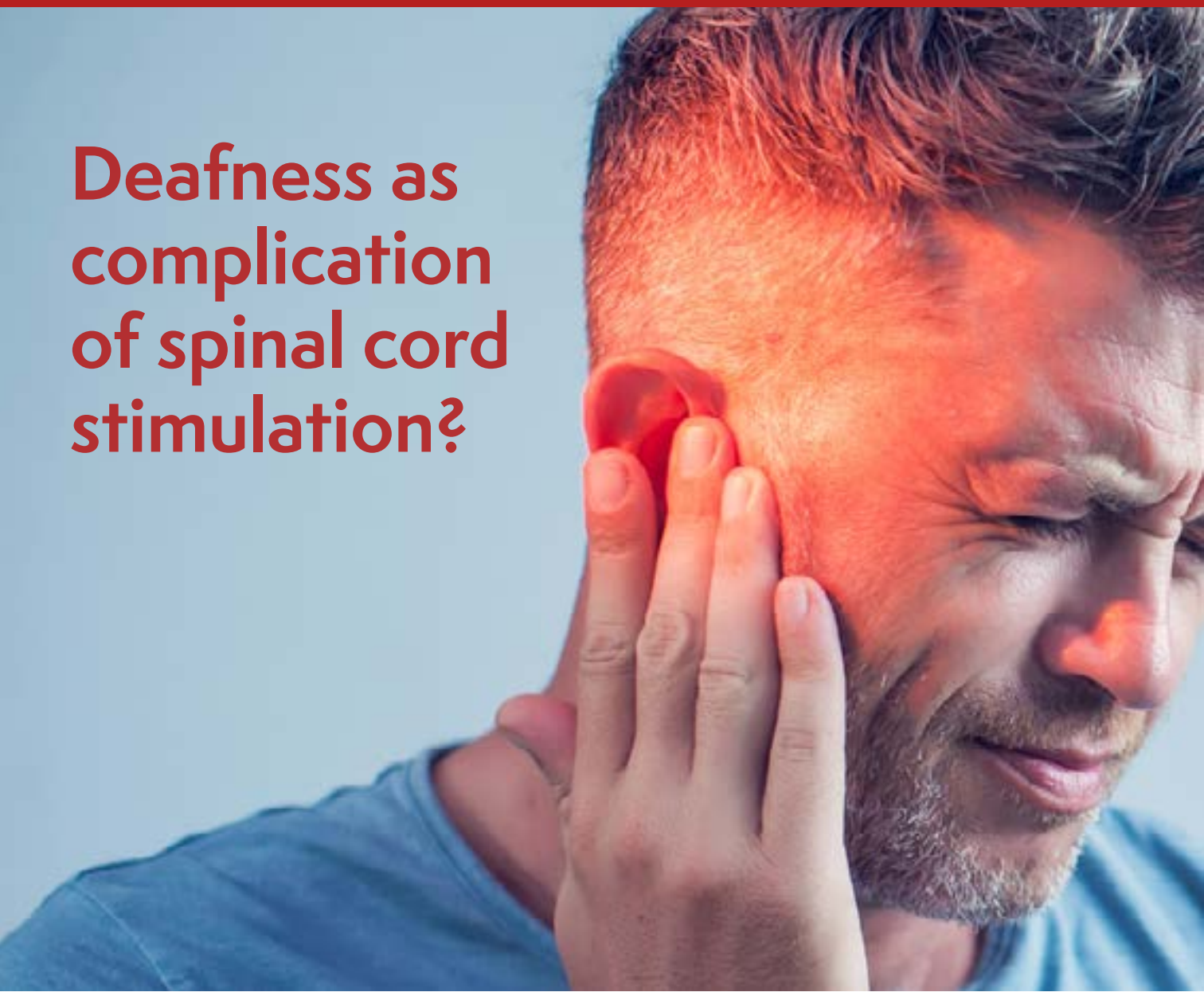
FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

AUTUMN 2023

TRANSMITTER

THE MEMBERSHIP MAGAZINE FOR THE FACULTY OF PAIN MEDICINE ISSUE 28



Deafness as complication of spinal cord stimulation?

FPM CENSUS 2022

OPIOIDS AND SURGERY ONLINE OPEN COURSE

FPM CREDENTIALING

FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

UPCOMING EVENTS

FPM 15th Annual Meeting

Tuesday 28 November 2023

Communication Skills Course

Thursday 18 January 2024

Acute/In-hospital Pain Study Days

28—29 February 2024

SAVE THE DATES!

@FacultyPainMed

www.fpm.ac.uk/events

Faculty of Pain Medicine Annual Meeting

Tuesday 28 November 2023

Location: Hybrid (London & online)

BOOKINGS NOW OPEN!

09:30	**Welcome and Introduction**	Dr Dev Srivastava
09:40	Influence of Adverse childhood experiences in Pain Management	Dr Deepak Ravindran
10:10	Antidepressants lack evidence for treating chronic pain: Cochrane review	Prof Tamar Pincus
10:40	What can Rheumatologists and pain physicians learn from each other?	Dr David Walsh
11:10	**Break**	
11:30	Faculty Developments	Dr Lorraine de Gray, FPM Dean
11:45	National Consultant Information Programme	Dr Mike Hutton
12:15	*Keynote:* The Genesis of Pain	Dr Michael Hudspith
12:55	Trainee Poster Competition Winner Presentation	
13:10	Awards Presentations	Dr Lorraine de Gray, FPM Dean
13:20	**Lunch break**	
14:10	Setting up an Intrathecal Opioid pump service in today's NHS	Dr Somnath Bagchi
14:40	How to obtain a research grant in chronic pain	Prof Martin Underwood
15:10	**Break**	
15:30	The FPM / RCoA UK Pain Medicine Workforce census - update	Dr Sonia Pierce
16:00	Gap Analysis of UK pain services and ACSA standards - update & results	Dr Dev Srivastava
16:30	**Summary & Closure**	Dr Dev Srivastava

Booking info:
www.fpm.ac.uk/events/fpm-annual-meeting-2023

Hybrid event

5 CPD points

Please note that programme and timings may be subject to change.

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This and back issues available online at **www.fpm.ac.uk**

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Dr Manohar Sharma
Clinical Editor

WELCOME

I welcome you to this autumn edition of the Faculty of Pain Medicine's *Transmitter*. It has been challenging to manage significant pressure on the National Health Service due to backlog and impact of industrial action involving various healthcare professional groups. This is not showing any imminent signs of resolution and our service pressures may continue to grow.

Credentialing in Pain Medicine has started to gather pace as GMC has approved the curriculum. This is excellent news for the development of our specialty and will help provision of pain management services. FPM is planning to provide clarity for members currently working in pain medicine of the forthcoming GMC credentialing process, especially on the issue of retrospective credentialing.

The Gap Analysis survey submission by our members is being analysed by PSC. With credentials in Pain Medicine, a gap analysis survey output will help in mapping the current Pain Medicine practice to the *Core Standards.* Anaesthesia Clinical Services Accreditation Standards (ACSA) currently has five Domains, with Domain 5 being optional and chronic pain can potentially fit in to this domain. The Gap Analysis will help in framing the key performance indicators for the ACSA standards for Pain Medicine. This will be a very important step towards benchmarking quality pain services with required high standards.

FPM PSC will be looking for new members to join — please consider applying for these positions to support FPM.

I would like to bring to your attention the FPM Census 2022 report, presented by Dr Sonia Pierce in this edition. It highlights our workforce data, pointing out some of the challenges in pain services across the UK.

Transmitter and the Faculty's webpage are an excellent opportunity to share any best practices or clinical experience which may be of relevance to peers. It should be in the form of a short write-up on innovative work done within your service, or you may have an unusual clinical experience that may help FPM members.

I also invite you all to attend the FPM Annual Meeting on 28 November 2023. This is the Faculty's first hybrid event, so if you are unable to travel to London you can join from anywhere in the world. The meeting promises to be stimulating, with a unique agenda and a diverse line-up of speakers. I am sure it will also be a great opportunity to network and learn from each other. This way FPM and Pain Medicine in the UK will continue to evolve, grow and strengthen to successfully face and live up to new challenges.

Manohar Sharma

Dr Lorraine de Gray
FPM Dean

MESSAGE FROM THE DEAN

It gives me immense pleasure to be able to write that in August 2023, the General Medical Council (GMC) approved the Curriculum for the Credential in Specialist Pain Medicine. This is a significant milestone for our Fellows and Members.

