Pain medicine: a trainees' perspective

I am currently the trainee representative for the Faculty of Pain Medicine and an Advanced Pain Medicine trainee in the North West Deanery. I applied to do my Advanced Year in Pain Medicine after working in the financially resource poor world for a medical Non Government Organisation (NGO). It was the lack of basic pain relief available to a large proportion of the world's population that cemented my commitment to a career in Pain Medicine.

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Pain Medicine training is undergoing developments in order to set standards and improve the training experience. In 2007 the Faculty of Pain Medicine was created with the remit of representing the professional, educational and training needs of Pain Medicine doctors. Prior to this the Royal College of Anaesthetists and the British Pain Society had been instrumental in educating the medical community. Pain training for all anaesthetists begins as part of basic level training. Acute pain and some chronic pain is included in the basic level core competencies. Specialist Pain Training in the UK now consists of 20 half day sessions at ST 3–4 (compulsory for all anaesthetists), a four to twelve week block in Higher Training and a twelve month block in Advanced Training. Higher Pain Medicine training may be a stand-alone optional experience for those wanting a career as part of an acute pain medicine team. Trainees embarking on a Pain Medicine career with substantial commitment undertake an advanced year and usually spend this in a single tertiary pain centre, or a number of units each with differing educational opportunities. During this, training experience is gained in consultation skills, pain procedures and learning how to manage a clinic. All advanced trainees are encouraged to spend time in clinics with other allied specialties, for example rheumatology or neurosurgery, gaining insight in to diagnosis and management in these respective specialties. We are also given the freedom to develop 'special interests' in Pain Medicine from 'dropdown' parts of the Advanced Pain Medicine curriculum in paediatric pain medicine, cancer pain medicine and Spinal Cord Stimulation.

The FFPMRCA exam was established last year covering both practical clinical knowledge and knowledge of relevant sciences. It is similar in structure to the final FRCA with an initial written exam consisting of MTF (multiple true false), SBA (single best answer) and EMQ (extended matching questions). If that is passed it is followed by two Structured Oral Examinations one clinical and one on relevant basic sciences. The aim of the examination is to enhance the practise of Pain Medicine in the UK and ultimately benefit patient care. Having completed this new robust training scheme pain trainees are entering into the ever changing and expanding field of Pain Medicine practice. As with all medical specialties the future is a little uncertain. Nobody knows for sure how government policy and legislation will affect the specialty. There are currently an estimated 10 million adults suffering from long term persistent pain in the UK. Some sources estimate that 20% of the UK's total health expenditure is taken up treating back pain alone and that this costs the exchequer five billion pounds a year. There is definitely a need for Pain Medicine specialists, both holistically and from a health economics point of view. We now have a dedicated Faculty, dedicated journals, research facilities and training. The last decade has seen the increasing use of powerful imaging technology (fMRI and PET scanning) to look at brain function related to pain. The biopsychosocial model of pain has become widely accepted and knowledge in the field of neurobiology is increasing rapidly. Pain is a hot topic. In tandem with this increase in scientific research and clinical trials there has been an increase in the use of evidence based medicine when treating pain patients.

The day to day life of a pain specialist is very varied; time is usually split between anaesthetics, pain clinics and pain theatre lists. Some specialists choose to have an additional interest in acute pain and will have an acute pain ward round as part

of their job plan. Clinics can be consultant lead, in tandem with another member of the team or run as an MDT (Multi-Disciplinary Team) clinic. The make-up of MDTs varies but is commonly a mix of a specialist in Pain Management from the areas of Medical, Nursing, Physiotherapy and Psychology. Common invasive procedures lists include interventions targeting the facet joint and its nerve supply, epidurals and simple peripheral nerve blocks. What else is offered varies considerably, and often develops once in a consultant post. There are increasing numbers of high tech interventions available to treat long term chronic pain. Many centres offer radio frequency ablation and some specialist centres are carrying out neuromodulation with spinal cord stimulators and the insertion of implantable infusion devises. I offer acupuncture as a treatment option having learnt to do so on a BMAS (British Medical Acupuncture Society) course. I enjoy the fact that I can be working in a MDT clinic in the morning dealing with patients with complex medical, psychological and social issues then spend the afternoon carrying out a varied range of pain procedures.

I personally feel the main skill needed to be a pain physician is good communication. Patients often end up in pain clinic at the end of a long journey via other specialties. They have usually undergone multiple investigations and some have had surgery. At the end of this journey many feel that there is nothing more that can be done to help them. They are a vulnerable group who have higher than average rates of mental health disorders including depression and suicide and are more likely to have undergone significant trauma and abuse in their lives. As a result of chronic pain they are also more likely to be unemployed and socially isolated. The consequences of poor communication can be catastrophic, not only leading to poor pain management but potentially perpetuating the downward spiral of their existence.

Pain Medicine can offer the dedicated a rich and varied career. It regularly tests my medical knowledge to the full and allows me to practice medicine beyond the confines of theatre anaesthetics. There is a real joy to relieving pain and distress in children and great satisfaction in providing good quality, holistic end of life care. It's not for the faint hearted; compassion and patience are required to excess and it doesn't have the 'exciting quick highs' seen with emergency anaesthesia and intensive care. Pain Medicine is much more of a long game. Think of it as a five day test match rather than a 20:20 game. You have to manage your own expectations as well as those of the patients; we don't 'cure' many people but can still substantially improve their quality of life.