FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

Newsletter of the Faculty of Pain Medicine AUTUMN 2018

TRANSMITTER

Hong Kong Pain Exam

Spotlight on: Leicester

New Consultant Feedback

Best Practice for Clinic Letters

Essential Pain Management: Zambia

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Seemingly in response to high profile campaigning with regard to the effectiveness of cannabinoids in some rare epilepsies of childhood, specialists are now able to prescribe cannabinoids for patients with several conditions, including chronic pain. This has pre-empted a NICE technology appraisal on cannabidiol in rare epilepsies and a clinical guideline on cannabis-based products for medicinal use, both still in development. This politically driven acceleration of normal processes sits in a context of increasing medicalisation, and legalisation, of cannabis-based products in many jurisdictions. The Faculty of Pain Medicine, along with many other medical organisations, has issued a position statement urging caution in prescribing cannabinoids for chronic pain. This stance appears to have widespread support amongst the UK pain fraternity as evidenced by the "google group" letter to the Times with 166 signatories. In this issue of Transmitter your Dean details some of his additional thoughts on the matter. As many of us are already aware, patient pressure for cannabinoid prescriptions will be an increasing issue in the pain clinic.

Another area where there is pressure for change is the clinic letter. John Titterington encourages you to consider addressing this to the patient, rather than the GP. Both the GMC and Academy of Royal Medical Colleges advise you to adopt this approach. Personally, I have not made this change – yet. My reluctance stems from the biopsychosocial nature of pain. How do I communicate effectively to patients and parents that their beliefs and coping strategies are a fundamental part of the problem? Clearly, more training required; I haven't found the right course yet!

This issue of Transmitter is my last as Clinical Editor, as I demit from the Board. I wish my successor well. So, I extend a final thank you to all authors and the Faculty administrative team, primarily Emmy Kato-Clarke and Dawn Tillbrook-Evans on this occasion.

John Goddard

CONTENTS

Cannabis - a caution

Dr Barry Miller

Dean

On the road to health and happiness, we must travel carefully on rocky paths.

The Faculty has recently issued a position statement on the medicinal use of cannabinoids in Pain Medicine, to which this article is intended as "additional thoughts on the matter".

Over the coming months various cannabinoid products will become/or have already been licensed for medical use. The normal systems for regulation of pharmacological products seem to have been 'flexed' by the enormous public and political interest generated by the apparent success of cannabidiol, where other treatments have failed, in some forms of epilepsy in children. The caution here relates to the lack of published data on these case reports.

Across the US and Europe there are increasing pressures to decriminalise cannabinoids. The pressures come from two very separate groups; those interested in its potential for medicinal use, and those for recreational. The latter often supporting the former as a 'first step'.

It is not for the Faculty to comment on recreational use, or its use in areas of medicine outside of Pain. The Faculty is also not unaware of the widespread pressure both within medicine and without; and that sometimes an evidence-based approach goes against strongly held feelings.

The first steps in the UK came 20 years ago with House of Lords support for cannabinoids, particularly for spasticity in Multiple Sclerosis, and the subsequent licensing in 2010 of one product with a 1:1 ratio of THC (Tetrahydrocannabinol): Cannabidiol. Early enthusiasm, and studies in patients, have not indicated that this is a major beneficial product in the pain armamentarium.

The current proponents argue that many cannabinoids, particularly cannabidiol, already available as a 'health food supplement', have no or fewer psychotropic effects than other molecules (e.g. THC); although its apparent value in epilepsy would suggest that it has significant Central Nervous System interactions.

Though frequently commented on as a potential treatment in pain, long-term or short, the current evidence is woefully lacking, and most anecdotal reporting is very short-term. The most recent reviews in Cochrane[1] and Pain[2] have both indicated that the evidence base is very poor, and evidence of value very limited.

We are still on the upstroke of the opioid-concern curve, and those early hopes are now being washed away in justified anxieties of overuse and improper marketing, beyond good evidence. In the background, concerns over the Gabapentinoids and their psychotropic effects are becoming louder.

The Faculty takes the view that changes in the historical approach to cannabinoids are appropriate to allow for proper research and trials. It does not support the use of unrefined cannabis products which have been licensed in other counties for medical use, which seems a form of 'herbology'[3] that runs counter to the best pharmacological practice.

Practitioners aiming to prescribe licensed products for patients with severe chronic pain problems should do so in the context of a carefully considered management plan, patient consent, clear identifiable goals, follow-up and GP involvement. This is true for all treatments, but additional vigilance and record keeping is essential. This would best be suited to a limited number of specialist services and supporting national data collections.

The Faculty is pushing for a database of uses and effects, but it unclear if there is political will for this.

We do not know what long-term exposure to these compounds will be, and caution now is essential until long-term data become available.

A last word. Pain Medicine is often reliant on the use of off-licence medications. This is partly an issue with the licensing of products, when often there is no economic value to the manufacturer

in extending a drugs' recommendations once it is prescribable, but also that long-term studies are difficult, time consuming (by the very nature of 'chronic') and expensive for non-corporate bodies. This is a fundamental issue, which is particularly problematic for us. This does not mean we should not strive, and consider options of uncertainty, but it does mean that we must be increasingly cautious of the wider medico-legal environment and plan clearly for treatments of uncertain, short or long-term outcomes.

The future may hold greater clarity, and it may be that the outlook for cannabinoids in pain medicine is more positive than it now appears, but this doesn't prevent appropriate caution today.

[1] Mücke M, Phillips T, Radbruch L, Petzke F, Häuser W. Cannabis-based medicines for chronic neuropathic pain in adults. Cochrane Database of Systematic Reviews 2018, Issue 3. Art. No.: CD012182. DOI: 10.1002/14651858.CD012182.pub2

[2] Stockings E, Campbell G, Hall WD, Nielsen S, Zagic D, Rahman R, et al. Cannabis and cannabinoids for the treatment of people with chronic non-cancer pain conditions: a systematic review and meta-analysis of controlled and observational studies. PAIN. 2018;159(10):1932-54.

[3] Apologies to J. K. Rowling

FACULTY OF
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The Faculty has opened two new routes of membership:

Affiliate Fellowship and Affiliate

Affiliate Fellowship is open for application from any doctor in Pain Medicine (acute/inpatient and/or chronic) without the FFPMRCA examination.

Affiliate is a route open to any member of the multidisciplinary and multiprofessional pain management team.

Do pass this information on to your colleagues.

Both routes were opened at the end of September 2018. For more details on both routes, please see: https://www.fpm.ac.uk/faculty-of-pain-medicine/about-the-fpm/membership
or email contact@fpm.ac.uk

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** *Dr Shyam Balasubramanian*
Session One	
09.30 - 09.55	**Medico-legal implications of deviation from practice** *Dr Richard Sawyer, Oxford*
09.55 - 10.20	**Learning from patient narratives** *Dr Francine Toye, Oxford*
10.20 - 10.45	**Game theory: Improving pain clinic outcomes** *Dr Sandeep Kapur, Birmingham*
10.45 - 11.00	**Discussion**
11.00 - 11.20	**REFRESHMENTS**
Session Two	
11.20 - 12.00	**Faculty Developments** *Dr Barry Miller*
12.00 - 12.45	**Consciousness and Pain** *Baroness Greenfield, Oxford*
12.45 - 13.00	**Discussion**
13.00 - 14.00	**LUNCH**
Session Three	
14.00 - 14.45	**Opioid misuse- joint clincs:** **Pain clinician's perspective:** *Dr Jonathan Tring, Leicester* **Psychiatrist's perspective:** *Dr Andrew Ball, Leicester*
14.45 - 15.00	**Discussion**
Session Four	
15.00 - 15.30	**Pain in Cancer Survivors and its Management** *Dr Matthew Brown, London*
15:30 - 16:00	**Gaps in evidence in pain medicine** *Prof Gary Macfarlane, Aberdeen*
16.00 - 16.30	**DISCUSSION AND CLOSE**

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

FACULTY OF PAIN MEDICINE
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Programme organised by Dr Shyam Balasubramanian and Dr Manohar Sharma

Training and Assessment

Dr Lorraine de Gray

FPMTAC Chair

I would like to start my first report from the Training and Assessment Committee with acknowledging my gratitude and that of the Faculty to my predecessor, Dr Jon McGhie who has just handed over the reins to me as Chair of the committee. I have had the privilege of working alongside Jon as his deputy during the past two years and shall sorely miss his wisdom, diplomacy and unending enthusiasm. Jon has decided for the time being to take some time out of the Faculty for personal reasons and I wish him all the very best. TAC is currently working on various projects including the writing of the new curriculum and the credential in Pain Medicine.

