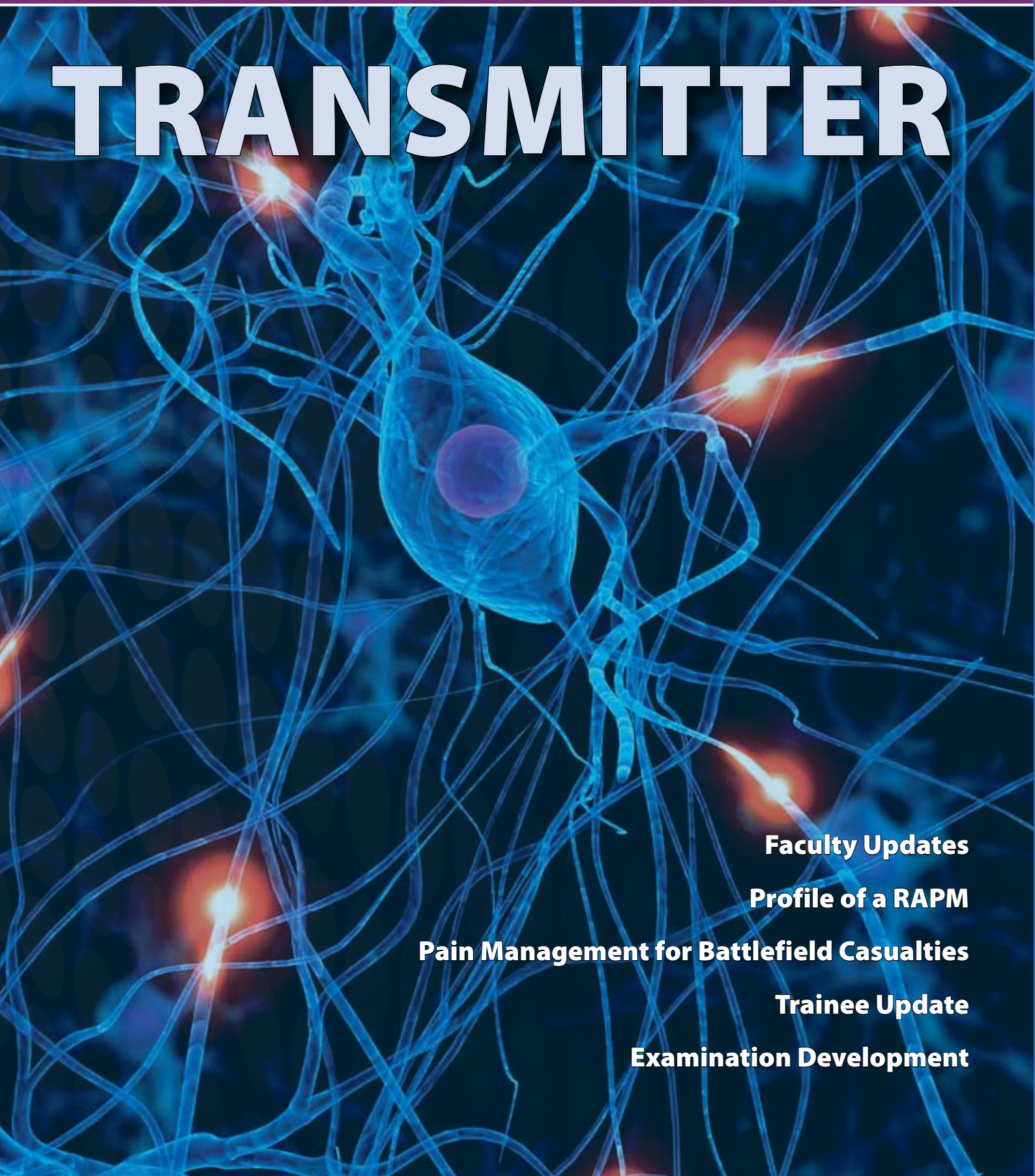
FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

Newsletter of the Faculty of Pain Medicine SPRING 2012

# TRANSMITTER



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FACULTY OF PAIN MEDICINE
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**The Faculty is five! We celebrated our fifth birthday on 2nd April 2012... So, a good time to reflect on what has happened, and more importantly what has been achieved over those five years.**

The Faculty has worked to create a structure which is geared to efficiency; it is our intention that through this we should serve you well, as Fellows and Members of all categories. We are always very keen to hear your opinion on what we can do to make the Faculty work better for you.

Over the last five years we have attempted to regularise and standardise Pain Medicine training within the RCoA curriculum; this has taken the form of the appointment of the 'army' of RAPMs and LPMESs, of a careful rewrite of the curriculum and the introduction of standardised assessment at all levels, but with a very formal process having been introduced for Advanced Pain Medicine training. Significantly we have introduced an examination as the gateway to the award of FFPMRCA.

Liaison, networking and partnerships have become very important, particularly in these times of pressure. Our relationship with the British Pain Society is sound and effective (and the Faculty is indebted to Professor Richard Langford for his efforts and warmth in this respect). That combined with our link to the Chronic Pain Policy Coalition has given strength to high level negotiations, of which we hear more in Dr Collett's article.

The Faculty has developed an educational programme which goes from strength to strength. Feedback suggests the events are relevant and of a high quality and we hear more of these in Dr Gupta's article.

*Kate Grady*

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# Message from the Dean


## Professor Dave Rowbotham

Dean of the Faculty of Pain Medicine


### Seeking your views on future strategy

The Board of the Faculty of Pain Medicine spent a day in January reviewing the progress of the FPM to date and where we might go next. We identified some important areas which we thought needed exploring. Projects, each led by a member of the FPM Board, are underway and will be reviewed at our next Board meeting in May. Definitive action and plans will emerge from this and later meetings.

We want the next stage of our development to reflect the views of our Fellows, so we are asking for your thoughts on the issues identified at our strategy meeting. Listed below are some of the issues:

Our training and communication network is based on the RCoA system of Regional Advisors and College Tutors. We are a small speciality and the training numbers are not evenly spread. Some regions have a couple of trainees, some have dozens. Should we have a different system? If so, what would such a system look like?

> "We want the next stage of our development to reflect the views of our Fellows"

Foundation Fellowship was open to Consultants who had substantive clinical sessions in pain, including acute pain. Standard Fellowship is now obtained by completion of Advanced Pain Training and success at the new examination. This was always the ambition of the Faculty, to ensure that Fellowship indicated first class training and assessment in all aspects of pain including complex chronic pain. Of course, this now means that those who have an interest in acute pain only and have not completed Advanced Pain Training cannot engage easily with the FPM. What should we do about this?

