Appendix 1 - Draft standards for approval

Australian Standards for Health Practitioner Pain Management Education

Australian Government

The Australian Standards for Health Practitioner Pain Management Education was funded through an Australian Government grant and their development was led by the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists.

FPM

Faculty of Pain Medicine
ANZCA

The college acknowledges the Traditional Custodians of Country throughout Australia and recognises their unique cultural and spiritual relationships to the land, waters and seas and their rich contribution to society. We pay our respects to ancestors and Elders, past, present and emerging.

The college acknowledges and respects Māori as the Tangata Whenua of Aotearoa and is committed to upholding the principles of Te Tiriti o Waitangi, fostering the college's relationship with Māori, supporting Māori fellows and trainees, and striving to improve the health of Māori.

The college recognises the special relationship between the Pacific peoples of New Zealand, Australia and the Pacific, and is committed to supporting those fellows and trainees of ANZCA, and improving the health of Pacific peoples.

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Foreword

The Faculty of Pain Medicine (FPM) is an internationally renowned professional medical body, established within the Australian and New Zealand College of Anaesthetists (ANZCA) in 1998 in response to the growing prevalence and significant impact of chronic pain in our communities. Our vision is to reduce the burden of pain on society through education, advocacy, training and research.

The increasing prevalence and ongoing impact of acute and chronic pain on individuals and the broader Australian community are well-established.[1,2] However, pain identification, diagnosis and treatment are often lacking, and there is an urgent need for more consistent, evidence-based pain management that reflects best practice approaches.[3] To achieve universal, high quality pain management practice across Australia and reduce the burden of pain, there is an identified need for increasing the knowledge, understanding and skill set of health practitioners.[4] This can be achieved by increasing the focus given to pain management health practitioner education and training initiatives and ensuring that these initiatives are designed, developed, delivered and evaluated at a high standard. Australia's *National Strategy for Health Practitioner Pain Management Education*,[5] funded by the Australian federal government and developed by FPM with extensive stakeholder consultation, provides a detailed blueprint for pain management education over the next decade.

During 2024-2025, FPM has again been the proud leader of a national Australian project focusing on delivery of the first of the five goals within the national strategy – the development of the *Australian Standards for Health Practitioner Pain Management Education*. This set of standards is designed to guide health practitioner pain management education across all health disciplines and all levels of education.

The *Australian Standards for Health Practitioner Pain Management Education* are the first of their kind in Australia and indeed, internationally. While voluntary at this stage, the standards are designed to sit above all relevant curricula, content and teaching approaches. They provide clear guidance to health educators, practitioners, educational institutions and professional associations to ensure a more consistent, evidence-based and comprehensive approach to pain management education. Ultimately, the standards are designed to ensure pain education and training equips health practitioners to deliver better, safer and more person-centred care to the many Australians living with pain.

On behalf of FPM, I thank the Australian government for funding this important project. I also extend my gratitude to the hundreds of stakeholders who gave their time, experience and expertise to contribute to the development of the standards – this achievement wouldn't have been possible without your contributions. I particularly acknowledge the members of the project's Governance Advisory Group, whose commitment and dedication to providing their relevant perspectives and guidance has been invaluable.

Finally, I wish to recognise the extraordinary work of the FPM project team and Professor Emily Haesler, whose expertise and dedication ensured this process was comprehensive, consultative and rigorous. Together, their efforts have produced a ground-breaking set of standards that position Australia as a global leader in health practitioner pain management education.

Dr Dilip Kapur
Dean, Faculty of Pain Medicine

Introduction

Background: Why are these standards important?

The *National Strategy for Health Practitioner Pain Management Education* was developed to guide the upskilling of the Australian health workforce in contemporary, evidence-based pain care with the aim of improving the health outcomes of people experiencing pain. The national strategy identified five goals, the first of which was the development of a set of nationally consistent standards for education and training of health practitioners on pain management. The national strategy stipulated that the standards are to be relevant across all health disciplines and levels of education, cover both acute and chronic pain, and be underpinned by the values and principles of the strategy.

In general, standards set out specifications and guidelines that aim to ensure products, services, and systems are safe, consistent, and reliable. In health contexts, standards are guiding principles that define expected competencies, goals, specifications and/or quality outcomes, and are therefore commonly agreed on principles of what is the ideal.[6,7] In many circumstances, standards also establish a common language that defines quality and safety criteria.[8] The many sets of standards which exist within the Australian health sector are designed to do just that – to promote safety, quality and consistency, as well as provide a common understanding and language among policy-makers, funders, administrators and health practitioners. They also give consumers of Australia's health services an understanding of the quality and level of care they should receive.

The *Australian Standards for Health Practitioner Pain Management Education* define the level of quality that can be expected for health practitioner pain management education and training in Australia and guide its development and delivery. It's anticipated that comprehensive implementation of these standards would ensure that education and training on pain management is of the highest quality, thereby substantially addressing the long identified deficit in the pain management-related knowledge and skills of Australian health practitioners.[9]

While use and uptake of the standards is voluntary, we trust that relevant health practitioners, educators, organisations and regulatory authorities will keenly adopt them in the development, delivery and evaluation of new education and training initiatives and in ongoing continuous improvement of education and training curricula.

Target audience

The target audience for the standards is:

- Educational organisations, health institutions and other stakeholders who are involved in the design, development and delivery of pain management education and training.
- Regulatory bodies, organisations and individuals who undertake roles ensuring the quality of health-related education and training initiatives.
- Individual health practitioners and health educators.
- Individuals who experience pain, their significant/relevant others and consumer advocacy groups.

Examples of the above include but are not limited to professional colleges, tertiary training organisations and government departments.

The standards are designed to apply to the education and training of health practitioners within all health disciplines and at all levels of their training. The term “health practitioners” throughout these standards refers to workers involved in delivering care and services to individuals with acute or chronic pain as part of health, aged care or disability services. This term includes both registered health professionals regulated by authoritative bodies such as the Australian Health Practitioner Regulation Agency (Ahpra), and healthcare workers who are self-regulated through their relevant professional organisation rather than under national law (examples include but are not limited to Aboriginal and Torres Strait Islander health workers and practitioners, exercise physiologists, nursing assistants, support workers, disability workers, and aged care workers).[10]

Scope of the standards

The *Australian Standards for Health Practitioner Pain Management Education* are relevant to the education and training of all Australian health practitioners. However, their application will be determined by the context in which pain management education and training is delivered. When applying the standards the following should be considered:

- The scope of practice of the health practitioners for whom pain management education and training is being delivered (for example health discipline, level of educator, level of experience).
- The scope and goals of the intended pain management education and training (for example whether the training is embedded in curricula or a stand-alone activity).
- The environmental context in which the intended learners are working, if known (for example primary or tertiary health settings, education).
- The characteristics of the cohort of individuals experiencing pain with whom the intended learners are working, if known (for example an adult versus paediatric population).

The six areas defined within the standards are broadly applicable to all health practitioners, contexts and settings to which pain management education and training applies. However, the applicability of specific standards within each area should be considered within the context of the above variations.

The diversity of individuals who experience pain

A key principle that has been embraced throughout the development of the *Australian Standards for Health Practitioner Pain Management Education* is acknowledgement of the diversity of individuals who experience pain. Individuals across the entire population experience pain, regardless of their age, diversity and identity. Their experience of pain, including its impact on function, lifestyle and quality of life will be subjective and highly personal.[11] However, the way in which every individual experiences pain will be influenced by their individual identity, diversity and overall life experiences, including their previous experiences with the health system and health professionals. It is also well-acknowledged that pain inequities are experienced by individuals according to their unique diversity[11-13] profile, including the intersectionality of different diversity factors. This must be

acknowledged and understood by every health practitioner so they can communicate, empathise and effectively work with individuals who experience pain within a framework that is culturally and psychologically safe and without unconscious bias.

The standards highlight the importance of educating all health practitioners who work with individuals who experience pain in a way that highlights the significance of diversity. While it is not the role of standards to outline the science underpinning the different ways individuals experience pain or specific ways in which health practitioners can address pain with consideration to diversity, this content must be a key focus in all education and training curricula. It's therefore highlighted through the standards as a component of best practice in pain management education and training. First and foremost, ensuring that health practitioners develop and maintain a strong understanding of the unique and diverse experiences of the individual is highlighted in *Standard 1: Person-centred approach to care*. The person-centred care approach to working with individuals who experience pain encapsulates important concepts that must be addressed in pain management education and training, and which are further highlighted in the other standards, particularly:

- Practising evidence-based pain management appropriate to the individual's specific goals, needs and circumstances (*Standard 3*).
- Reflecting on the way in which one's own practice influences the experiences of, and impacts on, the individual and their diverse factors (*Standard 4*).
- Effectively and appropriately communicating with the individual and their significant/relevant others (*Standard 5*).
- Collaborating with the individual and their significant/relevant others and pain management team (*Standard 6*).

By highlighting the diversity of individuals who experience pain, the standards seek to ensure that Australian health practitioners are well-equipped through their initial and ongoing education and training to deliver the highest quality of pain management to the entire Australian community experiencing pain.

Structure of the *Australian Standards for Health Practitioner Pain Management Education*

The *Australian Standards for Health Practitioner Pain Management Education* consist of six overarching standards that address the key concepts/domains that define high quality education and training in pain management. These standards should be considered within the context of the cycle of education and training development (see Figure 1).

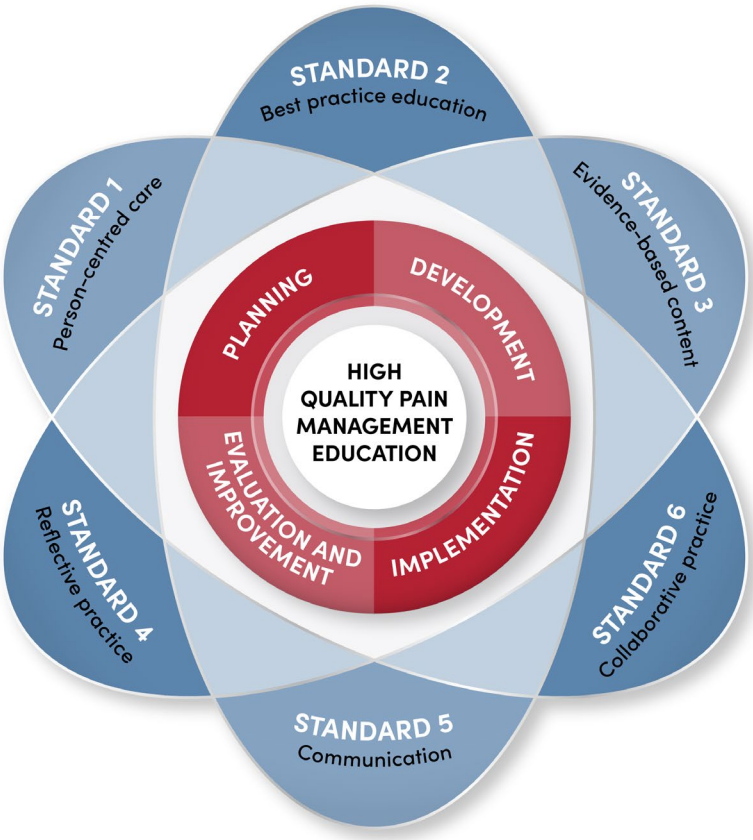


Figure 1: Relationship of the overarching standards to the education and training development cycle.

The model of education and training development illustrates the core stages fundamental in developing education and training for health practitioners. These stages define the cyclic process of planning, development, implementation (delivery) and evaluation and improvement that are used to ensure that education and training meets its goals and maintains a consistently high standard. The stages in this model are outlined in more detail below.

