Editorial II

The Faculty of Pain Medicine of the Royal College of Anaesthetists

Those who deny progress have many things in their favour. The collective amnesia of how things were in the past is the most powerful. . . . . And then there is a tendency, when thinking about whether progress has been made, to compare how things are with how they should be or how we would like them to be, rather than with how they once were.

Hippocratic Oaths Raymond Tallis 2004.

The establishment of a Faculty of Pain Medicine by the Royal College of Anaesthetists (RCoA) in April 2007 represented the passing of another major waypoint in the development of pain medicine, and it helped to demonstrate the distance travelled by the specialty in the last 50 yr. Pain medicine describes the work of specially qualified medical practitioners who undertake the comprehensive management of patients with acute, chronic, and cancer pain using physical, pharmacological, interventional, and psychological techniques in a multidisciplinary setting. The whole multidisciplinary care package is pain management; what the medical specialists do is pain medicine.

John Bonica sowed the seeds of the specialty 50 yr ago. In 1956, he wrote The Management of Pain—more than 1800 pages by a single author. At the same time, technological advances and powerful intellects allowed people such as Patrick Wall to bring new skills and ingenuity to research into pain mechanisms. Along with Ron Melzack, he described the gate control theory in 1965. In 1974, he was the founding editor of the journal Pain. When Wall and Melzack planned their Textbook of Pain (first published in 1984), publishers rejected the scheme by saying that ‘pain was not a subject’. The Intractable Pain Society (the forbear of the British Pain Society) was formally established in 1974, although the group had been meeting annually since 1967. The International Association for the Study of Pain (IASP) was established in 1975. Since these beginnings, the advances in the understanding of pain have been remarkable. John Bonica and Patrick Wall would have rejoiced at the exciting progress evidenced by the contents of this Postgraduate issue of the British Journal of Anaesthesia.

For patients, the management of cancer pain was probably the first great clinical success. In 1962, Cecily Saunders described the use of oral morphine for cancer pain and then St Christopher’s Hospice opened in 1967, heralding the birth of the hospice. The WHO published Cancer Pain Relief in 1986—a small book with a massive clinical impact.1 Acute pain management has been another major success story, albeit more recent, with significant improvement after publications such as Pain after Surgery2 in 1990 right through to the 2nd edition of Acute Pain Management: Scientific Evidence3 in 2005. The management of pain in infants and children has been transformed in25 yr with sophisticated analgesic techniques now used for the smallest babies. As an example of progress in the world of chronic pain, there has been a veritable revolution in the management of back pain.4

The rate of progress has been greater in some parts of the world. Australia and New Zealand have had a Faculty of Pain Medicine since 1998 and in Australia recently, pain medicine has been recognized by the Federal Government as a separate specialty.

Despite all this apparent progress, education in pain has appeared to lag behind in certain quarters. Surveys and guidelines often include exhortations to improve education in pain management for healthcare professionals at all levels. For example, the CSAG report on Services for Patients with Pain5 recommended that Professional Bodies ‘Ensure that teaching and training at all levels adequately covers pain management’.
Naively, many in the UK thought that the much-trumpeted NHS Quality Agenda (launched by A First Class Service Quality in the new NHS in 1998) would guarantee good pain control for NHS patients, but sadly, there is a perception that the important outcome measures appear to be quantitative rather than qualitative. In addition, Sandra H. Johnson may have struck a chord with many pain specialists in the UK when she wrote about the USA that there is ‘a complex ecosystem that supports ambivalence, denial, and suspicion of the circumstances of patients in pain and of those who treat them’. 7

In the UK, a vast majority of pain specialists are anaesthetists. The RCoA recognized that the time was ripe for anaesthetists involved in pain medicine to have more responsibility for specialist training in pain, so the Council approved the establishment of a Faculty of Pain Medicine within the RCoA. It is the first faculty established solely by the RCoA, although the College had shared responsibility for the Faculty of Accident and Emergency Medicine (now the fully independent Royal College of Emergency Medicine).

The Fellowship of the Faculty is an additional qualification and initial membership was restricted to Fellows of the RCoA, but there is provision within the Faculty Regulations to admit others, including pain specialists from non-anaesthetic specialties. Doctors who trained in other specialties will not possess the same competencies as anaesthetists who practice pain medicine, and vice versa. Great care will be required in the assessment of the ‘equivalence’ of the relevant training and experience of the different groups but potentially there is much to be gained from multi-specialty membership.