We are all aware of challenges of engaging with the new local clinical commissioning groups. What information would be of use and how can the FPM assist you in this?

The whole point of the FPM is to improve patient care. We have a patient representative on our Board; however, we think that there is more we can do to engage the public and our patients. How do you think we should do this?

Good communication is important for all organisations. We have a new website and produce regular articles for our Fellows, including this publication. Is this enough? How can we improve our communications with you?

Our local training assessments have been very successful. Should we continue with them as they are or should we make significant changes? We have a trainee representative on the Board. Is this sufficient to ensure effective representation and communication?

The Faculty has published a number of guidelines and recommendations. We want to do more of this. What guidelines and/or recommendations would you welcome? We aim to develop a network of clinics who want to be involved with clinical trials. Are you interested?

We are developing a Department of Health funded e-Learning package for pain management for all NHS healthcare professionals based on the successful RCoA e-Learning programme. Do you want to be involved?

These are some of the issues that we are considering presently. Please let us know your thoughts and suggestions by emailing fpm@rcoa.ac.uk.

# Training and Assessment


## Dr Kate Grady

Chair, FPM Training and Assessment Committee


Whilst the systematic work of the Training & Assessment Committee (TAC) continues, following the Board of the Faculty of Pain Medicine Away Day, the Committee forges in additional directions.

The membership of the TAC is set to change as Dr Barry Miller, a member, has become the Chair of the Regional Advisors in Pain Medicine (RAPMs) which is a co-opted place, thus making available another position on the Committee. We congratulate Barry on his appointment and welcome him in this new role to the Committee. We have an enormous debt of gratitude to pay to John Hughes who has served with thoughtfulness and diligence as the Chair of the RAPMs. We wish John well and look forward to future interaction with him.

At the Away Day attention was drawn to the role of the RAPM and the circumstances in which they can find themselves. The RAPM is the hand of the Faculty across the regions, and whilst many RAPMs are well supported by faithful Pain Medicine colleagues locally, unlike in anaesthesia, where there is 'critical mass', the RAPM can be fairly isolated in what is a key role to the Faculty and to the trainees and others in region.

It is recognised that the run up to the FFPMRCA examination is a time when added responsibilities will be placed on the RAPMs as they aid and prepare their Advanced Pain Medicine trainees for the examination. This has prompted the Board to consider improved support for the RAPMs. It has been identified that the role of the Local Pain Medicine Educational Supervisors (LPMESs) could be enhanced to fulfil this and to this end a register of LPMESs is being drawn up by the Faculty and held by the secretariat. We aim to communicate more directly with the LPMESs and anticipate that the balance of responsibility and workload will alter locally, bolstering the work of the RAPMs and allowing LPMESs a taste of the key work of the RAPMs. You will have received a letter asking you all as Fellows of the Faculty of Pain Medicine who encounter trainees in other ways for support, and to those who are able to offer this, we are grateful.

The Committee is keenly aware that 'assessment' is central and pertains to many areas of College and Faculty work to include links with the Training Committee of the RCoA, links with the Workplace Based Assessment (WBA) Group, links with the e-Portfolio group, and is part of our own process (to be combined with success in the forthcoming examination) for admission to the FFPMRCA; it has an obvious link, relevance and application to good contemporary practice of Pain Medicine which we expect of our trainees. Such cross-cutting forces make obvious the need for dovetailing in all of these areas and with that, a working group of the TAC has been set up to consider what we would like assessment to look like.

It has been recognised that routes of entry for various subspecialist areas of Pain Medicine, need to be reviewed and defined, and this work is commencing under the lead of Dr Mark Taylor and Professor Richard Langford.

Alongside the increased number of groups and committees on which the TAC has representation, we now also represent the Faculty on the Workforce Planning Strategy Group. The imminent activity of the Committee in this respect is to poll you as to resources, working patterns etc and we are very grateful to you for completing this form, which will provide very valuable and useful data.

The Committee has examined the area of WPBAs with particular regard to whether non (medical) doctors can 'sign off'. The Committee has decided that all Pain Medicine assessments have to be signed off by a Consultant or SAS grade anaesthetist. This may mean that Acute Pain Medicine module leads will see an increase in requests for assessment and sign off.

The TAC has further discussed Advanced Pain Medicine Training and agreed that the only duties that can be undertaken outside Pain Medicine training are 'on call' duties.

As ever, we remain indebted to and well supported in our work by Daniel, James, Anna and Andrea.

# Professional Standards


## Dr Karen Simpson

Chair, FPM Professional Standards Committee


The PSC was established in 2009; the depth and breadth of its role has developed since then in response to internal FPM requirements and external forces. It is timely to review the achievements of the PSC and to plan for its future direction in the short, medium and long term. Until now the PSC has been most focused on good clinical practice, education/meetings, patient safety and revalidation. Its members have also contributed to national consultations; there are about 20 each year from various bodies such as commissioners, NICE and the GMC.

### Standards and Guidelines

The PSC continues to develop standards and guidelines for clinical practice; some of this occurs independently and in other cases by joint working with other groups. A current initiative will involve developing guidelines for some spinal interventions with the Pain Interventions SIG of BPS. The issue of analgesia in secure environments is important. Dr Cathy Stannard is taking this forward with PSC support and she has organised a focused meeting of stakeholders to start work in this area.

The FPM and BPS have joined forces to call for Pain to be a Quality Standard. The FPM has appointed representatives on many RCoA committees such as revalidation and e-Portfolio. As a Faculty we must also represent and engage patients and carers, so our Patient Liaison Group representative has an essential role. We are also mindful that we need to have links with patient groups and charities.

> **"Communication with our Fellows and Members is as important as communication with outside agencies"**

### Events

Our Educational Meetings Advisor has continued to provide us with excellent annual meetings in 2011 and more are planned in 2012. Despite the one day national strike our November 2011 Annual meeting was very successful; the speakers were as always excellent and we awarded a number of prizes and medals at the event. The annual study days this year have all been well attended with good feedback. The three day meeting in January was a great success. Later in the year there will be a course specifically for trainees who will be sitting the FFPMRCA exam in 2012; details will follow.

### Revalidation

Work on revalidation continues and the situation is becoming clearer. An important role of the PSC is to remain updated and to provide feedback specific to Pain Medicine doctors. It is essential for Fellows/Members to keep an eye on the GMC website concerning this and other issues. Important new GMC recommendations from March 2012 include three pieces of guidance:

- Leadership and management for all doctors
- Raising and acting on concerns about patient safety
- Writing references

The document about raising concerns has very important implications for doctors in a management role.

