FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

Newsletter of the Faculty of Pain Medicine AUTUMN 2014

TRANSMITTER

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The adage that a week is a long time in politics came to the fore as the possibility of Scottish independence became a distinct possibility in September. I am no historian, but venture to suggest that Fellows and Members of the Faculty have, despite threats, lived during a time of sustained homeland stability. How serious the implications for the College and Faculty of an independent Scotland would have been I do not know, but no doubt legislative change would have been needed.

The United Kingdom remains, but perhaps this episode should serve to remind many of us of the differences that exist in healthcare between the devolved nations. This edition includes a Welsh update from Rhian Lewis and Sharmila Khot: as with Scotland in the last edition, it highlights advances in the recognition and provision of pain services that have yet to occur in England.

One thing that is going to change is legislation on drugs and driving. As prescribers of opioids and benzodiazepines, Pain Medicine doctors need to understand the implications and be able to advise their patients. A helpful resume is provided by Dr Rob Searle.

I would also like to highlight the article by Alan Fayaz regarding an academic training in Pain Medicine. As always, not easy, but achievable with perseverance.

I thank all the contributors to this edition for their time and, once again, Daniel Waeland and Anna Ripley for the production, which I front.

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Message from the Dean

Dr Kate Grady

Dean

The Faculty is at the centre of UK Pain Medicine practice, training and standards. We are keen therefore that is recognised as a 'go-to' organisation for Pain Medicine and to this end have been engaged in senior level discussion with a number of UK bodies. We recently met with Professor Mark Baker, Director of the Centre for Clinical Practice of the National Institute for Health and Care Excellence (NICE). The Faculty has for a small number of years (alongside the British Pain Society) been negotiating a NICE Quality Standard for persistent pain. This meeting gave us the reassurance that this is going to happen and in the foreseeable future.

In June we met with the editor of the British Medical Journal, Dr Fiona Godlee, and members of her team to discuss pain content for the journal. Again, in June we met with Dr Maureen Baker, Chair of the Royal College of General Practitioners. The RCGP is fully engaged with us on commissioning issues and standards across the breadth of delivery of pain management.

In September we had a very encouraging meeting with senior figures at the General Medical Council to discuss pain management learning at undergraduate level.

Our Professional Standards and Training and Assessment Committees are busy as ever and you can read more of their work in this publication. The examination continues to establish itself and to build a worthy reputation.

Commissioning is often a source of angst for those working in Pain Medicine. The Faculty makes clear statements about the place of specialist ('secondary' in 'old money') and specialised ('tertiary') Pain Medicine in the new world of patient referral. Our mantra of 'Right patient, right professional, right time' makes clear that a proportion of those with persistent pain do not get their problems resolved in primary care and in the community and these patients have a right to be referred into specialist care and specialised care if necessary. The UK Pain Consortium (the British Pain Society, the Chronic Pain Policy Coalition, the Clinical Reference Group for Specialised Pain Services, the Royal College of General Practitioners and ourselves) continues to meet regularly at this critical time. The Faculty is well represented on the Clinical Reference Group for Specialised Pain Services, which attends to issues of commissioning and protection of the specialty of Pain Medicine.

Work continues on the outputs of the Pain Summit of 2011. Our own 'Complex Pain' work stream is now at the stage of piloting in Southampton and, hopefully, in London.

Our Essential Pain Management (EPM) project, exporting this course crafted through the Australian and New Zealand College of Anaesthetists to parts of Africa is now in its stride. A further course has taken place in Uganda in September and courses are set to run in Malawi and Ethiopia. If you are keen to be involved in this work please contact us at fpm@rcoa.ac.uk.

The EPM course has been adapted into a shorter version known as EPM Lite, for delivery as a half day course to undergraduates. This project is well established in New Zealand and India. The Faculty is pioneering its introduction to UK medical schools; we piloted it in Bristol in September and we propose to roll it out to further UK medical schools. If you are involved in undergraduate education we are keen to hear from you so that we can establish a database of what is happening in undergraduate pain education. We are also keen to hear from those who might have the links to introduce 'Essential Pain Management Lite' to UK medical schools fpm@rcoa.ac.uk. We are hoping to pilot the course further and the GMC are keen to learn of our outcomes in this regard.

As Fellows, Associate Fellows, Members and trainees of Pain Medicine, we are eager to hear from you if you would like to discuss areas to which you feel the Faculty should turn its attention or areas of work in which you would like to become involved.

Drug Driving Regulations – changes to the law

Dr Rob Searle

FPMPSC member

Whilst many people are familiar with the dangers of drink driving and the laws in place to prevent this, similar dangers exist when driving under the influence of some drugs (whether taken illicitly or prescribed). Under section 4 of the Road Traffic Act (1988) it is an offence to drive whilst impaired through drugs; however unlike alcohol, there are currently no specified blood limits above which impairment is assumed. Proving the driver of a vehicle was impaired, and that the impairment was caused by drugs can therefore be complex, resulting in low conviction rates for this offence.

The government has announced primary legislation that will create a new offence of driving with a specified drug in the body above the accepted limit for that drug. The police will use roadside screening devices that will test saliva for the presence of drugs included in the legislation, with a subsequent blood sample confirming if the driver is over a specified limit. It is important that pain physicians are aware of the new legislation, as some drugs commonly prescribed in pain clinics will fall under the new rules.

The new regulations are expected to come into force in March 2015 and include a 'zero tolerance' approach to drugs associated with illegal use. These drugs will have very low limits set in the legislation, so any patients prescribed them are likely to test over the acceptable limit. A second group of commonly prescribed drugs will have limits set at a higher level than the 'zero tolerance' group. The higher limits are generally above the normal therapeutic range, however those on high doses could test above the specified limit for that drug.

For patients who are prescribed drugs in either category, the government has included a statutory medical defence. If the police are satisfied that a driver is taking the relevant medicine on the advice of a healthcare professional and in accordance with written instructions they will not be prosecuted. It may be helpful for patients to keep suitable evidence with them when they are driving. The statutory medical defence will not apply if the patient's driving is impaired due to drugs, and patients should still be warned not to drive if this is the case. Although it is the responsibility of the driver to consider whether their driving is, or might be impaired on any given occasion, it is the responsibility of prescribers to give suitable clinical advice to patients regarding the risks of their medicines. This advice should include:

- Not to drive if symptoms or signs develop suggesting their driving may be impaired (such as sleepiness, poor coordination, impaired or slow thinking, dizziness or visual problems).
- Not to drive at times when the risk may be temporarily increased (for example when first starting or when increasing or reducing the dose of a medication that may impair driving).
- To take care in circumstances that may increase the risk of their driving being impaired, such as: if additional medication that may impair driving is added (whether prescribed or over the counter); if there is a developing medical condition that may increase the risk of impairing side-effects; if additional medication is started that is known to alter the metabolism of their existing drugs.
- To be aware that alcohol when taken in combination with other impairing drugs can substantially increase the risk of accidents.

It is strongly recommended that clinicians read the detailed guidance for healthcare professionals that is available on the Department for Transport website:https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/325275/healthcare-profs-drug-driving.pdf.