The New Curriculum

The new curriculum is progressing following the GMC's publication of the Generic Professional Capabilities framework. This describes essential capabilities that would make a doctor demonstrate that they were able to provide safe, effective and high quality medical care. They are based on various themes including patient safety, leadership, quality improvement, safeguarding, team working, health and probity. The GMC has instructed all Royal Colleges to rewrite postgraduate curricula with an outcomes-based focus looking at the kind of capabilities doctors will have upon completion of the programme rather than the process by which these capabilities are achieved.

For instance, a learning outcome would be for a doctor training in Pain Medicine to have the capability of managing a patient attending an outpatient pain clinic. To manage such an outcome, a doctor requires the medical knowledge as well as the multiple competencies including communication, history-taking, examination, interdisciplinary working with other allied health professionals, law of consent, safe guarding, and law on mental capacity to name but a few. Some of these are generic, some are specialty driven. The concept of a learning outcome allows a more individual approach to training allowing flexibility and less time dependence.

The challenge for rewriting the curriculum will be to set out a comprehensive array of learning outcomes, mapping these to competencies and further developing assessment tools to gauge the standard of the outcome achieved.

The Credential: Raising the profile of Pain Medicine and opening the door to other specialties

In the past four months, Dr McGhie and I have co-authored a draft document for a credential in Pain Medicine with support from the Dean, Dr Barry Miller, the Vice Dean, Dr John Hughes and the Head of Faculty, Mr Daniel Waeland. The draft has been informally submitted to the GMC for consideration of piloting pain medicine as one of its first credentials.

Credentialing will raise the profile of Pain Medicine as a specialist area, allowing candidates with a recognised qualification to enhance their portfolio and justify the period of training within CCT programmes. Credentialing will also broaden the delivery of pain management training beyond existing medical boundaries. Currently specialists in Palliative Care Medicine, Rheumatologists and Neurologists all care for patients with persistent pain. However, most do not have the necessary depth of training and service support to manage these complex patients well. It will allow specialists from other fields to enhance their skills in pain management and improve patient care within their own services and as part of a multidisciplinary pain service.

There are exciting times ahead with one constant focus in mind - to raise standards of delivery of pain medicine and improve quality of care and safety for patients.

Trainee Update

Dr Helen Laycock

Trainee Representative

I am writing this during the August rotation and for pain trainees this is often a time of real change. Some of us are starting advanced training (welcome), others completing it (congratulations) and for those entering higher training, there is new exposure to the breadth of clinical Pain Medicine beyond that seen as intermediate and core trainees. Training can often feel like a list of requirements we need to fulfil, with little opportunity to have any input or give feedback on how things are going. Fortunately as pain trainees we have many opportunities to be supported, support each other and highlight issues to those involved in our training.

This all really starts with the Faculty of Pain Medicine. Having a Trainee Representative present at Board meetings gives us a voice, being heard by those who develop and lead our training which means trainee issues are listened to and acted upon. For example, historically only higher and advanced trainees could register with the Faculty. After highlighting that allowing registration at any stage of training might increase interest in pain, now trainees can register from the foundation years onwards. So if you have colleagues interested in Pain Medicine, encourage them to register as they will get Faculty updates and information.

The Faculty website contains a wealth of information on Pain Medicine, our training requirements and on local and national training days. The next national pain training day will be on the 12th April 2019 at the Royal College of Anaesthetists (check the website for more details). The programme for the day includes morning lectures organised by the London Pain Training Advisory Group and an afternoon meet up with some of the Faculty of Pain Medicine's Training and Advisory Committee members. Last year we were able to discuss issues and ask questions directly to those responsible for shaping our training.

The annual pain trainee survey is another important way the Faculty listens to our feedback. This asks higher and advanced trainees to answer questions regarding their training opportunities and experiences. Data from previous surveys have enabled the Faculty to address issues such as the impact of anaesthetic on calls on pain training opportunities. This year's survey has just closed and the results are being analysed, however I would encourage everyone to complete it next year. Use it as an opportunity to highlight both excellent training and areas that could be improved.

Throughout the year you can raise issues via your Regional Advisors for Pain Medicine (RAPMs), through myself as your national trainee representative or by directly emailing the Faculty. All feedback is treated as important and confidential.

Once registered with the Faculty all trainees receive emails updates, but also there is the opportunity to be added to the informal trainee WhatsApp group. I've personally found this helpful to connect with other trainees around the country, to ask advice on exam revision or find people to revise with, recommend useful courses and gain peer advice on being an advanced pain trainee.

Finally the Faculty mentoring and buddying scheme, launched last year, is an opportunity to gain support from a buddy or mentor whilst as a trainee and beyond. This could encompass anything from questions about clinical practice to managing work/life balance and is helpful when, as trainees, we are quite spread out geographically.

So feedback, get in contact, register with the Faculty or sign up to gain a mentor and be part of shaping the training experience both for yourself and for others.

RAPM Update

Dr Victor Mendis

RAPM Chair

I hope you all had a chance to enjoy the fabulous summer weather. This year has been a busy one with developments including curriculum re-writing, credentialing and new routes of affiliation.

LPMES

The role, appointment and recognition of Local Pain Medicine Educational Supervisors (LPMESs) has been an issue and the FPM recently carried out a census. Unfortunately, the response rate was very poor. However, the majority of those who responded felt that they had adequate time and recognition within their job plans to carry out the role. LPMESs are appointed by the relevant RAPM in consultation with the local hospitals pain consultants including the Clinical Director and Medical Director. The term of office is three years, which can be extended, upon satisfactory completion of the first term, by the RAPM in liaison with the Faculty and hospital. The LPMES has responsibility to provide a comprehensive training programme as detailed within the CCT, and is responsible for signing off Intermediate, Higher and Advanced Pain Trainees.

Paediatric Pain

Dr Paul Rolfe who is heading the Paediatric Pain Working Party has produced a draft report which suggests that geographically, there is a sparsity of service provision, affecting the amount of paediatric experience Advanced Pain Trainees gain. There are two aspects to training, core competencies and specialist paediatric pain medicine competencies and these need to be separated. Data from the logbooks shows only one in ten trainees had any chronic paediatric pain experience. This, combined with RAPM comments, show that areas are struggling with logistics but there is also a workforce and service provision issue. The Training and Assessment Committee will focus on this and devise a work stream to deal with this.

Quality Assessment

From a quality assessment point of view, the bestowment of Fellowship has now been moved to after the examination and therefore we have amended the Quarterly Assessment Form to include a special sign off from the RAPM, to ensure a uniform quality standard. Please make sure that the appropriate and updated forms are being used for final sign off. A guidance document has been prepared with regards to work place based assessments and hopefully I will be able to share this with you later this year. Registration with the FPM has now been opened to core/foundation trainees who want to keep up to date with Faculty news and the application forms can be downloaded here https://www.rcoa.ac.uk/node/28150.

