FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

Newsletter of the Faculty of Pain Medicine AUTUMN 2011

TRANSMITTER ONLINE

Major Faculty updates

FFPMRCA examination development

Pain Summit

A GP's view of opioid prescribing

Revalidation

Events, training and more

FACULTY OF PAIN MEDICINE
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Welcome to the Faculty of Pain Medicine's fourth newsletter

As the summer draws in and we turn to chilly autumn days, the emotional remnant of the beginning of the academic year brings a vigour and enthusiasm for the activities of the weeks and months to come not least for the Faculty...

We are delighted to welcome you back to the 4th Transmitter. In this edition we have the regular reports from the Dean, Chairs of the Committees, the Examination Executive, the representatives of the Regional Advisors in Pain Medicine, the trainees with an interest in pain medicine and the organiser of our meetings. We have so much to reflect on, particularly as the Faculty approaches its fifth birthday in April of next year.

We have an interesting and complementary mix of guest articles: We are delighted to hear reflections from Dr Joan Hester, retiring FPM Board Member and Past President of the British Pain Society (to mention a small number of the many roles and responsibilities she has had during her distinguished career in Pain Medicine). We wish her well in her retirement - she will be missed enormously by our fraternity. Her sentiments compare with the thoughts of Dr Justin McCarthy, a General Practitioner, whose article observes changes in the prescribing of strong opioids over recent times.

We welcome expert opinion on revalidation from Mr Don Liu and a philosophical yet pragmatic excursion into the use of MSF in our subspecialty, given the peculiarities and idiosyncrasies of pain medicine, by Dr Barry Miller. These articles are timely as revalidation comes to the fore and we all sense a need for support and advice.

As ever, we are keen that Transmitter makes good reading for you and is relevant, worthwhile, applicable and hopefully inspiring. We should be delighted to hear of any suggestions for topics to cover, or offers of guest articles for future editions of Transmitter.

Kate Grady

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Available online at www.rcoa.ac.uk/fpm

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News from the Faculty

Professor Dave Rowbotham, Dean

The College is working on a new website and, as part of this project, the Faculty of Pain Medicine (FPM) will have its own site and address. Early pilots look very promising and we hope it will be up and running early in the New Year. Presently, we are thinking about the content of the FPM site and welcome any suggestions from our Fellows, Members and trainees.

Logbook

A new version of the FPM trainee logbook is soon to be published on the website. This has been developed by Roger Laishley and Barry Miller and includes more fields and improved functionality. We are now hearing that outputs from this software are beginning to inform trainee assessments and we think that the new version will be even better. Please keep an eye out for the new version and alert your trainees to it.

Membership

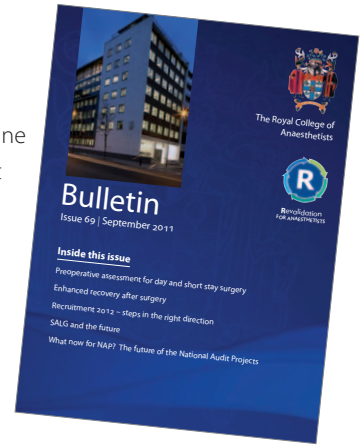
Those of you that are avid readers of our website may have noticed that we temporarily suspended applications for Membership of the Faculty. Many of the FPM regulations were adopted directly from those of the College and, although the regulations for Membership are well suited for the College, it became evident that they were not appropriate for the FPM. In summary, it was possible to apply for Membership (and the associated post-nominals) if, for example, you had taken the primary FRCA but had no exposure to pain medicine since then and may have even changed speciality. The new regulations have been simplified and approved. Applicants now have to be practising pain medicine in an appropriate environment with evidence of active CME (new regulations now on the website). This will not adversely affect applications from our SAS doctors.

Pain training

The long term future of our specialty depends on our trainees and their subsequent appointment as consultants in the NHS. At the September Faculty Board meeting, we discussed the effect of the current political and financial climate on the number of anaesthetic trainees who were taking on advanced pain training. For the last six months, trainees have been asked to register with the FPM but it is too early to use these data as an indicator. We discussed anecdotal reports that the numbers were diminishing. However, this was not the experience of many of our Board members and some were oversubscribed. We intend to monitor this closely with our new registration system and at the Regional Advisors in Pain Medicine meetings.

Workforce

The Centre for Workforce Intelligence (CfWI) has recently published their recommendations on medical training numbers over the medium term (2-4 years) (available at www.cfwi.org.uk). Pain management was considered with anaesthesia as we are not a recognised medical speciality. The CfWI recommended a continuation of the strategy of increasing the numbers of GP trainees in order to achieve a GP workforce of 'historic levels'. Increases were recommended in Allergy, Cardiothoracic Surgery, Community Sexual and Reproductive Health, Dermatology, Geriatric Medicine and Interventional Radiology. They advised moderate reductions in Anaesthesia, General Surgery, Obstetrics and Gynaecology, Trauma and Orthopaedic Surgery, ENT and Renal Medicine. It was good to see that, despite the reduction in anaesthesia numbers, the CfWI highlighted the role of pain medicine in anaesthesia and recognised that this was increasing.



Strategy

As I mentioned in the recent RCoA Bulletin, the FPM Board is undertaking a review of its strategy. The basic infrastructure has been established, training and assessment schemes are in place, examination preparations are progressing and we are holding regular well attended meetings. The question is: what should we do next? Carry on as we are or take on new activities? Topics for consideration may include: further educational activities; extending partnerships; how we can better serve our Fellows, Members, trainees and patients; new guidelines and recommendations; research; and how to further promote pain medicine in the NHS. What do you think? Please let us know.

Training and Assessment Committee

Dr Kate Grady, Vice Dean and Chair of the FPM Training and Assessment Committee

The work of the Training and Assessment Committee is now well established, embedded and very structured. Our work is ongoing, punctuated by four meetings a year, two face to face at the RCoA and two as teleconferences. The Training and Assessment Committee concerns itself with all matters of pain medicine training in anaesthesia in the United Kingdom. It has a day to day and strategic role in this respect. The Committee is a cohesive body, although, over time, its members have developed individual and specialised roles and areas of expertise, acting as agents of the FPM on RCoA committees, groups within the College and other educational endeavours.

Roles and Responsibilities

Dr Mark Taylor represents us on the MSF Working Group and also has had a significant role in the writing of the pain medicine sections of the curriculum and offers expertise in ongoing associated matters. Dr Barry Miller, together with Dr Roger Laishley from the Board of the FPM, designed and have responsibility for the pain medicine logbook and its implementation. Dr Miller is also a member of the e-Portfolio Working Group, the Assessment Working Group and has recently joined the Workforce Planning Strategy Group. Dr Roger Okell sits on the Training Committee and Quality Management of Training Committee of the RCoA. Dr Nick Plunkett oversees the busy OOPE process with respect to pain medicine and is an assessor of FFPMRCA applications, as are Dr John Hughes, Dr Mark Taylor and Dr Jon McGhie. Four Board members sit of the Training and Assessment Committee, Professor Ian Power, Dr Mark Taylor, Dr Stephen Ward and me. Dr Neeraj Saxena continues to represent the interests of the trainees' body at both Training and Assessment Committee and Board level. We are delighted to continue to co-opt Dr John Hughes to be that vital point of liaison with the Regional Advisors in Pain Medicine and Dr Jeremy Cashman as lead question writer. Dr Nick Plunkett has been appointed as deputy chair for the FFPMRCA examination.