Zero Tolerance Drugs Group		
Cannabis (THC)	MDMA (Ecstasy)	Ketamine
Cocaine (and a cocaine metabolite BZE)	Lysergic Acid Diethylamide (LSD)	Heroin/ diamorphine metabolite (6-MAM)
Methylamphetamine		
Prescription Drugs Group		
Clonazepam	Flunitrazepam	Oxazepam
Diazepam	Lorazepam	Temazepam
Methadone	Morphine	

Pain in Wales: Past, Present and Future

Dr Rhian Lewis

Chair, RCoA/NSAG Pain Subgroup

Dr Sharmila Khot

RAPM for Wales

"*Gwell i mi golli mywyd na chan boen nychu'n y byd. Better for me to lose my life than stay in this world with pain*" – Tudur Aled (1465-1525)

The above lines from a medieval Welsh poet show that pain then, as now, was a cause of extreme despair. In the mid-1990s, the pain service in Bangor consisted of four sessions of consultant time, with an average annual throughput of 200 new patients. The pain service in Cardiff then had a referral rate of 400 patients a year. Demand has escalated significantly: the current services are multidisciplinary, and throughput has increased to around 1,000 new patients a year in Bangor, and 1,600 in Cardiff.

Pain services in Wales have stepped out of the shadows over the last quarter century, and are now recognised as an important component of the services offered by NHS Wales. Each of the seven Health Boards in Wales currently offers one or more pain services, though the range of provision varies.

In 2008, the Welsh Government released a consultation document on pain services, 'Designed for People with Chronic Conditions: Chronic Non-Malignant Pain'. This outlined the needs of people in pain and emphasised the requirement for evidence-based multidisciplinary provision. The aim was to enable services to develop within a rigorous framework, and led to improvements in the scope and staffing of pain service provision.

July 2012 saw the first meeting of the Pain Subgroup of the RCoA/National Speciality Advisory Group (Anaesthesia), whose role is to provide a single source of specialist advice to the Welsh Government on pain service provision. The group meets twice a year, and although there are indications that the advisory structure may change in the next few years, a similar body is likely to remain an ongoing feature of the Welsh Government's policy development process.

The Welsh Pain Society (WPS), a multidisciplinary group, has been in existence for over 30 years. Its well-attended Annual Scientific Meeting has gradually evolved into a CPD forum with multidisciplinary networking opportunities, a crucial meeting-place when clinics are spread over a Deanery with one of the largest geographical areas in the UK.

In 2013, the RCoA/NSAG (Pain Subgroup) and the WPS jointly commissioned an audit of pain service provision in Wales (Parsons et al 2013). This audit reports that NHS Wales provides eleven multidisciplinary chronic pain clinics, although the nature of the MDT arrangements varies considerably. Pain management consultants were involved in the delivery of all chronic pain services, with some clinics including a neuro-rehabilitation consultant, a palliative care consultant and up to three general practitioners with a special interest in pain management.

Ten services employed nurse specialists, and ten employed physiotherapists. Six of the eleven services utilised clinical psychologists, but only three used occupational therapists. All had access to a pharmacist. However, only four chronic pain clinics offered fully MDT clinics (defined as more than one discipline having a major role in decision-making).

Services are mainly secondary care-based, although there has been movement out of some District General

Hospitals into Community Hospitals and GP premises. Treatment provision varies considerably across Wales. Most clinics offer interventions when appropriate, and there are a limited number of sub-specialty clinics dealing with pelvic pain, diabetes, palliative care, and a nurse-led substance misuse service. Much of the follow-up work, along with provision of acupuncture, TENS, and medication review is nurse-led. There is one residential Pain Management Programme (PMP) based in Powys, seeing 50 patients per year, and five other health boards offer community PMPs. However, there is no correlation between local population and PMP provision, and organisation and numbers vary greatly.

In summary, five years after the launch of the 2008 document, several objectives have been met. Significant improvements have been made to chronic pain services in Wales, with a notable move towards multimodal and multidisciplinary services. There is, however, still some variation in provision due to historical reasons, geographical location and patchy service development. Lack of uniformity of facilities and inadequate resources contribute to long referral-to-treatment times and delays in access to PMPs, which both impact outcomes.

> **“Significant improvements have been made to chronic pain services in Wales, with a notable move towards multimodal and multidisciplinary services”**

Pain services in Wales therefore require further work to improve access to psychology, occupational therapy, specialised PMPs, and paediatric pain services as well as provide services delivering specialised interventions.

In a January 2014 speech following the report of the Bevan Commission, the Minister for Health in Wales, Mark Drakeford AM, committed NHS Wales to Prudent Healthcare principles. Professor Drakeford defined this as “healthcare that fits the needs and circumstances of patients and actively avoids wasteful care that is not to the patient’s benefit.”

Specifically, the Minister announced a series of four Prudent Healthcare workshops to be held before the end of March 2014. Each of these workshops aimed to apply Prudent Healthcare principles to a different clinical topic and to produce recommendations to the Minister for future clinical practice across NHS Wales. Cardiff and Vale University Health Board, in conjunction with Public Health Wales, hosted the pain management workshop (Khot and Shortland 2014), and is currently working towards developing a single point of access for chronic back pain as well as elaborating some of the other key ideas that arose from the workshop. Contributions are being received from patients living with chronic pain, and clinicians treating patients with chronic pain including GPs, pharmacists, pain clinicians, PMP leads, radiologists, physiotherapists and academics involved in pain research.

The future development of pain services in Wales will benefit from continued engagement with Prudent Health principles, with pain clinicians working collaboratively with other specialists involved in managing pain across their individual health boards in order to deliver the best and most appropriate care to the person suffering with chronic pain. Service evaluations underpinning service redesign will support the development of evidence-based patient pathways for early access to pain assessment and management services. The delivery of a comprehensive interdisciplinary service will also require locally-developed training structures for specialists involved in pain management.

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Professional Standards

Dr Beverly Collett

FPMPSC Chair

The Professional Standards Committee continues to be busy, being responsible for Pain Medicine matters relating to consultations, policy endorsement, good practice documentation, revalidation, policies relating to patient safety, competencies, clinical audit and doctors in difficulty.

The Good Pain Medicine Specialist is now up on the website and should be essential reading for those undertaking the comprehensive management of acute, chronic and cancer pain. It is written to supplement the General Medical Council's document, *Good Medical Practice*, and should assist in demonstrating professionalism and achieving revalidation. Dr Rob Searle was the main author and I would like to express my thanks to him for this impressive and helpful document.

The General Medical Council has a major consultation out at the present time which is asking for the public's views on improving patient protection and public confidence in doctors. The GMC have emphasised their role is not to protect the medical profession, but to protect patients. The Faculty of Pain Medicine will be contributing to the response from the Royal College of Anaesthetists.

Following on from the successful publication of Managing Pain in Secure Environments, the Faculty has obtained funding from Public Health England to prepare an education course for prison staff. This is a significant venture and a pilot programme will be available in early 2015. The Faculty is also leading work with Public Health England to produce an Opioid Prescribing Resource document. This will be a valuable tool for all health care professionals working in a variety of settings and will be available early next year.

