculum topics and outcomes, along with examples of how pain education can be delivered and a toolkit to provide support for institutions developing such curricula and delivering pain education. Although this approach has the potential to reach the widest audience of all, the challenge will be making the case for uptake. Again, this will need the case to be made at national level by representative organisations and at local level by committed, skilled champions.

Primary care pain education: the final frontier?

Only 2% of patients with persistent pain are seen by a specialist.⁷ The majority of those people who do seek healthcare are therefore being seen in general practice. Improving knowledge and skills within general practice – where a minimum of 22% of consultations⁸ relate to pain – must be a key aim of anyone seeking to improve healthcare outcomes for people with chronic pain.

Historically, the lack of national prioritisation, such as through the Quality Outcome Framework (QoF) programme, has meant that chronic pain training has often not been prioritised locally. The decision by the National Quality Board to consult on including 'Pain Management' in the library of National Institute for Health and Clinical Excellence (NICE) quality standard topics⁹ may begin to address this. Other developments, too, have sparked interest at national level. Rising levels of opioid prescriptions have caught the attention of those who are keen to avoid risks associated with opioid dependency. Further system-level concerns – driven largely by cost pressures – over 'inappropriate prescribing' of opioid patches and anti-convulsants may also increase the central pressure for change.

There is an awareness by clinicians of the need to increase their knowledge and skills. A recent survey¹⁰ shows that 84% of GPs (primary care physicians) across Europe (including the UK) considered their initial training on chronic pain not comprehensive, with 89% recognising a need for more education on the topic. The UK compares poorly in international comparisons, with GPs in the UK receiving on average 3 hours of chronic pain training in the previous year compared with an average of 10 hours for GPs elsewhere in Europe, with 30% of them not having received any training in chronic pain in the previous year.

It would be unfair to berate GPs for this. The breadth of medicine is huge, and every specialist society and charity is keen to grab their attention. At the level of the profession, there is generally a great willingness by GPs to be educated in areas that are practically useful and that enhance the consultation experience for both the patient and clinician. Although the commonest reason cited by GPs for not attending chronic pain training was lack of time, previous experience of national prioritisation has been that shifts in national emphasis changes local priorities too, and demand for training rises. This applies not only to GPs, but also to the whole primary care team, including nurses, pharmacists, physiotherapists and service managers. This unity of purpose is essential to driving the change that is needed to make a difference for people living in pain.

For all these reasons, the decision by the Royal College of General Practitioners to recognise 'pain' as one of its clinical priority areas (2011–2014) is a landmark one. Overseen by a Clinical Champion, this provides an opportunity to draw focus on pain medicine within the community of GPs, to influence national policy on pain management and to make formal links with other organisations within the field of pain and pain medicine to develop shared activities.

A variety of projects are now under development under the banner of the Royal College of General Practitioners' clinical priorities programme. To support general practitioners' day-to-day work supporting people with chronic pain there are plans to give guidance on a structured '10-minute pain consultation', produce a 'Handbook of Primary Care Pain Management', undertake work to reach consensus on the use of standardised assessment tools (including within a routine GP consultation), to raise standards and awareness through the creation of a 'Pain Pledge' and – where possible – to make inroads into the long-term goal of influencing the core general practice curriculum. Working to influence the Department of Health and NHS, the Royal College of General Practitioners supports the development of the quality standard on 'Pain Management', and is keen to work with NICE to develop this, as well as incorporating it into the Commissioning Outcomes Framework, to ensure that high-quality treatment and support for people in pain is embedded throughout the health system. Furthermore, a full programme of work has begun, developing appropriate commissioning guidance for pain for Clinical Commissioning Groups. Finally, the enhanced recognition of the importance of pain management in primary care has facilitated closer work with organisations such as the British Pain Society and Pain UK. By working closely with the British Pain Society, the Royal College of General Practitioners can explore ways to promote the implementation of the Pain Pathways, currently nearly finalised,¹¹ and the Opioid Guidance for Primary Care,¹¹ including looking at ways to integrate these into the computer systems already used by general practitioners. Other collaborations will include working with Pain UK and other patient organisations to promote the 'Pain Pledge', and working with Cardiff University to further develop e-learning opportunities suitable for general practitioners and specifically to support the competency framework for Practitioners with a Special Interest in Chronic Pain¹² that they have developed. There may be opportunities to work with the Department of Health, which has released money to develop non-specialist e-learning modules.¹³ The centrality of general practice in the patient journey makes it appropriate that the Royal College of General Practitioners is at the heart of

these projects, supporting the development and implementation of resources that improve healthcare for people in pain.

Time for change

A great many resources are already available for clinicians wanting to learn more about pain management. The greater challenge is how to reach health professionals who do not want to specialise in pain, and those who are not aware the importance of accurate pain assessment and effective pain management. Many non-specialist healthcare professionals do not appear to be adequately prepared to take preventative action, to recognise when early intervention is required, to be able to assess and evaluate appropriately and to initiate the right treatment at the right time and to seek help.

Partly this is an issue about resources. Clinicians are under increasing time pressure and both study leave and study funding are less abundant than was previously the case. One response to this has been to promote e-learning, which is less costly for both trainer and trainee in terms of both time and money. There is some encouraging research in health education for the use of techniques such as podcasts and iTunes,^{14,15} though this has not been demonstrated in pain education as such.

E-learning, however, will not be a panacea. First, as with other optional educational interventions, it can only be as effective as the uptake. While no doubt a very important resource for those already eager to learn more about pain management, it does nothing to reach those who do not see this as a priority. Second, clinical behaviour – like other human behaviours – does not necessarily change in response to information.¹⁶ While knowledge and skills are necessary to enable high-quality clinical care for people in pain, on their own they are seldom sufficient.

Many of the resources are now in place – or will soon be in place – to improve healthcare outcomes for people in pain. Education packages are available and clinical pathways and commissioning guidance will be produced. Training for specialist doctors is now highly developed, and training for other clinicians is increasingly recognised as important. A national recommended curriculum for undergraduates will soon be published.

What is needed now is a change in behaviour, and broader cultural change in healthcare is needed to drive that behavioural change. Public attitudes must shift so that there is an expectation that clinical encounters will discuss pain – and pain relief – and that simply being told to ‘put up with it’ is not an

acceptable approach. Generalist and specialist clinicians need to perceive that public and professional expectations include routinely asking patients about their pain, measuring the level and impact of pain and recording this in a standard format in clinical records. Patients and clinicians need to find a way to balance the search for, and treatment of, underlying pathology with the successful management of pain that enables patients to lead a full life. Policy-makers need to describe what good pain management and pain services look like, commission for them and reward good practice and good outcomes where they are seen.

The cumulative effect of these sorts of changes will be to create an environment in the health system where it is not only unacceptable to continue to practise with poorly developed knowledge and skills about pain, but where it is unthinkable to not use this knowledge and these skills in every clinical encounter with a person in pain. We must now prepare for the next phase of the educational challenge for pain: to campaign for the policy and social environment where knowledge becomes practice, skills become habit and excellence becomes the norm.

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