FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

Newsletter of the Faculty of Pain Medicine

SPRING 2018

TRANSMITTER

FACULTY OF
PAIN MEDICINE
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As I write this in the middle of March, there is snow on the ground and winter lingers on. As do the woes of the National Health Service. Whether you believe more money is the answer, or that the system is fundamentally broken, pressures on services will no doubt increase.

Dip into this issue of Transmitter for some examples of where the Faculty is trying to help support its Fellows with current issues. Dr Baranidharan reports on a joint initiative with The British Pain Society to provide guidance on validated outcome measures; it is anticipated this will be available in the coming months. Governance is a hot topic. Dr Paul Wilkinson, chair of the Professional Standards Committee (PSC), brings your attention to the recently published consensus statement on the use of corticosteroids for neuraxial procedures in the UK. During the development of the statement the evidence that I found most compelling was that "In a study using porcine models, all particulate injections into the vertebral artery resulted in catastrophic outcome whereas non-particulate steroid injections resulted in full clinical recovery": I am pleased this information made it to the final document. Dr Wilkinson also provides a separate article on the musings of the PSC with regard to the pooling of interventional lists.

The role of trainee representative to the Board has rotated. Thanks to Sheila Black whose achievements during her term are highlighted in the report from her successor Helen Laycock. Welcome to Helen; and also to Sheila in a new role as consultant member of the Training and Assessment Committee.

As always, thanks to all authors and the Faculty administrative team, particularly Emmy Kato-Clarke.

John Goddard

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Deans' Statement: New Year, New Intake

Dr Barry Miller

Dean

"I wonder if other dogs think poodles are members of a weird religious cult." Rita Rudner

2017 was a busy year; our tenth anniversary and an opportunity to reflect on our successes and form plans for a future with new challenges.

Looking Outward

From the beginning it was recognised that although anaesthetists made up the majority of Pain Medicine specialists in the UK, there remained a large number who trained in different specialties. Over time we have been moving to expand our charter and remit, to become the natural home of all medically qualified pain medicine practitioners. Over the last 12 months, led by John Hughes, Vice Dean, we have been involved with Palliative Care physicians with a significant practice in Pain Medicine. It has always been obvious that there is a close link between the two specialties and yet we have drifted apart. This will be an opportunity to recognise that we have much common ground, and that links should be renewed and formalised. We are working towards a mechanism for Palliative Care consultants to join, as Fellows, and will be developing curricula in tune with the new GMC's principle of transferable skills that I hope will encourage more to train with us and join.

Looking inward

When the new curriculum was created it was hoped that all Pain practitioners whether acute or chronic (or both) would complete a year's training in Advanced Pain Medicine and become Fellows. This is clearly not what is happening in the real world: often Acute or Inpatient Pain services exist separately from a Chronic pain service or there simply isn't a Chronic Pain service on site, but the need for in-hospital pain services and advice remains an important activity in any hospital. Some will have taken the Higher Pain Training option during their pre-CCT training, but many taking on the mantel of Acute Pain later in their careers will not have had the opportunity, or considered it at that time.

The Faculty is looking to re-engage with this important group and has developed the Affiliate Fellowship to encourage engagement and help develop improved professional standards and education. This will include guidance on post-CCT training needs in this rapidly expanding sphere, moving from the basics of postoperative pain management into the broader field of all in-hospital pain problems. The increasingly important interface of discharge analgesia and guidance to patients and General Practitioners, combined with increasing concerns over opioids and the likely rescheduling of the Gabapentinoids, will place an increasing focus on this area. Look out for more details on Affiliate Fellowship, which will launch in July.

Credentialing

Credentialing as a means of recognising specialist areas of medicine, but separate from the, now closed, subspecialty register of the CCT has been on the GMC's agenda since 2008, and was brought to greater prominence in the 'Shape of Training' review of 2013. With major changes requested by the GMC to rewrite all medical curricula to uniform patterns, allowing for transferable skills, and a change from competency based to outcome based, the Faculty is engaging actively to help develop credential(s) in Pain Medicine. The time course is uncertain, but the prospect of a highly trained individual, with, at last, enhanced recognition remains our goal.

Opioids…… again

There is no let-up in the focus on this area of prescribing, and I encourage all to develop links with local GPs, CCGs and hospital colleagues, to review or develop local guidance and meet the pressures, and threats, to good quality pain medicine practice. Of course, this also applies to all other aspects of care.

New Members Update

Dr John Hughes

Vice Dean

Over the last year the New Membership Working Party has developed the project for new routes of entry to the Faculty of Pain Medicine. These have been ratified by both the Board of the FPM and Council of RCoA.

Foundation Fellowship (Second Phase)

This route instigates a process similar to the original Foundation Fellowship, which was limited to Anaesthetic Pain Medicine Consultants. Applicants would be a Member or Fellow (by examination) of one of their parent Royal Colleges, in good standing in a specialty prescribed in the relevant application form. They would hold a substantive or honorary NHS consultant position with sessions, or a contracted clinical commitment within their job plan to Pain Medicine as stated in the relevant application form. This would allow established Pain Medicine consultants from related specialties to join the FPM family.

Discussion is ongoing with the Palliative Care Medicine Specialty Advisory Committee as a pilot exercise, with the intention of expanding to include (in the first instance) Neurology, Rehabilitation Medicine and Rheumatology. Discussions have also begun with the GMC regarding training options.

> **"The route would create a strong connection to the Acute/Inpatient Pain Medicine community which will considerably help with the growing work of the FPM**

The FPM would not plan to open this route until a solution is found to the future training of non-anaesthetic Pain Medicine trainees, which (as above) is being actively pursued.

Affiliate Fellowship

Affiliate Fellowship would be used for consultants who are associated with pain medicine (i.e. acute/inpatient pain services). It would not be associated with post-nominals and the fee would be set below that of full Fellowship.

This new route would allow Acute/Inpatient Pain Medicine consultants to join the FPM family whist still recognising the difference in training requirements between Affiliate Fellows and those who have undertaken full Advanced Pain Training and the examination (Fellow by Examination). The route would create a strong connection to the Acute/Inpatient Pain Medicine community which will considerably help with the growing work of the FPM in this area including; Core Standards, education, training etc.

The plan would be to open this in late 2018 as soon as the new route comes into regulatory being.

Having undertaken this work it is apparent that there are a number of chronic pain consultants who have for various reasons (largely changes in regulations and time limits) found themselves in a position that makes them ineligible for any of the current membership routes. This seems inequitable and something that should be addressed at the same time as the new routes of membership. This is currently under way and will be addressed as the new routes open.

