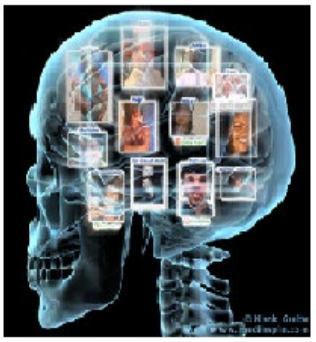
Curriculum for the Specialist Training Programme in Pain Medicine

Faculty of Pain Medicine CAI



Nemo sit in miseria

CAI
SALUS DUM VIGILAMUS
PATRON: MICHAEL D. HIGGINS, PRESIDENT OF IRELAND

Foreword

Réamhrá

Is é“Nemo sit in miseria” mana Dáimh an Leighis Piain. Is é an bhrí atá leis an ráiteas seo nó nár choir do éinne a bheith ainniseach. Is é príomh chuspóir an Dáimh nó an chéad ghlúin eile de dhochtúirí a oiliúnt ar ardchaighdeán, le aire den scoth a thabhairt do othair a bhfuil pian casta, ainsealach orthu.

Cuireadh tús leis an Dámh ag searmanas foirmiúil i gColáiste Ríoga na Lianna i mí na Samhna, 2008. Bhí an Teastas sa Leigheas Piain, ina raibh an Dámh ina bhun, ar an chéad scrúdú dá leithéid san Eoraip. Lean an Scrúdú Comhaltachta sa Leigheas Piain ar aghaidh ón Teastas sin. Is cúis bróid sin don Dámh. Ba mhaith liom buíochas ó chroí a ghabháil leis na Déin a thainig romham agus iar-chomhaltaí bhoird an Dáimh. Rinne siad sár obair ar an tioinscnamh seo le blianta anuas. Is toradh oibre suntasaigh an aighneacht seo a chuireann an Dámh faoi bhreith ag an am seo. Fuair muid comhairle ó shaineolaithe i réimsí ábhartha nuair a cuireadh an doiciméad seo le chéile agus gabhaim buíochas leosan freisin.

Foreword

The motto of the Faculty of Pain Medicine is “Nemo sit in miseria” (“Let no one be in misery”). The goal of the Faculty is to train doctors to a high standard to become the next generation of clinicians with the expertise necessary to manage complex pain conditions.

The Faculty was formally inaugurated at a ceremony in the Royal College of Physicians of Ireland in November, 2008. The Diploma in Pain Medicine examination run by the Faculty was the first such postgraduate examination in Europe. The Fellowship in Pain Medicine was a natural progression from this project. I wish to thank the Deans and colleagues who served on the Pain Medicine Faculty before me and who have contributed to this submission. This document is the culmination of considerable work and consultations with a range of experts in fields relevant to pain medicine. I wish to acknowledge these individuals and thank them for their contributions.

Dr Hugh Gallagher, Dean Faculty of Pain Medicine CAI (2021 – 2024)

Acknowledgements

The authors of the Curriculum for the Specialist Training Programme in Pain Medicine (the 'Curriculum') wish to acknowledge previous Boards of the Faculty who have made available previous curriculum and syllabus documentation which have served as an important resource in the writing of this curriculum. The authors of this document gratefully acknowledge the Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine ('FPM ANZCA) and European Pain Federation ('EFIC') for generously sharing material from their respective curricula.

The Curriculum is the product of a collaboration between multiple stakeholders, including but not limited to Faculty Board Members, practising Pain Medicine Consultants and Consultants from other associated specialties (e.g. Addiction Medicine, Rheumatology, Neurosurgery and Palliative Care), current and past Pain Medicine Trainees, the Committee of Anaesthesiology Trainees ('CAT'), Faculties, Societies and Consultants with areas of special interest.

Status of Curriculum

This document outlines the Curriculum for the Specialist Training Programme in Pain Medicine as submitted to the Medical Council. Information in this document is accurate at date of publication. As the pain medicine profession and healthcare system in Ireland continues to evolve, changes to the document may be required. The Faculty intends to carry out reviews on a 5 year yearly basis. The Faculty reserves the right to amend or replace the Curriculum in line with best practice. Interpretation of any aspect of the document and subsequent changes will be determined by the Faculty through its Board.

By accepting a place on the Specialist Training Programme in Pain Medicine (the 'Training Programme' or 'Programme'), a trainee is agreeing to be bound by the rules and regulations outlined in this document, all College Policies that apply to trainees, the provisions of the Training Agreement and any subsequent changes.

Irrespective of the date of the commencement of their training, a trainee will be bound by the version of this document in force at a given time. In the event that there is a discrepancy between the Training Agreement and the Curriculum, the Curriculum will prevail. This Curriculum is effective from July 2023.

Brief History of the Faculty of Pain Medicine in Ireland & Shield

(As told by Dr Camillus Power - Foundation Vice Dean 2007-2009, Dean 2009 – 2012)

'It begins with the design of a "syringe-like device". This was the first known prototype of such a standard tool in medicine, designed by surgeon Mr Francis Rynd in the Meath Hospital in 1844 to deliver a subvutaneous injection of morphine and creosote (akin to phenol) subcutaneously for the relief of facial pain in a patient. This historical event is represented in our Shield and Annual Lecture series which has attracted leading speakers from the International field of Pain Medicine.

Mr Francis Rynd (Surgeon Meath Hospital 1844) and the first syringe

More recently, Dr Hugh Raftery was a founding member of the British and Irish Pain Society in the 1970s. This existed as our Chapter of the International Association for the Study of Pain ('IASP'). We set up our own Irish Pain Society Chapter in 2001, led by Dr Róisín MacSullivan. The latter pioneered intrathecal drug delivery in Ireland, while Dr Declan O'Keeffe developed the field of neuromodulation and set up the first Irish Pain Management Programme in 1992. Dr Raftery and Dr Lorna Browne developed interventional facial pain procedures.

A meeting of an Advisory Group of Pain Specialists took place in the Dean's Office RCSI on the 21st March 1998, chaired by Dr Declan O'Keeffe, with representation from most pain specialists in Ireland. They discussed a pathway towards an Irish Pain Society and an exam. The Dean of the Faculty of Anaesthetists RCSI, Professor Howard Fee advised that the group have an all-Ireland focus, with representation from Northern Ireland. This naturally led to Dr Cooper's official group within the College. Dr John Cooper, ex Dean of the Faculty of Anaesthesia from Belfast, then chaired the Board of Pain Medicine set up by the College in 1999. This group successfully inaugurated the first Pain Medicine Diploma examination in

Europe in 2001 (held in the Pillar Room at the Rotunda Hospital and launched by then Minister for Health, Mr Micheál Martin). Dr Liam Conroy played a key role in nurturing and developing this exam – which took place on 3 occasions at the Mercy University Hospital Cork.

The Board evolved into the Foundation Pain Medicine Faculty in 2007 at the invitation of the Council of CAI and Dr David Hill from Council was appointed as the Foundation Dean. The Foundation Board included:

- Dr David Hill, Dr Declan O'Keeffe, Dr Hugh Gallagher, Dr Ray Victory, Dr Camillus Power, Prof Connail McCrory, Dr Joe Fitzgerald, Dr Róisin MacSullivan, Dr Frank Chambers, Dr Josh Keaveny, Dr Valerie Pollard, Dr Liam Conroy, Dr John Browne, Dr Donal Harney, Dr David O'Gorman, Dr Richard McEllestrim.

The Foundation ceremony with the award of Foundation Pain Medicine fellowships took place in the RCPI in 2008. The new Board elected Dr Power as Vice Dean to succeed as Dean in 2009-2012, followed in subsequent elections by:

- Dr Josh Keaveny (2012-15)
- Prof Connail McCrory 2015-18
- Dr Brendan Conroy (2018-2021)
- Dr Hugh Gallagher (2021 – 2024)

The Faculty submitted the application for specialty recognition in 2012 which was granted by the Medical Council in 2014. This Curriculum is part of the Medical Council Accreditation process and is led by Dr Therese O'Connor.

The Shield was granted to the Faculty in 2010 by the Chief Herald of Ireland.

The symbols and motto on the shield are well worked out and agreed with the Chief Herald. The Golden poppy represents analgesia and also links to the same symbol in the College grant of arms, the two golden bands meeting ajar represent "lightning" in heraldry. The Chief Herald and Faculty agreed that this could stand for neuromodulation, which is based on electricity and harks back to the use of electricity for pain in antiquity and the use of *Torpedo mamorata* (black torpedo fish) for the treatment of headaches in Roman times. The final symbol which looks like a dagger is taken from the Rynd family shield and is a nod to our greatest historical name in the origin of pain medicine. It also indicates pain interventions or procedures and, given that Francis Rynd was a surgeon, the symbol resembles a surgical instrument.

The red colour represents pain and the golden hue represents the physician, there was a long discussion at the time about using red and black as a complementary paring, which is common in heraldry, but we objected as we thought that the black might be too depressing. The red and gold combination look more uplifting - which leads nicely into the motto.

The origin of the motto is as follows - there is an ancient invocation in Sanskrit (see below) which is commonly recited at many medical meetings in India:

May all be Happy,
May all be Healthy,
May all see good things
And may no one be in misery of any sort

ॐ सर्वे भवन्तु सुखिनः सर्वे सन्तु निरामयाः । सर्वे भद्राणि पश्यन्तु मा कश्चिद्दुःखभाग्भवेत् । ॐ शान्तिः शान्तिः शान्तिः ॥	Om Sarve Bhavantu Sukhinah, Sarve Santu Nir-Aamayaah | Sarve Bhadraanni Pashyantu, Maa Kashcid-Duhkha-Bhaag-Bhavet | Om Shaantih Shaantih Shaantih ||

It is known as the "prayer of the wise"- we suggested to the Chief Herald that the last line captured the essence of a cognitive pain management programme where we teach patients to have a quality of life despite suffering from the persisting pain - in essence not to add misery to the pain - this was accepted as a motto but not in sanskrit! So, a Latin teacher (Mr Daniel O Connor at the John Scottus School) translated this for us and therefore we now have "*Nemo Sit in Miseria*" - let no one be in misery. The original sanskrit invocation was recited at the inaugural Faculty launch in RCPI in 2008 so there is that historical resonance to this motto.

Rynd Lecturers from 2012 - 2023:

2012: Dr Robert Levy (USA)
2013: Prof Michael J Cousins (Australia)
2014: Dr Michael Stanton-Hicks (USA)
2015: Prof Clifford Woolfe (USA)
2016: Prof Frank Huygen (Netherlands)
2017: Prof Andrew Rice (UK)
2018: Prof Ralf Baron (Germany)
2019: Mr Daniel Rawluk (Ireland)
2020: Prof Henrik Kehlet (Denmark)
2021: Prof Irene Tracey (UK)
2022: Prof Nadine Attal
2023: Prof Gisèle Pickering

International visitors of distinction to the Faculty of Pain Medicine:

- Dr Roger Gouke (Perth Australia), Dean of The Faculty of Pain Medicine in Australia and New Zealand made a presentation (see photo below) to Dr David Hill to welcome our new Faculty to the World Fraternity of Pain Medicine at the CAI ASM 2008

- The late Dr Tess Cramond (nee Brophy) one of the founders of Pain Medicine in Queensland Australia and a guest of honour at our inaugural Pain Medicine ASM in 2012 made a personal presentation of a work of art to the Faculty at the ASM formal

dinner in the College Board Room. Of note she had previously donated the Brophy Medal for College exams in honour of her Irish Australian parents.

Prof Jeanne Moriarty (President of CAI 2009 - 2012), Dr Tess Cramond, Dr Camillus Power – 2012

Introduction

The Faculty of Pain Medicine CAI (the 'Faculty' or 'FPM'), a faculty of the College of Anaesthesiologists of Ireland (the 'College' or 'CAI'), is the educational organisation in Ireland for Specialists in Pain Medicine and for specialists in training ('trainees') and is directly responsible for the education and training of specialists in Pain Medicine in Ireland. The Faculty provides a two-year training programme in Pain Medicine, undertaken in hospitals and clinical placements approved by FPM, leading to the specialist qualification of Certificate of Satisfactory Completion of Specialist Training ('CSCST') in Pain Medicine.

Scope of Practice in Ireland

The specialty of Pain Medicine is concerned with the study of pain from a bio-psychosocial perspective. Clinically, this incorporates the evaluation, treatment and rehabilitation of persons with chronic pain. The field spans three major clinical areas:

1. Acute pain:
    - post-operative, post-trauma, acute episodes of pain in medical conditions.
2. Chronic pain:
    - including more than 200 conditions described in the International Association for the Study of Pain ('IASP') Taxonomy*
3. Cancer pain:
    - pain due to tumour invasion or compression, pain related to diagnostic or therapeutic procedures, pain due to cancer treatment.

**Reference: "Part III: Pain Terms, A Current List with Definitions and Notes on Usage" (pp 209-214) Classification of Chronic Pain, Second Edition, IASP Task Force on Taxonomy, edited by H. Merskey and N. Bogduk, IASP Press, Seattle, ©1994.*

Aims of the Curriculum

The purpose of the curriculum is to define the required learning, teaching and assessment of the FPM training programme.

Specifically, the curriculum aims to:

- Articulate the scope of practice required by a Specialist in Pain Medicine, including breadth of knowledge, range of skills and professional behaviours necessary for quality patient care;

- Guide supervisors of training and other Fellows involved in the Training Programme with respect to suitable learning experiences for trainees;
- Foster trainees' self-directed learning by providing clear objectives;
- Promote regular and productive interaction between trainees and supervisors, through formative workplace-based assessments and feedback;
- Provide consistency of standards and outcomes across different training settings;
- Enable comparison with international training programmes with respect to standards of experience, education and assessment;
- Provide a framework to inform the scope of continuing professional development activities.

Key Sections Of The Curriculum

Part A: Overview and Training Regulations

Section 1: The Medical Council's Eight Domains of Good Professional Practice

Section 2: Training Regulations

Section 3: Examination Regulations

Part B: Clinical Components

Fundamentals/Foundation

Essential Topics

Appendices

Appendix 1: Training Diary and E-Portfolio

Appendix 2: Workplace Based Assessments

Appendix 3: In-Training Assessment Template

Appendix 4: List of Accredited Hospitals

Glossary of Terms

CURRICULUM & TRAINING DIAGRAM

Medical Council Eight Domains of Good Professional Practice

TWO YEAR POST CSCST TRAINING PROGRAMME
In-Training Assessments / Annual Progression Reviews

COMPETENCY COMPLETION
Fundamentals/Foundation and Essential Topics – Minimum Volumes of Practice / e-Portfolio / Workplace Based Assessments ('WBAs') / Clinical Case Series

FFPMCAI exam during 2nd year (after 18 months training)

CLINICAL COMPONENTS

Fundamentals/Foundation

1. Anatomy and Physiology of Pain
2. Pathophysiology of Pain
3. Epidemiology of Pain
4. Pharmacology Applied to Pain Medicine

Essential Topics

1. Bio-Psychosocial Aspects of Pain
2. Assessment of Pain and Pain-related Conditions
3. Acute Pain
4. Neuropathic Pain
5. Cancer Pain
6. Visceral Pain
7. Headache and Orofacial Pain
8. Neck and Back (Spinal) Pain
9. 9a) Musculoskeletal Pain (MSK) General and 9b) MSK Pain - Fibromyalgia Syndrome (FMS) and Chronic Widespread Pain (CWP)
10. Complex Regional Pain Syndromes
11. Problematic Substance Use
12. Psychiatry and Chronic Pain
13. Rheumatology and Pain
14. Pelvic Pain
15. Neuromodulation
16. Intrathecal Drug Delivery Systems
17. Pain Management Programmes (PMPs) and Pain Management Education Programmes (PMEPs)

Exit Interview

Specialist in Pain Medicine (CSCST after 2 years Pain Medicine Training Programme completed)

Part A: Overview and Training Regulations

SECTION 1. Medical Council Eight Domains of Good Professional Practice

The Medical Council has outlined 8 key areas or domains that constitute good professional practice in medical care within Ireland. These domains delineate a framework of competence that permeates the entire continuum of professional development from formal medical education to the maintenance of professional competence.

