



FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

Newsletter of the Faculty of Pain Medicine

SPRING 2014

RANSMITTER

Workforce Census Update

What is a Psychosocial Assessment?

Training in Paediatric Pain Medicine

Chronic Pain Management in Scotland



Spring is upon us and this year it heralds a new Clinical Editor for *Transmitter*. Following Kate Grady's well deserved election as Dean of the Faculty of Pain Medicine, I was asked to take on the role of Clinical Editor of *Transmitter*: a hard act to follow, but I accepted the invitation.



This issue contains the usual mix of regular updates from individuals and committees along with some commissioned and non-commissioned articles. Steve Gilbert details the immense progress that is being made in Scotland on implementing a service model for chronic pain on the back of governmental support; the Faculty and other pain organisations continue to lobby for similar governmental support in England.

Jeremy Cashman's article on standard setting for the FFPMRCA examination will, I hope, reassure our readers with regard to the robust processes that are applied to the exam: as an examiner it is highly reassuring to know that we are performing reliably and consistently. Paul Rolfe provides an overview of his Advanced Pain Training undertaken whilst holding down a consultant post. I believe his experience supports the Faculty's position on training for Paediatric Pain Medicine and that, currently, bespoke training in some of the specialty modules, such as paediatrics, does probably need to be the 'norm'.

I would like to thank Daniel Waeland, Managing Editor and also Anna Ripley for her support in producing this edition of *Transmitter* in a timely fashion. And, finally, I wish to encourage our readers to submit non-commissioned articles. *Transmitter* is a platform for you to express your views and experiences; it also makes my job easier. A win-win situation!

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Message from the Dean



Dr Kate Grady
Dean

At the Faculty Board meeting of 27 February, it was noted with great sadness that Dr Andrew Lawson, a Fellow, a friend and a supporter of the Faculty, had passed away. The Board stood to pay tribute and reflect. We offer our deepest sympathy to Andrew's family and friends.

We welcome Dr Andy Nicolaou as a member of the Board, and Dr Mark Rockett as a co-opted member representing the large number of Acute Pain Medicine specialists who are Fellows of the Faculty. We are conscious of the evolving and changing nature of our clinical roles and the Faculty needs to give thought and planning in this regard. Mark has an established track record within the Faculty as an FPPMCA examiner. In addition, he is the representative of the Faculty on the College's newly formed Peri-Operative Medicine Task and Finish Group, an area in which Pain Medicine will have a significant contribution to make.

We are also delighted to welcome as a co-opted member Dr Lorraine De Gray, who has been elected as the Chair of the Regional Advisors in Pain Medicine.

The Faculty now has regular joint executive meetings with the British Pain Society (BPS), as an information sharing function. The UK Pain Consortium, which we have created, held its first meeting in December 2013. It brings together representatives from bodies involved with pain, namely the BPS, the Chronic Pain Policy Coalition, the Clinical Reference Group for Specialised Pain Services, the Royal College of General Practitioners and ourselves.

Work continues on the outputs of the Pain Summit of 2011. Our own 'Complex Pain' work stream is to

define methods of screening for complex pain at initial presentation, and to define clearly the routes and pathways for managing complex, unresolving or unresponsive pain. Ultimately this will see needy patients seeing Pain Medicine specialists in a timely way - 'The right patient seeing the right health professional at the right time'. Essential to this is an ongoing output of capable and committed Pain Medicine specialists.

The Shape of Training review was published in October 2013. We now await the outcome of a meeting with regard to what extent implementation is to be considered. The Faculty of Pain Medicine is clear that skilled pain management across inpatient and outpatient settings requires the input of those qualified in Pain Medicine: to include assessment of complex cases, comprehensive understanding of physiological and pharmacological processes, identification of psychological drivers and the provision of skilled interventions for long term pain problems. The need to deliver this will be ongoing and we must ensure those caring for patients with unresolved or complex pain are appropriately qualified and trained.

We had our Annual Meeting on 22 November 2013. This was a day of celebration: celebration of the life and work of Professor Patrick Wall with the delivery of the Patrick Wall lecture by Professor Martin Koltzenburg and the awarding of the Patrick Wall medal to him; celebration in the presentation of the award of Fellowship by Election to Professor Maria Fitzgerald and Professor Sir Michael Bond whose biographies can be found on page 30. Celebration too for the future: Faculty Fellows, Members and Associates drawn together as the future of Pain Medicine in the UK.

The third sitting of the FPPMCA Examination has been held. Forty one people have been awarded the Fellowship of the Faculty through assessment *and* examination, an arduous and rigorous test and indeed a mark of success. They are to be awarded their certificates at the Diplomates' Day, which will be held at Westminster Hall on 2 May 2014. Congratulations to you all!

The Hong Kong College of Anaesthetists



Dr Mark Taylor

Vice Dean

In 2013, the Dean received an invitation to the Faculty to provide an external examiner for the Diploma in Pain Medicine examination run by the Faculty of Pain Medicine of the Hong Kong College of Anaesthetists. As Vice Dean and an examiner there was no hesitation in my acceptance to represent the college, which would be my third visit to Hong Kong in two years.

Postgraduate medical specialist training, standards and CPD in Hong Kong are, by statute, regulated by the Academy of Medicine while registration, the specialist register and disciplinary matters are regulated by the Medical Council of Hong Kong.

The Hong Kong Faculty of Pain Medicine started a 12 month training in Pain Medicine with Diploma examination about 15 years ago. I was the external examiner for the last of the Diploma exams, as in 2011 their Faculty proposed a new Fellowship in Pain Medicine.

The format and syllabus of the Diploma exam differs from FPM Fellowship exam. The exam is clinically focused without emphasis on the basic sciences related to Pain Medicine. There is no MCQ but two written papers set by the examiners, the first with six short answers and a second with two clinical scenarios. Question and standard setting was all accomplished by email and I received copies of the written papers by FedEx within 48 hours.

The oral part of the examination was held on Friday 15 November at the purpose built Academy of Medicine and medical colleges offices at Aberdeen on the South of Hong Kong Island. I met Steven Wong, the chairman of the Faculty and my fellow

examiners, some of whom had the Australasian pain fellowship, at an excellent examiners dinner the previous evening at Hong Kong Central.

The candidates had two 30 minute clinical oral examinations similar in format to our clinical Structured Oral Examination (SOE). Each oral had structured questions, with 15 minutes from each of two examiners. The candidates performed well with a high standard of knowledge and clinical judgement.

The following day, as invited Faculty I talked on Pain Clinic Management of Facial Pain and Trigeminal Neuralgia at the Hong Kong Annual Scientific Anaesthesiology meeting. I was honoured to be a guest at the 27 Conferment Ceremony of the Hong Kong College of Anaesthetists which was attended by representatives of other medical colleges and Professor Jin Lui, President of the Chinese Society of Anesthesiology.

I wish to thank Dr Steven Wong, Kitty Cheung and other members of the Faculty team for their excellent organisation and hospitality during my visit. I learnt, despite cultural, social and organisational differences, that there are many similarities in Pain Medicine practice standards between Hong Kong and the United Kingdom.



Dr Taylor participating in the Academic Procession at the 27th Hong Kong College of Anaesthetists Conferment Ceremony

What is a Psychosocial Assessment?



Dr Amanda C de C Williams Reader in Clinical Health Psychology

Guidelines (e.g. BPS/Map of Medicine) increasingly recommend assessment of psychological and social issues which impact on the patient's presentation of pain, current coping with pain, or treatment decisions. This leaves the clinician to decide how to do it: informally, through judicious questions as part of the history; or with one or more questionnaires prior to the consultation. Both can be useful, and the decision depends on the patient/s, the purpose of assessment, and the relationship to the patient. Asking "what questionnaires should I use?" without identifying the question and the population is like asking "what tests should I do?" before knowing the symptoms or seeing the patient.

Using standard questions, as recommended for instance in the European Association for Urology (EAU) guidelines on chronic pain (www.uroweb.org/guidelines/), can be more informative and more clinically useful than questionnaires. In pelvic pain, questions concerning anxiety about the cause of the pain, such as "What do you believe or fear is the cause of your pain?"¹, and its emotional impact, are more informative than questionnaires on generalised anxiety or depression, and more acceptable to the patient because they are in the context of the pain problem. For back pain, we are fortunate to have the STarTBack tool (www.keele.ac.uk/sbst/), in which five of the nine questions address psychological variables (e.g. "I feel that my back pain is terrible and it's never going to get any better"). Scoring identifies 'yellow flags', that is, psychosocial issues of concern to be taken into account in treatment decisions.

Beyond these approaches is a bewildering range of instruments purporting to measure a wide (and not necessarily pain-related) variety of beliefs, thinking biases, emotions, and behaviours. Those commonly used

in psychologically based treatment trials bear a weak relationship to the main concerns of people with pain², with the highest priority, enjoyment of life, barely addressed by any study. Quality of life instruments, unfortunately, more often conceptualise psychological health as absence of mental health problems, and performance (rather than enjoyment) of particular activities.

So how to choose among the variety? First, what domains will you cover? Mood? Function? Quality of life? The IMMPACT (www.immpact.org/) guidelines are helpful up to a point. But there is considerable overlap, even when the titles of the instruments suggest otherwise. Disability checklists and coping questionnaires, for instance, often consist of similar questions about what the patient can and cannot do. Second, many constructs are refined and treated as unidimensional when they have no basis in theory, no correlates in brain processes, and are highly unlikely to be linear. Some, like anxiety, draw on respectable theory and development; others, such as catastrophising, turn out to be robust across populations and situations, and to have real-life correlates. Many others are ramshackle collections, culturally bound and unstable, despite claims of reliability (achieved by narrowness and repetition) and validity (always a work in progress, not a fixed property). Even apparently coherent diagnostic checklists give false promise of homogeneity: there are over 600,000 ways to meet the DSM-5 diagnosis for PTSD³. Third, many are very poorly constructed, with complex wording and response options that neither match the questions nor quantify the metric of clinical importance.