Faculty of Pain Medicine Study Day

Psychology for Pain Medicine

Wednesday 6th June 2018

09.00 - 09.20	**Registration & Welcome**
Session One	
09.20 - 09.50	**Nuts and bolts of psychology for Pain Medicine** *Dr Zoey Malpus, Consultant Clinical Psychologist, Manchester*
09.50 - 10.00	**Discussion**
10.00 - 11.00	**Pain Clinic Consultation & Motivational interview skills** *Dr Mike O'Connor, Consultant in Pain Medicine, Bristol*
11.00 - 11.30	**Refreshments**
Session Two	
11.30 - 12.00	**Managing a patient in pain clinic with suicidal ideation** *Dr Natalie Lane, Highly Specialist Clinical Psychologist, Liverpool*
12.00 - 12.30	**Psychological interventions in in-patient settings** *Dr Jeremy Gauntlett-Gilbert, Principal Clinical Psychologist, Bath*
12.30 - 13.00	**Discussion**
13.00 - 14.00	**Lunch**
Session Three	
14.00 - 15.00	**Breakout session 1** **How to consult and explain chronic pain in Fibromyalgia: Medical perspective** *Dr Anthony Davies, Consultant in Anaesthesia and Pain Management, Plymouth*
15.00 - 16.00	**Breakout session 2** **How to consult and explain chronic pain: Psychology Perspective** *Dr Zoey Malpus and Dr Jeremy Gauntlett-Gilbert*
16.00 - 16.30	**Discussion & Close**

RCoA, London
5 CPD Points
Consultants: £175
Trainees/nurses: £140
Code: DB3

FACULTY OF PAIN MEDICINE
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Faculty Events

Dr Shyam Balasubramanian

Educational Meetings Advisor

Dr Manohar Sharma

Deputy Educational Meetings Advisor

The Faculty of Pain Medicine is committed to continuing professional development and organises study days, joint meetings and annual meetings to benefit doctors and nurses from all specialties interested in Pain Medicine.

The prestigious 10th Annual Meeting held in December 2017 with the theme 'Core Topics in Pain Medicine' was yet another successful educational event organised by the Faculty. Experts from different sub-specialties made the day informative by sharing their knowledge and clinical expertise. Topics included acceptable pain management in enhanced recovery programmes, cancer recurrence and regional anaesthesia, body reprogramming in fibromyalgia and biological mechanisms of action of interventional pain techniques.

The Patrick Wall lecture, 'Cell transplants for treatment of chronic neuropathic pain' presented by Professor Allan Basbaum was fascinating. If the research work translates to clinical practice, in the future, we may move away from 'symptom management' to 'treatment of the disease'. The debate on multi-disciplinary team approaches to pain management stimulated interesting discussions. Dr Miller, our Dean, presented achievements of the FPM and recent developments in setting standards in clinical practice.

Following the grand success from the past years, the two study days in February were dedicated exclusively to Acute Pain. We developed an innovative style: 'Twenty topics in Acute Pain'. The objective was to move away from lengthy didactic talks to short and informative presentations relevant to our day to day practice. Participants were interested in learning about judicious use of different fascial planes such as erector spinae plane, quadratus lumborum plane and fascia iliaca for safe, easier and effective pain management. Both the days were well attended and attracted positive feedback. A highlight included the interactive discussions facilitated by Dr Jane Quinlan and Dr Mark Rockett. Most of the discussions were around exploring the role of non-opioid analgesics and techniques in acute pain management.

Although the concept of the 'bio-psycho-social model' is very familiar pain clinicians, the knowledge and the competencies to address the psychological aspects of patients with Chronic Pain still remains patchy. To date, we have received several requests to organise an event on psychological interventions in pain medicine. We are sensitive to the needs of our members and will be conducting a study day on 'Psychology for Pain Medicine' on the 6th of June 2018. The programme comprises of basic orientation lectures, guidance on managing patients with suicidal ideations and interactive workshops on how to run effective consultations when managing patients with psychological comorbidities. Details of the programme and the link for bookings are available at: https://www.rcoa.ac.uk/faculty-of-pain-medicine/events/recent-advances.

Our educational meetings are a great opportunity to meet colleagues and update knowledge across the horizon of Chronic Pain as well as learn what might be around the corner and of interest to all. If you have any new ideas, or an interest in contributing to these events, then, please contact either Dr Shyam Balasubramanian (doctorshyam@hotmail.com) or Dr Manohar Sharma (manoharpain@yahoo.co.uk).

Body Reprogramming: A novel approach to Fibromyalgia

Dr Tony Davies

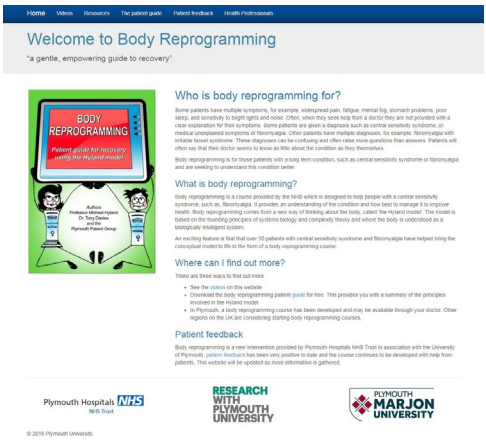
FPMPSC Member

A senior AHP colleague recently asked me why I took such a professional interest in Fibromyalgia when other medical colleagues seemed to greet this condition with frustration or disinterest. It is likely that a psychology degree, year-long clinical psychology attachment and psychiatric post have all helped nurture an interest in medically unexplained symptomology. The real catalyst however is a long-standing interest in narrative medicine.

Frequently I hear these patients echo that they have not been listened to in primary care and their doctor perceived as having little understanding of the disorder. The most astonishing alleged comment from a professional was …*"you have shit life syndrome, nothing can be done and you should just get on with it."* A combination of clinical trivialisation and amputation of therapeutic hope is an unpleasant cocktail for any patient.

For me, the real driver for progress came during a meeting on translational research with theoretical psychologist, Professor Michael Hyland. We explored the novel conceptual model he had developed for Chronic Fatigue Syndrome and this resonated for other Central Sensitivity Syndromes, particularly Fibromyalgia. The theoretical tenets seemed to underpin the clinical approach I had developed professionally and triggered the following collaborative work.

We developed a Fibromyalgia syndrome (FMS) specific group programme based on this 'Hyland' conceptual model. A patient guide was developed with the active involvement of the patients involved. This guide is now freely available on the website www.bodyreprogramming.org.



Within six weeks of being published online an Internal Specialist in Argentina contacted us and volunteered to translate the patient guide into Spanish! As an aside, Google Analytics is a fascinating way of understanding the international geographical distribution of those who access your website.

As with many long-term pain conditions, a tiered clinical strategy is desirable. For us Tier 1 incorporates individual based management of the condition in primary care with the aforementioned guide serving as a key resource. A number of primary care presentations were undertaken by the author, initially during scheduled talks but soon by invite as the local health community requested further insight. Without this engagement in primary care, real sustained change would be muted. A key educational component is also the incorporation of training into the GP VTS programme. Feedback to date has been unequivocally positive. It surprised me however when a senior pain colleague stated that GPs already understood this condition and so we could abrogate all medical responsibility to them. This had not been my experience locally and indeed generated bemusement from a number of primary colleagues I shared this anecdote with!

Tier 2 has been developed as a 6 week x 2 hour community based FMS group programme structured within a psychoeducational framework facilitated by a lifestyle coordinator. Lifestyle management aspects are actively promoted within the conceptual model as well as guiding a conservative medication

usage with many patients reducing their intake whilst on the course. Attendance to date has been impressive and also quantitative and qualitative data so far has been extremely encouraging. Our Tier 2 is geared toward early intervention when evidence for therapeutic progress is strongest.