Trainees

The Committee had another strong presence at the Trainees' meeting at the British Pain Society Annual Scientific Meeting 2011, organised by Dr Saxena. This was an opportunity for an open question and answer session and where problems or difficulties were perceived (such as with access to advice on pain medicine training), these are being or have been addressed by the Committee and communicated back to trainees, through Dr Saxena.

Curriculum

The 2010 curriculum, 'the CCT in Anaesthetics', is embedding well. There are pain medicine units at basic, intermediate, higher and advanced levels. Within the advanced pain medicine curriculum there are optional specialist modules of paediatric pain medicine, spinal cord stimulation and cancer pain medicine and a further, on intrathecal drug delivery has recently been given General Medical Council approval. To complement the curriculum, the Committee (led by Dr Mark Taylor) has developed a series of Frequently Asked Questions covering the curriculum, pain medicine training in general, and the forthcoming FFPMRCA examination. These are posted on the FPM website.

Assessment

The assessment process is now being brought into the e portfolio. The assessment system for Advanced Pain Medicine training is very well established. The cross regional marking system for the case reports is working well. Discussion with the Faculty of ICM surrounding their marking and supervision systems for case reports has prompted some revision for us in this area, and this is being taken forward by Dr Barry Miller.

Regional Issues

Strong links with the Regional Advisors in Pain Medicine (RAPMs) are vital to the work of both the Committee and the Board; these are made through Dr John Hughes, a constant driving force of excellence. We are very appreciative of the intense efforts and aware of the effectiveness of the Regional Advisors in Pain Medicine and the Local Pain Medicine Educational Supervisors and offer gratitude and sincere thanks to them. Dr Hughes has taken the opportunity to contribute audit templates relevant to training in pain medicine to the RCoA Audit Recipe Book. These will form the basis of audits to be conducted throughout the UK looking at aspects of pain medicine training at advanced and the other levels. They will be available to all as the Audit Recipe Book is published in 2012.

Standards

The committee is keenly aware of its duty to all trainees and trainers in pain medicine and in turn to patients. We aim for the highest standards in education and training, in recruitment to the specialist area and in enrolment to the Faculty.

Thanks

The committee is indebted as ever to Daniel Waeland and to James Goodwin, to Anna Ripley and Andrea Rowe for their dedication to us and for their contributions. Thanks also go to the Training and Examinations and the Education Directorates of the RCoA for their invaluable support. As Chair of this Committee, I am indebted to its members for their loyalty and commitment, drive and enthusiasm, and their constant support.

Professional Standards Committee

Dr Karen Simpson, Chair, Professional Standards Committee

The months leading up to summer holidays were busy for the PSC; good practice, professional standards, patient safety and revalidation provided most of the workload. However the PSC continues to contribute to wider national issues and we are mindful that we need to engage as many Fellows in this process as possible. Please contact the FPM if you want to suggest areas that we should look at or contribute to. It is also vital to represent and engage patients and carers - so I was pleased to thank Kate Rivett for all her valuable contributions as she demitted office, and to welcome Sara Payne to the Committee as the new representative of the Patient Liaison Group.

Events

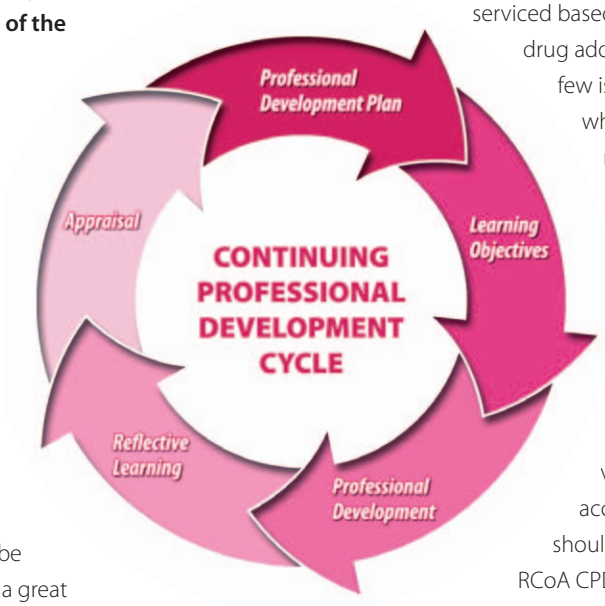
Our Educational Meetings Advisor Sanjeeva Gupta has surpassed himself with more very interesting meetings planned for this year and early in 2012. The Cancer Pain meeting in June 2011 was a great success with excellent feedback. There will be an Acute Pain day in November 2011 that will cover current issues. In addition please do not forget to put 30 November 2011 Annual Fellows and Members Study Day in your diary! It will be a superb day with top speakers, but also a great chance for us all to meet to catch up and compare the national scene. A three day meeting is planned for January that is likely to prove popular with Fellows and Members, but I am sure also with future candidates for the FFPMRCA exam – details will follow.

Publication

There are now many useful publications for pain services on the RCoA and FPM WebPages. Have a look at these as they may help those units that are struggling to maintain standards and training in the face of growing service pressures. The Guidance on provision of acute and chronic pain services is particularly pertinent.

Consultation

The issue of driving whilst taking opioids comes up at every opioid meeting. Dr Cathy Stannard is taking this forward with the DVLA on the FPMPSCs behalf; we hope to be able to collaborate in producing clear and helpful recommendations for primary and secondary care. Similarly initial negotiations have occurred concerning a document produced by the Department of Health that is the first serviced based study relating to over the counter drug addiction. The PSC noted that there are a few issues with this e.g. it does not explore why patients are taking over the counter medicines, it does not address patients with ongoing needs and it does not reach any scientific conclusions. The PSC agreed that the Faculty needs to provide a professional response - this is work in progress.



Revalidation and CPD

Work on revalidation continues; it is vital that all doctors record their CPD accurately. If they do so then the process should be straightforward. The launch of the RCoA CPD system occurred this summer. The RCoA has developed an online system to support Consultant and career grade doctors in planning and recording CPD. There is: - a searchable database of RCoA CPD approved events; users can search for events by dates, CPD matrix topics, title and keywords and subscribe to individual events in their CPD diaries; a CPD diary that allows the user to record activity and add a reflective review; personal development plan that is linked to the CPD diary; CPD activity summaries providing a record of annual and five yearly CPD when completed and a breakdown of credits gained from internal, external, clinical and non-clinical CPD. The site has a link to register – try it it's excellent.

Finally the PSC depends on team work and my thanks as always to our administrate team under the guidance of Daniel without whose calm efficiency we could not function.

Regional Update

Dr John Hughes, Chair of the Regional Advisors in Pain Medicine

The summer months have not been quiet as the RAPMs have been introducing the changes detailed in the recently published Faculty guidance on the Roles and Responsibilities of RAPMs along with those for Local Pain Medicine Educational Supervisors (LPMESs). Although at first look this appears to be a significant development, in reality this is a formalisation of systems developed over the years by the RAPMs in order to have clear lines of communication and local points of contact for trainees and College Tutors.