Any assessment is a compromise between brevity and inclusiveness. There is also an ethical dimension: psychosocial assessment needs to be defined in detail in relation to your patients' needs and resources (of patience) as well as your clinical or research needs and intentions, the quality of instruments available, and the resources available to score, record and enter the data so that it is used.

1. Howard FM. Chronic pelvic pain. *Obstet Gynecol* 2003;101:594-611.
2. Beale M, Cella M, Williams ACdeC. Comparing patients' and clinician-researchers' outcome choice for psychological treatment of chronic pain. *Pain* 2011;152:2283-2286.
3. Galatzer-Levy IR, Bryant RA. 636,120 ways to have Posttraumatic Stress Disorder. *Persp Psychol Science* 2013;8:651-662.

Essential Pain Management – FAQs

What is the Essential Pain Management programme?

- In developing countries, pain is often poorly assessed and treated due to lack of staff, inadequate knowledge and the scarcity or absence of analgesic drugs.
- The Essential Pain Management (EPM) course has been developed to improve pain management worldwide by working with health workers at a local level.
- It is a cost-effective, multi-disciplinary programme, which encourages early handover of teaching to local instructors. It aims to improve knowledge of pain, to provide a simple framework for managing pain and to explore ways of overcoming local barriers.

Why is there a need for an Essential Pain Management programme?

- Pain is often poorly treated.
- Improving knowledge and attitudes can lead to improved pain management.
- Simple and inexpensive treatments can make a big difference.

History of the Essential Pain Management programme

- The EPM programme was developed in Australia and New Zealand. The first course was held in Papua New Guinea in April 2010. Subsequent courses have been run throughout South East Asia, Mongolia, the Pacific Islands, Uganda and Rwanda. The Australian and New Zealand College of Anaesthetists has provided the majority of the funding for ongoing course delivery and development.
- In 2013 pain specialists from the United Kingdom participated in EPM courses in Nepal, Myanmar and Uganda.

About the Essential Pain Management programme

- There are two parts to the EPM programme – the EPM Workshop and the EPM Instructor Workshop. Manuals and slides have been developed for both workshops.
- The EPM Workshop is a one-day programme of interactive lectures and group discussions.

The workshop teaches a system for recognising, assessing and treating pain and addresses pain management barriers.

- The EPM Instructor Workshop is a half-day programme designed to provide participants with the knowledge and skills to become EPM instructors. Early handover of teaching to local instructors is very important because it encourages cooperation between local health workers, and because local instructors are more likely to understand specific local problems.
- In most courses on the third day the newly qualified local instructors are supervised whilst they deliver the basic EPM Workshop to a whole new cohort of participants.

Who can attend?

- The EPM programme is designed for any health worker who comes in contact with patients who have pain. It is aimed at “grass roots” workers and complements other higher level initiatives to improve pain management, for example, improving supply of morphine and other analgesics.
- Participants may include doctors, nurses, clinic workers, pharmacists and other health workers. For some, the information in the EPM Workshop will be new. For others, the course will provide revision and a framework for teaching others. The workshop is also suitable for trainee doctors and nurses.

What is the next step?

- EPM is a cost-effective way of improving management of pain of all types (acute or chronic, cancer or non-cancer).
- The Association of Anaesthetists of Great Britain and Ireland and the Royal College of Anaesthetists in the UK have agreed to provide support for further EPM courses, particularly in Africa. This is in addition to courses which will continue to be organized and funded from Australia and New Zealand.

If you are interested in running EPM at your hospital or for further information about the programme, please contact The Faculty of Pain Medicine of the Royal College of Anaesthetists at: fpm@rcoa.ac.uk

Pan-Thames Pain Training



Dr Richard Griffiths
RAMP South London



Dr Victor Mendis
RAMP North London

North Thames

The North Thames region has training opportunities that provide an anaesthetic trainee with the necessary skills and training to enable them to commence a consultant post with a major interest in Pain Medicine and also enable them to be prepared for the examination of the Faculty of Pain Medicine. The majority are rotational posts within central London Trusts (Barts Health, Chelsea and Westminster, The Royal Free, St Mary's, University College Hospitals) and peripheral Trusts (Mid Essex, Royal National Orthopaedic Hospital and Hillingdon). The Royal Marsden and Great Ormond Street Children's Hospital offer specialist modules in cancer pain and paediatric pain respectively. Basildon offers a specialist module in spinal cord stimulation. There are also a number of specialist clinics (pelvic pain, facial pain, headaches) in some central London Trusts. There is scope for research in many of the centres within the rotation. Trainees are assessed quarterly by the local Supervisors and six monthly by the Regional Advisor in Pain Medicine and Training Programme Director. In addition to the structured teaching by each centre, there is a monthly Pan-London study day with a very well organised teaching programme.

In an effort to improve and optimise the quality of training, North Thames recently undertook a 'root and branch' re-assessment of all its training centres. The FPM document *Checklist for Schools of Anaesthesia and hospitals seeking to provide Advanced training in Pain Medicine for anaesthetists* was used for this purpose and sent to all current centres and also to centres

who had expressed an interest in providing Advanced Pain Training. The data collected was analysed and recommendations were made. This has led to re-organisation of training centres and rotations within North Thames to ensure optimum delivery of the RCoA curriculum. We in North Thames are fortunate to have dedicated trainers who are very keen to improve the quality and standards of Pain Training.

South Thames

Pain Medicine training in the South Thames region is composed of central London Trusts (Guys and St Thomas, Kings and St George's hospitals) and surrounding Trusts (Medway, Brighton, Maidstone and Tunbridge Wells, Ashford/St Peter's, Epsom/St Helier). The central Trusts deliver sub-specialist care including complex interventions, spinal cord implantation and psychological therapies. The peripheral hospitals have concentrated on 'bread and butter' pain management including high volume clinics, procedures (under X-Ray and ultrasound) and acute pain management. Cancer pain experience is often under represented at both types of centre and efforts persist to improve this.

Within South Thames the model of training that has developed over time is one where a trainee will spend 6 months in each centre - preferably the peripheral centre first - allowing a balance between patient mix, numbers and experience.

Since the introduction of Pan-Thames recruitment for advanced pain training, trainees nationwide have scrutinised this model and, broadly, accepted it as reasonable. However, following the review of Advanced Pain Training in North Thames this will be examined further and, one suspects, changes will need to occur to ensure delivery of the RCoA curriculum. The review of South Thames pain training will commence this coming summer (2014).

A further facet is ensuring pain training in the Kent, Surrey and Sussex Deanery (KSS) is supported. It is clear that delivering complex pain interventions away from London is a challenge and one we will address this coming year with the review. We will endeavour to ensure any doctor commencing Advanced Pain Training in the Pan Thames area, and KSS will have full access to all areas required by the RCoA curriculum.

Training and Assessment



Dr Barry Miller

FPMTAC Chair

Teaching and training are evolving processes; as much for the teachers as for the trainees. Since the core curriculum for Advanced Pain Training (APT) was developed by the first chair, now Dean, Dr Kate Grady, the committee has been tasked with updates, amendments, analysing the assessment techniques and reviewing the Fellowship of the Faculty itself. This is a considerable and expanding body of work, and I am grateful to all members of the committee and especially to Dr Jon McGhie, now appointed as the Deputy Chair.

Advanced Pain Training

Since the curriculum came into being, and Advanced training was broadly defined as competency-based, (but which would take about a year of training), there have been calls to define this more clearly. It was noted that in Pain Medicine the majority of training and experience opportunities occur during the daytime of the normal working week, while in anaesthesia these occur 24/7, and that many APTs (Advanced Pain Trainees) are still covering varying degrees of anaesthesia, particularly the on call / evening and night shift work.

We have recently agreed with the Royal College and the GMC a curriculum amendment¹: *"It is unlikely that trainees who spend time outside the Pain Medicine environment engaged in general anaesthetic duties will be able to successfully complete Advanced Pain Training. Therefore the expectation is that trainees will need to spend substantially the whole of their daytime working hours engaged in Pain Medicine related duties. This of course would not prevent pain trainees being used on occasion to provide general anaesthetic cover for unforeseen emergency cases."*

The committee is particularly grateful to Dr Okell who steered this through the various groups. We anticipate

that this would be a minimum of 200 sessions², but it is important to recognise that training remains competency-based and some trainees may require more exposure than others. It is also important for trainees to maintain their skills, consistent with the principle of spiral learning, in their post-APT rotations, usually 6-12 months, and we would encourage that APTs rotate to hospitals with Pain Services and have at least one session per week to retain skills.

Cancer Pain Training³

One area of particular concern is the exposure of trainees within the Advanced curriculum to cancer pain conditions. Many, though not all, adult Pain Services have little or no contact with this group of patients who may be served within specialist units or by individuals not associated with the APT units. The Faculty had indicated that trainees should attend around 16-20 sessions (8-10% - as described above). This may be in oncology, palliative medicine, or specialised Pain Medicine units, and consist of a mixture of out-patient, in-patient or theatre activities depending on local availability. It may require secondments outside of the principle training region. This is detailed on the FAQ area of the website.

Fellowship of the Faculty

The routes to Fellowship, Membership and other associations with the Faculty have recently undergone a significant revision. Fellowship is now only by examination⁴, and we have introduced the Diplomate Fellowship status for those who have passed the Faculty's examination but are not Fellows of the Royal College of Anaesthetists. These groups are entitled to use the relevant post-nominals (FFPMRCA or DFPMRCA). Links to the Faculty, without post-nominals, are available to other groups, with details in the 'Membership' area.