Tier 3 is for those with psychosocial complexity, particularly where physical or psychological trauma has played a key part. The conceptual model appears to dovetail well with Third Wave CBT approaches such as ACT and Compassion Focused Therapy. Psychologists can be wedded to their favoured professional philosophies but interestingly this approach has conjured a vibrant response from my local colleagues. There has been longstanding debate about the relative strengths of condition specific versus generic groups. The former appears particularly challenging when all the patients have Fibromyalgia but interestingly the conceptual model appears to provide a reassuring framework and can apply to all those with a central sensitivity syndrome.

Should pain clinicians be involved in managing Fibromyalgia? Some colleagues would prefer to say no. Research data shows that FMS patients consume significant healthcare resources. Also a recent local audit indicates that these patients continue to be referred around the health-care community when there is no perceived closure either diagnostically or therapeutically. Some sadly gravitate to more invasive options. As Pain Medicine specialists I believe we have a central role in promoting clinical closure and nurturing a less bio-medically orientated model.

This approach has made clinical management a much more professionally satisfying experience and constructive patient feedback from the group programmes can be viewed on the website. For me the future for this cohort of patients seems slightly rosier!

Pooling of Patients on Procedure Lists

It is evident that there is considerable variation in practice in the United Kingdom with use of both individual doctor lists and pooled doctor lists. Pooled lists can have organisational advantages of convenience, improved access to treatment, and equality of waiting time between patients and increased flexibility.

Real or potential difficulties include difference in practice between doctors, issues of ensuring consistency of operative approach, lack of clinical continuity and perceived reduced professionalism. There are increased systems' risks such as a doctor facing an unexpected procedure or one that he or she would not choose to undertake in the observed clinical circumstances. Members of the PSC also recognise that procedures are being delegated to non-medical staff in some centres which mandates robust governance procedures. This matter is considered in separate guidance.

Whatever approach is chosen (pooled or individual lists), there are professional obligations to ensure patient safety, the minimisation of risk and informed consent. Processes must be in place to ensure the highest standards of care and doctors must not be pressured to work in an unsafe, unfamiliar or unacceptable way.

Patients must be presented with appropriate and timely information supportive to the consent process including risks and benefits of alternative treatments including no treatment. The PSC took the view that part of that consent process should also include information about which system (pooled or individual) was in place and who may undertake the procedure. Ideally patients should be provided with choice regarding this.

The PSC viewed that it could not advocate one system over another. Members viewed that pooling of lists raised more governance issues than individual list allocation; however, pooling of lists was likely to meet the necessary standards when decision-making was straightforward, procedures were simple and where doctors worked in a similar way.

Essential Pain Management

Dr Clare Roques

EPMAG Chair

Since its creation in 2010 the educational programme Essential Pain Management (EPM) has been run in over 50 countries and translated into seven languages. Although it was originally conceived (by its authors, Roger Goucke and Wayne Morriss) to be used in low resource environments it is now widely used in high income settings, and is taught in many medical schools in the UK. The expansion of EPM led to the creation of the UK EPM Advisory Group (EPMAG) at the Faculty of Pain Medicine (FPM) which coordinates the delivery of EPM workshops by UK instructors in low resource environments (primarily in Africa) as well as in UK medical schools.

Creating a sustainable model of EPM delivery, particularly in low resource settings, has always been a key concern of the EPMAG, but implementing and evaluating this has presented many challenges. We have recently embarked on a 12 month project, specifically to address these challenges, funded by the Tropical Health Education Trust (THET) in partnership with the World Federation of Societies of Anaesthesiologists and St Mary's Hospital Lacor in Uganda. The EPMAG (through funding from the RCoA and the Association of Anaesthetists of Great Britain and Ireland (AAGBI) Foundation) has already supported two sets of EPM workshops at St Mary's Hospital Lacor (building on a set run in Kampala (funded by the AAGBI Foundation and the British Pain Society).

The project consists of three components. Firstly, EPM workshops will be run across the country initially with a combination of UK and Ugandan instructors but with diminishing input from the UK team with the St Mary's Hospital team acting as the Ugandan hub for this work. The workshops will be run in St Mary's Hospital Lacor and in Kumi Hospital in the eastern region of the country. The aim of this arm of the project is to build and support the cohort of Ugandan EPM instructors.

Secondly, we are incorporating a comprehensive evaluation programme to both support and enable modification of the EPM workshops in order to suit the particular context. Until now evaluation has largely rested on the immediate assessment of knowledge exchanged during the workshops, incorporating a combination of multiple choice question (MCQ) test scores and standard feedback questionnaires. While useful, we acknowledge the limitations of these data in providing a picture of both long-term knowledge retention and the clinical impact of EPM. We will, therefore, continue to collect these data but will supplement it by monitoring the MCQ scores of participants for the duration of the project. A key component of the EPM workshops is the identification of local barriers to the provision of effective pain management. We will be formally recording these barriers and following up on efforts to overcome them. These data will be collated, in combination with clinical audit carried out at the host institutions, to monitor key indicators such as the measurement of pain scores and the amount of analgesics prescribed and administered.

Whilst running EPM and indeed creating funding proposals, we have identified a fundamental deficit in published data mapping the provision of pain management services, including the delivery of education. The third component of the partnership project aims to address this by carrying out a survey across Uganda. We will be identifying key informants from regional referral units across the country to map the delivery of pain management, identifying deficits and solutions, and thereby creating important data for future advocacy work.

If you are interested in being involved in any of the work of the EPMAG please email Claire Driver at the FPM (contact@fpm.ac.uk). More information of the EPMAG's global and UK projects is available at the 'Faculty Initiatives' section of the FPM website.

Outcome Measures

Dr G Baranidharan

Working Party Chair

The National Health Service (NHS) is a publicly funded organisation providing health care in the UK and employing more than 1.5 million people. There is ever growing technological advancement with increased life expectancy. This, in turn, costs more for the NHS and the people who commission the NHS.

NHS pain services are currently commissioned by different clinical commissioning groups (CCG) based on their local infrastructure and requirements. We have NHS performance indicators (for example the 18 week rule) to assess each unit's ability to provide service rather than patient outcome measures. Outcome measures are not normally required to show the effectiveness of management. This situation is currently changing and some CCGs are requesting outcome-based commissioning. This is a relatively new approach to commissioning health and social services in the UK. It encourages value for money and a better outcome for the patients.

Pain has a multifactorial impact on life. There are various outcome measures developed to assess and monitor treatment. The Initiative on Methods, Measurement and Pain Assessment in Clinical Trials (IMMPACT) guidelines were developed to address the deficiencies in outcome measures for clinical trials. This addresses various domains in managing pain and its effects on life.

A working party of the Faculty of Pain Medicine and the British Pain Society are developing a document to assist pain services across the country in selecting appropriate outcome measures. The working party has considered Pain Measurement in the following domains: Pain Interference, Physical Functioning, Emotional Distress and Functioning, Quality of Life and Patient reported outcome. The document aims to explain the outcome measures development, copyright, reliability, validity, and appropriateness.

