



FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

Newsletter of the Faculty of Pain Medicine

Autumn 2016

RANSMITTER

Examination Audit

Spotlight on Sheffield

Essential Pain Management

Pain in Secure Environments

Workshop for Children with Chronic Pain

Major change has occurred; not only Brexit, but also within the Faculty. Barry Miller's significant contributions as Chair of the RAPM and Training and Assessment Committee have been recognised in his



election as our new Dean. Congratulations to Barry. Congratulations also to John Hughes, another ex-RAPM Chair, on his election as Vice-Dean. Not strictly Faculty business, but mention should be made of John Hughes' re-appointment as chair of the Adult Pain Services CRG and Glyn Williams' appointment to the Specialised Surgery in Children CRG: important Faculty perspectives to specialised commissioning for pain services.

Our thanks of course to Kate Grady, who steps down as Dean having contributed significantly to the continuing development of the Faculty, notably in the establishment of the FPPMCA exam which continues to perform well.

Like Brexit, there are significant challenges ahead for the Faculty. Leaving aside external challenges such as 'Shape of Training' and GMC credentialing, which Barry mentions in his statement, a major issue is to represent all aspects of Pain Medicine practice authoritatively. In this issue there are several references to a new working group looking to include non-anaesthetic doctors within the ranks of the Faculty. There is also the problem of training and fellowship for acute pain medicine practitioners. These problems are being addressed; the solutions may not be easy, but your new Dean is committed to progress and has the support of the College.

As usual, my thanks to authors and the FPM admin team.

John Goddard

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Message from the Dean



Dr Barry Miller
Dean

Memories are the key, not to the past, but to the future.

Corrie Ten Boom

The eagle-eyed amongst you will spot that I have written in a number of different guises in the past, and it is with an enormous sense of honour that I am now writing as Dean. I want to start by thanking my immediate predecessor, Dr Kate Grady, a member of the founding board that negotiated with the Royal College to create this, its first Faculty, in 2007. Dr Grady has been a tireless worker in expanding the borders of our remit, and developing international links. It will be a hard act to follow.

Next year is our tenth anniversary, and also the 25th of our parent College. This is an ideal time to take stock of who we are and where we are, and use that to guide us forward.

Who we are?

The Faculty was created with a broad church of opinion and practice, relating to the various practices of Pain Medicine within Anaesthesia. This is an important recognition, as it has become clear that some areas of practice are more supported than others.

As the curriculum was developed the idea that all Pain Medicine practitioners should have a comprehensive training in all areas of independent practice evolved. This has led to two linked areas to address. That Pain Medicine in one form or another is practised by many who did Advanced training, or equivalents, in areas other than Pain; and that opportunities to take an interest in a branch of Pain practice should not be limited to the choices made in the pre-specialist register environment. Throughout medicine (Shape of Training, GMC Credentialing, CME, anyone?) there is a recognition that learning should be lifelong, not just to maintain

skills, but to develop new ones. It is essential that we support all those, at all career stages.

Where are we?

Pain Medicine in the UK has developed, and is primarily practised by those who trained in Anaesthesia. From the outside that always seems a little odd, and the curious history from anaesthesia, analgesia and nerve blocks to the current multi-disciplinary pain management service is an interesting observation of serendipity. But that also informs us that there are many secondary care doctors with similar skills, practising essentially the same medicine from many varied backgrounds. It is clear that as we can offer them a potential home, they could provide us with a variety of unique insights that we will need to expand our perspectives and improve the lives of the patients we serve. The Faculty has formed a working group to explore the options.

Pain Medicine is under scrutiny and pressure as never before. As we have been more vocal in advocating the importance of pain relief beyond the simplistic: see, investigate, treat, discharge model of healthcare, so expectations and costs have risen. We need to become more vocal both within medicine and with the wider public on the nature, and cost, of widespread unsupported suffering. This is our *raison d'être*.

Faculty Development

The Faculty has two core functions, to develop and lead in training and professional standards. But these simple concepts fail to give breadth and colour to the task. We are a part of the national, and international, community looking to influence the overall agenda on medical practice.

We have a unique viewpoint, covering a symptom common to all other areas. Sometimes we are invited to respond, at other times we raise our voice when it is not sought. We are in conversation with politicians, government, DVLA, MHRA, GMC, Medical Colleges and Societies, etc. (And 'etc' is a big list!)

The most important ambition is to BE involved in the developing debates on the nation's health.



**The Faculty will be celebrating it's
10th anniversary in 2017**



**The FPM 10th
Annual Meeting
on 1st December
2017 will feature
an international
speaker.**



We would like to hear from you.

**Please let us know what article topics
you would like to see in the next FPM10
special edition of Transmitter.**



**Keep a look out
for the dedicated
FPM10 area of the
FPM website
- coming soon!**



**2017 also marks the RCoA's 25th
Anniversary.**

**One of the RCoA 25 key messages is
Reducing the impact of Pain.**

New Workshop for Children with Chronic Pain



Dr Thanthullu Vasu

Consultant in Pain Medicine

Children in chronic pain – why is it important?

Chronic persistent pain in children is an under-recognised and under-treated problem; it is a public health concern of major significance (1). Persistent pain in children does not just affect the child or their family, but it is a significant financial burden to the UK economy. Leicestershire paediatric pain service is a well established multidisciplinary service that caters for referrals from a wide geographical area all over the Midlands. We see around 100 children per year in this MDT clinic. More than 25% of our referrals come from outside our neighbouring counties, suggesting the need for these services nationally.

What do we offer?

Our multidisciplinary service is run by a Consultant in Pain Medicine, Consultant Paediatrician, two Consultant Psychologists, two Paediatric Specialist Pain Nurses and a Paediatric Physiotherapist. Our main aim is to educate these children and their parents regarding the pathophysiology of chronic pain and how to manage it. We teach about coping and pacing strategies, breathing and relaxation techniques and direct them towards self-management techniques including the *Pain Toolkit* and educational videos (2, 3). We offer advice on topical and oral medications, run a nurse-led TENS and acupuncture clinic and we direct them towards physiotherapy, individual psychology appointments or an adolescent pain management group. Unfortunately, there was a need for special workshop for younger children aged 7 to 12 years who do not fit the criteria for the adolescent programme.

What is this workshop?

We have developed an innovative art-and-craft based Relaxation and Distraction workshop for children aged 7-12 years old who suffer with chronic pain, along with their parents. This workshop is run by multidisciplinary staff with the following goals:

- Education on the pathophysiology of chronic pain
- Using analogies and metaphors in this education for simple understanding
- Using art and craft as a distraction tool
- Relaxation by means of breathing exercises
- Distraction strategies
- Use of imagery in pain management
- Use of this to promote health (eating, drinking and sleep hygiene)
- Education of parents regarding chronic pain, coping and pacing strategies
- Education of parents about self-awareness and stress management

**GRÜNENTHAL
PAIN AWARDS
2016**
PAIN, GENERAL
CATEGORY

£5,000

Awarded to:
Dr Thanthullu Vasu
Relaxation and distraction workshop for children in chronic pain and their parents. Multidisciplinary Paediatric Chronic Pain Team, Leicester General Hospital.

Date: 9th May 2016

By: The Pain Awards Judging Panel on behalf of Grünenthal Ltd

A grant for service provision for the benefit of patients to the value of £5,000

These Awards and the cash sum(s) relating thereto shall only be taken to have been awarded to the recipient(s) named above and no other person(s) shall be entitled to claim any award or cash sum(s) relating thereto. The award(s) shall be made by Grünenthal Ltd. 99915 0001/19 Date of Presentation: April 2016

How is the workshop run?

We include 6-8 children selected from our clinic. The workshop is run for a whole day during school holidays. Parents attend along with their children. Two Paediatric Specialist Nurses and a Paediatric Physiotherapist are part of the workshop; outcome is measured by a Paediatric Psychologist and overall governance is managed by the Pain Consultant.

