

Workshop review & reflections

Making small ripples in a big pond: Reflections from attending “*Intensive Interdisciplinary Multimodal Pediatric Pain Management - A professional workshop*” Datteln, Germany

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Multi-professional working is an established model of care for the treatment of chronic pain in children and adolescents. The workshop held by the German Paediatric Pain Centre, Datteln and the Pediatric Pain Rehabilitation Center at Boston Children’s Hospital in June 2019, encouraged the attendance of teams, not individuals, giving a clear message about successful interdisciplinary working. Its aim was simple: to promote the topic of chronic pain treatment internationally in the hope of improving management and assisting service development around the world. I will describe its personal impact on myself as a clinician and the downstream effect this workshop had for our service.

I am a child psychiatrist and paediatrician working part-time in the field of chronic pain in New Zealand. Like many services, we struggle for funding and resources but remain a passionate and dedicated team. I chose to attend this workshop as someone new to the speciality to find out more about how large internationally-renowned services worked and to get a sense of how we were doing as a team. We were fortunate that generous grants from the hospital foundation allowed most members of our multi-professional team to attend.

The workshop was intentionally small, with 42 attendees from Europe, North America and

Australasia, from well-established facilities to pain teams wishing to develop a rehabilitation function. Members of both interdisciplinary teams from Datteln and Boston spoke in detail about their models of care, including admission criteria, structure and content. Hearing about both the similarities and differences that exist between these two established programs was informative. Hearing from big centers is often disheartening as it can reinforce what resources you lack to achieve new goals. However this workshop provided in-depth descriptions of treatment pathways and generously shared resources, which meant that attendees could consider implementing some of the methods shared into their clinics. This was further strengthened by hearing the perspectives of services from two different cultures and allowed us to decide what would fit us best.

We learned together as a whole group or in parallel sessions designed for those working in psychological health, medical care and allied health. Lecture notes were available for the concurrent sessions as everyone was interested in the content of the sessions they did not attend. I attended the stream for medical doctors and particularly enjoyed hearing up to date evidence on pharmacological therapies. A suggestion to enhance more cross-professional learning was to change the session

titles from the names of the profession to the content of the session.

Time was allocated for teams to reflect about their services and how they could move forward. In busy health systems, where time is so often limited, teams were given the space to talk about their future goals. Our team discussed ways we could work smarter and left feeling energized and ready to make changes. We have since given more emphasis to offering discrete blocks of care, for example, weekly input from the multi-professional team for six weeks with written goals reviewed at the end of this time period. Prior to this, periods of treatment were less well-defined, which meant that treatment plans were not reviewed on a scheduled basis. We were also very flexible in regards to families' other commitments, due to work and distances they needed to travel. This meant that care often became fragmented and the burden for re-arranging cancelled appointments fell on the staff. Families now have to make a conscious commitment to treatment at the start of each block. Based on anecdotal impressions of this change, the approach seems to be keeping children, their families and us on track better. Our service participates in an outcome collaborative, the electronic persistent pain outcomes collaboration assessment tool (ePOCC) but completion of this by families at 6 and 12 month follow up has been poor. We realized how rich this missing information was for our assessment of how we are performing and to measure the effectiveness of any changes we might make to the service. We made a resolution to await the completion of the ePOCC form before confirming the follow-up clinic appointments. I also learned a lot about the scope of practice of my fellow team members and how they wished to work differently. A few months later we still feel more cohesive as a team and I am proud of our working relationships which I know helps our patients.

As a bonus, we were able to tour the state of the art pain facility in Datteln and I did this with some reticence. We simply could not achieve what they had because of the size of our country and the funding structure of our health care system. A hidden curriculum is a side effect of formal education-learning things that have not been openly intended. During the tour, I thought about the

environment provided for recovery and growth. The facility is set in beautiful gardens and the aesthetics of the modern outpatient center asserts the theme of bravery and courage through paintings and photographs amongst other themes. Sitting in the outpatient area, I imagined as a child I would feel hopeful, valued and understood. I wondered if a young person's recovery might begin at the moment they arrived in the building. This inspired me to contemplate what less well-resourced institutions could do to convey a similar message.

In a separate session, we were given advice on how to advocate for funding using the experience of clinicians that had been successful in doing so. Some of the European countries attending discussed collaborating with each other to raise awareness of chronic pain and access funding. The take home message for me was to think outside the box. I lamented our clinic room with its blank walls, lack of temperature control and frequent extraneous noise interruptions such as children playing the xylophone in the play area or the transport helicopter landing nearby. I thought about how we could create an environment that was more welcoming, hopeful and promoted recovery. This stimulated me to contact a friend who had expressed an interest in philanthropy and owned a large graphic design company. After some discussion, he agreed to help create visual images for the Pain Kete which is our chronic pain resource for children and families. *Kete* is the Māori word for a carrying basket made by weaving together the leaves of New Zealand Flax. The images we created have a New Zealand outdoors theme and are fun and attractive. I also designed an image depicting the process of recovery to be used as art work for our clinic and as a therapeutic tool (see Figure 1). By creating it especially for New Zealanders, I hope it conveys to patients and families that they are valued and it gives them the confidence to move forward. Both are yet to be finalized as we are using an iterative process by seeking feedback from children, adolescents and parents at different stages of the design. Once finalized, children, families and professionals in New Zealand will be able to use this resource by accessing it through our hospital website. We would also welcome its use internationally. I also hope we can provide some

training workshops in New Zealand that are based around this resource.

It was a pleasure to attend this workshop and learn what others are doing internationally, share experiences, ideas and make connections. The workshop reassured me we were doing well as a service and gave food for thought in more ways than I had expected.

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Figure 1. Poster developed to display in clinic room.