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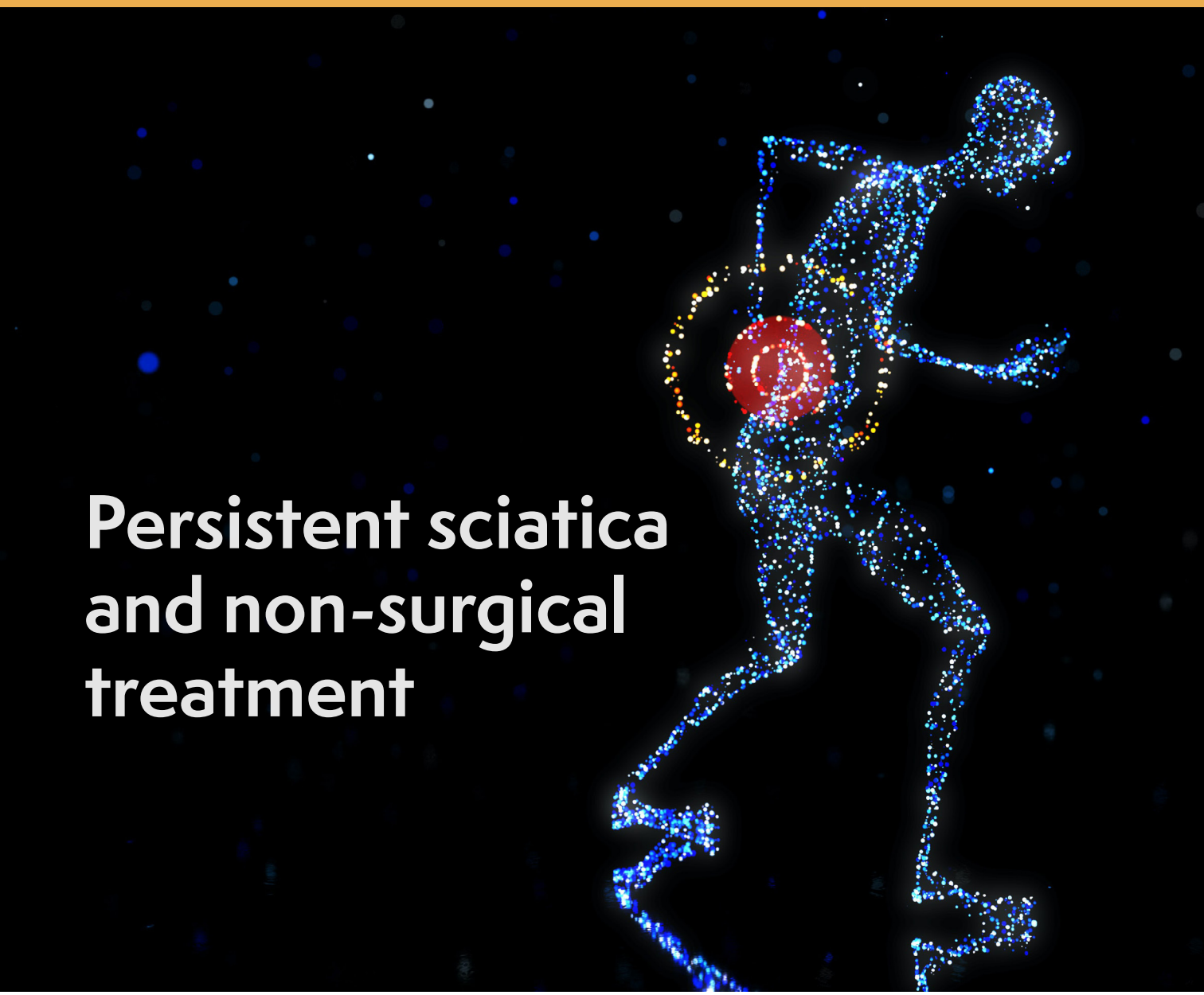

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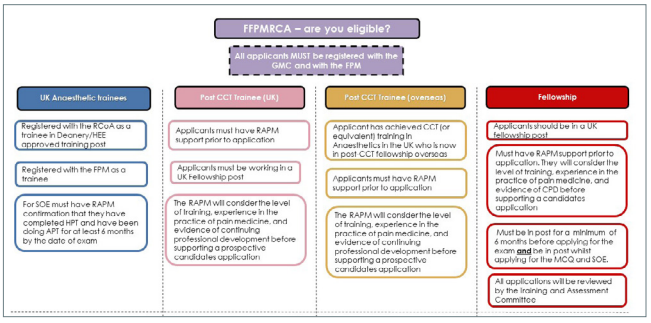

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WELCOME

Welcome to *Transmitter* — Spring 2022 Edition!
In the last edition in October 2021 we had hoped that by Spring 2022 we would be out of the pandemic and getting accustomed to living with it.

We had hoped for a more normal clinical service including face-to-face interaction to resume, including more interaction between the FPM and members. This seems to be happening albeit slowly. We are enduring significant challenges with the NHS recovery plan to tackle elective backlog due to huge numbers waiting and staffing pressures. There is still a very high transmission of COVID-19 and impact on staff morale coupled with considerable upheaval in Europe and concern with the cost-of-living crisis.

There are significant changes in the FPM Board and Professional Standards Committee (PSC) leadership. I would like to offer sincere thanks to Dr John Hughes (Dean FPM) and Dr Paul Wilkinson (Chair PSC) for their term in office and sterling role to help FPM in its duty to support members and trainees with ongoing guidance and support during COVID-19 pandemic and also to drive the core business of FPM forward to improve Standards and Education in Pain Medicine. Some of these vital work streams as highlighted in this edition include: Collaboration with "the Best MSK Health Stakeholder Group which is part of the Best MSK Health Collaborative", GMC Specialist Pain credential, imminent publication of the *Four Nations Strategy for Pain Management* and Pragmatic Pain concept for complex cases as published by FPM in *Practical Pain Management in Specialist Care*. I am confident that the Faculty will continue to evolve and strengthen to further the specialty of Pain Medicine going forward with Dr Ganesan Baranidharan as PSC Chair.

Drs Sabina Bachtold and Tacson Fernandez offer their account of observing the October 2021 sitting of the FPM oral examination. I am sure their account will encourage future candidates. All FFPMRCA MCQ examinations going forward will be delivered remotely, noting good feedback from candidates, and I am sure this is a positive change. There is further information on eligibility criteria for the FFPMRCA exam in this edition. I also want to highlight an article on 'Consent, our memories and clinical record keeping', of huge relevance to our clinical practice.

Manohar Sharma

WORKFORCE CENSUS 2022

The Faculty's workforce census will be launching in Autumn 2022 and will be sent out via Survey Monkey.

More details will be circulated at a later date. We urge all Fellows and members to participate.

Dr John Hughes
FPM Dean

MESSAGE FROM THE DEAN

This is my final Dean's statement and it does not seem two minutes since I was penning my first in the autumn of 2019. None of us could imagine what has occured over the last three years with COVID and now the war in Ukraine. I will use this article to look both forwards and back as both opportunities and benefits have developed over the last two years.

People with pain comprise a significant number of the population and account for a large proportion of consultations across the whole health system. A significant proportion of those have pain that interferes with their daily function. The cost to society, be it public or personal, is vast. This has not gone unnoticed.

The COVID crisis has forced change and allowed contact with parts of the NHS we have not had access to before. The speed of change has had to be fast with the result that the ways things were done will no longer work. From the Faculty's perspective, we joined the Best MSK Health Stakeholder Group, part of the Best MSK Health Collaborative. This group is broad comprising patient/lived experience, professional, charity and NHSE membership. It can guide and support change but also challenge and offer solutions. Discussions are open, robust and positive with a common focus. Output is starting to come through looking at, spinal services, fragility fractures and supporting people who are waiting for treatment.

A period of change

Our healthcare systems are in a period of change and starting to move to a more personalised level of care where patients become fully engaged in their own management. There is a greater awareness and move to implement access to the psychosocial components of pain management. This should not however be at the expense of the biology underpinning our very existence as human beings. This concept of a biopsychosocial model is not new to the world of pain management. The difficulty has been getting all the three elements working together in unison rather than in a piecemeal fashion.

There is currently an opportunity to influence how pain management is delivered. More of the same will not work. It is imperative that the various components of pain management become better integrated across the whole health and social sector, that training is improved and the skills of specialists in pain management are better utilised. This will require alterations in working practice (already occurring in some areas) to improve patient flow and management. To that end, the Faculty will soon be publishing, alongside a broad range of patient and professional organisations a *Four Nation Strategy for Pain Management*. It provides a high level overarching framework where pain management integrates across other stakeholder sectors of both health and social care, be they community, primary care, specialist services, including psychological, mental health, social services and peer support. It can be used to coordinate, deliver and further develop care using the resources and pathways already available whilst supporting future quality service developments.

We continue to work with the GMC developing a credential for the Pain Medicine specialist which will provide a formal recognition for the specialty which will benefit both public and professionals alike. We are also involved in pain training across other healthcare sectors (such as e-PAIN) and are actively supporting better integration of pain management training across all healthcare providers. This will help develop the workforce required if pain is to be better managed as suggested in the four nation strategy.

A pragmatic approach

With these changes there is a challenge in balancing population-based evidence and individual care involving complex biopsychosocial interactions. Although many individuals will respond to a pathway of care, those that do not, or fail to respond, need to be managed as well. Here the Faculty is looking at a more pragmatic approach utilising the evidence base, understanding its limitations as well as incorporating informed guidance, clinical expertise and lived experience to ensure high quality, safe and personalised management with high patient satisfaction. To that end, we recently published *Practical Pain Management in Specialist Care: How to help people with chronic pain when population based national guidance fails to help.* This is the first of a series of documents that will help explore this dilemma.