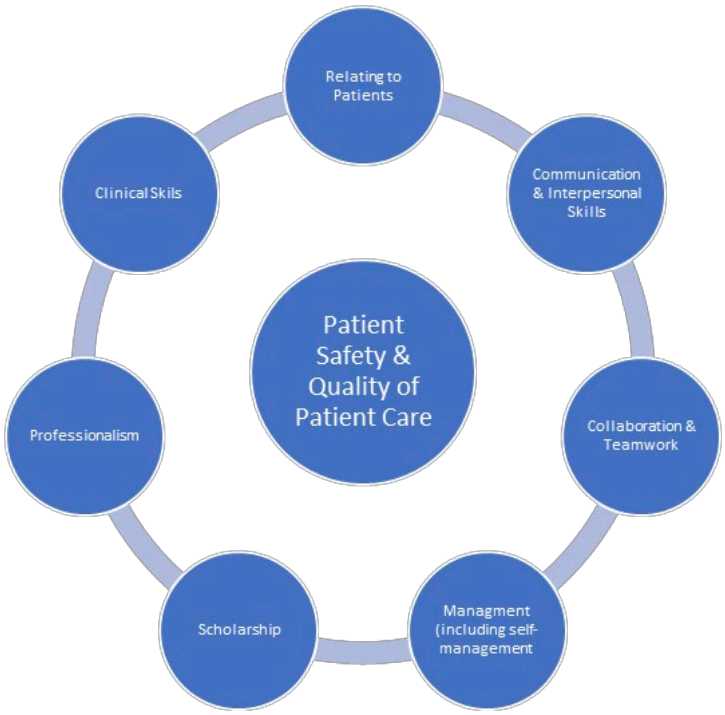


Figure 1: Eight Domains of Good Professional Practice (Medical Council)

'Good professional practice' encompasses much more than the development of robust knowledge and skills within pain medicine. Of additional importance to these more clinically orientated conceptions are the attitudes, knowledge and skills that contribute to a holistic philosophy of patient care. Each of the eight domains of good professional practice are briefly elaborated on in the following sections and are adapted from the Medical Council's Professional Competence Guidelines for Doctors.

Each domain description below is followed by key themes that the trainee needs to understand and put into practice.

1. Patient Safety & Quality of Patient Care

A Specialist in Pain Medicine has accountability to his/her patients, to the organisation where they are employed, to their professional body and to the Medical Council.

Patient safety is at the heart of everything overseen by the Faculty of Pain Medicine CAI ('the Faculty' or 'FPM') and underpins our training, education and examinations. We are committed to a culture of safety. The FPM has a deliberate commitment to ensuring patient safety and quality of care throughout training. Patient safety and quality of care has many dimensions and is positioned at the centre of all patient interactions so that the importance of patient safety and quality of care is daily reinforced.

The role of the Specialist in Pain Medicine includes being an advocate for patients and colleagues, demonstrating a commitment to patients through ethical practice, and actively contributing to the continuous improvement of health care quality and patient safety.

The World Health Organisation ('WHO') Patient Safety Curriculum Guide cites multiple opportunities to ensure patient safety. For the Specialist in Pain Medicine in the clinical setting, pertinent topics include infection prevention and control, patient safety and appropriateness of invasive procedures and improving medication safety. The full document is available at WHO Patient Safety Guide. The following key points have been identified for the Specialist in Pain Medicine trainee.

The Specialist in Pain Medicine trainee ('trainee') has a responsibility to:

Adhere to guidelines for infection prevention and control:

- Accept responsibility for minimising opportunities for infection transmission;
- Apply standard and transmission-based precautions;
- Educate patients and their families/visitors about clean hands and infection transmission.

Actively participate in measures to ensure patient safety associated with invasive procedures:

- Follow verification processes to ensure right patient, right side and right procedure (e.g. pre-procedure checklist);
- Practice techniques that reduce risks and errors (e.g. time-outs, briefings, debriefings, stating concerns);
- Participate in an educational process for reviewing mortality and morbidity;
- Actively engage as a team member;
- Actively engage with the patient at all times;
- Document all procedures in a legible and timely manner.

Understand and engage with practices to improve medication safety:

- Understand the issues and risks involved in the use of medication;
- Understand common sources of error;
- Understand the responsibilities associated with prescribing and administering medication;
- Know which medications are high-risk;
- Develop checking habits.

2. Relating to Patients

This involves a partnership built on mutual respect, confidentiality, honesty, responsibility and accountability.

One of the core tenets of good medical practice is a trusting relationship between patient and doctor.

The Specialist in Pain Medicine training programme aims to develop positive relationships with patients, which are characterised by trust and the involvement of patients and families as partners in their care.

By the end of training, the trainee will be expected to:

- Demonstrate cultural awareness and sensitivity with patients and colleagues;

- Describe how the special history of minority groups, e.g. travelling community, refugee community, impacts on their current health status, education and communication;
- Discuss how patients' culture and / or ethnicity can have an important effect on their health outcomes;
- Discuss the importance of understanding patients' cultures and responding to their individual needs;
- Discuss the importance of incorporating health beliefs of the individual / community into management modalities in a culturally sensitive manner;
- Discuss the importance of not discriminating against patients or colleagues on any grounds;
- Discuss the importance of treating all patients and people seeking access to health services with respect.

Understand basic communication techniques including informed consent. Describe how informed consent in pain medicine may be affected by the context in which it is obtained (as set out in Appendix C of the Guide to Professional Conduct and Ethics for Registered Medical Practitioners (amended) 8th Edition including:

- The amount of information the patient needs before making a decision about their care;
- The risks associated with the treatment being proposed, as well as possible complications and the chances of success / failure of the treatment;
- The requirement that the patient's ability to understand and communicate should be taken into account and every effort should be made to meet the patient's communication needs;
- The need to ask the patient if the information has been understood, whether further information is required, and whether he/she has any questions or would like more information about the proposed treatment;
- The understanding that consent is not a one-off event, but a continuing dialogue with the patient, keeping them up-to-date with any further treatments that might be available;

- That patients should be given enough time to consider their options and reach a decision about treatment being offered;
- That it is better not to seek consent from a patient who is stressed, sedated or in severe pain and, therefore, less able to make a calm and reasoned decision.
- That it is the duty and responsibility of the treating doctor to ensure that informed consent has been given, and that if delegated to a colleague, that he/she is able to explain the treatment and associated risks to the patient and to answer questions and discuss issues regarding the treatment with the patient;
- That the treating doctor must respect the patient's right to refuse or withdraw consent. In this situation, where possible, a referral for a second opinion should be offered;
- That issues around adult patients who do not have capacity to make a decision about treatment offered, that the principles outlined in the Medical Council 'Guide to Professional Conduct and Ethics for Registered Medical Practitioners' sections 9.1 – 10.6 are adhered to as much as is possible;
- That in the case of children and young people receiving treatment that issues around consent as outlined in the Medical Council 'Guide to Professional Conduct and Ethics for Registered Medical Practitioners' sections 18.1 – 18.8 are adhered to as much as is possible.

Demonstrate understanding of principles of confidentiality, including access to, content of, and security of records (as set out in Sections 29.1 – 31.3 of the Medical Council 'Guide to Professional Conduct and Ethics for Registered Medical Practitioners').

Understand the principles of open disclosure; Specific focus is placed on patient pertinent interactions in pain medicine.

To discuss all aspects of end of life care, including Advanced Healthcare Directives, and demonstrate sensitivity towards patients, families and colleagues in these circumstances.

3. Communication and Interpersonal Skills

Professional practitioners must possess excellent interpersonal communication abilities to enable the effective exchange of information and allow for positive collaborations. This encompasses working with patients and their families as well as other clinical and non-clinical colleagues and the general public.

As a communicator, the Specialist in Pain Medicine offers the patient a relationship with a professional who has particular interest and expertise in the pain, which is the focus of their concern and suffering. The Specialist in Pain Medicine is able to listen, interpret and explain the predicament and concerns of the patient in a broad bio-psychosocial framework.

By the end of training, the trainee will be able to:

Therapeutic Relationships

- Establish therapeutic relationships with patients, their families and carers;
- Communicate using a patient-centred approach that encourages patient trust and autonomy, and is characterised by empathy and respect;
- Demonstrate effective communication skills such as active listening, and attending to verbal and non-verbal cues;
- Optimise the physical environment for patient comfort, dignity, privacy, engagement and safety;
- Recognise and address miscommunication, and barriers to communication;
- Accurately explain relevant information, in both oral and written format;
- Document patient interactions in a legible and timely manner;
- Recognise and negotiate challenging communication situations, including conflict and emotionally charged situations:
- Be conscious of varying levels of health literacy and incorporate strategies to enhance communication e.g. use of plain language in written and verbal communication, incorporate teach-back method during consultation (by asking patient/family to repeat back what has been said to ensure comprehension).

Obtaining relevant information

- Gather, prioritise and synthesise information from a variety of sources about the patient's pain experience;
- Utilise appropriate personnel and resources to facilitate communication with patients from culturally and linguistically diverse populations;
- Utilise appropriate personnel and resources to obtain information from patients with communication impairment.

Sharing Information with Patients and Relevant Others

- Facilitate informed choices with respect to treatment options;
- Encourage shared decision-making;
- Respect diversity and difference and the impact these have upon decision-making;
- Provide patients with information regarding model of care, discharge and follow-up;
- Explain unanticipated complications to patients, their families and other healthcare providers;
- Assist patients and others to identify and make use of useful information and communication technologies;
- Share information with other professionals as appropriate;
- Demonstrate effective written and verbal communication skills tailored to audience, purpose, intent and context;
- Comprehensively document the assessment and agreed management plan for the individual patient;
- Demonstrate skills for communicating in medico-legal settings, with administrative bodies, consumer groups and the broader community.

4. Collaboration and Teamwork

Specialists in Pain Medicine should co-operate with their colleagues and be able to work effectively with healthcare providers and teams from a range of disciplines outside their respective area of expertise. They should ensure that clear lines of communication and systems for accountability are in place among all involved team members in order to protect their patients.

As a collaborator, the Specialist in Pain Medicine effectively works in a healthcare team to aim to achieve optimal patient care.

By the end of training, the trainee will be able to:

Work with healthcare professionals:

- Develop rapport, trust and ethical therapeutic relationships;
- Negotiate overlapping and shared responsibilities with inter-professional healthcare providers for episodic or ongoing patient care and safety;
- Participate constructively as a member of a multidisciplinary team;
- Demonstrate ability to work respectfully with other agencies involved in patients' care and wellbeing.

Practice effective co-operation and conflict mitigation:

- Demonstrate consideration for the professional perspectives, goals and priorities of all team members;
- Negotiate and work with others to minimise and resolve conflict;
- Respect and acknowledge differences, misunderstandings and limitations in oneself and other healthcare professionals that contribute to inter-personal tension(s);
- Participate in team debriefings and implement strategies to improve performance;
- Facilitate comprehensive referral to another service when necessary;
- Respond promptly to requests for assistance or advice;
- Effectively work with other healthcare professionals to prevent and resolve inter-professional conflict;
- Participate effectively and appropriately in the inter-professional healthcare team.

5. Management (including Self-Management)

A Specialist in Pain Medicine should have an understanding of how working in the health care system, delivering patient care and how other professional activities affect other healthcare professionals, the healthcare system and society in general. As leader and manager, the Specialist in Pain Medicine has the ability to make and manage decisions about resource allocation as may apply personally, professionally and at an organisational level, to provide leadership and to contribute to the effectiveness of the healthcare system.

By the end of training, the trainee will be able to:

Understand their role within the healthcare system:

- Contribute to the improvement of healthcare delivery in teams, organisations and systems;
- Define the characteristics underpinning the provision of quality patient-centred pain management services that are safe, effective, efficient and timely;
- Understand the financial, administrative and human resource requirements in order to manage a pain management unit;
- Contribute to the process of quality assurance, quality improvement and accreditation activities within their department/practice;
- Use and adapt systems to learn from adverse events and critical incidents;
- Identify the operational structures and their role in pain management service/practice;
- Demonstrate management in the allocation of resources. Allocate finite healthcare resources appropriately;
- Understand how to respond, manage and learn from a complaint or legal proceeding;
- Contribute to clinical governance, forums, committees and meetings at various organisational levels as appropriate;
- Develop efficient and effective work practices.

Have an approach to self-management:

The Faculty and the College is committed to supporting trainees' wellbeing throughout their working life. The Faculty advises trainees to monitor their physical and emotional wellbeing and to seek assistance early if they have any concerns or feel they are experiencing significant stress. A trainee has a responsibility to:

- Be committed to maintaining one's own health, and sustainable practice;
- Identify risks to personal physical and mental well-being;
- Adopt strategies to enhance personal and professional awareness and insight, such as developing a mentor relationship, peer support networks and strategies to mitigate stress;
- Organise, prioritise and delegate tasks in order to achieve manageable workloads;
- Develop leadership and effective management skills in professional practice;
- Demonstrate self-reflection to appraise and improve efficiency and effectiveness in the workplace;

Further information for resources for personal wellbeing are available on the College website.

Have an approach to support colleagues:

- Recognise and respond to other professionals in need, including understanding formal pathways for assistance;
- Appreciate professional obligations, and the interventions required, when a colleague is impaired or practicing beyond the limits of their capabilities;
- Promote a culture that recognises, supports and responds effectively to a colleague in need.

Understand how their daily practice influences society in general:

- Minimise the environmental impact of pain medicine and incorporate sustainability into their daily practice;
- Understand the contribution of the practice of pain medicine to the carbon footprint of healthcare practices;
- Support education, research and continuous improvement in sustainability.

6. Scholarship

A Specialist in Pain Medicine, like other medical practitioners, must acquire, understand and demonstrate the large body of knowledge at the forefront of learning within their specialty, as part of the continuum of lifelong learning. They must also demonstrate the capacity to source the best information and evidence to guide their practice as part of a commitment to scholarly activity.

As a scholar, the Specialist in Pain Medicine demonstrates active commitment to learning, to the creation, dissemination, application and translation of knowledge relevant to pain medicine, and to the education of their patients, students, colleagues and within the community.

The Specialist in Pain Medicine will be expected to engage in continuous enhancement of professional activities through ongoing learning:

By the end of training, the trainee will be able to:

Practice ongoing professional learning:

- Identify opportunities for further professional development and learning;
- Participate in relevant professional and educational development in pain medicine and apply insights in practice;
- Participate in practice evaluation, quality improvement and audit activities
- Maintain a record of professional competence by means of their training diary.

Critically appraise information:

- Contribute to the development of pain medicine by carrying out research and/or audit;
- Describe the principles of assessing scientific pain-related evidence, including:
    - Grades of evidence and methodologies and difficulties of combining evidence as in systematic reviews and meta-analyses/metasyntheses;
    - Databases such as Cochrane database of systematic reviews;

    - Influence of bias, chance, multiple comparisons and confounding variables in studies;
    - Publication bias;
    - Critically interpret and summarise advanced evidence-based knowledge with patients and interprofessional team understanding the strengths and limitations of pain management strategies.
- Critically discuss the involvement of patients in research
- Understand and uphold ethical principles guiding research in humans including:
    - Social and Clinical value;
    - Scientific validity;
    - Fair participant selection;
    - Favourable risk-benefit ratio;
    - Independent review;
    - Informed consent;
    - Respect for potential and enrolled participants;
    - Historical review of abuses of medical ethics.
- Demonstrate ability to integrate knowledge in the clinical and social sciences relevant to pain medicine;
- Describe the application and limitation of evidence-based medicine;
- Critically appraise scientific literature and translate evidence into decision-making about the care of the patients with pain;
- Demonstrates an understanding of research methodology, including the:
    - Principles of clinical epidemiology
    - Principles of biostatistics
    - Concepts of reliability, validity, sensitivity, specificity, bias, false positivity and false negativity;
- Identify learning needs, effective teaching strategies and desired learning outcomes;
- Demonstrate effective teaching of pain medicine;
- Provide meaningful feedback to others;
- Keep up to date with new knowledge and practices in pain medicine;
- Describe the principles and processes of research and scientific enquiry including:
    - Research ethics;

- Asking a research question;
- Conducting a systematic search for evidence;
- Selecting and developing appropriate statistical analysis;
- Formatting and processing for research papers for publication;
- Contribute to clinical trials and/or research projects.

Ongoing Professional Competence, and demonstration on scholarship should be documented in the training diary (e-logbook), see Appendix 1: Training Diary and E-Portfolio. The training diary is a reflection of the requirements of the CAI Professional Competence Scheme ('PCS'). All doctors registered and working in Ireland have a legal duty to maintain a record of their professional competence.

7. Professionalism

Specialist in Pain Medicine, like all medical practitioners, must show a commitment to upholding the standards outlined in the Medical Council's 'Guide to Professional Conduct and Ethics for Registered Medical Practitioners' 8th Edition, 2019.

As a professional, the Specialist in Pain Medicine has a unique role arising out of their advanced knowledge of the phenomenon of pain and its complex expression in people. Such work requires mastery of a complex skill set and the knowledge underpinning this, in addition to the art of medicine. The Specialist in Pain Medicine is committed to the health and wellbeing of individuals and society through ethical practice, characterised by high personal standards of behaviour, accountability and leadership.