Curriculum issues

There has been significant progress in instituting the new curriculum. There have been challenges but these have not been insurmountable.

Clarification has been given with regard to Higher training and the curriculum recently reworded to state: '… the optional higher unit of pain medicine should be in blocks of four to twelve weeks in duration and consist of a minimum of twenty sessions.' Twenty sessions here is to be recognised as an absolute minimum – the figure is selected to marry up with the conditions for other higher units in the CCT in Anaesthetics. It is important to recognise that the curriculum is both time and competency based. Trainees must be able to reach all the competencies within the higher pain medicine section of the curriculum and its length needs to reflect that. The general consensus has been that this takes twelve weeks but may vary by region.

There has also been recent discussion with regard to DOPS at higher level. This is under review currently and altered guidance will follow.

RAPM meetings

The RAPMs have two formal meetings per year. One occurs during the BPS ASM thus providing opportunities for Fellows, trainees and others to meet and discuss issues informally with RAPMs, Board and Committee members along with Faculty administrative leads. The other meeting coincides with the winter RA Anaesthesia meeting providing a useful opportunity for both RAs and RAPMs to meet and discuss issues similar to both. Part of that day is set aside for the RAPMs to meet alone. The next meeting, in November has a section specifically as an update on the FFPMRCA examination process. Some of the RAPMs are examiners others are not. This session will allow the RAPMs to better advise and support potential candidates with regard to structure and preparation.

Other areas of discussion

The Pain logbook is still under test but feedback has been good. Further comments are welcomed. It is suggested that this be used for all higher and advanced trainees for their pain training. Other anaesthetic trainees who feel they may follow a path in pain medicine should also consider using it for the pain components of their training.

As a reminder all Advanced Pain Trainees should be registered with the Faculty but it is strongly suggested that Higher Pain Trainees should do the same. This allows for timely information to be sent out from the Faculty as well as for Faculty planning with regard to meetings, examinations etc.

With the advent of the examination the number of case reports has been reduced to 2 during the advanced training year. These are to be forwarded to the Faculty where a benchmarking exercise is underway along with the development of a formal marking system. The current local marking remains in place and is taken into account for FFPMRCA applications.

Finally it is with great regret that we learned of the death of Pete MacKenzie this summer. He was one of the original RAPMs who was very active in developing the role. He not only brought ideas to the table but also supported others at the same time. He went on to be active in other areas of the Faculty and a formal tribute can be found in this issue. He will be missed and his contribution as an RAPM should not be forgotten or underestimated.

Pain Medicine training in Mersey Deanery

Dr Roger Okell, Mersey Regional Advisor

Mersey Deanery is relatively compact. Within the Deanery, there are 13 Teaching and General Hospital Trusts, which are located in Merseyside, Wirral and Cheshire. Every hospital makes a contribution to pain medicine training and has a Local Pain Medicine Educational Supervisor to oversee this. The Mersey Pain Training Committee meets twice yearly to discuss the organisation of pain medicine training in the Deanery. There is close liaison with the Mersey School of Anaesthesia Board. Pain medicine has its own pages at the Deanery Website.

Pain medicine training in the Mersey Deanery is enhanced by time at three very prestigious units – the Walton Centre, the National Refractory Angina Centre, and Alder Hey Hospital where we are able to offer training in paediatric pain medicine. We have currently three Advanced Pain Medicine training posts. These posts have regularly been made available to trainees applying from training programmes outside the Mersey region.

Consultants with an interest in pain medicine contribute to teaching at the basic science and anaesthesia course and the FRCA course at the Mersey Series of Anaesthesia. The Clinical Management of Chronic Pain course runs annually at the Walton Centre and attracts attendees from across the UK. There are regular pain meetings at the Walton Centre including an annual eponymous lecture. The multidisciplinary Mersey Pain Group also runs several academic meetings each year.

Trainee Update

Dr Neeraj Saxena, Trainee Representative for the Faculty

Examination update

Those of us who have started their advanced pain training from February this year will be sitting the exam for the FFPMRCA and have been eagerly awaiting more information; these details are now available on the FPM website. The two part exam will include a written section and an oral section. The written section will consist of multiple choice questions (including multiple true false, single best answers and extended matching questions). There will be no negative marking. This is in line with the current FRCA examinations. The oral section will contain a clinical part (one long case and three short clinical questions) and a science part (covering anatomy, physiology, pharmacology and a section covering psychology, epidemiology and clinical measurement. Quite importantly, the Faculty's annual 'Current Concepts in Pain Medicine' course in January next year will include a day covering topics pertinent to the preparation for the examination.

Trainees' meeting at the BPS

The pain trainees' annual meeting took place during the British Pain Society Annual Scientific Meeting in Edinburgh and was well attended by the trainees. This meeting provides one of the few opportunities for trainees from different regions to come together and share their unique experiences and thoughts about pain training. This meeting is also very popular with the trainers and most of the Faculty's Board members and a few RAPMs also joined in to interact with the trainees.

As expected there was a fair amount of discussion about the general pain training issues, however, the upcoming FFPMRCA exam was the highlight. While their was still a bit of apprehension among some of the current advanced pain trainees regarding the exam, everybody understood and believed in the importance and added value of obtaining the FFPMRCA following it. Discussion among the trainees continued well beyond the stipulated one hour which was unsurprising as there is always so much more to talk about! It was really inspiring to see the passion and excitement all trainees associate with their careers in pain medicine. I sincerely thank everyone who made the effort to attend it and hope it was useful to them.

And last but not least, please keep your comments, thoughts and queries relating to FPM and pain training coming in either directly to me (**drneesax@yahoo.co.uk**) or through our closed forum on Doctors.net (**www.doctors.net.uk/Forum/viewTopics.aspx?forum_id=430**).

2011 Trainee Publication Prize

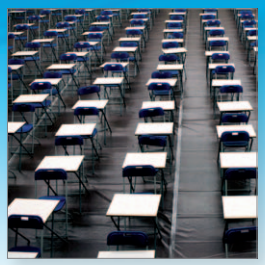
Congratulations to Dr Simon Law, who was awarded the 2011 Trainee Publication Prize for his work on a Cochrane Review on 'Triptans for acute cluster headache' that was published in the Cochrane database of Systematic Reviews in issue 4 2010.

The review has been well received, and has been cited at least eight times in the short period since it was published. The research has been presented at a headache symposium, drawn on for the emergency room guidelines for treatment of acute clusters in the United States.

Dr Law will present a short summary of the article at the Annual Meeting for Fellows and Members on 30th November and receive his certificate. Part of his prize will also be the opportunity to attend all the lectures on the day and meet many Fellows and Members of the Faculty.

Examination Development

Dr Kate Grady, Project Clinical Lead
Mr Daniel Waeland, Project Manager



The FFPMRCA Examination will be introduced in autumn 2012 for all Pain Medicine trainees who entered their Advanced training on or after 1 February 2011. The FFPMRCA will comprise two sections, the first a written paper of Multiple Choice Questions and the second a Structured Oral Examination. Below are a series of key areas of the Examination Project with a short update on each.

Guidance

A guidance document was sent to all trainees who registered with us via our trainee representative, Neeraj and is posted on the website. The Examination Regulations were added to the website in September.