There are the ongoing issues around drugs of dependence and associated withdrawal with publications likely to be forthcoming during this year. There are two populations: one being those newly presenting and being considered for trials of these drugs, and the other are those already on them and often at high dosage. There needs to be clarity on how to approach both groups and provide support for those where drug optimisation is suggested. Such support is not readily available, what is best for each patient will vary.

It has already been seen that withdrawal of drugs without support can have significant negative consequences. Also those patients that gain significant functional benefit should not be denied such agents. The Faculty will continue putting the case that a personalised care approach is important if the best outcomes are to be achieved.

A great privilege

It has been a great privilege to be Dean and although I am sad to be stepping aside it is time and I look forward to following the further development of the Faculty. Dr de Gray has been a star as Vice Dean making the journey all the more enjoyable. We have a very strong Board and Committees. The advances of the last three years are down to them and their commitment under difficult circumstances to engage fully with the faculty whilst also attending to the day job and family.

There will always be more to do, but with the enthusiasm and experience of the current team along with the calibre of those offering to fill the posts as they open up I am confident the Faculty will continue to develop and further the specialty of Pain Medicine going forward. The secretariat has been fantastic considering the changes in staff and working practices. Without them we would not have done half as much. The support, cajoling, reminding, the turn round of documents and ease with which they work has made my role a joy and pleasure. My final word goes to my wife for her continued support and encouragement. I remain optimistic for the years to come.

MANAGING PAIN

The Faculty, alongside colleagues from across the spectrum of pain management, participated in the recent Managing Pain campaign from Health Awareness UK, published online and in *The Guardian*.

Click through to read an article from FPM Dean Dr John Hughes and Vice Dean Dr Lorraine de Gray on how training is helping to improve pain services.

https://bit.ly/3PQyzHh

#ManagingPain2022

"Without a consent, either written or oral, no surgery may be performed. This is not a mere formality; it is an important individual right to have control over one's own body, even where medical treatment is involved. It is the patient, not the doctor, who decides whether surgery will be performed, where it will be done, when it will be done and by whom it will be done."

— Linden J Allan v. New Mount Sinai Hospital (1980) 28 OR 356

CONSENT, OUR MEMORIES AND CLINICAL RECORD KEEPING

Dr Rajesh Munglani
Consultant in Pain Medicine, Cambridge

Mr Giles Eyre
Barrister

Dr Paul Wilkinson
FPMPSC Chair

It is clear that the required legal standard of assessment for clinician-patient interaction during the consent process is much higher now. We consider the practical implications of the evolution of the law to everyday medical practice.

Medical note-taking

The authors start by highlighting, with some trepidation, the case of Toombes v Mitchell (2021). In 2001, following a specific consultation by a GP with a patient who was asking for pre-conceptual advice, the Court found that the GP failed to mention that not taking a supplement of folic acid prior to conception may lead to the birth of a child with spina bifida. The Court also found that, had the mother been correctly advised, she would have taken such supplementation, delayed conception and subsequently given birth to a healthy child, thereby avoiding the devastating consequences of spina bifida for her child[1]. The claim succeeded on liability. While damages are still to be assessed, the GP's medical insurers potentially have now become liable for the cost of the consequences of the disability throughout the life of the child. In the ensuing internet commentary, some (mainly clinicians) have argued that folic acid supplementation is not guaranteed to prevent spina bifida and the other awful complications of that disease. This, however, misses the point of this liability trial, that is that the finding against the GP is very much based on the paucity of medical note-taking in this case.

On reading the judgment, the arguments around the efficacy of folic acid supplementation are not central but rather the comments of the Judge on the recordkeeping of the GP in 2001. The GP's note was found to be completely inadequate, a fact accepted by the GP, and this was compounded by the fact that the GP himself had no recollection of the consultation and was entirely reliant on stating what would have been his declared usual practice at the time.

> Simply obtaining a signature on a consent form is not indicative of an adequate consenting process

clinicians do not set out to harm their patients, but they are busy and have to rapidly assess any situation to decide what needs to be done. Most of the time they tend to be very good at this. However, the days when the Courts would trust that a doctor would have the best interests of the patient are no longer presumed. Instead, it is left to lawyers, often many years later, to scrutinise the available evidence, which often includes a very detailed patient witness statement, and in such circumstances the doctor flounders, relying on a vague memory, guessing at what they would have typically done or said and often relying on a brief scribbled or a badly typewritten note. In such situations memory has been shown to be remarkably plastic and indeed it changes every time we recall it. Both we clinicians and patients simultaneously can be honestly and completely wrong about a version of events. To recall accurately a brief uneventful conversation with a patient from 20 years ago is asking too much in today's litigious society[2,3].

Decision making

With that in mind, we turn to the Supreme Court judgment in Montgomery (2015) which has put the patient at the heart of decision making. The previous and current GMC guidelines[4] had always made it clear that such an approach was best but the Courts for many years had followed a different legal standard for judging the consenting process. The Courts had followed the Bolam principal that a doctor's action would be assessed by the standard of what a responsible body of doctors would have done, unless, applying the Bolitho principal where an alternative practice was put forward, that standard was found not to withstand logical scrutiny[5]. While such principals still apply in assessing the practice of a doctor in treatment and diagnosis, now, when considering the specific issue of the consenting process, a different legal standard now applies, and indeed is being applied retrospectively. This is not the place to go into the details of the case of Nadine Montgomery but, suffice to say, it is tragic and heart-breaking to read even now. Quoting from the judgment:[6]

"*The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments.*

"The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it." [emphasis added]

The MDU[7] has also highlighted a number of other critical points:

- a material risk doesn't only depend on how severe it is or how

frequently it occurs, but on the importance a patients attaches to it

- the clinician's role involves sufficiently communicating with the patient to make sure that they understand the risks of a treatment so that they can make an informed decision
- simply obtaining a signature on a consent form is not indiciative of an adequate consenting process.

The key point in relation to the standard required of a doctor is not just what a responsible doctor considers reasonable to tell the patient about an intended treatment, but what a reasonable patient with that specific patient's characteristic, might attach importance to. The locus of control has irrevocably shifted away from the doctor and towards the patient. When examining in court such a conversation about consent which has likely taken place many years previously, the only way to demonstrate that a doctor followed such principles is to keep detailed records of the consenting process. Otherwise we are simply left with the (unreliable) memories of both the doctor and the patient to go on.

A clinician's responsiblility

Along with the case of Montgomery there are a number of further legal judgments that should be noted by the medical profession. In the case of Pearce v UBH[8], the Court found that if the clinician had told the mother that his advice to delay the birth would increase the risk of stillbirth, she would have opted for an earlier delivery. Instead, the child was stillborn. This judgment emphasises that it is the clinician's responsibility to inform a patient of a risk which would affect the judgement of a reasonable patient. The clinician must provide the information needed so that the patient can make that choice.

In Thefaut v Johnston (2017), the clinician was criticised for being overly optimistic about the likely success of a procedure and under-estimating the risks, and of not providing enough time for the patient to make a decision. In this judgment it was emphasised that as well as the medical characteristics, patient factors including social factors needed to be taken into account in the consenting process.

> The required standard of assessment for clinician-patient interaction during the consent process is much higher now

The issue of recording of the consent was the issue in the subsequent case of Hassel v Hillingdon (2018)[9]. Mrs Hassell was 41 and had undergone two previous lumbar spinal operations. In 2011 she presented with left arm pain and an MRI scan showed a disc lesion at C5/6. Following a neck injection which failed to relieve her symptoms, she was advised to have a cervical fusion of C5 and C6 or disc replacement. The consent process was not well documented and it was neither clear what risks of surgery were referred to, nor whether there was any discussion about an alternative conservative treatment. Mrs Hassell awoke from the operation in 2011 with tetraparesis secondary to spinal cord injury. The surgery was not blamed i.e. there was no breach of duty found by the Court as regards the technical aspects of surgery; it was simply a consequence of the risk of even well-performed surgery. Even though she signed a consent form which listed 'cord injury' as a risk, it was found by the Court that Mrs Hassell had not given properly informed consent to surgery and, had she been given proper advice, would not have gone ahead. The Court found that a brief warning wasn't sufficient. She had neither been (properly) warned of the risk of spinal cord injury nor adequately informed of alternative conservative treatments[10,11,12]. Despite the operation being performed to a reasonable standard, the operation nevertheless should not have gone ahead and the Trust was liable for the complication of tetraparesis and resulting damages of £4.4 million, including all the future care costs.

In Jones v Royal Devon and Exeter NHS (2015)[13], Mrs Kathleen Jones had been added to the waiting list in the expectation of having surgery performed by her Consultant Spinal Surgeon, only to discover on the morning of the operation that it was to be carried out by a more junior and much less experienced spinal fellow at the hospital. Unfortunately, the operation went badly although performed non-negligently, and Mrs Jones was left with serious and permanent injuries as a result. The Court further found that the claimant would not have agreed to have the operation performed had she been told in advance it was not the Consultant of her choice operating, and ruled that it was too late for her to be expected to exercise informed choice when, moments before the operation, she was eventually told by a theatre nurse that her surgeon was not available:

"…although there was no breach of duty to warn the claimant of the risks of the operation, it was an infringement of her right 'to make an informed choice as to whether, and if so when, and by whom to be operated on.' Unless a remedy is provided in the present case that right would be a hollow one."[14]

In Spencer v Hillingdon (2015)[15], the patient

was not warned about a future possible complication of a procedure and suffered as a result. Post-operatively the patient became unwell but did not realise the significance of calf pain as a presenting symptom and then suffered bilateral pulmonary emboli. The Court decided that the patient should have been warned about possible symptoms of a complication. Patients must be warned about the possible consequences of a procedure. If the patient would not have consented to the procedure if appropriately consented and suffers harm then the clinician becomes liable.