1. Curriculum for a CCT in Anaesthesia 2010 2nd Edition v1.5 section 12.4.3
2. A session here is taken as the common half day or 3.5-4 hour PA usage
3. This is for all trainees, NOT a reference to the specialist Cancer Pain sub-unit module
4. Fellowship *ad eundem* is an exception to this, but is aimed at special recognition for individuals

Workforce Update



Dr Jon McGhie

FPM, Workforce Lead

The Workforce Planning Group presented an analysis of the 2012 census data in the last *Transmitter* issue. The Faculty of Pain Medicine used this information to answer questions raised by the Centre for Workforce Intelligence's (CfWI) review of anaesthetic services.

Since that submission we have been able to compile information on the missing regions to complete the data set. This information is reported here and will now form the baseline for future comparison when the census is repeated. Some stats can be found on the following page.

Discussion

Country	Chronic Pain Specialists per 100,000 population	Reported referral rate as % of total population	Average new referrals per specialist annually
Scotland	1.0	0.29	285
NI	0.9	0.31	329
Wales	0.8	0.27	351
England	0.8	0.25	317

As an analysis by country, both Scotland and NI are well represented by chronic pain specialists. The higher referral rate in NI means the average number of new patient referrals per specialist per year is greater. Wales and England are similar in both representation by specialists and proportion of referrals.

While the cumulative data suggests an average of 0.8 chronic pain consultants per 100,000 people, there are significant regional variations in England. Northern, East of England (EoE), West Midlands and Kent, Surrey & Sussex (KSS) Deaneries appear to be especially under represented for chronic pain. For

KSS and EoE this is supported by the >500 referrals per chronic pain doctor reported by the pain centres; this is well above the national average of 320 referred patients per specialist (for England, Wales & NI).

The referral rate reported by both West Midlands and Northern regions is a low outlier, yet referrals per specialist appear normal. If the reported data is accurate, then the low ratio of specialists per 100,000 people may exist because of historical under referring — i.e. the pain services haven't had a need to recruit towards the national average. Alternatively, if under reporting has skewed data in these areas and the average referral rate of 0.25% is applied, then we would expect Northern and West Midlands regions to have 562 and 425 patient referrals per specialist annually. Clinicians at the coalface within these regions will have the best idea as to whether under-reporting or under-referring is at play!

Limitations

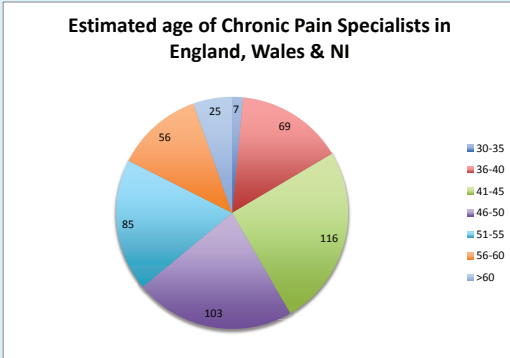
- While regional comparison may be useful to identify workforce discrepancies and inform on recruitment for future service development, there are some caveats.
- The original census primarily sought to identify chronic pain specialists. The data poorly represents nurse specialists and GPs with a specialist interest that may also see new chronic pain referrals. Part-time workers are also not identified and this will skew the referrals per specialist ratios — the raw calculation assumes equal working per specialist per region.
- The data presented should only inform local decision making if it is felt to be an accurate reflection of local workload.
- As the Deanery boundaries have now altered to become Local Education & Training Boards (LETBs), for some merged regions the national average will be the most useful standard to apply against local referrals per annum data.

Future

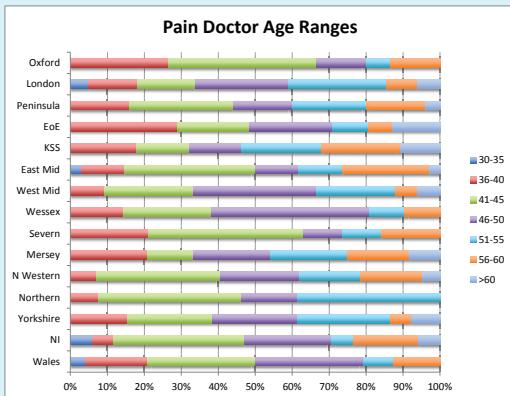
We are grateful to all the RAPMs who gave their time to clarify and chase-up missing census data. We would welcome feedback and comments on the utility of this information and your thoughts on what additional data collection you feel will be helpful in the future.

Summary of Workforce Planning Data for Chronic Pain Specialists in UK

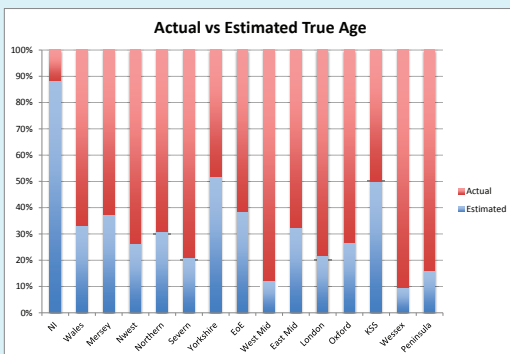
Estimated age of chronic pain specialists in England/Wales & NI



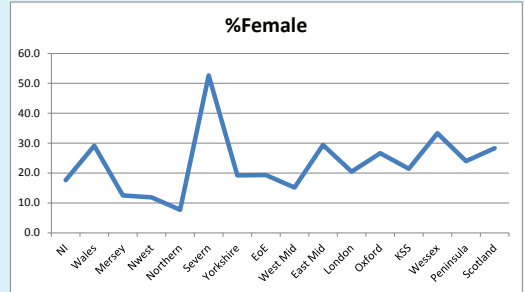
Workforce is skewed at point of census. Almost half of the consultants are between 41-50yrs, the majority of the workforce is older than 46 yrs.



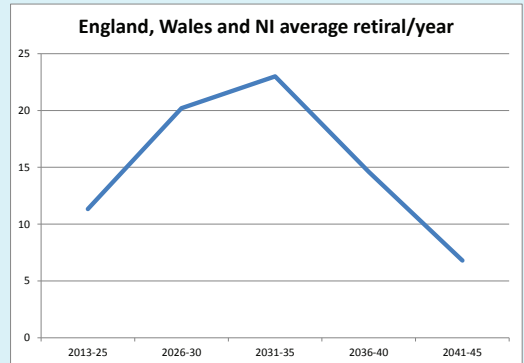
68% of the information is accurate by Date of Birth (DoB), the remaining data is extrapolated from date of medical graduation and therefore up to 32% of the data may underestimate true age.



22% of consultant chronic pain specialists in England/Wales & NI are female.



Estimated retirement frequency of Chronic Pain Specialists in England/Wales & NI



Key Points:

- Between 2013-45 average number of retirements per year = 14.
- Adjusting for UK pension change and a raised retirement age of ~67yrs, between 2026-45 average number of retirements per year = 17.
- Prior to the census, between 2007-12 there was on average 31 posts/yr advertised nationally for chronic pain specialists.
- 58% of the current workforce is predicted to retire between 2031-40.
- Future service expansion/contraction should take into account expected fluctuations in the retirement frequency of the chronic pain specialist workforce.

Chronic Pain Management in Scotland



Dr Steve Gilbert

Lead Clinician, Chronic Pain Scotland

There has been significant progress in implementation of the Scottish Service Model for Chronic Pain over the last five years. This update will cover some of the work that has been done and the next steps that we need.

Progress since 2013

- All Boards in Scotland have signed up to and are developing a local Service Improvement Group (SIG).
- GPs and Community Pharmacists are involved in the SIGs and contributing to the development of the pathways for pain assessment and management.
- A data collection exercise was carried out in all pain services in October and November 2013 – covering patient demographics, EQ5D and patient experience. Full data was provided by 12/14 of the Boards. The national facilitators and I carried out semi structured interviews with all Boards to get a clearer picture of the current provision of pain management. The report from this exercise will be published at the beginning of April and available on the Healthcare Improvement Scotland website.
- Musculoskeletal (MSK) services will be subject to a national target this year that all patients referred to AHP services will be seen within 4 weeks. A similar target for psychology services is also being introduced (18 weeks) by the end of 2014.
- Chronic pain service development will be part of Local Delivery Plans for NHS Boards from 2014 and the Boards will be required to report progress directly to Scottish Government.
- We have been working on coordinating guidelines for referral and management for specialised interventional techniques.
- The SIGN Guideline for the Management of Chronic Pain was published in December 2013 www.sign.ac.uk Guideline 136.

- The Scottish Pain Research Community has held three successful meetings highlighting the range of research being carried out around Scotland. The Research sub-group of the Steering Group has been successful in obtaining a Chief Scientific Officer grant to carry out research on opioid prescribing in Scotland.

Next Steps

- The last three years as National Lead Clinician have flown by and I will be getting “back to normal” at the beginning of April.
- Healthcare Improvement Scotland’s involvement with Chronic Pain improvement will take a back seat on 31 March 2014, handing on the baton to the National Chronic Pain Steering Group. There will be continuing support from the Scottish Government which includes funding the Chair of the National Chronic Pain Steering Group (0.2 WTE) plus administrative support and a National Co-ordinator (0.4 WTE). The new chair is Dr Mary Harper, NHS Dumfries and Galloway, and the co-ordinator is Paul Cameron, NHS Fife. Scottish Government is also in the process of appointing a new National Lead Clinician for Chronic Pain.
- The National Chronic Pain Steering Group will meet four times a year to lead improvement and monitor progress.
- The SIGs will also be required to report to the Scottish Government on progress. The template for reporting has been shared with the steering group and SIGs.
- There will be a meeting of Service Improvement Groups on 20 March 2014 to share progress and learn from others.
- Blair Smith will lead the Research and Data subgroup to explore how data collection can become more sustainable and be able to track pain management activity and outcomes in a systematic, national framework.