Scope

The questions will be mapped against the Pain Medicine and Generic sections of the CCT in Anaesthetics.

Eligibility

Doctors who have undertaken at least six months of their Advanced Pain Medicine Training year (including those who have completed the entire year). These arrangements may change in the future when the two parts of the examination may be are uncoupled following an initial period of quality assessment.

FFPMRCA

Doctors who have completed Advanced Pain Medicine Training as part of a CCT programme who hold the FRCA qualification and are successful in the Pain Medicine examination will be awarded the FFPMRCA.

DFPMRCA

Doctors who have completed Advanced Pain Medicine Training as part of a CCT programme and are successful in the Pain Medicine examination but who have qualifications other than the FRCA will be awarded a Diploma of the FPMRCA subject to the further criteria detailed in the Regulations.

Application

Over the next nine months, the Examinations section of the FPM website will transform into an application portal for the FFPMRCA Examination with full details on application forms and paperwork requirements. The process will run similarly to the FRCA.

Dates and timings

The first MCQ paper will be held on 19 September 2012 with the SOE component following on 14 November (with a second day on 15 November if numbers require). The spring MCQ paper will be held on 29 January 2013 with the SOE on the 3 April 2013.

Format

The MCQ will consist of a three-hour paper comprising 40 Multiple True/False questions, 25 Single Best Answer questions and 25 Extended Matching Questions. The SOE will be divided into two subsections. The Clinical Pain Medicine SOE will be 50 minutes in duration and consist of a Long Case and three Short Clinical Questions. The Science SOE will be 30 minutes in duration and consist of four advanced science oral questions.

Questions

Example questions for all parts of the examination are available on the FPM website.

Preparation

The Examination Guidance document circulated earlier in the year has detailed advice on preparation. Please also discuss this with your Regional Advisor in Pain Medicine.

Course

The January course will have a number of talks relevant to those preparing for the examination. Please see the events section for further information.

Fees

The fee for the examination is near agreement following confirmation of the budget for the first examination in 2012. As noted in the previous edition of Transmitter, the total income from fees will need to cover the full cost of the examination but will not run to a profit.

Standard setting

The examiners have been busy question writing all summer as well as taking the first steps towards standard setting the examination. A criterion referencing day was held in July with the assistance of examiners, RAs in Pain Medicine and pain medicine consultants. Further days involving recently appointed consultants are planned for early 2012. A two day examiner seminar in November includes training for the oral component of the examination for examiners as well as an opportunity to standard set the oral component.

For more information updates, please visit the following URL: **http://www.rcoa.ac.uk/index.asp?PageID=1773**.

Update on revalidation

Mr Don Liu, RCoA
Revalidation Project Manager

Work on revalidation continues with recent focus being on establishing the core supporting information items (or 'evidence') that doctors will need to submit for their annual appraisal. The Colleges and Faculties have been working collaboratively with the GMC to identify this evidence base. Colleges are now developing the necessary specialty specific guidance so that the appraisal process is a meaningful one for their Fellows and Members. The Revalidation Development Committee at the RCoA, with input from the FPM, co-ordinates the development of this guidance to cover the specialty elements in CPD, audit, review of clinical outcomes and other activities from which the required supporting information for appraisal is derived. A draft guidance document on supporting information is available from the College's revalidation website and will be used by anaesthetists and pain medicine specialists participating in the Department of Health's 2011/2012 revalidation pilot.

Also available on the College website is guidance on colleague and patient feedback – a requirement for appraisal and revalidation. Dr Ramani Moonesinghe has been leading a working group to provide guidance on choosing an appropriate questionnaire, implementation and the choice of individuals to provide feedback. Dr Mark Taylor from the Board of the Faculty of Pain Medicine is a member of this group, to input from the pain medicine perspective and represent pain clinicians in this respect. The working group recognises the challenges in capturing valid and reliable patient feedback and has recommended different approaches, including using departmental level data, depending on specific areas of practice in anaesthesia, pain medicine and critical care. This version of Transmitter has an article addressing multi source feedback in pain medicine written by Dr Barry Miller.

The College's new online CPD system has been launched. This resource will allow you to search for College accredited CPD activities, create personal development plans and record your educational activities and credits. It will also support revalidation. You will be able to produce an end of year summary of your educational activities mapped to the CPD Matrix to demonstrate, during your appraisal, how you keep up to date, maintain and enhance the quality of your professional work. All consultants and career grades are encouraged to register their interest in using the online CPD system – an electronic registration form is available on the College website (**www.rcoa.ac.uk/cpd**).

For further details about revalidation go to **www.rcoa.ac.uk/revalidation** or email **revalidation@rcoa.ac.uk**.

Consultations

Dr Rob Searle
Dr Douglas Justins

Urinary Incontinence: updating NICE Clinical Guidelines

Dr Rob Searle

Urinary Incontinence, predominantly caused by either overactivity of the bladder or stress incontinence, is a common problem in the UK, with prevalence for women of 34%. With the increasing popularity of treatments such as neuromodulation and botulinum toxin injection, and new drug formulations for the medical management of this condition, NICE in conjunction with the National Collaborating Centre for Women and Children's Health is undertaking an update of previously published guidelines on the management of urinary incontinence in women.

In light of its experience with neuromodulation, The Faculty of Pain Medicine has advised on the scope of the updated guidelines, which will include examining the effectiveness (both clinical and economic) and acceptability of techniques such as sacral nerve and posterior tibial nerve stimulation.

NICE clinical guideline on the management of sickle cell crisis in hospital

Dr Douglas Justins

It is estimated that there are between 12,500 to 15,000 patients with sickle cell disease in the UK and the prevalence is increasing. The management of painful sickle cell crisis can be challenging and this was highlighted in the NCEPOD report A Sickle Crisis? (2008). Amongst other things NCEPOD identified shortcomings in the management of acute sickle pain as a major issue with the acute painful episode often superimposed upon pre-existing chronic pain. The widespread variability in the management of patients with painful sickle cell crisis caught the attention of the Department of Health and MPs so that NICE was asked to produce a clinical guideline on the management of sickle cell crisis in hospital.

NICE organised a scoping workshop on 12 May 2011. This workshop was attended by Douglas Justins on behalf of the Faculty of Pain Medicine and Joan Hester on behalf of the British Pain Society. The public consultation on the Draft Scope closed on 5 July 2011. The management of sickle cell crisis is a truly multidisciplinary enterprise and the proposed membership of the Guideline Development Group included a pain specialist along with members from nursing, haematology, paediatrics, A&E, general medicine, pharmacy and, very importantly, patients. Development of the guideline recommendations is scheduled to commence in September 2011 and pain management should feature prominently in these guidelines.

Colleague and Patient Feedback in Pain Medicine – It's about the numbers

Dr Barry Miller, FPMTAC member

The revalidation proposals move inexorably onwards and it is clear that, although there is still some way to go until completion, much of the basic framework required by the GMC is in place.

Feedback from everyday practice, from both patients and colleagues, is a core part of the required supporting information. The tool used for this purpose is the MSF (Multi-Source Feedback/360º appraisal). The RCoA Working Group on Colleague and Patient Feedback, which included Pain Faculty representation, has recently produced guidance, and an article can be found in Septembers Bulletin.[1] This guidance is also referred to in Mr Don Liu's article in this edition of Transmitter. As with many tools, it is important that its implementation, local or national, is suitable to the needs of the speciality, and the specialist, it is being applied to.

