Making Pain Management Education Work By Focusing On Nurses’ Values And Culture

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Conflict of Interest Disclosure

- Conflicts of Interest for ALL listed contributors.
  - E. Bernhofer, NONE

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Objectives

The participant in this learning session will be able to:

1. Describe why understanding the values and culture of the pain care provider are critical to providing optimal pain care for patients.

2. Summarize the essential didactic elements that a basic nursing pain management class should include.

3. Discuss personal values and approaches to providing pain care.
A little background…
Cleveland Clinic
- A 1266 bed, quaternary medical center in Cleveland, Ohio
- 180 acres and 44 buildings
- Approximately 53,000 admissions per year
- 940 patients average daily census
- 65 nursing units
- Over 3100 nurses

And just like everywhere else, patients have pain!

A little history…
- In 2009, first series of ‘Pain Champion’ Pain Management Classes
  - Due to extremely low HCAHPS scores
  - Started by a Med/Surg Nursing Director
  - Specifically for nurses at the time
  - Great faculty!
A little more…

- After 5 years and 22 full-day classes…
  - Over 1400 nurses have participated
  - HCAHPS scores began to rise somewhat
  - Anecdotal stories…
    - Better pain care
    - No difference in pain care
  - Great post-class test scores
  - No real measures of patient-centered outcomes

So the question became…

What were we doing right??

…..or wrong??

Could it be?

- Still not providing enough necessary education to enough nurses?
- Not involving physicians and other caregivers enough?
  - Physician education
  - Nurse/physician collaboration
- Not enough time in the day?
- Not enough administrative buy-in and prioritization?
- Not enough useful measures of outcome?
Remembering the nature of pain

• It is unlike any other symptom that we assess and treat
  - The subjectivity
  - The emotions
  - The medications
  - The stigma
• It requires trust on the part of both patient and caregiver
• The patient’s and caregiver’s pain values and culture make a difference

We always say...

1. The patient’s culture, values, understanding of pain, background, etc. need to be taken into consideration.

2. AND we say that caregiver attitudes and bias makes a difference

• BUT…. We just don’t emphasize point #2 in our classes

We must remember

• Optimal pain care often falls victim to the values and culture of the caregiver despite what they learn in a class!

• The commanding influence of the personal values and culture that each nurse-learner brings to a pain management course cannot be overestimated since values drive behavior.
Could it be that the failures of pain management education to have a large, positive impact on the actual pain care that patients receive in the hospital may not be entirely due to the course content or teaching style, but may have everything to do with the values and culture that the learners bring with them.

Unless the overarching influence of the care-giver’s own personal values and culture are addressed, the information imparted in a pain management class will not translate into practice change!

Like most clinicians, nurses will take time for what they value and will work within the prevailing culture in order to accomplish their daily objectives.

A dramatic shift is necessary in pain management education, moving the emphasis from the didactic to the exploration of personal values regarding pain and those who suffer from it.
When we realize there’s more to it, we often start with emotional appeal

What’s wrong with that?

Emotional appeal only works if you know exactly where the other person is coming from...

So...

• You can use emotional appeal
• But remember... you must know your audience very well!

• For example, using pictures, stories, movie clips, and case studies of patients with intractable pain, may have little impact on the pragmatic nurse who believes pain behavior can be an act in order to elicit sympathy for more drugs.
Beyond emotion, what else motivates nurses to learn and use better pain management skills?

- OWNERSHIP of the problem (being evaluated, personal responsibility, accountability)?
- Avoiding moral distress?
- Personal MORAL IMPERATIVE (you must do this in response to ethical behavior and personal moral obligation)?
- Other: Job satisfaction? – personal impact?

Values

• Definition – level of worth or importance (owning problem, moral imperative, personal impact)
• Also – beliefs shared by the members of a culture
• And – values influence behaviors, attitudes, and serve as guidelines of behavior

Pain culture

• Culture – a set of rules and standards developed over time and set for members of a society to follow – when behavior falls in the range of the rules, it is ‘acceptable’. Perceiving, expressing, and controlling pain is a cultural phenomenon.

• Ethnic cultures
• Regional cultures
• Racial cultures
• Subset cultures
• Family cultures
• Consider your own for a moment:
  - Perceiving – Expressing - Controlling
Ethics in Nursing

- Provision 1 of the Code of ethics for nurses with interpretive statements: The nurse, in all professional relationships practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems. (American Nurses Association, 2001)

Ethics

- Autonomy: Support independence
- Beneficence: Do only good
- Nonmaleficence: Do no harm
- Justice: Equal and fair treatment

- How do we use these principles to ensure better pain care?
  - It may be difficult to treat all people the same!

