

**ORIGINAL ARTICLE**

**Research on the Influence of Health Care Professional's Personal Experience of Pain on the Management of Pain**

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**Abstract**

**Background.** Previous research has indicated that there is improvement in pain relief when the staff is more conscious about everyday pain management.

**Aim.** This study was designed to gain insight into the way the personal experience of pain affects the attitude of Health Care Professionals towards pain management. The research was undertaken between May and September 2004. It was conducted in a Greek general hospital.

**Method.** Qualitative methods of enquiry were employed and a phenomenological approach was adopted, based on un-structured interviews. Fifteen Health Care Professionals who had had personal experience of pain participated in this study. The tape-recorded interviews were transcribed and content analysis on them was adopted.

**Findings.** All participants recognized the staff's insufficient knowledge of pain management. They assessed that the personal experience of pain is a chance for self-criticism. They also noticed that after this experience they are more sensitive to the problem of pain and more aware of the patients' needs. Furthermore, they proposed educational interventions that will focus on a holistic approach and on improving communication skills.

**Conclusions.** According to this study's findings the Health Care Professionals' personal experiences of pain helped them gain insight into the complex issue of pain. It would be unethical and irrational for Health Care Professionals to seek pain in order to improve their pain management skills, yet they can gain knowledge from those who have experienced pain and thereby improve their understanding and everyday clinical pain management.

**Key words:** experience, pain, phenomenology, nurse-patient interaction

## INTRODUCTION

Several studies have indicated that patients are often dissatisfied with the treatment and relief of their pain, yet some fail to report their pain due to fear of strong medication and the belief that an increase in pain signifies disease progression. This fear of the possibility of disease progression leads to the avoidance of reporting pain (Tcherny *et al.* 2003, Young *et al.* 2003, McDonald *et al.* 2007). On the other hand, staff members have been accused of inadequate assessment and documentation of pain and insufficient knowledge of pain management. The complexity of the problem is compounded by a lack of psychosocial support services in Greece (Patiraki-Kourbani *et al.* 2004, Tafas *et al.* 2002, Bookbinder 1996).

## LITERATURE REVIEW

For the literature review, searches were made on major databases: Medline, Cinahl, Psychinfo, Medical and Nursing and Journals databases using key words which included: pain, experience, hospitalization, pain management.

The International Association for the Study of Pain defines pain as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage” (Merskey & Bogduk 1994). Pain has been described as an extremely complex issue which covers various physical, psychological and emotional experiences, from throbbing and itching sensations to the intense pain of an injury or the ‘*pain*’ of disappointed love (Starr, 1995).

As pain has both psychological and physiological meanings, it has been accepted as a subjective phenomenon. According to some authors, there is no objective way of demonstrating that someone is in pain, or how much pain or what kind of pain he is experiencing. Furthermore, suffering is a subjective experience, which is not necessarily tied to apparent injury (Smith 1998). Therefore, when a patient reports or acts as if in pain, the HCPs should respond in an active way.

The opposite view accepts pain as a subjective experience and can even initiate a suspicious attitude towards the patient’s personal accounts of pain. Unfortunately, there is a hidden possibility that the HCPs might underestimate genuine pain, claiming that the patient may have “psychiatric problems” and not give appropriate care to their clients. Pain can affect the total being of a person including mood and intellectual ability (Thielke *et al.* 2007). Therefore, it is necessary to trust the patient and understand his behavior in the context of the circumstances.

To assess pain, assessment instruments may be used. A unidimensional measure, which is widely used, is the visual analogue scale. It is a 10cm line, on the ends of which are indications of the extremes of pain intensity, from ‘no pain’ to the ‘worst pain possible’ (Peters *et al.* 2007). Patients indicate which pain description along the line best represents their current experience. However, the disadvantage of the visual analogue scale and the other unidimensional single-item scales is that they measure only the intensity of pain. Multidimensional measures such as the McGill Pain Questionnaire provide a more comprehensive description of an individual’s pain experience assessing the sensory, affective and miscellaneous characteristics of pain. Patients select the words that describe their level of suffering at that moment (Gagliese & Melzack 1997).

### *The HCPS’ attitude towards pain*

HCPs can easily underestimate the importance of discovering the uniqueness of individuals and assessing their views accurately (Drew *et al.* 1989). Stereotypes are often used in their approach to patients. Agreement was found between patients and professionals using a 40 needs listed, but there was an indication that all the professionals identified approximately the same needs for every patient (Hansen *et al.* 2002).

