TRANSMITTER

Spring 2019

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Trainee perspective on OOPR

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FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

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WELCOME

Dr Manohar Sharma

Clinical Editor

It gives me great pleasure to write my first editorial and present the Spring 2019 edition of Transmitter. Amongst other significant publications, The Faculty of Pain Medicine has just published a "Framework of operation guidance for improving pain services for adults across the United Kingdom with cancer or life limiting disease". The document is endorsed by the Association for Palliative Medicine, Association of Cancer Physicians and the Royal College of Radiologists (Faculty of Clinical Oncology). This is timely considering the significant unmet need of, and lack of suitable provision of pain management services for, this group of patients. This document emphasises the importance of Level 3 services in Specialist Pain Clinics collaboration with Palliative Medicine and referring those needing complex pain techniques to the Level 4 services for Highly Specialised Pain Management Services. This guidance is likely to find feet only with the help of regional champions in the UK to develop and promote collaboration with Palliative Medicine as a first step. This should then help develop regional networks with Level 4 services as a hub. These will need support from commissioners in all of the devolved nations of the UK and enthusiasm from members.

The opioid 'de-addiction' clinics experience from Leicester is an excellent example of collaboration between Pain Medicine and Psychiatry. This work highlights the complexities and needs of challenging subsets of patients in our daily practice. I hope that this will generate further interest in other Pain Clinics in the UK with the current rising awareness of the negative impacts of high dose opioid usage for chronic non-malignant pain.

A private medical cannabis clinic for chronic pain opened in Manchester recently. Our Dean, Dr Barry Miller, has issued a statement on the FPM website to express deep concern since there is very limited data available on the use of cannabinoids for pain management and these clinics are being introduced before the findings of research being undertaken by the National Institute for Clinical Excellence (NICE) are published. I look forward to that publication from NICE.

Manohar Sharma

Message from the Dean

Dr Barry Miller
Faculty Dean

"Medicine is all about making definitive decisions on inadequate evidence"

Dr Dennis Harold Miller c1985

This is my last "Deans Statement". It seems only yesterday that I reached this pinnacle and looked out with a sense of …...vertigo. I will admit to much sadness on stepping down. I have been writing regular articles for Transmitter, in one guise or another, since 2011. I have been chased, cajoled and threatened to get them in at a time vaguely related to the deadline.

I became a Fellow of the Faculty at the beginning, joining the inaugural Training & Assessment Committee under the Chair of Dr Kate Grady, who has been a great support throughout.

It has changed, from the early days of setting out our positions in regards to the basics of training and professional standards, to embracing the opportunities to embed our ideals into undergraduate training, postgraduate developments beyond anaesthesia and taking on national debates about how the profession should respond to major changes in the health economy.

Cannabis

Changes in the law last year have seen a significant increase in interest, with consequent pressures to many services. The Faculty's guidance was publish last year, and as with a number of other pieces of advice, came as a disappointment to some who felt that this potential new panacea was being ignored.

From a professional point of view it is essential that the Faculty takes stock of the evidence and the frameworks within which we practice.

We can only comment on the issues as they relate to pain. Not childhood epilepsies, recreational use, or anything else.

The evidence is quite clear – there is very little; it is of poor quality, covers a variety of different products, treatment trials invariably fail to report harms in any systematic way and we have little longterm data.

We are being asked (pressured) to prescribe, and maintain, patients on substances that have no licence as medicinal products. Not off-licence use, which is our bread and butter, not occasional uses, but potentially longterm, with repeat prescriptions provided only in secondary care.

A cursory glance at the internet will reveal very significant players in this potential market, and it is clear why they should want to avoid the type of scrutiny applied to all other pharmaceutical compounds. Both in terms of cost, and the risk of potentially showing that they don't work, or are harmful.

What is the situation for a foetus exposed? For longterm organ damage? As potentially carcinogenic?

Consider drugs such as Thalidomide, Rofecoxib, Rosiglitazone. And these drugs have undergone fairly rigorous pre- and post licensing assessment.

The issues of tolerance and withdrawal cannot be ignored – if these substances are modifying endocannabinoid pain pathways, even without any obvious cognitive signs, what happens if they are withdrawn?

I do not know what the answers to these questions are; more importantly no one does. But to prescribe, or encourage others to prescribe, on a potentially large scale on the current evidence base is a very questionable enterprise.

The recent announcement of clinics to be set up by the industry is a concerning development. If in 5 or 10 years the data seems to show they are safe and effective this stance will still have been the correct one at this time.

To rely on anecdote, political pressure, legalisation for recreational purposes (a Political and Public Health issue), faith in the magic of herbs used by mankind since the dawn of time is not a mechanism for safe medicine.

The Future – a personal opinion
Pain Medicine is at a crossroads. There are fundamental challenges that we must address as doctors if we are to survive.

Two issues, core to practice, are gaining increasingly regulatory attention. One is drugs. The other, injections.

Already I can feel a wave of anxiety coming backwards through time to me sitting at my keyboard.

Pain Medicine is dedicated to relieving suffering. That is our raison d'etre. This is often done in the absence of a definitive diagnosis, or where the diagnosis and recognised treatments have failed to solve the problem. We take anecdote and weak studies as the best guides we have to help, we often have little choice. Studies in Pain Medicine are difficult both because the conditions we treat may not have a single underlying pathology, and because there is little money in it for manufacturers of new products.

We content ourselves that patients we work with often have not been helped by the practitioners before us, who looked for diagnostic certainty and were confused by their treatments, not leading to a long term improvement.

I think this has led to woolly thinking, and as evidence grows against current practices we are reluctant to change our habits.

It is useful to look at the studies that organisations like NICE *excluded* from their final outcomes to recognise the serious issues of statistical inadequacy and bias that we face. And also the wider societal issues. The use of drugs to treat an increasing number of health and health related issues has expanded almost exponentially over the last 50 years. Drugs to treat illness we cannot define and to prevent illnesses we may not be at risk of. The use of drugs with good short term outcomes, and far from certain longer term results.

We will need to consider these from the outset, and with clear patient invovlement.

This is not new, and has been in various documents for a long time – but it is rarely a core aspect of the consultation. It also means that the limited scope of seeing patients with rapid discharge needs to be reviewed. The new "Outcome Measures" document is aimed at giving guidance for quantitative assessments, but drug reduction regimes must be safe, sensible and humane, avoiding destructive withdrawal symptoms and the loss of confidence in the potential for other managements.

Injection therapies are a core to many pain services. Developed out of the desire to extend the value of acute regional techniques, without their inherent sensory and motor issues. They remain an essential part of the treatments available, and can be life transforming. The NICE guidelines on Low Back Pain and Sciatica are perhaps just the first significant challenge to the way we view them. The focus on services as income generators based on frequent (2-4x year) low back injections (Facet Joint especially) is not sustainable, CCGs have found a reason not to pay, and the good evidence doesn't support the practice. We can argue individual cases of success and anecdote, the inadequacy of studies and study models, but these arguments carry little weight with those who hold the purse strings for limited resources, or those who take an impassioned view of all the data.

Multidisciplinary Pain Management models have yielded some of the best outcomes we have, but their acceptance is patchy. Many services have not embraced or been unable to reorganise due to the pressures of finance, service commitment and the general inertia built into the NHS to gain the best benefit, with various 'members' of the 'team' often working in silos, with limited understanding of what each can do, either individually or collectively. To be fair this has not been helped by new providers offering cheaper solutions to CCGs without the 'expensive medical' component. Anecdote and case reports (the issue I have just railed about – the irony is not lost on me) suggests that these have had a significant impact on services, but also – unsurprisingly – as patients begin to roll out of these new, inadequate, pathways they are returning to GPs looking for better care – what we are, or what we should be.

We have often hidden from CCGs, in the coattails of our predominantly Anaesthetic contracts, or been ignored when we have tried. But we need to work more closely with allied healthcare specialties, and initiate, not just respond belatedly, to the conversations with CCGs on what they want or think they want, to avoid poorly constructed predatory models getting a foothold.

I am optimistic that we are up to the challenge, and I still have a birds eye view.

Faculty of Pain Medicine 12th Annual Meeting

Topical Issues in Pain Medicine

Friday 29th November 2019

09.00 - 09.20	**REGISTRATION AND REFRESHMENTS**
09.20 - 09.30	**Welcome and Introduction**
Session One	
09.30 - 10.00	**CRPS and limb amputation - update for practice**
10.00 - 10.30	**Opioid and gabapentinoid co-prescribing for chronic pain: a toxic cocktail?**
10.30 - 10.50	**Discussion**
10.50 - 11.20	**REFRESHMENTS**
Session Two	
11.20 - 12.00	**Faculty Developments**
12.00 - 12.45	**Patrick Wall Lecture TBC**
12.45 - 13.00	**Discussion**
13.00 - 14.00	**LUNCH**
Session Three	
14.00 - 15.00	**Debate: Cannabinoids should now be prescribed for chronic pain**
15.00 - 15.30	**Are acute pain teams value for money?**
15:30 - 16:00	**Analgesic use for pain in pregnancy - what can be safely prescribed?**
16.00 - 16.30	**DISCUSSION AND CLOSE**

RCoA, London
5 CPD Points
Consultants and SAS Grades: £205
Trainees/nurses: £150
Code: B08

Please note that the programme and timings are subject to change.

FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

Programme organised by Dr Shyam Balasubramanian and Dr Manohar Sharma

Outcome Measures

Dr Ganesan Barani

Working Party Chair

Outcome Measures is a joint project of the Faculty of Pain Medicine (FPM) and the British Pain Society (BPS), to provide guidance on the various available outcome measures used by pain services. This project has been supported by the national Clinical Reference Group for Specialised Pain Services.