Education and training development cycle

1. Planning

In the initial stage, planning the education and training, the educational goals, needs, and learning objectives are defined; the target audience and required resources are determined; and learning methods and assessment strategies established. The planning phase includes:

- **Needs assessment:** Identifying the needs of the stakeholders, including the needs of the relevant population of people experiencing pain, needs of the target health practitioner audience and the education and training goals are aligned with these needs.
- **Goals and objectives:** Broad aspirations and specific objectives for the educational program are determined, and specific, measurable, achievable, relevant, and time-bound learning outcomes are defined.
- **Methods:** The most appropriate learning methods and techniques to achieve the objectives are determined.
- **Evaluation:** A plan is developed for how student learning and program effectiveness will be evaluated.

2. Development

In the next stage, a curriculum and/or course content addressing stakeholder needs, goals and objectives is developed, incorporating the planned methods and evaluation. The development phase includes:

- **Curriculum development:** Curriculum is created, including the learning outcomes, course content, instructional activities, learning materials and assessment tools, ensuring the course meets the identified learning objectives and learning standards.
- **Delivery methods:** Designing the learning environment, including physical spaces and online platforms.

3. Implementation

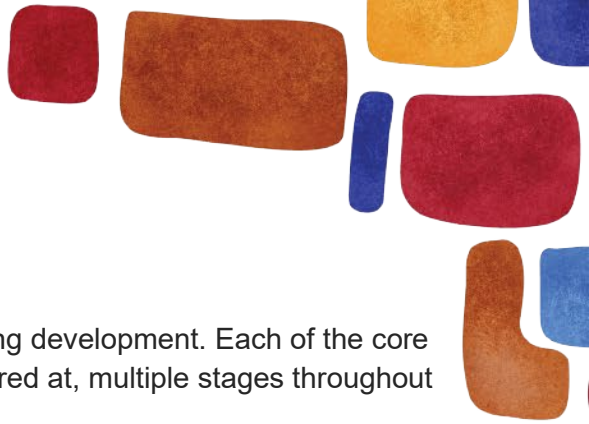
In the next stage, the course content and learning activities are delivered, feedback is provided, and learner progress is assessed. The implementation phase includes:

- **Course delivery:** Course content is delivered using effective teaching methods, activities, and assessments.
- **Assessment and feedback:** Feedback is provided to learners on their performance using formal and/or informal feedback and assessment mechanisms.

4. Evaluation and improvement

The next phase addresses ongoing evaluation and refinement of the education and training based on stakeholder response, learner feedback and performance data to ensure the education is maintained at a high standard. This stage includes:

- **Evaluation:** Data on the learner outcomes and program effectiveness is collected. This may also extend to collecting data from patient stakeholders who experience pain.
- **Feedback and reflection:** Educators reflect on their practices and identify areas for improvement.
- **Continuous improvement:** Evaluations and reflection are used to refine the education and training program, including curriculum, course content, delivery methods and assessment.



The six standards intersect with the model of education and training development. Each of the core themes of these standards are relevant to, and should be considered at, multiple stages throughout the cycle of education and training development.

Each of the themes captured by the standards are further delineated within several specific standards that define the level of quality that education and training in pain management should achieve to be of the highest quality. Criteria outline how meeting the standard is demonstrated. Individual standards and their criteria will be relevant to various stages in the development cycle, depending on their specific focus.

Overview of the standards

Standard 1: Person-centred approach to care	
1	**Education and training on pain management for health practitioners promotes a person-centred approach to care.**
1.1	Education and training on pain management promotes knowledge and understanding of a person-centred approach to care.
1.2	Education and training on pain management builds the skills and confidence integral for delivering a person-centred approach to care.
Standard 2: Best practice education	
2	**Education and training on pain management for health practitioners is developed and delivered in alignment with best practice approaches to learning and teaching.**
2.1	Education and training on pain management is informed by the needs of people who experience pain.
2.2	Education and training on pain management meets the needs of learners.
2.3	Education and training on pain management is consistent with best practice approaches to learning and teaching.
2.4	Education and training on pain management is designed, delivered and evaluated by people with appropriate knowledge, skills and content expertise.
Standard 3: Evidence-based content	
3	**The content of education and training on pain management for health practitioners is evidence-based.**
3.1	The content of education and training on pain and its management is based on the best available evidence.
3.2	The content of education and training on pain management is underpinned by the best evidence fundamental to understanding the pain experience.
3.3	The content of education and training on pain management is underpinned by the best evidence on strategies and skills to manage the pain experienced by people.
3.4	Education and training on pain management encourages health practitioners to develop skills in accessing, evaluating and generating evidence.

Standard 4: Reflective practice	
4	**Education and training on pain management actively engages learners in reflective practice and self-awareness.**
4.1	Education and training on pain management actively engages learners in reflective practice and opportunities to promote self-awareness.
Standard 5: Communication	
5	**Education and training on pain management develops a health practitioner's understanding of, and effective skills in, communicating with people experiencing pain.**
5.1	Education and training on pain management promotes understanding of factors that influence communication.
5.2	Education and training on pain management builds effective communication skills when working with people experiencing pain.
5.3	Education and training on pain management provides strategies to deliver meaningful education to people experiencing pain.
Standard 6: Collaborative approach to care	
6	**Education and training on pain management for health practitioners embeds a collaborative approach to pain management.**
6.1	Education and training on pain management provides an understanding of a collaborative approach to care when working with people experiencing pain.
6.2	Education and training on pain management incorporates the skills, behaviours and attitudes integral to effective collaborative care.

The standards in detail

Standard 1: Education and training on pain management for health practitioners promotes a person-centred approach to care.

Intent of the standard

A person's experience of pain is unique and influenced by many factors including biological, psychological, social, cultural aspects, their past experiences and their diversity. A person-centred approach to managing pain considers the individual as a 'whole person' and acknowledges their preferences, needs, values, goals and their central role in determining what matters most in their pain management journey. The intent of this standard is to ensure that education and training on pain management reinforces the significance of person-centeredness and provides opportunity for health practitioners to develop skills that promote person-centred approaches when working with the diverse range of people who experience pain.

Setting the context

> *"A person-centred approach treats each person respectfully as an individual human being and not just as a condition to be treated. It involves seeking out and understanding what is important to the patient, their families, carers and support people, fostering trust and establishing mutual respect. It also means working together to share decisions and plan care."*[14 pS94]

> *"So, thinking about the patient as a whole in their social and psychological context … addressing all issues contributing to a patient's pain experience will develop socially responsible and safe patient care around pain."* – Stakeholder consultation workshop participant

Background

A person-centred approach is a holistic way of conceptualising health. Rather than focusing on health conditions and diseases, person-centred care focuses on treating and respecting everyone as a person.[14-18] It is typified in approaches that consider the individual's comprehensive experience of their pain, including their psychosocial, environmental, cultural and spiritual context.[14] This is achieved through determining an individual's preferences, needs and values,[15] acknowledging and equitably catering for diversity, and actively engaging them in shared decision-making.[14-16,19,20] A person-centred approach is well-recognised as fundamental to high quality health care[15,21-25] and is embedded in practice frameworks,[25,26] educational outcomes[27-29] and scopes of practice for health professionals in Australia.[30]

The person-centred care approach is particularly relevant when working with a person experiencing pain. Person-centred approaches to care focus on understanding and validating the individual and their experiences, values, goals and strengths, engaging them in decision-making, and implementing individualised management and monitoring of their pain.[15,19,31] Particularly for people experiencing recurrent or chronic/persistent pain, such an approach enables the individual to play an active role in their own self-management, grow in confidence and attain a sense of control.[21,32] By promoting active engagement using a person-centred approach, individuals experiencing pain have their diverse needs met and are more likely to adhere to their pain management plan.[21] This individualised focus can empower the person to carry on with an improved quality of living.[14,17,22,31]

Implementing a person-centred approach to pain management

Developing and maintaining a positive and mutually trusting therapeutic alliance is critical in a person-centred approach and to the success of treatment.[17,21,23] The adoption of an appropriate communication style whereby the health practitioner practices with competence, empathy and genuineness, actively listens, meets the person's need for information and confirms mutual understanding are all important.[15,23,31,33] Acknowledging and addressing the emotions of the individual and their significant/relevant others, managing uncertainty, building confidence and skills and providing evidence-based pain management resources and strategies are also fundamental to a patient-centred approach to pain management.[14,22,23] Interdisciplinary collaboration is also fundamental to implementing a person-centred approach that meets the diverse needs of people who experience pain.

Person-centred approach in pain management education

While many health practitioners support a person-centred approach in principle, their knowledge, skills and confidence in delivering person-centred pain management are identified as areas that require ongoing reinforcement through pain management education. Achieving and maintaining strong knowledge of, and competency in, person-centred care delivery can empower health practitioners to overcome barriers (for example structural, attitudinal and time) to its consistent implementation.[20,28,34] By building and supporting the skills of health practitioners, the person-centred care standard defines a standard of pain education that supports better outcomes for Australian individuals experiencing pain.

Details of the standard

To meet the overarching person-centred approach to care standard, the pain management education and training is in line with the following standards and criteria:

1.1 - Education and training on pain management promotes knowledge and understanding of a person-centred approach to care.

Criteria to meet this standard:

- Promotes an understanding of the concept of a person-centred approach to care and why it is important.
- Promotes an understanding of the potential role of significant/relevant others in the lives of people experiencing pain.
- Incorporates the biophysical, psychological, cultural and social elements of a person's life in understanding a person's experience of pain and its impact (examples include but are not limited to use of the biopsychosocial model, the Whole Person Model).
- Promotes an understanding of the influence of diversity factors on the person's experience of pain.
- Promotes the concept of self-management and the importance of supporting self-management when working with people experiencing pain.
- Promotes the importance of creating a safe environment for the person experiencing pain, including cultural safety and psychological safety.
- Promotes cultural responsiveness and a trauma-informed care approach when working with people experiencing pain.
- Promotes an understanding of strengths-based approaches when working with people experiencing pain.
- Identifies potential system-based challenges and solutions to adopting a person-centred approach to care when working with people experiencing pain (examples include but are not limited to structural, geographic and time limitations; availability and accessibility of services).

1.2 - Education and training on pain management builds the skills and confidence integral for delivering a person-centred approach to care.

Criteria to meet this standard:

- Builds skills and confidence in use of a person-centred care approach to assessing and managing pain (examples include but are not limited to consideration of the person's needs in the context of the biopsychosocial model, formulating an individualised management plan, incorporating culturally appropriate pain management strategies, supporting self-management, implementing a collaborative approach to care).
- Builds skills and confidence in use of relationship-building approaches (examples include but are not limited to communication skills, active listening, validation, establishing a positive therapeutic alliance, shared decision-making) required to appropriately and effectively work with people experiencing pain.

Standard 2: Education and training on pain management for health practitioners is developed and delivered in alignment with best practice approaches to learning and teaching.

Intent of the standard

Health practitioners who work with people experiencing pain must have the knowledge, skills, and attitudes to appropriately and effectively address a person's pain management needs. To achieve this goal, the content of pain management education and training must reflect the needs of both health practitioners as learners and the diverse range of individuals who experience pain. Education and training must be developed and delivered using educational approaches that promote acquisition of knowledge and skills appropriate to delivery of pain management for the entire Australian population.