The Pathfinder Project working group for low back and radicular pain, chaired by Professor Charles Greenough, the National Clinical Director for Spinal Disorders, has now completed its work. The project group has produced an algorithm which suggests a pathway for the management of low back and radicular pain, and the key triage points and personnel that are necessary to better manage this difficult and costly problem. This was a multispecialty, multidisciplinary working group and, as one would expect with such a large group, there was much discussion before a consensus was reached. There was heated debate about whether to include recommendations from NICE Guidance CG88 within this pathway, especially as this is currently being updated. It is hoped that it will form a basis for you and other interested clinicians (e.g. orthopaedic surgeons, neurosurgeons, physiotherapists) to jointly discuss with your local CCGs how to establish such a pathway for patients with back and radicular pain.

Core Standards for Pain Management Services is moving ahead and the Faculty has agreement from the multiprofessional authors for the various chapters and support from their respective professional bodies and organisations. This is a very important piece of work and one which will evolve as time progresses. However, in this current time of change in the NHS, it is important to state what facilities, what skills and expertise, people who work in pain management services should possess, so that standards for patients are upheld.

The Faculty is continuing to work on patient information and our interventional procedures patient leaflets are underway and will be available on the website by the end of the year. We are also working on guidance for core components of a good comprehensive Pain Medicine consultation, this will be available on the website in the near future.

The Professional Standards Committee does much work behind the scenes and so I am grateful that all members of the Committee are enthusiastic and committed to furthering this work. Without the invaluable assistance of Daniel Waeland, Anna Ripley, James Goodwin and Dawn Evans, none of this would be possible.

FPMTAC Chair: A Personal View

Dr Barry Miller

FPMTAC Chair

"*It is difficult to make predictions, especially about the future*" – Origin uncertain!

This slot is normally reserved for updates on the work of the Training & Assessment Committee. I can't say that the summer months have been especially quiet, but there are not always exciting headline activities to detail. I thought, instead, that I would give a personal viewpoint. Perhaps a little polemical, but that's just my way...

Evolution can occur as a result of gradual changes in the environment, or a meteor strike. For any given species these may be a benefit or a catastrophe. Sixty-five million years ago, the dinosaurs were at the wrong end the process, while the mammals took up the challenge with some success. The NHS seems constantly to be grappling with changes which threaten and tempt with varying measure.

> **"The Training & Assessment Committee draws a line in the sand. It says this is how we use the opportunities to create a safe and effective pain physician"**

In creating a training scheme, the learning environment itself is frequently overlooked; changes may occur as a direct result in educational intentions (PMETB, Shape of Training) or a by-product of changes in the NHS (2012 Health and Social Care Act) often both – each vying for attention and resources, and not infrequently at odds. The Training & Assessment Committee is tasked with creating an educational framework and keeping it up-to-date. This may mean small changes to the curriculum itself, negotiated with the RCoA and the GMC, guidance documentation to its implementation and collecting and analysing data submitted on logbooks, case reports, exam results etc. It also means watching the healthcare environment beyond, and how it changes.

There is sometimes a tendency to view the past with a degree of nostalgia, those halcyon summer days of yore. Trainees had longer to hone their skills – usually between 2-5 am anaesthetising an individual with a fractured neck or femur; in 32+ hour shifts, diagnosing a tricky condition at 5pm on a Monday afternoon clinic after a weekend on-call; or flitting from one job to another, constantly polishing a CV. Unfortunately I misplaced my rose tinted glasses some time ago.

So, do I think the current system is ideal? I don't think so. But it is the one we've got.

The committee has to produce a workable system. Around us, the maelstrom of change whirls, various inquiries setting out their views of a new and brighter future – some accepting our input, some not; reviewing the EWTD, the whole training environment (Shape of Training), the work environment (trusts, CCGs and the private sector), to define what should be treated, and what should not (NICE, maybe), to define what is *specialist* and what is *specialised*.

The committee draws a line in the sand. It says this is how we use the opportunities to create a safe and effective pain physician. We have created, and constantly reassess; a curriculum, logs of training activities and an exam. We create guidance on how these should be implemented, review feedback from the RAPM, LPMES, trainees and working pain physicians.

Feedback is essential. It is vital to know what works and what is problematic. Yesterday's certainties are today's doubts. How long would it take to teach everything and every skill in Pain Medicine? A lifetime? Longer? What we actually have is about 15 months (Higher and Advanced) – competency based, with variable weekly commitments to our parent subject. We have motivated, enthusiastic trainees and trainers. Let's keep it that way.

FFPMRCA Examination Update

Dr Karen Simpson

Chair of the Court of Examiners

I hope that this update on the FFPMRCA examination finds you all in good spirits having had a nice warm summer and already thinking about Christmas. It is hard to believe that the fourth sitting of the Fellowship has occurred and we are already planning the fifth in October 2014. As expected, candidate numbers have stabilised after the initial large cohort.

Dr Cashman has provided a detailed analysis of the results so far; the Court of Examiners has used this data to underpin all decisions about the exam processes. This detailed number crunching exercise has demonstrated that our quality control systems are excellent. I am indebted to Jeremy for his hard work and delighted that Dr Tony Davies has agreed to acquire the necessary skills to oversee this essential aspect of the exam in due course. The examination is also quality assured by routine audit at the SOEs. All examiners have been audited and all have performed well; these audits will form part of ongoing examiner appraisal.

There have now been several UK visitors and some from abroad who have spent a day observing the SOE. I take great care to gain feedback when I debrief them at the end of their day with us. All have commented in a very positive way about the organisation of their day and our exam processes and standards in general.

I am pleased to announce the appointment of three new examiners: Victor Mendis (London); Richard Sawyer (Oxford); Jeremy Weinbren (London) and three new question writers: Ganesan Baranidharan (Leeds); Saravanakumar Kanakarajan (Scotland) and Vivek Mehta (London). The new examiners will be formally admitted to the Court of Examiners at the next exam and after a period of training they will examine for the first time in April 2015.

The question writers will join the MCQ group with immediate effect and I am sure they will be a true asset allowing us to release more example MCQs for trainees. The appointment process forced very difficult choices for the selectors because the applications were all so strong. In my view this truly shows the maturity and talent that the field of Pain Medicine now enjoys in its consultant body.

In May 2014 I was honoured to attend Diplomates Day at Central Hall Westminster with Kate Grady and Dave Rowbotham on behalf of the FFPMRCA examiners. It was a long awaited experience for me to see our first Fellows by examination mount the creaky steps to the stage to receive recognition for their hard work from the RCoA President, J-P van Besouw.

The exam section on the FPM website is an excellent resource and I hope that trainees and trainers will check the site regularly for updates about the exam and related matters. Finally, I would like to give my personal thanks to my fellow examiners, and to Kate Grady, Daniel Waeland, Graham Clissett and all the Faculty/ Exam staff who have made my transition to the role of Examinations Chairman such a pleasant experience and who ensure that each exam runs like a well oiled machine. In the words of Marcus Aurelius (121-180 AD): "The secret of all victory lies in the organisation of the non-obvious", and the Faculty and Exams staff certainly excel at this particular talent.