Use of technology in the workshop

- 'Pain Toolkit' education through the electronic tablets routinely used in our Paediatric service.
- Breathing exercises with 'Breathe2relax' app that is routinely used; this is a free app that can be used with the Trust electronic tablets and computers.
- "Understanding chronic pain in five minutes" a free YouTube video which is routinely used in our service through electronic tablets/ computers.

Patient related Outcome measurements

We use standard questionnaires to measure outcome, as in our pain management group. We score a very high satisfaction score of more than 99% in our *Friends and Family* test.

We have been very fortunate to receive the *Grunenthal* national award for 2016 which helps us to fiscally manage this project for three years before approaching our commissioners. Our team was interviewed by the Awards' production team and the video is available to watch at <https://www.youtube.com/watch?v=3rblKa5IFRO>

For more details on paediatric chronic pain, please access Vasu T *Pain News* Mar 2016; Vol 14, Issue 1: P 35-37

References:

- (1). WHO guidelines on the pharmacological treatment of persistent pain in children with medical illness, World Health Organisation, 2012.
- (2). www.paintoolkit.org
- (3). www.youtube.com/watch?v=C_3pbB93rvI, accessed on 2nd November 2015



Dr Vasu and the multidisciplinary group who run the workshop

FPM Contribution to Appointment Advisory Committees (AACs)



Dr Victor Mendis
RA (North Thames) and Assessor

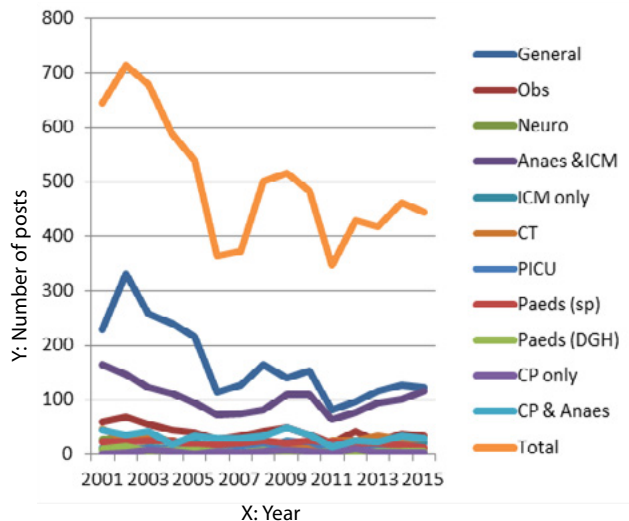
An AAC is a legally constituted interview panel which is established by an employing body when appointing consultants. The remit of an AAC is to decide which, if any, of the applicants is suitable for appointment and to make a recommendation to the employing body. Advice is offered to employing authorities on job descriptions (JDs), job plans and person specifications by the Regional Advisers in Pain Medicine (RAPMs) and, where these meet College standards, approval is granted by the College prior to advertisement and recruitment. One of the main reasons for professional review of a proposed job is to ensure that the content is deliverable safely and effectively in accordance with best practice guidance, and that the post holder can comply with the need to maintain and develop clinical and non-clinical knowledge and skills, and maintain a licence to practise and revalidate. This is all in the interest of the patient, the employer and the post holder. There are no absolute rules about the mix of clinical sessions and the RAPMs use their considerable experience of practice and training to make a considered judgement when reviewing a job plan.

The College is not a statutory authority and has few sanctions it can bring to bear if an employer is determined to continue regardless of contrary advice. However in practice it is rare for College advice to go unheeded and most employers find that independent external ratification of posts is helpful for their own assurance and successful recruitment. The College has developed an 'approved post' logo in order to clearly validate when a post has been deemed suitable. The College and RAPMs play an important role in helping employing authorities to prepare high-quality job descriptions, particularly when they are consulted at an early stage in the process. It is important for RAPMs and the College's credibility that they respond quickly and positively and that

they comment only on issues relevant to the College role. To enable the review and approval process to be speedy and efficient, all job approval requests should be submitted by the employer direct to the College. When the AAC co-ordinator receives the email from the employer with the date and time of the AAC, it triggers the search for an assessor. All assessors are on a database including their sub speciality interests, preferred day(s) they can attend an AAC, their region, contact details and any annual leave or other information that may preclude them from attending the AAC. The AAC assessor's role is primarily to assess the candidates and, ultimately assure themselves, the panel and the College, that the successful appointee is suitably qualified for the post. In addition they provide some external bench marking and validation.

College approval of a post is valid for six calendar months, provided that there are no significant changes to the original post. Between, the period of the 15th August 2015 - 15th August 2016, there were 37 requests to find an assessor for posts including some form of pain management. Of those 37, 25 actually went ahead. The others didn't for a variety of reasons (cancelled, only 1 candidate, unable to find assessor etc.). During this same time, there were 38 requests to approve JDs, and only 3 of those were not approved.

Data from the RCoA workforce planning, illustrate below the number of jobs advertised in Anaesthetics and subspecialties since 2001.



Professional Standards



Dr Paul Wilkinson
FPMPC Chair

It is a great honour to be appointed to the role of Chair of the Professional Standards Committee (PSC) and to succeed my friend and colleague Dr Beverly Collett OBE, whose commitment and considerable work has been second to none. Amongst her many achievements, perhaps the pivotal one, was driving our Core Standards for Pain Medicine Services (CSPMS) document which is an enormous step forward for the development of our speciality.

Going forward, I hope that we can build further on her hard work and success and as I here provide my first report.

I would like to draw your attention to an important issue that has emerged relating to 'fitness to drive' of patients with chronic pain. At the centre of the issues was a perceived concern by the PSC about a shift from patients determining their own fitness to drive to a medical diagnosis of unfitness to drive based around sleepiness in the new DVLA guidance.

Dr Wynn Parry, the Chief Medical Officer for the DVLA, attended the last PSC meeting in September. Here the PSC established a basis of future collaborative working with the DVLA. We were reassured that the responsibility lies with our patients but doctors will have increased responsibilities to report when patients drive if unfit to do so and in addition to record the advice given. The PSC will shortly be providing further guidance about other responsibilities of medical professionals in relation to assessing fitness to drive.

The Faculty of Pain Medicine invasive procedures checklist has been well received. To align this with NHS England safety work - The National Safety Standards for Invasive Procedures (NatSSIPs) - this will be modified to be consistent with similar

documents. Further work to produce a checklist for Intrathecal Pump refills is also underway.

Patient Information Leaflets for interventional procedures has been a complex area of work. There is considerable variation in practice and we have been working to overcome the challenges of creating a document that is detailed enough to use, but captures the usual practices of the majority of practitioners. The final drafts of these documents will be released in due course, but further consultations will be required.

The Professional Standards Committee continues to work on a number of other projects including its programme to improve the management of pain in secure environments. It also continues with work to develop guidance on the use of particulate epidural steroids and with other professional groups on the CRPS guidance. Consideration of the issue of amputation in CRPS has been a key recent strand of that work.

Building on CSPMS, the PSC is developing a dashboard of standards to facilitate quality improvement. The exact shape of development of this is a key area of future work for the PSC.

A further challenge is to provide advice on Consultation length, viewed from the time required to perform the itemised tasks to undertaking consultation to a required standard whilst respecting variations in practice. We thank seven consultants from different centres for their analysis. These data indicate a considerable variation in consultation length and patient complexity. More work is required to ensure appropriate recommendation.

I thank Tony Davis for continuing to work on the Professional Standards Committee as Deputy Chair of the Committee and congratulate Dr Balasubramanian, who has taken on the role of Educational Meeting Lead and Dr Manohar Sharma, who has taken up the new Deputy Educational Meeting Advisor position.

I would also like to thank all members of the Professional Standards Committee for their continuing support on work that is pivotal to the function of the Faculty.