The working party has only considered outcome measures that have been validated. We have also looked at commonly used outcome measures, but haven't incorporated them if they did not have evidence in chronic pain. The working party was not tasked to do an extensive evidence review and paediatrics and acute pain are not a part of the current remit. These aspects will be considered in the second phase of the development. This document will need regular updates as more evidence evolves.

The outcome measures document is in its final stages. This will be published once the FPM Board and BPS Council have reviewed and approved. Each hospital can choose the outcome measures they would incorporate and use them after reviewing the copyright restrictions. The document will also contain the details of how to apply for permission to use the measure.

Corticosteroids: rare risk of central serous chorioretinopathy

The MHRA have warned that corticosteroid administration (including by the epidural or intra-articular route) may rarely cause central serous chorioretinopathy. This may lead to retinal detachment and visual loss. Patients should be advised to report any new visual disturbance after corticosteroid use.

https://www.gov.uk/drug-safety-update/corticosteroids-rare-risk-of-central-serous-chorioretinopathy-with-local-as-well-as-systemic-administration *(accessed 23rd March 2018)*

Medicines & Healthcare products Regulatory Agency

Professional Standards

Dr Paul Wilkinson

FPMPSC Chair

The Professional Standards Committee (PSC) has once again been extremely busy and I have the pleasure to provide a brief overview of ongoing activity. I will focus on three recently completed pieces of work.

Consensus statement on the use of Corticosteroids for Neuraxial Procedures in the UK

This has proved to be a very complex piece of work. I thank Tony Davies specifically for navigating a way forward. The key concern is of reported catastrophic neurological complications with transforaminal injections in the cervical region with particulate steroids, likely to be due to an unintended intravascular injection, the particulate steroid and vascular ischaemia.

The published document provides a brief review of the literature and a position statement. There was agreement that particulate steroids **must not** be used for transforaminal cervical epidural injections on the basis of the rare, but catastrophic complications. However, advice on the use of steroids in other anatomical locations, or by a different route of steroid delivery, proved problematical: so too did navigating through complex discussions about the relative efficacy of different steroids, the transferability of existing evidence and the weight of evidence that existed for wider risk in other contexts.

In the absence of definitive evidence, the adopted approach is largely based on consent. There is increased responsibility of practitioners to provide thorough consent, including the known risks of particulate steroids, risks related to the route and location of injection, and risk of neuro toxicity. Therefore prevailing view is that it is the discussion and documentation of indication, efficacy, safety and alternate treatments that is pivotal rather than specific 'never-do' statements.

Driving and Medicines

The second piece of work, led by Dr Robert Searle, relates to advice about medicines and driving. Previously, we provided guidance for patients, but there was a need to help practitioners provide advice to patients. This is against a backdrop of legislative restrictions and an increase in public health concerns relating to prescribed medicines and driving. This new publication covers not only opioids, but other forms of pain prescription medication helping with shared decision making, ensuring the highest standards of advice by pain specialists while maintaining public safety on the roads.

Extended Scope Practitioners

The third piece of work that I wish to highlight relates to Extended Scope Practitioners (ESP). It is clear from member queries that this is an issue on which members are seeking direction. The PSC exists to provide advice on standards of practice related to pain specialists and not other groups. However, there is a responsibility on the pain specialist to provide education and support for ESPs if supporting this practice. Based on work done by the RCoA for Anaesthetic Practitioners, Dr Baranidharan has led on developing professional guidance for pain specialists. Specifically, the new document provides guidance as to how professional standards are applied to the provision of education and support to extended scope practitioners. The PSC views that this practice should not be supported without necessary safeguards and there is a duty of practitioners to identify where standards are not being met.

This pivotal piece of work will enable pain specialists to work with new clinical developments, but maintain safety and best practice.

Other work

I have focused on three important pieces of work but there has been much more activity from the PSC. Below are a few key issues which I will report on, in more detail, at the appropriate time.

- The development and refinement of a dashboard of clinical standards continues. There is significant work related to the issue of prescribed medicines, most importantly opioids, and matters of public health concern with many press queries.

- A revised publication for complex regional pain syndrome is imminent and we are taking the first steps to provide more comprehensive standards for cancer pain treatment, working collaborately with other stakeholders.

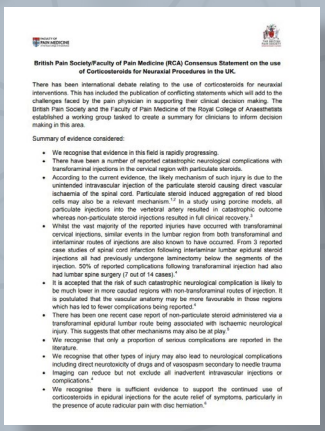
- The PSC is also considering what further support can be provided to help with commissioning beyond the information provided in our core standards document.

Finally...

Once again I would like to thank all members of the Professional Standards Committee for their hard work which is not only strengthening clinical practice but enhancing the reputation of the Faculty of Pain Medicine amongst governmental and other organisations.

You can find these and other guidelines at:

www.fpm.ac.uk/faculty-of-pain-medicine/guidelines

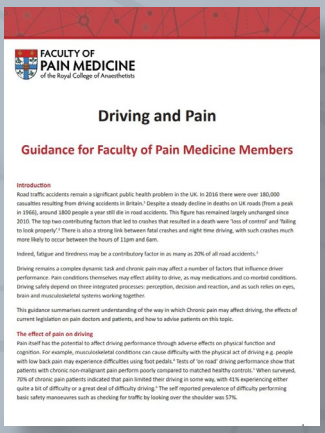


British Pain Society/Faculty of Pain Medicine (RCA) Consensus Statement on the use of Corticosteroids for Neuraxial Procedures in the UK.

There has been international debate relating to the use of corticosteroids for neuraxial interventions. This has included the publication of conflicting statements which will add to the challenges faced by the pain physician in supporting their clinical decision making. The British Pain Society and the Faculty of Pain Medicine of the Royal College of Anaesthetists established a working group tasked to create a summary for clinicians to inform decision making in this area.