### Communications

The FPM website is being redeveloped as part of a wider RCoA project and it is an essential resource. *Transmitter* has been a popular channel of communication and is now being revamped. Communication is so important that it has been decided that a separate Communications working party of the FPM may be needed in the future.

Communications has been an essential part of the remit of the PSC; communication with our Fellows and Members is as important as communication with outside agencies. The FPM exists to support our Fellows and Members and two way dialogue is essential. We rely on our Regional Advisors in Pain Medicine and their appointed Local Pain Medicine Educational Supervisors to keep us informed about the national Pain Medicine scene. However we welcome individual feedback, ideas and questions from all of our Fellows and Members; please do get in touch.

# Pain Summit 2011


## Dr Beverly Collett

Board member, Chair of the Pain Summit Steering Group


On Tuesday 22nd November the Pain Summit 2011 took place at Central Hall, Westminster. The Summit was a joint initiative of the Faculty of Pain Medicine, the Royal College of General Practitioners, the Chronic Pain Policy Coalition (CPPC) and the British Pain Society. The Summit was attended by over 150 people and attracted a wide variety of delegates including healthcare professionals, commissioners and patient groups.

The Pain Summit was opened by Earl Howe, Parliamentary Under-Secretary of State for Quality at the Department of Health, who confirmed that the Government does recognise the enormous collective burden of pain and the impact that it has on society. He noted that 'the successful management of chronic pain requires seamless integration between primary, secondary and tertiary care'. He commented that the Government's challenge is to create an environment for innovation and excellence to flourish and that consideration is being given to the inclusion of pain management in the NHS quality standards.

Professor Sir Bruce Keogh, Medical Director of the NHS referred to the National Pain Audit and the marked variation in access to pain services across the country. He invited delegates to define what is needed to make the NHS 'good' in terms of treating acute and chronic pain and to tell him and Earl Howe how they can help deliver the services that delegates want for people living with pain. The plenary sessions were completed by Professor Dame Carol Black, National Clinical Director for Health and Work, who highlighted that more should be done to enable those with pain to remain at work and feel of value in the workplace.

There were personal accounts of living with pain from patients and patient organisations and two panel discussions with professionals and patients focusing on the impact of chronic pain and the delivery of services for people living with pain. Delegates then split into smaller groups to attend workshops on the themes of Education, Public Health and Quality Commissioning to discuss the issues that these subject areas raised.

In the afternoon, four speakers reported on some current initiatives, including the Health Foundation's Co-creating Health Initiative, the formation of Pain UK - a recently formed charity coordinating work from other charities involved in pain to produce a strengthened UK voice, the British Pain Society's Pain Patient Pathway Mapping Guidelines and the role of the Royal College of General Practitioners Clinical Champion for Pain, Dr Martin Johnson.

After brief reports of the workshops, I spoke as Chair of the Pain Summit Steering Group about the next steps for the Pain Summit work, then the day was concluded with remarks from former Chief Medical Officer Professor Sir Liam Donaldson. Sir Liam suggested a 5 point plan:

1. Undertake a burden of disease analysis to be able to describe the scale of the problem
2. Ensure that chronic pain is seen as a 'high street disease' in the eyes of the public and the media
3. Embed chronic pain within an NHS performance framework and ideally more than one
4. Showcase centres of excellence
5. Achieve universal use of pain as a clinical metric in the same way as blood pressure is regularly recorded

It was a privilege to be part of this day that brought so many organizations and individuals together working to produce a unified plan for the better management of pain throughout primary, secondary and tertiary care. November 22nd was just the beginning of the Pain Summit's work; a report detailing the activities of the day was published in December, a copy can be downloaded from the Pain Summit website. The ideas and feedback received from the workshops will provide the basis for a fuller post-Summit report to be published in July 2012.

**www.painsummit.org.uk**

# Regional Update


## Dr Barry Miller

Chair of the RAPMs


Having just taken over as the Chair, I start by thanking John Hughes who has done fantastic work over the last two years, and I feel I am taking the baton at a running pace, appropriate perhaps in this Olympic year. This is an important year for the Faculty with the introduction of the examination, and also to start widening communication with the RAPMs and LPMESs.

The importance of these two groups cannot be overemphasised. They are the local eyes, ears and voices of the Faculty. Although primarily involved in the organisation and provision of Pain Medicine education to anaesthetists in training, they are increasingly involved in Revalidation & Relicensing, and are frequently asked about matters outside of their defined responsibilities, and it is recognised that this needs support.

### Case Reports

With the introduction of the examination, only two of these are required. The guidance has recently been significantly updated. Case Reports are a formative exercise, not an examination. It is expected that the trainee will discuss the topics chosen, and will likely need to amend the report after discussion by the LPMES and/or RAPM. They should be emailed to the Faculty for review, with the local marks. It is emphasised that the final arbiter of their suitability as part of the CCT/CESR(P) process remains with the local RAPM, but satisfactory completion of Case Reports will remain one of the criteria for Fellowship, and it is a requirement that an assessment has taken place.

### Trainee Experience

There has been much debate about what a trainee should have seen and done, whether in Intermediate, Higher or Advanced training.

For the first two the curriculum and guidance have focused on the number of sessions and a limited number of tasks – the Higher curriculum is currently undergoing revision as it has been recognised that the requirements have proven difficult to achieve.

At Advanced level the situation is less clear. A review of the logbooks, supplied over the last few years from Faculty applicants, has indicated a wide variety of exposure both in the clinic, theatre, and other environments. These reflect the broad church of Pain Medicine practice. The Faculty will be looking to collect more focused data on trainee experience over the next few years, and the ongoing logbook project will be at the heart of this. It is however recognised that not all trainees use it, and so a related project to set minimum standards of data collection and summary is underway. In time it may be possible to give clearer guidelines in some areas but the RAPMs remain the independent decision makers.

### Communication

The RAPMs have recently received a request for details on all the LPMESs, and we are also looking to find the total number of Pain Medicine practitioners, what has occurred in the recent past, and plans for the immediate future – another request is on its way (if it hasn't already reached you). Communication is at the core of everything that we do, and if we don't talk and share, how will we know?

This is not intended as a one way process, with missives simply being sent out from the centre. We are looking to develop the existing networks. We are a small Faculty, and our voice is dependent on your support and involvement. Take the time to tell us of local issues, and – occasionally – fill in the odd (and I know they do seem odd) questionnaire.