In 2015, the GMC introduced the concept of credentialing as a novel way of recognising a doctor's expertise in a field of practice. In 2017, the FPM applied to the GMC and was approved as an 'Early Adopter', embarking on a long pathway, working with the GMC as one of the five Early Adopters for credentialing. Together with Rural and Remote Medicine and Mechanical Thrombectomy, Pain Medicine has now reached this milestone. For the first time ever, doctors who are trained in specialist Pain Medicine, will be recognised as such on the Specialist GMC Register of Medical Practitioners.

Opportunities

To date, specialist training in Pain Medicine has largely only been open as part of the CCT training in Anaesthesia or post CCT for a small number of consultants who wish to pursue training. Credentialing will be integrated into the CCT curriculum for Anaesthesia but will also open the route of training to other specialities, general practitioners and to Specialty Grade Doctors. The curriculum has been developed taking into account the different specialty backgrounds that doctors may come from, providing detailed information for both trainers and trainees alike.

We are hoping that the credential will provide a much-needed increase in our current work force — most regions in the UK have less than 0.5 of a pain specialist per 100,000 population.

Although credentialing is not mandatory, we hope that doctors who wish to work in the field of Pain Medicine will complete training and aspire to hold this recognition of training. Credentialing will increase public safety as both employers and the public will be able to ascertain whether their pain specialist has trained to the highest standards possible.

Framework

In April 2023, the GMC published *Delivering GMC Credentials for doctors – A framework for delivery of the early adopters,* setting out how credentials will be rolled out. Statutory Education Bodies (SEBs) are responsible for governance and delivery, while the Credential Development Bodies (in our case the FPM) will maintain curricula, provide guidance, and support quality assurance processes.

We are currently working with the postgraduate Dean for Anaesthesia Dr Andy Whallett to implement the credential in practice. There will be guidance issued for retrospective credential awards and advice regarding training going forward. Please do keep an eye out for the FPM website which will be updated as more information arises.

Milestone

Credentialing for the Pain Medicine Specialist is an integral part of the FPM *Four Nation Strategy for Pain Management*. Achieving this significant milestone has taken five years of hard work and perseverance. It would not have been possible without input from Board Members, our Training & Assessment Committee and our secretariat. I am indebted to them all for their support and hard work.

Board Election

It gives me great pleasure to welcome Dr Helen Makins to the Board of the Faculty of Pain Medicine. Dr Makins will commence her six-year term in March 2024.

"Success is no accident. It is hard work, perseverance, learning, studying, sacrifice and most of all, love of what you are doing or learning to do." — Walter Elliott

NEW BOARD MEMBER

Dr Helen Makins

Cheltenham Hospital, Cheltenham

"I would like to say a huge thank you to all those who voted and particularly to those who put their confidence in me at the recent FPM Board election. It is a pleasure and a privilege to represent colleagues in this way and I am very excited to be part of the team. Pain Medicine is evolving as a specialty, which brings many opportunities for us all, from education to the development of the services and systems in which we work. I look forward to playing an active role in shaping current and new initiatives to effectively support Faculty members."

FACULTY UPDATE

New Fellows by Examination and Assessment

Richard Berwick
Ahmed Foly
Carla Hakim
Mohammed Khilji
Greta Mattocks
Dermot McGuckin
Arjun Amer Nesaratnam
Vatsala Padmanabhan
Harriet Scott
Sara Siew
Bjorn Birk

New Affiliate Fellows

Ram Dhotarkar

New Members

Muhammad Tahseen Talib
Ramkumar Kalaiyarasan
Usama Ahmed

DEAFNESS AS COMPLICATION OF SPINAL CORD STIMULATION?

The protracted process of consent for Spinal Cord Stimulation (SCS) never included deafness, so I was surprised when one of my patients suddenly developed sensorineural deafness following a spinal cord stimulator. How did this happen?

Dr Mohammad Riziq
Fellow in Pain Medicine
Leeds

Dr John Titterington
Consultant in Pain Medicine
Leeds

A working young lady, a dog groomer, was extensively investigated and diagnosed with meralgia paraesthetica by a plastic surgeon. Unfortunately, despite two decompressions surgeries her pain remained unchanged. She was referred and assessed for spinal cord stimulation. Not an entirely straightforward case: a previous laparoscopy for pelvic pain; 60+ previous A&E attendances raised a flag — she was often injured in her work and was a free-runner; there was an episode of sexual abuse aged 12 and some support by an early intervention in psychosis team. The multidisciplinary team felt that the abuse was historic, she was now stable and had a good support network, overall she was suitable for an implant.

Complications

The case went fine technically; first attempt, no cerebrospinal fluid (CSF) leaking out of the Tuohy needle. Strangely shortly after the procedure she started with positional headache, photophobia, neck stiffness and nausea/vomiting. She was admitted, a lumbar puncture (LP) and bloods excluded meningitis. Post dural puncture headache (PDPH) was diagnosed. Unfortunately, severe positional headache did not respond to repeat occipital nerve block and she had an epidural blood patch with seemingly immediate relief. Sorted? Annoyingly not... she was re-admitted that night. Now, in addition she also had worrying balance problems and numbness in the right great toe. She was admitted under neurology, bloods and CT head were normal. MRI head/spine did not show any signs of low pressure or any other abnormality. Whilst under observation on the ward, she developed tinnitus which was followed by profound sudden onset 50 dB sensorineural hearing loss on the left (see Figure 1). This was put down to repeated spinal intervention — SCS implant, epidural blood patch and a diagnostic LP.

How can hearing loss be caused by spinal interventions? It's the same mechanism as the other described cranial nerve palsies after dural puncture and probable low CSF pressure. Intracranial hypotension causes stretch of the intracranial nerves and certain nerve palsies. Eye motor palsies due to the oculomotor, trochlear and abducens palsies. Facial droop due to facial nerve stretch and hearing problems are due to vestibulocochlear nerve stretch[1].