The NHS is moving towards outcome-based commissioning which encourages value for money and better outcomes for patients. NHS pain services are currently commissioned by different clinical commissioning groups (CCGs) based on their local infrastructure and requirements. NHS performance indicators, such as the 18 weeks' wait, are used to assess quality of services. Outcome measures are not normally required to show service effectiveness, but this is currently changing and some CCGs are requesting outcomes to inform commissioning.

This document was prepared by a working group to guide pain services across the country in selection of the most appropriate outcome measures for their needs. No single scale can meet all needs: the choice of outcome/s for a service depends on the treatments offered, the aims of treatment, and on the population treated.

The group was tasked to review already available and free to use measures, easily used in the clinical and telephone follow-up environment.

It should provide a well-established and validated outcome measures that cover the domains of pain improvement, functional improvement, psychological improvement, and overall satisfaction applicable in the secondary and tertiary care setting. It is likely that a few measures will be needed for different aspects of services and it is accepted that none will be perfect. New original research, and systematic/meta-analysis reviews were outside the remit of this group.

Most of the validated questionnaires analysed were from the "Core Outcome Measures for Chronic Pain Clinical Trials: IMMPACT Recommendations." Other outcome measures were added if it was agreed amongst the group that they were commonly used in pain clinics, and we presented the ones with good validation and evidence in the use of chronic pain. It should be noted that the analysis of all the many available outcome measures was not done due to the clear objectives assigned to the working group and the time frame involved. It is envisaged that this document will continually evolve, based on feedback, experience of its use and the availability of further evidence.

The document is published and can be found on the FPM and BPS websites:
https://www.fpm.ac.uk/system/files/FPM-outcome-measures-2019.pdf

Professional Standards Committee Update

Dr Paul Wilkinson
FPMPSC Chair

As we enter 2019, it gives me great pleasure to summarise a number of ongoing activities of the Professional Standards Committee (PSC) of the FPM.

The provision of pain services to palliative care has been suboptimal with significant variation throughout the UK. Under the Chairmanship of Baroness Finlay of Llandaff, Members of the FPM Board and PSC have worked with other professional stakeholder groups to provide a framework of operational guidance for improving pain services for adults across the United Kingdom with cancer or life limiting disease. 350,000 people in the UK are diagnosed with cancer each year and 160,000 die from the disease, with pain being the commonest symptom of cancer diagnosis. This document is designed firstly to inform and stimulate delivery of Level 3 services (linked palliative medicine and specialist pain management) in secondary care offered by most district level hospitals. Secondly, it serves to identify referral pathways to level 4 services (Highly Specialist Pain Management). The document further provides guidance on the shape of services to be provided by Commissioning bodies, including specialists, and directs assessment and management of complex analgesic combinations. There should be fluid onward referral to Highly Specialist Pain Management Services.

This work represents a very significant achievement and thanks must be given to Professor Mike Bennett for orchestrating this piece. It can be found with other Faculty guidance at: www.fpm.ac.uk/faculty-of-pain-medicine/guidelines.

The publication, which will provide commissioning support for members, is now published on the Faculty website. It has been a complex document to produce with extensive discussion on many of the finer points, but hopefully will be very helpful in promoting best commissioning practice.

Members of the PSC led by Dr Gupta are working to produce a policy for guideline engagement. This is to maximise awareness of FPM publications and increase and enable implementation. The Academy of Medical Royal Colleges have highlighted the need to provide more focus on implementation to maximise the yield on work undertaken by professional bodies such as the Faculty of Pain Medicine and this work is our response.

Dr Searle has led on updating the document on the role of pain consultants and work is ongoing to improve the gap analysis tool.

The Faculty will also contribute to the RCoA Audit Recipe Book, which has underpinned high quality anaesthetic audits for many years. Dr Weiss and Dr Taylor continue to lead the update on Core Standards for Pain Management Services. Finally extensive consideration has been given to enable recommendation for clinic review times. With variations in practice, it is very difficult to give concrete advice, but Dr Davies has led a comprehensive consideration of the issues that help frame decision making regarding review times.

The PSC has continued oversight of a thriving event programme and has finally completed the update of the last of the medicine patient information leaflets (anti-inflammatories).

Finally, the Faculty has four opioid related work streams which come under the PSC umbrella and these are discussed in the next article...

FPM Action on Opioid Issues

Against the backdrop of the increase in public and professional concern regarding the rise in opioid prescriptions in the UK, which correlates closely with an increase in opioid related deaths, the Board and PSC have been proactive on the opioid issue. Over the last year there have been many requests for comments or information from various media sources and the FPM has been active in trying to ensure that the appropriate messages reach the general public.

There is limited evidence for the use of opioids in chronic non-malignant pain. The prevailing view of the FPM is opioids do work for chronic pain in selected patients as part of a comprehensive pain management plan. Throughout this debate, emphasis must remain on the devastating impact of chronic pain on individuals, causing distress and disability, and to the huge economic and societal costs. It is clear that there is considerable variation in prescription opioids across the UK with too many patients on too high opioids or taking opioids without benefit.

Underpinning this effort are four key streams of work:-

1. Opioids Aware

www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware

The Faculty is continuing to update and promote the Opioids Aware Resource. The negative effect of opioids must not to be ignored, but opioid painkillers may benefit many patients, which are not replicated in other drugs and cannot be easily replaced. We continue to update the resource in conjunction with Public Health England, for professionals and patients to enable the effective and safe use of opioid medications.

2. A briefing statement to health professionals on the management of opioid medications.

www.fpm.ac.uk/system/files/FPM-Opioid-letter-2018.pdf

The FPM recently issued a briefing statement to health professionals on the management of opioid medications. This was circulated as widely as possible, including to General Practitioners and Community Pharmacists. The document highlighted an urgent need to:

- Screen and assess people on opioids
- Make clinical decisions about opioid reduction, where appropriate
- Identify the best clinical approach and ensure there are appropriate sources to deal with those patients captured by the screening process
- Finally enclose a corporate approach to the management of those who are non-compliant

There has been widespread positive feedback on this document. The Faculty is also aware of various local initiatives to implement local screening and opioid management.

3. A FPM/RCoA initiative to reduce the opioid load into the community after surgery and enable timely reduction.

The third stream of work relates to a new working party in conjunction with the Royal College of Anaesthetists, Royal College of Surgeons, Royal College of General Practitioners and other stakeholders.

In the USA there is a significant opioid load in the community following continuation of opioids after surgery. It is also recognised that this issue is complicated by patients who take opioids pre-operatively while others may develop post-surgical pain for which continuation of opioids is rarely the preferred treatment. Though the precise scale of this problem in the UK is not fully understood, there is a need for increased awareness of this issue. The aim of this group is to establish an evidence-based clinical framework to support local decision making and policy regarding opioid management peri-operatively and after discharge. The idea of healthcare communities working together to drive best practice is the central aim of this working group.

4. An upcoming resource to enable best practice in opioid reduction.

The work aims to help best practice in the reduction of opioid medicines. This is aimed at pain specialists, although it may have wider use beyond specialist care. This working group first met in February 2019.

While there is great concern about inappropriate opioid use in the UK, these efforts will help minimise this problem enabled by a very different health service structure in the UK compared to that of the USA.

Opioid 'De-addiction' Clinics: The Leicester Experience

Dr Andrew Ball

Clinical Lead, Turning Point, Leicester

Dr Jonathan Tring

Consultant in Anaesthesia and Pain Medicine

The common practise of applying opioid based analgesic protocols to the management of chronic non-cancer pain has provided neither freedom from distress nor improved functionality for many patients over the years. The potential detrimental effects of opioids have been highlighted extensively in the medical and mainstream media in recent times, but despite campaigns to raise awareness of these issues by professional bodies, including the Faculty of Pain Medicine, high levels of opioid prescribing are still frequently encountered in UK pain clinics. Consequently, many pain physicians see a significant subset of patients who experience iatrogenic opioid dependence (IOD) in addition to their chronic pain illness and this can prove extremely challenging to manage. In our centre, it has been difficult to establish how many patients in primary and secondary care might be at risk of IOD. However, we know with certainty that several thousand patients within our local primary care areas are receiving long term opioid prescriptions, excluding those on cancer care pathways. Our own pain clinic surveys have shown that nearly 80% of inpatient referrals to our pain service involve opioid use of several months duration at levels exceeding 120mg morphine equivalent per day and 90% of opioid consuming patients had their medication initiated and escalated in primary care, with tramadol being the drug most commonly used.

At the University Hospitals of Leicester NHS Trust, we set up a specialised joint pain medicine/psychiatry opioid de-addiction clinic six years ago to address an increasing problem with frequent hospital attenders presenting with chronic pain and habitual prescription opioid use. This clinic is staffed by a consultant in pain medicine and a consultant psychiatrist from the drug and alcohol misuse service. We see approximately 150 new patients per year, and 100 follow-ups. Referrals come to us via the emergency department, GPs and inpatient teams. Patients will usually be taking at least 120mg morphine equivalent per day with continuing pain and exhibiting poor coping mechanisms or signs of compulsion, drug seeking behaviour and/or mental health issues, including substance and alcohol misuse. Many of our patients have entrenched views about their medical diagnoses and medications, with high levels of reported distress and disability being the norm. We constructively challenge these perceptions to allow the patient to consider potentially beneficial pain management modalities other than medication. The initial consultation lasts one hour and a full medical and pain history is taken, including the impact of psychosocial issues which might be driving drug seeking behaviour. We frequently find that opioids are being used to modify mood, reduce stress or induce sleep and it is therefore essential to address underlying precipitating factors.