Take home message

Clinicians can no longer approach consent with a paternalistic attitude and decide what treatments are best for their patient. The emphasis now is on a patient's choice made following thorough discussion and after being informed in detail of all clinically appropriate options. The patient has the legal right to choose a therapeutic option accepting its possible impact on their health. The medical advice about treatment options has to consider medical factors but must also take into account patient value judgements, including psychosocial factors that are important to the patient.

We as clinicians are required to familiarise ourselves with our patients sufficiently well to understand their views and values and thereby support them in the decision-making process. Practically, this will mean that clinics will run slower with fewer patients. Also, fewer patients are likely to opt for treatment once they are given a realistic assessment of the longer term success rates and risks of a procedure. This aspect is especially pertinent to Pain Medicine. A rushed consent process performed at the bedside by a clinician on a busy day case list with a patient drawn from a pooled waiting list, where the clinician is unfamiliar with the patient and vice versa, is arguably a sad norm. This norm is also, sadly, a recipe for patient harm and litigative threat.

A well-known personal injury barrister once said that if they can't get you on breach of duty (i.e. your standard of treatment was up to scratch), they will get you on consent. The patient (and now claimant) will say, "If I had been told this might happen I would never have consented to go ahead". In that scenario, the clinician becomes liable for ensuing complications, even if the procedure is done perfectly, because it should never have gone ahead in the first place.

The question in the Court's mind in all these cases is, 'Did you as the clinician explain the choices open to the patient properly? Did you spend enough time with them?' With the current way clinics and procedures are recorded, it is often not difficult to assess how much (or little) time was spent with an individual patient. A detailed clinic letter recording not only the relevant medical factors but the relevant patient factors, and those discussed as essential to the decision made, becomes a vital part of the evidence. The clinical letter must be written in a patient-centred, jargon-free fashion. This letter may end up undergoing intense scrutiny in the years that follow: read them carefully before they go out!

The required standard of assessment for clinician-patient interaction during the consent process is much higher now. So, ensure your clinical manager allows you to run your clinics and pooled waiting lists in a fashion which is consistent with the above aims. This will mean fewer patients, and more time spent with each. Dictate a much longer clinical letter which encapsulates what was discussed, even though it means upsetting your secretary.

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Further reading

Clinical practice and the law: A legal primer for clinicians by Giles Eyre. ISBN 978-0956934123 Professional Solutions Publications (26 Oct 2018)

Mr Martin Wilby
Consultant
Neurosurgeon

PERSISTENT SCIATICA

Radicular pain down the leg associated with sensory symptoms following a lumbosacral dermatome has numerous causes but by far the most common is a herniated lumbar disc (HLD).

Whilst a minority of HLD presenting with significant motor weakness or cauda equina syndrome require surgery, there is a great deal of evidence suggesting that the natural history of the condition is self-limiting over time which suggests a strong role for non-surgical treatments. An excellent review article on the diagnosis and management of sciatica can be found at BMJ 2007;334:1313.

For patients struggling with symptoms in spite of analgesia/reassurance/ non-invasive treatments then two invasive treatments exist; trans-foraminal epidural steroid (TFESI; although inter-laminar approaches may also have benefit) and surgery. Previous large studies have looked at surgical vs non-surgical management of sciatica but all have various methodological limitations.

The Maine study (Atlas 2005) reported on surgical vs non-surgical management of sciatica for 507 patients with long term follow up (10 years). Patients were non-randomised however and followed prospectively by local clinicians. A number of outcomes used were descriptive and epidural injections only comprised 18.5% of the non-surgical group. Although surgery was reported to give higher patient satisfaction and modest improvements in low back pain, interestingly the improvement in leg pain was similar in both the surgical and non-surgical groups (69.2 % surgical vs 64.3% non-surgical). Surgical morbidity was reported but was limited as it was surgeon-reported. However 1:275 nerve root injuries were recorded.

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Previous large studies have looked at surgical vs non-surgical management of sciatica but all have various methodological limitations

The Spine Patients Outcomes Research Trial (SPORT; Weinstein 2006) was another land-mark study from the US and again compared surgical vs non-surgical treatments for sciatica. This study however had two streams; 501 patients randomised to receive either non-operative care or surgery and 743 prospectively observed patients. All enrolled patients however were required to have had sciatica symptoms for 6 weeks prior to enrolment. For the non-surgical group, treatment was quite variable including use of braces, corsets, acupuncture and TENS devices. Not all patients received injections with only 56% of non-surgical patients having received an "injection". Although the study suggested surgery was superior to non-surgical treatment, the intention to treat primary analysis revealed no significant difference in outcomes between the groups. Secondary analyses revealed favourable surgical results. Crossover was a big problem for the interpretation of the data with 49% of non-surgical patients receiving surgery. Morbidity was reported with dural tear at 3% and re-operation rate at 15% in eight years. It isn't clear what proportion of patients in the "other" group of adverse events suffered a nerve injury but one patient suffered a vascular injury.

Buttermann (2004) reported his personal series of 100 patients from a single institution and randomised sciatica patients with HLD to surgery or inter-laminar epidural steroid injection and found that by doing so he avoided surgery in half of his patients.

More recently, Bailey (2020) reported another single centre study comparing randomised surgery to best conservative care for sciatica secondary to HLD and only included patients with sciatica between four months and 12 months duration (termed persistent sciatica). This study utilised leg pain as the primary outcome and studied 128 patients. Epidural injections were used in the conservative arm but it is not clear what percentage of patients received these within the group. This study found surgery to be more effective than conservative care.

NERVES (funded by the NHS) therefore represents the first direct like for like randomised multi-centre study with patients randomised to TFESI or surgery in a 1:1 ratio for sciatica secondary to HLD between 6 weeks and 12 months duration. All patients were required to have MRI concordance with clinical features of sciatica resistant to non-invasive treatment. Oswestry Disability Questionnaire (ODQ) was used as the primary outcome measure at 18 weeks post randomisation and the cohort was identical to the group chosen by Bailey as above dealing with persistent sciatica rather than acute or early sciatica (mean duration of symptoms greater than 21 weeks). 163 patients were recruited from 11 UK centres. At week 18, ODQ scores were 30·02 (SD 24·38) for 63 assessed patients in the TFESI group and 22·30 (19·83) for 61 assessed patients in the surgery group. Mean improvement was 24·52 points (18·89) for the TFESI group and 26·74 points (21·35) for the surgery group, with an estimated treatment difference of −4·25 (95% CI −11·09 to 2·59; p=0·22). No secondary outcome observed a significant difference between the groups (VAS/Leg and back pain/ Modified Roland Morris outcome for sciatica/COMI). There were four serious adverse events in four participants associated with surgery, and none with TFESI. Compared with TFESI, surgery had an incremental cost-effectiveness ratio of £38,737 per quality-adjusted life-year gained, and a 0·17 probability of being cost-effective at a willingness-to-pay threshold of £20,000 per quality-adjusted life-year. Strict data collection regarding adverse events was carried out independently of surgeons' assessment as well as a thorough health economic analysis. Although there was crossover between the groups with patients allocated to TFESI changing to surgery, at the time of the primary outcome assessment, only 12.5 % of patients had crossed over treatments. Of the non-surgical group, 59% avoided surgery.

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>
> It is not cost-effective for surgery to be the first line strategy for all patients

This data would support a clear role for TFESI in the management of persistent sciatica secondary to HLD. It is not cost-effective for surgery to be the first line strategy for all patients but there are clearly clinical situations such as foot drop or bilateral sciatica/CES where surgery is the only option. Only two patients in NERVES were randomised to injection where the disc prolapse size was greater than 50% of the canal diameter on axial MRI imaging. The author would therefore emphasise clinical awareness and due caution when considering TFESI for "massive" HLD. With NICE guidance being phased out from next month, perhaps the next step would be to develop radicular pain pathways in isolation of backpain with robust systems in place to ensure the absence of foot drop/CES. In principle, significant symptom improvement could be delivered safely to patients faster and less costly for this disabling condition.

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IMPORTANT NEW FPM PUBLICATION: PRACTICAL PAIN MANAGEMENT

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Dr Paul Wilkinson
FPMPSC Chair

NICE have recently produced guidance on assessment management of chronic pain in the over 16s[1] which has caused considerable professional anxiety. In a recent survey by the Faculty, the vast majority of members disagreed with the guidance on management of primary pain.

In addition, fewer than 15% of those surveyed use the diagnosis of chronic primary pain (CPP) in clinical practice. 85% of those surveyed disagreed with the management of CRPS being included under the umbrella term of CPP. However most agreed that there was some value in the guidance of assessment of chronic pain.

There is significant concern about the way evidence has been assessed by NICE in contrast to Cochrane[2]. The approaches of NICE and Cochrane produce very different conclusions from similar evidential data sets. At the heart of the problem, appears to be the decision by NICE to restrict consideration of various trials, leading to an apparent lack of any long term evidence for pain treatments. This restriction, along with other factors such as underfunding of pain trials, and the challenge of designing good quality trials in complex phenomenon of pain has led to a paucity of data or meaningful recommendations needed to guide clinical pain management. Indeed, the NICE guidelines offer very few positive clinical recommendations and instead offers a lot negative conclusions which do not sit well with the vast majority of

clinical experience. This has led to the opinion of many Clinicians that the current NICE guidelines are almost irrelevant as an aid to everyday patient-centred pain management.