By the end of training, the trainee will be able to:

- Discuss bioethical principles of justice, autonomy, beneficence and non-maleficence;
- Demonstrate ethical behaviours in relationships and practice with patients and colleagues, including honesty, integrity, commitment, compassion, respect and altruism;
- Demonstrate understanding of the responsibilities involved in continuing care of patients with complex pain conditions and the need to make arrangements to transfer their care if one is in unable to continue to provide care due to illness or other reasons;
- Recognise limitations of expertise and seek guidance where appropriate.

- Recognise and respond to ethical issues encountered in practice, including conflict of interest (as set out in sections 62.1 – 62.8 of the Medical Council 'Guide to Professional Conduct and Ethics for Registered Medical Practitioners') including:
    - that financial considerations must not be allowed to influence or appear to influence management of patient. Patients must be informed about any beneficial interest of the doctor, or a close family member of the doctor, in a private clinic, hospital, pharmacy or other institution to which he/she proposes to send a patient for investigation or treatment;
    - that if associated with private clinics or hospitals that the doctor must make sure that the services offered to patients conform to the clinical and ethical standards of the medical profession;
    - that gifts should not be accepted from pharmaceutical, medical devices or other commercial enterprises, excluding attending educational meetings or accepting reasonable fees for professional services to commercial bodies;
    - that doctors should be aware that even low-value promotional materials can influence prescribing and treatment decisions;
- Demonstrate professional integrity and ethical conduct in response to industry marketing strategies;
- Ensure that provision of information to the public and advertising is provided in accordance with Medical Council guidelines (sections 44.2 - 44.6 of the Medical Council 'Guide to Professional Conduct and Ethics for Registered Medical Practitioners') including:
    - The need for information published to be factually accurate, evidence-based and not misleading;
    - That letter headings, prescriptions and all other documentation related to a doctor's practice as well as advertising principles should be in accordance with Medical Council guidance.

That telemedicine should be in accordance with Medical Council guidance (sections 43.1 – 43.4 of the 'Guide to Professional Conduct and Ethics for Registered Medical Practitioners') including:

- That telemedicine that is provided within the state should be provided by a doctor who is registered with the Medical Council of Ireland;
- That the same standards of good practice as set out in the Medical Council 'Guide to Professional Conduct and Ethics for Registered Medical Practitioners'for traditional medical practice are applied to telemedicine, in particular:
    - the need to make sure that patients have given their consent to conduct a consultation through telemedicine and consent to any treatment provided;
    - the requirement to follow Medical Council guidance on advertising of websites or similar media;
    - the need to protect the privacy of patient information through effective security measures;
    - the need to protect patients' privacy by following Medical Council guidance on confidentiality and medical records;
    - That there remains the requirement to comply with data protection principles if any patient personal information is transferred to other jurisdictions;
    - That the patient's General Practitioner should be informed of the consultation.
- That the doctor providing telemedicine services should satisfy himself/herself that the services being provided through telemedicine are safe and suitable for patients. The doctor should explain to patients that there are aspects of telemedicine that are different to traditional medical practice for example, a consultation through telemedicine does not involve a physical examination, and any additional risks that might arise as a result.

Demonstrate knowledge of the Legal and Regulatory environment involved in providing a pain medicine service including that they should:

- Be aware of the Principles of Freedom of Information legislation (See Appendix A of the Medical Council 'Guide to Professional Conduct and Ethics for Registered Medical Practitioners');
- Be aware of the relevant Information on Confidentiality (Appendix B, Medical Council 'Guide to Professional Conduct and Ethics for Registered Medical Practitioners');

- Be aware of legislation on Information for Patients before giving Informed Consent (Appendix C, Medical Council 'Guide to Professional Conduct and Ethics for Registered Medical Practitioners');
- Adhere to the regulatory and legal obligations required of practice in Ireland;
- Recognise and respond to others' unprofessional behaviour, which may include notification to regulatory authorities;
- Demonstrate detailed knowledge of regulations with respect to controlled substances in Ireland;
- Demonstrate detailed knowledge of the regulations regarding the use of cannabinoids in Ireland;
- That the Medical Council Guidance on Prescribing is adhered to and, in particular, that the doctors practicing pain medicine are aware of the dangers of drug dependency, especially opioid dependency in patients with chronic pain (section 42.7 in Medical Council 'Guide to Professional Conduct and Ethics for Registered Medical Practitioners').

8. Clinical Skills

The development and maintenance of professional capability in the domain of clinical skills in pain medicine is required.

As a clinician, the Specialist in Pain Medicine dynamically applies high-level knowledge, skills and professional attitudes in the practice of pain medicine across stable, unpredictable and complex situations.

This Specialist in Pain Medicine requires in particular, the skills and knowledge to be acquired during the course of pain medicine training.

The clinical skills to be acquired during training are outlined in Part B: Clinical Components. Competence should be demonstrated through the achievement of minimum volume of practice, and workplace based assessments, as outlined at the end of each section in Part B: Clinical Components and Appendix 2: Workplace Based Assessments. This fulfils the

requirement to demonstrate and provide evidence of best practice for patient care, which lie at the forefront of the discipline.

By the end of training, the trainee will be expected to:

- practice medicine within their defined scope of practice and expertise;
- perform a complete patient-centred clinical assessment and establish a management plan;
- demonstrate proficient and appropriate technical and procedural skills;
- demonstrate safe, effective and efficient patient centred care;

These eight domains of good professional practice are not unique to Specialist in Pain Medicine training and professional practice in pain medicine and are applicable in all contexts of medical practice for all doctors practicing in Ireland.

SECTION 2. Training Regulations

Governance

The Faculty of Pain Medicine CAI (the 'Faculty' or 'FPM') of the College of Anaesthesiologists of Ireland (the 'College' or 'CAI') has overall responsibility for the implementation and maintenance of the Specialist Training Programme in Pain Medicine ('the Training Programme' or 'Programme'. The FPM is governed by the Constitution of the College as overseen by the Council of the College ('Council') and reports to the Training Committee of the College. This Committee oversees all training programmes of the College. The FPM is responsible for the following:

- Approval of hospital training posts;
- Recruitment of trainees for the Training Programme;
- Allocation of trainees to approved hospital posts ('rotations');
- Assessment and progression of trainees during the programme;
- Recommendation for the award of Certificate of Satisfactory Completion of Specialist Training in Pain Medicine ('CSCST').

The day to day operation of the Training Programme in Pain Medicine is managed by the FPM supported by the CAI Director and Deputy Director of Training. The day to day administration is carried out by the Faculty Administrator. The FPM comprises the following:

- The Dean of the Faculty;
- Vice-Dean;
- Honorary Secretary;
- Examinations Chair;
- Training / Hospital Accreditation Chair;
- Credentials Chair;
- Trainee Representative;
- General Practice Representative;
- Surgery Representative;
- Lay Representative.

Structure of the Training Programme

Training in Pain Medicine, like that of Specialist Anaesthesiology Training ('SAT') and Intensive Care Medicine ('ICM') training, comprises a programme of training, assessment, formal

examination and accreditation which is organised and regulated by the Faculty, through the CAI.

The minimum programme duration is two years which is undertaken following completion of a recognised base specialty programme, usually Anaesthesiology. Transition from Year 1 to Year 2 is subject to satisfactory in-hospital assessment and a satisfactory Progression Review.

At the end of Year 2, the award of CSCST is subject to:

- successful completion of the Fellowship in Pain Medicine examination;
- successful completion of all clinical competencies and Workplace Based Assessments ('WBAs')
- successful completion of the Clinical Case Series and
- a satisfactory Exit Interview.

Entry to the Specialist Training Programme in Pain Medicine

Recruitment to the Training Programme is managed by the FPM Administrator. The Training Programme runs from July each year. Applications are invited through advertisement on the FPM website, usually in September for appointment the following November / December and commencement on the programme in July. Entry to the programme is by competition including interview(s).

Application Criteria

- Applicants must have completed training in a recognised base specialty, e.g. CSCST in Anaesthesiology (CAI certification is in Anaesthesiology, Intensive Care and Pain Medicine). An applicant who has undertaken their anaesthesiology training outside of the CAI National Specialist Anaesthesiology Training Programme and has applied for entry to the specialist division of the register for anaesthesiology, may apply to the Pain Medicine Training Programme. If successful at interview, entry will be contingent on the success of their Specialist Register application prior to the start date of training, i.e. the Medical Council must have confirmed that they have met the criteria for entry to the anaesthesiology division of the register;

- No retrospective recognition will be allowed for pain medicine experience gained prior to entry into the Training Programme i.e. the full minimum two years training must be completed in Ireland for all applicants appointed;
- Application must be accompanied by the appropriate fee and any stipulated certificates as required;
- Applications must be submitted by the advertised closing date.

Appointment of Trainees

- Successful applicants will receive a formal notice of appointment and will be required to sign a Training Agreement before commencing the Training Programme. The Training Agreement sets out the conditions applicable to the trainee's participation on the programme but is not a contract of employment;
- Successful applicants may not defer their place on the Training Programme to the following year;
- Successful applicants will remain on the Trainee Specialist Register for the duration of the Programme.

Appointment to allocated hospital

- On appointment, trainees will be allocated to a training hospital and to a Supervisor of Training (the 'supervisor'). Trainees will have been ranked at interview and may choose from the available rotations in accordance with their ranking (subject to approval by the FPM, ensuring that the trainee gains experience in pain medicine in different hospital settings). A trainee will be allocated four six-monthly rotations during the two-year programme;
- The trainee will be contacted by the Medical Manpower Department of each hospital before the commencement of a 6/12 rotation to arrange the contractual aspects of their employment. The Faculty has no function in contractual matters or salary issues between trainees and their employers;
- For each rotation the trainee will receive a contract of employment from the training hospital setting out the terms and conditions of the trainee's employment for that period. The training hospital, as the employer, and not the Faculty, will be responsible for the remuneration of the trainee and all management issues to include payroll,

reporting lines, organisation of working time, allocation of tasks, annual leave, workplace grievances and disciplinary issues;

- Employment at a training site is subject to the local recruitment and other employment policies. No contract of employment will exist, at any time, between the Faculty or College and the trainee. Workplace grievances relating to conditions of employment must be addressed with the employer;
- Trainees should familiarise themselves with the medical and well-being supports available at a local level and within the broader hospital environment.

Examination Requirements

Trainees are required to complete the Fellowship Examination (FFPMCAI) to enable them successfully complete the Programme. Full details of the examination requirements are outlined in the Examination Regulations in Section 3.

Progression

A formal progression review takes place at the end of Year 1 when Workplace Based Assessment ('WBA's), supervisor reports and the trainee's e-portfolio are assessed. This process is summative, with oversight at the level of the Faculty. The trainee may only progress on successful passing of the progression review.

Award of CSCST

To be awarded a CSCST in Pain Medicine, a trainee must meet all of the requirements in this section:

Experience

- Rotate to hospital sites as allocated by the Faculty. Rotations are designed to ensure all competencies can be achieved within the two-year Training Programme although the Faculty reserves the right to require further training or assessment;
- Provide evidence of sufficient case mix by means of an up to date log book which should reflect the minimum volume requirements outlined in the Guide to the Clinical Components of the Curriculum;
- Complete on-call duties to maintain anaesthesiology skills and where appropriate additional on-call duties to pain medicine;
- Successful completion of the Clinical Case Series.

Knowledge

- Successful completion of the FFPMCAI examination;
- Completion of the Cadaver Based Procedure Course.

Competency

The trainee demonstrates satisfactory standards of competence in all elements of observable and measurable knowledge, skills, abilities and professionalism which contribute to the safe and efficient delivery of pain medicine services and:

- The trainee demonstrates the ability for independent clinical practice with clinical judgement to safely plan and deliver care with a range of techniques;
- The trainee performs at the expected standard for each of the clinical units;
- The trainee demonstrates excellence in all domains of Good Professional Practice.

Full details of the skills and competencies, together with assessment and sign off requirements are outlined in Part B Clinical Components. A summary of the competencies is outlined under Structure of the Curriculum.

A trainee in pain medicine is required to engage with their supervising consultant to develop their competencies, skills, dexterity and professionalism in clinical practice. This is documented using workplace based feedback reports / tools namely Case Based Discussion (CBD), Direct Observation of Procedural Skills (DOPS) and Mini Clinical Evaluation Excercise (Mini-CEX). These documents should be recorded in the trainee's e-Portfolio. The numbers required for each competency are outlined in Part B Clinical Components.

Progress towards achieving these competencies will be monitored by the supervisor on behalf of the Faculty on an ongoing basis.

Achievement of the competencies can be finalised during the In-Training Assessment process ('ITA') by the supervisor assigned to each trainee and confirmation will be by means of the Progression and Exit Interviews undertaken by the Faculty.

Professionalism

Trainees will have completed the Professionalism in Practice Module as part of their base specialty training. In addition, trainees are required to demonstrate:

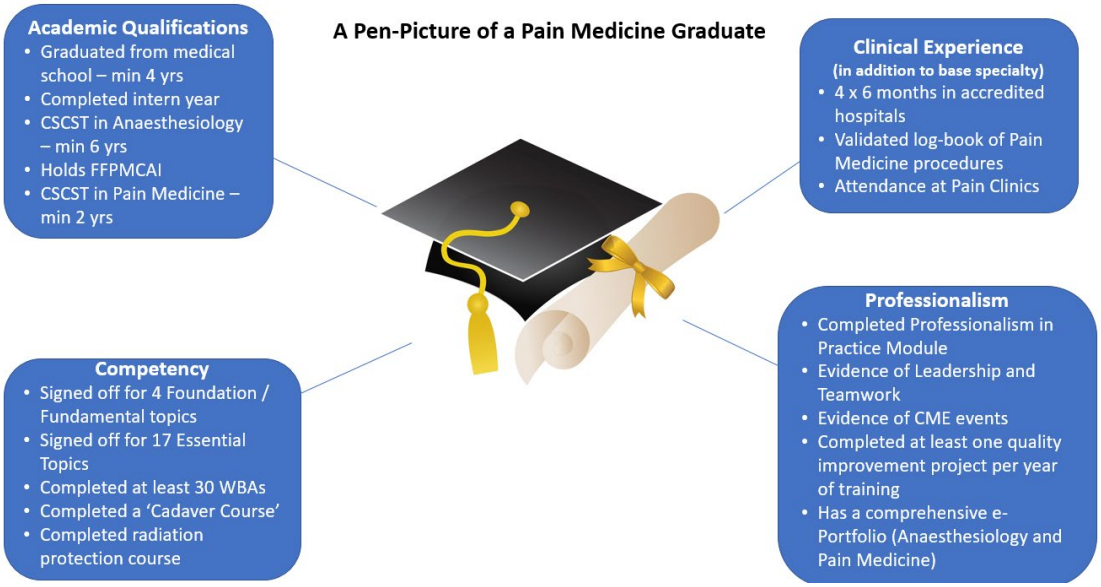
- Evidence of Leadership and Teamwork – experience in leading a multi-disciplinary team, leading a chronic pain clinic, liaising with other healthcare professionals, management of a teaching programme, completion of audits, presentation of research, audit or case series at hospital or Faculty event;
- Contribution to the broader pain medicine community, e.g. role of representative on the Faculty, membership of other professional bodies, use of non-clinical time and special projects, e.g. with the Faculty, the Irish Pain Society / volunteering for Careers / Open Days;
- Completion of the training diary (see Appendix 1: Training Diary and E-Portfolio) to demonstrate:
    - Attendance at educational events organised by the Faculty, CAI, Hospitals and Societies
    - Completion of one quality improvement project which may be an audit per year of training. Clinical Audit can be defined as the "systematic review and evaluation of current practice with reference to research based standards to improve patient care." The setting of standards, measurement of practice compared to 'gold standard', identification of deficiencies and addressing deficiencies (closing the loop) is an accepted model of clinical audit as defined by the Medical Council;
- Maintenance of log book as outlined under Experience above;
- Completion of the e-Portfolio as outlined in the Clinical Components Section;
- Evidence of engagement with the prescribed number of Workplace Based Assessments as outlined in the Clinical Components Section. Further information regarding Workplace Based Assessments is outlined in Appendix 2: Workplace Based Assessments

Review of a trainee's progress under the four headings above – **Experience, Knowledge, Competency and Professionalism -** will be carried out at the bi-annual ITA and Progression

Review from Year 1 to Year 2. In order to be awarded a CSCST in Pain Medicine CAI, a trainee must meet all the requirements under these four headings and complete a satisfactory exit interview.

