

## Beyond the Gap: Knowledge Mobilisation and the Journal as a Site of Change

*Pain and Rehabilitation*  
Volume 56 Issue 1 2026

There is a statistic that circulates widely in healthcare improvement circles, and it is worth repeating here. On average, it takes seventeen years for robust research evidence to become routine clinical practice <sup>1</sup>. Only around sixty percent of care is in line with evidence-based guidelines. Thirty percent is some form of waste or low value. Ten percent causes harm <sup>2</sup>.

These are not figures designed to shock. They reflect decades of careful research into what happens, or fails to happen, when knowledge produced in one setting tries to reach the people who need it in another <sup>3</sup>. They are a genuine problem, and they matter to everyone working in pain and rehabilitation.

But the framing that usually accompanies them is worth examining. Because that framing shapes not just how we think about the problem, but what solutions we can even imagine.

The dominant image is of a gap. Research produces knowledge on one side. Practice needs it on the other. The job is to build a bridge. Journals, in this picture, are part of the bridging infrastructure: publish the research, make it accessible, and hope it travels.

There is something right about this. Access matters. Speed matters. Clarity matters. But the gap metaphor brings hidden assumptions with it, and those assumptions end up shaping everything: what counts as publishable knowledge, who produces it, who is expected to receive it, and who never quite feels entitled to participate at all.

The core assumption is this: That there is a singular form of knowledge/truth. Knowledge flows in one direction. Researchers generate it. Clinicians apply it. Patients receive it. Even when we use more sophisticated language about co-production or knowledge exchange, the underlying image tends to stay the same e.g. <sup>4</sup>. There is an upstream and a downstream.

This is a particular problem in pain and rehabilitation. Chronic pain does not yield easily to that model. It is multiple, contextual, biographical, relational and

stubbornly complex in ways that no single study, however rigorous, can fully account for. The research base is essential. So is the practitioner's accumulated clinical judgement, developed through years of working with people who do not present as cleanly as trial participants. So is the patient's own knowledge of their body, their history, beliefs, expectations and what is and is not helpful. Scientific knowledge, practical skill and expertise, and professional judgement and practical wisdom are distinct but equally necessary forms of knowing <sup>5</sup>. Good care in this field depends on both their meaning and integration.

The knowledge mobilisation field has been making this argument for some time, tracing a progression from linear models of knowledge transfer through relational models toward systems-informed approaches in which knowledge gains meaning through social processes and is genuinely reconstituted through use <sup>6,7</sup>. A clinician who takes a research finding and applies it thoughtfully to a specific patient's situation is not simply consuming knowledge. They are doing something generative: integrating a particular form of evidence with context, with judgement, with the patient's own understanding, and producing something that was not contained in the original paper.

This is a more demanding picture of what knowledge mobilisation actually requires. It is also, we think, a more honest one. And it has direct consequences for what a journal in this field should look like.

Journals are not neutral. Every editorial decision, from what types of submission to accept, to whether to charge authors to publish, to who gets invited to peer review, enacts a set of assumptions about whose knowledge counts and who has the right to contribute to it. These decisions accumulate into structures, and those structures have real effects on what gets published, what gets written, and who feels able to submit at all <sup>8</sup>.

The academic publishing system, for all its genuine achievements, was not designed with clinical practitioners in mind as producers of knowledge. As it relates to medicine and healthcare, it was built around

a particular model of scholarly production: hypothesis-driven, methodologically formalised, institution-affiliated, and structured according to conventions that take years of training to absorb. The practitioner who has generated real insight through working with patients, the student who has noticed something important, the person living with pain who has hard-won understanding of what it is like to navigate services: none of them map naturally onto that particular model. The feeling that your knowledge is "not academic enough" is not a personal failing. It is a predictable response to a system that was not built to receive it.

The incentive structures of academic publishing, including the pressure to publish in high-impact journals to secure career progression, shape what researchers choose to study and submit in the first place, with studies and perspectives that do not fit the prevailing grain of a field tending not to reach publication, not necessarily because they are rejected, but because they are never submitted <sup>9</sup>. The gatekeeping function of journals is real and consequential, and the question of where human judgement should be exercised and where it risks being bypassed or eroded matters enormously for the integrity of what enters the literature.

This journal was built around a different set of assumptions. It is worth being clear about what those assumptions are and why they lead to the decisions we have made.

Pain and Rehabilitation is free to publish and fully open access. This is partly about fairness, but it is also something more structural than that. If knowledge mobilisation requires knowledge to reach the people who need it, then a journal that charges authors to contribute or readers to access is working against its own stated purpose. The economics of academic publishing have concentrated power in ways that consistently disadvantage practitioners without institutional research budgets, researchers in under-resourced settings, and patients or carers with no affiliation at all <sup>10</sup>.