A significant concern that has been expressed to the Faculty is that in dealing with a group of patients with particularly difficult problems, unrepresentative, and professionally damaging, criticism is a risk of poor MSF implementation.

It is worth making a few general remarks about the MSF tool.

- It is a formalised mechanism of appraising 'professional behaviour', and as such it is important to recognise[2]
  - There is not, and cannot be, any proof that it is accurate.
  - There is only evidence of internal consistency and validity
  - There is no evidence that it has predictive validity – in trainees who score well it is not known that they actually do well
- It is a formative, not summative assessment.
  - It is designed and tested only to help in self-reflection and **NOT** a summary of behaviour.
  - This is clearly an issue of confusion, both to doctors and managers, and anecdotal information suggests that managers are using it inappropriately to assess doctors in and around disciplinary activities, and that doctors are concerned about the impact of a 'poor' feedback.[3]

In medicine, the questions are mapped to the GMC's Good Medical Practice guidelines[4] from the underlying philosophy of the assessment: Relationships with Customers (Patients Relatives/Carers); Relationships with Colleagues (Junior/Peer/Managerial/External); Information Gathering/Note-keeping; Time Management/Diligence. The GMC initially considered some form of accrediting process in tool creation,[5] but has now produced generic guidance on the creation of tools,[6] and is also developing its own generic questionnaires.[7] The College has already produced a tool for use with trainees,[8] and some other Colleges have an in-house tool for Consultants and other non-training grades.[9]

For the professional raters, the advice from the Royal College of Anaesthetists is applicable[10] taking into account some of the different sites, and individuals that may be worked with (e.g. out-patients staff, radiographers, etc). It is suggested the number of raters, confidentiality, and how long a rater has worked with the ratee produce the most consistent results.[11]

The area most susceptible to poor data collection is patient feedback. This presents a potentially serious problem of small sample sizes, potentially containing strong views that will not reflect a true picture of the individual. This is best countered by addressing the two areas of risk. The questions, and the number of raters.

There is increasing discussion of tools that have been validated. A poor tool produces rubbish, no matter how many raters are chosen, and a good tool will produce rubbish if the numbers of raters are inadequate (we may agree with the results of the latter, or not, but with too few raters no value can be assumed from the results).

A good example is the Royal College of Psychiatrists, who faced a similar issue. They have developed a questionnaire assessed by 13 colleagues and 25 patients.[9] The patient numbers are worth emphasising in that this still only produced a generalisability coefficient of 0.75,[12] and this should emphasise the importance of MSF as a tool for self-reflection, and not one of judgement. It is inappropriate as 'evidence' in a disciplinary hearing etc, but may be useful in guiding an individual in changing behaviour and rehabilitation. The difference may appear subtle, but is at the core to understanding and using the tool effectively.

The GMC is currently finalising its own patient,[3] and professional, questionnaires.[7] It is unclear whether their reluctance to use the terms MSF or 360º appraisal is significant.

The RCoA suggests a minimum of ten professional raters, and that a sample of 12–15 are chosen,[10] it would seem reasonable that with the greater potential for variability amongst patients, who have far less professional exposure, and a greater emotional investment in their time with a doctor, a much higher figure would be needed to ensure the clarity of the result.

The tool is required only once within the five-year revalidation cycle, and it is important that the results are meaningful, and it is important to follow both the GMC and College published guidance when using a MSF.

We would like to acknowledge the contribution to this article from Dr Mark Taylor, the Faculty of Pain Medicine representative on the RCoA Working Group on Colleague and Patient Feedback.

Colleague and Patient Feedback in Pain Medicine – It's about the numbers
Continued...

References

1 RCoA Bulletin, September 2011.

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A life in pain: a personal perspective

Dr Joan Hester, Consultant in Pain Medicine

Pain medicine practice has changed considerably over the past 30 years. It has been a fascinating journey into the unknown. We now have much better understanding of the mechanisms and the science of pain, but the available methods of treating pain have not kept pace with scientific knowledge; more has been taken away than has been added to the armamentarium. This may be perceived as the 'downside' of being a pain physician; pain medicine requires an optimistic outlook. But there are rewards, simply giving the right choice of analgesia, in the right dose, at the right time, can require considerable expertise.

I was appointed a Consultant Anaesthetist in Eastbourne a few days before my 30th birthday in 1976. A short while after I took up my appointment the Head of Department asked if I would consider setting up a Pain clinic as there were so many requests from surgical colleagues for pain relieving injections, particularly lumbar sympathetic block for ischaemic pain. I had learnt the technique, using imaging, while a Senior Registrar at Guy's Hospital, where I was asked by a cardiac surgeon, on more than one occasion, to perform a chemical sympathectomy on his private patients in the London Clinic! In those days one did what was asked without hesitation. Fortunately the outcomes were good, and one young man with a non healing traumatic leg wound did spectacularly well. I received other rudimentary training but no structured training; there were huge gaps in my knowledge. I always had a voracious appetite for medicine; I read journals, books, attended meetings, and listened to my colleagues and peers. I learned through the skin from the long hours spent practising medicine, it became a part of life; the quest and delight in learning about medicine has never dissipated.

There was no resistance to starting a new pain clinic in 1978, no committees to give their approval, no financial restraint, no forms to fill in, nobody to say 'no you can't'. The culture was one of 'yes we can', 'we would like to help'; 'what do you need?' That is the biggest, and saddest, change that I have witnessed in my lifetime's practice in the NHS. So, the clinic started, one half day a week, and the rest is history, as they say. In the early days I was referred a large number of patients with cancer pain as there were no palliative care services. Eastbourne was still under the shadow of Dr Bodkin Adams, the GP of the 1950s who was alleged to have murdered some of his patients with an overdose of morphine. 'Where there is a Will there is a way' was the catch phrase of the time. Understandably, the next generation of Eastbourne GPs were hesitant to prescribe large doses of opioids, even for cancer pain. I performed a number of coeliac plexus and other blocks but realised that a more comprehensive service was needed and initiated the first Macmillan nurse appointment, and then co-founded St Wilfrid's Hospice. Gradually the number of cancer patients referred to me dwindled and then disappeared altogether for a number of years as palliative medicine grew as a speciality. Now it has come full circle and I am working again in a Hospice, this time St Christopher's Hospice, Sydenham. The demand for interventional procedures for cancer pain is, once again, rising rapidly. This is due in large part to the changing nature of cancer pain as treatments become more complex, and the terminal phase of the illness becomes more prolonged and difficult.

Over more than thirty years of practice I have used fewer and fewer injections for non cancer pain, partly because they are of limited effectiveness and there is a complication rate, but, more importantly, because I find they are not needed. Lumbar sympathetic block is an example of an injection that worked well, but now radiologists dilate small arteries, BoTox is used for sweating, and the block is not needed. Expert palliative care has overtaken the need for coeliac plexus block.