# RAPM Survey


## Dr John Hughes

RAPM, Northern Deanery


All RAPMs were surveyed in September 2011 as part of an exercise to assess the effects of various changes over recent years. The returns were enlightening but less than complete as only 12 of the 20 RAPMs returned the questionnaires.

### Regional Organisation

In the regions replying, most had all or nearly all Local Pain Medicine Educational Supervisors (LPMESs) in position. Formal Pain Medicine Educational Business Meetings were set up in most regions with an average of 1-2 meetings per year (range 0-4). All have regular electronic communications with varying degrees of activity. The model in Scotland is unique and robust with all RAPMs meeting at least annually and in communication more frequently.

The updated Review Form for Higher and Advanced Pain Training is being rolled out in the regions at varying speeds. Some are only using the form for Advanced training centres but most are planning to use it for all training units over time. Those that have partially or fully implemented the form have found it beneficial. The aim is to submit the form every 3 years to help the RAPM and the FPM gain a view of the training opportunities and capacity available in any given region.

### Advanced Pain Training (APT)

From the 12 replies there are 42 APT posts over those regions, with 37 filled. Looking over all the returns, 5 regions tended to be oversubscribed for trainees wanting to pursue APT, 4 were undersubscribed and 3 usually in balance. There is thus some regional variation. There are also two discretional APT positions that are varyingly filled with anaesthetic trainees. One further APT position was in development.

### Higher Pain Training (HPT)

Responses on the impact of HPT were more variable. Most APT centres will provide HPT but in some regions there are units that will be able to provide HPT but not APT. As yet trainees with an interest are only starting to come through on the new curriculum at this level and require the HPT elements. The main observation is that trainees will have to be very organised in order to complete the competencies within the timeframe for training and it is clear that the regional structures are trying to develop and make it happen.

### Other Pressures

It was clear that Pain Services are under pressure and in a state of change with regard to how pain management will be delivered in the future. Responses included observations on maintaining multi-professional units of appropriately trained and experienced practioners across disciplines; others mentioned the changing climate on invasive or repeated invasive procedures. This lead to comments on delivery of training in the years to come, should pain management become fragmented across providers.

There was a desire to have more support or information for RAPMs and LPMESs. Some felt that it was time to look at Basic and Intermediate Pain Training in more detail now that Higher and Advanced Pain Training have been defined and clarified.

### Comments

This survey has served to demonstrate that Pain Medicine training has developed since the introduction of RAPMs and more recently the FPM. Most regions have structures in place for organising and managing Pain Medicine training. The advent of LPMESs and the Review Form are helping. There appeared to be sufficient APT positions which are being filled. The APT structures are well developed and aim to provide a national standard. This continues to be strengthened along with the new examination. The introduction of HPT is working into the system but the capacity appears to be there to accommodate it. There are some anxieties with regard to changes in pain management services and the effect this may have on training.

There are still weaknesses as demonstrated by the poor return rate for the survey. There is also scope to develop the communication links between FPM and RAPMs, and work on this is on-going. Overall this survey suggests progress, with more robust systems now in place throughout the regions. However there is no room for complacency as there are weaknesses and areas to develop which have been highlighted.

# Profile of a RAPM

## Dr Andrew Nicolaou

### Consultant in Pain Medicine, Former RAPM South Thames

The Regional Advisors in Pain Medicine (RAPMs) came into existence in 2003 with most Schools of Anaesthesia appointing a RAPM. In my own patch, the South Thames region, we have always had just one RAPM holding responsibility across three schools.

As I prepare to demit on completion of my third term, I will use this article as a sort of diary/job description for my successor. A significant part of the workload is behind the scenes. The roles and responsibilities are clearly defined by the Faculty, with the key aim to facilitate and promote Pain Medicine training. The structure and quality of this training and how it is delivered is your core business.

How does a usual week look? Be prepared for the emails, calls, requests for meetings, appraisals, assessments, general advice, examination queries, interviews, questions about jobs, going overseas, research/audit projects, part-time training, all sorts- you get the picture. I like to hear how my trainees are settling in (we do 6 month slots at our eight Advanced Pain Medicine training centres in South Thames). It is vital the RAPM has their ear to the ground and knows what's going on in the region and beyond. Recent teaching to the medical students and FY2 doctors has also generated interest in Pain Medicine both as a discipline and as a career option. Increasingly trainees from other specialities enquire about Pain Medicine training.

Matters to deal with include an assessment issue (best to hear about problems early) and clarification of our setup for higher Pain Medicine training to a Pain Medicine trainer. I then have a 'policeman' role to ensure that the impact of anaesthetic on-call is the only time away from Pain Medicine training. Often a simple explanation and clarification is needed to sort things out.

I finish my RAPM report to the St. Georges' School Board and also to the London Academy of Anaesthesia where I represent Pain Medicine. Our London Pain Training Advisory Group (LPTAG) meeting is soon, with matters under consideration including a more coordinated and uniform approach to recruitment across London and further development of the specialist modules such as cancer pain.

The RAPM role includes the approval of Pain Medicine Consultant posts. I ensure as best I can, a balanced clinical workload and appropriate clinical administration with adequate Supporting Professional Activity (SPA) time. This does seem to be becoming harder for all specialties. Frontline clinicians understand that our jobs are difficult and demanding, activity is very much consultant delivered and generates considerable associated clinical administration – a requirement of the evolving NHS and patient expectation.

The recent letter from the Chief Medical Officers, Sir Bruce Keogh and Sir Peter Rubin to NHS employers regarding support for work of wider benefit to healthcare is salient. My successor must have support in order to operate effectively and immerse him- or herself in the role of RAPM.

I am in no doubt that the new FFPMRCA examination will raise standards and recognition for Pain Medicine. Our trainees know to work hard and not underestimate preparation – this message is filtering down nationally, but still lots of questions abound about the exam. As with anything new, uncertainty breeds anxiety. This will be a fair test with the warning given that anything on the curriculum is fair game.

After the examination the next major cause of anxiety is what the future holds in terms of the job market.This is clearly unsettling trainees and I feel impacting on recruitment. I have no crystal ball; there are huge financial constraints in the NHS and an ever changing commissioning landscape, but I am confident overall. Colleagues in other disciplines and primary care do recognise and appreciate what we can offer especially when engaged at an early stage. I am sure that our stock is rising in Pain Medicine as a result of all the hard work by many, and more so with raising the bar with training and standards and now the exam.

