Pain Education: Molding the Trainee-Patient Dialogue

“M"rs. Allgood, we’re here to help you live a richer, fuller life.”

“Our multidisciplinary team reviewed your situation and designed a program especially for you. By following our carefully planned recommendations, you will experience decreased pain and improved quality of life. Your pain will move from the foreground to the background of your thoughts as you move forward with your life despite pain. But we need your cooperation and participation. Although our team is one of the best, you must do your part.”

“Thank you so much, doctor! I realize my pain does not have to be entirely gone in order to enjoy many of my former activities. I have followed your prescribed treatments, returned to work, and find it rewarding and gratifying. Thank you for helping me regain my life in spite of pain!”

. . . and then my office chair tilted all the way back, spilling me on the floor and waking me up.

Why Does This Dream Rarely Come True?

For most pain management specialists, the above daydream rarely comes true. Very few patients say, “I am adhering to your treatment recommendations, and as a result I am successfully managing my pain.” Yet somehow we practice as though we believe all we need to do is give our patients treatment instructions and they will automatically, and even willingly, comply. We feel that because we understand the complex disease entity called chronic pain, if our patients would only do what we tell them to, they could control their pain. However, an ideal plan orchestrated by a team of experts is destined to fail unless we—the experts—successfully translate that knowledge in such a way that patients agree with it, internalize it, and adopt it into their lifestyle.

Much as we expect patients to adhere to our recommendations, we expect health care trainees to understand and apply the insights into pain management that we share with them. A few years ago, I realized we were spending a large portion of our case conference time educating pain trainees about psychological aspects of pain management. I suggested to our director that, as the pain treatment program’s clinical psychologist, I teach these concepts and designed a 12-month course based on the IASP core curriculum.1 Degrees in both psychology and education served me well in this endeavor, and our departmental chairman suggested I publish my curriculum. Literature reviews did not reveal similar concise surveys of this topic for non-psychologist clinical trainees. A questionnaire administered at a recent Tennessee Pain Society Meeting also did not unearth any such curriculum.2 Leaders in the field of pain management, including members of the Core Curriculum Task Force who are now revising the
IASP curriculum, responded to my email queries by stating they were not aware of any curriculum other than the broad content outline they had designed. One of those persons was the editor of *Pain: Clinical Updates*, who suggested that the present issue be devoted to the topic of education as a therapeutic intervention for patients, and a key component of the pain clinician’s armamentarium. While preparing this piece, I learned of a Web-based postgraduate course developed in Australia (www.painmgmt.usyd.edu.au). According to Michael Cousins, one of its developers, this distance learning course covers all aspects of the broad topic of pain. Professor Cousins explained to me that the course is not skills based; learners are not taught as aspects of the broad topic of pain. Professor Cousins explained to me that the course is not skills based; learners are not taught

The IASP task force has designed a solid content outline. We expect pain residents and fellows to understand and apply this knowledge, much as we expect patients to adhere to knowledge shared with them. How do we help both types of learners translate knowledge into practice? One way is to provide a “hook” to capture their interest. One type of “hook” is to begin with the end.

Begin with the End

When we “begin with the end” with patients, we ask them to tell us their goal. “If you had no pain, or less pain, how would your life be different? What would you be doing?”

A middle-aged female patient’s goal might be to play with her grandchildren. We may belittle the value of her goal and try to steer her toward our perception of a more productive goal, such as returning to work. If, however, she never liked her factory job in the first place, she will find myriad ways to thwart our efforts. On the other hand, if she creates her own narrative in which she is the central character, she will provide her own motivation to succeed. We can then collaborate in crafting a treatment plan to advance her toward her goal. For example, in order to play with her grandchildren she may need decreased pain intensity, increased stamina, restful sleep, stress management skills, and assertiveness skills, such as telling them: “I need you to play quietly for 20 minutes while I use a cold pack.”

An alternative to beginning with the end is to engage in a “step process” of treatment; we start with “X” treatment and if that is unsuccessful we move to “Y,” and if that is also ineffective then we resort to “Z.” The “step process” is a graduated treatment program that usually moves from least to most invasive, e.g., from non-opioid medication to implantable devices. When we reverse the process and begin with the end, we allow patients to define their desired functional goal (playing with grandchildren) versus imposing our own perception of their needed outcome (returning to work). Although beginning with the end may provide the same types of treatment as the “step process,” patient-derived outcomes are more likely, in my view, to promote better adherence to the treatment recommendations.