The range of submission types we accept follows the same logic. We publish original research, service evaluations, systematic reviews and protocols. We also publish perspectives pieces, personal narratives, reflections, poetry, video and photo essays, film and book reviews, and practice-based blogs. This is not

about lowering the bar. It is about recognising that different forms of knowing require different forms of expression, and that insisting everything fits the shape of a biomedical empirical paper guarantees the exclusion of knowledge that does not. Effective knowledge mobilisation depends on the active integration of research-derived knowledge with tacit, experiential and contextual knowledge: the kind of knowledge that practitioners and patients hold, and that rarely surfaces in conventional academic formats <sup>11</sup>.

Jacobs and colleagues' service evaluation in this issue <sup>12</sup> illustrates this. By conducting individual narrative interviews with people living with pain and attending carefully to their stories, the team generated understanding of trauma-informed pain care that would not have emerged from any outcome measure or trial protocol. Participants described waiting fifteen years to access treatment, navigating healthcare systems that compounded their distress, and the particular safety of being in a room where, as one participant put it, "everybody in the room was going through the same thing." <sup>12</sup> That knowledge, granular, contextual, and carried in people's own words, directly shaped changes in clinical practice. It belongs in the literature in the form it takes here.

We have also simplified the submission process itself. Authors can submit a complete manuscript as a single Word or PDF file with no formatting requirements at the initial stage. Formatting only becomes relevant after acceptance. It is a small change, but it addresses a real barrier: the sense that you need to already know the rules of academic publishing before you can enter it. You do not.

The feature of this journal that perhaps most directly embodies this approach is the role of our Lived Experience Associate Editor, Niki Jones.

Niki lives with chronic pain and long-term conditions and holds an editorial position with genuine responsibility. For every issue, she writes an editorial that engages with the articles we have published, discusses what they contain, and reframes their content for a wider audience: for people living with pain, for carers, for families, for anyone whose relationship to this knowledge is not primarily a professional one.

It is worth being clear about what this role is and what it is not. It is not a patient representative sitting alongside the "real" editors to check that things sound accessible. It is an editorial voice with its own authority, grounded in a form of knowledge that no amount of professional training can substitute for. Niki's understanding of what it means to live with chronic pain, to navigate healthcare systems, to know from the inside what matters and what does not, is not a supplement to clinical and research knowledge. In this field, it is foundational. Knowledge mobilisation, at its core, is about connecting and encouraging people to share explicit and tacit knowledge and to use that knowledge to inform decision making<sup>13</sup>, and Niki's role is a structural expression of exactly that.

Her editorials are themselves acts of knowledge mobilisation. They take knowledge produced in one form and reconstitute it in another: not simplifying it, but contextualising it, making connections, asking questions that the original papers may not have considered, and making the knowledge meaningful to people who might not have been the original intended audience. This kind of active, relational work of connecting different bodies of knowledge and different communities of people is central to what effective knowledge mobilisation looks like in practice<sup>14</sup>. What makes Niki's role distinctive is that this brokering is not being done by a researcher or a professional intermediary, but by someone whose primary expertise is lived.

In this issue, Niki reads MacSween's mapping of CPPP services<sup>15</sup> not as a data exercise but as a human question: what does it mean that where you live determines whether you can access care for your pain? She writes that she would "always argue that a quality-of-life assessment be included as this seems to me to be the real-world indicator of effectiveness" and asks directly whether the NICE guidelines that are supposed to guarantee equitable access are "fit for purpose."<sup>16</sup> These are not questions that arise from the data alone. They arise from the experience of being the person the research is supposed to serve. That is an example of what lived-experience input contributes, and it is not incidental to the knowledge this journal produces. It is integral to it.

We are also, in an upcoming issue, publishing a special edition devoted to knowledge mobilisation as a topic in its own right, drawing together perspectives from inter-disciplinary research, practice and lived

experience on what it means to get knowledge to work in pain and rehabilitation.

We mention this not just to flag it, but because its existence reflects something we feel strongly about: knowledge mobilisation is not a technical problem to be solved upstream of clinical practice. It is a question that belongs to everyone in this field, and one this journal wants to keep asking.

A few words, then, directly to the people most likely to be reading this.

If you are a clinician: you are already generating knowledge. Every patient you work with, every decision you make, every outcome you observe and reflect on, every service you help to shape or evaluate is a source of insight that this field needs. You do not need to convert that knowledge into something it is not in order to share it here. We accept service evaluations, reflections, practice-based accounts and personal narratives because we believe these forms of knowledge belong in the literature. If you have been sitting on something because you were not sure it was publishable, please consider submitting it. The review process is here to develop your work, not to exclude it.

If you are a researcher or academic: knowledge mobilisation does not begin when you finish a study and look for somewhere to publish it. It begins with the questions you choose to ask, the people you involve, the forms in which you choose to share your work, and the communities you direct it toward<sup>17</sup>. Publishing in a fully open access journal, in a field with genuine clinical and patient stakes, with a readership that spans research, practice and lived experience, is one way of making different choices about all of those things.

For both: pain and rehabilitation sit at the intersection of research, practice, policy, engagement and lived experience. Getting knowledge to work across that intersection is not a logistics problem. It is a question of whether the structures we build for sharing knowledge actually reflect what we believe about whose knowledge matters. The architecture of this journal is our attempt to answer that question. We hope you will contribute to it.