As a continuing quality assurance procedure I would kindly request all RAPMs who have received Hospital Review Forms from the Faculty to continue pursuing outstanding forms that have not yet been completed by LPMESs and if you are not receiving any responses, please advise the Faculty who will be able to send an official letter.

The Faculty has always had a strong view that it should be an all embracing home for doctors active in all types of Pain Medicine and therefore have launched Affiliate Fellowship, which we hope will see many interested members join and allow the FPM to evolve to have much stronger connections to the world of Acute/Inpatient Pain Medicine.

This will be my last update as Chair; Dr Peter Cole will be taking over in January 2019. I will be completing my second term as RA in December and the appointment process for my successor is underway. I would like to thank all the RAs and the Faculty staff for supporting me during my period as Chair and all the LPMESs in North Thames for their continued hard work in providing a very high quality of Pain training in the region.

Fellowships and Training in Leicester

Dr Yehia Kamel

RAPM

Dr Sadiq Bhayani

Consultant in Anaesthesia and Pain Medicine

Dr Thanthullu Vasu

Consultant in Pain Medicine

How do you live up to a legacy and how could you keep the flame of excellence kindled? How do you provide service commitments while maintaining the highest standards in education and training?

Such were the challenges that faced me as I took on the role of Regional Advisor in Pain Medicine, my colleagues Dr Bhayani as Local Pain Medical Education Supervisor, Dr Vasu as Lead Clinician, and the rest of our consultant colleagues.
In relative terms we were suddenly a young consultant body having inherited a reputable and big department that had once boasted renowned names in the field of Pain Medicine. As daunting as the task was, we showed resolve, dedication, zeal and perseverance. We worked hard and never lost sight of our goals: attaining the highest summit.

Across Leicester and South Trent training in Pain Medicine is offered at the University Hospitals of Leicester (UHL), Northampton General Hospital and Kettering General Hospital.

Advanced Pain Training is provided within UHL. Indeed, one of the most cogent proofs of our acumen and success was our choice in the recruitment of Advanced Pain Trainees.

The University Hospitals of Leicester NHS Trust offers a fantastic opportunity for Advanced Pain Training. We have a variety of specialised pain services including: facial pain clinics, pelvic pain clinics, a pain in drug problem patients' clinic, a paediatric pain clinic and a complex pain management programme. Our paediatric multidisciplinary pain clinic receives referrals not only from the whole of the Midlands, but also from further away. The service received the National Grunenthal Pain Awards in 2016 for innovation in starting new workshops for children aged 7-12 and their parents. The paediatric clinic is a pioneer in communication skills and uses a variety of metaphors in pain management; we receive health care professionals from all over the country visiting us to learn communication skills in this complex MDT setting. In addition to that, we are proud of our taking an integral and pivotal role in the newly founded Pancreatitis MDT clinics, the first in England. Advanced Pain Trainees regularly attend all of these specialised clinics and interventional lists, in addition to clinics in other specialties such as orthopaedics, neurology and most notably psychology.

Moreover, we have worked on various components of the Fellowship to make it productive and attractive for our trainees.

> **"We have a variety of specialised pain services ... Advanced Pain Trainees regularly attend all of these clinics and interventional lists in addition to clinics in other specialties.**

Our previous fellows and consultants in the department have worked on a manual to make the process of induction smooth. There are ample opportunities in audit and research, which our trainees are encouraged to participate in and indeed do take a very active role in. The same applies to service development projects. As such, our fellows have all invariably managed to present posters in national meetings. We have the first CME course in pain management in the country which was designed and presented by a fellow, which attracts delegates from all over the country and from various disciplines.

We deliver to our trainees a regular teaching programme covering exam and clinical topics according to a robust schedule, in addition to a hands-on ultrasound scanning club on a regular basis.

> **"In April 2018, our trainees achieved a 100% pass rate. One of them even received the highest score in the exam and a commendation from the Faculty.**

We have worked on the YouTube channel 'Leicester Pain Education' and we have managed to produce various procedural videos for our trainees and fellow consultants.

All our fellows get excellent teaching opportunities by participating in ultrasound courses and Final FRCA course with topics on Pain Medicine.

As preparation for the FFPMRCA exam is accorded the utmost attention and importance, we have a well organised question bank and examination material available for candidates. Credit goes to our fellows for their hard work in compiling this. We are confident that it will prove to be an immensely helpful resource for our future fellows. We also run mock exam viva practice for FFPMRCA exams for them. In addition to that we are proud to have successfully run an FFPMRCA Mock Viva day on the 27th of September.

There could be no more tribute to our combined efforts than the fact that, in April 2018, our trainees achieved a 100% pass rate. One of them even received the highest score in the exam and a commendation award from the Faculty of Pain Medicine; two trainees achieved the maximum score in the viva in this exam sitting.

In recognition of our efforts, the Pain Management team were nominated for the Best Educator Team of Year award from UHL trust.

Testimonial from Dr Mahesh Kodivalasa:

"I had a great time during my Fellowship year. The goals I have reached, recognition I have gained and success that I have achieved is all because of the distinguished personalities in the department. I had great mentoring support in every aspect of career building. I really look forward to take this spirit further and make them all proud."

Testimonial from Dr Bhavesh Raithatha:

"The Leicester Pain Fellowship incorporates a comprehensive curriculum, full of opportunities, which has been an extremely enjoyable experience. The phenomenal consultant support and the dedicated multidisciplinary team have ensured I have achieved excellent development throughout the year. I have accomplished astonishingly more than what I thought and gained the grounding to perform at my very best. The training and encouragement during the Fellowship has made me feel confident to work as a consultant in Pain Medicine."

Consultant Feedback

Dr HooKee Tsang

RAPM Mersey

The training and assessment of trainees as they progress through Pain Medicine modules within Anaesthesia training can vary from region to region. In some regions, Local Pain Medicine Educational Supervisors (LPMESs) play an active role in Higher and Advanced Pain Training only.

In recent times, there has been a national fall in trainees' interest in Advanced Pain Medicine training. Work to identify potential reasons for the reduced interest in Pain Medicine as a specialty has been conducted in a number of regions. Trainee surveys conducted in Liverpool and London have highlighted areas of training that required improvement. Up to 10% of trainees surveyed reported poor training experiences during intermediate pain training, with some requesting increased consultant teaching and hands-on experience rather than observation. It was also highlighted that intermediate training was not always completed in the form of dedicated modules, with some trainees reporting being moved to provide anaesthetic cover. Trainees also identified the FFPMRCA exam, the lack of understanding of the career pathway, and patient complexity as reasons for not pursuing a career in Pain Medicine.

The training surveys highlighted opportunities to improve Pain Medicine training, bust some myths, and promote the speciality at basic and intermediate levels. The Faculty of Pain Medicine has created additional guidance for Intermediate training which is available on the website (https://bit.ly/2PIbuKm). This will require the increased involvement of LPMES in all levels of training.

The Gold Guide (a reference guide to postgraduate specialty training) was updated in 2018 and is now in its 7th edition. It highlights three key elements that support trainees in the assessment of their progression. This includes:

- formative assessments and interactions (e.g. supervised learning events and other supervisor discussions)
- summative assessments (e.g. assessments of performance and examinations)
- triangulated judgement made by an educational supervisor.

The RCoA conducted a trainee survey in 2015 and made changes to assessments for specialty trainees. This included simplifying the use of workplace-based assessments, increased weight on the judgment of trainers, and strengthening the completion of unit of training assessment. The assessments continue to contain elements that are both formative (occurring throughout a module, and aiming to guide, reflect and aid a learner's progress via constructive feedback, for example, driving lessons) and summative (with the aim of testing a learner's overall knowledge at the end of a module, for example, a driving test that requires a final judgement of competence and assessment of learning).