It is important to remember that pain is a bio-psychosocial phenomenon and there is no reality to the mind/body split. All individuals using opioids will exhibit tolerance, dependency and withdrawal to varying degrees. There is no objective measure of 'addictiveness' of a drug or behaviour and a more useful concept is that of reinforcement. Drugs that have a rapid onset, such as oramorph, are more reinforcing than slower acting drugs such as buprenorphine patches. Short acting opioids need to be taken several times a day and the patient often goes into withdrawal in between doses. Consequently, the patient experiences both positive and negative reinforcement several times a day when using short acting preparations. Many of the patients we see in the clinic have been prescribed increasing doses of several different opioids and they will invariably have been through opioid withdrawal at some time. Most patients do not know what this frightening experience is at first and they usually interpret it as an exacerbation of their underlying pain condition.

Consequently, they resort to further opioid doses with subsequent worsening of symptoms. However, once they understand this process of withdrawal, the realisation can be a powerful motivation to reduce their opioid load.

Practical medication management can therefore be summarised by the 3R's: rationalisation, regularisation and reduction. Our therapeutic goals are: reduction in the haphazard use of multiple opioids; reduction in use of short acting opioids; slow reduction of total opioid load and weaning onto buprenorphine as the opioid of choice. We often recommend buprenorphine transdermal patches or once daily sublingual buprenorphine tablets, which are available in doses of 2, 4 and 8mg.

It is important to be able to tolerate the distress of the patient during the consultation. We frequently have to tell patients there is no 'cure' for their pain. Furthermore, we then ask them to reduce the 'painkillers' they might have been using for years on the advice of doctors. In order to do this, adequate clinic time is essential. Patients can find the consultation exhausting and we offer a short break halfway through, thus allowing an opportunity for the doctors to discuss the case and formulate suggestions before discussion with the patient. The process is dynamic and we make no demands on the patient. Rather, we try to project a positive view of change and invite the individual to initiate the process. Patients require a collaborative approach to reduce opioid load and they can often feel frightened if they sense a loss of control over the process. Therefore, we ensure reduction goals are realistic and achievable because a slow weaning schedule is more likely to result in sustained abstinence. We emphasise that reduction should be achieved at the patient's own pace, that it is not 'all or nothing' and that the worse that can happen is they remain as they are. It is important that opioid prescriptions are not altered unilaterally without prior agreement with the patient as this frequently leads to confrontation, disengagement and relapse into medication reliance.

The use of Motivational Interviewing (Miller and Rollnick) is a helpful tool to guide the patient towards engagement and behaviour modification. Its use of reflective listening, rolling with resistance and amplification of change talk reduces the potential for conflict and gives professionals more confidence in helping a potentially challenging patient group.

There is significant psychiatric co-morbidity within the patients referred to the clinic. Although it is outside the remit of the clinic to treat psychiatric conditions, we often write to GPs asking for a psychiatric referral and we include mental health colleagues in our correspondence. Liaison with all stakeholders is crucial and weak communication will invariably compromise the patient's progress and lead to complaints and disengagement. We copy clinic letters to patients to avoid misinterpretation of what can be long and complex consultations. We provide clear recommendations for medication reduction following discussion and agreement with the patient.

Our follow-up data shows that 55% of patients who attend this clinic either wean off opioids completely or reduce them to levels below 120mg morphine equivalent per day. 26% achieve less dramatic reductions and 19% fail to engage with us.

The opioid de-addiction clinic helps to address the needs of a challenging subset of patients in our hospital and hopefully clinics will evolve in other centres. This will enable collaborative data collection and shared experience to benefit a growing number of patients with IOD.

Further reading:

Miller, W. R., & Rollnick, S. (2012). Motivational Interviewing, Helping People Change, 3rd ed. New York: Guilford Press. ISBN 978-1-60918-227-4.

Opioids Aware. *A resource for patients and health-care professionals to support prescribing of opioid medicines for pain*. Available from: https://www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware

Consent and the Ever Present Threat of Clinical Negligence Litigation in Pain Medicine

Dr Richard J Sawyer

Consultant in Anaesthesia and Pain Management

The practice of pain medicine is potentially fraught with litigation related risks. It could be said that we work in a veritable minefield with hazards present at every turn. With the ruling in Montgomery vs Lanarkshire Healthcare[1] in 2015 and subsequent cases, these risks are more real today than ever before, particularly with respect to issues surrounding the consent process and the need for providing patient centred information.

Evidence from NHS Resolution indicates that litigation cases are on a downward trend (fig 1) since 2013/14.[2] When looking further at the data (fig 2) it is evident that the main targets for litigation are surgeons. The number of cases against anaesthetists are actually very few when compared to the surgeons!

the 1970/80s to 10% in the 1990s.[3] With an aging population requiring pain management input this trend is likely to continue. The American data showed that interventional procedures with resultant nerve damage were the biggest sub-group of claimants.

More recent evidence from an analysis of outpatient medication management in chronic pain related medicolegal cases has shown a disturbing rise in non-interventional related alleged damaging events.[4] The overwhelming majority of these claims were related to improper medication management. The evidence shows that opioid related adverse events (death, addiction and emotional trauma/abandonment) are the most frequently cited allegations. An important and apposite quote from the article is the following 'When

NHS Resolution

Total number of clinical negligence claims by financial year of incident as at 31/03/17
(since 1981/82, all clinical negligence schemes, including "below excess" claims handled by trusts)

Fig 1.

Despite requesting information from NHS Resolution via a Freedom of Information request, I was unable to obtain data as to the number of chronic pain management related cases that have gone through NHS Resolution within the anaesthesia group. Data reflective of UK pain management practice is unfortunately sorely lacking.

Historical evidence from the ASA American Closed Claims Analysis group showed that chronic pain management related cases rose from 2-3 % in

treating opioid-dependent patients with complex medical and psychiatric comorbidities, our analysis leads us to suggest that physicians should educate patients about the risks, benefits and alternatives of opioid therapy, perform compliance monitoring, and maintain vigilance for aberrant behaviours.'

In the judgment in Montgomery and Lanarkshire, Kerr LJ made a similarly powerful statement: 'The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any

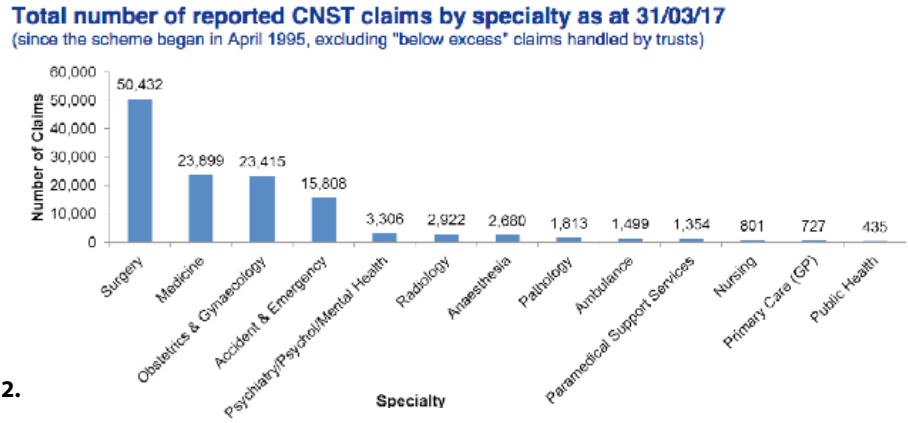


Fig 2.

material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments.' It is vital for pain physicians to be aware of the concept of materiality. Again as stated by Kerr LJ, "The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is, or should be aware that the particular patient would be likely to attach significance to it."

We are working in an environment in which the legal goalposts are constantly moving, and they are moving in such a way as to make our pain management practice more demanding particularly in the way in which information is explained to patients.

A further recent case, Thefault v Johnstone[5] has built further upon the issues surrounding the consenting process. This case demonstrated that courts will find in favour of claimants where non-negligent complications occur on the background of a poor consenting process. This case is a salutary reminder that risks need to be clearly explained and that benefits are not unduly overstated.[6] This case is relevant to the practice of pain medicine in that the benefits of interventional procedures or a course of analgesic medication, should be realistically explained, including that there is a potential failure rate. It is also necessary to explain to patients that 'doing nothing' is an option which should be considered.

So what recommendations are available to mitigate the risks surrounding embarking on a course of pain management, be it an interventional procedure or initiating a course of analgesic medication?

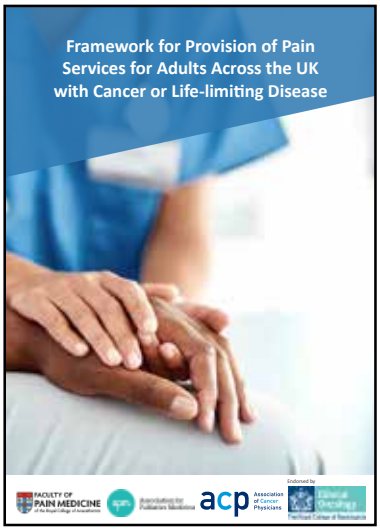
- Document, Document, Document! Good documentation is vital.
- Document that a discussion has taken place about management options, including the option of doing nothing! Discuss the natural history of a pain condition.
- Document that patient information leaflets (PIL) have been provided.
- Use clinic letters to document that appropriate advice has been given.
- Remember the consent process is an ongoing process and requires time and space to allow a patient to reflect on the recommendations and advice given. It is not just about getting the signature on the consent form.
- Be cautious about over-stating the success of treatment interventions.
- Be realistic about risks.
- Respect that patients may change their mind.