Pain in Secure Environments (PinSE)



Dr Mike Basler
Consultant in
Anaesthesia and Pain
Management



Dr Colin Rae
Consultant in
Anaesthesia and Pain
Management

"The road to hell is paved with good intentions"
– Samuel Johnson

Clinicians working in the field of pain management are aware of the significant issue of addiction to prescribed medication. This has a wide ranging impact on patients with chronic pain, their families and the communities they live in. Unfortunately, it is an issue that has also tarnished the reputation of clinicians working in the field of Pain Medicine who, to some, have a perceived complicity in the creation of this problem. We now live in an environment where medications prescribed for chronic pain are like a sword of Damocles hanging over the specialty.

In the US, health insurance claims for opioid dependence have risen by a staggering 3200 % in the last 7 years. Doctors have been jailed for excessive pain killer prescription. Addiction lawsuits are common and most recently, high dose preparations of many common opioids e.g. Fentanyl patches, are being banned. Whilst many hope that these problems are only an issue across the Atlantic, they would do well to look at UK figures, as well as the increase in demand for specialised pain and addiction services in the UK to deal with the problem.

Nowhere do these issues come more sharply into focus than in the UK prison service. Prisoners are an itinerant population with chaotic utilisation of health care, often incomplete medical histories

and typically a combination of chronic physical and mental health problems. Personality disorders are common and exist in association with alcohol, smoking and substance abuse. It is not surprising that their multiple health problems may have chronic pain as part of their presentation.

Expertise is essential to assess and appropriately manage the individuals' pain including the use of analgesics when clinically indicated. At the same time, the clinician must be conscious of the restrictions and difficulties of the setting in which that person is held and be mindful of the potential to cause wider harm.

At any one time, there are approximately 250000 people in the UK who are interacting with the prison services, either as inmates, or in the parole system. Data show that two thirds of all prisoners have used one illicit drug in the year prior to incarceration and 30% of all the people treated for substance misuse in England are in prison. Psychoactive/Central Nervous System drugs account for 30% of all prisons prescriptions, with analgesics not far behind at 15%. It well known that pain relieving medications, including the Gabapentinoids (now the subject of a Public Health England misuse warning), have a currency in prisons and a day's supply equates to roughly £30.

With these issues in mind, the Faculty of Pain Medicine (under the enthusiastic guise of Dr. Cathy Stannard), the Department of Health, the Royal College of General Practitioners (RCGP) and the British Pain Society (BPS) produced a collaborative piece of work titled 'Managing Pain in Secure Settings'.

This publication followed on from the 'Pain and Substance Misuse' document that had been developed by the British Pain Society previously. Thereafter, there were a series of roadshows to disseminate good practice. It was from this project that Dr Stannard and a variety of key stakeholders, under the auspices of the Faculty of Pain Medicine, developed the Pain in Secure Environment (PinSE) training days.

Each training day involves lectures, case studies and collaborative and occasionally provocative discussion between participants and facilitators. So far, 7 highly successful training days have run, with a total of 125 participants from a variety of disciplines working in prisons. Not only is there much to debate, but the cross fertilisation of experience and knowledge is extremely important and is highly valued by those who work both inside and outside prisons.

Prison medication regimens are also unique. An initial decision will be made to allow some medicines to be kept "in possession", but the majority of medication will be given in sight and supervised and the "medicine queue" will form. During their incarceration, prisoners can travel between a variety of institutions and agencies. It is difficult to prevent logistical problems with their medications. Access to physiotherapy is limited

but gyms are available. Mental Health services are present but the needs are complex and pathology chronic. Often the interactions between prisoner, GP and the secondary care services can be less than fruitful and both sides of the equation have challenges to improve this. The PinSE days allow issues to be aired between all professions involved.

In these politically unstable times it seems popular to build walls and rely on sweeping generalisations to explain complex issues. Pain in Prison is one such complex issue, where a 'lock them up and throw away the key' attitude is likely to be as useful and naive as attempts to treat all pain with opioid medications. The Prison Reform trusts say that the state of our prisons is a measure of the state of our society. They also reflect the uncertainties of medical knowledge. As in the wider pain world, we still have a long way to go to produce better services for the hidden society that exists in prisons.



PAIN IN SECURE ENVIRONMENTS

A training day on Pain Management designed to educate professionals working in secure environments

Friday 18 November 2016 Royal College of Anaesthetists, Holborn, London

Monday 23 January 2017 Grand Central Hotel, Glasgow

Friday 7 April 2017 Royal College of Anaesthetists, Holborn, London

Delegate Fee: £250

For further details and to register, please visit www.fpm.ac.uk or email fpm@rcoa.ac.uk

Essential Pain Management (EPM)



Dr Clare Roques

Consultant in Anaesthesia and Pain Management



Dr Karen Gilmore

Consultant in Pain Management

Essential Pain Management (EPM) is an educational programme written by Roger Goucke and Wayne Morriss with the aim of improving pain management through education. Originally intended for use in low resource settings it has now been taught in over 40 countries. EPM has been supported by many organisations and its success has led to the creation of the EPM Sub-Committee of the Australian and New Zealand College of Anaesthetists and the EPM UK Advisory Group based at the Faculty of Pain Medicine.

How does EPM work?

On a one day course, participants are taught a simple framework for recognising, assessing and treating pain (RAT). Significant emphasis is given to non-pharmacological techniques. Time is spent discussing barriers to effective pain management and identifying local solutions. On the second day a number of the original participants are trained to become instructors, and on the third they deliver the one day course to a new group of participants. Strengths of the EPM programme include flexibility to accommodate the local situation, and the potential for early handover to local staff.

Malawi EPM

Malawi is by some measures the poorest country in the world(1). EPM courses were held in the two largest government-funded hospitals, Queen Elizabeth Central Hospital (QECH) in Blantyre and Kamuzu Central Hospital (KCH) in Lilongwe, the economic and administrative capital cities respectively.

Much of healthcare in Malawi is provided by non-medical staff, and participants were predominantly nurses and clinical officers with a small number of doctors. Courses have been run on three occasions in Malawi (2014-2016), with local staff taking on an increasing role with each successive course. The second course was taught by a combination of local instructors trained on the first course, and visiting instructors from the UK. The third course was the most interesting with regard to development of the EPM project. Instructors were entirely locally trained (a UK anaesthetic registrar gave some administrative support).



Teaching by local trained staff.

Printed course manuals, very expensive for a country as poor as Malawi, were successfully replaced with electronic copies downloaded onto participants' USB sticks, and exercise books and pens were provided. This enabled the course to be provided at a fraction of the original cost.

How can the success or otherwise of the Malawi EPM programme be judged?

163 healthcare workers have been trained in EPM and 32 as instructors. Testing of knowledge after the course showed significant improvement over pre-course tests. Satisfaction scores ranged from 4.7 to 4.96 out of a total possible score of 5. Many favourable comments were made eg "It has been an eye-opening session for me and it will greatly improve the way that I handle pain in patients". It is notable that the workshops run by newly trained instructors generated particularly high rates of positive feedback, lending weight to the argument that early handover to local instructors is successful. Healthcare workers engaged enthusiastically, at times passionately, in group discussions and suggested changes in practice. These included enabling better access to opioid medication, a universal pain scoring system compatible with high levels of illiteracy, and dissemination of the RAT formula. My personal view is that, in addition to the above, EPM raises the profile of pain and healthcare workers are empowered to make a difference despite the lack of resources.

Sustainability

Key to continuation of a local EPM project is a cohort of able and enthusiastic instructors. There is now such a group in Blantyre and there are plans to hold six-monthly one day courses at QECH, further courses in several southern hospitals and a three day course at the northern Mzuzu Central Hospital. Although significant progress in Malawi has been made towards local affordability, funding for food and stationary remain significant issues. Creative and individual solutions may be required to overcome these barriers.