Qualification in Pain Medicine

Holders of the CSCST in Pain Medicine are Specialists in Pain Medicine who have been trained in all aspects of the assessment, management, including interventional procedures, for acute pain, chronic pain and cancer pain. Of note, all participants will already have completed a six-year programme in Anaesthesiology, Intensive Care and Pain Medicine with a special emphasis on acute pain and regional anaesthesia. A 'Pen-Picture' of a graduate of the Specialist Training Programme in Pain Medicine is illustrated below:



Right to decline to award CSCST

The FPM reserves the right to decline to award a CSCST in circumstances where any of the requirements set out in detail in the above section Award of CSCST are not complied with by the trainee. To summarise, the circumstances under which a CSCST will not be awarded are outlined below:

Experience

Failure to complete any of the requirements under the 'Experience' section of the Award of CSCST above, including but not limited to:

- Failure to satisfactorily complete one or more rotations as allocated;
- Failure to maintain the log book as required and / or failure to meet minimum volume requirements;
- Failure to satisfactorily complete appropriate on call duties;
- Failure to satisfactorily complete the Clinical Case Series.

Knowledge

- Failure to successfully complete the FFPMCAI examination within proscribed timelines;
- Failure to successfully complete the Cadaver Based Procedure Course.

Competency

Failure to complete any of the requirements under the 'Competency' section of the Award of CSCST above, including but not limited to:

- Failure to satisfactorily complete the prescribed number of workplace based feedback reports;
- Failure to achieve the expected standard within each clinical unit, as stipulated in the Structure of the Curriculum.

Professionalism

Failure to complete any of the requirements under the 'Professionalism' section of the Award of CSCST above, including but not limited to:

- Failure to demonstrate appropriate levels of leadership, professional and / or teamwork;
- Failure to complete the training diary to the standard required;
- Failure to satisfactorily maintain a record of workplace based feedback reports / tools.

Progression Through Training

Overview

Training is structured across the two years of the programme with a summary of each year as follows:

Year 1

The focus during Year 1 will be on the pain medicine roles in clinical practice. Adherence to the Medical Domains of Good Professional practice is the foundation of training. The aims of training in Year 1 are:

- To be able to take an accurate history relating to pain medicine and perform an accurate physical examination;
- To understand the indication, contraindications and side effects of the medications used in pain medicine therapy;
- To understand the role of physiotherapy and clinical psychology;
- To understand the indications for and interpretation of radiological assessment and blood assessment relevant to pain medicine;
- To learn to develop an integrated and comprehensive treatment plan for patients with chronic and cancer pain and to develop effective communication skills with patients and their families;
- To participate in multi-disciplinary treatment discussions regarding the development of a treatment plan;
- To learn the indications, performance and post-interventional management of pain intervention procedures.

Year 2

The focus during Year 2 is to develop the learning achieved after successful completion of Year 1. The focus is principally on developing interventional skills, collaboration with other disciplines, involvement in research and audit and developing a greater degree of clinical independence particularly in the last quarter of training. Key aspects for Year 2 include:

- The indications, performance and post-interventional management of pain medicine interventional procedures;
- Developing effective communication skills with patients and their families;
- Integrating fully into a collaborative approach with both medical specialists and others such as physiotherapy, psychology and occupational therapists.

Clinical Case Series

Each trainee is required to complete a Clinical Case Series during the course of the two-year programme. At some stage, during the course of the first six months or shortly thereafter, the trainee identifies 3 patients to follow through from initial consultation to eventual outcome. These cases can be selected from one area of interest in pain or from three different areas.

The object of the exercise is to ensure that the trainee has a comprehensive understanding of patient assessment and therapeutic interventions. Furthermore, that the trainee demonstrates an extended scope of practice that may consider alternative therapeutic options including inputs from current research, audits and consensus statements. It is also an opportunity for the trainee to share their reflective practice in preparing this case series. In summary, this is an opportunity for the Faculty to develop the professionalism of a future consultant in pain medicine.

The requirements and means of assessment will be determined by the Faculty and notified to the trainees at the start of Year 1.

Determination of Progression

Ultimate progression of trainees is determined by the Faculty. Assessment of trainees takes two forms:

- in the hospital with the supervisor during each six-month rotation;
- by means of a Progression Review, held annually and conducted by the Faculty.

Note: *Assessments carried out in the hospital are considered to be formative, whereas the Progression Reviews held by the Faculty are considered summative, i.e. they must be completed successfully for a trainee to progress.*

Courses

All trainees on the Programme will have completed the two mandatory courses relating to Professionalism:

- SAT 1 Professional Competence Development Programme

- Professionalism in Practice Module

In addition, trainees will be expected to complete the following courses:

- Cadaver Based Procedure Course – available through the FPM;
- Radiation Safety Course – completion of this course is a Medical Council requirement for any doctor using x-ray equipment and is available in a number of hospitals.

Trainees should make arrangements to complete these courses and upload the certificates to their e-Portfolio.

Commencement of Training

On commencement of each rotation, the trainee will meet with the supervisor and agree training objectives for the following six months. The agreed objectives should be recorded on the trainee's e-Portfolio. In all circumstances, the trainee and supervisor should arrange a further meeting at the mid-way point of the rotation to ensure that these objectives are being met, and again at the end of the rotation, and maintain a record of these meetings on the trainee's e-Portfolio. Objectives and completion of competencies should be discussed at the beginning of each rotation.

Assessment of Training

There is a two-fold approach to the assessment process:

- continuous assessment throughout each hospital rotation, culminating in a formal In-Training Assessment ('ITA') at the end of each six months, a Progression Review at the end of Year 1 and an Exit Interview at end of Year 2;
- competency completion, where the trainee's completion of the clinical components is assessed on an ongoing basis through use of Workplace Based Assessment ('WBA') tools, i.e. Case Based Discussion ('CBD'), Direct Observation of Procedural Skills ('DOPS') and Mini Clinical Evaluation Excercise ('Mini-CEX') leading to eventual 'sign off' for each competency. Assessment of competencies is outlined in detail in Part B: Clinical Components.

The sections below outline the In-Training Assessment, Progression and Exit Review processes. In general, responsibility for monitoring of pain medicine trainees lies with the pain medicine consultants within the Department of Pain Medicine in their hospital, which

usually operates within the Department of Anaesthesiology. For the purposes of the Curriculum, 'Hospital Department' is the term used to refer to the area with responsibility for pain medicine training within the accredited training site.

In-Training Assessments ('ITA') – Summary

The ITA Process is conducted by the Faculty assigned Supervisor of Training (the 'supervisor') within the Hospital Department of the accredited hospital and is an integral part of the assessments for the Training Programme. It complements other assessments, such as the Fellowship in Pain Medicine examination, by assessing trainee performance in the workplace. The ITA report to the Faculty is the end result of a six-month long process with three well defined stages, outlined in further detail below.

The ITA Process in Detail

The goals of the ITA Process are to:

- Discuss and set appropriate clinical and educational goals for the training period for each trainee;
- Ensure that both the Hospital Department and trainee expectations are understood and agreed so that a realistic plan for the period is confirmed;
- Assess a trainee's progress towards obtaining the agreed clinical and educational goals;
- Provide trainees with regular, constructive feedback;
- Develop any remedial activities that may be required to ensure that the trainee is performing at or above the level expected for their stage of training.

Start of each six-month rotation

- Trainee and supervisor meet to set objectives for the six-month rotation, identifying required modules, competencies, educational activity, examination preparation and course attendance. The agreed objectives should be recorded on the trainee's e-Portfolio;
- The Hospital Department should be aware of agreed objectives so that the trainee can be facilitated in meeting their objectives.

Middle of each six-month rotation

- A departmental meeting of consultants involved in training should be held in the hospital half way through the six-month period;
- The progress of each trainee should be discussed including assessment of progress towards meeting goals and objectives using the log book and feedback forms (CBD, DOPS and Mini CEX);
- The supervisor should meet with each trainee to discuss progress and understand how the trainee views their own progress. A record of these meetings should be noted on the trainee's e-Portfolio.

Trainee not progressing at middle of rotation:

In the event that it is identified at this stage that a trainee is not progressing in terms of their skills and training in line with expectations, the supervisor should arrange to meet the trainee and the steps outlined below should be followed:

- Identify areas that need to be addressed by clearly explaining deficiencies and communicating the expected standard;
- Put in place appropriate supports e.g.:
    - Targeted training involving closer additional supervision and more frequent feedback on progress;
    - Intensified supervision or opportunity for repeat experience.
- Ensure that steps are agreed with the trainee;
- Set a date for progress to be reviewed ensuring enough time is allowed for the trainee to have made progress;
- The supervisor should organise individualised learning experiences if appropriate to assist with difficulties with examination preparation or presentation technique, acquisition of clinical skills or interpersonal skills development. The trainee has a responsibility to actively participate in these activities;
- Document each meeting and have document signed by supervisor and the trainee.

The above steps are to ensure that the trainee is not presented with issues regarding their progress at a time when it is too late to remedy.

End of the six-month rotation

- A departmental meeting should be held in the hospital at least two weeks prior to the end of the six-month training period at which each trainee's progress will be discussed in advance of completion of the ITAs. The ITA template is available within the e-Portfolio and a copy is included in Appendix 3: In-Training Assessment Template
- In advance of this meeting the supervisor should ensure that each trainee has supplied them with a summary of their logbook activity for the six-month period. This will provide the department with the scope of clinical activity the trainee has been exposed to and will contribute to departmental assessment and signing off for each unit;
- If requested to do so, the trainee should provide further evidence, including a summary of their training diary, WBAs and reflective practice in advance of the departmental meeting;
- All the consultants in pain medicine should be in attendance at the meeting or, if unable to attend, consulted in advance to inform the meeting. Given the fact that the trainee will be performing duties in the wider department of anaesthesiology, input from the Anaesthesiology Department should form part of the review as should input from the multidisciplinary team;
- The clinical progress of each trainee should be discussed and assessed by reference to the criteria outlined in the Part B: Clinical Components;
- A consensus opinion of consultants present should then be entered on to the ITA for disclosure to the trainee;
- The supervisor should arrange individual meetings with each trainee where the trainee has an opportunity to discuss their assessment with the supervisor and to receive feedback;
- If the trainee is in agreement with the ITA, electronic sign off on the e-Portfolio should be completed by both the trainee and the supervisor;

- The supervisor is responsible for completing the ITAs online. The details of the assessment should always be discussed with the trainee and this should be indicated on the ITA.

Unsatisfactory ITA

In the event that a trainee who had been identified as not progressing in line with expectations at the mid-point assessment, or earlier, and the steps outlined above have not resulted in sufficient progress being made, the trainee should receive an 'Unsatisfactory' marking on the on-line ITA form with the reasons clearly documented and explained to the trainee;

- If the trainee is not in agreement with the assessment, this should be referred to the Faculty;
- An 'Unsatisfactory' ITA should be notified to the Faculty Administrator in advance of the trainee's Progression Review or on completion in the case of a July – January rotation. Refer to **Trainee not progressing in line with expectations** below for next steps.

Confirmation of Competencies

- At the end of the rotation meeting, agreement should be reached between the supervisor and the trainee regarding completion of competencies. This should be in line with the criteria outlined in the Part B: Clinical Components and evidenced by up to date log book entries;
- The supervisor should complete on-line sign off for each competency as appropriate. The number of procedures outlined in Part B is indicative only. Ultimately, sign off of any competency is determined by the Supervisor based on assessment of procedural performance.

Note regarding leave:

Where a trainee has been on leave, other than annual leave, during the six-month period, satisfactory sign off requires that at least 3 months with full and appropriate on call duties have been completed.

Progression Review

A Progression Review meeting is held at the end of Year 1 where one or more members of the Faculty and the Faculty Administrator will arrange to meet each trainee. This provides an opportunity for both the Faculty and the trainee to discuss training progress and for the trainee to provide feedback on the programme.

Reviews will be organised by the Faculty Administrator and at least two weeks' notice will usually be provided. It is mandatory for trainees to attend.

The progression review will also provide an opportunity for discussion on reflective practice examples carried out by the trainee (see Appendix 1: Training Diary and E-Portfolio).

The Progression Review meeting is an integral part of the programme. It provides an opportunity for the Faculty to establish that a trainee is progressing according to expectations and to identify at an early stage if intervention is required. It is essential that the trainee prepares appropriately for this review meeting.

At the interview, each trainee should bring:

- Summary of their log book;
- Summary of their training diary;
- Summary of their workplace based assessment e-portfolio;
- Evidence of reflective practice.

The Faculty will bring:

- Previous ITAs;
- Up to date information on competencies completed;
- Examination results.

The trainee's progress will be discussed in detail. Where the review is considered satisfactory, the Faculty will confirm progression.

It is expected that any trainee whose progress is not considered satisfactory will have been identified in advance of the progression review, during the course of the ITA process. In the

event that the progression review is not satisfactory the process outlined below will be followed.

Trainee not progressing in line with expectations

Where either a supervisor, or a trainee themselves, identifies that a trainee is experiencing difficulty with any element of the programme, be that from a clinical or knowledge perspective, the matter should be referred to the Faculty Administrator. Any steps taken will be in recognition of the senior status of the trainee, e.g. someone who has successfully completed a six-year specialist programme. The 'Trainee in Difficulty' process outlined below is designed to assist supervisors and the Faculty to support the trainee in addressing any issues identified.

Unless the issues are serious, i.e. threaten patient safety, or are reasonably believed to represent professional misconduct, the approach for training issues is one of a staged response providing support and remedial strategies to improve performance. The objective is to overcome difficulties in a supportive, holistic and collaborative manner within a specified timeframe. Where an issue arises which is reasonably considered to be serious or is reasonably believed to represent professional misconduct, the Faculty reserves the right to suspend the trainee, as a precautionary measure, from the Pain Medicine Training Programme pending the outcome of any investigation, disciplinary process or Medical Council process which is implemented.

Trainee in Difficulty Process

Where a trainee has received an 'Unsatisfactory' marking in an ITA as outlined above or separately identified as experiencing difficulty by a supervisor, the trainee should be invited to meet with representatives of the Faculty. The meeting should proceed as follows:

- Set aside a formal time for the meeting, providing sufficient advance notice to the trainee;
- Provide the trainee with the opportunity to give their own assessment, allowing them to identify and discuss any difficulties they may be experiencing;
- Identify areas that need to be addressed by clearly explaining deficiencies and communicating the expected standard;

- Put in place appropriate supports e.g.
    - Targeted training involving closer additional supervision and more frequent feedback on progress;
    - Intensified supervision or opportunity for repeat experience;
- Ensure that steps are agreed with the trainee;
- Set a date for progress to be reviewed ensuring enough time is allowed for the trainee to have made progress;
- The supervisor should organise individualised learning experiences if appropriate to assist with difficulties with examination preparation or presentation technique, acquisition of clinical skills or interpersonal skills development. The trainee has a responsibility to actively participate in these activities;
- Document each meeting. The document must be signed by the Faculty representatives and the trainee.

If these steps do not result in sufficient progress being made, the matter should be reported to the Faculty Board where consideration will be given to providing extended training time. Where it is viewed that the difficulties identified can be corrected within a defined time period of not greater than 6 months, the Faculty can propose to the trainee that their programme be extended for a further 6 months.

If the trainee is in agreement, an additional six month rotation will be arranged. During this extended time period, the matter will be considered as remaining live. If after this extended training time the trainee difficulties previously identified remain, the Faculty will determine whether it is appropriate for the trainee to continue on the programme. Where the trainee feels that the decision of the Faculty regarding their clinical progress is unfair, they have a right to appeal the decision. The appeals process is outlined under Trainee Appeals Process below.

Note regarding documentation: *It is essential that proper records of discussions and any actions agreed with the trainee are maintained by the Supervisor of Training. The trainee's acknowledgment should be obtained by means of their signature on the appropriate documents, e.g. action plans, intermediate assessments etc.*

Exit interview

For trainees completing their second year of the Programme, a formal exit interview will be arranged by the Faculty after completion of the Fellowship Examination and the Clinical Case Series interview. The purpose of the review will be to ensure that all training requirements have been completed and all competencies signed off. In addition, the trainee's feedback on the programme will be sought and their plans post-qualification ascertained.

The trainee should bring the following to the interview:

- A summary of their log book;
- A summary of their training diary;
- A summary of ther workplace based feedback reports;
- An audit of their non-clinical time activity where this applies;
- An up-to-date CV;
- Summary of engagement with reflective practice.

Where the exit interview is considered satisfactory, and all other requirements have been fulfilled, the Faculty will confirm completion of training.

Trainee Appeals Process

A trainee can appeal a decision made by the Faculty in relation to the progress of their training. In the first instance, the trainee can request a review of the decision by the Faculty, process outlined below:

- Trainee submits a request for a review of the decision in writing to the Honorary Secretary of the Faculty within 10 days of notification of the decision;
- The Faculty Chair of Training invites the trainee to meet a delegation of the Faculty The trainee may bring representation which must be notified in advance (at least five working days' notice);
- The delegation considers the request to review the original decision and brings its deliberations to the full Board of the Faculty which adjudicates on the matter. The outcome of this meeting will be notified to the trainee;

- If the trainee remains dissatisfied with the outcome, they have the right to appeal the outcome to the Council of the College. They should notify the Honorary Secretary of the Faculty, within 10 working days of the decision, that they wish to make a formal appeal. The Secretary of the Faculty will then write to the Honorary Secretary of Council informing them that an appeal has been lodged within the specified time limit. This letter will include a summary of the decision and grounds for appeal.
- The Council will then invoke its appeals process and communicate directly with the trainee to advise next steps.