All of the above takes time and is sometimes very difficult given the restrictions placed on our NHS clinics. Unfortunately, the Courts will not be sympathetic to a defence that there was no time! Patients deserve to be made as fully informed about their clinical condition as much as possible. It is our responsibility to provide our patients with the required information in a clear and unambiguous manner.[7] As a consequence of good doctor – patient dialogue, hopefully litigation cases against pain physicians won't escalate further over the coming years.

References:

1. *Montgomery vs Lanarkshire Healthcare* [2015] UKSC 11 75
2. NHS Resolution Fact sheet 2016/17 https://resolution.nhs.uk/wp-content/uploads/2018/09/Fact-sheet-3-Claims-information-2016-17.pdf
3. Dermot R et al. Chronic Pain Management: ASA closed claims project. *Anaesthesiology* 2004; 100 (1): 98-105
4. Abrecht CR *et al.* A contemporary medicolegal analysis of outpatient medication management in chronic pain. *Anaes and Analgesia* 2017; 125 (5): 1761-1768
5. *Thefault v Johnstone* [2017] EWHC 497
6. De Bono J. Thefaut v. Johnstone (2017): a game changer for consent in elective surgery. *Bone and Joint* 2017: 6(4)
7. Consent: Patients and doctors making decisions together (2008). GMC https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent

Further Reading: Munglani R, Eyre G, Sharma M. Consent in pain medicine: law and implications for practice. *Pain News* 2018 (a series of 3 articles).



The Faculty, along with the Association for Palliative Medicine, Association of Cancer Physicians and the Royal College of Radiologists (Faculty of Clinical Oncology), has written a framework for pain service provisions for adults in the UK who have cancer or life-limiting diseases.

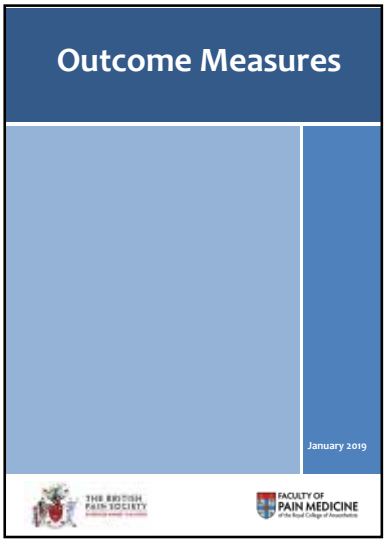
The guidance aims to improve pain services for adults across the UK with cancer or life-limiting disease with closer integration of pain management, oncology and palliative care services.

The full guidance is available at: https://www.rcoa.ac.uk/system/files/FPM-Framework-pain-services-cancer-and-life-limiting-disease-2019_1.pdf

The Faculty has produced guidance for its Members on driving and pain.

This document outlines the effect of pain on driving and the effect of differing analgesics on a patient's fitness to drive. It also provides general guidance to doctors on what the circumstances are that can lead to impairment of driving and what their patients should be informed of.

The full guidance is available at: https://www.rcoa.ac.uk/sites/default/files/FPM-Driving-and-Pain-members-information.pdf



The Faculty and the British Pain Society (BPS) have jointly developed a practical guidance document of outcome scales which are appropriate to pain management.

These measures will improve patient care and allow benchmarking against other services and against targets, helping to bring uniformity locally and nationally.

Each scale is presented with a brief description, the advantages and disadvantages, information on use and copyright.

The full guidance is available at: https://www.rcoa.ac.uk/system/files/FPM-outcome-measures-2019.pdf

Essential Pain Management-UK Update (EPM-UK)

Dr Mike O'Connor and Dr Helen Makins

on behalf of the EPM Advisory Group

We have just received an update from the Australia and New Zealand College of Anaesthetists (ANZCA) that the UK is one of 55 countries where EPM has been taught around the world. It is exciting to see this international progress but even more encouraging that closer to home, within the UK, the initiative progresses. Whilst continuing our original work in medical schools, we are now reaching an array of other undergraduate and postgraduate groups of medical and allied health professionals, who are both attending teaching sessions and running them. Nurse-led courses have been a notable success.

We have had several excellent opportunities to present at national pain meetings and to run train the trainer sessions at these. Whilst not in any way an essential requirement for teaching EPM, these sessions have increased awareness beyond College initiatives and have resulted in numerous enquiries and enhanced course uptake. In Newcastle, Sailesh Mishra, has run a trainer course for a group of intermediate anaesthetic trainees, resulting in improved understanding of pain for those participating as well as creating a pool of local enthusiastic trainers.

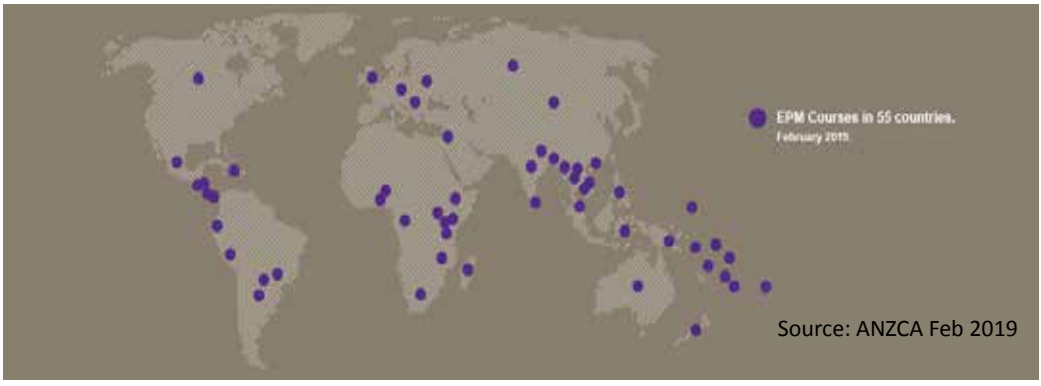
We have had considerable success adapting the course to a range of time slots and for a variety of professional groups, including nurses, physiotherapists, undergraduate doctors, foundation doctors, core medical, surgical, anaesthetic and GP trainees. Whilst the unique EPM simple framework remains the same for all groups (Recognition, Assessment and Treatment), the case studies become more complex and varied depending on the group. It has been interesting to see that through all groups, there appears to be a common misconception that the WHO pain ladder can be applied to all situations. By the end of the session, this has been addressed in a simple structured manner with excellent feedback.

We recently hosted our first teleconference for a number of regional EPM leads, geographically located around the country and listed below. This was a forum for reflection on progress and future planning, with excellent work and commitment evident around the country. Each regional lead has experience of using EPM in their own teaching and all are willing and able to share expertise and support local initiatives. We hope that this network will also enable us to keep track of courses running around the UK and are hugely grateful for the hard work and enthusiasm of this group.

Please do get in touch to know more about EPM, either through your nearest regional link below or by contacting the team through Claire Driver, Training & Membership Adminstrator: cdriver@fpm.ac.uk.

If you are already using EPM in your teaching, please keep an eye out for our upcoming advertisement for additional regional leads.

Regional Leads:
Dr Alan Fayaz – London
Dr Karen Gilmore – Plymouth
Dr Venkat Hariharan – Milton Keynes
Dr Helen Makins – Bristol
Dr Sailesh Mishra – Newcastle
Dr Jonathan Rajan – Manchester
Dr William Rea – Birmingham
Dr Naomi Scott – Aberdeen
Dr Hoo Kee Tsang - Liverpool



Essential Pain Management in Pakistan; A New Beginning

Dr Usman Bashir

Consultant in Anaesthesia and Pain Management, Lahore, Pakistan

The educational programme Essential Pain Management (EPM) was introduced to Pakistan in March 2018 by Dr Usman Bashir at Lahore General Hospital, a busy tertiary care public sector facility. The project was launched with mentor and administrative support from the EPM Advisory Group of the Faculty of Pain Medicine. A key factor in the success of Pakistan's first EPM workshop is attributed to the support provided by local leadership, notably Prof Jodat Saleem who provided administrative and funding related support to organisational matters and the President of the Society for Treatment and Study of Pain (STSP), Lahore, who formally inaugurated the first workshop and pledged to facilitate EPM and its related activities at a national level. The workshop was run alongside the annual conference of the Pakistan Society of Anaesthesiologists (PSA) where Dr Usman Bashir was an invited guest speaker talking about Global inequalities in Pain Management and their solutions.

Building on this initial success, a second set of EPM workshops was conducted in October 2018 at the country's leading cancer hospital, Shaukat Khanum Memorial Hospital, Lahore. Again, local leadership and engagement played a key role in success of this course. This time, new instructors from widespread geographical areas of the country attended to learn to teach EPM and help spread the cause further. These local instructors have gone on to run EPM courses in their hospitals subsequently. The secretary general of the STSP who attended the October course to become an EPM instructor, announced that EPM would be included under STSP projects. So far, all EPM workshops have been self-funded and well supported in the local institutions.