I am now referred a high proportion of patients with back pain, and many cases of 'unexplained pain'. Pain physicians must have the ability to use their knowledge of the science of pain within the context of the patient's medical condition and psychosocial situation to make a plausible explanation of why the pain exists and does not go away, and to formulate an individual management plan. These things cannot be rushed; curtailing the time spent with patients to improve throughput is a retrograde step that must be resisted. Simple advice often works just as well as complicated procedures. The doctor patient relationship is just as effective as it was thirty years ago; doctors are no longer empowered to believe in it.

Drugs have come and gone over my lifetime of practice. Can I say that there has been an advance in therapeutics that has been highly beneficial? Sadly, not really; despite all the research, the promotions and the hype, the most effective drugs for managing chronic pain are tricyclics, lidocaine and opioids. Why has the number of prescriptions of opioids for non-cancer pain risen exponentially over the past 10 years? Instead of previous under-use in cancer pain there is a new threat to society, that of the overuse of opioids for persistent non cancer pain. It is a fine balance and one that we have not yet got right.

That is the challenge. After all these years of practice there is still a great deal to learn.

Is there a life after Pain? I very much hope so, when it arrives!

Pain Summit 2011

Dr Beverly Collett, Board member Chair, Chronic Pain Policy Coalition

The Pain Summit 2011 will take place on Tuesday, 22 November 2011 at Central Hall, Westminster. It is a joint venture of the Faculty of Pain Medicine of the Royal College of Anaesthetists, the British Pain Society, the Royal College of General Practitioners and the Chronic Pain Policy Coalition.

The Pain Summit hopes to bring together a powerful coalition to raise awareness of the extent of the problems associated with chronic pain and to reach a consensus on what more could be done to reduce the impact of chronic pain on those living with it as well as on society more generally.

The burden of persistent pain

Persistent pain affects 7.8 million people in the United Kingdom. The commonest causes are back pain and osteoarthritis, but there are many people living with visceral pain, post-surgical pain and neuropathic pain.

Pain can devastate lives. Forty nine percent of people with pain take time off from work, 25% of people with pain have lost their job and 24% have been diagnosed with depression. Patients with pain consult their General Practitioners more frequently and are hospitalised more often than the general population. Risk of death by suicide doubles in chronic pain patients and there is new data from fMRI studies which shows altered cerebral processing and loss of grey matter in people with pain disorders.

Persistent pain has a huge economic impact on the UK. Pain is the second most common reason given by claimants of Incapacity Benefit with £3.8 million per year spent on Incapacity Benefit for those with chronic pain. In 2000, the cost of back pain was £12.3 billion (22% of the UK health expenditure), mainly due to work days lost.

Why now?

The proposed changes in the National Health Service and in particular the establishment of Clinical Commissioning Groups gives an opportunity to improve commissioning of services for people with pain. The optimal management of pain requires a broad holistic model of care involving medical, psychological and social components. This model of care involves improved integration between Primary and Secondary care provision. Better education about pain for all health care professionals and for the general public is essential.

How?

The Pain Summit 2011 is the first year of a three-year strategy. The aim of this first year is to create a shared vision from health care professionals, members of the Department of Health, the Department of Work and Pensions, employers and people in pain of the nature of the problem of chronic pain and solutions. Year Two will be to share the developed action plans with health care professionals, Commissioners, Public Health, the media, the general public and those responsible for work, social care, health and well-being.

Scotland, Wales and Northern Ireland are developing strategies to improve the provision of pain services to their populations depending on their own local circumstances. The Pain Summit 2011 will focus on England but is cognisant of these activities and close liaison has been established to ensure common themes are addressed.

Pain Summit Programme

The programme features contributions from key figures within the health service, clinicians and individuals living with pain. Earl Howe, Parliamentary under Secretary for Quality, Sir Bruce Keogh, Medical Director of the NHS and Dame Carol Black, National Director for Health and Work are all confirmed plenary speakers. After the initial plenary sessions, there will be a panel discussion on 'How the NHS in England can help address the problems'.

Delegates will then take part in one of three specialised participative workshops on Education, Quality Commissioning, and Pain in the wider context, public health, school, work and the environment, which will form the basis for a Post-Summit report, to be circulated to policymakers and healthcare professionals early next year to disseminate and promote the actions agreed upon at the Summit.

For more information, and to keep up-to-date with progress on the Summit, please visit our website (**www.painsummit.org.uk**), email us (**info@painsummit.org.uk**), or follow us on Twitter @ PainSummit.

Steering Group

Dr Beverly Collett-Facilitator, Neil Betteridge- Lay member, Dr Alf Collins - Department of Health Long-Term Conditions, Charles Dobson-Department of Health, Dr Benjamin Ellis-Senior Clinical Policy Adviser, Dr Martin Johnson - Clinical Champion for Pain Royal College of General Practitioners, Professor Richard Langford- President British Pain Society, Kathryn Murphy- Lay member, Dr Cathy Price-Clinical Commissioner, Consultant Advisor NETSCC, Professor David Rowbotham- Dean Faculty of Pain Medicine, Rachel Downing-Pain Summit Project Manager.

Reference Group

To oversee the Steering Group and aims to represent all interested stakeholders including: patient organisations, commissioners, Royal Colleges, equipment manufacturing companies, research organisations, pharmaceutical companies, undergraduate and postgraduate education providers, health care professional organisations, social care organisations, occupational health organisations.

A GP's View of Opioid Prescribing

Dr Justin McCarthy, Stockton Heath Medical Centre

Such are the pressures of modern General Practice that increasingly our time is being spent on activities away from consulting. Those unfamiliar with our responsibilities may not be aware of the hidden challenges lurking in the prescription tray. This work is often completed after evening surgery, when patients and staff have left for home. In it you used to find repeat prescriptions that had been printed off and simply needed checking and signing. It now seems acceptable for requests to appear on scraps of paper, handwritten but often illegible and from patients and consultants alike. 'Full letter to follow!' is a regular message from colleagues. I sometimes wonder whether I should write to them and bring them up to date with the latest prescribing advice from my defence organisation, but I have enough dictation to complete already. Dealing with such requests is far from simple –it requires cross referencing of each request with the medical records and the BNF, before making a final decision about whether the prescription is appropriate, cost effective, evidence based and justified.

The new world of commissioning has charged us with the responsibility of ensuring we make best use of our prescribing budget for all patients, never mind taking responsibility for any unexpected consequences arising from taking the new medicine. This is not really a new responsibility but the lessons of evidence based medicine now make it clear we should at the very least do no harm. We may decide not to issue a prescription, for the simple reason we do not wish to accept clinical responsibility for what may ensue. However failure to issue the prescription is met with a mixture of frustration and anger by the patient.'Why can't you just prescribe it? I have seen the specialist and that's what he has recommended.' Frequently we are writing back to our colleagues asking them to outline the reasons for their specific recommendations

This applies increasingly to the use of strong opioids for patients with chronic non malignant pain. Requests for prescriptions may fail to comply with good practice guidelines[1] that 'the decision to start long term opioids therapy should be considered carefully by the prescriber, the patient and his /her carers and other members of the healthcare team.' Further there is often no mention of trial, titration, evaluation or arrangements for sharing in that.

Primary Care has robust systems in place, with information effectively cascaded between practices, highlighting characters who may present, often as temporary residents, requesting either benzodiazepines or opioid analgesics. I am sure if they circulated photographs, they would probably be of unshaven young men in casual/scruffy dress. Best practice is to ask for the details of the patient's home general practice and then contact the practice, often trying to speak to a GP directly but at the very least to establish that their GP would be happy for us to issue the requested drugs. The patients have often scarpered before we have an answer.