Will I miss all this? – yes, of course but it is time to move on. I am grateful for the help and advice over the years received from my fellow RAPMs and anaesthetic RAs and the College and the Faculty. I shall concentrate on the new examination and help continue to guide pain training in London as Chair of LPTAG.

# Trainee Update


## Dr Neeraj Saxena

Trainee Representative for the Faculty


### Fellowship examination

The examination for the award of FFPMRCA is all set for its first sitting on 19th September 2012. All Advanced Pain trainees should have received the 'Rules and Regulations' document in relation to the examination via email. If not, it is available on the FPM website too.

The Faculty has organised a two-day tutorial series to assist trainees preparing for the examination. To be held at the Royal College venue on the 24-25th May it will include tutorials and lectures covering a wide range of examination related topics and would require attendees' preparation and participation. Further details on the booking process are available on the FPM website.

### Trainees' feedback

Hopefully, you will have received information about our annual trainees' meeting during the British Pain Society's Annual Meeting in Liverpool on the 26th April. It has been a very successful and useful event in the past, giving us an opportunity to meet each other and discuss common issues and experiences. Since most Faculty Board/Committee members and other Regional Advisors in Pain Medicine also attend this meeting, it provides a valuable opportunity for trainees to interact with them and vice-versa. I hope it will be well attended and enjoyable.

Once again, I would like to reiterate that the Faculty highly values our feedback. I would request trainees to mail me (drneesax@yahoo.co.uk) or the Faculty directly with any issues they would like raised at any of their meetings (it can be done anonymously, if you prefer!)

### Last, but not least

This will be my last Trainee Representative update in the newsletter as I will be coming to the end of my term later this year. I would like to thank all the trainees who have kindly responded to my regular emails and contributed their opinions and thoughts. I can assure you that the Faculty's Board and Committees do not just work tirelessly to ensure the highest possible training standards but are equally concerned about our anxieties (drop in pain Consultant jobs, impact of service reconfigurations on training etc.). The least we can do is to support them by interacting and being a part of the communication process (for example our closed trainees' forum on www.doctors.net.uk). I strongly believe that the motivation and drive which got us interested in Pain Medicine in the first place will thrive despite the expected turbulence ahead.

Version 2 of the Advanced Pain Trainee logbook is now available on the FPM website: www.fpm.ac.uk.

FACULTY OF PAIN MEDICINE
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## 2012 Trainee Publication Prize

The 2012 Trainee Publication Prize will go live in early summer, with preceding advertisements on the FPM website as well as in the College *Bulletin*.

Fellows and members of the Faculty are requested to please let anyone who may be interested know about the prize.

Publications submitted for the 2012 prize must have been peer-reviewed, published during 2011, be on a topic relevant to Pain Medicine and based on original research or a systematic review which includes metanalysis.

The submitter must have been a trainee when the article was published.

All entries should be submitted electronically via **fpm@rcoa.ac.uk**.

# A Tale of Two Cities


## Dr Sumit Gulati

Advanced Pain Medicine Trainee


**Dr Sumit Gultati is an ST7 at Leeds Teaching Hospitals who undertook Advanced Pain Training from 2010-2011 at UCL Hospitals and the Royal National Orthopaedic Hospital. Here he recounts his experience of this period of his training.**

I consider myself one of a trainee cohort which has seen more changes in anaesthetic and Pain Medicine training than any other, over such a relatively short period of time. This started with the activities of MMC in 2006, followed by the increased role of PMETB and the GMC in training. This led to significant changes in the pattern of the FRCA examination and then the rolling out of new curricula in 2007 and 2010. The Faculty of Pain Medicine (FPM) came into existence in 2007 and set up structured training in Pain Medicine. The work of the FPM in formalising Advanced Pain Medicine Training continues with further promotion of Higher Pain Medicine Training and the FFPMRCA examination, amongst other things.

### Decisions

Having set my thoughts on Advanced Pain Medicine Training it was 'decision time' in year three. I had the choice to join the excellent local programme in Leeds/Bradford, or explore something further afield. I decided to explore an Out of Programme Pain Medicine Fellowship and focused on London for my 'year out'.

The opportunity to train Out of Programme is an exciting prospect and yet a daunting one as it brings one out of their professional and personal comfort zone. I set my mind to take the challenge and found myself applying for a prestigious London attachment in the beginning of 2010. The excitement was soon followed by the painstaking arrangements to move regions for a year, which I must admit appear trivial in hindsight when compared to what I gained.

My Pain Medicine training can be best described as a tale of two cities - Leeds and London, both vibrant in their own unique way, and both with an enviable record in training and academia.

### Getting to Grips

The transformation from several years of anaesthetic practice to full-time Pain Medicine was interesting and full of challenges. In the first few weeks of supernumerary training, sitting in clinics for up to 8 hours and trying to understand the patient's medical and social problems and expectations, was a major learning curve. This curve remained steep for the first few months, especially as hitherto someone else used to liaise with the GP, chase up investigations, dictate letters, organise theatre lists and follow up and discharge patients. Not only was there a déjà vu of SHO years, I was now face to face with a new specialty, a new patient subgroup and a different way of working. Challenges gave way to a 'can-do' thrill and I soon started to look forward to those long Fridays, which often started with a run in the Regents Park and ended with a walk down to a central London restaurant or pub.

### Diverse experiences

While the competency-based assessment and training underpins the Advanced Pain Medicine Training, the unique flavour that each Pain Medicine department offers leads to vastly differing experiences. Unlike Anaesthesia, Pain Medicine is known for a uniquely diverse style of practice, often based on the experiences of the team, the available services, patient subgroups, and interpretation of evidence base. I spent the first 6 months in an orthopaedic centre of excellence with a patient subgroup of complex spinal pain, spinal cord injury, peripheral neuropathy, hypermobility, CRPS, rheumatological and joint problems and the next 6 months were spent seeing patients with cancer, visceral, pelvic, neurological and maxillofacial pain and headache.

### Teams

While the composition of pain management teams remains roughly similar, the interaction and level of involvement of specialist nurses and allied health professionals differs across the board. I continued to learn and understand the dynamics of teams and roles of different members and whom to seek help from and refer patients to. For example, it wasn't until my last 6 months that I realised the difference between a hands-on and hands-off physiotherapist as in the orthopaedic hospital the same physiotherapist did everything.

## Patients

The eclectic cultural mix, characteristic of London was interesting as the values and beliefs differed in regards to how they would deal with their pain and the treatment offered. The stark contrasts often required different management approaches not only for the myriad clinical conditions but also to factor in the difference between the well heeled and the underprivileged, the English and non-English speaking, the war veterans and the victims of torture.