Summary of evidence considered:

- We recognise that evidence in this field is rapidly progressing.
- There have been a number of reported catastrophic neurological complications with transforaminal injections in the cervical region with particulate steroids.
- According to the current evidence, the likely mechanism of such injury is due to the unintended intravascular injection of the particulate steroid causing direct vascular ischaemia of the spinal cord. Particulate steroid induced aggregation of red blood cells may also be a relevant mechanism.[1,2] In a study using porcine models, all particulate injections into the vertebral artery resulted in catastrophic outcome whereas non-particulate steroid injections resulted in full clinical recovery.[3]
- Whilst the vast majority of the reported injuries have occurred with transforaminal cervical injections, similar events in the lumbar region from both transforaminal and interlaminar routes of injections are also known to have occurred. From 3 reported case studies of spinal cord infarction following interlaminar lumbar epidural steroid injections all had previously undergone laminectomy below the segments of the injection. 50% of reported complications following transforaminal injection had also had lumbar spine surgery (7 out of 14 cases).[4]
- It is accepted that the risk of such catastrophic neurological complication is likely to be much lower in more caudad regions with non-transforaminal routes of injection. It is postulated that the vascular anatomy may be more favourable in those regions which has led to fewer complications being reported.[4]
- There has been one recent case report of non-particulate steroid administered via a transforaminal epidural lumbar route being associated with ischaemic neurological injury. This suggests that other mechanisms may also be at play.[5]
- We recognise that only a proportion of serious complications are reported in the literature.
- We recognise that other types of injury may also lead to neurological complications including direct neurotoxicity of drugs and of vasospasm secondary to needle trauma
- Imaging can reduce but not exclude all inadvertent intravascular injections or complications.[4]
- We recognise there is sufficient evidence to support the continued use of corticosteroids in epidural injections for the acute relief of symptoms, particularly in the presence of acute radicular pain with disc herniation.[6]



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Driving and Pain

Guidance for Faculty of Pain Medicine Members

Introduction

Road traffic accidents remain a significant public health problem in the UK. In 2016 there were over 180,000 casualties resulting from driving accidents in Britain.[1] Despite a steady decline in deaths on UK roads (from a peak in 1966), around 1800 people a year still die in road accidents. This figure has remained largely unchanged since 2010. The top two contributing factors that led to crashes that resulted in a death were 'loss of control' and 'failing to look properly'.[2] There is also a strong link between fatal crashes and night time driving, with such crashes much more likely to occur between the hours of 11pm and 6am.

Indeed, fatigue and tiredness may be a contributory factor in as many as 20% of all road accidents.[3]

Driving remains a complex dynamic task and chronic pain may affect a number of factors that influence driver performance. Pain conditions themselves may effect ability to drive, as may medications and co-morbid conditions. Driving safety depend on three integrated processes: perception, decision and reaction, and as such relies on eyes, brain and musculoskeletal systems working together.

This guidance summarises current understanding of the way in which Chronic pain may affect driving, the effects of current legislation on pain doctors and patients, and how to advise patients on this topic.

The effect of pain on driving

Pain itself has the potential to affect driving performance through adverse effects on physical function and cognition. For example, musculoskeletal conditions can cause difficulty with the physical act of driving e.g. people with low back pain may experience difficulties using foot pedals.[4] Tests of 'on road' driving performance show that patients with chronic non-malignant pain perform poorly compared to matched healthy controls.[5] When surveyed, 70% of chronic pain patients indicated that pain limited their driving in some way, with 41% experiencing either quite a bit of difficulty or a great deal of difficulty driving.[6] The self reported prevalence of difficulty performing basic safety manoeuvres such as checking for traffic by looking over the shoulder was 57%.

FACULTY OF PAIN MEDICINE
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Standards for the members of the Faculty of Pain Medicine (FPM) for training and administration of pain interventions by non-medical practitioners

Patient safety is paramount and is at the heart of delivering NHS services. This document is a guideline developed by the Faculty of Pain Medicine, professional standards committee. The standards document is for the members of the FPM involved in training and delivering pain interventions by non-medical/non-doctor practitioners such as Extended Scope Practitioners (ESP).

Training

The ESP being trained should be an integral part of the pain service. They should be involved in multidisciplinary team meetings and care for the patients in an outpatient setting. They should be trained in the bio psycho social aspects of pain management. The potential impact on pain medicine training opportunities continues to raise concern and must remain under close scrutiny by the FPM and local departments.

The FPM has a comprehensive curriculum designed for the anaesthetic pain medicine trainees. The curriculum offers a foundation for any training delivered by members of the Faculty of Pain Medicine. The trainer should be actively involved in teaching and training with the FPM and be up to date with changes in the field of clinical and interventional pain practice. The training should focus on the principles, practice and evidence for the clinical decision to do an intervention and the technique of neural blockade to treat pain including,

- Selection of patients based on history and clinical examination
- Thorough knowledge of general and radiological anatomy
- Ability to discuss the benefits, complications and alternatives of the proposed interventions with patients and so obtain informed consent in line with the Montgomery ruling.
- Technical proficiency in performing pain interventions
- The ability to manage complication, including up to date resuscitation training
- Work in a pain MDT setting
- Continuous professional development (CPD)

These can be documented using standard teaching and assessment forms such as Clinical Evaluation Exercise (CEX), Direct Observation of Procedural Skills (DOPS), Anaesthesia List Management Tool (ALMAT) and Case Based Discussion (CBD)

Supervision

1. The Faculty of Pain Medicine acknowledges that development of ESP roles is taking place. The FPM would only support role enhancement when statutory regulation is in place. Responsibility where such role enhancement exists currently remains a local governance issue

Training and Assessment

Dr Jon McGhie

FPMTAC Chair

Following the recent changes to bestow FFPMRCA post nominals directly from a successful pass in the examination and the removal of case reports as a requirement within Advanced Pain Training [1] the Training and Assessment Committee is now focussing its attention on adapting the existing pain curriculum to meet the changes required for Shape of Training compliance. This is a development that is happening in parallel with RCoA processes, but the FPM faces additional considerations; pain training is compulsory for anaesthetists up until intermediate level but optional thereafter. Future changes to the curriculum will need to continue to reflect this situation, while permitting greater access to higher and advanced training for non-anaesthetic groups; recognising that some of the new core and specialised competencies will be achieved at different stages by trainees from differing specialties.

There is some guidance now available to support these changes; the GMC have released their guidance on Generic Professional Competencies (GPCs) and how to integrate these into curricula. [2] The Royal College of Physicians have already adapted their future core level Internal Medicine (IM) programme in this manner. [3] The Royal College of Paediatrics and Child Health have published their new curriculum and assessments in a modular fashion. [4] We will be looking at both of these examples for guidance as the clinical competencies assessed and evidenced in the IM curriculum and the structure of the paediatric curriculum overlap with elements of pain training. The overarching process will be to reduce the frequency and potential variability of current clinical assessments and adopt a core set which gives reassurance on clinical progress and attainment of high level objectives and is less burdensome across the different training stages.

Collaboration between TAC, the New Membership Working party led by Dr Hughes and the FPM Board is taking place simultaneously, as these changes have implications on how pain training will exist within the 'credentialed' model that the GMC is advocating as an option for some specialties. The current FFPMRCA exam structure and its timing will also need to be embedded into the new curriculum. We will keep you informed well in advance of any planned changes.

Dr Cole has produced a detailed summary of the recent census results which are published in this issue. Within these results we have identified a number of individuals who practice pain medicine clinically but have no current association to the FPM. Feedback suggests that some of these individuals may have been caught between closure of the old fellowship by assessment route and the introduction of the FPMRCA exam. As we are currently working to create an affiliation route for acute pain specialists who wish to join the FPM we are broadening the scope of this work to review this cohort of chronic pain specialists to see if a similar route of access may be appropriate for them. Further details on these developments will be given in due course.

Finally, I would like to welcome Dr Helen Laycock onto TAC as the new pain trainee representative. Helen has a strong research interest and is looking to build upon the momentum established in this area by Sheila Black and Mark Rockett. We are pleased to have Helen on board and trainees should contact her with any training issue or query that they wish TAC to deal with. I am also pleased to say that Sheila is going to continue as a consultant member on TAC and we are grateful for her continued hard work and enthusiasm!