Pain management has long recognised that trial results in larger populations cannot predict the response of an individual to any pain treatment. Typically, we offer treatments and assess the response of an individual patient to such a specific treatment in our clinics, before deciding whether it is successful and should be continued. The ultimate aim is to reduce the impact of pain distress, disability in a particular patient leading to better quality of life measures.

To address the lack of practical guidance in the NICE guidance the FPM has produced a document titled 'Practical Pain Management in Specialist Care: How to help people with chronic pain when population based national guidance fails to help to assist clinicians'.

This document serves to empower and reassure professionals, people with chronic pain and commissioners to make the best decisions for an individual patient. It acknowledges that the level of population based determination of efficacy of some pain management strategies is modest but the societal cost of not attempting to offer treatment to individuals with pain is enormous, when it is clear that a subgroup of patients are likely to respond favourably to treatment even if that treatment is not applicable to all patients in pain.

Specifically, there is risk that sole reliance on NICE guidance to determine which treatments to offer will lead to a needless increase in suffering of specific groups of patients. The FPM also emphasises that it does not support treatments which have no credible evidence base or treatment rationale and furthermore the safety of the patient must be paramount and the consent process meticulous.

This document sets out the FPM position and gives general principles to follow. In the future, the FPM will provide guidance focusing on pragmatic pathways of care.

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OPIOIDS AWARE KETAMINE UPDATE

We have also recently updated the Opioids Aware resource with information on Ketamine.

This information can be found in the 'Other Medicines' section of the resource:

www.fpm.ac.uk/opioids-aware

Dr Paul Wilkinson
PSC Chair

PROFESSIONAL STANDARDS

This is my last report for the Professional Standards Committee of the Faculty of Pain Medicine. It has been a great privilege to serve as chair for two terms over the last six years. I would like to introduce the new Chair, Dr Ganesan Baranidharan...

...who will be known to most of you and who has been a stalwart of the Professional Standard Committee for many years and will continue the excellent work. During my six years as Chair, we have managed in the order of 25 new Faculty of Pain Medicine publications, around 30 refreshed publications, over 50 consultations and various position statements.

Due to the hard work and considerable effort of members of the Professional Standards Committee, the Faculty of Pain Medicine now also has updated *Core Standards*, which is a crucial document for our future. I must specifically thank Robert Searle and Anna Weiss for their considerable effort in bringing this renewed version together. Many of our other documents link into this or are derived from this bedrock.

COVID

We have faced the COVID challenge and produced multiple guidance at short notice. Through our multiprofessional guidance group we have also produced guidance to help reduce the community load of opioids from surgery. The stature of the Faculty in promoting the highest standards of pain practice within our professional group and influencing practice beyond, continues to grow from strength to strength. I know that with the new Chair, the continuation of this process is in safe hands.

Practical pain management

As stated in the Royal College of Anaesthetists' *Bulletin* (and discussed elsewhere in this issue) NICE have recently produced guidance on assessment and management of chronic pain in the over 16s, which has caused considerable professional anxiety and dominated attention in recent months. We undertook a survey which showed that most members disagreed with their guidance on the management of primary pain and few people actually use this diagnosis in clinical practice. In addition to bringing political attention to some of these issues at a Westminster forum, we have produced a new document titled *Practical Pain Management and Specialist Care* to assist clinicians. It is important that the Faculty continue to support practices only underpinned by the best possible evidence. However, it is clear that the current positivist approached evidence is not serving pain practice well. The first document gives general principles to follow for practical pain management. Patient safety is clearly very important, and it is also important that practitioners are given some latitude to provide the best care for their patients. The follow on from this work will involve reconsidering the issue of practical pain pathways and how we integrate treatments while being mindful to emphasise safety and consent.

Cancer Pain

A further important area of work is with the National Cancer Pain Network. Dr Matthew Brown continues to lead this work with Manohar Sharma. The network comprises four focus groups which are considering interventions, education guidance, project advocacy and survivorship bound by a steering commitment and including two trainee representatives. This is an important piece of work with the aim of operationalising the strategic content of a previous cancer publication from the Faculty in this area.

Consent

Dr Searle has been leading on some best practice examples for consent. This is being undertaken with legal support and the kind involvement of Dr Munglani. This will be issued within the next few months with the aim of providing specific support to pain practitioners in navigating the General Medical Council for more generic guidance.

Medicines

The Medicines Advisory Group, which is a sub-committee of the Professional Standards Committee, continues its work under stewardship of Dr Barry Miller. Ketamine guidance has recently been signed off. Guidance on reducing opioids is a further piece of work with the involvement of MAG and is at final review.

A further important piece of work is working out a strategy to bridge the gap between *Core Standards* and existing levels of practice. This project is being taken forward by a small working group of PSC members. We continue to be mindful of our publications on COVID, but hopefully going forwards, our focus will be firmly switched to other work.

Core commitments

In addition to the specific projects above, we continue with core commitments including CPD and revalidation updates, oversight of the neuromodulation registry, maintenance of our core publication portfolio and formulating Faculty positions on a number of consultations as well as managing patient and professional queries.

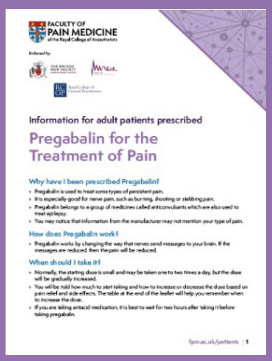
I thank the Faculty again for affording me the honour of chairing this committee over the last six years.

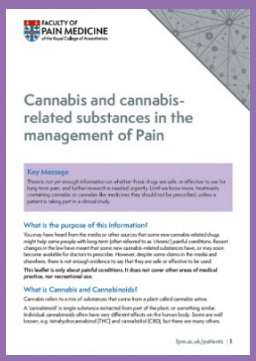
PATIENT INFORMATION LEAFLETS

The Faculty website contains various Patient information leaflets on medications and interventions commonly used to treat persistent pain.

These leaflets were created with the help of multi-professionals as well as patient representatives and are intended to be handed out to patients when they are prescribed these medications/undertake procedures. The leaflets can be used within a variety of clinical settings including Pain Management Services, GP practice, community pharmacies and physiotherapy clinics.

Visit www.fpm.ac.uk/patients/patient-info for more





PATIENT LEAFLET QR CODES

We are creating QR codes for our patient information leaflets. These can be used in clinics to cut down on the need for printing and means that patients can instantly access leaflets. Visit www.fpm.ac.uk/patients/patient-info or scan the QR code with your phone or tablet.

Dr Emma Baird
Inpatient Pain
Medicine Lead

ACSA AND PAIN MEDICINE

Anaesthesia Clinical Services Accreditation (ACSA) is a voluntary accreditation scheme for NHS and independent sector organisations which supports anaesthesia departments in continuous quality improvement through peer review.

Participating departments self-assess local guidelines and practice against a set of nationally recognised, evidence-based standards which reflect the College's Guidelines for the Provision of Anaesthetic Services (GPAS).

Comprehensive peer review

Currently, 140 departments of anaesthesia are registered with ACSA, which is approximately 75% of all departments in the UK and, of these, 51 are accredited. Departments registered with the scheme have access on a dedicated ACSA portal, to a 'Good Practice Library' as well as the self-assessment tool. They have the option to progress to a fee-based subscription, which provides a comprehensive peer review with direct feedback on service delivery to enable and support achieving accreditation.

Improve opiod stewardship

ACSA have welcomed Faculty of Pain Medicine involvement in improving the inpatient pain related sections of the ACSA accreditation. The new additions will appear in the 2022 version of the ACSA handbook. Many of the new additions reflect the drive to improve opioid stewardship. These measure aims to try and mitigate the harm these medications can cause, including reducing the risks of persistent post-operative opioid use. We have also highlighted the need to risk assess patients in the perioperative period that are at high risk of severe pain and persistent pain. Once identified there needs to be a pathway that these patients can follow with the aim of reducing the risk of them suffering from severe pain and progressing to persistent pain post operatively or post trauma.

An exciting development

The inclusion of more pain standards from the Inpatient Pain Guidelines for Provision of Service into the ACSA accreditation is an exciting development. We are hoping it will improve the provision of inpatient pain services nationally by pushing trusts to finance the services we all aspire to deliver. Inpatient pain has always struggled to 'sell itself' and the patient benefits it produces. Getting as much as we can into national guidance documents and national accreditation is an important step towards raising standards for inpatient pain.

RCoA Royal College of Anaesthetists | ACSA Anaesthesia Clinical Services Accreditation

Dr Barry Miller
MAG Chair

INSTANT GRATIFICATION IS NOT A THERAPEUTIC MODEL

"In Brachial Neuralgia powerful analgesics must be prescribed in full doses." — A Therapeutic Index, 1955.

Medications are notoriously difficult to change or stop, even when ineffective. Currently, there is increased focus on optimisation, withdrawal and deprescribing and the reasons for prescribing are, rightly, under scrutiny.

The need for clarity around decisions has never been stronger. Detail at the beginning can be the difference between a protracted and acrimonious process or a consensual agreement. This is an issue for the patient, the initial prescriber and those that share the prescribing responsibilities. The current enthusiasm for quick 'see and discharge' periods make longterm care and adequate decision making very difficult.

