PROVIDING ADVANCED TRAINING IN PAIN MEDICINE FOR ANAESTHETISTS

Guide for Regional Advisors, Trainers and Trainees
Providing advanced pain medicine training for anaesthetists

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These criteria are for pain management units or training programmes providing advanced training of anaesthetists in pain medicine according to the criteria for competency based training as published in the current version of CCT in Anaesthesia (see Royal College of Anaesthetists’ website). It is essential that the arrangements for those trainees seeking advanced training do not detract from the training in pain medicine that must be provided for all trainee anaesthetists at various times in their training. Interpretation of these recommendations should be supplemented by advice from the Regional Advisor in Pain Medicine (RAPM).

Organisation of pain management services and training

1. Pain services within the training programme must be sufficiently busy and employ sufficient staff to offer full time training in pain medicine and to offer a wide, balanced, range of clinical experience in the management of acute, chronic and cancer pain.
2. Commonly more than one centre combines to create a comprehensive training programme; the individual centres may offer training in only one particular aspect of pain medicine.
3. Where the training occurs in more than one hospital, there will usually be a single centre that has a large, anaesthetist-led pain medicine service serving as the central focus for the overall training.
4. At least one of the training centres must have links to a palliative care service. Training in the relevant aspects of Palliative Medicine may be from such links or from an attachment to a specialist palliative care unit. Trainees must still obtain experience of the management of cancer pain in a general hospital setting.
5. The Advanced training programme is competency based but it is recommended that the programme should provide twelve months training in Advanced pain medicine. Ideally this period should be continuous but in special cases could be completed in separate modules with the minimum acceptable continuous period being six months.
6. Special arrangements must be made for trainees in less than full time training posts, so that their equivalent training can be accomplished within an acceptable period.
7. Specialised arrangements may need to be made for trainees who express an interest in the subspeciality aspects of Advanced training - as described in the Curriculum in Anaesthesia (See website for up-to-date details). It may not always be possible to accommodate these requests.
8. Trainees who express an interest in Advanced Pain training, would still be expected to complete a three months Higher Pain training module, but, where possible, this would be arranged in a centre offering Advanced Pain training, and opportunities to explore the speciality would be made available.

Consultant sessions in pain medicine

1. There must be sufficient consultant sessions devoted to acute, chronic and cancer pain in the main centre so that there is supervision and training available throughout the whole working week.
2. The majority of the consultant sessions should be provided by a minimum of two (2) different consultant anaesthetists who have a substantial sessional commitment to pain medicine.
3. Consultant sessions in other specialties such as palliative care, neurology, orthopaedics, rheumatology, rehabilitation medicine and psychiatry can count towards the sessions but must not exceed 20%. Consultants in the other specialties must be familiar with the aims and objectives of advanced training of anaesthetists in pain medicine.

Other staff in the pain management service

1. Clinical input to the pain service from a psychologist with expertise in pain medicine is essential; there should be an appropriate number of identified sessions for this input. This may vary if there are a
number of hospitals providing training, but should be a significant aspect for at least 3 months of training.

2. There must be appropriate provision of specialist nurses in both acute and chronic pain.
3. There must be provision of diagnostic services e.g. laboratory, radiology and neurophysiology.
4. There must be links with necessary clinical support services e.g. physiotherapy, occupational therapy, social work, pharmacy, medical physics and orthotics.
5. There must be full time secretarial, administrative and clerical support staff.
6. There must be a well-defined management structure for the pain service.

Physical facilities for the pain management service

1. The main pain management facility should have permanent accommodation that includes designated office space for the secretarial, administrative and other support staff.
2. Appropriate rooms for consultation and treatment must be available.
3. In those centres undertaking more complex interventional pain medicine, in-patient beds should be available for patients with pain problems to be admitted under the care of the Pain Management Team. Normally such beds should be located on a ward where the nursing staff are familiar with the management of these patients. If designated inpatient beds for pain medicine are not needed then there must be a satisfactory arrangement for admitting patients into other beds when appropriate.
4. There should be appropriate accommodation for trainees with access to computers and information technology.