[1] August 2017: www.fpm.ac.uk/faculty-of-pain-medicine/transmitter

[2] www.gmc-uk.org/education/postgraduate/standards_for_curricula.asp

[3] www.jrcptb.org.uk/new-internal-medicine-curriculum

[4] hwww.rcpch.ac.uk/progress

Trainee Update

Dr Helen Laycock

Faculty Trainee Representative

In February of this year I took over the role of Trainee Representative from Shelia Black. I'd first like to thank Sheila for all her hard work over the last two years as your Trainee Representative. She commenced a number of trainee initiatives whilst in the role, including being a founding member of PAIN-TRAIN, organising the national survey on referral times for patients to reach chronic pain services, helping to establish teaching sessions for pain trainees in the North of England and representing your views to the Faculty, through the Board and Training and Assessment Committee. I'd like to wish her all the best in her new consultant post.

> **"There is an active national pain trainee WhatsApp group and email list to allow communication about teaching, courses and other topical pain issues.**

Although only few weeks into my term of office, I have already heard from a number of new trainees signing up to the Faculty at higher and advanced training levels. Welcome to all of you.

I am a Clinical Lecturer in Pain Medicine at Imperial College and a ST7 Advanced Pain Trainee in North West London. Although originally from South Yorkshire, I attended medical school at Imperial College, London and have undertaken all of my Anaesthetic training on the North West London rotation. I was an academic trainee representative in London during my Academic Research Fellowship and PhD, and am used to representing trainee views to committees regionally. As a founding member of the Pan London Perioperative Audit and Research Network (www.uk-plan.net), I'm passionate about collaborative trainee networks enabling trainees to work together, experience research and audit and learn collectively. I'm excited about becoming your new trainee representative. As pain trainees, we are a small cohort, with very unique training needs, who are spread out from each other geographically.

There is an active national pain trainee WhatsApp group and email list to allow communication about teaching, courses and other topical pain issues. Please email me or the Faculty with your contact details (helen.laycock@doctors.org.uk or contact@fpm.ac.uk) should you want to be included in these and I hope in my term to represent all of your ideas, issues or queries to the Faculty.

As mentioned in the last Transmitter article, both London and North of England pain teaching sessions are being held regularly. They are run as face-to-face sessions, however (technology permitting) they are also video linked, so you can also access these remotely. Please take advantage of what are a fantastic program of speakers and topics, covering many essential exam topics.

Finally a big congratulations to PAIN-TRAIN (www.paintrainuk.com), the national pain trainee research network. The first project GABACUTE, a snapshot project that looked at perioperative use of gabapentinoids and also anaesthetists' attitudes towards their use, has just completed its data collection period. Approval was gained in over 40 sites across the UK to run the project and the initial data collection period has involved people with a range of experience in pain medicine (from medical students to advanced pain trainees). This is a fantastic response, from a large number of trainees. Having run data collection locally, I appreciate how much effort everyone involved in the project has contributed so far, and I cannot wait to see the national results now data analysis is commencing.

FPM Workforce Census

Dr Peter Cole

FPM Workforce Lead

With thanks to all colleagues who contributed to the census and to the members of the Workforce team: Daniel Waeland, Jon McGhie, Victor Mendis, Claire Driver and Anna Ripley

The first FPM census took place in 2012. The RCoA Medical Workforce Census Report 2015 provided information necessary for anaesthetic and intensive care workforce planning, however did not separate anaesthetists from those who work in pain medicine. This second FPM Census was rolled out in the spring of 2017 with a questionnaire developed by the Training and Assessment Committee. The 2017 Census looked at the demographics of current pain consultants together with their pain interests; it included questions on job plans and the department that the Consultant worked in.

The 2012 Census started as a 'survey monkey' questionnaire which was emailed to all members. Despite encouragment, the response rate was only 33%. For the 2017 census a 'hub and spoke' approach, where the RAPM and LPMES were responsible for the local data collection, was developed. The RAPM would coordinate and collect the replies from the LPMES who had collected the information from colleagues in their hospital. In hospitals where there was no LPMES, the RAPM sent questionnaires directly to the consultants.

There were 484 responses to the survey (approximately 76.8%). The response rate varied between regions, of the 21 regions 7 had a 100% response rate whereas 6 regions returned less than 30% (response rate range 14.3-100%). Feedback identified confidentiality concerns and returning directly to the Faculty may improve response rate for future surveys.

Demographics

- 75% of respondents were male, 25% female.
- There was 1 consultant in the 30-34 category and 3 over 70; 61% were over 46 years of age

Faculty Affiliation

- The majority of respondents were Fellows of the Faculty and 7 were Associate Fellows
- 72 consultants were not affiliated to the Faculty.

Pain Interests

- 62% worked in chronic pain only, 11% in acute pain and 27% in both acute and chronic pain.
- 8% worked with paediatric chronic patients, 11% with paediatric acute pain and 9% with both acute and chronic paediatric.
- Almost all (98.3%) consultants working in chronic pain clinics were anaesthetists, with a few exceptions; 2 general medicine, 1 GP, 1 gynaecologist, 1 paediatrician, 1 psychiatrist and 1 rehab medicine.

Pain Work/Job Plan

- The average (mean) number of pain PAs was 4.24 per week with an average of 8 total PAs. The mean SPAs was 1.79. 56% of respondents felt that their SPA allocation was not enough time for a dual specialty consultant.

The Department

- 12% worked in clinics as solo/lone practitioners with no multidisciplinary team support. Of the multidisciplinary clinics; 16% doctor plus one other (nurse, physiotherapist, occupational therapist), 14% two others members of a multidisciplinary team, more than half clinics (58%) were fully multidisciplinary with three or more disciplines (16% reported that clinics were run in their departments by non anaesthetists.
- 76% worked in clinics that had local access to a pain management programme.

Planned Retirement Age and Change in Number of Working Hours Per Week

- 58% planned to retire earlier, but 42% planned to retire later.
- 1 in 6 of respondents had already reduced their working hours due to changes in annual allowance.

Key points

1. 61% of the workforce are over 46 years of age, this is a slight increase from 56% in the previous census and supports the finding from the 2015 anaesthetic census of a continued ageing consultant workforce.
2. 25% of the pain consultant workforce are female; this is slight increase from 22% in the previous census and continues to be lower than the 32% of females that make up the anaesthetic consultant workforce.
3. The finding that 72 of respondents had no affiliation with the Faculty of Pain Medicine has stimulated a review of membership categories and ongoing discussions at Board level.
4. Pain consultants' workload per week revealed a mean of 8 direct PAs and 1.79 SPAs; this is less than the findings from the 2015 the Anaesthetic Census where 74% worked more than 10 PAs per week.
5. This is the first time a medical workforce censuses has looked at the potential impact of tax reforms (life time allowance and annual allowance) and the effects of the introduction of the 2015 NHS Pension on the number of working hours per week and on planned retirement age.
6. The number of respondents planning to retire earlier (58%) may be offset to some degree by the number planning to retire later (42%). The NHS pension encourages working longer although the reduced lifetime allowance may result in a large tax bill if they do so.
7. Annual allowance and job plans; the 2015 Summer Budget announced important changes to the annual allowance – by earning more than a specified amount each year tax relief on pension contributions will be reduced. The main changes first applied in the 2016/17 tax year and although this survey was carried out soon after the end of that tax year already 1 in 6 of the pain workforce had reduced their weekly working hours.
8. This reduction in working hours (i.e. the amount of work each consultant does per week) and potential impact on retirement age has workforce implications not only in pain medicine but across the whole of the medical workforce and has been brought to the attention of the RCoA Workforce Advisory Group and the AAGBI and will be monitored closely.