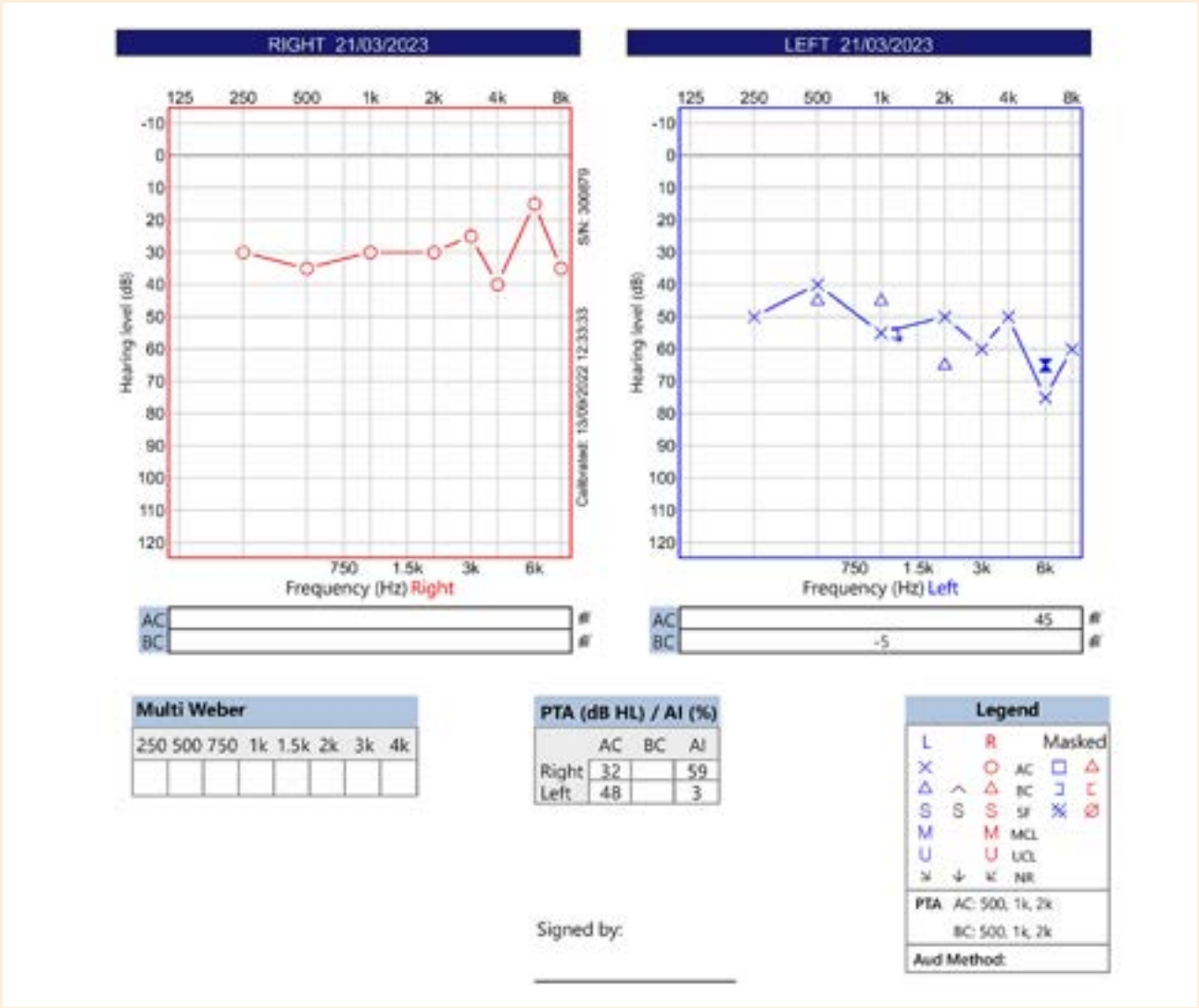

Figure 1: *Patient hearing test for both ears.*

Sensorineural hearing loss post-lumbar puncture

Looking over the literature, we found a huge review revealing 21 cases of sensorineural hearing loss post-lumbar puncture[2]. The age range was 25–66 years. Mostly in females (15/21) and unilateral (12/21). 57% reported concurrent headache. No patients had hearing loss alone, other symptoms included tinnitus (52%), vertigo (33%) and vomiting (19%). It was recognized quickly, usually on the day of the procedure, the latest was four days post-procedure. Interestingly eight patients were treated with an epidural blood patch — five of these immediately improved. Overall, in any event most cases slowly spontaneously recovered with only five of the 21 cases reporting no long-term recovery.

Our case was slightly odd. Firstly, the procedure was easy and no CSF leak was noted at lead placement. Interestingly CSF is sometimes not aspirated or free flowing after dural puncture. A study of post dural puncture headache including 745 percutaneous lead placements resulted in six cases of PDPH. In two of these cases, there was no documented intra-operative thecal puncture and it was only diagnosed subsequently[3]. The authors feel that sometimes just the tip of the Tuohy needle may puncture the dural sac allowing epidural placement of the lead but as the normal CSF pressure

Subtle hearing problems and tinnitus are surprisingly common after spinal interventions but often the accompanying headache is more profound and is the patient's main complaint.

is 5-10mmHG, it may not be enough for CSF to drip from the Tuohy needle in prone position against gravity.

Secondly there was no intracranial hypotension demonstrated on CT or MRI scan. Our usual model for the cause of headache after dural puncture is well known, intracranial hypotension caused by CSF leak, accentuated by the upright position causes sagging of intracranial structures, meningeal stretch and headache. However, not all patients with PDPH have low CSF pressure. Further pathophysiologic mechanisms have been proposed including CSF hypotension which results in compensatory meningeal venodilation, with headache caused by acute venous distention.

So despite an MRI not demonstrating low CSF pressure, the patient may have had dural puncture and post dural puncture headache and associated other neurological consequences. However the hearing loss ended up occurring almost 30 days following the initial SCS implant and 20 days after the last lumbar puncture. Could it be that it was the ups and downs in pressure by the various interventions and resultant sheer forces that caused this unusually late presentation, or could the patient merely have developed co-incidental sudden sensorineural hearing loss (SSNHL).

Causes of sensorineural hearing loss

SSNHL is mostly idiopathic. It is relatively common in otologic and audiologic practices with an incidence of 5-20 per 100,000[4]. Nearly all cases (98%) are unilateral. Accompanying symptoms include tinnitus (41% to 90%) and dizziness (29% to 56%). Many patients report first noting their hearing loss on awakening and indeed this is what happened in our case.

Overall it is unclear whether the hearing loss was caused by the repeat spinal interventions or was spontaneous. There is a history of abuse, alcoholism and life stress which are risk factors for functional problems. It could be that this patient suffered a flare of functional neurological disorder (this was the neurological diagnosis) resulting in headaches and neurology rather than PDPH and then spontaneous SSNHL. The SCS was actually working really well for her leg pain! But unsurprisingly after all these events sparked by the implant, she wanted it removed. Her leg pain is currently an ongoing issue.

This complication, whether I caused it or not, sparked my interest and I found the subsequent reading around the subject enlightening. Subtle hearing problems and tinnitus are surprisingly common after spinal interventions but often the accompanying headache is more profound and is the patient's main complaint. If there are hearing problems with or without headache soon after a dural puncture it may well be worth trying a blood patch[5].

NB: The patient has consented the publication of this case.

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1. Wildsmith JA, Lee LA, Neurological sequelae of spinal anaesthesia. BJA 1989; 63:505-508.
2. Sensorineural hearing loss following lumbar puncture, spinal anaesthesia or epidural anaesthesia: a case series and literature review. M Alwan and G Hurtado.
3. The Incidence and Management of Postdural Puncture Headache in Patients Undergoing Percutaneous Lead Placement for Spinal Cord Stimulation. Thomas T. Simopoulos, Sanjiv Sharma, Musa Aner, Jatinder S. Gill
4. Sudden Sensorineural Hearing Loss: A Review of Diagnosis, Treatment, and Prognosis. Maggie Kuhn, Selena E. Heman-Ackah, Jamil A. Shaikh, and Pamela C. Roehm
5. Blood patch for the treatment of post-dural puncture tinnitus. Wei Jia and Fiqry Fadhlillah

Dr Sonia Pierce
Consultant in Pain Medicine,
Betsi Cadwaladr University
Health Board

FPM CENSUS 2022

The 2022 Faculty of Pain Medicine Census provides a rich source of workforce data, highlighting some of the challenges in pain services across the UK.

We would like to thank you, the doctors working in Pain Medicine across the UK for taking precious time to complete the survey. We also appreciate the efforts of the Clinical Directors in Anaesthesia, who supported our work by disseminating the census survey to ensure we capture responses from the breadth of the workforce. We also particularly wish to thank the Faculties team including Susan Hall, Emmy Kato-Clarke and Claire Driver-Edwards who have contributed an enormous amount of time and dedication to develop, disseminate and analyse the survey. Thank you.

Census report

The third Faculty of Pain Medicine census was launched in Autumn/Winter 2022, to update and build on the information gathered in the FPM's 2012[1] and 2017[2] censuses. Many of the same questions used in the 2017 census were repeated, some were modified and new questions added to look at the current demographics of the workforce. The questions introduced in 2017 to look at the impact of recent tax and pension changes were further developed and a new question relating to the GMC Credential in Pain Medicine was added. The questions were reviewed by the FPM Board and the census was then circulated via a SurveyMonkey link to all members on the FPM distribution list. In attempt to capture respondents not yet affiliated with the FPM, the link was also circulated to Clinical Directors in Anaesthesia, via the RCoA mailing list, with a request to forward to all Pain Medicine specialists in their hospitals. Responses were anonymous, based on feedback from the 2017 census to maximise returns. The response rate was initially very low, so the survey deadline was extended beyond the initial 6 weeks and reminders were sent to all FPM members.

When the survey link closed in early 2023, the Faculty of Pain Medicine 2022 census had received 283 responses, which is less than half of the 701 doctors currently registered with the FPM. The data presented in this report covers the breadth of the questions asked, but it is difficult to derive meaningful conclusions because of the low response rate. Of those respondents, 84% were affiliated with the Faculty of Pain Medicine in some way, and a large number were active in educational roles and Faculty positions, such as RAPMs and committee members. Where appropriate we have included comparative data from the previous FPM Workforce Census carried out in 2017[1]. There is also some data for comparison from the RCoA *Medical Workforce Census Report* in 2015[3] and 2020[4]. This is a summary of some of the key findings; the report in full can be accessed on the FPM website.

What is the current Pain Medicine Specialist workforce?

- The proportion of female doctors in Pain Medicine appears to have increased slightly since the 2017 census, with 28.6% of the respondents female, compared with 25% in 2017 and up from 22% in 2015.
- The workforce appears to be getting older, with 73.1% of respondents in the 46–69 year-old age category, compared with 61% in 2017. There were fewer Pain Medicine Specialists in the 35-39 and 40-44 year old age brackets, compared with five years earlier (Figure 1).