The enthusiastic uptake of EPM by local healthcare professionals and medical staff has led to almost 60 participants attending each day of the courses. Another highlight of introducing EPM in Pakistan has been the discussion generated amongst the instructors relating to local pain management barriers and their solutions. Topics of discussion include: health care worker related barriers, medication barriers, system and organisational barriers, and patient-related and cultural barriers. This has led to the identification of SMART (specific, measurable, attainable, relevant, time bound) objectives that are then selected by trainers to address at their own place of work. Specific examples of these

First EPM Introduction March 2018

objectives or quality improvement projects include: the development of an Acute Pain Team, the introduction of anaesthesia led post-surgical acute pain management plans, the development of a post anaesthesia care unit with integrated pain management protocols, the inclusion of pain scores to new uniform vital signs charts supported by the STSP, and the incorporation of EPM to undergraduate medical and nursing curricula and induction days for medical staff. At the time of writing some of these targets have already been achieved while work is on-going on others. All the barriers and targets identified by local instructors have been formally recorded so that in future we can monitor the impact on improvement in pain education and service delivery.

Overall, EPM and its related activity has started a positive momentum in Pakistan to improve awareness and treatment of inpatient pain management. EPM has acted as a structured educational tool for participants and trainers, but it has also initiated number of targeted quality improvement activities through the identification of barriers and their solutions. This clearly reflects the involvement of eminent academics and leading consultants in anaesthesiology as local instructors, and demonstrates their pivotal role in the success of EPM in Pakistan.

Future planning and delivery at a national level will require continued collaboration with local societies such as the PSA, the STSP and the University of Health Sciences alongside liaison with the EPM teams at the FPM, the Australian and New Zealand College of Anaesthetists and the World Federation of Societies of Anaesthesiologists. Our main challenge is to develop a sustainable, nationwide action plan. A key step in this process will include the country-wide mapping of local service delivery and deficits, as well as local barriers and their solutions.

EPM Instructors March 2018

Training and Assessment Update

Dr Lorraine de Gray

FPMTAC Chair

The Training and Assessment Committee (TAC) had its first meeting for 2019 in January. The Credential and the new Anaesthetic Curriculum are a major focus of attention for the committee at present. We also continue to look at new ways to improve teaching and training. Various projects have been planned and will be ongoing in the following months.

The number of trainees taking up higher and advanced pain medicine posts remains at a steady but low number. The committee continues to listen very carefully to feedback from its trainees and I encourage all trainees to participate fully in the annual trainee survey. Dr Helen Laycock is the trainee representative on TAC.

The e-Portfolio platform and electronic log book is well under way and now incorporates specific sections for recording clinical activity and continued professional development pertaining to pain medicine. Dr Sheila Black leads on this project, working closely with the College Team responsible for ongoing maintenance and development of this important tool.

Hospital Review Forms are finally nearing completion and we anticipate that by the middle of 2019, trainees will be able to access this very valuable resource for all hospitals that provide training at higher and advanced pain levels. In a similar vein, by the end of the year, we aim to have a complete map of hospitals offering training in Paediatric pain medicine. The Paediatric pain working party document is nearly complete and will be available on the FPM website. The Committee recognises that access to paediatric training in pain medicine is currently limited to certain regions only. The map of paediatric pain medicine will help trainees, RAPM and LPMES source and access this training and we will work to ensure that neighbouring regions are accessible for trainees who do not have sufficient exposure to paediatric patients in their local training hospitals. Dr Paul Rolfe leads on this project.

Communication skills is another project that Dr Nick Campkin and I are working on.

Communication skills are essential for all doctors, but even more so for managing patients who have pain. We aim to look at simulation and a future study day as a way of promoting improvement in this area.

Dr Emma Baird is a welcome addition to TAC and has taken over from Dr Mark Rockett advising on issues relating to training in Acute/Inpatient pain medicine. The FPM and the Committee are indebted to Dr Rockett for his invaluable expertise and hard work over the past few years and I would like to take this opportunity to thank him on behalf of the rest of the Committee. Dr Baird will continue to support training in this area and will liaise with the Perioperative Medicine Board to ensure that training in pain medicine continues to feature as a very important aspect of perioperative care.

Dr Douglas Natusch represents the Court of Examiners for the FFPMRCA exam, and is also the Clinical Lead for e-Learning. In its 14th sitting, the exam continues to go from strength to strength.

Dr Victor Mendis leads on the Medical Training Initiative and Dr Hoo Kee Tsang provides an invaluable link with the Anaesthetic Training and Assessment Committee. Dr Peter Cole, has just taken over from Dr Mendis as Chair of the Regional Advisors in Pain Medicine and helps me with workforce planning.

Do continue to read the FPM website to keep up to date with the above projects.

The GMC Credentialing Process

The General Medical Council (GMC) defines credentialing as *"a process which provides formal accreditation of competences (which include knowledge, skills and performance) in a defined area of practice, at a level that provides confidence that the individual is fit to practise in that area".*

The concept behind Credentialing is to help protect patients and make sure that future healthcare developments are safe and effective. Doctors who meet the GMC standard for a specific credential in particular fields of practice will have this recorded in their entry on the List of Registered Medical Practitioners (the medical register).

The GMC has stated that it will only consider introduction of regulated credentials in particular fields of practice where:

1. patient protection cannot be met in other ways
2. a demonstrable service need exists
3. its development is practical and feasible
4. organisations that are authorities in the field can support it.

Application by the FPM for a Credential:

In February 2019, the Faculty put in a draft application and a draft Curriculum to the Curriculum Oversight Group (COG) of the GMC to be considered as a pilot for one of the first Credentials in the UK. The Faculty of Pain Medicine believes that there is a case for change in postgraduate training in Pain Medicine in the form of implementation of a Credential or formal recognition of training in Pain Medicine for the following reasons:

1. In the first instance, there is an expected shortfall in output of pain medicine specialists in the forthcoming decades. The FPM 2017 work force census showed that 61% of current Consultant Anaesthetists practising in the field of pain medicine are over the age of 46 years. This cannot be simply solved by increasing the number of anaesthetic trainees being put through a CCT programme as there is no guarantee that the percentage of these that will take up advanced training in pain medicine.
2. There is no doubt a variation in standards of care with regards to delivery of pain medicine, largely due to variations in commissioning and also due to the push for horizontal movement of consultants to fill service gaps in Anaesthesia.
3. There is a risk inherent in the practise of interventional pain procedures undertaken in the non-NHS setting by specialists who may not have had any formal training in pain medicine.

> **"Credentialing will also broaden the delivery of pain management training beyond existing medical boundries**

All of these can be addressed by the establishment of a pain credential that will clearly define the minimum standard of training to be achieved by a specialist who wishes to practice Pain Medicine in the UK. Credentialing will raise the profile of pain medicine as a sub-specialty, providing candidates with a recognised 'qualification' to enhance their portfolio and justify the period of training within CCT programmes to Training Programme Directors and employing NHS Trusts and Health Boards.

It may therefore attract more pre and post CCT holders in Anaesthesia to consider specialising in Pain Medicine. Credentialing will also broaden the delivery of pain management training beyond existing medical boundaries. A Credential may also allow pre or post CCT holders in closely allied specialities such as Palliative Care, Rheumatology, Rehabilitation medicine and Neurology, the opportunity to train in pain medicine at a pre-CCT or post-CCT stage in their career and then use these skills to enhance patient care in their own areas of practice or use them to better support the general pain management workforce.

The Faculty is currently awaiting a response from the GMC and we will keep you updated with developments over the next few months.

Regional Advisors in Pain Medicine - Updates

Dr Peter Cole

RAPM Chair

I would like to thank Dr Mendis for his work as RAPM Chair over the last two years, in particular improving pain training by helping to extend London's teaching days to all UK trainees/regions via "Go To Meeting" and by developing the Local Pain Medicine Educational Supervisors (LPMES) role to be more involved with FPM by organising two LPMES conferences.

We welcome three new Regional Advisors; Dr Jeremy Weinbren takes over from Dr Mendis as RAPM for North London, for Severn Dr Gaurav Chhabra takes over from from Dr Murli Krishna, and for the West Midlands, Dr Shyam Balasubramanian takes over from Dr William Rea. Thank you to the outgoing RAPMs for their contributions.

> **"Almost one third of the 630 consultants working in Pain Medicine in the UK are either Regional Advisors or LPMESs**

From the 2017 workforce census and from Faculty reports, almost one third of the 630 consultants working in Pain Medicine in the UK are either Regional Advisors (21) or LPMESs (193). The census also revealed that 72 of the 484 respondents had no links with the Faculty, this includes many in the role of LPMES. As a result of this, Faculty membership routes have now been expanded, I encourage those who have not yet registered to do so, application forms are available on the FPM membership webpage: www.fpm.ac.uk/faculty-of-pain-medicine/about-the-fpm/membership.

Through the network of the LPMESs, the Trainee rep, the RAs and the Training and Assessment Committee (TAC), the Faculty have developed a clear structure to provide support and training for anaesthetists interested in a career in pain medicine, however it is of concern that higher and advanced trainee numbers are down compared to last year. It is essential that all pain Consultants, LPMESs and RAs are aware of this so that we can reach out to and encourage trainees at the early stage of their careers. Especially important during their intermediate training.

The LPMES conferences received excellent feedback and the date for the third meeting is subject to securing sponsorship, but is provisionally agreed for autumn 2019.

The roles and responsibilities for Regional Advisors and Local Pain Medicine Educational Supervisors on the Faculty website provide a useful reference for those in post and for those considering either post in the future. Each role's term of service is 3 years, and this can be extended to a second term upon satisfactory completion of their first term, by the RAPM for LPMES and the Board of the Faculty for the RAPM. Faculty records for terms of office are incomplete for LPMES as these were historically managed locally by the RA. A recent survey of LPMES revealed that, of the 83 of 193 who responded, 18% had been in post for more than 2 terms. It is the aim of the Faculty to keep accurate records centrally so if you are an LPMES please email Claire Driver at contact@fpm.ac.uk with this information. The RAPM will be completing missing records. It may be that there are no suitable replacements for the LPMES role and that the post holder needs to continue, however if there is a colleague in their department who is keen to take this on then this should also be made possible.