Accredited Leave

Leave from the two year programme is not normally available. Exceptions may be considered where an opportunity arises for a trainee to undertake a Fellowship overseas in a sub-specialty not currently available in Ireland. Where such an opportunity arises, the trainee should contact the FPM Administrator who will refer to the Faculty for decision.

Committee of Anaesthesiology Trainees ('CAT')

The role of the Committee is to give trainees a formal voice and role within the College, influencing and shaping the Training Programmes, including Pain Medicine training programmes. Pain medicine trainees will have a representative on the Committee.

Protected Time for Trainees

In line with HSE NDTP requirements, the College has developed a process to record protected training time for our trainees.

"Protected training time refers to the time a trainee spends on-site in the hospital that is reserved for training purposes only, with no bleeps or obligations to attend work duties during the training session". Under the Organisation of Working Time Act, trainees are entitled to protected training time and in compliance with HSE regulations, trainees need to be in a position to provide proof of same. In order to capture this information, there is a section in the training diary in the e-Portfolio where a trainee can record protected training time. This information will be gathered and used to assist with identifying training sites that fail to deliver protected training time.

Non-Clinical Time

The Faculty requires that non-clinical time be made available each week to trainees in each year of training provided that the specific use of the non-clinical time is agreed in advance with the supervisor or Department Chair, see guidelines for use of the non-clinical time below:

- Faculty on CAI organised courses - clinical skills, examination preparation or other approved course;
- Participant, Teacher or Facilitator of hospital based academic activity;
- Agreed Research activity;
- Agreed Audit activity;
- Agreed Clinical guidelines activity;
- Hospital or CAI Management/administrative duties e.g. CAT representative.

Application to use non-clinical time on a regular basis for a defined research or audit activity should be made in writing to the Department Chair prior to or as early as possible during a rotation.

A report on the availability, use and productivity of non-clinical time will be required from each trainee as part of the in-training assessment. This report will form part of their training portfolio and is required at the Exit Interview.

Trainee Review of Hospital Sites

Trainees are asked to take part in a six-monthly online survey to review the hospital sites. The survey is managed by the FPM Administrator. It cannot be accessed by the hospitals and it is not available to view by anyone other than the trainee, the Faculty and the College. The information gathered is anonymised and used as part of the hospital inspection process. The survey does provide valuable information for the Faculty and the hospitals in seeking to make improvements for trainees and to the training programme. The survey results are monitored by the Faculty and will be used to manage any training issues within hospitals which may need to be resolved. They also offer additional insight into the condition of a training site during the accreditation inspection process.

Guidelines for Supervisors of Training

Introduction

Supervisors of Training ('supervisors') are the Faculty's representatives in accredited training hospitals. They are the primary link between the trainees, the hospital site and the Faculty. They are responsible for the organisation of training activity at the training site, ongoing monitoring of trainees' progress and ultimate assessment of trainees at the end of each rotation.

Role of Consultants as Trainers:

While the supervisor has primary responsibility for the organisation of training at the hospital site, all pain medicine consultants coming into contact with trainees are considered trainers. To be recognised as a trainer by the College, a consultant must:

- Hold the FFPMCAI or equivalent;
- Be 'In Good Standing' with both the Faculty and CAI;
- Be registered on the Specialist Division of the Register for Anaesthesiology with the Medical Council of Ireland;
- Be registered on and compliant with a Medical Council accredited Professional Competence Scheme ('PCS');
- Be employed in a hospital that has been inspected and accredited by the Faculty.

All consultants acting as Faculty Trainers have a responsibility to:

- Allow trainees to gain experience under supervision;
- Help and support trainees using the prescribed workplace based feedback tools;
- Assist trainees to achieve their goals in the areas of knowledge, experience, competency and professionalism;
- Provide ongoing feedback to supervisors and contribute to end of rotation In-Training Assessment process;
- Contribute to the hospital and Faculty teaching and examination programmes;
- Adhere to all HSE, CAI and Faculty policies.

Appointment of Supervisors:

To be eligible for appointment as a supervisor, a consultant must meet the following criteria:

- Hold the FFPMCAI or equivalent;
- Be 'In Good Standing' with the Faculty and College;
- Be registered on the Specialist Division of the Register for Anaesthesiology with the Medical Council of Ireland;
- Be registered on and compliant with a Medical Council accredited PCS;
- Be employed as a permanent consultant at an inspected and accredited training site.

The Faculty appoints a supervisor to each accredited training site. A supervisor is appointed for a term of five years. The Faculty Administrator maintains a log of supervisor appointments. The Faculty reviews the appointments on a five yearly basis.

Duties of Supervisors:

The principal duties of the supervisor are outlined below:

- On allocation of trainees to hospital sites, the supervisor should contact the trainee to arrange for the start of rotation meeting to agree objectives for the six-month period;
- The supervisor should be familiar with curriculum requirements, training guidelines and examination regulations;
- The supervisor should be familiar with all electronic processes for trainee management, e.g. log books, training diary and assessment tools;
- The supervisor is primarily responsible for the in-hospital training, including teaching, presentations, access to modules and competencies;
- The supervisor is primarily responsible for monitoring trainees:
    - Meeting trainees at the start of the rotation to agree goals and objectives;
    - Meeting trainees in the middle of the six months' rotation to provide the opportunity for one-to-one meetings to gauge progress, provide feedback and take remedial action if required;
    - Arranging the end of rotation meeting.

- The supervisor is responsible for releasing pain medicine trainees for non-clinical time, where this has been agreed;
- The supervisor should keep the Faculty informed of relevant developments that may influence trainee's performance and wellbeing;
- The supervisor is primarily responsible for the Trainee Assessment process. Full details are outlined under 'Assessment of Training' in the 'Progression Through Training' section above;
- The supervisor is responsible for signing off the clinical competencies. This is completed through the trainee's e-portfolio;
- The supervisor is responsible for supporting the trainee in the completion of the Clinical Case Series;
- The supervisor should attend the Faculty annual training / information day.

Duties of the Faculty of Pain Medicine:

The Faculty has a responsibility to ensure that supervisors are equipped to carry out their role. In this regard, the Faculty undertakes to:

- Provide appropriate information to supervisors on appointment;
- Provide access to relevant electronic facilities, e.g. assessment tools, competency sign off;
- Hold a supervisor training / information day at least annually;
- Be available for one-to one meetings, if required, as a means of orientation for new supervisors;
- Invite supervisors to participate in working groups as appropriate, e.g. where key change to current practice is under consideration;
- Provide appropriate Continuing Professional Development ('CPD') points for supervisor / trainee educational activity, as a guide 1.5 hours per trainee per six-month period.

Responsibilities of Anaesthesiology Departments and Pain Medicine Consultants:

The role of the supervisor is ongoing and it is critical that the supervisor has the support of both the Anaesthesiology Department and the pain medicine consultants at the accredited

training site. The College recommends that the Anaesthesiology Department provides appropriate support, including:

- Access to private space for meeting with trainees;
- Access to administrative assistance and office equipment as appropriate;
- Making available protected time. It is expected that supervisors will need, at a minimum, the equivalent of 6 working days throughout a six-month rotation, allowing time at the critical start, middle and end periods for appropriate engagement with trainees.

Hospital Accreditation

Specialist Pain Medicine Training for the awarding of dual certification may only be undertaken in training sites which are accredited for training by the CAI and the Faculty. The main aim of the accreditation process is to ensure high quality training for trainees. The accreditation process for pain medicine is managed in tandem with the anaesthesiology accreditation process by the CAI Training Department. Training sites are inspected jointly by the College and the Faculty for pain medicine training in 5 yearly cycles.

A hospital accreditation may occur in the following circumstances:

- A routine scheduled accreditation inspection as part of the five-year cycle;
- An accreditation inspection of a new department;
- An early site inspection triggered by urgent issues which include, but are not limited to, patient safety issues, urgent training issues, issues affecting the trainee or issues affecting the reputation of the CAI. These inspections may range from formal discussions with the supervisor and head of department, to a full inspection;
- A scheduled re-inspection arising out of concerns raised at a previous inspection

The Guidelines for Hospital Accreditation are outlined in detail in the CAI Curriculum for the National Specialist Anaesthesiology Training Programme (*Appendix 4 of that document*).

SECTION 3. Examination Regulations

Introduction

The Fellowship Examination of the Faculty of Pain Medicine CAI (the 'FFPMCAI') is governed by the CAI Regulations for Examinations available on the College website. The CAI Regulations for Examinations govern the conduct of all CAI examinations leading to the award of Membership or Fellowship of the College and / or Faculties. These regulations specify procedures for all examinations, guidance in the event of failure, the appeals process, the procedures for making representations and sanctions or infringements and all of these aspects apply to the FFPMCAI.

For the purposes of this curriculum, the Examination Regulations section contained herein outlines aspects applying specifically to the FFPMCAI.

Eligibility

The FFPMCAI Examination, which is an exit exam, is taken during the 2nd year of the Training Programme and must be passed to enable a trainee be awarded a CSCST in Pain Medicine.

A trainee has a maximum of 4 attempts to pass the Fellowship Exam. A trainee who has completed two years on the training programme, meeting all requirements as set out in the Curriculum other than passing the Fellowship exam, may subsequently attempt the examination while outside of the programme subject to the maximum number of 4 attempts, but will not be awarded CSCST until they pass the exam.

Consideration may be given to allowing an additional 12 month period within the programme to facilitate re-sitting the exam. This is at the discretion of the Faculty Board and where it is agreed, an appropriate additional allocation will be arranged and the trainee will remain on the programme for a further 12 months. Where the trainee is successful at the next attempt, CSCST will be awarded. Where the trainee is not successful at the next attempt, their training will cease at the end of that training year without any award of CSCST. The trainee may still re-sit the examination subject to the maximum number of attempts. If subsequently successful within the maximum number of 4 attempts, they will be then be awarded CSCST.

Application Process

Dates of Examinations will be published in the Examinations Calendar of the College and will be available to view on the College web site at www.anaesthesia.ie.

Application forms for admission to the Examination may be obtained from the Examinations Office of the College. Applications must reach the Examinations Office by the closing date specified and be accompanied by the appropriate fee.

Format

There are two parts to the Fellowship Exam:

- Written examination which must be taken in one sitting and passed before undertaking the clinical examination;
- Clinical examination which must be taken in one sitting and only undertaken on successful completion of the written examination.

Structure of the Examination

The examination will be based on the Clinical Components section of the Curriculum.

Written Examination

The written examination will comprise 90 Single best answer ('SBA') questions.

Clinical Examination

The clinical examination will comprise of a clinical patient review case and 2 x structured oral examinations ('SOE'), see details below:

- Clinical case: The candidate is provided with a patient review and given 30 minutes to complete their assessment. This is followed by a 30 minute examination by two examiners. The examination may include some short minor cases at the discretion of the examiners;
- SOE 1: 30 minute examination: clinical / audit / professionalism, conducted by two examiners;
- SOE 2: 30 minute examination: clinical / equipment / interventional pain management, conducted by two examiners.

Details of preparation courses and sample papers are available on the College website.

Part B: Clinical Components

Guide to the Clinical Components of the Curriculum

The clinical components of the Curriculum are subdivided into two sections:

Fundamentals/Foundation addresses the major subjects underlying the basic understanding of the principles of pain medicine. This knowledge is developed throughout training and assessed by examination.

Essential Topics - clinical areas requiring further specialised knowledge and skills to manage patients in specific contexts.

CLINICAL COMPONENTS
Fundamentals/Foundation 1. Anatomy and Physiology of Pain 2. Pathophysiology of Pain 3. Epidemiology of Pain 4. Pharmacology Applied to Pain Medicine
Essential Topics 1. Bio-Psychosocial Aspects of Pain 2. Assessment of Pain and Pain-related Conditions 3. Acute Pain 4. Neuropathic Pain 5. Cancer Pain 6. Visceral Pain 7. Headache and Orofacial Pain 8. Neck and Back (Spinal) Pain 9. 9a) Musculoskeletal (MSK) Pain General and 9b) MSK - Fibromyalgia Syndrome (FMS) and Chronic Widespread Pain (CWP) 10. Complex Regional Pain Syndromes 11. Problematic Substance Use 12. Psychiatry and Chronic Pain 13. Rheumatology and Pain 14. Pelvic Pain 15. Neuromodulation 16. Intrathecal Drug Delivery Systems 17. Pain Management Programmes (PMPs) and Pain Management Education Programmes (PMEPs)

Each unit is structured with a:

- Title of the unit
- Description of the learning outcomes for each of the competencies within the unit

The table is structured as follows:

Title:

Ref:	Medical Council Domain	K/S/A	Learning Objective	Assessment method

The **reference code** is formatted as follows:

- Initial two letters identify the unit either as Fundamentals / Foundation (FF) or Essential Topics (ET)
- The middle letters relate to the specific competence, e.g. AP = Anatomy and Physiology of Pain
- The number is unique to that standard

The **Medical Council Domain** is a numerical number associated with each of the Medical domains, as mentioned in the **Medical Council's Eight Domains of Professional Practice**.

1 – Patient Safety and Quality of Care

2 – Relating to Patients

3 – Communication and Interpersonal Skills

4 – Collaboration and Teamwork

5 – Management (including self-management)

6 – Scholarship

7 – Professionalism

8 – Clinical Skills

K/S/A Denotes the attribute tested by the learning objective in the unit. This is either a learning objective related to knowledge, skill, or attitude.

The **Learning Objective** is a short statement outlining the specific learning objective required.

The **Assessment Method** is the method used for assessment of the learning objective. This can be by one or more of Examination ('FFPMCAI'), Case Based Discussion ('CBD'), Direct Observation of Procedural (clinical) Skill ('DOPS') or Mini Clinical Evaluation Exercise ('Mini-CEX'). In the case of the 4 Fundamental / Foundation topics, these will all be examined by means of the Fellowship Examination and are suitable for use of CBD. For these topics, DOPS or Mini-CEX do not apply. For the 17 Essential Topics, all are subject to examination and all are suitable for use of CBD so these methods will not be listed. Where a DOPS or Mini-CEX also applies, this will be stated.

Each Essential Topic unit ends with a table of recommendations:

- **Volume of Practice ('VOP')** – trainees are required to record their VOP on their e-Portfolio. The recommended VOPs in the tables include aspects such as procedures, ward rounds, clinics, consultations etc. These are minimum recommendations. The minimum volume of practice does not reflect the importance of the type of procedure or estimate the number of cases required to achieve competence. Variances in local practices and individual learning necessitate that volume of practice be one component in a range of assessment strategies.
- **Workplace Based Assessments ('WBAs')** – trainees are required to complete a number of WBAs over the course of the two years. At a minimum, trainees should complete 12 WBAs in Year 1 and 20 in Year 2. This can be a mix of CBD / DOPS / Mini-CEX but CBDs should comprise no more than 40% of overall WBAs.

Fundamentals / Foundation Knowledge

Note: Volumes of Practice do not apply to the 4 Fundamental / Foundation components. These will be examined by means of the Fellowship Examination and are suitable for use of CBD.