So what are the educational challenges that face pain medicine towards the end of the first decade of the twenty-first century? For the Faculty, the first priority will be improving education in pain for those who wish to be pain specialists, then for all anaesthetic trainees, then for other medical practitioners, and then even more widely.

For some time, anaesthetic training in pain has had to face the generalist vs specialist question, because all anaesthetists are involved in pain management to some degree. Most deal with postoperative pain as a part of giving anaesthesia. Some do anaesthesia and also work in a pain clinic. Others do full time pain. The training programme has to cope with the different needs and aspirations of the trainees. The CCT in Anaesthesia describes the College’s competency-based training programme with carefully defined knowledge, skills, and attitudes linked to workplace-based assessments at all levels of training. 8 Training in pain medicine is accommodated within this scheme.

Almost a decade ago, Huggins and colleagues 9 painted a very gloomy picture when highlighting the difficulties of obtaining pain training for anaesthetists. The obstacles were: overwhelming service demands; obsession with meeting targets; redeployment to anaesthesia; and pain held in low regard. Many of those hurdles have been overcome, but nowadays there are major pressures on the time available for training as a result of working time directives and other changes to training. How can pain training be squeezed into even shorter time? Should advanced pain training become a post-accreditation qualification? The problem of falling caseloads for anaesthetists was highlighted by Underwood and McIndoe. 10 There is a complex relationship between the number of cases and the acquisition of competence, and there are many reasons why trainees progress at different rates. It has been estimated that 80% of competence is achieved after about 30 cases but that there is continued improvement over 100 or more cases. 11 How can trainees gain experience of that number of cases in pain medicine, especially for procedures (e.g. coeliac plexus blocks and neurostimulation)? There is a need, among other things, for alternative teaching methods and a recognition that educational development has to continue even though formal training has been completed.

How do we ensure that pain specialists recognize their limitations and are competent in all that they undertake? How can a single specialist be trained to know all about the minutiae of orthopaedics, rheumatology, gastroenterology, neurology, gynaecology, psychiatry, dentistry, vascular surgery, oncology, and so on—yet patients from any or all of these specialities might present to a pain clinic?

Educating pain practitioners to understand evidence-based medicine is another major challenge. The widespread acceptance of pain management services has been bedevilled by seemingly irreconcilable differences between various practitioners who sometimes hold their beliefs with passionate, almost religious fervour. Pain management certainly had its share of single-issue enthusiasts, although it stands as testimony to education that their numbers are dwindling. Their continued existence attests to the public’s unquenchable appetite for magic and wizardry as a route to pain relief. These practitioners are often peddling mono-therapeutic approaches to what are usually complex, multi-dimensional, biopsychosocial problems. An examination of nineteenth century medicine reveals the fervent advocacy of metallotherapy, blue light rays, and mesmerism. What will future medical historians make of some of the treatments being promoted at the beginning of the twenty-first century? This raises important questions about the way in which the individuals understand pain (understanding is the key to education). In addition, these therapeutic contradictions are readily apparent to purchasers and providers of health care. Pain medicine needs to convince purchasers and providers that it is not selling snake oil and that it is treating patients in a rational, evidence-based fashion.

How do part-time pain specialists maintain their continuing professional development in all the topics of pain medicine plus another major specialty? Most are
anaesthetists who continue with anaesthesia and may do general on-call. How will they cope with revalidation in the UK? Can the generalist anaesthetist who has some involvement in pain medicine get away with a different standard of competence in comparison with the specialist who does only pain? Patients (and their lawyers) are less tolerant of the ‘jack of all trades’.

How many pain medicine specialists are needed? Other countries are concerned that they are producing too many pain specialists. The number of consultant posts with a pain interest advertised in the BMJ each year between 2000 and 2007 ranged from 27 to 59. It is impossible to know what is going to happen in the future in the devolved countries of the UK. The Scottish NHS has made a strong commitment to chronic pain services, but this is not the case elsewhere.12

Once anaesthetic training in pain is secured, the next educational challenge for pain medicine is improving the teaching for undergraduate and postgraduate medical practitioners. How to deal with the wide diversity of medical practice? Pain is a ubiquitous symptom for patients in most branches of medicine. Practitioners in primary care and most hospital-based specialties undertake the care of these patients. Primary care and general practice pose a special challenge.13 Palliative medicine has been a success story. Is there further argument here for integrated training (and services?) that includes not just the traditional fiefdoms of acute and chronic pain but many aspects of palliative care as well? It would make financial and clinical sense and it would certainly be educationally sensible to break down some of the artificially contrived barriers.