## Training

Training in Pain Medicine differs from anaesthesia in content and delivery. History taking, examination, diagnosis making and carrying out complex procedures require a combination of supervision, self-directed learning and attendance at relevant courses. Time constraints during a busy outpatient clinic often mean that teaching and discussions over a cup of coffee are not possible.

Working in London offers the opportunity to attend some excellent meetings being held right at the doorstep, the most memorable one I attended was in Guys Hospital with a live workshop by European, American and UK specialists. The London Deanery is unique in offering monthly study days for APTs. It not only brought some of the best speakers, it brought together the fifteen or so APTs who would end up talking passionately about their training programmes and future prospects over a drink in a Russell Square pub.

> "Challenges lead to opportunities and I can foresee the pain consultant stepping out of the confines of hospital and emerging in more innovative roles as a leader, clinician and trainer"

A national survey that I conducted in June 2011 showed that 95% of the APTs were overall satisfied with their training programme, while they reported lesser satisfaction in training of advanced interventions and paediatric pain. Overall the survey indicates that the goals of training are being met satisfactorily in most departments and I consider this as a resounding success for the Faculty and the Regional Advisors in Pain Medicine (RAPMs).

## Management experience

The APT year provides a great opportunity to enhance management experience and understand functioning of pain clinics and patient pathways. I had the opportunity to coordinate the National Pain Audit at my hospital, which is an ambitious project to improve quality of care and access to pain services. I also represented the FPM at the BMJ Careers Fair.

## Networking

An exchange of ideas and information has never been more important than it is today. There is now an unparalleled opportunity to network with peers, senior specialists, researchers and managers and learn not only about the clinical aspects but also the political map of the future of pain services in NHS.

## Challenges and Opportunities

A precarious situation may prevail currently, where APTs could outnumber the consultant jobs available in the NHS in coming years. Challenges lead to opportunities and I can foresee the pain consultant stepping out of the confines of hospital and emerging in more innovative roles as a leader, clinician and trainer.

I congratulate the Faculty of Pain Medicine, Regional Advisors in Pain Medicine and Local Pain Medicine Educational Supervisors across the two cities for taking Pain Medicine training from strength to strength and working tirelessly with the unified aim of putting the Faculty on top of the world map for Pain Medicine training. I hope to be able to join them in future in raising the standards as a Fellow and a consultant.

# Examination Development

**Dr Kate Grady** Project Clinical Lead
**Mr Daniel Waeland** Project Manager

We are finally in the year of our first Faculty examination with only five months to go until the first MCQ paper in September. The Faculty's most sincere appreciation goes to the examiners who have given up so much of their time to create the Faculty question bank. The Board's thanks also go to Jeremy Cashman (Standard Setting), Adrian Dashfield (Clinical SOEs), Doug Natusch (FileMaker Pro), Mike O'Connor (MCQs and Quality Assurance), Mick Serpell (Science SOEs) and Nick Plunkett (Deputy Chair of the Court of Examiners) for their expertise, patience and hard work in their respective lead areas.

The examiners met for their final two-day meeting in March to set the paper and agree the standard for the first examination as well as the various statistical methods that will be used to inform the final pass mark. They also undertook further SOE practice during the meeting.

The RCoA have agreed that the FRCA Examination Team will run the FFPMRCA Examination for the Faculty. The Team, managed by Graham Clissett, will bring all their know-how and efficiency to our examination and are currently working on the Pain Medicine examination web portal which will be available by the summer, with applications for the first MCQ accepted from 25th June.

## Tutorials

The Faculty has set up a Tutorial Series for the examination in order to assist trainees in their preparation for the examination. The first Series will be held across two days on the 24th and 25th May 2012. This replaces the previously advertised Summer Study Day originally scheduled to be held on 25th May. The Tutorial Series will consist of a run of individual tutorials comprising a tutor and 3+ trainees (depending on the final number of attendees). Trainees will move around six tutorials, with each touching on a different subject. There will also be lectures with plenty of time given for Q&As. All topics will be taken from the list of 27 topics e-published on the FPM website: www.fpm.ac.uk.

In the future, the tutorials will run bi-annually, circa 3 months prior to the MCQ paper of each sitting of the examination. They will be single days and are planned to have the same format as that described above. The next Tutorial Series will take place on 14th December 2012. If you would like to attend the May Tutorials, please contact the Faculties Department at fpm@rcoa.ac.uk.

## Regulations

The Regulations for the examination have now been approved by the Board of the Faculty and the Council of the Royal College of Anaesthetists and are available on the website. The Regulations contain details of the eligibility criteria for the examination as well as information on the marking systems and examination structure.

## Award of the FFPMRCA and DFPMRCA

Applications for the examination are allowed from trainees who expect to have completed 6 months of their Advanced Pain Medicine Training by the date of the examination. For the full award of the FFPMRCA and DFPMRCA the trainee will need to complete their full CCT programme to include Advanced Pain Training, have been successful in the examination and apply for Fellowship by Assessment or Associate Fellowship respectively for award of the post-nominals.

## Fees

The final fees for the examination have now been agreed by the Examination Executive and the Royal College of Anaesthetists. Throughout the examination project we have tried to ensure that the examination stays as affordable as possible, even without the economy of scale which benefits some examinations like the FRCA. The examination crucially will not be run for profit but funded for sustainability.

The examination has been introduced to define the standard of practice of Pain Medicine in the United Kingdom. The examination will encourage learning and rigorous training and in turn impact positively on our practice and the care delivered to our patients. It is expected therefore, that the examination will increase the stature of the Faculty and make the FFPMRCA a prestigious qualification. The existence of the examination will bring the FPM into line with other faculties nationally and internationally.