There are a range of resources available on the Managed Knowledge Network website. A new website www.chronicpainscotland.org/ is under development to provide quality assured information for patients, professionals and SIG’s.

If you want to know more please contact Paul Cameron on paul.cameron@nhs.net or Mary Harper on mary.harper@nhs.net.

Regional Update



Dr Lorraine de Gray

RAPM Chair

In January 2014, I took over as Chair of Regional Advisors in Pain Medicine from Barry Miller and I would like to take this opportunity to thank Barry for all his hard work over the past two years. Barry has now taken over as chair of the Training and Assessment Committee and I continue to look to him for invaluable advice.

In his last *Transmitter* article in Autumn 2013, Barry wrote that communication is crucial and I couldn't agree more – in the next two years I would like to open the roads of communication further to all doctors in the field of Pain Medicine. As part of workforce planning and quality assurance we are currently looking at mapping out all regions within the United Kingdom, looking at all hospitals which provide training in Pain Medicine as well as those that provide acute and chronic pain services but are currently not involved in training.

As Regional Advisors in Pain Medicine (RAPMs) we have regular meetings and updates but this is not so for the Local Pain Medical Educational Supervisors (LPMES) and one of my ambitions, during my time as Chair, is to set up a process where we can have regular engagement with all LPMESs – watch this space.

My remit as an RAPM would not exist if it were not for trainees. In a recent survey trainees have flagged up a variety of issues including lack of formal pain teaching in preparation for the FFPMRCA in some regions as well as a lack of exposure to some

aspects of pain training, in particular paediatrics, cancer and, in some regions, psychology. Whereas specialist areas such as neuromodulation, intrathecal drug delivery and perhaps paediatrics may be seen as optional modules to sub-specialise in a post-CCT training post, other areas such as psychology and cancer pain form a crucial part of the daily practice of Pain Medicine for most doctors practicing in the NHS.

These issues in training need to be addressed. I would like to assure all trainees that such feedback is not just only acknowledged, but is also carefully considered and acted upon by the Faculty.

I would like to encourage all trainees to continue responding to such surveys and to be confident in approaching their LPMES or RAPM or myself at any stage of their training, if they consider any part of their training year to be lacking in any aspect. Time is of the essence as a year of Advanced Pain Training goes by very quickly. Never be afraid to speak up.

“ Time is of the essence as a year of Advanced Pain Training goes by very quickly. Never be afraid to speak up ”

In some regions there appears to have been a drop in the number of anaesthetic Specialty registrars applying for Higher or Advanced Pain Training. Rumour has it that the new exam and/or concerns about availability of

consultant posts in Pain Medicine are the cause. For those trainees who have any concerns about the new FFPMRCA exam, I would like to reassure you that trainees who have sat the exam have been very positive about the experience and the relevance of the exam to the day to day practice of Pain Medicine. Talk to your colleagues who have sat the exam.

For those trainees who have concerns about the availability of consultant posts in Pain Medicine, do consider the figures. Like any other specialty the job opportunities wax and wane, due to regional needs and/or consultant demographics, but there will always be a need for doctors in Pain Medicine as our data on consultant Advisory Appointment Committees clearly shows.

Training in Paediatric Pain Medicine



Dr Paul Rolfe

Consultant Paediatric Anaesthetist

As a trainee I would have never imagined that seven years after my appointment as a consultant I would be just completing my training in Pain Medicine.

I undertook sub-specialty training in both Intensive Care Medicine and paediatric anaesthesia in East Anglia and later in London before returning to Cambridge as a paediatric anaesthetist in 2007. Pain Medicine was not on the horizon for me at that point, but like many things in life, a fortunate chain of events lead me to realise what I had been missing. Not long after I started we were delighted to welcome our first clinical nurse specialist in paediatric pain to the Trust. I volunteered to work with our new nurse, Meryl, to develop acute pain services for children in Cambridge and we have grown from there. Last year our pain service cared for 500 children.

What I was soon to discover was that I would be spending an ever increasing amount of time caring for children with complex pain problems. This was not completely unexpected. Many of these children were similar to those I had looked after in a children's hospital during my training. However, despite this two things troubled me. Firstly, some of these children had inadequately treated persistent pain with no clear service directing pain management. Secondly, was I the right clinician to be caring for them and if so could I deliver appropriate care given our limited resources?

We joined the Paediatric Pain Travelling Club (PPTC) early on. This is a group of mainly specialist nurses and consultant paediatric anaesthetists who have an interest in children's pain management. This has proved to be an invaluable support network from what is a relatively small paediatric pain community. There is a popular national meeting held in a different location

each year, hosted by one of the member pain teams. Regular contact with experts in Paediatric Pain Medicine gave me a wider perspective on the national provision of services for children with complex pain. The number of centres offering a specialist Pain Medicine service is indeed relatively small. The specialists in these centres tended to be paediatric anaesthetists with expertise in Pain Medicine. Children are certainly seen in adult pain services in many areas of the UK; however, appropriate multidisciplinary pain management may not be available locally for many children. Hopefully with the advent of a separate service specification for paediatric chronic pain in 2013, specialist commissioning of these services will improve access for those who need it.

I enjoyed my paediatric pain work immensely and wanted to develop our service and my own skills. From a personal perspective I wanted to become a credible children's pain specialist. Although comfortable caring for children and their families I didn't have the benefit of advanced pain training. Having sought the advice of Faculty Board members, paediatric pain specialists and my Regional Advisor in Pain Medicine it was clear that I would need to achieve the competencies acquired during Advanced Pain Training and then apply for the FFPMRCA by assessment via the experience route. Although I wanted to gain specialist paediatric pain experience I did not want to limit my training to a purely paediatric focus.

I now realise I took the flexibility afforded by training, when I was a trainee, more for granted than I had realised. I was now in a consultant role with almost twelve programmed activities on my job plan, a wife with a career and two small children to consider. Training would need to be in my own time, at my expense and completed within a sensible timeframe. With the support of my Trust and colleagues I was able to reduce my hours so that I would be able to spend three days a week training in Pain Medicine. I was extremely fortunate to be able to fill a vacant position on the regional Advanced Pain Training program, working under the supervision of the Regional Advisor.

The Faculty of Pain Medicine produced guidance on the competencies for Paediatric Pain Medicine in

2010. An optional 3 month paediatric pain module has since been available for advanced pain trainees. The guidance from the Faculty for those wishing to pursue specialist Paediatric Pain Medicine training was produced after I started my period of training. The current recommendation is that 12 months advanced paediatric anaesthesia training as well as 12-15 months of Advanced Pain Training, including 3-6 months of Paediatric Pain Medicine are required.

Opportunities for substantial periods of paediatric pain training are limited in the UK, although a combined paediatric anaesthesia and pain fellowship is available at Great Ormond Street. I am extremely grateful that I was able to arrange focused paediatric pain training over 4 months with attachments at Sheffield Children's Hospital, Leeds Children's Hospital, Great Ormond Street Hospital and the Royal National Hospital for Rheumatic Diseases in Bath, where I attended an adolescent pain management programme.

This experience took 15 months to complete and I have enjoyed every opportunity to meet new people, learn new skills and expand my knowledge. I have no regrets about my experience. However, it was hard work and left me with very little spare time. I would definitely advise any consultant considering a similar journey to mine to immerse themselves completely into the experience and be prepared to devote the necessary time to do the training justice. Returning to a period of extended training, with supervised intervention lists and sitting in on consultant clinics was not the difficult transition you might expect. It was refreshing to spend more time than the occasional theatre list with consultant colleagues, learning new skills and watching their interactions with patients.

I agree completely that exposure to both Paediatric and Adult Pain Medicine is invaluable for those who wish to pursue an interest in specialist paediatric Pain Medicine. They are not completely separate entities; there are transferable skills to be learnt from each discipline. Rather like the sub-specialties of anaesthesia, the valuable experience is in learning how to use more general principles, skills and knowledge and apply them to a specific population.

Although paediatric pain practice is traditionally less interventional than its adult counterpart, some selected children do indeed benefit from

the use of regional blocks. It would be difficult to achieve competence in procedural skills that are rarely performed in children if only trained in the paediatric environment and it would also be wrong to completely dismiss a technique which is geared towards adult practice that may be potentially very useful in the management of some children.

The one aspect of my paediatric experience that really stood out for me is that the management of complex pain in children is a true team sport and completely reliant on the strength of its constituent parts. I am grateful to all the therapists and psychologists who patiently mentored me. My experience has been all the richer for their knowledge and advice. Although too many to name individually I would like thank everyone that has given their time and energy in supporting me. In particular I must thank Dr John Goddard for his fantastic help with constructing the paediatric programme, and Dr Lorraine de Gray, my Regional Advisor. Without her tireless support and help my plans would never have taken off the ground.

This brings me to the end of one journey and to the start of another. The next one will be just as challenging and probably much longer but I will endeavour to develop a multidisciplinary pain service for the children of Cambridge and the Eastern region.

2014 Faculty Calendar

MEETING: Board of the FPM	8 May
MEETING: FPM Professional Standards Cmte	16 May
EVENT: FFPMRCA Exam Tutorial	30 May
EVENT: FPM/BRS Joint Study Day	20 June
MEETING: FPM Training & Assessment Cmte	11 July
MEETING: Board of the FPM	18 Sept
MEETING: FPM Professional Standards Cmte	19 Sept
MEETING: FPM Training & Assessment Cmte	24 Oct
EVENT: FPM Annual Meeting	14 Nov

Please note that all dates may be subject to change.