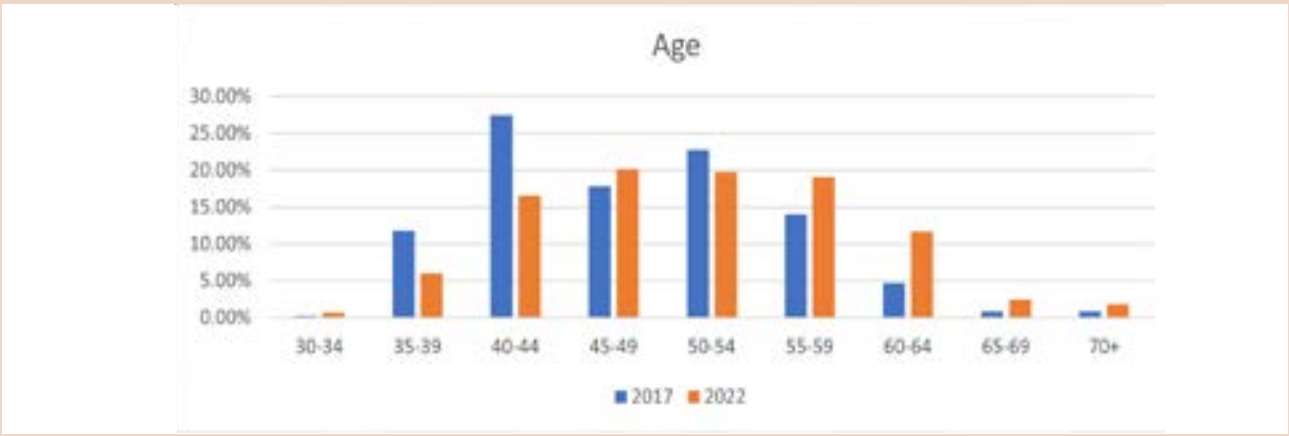

Figure 1: *Workforce Age*

- The vast majority of pain consultants continue to list anaesthesia as their base specialty (96%), but respondents in 2022 also listed general practice, palliative care and oral medicine as base specialties. The forthcoming credential in Pain Medicine will open the route of training to non-anaesthetists in a range of specialty backgrounds, ensuring a wider potential future workforce.
- It is worth noting that the 2020 RCoA Medical Workforce census[4] asked clinical directors about numbers of colleagues with specific specialty areas in their job plans. There were 568 Consultants and 45 Specialty Grade Doctors with chronic pain PAs. This is significantly higher than the number of responses to this 2022 pain census, especially as the number of doctors with inpatient pain DCCs were not mentioned in their report.
- The majority of the respondents' scope of pain practice was entirely in adult Pain Medicine, with 5% undertaking a role in only paediatric Pain Medicine (see Figure 2).
- Of those who worked in adult Pain Medicine, the majority (57%) worked in entirely outpatient based settings and 11% practice Pain Medicine in inpatient settings only. Although the differences are small, there is a slight increasing trend for Pain Medicine specialists in paediatric practice to work solely in either outpatient or inpatient settings.
- The average (mean) number of Direct Clinical Care Programmed Activities (DCC-PAs) worked in Pain Medicine has increased from 4.24 in 2017 to 4.57 in 2022. The total DCCs per week has remained

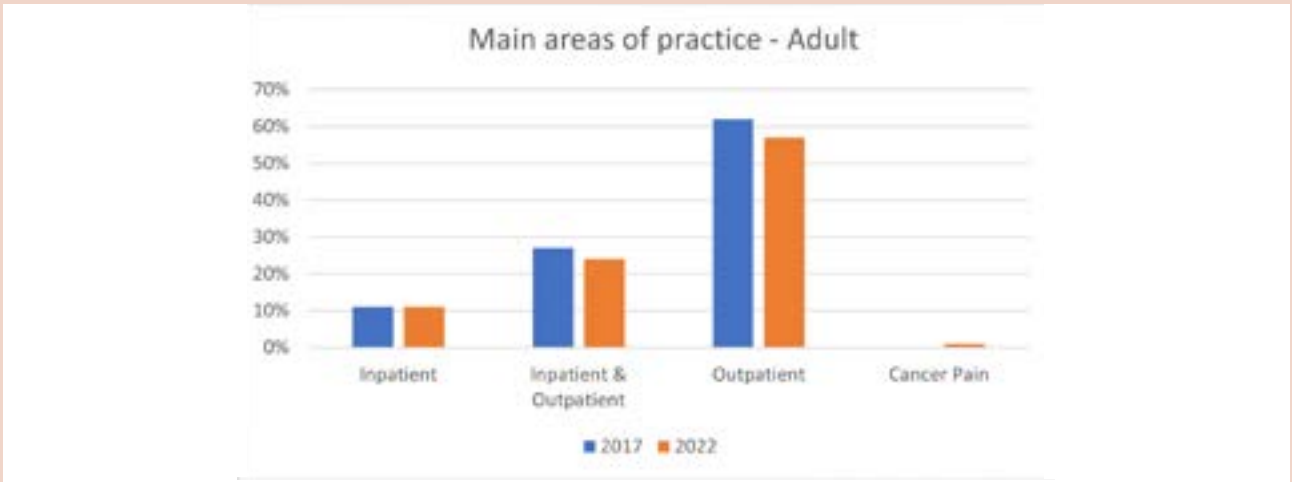

Figure 2: *Main areas of practice - Adult*

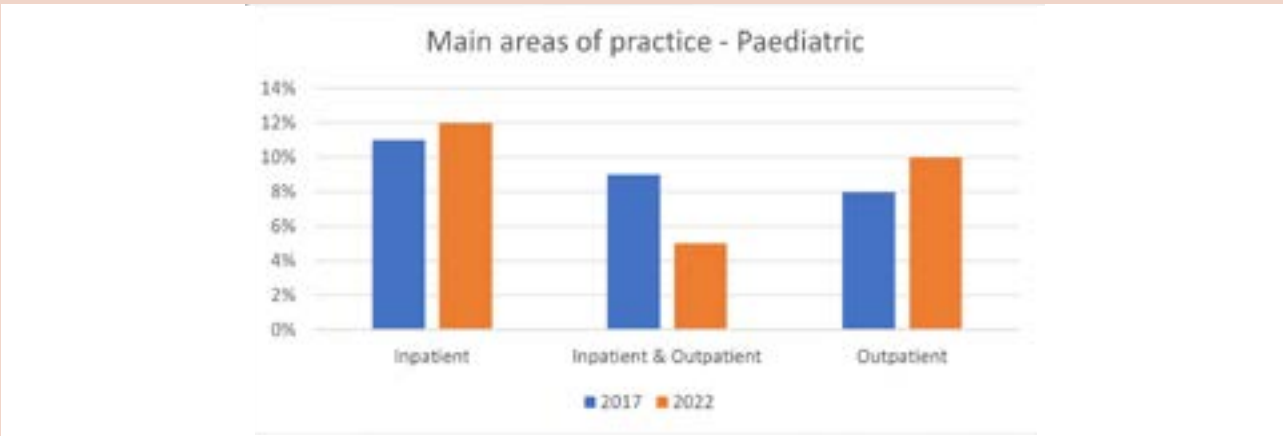

Figure 3: *Main areas of practice - Paediatric*

similar at 7.93 (compared to 8 in 2022), which means an increasing proportion of a specialist's week is dedicated to clinical work in Pain Medicine, with the remainder in anaesthetics or another specialty.

- The data suggest that the average Supporting Professional Activities sessions in Pain Medicine has decreased since 2017. However, it is worth noting that in 2022, 128 of the 283 respondents were unsure of their SPAs in Pain Medicine allocation, and 42% stated their allocation was not sufficient.

Multi-disciplinary team working

- We asked about multidisciplinary working for both outpatient and inpatient teams, with 66% of outpatient teams reporting they comprise of three or more disciplines and 29% are made up of 4 or more and 7% reporting 5 or more disciplines. In comparison, 13% of inpatient Pain Medicine teams comprise three or more disciplines.

Retirement plans

- The majority of the Pain Medicine Specialists who responded plan to retire between the ages of 60 and 64. A notable 7% plan to retire from the age of 70 onwards, which perhaps reflects the favourable work/life balance that a career in Pain Medicine offers.
- We asked recipients a series of questions surrounding their future plans. It is clear the changes to the NHS Pension Scheme, Tax Reforms to annual allowance or the McCloud Remedy have altered both plans for working hours and planned retirement age. 58% of respondents plan to decrease hours and 53% plan to retire earlier. In the 2017 Census, the numbers planning to retire early were offset by a large proportion of respondents (42%) who planned to retire later but this has not been seen in 2022, with only 4% planning to retire later.

Service Lead

- The second half of the survey asked questions of respondents who were the Clinical Lead for the pain service only. This was looking primarily at data on vacancies, and it was assumed that only one person from each pain service would respond, to avoid duplication of vacant post numbers. Some data will be missing because of the low response rate but also acknowledging that only 87% of respondents to the first part of the survey said they had a medically qualified service lead.
- Of the 92 Clinical Leads who responded, a signficant 48% reported they had vacant Consultant posts in their department. Of these, 69% responded that they had tried to recruit, which highlights the current challenges in recruitment. Despite the current vacancies, there are relatively healthy rates of recruitment, with 84% or respondents reporting they have recruited to a consultant post in the past year and 25% recruiting to specialty grade posts. 69% have hired locum staff in the past year to manage workforce pressures.