Setting the context

> *"Vital that education about pain is delivered in a way that is meaningful to the learner and based on relevant learning theories and established practices."* – Stakeholder consultation workshop participant

> *"Knowledge around appropriate pain management has changed dramatically in the last two decades. Taking this into account, conventional or reductionist approaches to teaching pain may inadvertently contribute to an incomplete understanding of pain in healthcare professions. It is therefore necessary to improve contemporary pain teaching and prioritise fit-for-purpose pain education for all healthcare practitioners."*[35]

Background

Given its high prevalence in Australia,[36] most health practitioners will work with individuals experiencing acute and/or chronic pain. Pain management education for all health practitioners, regardless of their discipline or career stage, must be undertaken effectively, efficiently and appropriately. However, evidence suggests that pain management education is less than optimal. Many health practitioners have limited understanding of the experiences of individuals with pain,[37] and often lack the requisite knowledge, skills and attitudes to safely and effectively work with these individuals.[36,37] The learning and teaching standard highlights the aspects that are important in designing, developing, delivering and evaluating high quality pain management education.

Diverse needs of learners

The principles of person-centred, collaborative and evidence-based pain management are recognised as best practice.[38-42] These key tenets must be emphasised in the content of health practitioner education on pain management. However, they also have implications for the design, development, delivery and evaluation of that education.[39] The diversity of people experiencing pain

is mirrored in the demographic diversity of both health and medical student learners and qualified health practitioners working with individuals experiencing pain. The myriad of different geographic, social and clinical contexts in which pain management occurs adds yet another variable. Therefore, every effort should be made to avoid a "one-size-fits-all" approach to the development and delivery of pain management education. Despite this, health practitioner education often includes limited or superficial content on the experience and management of pain and continues to rely on traditional didactic approaches.[36,43]

Contemporary pedagogical approaches to optimise pain management education

Contemporary learning and teaching approaches require educators to place the learner at the centre of education and training initiatives.[36] Adult learning principles, in conjunction with active and experiential learning strategies, are essential to convey the requisite emphasis on both "knowing" at the cognitive level and "doing" at the capability/competency level.[34,38,41,44] As outlined in the learning and teaching standard, this includes opportunities to practise the application of theory in a range of real-world situations and settings.

Identifying clear learning needs and objectives is consistent with robust and contemporary learning and teaching approaches. By identifying the needs of both health practitioner learners and individuals experiencing pain, elements of the curriculum such as content, learning experiences, teaching strategies and assessment can be aligned to those needs.[36] This ensures that pain management education addresses the real needs of the Australian community. Current and emerging technologies are becoming increasingly important as teaching and learning tools, and their considered use can be beneficial. For example, technology enables increased accessibility, facilitates individualised learning, and reduces costs associated with the teaching process.[45] By defining gold standard education delivery that supports learning and promotes outcomes, the learning and teaching standard seeks to ensure that health practitioners are well-equipped to provide high quality care for Australians experiencing pain.

Details of the standard

To meet the overarching learning and teaching standard, the pain management education and training is in line with the following standards and criteria:

2.1 - Education and training on pain management is informed by the needs of people who experience pain.

Criteria to meet this standard:

- Is based on the identified needs of people who experience pain (examples include but are not limited to a needs assessment, identified care gaps).
- Employs co-design/co-production principles, that is involves people experiencing pain, people with lived experience of pain or their significant/relevant others.
- Integrates the diverse voices and experiences of people who experience pain.

2.2 - Education and training on pain management meets the needs of learners.

Criteria to meet this standard:

- Addresses the identified knowledge and skills required by health practitioners (examples include but not limited to those identified by a needs assessment).
- Employs adult learning principles and approaches.
- Is learner-centred.
- Recognises diversity factors of learners and supports diverse learners effectively.
- Implements delivery models appropriate to the learner's setting and context (examples include but are not limited to online options for rural/remote learners, simulation).
- Promotes self-guided learning and reflective practice.

2.3 - Education and training on pain management is consistent with best practice approaches to learning and teaching.

Criteria to meet this standard:

- Utilises a range of learning and teaching activities appropriate to the content and learning outcomes (examples include but are not limited to interdisciplinary learning, experiential learning).
- Includes an assessment framework that aligns with the learning outcomes, content and the needs of learners (for example, constructive alignment).
- Defines learning outcomes (examples include but not limited to the use of the SMART framework, GROW framework, Bloom's Taxonomy).
- Includes a range of feedback and assessment strategies to demonstrate achievement of learning outcomes.
- Uses current and emerging technologies to assist equitable access to learning.
- Actively engages learners.
- Provides opportunities for the learner to implement new knowledge and skills in a safe setting that reflects the genuine practice environment.
- Is regularly reviewed and revised based on the latest evidence, reflection, feedback and evaluation.

2.4 - Education and training on pain management is designed, delivered and evaluated by people with appropriate knowledge, skills and content expertise.

Criteria to meet this standard:

- Is designed, developed, delivered and evaluated with input from appropriately skilled educators.
- Is designed, developed, delivered and evaluated with input from people with appropriate knowledge, skills and/or experience in pain and its management (examples include but are not limited to health practitioners from multidisciplinary backgrounds, people experiencing pain and people from diverse backgrounds).

Standard 3: The content of education and training on pain management for health practitioners is evidence-based.

Intent of the standard

Evidence-based approaches to pain management are fundamental to provision of high-quality health care. The intent of this standard is to ensure that education and training on pain management for health practitioners is underpinned by robust and contemporary evidence and promotes implementation of evidence-based practice that is appropriate and relevant to the needs of the diverse range of individuals who experience pain.

Setting the context

> *"To ensure that future healthcare users can be assured of receiving such care, healthcare professions must effectively incorporate the necessary knowledge, skills and attitudes required for evidence-based practice into education programmes … In addition to developing competence in the fundamental evidence-based practice steps of 'Ask', 'Acquire', 'Appraise', 'Apply' and 'Assess', developing competence in effectively communicating evidence to others, in particular patients/service users, is an area newly emphasised as requiring additional attention by healthcare educators."*[46 p.103]

Background

Evidence-based practice (EBP) is the foundation of high-quality healthcare. Evidence-based pain management practice refers to the use of the best available evidence together with the clinical expertise of the health practitioner and the preferences of the individual experiencing pain to inform decisions about the individual's healthcare.[47,48] Implementation of EBP is supported by clinical practice guidelines, standards of practice, clinical care standards and clinical pathways.[49]

Evidence in pain management education

Pain management education at all stages of a health practitioner's career must be evidence-based and promote the knowledge and skills to implement EBP. This is particularly important given the ever expanding and changing evidence base and knowledge regarding the most effective, efficient and appropriate pain management treatment and management approaches. However, research continues to show gaps between EBP and the clinical care[46,50] received by individuals experiencing pain. The evidence-based education standard seeks to address this gap by embedding an expectation of evidence-based content as underpinning all pain management education. This includes conveying the fundamental science required to understand the experience of pain, as well as management strategies supported by evidence.

Evidence sources to underpin pain management education

To support evidence-based education, the standards recognise the International Association for the Study of Pain's pain curricula[51] as a source that provides foundation knowledge for health practitioners of all disciplines on the experience of pain. Other high level evidence sources include clinical guidelines and clinical care standards (non-exhaustive examples of which are referenced[49,52-56]) governing pain management or health conditions for which pain is a major feature. When developing pain management education courses or activities, educators must seek out sources from recognised organisations and guideline development groups and access the most recent research on pain and its management.

Promoting engagement with evidence in pain management practice

Apart from increasing health practitioners' knowledge and understanding regarding pain and its management, it is also important that learners develop the academic skills to interact with evidence on pain and its management. This includes skills in accessing, analysing and implementing the best available evidence, as well as contributing to quality improvement through service-wide evidence translation activities and research generation. This skill set is outlined in the standards/criteria for Australian health practitioners.[57,58] Pain management education should support these skills by ensuring health practitioners develop and maintain their competence and confidence to engage with and apply evidence in their pain management practice. The evidence-based education standard reinforces the expectation that Australian health practitioners working with individuals experiencing pain will develop and maintain competency in translating evidence to practice.

Details of the standard

To meet the overarching evidence-based education standard, the pain management education and training is in line with the following standards and criteria:

3.1 - The content of education and training on pain and its management is based on the best available evidence.

Criteria to meet this standard:

- Underpins content with the best available evidence.
- Cites the evidence underpinning education and training content and makes this available to
- the learner when possible.
- Promotes the learner's engagement with reputable information sources (examples include but are not limited to clinical practice guidelines, peer-reviewed journals, recognised/reputable organisations).

3.2 - The content of education and training on pain management is underpinned by the best evidence fundamental to understanding the pain experience.

Criteria to meet this standard:

- Promotes application of the International Association for the Study of Pain's definition of "pain" and the Declaration of Montreal and their corresponding implications for practice appropriate to the health practitioner's role and scope of practice.
- Promotes an understanding of pain mechanisms and contemporary pain theories.
- Promotes an understanding of the psychological, social, cultural and other contextual factors contributing to a person's experience of pain.
- Promotes an understanding of different types of pain (for example, duration, underlying processes, location, function) and the impact on the person's pain experience.

3.3 - The content of education and training on pain management is underpinned by the best available evidence on strategies and skills to manage the pain experienced by people.

Criteria to meet this standard (as appropriate to the learning outcomes):

- Develops clinical reasoning and critical thinking relevant to the management of people experiencing pain, and appropriate to the health practitioner's role and scope of practice.
- Includes evidence-based approaches to pain assessment and its interpretation.
- Incorporates evidence-based approaches to managing different types of pain.
- Includes the provision of education to people and their significant/relevant others about pain, relevant to the person's needs and situation.
- Includes evidence-based, non-pharmacological, physical strategies for management of pain, including promotion of clinical approaches when appropriate (examples include but are not limited to exercise, physical therapies, behavioural approaches, sleep management).
- Includes evidence-based, psychological strategies for management of pain (examples include but are not limited to Cognitive Behavioural Therapy, Acceptance Commitment Therapy, mindfulness therapy).
- Includes evidence-based interventions to promote social support for people experiencing pain.
- Includes evidence-based information on topical and systemic pain medicines including prescribing and administration, when necessary.
- Includes the safe use of pain medicines and recognition of associated harms (for example, dependence, overuse, polypharmacy).
- Includes evidence-based surgical strategies and procedural techniques for the management of pain.

3.4 - Education and training on pain management encourages health practitioners to develop skills in accessing, evaluating and generating evidence.

Criteria to meet this standard:

- Promotes the importance of continuing professional development to maintain evidence-based practice.
- Encourages health practitioners to regularly access and review evidence as a component of their clinical practice.
- Incorporates and/or promotes critical thinking when evaluating evidence sources.
- Encourages learners to reflect on the application of available evidence to different cultural settings, communities and diverse populations.
- Promotes the learner's engagement with, and implementation of, pain management research (examples include but are not limited to participation in research opportunities, translational research, clinical audit, case reviews).

Standard 4: Education and training on pain management actively engages learners in reflective practice and self-awareness.

Intent of this standard

Reflection leading to self-awareness is a process by which a health professional deliberately, objectively and regularly examines their underlying principles, including their personal values and attitudes and the influence these have on their practice. Reflection and self-awareness are central tenets to health practice and to professional development. These skills are particularly relevant when working with individuals experiencing pain to ensure pain management is unhindered by unconscious (implicit) biases, prejudices, or inaccurate information or approaches that could lead to inequity or disparate treatment and outcomes. As such, pain management education and training designed for health practitioners must embed and reinforce these concepts to encourage their integration into routine practice.