I would like to thank the Association of Anaesthetists of Great Britain and Ireland Foundation and the Royal College of Anaesthetists for their support of the EPM project.

(1) 2015 Gross National Income per capita, World Bank.



Training and Assessment



Dr Jon McGhie
TAC Chair

As next year marks the 10th anniversary of the FPM, this is the perfect time to reflect upon the progress and direction of UK pain training.

The first five years of the Faculty were spent recognising and standardising the pain training resources and frameworks that existed before its inception. The last five years has been spent developing the curriculum, issuing training guidelines, establishing vertical lines of communication and creating the examination. Following the May Board meeting, which collated ideas and feedback from members, we have identified strategies to develop these achievements over the next five years. For TAC this will involve creating better communication and training links across adjacent regions and adapting our training framework when the GMC announces its curriculum change recommendations. Specifically, as a response to trainee feedback, we will give more structured guidance on teaching within APT, redevelop the logbook and we will facilitate interactions between APT and specialised training opportunities on a regional basis. We will also participate in a new FPM working group, led by Dr Hughes, as the FPM looks to broaden the relevance of pain and pain training opportunities to non-anaesthetic groups. Pain management transcends specialty and many of you will know locally of specialists in rehabilitation medicine or palliative care as well as neurologists, rheumatologists and psychiatrists who are interested in or contribute to your pain services. This is an exciting development, challenging but achievable, and TAC will contribute constructively to the training changes necessary to realise this goal.

However, these aspirations exist at a difficult time for the NHS; what a difference a few months can make! Since my last update, Brexit and ongoing

tensions over the new junior doctor's contract have dominated the political landscape and brought continued focus towards the sustainability of the NHS. The Government continues to pursue an agenda of 7-day working, against a backdrop of multi-professional advice warning this is not achievable within current financial constraints, and they have been accused of alienating a generation of doctors at a point when workforce planning projections predict future shortfall across many specialities, including anaesthesia. Pain Medicine will not be immune from this issue. Worryingly, we already have survey responses from anaesthetic trainees (at intermediate and higher levels of pain training) which warn of a dip in interest towards UK APT, citing workforce uncertainty as one of the potential barriers. Our historical census information has highlighted that we are currently under-staffed. Taken to an extreme conclusion, if this predicament worsens there may be regions in the future where pain service staffing become unsustainable and pain facilities will need to be closed or rationed. While expansion of the pain workforce by enveloping other specialties within the umbrella of the FPM may be one way to mitigate this future workforce crisis, this solution is a long way off. The workforce leads on TAC will continue to monitor these trends. We would welcome any local examples of workforce difficulty that you are experiencing, especially with regard to recruitment and retention of staff.

Nevertheless, I would like to reassure anaesthetists who wish to pursue a pain career but are anxious about future job prospects and possible non-anaesthetic competition, that despite being a multidisciplinary Faculty for almost two decades, in its 2015 annual report the Australian FPM highlighted that two thirds of the fellows were from an anaesthetic background. So broadening the specialists who can train in Pain Medicine will not be at the expense of anaesthesia but rather in addition to anaesthesia. It is imperative therefore that we continue to attract anaesthetists towards APT and careers in Pain Medicine. We all have a professional responsibility to ensure that locally our training environments are inviting and supportive to attract the next generation of pain specialists and TAC will continue to support you in achieving this.

'Audit' of examiners in the FPMRCA SOE



Dr Michael O'Connor
Former Consultant in Pain
Medicine

'Audit'. Yes deliberate scare quotes – the (worthy but potentially a bit dull) comparison of practice against standards.

When I was a new consultant visiting the exams in the late 1980s, there were few explicit standards around. The questions were certainly not standardised, examiners brought their own. How examiners behaved was, de facto, 'The Standard' and as far as I could see, it worked pretty well.

By the time I became an examiner in the 1990s times were changing, standards and audit were becoming obligatory. Questions were taken from a bank which was regularly reviewed. Standards were set for examiner behaviour but what were these behavioural standards to be? Well, they were such stunners as, "The examiner greets the candidate and is polite". The auditor ticked his boxes and seldom gave any feedback to the examiners beyond, "That was fine". Lest this all sounds a bit inadequate I should point out that this was the very early days of clinical governance and audit in the Health Service generally, and that there were many parallel moves going on to improve the exams. For example a lot of work was going into examiner training; new examiners were being filmed and given individual feedback on their performance. However, while audit of examiners ensured we met minimum standards of behaviour, it remained well worthy but largely dull.

The game-changer was led by Jane Pateman with the expansion from box-ticking "audit" to 'professional observation'. Rather than simply comparing behaviour against standards, professional observation was, "a contemporaneous account of observed behaviours which are then discussed with the subject". Rather than the 'audit' of individual examiners, professional observation changed to observation of a pair of examiners using the same questions on two consecutive candidates before the

observer/auditor gave feedback. This enabled a comparative approach, so that the professional observation conversation between observer and examiners was much more, "We could all see that the candidate was very nervous; you had very different styles of questioning, which did you think helped the candidate settle down most?" or "I liked it that you were both conscious of the need to allow the anxious candidate time to answer without letting pauses become too long".

We have been running this approach to the FPM Structured Oral Exam for a few years now - how do examiners actually perform? Rather well actually! From the beginning of the FPM exam I have been impressed at how easily new examiners have taken to conducting the SOE, far more so than in other College exams (entirely anecdotal evidence of course). I think the reason is that conducting an SOE is extraordinarily like a Pain Clinic conversation: Introduce yourself, be polite, settle the candidate/patient down, start with open questions and use more probing, closed questions to elucidate detail.

Is all now perfect? Well, not quite. One big problem is that time is tight with short intervals between candidates. If the candidate has done well there is time for the observer to have a conversation with the examiners. If the candidate has performed less well, the examiners are occupied reviewing the candidate's answers and recording their areas of concern. So in those situations where observer feedback to the examiners would be of most value, we have the least time to do it. There remains some more work to do, perhaps by tweaking our timings on the day of the exam a little so that we can really get the maximum value from professional observation and feedback.



FFPMRCA Exam Tutorials

FFPMRCA Exam Tutorials are held biannually.

The next tutorial will be taking place on:

Friday 3rd March 2017

Location: The Royal College of Anaesthetists

Fee: £95.00

For more details please visit www.fpm.ac.uk

FFPMRCA Examination Update



Dr Nick Plunkett

Deputy Chair of the Court of Examiners



Dr Karen Simpson

Chair of the Court of Examiners

Since the last Transmitter FFPMRCA examination report, the 8th sitting of the exam has been completed. A total of 20 candidates sat the MCQ and 13 passed; using rigorous quality control the Court of Examiners determined a pass mark that was equivalent to previous sittings. There was a slightly reduced pass rate of 65% compared to previous sittings. On 12th April 2016, 14 candidates presented for the SOE. The pass mark was determined by the usual

quality control measures with a combination of statistical analysis and expert judgement; eight candidates achieved the required score giving a pass rate of 57%. This is slightly less than at some previous sittings, but within the overall range as established over the last 5 sittings (56-71%, average over five sittings 60%).

It was noteworthy that the spread of marks was either at or above the pass mark, or significantly (in two cases very significantly) below it, i.e. there was a very clear cut point between those candidates who passed and those who failed. In this situation there needs to be little discussion by the Court of Examiners when assessing the marks, as there were so few borderline cases. The examination is designed to make sure that borderline candidates are given careful consideration and the 'benefit of any doubt'.