Figure 4: *Scope of practice*

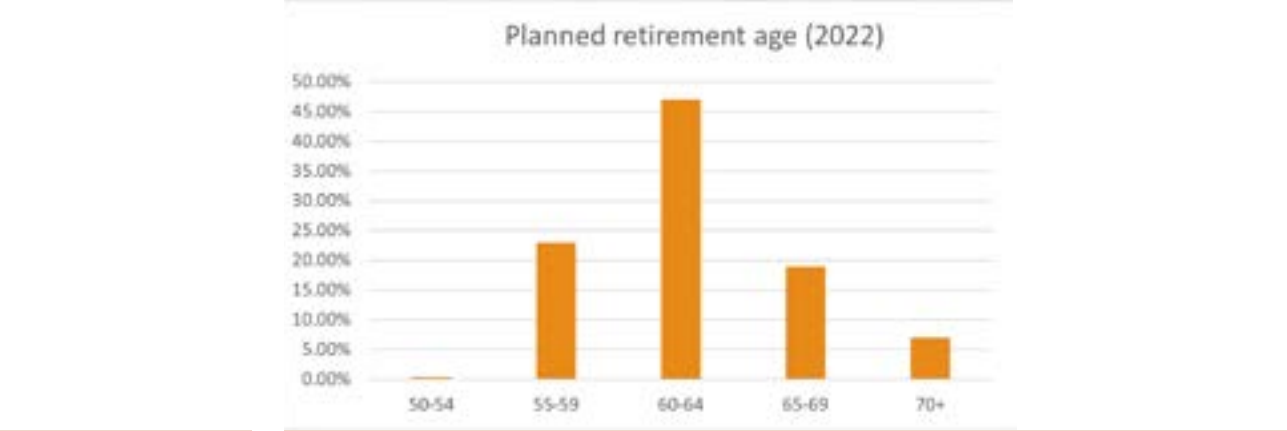

Figure 5: *Planned retirement age*

Credential in Pain Medicine

- The 2022 Census explored views on the forthcoming GMC Credential in Pain Medicine. 64% of respondents answered they would wish to be considered for retrospective credentialing. However, the remainder responded they were either unsure, did not wish to be considered for the credential or did not answer the question.
- This highlights the lack of clarity amongst doctors currently working in Pain Medicine of the forthcoming GMC credentialing process. This work has been ongoing since 2018, with the curriculum for the Credential for the Pain Medicine Specialist being finally approved in August 2023.

  The FPM is currently working with the GMC and Statutory Education Bodies of the Four Nations to implement the Credential which will be open to pre- and post-CCT doctors as well as Specialty Grade doctors. It will provide depth and stability to the workforce of doctors who work as Pain Medicine Specialists within the UK, whilst raising standards in the practice of Pain Medicine. Credential Holders will be listed as Pain Medicine Specialists in the GMC List of Registered Practitioners. This importantly improves patient safety as it allows recognition of specialist training in Pain Medicine by patients and employers. Further information can be found in the October 2022 RCoA *Bulletin*.[5]

Limitations and suggestions for future

The number of responses to the previous census carried out in 2017 was significantly higher, with 484 individual responses. A different strategy was employed then, using a hub and spoke model, with the RAPMs and the local Pain Medicine educational supervisors tasked with disseminating and chasing responses. Feedback from the 2017 census identified confidentiality concerns, hence in 2022 we elected to disseminate and collate responses anonymously, via the FPM. It is disappointing that the number of responses has dropped but is likely to reflect the current workforce pressures and clinical workloads, as well as probable 'survey fatigue'.

In future years, reverting back to the model of RAPMs and/or Faculty Tutor (Pain) collating responses or perhaps developing an incentive for completing the survey could be considered.

If you have any suggestions for future questions that you think would be helpful to include, please contact us on contact@fpm.co.uk.

Survey authors: Sonia Pierce, Lorraine de Gray, Susan Hall, Claire Driver-Edwards, Emmy Kato-Clark.

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3. RCoA Medical Workforce Census Report 2015: https://www.rcoa.ac.uk/sites/default/files/documents/2019-09/CENSUS-REPORT-2015.pdf
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Dr Ganesan Baranidharan
FPMPSC Chair &
Vice Dean

PROFESSIONAL STANDARDS

I would like to take this opportunity to congratulate and welcome Dr. Manohar Sharma, the incoming chair of the Professional Standards Committee (PSC). PSC is seeing a huge change in their working membership over the coming months.

The PSC has worked hard with a few members reaching the end of their second terms on the committee. Thanks to Dr Devjit Srivastava, Dr Sailesh Mishra, Dr Suzanne Carty, Dr Matthew Brown, and Dr Sanjeeva Gupta who will be completing their terms in the coming months. They have contributed hugely in the last five years towards various working parties and still are currently working on PSC work-streams. We welcome Dr Sue Jeffs to the PSC membership. The PSC committee is currently looking for enthusiastic members; information regarding the recruitment has been forwarded to the members and can be found on the FPM website.

Wellbeing

A recent article in the *Times* has created an awareness of the difficulties faced by some fellows and trainees in approaching for help. We have discussed this both at the Board and the PSC and are working on creating a safe space to raise these issues. There will be an Equality and Diversity Champion who will also lead on the wellbeing of our Fellows and Trainees. We will provide more information on this in future updates

Gap Analysis

With the credential in Pain Medicine, the results of the recently concluded Gap Analysis survey are key in mapping the current practice to *Core Standards*. Anaesthesia Clinical Services Accreditation Standards (ACSA) currently has five Domains with Domain 5 being optional and consisting of Cardiothoracic, Neuro, Ophthalmic and Vascular Anaesthesia. The Gap Analysis helps framing the key performance indicators for the ACSA standards, a very important step towards providing quality service with high standards.

Opioids Aware

The Faculty's review of the Opioids Aware web resource is progressing well with a complete update expected before the end of this year with references aligning to the CDC guidance, Canadian guidance, etc. The guidance on opioid reduction for Fellows is at its final stages of publication.

Reflections

There is an excellent opportunity to share any best practices. It will be in the form of a short write-up on innovative work done within your service. Please consider sending your articles; we can share them with the Fellows. See examples here.

Core Standards

Core Standards are being edited to reflect the new terminologies used in the training of Pain Medicine specialists. We are initiating the review earlier than planned to align the *Core Standards* to the credential documents.

Publications

The PSC has updated most documents, and patient information leaflets and has commissioned new leaflets on Knee Radio Frequency Ablation procedures to be added to the current intervention leaflets.

OPIOIDS AND SURGERY MASSIVE OPEN ONLINE COURSE

Dr Dermot McGuckin
ST7 in Pain Medicine
University College London

Dr Fausto Morell-Ducos
Consultant in Pain Medicine
University College London

Dr Jamie Smart
Consultant in Pain Medicine
University College London

An innovative approach to improve the understanding and implementation of perioperative opioid stewardship and transform practice.

Opioids play an important role in facilitating recovery and return to function after surgery. However, it is now well-established that surgery is a risk factor for persistent postoperative opioid use[1], and pre-operative opioid use is associated with an increased risk of perioperative complications[2].

Perioperative opioid stewardship is a practical approach providing a systematic, multi-layered framework aimed at minimising the risks associated with opioid use around the time of surgery, whilst allowing their safe administration to those patients most likely to benefit from them. It is increasingly regarded as a solution to the problem of prescription opioid-related harm but there is a lack of structured curriculums to develop healthcare professionals' skills in competent opioid management.

To address this, in partnership with University College London (UCL) and FutureLearn, we have developed *Opioids and Surgery*, a Massive Open Online Course (MOOC). The MOOC concept has grown exponentially in availability and popularity since 2012. Delivered completely online, free to access and open to all, MOOCs defy traditional classroom limits, enabling education to be delivered flexibly and at scale.

Who is the course for?

Opioids and Surgery has been designed for a global audience, including all members of the multidisciplinary team involved in providing pain relief for patients who are having, or have had, surgery:

- Doctors, nurses and physician associates providing anaesthesia, surgical or perioperative care
- Nurses and specialists caring for patients recovering from surgery in the Recovery room, Post-Anaesthetic Care Unit, Critical Care Unit and on surgical wards
- Specialist pain nurses
- General practitioners
- Physiotherapists, clinical psychologists, chiropractors, osteopaths and other allied health

LEARNING OBJECTIVES

- Explain the reasons for persistent postoperative opioid use and its contribution to the development of the international opioid epidemic.
- Engage in a discussion on global variation in perioperative opioid use with healthcare professionals from around the world.
- Justify the reasons for using different opioid and non-opioid analgesics for the management of acute pain in the perioperative setting.
- Summarise the basic pharmacology of opioids and the mechanisms associated with their therapeutic and harmful effects.
- Evaluate the component parts of opioid stewardship which are aimed at reducing persistent postoperative opioid use and its subsequent harms.
- Reflect upon the challenges of managing perioperative pain in patients with opioid tolerance and/or dependence.

professionals with an interest in Pain Medicine

- Students training in these individual professions.