Setting the context

> *"There are not many areas of health care where bias is more prevalent than in pain management. Practitioners need to be self-reflective, and able to identify and counteract their own biases."* – Stakeholder consultation workshop participant

> *"Reflective practice requires applying a critical lens to attitudes, biases, assumptions, beliefs, knowledge, skills, experiences, and quality of thinking/actions. It has the goal of improving performance to improve outcomes."*[59] *p.5*

Background

Reflective practice (also referred to as critical thinking or reflection[60]) is considered a critical component of clinical practice and is reflected in the codes of practice for many health practitioners.[57,58,61,62] Reflective practice defines the process whereby health practitioners actively and iteratively examine their thoughts, attitudes, actions and personal underpinning conceptual and/or ethical framework.[61] The process seeks to advance professional practice through personal exploration, mindfulness and self-awareness.[61,63,64] Reflective practice also has personal benefits with respect to the health practitioner's own health and wellbeing.

The role of reflective practice in pain management

Reflective practice is particularly relevant in the context of pain management because it is demonstrated to have a positive influence on core tenets of pain management – delivery of person-centred care[63] (outlined in the person-centred care standard) and person-centred communication[65] (outlined in the communication standard). The process of reflective practice enables health practitioners to identify and address any negative, preconceived, personal attitudes or views they hold (often unconsciously). Given the identified issue of stigmatisation that many individuals

experiencing chronic pain face (for example, being viewed as untrustworthy, depressed, drug-seeking or drug-abusing), health practitioners undertaking personal improvement processes that address these possible biases can contribute to the delivery of higher quality care.[37] Likewise, reflective practice can assist health practitioners to deliver more equitable and bias-free care to diverse groups experiencing chronic pain (for example, Aboriginal and Torres Strait Islander peoples, women and people from other cultural groups).[66,67]

Reflective practice education

Incorporating reflective practice into a health practitioner's initial education and training promotes lifelong learning and self-awareness.[61,68,69] Early exposure to self-reflective practice should reinforce the importance of reflective practice as an ongoing component of professional development. Despite its acknowledged importance and value, reflective practice is identified as an area requiring improvement within health-related education and training curricula.[60,70] Barriers to the teaching of reflective practice include the limited understanding health educators may have with respect to reflective practice and skills acquisition that should be taught,[59,61] as well as the large volume of content required in health curricula,[61] a perceived lack of value of reflective practice from the perspective of both learners and the educators, and lack of organisational/institutional commitment.[61,70] When efforts to address reflective practice within pain management education are inauthentic, there is a risk that learners will become disengaged.[70]

Educators play an important role in embedding this lifelong professional skill. Educator modelling, particularly with respect to willingness to engage in reflection, is identified as an important teaching strategy.[59,63,71] Rather than assuming that all learners intrinsically know how to undertake reflection, reflective skills and strategies should be taught and practised.[59,61] Some strategies include formal narrative writing, small group discussions, the use of video-recordings, peer support and mentorship. Creating appropriate safe spaces and a supportive atmosphere for reflective activities facilitates the ability of learners to engage meaningfully in the reflective process.[60,70]

Details of the standard

To meet the reflective practice and self-awareness standard, the pain management education and training is consistent with the following associated standards and criteria:

4.1 - Education and training on pain management actively engages learners in reflective practice and opportunities to promote increased self-awareness.

Criteria to meet this standard:

- Incorporates reflection as a fundamental component of working with people experiencing pain.
- Promotes the significance of reflection in professional practice to foster the development of self-awareness, particularly when supporting individuals experiencing pain.
- Actively engages and supports learners in a range of reflective practice strategies appropriate to their knowledge, skills, experience and needs (examples include but are not limited to the

consideration of patient feedback, Gibbs Reflective Cycle, hot debrief, John's Model of Structured Reflection, 360-degree feedback approach).

- Provides opportunities to enable learners to examine their personal values, attitudes, biases and preconceived notions regarding people experiencing pain.
- Facilitates reflection on trauma-informed care principles including safety, trust, choice, collaboration and empowerment.
- Facilitates reflection on cultural responsiveness, diversity and inclusion.

Standard 5: Education and training on pain management develops a health practitioner's understanding of, and effective skills in, communicating with people experiencing pain.

Intent of this standard

Every person's experience of pain is personal, unique, and often complex. It is recognised that both the experience of pain, and the way that an individual communicates is influenced by their biological, psychosocial, cultural and demographic context. A health practitioner working with a person experiencing pain must have a sound understanding of communication principles and corresponding skills to communicate effectively with each person. The intent of this standard is to reinforce the importance of communication when working with a person experiencing pain, and to promote the health practitioner's development and application of the advanced communication skills required to implement quality pain management.

Setting the context

> *"Communication is key in every clinical encounter and is often regarded as lower value than the learning and understanding of professional 'technical skills'."* – Stakeholder consultation workshop participant

> *"The essence of the framework was captured simply and poignantly by one priority in particular; 'listen to me, learn from me and hear what I am telling you, so it makes me feel my concerns have been understood.' This priority articulates how listening carefully, validating, and acknowledging individual pain stories might be one of the most positive, safe, low-cost, and impactful aspects of care."*[41 p.e1159]

Background

Effective communication underpins every aspect of healthcare delivery and practice,[57,58,62,72] leading to better outcomes for patients and improved health practitioner satisfaction.[73] Effective communication between health practitioners and individuals experiencing pain is particularly vital because pain management is often complex.[37,41,74] This complexity can be exacerbated if the individual experiences inappropriate or frustrating interactions with the health system or is non-verbal. Therefore, health practitioner training requires a major focus on improving skills in effective communication, including listening, hearing, speaking and explaining.[41,75,76] The communication standard seeks to address the importance of ensuring all health practitioners working with individuals experiencing pain develop and maintain an understanding of factors that influence communication and strong interpersonal skills.

Communication skills in pain management

Individuals experiencing pain are often vulnerable when seeking healthcare, and fears that they will not receive adequate pain management or will be disbelieved or dismissed are not uncommon,[37,41] particularly for those with chronic and/or undifferentiated pain. A health practitioner's communication knowledge and skills are vital in developing a positive therapeutic alliance with the individual and their significant / relevant others[37] that will facilitate shared decision making and a holistic and tailored approach to pain management.[40,41] Providing an environment in which individuals feel culturally, psychologically and physically safe to share their lived experience and concerns is important.[41,67,77,78] Empathic and active listening is aided by understanding the diverse ways in which individuals experiencing pain may communicate (for example, verbal, non-verbal, paraverbal) as well as awareness of one's own communication styles.[41,73] Being able to adapt communication to the individual's unique circumstances, skills in acceptance and validation,[40,41,76] use of language that is appropriate to a person's level of understanding,[41] and ability to promote self-confidence[41] are all fundamental communication skills for health practitioners working with individuals experiencing pain. The communication standard highlights the importance of ensuring these skills are consistently addressed and reinforced in pain management education.

Communicating with diverse populations

The tailoring of communication skills to meet the needs of a diverse population is a major consideration within the context of pain management. It is well-acknowledged that many diverse individuals often feel misunderstood by their health practitioners, and evidence shows that there are significant gender and racial disparities in pain management.[38,79] When working with individuals experiencing pain, their social, cultural and demographic circumstances (including but not limited to gender, race, ethnicity, age, geography and other aspects) cannot be considered in isolation. Different aspects of the individual's identity can expose them to overlapping forms of discrimination and marginalisation or privilege (referred to as "intersectionality"). Pain education for health practitioners working with individuals experiencing pain must instil a strong understanding and practical application of communication approaches and frameworks appropriate to individuals from wide backgrounds and identities.[67,80] Some examples include effective use of interpreter services and telehealth, Clinical Yarning,[67] appropriate involvement of significant/relevant others,[77] family-centred care approaches,[78] and trauma-informed approaches to care.[81] The *Australian Standards for Health Practitioner Pain Management Education* as a whole recognise the significance of diversity in the experience of pain and the importance of equipping health practitioners with the required skills to effectively work in with the diverse population of Australians who experience pain.

Details of the standard

To meet the communication standard, the pain management education and training is in line with the following associated standards and criteria:

5.1 - Education and training on pain management promotes understanding of factors that influence communication.

Criteria to meet this standard:

- Promotes understanding of the different ways in which diverse groups of people may communicate their pain.
- Promotes understanding of the different ways in which people may express their pain (for example, verbal, non-verbal, paraverbal forms of communication).
- Promotes understanding of different dynamics and approaches when communicating with significant/relevant others in the lives of people experiencing pain.
- Promotes understanding of the influence of unconscious bias, privilege and communication styles on the therapeutic relationship.
- Promotes understanding of culturally responsive communication styles as they relate to Aboriginal and Torres Strait Islander peoples, including an awareness of the impact of colonisation, intergenerational trauma and racism.
- Promotes understanding of culturally responsive communication styles as they relate to multicultural people, including an awareness of the impact of racial discrimination.

5.2 - Education and training on pain management builds effective communication skills when working with people experiencing pain.

Criteria to meet this standard:

- Facilitates practice in the tailoring of communication skills, strategies and modes to meet the diverse backgrounds and needs of individuals.
- Facilitates practice of empathic and respectful communication strategies (examples include but are not limited to strategies to develop a positive therapeutic alliance, eliciting a person's pain story, validation of the person's experience and determining priorities and goals).
- Facilitates practice of culturally appropriate language and responsive communication approaches relevant to Aboriginal and Torres Strait Islander peoples and culturally and linguistically diverse people (examples include but are not limited to Clinical Yarning, working with interpreters, use of professionally translated information resources).
- Facilitates practice in communication within a trauma-informed approach to care.

5.3 - Education and training on pain management provides strategies to deliver meaningful education to people experiencing pain.

Criteria to meet this standard:

- Promotes the importance of providing information and education relevant to the needs and preferences of the person experiencing pain and their significant/relevant others.
- Incorporates understanding of a person's level of health/pain literacy and the skills involved in tailoring communication and education approaches accordingly.
- Promotes the importance of consistent and constructive health and pain-related messaging and dialogue.
- Examines and facilitates practice of communication approaches designed to build a person's confidence and competence in managing their health and their pain over time.
- Incorporates strategies to address common myths and misinformed expectations related to pain (examples include but are not limited to pain mechanisms and pain management options not supported by contemporary evidence or which may be or are potentially harmful).
- Promotes the broader role of health practitioners in pain-related advocacy activities (for example, community education).

Standard 6: Education and training on pain management for health practitioners embeds a collaborative approach to pain management.

Intent of this standard

The pain experience is often complex and influenced by a range of biological, psychological, cultural and social factors. Appropriately and effectively addressing a person's pain often requires the expertise and knowledge of more than one health discipline. The intent of this standard is to ensure pain management education and training promotes the knowledge, skills, behaviours and attitudes to enable health practitioners to work collaboratively to meet the diverse needs of the person experiencing pain.

Setting the context

> *"There is a general lack of awareness of the roles of most professions other than medical/nursing, psychology and physiotherapy. Many great opportunities are missed when those professions are unaware of what others can offer. The education should both embed an interdisciplinary approach and educate about the broader discipline offerings."* – Stakeholder consultation workshop participant

> *"Collaborative approaches are invaluable when pain management is complex, requiring the knowledge and skills of more than one profession. It is logical then, that to work together, future health care workers would benefit from learning together to understand each other's roles and responsibilities and how to communicate using common language."*[43 p.2]

Background

Given that pain is a consequence of a range of biological, psychological, cultural and social factors and is often complex to understand, assess and manage,[74,82] comprehensive expertise is required to meet the needs of the individual experiencing pain. Collaborative approaches to care (also referred to as "interprofessional", "interdisciplinary", or "multidisciplinary care") recognise that all health disciplines work within varying domains and scopes, often using different clinical frameworks and with different expertise.[58,62,72] Collaborative care approaches to pain management allow the individual to benefit from the expertise, skills and treatment modalities of various health disciplines who work together and in partnership with the individual to understand and manage that person's pain and meet their identified goals and needs.[43,82-86] Individuals experiencing pain generally appreciate health practitioners who engage with a team to meet their needs,[37,41] particularly when their care goals focus on restoration of physical and psychosocial functions and mental health wellbeing rather than a quick or complete cure.[41,85] The collaborative approach to care standard highlights the importance of collaboration in addressing pain management and seeks to embed the

principle in pain management education to promote high quality care models for pain management in Australia.