Continuing the policy of demonstrating the highest levels of Quality Assurance, Dr Jeremy Weinbren presented data showing the stability of the FFPMRCA examination over its seven diets. The predicted pass mark, utilising Angoff scoring, matched the actual pass mark, indicating the validity of this technique, and confirmed its utility in helping to set the pass mark accurately. There were further data to show that another validated technique also routinely employed (Hofstee) has been highly reliable, showing a tight relationship

FFPMRCA Examination Calendar Spring 2017

	FFPMRCA MCQ	FFPMRCA SOE
Applications and fees not accepted before	Mon 1 Nov 2016	Mon 6 Feb 2017
Closing date for FFPMRCA Exam applications	Thurs 15 Dec 2016	Thurs 9 Mar 2017
Examination Date	Wed 1 Feb 2017	Tues 4 Apr 2017 (backup day 5 Apr)
Examination Fees	£510	£720

over the seven exams in successfully determining the pass mark boundaries. In addition, data were presented that showed that the SOE exam subsections (Science and Clinical) had a range of values with respect to both relevance and difficulty within an acceptably narrow range. As the examination and its processes mature, it is reassuring that the techniques that have been used to set standards were, and remain, highly valid in supporting the expert judgement of the examiners, and the data have been stable and reliable over the past four years.

The examiners were audited in real time whilst conducting the SOE exam, as is our usual practice. This aspect of Quality Assurance is the subject of a further article by Dr Mike O'Connor, FPM Exam Audit Lead in this edition of Transmitter.

Two visitors attended the April 2016 SOE examination, Dr Mohjir Baloch (Frimley Park Hospital) and Dr Alistair Dodds (City Hospitals Sunderland). Both enjoyed the day; they felt that the examination was a fair test of knowledge and understanding, and that it was conducted in a manner befitting its importance as a high stakes examination.

Karen Simpson attended the Fellowship of Pain Medicine Examination in Hong Kong as an external examiner in 2016. She was involved in question setting, marking and viva examinations. It was an enjoyable and interesting experience; the local examiners were all very welcoming and it was a pleasure to assist in the conduct of their exam.

As before, special thanks to all examiners and question writers who commit much time and effort to the examinations, and the important work of constructing questions and quality assuring them, which goes on all year round. Our very special thanks to two retiring examiners, Dr Beverly Collett and Dr Jeremy Cashman, for their significant expertise and commitment to the exam project from its inception to its current state of vitality. We wish them well!

Finally, many thanks to the RCoA Examinations Department, especially Graham Clissett, Beth Doyle and Neil Wiseman for their expertise in ensuring the exams and all related activity run so very smoothly.



2016 Case Report Prize Winner - Dr Katrina Dick

Congratulations to Dr Katrina Margaret Dick for winning the 2016 prize for her case report:

‘Postoperative chronic pain, can it be prevented?’

The full case report can be accessed from the ‘Awards and Recognition’ section of the Faculty website

Abstract:

Chronic post-operative pain was first defined in 1999. Since then the incidence of chronic post-surgical pain remains high. There are many complex reasons why patients might develop chronic pain after surgery: physiological, psychological and genetic. This case presentation explores post-operative chronic pain in a patient demonstrating some risk factors for chronicity, and discusses aetiological factors for development of this phenomenon.

Trainee Update



Dr Sheila Black
Faculty Trainee
Representative

Since the last Transmitter trainee update, I have taken over the role of Trainee Representative from Lucy Miller. I am thoroughly enjoying this role, especially being able to participate in development and change within the Faculty and training in Pain Medicine. It is great to engage with trainees around the country, hearing their experiences and views. I will share some of the main issues currently affecting trainees.

During the BPS conference in Harrogate in May, we had a small and informal trainee meeting. There was much to talk about, both positive and negative. A main topic was the impact of on-call commitments on pain training during the APT year. In April we surveyed the APT's and 40% of them expressed discontent that the on-call requirements were having a negative impact on training. Many of the rotas were of a 1 in 7 pattern, more onerous than the 1 in 8 pattern specified by the RCoA. This feeling was reflected in the Annual trainee survey.

Potential solutions to this problem discussed in Harrogate include exchanging night shifts for long days, thereby maximising the daytime availability or doing only weekend on-calls with maximal weekday pain sessions. Alternatively, on-calls could be removed entirely from the pain training year. This would result in drop in salary due to the unbanded nature, and some trainees feel that this may result in deskilling in anaesthesia. This question was raised in the Annual trainee survey. 7 APT's out of 13 believed that removing anaesthetic on-calls would not lead to deskilling in anaesthesia, while 4 were happy to continue to do on-calls.

New consultants taking on job plans which include regular sessions in acute pain ought to have completed higher pain training during ST5-7. We surveyed all anaesthetic trainees to find

out how they felt about higher pain training, and whether it adequately prepared them for leading acute pain services.

During HPT, most had 21-30 sessions during a 12 week unit. This reflects the amount of time spent with on-call commitments. 100% felt confident managing acute post-op pain, and 97% felt confident managing patients with chronic pain. 76-87% were confident managing pain in low back pain, poly-trauma, ICU, organ dysfunction, chest wall injury, the elderly and those on chronic opioid therapy.

Only 11 out of 29 agreed or strongly agreed that they felt able to lead an acute pain service, therefore 18 did not. The Training Committee is investigating the development of more extensive higher pain training specifically for those who wish to do acute pain, requiring up to 60 sessions, in order to better prepare trainees for this role.

Interestingly, the development of perioperative medicine has made 9 trainees more likely to pursue an acute pain interest. Another avenue being considered is a formal qualification in acute pain medicine in conjunction with affiliate membership of the FPM. Many trainees agreed that this would make them more likely to pursue acute pain medicine.

This year's Annual trainee survey was completed by 13 APT's and 6 HPT's. The main issues highlighted were impact of on-call commitments, logbooks and formal teaching. The pain logbook is currently under review to simplify data collection. Formal teaching sessions were provided less than once per month, with a distinct division between London trainees (where training is provided by LPTAG) and the rest of the country. This presents the greatest challenge to the future of pain training: providing good quality pain teaching and positive role models for trainees, and ensuring the next generation of pain consultants.

Finally, congratulations to Dr Katrina Margaret Dick who was awarded the 2016 Case Report Prize for 'Postoperative chronic pain, can it be prevented?'. This is an excellent piece of work, and the prize is well deserved.

An excellent year in Liverpool



Dr Salmin Aseri

Consultant in Pain Medicine
and Anaesthesia

I thoroughly enjoyed my training at the Walton Centre, an internationally renowned tertiary centre for Neurology, Neurosurgery and Pain Medicine in the Mersey Region. The Walton Centre has been at the forefront of the battle against chronic pain since the 1960s. It is one of the UK's four specialist centres which does cordotomy for cancer related pain, and works closely with the Palliative Care team at Woodland's Hospice. It is a pioneering unit for neuromodulation and developed the first Pain Management Programme (PMP) in the UK in 1983. I completed my Advanced Pain Training (APT) at the Walton Centre in February 2016.

I gained extensive clinical experience in biopsychosocial management of complex chronic pain including pharmacotherapy, interventions and rehabilitation. I attended Advanced Opioid MDT clinics managing opioid tolerant patients referred by secondary care pain clinics and GPs. As part of a neuromodulation MDT, I was involved in initial assessment, management, planning and performing SCS trials under supervision. I had experience in ITDD pump refills and assisted with sacral nerve implants and DRG stimulators. I attended weekly combined Palliative Care Pain Clinics at Woodland's Hospice which receives cordotomy referrals to Dr Manohar Sharma from all over the country. I did neurolytic saddle blocks and tunnelled epidurals. I saw complex facial pain in MDT clinic with a neurosurgeon and maxillo-facial surgeon and assisted in Trigeminal Balloon Compression for patients with trigeminal neuralgias. I attended specialist CRPS clinics receiving complex cases referred from all over the UK and also MDT pelvic pain clinics. I attended the Fast-Track Sciatica MDT Clinic with neurosurgeon reviewing urgent referrals with radicular pain where patients were randomised to Nerve Root Injection or surgical decompression as a part of an on-going research study (NERVES Trial).