The RCoA completion of unit of training form was redesigned to emphasise the following:

- A unit is being completed; not a 'sign off' nor a 'tick-box' exercise
- Designated trainers sign the completion of each unit
- Achievement of Core Clinical Learning Outcomes is essential
- Workplace-based assessments are only one source of evidence
- A trainer must comment on a trainee's professional attributes

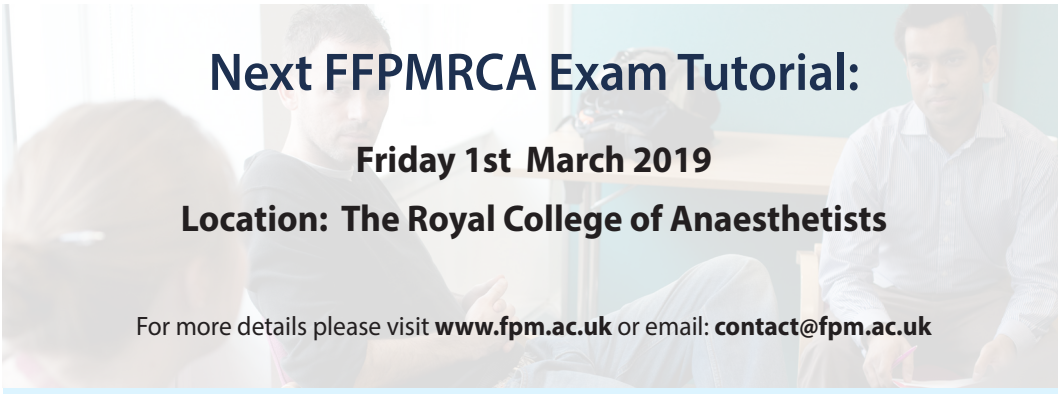
It is recommended that all consultants involved in training in each unit should be canvassed for their judgment on the trainee's performance. Consultant feedback is an essential component of the completion of unit assessment, with the recommendation that feedback should be completed at the end of specialist units. It is recognised that schools and some hospital trusts already run consultant feedback schemes, and there is a suggested consultant feedback form available on the RCoA website to help departments that do not yet have an established system.

The recent move towards specialists to assess and sign completion of units of training has increased the involvement of LPMESs, with College Tutors identifying LPMESs to assess and sign the completion of unit of training for Pain Medicine. This has resulted in feedback from LPMESs that the RCoA consultant feedback form is excessively focused on Anaesthesia, and does not reflect the needs of Pain Medicine training.

Despite the desire for dedicated Pain Medicine modules, trainees continue to gain Pain Medicine training across multiple centres, especially at basic and intermediate levels. Consultant feedback forms from various centres will allow the LPMES responsible for the unit of training to triangulate a trainee's progression through the unit. The increased involvement of LPMESs will enable the promotion of Pain Medicine as a specialty option.

The Faculty has developed a consultant feedback form for Pain Medicine as a guide for departments that have yet to develop their own specialty-specific form, which is also available on the Faculty of Pain Medicine website.

Acknowledgements:
Dr Victor Mendis for the London Pain Medicine trainee survey
Dr Oliver Pratt for help in developing the consultant feedback form



Next FFPMRCA Exam Tutorial:

Friday 1st March 2019

Location: The Royal College of Anaesthetists

For more details please visit **www.fpm.ac.uk** or email: **contact@fpm.ac.uk**

FFPMRCA Examination Calendar Spring 2019

	FFPMRCA MCQ	FFPMRCA SOE
Applications and fees **not** accepted before	Mon 29 Oct 2018	Mon 4 Feb 2019
Closing date for FFPMRCA Exam applications	Tues 11 Dec 2018	Tues 5 Mar 2019
Examination Date	**Wed 30 Jan 2019**	**Tues 2 Apr 2019**
Examination Fees	£520	£730

Essential Pain Management: Zambia

Dr Fozia Hayat

ZADP Senior Honourary Lecturer and Anaesthetic Trainee

Background: Being based in Zambia as an Honorary Lecturer and Senior Fellow with the Zambian Anaesthetic Development Project (ZADP) with an interest in pain medicine, I was well placed to be the in-country lead alongside Dr Masuzyo Zyambo, for the first Essential Pain Management (EPM) course in the country.

Zambia has a high burden of disease, with maternal mortality at 280 per 100,000 live births, death due to HIV and AIDS at 255 per 100,000[1], and limited resources for pain education and management. Before the EPM course, my experience showed a general belief that pain is good for individuals, an opiate-fearing culture, and a lack of education on the management of acute and chronic pain[2]. There is no data on the prevalence of chronic pain in Zambia and access to multi-modal analgesia is limited[3]. Compared to developed countries where opiates are being overused, in low and middle income countries there are few analgesic options for acute pain management and the fear of opiates can result in inadequate management of pain.

Pain Teaching: Of the 128 medical students that I taught, only a handful thought pain medicine was relevant and an area where we could improve as doctors. Visiting honorary lecturer, Dr Timothy Johnson, had delivered some teaching to the Master of Medicine (MMed) in Anaesthesia trainees and, over the last few years, there have been courses delivered by volunteers at the Universty Teaching Hospital, Lusaka. However, there is no regular, sustained teaching.

The EPM Global Programme was designed by Drs Roger Goucke and Wayne Morriss from Faculty of Pain Medicine ANZCA specifically for low and middle income countries. It is an ideal course to implement with local advocates. The first day of the EPM course is short and consists of brief lectures and interactive case studies, teaching a simple system to recognise, assess and treat pain and addressing barriers to pain management. Day two is a 'train the trainer day', where some of the participants from day oneare trained to become instructors, so that on day three they teach the workshop to a new cohort of participants, mentored by the original teachers from day one. Newly qualified local instructors can take ownership and teach sooner rather than later and are well placed to address local issues.

Hospital/Staff Selection: Staff from Levy Mwanawasa Hospital were the target participants for the course. This is a 187-bed capacity, second level hospital in Lusaka province with a catchment of 2.6 million people. The hospital has no dedicated pain clinic and no in-patient pain team.

Course Preparation and Participants: As a visiting clinician, I was aware there would be challenges in organising a course. The first task was to gain local endorsement and leadership; Dr Masuzyo Zyambo, a graduate MMed in anaesthetics with a keen interest in Pain Medicine, was one of the drivers for the course. The next task was to raise awareness so we arranged multiple meetings with the main stakeholders and senior clinicians. This allowed us to deliver an introductory lecture at grand round several months ahead of the course. We repeated this lecture so that awareness and advertising of the course generated enthusiasm and eagerness from potential participants. We specifically aimed to draw participants from key staff members such as heads of departments and department pharmacists and physiotherapists as well as other engaged, enthusiastic multi-disciplinary team members.

Course Venue and Catering: The venue for the course was on site but a short walk away from the main hospital. We felt that if we delivered the course on the main hospital site, it was likely that the participants would be allowed leave from clinical duties. If we had

held the course away from the main site, it would have produced additional travel expenses and limited the number of potential participants.

I had tried to get assurances in terms of equipment availability but I made sure to relay any changes back to the UK team and asked that a projector be brought along. Stationery and manuals were brought by the UK team, but we also had contacts for local printers if required.

I was quickly assured breaks and lunch provisions were essential and expected! Nshima is a staple part of the local diet and many would agree this carbohydrate load acts well as a post prandial sedative! We therefore contacted various caterers and decided upon the best value for money. Local knowledge was critical in terms of allocating our resouces and funding appropriately.