Course overview

Over three weeks, participants will spend 3-4 hours per week learning about the perioperative use of opioids, opioid pharmacology, and opioid stewardship via a mixture of peer-reviewed articles, video interviews with clinicians and experts, patient stories, interactive case discussions and quizzes.

Week 1: Opioids in the Perioperative Setting

In week one of the course, we set the scene by examining the causes and extent of the world-wide opioid crisis, and the role played by the use of prescribed opioids in the perioperative setting. We discuss the importance of managing perioperative pain and the challenges of balancing the utility of opioids against the risks of prescribed opioid-related harm and of inadequate perioperative pain management leading to poor patient outcomes.

Week 2: Opioid Pharmacology

In week two of the course, we examine the mechanisms of opioid tolerance, opioid use disorder and non-opioid responsive pain, as well as the concept of persistent postoperative opioid use. We also explore the specific pharmacokinetic and pharmacodynamic properties of different opioid drugs, and how these are responsible for both their desired analgesic actions and the adverse drug-related patient outcomes we try to avoid.

Week 3: Solutions & Best Practice

In the third and final week of the course, we focus on opioid stewardship. We discuss the practical approaches and interventions which can be taken to promote appropriate opioid prescribing and to minimise adverse drug events and persistent postoperative opioid use. We explore the concepts of opioid-free and opioid-sparing anaesthesia and analgesia, and discuss ways in which these can be achieved practically. We also examine how different legal frameworks influence the clinical use of opioids around the world.

Reflections

Developing the Opioids and Surgery MOOC has required a truly collaborative approach with an international, multidisciplinary faculty of educators and input from patients and lived experience experts. Collaborating with UCL Digital Education has ensured high quality pedagogy and quality assurance review throughout the course. We have also benefited from the collective knowledge and experience achieved through UCLH's successful teaching portfolio, which includes the distance learning MSc programmes in Perioperative Medicine and Pain Management, as well as the successful UCL/FutureLearn Perioperative Medicine in Action, Airway Matters and Transfer Medicine MOOCs, commended for their high learner retention and completion rates, so far attracting over 50,000 healthcare professionals from over 120 countries.

The Opioids and Surgery MOOC will launch on Monday 29 January 2024. To find out more details about the course and to register your interest, visit: https://www.futurelearn.com/courses/opioids-and-surgery.

References

1. Srivastava et al. Surgery and opioids: evidence-based expert consensus guidelines on the perioperative use of opioids in the United Kingdom. Br J Anaesth 2021;126(6):1208-1216

2. Quinlan et al. Preoperative opioid use: a modifiable risk factor for poor postoperative outcomes. Br J Anaesth 2021;127(3):327-331

Dr Nick Plunkett
Chair FFPMRCA

Dr Vivek Metha
Vice-Chair FFPMRCA

FFPMRCA EXAMINATION

Since the last Examinations report in *Transmitter*, the Faculty has delivered two more examinations — the MCQ exam in February, and the SOE Exam in April 2023.

There were 22 candidates for the MCQ, delivered remotely through the remote proctor TestReach. The Anghoff group met two weeks later to discuss the question responses as per longstanding practice to meet exam standards. As usual, a small number of questions were omitted from the total by reason of ambiguity or uncertainty, with the total marks scored out of 397 instead out of 400. Following application of Anghoff scores and other processes, a pass mark of approximately 68.5% was established, with a pass rate of approximately 68%, with 15 out of the 22 candidates achieving a pass, broadly consistent with historical pass rates.

17 candidates attended the SOE examination in April 2023. The exam was preceded, as is usual, by a whole Exam Board review of all questions to confirm standard for uniform examination delivery. After the exam, the Exam Board reviewed borderline candidates' performance, and following discussion, 11 of these candidates were considered to have reached a satisfactory standard, achieving or exceeding a pass mark at 31/40 - a pass rate of about 65%, which is again broadly consistent with recent average pass rates.

FPM Examination Prize

One candidate Dr Harriot Scott (Barts Health) scored 40/40 and had the best

Page left — FFPMRCA Examiners: *Ganesan Baranidharan, Adrian Dashfield, Tony Davies, Richard Howard, Mark Jackson, Senthil Jayaseelan, Graham Johnson, Saravana Kanakarajan, Vivek Mehta, Victor Mendis, Douglas Natusch, Andrew Nicolaou, Rhian Pennant-Lewis, Nick Plunkett, Jonathan Rajan, Arasu Rayen, Richard Sawyer, Mick Serpell, Karen Simpson, Jeremy Weinbren.*

MCQ score in the academic year with full marks at SOE. Dr Scott was awarded a FPM Examination Prize for the academic year and we warmly congratulate her for her achievement.

Observers and new Examiners

We were pleased to host two observers to the SOE examination: Dr Kavita Popity (Barts Health) and Dr Namita Arora (Peterborough). Both colleagues felt that the level at which the exam questions were pitched in terms of depth and scope of questioning, and the examination performance itself, was fair. We were glad to hear that they enjoyed the day.

Furthermore we were delighted to welcome three new examiners to our spring SOE examination: Dr Arasu Rayen (Sandwell and West Birmingham Trust), Dr Senthil Jayaseelan (Mersey and West Lancashire Trust), and Dr Jonathan Rajan (Northern Care Alliance). They successfully completed their examiner training, and we are certain that their many and varied skills will be put to good use. Welcome all!

Farewells

We were sorry to bid farewell to two foundation examiners: Dr Douglas Natusch (Devon) and Dr Rhian Pennant Lewis (Bangor, Wales). Doug and Rhian have been a part of the exam since its' inception in 2009 — writing and developing questions, participating actively and enthusiastically in group working, and mentoring newer recruits. In addition, Douglas and Rhian have been instrumental in overseeing and delivering the e-PAIN programme. The Faculty and the exam owe them a huge debt of gratitude for all they have done.

As ever, a heartfelt *Thank You* to the RCoA Examinations Department, whose professionalism and dedication to the FPM exam facilitate us to deliver it in the best possible way. Special thanks, and farewell goes out to Beth Doyle, a member of the department since we started the FPM exam, who has been our 'go-to' contact, tirelessly supportive, endlessly good-humoured, and a wonderful member of our team. We wish her all the very best in her new endeavour!

Finally, a brief word from myself: it has been a wonderful experience to lead such a talented group of pain professionals in the development and delivery of the FPM exam. It has also from a personal point of view been immensely fulfilling to work with such fine people, and now friends. My time in the role has come to an end, and I wish my hugely able successor Vivek all the very best in the role as Chair of FPM examinations.

FFPMRCA EXAMINATION CALENDAR

	FFPMRCA MCQ	FFPMRCA SOE
Application and fees not accepted before	Monday 6 November 2023	Monday 22 January 2024
Closing date for FFPMRCA exam applications	Thursday 14 December 2023	Wednesday 6 March 2024
Examination date	Tuesday 6 February 2024	Tuesday 16 April 2024
Examination fee	£610	£855

Visit www.fpm.ac.uk/training-examinations/ffpmrca-examinations for the latest updates on the FFPMRCA exam.

Dr Jonathan Rajan
RAPM Chair

RAPM UPDATE

"Autumn is a second spring when every leaf is a flower."
— Albert Camus

Certainly, there are many reasons to be optimistic as we head into the new season.

Faculty Tutor Day

The upcoming Faculty Tutor Day is being held as a hybrid face-to-face/virtual day on 2 November 2023. A number of updates are expected including from the Dean, Trainee Representative, Training & Assessment committee, Examinations Board as well as updates on credentialing and FPM Thrive.

Please do encourage your trainees and Faculty Tutors to submit questions for the Faculty Tutors Day to make the most of the event. I will also have the pleasure of speaking at the Regional Advisors in Anaesthesia meeting and would welcome any thoughts or questions that you may wish to pose to this group.

Teaching

Plans are being developed to establish a national teaching programme of tutorials and resources. This has been coordinated by Dr Sheila Black, Dr Nicola Johnson (Trainee Representative), Dr Sonia Pierce and the Training & Assessment Committee.