The BNF contains broad indications of usage and safety, but it is not a therapeutic manual of effect. "If [Drug A] doesn't work, try [Drug B]" — what does this mean? When is A deemed to have 'failed'? Partially? Completely? What dose of A to make a decision? What timescale? And where then next? Stop A and start B? Continue A and add in B? How many patients have you seen on Gabapentin 100mg TDS, for years? Patients expect, and are entitled, to see their correspondence, and letters are commonly now sent to them, and copied to the GP.

Use the letter

We no longer need to rely on a memory of a clinic conversation, written instructions on bits of spare paper, or even generic instruction leaflets. Use the letter to detail exactly how to start, to increase and to self assess the intended result, be clear on how a medication is taken, what options there are for increases or decreases and some idea of when a positive effect should be expected, with a mechanism to allow for withdrawal if ineffective or associated with side effects.

Also, clearly state that no positive outcome or fading effect will indicate the need to reduce and stop. It doesn't need to be sugar-coated, it should be clear. Put it at the top of the letter, a bullet pointed, bold: 'Plan'.

The value of intervention

Our end-points are not always easily measured. The Faculty's document on Outcome Measures (2019) gives guidance in the area . Questionnaires are often seen as cumbersome, but they do provide some reproducible evidence of the value of an intervention.

An initial assessment of analgesia after a few weeks is a promising start — no response in the short term is unlikely to herald a rosy future; but the situation in months may give a slightly better indication.

What has been achieved? Is the effect sustained? Is there a suggestion of dose creep? And when a decision is made to reduce or stop, the goals should be clear, the timescale real, and the potential difficulties made plain. Withdrawal pain flares are common with any analgesic medication, and are difficult, if not impossible to distinguish with an unmasking of a (partially) controlled underlying pain. Go slow, go small. Building confidence is essential needed for the patient and also for other professionals involved.

Patient relationships

Consider the hard pressed GP, needing to maintain their broad relationship with the patient for many years to come, over the narrow and vocal demands to reset the analgesics, or increase them, for short term gain now, against difficulties another day.

Instant gratification is not a therapeutic model!

Dr Emma Baird
Inpatient Pain
Medicine Lead

FPM THRIVE

FPM Thrive is the Faculty of Pain Medicine (FPM) career mentoring and personal development programme for all doctors with a career in Pain Medicine in the UK. To take part you need to be a member of the FPM.

Pain Medicine as a specialty is both rewarding and challenging. With a demanding career it can be hard to strike a balance between professional and personal life.

Transition points

There are important transition points and intense learning events throughout pain medicine careers when mentoring can be particularly effective. Mentoring is typically by a supportive relationship between two professionals with the aim of the mentee developing within their current role or for the future. The aims are usually set by the mentee with the mentor providing support and guidance.

Support

We are launching the FPMs new look mentoring scheme to all Pain Medicine doctors, irrespective of the stage in their career. Traditionally, mentoring would be for new Pain Medicine Consultants looking for help navigating the start of their careers. We are widening the mentoring program to include Advanced Pain Trainees and established Pain Medicine Consultants looking for general guidance and support or within a particular area of their practice. One example would be a Pain Medicine Doctor wanting to set up a new service, e.g. a pain management programme, who would like to be mentored by a clinician that is already running a successful programme.

> “We are launching the FPM's new look mentoring scheme to all Pain Medicine doctors, irrespective of the stage in their career

On the FPM website you will find the Thrive guidance document, a mentee and mentor flowchart as well as the application forms.

As part of the application form, you will be asked what area you would like to be mentored or a mentee in. We urge all with an interest to apply.

Areas included

- General help and advice
- Inpatient pain
- Transitional pain clinics
- Pain Psychology
- Pain Management Programs
- Neuromodulation
- Pain Interventions
- MDT clinics
- Pelvic pain Management
- Cancer Pain Management
- Paediatric Pain Management
- Management/Leadership within Pain
- Research/Academic Pain
- Pain Education/EPM

Once a Doctor has applied the FPM will endeavour to match you with a suitable mentee/mentor. In a small specialty it is not uncommon to feel isolated. We hope that this endeavour will help connect us all to improve not only our working lives but the care we offer to patients.

Thank you FICM

The FPM team would like to extend a huge thank you to the FICM Thrive team: Liz Thomas, Chair and Nish Desai, Thrive Lead, for their help and letting us use their documents.

Dr Victor Mendis
FPMTAC Chair

TRAINING & ASSESSMENT

I am delighted to announce the appointment of Dr Peter Cole as Deputy Chair of TAC. I would also like to welcome Dr Richard Berwick the new trainee representative and Dr Murthy Varanasi as the co-opted SAS representative on TAC.

I would also like to extend a very big thank you to Dr David Gore the outgoing Trainee Representative for his hard work over the last few years and wish him all success in his future endeavours.

Workforce and training

As we emerge from the pandemic, pain services have slowly returned with still limited access to certain aspects of pain training. The RCoA recently launched the Anaesthetic Workforce: UK state of the Nation report which makes clear, that the UK has a severe shortage of anaesthetists, with around 1400 fewer than needed and sets out how insufficient numbers of training places and poor retention are harming efforts to address the problem. In recent years we have seen fluctuating interest towards our speciality. Changes in the funding of Advanced Pain Training posts have impacted on the number of trainees, with the majority of posts restricted to recruiting from within their allocated School of Anaesthesia.

In the most recent 2017 census, it was noted that in the UK, there is one Pain Medicine consultant per 109k of the population comparing to one Pain Medicine consultant per 77k of population across Australia and New Zealand. With this in mind, Dr Hookee Tsang has been leading a sub group to develop additional content on 'A Career in Pain Medicine' for the Faculty website and also providing support and information to those interested in our speciality which has evolved and now lends opportunities for doctors to develop subspecialty interests in a variety of fields.

Curriculum

Trainees are in the process of transitioning to the new curriculum and a new curriculum implementation development group are in the process of gathering stakeholder feedback, and it will be a further 12 months before the new implementation has full sign-off from the GMC. TAC is aware of the ongoing issues for those who have transitioned with regards to their intermediate training. Paediatric pain training has also been an ongoing issue with disparity between regions and geographical access to training facilities. Centralised simulation based training accessible to all might be the way forward and Dr Helen Laycock and Dr Paul Rolfe have been tasked to create a proposal to be presented to the FPM Board.

Credential update

FPMTAC have reviewed and commented on the GMC pain credentialling document. Feedback provided following the initial submission was the need for more stakeholder support and clarity regarding assessments.

EPM

Dr Helen Makins leads on this, and the work has focused on providing resources for medical students. e-PAIN sessions are now live and the EPM Advisory Group have been considering how to get medical schools aware of EPM as a concept.

Exam eligibility for fellowship and MTI candidates

Fellowship and MTI candidates are accepted on a case-by-case basis and they must have the support of the RAPM and must be in a recognised training post for six months before applying for both the MCQ and the SOE. The regulations are under review and updates will be cascaded to the RAPMs via email as well as reported in *Transmitter*.

I am reassured by the positive comments from the recent trainee survey (despite the many challenges we all faced in the last two years) which highlights how trainees enjoyed working in multidisciplinary teams where they were able to access a variety of modalities to help their patients and to also work in a speciality with a dynamic and evolving research base.

Dr HooKee Tsang
RAPM Chair

RAPM UPDATE

2022 brings forth the Chinese Year of the Tiger. A tiger year is about new beginnings, an apt symbol of the times in which we live. This year presents significant challenges and opportunities in the delivery of pain training.

The NHS Recovery Plan will affect all of our services and potentially create opportunities to deliver training innovations. We have all adapted to virtual working and virtual teaching. The online FFPMRCA tutorials are a valuable resource for trainees. The Faculty is developing a centralised teaching programme to support the special interest area in Pain Medicine mapped to the 2021 curriculum. Dr Richard Berwick, our new Trainee Representative, will be leading this. If you would like to get involved please email: contact@fpm.ac.uk.

Curriculum transition

The Faculty Tutors' virtual meeting last year was well received and provided an update on the 2021 curriculum, which runs in parallel with the 2010 curriculum during a transition phase ending in January 2024. We will have trainees who have completed intermediate pain training on the 2010 curriculum and have now moved to Stage 2 on the 2021 curriculum. Intermediate pain and Stage 2 pain training are not equivalent, so trainees will require some top-up pain training for Stage 2 sign-off. Trainees will be able to use the lifelong learning platform (LLP) to guide them as to any top-up pain training that is required for Stage 2 pain sign-off.

The shift towards outcome-based training, with no minimum number of pain sessions required for each stage of training, has raised concerns amongst trainers in relation to the gradual erosion of the amount of pain training that existed in the 2010 curriculum. RAPMs and FTPs have worked with schools of anaesthesia to develop local solutions and ensure that the standard of training is maintained. In some Schools of Anaesthesia, pain training may not be afforded a dedicated module within the rotation. Ensuring adequate training is obtained from multiple training sites is a challenge for those tasked with the HALO sign-off. A possible solution is to ask trainees to complete the 'Capability Cluster Completion' (Triple C) form available on LLP for pain at each placement. This form allows trainees to cluster evidence on a number of capabilities within the pain component of the curriculum achieved at each placement. At the time of HALO sign-off, the trainee can present a number of 'Triple C' forms demonstrating the achievement of their pain learning outcomes for that stage of training.