Course Execution: Dr Masuzyo Zyambo and I were aided in running the course by ZADP and Dr Clare Roques and Dr Michael O'Connor from the UK EPM Advisory Group of the Faculty of Pain Medicine. During the three-day course we trained 29 enthusiastic multi-disciplinary individuals at Levy Mwanawasa Hospital. Remaining flexible was crucial as we had continuing changes in who attended, when they attended and the timings for various elements of the course, despite our best efforts.

In Zambia, it is customary for courses to be opened by senior staff members or even government officials. On this occasion Dr Chikoya, Chief Medical Superintendent, officially welcomed the course.

No matter where in the world you are technical glitches happen, ours included equipment being incompatible and the room being too bright for our portable projector, but very helpful staff members improvised in order for the course to go ahead successfully. Immediate evaluation of the course by participants was very positive.

We also recognised it is imperative to discuss how participants will have their expenses met in advance; the local Head of Clinical Care should lead these discussions and be the point of contact for delegates.

Further Plans: The newly qualified instructors from the course have remained in touch via WhatsApp and intend to improve their pain management protocols and deliver further EPM courses with the guidance of course director Dr Clare Roques. We hope to do further work looking at longer-term changes that have happened following the course.

Key Steps:

- Early local leadership and involvement
- Engage stakeholders early
- Visiting instructors to ideally have someone in country or make site visits
- Engage staff members and create enthusiasm
- Invitation to initial courses: motivate engaged individuals who also have leadership roles
- Involve the MDT (if there is one)
- Site and equipment check; have back-up plans
- Establish expenses
- Catering provision

Conclusion: That pain relief should be a basic human right is recognised by WHO and the UN, but there remains a huge global discrepancy in provision. In Zambia, the EPM course allowed us to provide a structured overview and basic training to a diverse group of individuals. Key steps are communication and engaging enthusiasm from local leaders and recruiting the right participants.

Acknowledgements

Dr Mike O'Connor, EPM Advisory Group, Faculty of Pain Medicine, Royal College of Anaesthetists and former Associate Dean, Bristol

Dr Clare Roques, Frimley Health NHS Foundation Trust, UK Chair, EPM Advisory Group, Faculty of Pain, Royal College of Anaesthetists

Masuzyo Zyambo, Senior Registrar, University Teaching Hospital Lusaka

The Zambian Anaesthetic Development Project

1 Country statistics and global health estimates, WHO and UN partners, January 2015

2 The Challenge of Pain Management in Zambia, P. Shilalukey Ngoma, https://www.academia.edu/1231818/The_Challenge_of_Pain_Management_in_Zambia

3 Education and Training for Pain Management in Developing Countries; a report by the IASP Developing Countries Task Force. Published November 15th 2007. International Association for the Study of Pain, Seattle, WA, USA www-iasp.pain.orgGoogle Scholar

e-PAIN

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Professional Standards

Dr Paul Wilkinson

FPMPSC Chair

Firstly, I would like to thank all members of the PSC 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.

Pain and palliative care: a new initiative

There are well recognised variation and deficits in the provision of services in the management of pain in cancer care. A major meeting was held on 23 April 2018 led by the Faculty of Pain Medicine and chaired by Baroness Finlay. The Faculty of Clinical Oncology, the Association of Cancer Physicians and the Association for Palliative Medicine. were all represented. It was decided that comprehensive guidance is to be produced for cancer pain services and Professor Michael Bennett will lead on a draft document. This initiative has been long awaited and is expected to be a significant development.

CRPS guideline revision: now complete

Under the leadership of Mark Taylor, we have been proactive in supporting the update on the guidance on CRPS with the issue of amputation being a significant consideration. The first version is likely familiar to most readers. This comprehensive multi-speciality document has been launched recently in Westminster.

Commissioning support for members: change of scope

There have been extensive discussions regarding the scope of a proposed document on commissioning. A key change is that it has been decided that this guidance document needs to be written for commissioners instead of a two stage process starting solely with a document for Fellows. This has been a complex piece of work drawing on existing core standards but with further expansion. A draft of this document was discussed at PSC in September and we will update when its ready for publication.

Consent for procedures: on hold

Dr James Taylor has written a draft of this document based on the RCS document but the GMC are reviewing their consent document. It has been decided to await the GMC document before releasing this to avoid any risk of competing messages.

Describing the role of pain consultants: strengthening our identity

Dr Searle has drafted a document defining the specific role of pain doctors to strengthen our identity. The commonest roles include acting as leads for pain teams, as a conduit to other healthcare professionals and providing advice on pathways and commissioning. There is also a need to emphasise the role with other specialties, such as palliative care, in providing specialist skills to these specialties.

Gap analysis: call for action

There here has been a modest but increasing uptake of this gap tool. This will identify what standards may be used by the CQC and to see where pain units are regarding standards. There is no ACSA like process to help pain units get ready for CQC process. We are striving to make this product useful and to ensure that those completing get the information that they need to benchmark themselves. A group has been formed to develop this further.

FPM/RCoA Opioid Prescribing Project

A working party has been set up through the RCoA on guidance relating to opioid reduction following surgery as there have been concerns about this and patients staying on opioids. There is a further working group to provide guidance to experts on opioid reduction and/or optimisation strategies.

The Hong Kong Exam

Dr Douglas Natusch

Consultant in Anaesthetics and Pain Medicine

In February 2018 the Faculty of Pain Medicine received a request from Dr Grace Hui, Lead Examiner for the Hong Kong Pain Exam for an external examiner. When a volunteer from the FPM Examiners was requested, I immediately replied 'yes'! This started the process of helping to write and then mark written papers and viva questions for the oral exam held in Hong Kong on Saturday 23rd June 2018.

Hong Kong is a specially administered region of the People's Republic of China having been a British Colony until 1997. With a population of around 7.4 million it is nearly the size of London, however squeezed into an area of just over 400 square miles it is the fourth most densely populated area in the world and high rise living is the norm. Hong Kong has its own College of Anaesthesiology and Board of Pain Medicine and the College is affiliated to the British Journal of Anaesthesia group. I have been a Consultant in Anaesthetics and Pain Medicine at Torbay Hospital in South Devon for 18 years. I have been an examiner for the FFPMRCA since its inception and I am the Structured Oral Exam (SOE) Clinical Lead. I am also the Clinical Lead for **e-PAIN**, the NHS Pain Management e-Learning program on behalf of the Faculty of Pain Medicine, the British Pain Society and e-Learning for Healthcare.

On 22nd June, while the UK was basking in sunshine, I landed in Hong Kong to one of the wettest and most humid days I have ever experienced. Rain, I was told, is seen as 'lucky' and I had plenty of luck and several soakings on my trip, one of my purchases out there being an umbrella! The exam followed a familiar pattern. Before arriving I had written essay questions with model answers and co-marked these with colleagues in Hong Kong, as well as writing material for the different sections of the clinical exam. A regular stream of emails between South Devon and Hong Kong was the norm for several months all efficiently co-ordinated by Fonia Lam, the exam administrator in Hong Kong. So, when I met my fellow examiners for the evening briefing the night before the exam, it felt more putting faces to names rather than meeting for the first time.

The next day I was picked up from my hotel and taken to the Pain Centre at a local teaching hospital where we ran the exam. Several hours of examining later, after a process all examiners know as 'call over' where the results are discussed and agreed, I was happy to endorse the results for the Hong Kong Board. Later I was given an FRCA graduation gown, the examiners gowned up and we had a short reception and ceremony for the successful candidates and their families. I should have anticipated being asked to speak but had not. I recall thanking the candidates for their hard work and dedication to their new speciality of Pain Medicine, as well as the Hong Kong College and Faculty for working hard to set up an exam for their trainees and received a very touching vote of thanks. It is not possible to really compare examinations, however in my opinion the candidates in Hong Kong were of the standard I would expect successful candidates sitting the FFPMRCA exam in London to be. The following day was my day off, but in fact much of the day was spent being looked after and shown around Hong Kong by my lovely colleagues and all too soon on Monday morning, I was on the jet home.

