FACULTY OF PAIN MEDICINE

of the Royal College of Anaesthetists

FPMTAC Response to Trainee Questions FPMTAC/002/Dec 2014

Here are some topics below which have been raised by trainees through Lucy Miller over the last few months. Hopefully this helps address or inform some of the issues. Do feel welcome to send any follow up queries either through Lucy or directly to the FPM at fpm@rcoa.ac.uk.

All individual trainee comments naturally remain anonymous.

1 Commissioning and standards

The Faculty is aware of the current concerns with regards to what impact commissioning will have on the future of Pain Medicine. The FPM released an early guidance document, which has been supplemented by ***Pain Management Services: Planning for the Future – Guiding clinicians in their engagement with commissioners***. Both documents are available online [1].

For tertiary / specialised services, the Faculty continues to work with the Clinical Reference Group for Specialised Pain Services.

For secondary / specialist services, the Faculty is now engaging with the Clinical Commissioning Groups and remains in liaison, through the RAPMs, with local developments.

Anna Weiss and Beverly Collett are taking forward a project to produce a multi-professionally agreed (RCGP, RCN, CSP, RPS etc.) document on the Provision of Pain Management Services. This document will define the necessary personnel and physical requirements to run a Pain Management service. Once complete, this document will be sent to NHS England and the Clinical Commissioning Groups. The first draft is already prepared and the document aims to be consulted upon in April and launched in the early summer.

[1] http://www.rcoa.ac.uk/faculty-of-pain-medicine/standards/commissioning

2 The Examination

2.1 What are the pass rates?

A couple of comments suggested the pass rate for the FFPMRCA is disproportionately low. We've included all the pass rates for the examination so far below to provide some hard data on this. With lower numbers taking the exam than the FRCA, the pass rates are more susceptible to variation. The only very low pass rate for the MCQ (the second sitting of 2013) was covered in the first TAC response to trainees.

As examinees can take each exam 6 times, the pass rates will also include some examinees taking the exam for second or third time so the pass rate for 'first timers' will be higher.

Sitting	MCQ pass rate	SOE pass rate
1st (2012)	91%	69%
2nd (2013)	82%	73%
3rd (2013)	44%	77%
4th (2014)	82%	56%
5th (2014)	68%	60%
Average	73%	67%

2.2 Basic science

One trainee mentioned that they were completely unprepared for the basic science in the exam. The FFPMRCA has always been explained as having a significant component of basic science within in, right from the first article on it in Spring 2010's Transmitter: "The format of the exam and its regulations will be based broadly on the final FRCA, utilising written and viva-based assessments on clinical management ***and the science underpinning our practice***." [Professor Dave Rowbotham]. The FPMTAC thought it would be helpful here to explain in some greater depth the reason why science is integral to the FFPMRCA.

Excellent knowledge of relevant science is a prerequisite to the safe and effective practice of Pain Medicine. One cannot expect to be considered appropriately trained to specialist level and competent in the role of Pain Consultant without demonstrating knowledge in the areas of science pertinent to pain practice. This will include anatomy, clinical pharmacology, physiology, epidemiology, clinical measurement, basic psychology, imaging and other relevant areas.

There is a perfect symmetry to the intensive assessment of the science of anaesthesia practice and its relationship to the safe and effective conduct of the anaesthetist, and that of the science and practice of pain medicine. It is expected that all examinees for FFPMRCA are anaesthetic trainees, and will have successfully completed FRCA or equivalent, and should have a desire to maintain the same high standard for their pain practice as they have for their anaesthetic practice.

As an example, RCoA would expect its fellows to understand the relevant physics underpinning the safe and effective delivery of anaesthetics gases to an anaesthetised patient, and tests its trainees to this standard as part of the FRCA examination. It is conceptually similar that the FPM would expect that the practising Pain physician would understand the basic principles of an image intensifier to ensure the safe and effective use of this device, and seek to examine FFPMRCA examination candidates to ensure this minimum standard is met.