Quality Assurance and Workforce

Dr Jon McGhie

QA/WP Group Chair

Dr Victor Mendis

QA/WP Group member

The Quality Assurance and Workforce Working Party was established to review communication streams between the FPM and the consultant body, primarily to ensure quality frameworks for training but also to facilitate accurate data collection for any future analysis of the pain workforce. In order that this information is accurate and up to date we felt it was best to collect it alongside information already captured from Regional Advisor in Pain Medicine (RAPM) submissions about Advanced Pain Medicine training centres. To achieve this we have updated two documents.

Firstly, a new biannual report form will be completed by the RAPMs. This form is primarily concerned with tracking local training opportunities relevant to Advanced Pain Medicine training, but we have added some questions relevant to personnel changes and facility changes that will allow us to answer questions about the workforce with confidence in between the official census. There are also questions relating to trainee requirements that have been generated by feedback from the annual trainee survey. While at first glance the form may seem daunting, the Faculty will pre-populate most of the domains with existing workforce data and we would ask for the RAPMs to keep it up to date on a 6 monthly cycle. Dr de Gray, Lead RAPM, will have a discussion about the practicalities of this at future RAPM meetings and feedback is welcomed.

Secondly, the group has updated the Hospital Review Form (HRF). The updated form is a more concise document and comes with supplementary guidance notes that outline the process of assessing hospitals that provide Advanced Pain Training (APT). Any centres that wish to apply to be recognised for APT should also complete this new form.

The Faculty will assess current APT centres on a 3 yearly cycle. The RAPM will send out electronic versions of the new review form to their Local Pain Medicine Educational Supervisors (LPMES) at trusts currently providing APT. The RAPM is responsible for the local coordination of this process and will set a 6 week deadline for completion and return of forms. An independent panel of assessors appointed by the RAPM will review the submitted forms. Ideally the panel will comprise of the local RAPM and Training Programme Director (TPD) as well as an RAPM from a neighbouring region.

When all the data is collated an approval checklist form is completed for each trust. This informs the ultimate decision regarding each centre's suitability to solely provide or contribute towards APT. If a particular trust or rotation does not fulfil the criteria, the panel will provide feedback and recommendations. A separate summary document of the location, duration and rotations involved in the APT posts within each region will be produced. The summary report for each centre will be available on the Faculty website.

The North Thames Region has completed the assessment process of all centres providing APT and the summary documents for each centre are on the FPM website. We will continue to post updated APT information with each quarterly cycle, ultimately creating a map of training opportunities across the UK, permitting trainees to compare APT posts and identify programmes that offer sub-specialty pain training opportunities in areas such as spinal cord stimulation, intrathecal drug delivery or paediatric pain.

By streamlining systems to promote robust and comprehensive review of the provision of APT, we hope to ensure consistently high standards of training.

Regional Update

Dr Lorraine de Gray

RAPM Chair

With clinical governance, transparency and accountability quite rightly high on the agenda in all areas of clinical practice, the Faculty of Pain Medicine is keen to ensure that there is a similar trail available both for the practice of and training in Pain Medicine. As Regional Advisors in Pain Medicine we have a key role to play both in ensuring that the highest quality of practice and training is delivered in our 'patch' and also to provide data and feedback to the Faculty.

This data is crucial for our Faculty to continue to develop and support a proactive and robust clinical governance and quality framework that enables it to measure and continuously improve the quality of the training it provides and the clinical practice it supports. This data is also invaluable in allowing the Faculty to provide judicious data when it comes to workforce planning.

> **"Delivering visible high quality training is also likely to attract more trainees considering a career in acute or chronic Pain Medicine"**

Three important documents have been specifically produced through the joint working of the Faculty secretariat, the Quality Assurance and Workforce Working Party and the Training & Assessment Committee. These include the *Roles and Responsibilities of Regional Advisors in Pain Medicine,* invaluable not only for the rookie RAPM but also for those longer in the tooth.

A second document that has just been created is the *RAPM Biannual Report*. This is a document that each RAPM has to fill in and submit to the Faculty every 6 months. It delivers feedback about availability of Higher and Advanced Pain Training in each region, outcome of the FFPMRCA exam, details with regards to formal teaching, as well as data regarding each consultant practicing Pain Medicine.

Later in the year, another document will be rolled out – the *Hospital Review Form*. This will look in greater detail at each hospital delivering training in Pain Medicine both in terms of facilities, diagnostics, consultant and other health professional staffing, access to subspecialist training such as paediatrics and cancer as well as a breakdown of patient demographics. Once this data is available, it will also provide an excellent resource to trainees who may be looking at what specific regions have to offer if they are considering an out of region training opportunity.

Delivering visible high quality training is also likely to attract more trainees to consider a career in acute and/or chronic Pain Medicine. There has been much discussion in recent years about falling numbers of trainees attracted to our specialty, with uncertainty about consultant posts and the FFPMRCA exam mooted as possible reasons. All evidence demonstrates that there has been no drop in consultant posts. All the trainees I have had contact with, who have sat the exam, have been very positive about the whole experience, reporting that the exam has made them feel more prepared to make the transition from trainee to consultant.

An important role of Regional Advisors is to attract more trainees to consider a career as pain physicians by trying to nurture trainees at an early stage during their basic and intermediate pain training. Various factors such as location, opportunity, work/life balance intertwine to influence or dictate the career pathway taken by any anaesthetist in training. However there is no doubt to my mind that a significant number of doctors are also swayed in their decision making by role models who inspire them and 'infect' them with their passion and love for their specialty. The aspiration to be such role models for our trainees should be one that all of us who have a role in training should have high on our agenda.

The North of England Pain Medicine Group (NEPG)

Dr Nick Plunkett

NEPG Chair

The NEPG presented its 6th Annual Meeting on Friday 6th June 2014. Like the five that preceded it, this was an all day event which has become a much valued fixture in the annual pain conference calendar. The popularity of this meeting is a direct consequence of the highest aspirations of its founders, Dr Manohar Sharma and Dr Sanjeeva Gupta. Their vision was to create a high quality regional Pain Medicine meeting to cater specifically for the unique educational needs of pain physicians in the locality of the North of England, with both speakers and delegates drawn primarily from the region.

Central to this vision is that the topics delivered are of specific interest to pain physicians, helping them keep up to date with current thinking in related areas of medical practice as well as specific Pain Medicine topics, covering all aspects relevant to the management of chronic, acute and cancer pain. The meeting has been fortunate to garner national and international speakers, many of whom practice Pain Medicine within the North of England region, as well as renowned speakers from other allied areas of medicine, surgery, palliative medicine, and other relevant topics, for example the changing healthcare economy and commissioning. The multidisciplinary nature of our work in the Pain Clinic is well recognised within the group and represented each year with relevant presentations from non-medical colleagues from within Pain Clinic practice.

In addition to the formal presentations, there is ample time for questions from the floor, and often lively debate ensues. It is frequently a particular duty incumbent on the chair to limit this interaction to time, such is the enthusiasm and interaction shared between speaker and floor! Informal discussion and networking continues during coffee and lunch breaks.