The national teaching programme aims to ensure equality of access for trainees across the regions, and facilitate the learning required for senior pain medicine trainees. The programme will almost certainly require contributions from Faculty Tutors nationwide.

Furthermore, senior trainees conducting their SIA in chronic Pain Medicine, no longer require 6 months in post prior to application for the FFPMRCA examination. Applications are now welcomed earlier in the course of the specialist interest year.

Wellbeing

The wellbeing of trainees has come into sharp focus following the publication of a recent Royal College of Surgeons bulletin on harassment in the workplace. Pain Medicine is a small speciality and as exposure to Pain Medicine is concentrated towards the end of the training, unhelpful or antagonistic behaviour may be underreported. On a positive note, there are more women training in Pain Medicine than in previous years.

Looking forward I am pleased to say both myself and the Training & Assessment committee will be exploring ways of improving the accountability and robustness of reporting systems to protect the integrity of training. An initial summary report will be presented to the Board in December of 2023. Contributions as to how the Faculty can encourage reporting of such issues at trainee level and beyond are very welcome. Please do email me to get in touch.

Specialist in Pain Medicine jobs

RAPMs are commonly asked to sit on job applications of panels. My recent experience with CESR applications has been complex and will hopefully be aided by the introduction of credentialing. That said, there remains no recognised Faculty guidance on the competencies required for a staff grade in Pain Medicine. To that end, I will be working with Dr Victor Mendis and the Training & Assessment Committee to develop such guidance in the coming months.

Last but not least I would like to thank Dr Asius Thayala Arasu Rayen and Dr Peter Cole for their service as RAPM for West Midlands and Oxford, and welcome Dr Mohjir Baloch in the new role as RAPM for the Oxford region.

Dr Victor Mendis
FPMTAC Chair

TRAINING & ASSESSMENT

The GMC has approved the curriculum for credentialing in Pain Medicine, which is excellent news for the development of our speciality. Together with Rural and Remote Medicine and Mechanical Thrombectomy, Pain Medicine has now reached this milestone.

Credentialing

For the first time ever, doctors who are trained in specialist Pain Medicine, will be recognised on the GMC Register of Medical Practitioners. The credential curriculum has been developed to take into account the different specialty backgrounds that doctors may come from, providing detailed information for both trainers and trainees alike. There will be guidance issued for retrospective credential awards and advice regarding training going forward. Our credential webpages will be updated as more information arises. Credentialing will provide a much-needed increase in our current workforce-most regions in the UK have less than 0.5 of a pain specialist per 100,000 population. It will also increase public safety as both employers and the public will be able to ascertain whether their pain specialist has been credentialed and hence trained to the highest standards possible.

Curriculum

The GMC has also approved the amendments to the RCoA 2021 curriculum and additional SIAs have been created in research. The new curriculum is more flexible in terms of routes to the Specialist Register: previous training experience can now be counted towards training; more CESR programmes are accessible within Trusts to meet the workforce needs. The 2010 curricula are due to cease next year. Those currently on the old curriculum, but who have taken maternity or statutory leave, have been granted an extension period so as not to moved onto the new curriculum with a very short time left in their training programme. We would expect Faculty Tutors and RAPMs to complete HALOs from Stage 2 upwards and that Educational Supervisors continue to complete Stage 1 HALOs for Pain Medicine.

Webpages

The **FPM training webpages** have now been updated and my sincere thanks to Mr Neil Wiseman and Dr Hoo Kee Tsang for their input.

EPM

Essential Pain Management (EPM) is running a couple of international courses scheduled in Senegal and Benin.

e-PAIN

I would encourage Pain Medicine Trainees to utilise training modules in e-PAIN, which could contribute towards gaining some of the competencies particularly in Paediatric Pain. Currently there are approximately 3,500 users and they are mainly nurses, paramedics and physiotherapists.

FPMLearning

We are widening the pool of contributors, aiming to capture a broader multi-disciplinary authorship with increased recognition for contributors. The Case of the Month is being modified in some months into a quiz format with answers to the questions to be found in Recommended Reading. The Radiology Corner is now up and running with a case and accompanying radiology images uploaded regularly.

Thank You

Finally, I would like to thank Dr Douglas Natusch and Dr Helen Laycock who have stood down from FPMTAC due to other commitments, for their hard work and input into TAC and wish them both all the very best.

Dr Nicola Johnson
Faculty Trainee Representative

TRAINEE UPDATE

As trainees we continue to navigate the challenges of long waiting lists, high levels of public demand and an ongoing industrial dispute. There have been few times when it has been as turbulent to be a medical trainee as over the last few years.

However, I hope those of you who joined us in Pain Medicine this August are feeling settled in your departments and enjoying what is on offer.

Trainee Survey

Thank you to those of you who completed the Trainee Survey. Some of you raised concerns around the breadth of training available in your region and others continue to be expected to cover the day-time portion of on-calls against FPM guidance. These issues will be fed back to the Board, as well as the Training & Assessment Committee who are already looking into solutions to these longstanding problems. I will highlight individual issues where permission has been given and the Faculty will work to address these.

Teaching Programme

Another issue emphasised in the trainee survey was the limited availability of formal teaching. After improvements in the national availability of regional teaching from the north of England and London, the Faculty is continuing to work towards developing a national teaching program. This will be delivered virtually via an online platform, and we aim to upload the presented resources to the Faculty website afterwards. The goal is to facilitate more equitable provision of teaching access for trainees across the country, as well as providing a network for trainees and an understanding of distribution of pain services nationally. I hope that this is something that can begin to be delivered from early next year.

FFPMRCA exam

The Faculty has accepted the RCoA's indpendent exam review on the structure and format of the current FFPMRCA exam. Whilst there are no immediate changes planned, there are likely to be some to the exam format over the next few years, so junior pain trainees are advised to keep an eye on the exam pages of the Faculty website for developments. If you are sitting the exam soon, you may have spotted that FPM has made several updates to the website. There is plenty of useful information on it on the expectations for the different stages of training. Of particular interest to senior trainees is the FPMLearning page which provides resources for the management of more complex cases in an exam-relevant context.

Dates for your Diaries

For those of you interested in developing your research and quality improvement credentials, Pain-Train held its Annual General Meeting on 28 September and is currently recruiting to committee. Pain-Train is the national network of trainees interested in pain research and audit. After a formal relaunch last year, they ran two successful education events, and their first project is currently ready to launch for this academic year. Their website www.paintrainuk.com offers more information on how you can get involved.

The FPM Trainee Day will be held on 10 May 2024 at the RCoA. We have moved it from the autumn to the summer to avoid exam clash. It should prove to be a sociable and educational event, so please book your study leave now!

Finally, I would encourage all of you to keep in touch by making sure that you are registered as a trainee via the Faculty website. I am always happy to be contacted through the Trainee WhatsApp group about any issues.

FPMLearning is updated every month. Be sure to have a look at the FPM's open resource for all pain trainees, providing a variety of teaching materials including case reports, journal club, recommended reading and podcasts.

www.fpm.ac.uk/fpmlearning

Become part of FPM Thrive

Are you interested in helping someone develop their career, find their perfect work/life balance, or do you need that extra something to help you achieve your goals?

Visit FPM Thrive for more on the Faculty's career mentoring and personal development programme.

ESSENTIAL PAIN MANAGEMENT — WHY AND HOW TO BE A PART OF THIS GROWING INITIATIVE?

Prof Sailesh Mishra
Deputy Clinical Lead
EPM UK

Prof Sibtain Anwar
Clinical Lead EPM UK

Essential Pain Management (EPM) is a cost-effective, multi-disciplinary global initiative aimed at working with local health workers to improve knowledge in pain management, to implement a simple framework for managing pain and to address and resolve local multifactorial barriers that impede delivery of effective pain management.

A survey among healthcare providers in 2011 by Briggs et al suggested the lack of any comprehensive training in pain management during their formal education, making formal training programmes like EPM valuable in filling this knowledge gap.[1]

In 2013 the EPM UK working group had its first meeting looking at introducing EPM into low-resource healthcare systems. It was soon realised that EPM is also an effective way of delivering undergraduate pain education to medical students at Universities across the UK and the pilot project was run in Bristol University in 2014. Since then, it has expanded across the UK to many other universities. The Faculty of Pain Medicine (FPM) has introduced the EPM teaching programme for undergraduate medical students, Foundation year doctors and for anaesthetic trainees and other groups to increase the understanding, recognition, assessment, and treatment of pain — regardless of its chronicity, nature, or underlying pathophysiology.

The strength of EPM lies in its simplicity. It lays out key concepts of classifying pain based on time, type, and mechanism. It follows a simple framework of Recognise, Assess and Treat (RAT). This acts as a constant reminder for the students who are then encouraged in small group workshops to discuss practical pain management in different situations.