Patients are more likely to adopt and adhere to a goal-oriented, jointly formulated treatment plan than to work through a checklist of steps designed for them. We can apply the same collaborative approach as we educate clinical pain trainees. When we begin with the end in mind, we ask trainees to describe their ideal pain practice. If they respond that they want their patients to improve, we may need them to specify what they mean by improvement. To some trainees, improvement means decreased pain intensity. Those singularly focused on the goal of decreasing pain intensity may invest their energies in providing medication to modulate pain pathways or elevate pain thresholds. Residents and fellows who define improvement as increased function along with decreased pain may be more willing to collaborate with physical therapists and psychologists. These trainees value psychological intervention, apply it to their practice, and continually analyze, synthesize, and re-evaluate its value to their patients, rather than learning just enough about psychological intervention to pass their pain medicine board exams.

Once we have “hooked” the patient or the trainee into wanting the pain management knowledge we as psychologists have to offer, how do we help them move from knowledge to application? One way is to manage the process of knowledge translation.

Knowledge Translation

Knowledge translation, based on the premise that “a large gulf remains between what we know and what we practice,” focuses on changing health outcomes using evidence-based clinical knowledge. Knowledge translation is defined as “the exchange, synthesis and ethically sound application of knowledge—within a complex system of interactions … to accelerate … a strengthened health care system.” This approach focuses on health outcomes and on changing behavior, and allows attention to be given to all possible participants, including patients and practitioners.

Different models of knowledge translation are used to close the gap between evidence-based research and practice. Davis presents a table that blends the knowledge translation models of Green and Pathman. Green et al. proposed a model in which interventions work in three ways: (1) to predispose to changing practice by increasing knowledge or skills; (2) to enable the change by conducive conditions within the practice and elsewhere; and (3) to reinforce the change, once it is made. The more recent model of Pathman utilizes evidence-based medicine to mark progress from awareness, agreement, and adoption to adherence.

The model in Table I applies Davis’s knowledge translation model and Pathman’s model to chronic pain patients and practitioners. This model emphasizes patient-centered care.

Patient-Centered Care

Patient-centered care is defined as an approach to care that encourages: (1) sharing control of the consultative dialogue, decisions about interventions, and management of health problems with the patient and (2) focusing in the consultation upon the patient as a whole person with individual preferences situated within social contexts. Patient-centered care contrasts with care that focuses on a body part or disease process.
on the premise that communication gaps during health care may result from health care providers’ focus on diseases and their management, rather than on individuals, their lives, and their health problems. Patient-centered treatment approaches are increasingly being advocated by consumers and clinicians and incorporated into training for health care providers. Some evidence indicates that patient-centered approaches may enhance patient satisfaction with care.7

The multidisciplinary pain treatment model (Table I) incorporates models of knowledge translation and patient-centered care. This model begins with the end. Pain treatment professionals begin by becoming aware of the patient’s goal. Treatment options are then discussed and agreed upon to help the patient reach the goal. The model is patient-centered in that clinicians focus on the patient rather than on the pain. The patient’s goal serves as a continuous motivation for treatment adherence.

### From Knowledge to Practice

How can we help patients and clinicians translate knowledge into practice? First, provide a “hook” to capture their interest. A suggested example is to begin with the end rather than forcing them to be passive recipients of the “step method.”

#### Table I

Multidisciplinary pain practice model for “beginning at the end”