Appraisal Forms to record activities undertaken by RAs and LPMESs are being developed which will benefit both the LPMES and RA as evidence for their annual appraisal and job plan but also useful for the Faculty to ensure appropriate level of engagement.

Spotlight on Leeds

Dr Sheila Black

Consultant in Pain Medicine, Leeds

With two recently appointed consultants making up the team of four clinicians in the pain management service in Leeds Teaching Hospitals NHS Trust, it seems an appropriate time to outline the excellent service we provide and the opportunities for training within our team.

Leeds patients are served by three physiotherapy based community pain services through which all GP referrals must go. They, in turn, refer to tertiary service for consideration of injections, complex medicines management, clinical psychology, tertiary physiotherapy, PMP and spinal cord stimulation. Enabled by regular educational input from the tertiary team, many patients are listed "direct to injection" for medial branch blocks and subsequent radiofrequency, and discharged back to the community for ongoing support.

We have developed an efficient MDT process which entails consultant assessment, information session with our dedicated clinical nurse specialists, clinical psychology assessment/therapy, physiotherapy, opioid reduction if required and discussion at monthly MDT. In our unit, we had an 87% trial-to-implant rate, so as a team we moved to implanting full system at first sitting, which optimised the patient experience and reduced waiting times, allowing us to implant over 150 patients in the last year.

We have a progressive approach to neuromodulation. We use kit from four companies to ensure optimal patient choice, tailored to their individual needs. Patients can receive a surgically placed paddle lead enabled by close liaison with spinal surgical colleagues. We are conducting a number of research studies in the field of neuromodulation, including therapies for treatment of non-surgical back pain, chronic pancreatitis, and peripheral vascular disease.

We have a dedicated research team who coordinate many studies, ranging from NIHR funded to industry sponsored and Investigator-initiated studies. We enjoy close collaboration with a number of medical specialties to facilitate recruitment. A new addition to the team is our post-doctoral research fellow, with expertise in data analysis, facilitating publication of our results.

Our well-established cancer pain service was set up by our recent colleague Dr Louise Lynch. Weekly clinics and palliative care MDT meetings enable identification of patients who could benefit from interventional input. In our weekly dedicated theatre session, we undertake advanced interventional procedures such as implanting Intrathecal drug delivery (ITDD) pumps, intrathecal neurolysis, sympathetic blocks (stellate, coeliac, ganglion impar). Close partnership with palliative services allows sharing of expertise, trialling new therapeutic approaches in hospices, and shared vision to excel as a level 4 centre for Highly Specialist Pain Management. Our professor in Palliative Medicine, Professor Mike Bennett, has led the development of a "Framework for provision of pain services for adults across the UK with cancer or life-limiting disease" for the Faculty of Pain Medicine (https://bit.ly/2FGryXg).

Our CNS team run nurse-led ITDD refill clinics. We run monthly MDT discussions, and will soon run our first ITDD study with input from medical, nursing staff and industry to ensure the highest standard of patient care.

Paediatric chronic pain clinics run weekly with full MDT assessment for each new patient, including chronic pain consultant, physiotherapy, psychology and occupational therapy. We have recently commenced a transition clinic for teenagers entering the adult pain service, which has been received extremely well.

Yorkshire and Humber School of Anaesthesia offers three regional training programmes: East (Hull) West (Leeds), South (Sheffield). Under the supervision of RAPM Dr Ganesan Baranidharan, Leeds offers two APT posts per year, with the 12 months split between Leeds and Bradford. We support intermediate and higher pain training with contribution from both acute and chronic pain services.

For 10 years, Leeds has hosted a pain intervention cadaver course teaching advanced techniques including lumbar/cervical/sacroiliac radiofrequency, spinal cord stimulation, intrathecal catheter implant and gasserian ganglion ablation. We enjoy excellent links with the University of Leeds within research into chronic pain conditions, and undergraduate teaching. In 2017-18, we integrated the EPM programme into the 4th year medical student curriculum.

e-PAIN Adapts

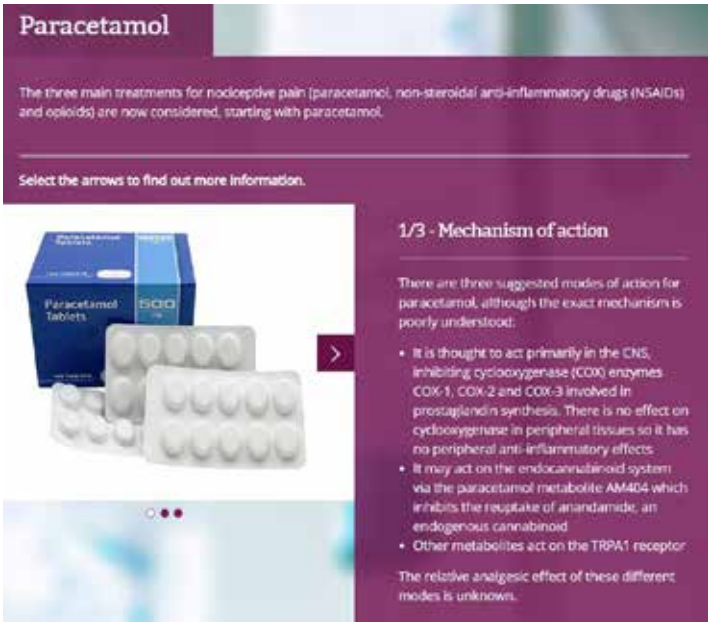
Dr Douglas Natusch and Dr Rhian Lewis

Clinical Leads, e-PAIN

Mention the word 'e-Learning' to anyone who works in the NHS and you will elicit a variety of responses, not always positive. This begs the question, why? Well, reading from a screen is not always as user-friendly in reality as from paper. NHS 'mandatory training', often in an e-Learning format, has occasionally been plagued with IT issues which has not always helped sell the concept.

As we know, the world changed after Mr S.Jobs stood up and waved an iPhone at an audience in California, more than a decade ago. Add to this the might of Social Media and at a stroke, the electronic landscape changed beyond all recognition. Suddenly the internet became mobile and accessible in your pocket.

So, why invest in e-Learning?
e-Learning provides an efficient and inexpensive way of publishing to reach a large audience and is amenable to updating easily. While we may think of e-Learning as formal 'sessions' with a timed start and end, followed by some self-assessment MCQs, in reality there is a huge amount of free open access material on the internet in all sorts of formats - written, audio, video, often nowadays tagged and called #FOAMed (Free Open Access Medical Education), all of which is e-Learning.



So, what about e-PAIN? Is it still relevant?
Yes! e-PAIN is a unique collaboration between the Faculty of Pain Medicine, the British Pain Society and e-Learning for Healthcare and is about distilling best multidisciplinary pain management practice in the UK. e-PAIN is guided by the IASP's Curriculum for Professional Education in Pain

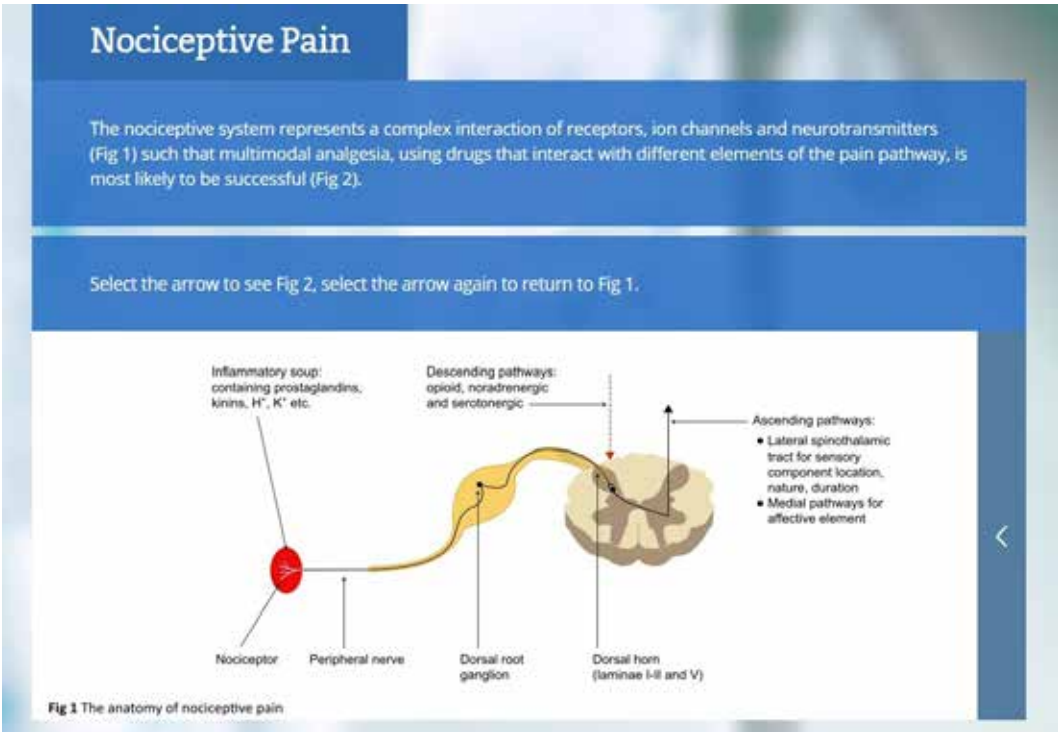


Fig 1 The anatomy of nociceptive pain

and is multidisciplinary in authorship, content and audience. We aim to get it out to as many people working in the NHS and studying Health Sciences as possible in order to spread good clinical practice in pain management. We achieve this by being open to anyone with an NHS email account or an OpenAthens Account.