The level of science expected to pass the exam that leads (with appropriate training) to FFPMRCA is similar to that which is expected for other international standard exams such as the FFPMANZCA.

2.3 Guidance for the examination

Covered within the Examinations FAQs [2]. When trainees ask for 'guidance' it is unclear what that specifically means. Do tell the Faculty (directly or via Lucy) exactly what you want and they will see if it can be provided – if it can't, they'll be open and tell you why. So far the request has been for further MCQs, but as with the FAQ on this, the Faculty is releasing these as fast as it can and at the end of 2014 recruited additional question writers to speed this process up.

[2] http://www.rcoa.ac.uk/system/files/FPM-EXM-FAQs.pdf

2.4 Make the examination compulsory

Currently, no College/Faculty examination is compulsory, as applicants for consultant positions can come from overseas, where that particular examination is not taken. The FFPMRCA, like the FRCA, therefore remains a desirable criterion on consultant Person Specifications. However, like the FRCA, UK applicants are increasingly expected to have the examination and the subsequent post-nominals amongst their wider portfolio of evidence in order to be successful at consultant AACs.

3 The status of Pain Medicine

3.1 On-call

Following feedback from the 2013 Trainee Survey, the FPM agreed a change with the RCoA and the GMC to the CCT in Anaesthetics as below:

"Whilst it is recognised that a non pain medicine on call commitment is often undertaken during the period of advanced pain medicine training, it should not be more onerous than 1:8 to ensure that it does not detract from training; it is the responsibility of local supervisors to ensure that if it does interfere, time in training will have to be extended to ensure the competencies are achieved. It is unlikely that trainees who spend time outside of the Pain Medicine environment engaged in general anaesthetic duties will be able to successfully obtain all of the competences required to complete Advanced Pain Training. Therefore, the expectation is that trainees will need to spend substantially the whole of their daytime working hours engaged in pain medicine related duties. This of course would not prevent pain trainees being used on occasion to provide general anaesthetic cover for unforeseen emergency cases." [3]

If your Pain Medicine training is suffering at the cost of on-call, let your RAPM or the Faculty know ASAP.

The Faculty will continue monitoring the effect of on-call in the Trainee Surveys which are reviewed in some detail, first by the secretariat and the Trainee Representative (in order to protect anonymity) and then by FPMTAC. The topic remains considerably complex, with some trainees preferring to concentrate on Pain Medicine experience whilst other trainees do not wish to lose on-call and have a resultant drop in salary. The bottom line is that a CCT marks only a division of responsibility in training – as consultants you will never stop learning and training. Training in the UK in Pain Medicine is 13-15 months (depending on the length of Higher Pain Training in your region) and will not be longer whilst Pain Medicine remains a specialist area of anaesthetics (more on that in 3.2 below) with an extra 3 months as part of intermediate and basic pain medicine experience (total of up to 18 months). What that means in practice is that as a consultant you will have a slightly steeper learning curve than an Australian Pain Medicine specialist who undertakes 24 months training.

[3] http://www.rcoa.ac.uk/system/files/TRG-CU-CCT-ANAES2010.pdf (Section 12.2.4.3)

3.2 Why are we a specialist area and not a formal sub-specialty?

The Royal College of Anaesthetists has historically not been supportive of subspecialties, seeing strength in the thorough and successful general training the CCT in Anaesthetics provides. The Faculty of Pain Medicine got agreement from the Royal College of Anaesthetists to apply for sub-specialty status in February 2012 and had an exploratory meeting with the GMC soon after. The GMC made it clear that the Shape of Training review had brought a portcullis down on any future specialty or subspecialty approvals. A subspecialty cannot self-declare, but must be approved by the GMC, as the legal regulator, and the four home nations.

The current movement with Shape of Training outcomes appear to reassign subspecialties as post-CST credentialing. The portcullis remains down, but in addition until there is further development with the Shape outcomes there remains considerable uncertainty about what the future will hold for subspecialties. The Faculty remains closely involved with these discussions at College-level.