In a further study, only 45% of 353 hospitalized patients who experienced reported that a HCP had asked them about their pain or included it as a comment in their records (Donovan *et al.* 1987). Another study of 242 hospitalized patients in pain revealed that in the notes of their caregivers there was no description or report of pain intensity (Gu & Belgrade 1993).

Studies on cancer patients and substance abuse patients in country showed that the latter group was seen as contributing to their own condition and this decreased the willingness of nurses to respond appropriately to their pain. Moreover the patients' desire to live or not (e.g. those who attempted suicide) was a factor that influenced the nurses' responses. As one nurse said 'it is difficult to provide good care for people who want to die when there are so many who want to live'. Age seems to be an important factor in the decision to spend time and energy on an individual. The elderly were perceived to use complaints in order to gain attention and were not trusted to describe their pain accurately. Nurses' preconceived notions about particular groups of patients can influence their care, sometimes in an unfair and negative way (Brockopp *et al.* 2003).

A Swedish study highlighted that pain relief can be improved with the staff's consciousness about the interference of their attitudes in pain management strategies (Blomqvist 2002). A major methodological weakness in all these studies is that no consideration was made as to whether the HCPs and the patients, who participated in each study, had the same cultural background because the culture of an individual affects not only their perception of pain but also how they express pain (Koutantji *et al.* 1998).

#### ***Educational gaps in connection with pain management***

Journal editorials have criticized the insufficient time and attention applied to pain education and proposed a curriculum for medical students that would increase exposure to pain theory and management (Liebeskind & Melzack 1988).

The current education system for health professionals has major gaps when it comes to pain management (Pilowsky, 1988). The development of educational programs regarding patient concerns and misconceptions would help patients who are in pain and encourage them to express themselves more freely (Wittink & Hoskins 2002).

#### ***Patients' perception of pain experience***

Individuals who are exposed to an identical physical stimulation, experience different degrees of pain. There are many factors that are thought to affect the perception of pain, apart from the stimulus. Some of them are personal characteristics genetic profile, and social or situational factors and a good sense of humor is often associated with less concern about pain (Kuiper & Nicholl 2004, Starr 1995).

When patients anticipate pain and fear it, this increases their reports of the pain intensity. In contrast, when patient are calmer, there is a reduction in stress and the reported intensity of pain is decreased. As long as the patient is in pain, recognizing the influence of depression, anxiety and general mood of the patient is crucial for pain management efficacy (Lappin 1988, Davis 2000, Adams & Bromley 1998).

A great range of emotional responses has been reported from fear and anxiety to the feelings of guilt and anger and these can affect relationships. A person in pain may also have to deal with feelings of low self-esteem and great frustration. However, there are also positive emotions like pride, when the patient manages to cope with pain, or joy, where people use humour as a mechanism to handle a stressful situation (Matz & Brown 1998).

#### **AIM AND OBJECTIVES**

The aim of this study was to explore the influences of the health care providers' personal experiences of pain upon their professional attitudes towards their patients. This study also attempted to examine potential positive attributes between nurses' personal pain history and the way this affected the management of patients' pain during their routine work.

These attributes included communication and support of the patients, the nurses' degree of self-control or professionalism, their empathetic interest in the patients' situation; the successful relief of the patients' pain before and after the nurses' experienced personal pain themselves.

The objectives were to investigate whether pain is:

- A reason for the health care professional to reconsider and review the way of dealing with the patient.
- An opportunity to notice various aspects in the attitude of health care providers, regarding the patients' approach and the dealing with pain that could be changed.
- A motive to preoccupy in the issue of pain management and a chance to query new tactics of the patients' approach that will improve Health Care Service.
- An initiator for self-criticism in the way of thinking and the attitude as a health care provider.
- Is helpful in re-valuing his or her profession and to re-estimate its worth.

## METHODOLOGY

### *Research approach and design*

The methodology used for the purpose of this qualitative study was a phenomenology approach, as reported by Polgar and Thomas (2000, p.92) who described it as: "both a system of philosophy and an approach to psychology and emphasizes the direct study of personal experiences". Phenomenology, as a research method, is a rigorous science bringing a language to human experiences (Sreubert & Carpenter 1999). This approach attempts to understand and describe 'essence' or 'eidos' which are experiences similar to all mankind (Hallet 1995).