Do you like your patient?

A Belgian study published in 2011 indicates that a patient’s "likeability" may be related to how seriously healthcare givers take their pain.

Findings include, “…that pain of disliked patients expressing high-intensity pain was estimated as less intense than pain of liked patients expressing high-intensity pain...less sensitive toward pain of negatively evaluated patient than to positively evaluated...”

Furthermore, the effect of likeability was only found significant in patients expressing high-intensity pain! What could this mean?

De Ruddere et al., 2011
Principlism: the non-emotional route

- Definition: Using the Principles of Ethics to make the right decision

- Formerly, ethical decision-making in medicine was, "a mixture of religion, shams, exhortation, legal precedents, various traditions, philosophies of life, miscellaneous moral rules, and epithets." (Clouser, 1993, p. S10)

- Principlism uses a systematic discarding of information extraneous to decision-making (Evans, 2001)

A systematic discarding of information extraneous to decision-making

- The 4 Ethics Principles provide the essential units necessary to calculate the right decision – calculable and logical – like money

- The 4 Principles become the common metric

- They set the VALUES in the CULTURE

Therefore Principlism becomes essential to practicing Ethics

- There is a need to legitimate decisions to the people who do not know/trust the decision-makers

  - Discard what is difficult to translate to the common metric: the 4 Ethical Principles

  - “How matters that affect the public ought to be deliberated and decided” (Evans, 2001, p. 1)
Having said all that...

• How can we understand our own values and culture regarding pain management?
• How can we use the principles of ethics to Discard what is difficult to translate to the common metric of the 4 Ethical Principles?
• How can we teach it?
• Does it make a difference to patients in the end?

How-to

• We, and our pain management students, must first understand our own Pain Management Approach to determine our values and culture and how we will use our knowledge and resources.

• Will we use Principlism?

Looking at Your Personal Pain Management Approach?

• Pain Management Approach (PMA™)
  - Your personal response to others with pain
  - Based on your knowledge, experience, attitudes, socialization, culture, and values
  - Will determine how you view ethical principles
  - Will determine how you use knowledge and resources
Benefits of understanding PMA™

- Pain care approach categories are based on how the individual clinician may approach patients from their own perspective.
- Knowing your PMA helps you understand patients and family with their own perspectives.
- Avoiding moral distress – doing what you can and telling yourself the truth about how well you cared for your patient.

Four PMA™ categories

- The Cautious
  - “people’s pain is hard to figure out”
- The Restrained
  - “afraid the cure is worse than the pain”
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- The Cautious
  - “people’s pain is hard to figure out”

- The Restrained
  - “afraid the cure is worse than the pain”

- The Pragmatic
  - “Life is pain. It is what it is.”

- The Empathetic
  - “it’s all just misery!”

Four types of PMA™

1. Cautious
   - Can’t believe every patient’s report of pain
   - Doesn’t understand the whole ‘pain thing’
   - Strengths: can prevent being manipulated; may lead to better assessment
   - Challenges: cynicism can damage trust; may lead to moral distress/confusion; may refrain from spending much time with patient
Four types of PMA™

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2. Restrained
   - Afraid that medication will hurt/kill the patient.
   - Doesn’t really know how to talk to someone in pain.
   - Strengths: aware of potential dangers; always cognizant of patient safety
   - Challenges: may cause harm by not treating pain aggressively; can suffer moral distress; may not spend much time with patient

Four types of PMA™

3. Pragmatic
   - Just get the job done - life is pain. It is what it is.
   - Besides, the patient’s pain is not their ultimate problem
   - Strengths: protects self from moral distress; usually administers meds without question; can make unemotional decisions
   - Challenges: rarely thinks ‘outside the box’; may not seek out resources to help patient beyond the ‘usual’.

4. Empathetic
   - Really feels for those in pain.
   - Wants to do everything possible no matter how long it takes
   - Strengths: will go to great lengths to advocate for better pain care; will be ‘present’ with patient
   - Challenges: may overlook harmful side effects; suffers moral distress; may not communicate well in high state of emotion
Determining your PMA™

Consider how you respond and make decisions in other areas of your life.

Consider where your values lie.

Take a fun quiz.
Of course, there's only so much time

- What is imperative to teach about pain management?
- What can you get into a 6-8 hour class
- What we did....

