Cancer Pain Education for Patients and the Public
Module VII
Professional Education as a Prerequisite to Patient Education:
Involving Colleagues in Pain Education

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I. Professional Education:

A. How much knowledge/skill do we need?
1. To educate, and to change practice?
a. A definition of pain.
b. An overview of the physiology of pain vs. an in-depth understanding of cell transport and pain pathways (Good, 1999).
1. Primary hyperalgesia = increased peripheral sensation.
2. Secondary hyperalgesia = central sensation.
3. Third messengers = recruited to permit genetic encoding of increased responsiveness of dorsal horn neurons.
4. Risk factors for persistent pain.
5. Suppressing the stress response.
c. Classifications of pain vs. types of pain.
1. Acute, chronic.
2. Muscular, neuritic, central, autonomic.
d. Details of a "good" assessment.
1. PQRST.
2. Detailed pain history.
3. Physical assessment.
4. Family history.
5. Gender sensitivity.
6. Beliefs.
7. Reassessment.
e. Goal setting.
f. An overview of pharmacotherapy vs. detailed study of action, interactions and side-effects.
1. Schedule, route, equianalgesia
2. By age group.
3. Ceiling effect, tolerance, dependence.
g. Non-pharamacologic strategies.
1. Radiation therapy.
2. Alternative/complementary therapies.
3. Cognitive-behavioral strategies.
4. Heat and cold.
5. Nerve blocks.
6. Surgery.

h. Application: case studies.
i. Patient-caregiver communication.

2. Does everyone need to be a pain management expert?
   a. Nurses (MSN, RN, ADN, LPN, UAP, PhD).
   b. Physicians, pharmacists, social workers, physical therapists, clergy.
   c. How many hours of education and practice?
3. Is knowledge enough?
   a. Mitchell Max (1992): Is education enough?
      1. Must change attitudes of professionals, patients & the public.
      2. Must oppose "established patterns of practice and tradition."
   b. Or, how do we measure change?
      1. Knowledge tests.
      2. Evidence of application in practice.
         a. APS quality assurance standards (APS, 1995).
         b. Pain Audit Tool (Ferrell et al., 1995).
         c. PRPMAT (Wallace et al., 1999).

B. We know we can increase knowledge, do we need to focus on how to change attitudes?
   1. How do we change attitudes?
      a. Case-based, practice enabling discussions (Elliott, et al., 1997).
      b. Behavioristic learning.
         1. Repetitive learning (stimulus and response).
         2. Perpetuation of established practice.
      c. Cognitive learning.
         1. Extending previous, well-organized knowledge.
         2. Using categorization to reduce complexity.
      d. Problem-solving.
         1. Focuses on variability and reduction in differences.
         2. Evaluating personal sensitivity to pain problems.
         3. Using the "teachable moment."
            a. Content is relevant.
            b. Emphasizing doing as well as knowing.
            c. Using repetition and opportunity for practice.
            d. Receiving positive reinforcement for behavior.
      e. Promote self-efficacy.
         1. Derived from previous performance or observing others.
         2. Decrease anxiety associated with evaluation.
         3. Decrease risk of failure or disappointment.
            a. Decrease self-protective behaviors.
            b. Promote well-developed, complex cognitive structures.
         4. Evaluate simplistic vs. complex approaches.
         5. Reestablish self-relevant beliefs.
      f. Promote reasoned action.
         1. If no significant barriers, e.g.
            a. No time or opportunity.
            b. Without requisite information, skills, or abilities.

2. Consider implications of actions.
3. Consider intentions resulting from
    a. Attitude toward a behavior.
    b. Environmental pressures.

g. Processing persuasive messages.
1. Need prior knowledge of subject matter.
2. Need multiple resources.
3. Consider true merit of information.
4. Simple-cue induced changes.

2. Will legislation change attitudes and behaviors?
a. Hyde-Nickles Bill - Pain Relief Promotion Act.
b. Hooley Bill - Conquering Pain Act of 1999.
c. JCAHO Standards

C. Will changing attitudes change behavior?
1. Comparing ethics (to act in accordance with values) to values.
a. Values are professional, personal and organizational.
b. Value indicators:
1. Goals.
2. Attitudes, feelings, conviction and beliefs.
3. Enhanced sense of empowerment.
2. Evaluate communication in relation to behavior change.
3. Increase interdisciplinary collaboration.
4. How long should it take?

