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Interprofessional pain learning and working: different perspectives

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Introduction

After suffering a stroke Mr Martin Stephen¹ decided to write about his experience, narrating a moving yet entertaining story towards recovery. Interestingly, to achieve this very recovery he felt he needed to get out of hospital and cure himself. Reading about his hospital experience I thought that the care he received did not place him at its centre and was fragmented. It consisted of healthcare providers working in parallel yet not with each other, and thus lacking any clear direction. During pain management, patients sometimes describe a similar journey in care and I often wonder if their experience would have been different if interprofessional working (IPW) principles were better implemented.

In current pain management practice it is accepted that IPW provides optimum care, but what is our actual understanding of it? What is the evidence to support it and does everyone think IPW is useful? A British Pain Society (BPS) workshop about IPW and interprofessional learning (IPL) recently offered the opportunity to be part of a dialogue about the topic with clinicians, academics and service users. I extended the discussion with clinical colleagues and in this article I explore some of the key issues arising, comparing comments from both environments.

Background of IPW and IPL

IPW suggests an integration of professions that allows them to work in a collaborative way and share responsibility for the outcome.² IPL is the process by which professionals learn from, with and about one another so as to promote this collaboration.³ The emphasis on IPW/IPL is increasing with the international and national publications that recognise the importance of collaborative work and places the care of patients at the centre. Ideally, this will reduce multiple referrals and enhance safe, well-informed and focused treatments.

In particular, the World Health Organization (WHO)⁴ in 2010 recognised the need for interprofessional care supported by interprofessional training. The Department of Health in its 2012 report⁵ sets

clear educational targets that embrace teamwork and flexibility within professions in a forever-changing environment. The National Institute for Health and Clinical Excellence guidelines all promote interprofessional approaches on a variety of painful conditions^{6–8} as best practice.

Moreover, a 2008 Cochrane review on subacute low back pain⁹ decisively concludes in favour of an interprofessional approach. Scascighini and Sprott,¹⁰ when reviewing chronic non-malignant pain, showed that good quality evidence favoured multidisciplinary pain programmes as the most effective care. Another review article on interprofessional management of chronic pain noted that ongoing collaborative communication was a key component for optimal care.¹¹

All reviews are not so supportive because there is an absence of research data. The Cochrane reviews on fibromyalgia¹² and neck and shoulder pain¹³ were inconclusive as to the benefits of interprofessional interventions. Additionally, as Carr and Watt-Watson¹⁴ highlight in this very issue, the evidence behind IPL leading to effective patient care is sparse and inconclusive, perhaps because of the very nature of the task. The main problem is that pain management is a complex and multifactorial intervention and it is very difficult to establish which component makes a difference in patient care. It is therefore equally complex to assess the effectiveness of either IPW or IPL in pain management.

Perspectives from a workshop and from a pain management team

It is difficult to establish strong evidence to support the use of IPL and IPW. However, collective clinical experience favours them as in practice they appear to

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promote communication and keep the patient at the centre of care. With increasing emphasis on IPL and IPW, the BPS Pain Education special interest group organised a successful seminar day in November 2011 focusing on the challenges of IPL/IPW.

The keynote workshop was led by Helena Lowe and Jayne Frisby from the Centre for the Advancement of Interprofessional Education (CAIPE),³ who explored the current political and academic IPL/IPW developments, nationally and internationally. At the beginning of the workshop delegates were split into groups and asked to comment on what IPL meant, what the perceived benefits and obstacles were and what 'they really thought'. Delegates were a mixed group of service users and clinical and/or academic pain management health professionals.

As a delegate, I found this a very beneficial exercise. It allowed us time to reflect on what the political agendas, educational curricula and evidence meant in everyday practice. At the end it produced a summary table (Column A, Table 1) offering a snapshot of opinions from 24 people who regularly implement IPL/IPW. However, as the workshop was part of a day focusing on education, this could have created a certain mindset influencing our comments. This raised the question of how a similar group of people would respond to the same set of questions when raised in a clinical setting.

In an effort to explore this idea further, members of the pain management team in which I work were approached with the initial comments collected from the workshop (Column A, Table 1). They were asked to read the comments and add, change or highlight anything. Elaborating and sharing opinion on the process to reach consensus was also encouraged. Permission was sought from members of the groups at both stages to use their anonymous comments for this opinion piece. A mixed group of nurses, physiotherapists, administrators, doctors and psychologists responded, nine in writing and one verbally. Column B of Table 1 summarises their feedback.

It should be noted that all of the commentators thought Column A (Table 1) was very comprehensive and one actually said he had nothing to add. In fact, there is a repetition of some comments in both columns because some of them were elaborated further in Column B.

Thoughts and personal viewpoint

In both columns of Table 1 there are comments about historical culture and professional boundaries being potential obstacles in IPW/IPL. This is perhaps because professionals feel comfortable within well-defined roles and when the boundaries of these roles are questioned it can lead to conflict. In addition, by

overlapping roles professionals might feel like they are losing their identity.

Nonetheless, the positive comments about IPW/IPL outweigh any scepticism. It is evident from the table that when faced with the challenges of dealing with such a complex clinical presentation such as pain we want to look to our colleagues for support. We have to identify the barriers and be prepared to overcome them, our egos and the practical difficulties because if we are united we are better placed to succeed against pain suffering.