Interdisciplinary pain management education

Despite the evidence that collaborative approaches to care are associated with improved patient outcomes and a more efficient health system,[87-89] health practitioner education has generally remained fragmented, failing to leverage the benefits that can be attained from interdisciplinary collaboration.[43] An interdisciplinary education model involves learners from two or more health professions interactively learning together. Such a model enables learners from different disciplines to learn the same content, experience information from the differing perspectives of other health disciplines, understand the roles, responsibilities, scopes of practice and treatment approaches of other health disciplines,[42,51,86] and improve referral pathways,[41] communication and collaboration when working with other disciplines in the care environment.[42,51,86] Undertaking education with other health disciplines who work with individuals experiencing pain can also assist in addressing preconceived notions about other professional groups and their scopes of practice.[38,43,90] Concerted efforts should be made to incorporate interactive, interdisciplinary learning opportunities that highlight the importance of, and skills involved in, collaborative care in the context of pain management. The collaborative approach to care standard embeds these principles as a requirement for high quality pain management education and provides guidance on strategies that can meet this goal.

Details of the standard

To meet the overarching collaborative approach to care standard, the pain management education and training is in line with the following standards and criteria:

6.1 - Education and training on pain management provides an understanding of a collaborative approach to care when working with people experiencing pain.

Criteria to meet this standard:

- Promotes the value and benefits of a collaborative approach to care in managing people's pain within the scope of practice and across disciplines and settings.
- Promotes the recognition that the person experiencing pain is central to the collaborative care team.
- Promotes the recognition of the role of significant/relevant others in the collaborative approach to care.
- Addresses the roles, responsibilities, scopes of practice and treatment approaches of different health disciplines commonly involved in pain management.
- Incorporates the importance of establishing and/or using existing referral pathways (examples include but not limited to those coordinated by Primary Health Networks, Optimal Cancer Care Pathways) to promote the needs of the person experiencing pain.

- Recognises and challenges barriers to implementing the collaborative approach to care (examples include but are not limited to workforce challenges in rural areas, access to funding).

6.2 - Education and training on pain management incorporates the skills, behaviours and attitudes integral to effective collaborative care.

Criteria to meet this standard:

- Promotes opportunities for interdisciplinary group learning.
- Promotes opportunities for practical application of the interpersonal skills and behaviours involved in the collaborative approach to care (examples include but are not limited to collaboration, communication, active listening, teamwork, team coordination, reflection on own role and the roles of others).
- Promotes discussion and understanding of the personal attitudes and values involved in the collaborative approach to care (examples include but not limited to mutual respect and humility, cooperation, openness to trust, ensuring the person experiencing pain and their support person are central to the collaborative care team).
- Encourages health practitioners to recognise and/or build their collaborative, interdisciplinary networks.
- Promotes reflection on self and team performance to inform and improve team effectiveness.

Glossary of terms

Best available evidence: The most valid, reliable and clinically relevant research evidence available to answer a clinical question. Best available evidence usually refers to research evidence (for example, synthesised research or empirical research) that is interpreted in the context of clinical expertise and/or preferences of the individual. Research evidence is usually assigned a level on a hierarchy based on the study design and an appraisal tool is used to determine whether the research is reliable and valid.[47,48]

Biopsychosocial: A model reflecting the development of illness through the complex interaction of biological factors, psychological factors and social factors.[91]

Bloom's Taxonomy: Bloom's Taxonomy is a widely recognised hierarchical framework used by educators to classify and structure educational objectives according to their complexity and specificity. This taxonomy encompasses three primary domains: cognitive (intellectual processes), affective (emotional responses and attitudes), and psychomotor (physical skills and abilities).[92,93]

Co-design/co-production: Co-design is a participatory and decision-making tool for problem solving where educators (and/or people responsible for health practitioner education) and people with lived experience of pain come together on equal ground to design pain management education and training initiatives. Co-production emphasises an active role in the next phase of developing, delivering and evaluating the education initiatives.[94]

Collaborative care: The combining of expertise, skills and treatment modalities of various health disciplines working together and in partnership with the person experiencing pain to manage the person's condition and meet their identified goals and needs.[84,85,90]

Cultural responsiveness: Cultural responsiveness is the ability to understand, respectfully communicate with and effectively interact with people across cultures acknowledging their diverse cultural identities, languages, religions, and practices. Cultural responsiveness is innately transformative and must incorporate knowledge (*knowing*), self-knowledge and behaviour (*being*) and action (*doing*). It is about the approaches we take in engaging with people and how we act to embed what we learn in practice. It promotes inclusion, equity, and the removal of barriers caused by cultural misunderstanding or systemic discrimination, ensuring that individuals feel valued, respected, and able to maintain their cultural identity. This requires genuine dialogue to improve practice and health outcomes. Cultural responsiveness is the means by which we achieve, maintain and govern cultural safety.[95]

Cultural safety: Cultural safety is based on the experience of the individual receiving care. Culturally safe practice is an individual health practitioner and/or organisation having the appropriate knowledge, skills and attitudes to deliver care to Aboriginal and Torres Strait Islander peoples. Culturally safe practice is undertaken through a process of reflection on one's own cultural identity and recognition of the impact their culture has on their own practice.[96]

Diversity: Diversity refers to the recognition and inclusion of a wide range of individual and collective differences that encompass various aspects of human identity, experience, and background.[97] These factors influence the way an individual experiences both pain, and their interaction with health practitioners and the health system.[11-13] These differences can include, but are not limited to:

- *Aboriginal and Torres Strait Islander cultures*: Recognises the unique cultural, historical, and social identities of Aboriginal and Torres Strait Islander peoples and their connection to Country, culture, and tradition.
- *Age and life stage*: Acknowledging the diverse perspectives and experiences across different age groups and life stages, from children to the elderly, and the various stages of life they experience and how these stages influence individuals' needs, priorities, and capabilities.
- *Cognitive and physical disability*: Acknowledging individuals with varying abilities, including those who may face challenges related to physical, sensory, or cognitive functions.
- *Culturally and linguistically diverse (CALD) backgrounds and ethnicity*: Recognising and respecting individuals from varied ethnic, cultural, ancestral and linguistic backgrounds, including those whose first language is not the dominant one in a given society.
- *Gender identity*: Acknowledging that gender is a spectrum, and understanding the experiences of different genders including those who identify outside of traditional male and female categories.
- *Geographic location*: Understanding how individuals in urban, rural, and remote areas may experience unique challenges and opportunities, particularly in relation to their access to services and resources.
- *Neurodiversity*: Acknowledging the differences in brain function and cognitive patterns, such as autism, ADHD, dyslexia, and other neurological conditions that lead to diverse thinking and behaviour.
- *People in care settings*: Recognising those living in various care environments, such as nursing homes, hospitals, or assisted living, and considering their specific needs for respect, autonomy, and dignity.
- *People with dementia and cognitive impairment*: Supporting individuals with progressive cognitive decline, including those living with dementia, and understanding their unique care and social needs.
- *People with experiences of trauma*: Acknowledging the impact of past traumatic events on individuals' mental, emotional, and physical wellbeing, and recognising the importance of providing trauma-informed care and support.
- *Sex*: Recognising the biological differences between male, female, and intersex individuals, while understanding that sex does not always align with gender identity.
- *Sexual orientation*: Recognising and respecting the diverse ways individuals experience and express their romantic and sexual attraction, including but not limited to heterosexual, homosexual, bisexual, pansexual, asexual, and other orientations.
- *Socio-economic status*: Recognising the impact of financial and social standing on people's opportunities, health outcomes, and overall quality of life.
- *Varying levels of health literacy*: Considering individuals' capacity to access, understand, and apply health information, which can be influenced by education, socioeconomic status, and personal experiences.

Together, these various dimensions of diversity reflect the complex, multifaceted nature of human identity and experience. In some circumstances, different aspects of a person's identity may expose them to overlapping forms of discrimination that can greatly increase their marginalisation. This is referred to as intersectionality.

Education and training: Education and training are two distinct but interconnected concepts. Education refers to the process of acquiring knowledge, skills, and values. It focuses on developing a broad understanding of various subjects and fostering critical thinking and analytical skills. On the other hand, training is a more specific and practical approach aimed at acquiring specific skills or competencies required for a particular job or task. It is often provided in a more hands-on and experiential manner, focusing on practical application rather than theoretical knowledge. While education provides a foundation for learning, training helps individuals apply that knowledge in real-world scenarios. Both education and training are essential for personal and professional development.

Evidence-based practice: A systematic approach to making and implementing clinical decisions about healthcare. The evidence-based practice process includes asking questions, identifying the best evidence to answer the question (examples include research, clinical expertise and/or preferences of the individual), appraising the evidence, implementing the evidence and evaluating the outcome. These steps are often referred to as the 5 'A's: Ask, Acquire, Appraise, Apply and Assess.[47,48]

Gibbs' Reflective Cycle: Gibbs' reflective cycle is a popular model to assist with reflective practice. It can be applied to reflection on any type of experience but is particularly useful to assist a person to learn from everyday situations. Gibbs' reflective cycle encourages a person to think systematically about the experience. It contains six stages and poses a key question to consider at each stage. It asks you for a clear description of the situation, and then leads you through the reflection and learning, to plan what you would do if the situation arose again.[98]

GROW framework: The GROW coaching framework is a structured framework that helps individuals achieve their goals through four key stages – Goal, Reality, Options and Will. It is designed to facilitate goal-setting, problem-solving and personal development through a structured conversation between the educator and the learner.[99]

Health/pain literacy: Health literacy is the ability to seek, access, understand and utilise health information, and is important for good health. By extension pain literacy is the degree to which a person is able to obtain, process and apply pain-related health information.[100] Health literacy is recognised as a determinant of an individual's ability to self-manage their pain.[101]

Health practitioner: A worker involved in delivering care and services to individuals managing acute or chronic pain. This term includes both registered health professionals regulated by authoritative bodies such as the Australian Health Practitioner Regulation Agency (Ahpra),[102] and health care workers who are self-regulated through their relevant professional organisations. It also includes health practitioners that are not currently regulated (e.g. aged care workers). Health

practitioners may work within various settings including health, aged care, or disability services, and encompass a broad spectrum of practices and disciplines in the healthcare field.