Phenomenology's orientation to concrete experiences, their meanings and to human relationships makes it particularly appealing for research in health care as it adopts a holistic approach towards the patient (Benner, 1994).

Porter (2000) suggested that phenomenology is the bedrock of most qualitative research and its application to nursing research can provide a greater understanding of being ill. This technique does not focus on just the physical aspect and management of disease and pain. It also acknowledges the subjective experience of pain and its affect on the professional's attitude. The research strategy was not an experimental one as there was no active intervention in the studied situation by the researcher.

Prior to the study, searches were made on major databases: Medline, Cinahl, Psychinfo, Medical and Nursing and Journals databases using key words and phrases: pain, experience, hospitalization, pain management, staff experience of pain.

### *The sample and setting*

The study sample was restricted to fifteen (15) HCPs who had had a personal pain history during hospitalization. They all worked in the same general hospital in Northern Greece and data was collected between May and September 2004. Although this purposeful sample was small, it was adequate for the purpose of this study, as small sample numbers are acceptable for in-depth qualitative research. The sample included three doctors, six nurses, three physiotherapists and three speech therapists. These four professions were chosen as they represented more than 90% of HCPs in the hospital. Furthermore, all these professionals worked in a multidisciplinary team in the assessment and management of pain.

Data collection took place, in the individuals' natural setting i.e. in the hospital where they worked. The purpose of conducting research in the participants' natural setting was to alter as little as possible, the field where phenomena take place.

### *Ethical considerations*

The study was granted ethical approval by the hospital's ethics committee and data collection started following the verbal approval of the manager of the hospital, where the research took place.

Written consent was obtained from the participants after they were given a full explanation of the nature and conditions of the study, assurances that their identity would be protected, and the right to withdraw at any time. As participation was confidential, their real names have been replaced with pseudonyms.

**Data collection**

In depth and un-structured interviews were used in order to investigate individuals’ multiple realities. Open-ended questions were used so that respondents could provide answers in their own words. Each interview was tape-recorded. The investigator was part of the interview process and tried to understand the participants’ thoughts and beliefs in an attempt to see the world from the participants’ point of view. Consequently interaction took place. The researcher transcribed the tape-recorded interviews after the completion of the data- collection process.

**Data analysis**

The transcriptions of the interviews composed the basis for the analysis of data. Coding and thematic analysis were used to analyze the interview data. The transcriptions were carefully studied and the important elements were organized into specific themes. Each theme was allocated a number during coding of the information. This part of the procedure required considerable time, as coding is an interactive process, i.e. the researcher coded and recoded as the scheme developed.

Once the coding was matched to the transcripts, an attempt was made to interpret their meaning in the context in which they appeared. The interviewer met the participants again in order to confirm the right interpretation of what they said which added credibility to the validity and reliability of the results (Guba & Lincoln 1983).

Specific phrases with significant meaning were linked with previous literature findings in order to explore and describe the phenomenon of pain.

This process is based on Colaizzi’s description of the data analysis process, as presented by Haase (1987).

**RESULTS**

The discussions concerning pain were coded to appropriate categories; four major themes emerged as shown in table 1:

**Table 1: Discussion themes**

1	Changing role from being a HCP to being a patient in pain
2	The HCPs’ views of their own pain
3	The influence that personal experience of pain has on HCPs’ relationships with patients
4	Suggestions from the HCPs for improving their pain management skills

**1. Changing role from being a HCP to being a patient in pain**

The hospitalization of HCPs placed them in the patients’ situation. This gave them the opportunity to assess their colleagues’ attitudes and to evaluate the services offered. Twelve of the fifteen participants were dissatisfied with the pain management they received and complained of the staff’s attitudes. All described their experience emphasizing different points.

Valia: “Quite a few faced their duties as a chore. I think that conscientious HCPs are devoted to their work, otherwise, they can not respond sensitively to the patients’ needs. I saw members of staff who were bored; they did not have the desire to help the patients and even worse I saw one of them arguing with a patient who was in pain!”

Nicky: “The HCPs’ attitude was awful. Many of them ignored –intentionally or not- that psychogenetic agents can also cause pain. Their attitude lacked congenial social behaviour and sound scientific training.”