1. Anatomy and Physiology of Pain

	Domains	KSA	**Anatomy and physiology of Pain** **By the end of training, the trainee will be able to:**
FF_AP_1	6, 8	K	Describe peripheral receptors and afferent fibres
FF_AP_2	6, 8	K	Describe peripheral sensitisation
FF_AP_3	6, 8	K	Describe transduction & transformation
FF_AP_4	6, 8	K	Describe spinal processing and nociceptive input
FF_AP_5	6, 8	K	Describe the anatomy of the pain pathways in spinal chord
FF_AP_6	6, 8	K	Describe ascending tracts and neurotransmitters involved
FF_AP_7	6, 8	K	Describe spinal processing in the spinal cord and brain to include • Ascending reticular system, nociceptive cortical network and reorganisation • Descending inhibitory control • The relationship between acute and chronic pain and the autonomic nervous system • The relationship between acute and chronic pain and the hypothalamus pituitary adrenal axis (HPAA)

	Domains	KSA	Anatomy and physiology of Pain By the end of training, the trainee will be able to:
			• The pain neuromatrix in the brain and its influence on pain transmission • Central sensitisation

2. Pathophysiology of Pain

	Domains	KSA	Pathophysiology of Pain By the end of training, the trainee will be able to:
FF_PP_1	6, 8	K	Outline definition of acute and chronic pain
FF_PP_2	6, 8	K	Outline classification of pain with regard to aetiology, location, type and temporal course
FF_PP_3	6	K	Describe in detail the International Classification of Diseases ('ICD') 11th Revision taxonomy on chronic pain and its significance for pain medicine
FF_PP_4	6	K	Describe Chronic Primary Pain (including Fibromyalgia, Non-Specific Low Back Pain)
FF_PP_5	6	K	Describe the six subgroups of ICD-11, pain secondary to an underlying disease (including Chronic Cancer-related Pain, Chronic Neuropathic Pain, Chronic Visceral Pain, Chronic post-traumatic and Post-Surgical Pain, Chronic Headache and Orofacial Pain, Chronic Musculoskeletal Pain)

	Domains	KSA	**Pathophysiology of Pain** **By the end of training, the trainee will be able to:**
FF_PP_6	6	K	Describe the International Classification of Functioning, Disability and Health ('ICF') and the relevance of combining ICD-11 and ICF (including better patient management through better diagnostic classification, and improved research reports on chronic pain by a more precise and adequate coding)
FF_PP_7	6	K	Describe the specific set of Functioning Properties (FPs) applied to chronic pain
FF_PP_8	6	K	Define and discuss: • Placebo • Nocebo • Placebo effect • Placebo response
FF_PP_9	6	K	Describe the difference between nociception and pain
FF_PP_10	6	K	Critically discuss the progression of Acute to Chronic Pain
FF_PP_11	6	K	Discuss the alteration in nociceptive processing involved in nociplastic pain conditions
FF_PP_12	6, 8	K	Describe and contrast nociceptive and neuropathic pain
FF_PP_13	6, 8	K	In the context of persistent pain states, define and contrast: • Allodynia • Hyperalgesia • Hyperpathia • Dysaesthesia

	Domains	KSA	**Pathophysiology of Pain** **By the end of training, the trainee will be able to:**
FF_PP_14	6	K	Describe central pain and causes
FF_PP_15	6	K	Describe phantom limb pain and factors that influence development and severity Discussion of a case of phantom limb pain and the factors that affect this type of pain
FF_PP_16	6	K	Compare and contrast somatic, visceral, sympathetic and referred pain
FF_PP_17	6	K	Describe pathophysiological mechanisms including wind-up, temporal and spatial summation in development of persistent pain states
FF_PP_18	6	K	Describe the association between acute and chronic pain and the risk of progression from acute to chronic pain.

3. Epidemiology of Pain

	Domains	KSA	**Epidemiology of Pain** **By the end of training, the trainee will be able to:**
FF_EP_1	5, 6	K	Describe the incidence and age-standardised prevalence of chronic pain in Ireland, in other developed and in developing countries
FF_EP_2	5, 6	K	Outline the socio-economic factors associated with chronic pain including: • Gender: describe the differences between gender pain thresholds and tolerances • Age: describe the association between acute pain, chronic pain and age • Socioeconomic factors: describe the relationship of adverse socioeconomic factors and pain • Individual factors: describe relationship between psychosocial, occupational and lifestyle factors and chronic pain
FF_EP_3	2, 3, 5, 6	K S	Discuss cost of chronic pain to a patient (direct & indirect)
FF_EP_4	4, 5, 6	K	Discuss the cost of chronic pain to the health care systems and the societal impact of pain

4. Pharmacology applied to Pain Medicine

	Domains	KSA	**Pharmacology applied to Pain Medicine** **At the end of training, the trainee will be able to:**
FF_PH_1	6, 8	K	Discuss the pharmacology of drugs used in pain management including: • Mechanism(s) of action • Site(s) of action • Potential adverse effects (including toxicity) • Indications, precautions and contraindications • Interaction with other drugs of the following drugs: • Paracetamol • Non-steroidal anti-inflammatory, selective & non-selective • Opioid agonists, partial agonists, agonist-antagonists and antagonists • Methadone • Tramadol • Tapentadol • Local anaesthetics • NMDA receptor antagonists • Anticonvulsants • Gabapentinoids • Antidepressants • Alpha 2 adrenoreceptor agonists • Corticosteroids • Capsaicin • Sodium channel blockers • Calcium channel blockers and modulators • Benzodiazepines • Botulinum toxin • Cannabinoids

	Domains	KSA	**Pharmacology applied to Pain Medicine** **At the end of training, the trainee will be able to:**
			• New Migraine Drugs
FF_PH_2	6, 8	K	Describe the principles of analgesic and opioid equivalence, including but not limited to: • Buprenorphine • Codeine, dihydrocodeine • Fentanyl • Hydromorphone • Methadone, Levomethadone • Morphine • Oxycodone • Tapentadol • Tramadol
FF_PH_3	6, 8	K	Describe pharmacokinetic and pharmacodynamic differences between the different routes of administration of drugs (for example onset/offset of action, efficacy, adverse effects) including: • Oral • Sublingual • Buccal • Rectal • Transdermal • Topical • Inhaled • Intranasal • Subcutaneous • Intramuscular • Intravenous • Intra-articular

	Domains	KSA	**Pharmacology applied to Pain Medicine** **At the end of training, the trainee will be able to:**
			• Spinal (epidural and intrathecal)
FF_PH_4	6, 8	K	Describe the pharmacology of opioids, including: • Mechanisms of action • Routes of administration and its clinical implications • Dose conversion between commonly used opioids and routes of administration • Adverse effects • Potential adverse drug interactions • Opioid tolerance and dependence • Appropriate prescribing

Essential Topics

Note: All aspects of the clinical components are subject to examination and are suitable for use of the Case Base Discussion assessment tool ('CBD'). The Fellowship Examination and CBDs are assumed as assessment types for all standards below. Where a Mini-CEX or DOPS also applies, this is highlighted under the 'Assessment Method' column.

1. Bio-Psychosocial Aspects of Pain

	Domains	KSA	Bio-Psychosocial Aspects of Pain By the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
ET_BPS_1	4,5,6	K	Demonstrate understanding of the integrated role of specialist disciplines in the bio-psychosocial management of pain including clinical psychology, physiotherapy, occupational therapy, nursing and social work	
	PATIENT TRIAGE			
ET_BPS_2	2,3,7	K	Demonstrate understanding of the process of triaging patients with respect to their underlying diagnosis, natural history and prognosis, urgency, complexity and facilities required, and psychosocial risk factors for ongoing chronicity	Mini-CEX
ET_BPS_3	3,4,5	K	Critically discuss situations when referral to specialist team members is appropriate	
ET_BPS_4	4,6	K	Discuss the application of the WHO ICF	
	ASSESSMENT PRINCIPLES			
ET_BPS_5	2,6,7	K A	Demonstrate understanding that pain in any one patient may attract different concurrent descriptors, and therefore, different inferred mechanisms	

	Domains	KSA	Bio-Psychosocial Aspects of Pain By the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
ET_BPS_6	2,7	K S	Observe ability to infer mechanism(s) of production of pain on the basis of clinical examination, irrespective of pre-existing diagnostic label(s)	
ET_BPS_7	6, 7 8	K A	Discuss the process of integrating multiple sources of information towards a multiaxial formulation of diagnosis – physical, psychological and psychosocial context	
ET_BPS_8	2,3,7	S A	Identify and explore patients' issues, concerns, beliefs, goals and expectations with respect to their pain experience and pain treatment	
	PATIENT ASSESSMENT			
ET_BPS_9	2,3,8	K S A	Carry out a focused biomedical assessment including but not limited to: • Response to current and past treatments • Nutritional status • Sleep function • Sexual function • Pharmacological management • General health indicators	DOPS / Mini-CEX
	PHYSICAL ASSESSMENT			
ET_BPS_10	2,3 7,8	K S A	Carry out a focused physical assessment including but not limited to: Demonstrate skills to undertake a physical assessment including levels of activity function, sleep etc Identify all red / orange (biomedical), yellow (psychosocial predictors), blue (social and economic factors), black (occupational) flags*	DOPS / Mini-CEX

	Domains	KSA	Bio-Psychosocial Aspects of Pain By the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
			Show understanding of the role of physiotherapy and when it is appropriate to refer for further specialist assessment and treatment **Reference: Main CJ, George SZ. Psychologically informed practice for management of low back pain: future directions in practice and research. Phys Ther 2011;91:820-824*	
	PSYCHOLOGICAL ASSESSMENT			
ET_BPS_11	2, 7 8	K S A	Elicit and interpret a detailed history of the concerns and beliefs of the patient regarding their pain: experiences and consequences of the pain	
ET_BPS_12	2,7,8	K S A	Perform a focussed assessment regarding but not limited to: home situation, eating, support, family and roles, employment and occupational factors, financial status, recreational activities, cultural beliefs, mobility	DOPS
ET_BPS_13	2, 4 6, 7	K A	Demonstrate an understanding of the detailed specialist assessment that a clinical psychologist will undertake relating to: • History of physical, emotional and sexual abuse • Family medical and psychological history • Personal psychological history • Past and current lifetime events • Identification of lifetime, current and daily stresses • Current psychological symptoms • Cognitive impairment • Resources: coping strategies, self-efficacy, support/lack of support from family and friends	

	Domains	KSA	Bio-Psychosocial Aspects of Pain By the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
			• Beliefs and anxieties about pain and the causes of pain • Expected prognosis • Interference with life • Changes to lifestyle and identity	
	PSYCHOLOGICAL MANAGEMENT			
ET_BPS_14	2,4,6 7	K S A	Demonstrate an understanding of the behavioural therapies available and delivered by clinical psychologists including but not limited to: • Education • Reduction of fear avoidance • Hypnosis • Relaxation/guided imagery • Biofeedback • Balancing/regulating rest and activities • Behavioural analysis • Operant aspects • Solution focused brief therapy • Mindfulness-based stress reduction	Mini-CEX
	PHYSICAL MANAGEMENT			
ET_BPS_15	2, 4 6, 7	K S A	Demonstrate an understanding of the range of treatment options that a charted physiotherapist can offer including: • TENS • Paced and graded activity • Physical activity and fitness • Goal setting • Neuro-dynamics	Mini-CEX

	Domains	KSA	Bio-Psychosocial Aspects of Pain By the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
			• Manual therapy, and their level of integration (peripheral, spinal, supra-spinal)	
ET_BPS_16	2,4,6	K	Demonstrate an understanding (including case discussion) of the physical assessment skills and the range of treatment options that occupational therapy can offer, including but not limited to: • Hand assessment • Energy conservation • Pacing • Relaxation	
ET_BPS_17	2,4,6	K	Demonstrate an understanding of the importance of integrating physiotherapy programme to work and leisure	
	SOCIAL MANAGEMENT			
ET_BPS_18	2,4,7	K A	Demonstrate an understanding of the role of work, occupational factors, career, finances, housing, recreational and leisure activities	
	VALIDATED TOOLS FOR ASSESSING AND MONITORING TREATMENT			
ET_BPS_19	2,3,4 6	K	Demonstrate critical selection of appropriate physical and psychological assessment and outcome measures across ICF domains (mood, quality of life, beliefs about pain, pain self-sufficiency, physical function, sleep, health literacy), including scoring tools available and examples of each	
ET_BPS_20	2,3, 4,6	K	Demonstrate ability to assess bio-psychosocial factors that elicit and maintain pain disorders with somatic causes	
ET_BPS_21	2,6	K S A	Show ability to choose appropriate and validated tools to assess and monitor treatment in specific populations such as:	Mini-CEX

	Domains	KSA	Bio-Psychosocial Aspects of Pain By the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
			• Older adults • Patients from linguistically or culturally diverse backgrounds • Patients who are cognitively impaired • Patients with behavioural issues	
	IMPLEMENTING A BIO-PSYCHOSOCIAL MANAGEMENT PLAN			
ET_BPS_22	1,2,3 7	S A	Discuss the process of explaining the diagnostic formulation and the proposed management plan to the patient, taking into account the patient's health literacy level Observe this process for five patients	
ET_BPS_23	1,2,3 4,6	S A	Demonstrate the process of explaining a therapeutic alliance with the patient towards implementation of the management plan through case-based discussion. Differentiate those patients who require: ○ Multimodal approach from one practitioner ○ Multidisciplinary approach from a team ○ Referral to other medical specialists and/or allied healthcare professionals	
ET_BPS_24	1,2,4 6,8	K S	Discuss the process of applying multidisciplinary treatment principles in pain management programmes. Discuss in context of case-based discussions.	
ET_BPS_25	1,2, 4,6,7 8	K S A	Demonstrate ability to adapt plans to the specific needs of patient groups, including but not limited to: ○ Pregnant women ○ Older adults (including those with dementia)	

	Domains	KSA	Bio-Psychosocial Aspects of Pain By the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
			○ Patients with mental health disorders ○ Opioid-tolerant ○ With active or past problematic substance use ○ Patients with intellectual and/or physical disabilities	

Minimum Volume of Practice Training Requirements for Bio-Psychosocial Aspects of Pain			
		Year 1	Year 2
Attend multi-disciplinary team meetings		10	10
Workplace Based Assessments			
Required WBAs over two years		1	
Available WBAs	CBD DOPS Mini-CEX	25 3 6	

2. Assessment of Pain and Pain-related Conditions

	Domains	KSA	**Assessment of Pain and Pain-related Conditions** **At the end of training, the trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)
ET_AS_1	2,5,6 8	K A	Describe how the following factors may influence the patient experience of illness and pain: • Social • Cultural • Psychological • Physical • Genetic • Age • Role of health literacy (patient's ability to seek, understand and implement health-related information to manage their health) • Religion • Traditional medical practices • Patients' and family's wishes, motivations, goals and strengths Bring in these factors when discussing at case-based discussions	
ET_AS_2	2,6, 8	K S	Describe patient and family's different responses to the experience of pain and illness including affective, cognitive and behavioural responses	
ET_AS_3	6	K	Outline the current Diagnostic and Statistical Manual of Mental Disorders ('DSM') and International Classification of Diseases ('ICD') framework for classification of mental disorders with particular reference to anxiety, problematic substance use and depressive disorders	

	Domains	KSA	**Assessment of Pain and Pain-related Conditions** **At the end of training, the trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)
ET_AS_4	1,2,3 6,8	K S A	Perform basic medical assessments of patients in an outpatient clinic including: • General history taking • General physical examination • Targeted pain-related physical examination • Examination of the neurological system • Musculoskeletal examination • Psychological function / mental state examination • Appropriate investigations indicated by the examination findings	Mini-CEX
ET_AS_5	6, 8	K S	Interpret the following basic investigations, including but not limited to: • Full blood count • Biochemical screening including liver function tests and myeloma screening • Thyroid function tests • Electrophysiology studies • Plain Radiographs (emphasis on spinal radiographs) • MRI and contrast MRI • CT • Isotope bone scans	
ET_AS_6	6, 8	K	Outline the grades of changes of joints in spine: spondylosis, spondylolisthesis, disc degenerative changes	
ET_AS_7	6, 8	K S A	Identify radiologic changes associated with disc infection, disc subluxation, vertebral collapse, Scheuermann disease, diffuse idiopathic skeletal hyperostosis	DOPS
ET_AS_8	6,8	K S	Interpret basic screening questionnaires of the psychological and somatic symptom burden for example:	

	Domains	KSA	Assessment of Pain and Pain-related Conditions At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
		A	• Short-form McGill questionnaire • State Trait Anxiety Inventory • Hospital Anxiety and Depression Scale • Pain DETECT • Pain self-efficacy questionnaire • Pain Catastrophing Scale • Beck Hopelessness Scale • EuroQOL 5-D • other relevant psychology-based Pain Scale	
ET_AS_9	2, 6 8	S A	Demonstrate basic problem-oriented synthesis of clinical information	

Minimum Volume of Practice Training Requirements for Assessment of Pain and Pain-related Conditions			
		Year 1	Year 2
Attend pain clinics		20	20
Workplace Based Assessments			
Required WBAs over two years		2	
Available WBAs	CBD DOPS Mini-CEX	9 1 1	

3. Acute Pain

	Domains	KSA	**Acute Pain** **At the end of training, the trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)
	Background			
ET_AP_1	4,6, 7, 8	K A	Demonstrate ability to discuss the role of the Acute Pain Service (physician-based and specialist nurse-based, physician supervised)	
ET_AP_2	4,6,8	K	Discuss the role of acute pain management in primary care	
ET_AP_3	1,5,6 ,8	K, S	Demonstrate ability to discuss general principles to enable the safe and effective delivery of all acute pain management techniques in hospitals including: education of staff, monitoring requirement of pain, responses to inadequate or excessive pain medication; use of “standard orders” and equipment used	
ET_AP_4	1,3,4 6, 7	K A	Discuss the issues related to the ongoing management of acute pain following discharge from hospital	
ET_AP_5	1,6,8	K S	Demonstrate the ability to evaluate the role of acute pain management in rehabilitation, including enhanced recovery or “fast-track” surgery principles	
ET_AP_6	1,2,6 8	K S	Demonstrate understanding of the evidence for acute pain management and promotion of enhanced recovery and rehabilitation in prevention of chronic pain	
ET_AP_7	1,2,6 7,8	K	Discuss the risk factors and mechanisms involved in the transition of acute to chronic pain and critically evaluate the evidence for measures that may mitigate this transition	
ET_AP_8	6, 8	K	Describe the pharmacokinetics and pharmacodynamics of opioids and local anaesthetics administered into the epidural space or intrathecally	