*Pain and Rehabilitation is freely available at [painandrehabilitation.co.uk](http://painandrehabilitation.co.uk). Submissions are open to clinicians, researchers, students, patients and carers. No author fees apply.*

## References

1. Balas, E.A., and Boren, S.A. (2000). Managing Clinical Knowledge for Health Care Improvement. Yearbook of medical informatics., 65.
2. Braithwaite, J., Glasziou, P., and Westbrook, J. (2020). The three numbers you need to know about healthcare: the 60-30-10 Challenge. BMC Med. 18, 102. <https://doi.org/10.1186/s12916-020-01563-4>.
3. Grimshaw, J.M., Eccles, M.P., Lavis, J.N., Hill, S.J., and Squires, J.E. (2012). Knowledge translation of research findings. Implement. Sci. 7, 50. <https://doi.org/10.1186/1748-5908-7-50>.
4. Wagner, A., Polak, P., and Świątkiewicz-Mośny, M. (2019). Who defines—who decides? Theorising the epistemic communities, communities of practice and interest groups in the healthcare field: a discursive approach. Soc. Theory Heal. 17, 192–212. <https://doi.org/10.1057/s41285-018-0073-6>.
5. Ward, V. (2017). Why, whose, what and how? A framework for knowledge mobilisers. Évid. Polic. 13, 477–497. <https://doi.org/10.1332/174426416x14634763278725>.
6. Best, A., and Holmes, B. (2010). Systems thinking, knowledge and action: towards better models and methods. Évid. Polic.: A J. Res., Debate Pr. 6, 145–159. <https://doi.org/10.1332/174426410x502284>.
7. Haynes, A., Rychetnik, L., Finegood, D., Irving, M., Freebairn, L., and Hawe, P. (2020). Applying systems thinking to knowledge mobilisation in public health. Heal. Res. Polic. Syst. 18, 134. <https://doi.org/10.1186/s12961-020-00600-1>.
8. Ferlie, E., Crilly, T., Jashapara, A., and Peckham, A. (2012). Knowledge mobilisation in healthcare: A critical review of health sector and generic management literature. Soc. Sci. Med. 74, 1297–1304. <https://doi.org/10.1016/j.socscimed.2011.11.042>.
9. Zhou, S., Lebrecht, A., Pithayarungsarit, P., and Monke, C. (2025). The Gatekeepers of Academia: Investigating Bias in Journal Publication Across Topics, Author Backgrounds, and Institutions. Learn. Publ. 38. <https://doi.org/10.1002/leap.2022>.
10. Larivière, V., Haustein, S., and Mongeon, P. (2015). The Oligopoly of Academic Publishers in the Digital Era. PLoS ONE 10, e0127502. <https://doi.org/10.1371/journal.pone.0127502>.
11. Durrant, H., Havers, R., Downe, J., and Martin, S. (2024). Improving evidence use: a systematic scoping review of local models of knowledge mobilisation. Évid. Polic. 20, 370–392. <https://doi.org/10.1332/174426421x16905563871215>.
12. Jacobs, C., Anderson, M., Chrysostomou, P., Kadri, K., Leteurtre, C., Jakubiec, P., and Scott, W. (2026). Patients' perceptions of a multidisciplinary pain management programme in relation to trauma-informed practice principles: a narrative-based qualitative service evaluation. Pain Rehabilitation 56. <https://doi.org/10.59210/2wwwxdk62>.
13. Bryant, S.L. (2025). Actioning actionable knowledge: What do we mean by knowledge mobilisation? Heal. Inf. Libr. J. 42, 225–231. <https://doi.org/10.1111/hir.70004>.
14. Davies, H.T., Powell, A.E., and Nutley, S.M. (2015). Mobilising knowledge to improve UK health care: learning from other countries and other sectors - a multimethod mapping study. Heal. Serv. Deliv. Res. 3, 1–190. <https://doi.org/10.3310/hsdr03270>.
15. MacSween, A., Newsome, R., White, L., Dickson, A., Greenwood, J., Ferguson, D., Santos, R., Ryan, C., and Martin, D. (2026). Delivery of the Comprehensive Multi-Disciplinary Combined Physical and Psychological Programme of the National Low Back and Radicular Pain Pathway in England and Wales: where do we stand? Pain Rehabilitation 56. <https://doi.org/10.59210/wmrkmd45>.
16. Jones, N. (2026). Where There is Pain, There is Always a Person. Pain Rehabilitation 56. <https://doi.org/10.59210/xdq6sq70>.
17. Nutley, S.M., Walter, I., and Davies, H.T.O. (2007). Using evidence. <https://doi.org/10.2307/j.ctt9qgwt1>.

**Dr Chris Seenan**

Faculty of Health, Sport and Society,  
University of Stirling, UK

**Dr Jackie Walumbe**

NIHR ARC North Thames and University College  
London, Institute of Neurology, UK

**Niki Jones**

Associate Editor, Pain and Rehabilitation