David: "Most HCPs seemed apathetic to the patient. The patient was not treated as a special person of value and uniqueness but rather as "a case" with or without medical interest. This is what annoyed me the most!"

Both Kristy and Rose talk about their need to be treated by HCPs who are friendly and capable of making them feel relaxed. But the reality often disappointed them.

Rose: "I was stressed and harassed. I expected the nurses and doctors to make me feel relaxed and give me courage. On the contrary I faced coldness."

Kristy: "Their attitude was often unfriendly and snappy which increased my stress and made me feel unhappy. When I was treated by HCPs who were friendly I felt more relaxed and even my pain was not so noticeable."

David noted: "During my hospitalization I was really annoyed about the impoliteness of some HCPs. I believe that good manners are very important in the health care service. For me, apart from what you have been taught by your family, it is also a matter of the correct professional stance. The HCPs certainly should have acquired these skills during their undergraduate studies."

George complained about the doctors' indifference with regards to his pain problem. "They treated me impersonally and although analgesics were prescribed, I was given the feeling that they did not care about me. Surely this is the vital point of holistic and successful pain management." He also reported that the doctors were reluctant to record the information he gave about his pain. "My main concern was that when I talked to them they did not keep notes and this resulted in the need to repeat again and again the same information."

Nicky had the same impression: They did not provide enough time for discussion in order to collect all the necessary information and complete a full history of my health problem and especially about my pain. They did not take notes of the effectiveness of the painkiller or the duration of pain relief, and this led to less efficient pain management."

In contrast, Akis assessed the HCPs' attitude as warm and satisfying. "They treated me, and all the others, humanely. They had sound scientific education and this helped me feel secure."

Some of the participants rationalized their comments to excuse the insufficient services.

Lewis: "I acknowledge that nurses get burn-out due to understaffing and being overworked. We are all human and our powers are limited"

George: "I am of the opinion that the inadequate and problematic pain management was mainly caused by understaffing. The load of responsibilities and duties that the HCPs have do not allow them enough time with the patient. Due to this we give priority to physical treatment at the expense of the patients' psychological state. Yet, psychological support is crucial, especially when dealing with pain."

Robin also spoke about specific circumstances that can help the staff to perform better. "The work conditions are so demanding that we usually become exhausted. The whole system badly affects the professional's self-esteem. It is so important to feel that however hard our work may be, it is still really worth it."

In the same context Nicky reported that the work environment made her often feel isolated and vulnerable. Nicky: "Many times my superiors made me feel useless and unimportant. Such attitudes can affect the quality of my work. When they do not respect my efforts, they drive me to act in a less productive way".

Akis suggested that hospital psychologists should support staff as well as patients: "HCPs who are fed up and stressed are not so supportive to their patients. That's why I believe it is necessary for the HCPs to be able to have discussions with a psychologist. The National Health System should provide this for the hospital staff in order to get some relief from the strain of the job and to preserve their psychic balance."

This proposal is in agreement with what George says: "I believe that as Health Providers we experience such strain in our job that we need somebody to lean on.

I think that a staff psychologist could relieve our stress. If we feel that somebody supports us then we have the strength to support others.”

## 2. The HCPs' views of their own pain

While Jim speaks about his experience he expresses the worry and the strain he experienced. “The cancer’s diagnosis announcement was terrifying. I experienced great stress and terrible psychic pain. This was more painful than the pain I experienced postoperatively. I could not handle it and for a period I was seriously depressed.”

Amy described her experience: “I needed hospitalization when I underwent surgery for my leg problem. The higher levels of pain were before the operation. The post-operative pain was lighter but I was anxious about whether I could use my leg again and walk properly.”

All participants claimed that they learned something from these experiences.

Akis: “I learnt that pain can teach. That life has ups and downs and that a person should be able to pass through all these.”

David: “Pain acts as a warning of a physical problem. It gives us the opportunity to live through an unpleasant situation which can improve our perspective on life.”

Valia spoke about the empowerment of her self-esteem. “I feel more able to cope with the difficulties that may come in my life. I think that as I managed to overcome this pain I will overcome any pain that might come.”

Lewis expressed a spiritual emotion; a faith in God. “I believe that this experience helped me to mature and become more human. It was a chance to come closer to God. Before this experience I had so many doubts and I was wondering why God allows so much unfairness in life. Now I feel my faith is at its strongest and I regard this as really important.”