It is against this backdrop that we are faced with increasing requests to prescribe strong opioids, with little other detail and advice. Patients for whom requests are made have very rarely had a clinical psychology assessment which is some cases would detect personality issues, family problems and unresolved litigation, and I am yet to receive a letter inviting me to express any of my potential concerns.

Medicine, in particular general practice, is picking up the pieces- treatments that we thought were doing the patients good have been shown through closer evaluation to have done otherwise. Think of all those patients requesting night sedation or those requesting benzodiazepines for low grade anxiety, they too would feel much better, at least in the short term, if we acceded to their requests. Similarly with strong opioids, the goals of therapy must be clear. The potential problems of strong opioid use in chronic non malignant pain have been well documented, as has the lack of evidence of long term effectiveness.[2]

As GPs we would welcome clear guidance from Pain Medicine Specialists, clearly defined goals and a treatment plan for each individual patient detailing the treatment, together with the duration of treatment with advice on what to do if they do not or partially respond and whether other treatments, non opioids or alternative, may be of benefit. Rather than receiving direct prescribing guidance we would welcome the opportunity to discuss patients and arrive at a consensus.

We may have useful local knowledge to share!

References

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FPM Events

Dr Sanjeeva Gupta, Educational Meetings Advisor to the Faculty of Pain Medicine

Hope you all had a good summer holiday. I would like to offer my thanks to those of you who have attended the FPM's recent courses and to those Fellows, Members and speakers who have made a contribution to our events. The Cancer Pain Management Study Day on the 10 June 2011 was well received with positive feedback.

There are two meetings organised in November 2011. The meeting on the 11 November 2011 is titled 'Acute Pain Medicine – Hot Topics' and the Annual Meeting for Fellows and Members is on the 30th November 2011 titled 'Pain Management in Special Situations'. Both meetings have eminent speakers and will be of great educational value.

The 'Current Concepts in Pain Medicine' meeting will be from 25–27 January 2012. You can attend one, two or all the three days of the meeting depending on your individual needs. The first day is likely to benefit pain medicine trainees planning to appear for the FFPMRCA examination. The programme on the second and third day should interest both the trainees and practising pain medicine specialists. The topics to be discussed during this meeting are included on the next page and the updated programme can be viewed on the RCoA/FPM website.

Your attendance, contribution, and feedback are key to the success of all the current and future meetings. If you have any suggestions regarding current or future meetings please contact me and I will be glad to discuss.

Email: SGupta6502@aol.com

Acute Pain Medicine – Hot Topics!

Study day, 11 November 2011

- **9.00–9.45 am**
  Registration and refreshments
- **Opioid PCA vs epidural – balance of evidence?**
  Dr S Kannan, Birmingham
- **Abdominal wall local anaesthetic blocks and catheter techniques**
  Dr R Bowie, Bradford
- **CRPS – is surgery on affected limbs always contraindicated?**
  Dr J Valentine, Norwich
- **Chronic pain after surgery – who's at risk?**
  Dr J Quinlan, Oxford
- **Acute pain in patients with chronic pain**
  Dr S Kapur, Birmingham
- **Acute pain in patients with cancer**
  Dr L Lynch, Leeds
- **Nerve injury after trauma, surgery and regional block – does ultrasound make a difference?**
  Dr A Krol, London
- **Pre-emptive analgesia – balance of evidence?**
  Dr K Kyriakides, Bradford
- **4.30 pm**
  Close

Pain Management in Special Situations

Annual meeting, 30 November 2011

- **9.30–10.00 am**
  Registration and refreshments
- **Chronic pain in paediatrics**
  Dr R Howard, London
- **Pain persists despite high dose opioid – what to do?**
  Dr C Stannard, Bristol
- **Pain management in victims of conflict**
  Dr D Aldington, Oxford
- **Award of Fellowships FPM**
- **Patrick Wall Lecture**
  Professor M Fitzgerald, London
- **Trainee Publication Prize**
- **Medically Unexplained Symptoms – myth and misunderstanding**
  Dr A Williams, London
- **Pain, depression and medically unexplained symptoms**
  Professor Peveler, Southampton
- **Pain in chronic neurological conditions**
  Dr P Nandi, London
- **Developments: FPM and FPM Examination**
  Dr J Cashman, London
- **5.00 pm**
  Close

FPM Events

Continued...

Current Concepts In Pain Medicine

25 to 27 January 2012

Day One

- Epidemiology of Pain
- Neurobiology of Nociceptive and Neuropathic Pain
- Pharmacology of Drugs used in Pain Medicine
- Anatomy in relation to Pain Medicine
- Radiological investigations in Pain Medicine
- Neurological Assessment in Pain Medicine
- Musculoskeletal Assessment in Pain Medicine
- Physical therapy and rehabilitation in Pain Management
- CBT and other commonly used psychological interventions in Pain Medicine
- Topic Discussion (two X 15 minutes each case)

Day Two

- Assessment and Management of Chronic Inflammatory Conditions
- Pain and Opioid Addiction
- Chronic Post Surgical Pain
- Evidence for Precision Diagnosis and Management of Spinal Pain and Radicular Pain
- Pain in non-surgical inpatients (on medical wards in ED etc..).
- Pain Medicine and the Elderly
- Pain and disability (to include disability assessment)
- 'Brain fog and pain' - Tackling the functional syndrome dilemma
- Assessment and management of a patient with cancer pain
- Chronic Pain: When is it appropriate to ask for help? Missed Diagnosis?

Day Three

- Updates on Neuromodulation
- Pain Management in a Paediatric Patient
- Updates on the role of ultrasound in chronic pain management?
- Updates in cancer pain management
- Updates in the management of CRPS
- Updates in the Management of Facial pain
- Updates in the Management of Chronic urogenital pain
- Updates in the Management of Abdominal Pain

Faculty Calendar

2011–2012 Events	
EVENT: Acute Pain Medicine Study Day	**11 Nov 2011**
EVENT: Fourth Annual Meeting	**30 Nov 2011**
MEETING: Board of the FPM	8 Dec 2011
MEETING: FPM Training & Assessment Committee	9 Dec 2011
MEETING: FPM Professional Standards Committee	20 Jan 2012
EVENT: Current Concepts in Pain Management	**25–27 Jan 2012**
MEETING: FPM Training and Assessment Committee	3 Feb 2012
MEETING: Board of the FPM	10 Feb 2012
MEETING: FPM Professional Standards Committee	30 Mar 2012
MEETING: FPM Training & Assessment Committee	27 Apr 2012
MEETING: Board of the FPM	4 May 2012
EVENT: Summer Study Day	**25 May 2012**
MEETING: FPM Professional Standards Committee	22 Jun 2012
MEETING: FPM Training & Assessment Committee	13 Jul 2012
MEETING: Board of FPM	20 Sep 2012
MEETING: FPM Professional Standards Committee	5 Oct 2012
EVENT: Winter Study Day	**17 Oct 2012**
MEETING: FPM Training & Assessment Committee	19 Oct 2012
EVENT: Fifth Annual Meeting	**22 Nov 2012**
MEETING: Board of the FPM	13 Dec 2012

All dates are subject to change.
Please ensure you check dates on the FPM Website.