Consistent approach

The Faculty continues to develop Essential Pain Medicine (EPM) as a framework for training on the assessment and management of pain. It is incorporated into a significant number of UK medical schools with ongoing work to develop training for foundation doctors. The EPM framework can also be adapted for anaesthetic trainees at different stages of training. Dr Helen Makin, Chair of the EPM advisory group, has successfully delivered Pain Medicine training for the Final FRCA using the EPM framework. Delivering pain training using EPM from undergraduate level through to specialist training has the advantage of creating consistency in our approach to pain management. As we adapt our training programmes for the 2021 curriculum, there is an opportunity for us to include EPM. If you are interested in integrating EPM within their pain training programme, please contact the Faculty.

Congratulations to Dr Berwick who, as I mentioned earlier, has been appointed as the new trainee representative, succeeding Dr David Gore, whose excellent work representing the interests of trainees is much appreciated; I wish Dr Gore well in his future career. There have also been RAPM changes. I would like to thank Dr Bendinger for his work as RAPM for Sheffield, and congratulate his successor, Dr Joel Perfitt. I would also like to thank Dr Kamel for his work as RAPM for Leicester and congratulate his successor Dr Raithatha Bhavesh.

NEW FPMTAC SAS REPRESENTATIVE

Dr Murthy Varanasi
TAC SAS Representative

I am the newly appointed SAS Representative member for FPMTAC. After graduating, I worked in some of the premier hospitals in India in anaesthesia and intensive care. I moved to the UK in 2003 to improve my skills and knowledge. My introduction to Pain Medicine was in 2009 and I enrolled myself in a MSc in Pain Management achieving a Diploma in 2011. I went into a training job in 2013 but had to leave training due to medical reasons. I continued working in Cardiff and Vale University Health Board as a Fellow in Regional Anaesthesia, where my interest in Acute Pain started.

I have held a long standing interest in acute (including regional anaesthesia) chronic/persistent pain management. Pursuing this interest, I undertook focused training in pain management and have been permanent member of the Pain Medicine department at Cwm Taf Morgannwg University Health Board, for over 5 years. Currently 20% of job planned time is spent in chronic pain management while the remain 80% is in anaesthesia. My clinical activities include outpatient clinics (independent clinics) and intervention lists (both independent and supervised, with consultant colleagues). I contribute regularly to the departmental clinical governance activities and multidisciplinary meetings.

I am particularly interested in developing and optimising digital technology to improve access to pain clinics, enhance patient experience and facilitate effective outcomes. I led the development of an online tool to assist in the initial assessment and triage of patients coming to pain service. I am an active member of the Welsh Pain Society and British Pain Society and am familiar with the challenges facing the pain speciality and services, particularly post-pandemic era. I am keen to contribute to the FPMTAC and the development of SAS roles in Pain Medicine.

e-PAIN NEW DEPUTY CLINICAL LEAD

Dr Deepak Ravindran
Clinical Lead for Pain Medicine, Royal Berkshire Hospital

I have been a full time NHS consultant and Clinical Lead in Pain Medicine at the Royal Berkshire Hospital in Reading with over 20 years of experience in pain management. I hold a triple certification in the speciality fields of musculoskeletal, Pain Medicine and lifestyle medicine and am author of the book *The Pain Free Mindset* for the public.

Having been the pain educational supervisor locally and involved in pain education in the community and within schools, I am very familiar using a variety of communication media. I am on the scientific advisory board/team member with many patient facing platforms such as Flippin Pain™ and Curable™. I hope to bring this knowledge and presence amongst patient facing communities to this project when we wish to expand our offerings and attract more authors from diverse settings to promote interdisciplinary learning.

I look forward to working with Dr Cox to enhance the course content, promote and recruit new editors/authors and help position ePAIN as a valuable resource of pain education in this Global Year of Translating pain knowledge into practice and the future.

Dr Richard Berwick
Faculty Trainee Representative

TRAINEE UPDATE

In February I took over from David Gore as trainee representative. David has done a fantastic job of representing the trainee network through the pandemic. This has been a particularly challenging and stressful time, especially with the ever-changing demands placed on us, and I would like to thank him for all his hard work.

As for myself, I am an Advanced pain trainee in the Northwest (Mersey). I did my clinical training in London and then moved to Liverpool. I work part-time, spending my non-clinical time in the lab studying the immunological basis of fibromyalgia! I have served on the Mersey Speciality Training Committee for several years as the LifelongLearning Representative, helping to design and implement the platform. Here, I saw the value of trainee advocacy, regular communication, and networking and I look forward to representing us all on the Board.

Great aspirations

I have great aspirations for Pain Medicine. I am passionate to see it advance and flourish, reaching our patients in new, impactful ways. As trainee representative, I plan to look at teaching, research opportunities, and sustainability. I am keen to develop these aspects within the trainee network and within the broader pain community. If anyone shares my passion and would like to take this further, please do contact me.

Trainee Survey

Responding to the comments from last year's trainee survey, (Autumn *Transmitter* 2021), there are few things we are working on:

- The Lifelong Learning Platform (LLP) version is the most commonly used logbook. The Faculty are aware that this logbook is not perfect, and we have recently presented a 'wish list' of adaptations to the LLP development team

- Access to teaching and exam resources remains a concern for trainees, with disparities in the regional opportunities. Along with the excellent FPMLearning resource, we are working on how a national training programme might be facilitated, perhaps, shared monthly between regions.

Following on from the experiences arising from the 2021 FRCA Final Written Exam and the October 2021 FFICM OSCE, an independent review of exams at the RCoA is being conducted. Professor John McLachlan has agreed to carry out this assessment process. Our FPM exams will also be included in this review. The scope of the review is broad and includes all aspects of the examination, especially the move to virtual delivery. It will also examine and assess the impact of exams on wellbeing and trainees. Knowing the exam process all too well, we will, of course, welcome this. An interim report was due in mid-April. I have received plenty of feedback and would like to thank all those who have contacted me thus far. Speaking to Prof McLachlan, I have no doubt that the review will be of benefit to trainees.

Get in touch

Finally, please do not hesitate to contact me about any issues relevant to training or other and I will do my best to help. You can contact me via fpmtraineerep@gmail.com or through the WhatsApp group. I am thoroughly looking forward to meeting and working with you all in the coming months and years!

FFPMRCA EXAMINATION UPDATE

Dr Nick Plunkett
Chair FFPMRCA

Dr Ganesan Baranidharan
Vice-Chair FFPMRCA

Since the last Examinations report in the autumn edition, the Faculty has delivered two further exams: the SOE on 13 October 2021, and the MCQ for the Spring sitting on 8 February 2022.

As the nation was still in the grip of COVID, the SOE was again performed remotely on 29 March 2022 (we all hope, for the last time!). FPM examiners and the RCoA Exams Department are now adept at delivering remote SOE, with examiner, auditor and candidate positive feedback received.

Exam performance

14 candidates presented and following the usual and robust quality assurance processes to define the pass mark, 10 candidates were considered to have achieved the required standard, with the pass mark set at 32. This represents a 71% pass rate, consistent with recent average pass rates.

At the MCQ remote sitting on 8 February there were 14 candidates and there were no reports of significant technical glitches.

The FPM Anghoff Group sat on the 22 February to consider the examination questions and raw results in detail. Each question was reviewed and two MTF and two EMQ questions were removed for reasons of ambiguity, and two further questions had the answer reversed, for which no candidate was disadvantaged. A total of 386 marks out of 400 marks were possible, and following the usual processes, an Anghoff raw pass mark of 275 was found, resulting in an overall pass mark of 69.23%, which 13/14 candidates achieved, giving a pass rate of 92%, higher than recent trending pass rates.

Remote delivery

All FFPMRCA MCQ examinations going forward will be delivered remotely, noting good feedback from candidates on the matter, an unexpected and serendipitous windfall from the COVID pandemic.

The Faculty have recently advertised for new examiners. We encourage all eligible colleagues with an interest and some experience in teaching, training, research, and assessment methods/examination to apply. Applicants are assessed according to robust criteria, and are invited from all fields of pain medicine including acute, chronic, cancer and paediatric pain medicine, with a special encouragement for female and BAME colleagues to apply.

Thank you

The FPM Court of Examiners would like to thank the RCOA Exams Department, especially Fiona Daniels, David Rowand, and Beth Doyle, for their dedication and resilience in continuing to deliver the FPM exams within the constraints imposed by COVID, and normalising, as much as is possible, the candidate experience.

EXAM ELIGIBILITY

The Fellowship of the Faculty of Pain Medicine FFPMCRA examination is delivered twice a year and has successfully raised the standard of Pain Medicine training since its inception in 2012.

Dr HooKee Tsang
RAPM Chair

The Faculty of Pain Medicine has received an increased number of enquiries from RAPMs relating to the FFPMRCA eligibility, especially for doctors who are in Pain Medicine Fellowship posts within the UK.

Applications for the FFPMRCA examination can be via a number of routes, and all applicants must be registered with the GMC and the Faculty of Pain Medicine.

Applications from potential candidates can fall into a number of categories:

- UK Anaesthetic Trainee
- Post-CCT Trainee (UK Fellowship post)
- Post-CCT Trainee (overseas Fellowship post)
- Pain Medicine Fellowship
- Consultant working in the UK
- Consultant working overseas
- Specialty/SAS
- Medical Training initiative (MTI)

There are Pain Medicine Fellowship posts within the UK that have not been formally recognised by their Regional HEE Anaesthetic School Board or the Faculty of Pain Medicine for Advanced Pain training. To ensure that the standard of Pain Medicine training is maintained we advise doctors taking up Pain Medicine Fellowships to discuss their training with their local RAPM before they start their post. The RAPM will be able to ensure appropriate assessment and review during the post. The RAPM will need to consider the level of Pain Medicine training, experience, and evidence of continuing professional development proportionate to the level of the examination before supporting a prospective candidate's application.