	Domains	KSA	**Acute Pain** **At the end of training, the trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)
ET_AP_9	6, 8	K	Describe the physiological consequences of a central neuroaxial (epidural or intrathecal) block with local anaesthetics and/or opioids.	
ET_AP_10	6, 8	K	Describe the adjuvant agents that may be used to enhance the quality or extend the duration of central neuraxial or regional blocks, and discuss their mechanisms of action, risks and benefits	
ET_AP_11	2 ,6, 7, 8	K A	Discuss the contribution of maladaptive psychological coping skills and psychiatric illness and socio-environmental factors to the experience of acute pain (pain ratings, opioid use) and the risks of persistent pain and prolonged opioid use after discharge from hospital	
ET_AP_12	1,4,5 6	K S	Critically discuss the importance of regular, institutional audits to ensure that goals of effective analgesia and patient satisfaction are being met, and also to serve as a benchmarking tool	
	Clinical Assessment of Acute Pain			
ET_AP_13	1,2,3 6,7,8	K S	Discuss assessment of acute pain (including acute neuropathic pain) in the adult patient, including the nonverbal patient and those from indigenous or other culturally and linguistically diverse communities, and the relevance of functional assessment	
ET_AP_14	1,2,6 8	K S A	Discuss assessment of acute pain in the older patient (especially those with dementia) including difficulties, relevance of functional assessment and use of other pain evaluation methods that do not rely on verbal ability Observe completion of assessment of acute pain in this group of patients	

	Domains	KSA	**Acute Pain** **At the end of training, the trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)
ET_AP_15	1,2,6 8	K S A	Discuss assessment of acute pain in children, including difficulties, relevance of functional assessment and use of paediatric pain scales	
ET_AP_16	1,2,6 8	K S	Demonstrate recognition of causes of delirium in the acute pain setting and the effect this may have on assessment and treatment of the patient with acute pain	
ET_AP_17	6, 8	K	Compare and contrast evidence base (NNT, NNH etc.) for efficacy and adverse effects in the management of acute pain with: • Paracetamol • Opioids • Non-steroidal anti-inflammatory medications (COX-1 & COX-2 inhibitors) • Tramadol • Tapentadol	
ET_AP_18	6,8	K	Critically discuss the principles of Multimodal analgesia	
ET_AP_19	6,8	K	Critically discuss the evidence base (NNT, NNH etc.) for the indications, efficacy and adverse effects of the following drugs in the management of acute pain: • NMDA-receptor antagonists • Anticonvulsants • Antidepressants • Alpha-2 adrenergic agonists • Inhalational agents • Calcitonin • Corticosteroids • IV Lidocaine	

	Domains	KSA	**Acute Pain** **At the end of training, the trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)
ET_AP_20	1,6,8	K S A	Demonstrate ability to assess and manage all opioid related adverse effects related to pharmacological therapies in acute pain management, including but not limited to: • Opioid-induced ventilatory impairment • Excessive sedation • Nausea and vomiting • Opioid associated pruritus • Constipation • Pruritis • Opioid associated cognitive dysfunction • Opioid induced hyperalgesia	Mini-CEX
ET_AP_21	1,2,6 8	K S	Describe the complications that may be associated with neuraxial analgesia and other regional analgesia (including secondary to needle/catheter insertion and drug administration) and how these may be mitigated and managed	
ET_AP_22	1,2,3 4,6	K S A	Outline a plan to transition patients to oral analgesia from patient-controlled analgesia (PCA), epidural or regional analgesia for the management of acute pain	Mini-CEX
ET_AP_23	1,6,8	K S	Discuss the use of ultrasound imaging in the performance of regional analgesic techniques	
ET_AP_24	1,2,6 7,8	K S	Discuss: • Risk-benefit analysis • Monitoring of efficacy • Safety considerations For patients receiving: ○ Patient Controlled Analgesia (PCA)	

	Domains	KSA	**Acute Pain** **At the end of training, the trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)
			○ Epidural analgesia, including patient-controlled epidural analgesia (PCEA) ○ Intrathecal analgesia ○ Plexus analgesia (including patient controlled regional analgesia) ○ Major peripheral nerve analgesia ○ Paravertebral analgesia ○ Sublingual analgesia ○ Erector spinae block ○ Wound block	
ET_AP_25	1,2,6 8	K S	Demonstrate ability to discuss issues specific to the management of acute pain in patients with: • Spinal cord injury • Burns • Trauma • Crush injuries and ischaemic limbs with risks of compartment syndrome • Patients with obstructive sleep apnoea • Patients who are pregnant or who are breast-feeding • Patients with renal impairment (including those on renal replacement therapies) • Patients with chronic pain • Opioid-tolerant patients • Patients with past or present problematic substance use	
ET_AP_26	1,2,6 8	K	Discuss the management of patients who are taking anticoagulants or anti-platelet agents and who have or	

	Domains	KSA	**Acute Pain** **At the end of training, the trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)
			about to receive catheters in situ for neuraxial or major peripheral nerve analgesia and the potential complications specific to the concurrent use of anticoagulant and antiplatelet agents in patients undergoing central neuraxial and major nerve blockade	
ET_AP_27	1,2,6	K	Discuss the management of patients undergoing repeated painful procedures including the use of topical anaesthesia, N_2O or psychological treatment (distraction, hypnosis)	
ET_AP_28	2,6	K	Discuss the management of acute pain by non-pharmacological methods e.g. hot/cold pack, TENS, low-laser therapy and psychological strategies e.g. distractions and breathing techniques, and supports for patients before and after surgery	
ET_AP_29	1,2,6 8	K	Evaluate efficacy of key interventions through assessment of key clinical and patient reported outcomes	
ET_AP_30	1,6,8	K	Critically discuss the evidence base for the indications, efficacy and adverse effects of the following in the management of acute pain: • Management of anxiety • Distraction • Information/Education about pain • Pre-medications and acute pain e.g. Gabapentinoids	
ET_AP_31	6, 8	K S A	Demonstrate ability to formulate a plan for acute pain and acute on chronic pain management, and manage consultations on the ward	Mini-CEX
ET_AP_32	3,4,5 7,8	K S A	Participate in acute pain management ward round and conduct a multidisciplinary round	Mini-CEX

	Domains	KSA	Acute Pain At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
ET_AP_33	1,2,6	K	List the predictive factors for chronic postsurgical pain and outline measures to prevent or minimise its occurrence	
ET_AP_34	1,2,6 8	K S A	Review critical incidents relating to ward management of acute pain	Mini CEX
ET_AP_35	1,2,6 8	K S A	Demonstrate setting up of and troubleshooting infusion devices for acute pain	DOPS

Minimum Volume of Practice Training Requirements For: Acute Pain			
		Year 1	Year 2
Ward based consultations		5	5
Attend acute pain team rounds		5	5
Workplace Based Assessments			
Required WBAs over two years		2	
Available WBAs	CBD DOPS Mini-CEX	35 1 5	

4. Neuropathic Pain

	Domains	KSA	Neuropathic Pain At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
ET_NP_1	6, 8	K	Describe the common types of chronic pain including: • nociceptive • neuropathic	

	Domains	KSA	**Neuropathic Pain** **At the end of training, the trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)
			• visceral pain	
ET_NP_2	6, 8	K	Critically discuss the main descriptors of pain and other pain-related terms as in the IASP Taxonomy	
ET_NP_3	6, 8	K	Distinguish between use of terms in relation to pain syndromes such as • nociceptive • neuropathic • hypersensitivity • nociplasticity	
	Applied Foundation Knowledge			
ET_NP_4	6, 8	K	Outline the neurobiological (functional and structural) basis of allodynia, hyperalgesia and hyperpathia	
ET_NP_5	6, 8	K	Describe the possible mechanism(s) leading to the experience of pain in the following examples of damage to the somatosensory nervous system using case-based discussions to illustrate: • Brain injury • Spinal Cord injury • Traumatic peripheral nerve injury, including that incurred during surgery • Compression neuropathy • Amputation of a limb *(See also Section 5: Cancer Pain)*	
	Clinical assessment of neuropathic pain and related pain			
ET_NP_6	2,6,8	K S A	Describe the purpose, scoring, interpretation and limitations of common tools to assess neuropathic pain and use tools under direct observation e.g. • Pain: DETECT	Mini-CEX

	Domains	KSA	Neuropathic Pain At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
			• Leeds Assessment of Neuropathic Symptoms and Signs (LANSS) • Douleur Neuropathique (DN4) • Neuropathic Pain Questionnaire (NPQ) • Others	
ET_NP_7	2,6,8	K S	Describe the different presentations of pain and clinical findings and in the following primary neurological diseases: • Stroke • Complex Regional Pain Syndrome (CRPS) types 1 & 2 • Trigeminal Neuralgia • Parkinson's disease • Multiple sclerosis • Syringomyelia • Peripheral neuropathies: diabetic, HIV-associated, toxic (alcohol), treatment related (chemotherapy), nutritional deficiencies (B12, Folate) • Acute herpes zoster infection and post-herpetic neuralgia • Phantom limb • Guillain-Barre syndrome • Neurofibromatosis • Erythromelalgia	
	Management of Neuropathic and Related Pain			
ET_NP_8	2,5,6 7,8	K S A	Critically discuss the general management of neuropathic pain	

	Domains	KSA	Neuropathic Pain At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
ET_NP_9	6, 8	K S	Critically discuss the pharmacological treatment of neuropathic pain	
ET_NP_10	6	K	Critically evaluate the evidence for the efficacy and adverse effects for drugs used in the treatment of neuropathic pain: • Antidepressants • Anticonvulsants • NMDA antagonists • Botulinum Toxin • Topical Lidocaine • Topical Capsaicin	
ET_NP_11	2,6,8	K S A	Describe the assessment and management of a selection of the following pain conditions using case-based discussions to illustrate: • Phantom limb pain • Neuropathic pain syndromes • Central post-stroke pain syndrome • Post-burn pain • Pain secondary to chronic neurological diseases	

Minimum Volume of Practice Training Requirements for : Neuropathic Pain			
		Year 1	Year 2
Attend mustidisciplinary discussions on neuropathic pain		3	3
Workplace Based Assessments			
Required WBAs over two years		2	
Available WBAs	CBD	11	
	Mini-CEX	1	

5. Cancer Pain

	Domains	KSA	Cancer Pain At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
	Background			
ET_CP_1	5,6,8	K S	Identify age and sociocultural influences on the experience of cancer and of cancer-related pain	
ET_CP_2	2,6,8	K S	Compare and contrast the assessment and management of persons with cancer pain and those with chronic non-cancer pain	
ET_CP_3	2,5,6 8	K	Recognise the problems faced by cancer survivors who have persistent pain	
ET_CP_4	5,6,8	K S A	Discuss the meaning and significance of the WHO analgesic guidelines for pain in persons with cancer	
ET_CP_5	6, 8	K S	Discuss the choice of analgesics in the WHO ladder and critically evaluate the evidence base	
ET_CP_6	2,6,7 8	K S A	Show awareness of protocols addressing unpleasant end-of-life symptoms: • Pain • Nausea/Vomiting • Respiratory distress • Pruritis • Fatigue • Emotional Distress	
ET_CP_7	3,4,6 8	S A	Recognise the essential role of close liaison with other teams, specifically from oncology, radiation oncology, palliative care and family general practitioners. Demonstrate liaison with other specialties under direct observation	
	Applied Foundation Knowledge			

	Domains	KSA	**Cancer Pain** **At the end of training, the trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)
ET_CP_8	6, 8	K	Discuss the biological mechanisms contributing to the experience of pain using case-based discussions to illustrate: • Arising out of a solid viscus • Arising out of a hollow viscus • Directly related to cancer (e.g. tumour invasion, compression, metastases etc) • Indirectly related to cancer (pressure areas, osteoporosis, acute herpes zoster infection, worsening back pain due to poor mobilisation) • Related to cancer treatments (eg surgery, radiotherapy, chemotherapy, hormone therapy or immunotherapy) *(See also Section 6: Visceral Pain)*	
ET_CP_9	6, 8	K	Recognise interactions of medications, particularly the anti-cancer drugs, with the cytochrome P450 enzyme system and how it might influence analgesic treatments	
ET_CP_10	6, 8	K	Discuss the analgesic benefits of cancer-modifying treatments using case-based discussions to illustrate such as: • Surgery • Chemotherapy • Radiotherapy • Hormone therapy	
ET_CP_11	6, 8	K	Discuss biological mechanisms contributing to: • Post-chemotherapy pain, with particular reference to:	

	Domains	KSA	Cancer Pain At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
			○ Chemotherapy-induced peripheral neuropathy ○ Mucositis • Post-radiotherapy neuropathic pain	
	Clinical assessment of cancer pain			
ET_CP_12	6, 8	K S	Define and distinguish between incident pain and incompletely relieved persistent pain	
ET_CP_13	6, 8	K S A	Apply a mechanism-based approach to identifying the origins and contributing factors to pain in cancer patients	DOPS
ET_CP_14	6, 8	K S	Describe the clinical presentations of mucositis induced by chemotherapy or immunotherapy	
ET_CP_15	6, 8	K S	Discuss the presentation of oncological emergencies in the patient with: • Acute spinal cord compression • Life-threatening increased intracranial pressure • Acute bowel obstruction and perforation of a viscus ○ Bleeding from tumour ○ Airway obstruction from tumour or post-radiotherapy • Hypercalcaemia • Long bone fracture	
	Management of cancer-related pain			
ET_CP_16	4,6,8	K S A	Discuss the different goals of care for a pre-terminal patient compared with those for a terminal patient	

	Domains	KSA	**Cancer Pain** **At the end of training, the trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)
ET_CP_17	4,6,8	K S	Discuss the role of cancer therapies in the management of cancer-related pain, including but not limited to: • Radiotherapy • Radiopharmaceuticals • Chemotherapy • Immune Therapy • Surgery	
ET_CP_18	4,6,8	K S	Discuss the management of acute pain in cancer patients • Diagnostic interventions • Therapeutic interventions • Surgery • Radiotherapy • Chemotherapy	
ET_CP_19	6, 8	K S	Discuss management of post-chemotherapy and post-radiotherapy pain	
ET_CP_20	6, 8	K S	Discuss the management of mucositis, with particular reference to children	
ET_CP_21	6, 8	S	Discuss the use of opioids in the patients with impaired renal or liver function	
ET_CP_22	6, 8	K S	Discuss the options for management of breakthrough cancer pain	
ET_CP_23	6, 8	K S	Discuss the management of opioid-related adverse events	
ET_CP_24	6,8	K S	Discuss the management of opioid analgesics including the role of opioid rotation in patients with inadequate pain relief or severe side effects	
ET_CP_25	6,8	K S	Critically discuss situations in which changing the route of analgesic administration may be required	

	Domains	KSA	**Cancer Pain** **At the end of training, the trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)
ET_CP_26	4,6	K S A	Outline the changes in pain management when a patient is: • No longer able to swallow • Unconscious • Likely to die within days	
ET_CP_27	6,8	K S	Critically discuss the use of other adjuvant analgesics in cancer pain including but not limited to: • Bisphosphonates • Denosumab • Corticosteroids • Ketamine • Antidepressants • Anticonvulsants	
ET_CP_28	6,8	K S A	Discuss the role of interventional procedures in the management of cancer pain that is unresponsive to non-invasive treatment, including but not limited to: • Neuraxial and intracerebroventricular administration of medications • Neurolytic blocks, with particular reference to: ○ Saddle block ○ Coeliac plexus block/Hypogastric plexus block/Ganglion Impar block ○ Intercostal nerve neurolysis • Surgical procedures ○ Cordotomy ○ Vertebroplasty procedures	DOPS / Mini-CEX
ET_CP_29	4, 6	K S	Critically discuss the use of chemotherapy and adjunctive medicines in patients with cancer pain	

