INTERVIEW

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Advancing the Provision of Pain Education and Learning (APPEAL)

Dr Emma Briggs* speaks to Dominic Chamberlain, Assistant Commissioning Editor:

Dr Emma Briggs is a Lecturer at King's College London (London, UK) in the Florence Nightingale School of Nursing and Midwifery. In 2013, she was appointed as a King's Teaching Fellow in recognition of leadership and excellence in teaching and learning, and her influential research in pain education. Dr Briggs's research has informed developments at a local and national level, including the UK's first interprofessional pain education learning unit for undergraduates from multiple disciplines at King's College London.

Dr Briggs chairs the British Pain Society Education Special Interest Group, a dynamic, interprofessional network of people passionate about improving pain education for healthcare professionals for the benefit of patients. The Special Interest Group members are involved in educational research and development, influencing change in undergraduate and postgraduate education at local, national and international levels. Dr Briggs also chairs the Royal College of Nursing London Pain Interest Group and is a strategic member of the King's Health Partners Pain Group, an interprofessional collaboration of scientists, clinicians and academics. As a member of the European Pain Federation EFIC® Education Taskforce, Dr Briggs and the team have been investigating the provision of pain education in medical schools across Europe as part of the APPEAL study.

Q What first drew you to pain management?

One particular patient sparked my interest, a 72-year-old gentleman who received an above-the-knee amputation had an excruciating stump and phantom limb pain. As an enthusiastic undergraduate student, I said, "I have come to assess your pain and we are going to try and get on top of it." He swore at me and asked me to leave him alone to die. That is how bad it had got, this normally gentle, positive man was reluctant to mobilize, hardly eating and drinking, unable to sleep and was experiencing depression. He later apologized for his language and aggression, but it was real moment of reflection, why and how had it got so bad for this gentleman? At that point I started to try and unravel

why this pain was so complex and why the treatment provided was not working. My undergraduate and postgraduate studies helped me understand the biopsychosocial experience of pain and why a multimodal and interprofessional approach is needed.

Q You have written about a variety of pain issues including cultural perceptions & expression of pain. What has been the most interesting area to be involved in so far & why?

My primary passion is around effective pain education for patients and healthcare professionals. I realized early on the importance of local practice development to improve pain management, but I wanted to have a wider influence. Education is key

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and being able to unravel this complex subject, and respectfully challenge people's existing views and misconceptions and help them learn about pain, is both challenging and rewarding.

Q What big changes/advances have you observed in pain management from a nursing perspective over your career so far?

My background is in acute pain and there have been huge changes, particularly in the UK, with regards to pain services. Hospitals have established multiprofessional inpatient services that have been able to promote changes in pain management. However, most people experiencing pain are in the community and in the last couple of years, particularly in the UK, there have been some really important developments. The Chief Medical Officer's report on chronic pain was pivotal and the top recommendation from that was that pain training of healthcare professionals should be part of their education. That led to a number of pieces of work including a National Pain Audit, a 3-year project to collect data on pain services and their activities across the UK [101]. In November 2011, the English Pain Summit took place – a joint initiative between The British Pain Society, Chronic Pain Policy Coalition, Faculty of Pain Medicine and the Royal College of General Practitioners [102]. In their report, published in 2012, four key recommendations and activity areas were set out that are now being taken forward by the groups involved. These policy and clinical developments have been fantastic, but we have a long way to go to improve things from the ground up. A recent survey by Health Survey England showed that 31% of men and 37% of women in England experience chronic pain; a third of the population [103].

Q Can you tell us a bit about the APPEAL study; what was the aim of the study & what did you find?

The APPEAL study aimed to establish a European benchmark in pain education. We looked for evidence of pain teaching in medical schools across Europe, investigated whether there are dedicated modules on pain and where else in the curriculum

there is compulsory pain teaching, and examined teaching methods and how pain was assessed within the curriculum.

This first phase was a cross-sectional survey of information available around the curriculum across 15 European countries in the academic year 2012–2013. The European countries were chosen based on the UN subregion of Europe to make sure that the countries included were representative of the greatest number of medical schools and student intake. There were a total of 249 accredited medical schools in these countries and we have data for 242 schools.

The consistency in teaching was variable; in fact there was no consistency across Europe. In eight out of ten schools there was no compulsory and dedicated teaching – in that there were no specific modules and teaching on pain. There were certain countries where this occurred namely: Belgium, Bulgaria, Denmark, Ireland, Portugal, Poland and Sweden. None of the medical schools in those countries had teaching modules specifically on pain that were compulsory.

We looked at those that did have compulsory dedicated teaching, but in the majority pain was dotted throughout the curriculum, so it could be found in pharmacology, neurophysiology or may come into palliative care, but it is in different places in the curriculum and there was no consistency as to where it appeared in the curriculum.

This suggests that pain education may not always be planned in a progressive way, as a topic. Our ideal is to have some compulsory and dedicated teaching on pain, but also recognizing that, as students look into different conditions, pain still needs to be threaded throughout the curriculum, but it does need some dedicated time.