Trainee Update



Dr Emma Baird

Faculty Trainee Representative

I am coming to the end of my two year term as trainee representative for the Faculty of Pain Medicine. During this period Pain Medicine (PM) training in the UK has undergone some massive changes. I count myself as very lucky to have been a small cog in the evolution of our great specialty. I would like to thank all my fellow trainees that have engaged and assisted me with my role and everyone at the Faculty, especially the overworked administration team.

With my stepping down in mind and the launch of this year's trainee survey nearing, I thought I would use this *Transmitter* article to reflect on what we as trainees have done to shape the future of PM training in the UK. When I started as trainee representative the first sitting of the FFPMRCA exam had not yet taken place. It was an uncertain time to be a PM Trainee. The pioneering group of pain trainees that sat the first exam however excelled. The Royal College of Anaesthetists were impressed with the high standards of the FFPMRCA and the FPM was impressed by its own trainees. Introducing a new exam was never going to be easy for both the Faculty and the trainees taking it. Setting and taking a new exam takes an incredible amount of hard work and dedication but I, and many of the trainees I chatted to, agree that it is the only way to improve the standards of PM training in the UK. We all want PM in the UK to be the best in the world. The only way that will happen is by starting at the grass roots. We trainees are the future of Pain Medicine. If we are trained well the delivery of PM to a high standard in the future will be assured.

The Faculty responded to trainees' worries when setting up the new exam. Curriculum guidance was published and they are currently striving to publish more example MCQs. A more robust guidance process has been

established and they are trying to adapt the Faculty run exam study day following our feedback.

Along with the exam, the Faculty have responded to the training needs that we have brought to their attention. Workplace Based Assessment paperwork has been adapted and a new version of the logbook was launched. Looking at last year's trainee survey results the Faculty identified that trainees were missing out on vital cancer pain experience; this is now being addressed. This year the survey will focus on other important areas that we may need to gain more experience in e.g. psychology and PMPs. Each region is now undergoing assessment to see if they are offering adequate training. The aim is to standardise PM training around the country. The FPM website is still evolving to include many more trainee-specific resources.

I guess the take home message is that the Faculty do listen to what we as trainees want and need. I didn't realise this until I started as your representative. They do what they do not because they want 'political power' but because they want to shape the future of Pain Medicine for the good of all of us. So take the time to engage with your Faculty. You may be very pleasantly surprised by how receptive they are. Which brings me nicely to my final points: The trainee meeting at this year's BPS ASM will be held on Thursday 1 May 2014 from 12.30-14.30 and the 2014 trainee survey will be launched shortly afterwards.



2014 Trainee Publication Prize

The 2014 Trainee Publication Prize will go live in early summer.

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

Publications submitted for the 2014 prize must have been peer-reviewed, published during 2013, 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

FFPMRCA Examination Report



Dr Karen Simpson Chair of the Court of Examiners

The third sitting of the Fellowship of the Faculty of Pain Medicine of the Royal College of Anaesthetists Examination was held in 2013. The MCQ took place on 4 September 2013 with a smaller group of 16 candidates; this compares with 22 candidates for the January 2013 paper and 32 candidates for the September 2012 paper. The combined MTF, SBA and EMQ pass/fail boundary was decided by the Chairman and Court of Examiners after summing the Angoff-based individual section pass marks that had been determined as 68%; this was lower than the January pass mark that was 72%.

Dr Jeremy Cashman then provided a detailed analysis that summarised how the Angoff group decided upon the pass mark for the September 2013 sitting. The small number of candidates made it difficult to draw firm conclusions so a statistical reliability comparison with previous papers was not possible. Nevertheless the following observations regarding the September 2013 MCQ paper are valid. The paper was of a similar level of difficulty to previous papers. The Angoff score did not indicate any increase in the standard expected. However, the paper was attempted by a somewhat less well prepared cohort of candidates. The pass rate simply reflected this combination of factors. I am indebted to Jeremy for the hours of work he put into analysing the exam results, thus ensuring that we meet the rigorous quality assurance needed to maintain our exam standards; he explains the process in more detail in his article in this edition of *Transmitter*.

The SOE examination took place on 15 October 2013; 13 candidates attended with a 77% pass rate. As usual the Angoff, Ebel, linear regression and Hofstee calculations were plotted against the exam data

post-exam. The Court of the FPM Examiners used the figures obtained as a starting point to inform the discussion of all candidates in the borderline area. The final pass mark was reached through a combination of statistical analysis and expert judgment.

Despite the reduced number of candidates most examiners took part in this examination. The examination has been quality assured since its outset; as usual in this examination two experienced FRCA examiners Mike O'Connor and Richard Howard were invited to audit the examiners' performance at SOE. All examiners received detailed feedback. All that were audited performed well, with close adherence to the guidance they had received during pre-examination training. There were three visitors to the examination: Dr Mehta of St Bartholomew's hospital, Dr Evans of Barnet General Hospital and Dr Kanakarajan of Aberdeen Royal Infirmary. All three visitors felt the overall standard was set correctly and all gave positive feedback.

The Court of FFPMRCA Examiners has recommended that all candidates who reach the level of 'distinction' in both parts of the FFPMRCA examination at their first attempt will receive a letter of commendation from the Chairman of FFPMRCA Examiners. A distinction is defined as: FFPMRCA MCQ top 10% of examination candidates at that sitting and FFPMRCA SOE a maximum score of 40 marks. At the discretion of the Board of the Faculty of Pain Medicine, the Candidate(s) who achieve the highest level of distinction in both parts of the FFPMRCA, based on the letters of commendation for each academic year, will be awarded the FFPMRCA Prize.

On completion of the Spring SOE examination a list of candidates who received commendation letters over the current academic year, along with their scores in each part of the examination, will be provided to the FFPMRCA Training and Assessment Committee. The Committee will make a recommendation to the Board of the Faculty of Pain Medicine for the award of the Prize, to the candidate(s) who has/have achieved the highest level of distinction from the commendations made for that academic year. The successful candidate will be advised in writing.

Standard Setting for the FFPMRCA Examination



Dr Jeremy Cashman Lead for Standard Setting

Background

In April 2010 the Postgraduate Medical Education and Training Board (PMETB) merged with the GMC. As a result of its new legal functions in relation to the regulation of, and setting standards for, specialty training the GMC produced *Reliability issues in the assessment of small cohorts*. The guidance was of particular relevance to medical Royal Colleges and Faculties who have small numbers of candidates for their examinations such as the Fellowship of the Faculty of Pain Medicine of the Royal College of Anaesthetists (FFPMRCA) examination which was under development at the time.

Reliability

According to the GMC, for high stakes medical examinations a reliability coefficient >0.8 , where 80% of the variance is due to genuine differences between candidates and 20% is due to error, is deemed the minimum acceptable. The only candidates who will be affected by this error are those around the pass mark and calculating the Standard Error of Measurement (SEM) and hence the Confidence Interval (CI) around the pass mark can be used to define borderline candidates. Thus for a pass mark of 50% with SEM 2.5%, the 95% confidence interval ($\text{Mean} \pm 2\text{SEMs}$) for borderline candidates would be between 45% and 55%.

GMC Standards

The GMC requires that standard setting methods must be appropriate and that reliability measurements are necessary. Two characteristics are required in order to calculate reliability; the examination should consist of an adequate number of items, and there must be an adequate number of candidates. The FFPMRCA examination satisfies the first requirement in having

a number of discrete component parts. However, each sitting of the FFPMRCA examination attracts a relatively small number (<30) of candidates. A sample size of around 100 is considered to be the minimum for a reliability coefficient >0.8 . Nevertheless the GMC accepts that measurement of reliability is problematic with small cohorts for the reasons outlined in its supplementary guidance document. Furthermore the GMC states that reference to the fact that the same assessment methods have been established to be reliable elsewhere using sufficiently large samples (viz. the FRCA examinations) is acceptable.

Criterion referencing

A standard is the score in a test that serves as a boundary between those who perform well enough and those who do not: the pass mark. Normative referenced standards by which a set proportion of candidates fail regardless of how well they perform have been replaced by criterion referenced standards by which candidates pass or fail depending on whether they meet specified criteria for assessment of competence. Although the pass mark should permit the competent candidate to pass whilst failing the incompetent candidate, there will always be uncertainty that it represents the exact score where competence is demonstrated. For this reason a number of criterion referenced standards are used to arrive at the pass mark for the different components of the FFPMRCA examination. Approaches to criterion referencing fall into four broad categories based on:

- Judgments of test items, e.g. Angoff, Ebel and Nedelsky methods
- Judgments of individual candidates, e.g. Regression based method
- Judgments of groups of candidates, e.g. Cohen and Wijnen methods
- Compromise methods, e.g. Hofstee.

To date the pass mark for the MCQ component of the examination has been arrived at using one of the judgements of test item methods (Angoff). Whilst the pass mark for the Structured Oral component of the examination has been arrived at using a combination of methods based on judgement of test items (Angoff and Ebel), judgements of individual candidates (Regression) and compromise (Hofstee) methods.

Setting the pass mark

In common with the Royal College of Anaesthetists, the Faculty employs Angoff Criterion Referencing for its MCQ paper. For each paper an Angoff group comprising of 10-15 experienced experts, of whom at least two are non examiners, pass judgment on the proportion of minimally competent (borderline) candidates who would correctly answer an item. When there is disagreement over the independent ratings of the experts, these are discussed by the whole group. If the question being judged has been used before, there may be statistical information ('normative' data) available on its previous performance.