Kristy acknowledged pain as a warning signal: “Pain is good, it shows a problem. My grandfather said only an alive person can feel pain.”

Nicky noted: “I believe that the pain increases our physical and psychic endurance.” It has also been claimed that pain helps the individual to see the world with ‘new eyes’ and somehow love it. Nicky, reported such a view: “Some people become soft after such an experience but others toughen. Personally after my going through such pain, I acquired a new view on life and I value this gift.”

David: “Pain is a difficult experience. However, we can benefit from it. This depends on how ‘ready’ we are for such a challenge.”

## 3. The influence that personal experience of pain has on HCPs' relationships with patients

The participants pin-pointed how their experience of pain altered their attitudes. Their personal pain experience helped them to develop a better approach to the patient in pain.

Akis: “I believe that compassion is a component of my character. After this experience of pain I feel that I more empathetic towards those in pain. Pain management should be a process of collaboration between the HCPs and patients. I can do my job in silence but I need the participation of the patient in this ‘game’, so I speak throughout the duration of treatment, giving them instructions that will help cope with their pain.”

Rose: “It was a chance to reconsider my previous attitude. Now it helps me to ‘feel’ the pain.”

Robin: “This personal experience has taught me that the main priority is to assess the patient’s psychological condition.”

Amy: “I realize that all this experience of suffering, enables me to treat my patients with increased sensitivity and humanity. It has been suggested that pain can be a tutor<sup>35</sup> and Amy’s comments are consistent with this. “Of course we should not seek pain but for me it was also a time for self-criticism. Now I can put myself in the patient’s shoes and understand the feeling of pain and anxiety they have.”

#### 4. Suggestions from the HCPs for improving pain management skills

The participants acknowledge the necessity for improvements to be made on the management of pain during hospitalization.

George highlighted: "I believe that the patient in pain should be treated instantly. We should not leave anyone suffering. I think that if a doctor or a nurse can put themselves in the patient's position they can respond more efficiently." He continues emphasizing the HCPs' needs for further education: "As a HCP I was never taught how to deal with pain, the importance of pain relief and the quickest way to provide it. It is a serious omission that there is no relevant module, neither in the medical nor in the nursing curriculum. It depends on the tutor's whim. This should be rectified."

Valia said: "Workshops and lectures can be useful tools in order to become more efficient in pain management. These should include the latest research and the HCPs' experiences relating to pain and its management. Practical tips should be given."

Nicky suggested: "Small studies within the hospital could bring a major improvement of pain management."

Both Valia and David perceive the appropriateness of communication between the patients and HCPs.

Valia: "The patients should be given sufficient time to express themselves. I think that before administering a painkiller, one should discuss what the pain feels like with the patient. Personally many times I felt better after a discussion and I did not feel so desperate for a painkiller."

While David stated: "Sound interpersonal relationships between staff and patients are crucial. For successful pain management we need HCPs who are sensitive, well-educated and professionally competent."

However, Valia believed that: "The sensitivity and the politeness of the HCPs is a matter of personal style."

#### DISCUSSION

An interpersonal focus of pain management is important. A holistic approach which communicates and observes verbal and body language is needed. Providing relief and comfort to the patient is an important medical and nursing responsibility, which should not only be the administration of medicine. There is a need to involve other kinds of interventions to the patients' treatment. As one interviewee pointed out activities such as visiting and talking can prove to be effective in order to divert their attention away from pain (McCaffery *et al.* 1994).

All interviewees reported that psychological support can help the patient feel secure and calm. They also noted how important it was for the HCPs to collect information for a complete pain history. The HCPs must observe and record the location, duration, frequency, degree of pain and any other characteristic that will help in the choice of effective management. The significance of continuous patient observation has been made clear in the Joint Commission of the Accreditation of Healthcare Organizations, which defined pain assessment as part of the vital signs measurement (Rosdahl & Kowalski 2003).

Nine participants pointed out the importance of the personality and sensitivity of the HCPs in providing effective and holistic pain management. Other studies confirm that the quality of this management also depends on the HCPs' personality. The individual's ability to empathize depends on having similar experiences. Therefore, absence of such experiences can make HCPs disadvantaged in comprehending the patient's pain (Donovan & Blake 2000).