What about the content and format of e-PAIN?
e-PAIN is never going to replace the 'Textbook of Pain', but many people don't need or want a textbook. e-PAIN was designed to meet a specific need and is going to migrate over time to a mobile, touch-controlled format called 'Adapt', pictured and we will be refreshing and updating the modules over the next couple of years. To those of you with trusty laptops or PCs, don't worry, Adapt is compatible! There will still be the linked self-assessment and module certificates for CPD, but we hope more people will dip in and out of the sessions as often as they want on their phones as well and use them as a mobile learning and teaching tool.

And #FOAMed? Where does this fit in?
We plan to embrace relevant #FOAMed. e-PAIN has an electronic library set up with different sections : 'Read' for articles; 'Listen' for Podcasts and 'Watch' for videos. By unhooking these from the core sessions we can collect useful links, put them through peer review and manage them in the library under the watchful eye of Dr Nancy Cox who we have recruited to be Librarian of what we hope will be a useful place to go to find articles, podcasts and videos to complement the core e-Learning sessions.

Interested?
Take a look: **www.e-pain.org.uk**

Trainee Update

Dr Helen Laycock

Faculty Trainee Representative

My last Transmitter article aimed to highlight all the possible ways trainees can connect and feedback about their training to the Faculty. One of these opportunities is the FPM national trainee survey, conducted annually. This survey ensures all answers are fully anonymised and the trainee representative collates and presents the results to the Training and Assessment Committee so that individual trainees cannot be identified from their responses. I would like to use this piece to summarise some of the themes you fed back about your training in 2018 and highlight how both we as trainees and the Faculty can address them.

There were 23 responses. Seventeen were from Advanced Pain Trainees and just under 20% were working less than full time. Responses came from trainees based in centres from across the UK.

It is important to start with things that are going well, and overall the survey highlighted most trainees receive very positive training experiences. Advanced Pain Training across the UK appears to be meeting its requirements in ensuring trainees complete their year feeling confident that they can work as consultants in Pain Medicine. Overall, responses highlighted that trainees felt they had appropriate supervision in both clinics and procedure lists during their APT year. Additionally, most trainees were able to access London or Northern regional teaching sessions either directly or by remote access. This year the survey asked about what prompted us to consider pain medicine as a career and there were common themes in the responses that centred around having positive experiences within their training. These encompassed the pain multidisciplinary team, the welcoming nature of pain departments and also specific role models they had worked with who had been inspirational. This is useful to remember, as we progress to the next stages of our professional careers. Being an inspirational clinician can shape peoples career choices and it is our job in the future to inspire our new colleagues to choose pain medicine.

Although most responses were positive, there were some areas that require improvement. Firstly, some APT posts have limited access to specialist services such as spinal cord stimulation, paediatrics and other multidisciplinary clinics. This year there were additional questions focused on paediatric pain training. Responses highlighted that training in both acute and chronic paediatric pain is limited, and some trainees do not feel confident in managing paediatric pain in either setting following their APT. There have been working groups looking at improving access to paediatric pain training within the Faculty and this work is ongoing. Some trainees have to visit other hospitals or centres to gain experience and this should be encouraged. How to access specialist pain services which are part of the curriculum should be discussed at our first educational meeting at the start of APT. This meeting should include where and how these opportunities fit your personal APT programme and you should be signposted to how to achieve these competencies. This year the trainee survey will explore this issue in more depth, but if access to these training opportunities has not been discussed, we as trainees, need to flag this up initially locally, then to our Regional Advisors, and finally to the Faculty. Additionally, there still are some trainees who are required to provide daytime anaesthetic services when they should be in pain training. This is despite clear guidance from the Faculty. Should this occur, it is important to flag it up locally and then, if it continues, to your Regional Advisor. Since the new junior doctors' contract, exception reporting is another way of highlighting training opportunities that are lost, and is useful to use. Finally, the national trainee day at the College each year allows trainees to meet the Training and Assessment Committee face to face and issues with training can also be highlighted in person.

So, whilst things look good for training in pain medicine, the survey has highlighted areas which require further attention including whether induction meetings enable the APT to be planned so that specialist training can be accessed and also some regions where access to paediatric pain training is difficult. Next year's survey will adapt to look into some of these issues in more detail, and please do let me know if there are other areas you feel should be considered.

Trainee Perspective on OOPR

Dr David Magee

Research Fellow and M.D.(Res) student

As a trainee undergoing an OOPR (Out Of Programme Research), I have been asked to share my experience in the hope that it may be useful to those considering the possibility of doing the same. Having recently completed Advanced Pain Training, I am now undertaking an M.D.(Res) degree at the Institute of Cancer Research, investigating the link between cancer metabolism and pain. My experience so far has been overwhelming positive; however, I have faced a number of challenges that are by no means unique to my project and will resonate with others undertaking an OOPR.

Working in a laboratory setting with colleagues from a basic science background has opened my eyes to the expertise and challenges faced by those working within this field. This appreciation and education, is undoubtedly providing me with a greater understanding of basic science, research methodology and research integrity. I envisage, therefore, that this opportunity will not only enhance my curriculum vitae but also make me a more rounded clinician when practicing as a pain specialist.

> **"The positive interest and respect from my clinical colleagues has been overwhelming**

Many trainees have suggested to me that negotiations with either training programme directors (TPD) or deaneries, regarding time out of training, can be difficult. I have also heard of some concerns that time out of training can negatively impact future career prospects. This is certainly not my experience. The process to apply for the OOPR was supported by my supervisors and TPD. Additionally, the positive interest and respect from my clinical colleagues has been overwhelming, which may well reflect the greater emphasis placed on research within the specialty in general.

Having said this, undertaking an OOPR can be challenging in a variety of ways. Firstly, it requires one to undertake a less structured path than trainees are perhaps used to. This, in addition to the change of pace is potentially unnerving at times. I am yet (beyond developing titanium-level resilience) to find a positive spin for undertaking weeks of preparation for a single experiment only to have it fall apart at the last second due to equipment failure. Couple this with seeing a number of your peers achieve their Certificate of Completion of Training (CCT) and begin the next stages of their careers can result in some frustrating moments.

What would I suggest to someone considering the prospect of an OOPR? A decision to take time out of training must be considered carefully. Unlike some of our surgical and medical colleagues, within our specialty there remains no requirement or pressure to take time out for research. Personal circumstances are a significant consideration. There are undoubtedly certain cost implications to consider, whether this be related to salary/banding or simply the decision to delay one's CCT.

If your circumstances are right, then without question, meticulous planning and clearly outlining the benefits you envisage from taking time out of programme are the key to successful applications. Similarly, early submissions for required approvals or grants can really facilitate hitting the ground running when you begin and will reduce stress. Additionally, I would advise getting to know your supervisors well before you begin. Having approachable, enthusiastic and knowledgeable supervisors has been instrumental for me in progressing and enjoying the work that I am doing.

Ultimately taking time out of training for research has the potential to be both career and life enhancing. It offers a fantastic opportunity to be contributing to the development of the specialty of pain medicine. As with most things, early preparation and organisation, facilitate success and reduce stress!

Events Update

Dr Shyam Balasubramanian

Educational Meetings Advisor

Dr Manohar Sharma

Deputy Educational Meetings Advisor

The Faculty of Pain Medicine is committed to continuous improvement of professional development and organises interdisciplinary meetings and annual meetings to benefit doctors and nurses from all specialties interested in pain medicine.

The 11th Annual Meeting of the Faculty was held in November 2018 with the theme of "Topical issues in Pain Medicine". Following earlier years' feedback, we included topics on: medico-legal implications of deviation from practice, learning from patient's narrative, 'game theory' to improve clinical outcomes, opioids misuse management in multidisciplinary clinics, pain in cancer survivors, and gaps in evidence in pain medicine. Baroness Greenfield delivered a fantastic lecture on 'pain and consciousness'. There were plenty of discussions following each presentation, and most of them carried significant implications for day to day clinical practice.

Dr Barry Miller, Dean of the Faculty, updated attendees on activities of our Faculty and the measures actively taken to raise the profile of our discipline.

Following the grand success from the past years, the two study days in February were dedicated exclusively to acute pain. In February 2019, we ran the event 'Hot Topics and Case Studies in Acute Pain' with the support from Dr Jane Quinlan.

The objective was to move away from lengthy didactic talks to a blend of talks and case studies encouraging and prompting interaction with attending delegates on clinically relevant points. Some of the topics included: Managing pain in a child for tonsillectomy, 'Is discharge analgesia fuelling the opioid crisis?', Acute post thoracotomy pain, Epidural vs paravertebral analgesia, Fascial plane blocks: Science and fallacy, Inhalational and intranasal analgesia, and Nerve injury following regional anaesthesia: medicolegal perspectives. The morning sessions included a series of short lectures updating on acute pain in complex scenarios. Afternoon sessions included case studies and interactive discussions with enthusiastic contributions from both the speakers and the delegates.