Hot debrief: A hot debrief is a five-15 minute team exercise that occurs immediately after an event. It can happen after positive or negative outcomes, but the aim is to generate insights into individual, team and systematic processes. The focus is on the process and not the outcome.[103]

International Association for the Study of Pain's definition of pain: "An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage," and is expanded upon by the addition of six key notes for further valuable context:

- Pain is always a personal experience that is influenced to varying degrees by biological, psychological, and social factors.
- Pain and nociception are different phenomena. Pain cannot be inferred solely from activity in sensory neurons.
- Through their life experiences, individuals learn the concept of pain.
- A person's report of an experience as pain should be respected.
- Although pain usually serves an adaptive role, it may have adverse effects on function and social and psychological well-being.
- Verbal description is only one of several behaviours to express pain; inability to communicate does not negate the possibility that a human or a nonhuman animal experiences pain.[104]

Intersectionality: Intersectionality refers to the ways in which diverse aspects of a person's identity can expose them to overlapping forms of discrimination and marginalisation.[80]

Johns' Model of Structured Reflection: Johns' Model for Structured Reflection was developed for use in the context of nursing but is relevant for other contexts. It assists with reflection and analysis of complex decision making, and in learning how to reflect. Johns suggested that when you reflect, you need to make sure that you 'look inwards' (consider your own thoughts and feelings), and 'look outwards' (consider the actual incident or situation, plus things like your actions in the situation and whether they were ethical, and the external factors that influenced you).[105]

Learner: In the context of this document, a learner is a health practitioner who is engaged in the process of acquiring/enhancing their knowledge, skills or understanding in pain management.

Learner-centred: The learner-centred approach is an holistic education strategy that prioritises the learner's needs, abilities, interests, and learning styles.[106,107] It is an educational philosophy that places the learner at the centre of the learning process, empowering them to take charge of their own learning journey.[108] Unlike traditional teaching methods, which often focus on the teacher's knowledge and the delivery of content, the learner-centred approach emphasises the learner's active participation and engagement in the learning process.[107]

Manage (pain): In the context of this document, the "management of pain" encapsulates the assessment, prevention, treatment and evaluation of a person's pain.

Needs assessment: The identification of gaps in knowledge or skills within a workforce. A training needs assessment considers the training needs of relevant stakeholders.[109]

Non-pharmacological: Healthcare approaches/interventions that are not primarily based on medication (e.g. social, psychological, physical, lifestyle approaches; self-management).

Pain: An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage.[104] Six key notes add further valuable context to this definition:

- Pain is always a personal experience that is influenced to varying degrees by biological, psychological, and social factors.
- Pain and nociception are different phenomena. Pain cannot be inferred solely from activity in sensory neurons.
- Through their life experiences, individuals learn the concept of pain.
- A person's report of an experience as pain should be respected.
- Although pain usually serves an adaptive role, it may have adverse effects on function and social and psychological well-being.
- Verbal description is only one of several behaviours to express pain; inability to communicate does not negate the possibility that a human or a nonhuman animal experiences pain.

Pain management: Pain management is an overall term to describe multiple types of healthcare approaches to assess, prevent, treat and evaluate a person's pain. Pain management encompasses pharmacological, non-pharmacological and other approaches to prevent, reduce or stop pain sensations and improve quality of life.

Pain mechanisms: Factors potentially contributing to the development and experience of pain; for example, specific pathobiology in pain processing (e.g. nociceptive, neuropathic and nociplastic mechanisms), psychosocial factors and movement system dysfunction.[110]

Pain theories: Theoretical frameworks to explain aspects of pain perception (an example includes but is not limited to the biopsychosocial model).

Paraverbal: Paraverbal refers to aspects of verbal communication aside from the words being used. This includes the tone, pitch, volume, speed, and cadence of speech.

Person-centred care: An approach that "treats each person respectfully as an individual human being, and not just as a condition to be treated. It involves seeking out and understanding what is important to the patient, their families, carers and support people, fostering trust and establishing mutual respect. It also means working together to share decisions and plan care."[111]

Psychological safety: Psychological safety describes the situation of feeling safe to speak up and share ideas, questions, or mistakes, without fear of negative consequences or reactions. People experiencing pain are part of their own health care team and the creation of a safe and inclusive space for patients is needed to allow them to be active members. Creating an atmosphere that

permits listening attentively, sharing information and focusing on the concerns and questions of people experiencing pain and their significant/relevant others are key aspects of an environment of psychological safety.[112]

Reflective practice: A process of thinking clearly, honestly, deeply, and critically about any aspect of our professional practice. It requires committing to creating space to deliberately reflect on one's work and has long been recognised as an integral part of safety and quality. Reflective practice is considered good practice and is foundational to processing the challenges of high stress and high risk associated with healthcare work. For example, reflective practice directly strengthens our work in patient safety and quality using structured reflective processes to consider things such as:

- the factors underpinning failures,
- opportunities for learning,
- distinguishing accountability,
- the interplay of culture
- opportunities to strengthen teamwork.[113]

Self-management: A set of approaches that helps children and adults with long-term conditions to take control of their treatment. Self-management is a systematic process of learning and practising new skills, which enable individuals to manage their health condition/s on a day-to-day basis. Consideration should be given to the life stage and the specific circumstances of the person experiencing pain (including but not limited to physical, cognitive and psychosocial limitations).

Shared decision-making: Shared decision-making involves discussion and collaboration between a person experiencing pain and their healthcare provider. It is about bringing together the person's values, goals and preferences with the best available evidence about benefits, risks and uncertainties of treatment, in order to reach the most appropriate healthcare decisions for that person.[114]

Significant/relevant others: A “significant other” is a person who plays an important role in the life of a person experiencing pain such as a member of the immediate family, a lover, a close friend, a family carer. Examples of “relevant others” include but are not limited to teachers, employers, paid carers.

SMART framework: SMART goals are a framework for setting objectives that are clear, trackable and achievable. The acronym SMART stands for specific, measurable, achievable, relevant and time-bound.

Strengths-based approach: A strength-based approach is a way of working that focuses on a person’s abilities, resilience, knowledge, capacities and positive qualities rather than deficits, or things that are lacking.[115,116]

Therapeutic alliance: The connection, warmth, bond and sense of support created between clinician and patient that empowers the two to work collaboratively to establish agreement on goals and care tasks.[117]

Trauma-informed care/approach: Trauma-informed care is based on the understanding that: a) a significant number of people have experienced trauma in their lives; b) trauma may be a factor for people in distress; c) the impact of trauma may be lifelong; d) trauma can impact the person, their emotions and relationships with others. Core trauma-informed principles include safety, trust, choice, collaboration, empowerment, respect for diversity.

Unconscious bias (also referred to as "implicit bias"): The holding of involuntary preconceived ideas and stereotypes (e.g. associated with diversity factors) that influences one's understanding of and interactions with particular groups of individuals, often with negative consequences.[118]

Validation: A process in which a listener communicates that a person's thoughts and feelings are understandable and legitimate.

Whole Person Model: Whole-person care is an approach to healthcare that takes into account the whole person, not just their physical health. It includes the mind, body, and spirit, and recognises that all of these factors play a role in overall health and wellbeing. Whole-person care is about more than just treating illness or injury. It is about preventive care and health promotion, and about helping people to live their best lives. It is about providing care that is tailored to the individual, and that meets their needs in a holistic way.[119]

Reference list

1. Deloitte Access Economics. *The cost of pain in Australia*. 2019 [cited 2025 30 August]; Available from: https://www.deloitte.com/au/en/services/economics/analysis/cost-pain-australia.html.
2. Chronic Pain Australia. *National Pain Report 2025. [Internet]*. 2025 [cited 2025 Aug 30]; Available from: https://chronicpainaustralia.org.au/blog/national-pain-report-2025-delayed-diagnosis-of-chronic-pain-is-robbing-australians-of-their-best-years/.
3. Henderson JV, Harrison CM, Britt HC, et. al. Prevalence, causes, severity, impact, and management of chronic pain in Australian general practice patients. Pain Med, 2013; 14(9): 1346-61.
4. Ng W, Slater H, Starcevich C, et. al. Barriers and enablers influencing healthcare professionals' adoption of a biopsychosocial approach to musculoskeletal pain: A systematic review and qualitative evidence synthesis. Pain, 2021; 162(8): 2154-85.
5. Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists (ANZCA), National Strategy for Health Practitioner Pain Management Education. 2023, ANZCA,: Melbourne, Victoria. p. 68.
6. MacNeil C, Mead S. A narrative approach to developing standards for trauma-informed peer support. Am J Eval, 2005; 26(2): 231-44.
7. International Organisation for Standardisation. *Standards [Internet]*. 2024 [cited 2024 June 3]; Available from: https://www.iso.org/standards.html.
8. Standards Australia Limited. *Standardisation Guide 001: Preparing standards. [Internet]*. 1968 [cited 2024 June 3]; Available from: https://www.standards.org.au/documents/sg-001-preparing-standards
9. Australian Government DoH. *National Strategic Action Plan for Pain mManagement [Internet]*. 2021 [cited 2025 June 30]; Available from: https://www.health.gov.au/sites/default/files/documents/2021/05/the-national-strategic-action-plan-for-pain-management-the-national-strategic-action-plan-for-pain-management.pdf.
10. Haesler E, Carville K, Australian Standards for Wound Prevention and Management. 2023, Australian Health Research Alliance, Wounds Australia, WA Health Translation Network,. p. 98.
11. Fillingim RB. Individual differences in pain: understanding the mosaic that makes pain personal. Pain, 2017; 158 (Suppl 1): S11-8.
12. Domenico LH, Tanner JJ, Mickle AM, et. al. Environmental and sociocultural factors are associated with pain-related brain structure among diverse individuals with chronic musculoskeletal pain: intersectional considerations. Sci Rep, 2024; 14(1): 7796.
13. Okolo CA, Olorunsogo T, Babawarun O. Cultural variability in pain perception: A review of cross-cultural studies. International Journal of Science and Research Archive, 2024; 11(1): 2550–6.
14. Slater H, Briggs A. Strengthening the pain care ecosystem to support equitable, person-centered, high-value musculoskeletal pain care. Pain, 2024; 165: S92–107.
15. Burton CD, Entwistle VA, Elliott AM, et. al. The value of different aspects of person-centred care: A series of discrete choice experiments in people with long-term conditions. BMJ Open, 2017; 7(4): e015689.
16. World Health Organization. *Integrated people-centred care. [Internet]*. 2025 [cited August 2025.
17. Claydon A, Paul-Taylor G. Physiotherapy student experiences of person-centered care in musculoskeletal outpatient departments. J Practice-based Learn Hlth Soc Care, 2017; 5(2): 69-83.
18. Hayes C, Rajappa H, *Person-centered pain medicine*, in *Person centered medicine*, J.E. Mezzich, et al., Editors. 2023, Springer Nature: Switzerland.

19. Entwistle VA, Cribb A, Watt IS, et. al. “The more you know, the more you realise it is really challenging to do”: Tensions and uncertainties in person-centred support for people with long-term conditions. Patient Educ Couns, 2018; 101(8): 1460-7.

20. Linton SJ, O'Sullivan PB, Zetterberg HE, et. al. The "future" pain clinician: Competencies needed to provide psychologically informed care. Scand J Pain, 2024; 24(1).

21. Ekman I, Swedberg K, Taft C, et. al. Person-centered care--ready for prime time. Eur J Cardiovasc Nurs, 2011; 10(4): 248-51.

22. Gagliardi AR, Nyhof BB, Dunn S, et. al. How is patient-centred care conceptualized in women’s health: A scoping review. BMC Women's Health, 2019; 19(1): 156.

23. Hutting N, Caneiro JP, Ong'wen OM, et. al. Patient-centered care in musculoskeletal practice: Key elements to support clinicians to focus on the person. Musculoskelet Sci Pract, 2022; 57: 102434.

24. Angelini E, Wolf A, Wijk H, et. al. The impact of implementing a person-centred pain management intervention on resistance to change and organizational culture. BMC Health Services Research, 2021; 21(1): 1323.

25. Australian Commission on Safety and Quality in Health Care (ACSQHC). *National Safety and Quality Health Service (NSQHS) Standards: Person-centred Care*. 2021 [cited August 2025.

26. Royal Australasian College of Physicians (RACP). *RACP Framework for improving person-centred care and consumer engagement. [Internet]*. 2024.