I went to Hong Kong thinking about the place and running an exam. I left feeling overwhelmed by hospitality and now think of the people. I would like to thank everyone involved, but special mention to Dr Grace Hui, Dr Steven Wong, Chairman of the Hong Kong Board, Dr Michelle Cheung and her husband Dr Tang and last, but by no means least, Fonia Lam, the HKCA administrator. Finally top tip, the best time to visit Hong Kong is November according to the locals!

Dear GP, Dear Patient: Best Practice for Clinic Letters

Dr John Titterington

Consultant in Pain Medicine

NEW PALS COMPLAINT (the subject line reads in my inbox), Mr Bloggs has taken offence at the tone and inaccurate content of your GP letter. Please write a response in triplicate with an explanation of your actions. Groan… Another great start to the week.

The traditional clinic letter summarises the medical findings and communicates the action plan to the GP. Most of us achieve this, some of us manage to do it very clearly and succinctly, and perhaps some go so far as to write technical masterpieces which manage to convey personality and panache. The AoMRC thinks that the clinic letter can do more (https://bit.ly/2M0q5eo). It can enhance your relationship with the patient, improve the patient's compliance with treatment and put the patient at the centre of their care. How? *By writing the clinic letter to your patient*.

But why go to the effort of making this change when the GP is the one who needs to know and you always copy the patient in anyway? Well for one it is a GMC duty outlined in good medical practice. In addition the NHS constitution states that patients have the right to be given information about the tests and treatment options and have the opportunity to correct any factual inaccuracies. We know from legal consent cases, that now more than ever, we must involve the patient in decision making. Letters to the GP tend to contain Latin terms, medical jargon and incomprehensible acronyms that even the GP will struggle to understand. And if the patient doesn't understand the risks and benefits of your management plan they will frequently visit the GP for an explanation of your terminology; a task the GP may approach with varying enthusiasm/accuracy resulting in uncertainty and frustration and a general waste of everybody's time.

Of course just changing the word after Dear from GP to Patient is not enough, the whole letter must be written with your particular patient in mind. The style and grammar may be very different to one's professional GP letter. Whilst writing style is individual, be it flowery and pleasant or maintaining professional distance, there are stylistic points that will enhance a letter to the patient. For instance it must be easy for the patient to understand. This is often achieved by using plain language; kidney rather than renal for example. Use of shorter sentences. Ideally there should be only one topic per paragraph. In general it should be personal and use the active voice. 'Your small joints in your lower back were tender' rather than 'The facet joints were tender to palpation'. With the individual in mind, it may be that you may wish to include diagrams, dosing schedules, graphs or larger text. Advice on where to seek further information perhaps online and inclusion of an email address to allow patients to feedback on inaccuracies is also advised.

My colleagues go one step further and dictate the letter with the patient in front of them, this can help focus the mind and avoid the pitfalls of saying things that may offend the patient. There are some details which will need sensitivity and tact when using this approach, but generally everything that needs including can be said. It also gives the patient a useful opportunity to correct factual inaccuracies there and then – 'it's my right leg, not left doctor…'

Writing the clinic letter to the patient not only fulfils your duties and reduces the frequency of complaints resembling my fictional (this time) Monday morning email, but it is also much more congruous with today's advocacy, rather than paternalistic, style of medicine. Of course studies have shown the benefits, not least that it reminds patients of the salient points discussed during the clinic visit. But in addition they like it. They feel supported, informed and they find the letter useful. We all want patients with good internal locus of control, the patient needs to get themselves better. This is an opportunity to put the patient in the centre of their care, to enhance your therapeutic relationship and to motivate the patient. Don't miss it!

Improving Pain Services for Patients with Cancer and Other Life Limiting Diseases Across the UK

Professor Mike Bennett

Project Lead, Cancer Pain Forum

The Faculty of Pain Medicine has been leading an initiative to produce a framework that will encourage closer working between Pain Medicine, Palliative Medicine and Oncology professionals to benefit patients with pain from cancer and other life-limiting diseases. This is a collaboration with the Association for Palliative Medicine, the Association of Cancer Physicians and the Faculty of Clinical Oncology.

Existing standards have been important in highlighting the need for closer integration between pain management and palliative care services and specifying that multidisciplinary teams are required for the delivery of specialised pain services, including management of intrathecal pumps. Standards and guidance also describe good clinical care and outcomes for patients with cancer pain in the UK. Finally, competencies exist for individuals involved in delivering cancer pain management. However, there is no supporting guidance for NHS Trusts or existing pain management, oncology and palliative care services on how an integrated service might be configured, how it might be commissioned, and what activities it should undertake.

New guidance is required to collate existing publications into a pain service specification for clinicians and commissioners. This guidance is timely because of the importance to the public of pain associated with life-limiting disease, the evidence of under-treatment or poor access to care, the need to show evidence of better pain management in CQC inspections from 2016, and the need to meet updated commissioning requirements for Highly Specialist Pain Management Services.

The draft framework builds on these documents and describes four levels of service provision (see Table 1 on the next page). The Framework in the Faculty's document is designed particularly to inform and stimulate delivery of Level 3 services in secondary care. This is likely to have the greatest impact with least cost in relation to meeting the needs of patients with cancer and other life-limiting diseases. Closer integration of pain management, oncology and palliative care services can result in more comprehensive pain assessment and a wider range of Level 3 and Level 4 services for patients comprising pharmacological, interventional, rehabilitative and psychological approaches. Although this will certainly benefit patients with more complex pain syndromes, those with less complex pain but who require more skilful balancing of analgesic medicines might be helped too.

The next steps involve finalising the document content and seeking approval from the key contributing organisations, then discussing with NHS England initially how such a framework might be implemented within the NHS. This is likely to involve some pilot work and testing the feasibility of collecting outcome measures.

Table 1:Levels of Service Provision

LEVEL	HEALTHCARE GROUP	ASSESSMENT	INTERVENTION
1	**All health care professionals**	Recognition of pain Screening of pain	Effective information giving and compassionate support Referral to oncology or palliative care professional Initiation of conventional analgesia
2	**All oncology and palliative care physicians and advanced practitioners**	Assessment of pain Diagnosis of pain disorder	Management and titration of conventional analgesia Support for self-management Referral to Specialist Pain Management as required
3	**Linked Palliative care and Specialist Pain Management in secondary care settings** Consultant in Pain Medicine jointly working with Consultant in Palliative Medicine, both with accredited training in pain management in cancer and other life-limiting diseases Access via referral from primary or secondary care professionals	Diagnosis of complex pain syndromes	Management of complex analgesic combinations, including high dose opioids Interventional procedures of varying complexity depending on local skills and resources Support for self-management Referral to Adult Highly Specialist Pain Management as required
4	**Adult Highly Specialist Pain Management in tertiary care settings** Specialist services across the UK with Consultant teams in Pain Medicine and Palliative Medicine Access only via referral from Level 3 services	Diagnosis of complex pain syndromes	Interventional procedures not available at local Level 3 and including some more complex procedures (e.g. implanted intrathecal drug delivery systems, cordotomy and other neurolytic procedures) Rehabilitative programmes Managing distress or other behaviours suggestive of complex drug dependence

Board Member Updates and Introductions

In 2018 the FPM Board welcomed two new members- Dr Nicholas Plunkett, in March, and Dr Lorraine de Gray, in May. Since then we have also held the Board Elections with Dr John Hughes being re-elected as Vice-Dean for his second term and Dr Manohar Sharma joining us from March 2019.