Comments from previous events:

'Very good programme – mix of topics and scope'

'Added a lot of information and insight'

'Very relevant to my practice – meeting other consultants with similar patients, but very different practices'

'Useful day – good to liaise with other pain medicine colleagues'

Faculty Update

Fellows, Members and Committees

New Fellows by Assessment

April 2011

Dr Balasubramanian Veemarajan

Dr Yeli Horswill

May 2011

Dr Chandrakant Pandurang Gosavi

Dr Catherina Mattheus

Dr Sailesh Kumar Mishra

Dr Thomas Gordon Gilkes

June 2011

Dr Ivan-Nin Ramos

July 2011

Dr Andreas Goebel

Dr Andrew Gunatilleke

Dr Quazi Al Mahmud Siddiqui

Dr Mahindra Goroba Chincholkar

Dr Rajib Dutta

Dr Suneil Harry Ramessur

August 2011

Dr Devjit Srivastava

Dr Azfer Usmani

September 2011

Dr Alvin Hoong

Dr Jin Yeo

Dr Robin Kulranjan Correa

New Associate Fellows

July 2011

Dr Ashish Pralhad Gulve

Dr Ashwin Arvind Kalbag

Dr Gerard Anthony Browne

September 2011

Dr Manian Murali Krishnan

Obituary

Dr Peter Alexander Mackenzie, 5 August 1963 to 11 July 2011

Pete Mackenzie, Scotland's first lead clinician for pain, died at home after a long illness on 11 July 2011. A highly influential figure in the field, Pete's pioneering clinical work and enthusiasm for pain education has left many positive changes for pain medicine in Scotland.

Pete excelled in a wide range of subjects in his school years in Perthshire and was an excellent musician and sportsman. Commencing medical studies in Glasgow in 1980, initially Pete undertook a career path which steered towards general practice but after some reflection this changed to anaesthesia. He undertook most of his training in the West of Scotland and his interest in Pain Medicine led to a fellowship at the Flinders Medical Centre in Adelaide under the supervision of Dr David Cherry.

He obtained a consultant post in pain medicine in 1999 at the Southern General Hospital and was integral in setting up a spinal cord stimulation service. Pete was keenly aware of the importance of communication skills and developed a DVD to tailor these to pain consultations. His enthusiasm for training and education in pain management led him to become the first Regional Advisor for Pain in the West of Scotland. At the same time, he was elected President of the North British Pain Association. Pete showed both skill and leadership, working well with the Scottish Cross Party parliamentary group on chronic pain, to support the specialty. With the inception of the Faculty of Pain Medicine he was offered the post of Lead Regional Advisor, but due to the diagnosis of cancer he was never able to take up this post.

Pete was supposed to have a gradual return to work after his treatment, but due to his genuine enthusiasm he continued to push the pain agenda forward and in April 2009 he was appointed as the first lead clinician for Chronic Pain, or 'Pain Tsar.' This post had been set up by the health minister to "provide leadership to the many clinicians - doctors, nurses and allied health professionals who work in the field, as well as taking charge of ensuring future progress." Knowing that this was an opportunity to provide real benefits to patients and clinicians, he threw himself into the work, laying strong foundations for the future delivery of pain medicine.

Pete had a wide circle of friends who enjoyed his keen sense of humour and enjoyment of life. The dignity shown by both Pete and his family throughout his illness is an example to all and, true to his nature, his memorial service was a celebration of his life and achievements rather than an expression of loss. He died as he lived – always working for the greater good of his family, his friends and his patients. Pete is survived by his wife Diane and his three children Luke, Hannah and Juliet.

Michael Basler, Colin Rae

Faculty Update

Biographies

The Faculty Committee Structure

Steve Gilbert, Co-optee: Lead Clinician for Chronic Pain, Scotland

Steve studied medicine and went into anaesthetic training in Glasgow before developing an interest in pain management, particularly through training in Glasgow and Bangor in North Wales.

He was appointed as a consultant in Anaesthetics and Pain Management at Queen Margaret Hospital in Fife 1997. Later he set up a petition to the Scottish Parliament in 1999, resulting in the formation of the Cross Party Working Group of the Scottish Parliament.

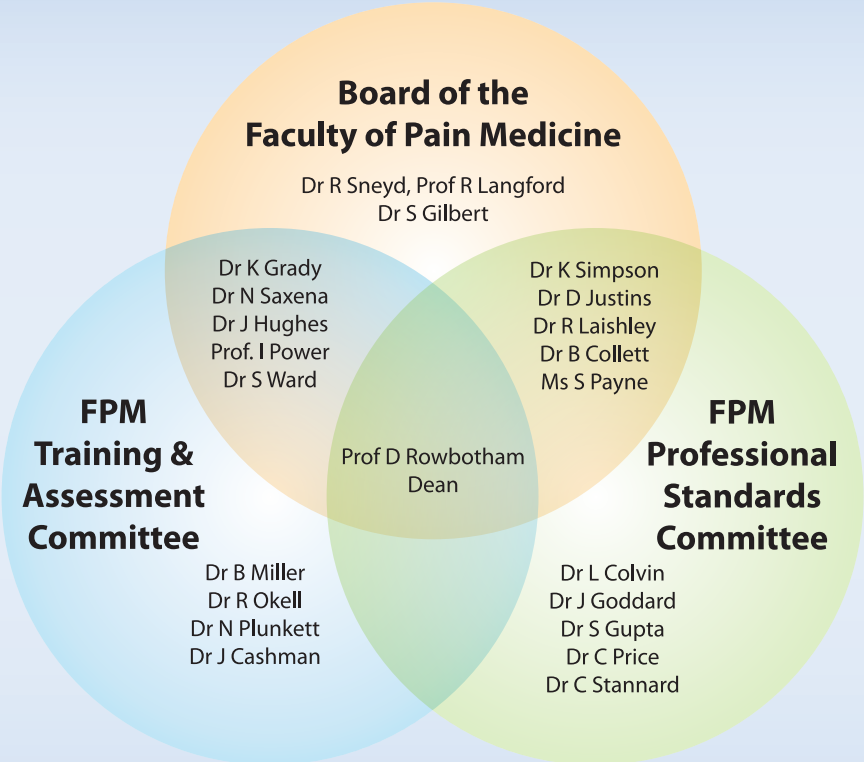
More recently he was appointed Scottish National Lead Clinician for Chronic Pain in May 2011 – 2 days a week secondment in addition to his work in Fife.

He has a particular Interest in explaining pain to patients and health professionals, multidisciplinary pain management, improving awareness of and access to pain management.

Apart from pain, he plays saxophone in a band and is a fanatical cyclist.

Sara Payne, Co-optee: Lay representative, Patient Liaison Group

Sara qualified and practised as a solicitor, specialising in intellectual property. She now has a range of patient advocate roles including membership of the MHRA's Specialist Advisory Committee on the Safety and Efficacy of Paediatric Medicines. Sara joined the Patient Liaison Group at the Royal College of Anaesthetists in March 2011 and combines this with a similar role at the Royal College of Surgeons. Her particular interests are in improving patient communication and involvement in their treatment in challenging circumstances in hospitals, such as intensive care units.



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