<table>
<thead>
<tr>
<th>Awareness</th>
<th>Agreement</th>
<th>Adoption</th>
<th>Adherence</th>
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</thead>
<tbody>
<tr>
<td><strong>Patient</strong></td>
<td>Treatment begins with the end: patients describe their interests and goals to practitioners.</td>
<td>Patients acknowledge their agreement with medical, psychological, and physical therapy regimens through verbal or written agreements.</td>
<td>Patients adopt and continually apply medical, psychological, and physical therapy treatment regimens.</td>
</tr>
<tr>
<td><strong>Practitioner</strong></td>
<td>Asks patients how their life would be different with no pain or less pain. Presents available medical treatments to help them meet their goals.</td>
<td>Patient and provider agree on a treatment plan, e.g., dosage and frequency for prescribed medications, exercise regimens, and medical procedures.</td>
<td>During follow-up, regimens and functional goals are modified and titrated. Invasive favor procedures, implantable devices may be considered.</td>
</tr>
<tr>
<td><strong>Psychologist</strong></td>
<td>Asks patients how their lives would be different with no pain or less pain. Educates patients about psychological interventions, e.g., behavioral, cognitive-behavioral therapy, relevant to their goal.</td>
<td>Patient and psychologist jointly select types of therapy that will help the patient meet his/her goal, e.g., behavioral therapy, cognitive-behavioral therapy, biofeedback, sleep education.</td>
<td>The patient adopts changes in behavior and thought processes through daily use of behavioral and cognitive-behavioral skills. On subsequent visits, additional skills are taught until the patient incorporates them into daily life.</td>
</tr>
<tr>
<td><strong>Physical therapist</strong></td>
<td>Asks patients how their life would be different with no pain or less pain. Instructs patients on range of motion and strengthening exercises that build strength and endurance needed to meet and maintain goals. May alert patients to movements that impede progress or worsen pain.</td>
<td>Patient and therapist agree on a physical therapy regimen. The therapist emphasizes the rationale for exercises to reach specific goals. Agreement is made, e.g., on the number of repetitions per set and number of sets per day. Agreement is also made regarding appropriate action if exercises or increased activity contribute to increased pain.</td>
<td>Patients incorporate physical therapy into their daily activity. On subsequent visits, the therapist introduces additional exercises that the patient adopts into daily life. The patient is then discharged to an independent home program.</td>
</tr>
</tbody>
</table>
The current trend toward competency-based education in resident/fellowship training programs differs from the step method. Competency-based education is built on the premise that we never really teach until the learner learns.

We may think we lack the time to involve patients in designing their own treatment plan. For millennia, health professionals have asked, “What is the minimum I can do to provide quality care and then efficiently move on to the next patient?” We may feel we do not have time to hear patients’ goals and certainly not enough time to allow questioning as patients analyze and synthesize the knowledge we translate to them. However, connecting with patients to determine their goals before therapeutic plans are formulated taps their own motivation to adopt and adhere to their treatment plan. Osler’s classic essay therapeutic plans are formulated taps their own motivation to adopt and adhere to their treatment plan. Osler’s classic essay on the medical system of ancient Greece—prepared by synthesizing scattered remarks on this topic as they appeared throughout Plato’s dialogues—echoes our seemingly modern concerns. The medical system in Plato’s Greece was a two-tiered one in which slaves were treated quickly and empirically while prosperous citizens received less hurried care. Nearly 2500 years ago Plato wrote:

And did you ever observe that there are two classes of patients in states, slaves and freemen; and the slave doctors run about and cure the slaves, or wait for them in the dispensaries—practitioners of this sort never talk to their patients individually, or let them talk about their own individual complaints? The slave-doctor prescribes what mere experience suggests, as if he had exact knowledge; and when he has given his orders, like a tyrant, he rushes off with equal assurance to some other servant who is ill… But the other doctor, who is a freeman, attends and practises upon freemen; and he carries his inquiries far back, and goes into the nature of the disorder; he enters into discourse with the patient and with his friends, and is at once getting information from the sick man, and also instructing him as far as he is able, and he will not prescribe for him until he has first convinced him; at last, when he has brought the patient more and more under his persuasive influences and set him on the road to health, he attempts to effect a cure. Now which is the better way of proceeding…? Is he the better who accomplishes his ends in a double way, or he who works in one way, and that the ruder and inferior?

We began this article with our daydream as pain management specialists that all we have to do is give our patients treatment instructions and they will automatically adopt them and adhere to them. Perhaps we will be more effective as practitioners and educators if we buy into their daydream, not ours. When patients and clinicians define their desired goal, they make themselves the heroes of their own scenarios, thereby enhancing their resolve to succeed. We in turn enhance our effectiveness as practitioners and educators by helping patients move from knowledge to application to reach their desired—and explicitly stated—goals.

As has been said, “Education (and perhaps medical practice) must have an end in view, for it is not an end in itself.”

By teaching a goal-oriented, patient-centered knowledge translation model, we can help trainees reconceptualize the patient-physician communication process, both in abstract terms and in their own practices.

References


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4 Printed in the U.S.A.