The essential didactic elements include:

Addressing the 4 pain management domains and core competencies of
1. Multidimensional nature of pain
2. Pain assessment and measurement
3. The management of pain
4. Clinical conditions and how context influences pain management

(Fishman et al, 2013)

Additionally

Core values and principles in Core Competencies for Pain Management (Fishman et al., 2013)
- Advocacy
- Collaboration
- Communication
- Compassion
- Comprehensive Care
- Cultural inclusiveness
- Empathy
- Ethical treatment
- Evidence-based practice
- Health disparities reduction
- Interprofessional teamwork
- Patient-centered care
Including the physicians (and others)

- At the end of EVERY class....
- Importance of Interdisciplinary teaching and learning

Including the physicians (and others) to make a difference

- What we tried
  - Remind them about Evidence-based practice!
  - Inviting the docs and others
  - CMEs

Rationale

- Pain management: Education, Resources, and Evidence-Based Practice will only be used as valued by the caregiver!
- Learning translates into action when the learner embraces the ideals that are taught as meaningful and imperative to them!
- We say that change happens from the top down – no – culture change happens from the bottom up! Then the top eventually sanctions the culture that was created from the bottom up. (grass-roots)
Our class agenda

Before
- Introduction to Pain: 30 min
- Biopsychosocial aspects: 45 min
- Opioid strategies: 45 min
- Assessment and Advocacy: 45 min
- Pharmacology: 45 min
- Chronic pain: 45 min
- PCA pumps: 45 min
- Epidural Analgesia: 45 min
- Peripheral nerve blocks and nerve catheters: 45 min

After
- Basic pain physio/psych: 40 min
- Impact of pain: 30 min
- Pharmacology: 40 min
- Non-Pharm Interventions: 40 min
- Pain Assessment: 30 min
- Pain needs at End of Life: 30 min
- Pain Management in the opioid tolerant (chronic pain or substance abuse): 30 min
- Pain Management Values, Ethics, Principlism: 30 min
- Identify your own PMA: 90 min

As it turned out...

- 6 hour class (7.5 hr day minus lunch & breaks)
  - First 4 hours are didactic
    - Basic pain physio/psych: 40 min
    - Impact of pain: 30 min
    - Pharmacology: 40 min
    - Non-Pharm Interventions: 40 min
    - Pain Assessment: 30 min
    - Pain needs at End of Life: 30 min
    - Pain Management in the opioid tolerant (chronic pain or substance abuse): 30 min
  - Second 2 hours are reflective
    - Pain Management Values, Ethics, Principlism: 30 min
    - Identify your own PMA: 90 min
Big Differences

Before
- Focus on
  - Physiology
  - Specific treatments
  - Very little non-pharmacological
  - Nothing on values and culture
  - Nothing on special populations
  - Very didactic

After
- Focus on
  - Physiology
  - Psychology
  - Common treatments, pharm and non-pharm
  - Special populations
  - Emphasis on values and culture
  - Time for interaction

Measures of effectiveness

Before
- Knowledge and Attitude Post-test
- Anecdotal stories
- HCAHPS
- Not much in patient outcomes

After
- Qualitative Study results
- Anecdotal Stories
- HCAHPS
- Still not much in patient outcomes
Learner comments - example

Before
“Most impact of class: good review on pharmacologic effect and peak onset.”

After
“I really enjoyed the group discussions and the bit of introspection from the quiz. Again gives insight into the reason I went into nursing.”

Quotes – on need for values
“Most impact of class: the constant need to remind ourselves pain is subjective.”

“Program is much more interesting than last year because of the PMA games.”

“Culture part of program needs to be longer.”

“Most impact of class: more open minded when it comes to pain assessments and the treatment of a patient’s pain overall. Likely will look at the entire pain experience differently and therefore not look at patients in ways previous looked at which will overall help my using treatments/actions.”

Quotes – same old, same old
“Most impact of class: Pharmacology pain medication, non-pharmacologic interventions”

“Most impact of class: Pharm. It’s good to know how the drugs work to inform the patient.”

“Most impact of class: review of the neuronal pathway”
What insights did our nurses gain??

- Recent qualitative study results:
  - Themes:
  - Demographics:
  - Conclusions:
- Not all rosy – still many biases and challenges
- Nurses still seem to like practical interventions best!
- Changing culture takes a lot of time!

What to teach. Where to start.

- Acknowledgement of personal biases
- Underlying problems of nurse-learner values and culture is the largest hurdle in the pain management class
- Not necessarily lack of didactic information
- Structure classes to provide the necessary information and experiences that enable the learners to come away questioning themselves, wondering why it is that they and their culture don’t make the management of their patient’s pain a moral imperative in their practice.
- Involve physicians and all disciplines!

In Summary

- Stop trying to approach teaching Pain Management like teaching any other class on diseases or clinical processes
In Summary

• Stop trying to approach teaching Pain Management like teaching any other class on diseases or clinical processes

• We can teach the content and how to access the resources but without the right values...

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