The meeting is held in Huddersfield, central to the region as a whole. Such is the increasing popularity of the event year on year that it draws approximately 100 attendees (the capacity of our current venue). Plans are afoot to move to an alternative venue nearby to cater for an expected modest increase in applicants. The meeting is currently free of charge, and is recognised for at least 5 RCoA CPD points (both of which factors are undoubtedly a draw), though the fact that so many attendees re-attend year on year indicates how well the meeting caters to their specific educational needs as evidenced by consistently excellent feedback and high quality suggestions for future meeting topics.

It is particularly valued by Higher and Advanced Pain Trainees who get the opportunity to network and meet acknowledged experts, liaise with each other informally, and have the opportunity to present their original work in poster form. A short business meeting rounds off the day, which is open to all. Debate fosters continuous refinement on all aspects of meeting content and delivery, reaffirming the founding principles. The meeting is sponsored by Pfizer, although there is no influence on the educational content whatsoever. We are grateful to Pfizer for their continued support.

NEPG has a Steering Committee, made up of one-two representatives from each of the locality pain groups, which act together as the constituency for the North of England Pain Group. These are the Mersey Pain Group (represented by Dr Rajiv Chawla and Dr Sumit Gulati), the Pennine Pain Interest Group (represented by Dr Dimple Vyas and Dr Louise Lynch), the Northern Region Pain Group (represented by Dr Ashish Gulve), the North West Pain Group (represented by Dr Arun Baskar), the East Yorkshire and Humberside Pain Group (represented by Dr Bhaskar Tandon and Dr Ashwin Mallaya), and the South Yorkshire Pain Group (represented by Dr Sameer Gupta).

Dr Sharma and Dr Gupta are to be lauded for the clarity of their vision as the annual meeting has been very successful since its inception. I am grateful to them and the Steering Committee for giving me the pleasant task of chairing NEPG for the next 3 years, and hope and trust it will continue to thrive.

Trainee Update

Dr Lucy Miller

Faculty Trainee Representative

Let me introduce myself; my name is Lucy Miller and I commenced Advanced Pain Training (APT) in the Bristol region at the start of this year. Although now full time, I have trained flexibly while having my children. I have been in the fortunate position of sitting on a number of committees previously both as the Bristol Deanery flexible training representative and in relation to my interest in human factors (non-technical skills). Firstly, I would like to thank Emma Baird for her tireless work over the past 2 years to maintain communication between us as trainees and the Faculty during a period of rapid change and development. I shall endeavour to follow her example and would like to invite you to contact me via my email lucymillers@doctors.org.uk on any issues you would like addressing.

The trainee meeting at the BPS conference in May was well attended. It highlighted the national variation in supervision and protection of trainees. The Faculty have since updated the website to support those trainees that are missing training opportunities. It is stated that Advanced Pain Trainees should not undertake day time on-call duties. Please inform myself or your Regional Advisor should this remain an issue. Further discussion was lent to the possibility of being removed from the out of hours on-call rota to increase training by 30-40% during the APT year. It was felt by those attending that this is a personal decision to be made on an individual basis as the increase in exposure to Pain Medicine training opportunities would result in a pay reduction.

The availability of formal teaching remains dependent on local arrangements but it is hoped that by publicising organised teaching sessions on the FPM website that more trainees may have the opportunity to attend. I am at present designing a password-protected website to enable trainees to film formal training and access it as an archive/educational source. If any trainee is technically able and keen to be involved please contact me. At the trainee meeting, the Faculty highlighted the consistency of available anaesthetic consultant jobs which include pain.

It is worth noting that the FFPMRCA exam tutorials at the College continue to take place twice a year and have had very good feedback. The College has recently recruited new examiners and question writers and as the bank of questions increase it will be possible to release more examples as a practice for those intending sitting the exam.

The FPM website is continually being updated and is now an important source of information. Please note the sections on what is expected during the APT year, the detailed curriculum (including 16-20 cancer cases) and also the examples of case summaries with the markings. These remain a requirement for completion of APT (together with a detailed logbook of cases) and are expected to reach a publishable standard, which will be marked by the LPMES or RAPM before being submitted to the Faculty. A new quarterly assessment form is soon to be released but please could I remind everyone of the importance of maintaining an up to date logbook. The Faculty has suggested a format that is available online, but it is not compulsory. It does however indicate the depth required for the final assessment.

Thank you to all those that completed the Trainee Survey. There were 40 respondents in total and it revealed some valuable training points which will be discussed at the next FPMTAC meeting. In summary, there is still some discrepancy between training opportunities in some regions with over half of the responses reporting a lack of paediatric pain and a third having limited oncology experience or research opportunities. The FPM has recently set up a new evidence resource which can be accessed on the website which is intended as an education source but also to encourage research opportunities together with the development of the FPM research programme. On-call commitments continue to impact on training opportunities for over 75% of trainees, with a fifth of respondents feeling that this prevents them from gaining the experience required as a future pain consultant. It is hoped that the recent change to the curriculum to protect trainees' day time pain clinics/lists will improve this situation and it will be closely looked at in the next survey and as part of the Faculty's overall quality work streams.

Integrating Research with Chronic Pain Training

Dr Alan Fayaz

Pain Medicine Trainee

Warning! Extending one's training can be addictive. My path to ST7 Anaesthesia had involved a Bachelor of Science in Psychology; Internal Medicine in Belgium; a foray into Cardiology; a year of Public Health as part of the Chief Medical Officer's Clinical Adviser Programme and now an MD (Res) at Imperial College integrated into an Advanced Pain Training programme. My research is centred around data collected by the National Centre for Social Research as part of the Health Survey for England, which in 2011 compiled data on chronic pain sufferers in the United Kingdom alongside a wealth of demographic variables and health indices, providing a fertile resource for would-be-epidemiologists to better our understanding of chronic pain.

The research fellowship is scheduled to run over 2 years during which time I am expected to (and should) meet the sessional requirements needed to achieve FFPMRCA as well as to dedicate time to complete a thesis in pain epidemiology. My salary comes from working a set number of shifts (six 24 hour shifts per month) at an Intensive Care Unit in a private hospital on Harley Street. While the parallel work-streams lack convention they allow me to progress with my training and pace my research in a way that would have been impossible had the two streams run in series.

In many ways I am surprised to find myself in this position having never anticipated a career in academic medicine. For my part this route isn't so much a means to an end but rather an end itself in so far as I am genuinely interested in both epidemiology and chronic pain, and this seemed like an excellent opportunity to combine the two together. There are downsides, of course, and veering from a well-trodden path carries complexity and uncertainty. A large chunk of the data I had hoped to review may no longer be accessible. My time away from anaesthesia has left me feeling a little deskilled, and formal research, even when salaried, is a fairly expensive process. The greatest challenge has been structuring my time to balance the tangible gains achievable from pain sessions against the (presently) abstract progress I am making with my research. On the other hand I am learning to structure systematic reviews, I am actually understanding multi-regression analysis and if I play my cards right I may even see my name in print in the not too distant future – all of which would have been very difficult within the constraints of a regular fellowship programme.