# Examination Calendar August 2012 – July 2013

| | FFPRMCA MCQ Examination | | FFPMRCA SOE Examination | |
|---|---|---|---|---|
| Applications and fees not accepted before | Monday 25th June 2012 | Monday 5th Nov 2012 | Thursday 27th Sept 2012 | Thursday 7th Feb 2013 |
| Closing date for Exam applications | Thursday 16th August 2012 | Thursday 13th Dec 2012 | Tuesday 16th Oct 2012 | Tuesday 26th Feb 2013 |
| Examination Date | **Wednesday 19th Sept 2012** | **Wednesday 30th Jan 2013** | **Wednesday 14th Nov 2012** (*backup day 15 Nov*) | **Wednesday 10th April 2013** (*backup day 11 Apr*) |

# Examination Calendar August 2013 – July 2014

| | FFPRMCA MCQ Examination | | FFPMRCA SOE Examination | |
|---|---|---|---|---|
| Applications and fees not accepted before | Monday 24th June 2013 | Monday 21st Oct 2013 | Thursday 12th Sept 2013 | Thursday 23rd Jan 2014 |
| Closing date for Exam applications | Thursday 15th Aug 2013 | Thursday 5th Dec 2013 | Thursday 26th Sep 2013 | Tuesday 18th Feb 2014 |
| Examination Date | **Wednesday 4th Sept 2013** | **Wednesday 15th Jan 2014** | **Tuesday 15th Oct 2013** (*backup day 16 Oct*) | **Wednesday 2nd April 2014** (*backup day 3 Apr*) |

# Examination Fees 2012 – 2013

Please note that fees for the 2013-2014 financial year have not yet been agreed

| | | | |
|---|---|---|---|
| MCQ Component | **£475** | SOE component | **£675** |

# Pain Management for Battlefield Casualties


## Lt Col Dominic Aldington

Consultant in Pain Management


Contrary to perceived wisdom[1] being injured on the battlefield is usually painful and analgesia is important, both immediately and throughout the casualty's care pathway[2].

## Acute Management

The first provider of analgesia is often the casualty themselves. UK military personnel are issued with 10mg im morphine autojects; approximately as efficacious as 400mg ibuprofen or 1g paracetamol albeit repeatable[3]. Further analgesia will be depend upon the skills of providers but could include additional morphine, paracetamol, fentanyl or ketamine. Arrival at the field hospital provides the gamut of expected analgesic options[4]. There is particular emphasis on regional anaesthetic techniques, especially continuous peripheral nerve blocks. While there is no good evidence to assume early use will change anything, amitriptyline and pregabalin are initiated as soon as possible with the understanding their use will be reviewed later. These will typically be used at 25mg amitriptyline daily and 75 mg pregabalin twice a day initially, but dose escalation will be swift; often doubling daily. In common with any patient transfer, analgesic management must be optimised prior to starting the repatriation, and the presence of a specialist repatriation team during this stimulating phase of a casualty's journey of care is vital[5].

Currently UK casualties return to the Queen Elizabeth Hospital in Birmingham (QEHB). Here the acute pain service review the casualty's analgesic management and start the casualty's education to empower the individual to take responsibility for their own pain management[6].

## Chronic Pain Management

As soon as appropriate the casualty will start their rehabilitation in earnest, often at the Defence Medical Rehabilitation Centre (DMRC) at Headley Court. Here the onus is on titrating the medication to effect, and down titration is usually the order of the day with patient education remaining a cornerstone[7]. Those few cases with pain resistant to conventional techniques are referred for consideration of neurostimulation.

## Audit, Research, Education

The importance of audit, research and education is not missed. Understandably highbrow research is difficult to conduct in the conflict environment so surveys and good audit are encouraged. As mentioned, education of the casualty is recognised as being important but so is that of the healthcare providers. All army doctors now have more than 9 hours of training in pain during their entry military course. All hospital staff of the field hospital receive specific pain training and undertake exercises prior to deployment. All military operational surgical teams receive specialist updates during their dedicated course[8]. The final component of education is that of the wider civilian world since the pain management system that has been developed may have benefits for all.

## Structure and Strategy

This is a component that is often overlooked when discussing pain management services, but is fundamental. This pain management system is overseen by the Military Pain Special Interest Group, part of Defence Anaesthesia. There is an explicit intention to ensure that all pain management techniques are integrated and sustainable, integrated between echelons of care, and sustainable beyond the deployment of any one provider. Particularly close links are ensured between pain services in QEHB and DMRC. Within DMRC close links exist between the pain clinic and the peripheral nerve injury clinic. There is also an explicit understanding that the role of the pain clinic is to support rehabilitation and not exist as an entity in its own right.

## Summary

Using an organised system, good analgesia and rehabilitation can be provided to battlefield casualties throughout their acute care.

### References


**(1)** Beecher HK. Pain in Men Wounded in Battle. Ann Surg. 1946 Jan.;123(1):96–105. **(2)** Aldington DJ, Mcquay HJ, Moore RA. End-to-end military pain management. Philos. Trans. R. Soc. Lond., B, Biol. Sci. 2011 Jan. 27;366(1562):268–275. **(3)** Moore, McQuay. Acute Pain. Bandolier. 2003 Mar. 4;:1–22. **(4)** Connor DJ, Ralph JK, Aldington DJ. Field hospital analgesia. Journal of the Royal Army Medical Corps. 2009 Mar.;155(1):49–56. **(5)** Flutter C, Ruth M, Aldington D. Pain management during Royal Air Force strategic aeromedical evacuations. Journal of the Royal Army Medical Corps. 2009 Mar.;155(1):61–63. **(6)** Edwards D, Bowden M, Aldington DJ. Pain management at Role 4. Journal of the Royal Army Medical Corps. 2009 Mar.;155(1):58–61. **(7)** Jagdish S, Davies M, Aldington D. Military chronic pain management. Journal of the Royal Army Medical Corps. 2009 Mar.;155(1):67. **(8)** Mercer SJ, Whittle C, Siggers B, Frazer RS. Simulation, human factors and defence anaesthesia. Journal of the Royal Army Medical Corps. 2010 Dec.;156(4 Suppl 1):365–369.

# FPM Events

## Dr Sanjeeva Gupta

### Educational Meetings Advisor

On behalf of the Faculty I would like to thank the Fellows, Members and speakers who have contributed to the Faculty's events and also those who have attended the past events.

The two meetings organised in November 2011 titled *Acute Pain Medicine – Hot Topics* and the Annual Meeting for Fellows and Members titled *Pain Management in Special Situations* and the three day *Current Concepts in Pain Medicine* meeting in January 2012 were well attended and some feedback and suggestions are listed below.

The next study day is on the 24th October 2012 and the Annual Meeting on the 22nd November 2012. If you have any suggestions regarding topics or if you would like to recommend a speaker for future events please contact me and I will be glad to discuss. Your attendance, contribution and feedback are essential for the success of all the events. I can be reached at SGupta6502@aol.com.

Dr Douglas Justins and Dr Kate Grady are organising the FFPMRCA Examination Tutorial Series on the 24th and 25th May 2012. For details please visit the FPM website at www.fpm.ac.uk.

