Clinician's Commentary on Wideman et al.¹

The article by Wideman and colleagues¹ is an important step forward in moving our profession to take its role in comprehensive pain management in Canada. The authors describe the steps required to change how pain is conceptualized by the profession, addressed by physical therapists in practice, and taught by educators nationwide. Its timing aligns with the current International Association for the Study of Pain–led international focus on pain education. The translation of science to clinical practice has finally begun to improve clinical understanding of pain, and next year the association is focusing its “Global Year” initiative on excellence in pain education.

Wideman and colleagues¹ recommendations and observations directly pertain to the Declaration of Montreal, an important visionary statement for pain care worldwide.^{2,3} This statement, a result of the 2010 International Pain Summit, directed attention to inadequate access to treatment for acute pain and clearly highlighted the need to recognize that chronic pain is a serious chronic health problem. Currently, no medical cure exists for many chronic pains, and the best medical treatment centres report significant long-term benefit in only 25%–30% of patients.^{4,5} Chronic pain, as with many chronic diseases, confronts individuals not only with the distress created by the ongoing symptoms but with the accompanying difficulties that compromise all aspects of their lives. A declaration bullet point highlighted that individuals with chronic pain require “access to management akin to other chronic diseases such as diabetes or chronic heart disease.”^{3(p.2674)} The Declaration of Montreal also acknowledged that “chronic pain with or without diagnosis is highly stigmatized,”^{3(p.2674)} and it stressed the basic human right to the acknowledgement of a person's pain and access to appropriate assessment and treatment of that pain by adequately trained health care professionals. To ensure appropriate pain care, the declaration had two stated obligations: the first pertained to changes in policy and health care access, and the second pertained to changes in the education of health care professionals.

Inadequate and even harmful pain management not only directly affects body function, but also limits activities, restricts participation, and affects the person's quality of life. As physical therapists, we generally operate within the bio-psychosocial model, which views illness as the result of a complex interaction of biologic, psychological, and social variables. An individual's health is accounted for by the interrelationships among biologic changes, psychological status, and social and cultural contexts. We learn that these variables shape the person's perception and response to illness. This approach is also key to understanding chronic pain.⁶ So, why do we drop this model when it comes to chronic pain prevention and management? When a person comes to us with pain, why do we revert to a disease (i.e., biomedical or biomechanical) model for clinical reasoning and view pain only as a symptom of tissue injury? The persistence of this model of clinical reasoning reflects the gap between research and practice, both in pain science knowledge and in its translation to clinical practice.

There is overwhelming evidence that chronic pain is not just acute pain that lasts longer. It is a complex chronic condition that involves pathological changes in the nervous and immune systems, as well as in tissue, and changes to the person.⁷ In the

few decades that I have been teaching, the science of pain has made significant advances in the domains of both basic science and clinical science. For example, the plasticity of both the peripheral and the central somatosensory systems is now commonly recognized not only by basic pain researchers but also by clinical researchers and specialists. In addition, the influence of cognitive, emotional, and social factors on pain processing and clinical pain outcomes has been extensively evaluated in a variety of painful conditions. Expert pain clinicians now support a neuroscience mechanism–based treatment approach to pain that focuses on the underlying nociceptive plasticity peripherally and centrally and further addresses the psychosocial factors that modify the pain experience.^{8,9} Thus, the growth of our role in the clinical management of pain will stagnate if we persist in viewing pain dichotomously, that is, when we reason that pain has either a tissue source or a psychological source.

As with other chronic health conditions, the experience of pain itself is complex and interdependent on biomedical, cognitive, emotional, social, and behavioural factors whose relationships and interrelationships can change over time. Persistent pain beliefs and expectations, ability to cope; mood, fear, and anger; social supports; medico-legal system; health care system; and employers are all factors that influence patients' investment in treatment, acceptance of responsibility, perceptions of disability, motivation to respond and adhere to treatment recommendations, expectancies regarding treatment and outcome, and acceptance of the treatment rationale. Physical therapy clinical reasoning will benefit from a thorough understanding of the nature of acute and chronic pain and current pain science.^{10,11} Our graduates must have the knowledge, skills, and attitudes to competently assess the person with pain and plan the physical therapy management within the bio-psychosocial model we use for all other health conditions.

Understanding and treating pain, particularly chronic pain and the transition from acute to chronic pain, intrinsically involves integrating medical science, humanities, policy, health care, and more.¹⁰ Patient-centred interprofessional collaboration has also been identified as a key factor in effective pain management.⁶ However, our entry-to-practice health care education is siloed on the basis of profession.¹² Even within profession, however, education is stratified on the basis of disease classification. As a result, pain is first taught as a symptom of underlying tissue pathology; the clinician then searches to identify the broken body part, which is then treated to eliminate the symptom. Although this biomechanical component of diagnosis is integral to professional training, it does not encompass teaching about pain. Gaps in pain knowledge and problematic beliefs have been reported for almost two decades among a variety of health professionals, and yet change in entry-to-practice pain education is lagging.^{13,14} Clearly, a more comprehensive set of changes to health care and clinician education is needed to improve care for chronic pain and help individuals avert the transition from acute to chronic pain.

Wideman and colleagues¹ took an in-depth look at the barriers to and facilitators of improvements in how pain is addressed by physical therapists and taught by physical therapy educators nationwide. Two of the strategies highlighted are (1) the need

for a minimum set of competencies for entry-to-practice physical therapists and (2) the need for improved outcomes assessment (for pain education). These strategies focus on improving the practical impact of education rather than just knowledge about pain symptoms, anatomy, and physiology. Competencies are developed to meet the needs of the patient or client and society. Pain competencies are thus a foundation for improving pain management throughout the life span, across the health care continuum, and within the diverse backgrounds of patients. This strategic approach is integral to preparing clinicians for person-centred pain care, responding to patients' needs to comprehensively improve health outcomes for people with chronic pain.

Recently, a set of consensus-derived pain management core competencies was established for pre-licensure health professionals.¹² On the basis of this, Hoeger Bement and colleagues¹⁵ published an example of the application of the core competencies for pain to the professional (entry-level) physical therapist curriculum. To help guarantee the adoption of the core competencies on pain management into a physical therapist curriculum, additional incentives may be required, including accreditation and inclusion in licensing.¹⁴

I was grateful to take part in the stakeholder workshop described by Wideman and colleagues.¹ I am thrilled to see progress in the profession toward initiatives such as those described, as well as the efforts of the Canadian Physiotherapy Association—Pain Science Division and the Pain Education in Physiotherapy Curriculum Initiative group. These initiatives are not only evidence based, but they are also leading the profession forward within the cultural transformation that is occurring in pain management so that we can best contribute our expertise and improve the health outcomes of people with pain. The groundwork exists for our profession to immediately begin to take action on Wideman and colleagues' recommendations in our curricula, continuing education, and our profession nationwide.

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