I attended rheumatology clinics at Aintree Hospital, Paediatric Pain MDT Clinics at Alder Hey Children's Hospital, Chronic Refractory Angina and Chest Pain at Broadgreen & RLH. I attended specialist Headache Clinics with a neurologist, seeing patients with primary headache and complex migraine and observed procedures like GONB and botox injections.

I attended monthly Pain Management Meetings with consultants and hospital management. I organised monthly Pain Relief Foundation Journal Club meetings and co-organised a "Manchester Peri-operative study day". I was actively involved in teaching anaesthetic trainees posted for intermediate Pain training, organising their rota and completing WPBA's. I received appreciation for contributing to the Liverpool Clinical Management of Chronic Pain course and was teaching faculty at a Pain link nurse study day and at MAFIT Pain Study day for Mersey Anaesthetic Trainees.

I supervised a medical student's service evaluation project "Pain Clinic Patient Satisfaction". I assisted in data collection for a service evaluation of Trigeminal Balloon Compression and completed an audit "Compliance with documentation of Labour Epidural Analgesia" which was presented at East Lancashire NHS Trust Audit meeting in Nov 2015. I was also involved in data collection for online tracking of high dose fentanyl prescribing by the GP's.

I presented posters entitled "A rare case of low-pressure headache secondary to spontaneous intracranial hypotension treated with epidural blood patch" at the ASRA International Pain Congress in Miami, USA in November 2015 and I co-authored a poster entitled "High-frequency (10 kHz) or conventional spinal cord stimulation for complex neuropathic pain patients?" presented at the Neuromodulation Society of North America ASM.

I would strongly recommend Advanced Pain Training at the Walton Centre.

Special thanks to: Dr Manohar Sharma (CD- Pain Medicine, Walton Centre), Dr Chawla (LPMES), Dr Tsang (RAPM), Dr Sarah Thornton (Head of School-NENW), Dr Ian Geraghty (Ex-Regional Advisor).

RAPM Update



Dr Lorraine de Gray

RAPM Chair

In a year where the UK won a record number of Olympic gold medals, had record high summer temperatures, to my mind this year holds the record for the speed that time is whizzing by.

Since the Spring edition of the Transmitter we have had some changes to our ranks - Dr William Rae is the new RAPM for West Midlands, taking over from Dr Helga Funkel. Our thanks go to Dr Funkel for her hard work and strong commitment in the past six years. Congratulations go to Dr Rae.

Dr Lisa Manchanda, RAPM West Scotland, Dr Gail Gillespie, RAPM East Scotland, Dr Allistair Dodds, RAPM Northern, and Dr Baranidharan, RAPM Yorkshire, have signed up to second three year terms. Congratulations to Dr Hoo-Kei Tsang, RAPM Mersey who joins the Training and Assessment Committee (TAC).

From a Quality Assurance perspective, the Faculty has now published data from the Hospital Review Forms from nine regions on its website. This data is an excellent source of information to help trainees make a well informed choice in deciding where they wish to pursue advanced training in pain medicine. It also provides a transparent method for RAPMs and TAC to quality manage training posts.

The RAPM Biannual Review form is in its fourth year, and now aims to obtain data of waiting times for first time appointments in hospitals across the UK.

Delivering paediatric pain training has always been challenging with a very patchy geographical distribution of provision due to lack of

commissioning and/or the necessary expertise to deliver it. In June the first Paediatric Pain training forum met, chaired by Dr Paul Rolfe. Action points resulting from this meeting include a plan to have recognised training centres across the UK which trainees can access to train in paediatric pain medicine. A census is also planned to acquire an accurate picture of by whom and where, paediatric pain clinics are being delivered, in particular outside recognised paediatric centres.

The current logbook is also under scrutiny in an attempt to make it more user friendly for the trainees and trainers. It is recognised that the current format allows a clear overview of the quantity and types of sessions attended but makes it rather challenging to collate a comprehensive overview of the actual quality of training and sessions attended. The Training and Assessment Committee is currently reviewing the logbook together with its author, Dr Roger Lashley.

Congratulations go to Dr Katrina Dick who has been awarded the first FPM Case Report Prize. I hope that recognising the hard work that trainees put in to providing a well-researched and written report will go a long way towards encouraging trainees to write their report in a timely fashion during their year of advanced pain training.

Congratulations also go to Dr Barry Miller and Dr John Hughes who have been elected Dean and Vice Dean of the Faculty respectively. Both former RAPMs and RAPM Chairs, I am sure you will join me in wishing them much wisdom and patience in leading our Faculty in these challenging times for the NHS. A huge thank you goes to Dr Kate Grady, outgoing Dean.

The first meeting for LPMESs is on 9th March 2017; please encourage your LPMES to attend. The session will be followed by a meeting for all RAPMs. In the interim, our next RAPM forum is on the 17th of November 2016 where I look forward to meeting the RAPMs once again. It will be the last time I shall be chairing the meeting as I will be handing over the reins to Dr Mendis at the end of the year. Tempus fugit.....

Local Pain Medicine Educational Supervisors (LPMES) Day

The Faculty will be hosting its first LPMES Day to develop engagement with LPMESs; this is an opportunity for you as a LPMES to discuss aspects of your role and the training programme with members of the Faculty.

**Thursday 9th March 2017
from 10am to 3pm**

The day will include **4 CPD points** and there is no charge

Speakers will include:

- The Dean
- RAPM Chair
- FPMTAC Chair and Deputy Chair

Topics will include:

- An overview of the Faculty
- HPT & APT programmes
- Exams
- Recruitment and workforce
- Quality assurance of training
- Case reports and logbooks
- regional training issues
- SPA allocation and recognition of LPMES role
- Allocated time for general discussion



Spaces are limited so please ensure you secure your place as soon as possible.

**Attendance will need to be confirmed prior to the event
with Jyoti Chand (Faculty Administrator) at jchand@roca.ac.uk**

A full agenda will be circulated nearer to the event.

Spotlight on Sheffield/North Trent



Dr Tiemo Vemmer
RAPM Sheffield

The painter Elizabeth Siddal, our local pre-Raphaelite, died in 1862 at the age of 33 years of an overdose of laudanum, used to treat ongoing pain and distress after a miscarriage a year earlier.

Things have progressed a bit since. Laudanum is of historical value but the modern practitioner prefers 'pain patches' to deal with pain and psycho-social distress. Elizabeth Siddal's modern successor was artistically slightly less gifted, limited to a colouring book in our waiting room.

Chemically, she had suffered from progress: the addictive tramadol had been replaced with non-addictive(?) fentanyl patches, in rapidly escalating doses. Soon she ended in the resuscitation room, in respiratory near-arrest. Luckily, one of the intermediate pain trainees covered the intensive care rota. He found two 50 mcg/h fentanyl patches on her back, calculated this as morphine equivalent of 360 mg/day and treated her appropriately. After discharge from intensive care she was referred to the pain service.

In the Sheffield/North Trent region we provide basic pain training at six sites, intermediate at three, higher at two, and advanced training at Sheffield teaching hospitals only.

At the basic level, one focus is procedural pain, avoiding the nocebo effect. Almost every trainee has learned to 'holler' 'Sharp scratch!!!', loud enough for the deafest examiner to hear and give a mark. Outside the exam hall, in clinical practice the evidence is clear: Needles hurt less when announced by neutral information, e.g. "I put some local anaesthetic in your

skin to numb it a bit" rather than loud alarming shouts.

Advanced training takes place at the regional tertiary centre, Sheffield teaching hospitals.

There are ample opportunities in a busy department. Nationwide, most problems with advanced pain training focus on access to paediatric pain, cancer and advanced interventions. Luckily, in Sheffield we have these well covered. Sheffield Children's Hospital has its own pain clinic with five consultants. A renowned palliative care department allows cross-specialty experiences.

Pain consultants with an interest in pain in cancer survivors work at Mexborough and Worksop.