27. Nursing and Midwifery Board, Ahpra. *Scope of practice and capabilities of nurses. [Internet]*. 2024 [cited 2025 August 18]; Available from: https://www.ahpra.gov.au/documents/default.aspx?record=WD23%2f33305&dbid=AP&chksum=FsI3w%2fFXn0MSIRmBC5WIEQ%3d%3d&_gl=1*166z03g*_ga*MjA0NjQ3MzM4My4xNzU1NDE0MzYx*_ga_F1G6LRCHZB*czE3NTU0MTQzNjAkbzEkZzAkdDE3NTU0MTQzNzIkajQ4JGwwJGgw.

28. Entwistle VA, Cribb A, Mitchell P, et. al. Unifying and universalizing Personalised Care? An analysis of a national curriculum with implications for policy and education relating to person-centred care. Patient Educ Couns, 2022; 105(12): 3422-8.

29. Royal Australian College of General Practitioners (RACGP). *RACGP 2022 Curriculum core competency framework. [Internet]*. 2022 [cited 2025 August 18].

30. Australian Government Department of Health Disability and Ageing, Unleashing the Potential of our Health Workforce: Scope of Practice Review. Final Report. 2024: https://www.health.gov.au/sites/default/files/2024-11/unleashing-the-potential-of-our-health-workforce-scope-of-practice-review-final-report_0.pdf.

31. Avallin T, Muntlin Å, Kitson A, et. al. Testing a model for person-centred pain management: A systematic review and synthesis guided by the Fundamentals of Care framework. J Clin Nurs, 2023; 32(19-20): 6811-31.

32. Johnston-Devin C, West S, Oprescu F, et. al. The evolution of informational needs of people with complex regional pain syndrome. Pain Management Nursing, 2025; 12(1).

33. Beales D, Slater H, Palsson T, et. al. Understanding and managing pelvic girdle pain from a person-centred biopsychosocial perspective. Musculoskelet Sci Pract, 2020; 48: 102152.

34. Burke HK, Sample PL, Bundy AC, et. al. Teaching reasoning, reflective practice, and evidence-based practice: Educator consensus strategies. J Occup Ther Edu, 2024; 8(4).

35. Cornwall J, Shipton E, Cowie M, et. al. (Re)Development of pain target competencies in a contemporary, multi-centre undergraduate medical curriculum: The importance of local cultural requirements. J Pain, 2024: 104696.

36. Shipton E, Bate F, Garrick R, et. al. Pain medicine content, teaching and assessment in medical school curricula in Australia and New Zealand. BMC Med Educ, 2018; 18(1): 110.

37. Johnston-Devin C, Oprescu F, Wallis M, et. al. Educational considerations for health professionals to effectively work with clients with complex regional pain syndrome. PLoS One, 2022; 17(6): e0269337.

38. Helms J, Frankart L, Bradner M, et. al. Interprofessional active learning for chronic pain: Transforming student learning from recall to application. J Med Educ Curric Dev, 2023; 10: no pages.

39. Hunter JP, Stinson J, Campbell F, et. al. A novel pain interprofessional education strategy for trainees: Assessing impact on interprofessional competencies and pediatric pain knowledge. Pain Res Manag, 2015; 20(1): e12-20.

40. Linton S, O'Sullivan P, Zetterberg H, et. al. The "future" pain clinician: Competencies needed to provide psychologically informed care. Scand J Pain, 2024; 24(1): 20240017.

41. Slater H, Jordan JE, O'Sullivan PB, et. al. "Listen to me, learn from me": A priority setting partnership for shaping interdisciplinary pain training to strengthen chronic pain care. Pain, 2022; 163(11): e1145-63.

42. Tolchin D, Ankam N, Rydberg L. Twelve tips for including disability education in undergraduate medical education. Med Teach, 2024; 46(9): 1152-9.

43. Gordon DB, Watt-Watson J, Hogans BB. Interprofessional pain education-with, from, and about competent, collaborative practice teams to transform pain care. Pain Rep, 2018; 3(3): e663.

44. Hansen A, Engel-Hills P, Jacobs C, et. al. Understandings and practices: Towards socially responsive curricula for the health professions. Adv Health Sci Educ Theory Pract, 2023; 28(4): 1131-49.

45. Michalik B, Sęk M, Szypuła A, et. al. New technological developments in medical education. J Educ Health Sport, 2024; 60: 204-20.

46. Lehane E, Leahy-Warren P, O'Riordan C, et. al. Evidence-based practice education for healthcare professions: an expert view. BMJ Evid Based Med, 2019; 24(3): 103-8.

47. Cole LG, Turner S, Graves BA. Walking the Walk: Integrating Evidence Into Clinical Experiences. Creat Nurs, 2019; 25(2): 148-153.

48. Sackett DL, Rosenberg WMC, Gray JAM, et. al. Evidence based medicine: What it is and what it isn't. BMJ, 1996; 312(7023): 71.

49. Australian Commission on Safety and Quality in Health Care (ACSQHC). *About the clinical care standards [Internet]*. 2022; Available from: https://www.safetyandquality.gov.au/standards/clinical-care-standards/about-clinical-care-standards.

50. Daly MM, DeAngelis TM. Teaching evidence-based practice across curricula: An overview of a professional development course for occupational therapy educators. Occup Ther Health Care, 2017; 31(1): 102-109.

51. International Association for the Study of Pain (IASP). *Curricula [Internet]*. 2025 [cited 2025 August 18]; Available from: https://www.iasp-pain.org/education/curricula/.

52. Cancer Council Australia. *Cancer pain management in adults clinical guidelines [Internet]*. 2024 [cited 2025 August 18].

53. Schug SA, Palmer GM, Scott DA, et. al., Acute pain management: Scientific evidence (5th edition) [Internet]. 2020, ANZCA & FPM, Melbourne.

54. Australian Commission on Safety and Quality in Health Care (ACSQHC), Opioid analgesic stewardship in acute pain clinical care standard [Internet]. 2022, ACSQHC.

55. Therapeutic Guidelines. *Pain and analgesia [Internet]*. 2020 [cited 2025 August 18]; Available from: https://tgldcdp.tg.org.au/topicTeaser?guidelinePage=Pain+and+Analgesia&etgAccess=true.

56. National Institute for Health and Care Excellence (NICE). *Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain, NICE guideline*

reference number: NG193 [Internet]. 2021 [cited 2025 August 18]; Available from: https://www.nice.org.uk/guidance/ng193.

57. Australian Medical Council (AMC). *Prevocational outcome statements [Internet]*. 2024 [cited 2025 August 18]; Available from: https://www.amc.org.au/wp-content/uploads/2022/07/Section-2A-Prevocational-outcome-statements-2.pdf.

58. Nursing and Midwifery Board, Ahpra. *Registered Nurse Standards of Practice [Internet]*. 2016 [cited 2025 August 18]; Available from: https://www.nursingmidwiferyboard.gov.au/documents/default.aspx?record=WD16%2f19524&dbid=AP&chksum=R5Pkrn8yVpb9bJvtpTRe8w%3d%3d.

59. Burke HK, Sample PL, Bundy AC, et. al. Teaching reasoning, reflective practice, and evidence-based practice: Educator consensus strategies J Occup Therapy Educ, 2024; 8: 4.

60. Ebert J, Anderson JR, Taylor LF. Enhancing reflective practice of student physical therapists through video-assisted self and peer-assessment: A pilot study Int J Teach Learn High Educ, 2020; 32(1): 31-8.

61. Butani L, Bannister SL, Rubin A, et. al. How educators conceptualize and teach reflective practice: A survey of North American pediatric medical educators. Acad Pediatr, 2017; 17(3): 303-9.

62. Medical Board, Ahpra. *Good medical practice: a code of conduct for doctors in Australia [Internet]*. 2020 [cited 2025 August 18]; Available from: https://www.ahpra.gov.au/documents/default.aspx?record=WD20%2f30051&dbid=AP&chksum=9BSTs75R4%2fcPJY7vrmzHPg%3d%3d&_gl=1*76cs7q*_ga*MjA0NjQ3MzM4My4xNzU1NDE0MzYx*_ga_F1G6LRCHZB*czE3NTU1NTg3NzEkbzMkZzEkdDE3NTU1NjAzMjUkajYwJGwwJGgw.

63. DunnGalvin A, Cooper JB, Shorten G, et. al. Applied reflective practice in medicine and anaesthesiology. Br J Anaesth, 2019; 122(5): 536-41.

64. Ramani S, McMahon GT, Armstrong EG. Continuing professional development to foster behaviour change: From principles to practice in health professions education. Med Teach, 2019; 41(9): 1045-52.

65. Garrison D, Lyness JM, Frank JB, et. al. Qualitative analysis of medical student impressions of a narrative exercise in the third-year psychiatry clerkship. Acad Med, 2011; 86(1): 85-9.

66. Brown MEL, Costache C, Bull Parker S, et. al. Exploring the perceptions of senior medical students on gender and pain: A qualitative study of the interplay between formal and hidden curricula. BMJ Open, 2024; 14(8): e080420.

67. Lin I, Flanagan W, Green C, et. al. Clinical yarning education: development and pilot evaluation of an education program to improve clinical communication in Aboriginal health care - participant, and health manager perspectives. BMC Med Educ, 2023; 23(1): 908.

68. Chen I, Goodman B, 3rd, Galicia-Castillo M, et. al. The EVMS pain education initiative: a multifaceted approach to resident education. J Pain, 2007; 8(2): 152-60.

69. Cook KJ, Messick C, Baylor C, et. al. A qualitative study of reflective practice in the workplace. Speech-language pathologists have their say. Int J Speech Lang Pathol, 2024; 26(5): 637-51.

70. Finlay L. Reflecting on reflective practice. Practice-Based Professional Learning, The Open University, 2008; Paper 52.

71. Benfield A, Jeffery H. Exploring evidence based practice implementation by occupational therapists: Implications for fieldwork. J Occup Therapy Educ, 2022; 6(4): 10.

72. Australian Health Practitioner Regulation Agency (Ahpra). *Shared code of conduct [Internet]*. 2024 [cited 2024 August 18]; Available from: https://www.ahpra.gov.au/Resources/Code-of-conduct/Shared-Code-of-conduct.aspx.

73. Ranjan P, Kumari A, Chakrawarty A. How can doctors improve their communication skills? J Clin Diagn Res, 2015; 9(3): Je01-4.

74. Shipton E, Steketee C, Visser E. The Pain Medicine Curriculum Framework-structured integration of pain medicine education into the medical curriculum. Front Pain Res, 2022; 3: 1057114.

75. Karp JF. Pain medicine Fellows need explicit training in engaging patients in patient-centered pain management. Pain Med, 2012; 13(8): 985-986.

76. Edmond SN, Keefe FJ. Validating pain communication: Current state of the science. Pain, 2015; 156(2): 215-9.

77. Sobrinho Valete CO, Albuquerque A, Luiz Ferreira EA. Empathic care of neonates: A critical literature review. Perm J, 2024; 28(1): 46-54.

78. Koechlin H, Locher C, Prchal A. Talking to children and families about chronic pain: The importance of pain education: An introduction for pediatricians and other health care Providers. Children, 2020; 7(10).

79. Victorian Government. *Inquiry into women's pain [Internet]*. 2025 [cited 2025 August 19]; Available from: https://www.health.vic.gov.au/inquiry-into-womens-pain.

80. Diversity Council of Australia (DCA). *Intersectionality [Internet]*. 2025 [cited 2025 August 18]; Available from: https://www.dca.org.au/resources/di-planning/intersectionality.