The other key finding relates to the number of teaching hours that were available. And, where there were dedicated modules on pain, this averaged 12 h, and where it was spread throughout the curriculum, medical students typically received just 9 h. This is a very low number of hours, 0.2% of a curriculum that is stipulated by a European directive to be 5500 h in total.

We did find that our data was very much skewed by France, where 27 out of 31 of

their schools have compulsory teaching on pain modules. France has had a series of national plans around pain since 1998, each of which has attracted funding. Since 2004 it has been compulsory that medical schools must have teaching on pain and it is included in the final examination.

Q What impact do you foresee/hope the APPEAL study can have on pain education?

We would hope that the study results raise the issues around the importance of pain education, so that our healthcare professionals of the future are adequately prepared to manage pain. Given that pain is an increasing health problem, the amount of education doesn't reflect the public health need, so we would like it to be a higher priority in the curriculum, and for universities to be delivering dedicated pain education.

In order to achieve this, we need some joint working. Each of the countries are going to have different needs, and we need to work together with the various bodies – the ministries of health, ministries of education, in the UK the Department of Health and in many cases regulatory bodies, for example, the General Medical Council. We do know of some good examples at a country-wide level, such as France, and at university level, such as the interprofessional program here at King's College London, and we can learn from and build on these.

Q What specific changes would you like to see implemented as a result of the APPEAL study in pain education?

A multidisciplinary taskforce of experts under the leadership of the European Pain Federation EFIC® that led the research have three recommendations:

- Establish a European framework for pain education to ensure consistency in pain education;
- Introduction of compulsory pain teaching for all undergraduate medical students;
- Improved documentation of pain teaching.

At a university level, an increase in the numbers of hours of pain teaching is

important, but it's also about the way that the teaching is delivered.

Part of the study observed the teaching methods and assessment methods. A lecture-based approach often promotes surface learning; it is about facts and knowledge, it promotes rote learning and 95% of our universities are using that technique. A total of 92% are assessing them through an examination, which also promotes factual recall. However, in order to manage pain effectively, healthcare professionals need to be able to assess and diagnose, they need good communication skills and empathy, they need good problem solving and clinical decision-making skills in order to unravel the complexities around pain. This is not necessarily going to be achieved by a lecture. So we need to think about how we deliver the pain education. Can we do it through problem-based learning; a student-centered technique that promotes learning through problem solving? Can we promote interprofessional pain education so that students can learn about others' roles in pain in order to be ready for practice, to work as an interprofessional team?

Q How difficult will it be to implement these changes?

Because different countries have different health priorities, it will be a challenge. The Taskforce is providing leadership at a European level with this initial study. This is the very first stage; it is the call to action. We need to have a European-wide strategy to support countries to make changes. But then it will come down to each of the countries involved, bearing in mind the different systems and universities, and ministries, among others. That needs to be carried out at a country-wide level, but there needs to be a European strategy. There is no minimum competency. A good place to start would be instead of stipulating that every university have 20 h of teaching, we should be focusing on the competencies. Our first recommendation is that we should have a common competency framework as a goal.

Q Where will you be focusing your attention in the future?

Continuing to improve pain education at a local, national and international level.

Here at King's College London, we have significantly improved our pain education and hopefully the pain management for our patients locally. We introduced the UK's first interprofessional pain management learning experience, which is run for 1300 students from six disciplines; dentistry, medicine, midwifery, nursing, pharmacy and physiotherapy. They all learn and work together in order to understand pain and its management. There are a number of universities that are consulting with us on that, in order to improve their education.

Nationally, I am the chair for the British Pain Society's Pain Education Special Interest Group, which works to raise the profile of pain education. We are a national network of people involved in pain education, and next year we are publishing guidelines for academics at universities to enhance and improve their pain education.

You often need a local champion, to drive progress forward, so I hope for the future to be focused around creating more champions. Also, tying in with that fact that chronic pain needs to be more widely recognized as a condition in its own right, as lack of recognition is part of the difficulty of getting it in the curriculum. Pain management is not seen as a specialty, meaning it is more challenging to get it into the curriculum, so our campaign will be around moving it up the agenda.

Internationally, the European Pain Federation EFIC Taskforce will be looking to implement its recommendations and encourage change at a countrywide and university level. I also work with the International Association for the Study of Pain Pain Education Special Interest Group who are important in supporting and driving change.

Q Finally do you have a message for our readership?

Inspire the next generation and get involved in educating people about pain; it might be individual undergraduate or postgraduate students, groups in clinical practice or university teaching. Actively seek out opportunities to inspire and improve pain education. In our interprofessional pain management learning unit, we have a number of facilitators, pain specialists who work with the students to stimulate, inspire and challenge, helping them learn about pain management and promoting pain as an important specialty.

Disclaimer

The opinions expressed in this interview are those of the interviewee and do not necessarily reflect the views of Future Medicine Ltd.

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