The judges' estimates are averaged for each item and the initial cutoff point is set as the sum of these averages. The 90% Confidence Interval for that exam is then used to arrive at the pass mark. In this way, the pass mark is set according to the difficulty level of the exam paper, and the performance of each candidate is compared to this standard.

Initially the pass mark for the oral component was set using four methods of criterion referencing (Angoff, Ebel, Regression and Hofstee). However, as a result of the consistency of agreement between the Regression and Hofstee methods only the latter two are used now. With the regression based method examiners make a global judgement about the performance of a candidate based on that particular oral interaction according to a six point scale, from clear fail to outstanding pass. In order to identify the

cut-off score all of the candidates' global judgements are plotted as a regression line against all of their test item numerical scores (see *Figure 1*).

With the Hofstee method examiners are asked to specify the minimum and maximum acceptable cut off scores (green lines in figure below). They are also asked to indicate the minimum and maximum acceptable fail rates (red line in figure below). The results are averaged and graphed to identify the rectangle bounded by fail rates and percent correct scores. A diagonal is drawn through the rectangle from top left (minimum score/maximum failure rate) to bottom right (maximum score/minimum failure rate) and the examinee performance curve is superimposed. The point where the diagonal intersects the examinee performance curve is taken as the cut-off score (see *Figure 2*).

The Regression and Hofstee methods can only be applied after all of the oral examinations have been completed. The performance of all borderline candidates, both above and below the cut-off, are then discussed by the court of examiners before a final decision is made.

Summary

Standard setting for a high stakes, low volume examination such as the FPPMRCA presents particular challenges with respect to assessing its reliability. Whilst accepting that there is no perfect standard setting method and that no method is absolutely accurate, the overall utility of the expert assessment process has proved to be robust.

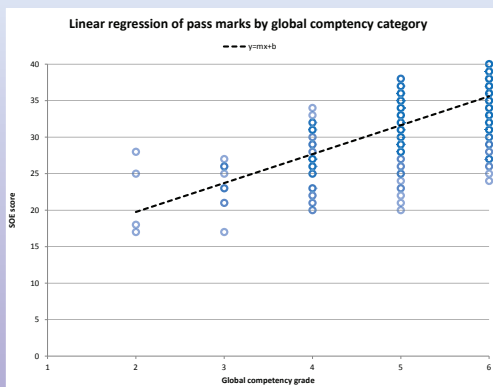


Figure 1

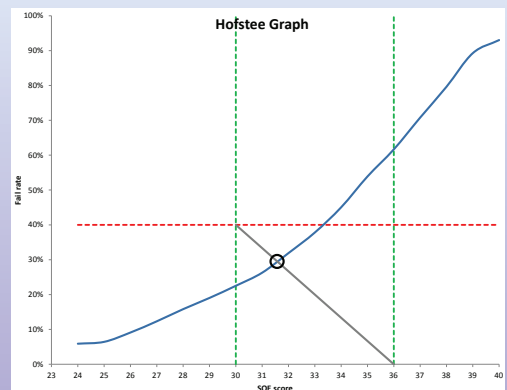


Figure 2

Observing the FPMRCA Examination

Dr V. Mehta, Consultant in Pain Medicine & Honorary Senior Lecturer, London

Having tutored in the FPMRCA crammer course and spoken a few times at the FPM course, I was naturally interested to observe the real thing. This would give me an opportunity to experience the exam situation and also judge the standard of both the preparation needed and quality of candidates taking up the challenge. So when the opportunity to observe the viva part of the FPMRCA examination arose, I was looking forward to the day.

The examination process is very well outlined in the FPMRCA booklet. Essentially the oral day comprises of two sessions (depending upon the number of candidates). One session consists of clinical scenarios (long and short cases) and the other session of basic science orals (four questions). The day started with a brief introduction by Dr Karen Simpson who has recently taken over the Chairmanship of the examination. Karen went through the process very diligently and explained the dos and don'ts of the examination. The examination is quite a young entity and a fairly recent addition to the area of assessments. But it has undergone a very rigorous process to ensure standardisation and the Faculty needs to be congratulated for this. The exam questions have all undergone very careful scrutiny and are discussed at length amongst examiners to eliminate any ambiguities before the actual examination.

The candidates had a very understandable anxiety as they walked to the table, but felt fairly assuaged once the questions (or for that matter answers!) started to roll out. The marking was very fair. Once the oral is finished for a candidate, the examiners would mark it independently without consulting each other. Once marked, they then would carefully tease out and discuss the responses given by the candidate.

The standard of the examination is what you would expect from an Advanced level pain trainee and definitely encapsulates the ethos of Pain Medicine as a multimodal specialist area in its own right. It needs preparation but success is definitely achievable. The examination itself sets a standard envisaged by the FPM and in all purposes is the pain qualification for the future.



Dr S.Kanakarajan, Consultant in Anaesthesia & Pain Medicine, Aberdeen

Last October, I got an opportunity to observe the Structured Oral Examination of the FPMRCA. It was an interesting experience. The day began with a briefing by Dr. Karen Simpson, Chair of the Court of Examiners, about the format of the exam, the floor plan, roles, the number of candidates and the dos and don'ts of the day. I was also given a sneak preview of question and answer keys chosen for the day.

As there were a low number of candidates for this sitting, both clinical and science orals were conducted in the morning itself. I observed one clinical and two science stations with six different examiners.

The questions covered a wide range of topics and were mapped to the Pain Medicine curriculum explicitly. The standard was set at a suitably high level. I was glad to see the depth of knowledge demonstrated by candidates for each question, particularly in the clinical. They covered areas essential to the practice of Pain Medicine.

The examiners were friendly, positive and encouraged candidates. Their commitment to maintain high and fair standards stood out. None of candidates burst into tears, which is a good sign of a standard examination! The emerging theme from the different questions was to assess whether the candidate would become a good Pain Medicine specialist in their independent practice able to incorporate a multi disciplinary way of working.



We are Recruiting!

FFPMRCA Examinerships and Examination Question Writers

The Faculty of Pain Medicine invites applications for three vacancies for the position of Examination Question Writer (2 year term) and two vacancies on the FPM Board of Examiners (5 year term).

Those recruited as FFPMRCA Examiners will have an active involvement in examining in the FPMRCA SOE and OSCE examinations.

Those recruited as Question Writers will support the Board of Examiners in the further development of FFPMRCA question banks.

The successful applicants will work with the MCQ Core Group in the first year and the SOE Core Groups during the second year.

Question Writers will also form part of the MCQ Angoff Group.

This is not an examining role and Question Writers will not form part of the Board of Examiners.

The closing date for receipt of completed application forms is **Friday 20th June 2014**.

Application forms can be downloaded from the Examinations section of the Faculty website or can be obtained from the Faculty of Pain Medicine by tel: 020 7092 1728 or Email: fpm@rcoa.ac.uk

Full details and person specification can be found on the FPM website at www.fpm.ac.uk

Professional Standards



Dr Beverly Collett

FPMSC Chair

I am delighted to be writing this as Chair of the Professional Standards Committee as high standards of Pain Medicine practice are key to the status of our profession and to how we progress forward in the challenging times ahead.

However, firstly I should like to pay tribute to Dr Karen Simpson who has so successfully chaired this committee over the past couple of years with her keen eye for detail and commitment to the highest quality of practice. I shall endeavor to follow her example during my term of office.

I am delighted to report that the British Pain Society (BPS) document *Standards of good practice for medial branch block injections and radiofrequency denervations for low back pain* has now been developed and endorsed by the Faculty of Pain Medicine. This lays down excellent standards for these procedures and will be well received. I would like to thank Sanjeeva Gupta, Karen Simpson and Paul Wilkinson for all their hard work in bringing this to fruition.

Patient information leaflets

As part of the Communications Working Party, the need for patient information leaflets was identified. A Working Party of healthcare professionals and patient representatives was established to formulate medication information leaflets. The first five of these will be available in April 2014 to be downloaded from the Faculty of Pain Medicine website. These can be used for patients within Pain Management Services or GP practices. We hope that you and your patients will find these accessible and easy to understand. I would value your feedback on these. Feedback can be sent to fpm@rcoa.ac.uk. Andy Nicolaou and Paul

Wilkinson are developing interventional procedures information sheets which will be available in the summer.

Drug driving legislation: Making roads safer

Plans are underway to introduce a new offence of driving with certain specified controlled drugs in the body. The Faculty responded to the consultation process last September supporting the initiative to eliminate driving under the influence of illicit drugs and when drivers are impaired by prescription medication. If a driver is thought to be impaired, a roadside test will be performed, followed up by a blood test if it is positive. Drugs that are being considered in this consultation are cannabis, cocaine, ecstasy, LSD, (meth)amphetamine, diamorphine, ketamine, benzodiazepines, methadone and morphine. The Department of Transport should be publishing their response to the consultation on the proposed legislation sometime in March. The legislation should then be enacted by autumn 2014. We understand that they will not be producing any patient information on prescribed medication when they publish their response. Once the Faculty knows the exact content of the proposed legislation, it will be producing guidance with recommendations to our Fellows and Members.

We will also work with the Chronic Pain Policy Coalition and the BPS to produce patient information, as we envisage that this legislation will cause patients to have questions and concerns with regard to their medication. We wonder whether there will also be a number of patients who request fentanyl or oxycodone as this cannot be identified by road-side testing. So, an interesting time ahead in this regard.

Meeting with the British Orthopaedic Association

The British Orthopaedic Association (BOA) has produced several guidance documents for consultation recently that impact on the work of Faculty members. The Faculty did not have the opportunity to be involved in the initial discussions relating to any of these. Following contact with the BOA, these documents are being revised and a meeting was held on 26 March 2014, to discuss future involvement of the Faculty with the BOA. Many thanks to John Goddard and Stephen Ward

for representing the Faculty at this meeting and to Daniel Waeland for making initial contact.