FPM stock image

The Sheffield clinics provide a large tertiary multidisciplinary intervention service which includes an active spinal cord stimulation programme.

In cooperation with the medical school, there is work on improving the pain teaching of medical students. The trainees have been very successful in the fellowship examination and all have managed to get substantial pain consultant posts after training. Sheffield offers further subspecialisation in children's pain and spinal cord stimulation.

Secondary care services are available at Chesterfield and Doncaster & Bassetlaw hospitals.

Doncaster Royal Infirmary will soon be recognised as a University of Sheffield teaching hospital. Doncaster & Bassetlaw Hospitals run the largest pain service in the area, serving people from South and West Yorkshire, Nottinghamshire, Lincolnshire and Derbyshire. A large multidisciplinary team of over 50 people headed by seven consultants work in a hub and spoke arrangement distributed over five sites. Mexborough is the centre of the universe, where flat earth is nailed to the firmament.

The pain clinic in Mexborough is well equipped with two wards, two minor operating theatres for procedures, a gym, and ample clinic space. The service is very busy with 3500 new patients annually, 3000 interventions, 20,000 acupuncture encounters and 8 integrated multimodal pain management programmes. Bassetlaw Hospital, Worksop, has a further clinic with interventional facilities. Outreach stations serve the community with access to consultant clinics, specialist pain nurses, pain physiotherapy, cognitive behavioural therapy and acupuncture. Acute pain services are based at the two main hospitals in Doncaster and Worksop.

There are subspecialty interests focussed on fibromyalgia, complex regional pain syndrome, pain in cancer survivors and medico-legal issues.

The main strength of this busy pain service is the integration between different treatment modalities, with weekly multidisciplinary team meetings, and a practical hand-in-hand approach to the management of complex patients.



FPM stock image

Faculty Events



Dr Sanjeeva Gupta
Educational Meetings
Advisor



**Dr Shyam
Balasubramanian**
Deputy Educational
Meetings Advisor

As always, our educational meetings are a great opportunity to meet colleagues, learn what's new and update our knowledge across the whole of pain. Our events go from strength to strength. Apart from addressing the key updates on the latest scientific developments, our meetings have a focus on day to day clinical practice. Our recent 'Musculoskeletal Examination Workshop', organised by Dr Meera Tewani, was well attended and attracted excellent feedback. The mission was to share the clinical examination skills and enhance knowledge of current practices.

Our Annual Meetings mark a milestone for many of us, and this year's programme, scheduled on 2nd Dec 2016 (Friday), again reflects the great diversity within Pain Medicine. In addition to the prestigious Patrick Wall Lecture on 'Better understanding of neuropathic pain: what it means for patient care', which will be delivered by Professor David Bennett, the highlights include talks on evidence for spinal injections for back pain, mental health problems in patients with persistent pain, transforaminal injections - particulate or non-particulate steroids, thoracic paravertebral blocks: role in acute and chronic pain management, and myofascial trigger points. Debate is an excellent way to critically appraise current best available evidence. This year, the topic for debate is: 'Epidural analgesia for abdominal surgery - friend or foe?' We are privileged to have Dr Barrie Fischer to argue

in favour of epidural analgesia and Dr William Harrop-Griffiths to challenge this intervention. The 2016 annual meeting programme has been designed to ensure that there are a range of topics for acute and chronic pain enthusiasts.

Following the grand success of the acute pain study day in February this year, the Faculty is planning to conduct a two day programme on 6/7 of February 2017. We are pleased to inform that the topics are finalised, the theme for first day is 'Acute Pain: Challenges & Complexities' and the second day is 'The Science & Art of Pain Management'. Along with lectures on the very latest developments, the afternoon session on the second day will also have interactive sessions in which delegates will have the opportunity to share their views with colleagues and get new ideas. These stimulating meetings will cover a whole range of pain topics that should interest practicing consultants, trainees and nurses and are open for booking now. Faculty members with innovative ideas and interests in contributing to the educational events can contact Dr Sanjeeva Gupta (sgupta6502@aol.com) or Dr Shyam Balasubramanian (doctorshyam@hotmail.com).

The Faculty would like to thank Sanjeeva Gupta who is stepping down as Educational Meetings Advisor. He has worked tirelessly for the last six years to create an exciting and dynamic programme of FPM events. Dr Shyam Balasubramanian steps up to become Educational Meetings Advisor and we welcome Dr Manohar Sharma, Consultant in Pain Medicine, Liverpool, who will be joining as the Deputy Educational Meetings Advisor for the Faculty of Pain Medicine in February 2017. Dr Manohar Sharma has rich academic credentials and experience in organising national and international pain meetings.

Faculty of Pain Medicine 9th Annual Meeting:

Core Topics in Pain Medicine

Friday 2nd December 2016

09.00 - 09.30	Registration & Welcome
09.30 - 09.40	Introduction
Session One	Chair: Dr Beverly Collett OBE
09.40 - 10.10	Spinal injections for back pain: What is the evidence? <i>Dr Stephen Ward, Consultant in Pain Medicine, Brighton</i>
10.10 - 10.40	Mental health problems in patients with persistent pain. <i>Dr Amanda Williams, Reader in Clinical Health Psychology, London</i>
10.40 - 10.50	Discussion
10.50 - 11.10	Developments: Faculty of Pain Medicine. <i>Dr Barry Miller, Dean, FPM</i>
11.10 - 11.25	Faculty Award Presentation
11.25 - 11.45	Refreshments
Session Two	Patrick Wall Guest Lecture: Moving towards a better understanding of neuropathic pain and what this means for patient care.
11.45 - 12.35	<i>Professor David Bennett, Wellcome Trust Senior Research Fellow Clinical Science, Oxford</i>
12.35 - 13.05	Transforaminal injections - particulate or non-particulate steroids: Does it matter? <i>Dr Manohar Sharma, Consultant in Pain Medicine, Liverpool</i>
13.05 - 13.20	Discussion
13.20 - 14.10	Lunch
Session Three	Chair: Dr Kate Grady
14.10 - 15.00	Debate: Epidural analgesia for abdominal surgery - Friend or foe? - Friend: <i>Dr Barrie Fischer, Consultant Anaesthetist, Redditch</i> - Foe: <i>Dr William Harrop-Griffiths, Consultant Anaesthetist & Honorary Clinical Senior Lecturer, London</i>
15.00 - 15.30	Thoracic paravertebral blocks: role in acute and chronic pain management. <i>Dr Shiv Kumar Singh, Consultant Anaesthetist, Liverpool</i>
15.30 - 16.00	Myofascial trigger points: Fact or myth? <i>Dr Nicholas Hacking, Consultant in Pain Management, Preston</i>
16.00 - 16.30	Discussion & Close

RCoA, London
5 CPD Points
£195 for Consultants, £140 for trainees/nurses
Code: B08



Faculty of Pain Medicine Study Day:

Acute Pain: Challenges & Complexities

Monday 6th February 2017

- 9.00 - 9.30 Registration and coffee
- 9.30 - 9.40 Introduction - *Dr S Gupta and Dr S Balasubramanian*
- Session one** **Chair - Dr J Quinlan**
9.40 - 10.05 Acute pain services, what is new?
Dr M Rockett - Pain Medicine Consultant, Plymouth
- 10.05 - 10.30 Essential Pain Management Lite
*Dr M O'Connor - Associate Dean, Severn Deanery and
Dr H Makins - Consultant in Anaesthesia and Pain Medicine, Gloucestershire*
- 10.30 - 10.55 Managing pain: Striking the right balance following joint replacements
Dr A Sardesai - Consultant in Anaesthesia, Cambridge
- 10.55 - 11.25 Discussion
- 11.25 - 11.45 Refreshments
- Session two** **Chair - Dr M Rockett**
11.45 - 12.15 Acute pain management in opioid dependent/abuse patients
Dr J Quinlan - Consultant in Anaesthesia and Pain Medicine, Oxford
- 12.15 - 12.45 Risk management in acute pain
Dr A Thacker - Consultant in Anaesthesia, Coventry
- 12.45 - 13.15 Discussion
- 13.15 - 14.10 Lunch
- Session three** **Chair - Dr S Gupta**
14.10 - 15.00 Debate: Intravenous lidocaine: the answer for effective post-operative pain management
*For: Dr S Nimmo - Consultant Anaesthetist, Edinburgh
Against: Dr M Rockett*
- 15.00 - 15.10 Discussion
- 15.10 - 15.35 Frequent attenders: the psychiatry of acute pain (re)admissions
Dr I Jordan - Consultant in Psychological Medicine, Oxford
- 15.35 - 16.00 Acute pain management in patients with chronic pain
Dr R Malhotra - Consultant in Anaesthesia and Pain Medicine, Liverpool
- 16.00 - 16.30 Discussion & Close