There are also Pain Medicine Fellowship posts focusing on specific sub-specialty components of Pain Medicine, such as cancer pain or neuromodulation. Applicants within such posts will need to liaise with

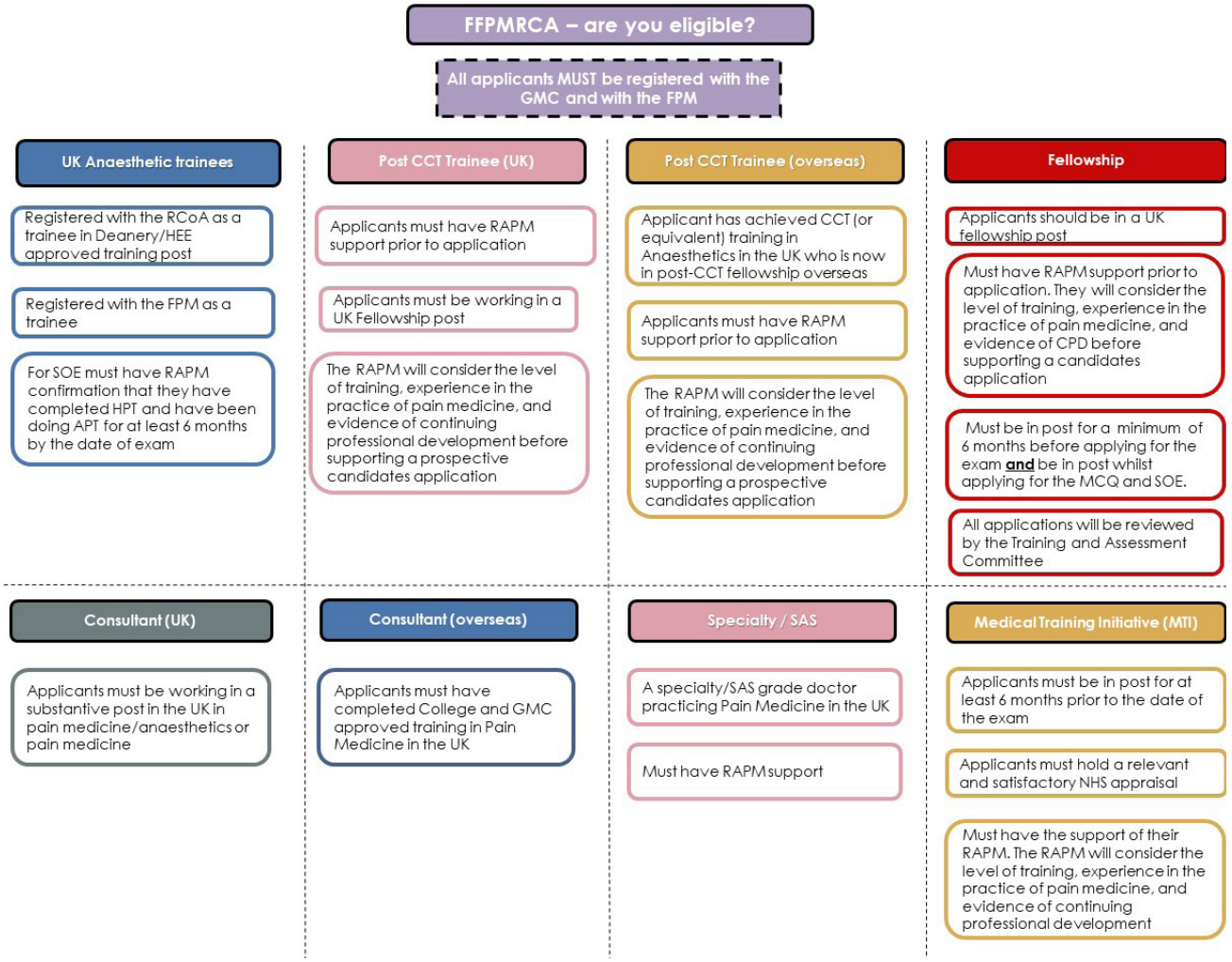


Figure 1: Exam eligibility chart

their local RAPM and explore training opportunities to achieve the learning outcomes required for the examination beyond the specialist field of their post.

Requirements

Currently, the applicant is required to have completed a minimum of six months within their Fellowship by the FFPMRCA examination date that is being applied for. All applications via this route are considered on a case-by-case basis by the Training & Assessment Committee, so applications must be made well in advance of the FFPMRCA examination application closing date.

Contact your RAPM early

We advise all doctors who are interested in taking up Pain Medicine training to contact their local RAPM prior to starting their post and to join the Faculty of Pain Medicine, who can also provide them with information on the requirements for the FFPMRCA examination.

Further information on eligibility for the FFPMRCA examination from other routes is available in **Figure 1** and the Faculty of Pain Medicine website and regulations https://fpm.ac.uk/training-examinations-examinations/exam-applications-and-structures.

Under review

The regulations are constantly under review so please look out for updates on eligibility requirements.

FFPMRCA SOE EXPERIENCE

Dr Sabina Bachtold
Consultant in Pain
Medicine and Anaesthesia,
Frimley Park Hospital

Dr Tacson Fernandez
Consultant in Pain
Medicine and Anaesthesia,
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At the October 2021 remote SOE sitting, we were pleased to welcome Drs Sabina Bachold and Tacson Fernandez, recently appointed consultants in anaesthesia and Pain Medicine. Both are also recent appointees also to the Anghoff referencing group, which helps define the pass-mark for the MCQ exam.

To assist both in their understanding of the central tenant that underpins standard setting (the "just passing candidate"), it was decided that Sabina and Tacson should attend as observers only at an SOE. This is a brief and largely unedited account of their experiences.

Dr Tacson Fernandez

The experience of appearing as a candidate for a speciality exam at the Faculty of Pain Medicine, while daunting, can be cherished, although only on completion! This year, there was the opportunity to participate in the process of understanding what it is to be an examiner. I was fortunate to participate in this process and learn from those who have been contributing for years.

> I have come to understand it as a process that puts objectivity and fairness at its heart.

First was the Anghoff scoring process — something I knew little about while taking the exams. This was an 'eye opener', a revelation into the workings of the system. I have come to understand it as a process that puts objectivity and fairness at its heart. Little did I know a process such as this existed where subject-matter experts would review every single MCQ in detail to ensure accuracy and also predict how many of the candidates would know the correct answers to the question. It is a process improved over time and experience.

Extensive preparation is indispensable to being an effective SOE examiner. The ability to focus on the task on hand — to elicit the best information from the candidate to support them

through the exam is an essential skill. Patience is a virtue, and the exam draws on this substantially. Rephrasing, restructuring the question, realigning with the candidate, supporting them when they 'blank out', going back to their areas of confidence and returning to topics where they struggled earlier, eliciting responses on the very same topic, making the environment as conducive to eliciting a good candidate performance as possible.

While a daunting task, it truly enthused me with the principles many of us are instilled with in our daily practice as pain physicians. Patiently listening, empathetically rephrasing our communication, guiding, and bringing insight when required. The process was one of learning and examining at the same time bringing forth the best in the examinee on the day. Most of all, it was an opportunity to contribute to the specialty and the Faculty for all that we have received and for the opportunity to share some of our experience.

Dr Sabina Bachtold

Having spent too much time sitting (sometimes repeatedly) postgraduate anaesthetic and Pain Medicine exams, it was only natural that I would fall into a consultant job plan with an interest in teaching for the FRCA examinations once I took up my first appointment. With this, I have expressed an interest to join in the FFPMRCA examination for Anghoff scoring of the MCQ paper.

> “I encourage the generation of amazing women consultants that I was fortunate to train with to express their interest and enrich the Court of Examiners in the years to come

More recently I have had the privilege to observe the SOE component of the exam. I had a delightful abrupt learning curve i.e. — what is Anghoff scoring?

I have also experienced with trepidation the interaction with examiners who only a few years ago were sitting across the table enquiring about my knowledge on the anatomy of the occipital nerves.

The FFPMRCA is a robust and rigorous exam that raises and keeps the standards of our specialty. I have learnt that there is an enormous amount of work that goes behind the scenes to ensure all of this — from selection of questions to ensure objectiveness and lack of ambiguity through to examiner's behaviour, which is regularly audited alongside the entire exam flow.

There is significant skill at play in supporting the candidates to get the most out of their knowledge. Whilst I used to think that this is a bit of myth, when I was a trainee, I can see that the examiners are there to help, not hinder.

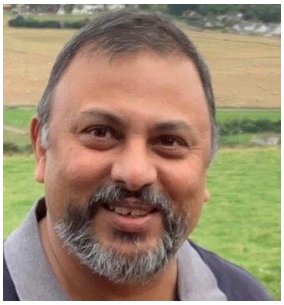
It is great to note that the examinership is not London-centric and there is clear appreciation of the value of involving examiners with different backgrounds and experience.

There is only one aspect to mention and I am aware that this is not something that's gone unnoticed by the FPM: the gender imbalance amongst the examiners. I encourage the generation of amazing women consultants that I was fortunate to train with to express their interest and enrich the Court of Examiners in the years to come.