Core Standards

The Faculty provided a response to the RCoA Guidance of the Provision of Anaesthetic Services for the provision of chronic pain management services. However, as we work in a multidisciplinary and sometimes multispecialty environment, the Faculty was of the opinion that this guidance was restrictive and did not adequately reflect our practice. The Faculty has decided to produce *Core Standards for Pain Management Services*, incorporating post-operative, acute, inpatient and outpatient work and liaising with other non-medical colleagues. We hope to produce a document with robust standards about the facilities, resources, staffing, training, education and practical issues relating to provision of Pain Management Services wherever they are located. Dr Anna Weiss is Chair of this Working Party and will be happy to involve you in feedback as this important work stream progresses.

Good Pain Doctor

The Faculty has rewritten its document on the Good Pain Doctor along the lines of the GMC document *Good Medical Practice*. Many thanks to Dr Rob Searle for all his hard work on this excellent document.

Pain Medicine Consultation Guide

The Faculty is of the opinion that there should be guidance and standards as to what should be covered in a pain management consultation by a Consultant in Pain Medicine. This is important as it lays down some minimum criteria to ensure that all

relevant aspects of a consultation are covered. This forthcoming publication is planned for 2014. Thanks to Tony Davies for leading on this work

Commissioning

In January 2014, the Royal College of General Practitioners (RCGP) launched their new commissioning document. This encourages pain clinicians to enter dialogue with their Clinical Commissioning Groups (CCGs) about commissioning services appropriate to their local patient need. I am aware from my discussion that this opportunity is sometimes not available to secondary care physicians and that CCGs in some regions have been keeping pain services at arms length.

At the national level the Clinical Reference Group for Specialised Pain Services, led by Dr Andrew Baranowski, has been emphasising the important role that Specialist Pain Management Services play as autonomous services within secondary or community care, their key role in escalating patients up to the more Specialised level of service and their key management role in managing the treatment plan sent onwards from the Specialised Service.

Pain in Secure Environments

Following the successful implementation of the project by Public Health England, the RCGP and the Faculty, from which came the document *Pain Management in Secure Environments*, Public Health England have invited the FPM to run an educational strategy for Pain Management in Prisons. Currently, this is being discussed but will be an exciting venture to take forward.

Examination Calendar August 2014 – July 2015

	FFPMRCA MCQ		FFPMRCA SOE	
Applications and fees not accepted before	Monday 23 Jun 2014	Monday 5 Nov 2014	Thursday 4 Sep 2014	Thursday 19 Feb 2015
Closing date for FFPMRCA Exam applications	Thursday 18 Aug 2014	Thursday 18 Dec 2014	Thursday 25 Sep 2014	Thursday 26 March 2015
Examination Date	Wednesday 3 Sep 2014	Wednesday 4 Feb 2015	Tuesday 21 Oct 2014	Tuesday 28 Apr 2015
Examination Fees	TBC	TBC	TBC	TBC

FPM Response to NICE Quality Standard – *Sickle Cell Crisis (December 2013)*

This quality standard covers the management of sickle cell crisis in people from the time of presenting to hospital until the time of discharge. Sickle cell disease is the name given to a group of lifelong inherited conditions of haemoglobin formation. Acute painful sickle cell episodes (also known as painful crises) are caused by blockage of the small blood vessels. The red blood cells in people with sickle cell disease behave differently under a variety of conditions, including dehydration, low oxygen levels and elevated temperature. Changes in any of these conditions may cause the cells to block small blood vessels and cause tissue infarction. Acute painful sickle cell episodes occur unpredictably, often without clear precipitating factors. Their frequency may vary from less than one episode a year to severe pain at least once a week. Pain can fluctuate in both intensity and duration, and may be excruciating.

The Faculty response was compiled by Dr Kristin Ullrich, Consultant in Anaesthesia and Pain Management, Barts Health NHS Trust. The full response can be accessed at www.fpm.ac.uk. A summary can be found below:

- The draft quality standard accurately reflects the key areas for quality improvement and that it would be possible to collect audit data for most of the proposed quality measures.
- **Quality Statement 2:** In our clinical experience, reassessment every 30min is difficult to achieve beyond the initial 1-2 hours. The suggested timescale for pain assessment is incongruent to the assessment for opioid-induced adverse effects (every hour) which may lead to inappropriate opioid prescribing or overreliance on intravenous (as supposed to transmucosal, oral or subcutaneous) opioids. We acknowledge that the NICE clinical guideline 143 had reached consensus on this recommendation and agree with their introduction statement "The primary goal in the management of an acute painful sickle cell episode is to achieve effective pain control both promptly and safely." As it would be impossible to audit the achievement of "satisfactory pain relief" in the absence of a definition we propose to formulate

the quality standard as "assessment of pain relief every 30min for the first hour after presentation to hospital", and to align the timescale thereafter with the assessment for adverse effects: hourly for the first 6 hours and then at least every 4 hours.

- **Quality Statement 3:** We suggest removing "blood pressure" from the list of required regular reassessments; it should be listed as "if clinically indicated". Repeated blood pressure measurements can lead to sickling in the affected arm and are often the reason why sickle cell patients might refuse to cooperate with clinical observations. Reduced sedation score and oxygen saturation (measured without nasal or mask oxygen) are the most important indicators for opioid-induced respiratory depression; the latter also aids early detection of acute chest syndrome.
- **Quality Statement 4:** To ensure awareness of healthcare professionals that acute chest syndrome is a potential complication is an important quality measure, in our view it is most strongly linked to training. Further guidance is recommended, e.g. mandatory training for staff of emergency departments and acute medicine departments in high prevalence areas. An alternative would be measurement of outcome quality: staff awareness about acute chest syndrome being a possible complication (see comment on quality statement 5 below).
- We propose to consider an additional quality standard on provision of discharge information (patient/GP) and specialist follow up, particularly for patients discharged on strong opioid analgesia. These patients should have a dose-reduction plan with timeline for complete withdrawal of strong opioids and a sole prescriber of opioids. Long-term use should be avoided as it can have major implications for the sickle cell sufferer, e.g. use of strong opioid analgesia between crises, development of opioid-induced hyperalgesia or endocrine changes etc.

Events Survey Results



Dr Paul Wilkinson

Consultant in Pain Medicine

Late in 2013, the Professional Standards Committee (PSC) undertook an educational survey on event provision. The aim was to determine the educational needs of Faculty members, to review whether existing provision matched need and to provide a platform to provide innovative future educational provision.

I thank Udaya Chakka for helping with a first draft of questions and thematic analysis, Sanjeeva Gupta and Shyam Balasubramanian who were involved throughout, as well as the PSC for ensuring the questions were fit for purpose.

We were delighted that nearly 80 people took the time to return questionnaires on Survey Monkey reflecting the perceived importance of this work. The results are summarised below.

Results

As expected, the majority of respondents were consultants but there were a significant number of responses from trainees.

The first question addressed was the issue of geographical location. Unfortunately, the question of venue is linked closely to cost. Arranging a meeting away from our London base leads to significant extra cost and the question reflected this. Most people preferred London but an almost equal number still wanted some geographical diversity, despite cost. The FPM will consider this against the potentially overriding factor of financial risk.

Most people wanted either presentations or workshops, with interest expressed also in other delivery methods. The FPM has taken this into consideration and will include a day containing both

workshops and lectures in the FPM events calendar. At the FPM Diagnostic Investigations study day on 4 February - a mixture of presentations and workshops were held and this format received positive feedback.

The topics of interest were far-reaching. Educational provision in dealing with complex cases, CPD based topics, IT and courses to improve ourselves as educators all came out with strong support, with preparation for exams being important for our trainees. We also asked what educational events you would want the FPM to organise; amongst the answers were many imaginative ideas which will provide an innovative platform for future educational events.

Most wanted notification through e-mail rather than paper, reflecting technological change, but were not yet ready for the use of social media networks. Most people were also willing to share any pain education resources and teaching materials, to build a directory of resources. This included e-learning, patient information leaflets, presentations, audits, exam questions and the offer of personal time. Most also supported the FPM continuing to have meetings with other organisations, as we are doing on 20 June with the British Society for Rheumatology.

Summary

Our first aim was to determine the educational needs of Faculty members; this has been achieved thanks to the survey response. The survey has enabled us to show that there is considerable support for current meetings, both content and format. Provision does match need, so the survey achieved its second aim. However, the undoubted power of this survey was creating interesting, valuable, innovative ideas for future educational meetings. People have showed considerable willingness to help with time, ideas and resources for future educational Faculty events.

Usefully, the voice of Faculty members and trainees have provided a platform to deliver and innovate future educational provision. Again, thanks to all those who responded.

The full results and a thematic analysis on suggested topics for events can be found on the FPM website at www.fpm.ac.uk.

FPM Annual Meeting 2013



Dr Shyam Balasubramanian Deputy Educational Meetings Advisor

The Annual Meeting of Faculty of Pain Medicine (FPM) of the Royal College of Anaesthetists held in November 2013, was a grand success. This is a reflection of the ever increasing enthusiasm of the Faculty members. Engaging presentations by top experts highlighted the recent advances in both clinical and basic science aspects of pain management.

Persistent post-surgical pain is a common cause for patients seeking the help of pain clinics. Dr Robert Searle presented the current evidence and discussed the different factors implicated in the development of chronic post-surgical pain. With current emphasis on moving the care closer to the community, Professor Blair Smith gave a timely talk on pain management in primary care. Dr Markham's presentation on medico-legal issues in chronic pain was an eye-opener. The need for meticulous communication and documentation were discussed in this session. The prestigious Patrick Wall Lecture was delivered by Professor Koltzenburg and revolved around the basic science of pain, the role of sodium channels and targets for novel analgesic drugs.