Clinical workload of the pain management service

1. The overall clinical workload of the pain management service would be expected to be large enough to provide a breadth and depth of clinical experience.
2. It would be expected that for acute post-operative pain there would be a minimum of 200 new patients managed by the service per annum. For chronic non-cancer pain and cancer pain there would be a minimum of 300 new patients managed by the service per annum. The numbers refer to the number of new cases seen by the pain service each year (inpatient or out-patient) and not to the number of patients to be personally managed by the trainee. For example the numbers could include new patients seen by the consultant with the trainee present as observer.
3. There should be a minimum of five (5) outpatient consultant half day sessions per week within the pain service devoted to pain medicine consultations and treatments.
4. In main training centres there should be a minimum of five (5) in-patient ward rounds for acute, chronic and cancer pain (conducted by medical and / or nursing staff) each week.
5. The overall number of therapeutic interventions such as neural blockade and similar procedures should total at least 500 per annum. These interventions should cover a wide range of procedures performed for acute, chronic and cancer pain.
6. Interventions such as neural blockade must not be the sole treatment modality offered by the institution and must be used in the context of a balanced, rational, multidisciplinary approach to pain medicine.
7. If specialised procedures such as percutaneous cordotomy, intrathecal drug delivery, complex spinal procedure and spinal cord stimulation are not performed in the institution, then there must be a guaranteed opportunity for the trainee to gain an understanding of these techniques in another institution.
8. If the service does not have a pain management programme, then there must be a guaranteed opportunity for the trainee to learn about this in another institution.

Therapeutic philosophy of the pain management service

1. The pain service must be conducted in accordance with the General Medical Council’s principles of good medical practice.
2. The assessment and treatment modalities on offer in the various components of the training programme must be truly multidisciplinary in nature so as to encompass pharmacological medicine, neural blockade, stimulation techniques, physical therapies, surgical techniques (including orthopaedic surgery and neurosurgery), neuromodulation, rehabilitation and psychological approaches in all patient groups (for example, vulnerable adults). These treatments must be provided by a multi-professional
3. There must be a culture of multidisciplinary co-operation with ready access to other specialist opinion in the hospital or hospitals, particularly when there is any doubt about diagnosis or the formulation of a management plan.

4. When dealing with chronic pain patients the trainees must appreciate the importance of: history taking and examination, arranging and following up appropriate investigations, formulating a management plan and communication within and outside the pain management team. Trainees must learn to assess, examine, investigate and plan treatments for a variety of different pain patients in different settings. There must be an opportunity for the trainee to follow the progress of patients over an extended period.

5. Pain medicine training must occur with clear lines of supervision from more senior team members. Initially very close supervision will be needed and as competencies develop more independent working should be possible. However trainees must always be able to access support from their supervisors.

6. The centre or institution should be able to demonstrate an evidence-based approach to pain medicine and should be able to instil in the trainees an understanding of critical appraisal of research publications in pain medicine.

Other activities of the pain management service

1. Regular multidisciplinary case conferences and clinical review sessions must occur to formulate management plans and review the progress of individual patients.

2. The pain service should document and respond to critical incidents and must be able to demonstrate that risk management strategies are in place.

3. Audit must occur regularly and adequate records should be kept of audit meetings and outcomes.

4. The centre or institution must have an on-going programme of research into pain mechanisms or management and normally the trainee will be expected to have an involvement, at an appropriate level, in this research.

Teaching facilities and their organisation

1. In each centre involved in the advanced pain medicine training programme there should be a well-defined weekly timetable in which the day to day training opportunities are clearly apparent.

2. There should be regular scheduled teaching sessions in addition to the interdisciplinary case conferences and audit sessions. These teaching sessions may include journal club, topic reviews or guest lectures.

3. The main centre must offer an active programme of teaching in pain medicine for undergraduate and postgraduate students (medical, nursing and other healthcare professionals); the trainee should contribute to these as a teacher.

4. There should be library facilities.

Supervision of training

1. The training programme must be accommodated within a School(s) of Anaesthesia.

2. Each training post in advanced pain medicine must have a well defined training programme with clearly stated learning aims and objectives that cover the advanced training competencies throughout the whole training period.

3. The training in pain medicine must be adequately supervised by appropriately trained specialists in pain medicine. The educational supervisor will normally have been appointed to a post with a specific interest in pain medicine by a properly constituted Advisory Appointment Committee in the UK at which an assessor nominated by the Royal College of Anaesthetists was present. Since appointment to their post the supervisor will have continued to work in pain medicine with a case-mix and workload sufficient to maintain acceptable clinical knowledge and skills.

4. When the programme involves several centres the Regional Advisor in Pain Medicine should have overall responsibility for the supervision of training but may choose to delegate aspects of supervision, as appropriate, to local pain training supervisors.

February 2008, amendments May–June 2010