Figure 1 - Consultant Age

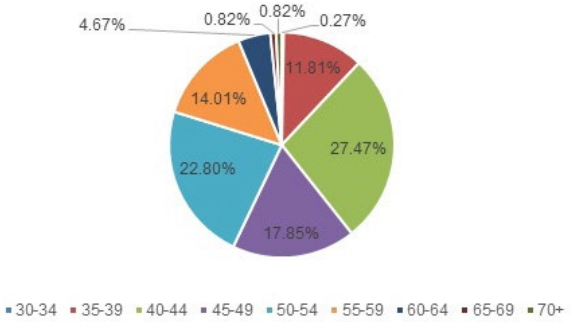


Figure 3- Base Specialty Breakdown

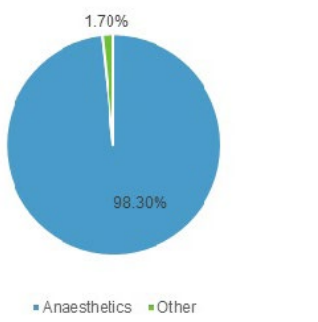


Figure 2 - Main Area of Practice

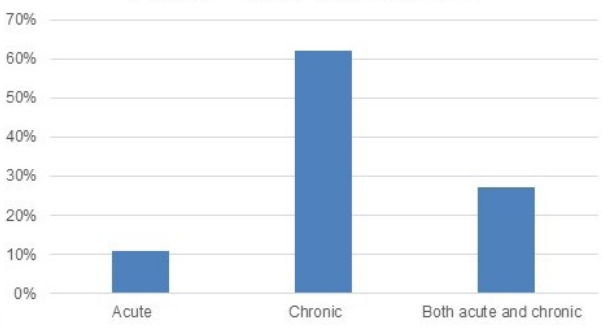
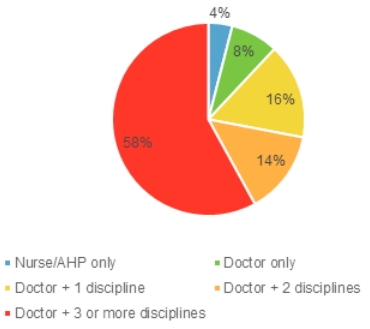


Figure 4 - Multi-disciplinary Clinic



FFPMRCA Examination

Dr Nick Plunkett

Chair, FFPMRCA Examinations

Dr Anthony Davies

Vice-Chair, FFPMRCA Examinations

The 11th MCQ took place on 30th August 2017 where 13 candidates attended. This is comparable to the candidate cohort for February 2017 which was 12. At this exam, the pass mark was 69.73%; equal to a raw score of 258 or above out of 370. The Core Group removed some questions from the total, before the pass mark was calculated, due to reasons of error or ambiguity in the question content. No candidates were disadvantaged in this process. After adjustment, the maximum scores available were: 194 in MTF (six stems removed), 92 in SBA (two questions removed) and 84 in EMQ (four questions removed). The pass mark was agreed by summating the Angoff-based individual sections using the same method as previously described. The candidate mean was 71.68%, with a pass rate of 69% (9 out of 13) which is 14 percentage points lower than the February 2017 pass rate of 83%.

Prior to the SOE examination the Court of Examiners carried out a paper checking exercise to assess the relevance and difficulty of the questions in line with other exams and the examiners' expectations. The Court assessed the question set used at the October exam to be at an acceptable level of difficulty and relevance, similar in overall difficulty to previous examinations. The SOE took place on Tuesday 17th October 2017 during which 14 candidates were assessed. 10 out of 14 candidates passed the FFPMRCA examination giving a 71% pass rate which is higher than the April 2017 and October 2016 pass rates of 61% and 57.2% respectively. Linear regression and Hofstee calculations were plotted against the exam data after the exam.

The statistical analysis was discussed by the Court of the Examiners and the data obtained were used as a starting point to agree the pass mark. The final pass mark of 31 out of 40 was reached through a combination of statistical analysis and expert judgment and this is in line with pass marks set for previous exams. The range of candidate scores was 21 to 38. Two candidates were borderline (scoring 30 and 32) and the performance of both was discussed at length by the Court of Examiners who agreed that their results should stand and the pass mark remained at 31.

Of the 14 candidates who sat the exam, 10 were on their first attempt, two on their second attempt and two on their 3rd attempt. 9 out 10 passed at their first attempt. One candidate passed at their third attempt. Both candidates sitting at their second attempt failed the exam and one candidate failed at their third attempt. The Court of Examiners agreed that all candidates who failed the exam should be invited to attend a guidance interview. No candidates at this sitting met the criteria for the prize.

The examination has been quality assured since its outset and this process is continually assessed and adjusted to meet best practice. This was the first exam where feedback was given using video footage, following the successful testing of the videoing process and equipment at the April exam. Examiner practice was found to be of a uniformly high standard, with feedback given to aid further improvement. Three visitors attended on the day and all felt the standard was set appropriately and gave positive feedback.

The Chair and Vice Chair would like to thank Graham Clissett and the examinations team for a polished and professional examination.

RAPM Update

Dr Victor Mendis

RAPM Chair

The 2nd Local Pain Medicine Educational Supervisors Day (LPMES) was held on the 8th March. We listened to your comments regard last year's event and this year held both group discussions and interactive sessions. We received positive feedback and are looking at options for next year's event.

I am delighted to welcome Dr Michael Neil who has taken over from Dr Gail Gillespie as RAPM for the East of Scotland and Dr Paul Rolfe who has taken over from Dr Lorraine De Gray as the RAPM for the East of England. Whilst welcoming Michael and Paul, I would like to thank both Lorraine and Gail for their work over the years.

There have been some concerns regarding the quality of workplace-based assessments, particularly about the lack of trainer commentary and we encourage trainers to take the time to give as much feedback as possible. This will be very valuable for the trainees. Dr Alistair Dodds has done some preliminary work on this and will run a workshop at the next LPMES Conference.

There have been changes to the award of the Fellowship recently. Candidates no longer have to go through a separate assessment process and will be awarded the Fellowship on passing the examination. This also means that there will no longer be a diploma. The new routes into the Fellowship will focus on trying to expand and manage pain medicine beyond anaesthesia. You can read John Hughes' update on the new membership routes for more detail.

Curriculum changes are imminent across all medical specialities when we move to outcome based learning and the general shift in curriculum would mean that pain medicine would be introduced through the medical curriculum as part of the shared competencies.