	FFPMRCA MCQ	**FFPMRCA SOE**
Application and fees not accepted before	Wednesday 1 June 2022	Monday 1 August 2022
Closing date for FFPMRCA exam applications	Thursday 14 July 2022	Friday 16 September 2022
Examination date	Wednesday 24 August 2022 **Online**	Tuesday 11 October 2022 **Face-to-face**
Examination fee	£560	£780

EVENTS UPDATE

Dr Manohar Sharma
Educational Meetings Advisor



Dr Devjit Srivastava
Deputy Educational Meetings Advisor

The FPM Annual Meeting 2021 was held virtually on 26 November. Some key highlights were: Persistent sciatica by Mr Martin Wilby; Radiofrequency denervation for low back pain by Dr Cathy Price; Condition-specific PMPs by Dr Kerry Mathews; and the Patrick Wall Lecture: Next generation chronic pain management: from idea to reality by Professor Christopher Eccleston. Overall feedback was very good.

The annual acute pain study days were held online this year and the quality of speakers and presentation was uniformly high with good attendee feedback.

Dr Manjit Matharu talked about the management of acute flare ups of trigeminal neuralgia (TGN) in the hospital setting. He emphasised the need to re-confirm the diagnosis of trigeminal and to order a MRI (CISS/FIESTA sequences) if the phenotype had changed. Dr Matharu took the audience through the most recent ICHD 3 diagnostic criteria for trigeminal neuralgia. Dr Jason Bolland (consultant Palliative Care) discussed the management of opioid-induced constipation. Overall, the importance of using less constipating opioids was emphasised and the value of non-pharmacological management was highlighted. Dr Ken Barker spoke about the environmental impact of N2O in that it accounts for 0.05-0.1% of all global emissions and given that anaesthesia is the largest hospital specialty, we are "individual super emitters" in that we emit 650 times more than the average citizen. Dr Barker highlighted that he had reduced his carbon footprint from 4,500 km/year driving equivalent to 20 km equivalent by abandoning N2O and by switching from Desflurane to Sevoflurane. Dr Andrew Toner from Australia spoke about the results of the LOLLIPOP RCT pilot study on the use of intravenous Lidocaine for breast surgery compared with placebo. Dr Rune Sort from Denmark updated the audience on the results of his RCT post-operative ankle pain after ORIF of ankle fracture. The RCT (n=150) compared the efficacy of peripheral nerve block (sciatic +saphenous) vs spinal anaesthesia. The patients in the nerve block group had a superior outcome. Dr Karim Ladha from Toronto presented his study of 1,313 patients (a sub group of the larger MET study) and concluded that post-operative

complications are likely to associated with persistent post-operative pain. He highlighted the need for further research to understand the mechanisms behind this connection. Mr Dileep Lobo from Nottingham updated the audience on the results of a survey of opioid prescription at post-operative discharge. The study reported that there was no difference in opioids prescribed at discharge after intermediate/complex surgery between opioid naïve patients and those taking opioids post-operatively. 32% of patients were prescribed opioids at discharge and the median OME (Oral Morphine Equivalent) ranged from 30-60 mg/day.

Dr Paul Farquar-Smith highlighted the recommendations from a recent practice advisory on cannabis utilising patients undergoing surgery. The major recommendations included the importance of eliciting a history of cannabis use, quantifying it, and ensuring contact with a cannabis authoriser (if one exists). Professor Patrice Forget updated us on the PANDOS, an observational study on pain and opioids after surgery in Europe. This is planned as a one week cohort study in UK and Europe. The aim is to provide detailed data regarding perioperative opioid use. Professor Balasubramanium from Boston spoke about perioperative neurocognitive disorders and highlighted the role of effective pain relief, using opioid sparing multimodal analgesia and preoperative cognitive training to prevent post-operative delirium.

Day 2

The second day of the conference started with a robust review of the practice of prescribing gabapentinoids perioperatively by Dr Harriet Kemp from London. She concluded her session by stating that there was perhaps less evidence for perioperative use of gabapentinoids than previously thought especially with regard to prevention of chronic post-surgical pain. Dr Nigel Penfold from the RCoA took the audience through the structure of the new CCT curriculum with reference to pain management and also heighted the role of credentialing. Dr Mark Rockett highlighted the role of psychological factors in perioperative pain especially anxiety and catastrophising. The main takeaway from his erudite talk was that anxiety and catastrophising affect acute and sub-acute pain perception and interventions to reduce them are likely to reduce acute and sub-acute post-operative pain.

Dr Amy Donnelly talked about the joint BPS/FPM patient leaflet on *Managing Pain After Surgery* which was well received by the audience. Prof Albert Dahan from Netherlands spoke on 'Nociception monitoring during surgery'. Nociceptive monitoring intraoperatively using AI algorithms and the nociception level index has the promise of less haemodynamic instability, use of less postoperative pain relief with less stress hormone release. Dr Charlotte Small talked about 'How to effectively run an acute pain round'. Charlotte highlighted the challenges she faces in running an acute pain service on her patch. Dr Neil Desai from London discussed the role of perineural adjuncts in addition to local anaesthetics and concluded that use of perineural dexamethasone has no significant advantage over the use of intravenous dexamethasone.

Debate

Dr Shyam Balasubramaniam and Dr Sandeep Kapur conducted a lively debate on the clinical use of Lidocaine infusion in anaesthesia and pain. The debate weighed the pros and cons of intravenous lidocaine and both speakers agreed that there was a need for more evidence on intravenous lidocaine efficacy and safety. In the interim, the intravenous lidocaine safety statement published in 'Anaesthesia' provides a template for safe use for practitioners. This debate tied in well with a lecture by Dr Andrew Toner from Australia on the first day who presented the results of a pilot RCT of intravenous lidocaine versus placebo in breast surgery patients (n=150). The safety events reported were transient fall in blood pressures that spontaneously resolved and these were equally distributed between the placebo and lidocaine group. The pain scores in PACU were minimally lower in the lidocaine group.

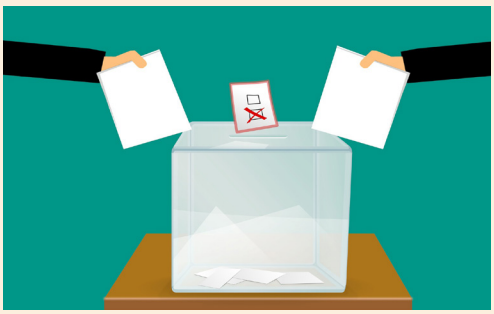
Dr PJ Tighe from Florida spoke about 'Patient and Procedural Determinants of Postoperative Pain Trajectories'. This was a fascinating talk in which Dr Tighe stressed that pain was "personal", patient factors were possibly more important than the type of surgery in determining post-operative pain trajectories. The second day was rounded up by Dr Dev Srivastava speaking about the emerging role of genetics in pain management. He talked about the influence of genetic hardware at birth (twin studies), the importance of single mutations (SNPs) in understanding pain and its emerging role in pharmacogenomics, the role of epigenetics and gene therapy in pain management.

Any suggestions?

The FPM Annual meeting on 25 November 2022 is also planned as face to face. If you have a relevant topic/speaker suggestion, please email Dev Srivastava or Manohar Sharma at dev.srivastava@nhs.scot or manohar.sharma@nhs.net.

FPM BOARD ELECTIONS 2022

Notice is hereby given that an election for one vacancy on the Board of the Faculty of Pain Medicine will be held on 12 August 2022.



The Board of the Faculty of Pain Medicine is the main decision-making body of the Faculty, responsible for its overall direction and strategy.

There will be one vacancy in 2023. Elected candidates will take office at the Board meeting on Friday 10 March 2023. The term of office will be six years in the first instance. Those elected will be eligible to be re-elected for a second term of four years. Those eligible to stand are: Foundation Fellows, Fellows by Examination & Assessment, Fellows ad eundem and Members of the Faculty complying with the conditions of the Ordinances and Regulations.

The election will be conducted entirely electronically so it is imperative that we have an up to date email address for you to ensure you receive the ballot papers. To update your primary email address please email contact@fpm.ac.uk or use the MyRCoA portal.

To find out more about the role and the election please see the dedicated page on our website: www.fpm.ac.uk/fpm-board-elections.

FACULTY UPDATE

New Fellows by Examination and Assessment

Ali Al-Ali
Kapil Dev Arora
Christopher Barringer
Thomas Dawes
Amit Gadre
David Gore
James McGuinness
Naresh Rajasekar
Pooja Shah
Faisal Ismail Shiekh

New Affiliate Members

Prithvi Madiyala

New Fellow Ad Eundem

Tacson Fernandez

New Associate Fellows

Amar Joshi

FPMLearning is updated every month. Be sure to have a look at the FPM's open resource for all pain trainees, providing a variety of teaching materials including case reports, journal club, recommended reading and podcasts.

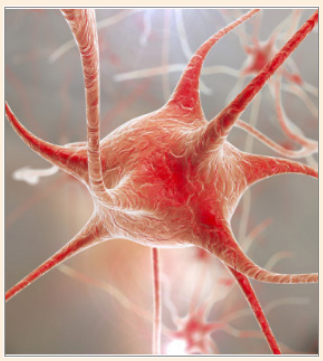
www.fpm.ac.uk/fpmlearning

LOOK OUT FOR THE THIRD FPM PODCAST COMING SOON!

You can listen to the two previous podcasts below at **www.fpm.ac.uk/fpmlearning/podcasts**.

Simplifying the management of complex pain in hospitals

Dr Doug Natusch, Dr Helen Makins and guests



Prescribing drugs for nerve pain for anaesthetists

Dr Doug Natusch and Dr Helen Makins

FACULTY OF
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