D. Role of educational institutions, practice agencies, regulatory agencies.
1. Curriculum Committee.
a. Text.
b. Faculty web pages.
2. CQI teams.
a. Group consensus building.
b. Decision-making techniques.
c. Rewards for behavior change.
3. JCAHO.
4. Board of Nursing/Board of Medical Examiners.
5. NLN.
6. AACN.

II. How to Involve Colleagues in Pain Education (Strategies)

A. Train the trainers/teachers (individuals, pairs, teams, communities).
1. 40-hour (8 hours x 5 days) course (Ferrell et al., 1993).
a. Patient Resource Nurse (PRN) Training Program.
b. Nurses in inpatient units and outpatient/ambulatory clinics, operating room and recovery, home health.
c. Increased teaching to co-workers and patients.
2. 1-day Role Model program for nurses, physicians and pharmacists (Janjan, et al., 1996).

a. Change in knowledge and attitudes.
b. Motivated to share principles with other health care professionals.

3. 1-day/week x 5 weeks program (Dalton, et al., 1996).
   a. 3 cohorts of 5 pairs.
   b. Outcomes.
      1. Change in knowledge and behavior.
      2. Traveling to education site may have taken time away from implementation.
      3. Documentation was problematic.
      4. Produced increase in feelings of credibility and consultative role.
4. 3-hour x 8 weeks program for ward teams (Francke et al., 1997).
   a. Increased quality but not quantity of activities.
   b. Need to combine education with implementation of assessment policy.
   c. Need more physician interest.
5. 3-day role model program (Ferrell, et. al., 1994).
   a. RN and MD pairs
   b Resource development and formulation of institutional policies
6. 2-day PRN educational program (Ferrell et. al, 1993).
   a. Problematic areas predominantly issues of pharmacology.
   b. Over time, pharmacology remained problematic.
7. 2-day minifellowship (Elliott et. al., 1997).
   a. Community opinion leader clinicians.
   b. Physicians' and nurses' knowledge and attitudes.
   c. Effectiveness may have been related to the local clinician culture, organizational structure, care setting.
   d. Needed more intense intervention (3-5 years).
   e. Suggest CQI; feedback on performance, improvement in interactions.

B. Educational strategies.
   1. Academic detailing.
   2. Study groups.
   3. Socialization programs.
   4. Clinical rounds.
   5. Case studies.
   6. Practicum.
   7. Reminder system.
   8. Opinion leaders.
   9. Educational influentials.
   10. Standardized patient assessment.

C. Suggestions (Clarke et. al., 1996):
   1. Incorporate self-rating tool on flow sheet.
   2. Distribute AHCPR guidelines.
   3. Use APS survey of satisfaction.
   4. Include information in all orientation programs.
   5. Establish Pain Information Bulletin space.
   6. Form a Pain Practice Group.
   7. Select interested nurses to be come "Pain Resource Nurses."

8. Work with other clinical services.

D. Be involved in local, regional and national organizations.
   1. State Pain Initiatives.
   2. American Pain Society.
   3. American Society of Pain Management Nurses.
   4. American Pain Foundation.
   5. Specialty organizations/ SIGs.

E. Read publications.

III. Issues in Implementation

A. Longer and/or more intense programs.
B. Combination of educational methods.
C. Opportunity for practice performance feedback.
D. Attitudes.
E. Context of clinical setting and practice behavior.
F. Lack of individual commitment.
G. System priorities.
H. System support and reinforcement.
I. Definition of outcomes (based on "effect desired").
   1. Charap, 1978: " surgical residents and nurses indicated that they believed that most patients are over- rather than under-medicated."
   2. Camp-Sorrell & O'Sullivan, 1991: lack of pain assessment documentation.
   3. Weber, M. & Huber, C. (1999) "rescue doses", laxative prescription and bowel movements were never or only scarcely documented by all physicians.
   4. Furstenberg, et al., 1998 "sample were not concerned about addiction, physicians less committed than nurses or pharmacists to providing optimal pain control."
J. Educating nurses and implementing daily assessment (De Rond, Van Dam, et al., (2000).
K. Developing an acute pain service (Van Niekerk & Martin, 2001).
L. United Kingdom: common misconceptions (Davis, McVicar, 2000)
M. New York: home health nurses (Glajchen & Bookbinder, 2001).
N. Australia: knowledge of pain in the elderly (Sloman, Ahem, Wright et al., 2001).
O. Belgium: change in knowledge and beliefs substantial (Bauwens, Distelmans, Storme at al., 2001).