Key aspects of EPM

- **Simple Framework:** EPM uses a simple and practical framework for managing pain and can be particularly effective in settings with limited resources. The simplicity ensures that EPM pain management practices can be readily adopted and integrated into established healthcare systems such as the local NHS Trust.
- **Addressing Barriers:** Identifying and addressing pain management barriers is essential to improving patient care. Barriers can include cultural beliefs of both patient and health care providers,

limited access to specific medications, perceptions about pain and stigma around how pain 'should' be managed. EPM UK workshops approach these barriers in a group discussion around clinical case scenarios. Addressing these barriers have been shown to bring about positive change in clinical practices.

- **Multidisciplinary Approach:** EPM emphasises on a multidisciplinary approach to pain management in providing holistic care. Pain is a complex biopsychosocial phenomenon that requires input from a team of healthcare professionals, including pain physicians, specialist nurses, physiotherapists, psychologists, and pharmacists.
- **Global Reach:** EPM as a formal way of pain management training is now actively delivered in over 55 countries, demonstrating its adaptability and scalability.

Does the EPM Model of training work?

EPM was delivered to 16 groups of year 5 medical students from Newcastle University over a 3-year period. The Recognise, Assess and Treat (RAT) model was found to be very effective in increasing the participant's confidence as they prepared to engage in active delivery of clinical care within months of completing the EPM workshop. A baseline measure of 'Do you feel confident to manage pain?' was taken at the start of each session, and again on completion of the half day EPM UK workshop. In total, 316 students in 16 groups participated in the workshops. At the start of the workshops, only 5 to 30 percent of students in each group reported feeling confident to manage pain; this had increased to an average of 81% by the end of the workshop.

Who can teach EPM?

Anyone involved in education and delivery of pain management can teach EPM. Instructor courses are organised internationally via the EPM Global Network. In the UK, these are hosted by the British Pain Society (BPS) and The National Acute Pain Symposium (NAPS) at their annual meetings as well as at the deanery level (e.g., Northen Deanery) at the Intermediate and Higher Pain Study Days for the anaesthetic trainees.

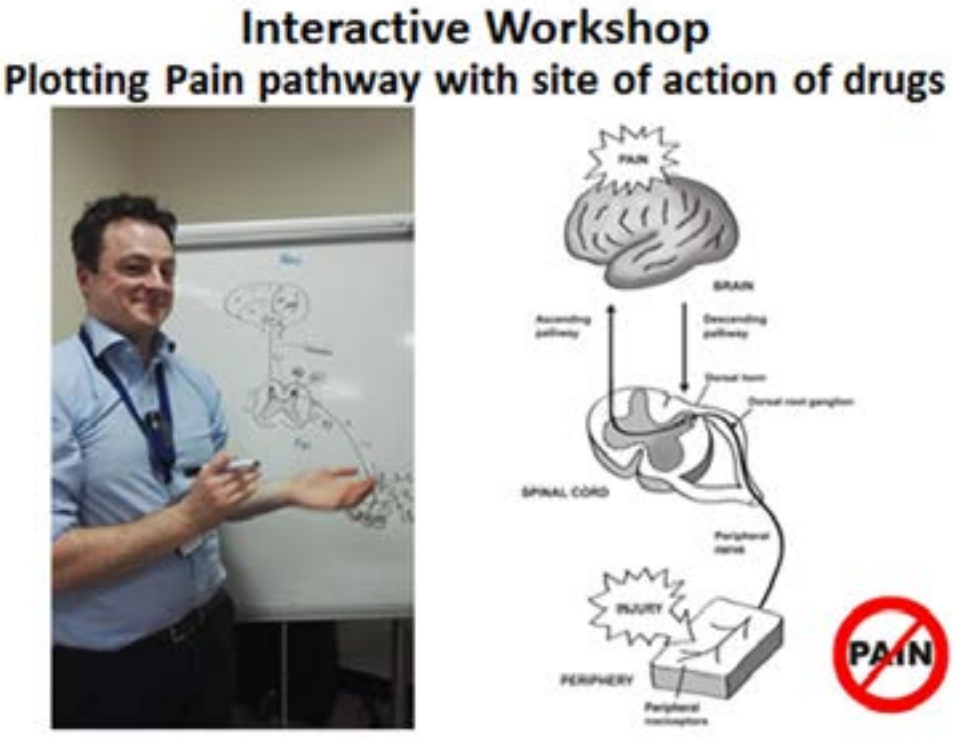


Figure 1: *Dr Neil Hall Delivering EPM Session*

EPM UK allows the content to be designed to address local needs acknowledging the variations in practices based on geographical locations. The Northeast of England has had challenges around opioids and Nefopam overprescribing, and the EPM workshops serve as a very useful platform to raise awareness and educate on rational pain management strategies.

Why should I consider becoming an EPM Instructor?

Some common generic skillsets to become an EPM Instructor for any healthcare professional include a sound understanding of pain management principles and practices, relevant clinical experience in pain management, good communication and teaching skills. Becoming an EPM Instructor can be rewarding in many ways.

- Enhanced expertise and formal acknowledgment of a specialist instructor role
- **Competitive advantage:** EPM Instructor certification can give a competitive edge in the job shortlisting and interviews.
- **Career advancement:** EPM Instructor experience can open doors to career advancement opportunities and leadership roles to be involved in different forums including EPM Global and EPM Advisory Group UK.
- **Educational roles and research opportunities:** EPM UK workshop data helps to demonstrate the impact of the course in improving patient care and filling existing gaps in training curricula.
- Interdisciplinary collaboration and community engagement in organising multidisciplinary EPM Workshops
- Personal fulfilment of promoting and educating on patient centred care
- Demonstrable SPA (Supporting professional activities) time allocation and utilisation.

References

1. Briggs EV, Carr EC, Whittaker MS. Survey of undergraduate pain curricula for healthcare professionals in the United Kingdom. Eur J Pain. 2011 Sep;15(8):789-95. doi: 10.1016/j.ejpain.2011.01.006. Epub 2011 Feb 16. PMID: 21330174. https://pubmed.ncbi.nlm.nih.gov/21330174/

Further Reading

1. More about EPM UK
2. Interactive Module
3. Global Essential Pain Management Platform

For further queries please email contact@fpm.ac.uk.

Figure 2: *Free EPM App on iOS*

FPM CLINICAL GUIDELINES

Patient information leaflets on interventions

www.fpm.ac.uk/patients/patient-info

These leaflets were created with the help of multi-professionals as well as patient representatives and are intended to be handed out to patients when they are prescribed these medications/ undertake procedures. The leaflets can be used within a variety of clinical settings including Pain Management Services, GP practice, community pharmacies and physiotherapy clinics.

Shared decision making and consent

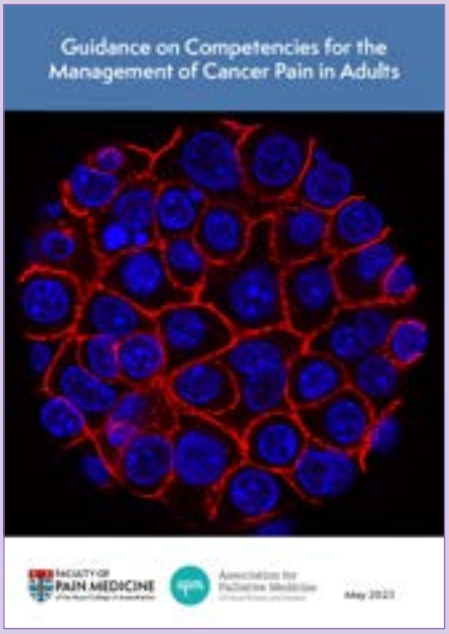
www.fpm.ac.uk/standards-guidelines/clinical-guidelines

The purpose of this document is to frame the principles of decision making and consent (as described by the GMC, legislation and case law), within the context of the practice of Pain Medicine. Case examples are used to illustrate potential pitfalls as well as key features of best practice, with direct reference to the appropriate GMC guidance, legislation or case law.

Guidance on competencies for management of cancer pain in adults

www.fpm.ac.uk/standards-guidelines/clinical-guidelines

This document describes two levels of involvement in the management of cancer pain: The first level outlines the core knowledge, skills and attitudes for all specialists in Pain Medicine who may need to be involved with this area. The second level outlines the advanced knowledge, skills and attitudes required of Pain Medicine specialists who work in teams providing a cancer pain service.



Safety checklists

www.fpm.ac.uk/standards-guidelines/clinical-guidelines

- Interventional Pain Procedures under local anaesthesia or sedation
- Intrathecal Drug Delivery Device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