There is little precedent for those who I haven't managed to put off with this article. I have been very fortunate in so far as my programme was initiated, supported and part-funded by the Pain and Anaesthesia Research Centre, closely affiliated with Barts Health NHS trusts, and heavily invested in promoting Academia within the speciality. A key step is to contact your respective Heads of School and Regional Advisors; they can assist in co-ordinating the necessary approval from the Royal College of Anaesthetists, Faculty of Pain Medicine and the relevant postgraduate deaneries. It helps if they are sympathetic and mine have been incredibly understanding of the dynamic and evolving path I have chosen to take. It goes without saying that this sympathy is unlikely in the absence of a well-structured and practical research plan. For my part, half way through, I expect another challenging and stimulating year ahead but I am hopeful that the experience will justify the hard work.

2014 Trainee Publication Prize

Congratulations to **Dr Helen Laycock,** who was awarded the 2014 Trainee Publication Prize for her work on 'Peripheral Mechanisms of Burn Injury-Associated Pain'. This review article was published in the *European Journal of Pharmacology* 716 (2013) 169-178.

Dr Laycock will present a short summary of the article at the **FPM Annual Meeting on 14 November 2014** and receive her certficiate.

The Faulty Board wish to thank all of those who entered a publication into the competition.

Acute Pain fellowship at the University of Toronto

Dr Moein Tavakkolizadeh

Locum Consultant in Pain Medicine

With the support of Faculty of Pain Medicine, many UK trusts are starting to recognise inpatient pain management as an area in need of improvement. Widespread availability of regional anaesthesia/analgesia service across the UK means more patients receive nerve blocks for a wider range of indications. Availability of high quality portable ultrasound machines, to guide the block performance in addition to improved training, have been instrumental for this expansion over the past decade.

I undertook an OOPT/E for one year during July 2012-July 2013 at Sunnybrook Hospital, University of Toronto. Toronto is Canada's largest city with a population of more than 6 million. Nearly half of its population are born outside of Canada and its multicultural structure made the transition from London to Toronto very easy. Despite its reputation, at least in my experience, the winter was mild and supplemented with a beautiful autumn and sunny summer. Ontario has stunning natural beauty and a fantastic outdoor lifestyle with a long skiing season and plenty of water sports during the warmer months.

The University of Toronto is continuously ranked among the top 20 universities in the world and its department of anaesthesia attracts many trainees from across the globe. There are up to 90 fellowship positions available annually which include Regional, Pain, Cardiac, Thoracic, Neurosurgery, Ambulatory, Paediatric, Airway, Clinical, Trauma, Critical care, Simulation, Transplant and Obstetric anaesthesia. This is delivered across six affiliated hospitals and five research institutes. A significant amount of resources are dedicated to research.

Sunnybrook Hospital is a large tertiary referral centre in North Toronto and the largest trauma centre in Canada. It offers all adult medical and surgical services including Cardiovascular, Hepatobiliary surgery, Burns and Palliative Care. The affiliated Holland Elective Orthopaedic Centre is where fellows spend about half of their time as a regional anaesthesia fellow. Around 3,000 joint replacements are performed annually, preferably under regional anaesthesia supplemented by regional analgesia based on perineural catheters at this centre. There is also a home nerve catheter service for ambulatory surgery.

The University of Toronto runs regular didactic teaching for fellows but there are also free or subsidised postgraduate courses that fellows are encouraged to complete during their fellowship. I completed a faculty development course titled 'Stepping Stones'; alternatively there are similar programmes run with a focus on leadership or healthcare management in developing countries.

The first month of the fellowship is fully supervised for induction, assessment and registration purposes. A typical week afterwards consists of one protected day for research and academic activities, a day in the 'block room', 1-2 days of general anaesthesia and 1-2 days of regional anaesthesia lists. Fellows supervise the acute pain service for 3-4 one-week blocks during the year. The leave and support arrangements are very reasonable. Different University of Toronto hospitals have different pay arrangements with a salary ranging $80-$120k Canadian dollars, which would cover the average living expenses of a young couple in Toronto. Canada owns a socialised healthcare system hence the transition from the NHS is rather smooth apart from the lack of ODPs! Overall I would rate this experience as 'excellent'. During my fellowship, I came across many UK-trained anaesthetists who had chosen to settle in Canada after their fellowships.

Since my return to the UK, I have been involved in developing regional anaesthesia services with a focus on nerve catheters and I have felt there is still a niche for expansion of such services within both inpatient and outpatient pain services including cancer patients. The fellowship application process is long and if you are considering or recommending such a fellowship I would suggest starting 1-2 years in advance. Further information can be found http://www.anesthesia.utoronto.ca/edu/fellowship/offered.htm.

Acute Pain Management – the shape of things to come?

Dr Mark Rockett

FPM Board Co-optee

Late last year I was co-opted as an acute pain representative to the Board of the Faculty of Pain Medicine. Whilst pondering what this role should involve and what the Faculty could do to support and advance acute Pain Medicine, I realized that very little was known about those of us who practice acute (or inpatient) Pain Medicine. There have been surveys of the composition of acute pain services in the past, and recently a start has been made on collecting patient level data[1,2]. Although the national survey by Duncan et al revealed some interesting data regarding the staffing of acute pain services, little information was gathered about the training and experience of anaesthetists working in this field.

With this in mind, the Faculty has produced a web-based acute pain service census, which was sent to lead clinicians throughout the UK. The lack of information regarding anaesthetists who work in inpatient pain became apparent when 117 individuals could be identified from the 312 acute trusts in the UK. The results of this survey should therefore be considered as a representative sample at best. The findings of this census will inform progress in the key domains of training, core standard setting and research/audit for acute Pain Medicine.

The changing role of the inpatient pain team

The role of acute and chronic pain physicians is changing in response to limited financial resources and increasing patient expectation. Many acute pain services now provide support for all hospital inpatients, medical and surgical alike. Pain is not isolated to the patients undergoing surgical procedures, and it would seem obvious that all patients should have equal access to expert pain management. Additionally, the focus of many chronic pain services on community working has left many acute inpatient services devoid of chronic pain management support. The optimum solution of a fully integrated acute and chronic pain service is unfortunately not always achievable.

Training and education

With the introduction of the FFPMRCA examination, Pain Medicine training and assessment in Britain has taken a dramatic leap forward. We can now be assured that our Fellows have a full and broad understanding of the complex biopsychosocial nature of chronic pain and its multidisciplinary management. However, this step-change in the specialty of Pain Medicine applies largely to those working in chronic Pain Medicine, potentially leaving acute pain physicians feeling disenfranchised.

Some clinicians work in both acute inpatient and chronic outpatient settings, but the majority of inpatient pain doctors work as theatre anaesthetists. When considering the training needs of inpatient pain management leads, it is important to appreciate the relatively small sessional commitment of most anaesthetists to inpatient pain services. The recent national inpatient pain survey of 184 acute trusts revealed that the majority of acute pain services had minimal consultant input with 56% relying on one consultant session per week and 11% had no formal consultant support at all. Less than a fifth of trusts provided more than 2 sessions per week[2].