Faculty of Pain Medicine Study Day:

The Science & Art of Pain Management

Tuesday 7th February 2017

9.00 - 9.30	Registration and coffee
9.30 - 9.40	Introduction - <i>Dr S Gupta and Dr S Balasubramanian</i>
Session one 9.40 - 10.10	Chair - Dr M Rockett Nocebo response: The art of communication <i>Dr P Farquhar Smith - Consultant in Pain Management and Anaesthesia, London</i>
10.10 - 10.40	Neuroimaging of placebo analgesia <i>Professor K Wiech - Associate Professor, Nuffield Department of Clinical Neurosciences, Oxford</i>
10.40 - 11.10	Relaxation & distraction in paediatric pain <i>Dr T Vasu - Consultant in Pain Medicine (2016 Gruenthal Award Winner), Leicester</i>
11.10 - 11.30	Discussion
11.30 - 11.50	Refreshments
Session two 11.50 - 12.20	Chair - Dr J Quinlan Litigations in pain management <i>MDU Speaker</i>
12.20 - 12.50	Prescribed medication, sleep and driving <i>Dr D Dawson, Sleep Specialist, Bradford</i>
12.50 - 13.15	Discussion
13.15 - 14.10	Lunch
Session three 14.10 - 14.50	Problem Based Learning Environment Case Scenario 1: The revolving door patient (recurrent pancreatitis) <i>Facilitators: Dr J Quinlan and Dr M Rockett</i>
14.50 - 15.30	Case Scenario 2: Chronic widespread pain <i>Facilitators: Dr T Vasu and Dr S Gupta</i>
15.30 - 16.10	Case Scenario 3: Postoperative pain in a vasculopath following amputation <i>Facilitators: Ms S Millerchip, Lead Acute Pain Nurse, Coventry & Warwickshire and Dr S Balasubramanian</i>
16.10 - 16.40	Discussion & Close

RCoA, London
5.5 CPD Points Code: B28
£175, £140 for trainees/nurses.
(book along with the 6th February for a reduced rate of: £330, £255 for trainees/nurses)



MDU



FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

British Pain Society Calendar of Events



To attend any of the below events, simply book online at:

www.britishpainsociety.org/mediacentre/events/

Patient Liaison Committee Webinar

Wednesday 18th January 2017 - Online

The Patient Liaison Committee will be hosting two 45 minute webinars, these will be free to view and will have the facility to ask questions at the end.

50th Anniversary Annual Scientific Meeting

Wednesday 3rd – Friday 5th May 2017 - Birmingham

Put the dates in your diary now for this flagship event – the 50th Anniversary Annual Scientific Meeting of the BPS. We are putting together an exciting and stimulating programme and will be announcing plenary speakers and parallel session topics in the near future. The ASM is a great opportunity to:

- Network with colleagues
- Keep up to date with the latest cutting edge research and developments relevant to pain
- Raise questions, partake in debates and discuss outcome
- Meet with poster exhibitors and discuss their research

For regular updates please visit: <https://www.britishpainsociety.org/2017-asm-birmingham/>

Living Well Right to the End

Philosophy & Ethics SIG Annual Meeting

26th to 29th June 2017 - Rydall Hall, Cumbria

How to live well at all can prove elusive and has been much debated for thousands of years. Is it to do with physical health or pleasure or a general sense of wellbeing or happiness or fulfilment or meaning or is it merely the absence of suffering??

Can we somehow enable those we care for to achieve a level of wellbeing even as they become ill and perhaps face death?

Can we achieve a measure of wellbeing in our own lives?

Our meeting this year takes place in the beautiful surroundings of Rydal Hall amongst the lakes and fells of Cumbria where we will be considering all of these issues.

Gonnae no dae that! – exploring patient and clinician fears

Pain Management Programmes SIG Biennial Conference

15th & 15th September 2017

Glasgow Caledonian University, Scotland

Speakers including: Amanda C-de-C Williams, Tamar Pincus, David Gillanders and Johannis Vlaeyen.

Social events:

- Wednesday evening: drinks reception in the iconic Glasgow City Chambers.
- Thursday evening: Scottish gin and real ale tasting, plus the chance to play the bagpipes at the National Piping Centre!

Further details for all our meetings can be found on our events listing page:

www.britishpainsociety.org/mediacentre/events/

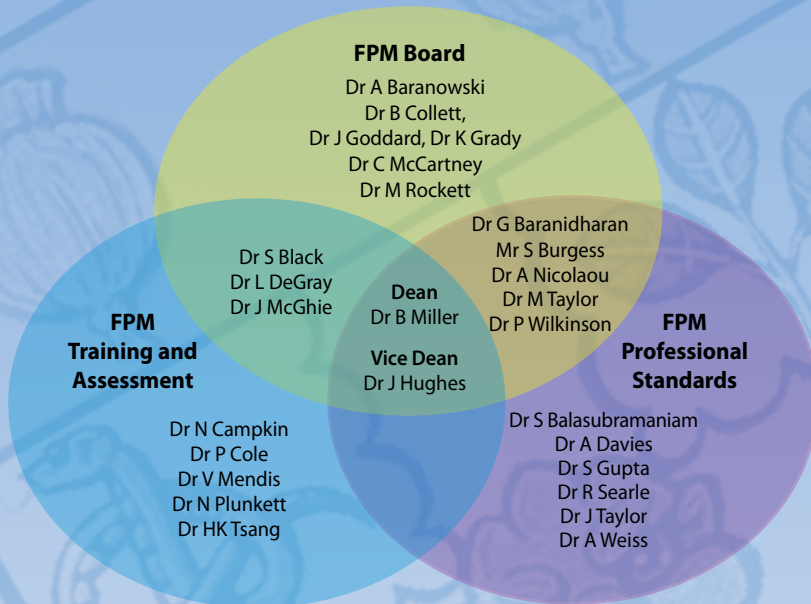
Faculty Update and Calendar

New Fellows

Dr Anand NATARAJAN
 Dr Attam Jeet SINGH
 Dr Salmin Saleh ASERI
 Dr Vinay Siddannagari ANJANA REDDY
 Dr Chaitanya Kumar HOSAHALLI VASAPPA

Dr Sunil ARORA
 Dr Jonathan Nirranjan RAJAN
 Dr Anu Gupta KANSAL
 Dr Matthew Richard David BROWN
 Dr Ruth Clare WHITEMAN

Committee Membership



2016-2017 Faculty Calendar

EVENT: FPM 9th Annual Meeting: Core Topics in Pain Medicine	2 Dec
MEETING: FPM Professional Standards Committee	8 Dec
MEETING: Board of the FPM	9 Dec
MEETING: FPM Training and Assessment Committee	27 Jan
EVENT: FPM Study Day. Acute Pain: Challenges & Complexities	6 Feb
EVENT: FPM Study Day. The Science & Art of Pain Management	7 Feb
MEETING: FPM Professional Standards Committee	2 March
MEETING: Board of the FPM	3 March

Please note that all dates may be subject to change

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