Dr Lorraine de Gray

I was appointed to the Board of the Faculty of Pain Medicine in May 2018. I am a full time Consultant in Pain Medicine at the Queen Elizabeth Hospital NHS Foundation Trust in King's Lynn, Norfolk. I have been involved in training in Pain Medicine since 2006, when I was appointed Local Pain Medical Educational Supervisor for Ipswich Hospital during my time working as a Consultant there. I became Regional Advisor in Pain Medicine and Board member for the East of England School of Anaesthesia in 2011 and remained in this post until 2017. I was elected Chair of the Regional Advisors in Pain Medicine from 2013 to 2016. During that time I was a co-opted Board member of the Faculty. Having served as a member of the Training and Assessment Committee since 2013 I have recently taken over as Chair of that Committee. I am also the Chair of the Curriculum Writing Group for Pain Medicine and am co-author for the proposed Credential in Pain Medicine. I have been specialty editor for pain medicine for the Journal of Anaesthesia, Intensive Care and Pain Medicine since 2016.

Dr Nicholas Plunkett

I am pleased and honoured to be appointed to the Board of the Faculty. As Fellows, we can all agree that the Faculty continues from strength to strength, and works tirelessly and with strategic direction in the fields of education, standards, professional advocacy and standing amongst other medical specialties. I, amongst others have experience in some of these areas, including prior membership of the Training and Assessment Committee, a founding examiner, and current Chair of the FFPMRCA Exam, as well as Clinical Lead of our local pain service at Sheffield Teaching Hospitals. Having attended three Board meetings to date, it is clear that the breadth and depth of issues under review is wide and varied, matched by the dedication and expertise of fellow Board members. My brief experience confirms that this is a Faculty with a firm grip on matters of importance to all of us, highly relevant to our work as clinicians and educators, negotiators (with our Trusts and CCGs), and advocates for pain patients and pain services nationwide. I will bring my time and commitment to serve the Board in any way, for the long-term pursuance of its noble goals.

Dr Manohar Sharma

I have been a full time Consultant in Pain Medicine at The Walton Centre NHS Trust in Liverpool since 2004 and I am the clinical lead for cancer pain and neuromodulation. From 2011 to 2017 I was the Pain Service Clinical Director. I have a keen interest in Pain Medicine education; currently I am Deputy Educational Meetings Adviser for the Faculty of Pain Medicine and an FPM examiner. I am the course director for the Liverpool Pain Course and the EFIC Cancer Pain School. I teach on many cadaver courses and support colleagues to develop interventional skills. I co-edited the book 'Complex Cancer Pain Management', which was awarded the BMA Medical Book of the year in 2015. I am a founding member and a past chairman of the North England Pain Medicine Group, a past chairman of the Interventional Pain SIG of the British Pain Society, and have organised many educational events promoting interdisciplinary working. I contribute to the Pain Clinical Reference Group on Pain commissioning. I am research active and have a number of on-going projects in neuromodulation, spinal pain and cancer related pain. I am keen to support the Faculty of Pain Medicine as a Board member with my clinical, educational, research and managerial experience.

Faculty Events

Dr Shyam Balasubramanian

Educational Meetings Advisor

Dr Manohar Sharma

Deputy Educational Meetings Advisor

The Faculty is committed to continuous improvement of professional development and organises study days and meetings to benefit doctors and nurses from all specialties interested in pain medicine.

The Psychology for Pain Medicine study day was conducted in June with the aim of improving our assessment of chronic pain patients and consultation experience for clinicians and patients. Topics included: Nuts and bolts of psychology for Pain Medicine, Pain clinic consultations and motivational interviewing skills, managing a patient in pain clinic with suicidal ideation and Psychological interventions in in-patient settings. Post lunch included break-out practical sessions on "How to consult and explain chronic pain in Fibromyalgia and chronic pain from medical and psychology perspectives". This was yet another excellent interdisciplinary meeting with carefully chosen Faculty. Experts from these subspecialties made the day informative by sharing their knowledge and clinical expertise. Feedback from this day is included: "Very useful update of psychological aspects of pain management", "essential to any clinician working in pain management", "excellent overview of MDT approach to improving chronic pain management", "value for money", "shame this study day is not mandatory" and "practical and enriching".

The 11th Annual Meeting of the Faculty is scheduled for 30th November 2018 on the theme of "Topical Issues in Pain Medicine". Following last year's feedback, we have included topics on: Medicolegal implications of deviation from practice, learning from patient's narrative, game theory to improve clinical outcomes, consciousness and pain, opioid misuse management in joint clinics, pain in cancer survivors and gaps in evidence in Pain Medicine. We are hopeful that this annual meeting will meet its objective by sharing updates on these topical issues from a clinical perspective.

Following the grand success from the past years, the two study days in February are dedicated exclusively to acute pain. On 4th and 5th February 2019, we have planned 'Hot Topics and Case Studies in Acute Pain'. The objective is to move away from lengthy didactic talks to a blend of talks and case studies encouraging and prompting more interaction with attending delegates. Overuse of opioids and implications for anaesthetic practice and management plan; medicolegal aspects of nerve injury following correctly performed nerve block for acute pain are some of the topics which will be covered. There are many other clinically relevant case studies and acute pain topics in these study days. We hope these will be informative and relevant to your day to day practice. Details of the programme and the link for the booking are available at: https://www.rcoa.ac.uk/faculty-of-pain-medicine/events/recent-advances

Myofascial pain is very common in chronic pain patients and diagnosis depends on correct examination technique and skills. To date, we have received several requests to organise an event on musculoskeletal examination skills in Pain Medicine. We are sensitive to the needs of our members and so will be conducting a 'Musculoskeletal examination skills study day' on Wednesday 12th June 2019. The programme will comprise of basic orientation lectures, guidance and demonstration on physical examination skills, and interactive workshops on how to perform musculoskeletal examination.

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

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Faculty of Pain Medicine Study Days: Hot Topics and Case Studies in Acute Pain - Day 1

Programme

09.00 - 09.20 Registration

9.20 - 9.30 Welcome and Introduction
Dr Manohar Sharma, Deputy Educational Meetings Advisor, FPM

9.30 - 10.00 Managing pain in a child for tonsilectomy
TBC

10.00 - 10.30 Is discharge analgesia fuelling the opioid crisis?
Dr Jane Quinlan, Oxford

10.30 - 10.45 Discussion

10.45 - 11.15 Refreshments and Networking

11.15 - 11.45 Analgesia following Caesarean
Dr Tracey Christmas, Cambridge

11.45 - 12.15 Acute post thoracotomy pain, epidural vs paravertebral analgesia
Dr Omar Al-Rawi, Liverpool

12.15 - 12.45 Fascial plane blocks: Science and fallacy
Dr Athmaja Thottungal, Kent & Canterbury

12.45 - 13.00 Discussion

13.00 - 14.00 Lunch

14.00 - 15.00 Case Study 1:
A patient on opioid substitution therapy presenting for an elective surgery
Dr Jane Quinlan, Oxford

15.00 - 16.00 Case Study 2:
Middle aged man with bilateral rib fractures following motorbike accident
Dr Carl Hillerman, Coventry

16.00 - 16.30 Discussion and conclusion

Date and Location

Monday 4th February 2019
9.00 - 16.30
RCoA, 35 Red Lion Square, London
WC1R 4SG

5 CPD points/ 10 CPD points for both days

This day is aimed at all those working within Services that involve Acute Pain Management. An informative day of updates, it is also an opportunity for networking.