81. New South Wales Government. *What is trauma-informed care? [Internet]* 2022 [cited 2025 August 18]; Available from: https://www.health.nsw.gov.au/mentalhealth/psychosocial/principles/Pages/trauma-informed.aspx.

82. Cohen SP, Vase L, Hooten WM. Chronic pain: an update on burden, best practices, and new advances. Lancet, 2021; 397(10289): 2082-97.

83. International Association for the Study of Pain (IASP). *Terminology [Internet]*. 2021 [cited 2025 August 19]; Available from: https://www.iasp-pain.org/resources/terminology/.

84. Gagnon CM, Scholten P, Atchison J. Multidimensional patient impression of change following interdisciplinary pain management. . Pain Pract, 2018; 18(8): 997-1010.

85. Danilov A, Danilov A, Barulin A, et. al. Interdisciplinary approach to chronic pain management. Postgrad Med, 2020; 132(sup3): 5-9.

86. Connell NB, Prathivadi P, Lorenz KA, et. al. Teaming in interdisciplinary chronic pain management interventions in primary care: A systematic review of randomized controlled trials. J Gen Intern Med, 2022; 37(6): 1501-12.

87. Thielke S, Corson K, Dobscha SK. Collaborative care for pain results in both symptom improvement and sustained reduction of pain and depression. Gen Hosp Psychiatry, 2015; 37(2): 139-43.

88. Heavey SC, Bleasdale J, Rosenfeld EA, et. al. Collaborative care models to improve pain and reduce opioid use in primary care: a systematic review. J Gen Intern Med, 2023; 38(13): 3021-40.

89. Boev C, Tydings D, Critchlow C. A qualitative exploration of nurse-physician collaboration in intensive care units. Intensive and Critical Care Nursing, 2022; 70: 103218.

90. Dunston R, Forman D, Thistlethwaite J, et. al. Repositioning interprofessional education from the margins to the centre of Australian health professional education - what is required? Aust Health Rev, 2019; 43(2): 224-9.

91. Gatchel RJ, Peng YB, Peters ML, et. al., The biopsychosocial approach to chronic pain: Scientific advances and future directions. 2007, American Psychological Association. p. 581-624.

92. Adams NE. Bloom's taxonomy of cognitive learning objectives. J Med Libr Assoc, 2015; 103(3): 152-3.

93. Ogbeide Stacy A, Johnson-Esparza Y, George D. Applying Bloom's Taxonomy in primary care behavioural health training. Clin Teach, 2025; 22(3): e70099.

94. Leake HB, Heathcote LC, Ferencz N, et. al. Co-design and evaluation of pain science messages on social media with adolescents with a history of chronic pain. J Pain, 2024; 25(9): 104580.

95. Indigenous Allied Health Australia (IAHA). *Cultural Responsiveness in Action Framework [Internet]*. 2015 [cited 2025 August 20]; Available from: https://iaha.com.au/workforce-support/training-and-development/cultural-responsiveness-in-action-training/.

96. Australian Indigenous Doctors' Association (AIDA). *AIDA's Cultural Safety Program [Internet]*. 2025 [cited 2025 August 20]; Available from: https://aida.org.au/cultural-safety-program/#whatis.

97. Diversity Council Australia (DCA). *What is diversity and inclusion? [Internet]*. 2025 [cited 2025 August 18]; Available from: https://www.dca.org.au/resources/di-planning/what-is-diversity-inclusion.

98. Harmon A. *Gibbs' reflective cycle [Internet]*. 2024 [cited 2025 August 18]; Available from: https://www.ebsco.com/research-starters/education/gibbs-reflective-cycle.

99. The Open University. *Workplace learning with coaching and mentoring: Using the GROW coaching model*. 2023 [cited 2025 August 18]; Available from: https://www.open.edu/openlearn/money-business/workplace-learning-coaching-and-mentoring/content-section-5.2.

100. Sylwander C, Wahl AK, Andersson MLE, et. al. Health literacy in individuals with knee pain—a mixed methods study. BMC Pub Health, 2023; 23(1): 1656.

101. Kim K, Yang Y, Wang Z, et. al. A systematic review of the association between health literacy and pain self-management. Patient Educ Couns, 2022; 105(6): 1427-40.

102. Australian Health Practitioner Regulation Agency (Ahpra). *About Registration [Internet]*. 2025 [cited 2025 August 20]; Available from: https://www.ahpra.gov.au/Registration.aspx.

103. Australian and New Zealand College of Anaesthetists (ANZCA). *Critical incident debriefing toolkit: 2: How to hot debrief [Internet]*. 2021 [cited 2025 August 18]; Available from: https://libguides.anzca.edu.au/criticalincident/hotdebrief.

104. International Association for the Study of Pain (IASP). *IASP Revises Its definition of pain for the first time since 1979 [Internet]*. 2020 [cited 2025 August 18]; Available from: https://www.iasp-pain.org/wp-content/uploads/2022/04/revised-definition-flysheet_R2-1-1-1.pdf.

105. Physiotherapy New Zealand. *Models of Reflection [Internet]*. 2017 [cited 2025 August 20]; Available from: https://pnz.org.nz/Attachment?Action=Download&Attachment_id=770.

106. Spencer JA, Jordan RK. Learner centred approaches in medical education. BMJ, 1999; 318: 1280-3.

107. Oyelana OO, Olson J, Caine V. An evolutionary concept analysis of learner-centered teaching. Nurse Educ Today, 2022; 108: 105187.

108. Ventres WB. Deeper teaching: from theory and practice to learner-centered medical education. J Gen Intern Med, 2023; 38(1): 213-5.

109. Grant J. Learning needs assessment: Assessing the need. BMJ, 2002; 324(7330): 156-9.

110. Chimenti RL, Frey-Law LA, Sluka KA. A mechanism-based approach to physical therapist management of pain. Phys Ther, 2018; 98(5): 302-314.

111. Australian Commission on Safety and Quality in Health Care (ACSQHC). *Person-centred care. [Internet]*. 2025 [cited 2025 August 30]; Available from: https://www.safetyandquality.gov.au/our-work/partnering-consumers/person-centred-care.

112. Ito A, Sato K, Yumoto Y, et. al. A concept analysis of psychological safety: Further understanding for application to health care. Nurs Open, 2022; 9(1): 467-89.

113. Harvey M, Walkerden G, Semple A, et. al. Reflecting on reflective practice: Issues, possibilities and guidance principles. High Educ Res Dev, 2025: 1-9.

114. Australian Commission on Safety and Quality in Health Care (ACSQHC). *Shared decision making [Internet]*. 2025 [cited 2025 August 30]; Available from: https://www.safetyandquality.gov.au/our-work/partnering-consumers/shared-decision-making.

115. Xie H. Strengths-based approach for mental health recovery. Iran J Psychiatry Behav Sci, 2013; 7(2): 5-10.

116. Graziosi M, Yaden DB, Clifton JDW, et. al. A strengths-based approach to chronic pain. The Journal of Positive Psychology, 2022; 17(3): 400-408.

117. Sturgiss EA, Sargent GM, Haesler E, et. al. Therapeutic alliance and obesity management in primary care: A cross-sectional pilot using the Working Alliance Inventory. Clin Obes, 2016; 6(6): 376-9.

118. Ogunleye TA. Unconscious bias. Dermatol Clin, 2023; 41(2): 285-90.

119. Thomas H, Best M, Mitchell G. Whole-person care in general practice: The nature of whole-person care. Aust J Gen Pract, 2020; 49: 54-60.

APPENDIX 1: Project method

The following section outlines the key phases and steps in developing the *Australian Standards for Health Practitioner Pain Management Education*, along with the major results achieved throughout the project.

Timeline	Phase	Details
Feb–Jun 2024	Project establishment	• Formation of the Faculty of Pain Medicine Project Team. • Engagement of an external consultant with expertise in the development of health-related standards.
	Foundations for stakeholder communication and involvement	• Development of a communications strategy. • Creation of a comprehensive stakeholder database. • Formation of a Governance Advisory Group comprising 18 representatives from relevant stakeholder groups.
	Confirmation of project method and context	• Review of the published literature and completion of an environmental scan to validate the project approach and identify and existing and/or similar standards. *Key findings:* *a) The proposed project method was appropriate for the development of standards.* *b) No standards for health practitioner pain management education existed in Australia or internationally at the time of the review.*
Jun–Oct 2024	Comprehensive stakeholder consultation	• Five in-person and three online national stakeholder consultation workshops with the aims of: • Increasing stakeholders' understanding of the context and aims of the project. • Gaining stakeholder perspectives re: the issues to potentially be covered by the standards. • Additional consultations with Aboriginal and Torres Strait Islander health practitioners and culturally and linguistically diverse health practitioners and people with lived experience of pain. *Summary: In total, 265 registrants from a wide range of relevant stakeholder groups and 207 attendees (=78% attendance rate). Attendees included people with lived experience of pain and representatives from a broad range of sectors (e.g. various levels of the health, education and government sectors), multiple health disciplines, diverse organisations (e.g. not-for-profit agencies, medical colleges, health professional associations, peak health organisations) and roles.*

Timeline	Phase	Details
Oct–Dec 2024	Analysis of stakeholder consultation data	• Analysis of consultation data using the Clarke and Braun[1] inductive analysis approach to identify themes for potential development as standards. • Confirmation of the internal validity of the identified themes by selected group of consultation workshop participants. • Confirmation of the external validity of the identified themes by people who had registered for the consultation workshops but were unable to attend.
Jan–Aug 2025	Drafting of standards	• Scoping review of relevant guidelines, policies and legislation to check that the identified themes did not raise conflict concerns. • Project Team and external consultant in conjunction with the Governance Advisory Group. • Further review of the relevant literature.
	Delphi process	• Involving the Governance Advisory Group + small group of other stakeholders (n=21) and using the RAND/UCLA Appropriateness Method. • Two rounds of voting with high levels of consensus and constructive feedback. *Summary: Confirmation of the six draft overarching standards and the refinement of the wording of all draft standards.*
	Major stakeholder consultation re: draft standards	• Consultation re: draft set of standards open to all interested persons. • Broad dissemination and promotion with survey open for one month. *Results:* • *164 organisations and individuals engaged with the survey (27 organisations and 137 individuals); 53% of individual respondents primarily worked identified as health practitioners, 31% were academics and 16% were health consumers. The organisations included universities, medical colleges, consumer advocacy groups, pain organisations and professional associations.* • *The quantitative results from the survey indicated that:* ➢ *at least 94.7% agreed or strongly agreed (range: 94.7–99.2%) with the draft overarching standards (themes).* ➢ *at least 90.7% agreed or strongly agreed (range: 90.7–97.3%) with the draft associated standards within each theme.* ➢ *at least 84.8% agreed or strongly agreed (range: 84.8–93.6%) with the draft criteria for each standard.*

Timeline	Phase	Details
	Finalisation of the draft standards	• Review and revision of the draft standards by the Project Team and the Governance Advisory Group based on the stakeholder consultation feedback. • Further review of the relevant literature in developing the background information for each of the overarching standards.
May–Aug 2025	Development of online hub	• Development of a central, online hub (microsite) for accessing, understanding, and promoting the newly developed pain management education standards (once approved by government).
Sep–Oct 2025	Approval and submission to government	• Approval of the final draft set of standards by the Faculty of Pain Medicine Board. • Submission of draft set of standards and final project report to government

APPENDIX 2: Acknowledgements

Governance Advisory Group

The role of this group was to provide guidance and advice from a broad range of consumer, clinical and education perspectives to the project team throughout the development of the *Australian Standards for Health Practitioner Pain Management Education*.

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