The expanding role of the inpatient pain service requires appropriate training in managing complex pain patients, and preventing the transition from acute to chronic pain. These training needs may not always be met by Higher Pain Medicine training as currently offered in the RCoA curriculum.

Core standards

The Faculty of Pain Medicine, together with stakeholders from the British Pain Society acute pain special interest group is working on a set of core standards for the provision of acute pain services, which is complementary to the Royal College of Anaesthetists guidelines for the provision of anaesthetic services (GPAS) document www.rcoa.ac.uk/gpas2014.

Research

Chronic under-investment in inpatient pain services has hampered progress in acute pain research. The development of an acute pain research network will serve to set research priorities and secure more significant funding for ongoing projects. This process will be complimentary to other research streams such as the James Lind Alliance and NIAA priority setting exercise (http://www.niaa.org.uk/PSP).

References:

1. Nagi, H. Acute pain services in the United Kingdom. *Acute Pain* 2004; 5: 89-107.

2. Duncan, F, et al. First steps toward understanding the variability in acute pain service provision and the quality of pain relief in everyday practice across the United Kingdom. *Pain Med* 2014; 15(1): 142-53.

ACMD Diversion & Illicit Supply of Medicines Inquiry – Call for Evidence Faculty response

The ACMD is a statutory and non-executive non-departmental public body, established by the Misuse of Drugs Act 1971. The ACMD has a statutory duty to keep under review the situation in the UK with respect to the misuse of drugs and to advise ministers of the measures which they consider should to be taken to deal with social problems which arise from drug misuse. The summarised response below, to a recent call for evidence, is from both the British Pain Society and the Faculty of Pain Medicine. The full repsonse can be found here: www.rcoa.ac.uk/system/files/FPM-ACMD-Response_0.pdf.

In your view, to what extent is diversion and illicit supply of medicines a problem in the UK? Specialists in pain management acknowledge that diversion and illicit supply of analgesic medicines does occur in the UK, however it is extremely difficult to quantify the extent of this. There are no data that tell us what happens to a prescription after it has been dispensed by a pharmacist.

Do you know of medicine diversion and illicit supply, if so where are these medicines coming from? The increasing number of deaths associated with tramadol is a concern and its availability over the internet has been identified as a source by which individuals may obtain excessive supplies. The recent change in legislation and its classification as a Schedule 3 controlled drug should bring this route of supply to an end.

Which medicines/drugs do you consider are being diverted and supplied illicitly? It would be unhelpful if concern regarding illicit use or diversion of prescription drugs resulted in reticence to prescribe the drugs to those who genuinely need and derive benefit from them. Other countries, namely the United States of America and Australia, have developed prescription monitoring schemes for controlled drugs. Such schemes allow greater sharing prescribing and dispensing information between healthcare professionals, including community pharmacists.

What problems have diversion and illicit supply of medicines caused for the public, patients and clinicians? Experience from the United States points up a clear relationship between quantity of controlled drugs prescribed and their misuse and associated morbidity and mortality. We do not know whether such a relationship pertains in the UK. Healthcare professionals play an important role in ensuring that prescription of controlled drugs is considered only when informed by knowledge of the risks of misuse for an individual.

What action should the healthcare and other relevant sectors take to resolve the issue of diversion and illicit supply of medicines? The British Pain Society and Faculty of Pain Medicine, in collaboration with RCGP and the Faculty of Addictions Royal College of Psychiatrists, have previously published guidance on the appropriate use of opioids for pain and also on pain management in substance misuse.

What action should the Government take to resolve the issues of diversion and illicit supply of medicines? Rather than updating existing guidance the BP, the FPM and other clinical and policy stakeholder groups propose to develop a central opioid prescribing resource. This will be based on the best available evidence regarding the benefits and harms of opioids which prescribers can then draw on to make a good clinical decision for an individual patient, influenced of course by the individual's clinical presentation, comorbidities and circumstances.

Faculty Events

Dr Sanjeeva Gupta

Educational Meetings Advisor

Dr Shyam Balasubramanian

Deputy Educational Meetings Advisor

The joint study day of the Faculty of Pain Medicine and British Society of Rheumatology in June 2014 was a great success. Excellent talks were presented by eminent speakers on musculoskeletal and inflammatory pain mechanisms, blood tests and inflammatory markers, rheumatology for pain consultants, Pain Medicine for rheumatology consultants, fibromyalgia, rheumatoid arthritis, hypermobility and pain and pain management in osteoarthritis.

The past decade has witnessed tremendous advances in the understanding and management of different persistent pain conditions. Interventional strategies are tailored to individual pain presentations. With ever growing sub-specialisation in pain services, the Faculty has decided to design the annual meeting on 14th November 2014 around the theme of 'Pain Management in Special Circumstances'. Pain conditions commonly encountered by clinicians will be discussed and eminent experts in the respective field will be talking about recent advances and share their personal experiences. The social impact of chronic pain and pain medications frequently appear in media headlines. At the Annual Meeting there will be presentations on 'drugs and driving' and 'pain management in secure environments'.

The controversy around the use of cannabinoids in managing pain continues. Now and then we all come across pain sufferers enquiring about the possibility of obtaining prescription cannabinoids. A debate on 'Cannabinoids in neuropathic pain' should enlighten the audience about the benefits and limitations of this less understood drug. Other interesting presentations include pain management in burns and in patients with traumatic rib fractures. Practical considerations whilst performing spinal interventions in patients on anticoagulants will also be discussed. The Patrick Wall guest lecture will be delivered by Professor Sue Fleetwood-Walker.

Clinical diagnosis depends upon history, examination and investigation. In February 2014, we conducted a successful workshop on diagnostic investigations in Pain Medicine. Next year, on 3rd of February 2015, we will be running workshops on musculoskeletal clinical examination skills. The day before, on 2nd of February 2015, we will be running a study day on CRPS. We would encourage members to attend this event to learn all about the various aspects of Complex Regional Pain Syndrome, including establishing/refining your service. Both these study days will comprise of workshops in small groups which will maximise the learning opportunity for participants.

Further details and booking information is available on the FPM and RCoA websites. Faculty members interested in knowing more about Continuing Professional Development activities or wishing to contribute to the educational events can contact us via fpm@rcoa.ac.uk.