Should non-anaesthetists who treat pain be trained to perform major interventions previously within the sole domain of anaesthetists? It is argued that non-anaesthetists do not know about major nerve blocks, local anaesthetic pharmacology, and resuscitation, but undoubtedly these doctors are doing it anyway (even epidurals in the home in the UK!), so it is in the best interest of patient care to ensure that all practitioners are properly trained.

Should pain medicine strive to be a ‘stand alone specialty’ or should it always be linked to a parent specialty (e.g. anaesthesia, neurology, rehabilitation medicine, and psychiatry) as an additional qualification? From an educational standpoint, many take the view that pain medicine should stay with anaesthesia for the foreseeable future and that those who wish to break free immediately should heed the words of Polonius to Laertes:

Those friends thou hast, and their adoption tried,
Grapple them to thy soul with hoops of steel.

There is little up-to-date information about undergraduate education in pain in the UK. A survey conducted by the RCoA in the 1990s revealed wide variation, with some centres of excellence and others that regarded pain in a derisory light. Similar conclusions have been reached throughout the world. Teaching pain-related topics in medical schools is fragmented; important topics are poorly covered; specific curricula for pain are uncommon; the teaching does not provide the skills needed in clinical practice.14–17

In the UK, the General Medical Council (GMC) expects medical students to know about and understand the principles of treatment for relieving pain and distress.18 During early postgraduate education, the GMC expects young doctors to develop an understanding of how pain relief can be provided, including pharmacological, physical, and psychological interventions.19 Thereafter, as postgraduate training progresses, there is wide variation within and between specialties, different training programmes, and individual hospitals.

A broader view reveals that similar problems apply for nurses, psychologists, physiotherapists, pharmacists, dentists, and many other healthcare professionals. How to provide appropriate education for all staff from different specialties with different amounts of patient contact and different degrees of responsibility? Who needs to be taught about pain? What needs to be taught about pain? Do all healthcare professionals need the same teaching? Is it necessary for a nurse on a surgical ward to know about all opioid and NMDA receptors in order to understand how to manage a patient with postoperative pain? Should everyone be taught together? Multi-professional education in an integrated undergraduate pain curriculum has been shown to improve the quality of care by fostering teamwork as a result of the common understanding that generates common goals.14 Obtaining that common understanding through uniformity in pain education is a challenge but there are firm foundations already provided. The IASP first published the Core Curriculum for Professional Education in Pain in 1991 with a 3rd edition published in 2005, edited by J. E. Charlton, and freely available on the IASP website.20

A huge challenge for pain medicine lies beyond the realm of educating healthcare professionals and involves reaching policy makers and healthcare administrators. Attempting to educate and influence the policy makers is a daunting undertaking. There has been some progress on issues such as rehabilitation and return to work, but always there is the dead hand of political necessity to slow progress if it is not electorally advantageous. Acute pain management represents an increased cost for individual hospitals, so evidence is required that effective pain management as part of multimodal therapy reduces overall costs of surgical procedures. Chronic pain management is cost-effective, but unfortunately it may be perceived to generate insufficient income in a procedure-orientated, fee-for-service system.

In addition, education is required for the media, the public, and, very importantly, patients. Pain is rarely newsworthy. Paediatric cardiology, drugs for breast cancer, and MRSA are! Also it is a thing to be wondered at that complementary medicine still attracts so much
interest and exerts so much influence at a time when financial resources for mainstream medicine are stretched. This is a failure of education of the public and purchasers. By being honest about the scientific evidence for conventional pain treatments, the specialty appears to be in a weak situation whereas the complementary and alternative sector enjoys continued support. The issue of pain education for developing countries represents another major challenge for professionals, policy makers, and patients as well. One of the biggest educational challenges in the developing world, and sometimes closer to home, is convincing the drug regulatory authorities regarding the rational use of opioids to relieve severe cancer pain.

Despite the continuing problems highlighted in this editorial, there has been tremendous progress in training and education in pain during the last 50 yr and this has led to substantial improvements in patient care. Further benefits will accrue with strengthening of the pain education content in undergraduate and postgraduate training for all healthcare professionals. Many major challenges remain and there is much more to be done but the formation of the Faculty of Pain Medicine is one giant step forward for pain medicine and anyone who cannot see that has forgotten the past.

Sometimes you have to wait until the evening to see how glorious the day has been.

Sophocles

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References