It is very interesting to see how similar the opinions between the two columns are. We all appear to be on the same page when it comes to strong collaborative work. There is, however, a significant difference between these tables. Delegates of the workshop appear to put the emphasis more on the professionals who are working together. The responses from my team seem to focus more on treatment and patient care. This might just be because the comments were gathered through a different process and in different environments. It might also suggest that physically being in a clinical environment it is more pertinent to thinking about treatments and patients.

Even more striking is how a simple exercise like this produced such a rich outcome of insightful comments. Table 1 demonstrates so many key issues around IPL/IPW. This highlights how paramount dialogue is in raising awareness, identifying obstacles and creating a shared understanding. All of these are necessary elements for progress, especially in areas such as pain management. Pain management is complex on both a scientific and a clinical level, and therefore only through effective communication and collaboration can we advance knowledge and patient care. In the words of Plato, dialogue is the winner in promoting knowledge.¹⁵

Conclusions

In summary, it appears that all disciplines and service users involved here were willing to work together and found IPL/IPW a positive, rewarding experience despite the difficulties. The WHO and Department of Health recognise that collaborative work promotes better patient care. The challenge is to always keep the patient at the centre of care whether we are sitting in clinics, classes, boardrooms or meetings or attending consultations. IPW/IPL can help communication and collaboration in order to reduce the number of disillusioned patients such as Mr Stephen. Nonetheless, more research is needed to investigate the effectiveness of IPW/IPL and we might want to reflect on whether the existing research models are adequate in exploring such a multifactorial and complex approach that is interprofessional pain management.

Table 1. Column A: keynote workshop – interprofessional working and learning delegates’ comments. Column B: Royal Free Hospital pain management employees’ comments.

Column A: Workshop	Column B: Established pain team
<i>What does interprofessional learning/education mean to you?</i>	
Collaborative working	Necessary/reality of clinical practice
Sharing of skills and knowledge	Best practice
Enhancing patient care	Part of identifying appropriate care pathways
Make working more enjoyable	Overlapping roles
Respect for each other’s roles and responsibilities	Respecting and understanding different roles, clinical/non-clinical
Understanding and appreciating other people’s cultures	Voice of each team member heard
Identifying/acknowledging common ground	Identifying conflicting perspectives
Easier to ask each other for help	Sets baseline understanding of differences to advance joint work
Creativity in chaos	Promote positive feedback
Promotion of teamwork	Disciplines moving together
Promotion of knowledge	Unite perspectives in plan making
Efficiency in resources	Joint assessment and treatment
Need to break down before building	Common understanding of core issues
Challenging professional barriers	Interprofessional meetings, clinical and non-clinical
	Joint courses and continuing development, clinical and non-clinical
<i>Benefits of interprofessional learning and working</i>	
Core skills	Consistent communication with patients across professions
Core/common base of education	Coherent and effective messages
Speaking the same language	Decreases repetition
Enhances pain assessment and management	Promotes interprofessional respect
More rewarding for professionals	Facilitates multidisciplinary work
Puts the patient at the centre of care	Advances non-clinical roles as part of team and patient care
Collaboration	Clinical reasoning better understood across disciplines
Better teamworking	Promotes personal development
Breaks down barriers	Promotes confidence
Range of expertise	Promotes knowledge, clinical and non-clinical
Addresses the multidimensional nature of pain	Prevents ‘revolving doors’
Awareness of how others approach problems	Prevents care fragmentation
Promotes respect	Global assessment of patient
New solutions	Puts the patient at the centre of care
Reduces cost	Promotes patient care and experience
Furthers development and research	
<i>What are the challenges/barriers?</i>	
Historical	Professional insecurity
Socialisation into a profession can be a barrier	Exposure to unknown territories can be intimidating
Professional inflexibility	Potentially costly
Preconceptions in general	Potentially time-consuming
Staff misconceptions	Hierarchical culture
Going into other people’s environment to educate	Clashing egos
Fear – lack of knowledge, embarrassment	‘Not my problem area’
Confidence	Complicate and confuse patient management plans
Curricular planning	Dilute views
Lack of time to release people for education	Different endpoints
Lack of dedicated quality time	Lack of understanding of clinical relevance and benefits
Lack of funding	
Lack of interest	

(continued)

Table 1. (continued)

Column A: Workshop	Column B: Established pain team
<p>'At the water cooler' – what do you really think?</p> <p>Does interprofessional learning lead to the dumbing down of professional skills?</p> <p>Superiority/inferiority complexes</p> <p>Power struggles</p> <p>Re-evaluate hierarchy</p> <p>Interprofessional is not working with the patients</p> <p>Where is the evidence for interprofessional education/learning?</p> <p>Are we really working towards the same goals?</p> <p>Goal is bigger than the personalities</p> <p>Difficult to think differently</p> <p>Comfortable in our silos</p> <p>Protection of roles</p> <p>Can be difficult to address the different needs of the interprofessional groups</p> <p>Fear of the unknown</p> <p>Need to start at the beginning</p> <p>Commissioning – lack of understanding of chronic pain</p>	<p>Interprofessional does not include only healthcare providers</p> <p>Weaknesses exposed</p> <p>Skilfully planned interprofessional learning is most effective</p> <p>Gradual exposure to new areas of knowledge</p> <p>Improved patient experience</p> <p>First steps for interprofessional learning/working – cultural shift will take time</p>

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