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] This person-centred model facilitates consideration of the multitude of factors (including multimorbidity) that can both influence and be influenced by pain.

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; one's skills, attitudes and behaviours, the power differentials involved in delivering safe and responsive care and recognition of the impact culture has on clinical practice.[100] It includes acknowledgement of colonisation and systemic racism, and the resulting factors that impact the health of Aboriginal and Torres Strait Islander individuals and their communities.[48]

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.
- *Culturally and linguistically diverse backgrounds (CALD) 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.
- *Neurocognitive and intellectual disabilities*: Acknowledging individuals who may face challenges with varying cognitive functions and intellectual abilities.
- *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, including atypical and paradoxical perceptions and expressions of pain.
- *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.

- *Physical disability*: Acknowledging individuals with who may face challenges related to varying physical or sensory abilities.
- *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 5-15 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-determined decision making: Self-determination refers to the principle that individuals have a right to shape their own lives and, where they choose, this involves participating in decisions that affect their lives, including in relation to their health care. Self-determined decision making emphasises free participation, self-advocacy, genuine engagement and cultural respect, and is particularly crucial for groups that have traditionally been excluded from decisions regarding their lives, including Aboriginal and Torres Strait Islander people and people with intellectual or other neurocognitive disabilities.[48,118,119]

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 strengths-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, rapport and sense of support created between clinician and individual experiencing pain that empowers the two to work collaboratively to establish agreement on goals and care tasks.[123]

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. This includes their entire physical health (e.g. multimorbidities) and also extends beyond 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 full needs of the individual and that meets their needs in a holistic way.[125]