A musculoskeletal component of pain is common in patients with chronic pain and successful management depends on reaching the correct diagnosis, utilising proper examination techniques and skills. To date, we have received several requests to organise an event on musculoskeletal examination skills in pain medicine. We aim to be responsive to the needs of our members and will be conducting a study day on 'Musculoskeletal System Examination for Diagnosing Pain Problems' on Wednesday 12th June 2019. Dr Meera Tewani has been instrumental in planning this study day. The programme will comprise of basic orientation lectures, guidance and demonstration on physical examination skills, and interactive workshops on how to perform musculoskeletal examinations. Details of the programme and the link for the booking are available at: https://www.fpm.ac.uk/faculty-of-pain-medicine/events/recent-advances.

Our educational meetings are a great opportunity to meet and update knowledge across the horizon of chronic pain and to consider what might be around the corner and of interest to all. If you have any ideas or an interest in contributing to these events, then please contact either Dr Shyam Balasubramanian (doctorshyam@hotmail.com) or Dr Manohar Sharma (manoharpain@yahoo.co.uk).

FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

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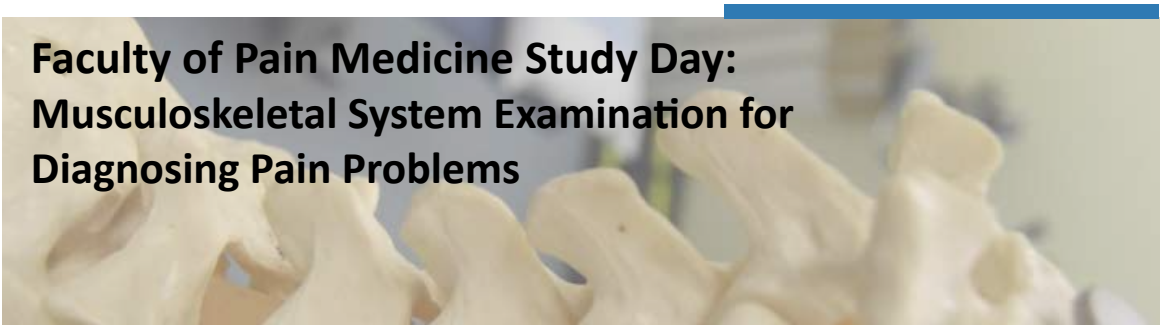
Faculty of Pain Medicine Study Day: Musculoskeletal System Examination for Diagnosing Pain Problems



Programme

8.50 - 9.20 Registration

9.20 - 9.30 **Welcome and Introduction**
Dr M Sharma, Deputy Educational Meetings Advisor, FPM

9.30 - 9.50 **The role of clinical examination**
Dr M Tewani, Pain Medicine Consultant, Heart of England NHS Trust

10.00 - 12.50 **Three workshops of 50 minutes**

10.50 - 11.10 Refreshments

Examination of the lumbar spine and pelvis
Dr J Tanner, Musculoskeletal Physician and Medical Osteopath, West Sussex

Examination of the hips and knees
Mr N Kharwadkar, Consultant Orthopaedic & Trauma Surgeon, Birmingham

Examination of the ankles and feet
Dr V Ketkar, Musculoskeletal and Sports Physician, Birmingham
Dr A Khan, Rheumatologist, Birmingham

12.50 - 13.40 Lunch

13.40 - 16.30 **Three workshops of 50 minutes**

Examination of the cervical and thoracic spine
Dr D Ravindran, Consultant in Anaesthesia and Pain Medicine, Reading

Examination of the wrists and hands
Dr A Khan (wrists and hands)
Dr V Ketkar (elbows)

Examination of the shoulder joint
Dr K Srinivas, Orthopaedic Consultant, Midlands
Dr M Tewani

16.30 - 17.00 **Quiz, discussion, feedback and close**

Date and Location

Wednesday 12th June 2019
8.50 - 17.00
RCoA, 35 Red Lion Square, London
WC1R 4SG

5 CPD points

This day consists of basic orientation lectures, guidance and demonstration on physical examination skills, interactive workshops on how to perform musculoskeletal examination with a quiz and discussion to round the day off.

Fees and Registrations

Consultants/SAS doctors: £175
Trainees/Nurses: £140

Register online:
https://www.rcoa.ac.uk/faculty-of-pain-medicine/news-and-events

Programme organised by Dr Meera Tewani, Dr Shyam Balasubramanian and Dr Manohar Sharma.

Please note that the programme and timings are subject to change.

FFPMRCA Examination Update

Dr Nick Plunkett
Chair, FFPMRCA Examinations

Since our last report in the winter Transmitter 2018, the fourteenth sitting of the FFPMRCA MCQ examination has now occurred.

The MCQ took place on 30 January 2019. 15 candidates presented for this sitting. The Anghoff Group met on 6th February and discussed individual Anghoff scores, and scrutinised questions. Following discussion, it was decided to remove some questions from the total (19 out of 400 possible marks), as the Group judged there to be error or ambiguity in the question content, before the pass mark was calculated. No candidates were disadvantaged in this process. The pass mark was agreed by summating the Anghoff-based individual scores using the same methodology as previously described, before applying the usual Standard Error of the Mean (SEM) of 1.64. The pass mark was found to be 69.29% (similar to the pass mark at the previous Autumn sitting of 70.03%), equal to a raw score of 264 or above out of 381.

10 out of 15 candidates achieved a pass, giving a pass rate of 67%, rather less than the pass rate from the previous Autumn sitting (82%). The average pass rate for all 14 sittings to date is 77% for the MCQ.

The next SOE sitting is 2nd April 2019 and I look forward to reporting this in the next Transmitter.

FFPMRCA Examination Calendar August 2019 - July 2020

	FFPMRCA MCQ		FFPMRCA SOE	
Applications and fees **not** accepted before	Mon 17 Jun 2019	Mon 28 Oct 2019	Mon 19 Aug 2019	Mon 3 Feb 2020
Closing date for FFPMRCA Exam applications	Thurs 1 Aug 2019	Thurs 12 Dec 2019	Thurs 26 Sep 2019	Thurs 5 Mar 2020
Examination Date	**Wed 28 Aug 2019**	**Wed 5 Feb 2020**	**Tues 22 Oct 2019**	**Tues 31 Mar 2020**
Examination Fees	£530	£530	£740	£740

FFPMRCA EXAM TUTORIAL

Monday 2nd September

For more information and online booking:
www.fpm.ac.uk/faculty-of-pain-medicine/events/examination-tutorials

British Pain Society Calendar of Events

52nd Annual Scientific Meeting
1st – 3rd May 2019
Hilton London Tower Bridge

The British Pain Society would like to invite all healthcare professionals to attend its 2019 Annual Scientific Meeting (ASM), which will be held at Hilton London Tower Bridge. The Plenary sessions will include:

Patrick Wall Lecture: Descending Pain Modulatory Systems: Mechanisms, Significance and Translation| Professor Bridget Lumb
Neuromodulation; a review of the evidence and its clinical applications| Professor Paul Eldridge
Barriers to the use of Cannabis and cannabinoids to treat pain | Dr Stephen Alexander
BPS Lecture: How can we better stratify patients with neuropathic pain and what are the implications for treatment? | Professor David Bennett

For bookings, please visit:
https://www.britishpainsociety.org/meeting-booking/2019-annual-scientific-meeting/

Philosophy and Ethics Special Interest Group 2019 Meeting
24th – 26th June 2019
Rydall Hall, Cumbria

This Philosophy and Ethics Special Interest Group 2019 Meeting will focus on "Exploring the Future of Pain Medicine: Caring for the Patient and the Clinician".

The meeting this year takes place in the beautiful surroundings of Rydal Hall amongst the lakes and fells of Cumbria.

Pain Management Programmes SIG Biennial Conference
11th & 12th September 2019
Bristol

The Pain Management Programmes SIG will be holding their Biennial National Conference in Bristol on 11th & 12th September 2019. The Conference will be focusing on the "biopsychosocial".

Topics will include Epidemiology of Chronic Pain, Promoting Social Connectivity, Pain Expression in Social and Cultural Contexts, Social Prescribing and The Challenge of Capturing Social Outcomes.

Further details for all our meetings can be found on our events listing page:
https://www.britishpainsociety.org/mediacentre/events/

Faculty Update

New Fellows by Examination and Assessment

Simon Raphael Braude
Richard Michael Gordon-Williams
Edward Clive Keevil
Damian Laba
Muhammad Abdussalam Laklouk
Yin Yee Ng
Sangram Gokulsingh Patil
Joel Stephen Perfitt
Maria Klara Stasiowska

New Affilate Fellows

Emma Baird
Christian Egeler
Duncan Hamilton
Carl Hillerman
Joellene Mitchell
Jenny Parsons
Piyush Singh
Mohan Vellalapalayam Sathyamoorthy

2019 Faculty Calendar

MEETING: FPM Professional Standards Committee	16 May 2019
MEETING: Board of the FPM	24 May 2019
EVENT: Musculoskeletal System Examination Study Day	12 June 2019
MEETING: FPM Training and Assessment Committee	5 July 2019
EVENT: FFPMRCA Exam Tutorial	2 September 2019
MEETING: FPM Professional Standards Committee	12 September 2019
MEETING: Board of the FPM	13 September 2019
MEETING: FPM Training and Assessment Committee	11 October 2019
EVENT: 12th Annual Meeting: Topical Issues in Pain	29 November 2019
MEETING: FPM Professional Standards Committee	5 December 2019
MEETING: Board of the FPM	6 December 2019
MEETING: FPM Training and Assessment Committee	24th January 2020

Please note that all dates may be subject to change

The Faculty of Pain Medicine
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