Comments from Rheumatology Study Day

"Excellent, hugely worthwhile"

"Good array of speakers and coverage of topics"

"Very educational, good background information"

"Very valuable and relevant to my practice"

Faculty of Pain Medicine 7th Annual Meeting:

Pain Management in Special Circumstances

Friday 14th November 2014

09.35 – 09.45	Registration & Welcome
09.45 – 10.15	Pain management in secure environments *Dr Cathy Stannard, Bristol*
10.15 – 10.45	Opioids and Driving *Dr Rob Searle, Cornwall*
10.45 – 11.05	Discussion
11.05 – 11.25	Refreshment
11.25 – 12.00	Managing pain in burns patients *Dr Winston de Mello, Manchester*
12.00 – 12.30	Patrick Wall guest lecture *Professor Sue Fleetwood-Walker, Edinburgh*
12.30 – 13.30	Lunch
13:30 – 14:25	Debate: Cannabis in neuropathic pain For: *Dr William Notcutt, Great Yarmouth* Against: *Dr Paul Farquhar-Smith, London*
14.25 – 14.55	Pain Management following rib fractures *Dr Carl Hillerman, Coventry*
14.55 – 15.05	Discussion
15:05 – 15:25	Refreshment
15:25 – 15:55	Anticoagulants and Spinal Interventions *Dr Manohar Sharma, Liverpool*
15.55 – 16.05	Discussion
16:05 – 16:15	Trainee Publication Prize
16:15 – 16:35	Developments: FPM: *Dr Kate Grady, Dean*
16:35 – 16:45	Discussion & Close

RCoA, London
5 CPD Points
£190 for Consultants, £135 for trainees.
Code: B08

FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

Faculty of Pain Medicine Study Day:

All You Need To Know About Complex Regional Pain Syndrome

Monday 2nd February 2015

9.00 to 9.30	Registration and coffee
9.30 to 9.45	Introduction - *Dr A Goebel and Dr S Gupta*
9.45 to 10.10	Current concepts on the pathophysiology of CRPS and recent advances *Dr A Goebel - Pain Medicine Consultant, Liverpool*
10.10 to 10.35	CRPS diagnosis, and the role of investigations in CRPS *Dr R Haigh - Consultant Rheumatologist, Exeter*
10.35 - 10.50	Discussion
10.50 to 11.10	Refreshments
11.10 to 11.35	Pharmacological management for optimal outcome in CRPS *Dr M Rockett - Pain Medicine Consultant, Plymouth*
11.35 - 12.00	Physiotherapy and multidisciplinary Pain Management Programme treatment for CRPS *Mrs Selina Johnson - Liverpool*
12.00 - 12.25	The role for interventional pain management in CRPS *Dr Simon Thompson - Pain Medicine Consultant, Basildon*
12.25 - 12.40	Discussion
12.40 to 13.30	Lunch
13.30 to 15.30	*Three workshops of 40 minutes each.*
	1 Setting up a service for early CRPS including collaboration with acute-care *Mrs Fiona Cowell and Dr Dominic Hegarty*
	2 Setting up and running a Specialist CRPS clinic for longstanding CRPS, including regional referral pathways *Dr A Goebel and Mrs S Johnson*
	3 All you ever wanted to learn about commissinoing your CRPS service *Mrs E Chadwick - Assistant Divisional GM - Neurosurgery, Liverpool*
15.30 to 15.45	Discussion
15.30 to 15.45	Refreshment
15.45 - 16.10	The Elephant in the Room: Medicolegal issues *Dr R Munglani - Pain Medicine Consultant, Cambridge*
16.10 to 16.35	Primary and secondary prevention of CRPS *Dr M Rockett*
16.35 - 17.00	Discussion, feedback and close

RCoA, London
5 CPD Points
£170, £140 for trainees.
(book along with the 3rd February for a reduced rate of: £320, £255 for trainees)
Code: B28

Programme organised by Dr Andreas Goebel

FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

Faculty of Pain Medicine Study Day:

Musculoskeletal System Examination for Diagnosing Pain Problems

Tuesday 3rd February 2015

08.50 – 09.20	Registration
09.20 – 09.30	Introduction - *Dr M Tewani and Dr S Balasubramanian*
09.30 – 09.50	The role of clinical examination *Dr M Tewani - Pain Medicine Consultant, Warwick*
10.00 – 10.50	Examination of the Lumbar Spine and Pelvis *Dr J Tanner - Orthopaedic and sports medicine specialist, London* *Dr V Ketkar - Musculoskeletal Physician, Birmingham*
10.50 – 11.10	Refreshments
11.10 – 12.00	Examination of the Hips and Knees *Dr P Gregory - General Practitioner, Warwick* *Dr D Ravindran - Pain Medicine Consultant, Reading*
12.00 – 12.50	Examination of the Ankles and Feet *Dr S Rigby - Rheumatology Consultant, Warwick*
12.50 – 13.40	Lunch
13.40 – 14.30	Examination of the Cervical and Thoracic Spine *Dr J Tanner, Dr D Ravindran*
14.30 – 15.20	Examination of the Wrists, Hands and Elbows *Dr S Rigby, Dr P Gregory*
15.20 – 15.40	Refreshments
15.40 – 16.30	Examination of the Shoulders *Dr V Ketkar, Mr Matt Stanislas - shoulder and upper limb specialist*
16.30 – 16.50	Discussion
16.50 - 17.00	Feedback and close

RCoA, London
5 CPD Points
£170, £140 for trainees.
(book along with the 2nd February for a reduced rate of: £320, £255 for trainees)
Code: B28

Programme organised by Dr Meera Tewani

Faculty Update and Calendars

New Fellows

Graham SIMPSON
Amod MANOCHA
Rajinikanth SUNDARA RAJAN
Dmitry KRUGLOV
Paul ROLFE
Owen BODYCOMBE
Alifa TAMEEM
Moein TAVAKKOLIZEDAH
Yehia KAMEL
Shankar RAMASWAMY
Lorraine HARRINGTON
Sanjay KURVINAKOP
Sadiq Salim BHAYANI
Christopher HALEY
Sundara Mahalingham MUTHUKRISHNAN
Sangeeta DAS
Gordon STEWART

New Associate Fellows

Petr HAJEK
Stefano PALMISANI

New Diplomates

Kiran SACHANE

Examination Calendar Nov 2014 – July 2015

	FFPMRCA MCQ	FFPMRCA SOE
Applications and fees not accepted before	Monday 3 Nov 2014	Thursday 19 Feb 2015
Closing date for FFPMRCA Exam applications	Thursday 18 Dec 2014	Thursday 26 March 2015
Examination Date	**Wednesday 4 Feb 2015**	**Tuesday 28 Apr 2015**
Examination Fees	£505	£710

2014–2015 Faculty Calendar

MEETING: FPM Training & Assessment Cmte	24 Oct 2014
EVENT: FPM Annual Meeting	**14 Nov 2014**
EVENT: FFPMRCA Exam tutorial	**28 Nov 2014**
MEETING: Board of the FPM	11 Dec 2014
MEETING: FPM Professional Standards Cmte	12 Dec 2014
MEETING: FPM Training & Assessment Cmte	30 Jan 2015
EVENT: FPM CRPS Study day	**2 Feb 2015**
EVENT: FPM Examinations Study day	**3 Feb 2015**
MEETING: FPM Professional Standards Cmte	5 Feb 2015
MEETING: Board of the FPM	6 Feb 2015
MEETING: FPM Training & Assessment Cmte	24 April 2015

Please note that all dates may be subject to change.

Save the date

Annual Scientific Meeting
21 April – 23 April 2015
Glasgow

Don't forget to save the date to attend the British Pain Society's 48th ASM in Glasgow 21 April – 23 April 2015

Why you should attend:

- Network with colleagues
- Raise questions, partake in debates and discuss outcomes
- Meet with poster exhibitors and discuss their research
- Meet with technical exhibitors and hear about their products and services
- Discuss your own research

We look forward to seeing you in Glasgow.

The British Pain Society

The Faculty of Pain Medicine
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