The findings also suggest that the HCPs become more sensitive to patient pain after their own experience of pain. The participants' statements: This experience helps me now to 'feel' the pain", or "Now I can put myself in the patient's shoes and empathise with them" confirm that pain can be the teacher who will help us to see the fellow-being in a different way with interest and love.



The HCPs' became more aware of the necessity to communicate and support the patient (Carlson *et al.* 2003).

The participants also emphasized the importance of understanding the patient's psychic condition for successful pain relief. After all, to reassure the patient is a critical medical and nursing task. Moreover, the patient's emotional situation has a major role in his or her response to pain. Therefore the interventions should also consider the patient's mood. Empathizing with the patient need not depend on the HCPs necessarily experiencing pain. This can be an acquired skill through learning. However, the HCPs who have had such experiences can be of great benefit if this skill is imparted to the rest of the health care team. Staff becomes more conscious of the patients' view point and better pain relief is achieved (Holm *et al.* 1989).

The participants suggested that systematic educational interventions for pain should be on the curricula of all health disciplines, so that the HCPs may learn to question their practice, reflect on new knowledge and improve the standard of pain relief methods. This need has recently been identified (Whitcomb 2003). A pain management module could address misconceptions and barriers that lead to inadequate pain management and introduce a more compassionate approach (Kedziera 2001). An efficacious program about pain management should aim to encourage both staff and patients to ask questions. Fear, stress and lack of knowledge have been identified as factors that generate or predispose the person to more pain (Dehghani *et al.* 2003).

Although twelve of the fifteen participants (as patients) expressed negative experiences in relation to the HCPs' attitudes, it seems that this was a motive for them to avoid practicing similar attitudes. Although they did not complain about being denied pain relief, the indifferent and impolite attitude of the staff was an indicator that some staff had insufficient pain management skills. This finding challenges all research which is confined only to pharmacological pain control when measuring patients' satisfaction of pain management. This should take into account, not only the right administration of

analgesics but also a host of other variables e.g. the mode of communication with the staff (Thomas *et al.* 1998, Ryoo & Park 2002).

Three of the participants doubted whether the patients' complaints of pain were always real. This way of tackling the issue has also been the subject of many studies which show how the staffs' preconceived notions can influence patient care, sometimes in a negative or unfair way. Nevertheless, even if there are a few HCPs who doubt the patients' descriptions of their pain and trust more their own 'instinct' to assess it, the basis for satisfactory pain management is: should the patient claim to be in pain, then the pain is real.

The day-to-day reality in hospitals points to the immediate need for more research in the broad field of pain management in order to provide HCPs with advanced theoretical knowledge and create the proper supportive conditions in order to 'translate' this knowledge to advanced practice for the improvement of patient care.

However, it is worth mentioning that apart from theoretical knowledge, sometimes it is the personal empirical sense of a painful experience that makes a person more sensitive and gives him an insight into coping with pain. Personal experience of illness is of relevance to the health care professions, which could be incorporated into advanced professional practice (Rolfe and Fulbrook 1998).

Staff needs to be taught interpersonal skills which will still enable them to keep a safe emotional distance (some feel they need when caring for very ill people), yet enable them to connect with the patient. Such skills include the mastery of key care questions, the art of diplomacy and tact, holistic nursing skills and the vital importance of simple kindness, politeness and respect for the patient – an individual in a strange, unfamiliar environment.

## CONCLUSIONS

This pilot study shows that personal experience of pain can enable HCPs to comprehend better the complexity of pain and empathize with the patient in pain and be more astutely aware of their needs. Fortunately, HCPs can gain knowledge from

colleagues who have had personal experience of pain whilst in hospital, and also from their patients' experiences should time be given for discussions to gain this insight. Improved approaches would lead to greater understanding of pain and a holistic improvement in pain management.

This study shows that the personal experience of pain as an inpatient also gave the HCPs a chance to be self-critical of their own standards as HCPs and to adopt new ways of delivering pain relief once they returned to the work force. It also helped them to recognize psychological issues which, along with the physical ones, can exacerbate or lessen the feeling of pain.

Pain is experienced by all peoples throughout time and has no boundaries. It is recommended that health care educational establishments should enrich their curriculum with a pain management module using those who have had personal experience of pain to illustrate the importance of empathetic pain management. It would also be advantageous to invite ex-patients who had substantial experiences of pain to illustrate where gaps in the system need improving.

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