With regards to raising awareness and concerns about use of opioids in chronic pain conditions, Drs Vasu and Rayen debated the usefulness of these medications in functional pain syndromes. Dr Kapur gave a scintillating presentation on the medical and social aspects of whiplash injury. Dr Antrobus shared his experience in establishing and developing a cancer pain management service.

Dr Kate Grady informed the members of previous and future FPM activities, which are covered in detail in the rest of this edition of *Transmitter*.

The Annual Meeting would not have been a success without your involvement. Apart from providing an important contribution to our CPD, the day provided an opportunity to network with our peers and experts in the pain field. We look forward to seeing you again at our future educational events.



Professor Sir Michael Bond, The Dean and Professor Maria Fitzgerald after receiving their Fellowships by Election



Dr Oliver Seyfried receiving the Trainee Publication Prize from the Dean

Comments from the event

"Well balanced, up to date and relevant"

"A useful meeting with good balance of established and contentious material."

"Excellent from heavy-weight speakers"

"Thoroughly enjoyed the day"

"Very informative, good mix of basic science and clinical work"

Faculty Events



Dr Sanjeeva Gupta

Educational Meetings Advisor

The meeting on acute pain management on the 3 February 2014 was organised by Dr Namita Singh and was well attended. Dr Singh outlined the challenges of providing effective acute pain management and discussed procedure based pain management.

Dr Stannard gave an excellent presentation on pain management in opioid dependent patients. Delegates were interested to learn the management of patients on strong opioids who are discharged from surgical wards. Among the delegates, there was a unanimous opinion that it is unsafe to administer opioids by multiple routes.

Dr Patel presented on pain management in the paediatric patient. The recent MHRA advice on the use of codeine in children was discussed. (www.mhra.gov.uk/safetyinformation/DrugSafetyUpdate/CON287006)

Dr Lucas outlined pain management in the obstetric patient, with two notable messages: Codeine should not be given to breast feeding mothers and that Paracetamol may not be as safe as previously considered during pregnancy (J. Epidemiol. 2013; 42 (6): 1702-1713.).

Dr Seidel discussed pain management in the obese patient. Obese patients are at increased risk of obstructive sleep apnoea. Although challenging, opioid sparing strategies and regional anaesthesia can be helpful.

Dr John shared his experience about enhanced recovery after hip and knee arthroplasty and presented the results of his audit which showed a reduction in hospital stay following enhanced

recovery. Dr Checketts discussed the role of regional anaesthesia for enhanced recovery after surgery.

Dr Fisher presented on evidence based postoperative pain management and informed the delegates about procedure specific postoperative pain management (PROSPECT – www.postoppain.org).

Dr Kumar outlined the role of ultrasound in identifying the epidural space and discussed the evidence.

The meeting on 'Diagnostic Investigations in Pain Medicine' on the 4th February 2014 consisted of didactic lectures and workshops. The meeting started with an excellent presentation on the role of investigations in Pain Medicine by Dr Justins.

It was a good opportunity to hear about the role of radiological investigations in Pain Medicine from Dr Chandramohan, Dr Groves and Dr Muthukumar, all consultant radiologists. They discussed the indications and interpretation of X-rays, MRI Scans, CT Scans, and other radiological investigations, in their didactic lectures and their workshops.

Dr Purves conducted a workshop on indications and limitations of nerve conduction studies and clarified what neurophysiological techniques can and cannot offer us in real life clinical practice with a brief look at emerging possibilities.

Dr Krol and Dr Balasubramanian conducted workshops on ultrasound guided diagnostic procedures in Pain Medicine. Ultrasound scanning in the head and neck and the lumbo-sacral spine area was demonstrated on live models.

Future Events

Our next Study day is being run jointly with the British Society for Rheumatology on Friday 20 June (bookings are now open), and the 2014 Annual Meeting is being held on Friday 14 November. We appreciate your continued support of the Faculty run events and hope to see you all later in the year.

Full details of the FPM events can be found on the FPM website at www.fpm.ac.uk

Faculty of Pain Medicine and the British Society for Rheumatology Joint Study Day

Friday 20th June 2014

09.00 to 9.25 Registration

09.25 to 9.30 Introduction

9.30 to 10.00 Musculoskeletal and inflammatory pain mechanisms
Prof David Walsh, Consultant Rheumatologist, Nottingham

10.00 to 10.30 Blood tests and Inflammatory Markers – What to look for?
Dr Nick Shenker, Cambridge University Hospitals

10.30 to 10.45 Discussion

10.45 to 11.10 Refreshments

11.10 to 11.40 Rheumatology for the Pain Medicine consultant
Dr Richard Haigh, Consultant Rheumatologist, Royal Devon & Exeter

11.40 to 12.10 Pain Medicine for the Rheumatology consultant
Dr Mark Abrahams, Consultant Anaesthetist, Cambridge

12.10 to 12.30 Discussion

12.30 to 13.30 Lunch

13.30 to 14.00 Fibromyalgia – Mechanisms and Management
Prof Ernest Choy, Cardiff

14.00 to 14.30 Rheumatoid Arthritis – Mechanisms and Management
Dr Benjamin Ellis, Specialty Registrar in Rheumatology, London

14.30 to 14.45 Discussion

14.45 to 15.10 Refreshment

15.10 to 15.40 Hypermobility and pain – what are the genes, what can you do?
Dr Helen Cohen, Consultant Rheumatologist, London

15.40 to 16.10 Pain management in osteoarthritis: NICE guideline 2014
Prof Phil Conaghan, Consultant Rheumatologist, Leeds

16.10 to 16.30 Discussion, Feedback and Close

RCoA, London
5 CPD Points
£165, £135 for trainees.
Code: C83

BSR
The British Society for Rheumatology



FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

The British Pain Society Calendar of Events 2014

The British Pain Society Annual Scientific Meeting 2014

29 April - 1 May
Manchester

Orofacial Pain (30th Study Day)

Tuesday 17th June
Churchill House, London

Philosophy & Ethics SIG Annual Conference

Monday 30th June – Thursday 3rd July
Rydal Hall, Ambleside, Cumbria

Cancer Pain (31st Study Day)

Wednesday 23rd July
Churchill House, London

Interventional Pain Medicine SIG Annual Meeting

Friday 17th October
Manchester

Patient Liaison Committee – Annual Seminar

Thursday 23rd October
Churchill House, London

Musculoskeletal Pain (32nd Study Day)

Tuesday 28th October
Churchill House, London

Pain Education (33rd Study Day)

Monday 24th November
Churchill House, London

More information can be found on our website
http://www.britishpainsociety.org/meet_home.htm
Or email meetings@britishpainsociety.org



THE BRITISH PAIN SOCIETY

Faculty Update

New Fellows

Karthikeyan PONUSAMY

Ashok DAS

Michal CZERNICKI

Sonny MANO

Arumugam PITCHIAH

Ravindra HARISH

James WILSON

Yee Cze TANG

Bernard NAWARSKI

Julian SCOTT-WARREN

Timothy WILSON

Bret CLAXTON

Kim CARTER

Roman CREGG

Rishi KHANNA

David PANG

Pushpa BHEEMAPPA

New Associate Fellows

Lois FELL

New Members

Kanar AL-QURAGOOI

Fellow by Election – Professor Maria Fitzgerald

Maria Fitzgerald is a world renowned researcher and teacher who has made an outstanding contribution to the field of Pain Medicine. Maria graduated from Oxford University and went on to do a PhD in physiology at UCL. She later obtained an MRC postdoctoral training fellowship to work with Patrick Wall in his lab at UCL, which marked the start of her career as a highly distinguished neuroscientist working in the field of pain. Among her many notable achievements Maria has pioneered the use of neurophysiological techniques to study the mechanisms of infant pain, resulting in many groundbreaking experiments and discoveries along with publications in distinguished scientific journals such as Nature from the very beginning of her career. Maria became Professor of Developmental Neurobiology in 1995, and has received many academic awards and other acknowledgments in recognition of her outstanding work.

Fellow by Election – Professor Sir Michael Bond

Professor Bond has background training in psychiatry, surgery and neurosurgery. He conducted his first research activities in the field of pain in the early 1960s and since that time, has been primarily involved in psychological and psychiatric aspects of the analysis and treatment of acute and chronic pain. He established the first in-patient unit in Britain for the management of patients with chronic pain problems driven primarily by psychological factors. Together with Professor Pilowsky, he published the first recorded use of the analogue scale, VAS, for pain measurement in 1966 and was part of the team lead by Professor Harold Merskey, which developed the IASP Definition of Pain and Pain Terms. He has been President of the British Pain Society. He was a member of the Council of IASP intermittently from 1981 and its President from 2002 to 2005. Professor Bond also headed the IASP Developing Countries Working Group which he founded and which facilitates education and clinical training through IASP grants.

Patrick Wall Award– Professor Martin Koltzenburg

Martin Koltzenburg is Professor of Clinical Neurophysiology, at the UCL Institute of Neurology and Co-Director of the MRC Centre for Neuromuscular Diseases. He is an Honorary Consultant Neurologist and Head of the Department of Clinical Neurophysiology at The National Hospital for Neurology and Neurosurgery at Queen Square in London. During medical school in Kiel, Germany, he spent an intercalated BSc at UCL and worked in the group led by Pat Wall and has continued to work in pain research ever since. Martin's clinical work focuses on neurophysiological techniques in the assessments of neuromuscular disorders including neuropathic pain and translational methods in drug discovery. His basic science team investigates the properties of sensory neurons on a cellular and system level. This includes the analysis of how specific subpopulations of nociceptive neurons emerge during early embryonic development, how they function in normal life and how changes of their properties lead to chronic pain.

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