Some of the many useful events suggestions on which we are working at present include:

- Full day on uro-genital pain management
- Full day on CRPS
- Role of injections / intervention
- Radiology for pain doctors
- Management of pain services by:
  - Clinical leads
  - Complaints
  - Difficult patient and their relatives
  - Discharging patients that want to 'hold on' to appointments
- Communication skills in the pain setting

The Faculty welcomes all suggestions and feedback on its events from Fellows and Members. If you wish to contribute please do not hesitate to get in touch.

## Faculty Calendar

| **2012 Events and Meetings** | |
|---|---|
| MEETING: Board of the FPM | 4 May |
| MEETING: FPM Training & Assessment Cmte | 11 May |
| **EVENT: Examination Tutorial Series** | **24-25 May** |
| MEETING: FPM Professional Standards Cmte | 22 June |
| MEETING: FPM Training & Assessment Cmte | 13 July |
| MEETING: Board of the FPM | 20 Sep |
| MEETING: FPM Professional Standards Cmte | 5 Oct |
| **EVENT: Winter Study Day** | **24 Oct** |
| MEETING: FPM Training & Assessment Cmte | 19 Oct |
| **EVENT: Fifth Annual Meeting** | **22 Nov** |
| MEETING: Board of the FPM | 13 Dec |
| **EVENT: Examination Tutorial** | **14 Dec** |

Please note that all dates may be subject to change. Please ensure you check dates on the FPM website when booking.

### Comments from previous events

*Acute Pain Medicine - Hot Topics*

**"Relevant topics to practice... a very useful meeting."**
**"Good update on some acute pain problems."**
**"Very good and stuimulating. I've learnt a lot."**

*Annual Meeting - Pain Management in Special Situations*

**"A good mix of experts and discplines amongst the speakers."**
**"As a non-pain specialist, an excellent update, particluarly on basic neurobiology."**
**"Very interesting, practical and down to earth topics."**

*Current Concepts in Pain Medicine*

**"Excellent programme, superb topics and experts. Very impressed with the quality of the speakers and found myself wishing that their talks were longer."**
**"Loved it. So good to have the most of Pain Medicine covered by experts so clearly. Also, loved the use of the non-pain doctor speakers e.g. the rheumatologist."**

# Faculty Update

## Fellows, Members and Committees

## New Fellows by Assessment

**September 2011**

Vishwanath SIDDALINGAIAH
Abir DOGER
William Edward REA
Muralidhar THONDEBHAVI SUBBARAMAIAH
Sivakumar RAGHAVAN

**November 2011**

Mohamed Mohamed Salah El Din EL TOUKHY
Christopher James George GREEN
Mandar Mohan JOSHI
Chin Han Michael LEE
Paul Inder BHALLA

**January 2012**

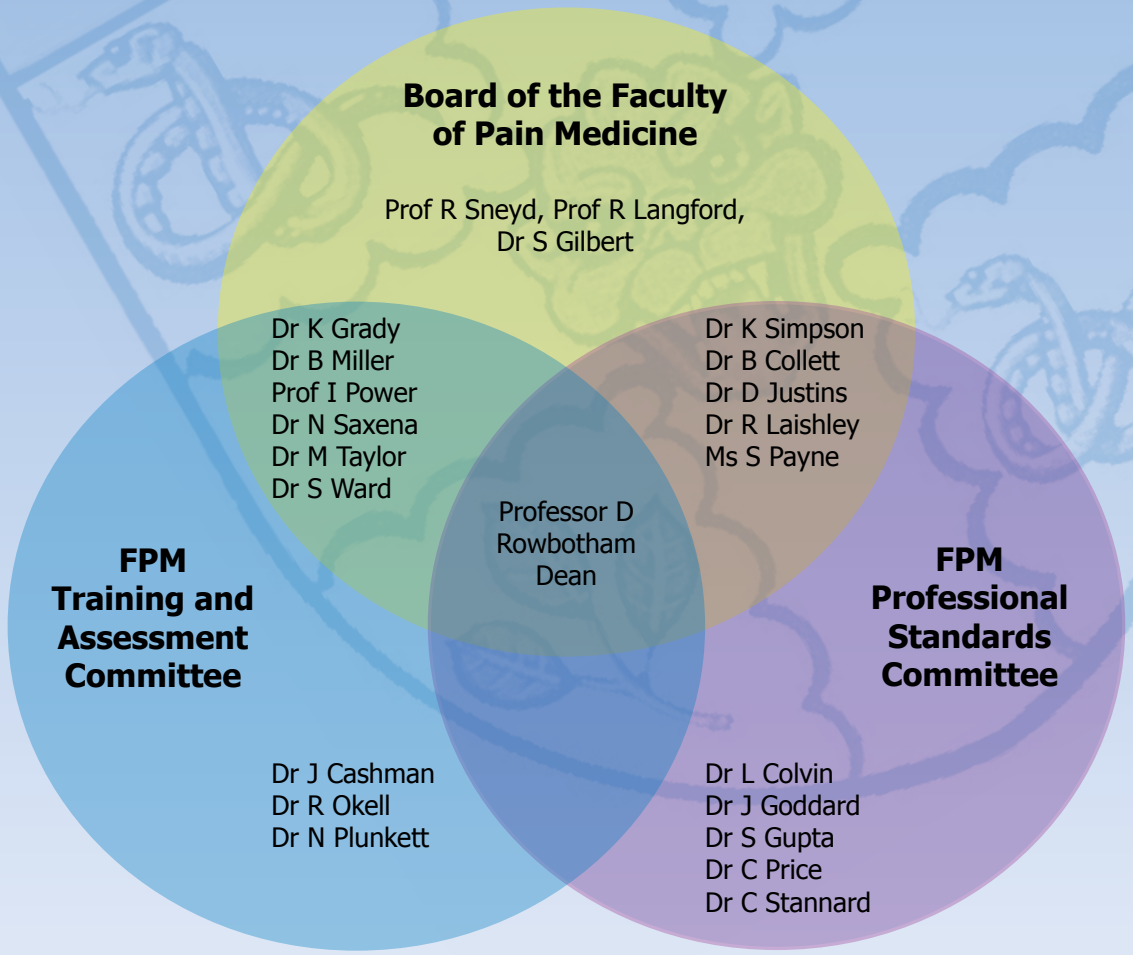
Aileen Elizabeth Grace CLYDE
Shamim HAIDER

**February 2012**

Arun NATARAJAN
David John BEARD
Johann Naveen EMMANUEL
Anup Subhash BAGADE

**March 2012**

Mohammed Akram ALI
Seshu Babu TATIKOLA



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