3 Are there Pain Medicine consultant jobs out there?

Dr Jon McGhie is currently leading a Working Party on Quality & Workforce. The outcomes from his review of workforce here [4]. The Faculty submitted a response to HEE's Call for Evidence on workforce providing this and related data and noting that "This expanding, elderly population with significant co-morbidities is likely to increase demand for chronic pain services." [HEE Call for Evidence]

The table below is extrapolated from the AAC data held by the College. With the exception of 2011, there has been a constant amount of Pain Medicine consultant posts in the region of 30-40 annually, which is in line with APT numbers. Notably, a number of AACs have been cancelled. Cancellations can happen for a number of reasons, but the most common reason has been due to lack of suitable applicants, correlating to a shortfall in trained specialists. 2014 date to follow soon on the website.

Year	Consultant posts with Pain Medicine sessions	AACs cancelled
2007	32	3
2008	38	3
2009	38	1
2010	31	6
2011	19	0
2012	39	3
2013	31	2

[4] http://www.rcoa.ac.uk/faculty-of-pain-medicine/workforce

4 How to publicise Pain Medicine as a career option

4.1 The website

The first, basic versions of the career pages for Pain Medicine have been available on the website for some months [4]. Emma Baird and Lucy Miller are currently working on the second iteration which will go live this summer. If you have any ideas, do let us know. We would also welcome additional career stories. Once the second version goes live, we will do a full launch and circulate the information widely.

[4] http://www.rcoa.ac.uk/faculty-of-pain-medicine/a-career-in-pain-medicine

4.2 Newsletters and publications

The Faculty (with the BPS and the CPPC) recently met with the BMJ and is working towards a range of articles on Pain Medicine. There is a regular article in the RCoA Bulletin and the option to publish a trainee experience in the RCoA trainee newsletter, *The Gas* – if anyone is keen, let Lucy know. If you have any other article / publication suggestions do let us know.

4.3 Exposure

The 2010 curriculum more clearly defines the exposure all anaesthetists should get to basic and intermediate Pain Medicine training. The Faculty will also be commenting on the current Foundation curriculum consultation to recommend that Pain Management is included as a key component. We are also working with the RCGP and the BPS to consider the role of Pain Management within undergraduate curricula.

5 Other training

5.1 Curriculum Guidance

This was developed by Roger Okell on behalf of the FPMTAC and with input from FFPMRCA examiners. It was mentioned recently that trainees may not be familiar with it so here is a link directly to it [5]. This is part of our general page on training and assessment [6]. The Guidance expands elements of the curriculum to give a greater view of the exposure to training areas and interventions required during your APT.

[5] http://www.rcoa.ac.uk/system/files/FPM-Scope-of-Advanced-Pain-Training_0.pdf
[6] http://www.rcoa.ac.uk/faculty-of-pain-medicine/training-examination-and-assessment

5.2 Case Reports

From 1st January 2015, trainees will only need to submit ONE case report as part of their Advanced Pain Training and Fellowship application; these will still need to be marked locally and submitted to the Faculty for cross marking.

There has been a request for guidance on the case report. This has been available for some time online. The FPM Case Report Guidance, which is based on the FICM Guidance, is available here: http://www.rcoa.ac.uk/faculty-of-pain-medicine/training-examination-and-assessment/case-reports

Do keep checking this and other online resources as we update and expand these dependent on recent developments or on trainee/trainer requests.

5.3 London Deanery study days

The London Pain Training Advisory Group has formally agreed to allow trainees from the rest of the UK to attend their training days. Dates are available through the Trainee Representative and online. The first few 'open' London days have been a great success we hear, with trainees as far as Scotland being able to attend.

5.4 Issues with study leave

Some trainees raised issues with study leave, which were new to the FPMTAC. If anyone can provide specific examples, this would greatly aid us in finding a solution.