Fees and Registrations

Consultants/SAS doctors: £175
Trainees/Nurses: £140
Book along with the 5th February for a reduced rate of: £330/£255

Register online
https://www.rcoa.ac.uk/faculty-of-pain-medicine/news-and-events

Programme organised by Dr Shyam Balasubramanian, Dr Manohar Sharma and Dr Jane Quinlan

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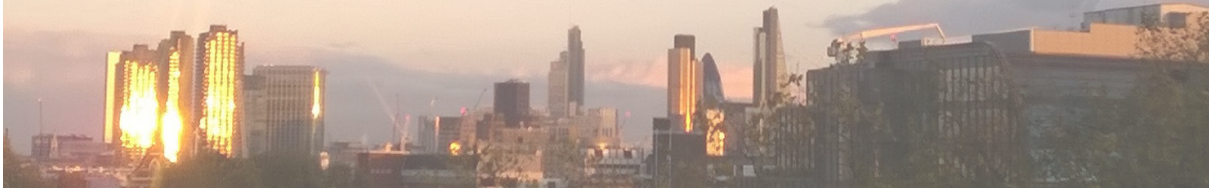
Faculty of Pain Medicine Study Days: Hot Topics and Case Studies in Acute Pain - Day 2



Programme

09.00 - 09.20 Registration

9.20 - 9.30 Welcome and Introduction
Dr Shyam Balasubramanian, Educational Meetings Advisor, FPM

9.30 - 10.00 Intravenous lidocaine and magnesium for acute pain
Dr Shankar Ramaswamy, London

10.00 - 10.30 Inhalational and intranasal analgesia
Mr Lucas Hawkes-Frost

10.30 - 10.45 Discussion

10.45 - 11.15 Refreshments and Networking

11.15 - 11.45 Acute pain outcome data
Dr Kristen Ullrich, London

11.45 - 12.15 Post-dural puncture headache: a benign entity?
Dr Niraj Gopinath, Leicester

12.15 - 12.45 Getting canny with catheters
Dr Sundaram Ram, Hull

12.45 - 13.00 Discussion

13.00 - 14.00 Lunch

14.00 - 15.00 Case Study 1:
Analagesia for high-risk patients - an older adult with multiple medical comorbidity and a fractured neck of femur
Dr Ben Edwards, Sheffield

15.00 - 16.00 Case Study 2:
Nerve injury following regional anaesthesia, medicolegal perspectives
Dr Rajesh Munglani, Cambridge

16.00 - 16.30 Discussion and conclusion

Date and Location

Tuesday 5th February 2019
9.00 - 16.30
RCoA, 35 Red Lion Square, London
WC1R 4SG

5 CPD points/ 10 CPD points for both days

This day is aimed at all those working within Services that involve Acute Pain Management. An informative day of updates, it is also an opportunity for networking.

Fees and Registrations

Consultants/SAS doctors: £175
Trainees/Nurses: £140
Book along with the 4th February for a reduced rate of: £330/£255

Register online
https://www.rcoa.ac.uk/faculty-of-pain-medicine/news-and-events

Programme organised by Dr Shyam Balasubramanian, Dr Manohar Sharma and Dr Jane Quinlan

British Pain Society Calendar of Events

THE BRITISH PAIN SOCIETY
EXPERTISE WHERE IT MATTERS

Implanted Pelvic Materials and Chronic Pain: The Full Story- Study Day

12th November 2018
Churchill House, London

This Study Day will focus on why some of those living with mesh may suffer chronic pain and what are the best ways of investigating, managing and supporting these individuals for the future. Topics will include epidemiology of mesh and its pathophysiology when chronic pain occurs as well as the role of investigation, surgery and pain management techniques, including the difficulties faced in pain management clinics. The speakers are all regarded as world leaders in their field.

Philosophy and Ethics Study Day

10th December 2018
Churchill House, London

Part of the education study programme of events, this Study Day will be organised by our Philosophy and Ethics Special Interest Group. We are putting together an exciting and stimulating programme.

52nd Annual Scientific Meeting

1st - 3rd May 2019
Hilton London Tower Bridge

Put the dates in your diary now for the 52nd Annual Scientific Meeting of the BPS. We are putting together an exciting and stimulating programme and will be announcing plenary speakers in the near future. The ASM is a great opportunity to:

- Network with colleagues
- Keep up to date with the latest cutting edge research and developments relevant to pain
- Raise questions, partake in debates and discuss outcome
- Meet with poster exhibitors and discuss their research

For regular updates please visit: https://www.britishpainsociety.org/2019-asm-london/

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

Faculty Update and Calendar

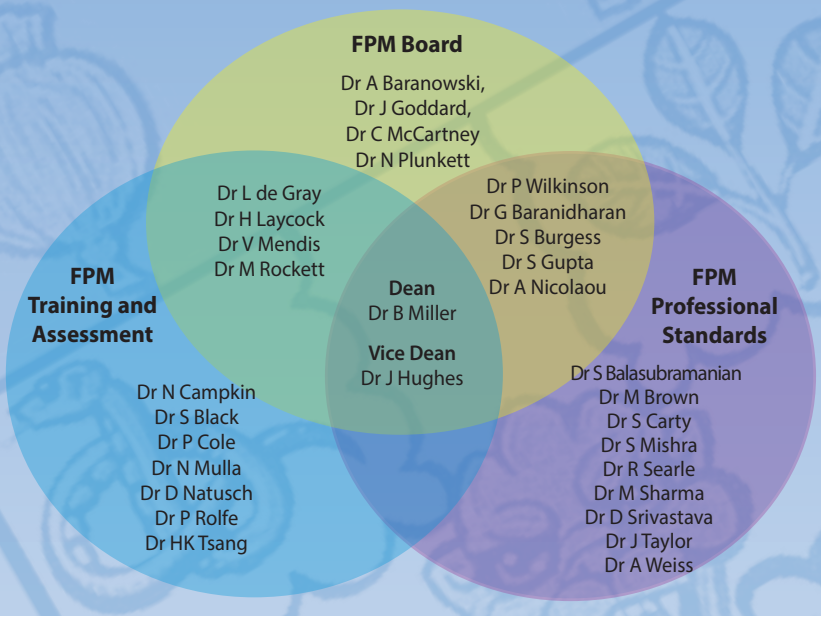
New Fellows

Dr Nauman Muhammad Akhtar
Dr Sabina Maria Bachtold
Dr Usman Bashir
Dr Udaya Kumar Chakka
Dr Roopa Chatterjee
Dr Athanasia Chatziperi
Dr Nancy Diana Cox
Dr Joanna Elizabeth Harding
Dr Pradeep Mukund Ingle
Dr Muhammad Kashif
Dr Mahesh Kodivalasa
Dr David John Magee
Dr Fausto Merilio Morell Ducos
Dr Zhi Hao Oon
Dr Bhavesh Bharat Raithatha
Dr John Ashley Titterington
Dr Thomas Edward Forster Walton
Dr Caroline Helen Whymark
Dr John M. Schutzer-Weissmann

New Affiliate Fellows

Dr Bernadette Ratnayake
Dr Venkat Hariharan

Committee Membership



2018 - 2019 Faculty Calendar

EVENT: FPM 11th Anniversary Meeting	30 November 2018
MEETING: FPM Professional Standards Committee	6 December 2018
MEETING: Board of the FPM	7 December 2018
MEETING: FPM Training and Assessment Committee	25 January 2019
EVENT: Acute Pain Study Days	4/5 February 2019
MEETING: FPM Professional Standards Committee	28 February 2019
MEETING: Board of the FPM	8 March 2019

Please note that all dates may be subject to change

The Faculty of Pain Medicine
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