I am hoping that the career packages for trainees and trainers prepared by the Faculty are being cascaded to all anaesthetic trainees on trust induction days, which may be a way of attracting more trainees to take up a career in Pain Medicine.

Paediatric pain training remains an issue and the Faculty understands the limitations in certain regions. Dr Paul Rolfe is heading a working party and work is in progress on how to improve the situation.

Dr Tim Vemmer RAPM, did a presentation on communication issues and challenges faced by trainees and has kindly created a 10 minute module which will soon be available on the Faculty website.

Dr Peter Cole continues to lead on workforce issues and recently carried out a workforce census, which for the first time has highlighted workforce implications. It is very important that we all continue to respond to such surveys in the future to enable us to produce the necessary data for workforce planning. I also kindly request all RAPMs and LPMESs to kindly return the hospital review forms in a timely manner which helps update our records.

Faculty of Pain Medicine 11th Annual Meeting

Topical Issues in Pain

Friday 30th November 2018

09.00 - 09.20	**REGISTRATION AND REFRESHMENTS**
09.20 - 09.30	Welcome and Introduction
Session One	
09.30 - 09.55	Medico-legal implications of deviation from practice
09.55 - 10.20	Learning from patient narratives
10.20 - 10.45	Game theory: Improving pain clinic outcomes
10.45 - 11.00	Discussion
11.00 - 11.20	**REFRESHMENTS**
Session Two	
11.20 - 12.00	Faculty Developments
12.00 - 12.45	Consciousness and Pain
12.45 - 13.00	Discussion
13.00 - 14.00	**LUNCH**
Session Three	
14.00 - 14.45	Opioid misuse- joint clincs: Pain clinician's perspective Psychiatrist's perspective
14.45 - 15.00	Discussion
Session Four	
15.00 - 15.30	Pain in Cancer Survivors and its Management
15:30 - 16:00	Gaps in evidence in pain medicine
16.00 - 16.30	**DISCUSSION AND CLOSE**

RCoA, London
5 CPD Points
Consultants: £200
Trainees/nurses: £140
Code: B08

FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

Programme organised by Dr Shyam Balasubramanian and Dr Manohar Sharma

British Pain Society Calendar of Events

To attend any of the events below, simply book online at:
www.britishpainsociety.org/mediacentre/events/

THE BRITISH PAIN SOCIETY
EXPERTISE WHERE IT MATTERS

Pre-ASM Meeting: Introduction to Pain Work for Psychologists

30 April 2018
Hilton Brighton Metropole

The session, presented by Dr Nick Ambler and Dr Patrick Hill, aims to provide psychologists new to working in pain management with an overview of the theory and research literature, the application of this to clinical assessment and intervention at individual and group level. The workshop will be very interactive and have a strong clinical focus. The day will begin with a discussion with participants about their aims for taking part including the opportunity to discuss specific clinical challenges they may have encountered.

Pre-ASM Meeting: Pain: Where are we and where are we going?

30 April 2018
Hilton Brighton Metropole

This is a joint meeting between the BPS Interventional Pain Management and Neuropathic Pain Special Interest Groups and NSUKI. We have looked to deliver a meeting which covers innovative and novel interventions alongside education on Neuromodulation and advances in Neuropathic pain diagnosis and treatments. There is something for everyone with regards the clinical management of pain.

Annual Scientific Meeting

1 & 2 May 2018
Hilton Brighton Metropole

The British Pain Society would like to invite all healthcare professionals to attend its 2018 Annual Scientific Meeting (ASM), which will be held in Brighton at the Hilton Brighton Metropole.

The Plenary sessions will include:
Patrick Wall Lecture Pain in Mice and Man: Ironic Adventures in Translation | Professor Jeffrey Mogill
A Gut Feeling About Brain Function: Microbiome as a Key Regulator of Visceral Pain | Dr John Cryan
Pain after torture: progress, setbacks, and prospects | Dr Amanda Williams
BPS Lecture Chronic pain epidemiology: from population health to health policy | Professor Blair Smith

Philosophy and Ethics Special Interest Group 2018 Meeting

2-5 July 2018
Launde Abbey, Leicestershire

The themes for 2018 will be 'Burnout' and 'Skilful Use of Language' and they may well overlap to some extent.

Further details for all our meetings can be found on our events listing page:
www.britishpainsociety.org/mediacentre/events/

Faculty Update and Calendar

New Fellows

Archana Ninaad Aware
Martyna Anna Berwertz
Hannah Louise Dawe
Pallavbhai Virendrabhai Desai
Katharine Ann Howells
Bradley Lewinsohn
Nishi Patel
Danielle Mary Reddi
James Shannon
Mochail Athanasios Karvelis
Min Liu
Hari Sankar Ankireddy
Kerry Elliott

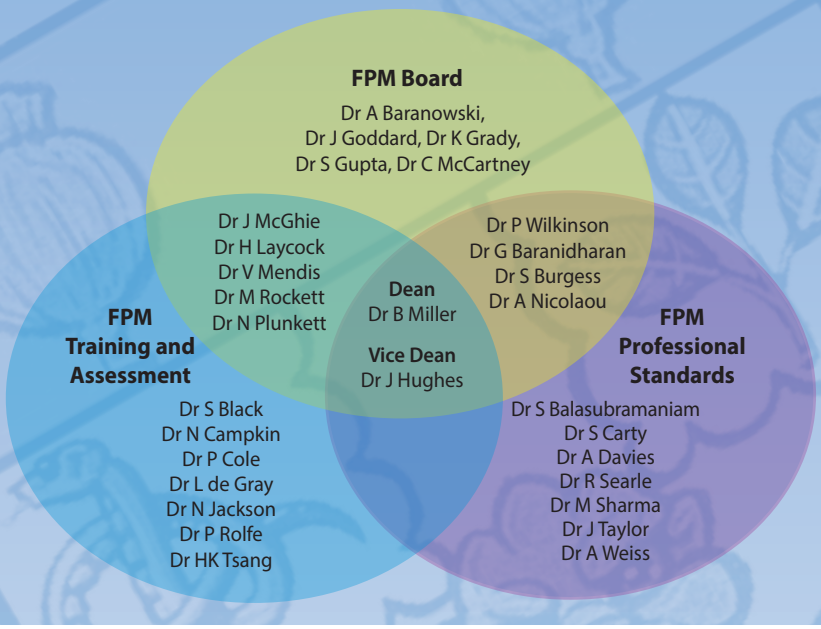
New Associate Fellows

Conor Farrell

New Members

Neil Hall

Committee Membership



2018 Faculty Calendar	
MEETING: FPM Training and Assessment Committee	27 April 2018
MEETING: FPM Professional Standards Committee	17 May 2018
MEETING: Board of the FPM	18 May 2018
EVENT: Summer Study Day	6 June 2018
MEETING: FPM Training and Assessment Committee	29 June 2018
MEETING: FPM Professional Standards Committee	13 September 2018
MEETING: Board of the FPM	14 September 2018
MEETING: FPM Training and Assessment Committee	5 October 2018

Please note that all dates may be subject to change

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