	Domains	KSA	Cancer Pain At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
ET_CP_30	6	K A	Discuss the evidence base for other analgesics in the management of pain and other symptoms in patients with terminal disease	
ET_CP_31	6, 8	K S A	Discuss the assessment and management of cancer pain in special populations such as older adults, children, adults with learning disabilities and those with problematic substance use	Mini-CEX
ET_CP_32	4,6,8	K S A	Address management of pain and other symptoms at end-of-life	Mini-CEX
ET_CP_33	2,4,6 8	K S A	Outline the value of Palliative Care regarding structure and process of care	Mini-CEX
ET_CP_34	2,6,8	K S A	Demonstrate capacity to set up a subcutaneous pump for palliative care	DOPS

Minimum Volume of Practice Training Requirements For: Cancer Pain			
		Year 1	Year 2
Assessment of patient with cancer pain in-patient / out-patient setting		5	5
Attend multidisciplinary discussions on cancer pain		5	5
Workplace Based Assessments			
Required WBAs over two years		2	
Available WBAs	CBD DOPS Mini-CEX	34 3 4	

6. Visceral Pain

	Domains	KSA	Visceral pain At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
	Background			
ET_VP_1	6, 8	K A	Appreciate the taxonomy of functional gastrointestinal disorders and chronic pelvic pain syndromes	
ET_VP_2	6, 8	K	Discuss the concurrence of somatic and visceral pain syndromes	
ET_VP_3	6, 8	K A	Describe the epidemiology of principal visceral pain conditions and their societal impact	
	Applied Foundation Knowledge			
ET_VP_4	6, 8	K	Outline the definition and classification of visceral pain	
ET_VP_5	6, 8	K A	Demonstrate an understanding of the following with respect to acute and chronic visceral pain, using case-based discussions to illustrate: • Neuroanatomy ○ Central pathways ○ Peripheral pathways ○ Innervation of viscera within: thorax, abdomen & pelvis ○ With particular reference to: ▪ Stellate ganglion ▪ Splanchnic nerves ▪ Coeliac ganglion ▪ Hypogastric plexus ▪ Ganglion Impar ▪ Pudendal nerve • Neurophysiology ○ Visceral sensitisation ○ Visceral nociceptors	

	Domains	KSA	**Visceral pain** **At the end of training, the trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)
			○ Visceral pain & hyperalgesia ○ Visceral hypersensitivity ○ Neurophysiological basis of referred visceral pain ○ The gut-brain axis ○ Microbiomes and pain relationship • Biopsychosocial issues of visceral pain	
ET_VP_6	6	K	Demonstrate an understanding of the neurobiology underlying: • Visceral pain • Visceral hyperalgesia *(See also section 5: Cancer Pain)*	
ET_VP_7	6	K	Discuss current concepts of referred pain • Viscero-somatic • Viscero-visceral • Somato-somatic	
ET_VP_8	6	K	Discuss the "gut-brain axis" and the neuro-humeral functions of the gut	
	Clinical assessment of visceral pain			
ET_VP_9	2,3,8	K S	Elicit a history of painful visceral dysfunction, including but not limited to: • Dysuria • Dyschezia • Dysmenorrhoea • Dyspareunia	Mini-CEX
ET_VP_10	1,2 4,6,8	K S	Identify clinical features that suggest active visceral disease	

	Domains	KSA	**Visceral pain** **At the end of training, the trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)
ET_VP_11	6,8	K S	Distinguish clinically between: • Active visceral nociception • Visceral hyperalgesia • Referred pain with and without hyperalgesia: ○ Viscero-somatic ○ Viscero-visceral	
ET_VP_12	6	K S	Interpret laboratory tests and imaging • e.g. Basic LFT patterns • e.g. CT/MRI abdomen; major abdominal pathological findings e.g. pancreatic cancer, spinal metastases.	
ET_VP_13	6,8	K S	Demonstrate a mechanistic approach to identifying non-visceral causes of thoracic, abdominal and pelvic pain	
ET_VP_14	6,8	K S	Demonstrate a mechanistic approach to differentiating causes of pain at the somatic-visceral interface of the pelvis and perineum, in female and in male patients	
ET_VP_15	6	K A	Outline features for evaluating the clinical history of suspected functional abdominal pain syndrome	
ET_VP_16	4,6	K S A	Outline features of a psychosocial assessment of visceral pain Demonstrate this type of assessment	
ET_VP_17	4,6	K	Outline features of a physical assessment of visceral pain. Demonstrate this type of assessment	
	Management of Visceral Pain			
ET_VP_18	6, 8	K	Discuss the principles of pharmacotherapy for visceral pain and visceral hyperalgesia	
ET_VP_19	6, 8	K	Discuss the evidence base for the indications, effectiveness and adverse effects of the following therapies:	

	Domains	KSA	**Visceral pain** **At the end of training, the trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)

			• Physiotherapy
			• Physical therapies (e.g. acupuncture)
			• Interventional therapies
			  ○ Radiofrequency techniques
			  ○ Neuromodulation
			  ○ Intrathecal
			  ○ Electrical stimulation (TENS)
			  ○ Neurolytic techniques	

ET_VP_20	6, 8	K A	Discuss the evidence base for the indications and effectiveness of psychological interventions used for the management of chronic visceral pain.	
ET_VP_21	6, 8	K A	Discuss treatment options for the management of: • Functional pain syndromes e.g. irritable bowel syndrome, chronic functional abdominal pain, painful bladder syndrome and functional chest pain • Organic visceral pain disorders such as chronic pancreatitis and inflammatory bowel diseases • Abdominal wall pain • Anorectal pain • Pelvic pain syndrome	
ET_VP_22	6, 8	K	Discuss treatment options for capsular pain associated with liver, spleen and renal pathology	
ET_VP_23	6, 8	K	Discuss the role of exogenous gonadal hormones in treatment of gynaecological visceral pain	
ET_VP_24	6, 8	K	Evaluate efficacy of key interventions through assessment of key clinical and patient reported outcomes	

	Domains	KSA	Visceral pain At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
ET_VP_25	2,6,8	K S A	Demonstrate ability to carry out appropriate visceral procedures	DOPS

Minimum Volume of Practice Training Requirements for: Visceral Pain			
		Year 1 (Observe only)	Year 2 (Perform)
Coeliac plexus block		2	2
Hypogastic plexus block		2	2
Ganglion impar block		1	1
Workplace Based Assessments			
Required WBAs over two years		2	
Available WBAs	CBD DOPS Mini-CEX	25 1 1	

7. Headache and Orofacial Pain

	Domains	KSA	Headache and Orofacial pain At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
	Background			
ET_HF_1	6, 8	K	Appraise the International Classification of Headache Disorders	
ET_HF_2	6, 8	K	Discuss accepted definitions of terms associated with headache disorders and orofacial pain conditions	
ET_HF_3	6, 8	K	Describe a taxonomy of orofacial pain	
	Applied Foundation Knowledge			
ET_HF_4	6, 8	K	Describe the anatomy of the cranial and upper cervical nerves and the innervation of the scalp, sinuses and teeth	
ET_HF_5	6, 8	K	Describe potential neurobiological mechanisms for:	

	Domains	KSA	Headache and Orofacial pain At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
			• Primary and secondary headaches • Orofacial pain • Oro-Dental pain	
ET_HF_6	6, 8	K	Discuss the pathophysiology of trigeminal neuralgia	
ET_HF_7	6	K	Discuss the pathophysiology of: • Migraine • Post-traumatic headache • Post-dural puncture headache • Post-craniotomy headache	
	Clinical Assessment of Headache and Orofacial Pain			
ET_HF_8	2,6,8	K S A	Perform a cranial nerve examination	Mini-CEX
ET_HF_9	2,6,8	K S A	Perform an examination of the face including the temporomandibular system and intraoral examination	Mini-CEX
ET_HF_10	2,6,8	K S A	Perform an examination of the cervical spine	Mini-CEX
ET_HF_11	2,6,8	K S	Detail the critical factors for assessing life-threatening headache	
ET_HF_12	6, 8	K S	Demonstrate awareness of potential causes of headache that may be overlooked on initial assessment including: • Idiopathic intracranial hypertension • Low cerebrospinal fluid ('CSF'), low pressure headache, intracranial hypotension • Post-craniotomy headache • Space-occupying lesions	

	Domains	KSA	**Headache and Orofacial pain** **At the end of training, the trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)
			• Vascular disease, especially temporal arteritis • Cervical artery dysfunction • Pathology of the eyes and ears • Sinus pathology	
ET_HF_13	6, 8	K S	Distinguish between the clinical features of the following primary chronic daily headache syndromes: • Migraine (with and without aura) • Transformed migraine • Tension-type headache • Trigeminal autonomic cephalgias (cluster headache, paroxysmal hemicrania, short-lasting unilateral neuralgiform headache attacks, hemicrania continua)	

ET_HF_14	6, 8	K
		S
			Distinguish between the clinical features of the following secondary chronic daily headache syndromes:
			• Medication-related
			  ○ Medication overuse headache
			  ○ Medication-induced side effects
			• Post-traumatic
			  ○ Headache attributable to head injury
			  ○ Headache attributable to neck injury or whiplash trauma
			• Disorders of intracranial pressure
			  ○ Increased intracranial pressure
			  ○ Decreased intracranial pressure
			• Headache referred from other structures
			  ○ Tension-type headache
			  ○ Cervicogenic headache	

	Domains	KSA	Headache and Orofacial pain At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
	Orofacial Pain			
ET_HF_15	2,6 8	K S	Recognise the clinical features of: • Trigeminal Neuralgia and its variants • Secondary trigeminal neuralgia – e.g. multiple sclerosis, tumour • Glossopharyngeal neuralgia • Post-herpetic neuralgia • Trigeminal neuropathic pain related to past-trauma • Post-stroke pain • "Burning mouth" syndrome	
ET_HF_16	6, 8	K S	Describe the use of investigations such as MRI for trigeminal neuralgia	
ET_HF_17	6, 8	K S	Apply a differential diagnosis approach to determining the anatomical origin of persistent idiopathic facial pain, "atypical facial pain"	
ET_HF_18	2,4,6 8	K S A	Distinguish pain of odontogenic (especially cracked tooth) and non-odontogenic origin and appreciating the role of the dentist in ruling out odontogenic causes	
ET_HF_19	6, 8	K	Describe the spectrum of diagnostic criteria for temporomandibular disorders	
ET_HF_20	4,5 6,8	K A	Discuss the importance of psychosocial factors as predictors of chronicity in temporomandibular disorders	
	Management of Headache			
ET_HF_21	6, 8	K A	Discuss the evidence base for non-drug interventions in primary and secondary headaches: • Education and information (counselling) including the importance of: o Keeping a diary	

	Domains	KSA	Headache and Orofacial pain At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
			○ Relaxation ○ Aerobic exercise ○ Sleep hygiene ○ Diet • Cognitive Behavioural Therapy ('CBT') • Biofeedback • Physical therapy (e.g. acupuncture, massage) • Manual therapy • Role of patient support groups	
ET_HF_22	6, 8	K	Discuss the evidence base for pharmacological treatment of acute migraine: • Paracetamol • Non-steroidal anti-inflammatory drugs • Anti-emetics • Triptans • Opioids	
ET_HF_23	6	K	Discuss the evidence base for pharmacological prophylaxis of migraine in adults: • Beta-blockers • Calcium channel blockers • Sodium valproate • Tricyclic antidepressants • Selective serotonin-noradrenaline reuptake inhibitors ('SNRI's) • Topiramate • Pizotifen • Gabapentinoids • Calcitonin gene related peptide (CGRP) therapies	

	Domains	KSA	Headache and Orofacial pain At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
ET_HF_24	6,8	K	Discuss the evidence base for and the role of botulinum toxin in the prophylactic management of chronic migraine	
ET_HF_25	6,8	K S	Discuss the limited role of invasive treatment options e.g. occipital nerve stimulation for refractory migraine, and cluster headache	
ET_HF_26	6, 8	K	Describe the treatment options available in the management of medication over-use headache	
	Management of Orofacial Pain			
ET_HF_27	6, 8	K	Discuss the evidence base, recommendations and side effects for pharmacological treatment of trigeminal neuralgia with: • Carbamazepine • Oxcarbamazepine • Lamotrigine • Gabapentin and pregabalin • Clonazepam • Baclofen • Levetirazetame • Angiotensin-II receptor antagonists • Others	
ET_HF_28	4,6	K S	Discuss the efficacy and complications of surgical options for trigeminal neuralgia: • Neurovascular decompression • Radiofrequency ablation • Balloon compression • Gamma knife • Glycerol rhizotomy • Partial rhizotomy	

	Domains	KSA	**Headache and Orofacial pain** **At the end of training, the trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)
			• Stereotactic radiosurgery	
ET_HF_29	6,8	K S	Discuss the evidence base for management of painful trigeminal neuropathy with trigeminal ganglion stimulation	
ET_HF_30	4,6,8	K	Discuss the evidence base behind these treatments for temporomandibular disorders: • Education and information (counselling) • CBT • Jaw exercises • Occlusal appliances • Physical therapies (e.g. acupuncture, massage) or physiotherapy techniques • Temporomandibular joint arthroscopy • Temporomandibular joint surgery	
ET_HF_31	2,6,8	K S A	Appreciate the need to manage temporomandibular pain early and holistically to prevent chronicity	
ET_HF_32	6	K	Discuss the evidence base for management of “burning mouth” syndrome	
ET_HF_33	6	K	Discuss the evidence base for management of persistent idiopathic facial pain	
ET_HF_34	6	K	Discuss the evidence for use of motor cortex stimulation	
ET_HF_35	2,6,8	K S A	Evaluate efficacy of key interventions through assessment of key clinical and patient reported outcomes	
ET_HF_36	6,8	S	Perform Occipital Nerve Block / Botulinum Toxin injection / Occipital Nerve Stimulation / Trigeminal Nerve Radiofrequency Ablation	DOPS

	Domains	KSA	Headache and Orofacial pain At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)

Minimum Volume of Practice Training Requirements for: Headache/Orofacial pain			
		Year 1	Year 2
Observe			
Trigeminal Nerve Radiofrequency Ablation		2	
Occipital Nerve Blocks +/- local stimulation		5	
Botulinum Toxin injection		3	
Perform			
Trigeminal Nerve Radiofrequency Ablation			2
Occipital Nerve Blocks +/- local stimulation		5	5
Botulinum Toxin injection			3
Workplace Based Assessments			
Required WBAs over two years		2	
Available WBAs	CBD DOPS Mini CEX	36 1 3	

8. Neck & Back (Spinal) Pain

	Domains	KSA	Neck & Back (Spinal) Pain At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD
	Background			
ET_SP_1	6	K	Compare and contrast the current IASP Classification of Spinal Pain with other classification systems	
ET_SP_2	6	K	Discuss the diagnostic terminology of spinal pain	
ET_SP_3	2,6	K	Discuss the public health dimensions of the problem of spinal pain, including but not limited to: • Prevalence • Demography • Personal and societal costs including but not limited to: ○ Effects on the quality of life ○ Ability to work	

	Domains	KSA	Neck & Back (Spinal) Pain At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD
			○ Social function ○ Disability and sickness benefits ○ Lost productivity	
ET_SP_4	2,6	K	Recognise major risk factors, including psychosocial, for transition of acute to chronic low back pain	
ET_SP_5	2,6	K	Recognise risk factors for transition of acute to chronic neck pain following “whiplash” injury	
ET_SP_6	6	K	Discuss factors predictive of chronicity after acute spinal pain, including but not restricted to the “flag” system	
	Applied Foundation Knowledge			
ET_SP_7	6	K	Describe the neuroanatomy and function of the spine and identify potential structures that can be associated with pain	
ET_SP_8	6,8	K S	Critically appraise the value of epidural injections, zygo-apophyseal joint injections, medial branch blocks and denervation as part of a long-term plan and as a part of the diagnostic process	
	Clinical Assessment of Neck and Back pain			
ET_SP_9	1,6,8	K S	Discuss initial evaluation of spinal pain, including risk assessment and risk stratification tools e.g. STarT Back.	
ET_SP_10	1,6,8	K	Discuss the rationale and use of questionnaires for assessing dimensions of chronic spinal pain e.g. • Oswestry Low back Pain Disability Questionnaire • Roland Morris Disability Questionnaire • Assessment of mood, anxiety, catastrophising Demonstrate their use for assessment in this group of patients	

	Domains	KSA	**Neck & Back (Spinal) Pain** **At the end of training, the trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD
ET_SP_11	6	K	Identify the potential specific causes of acute and chronic spinal pain including but not limited to: • Infection • Trauma • Neoplasia • Metabolic bone disease • Inflammatory disease • Pain hypersensitivity/augmentation.	
ET_SP_12	6,8	S	Distinguish between radiculopathic and referred pain, with respect to limb girdle or limb pain associated with spinal pain. Demonstrate in this group of patients	Mini-CEX
ET_SP_13	6,8	S	Critically interpret commonly used physical examination tests for upper and lower limbs e.g. Lasegue/straight leg raise test, slump test etc. Demonstrate same	Mini-CEX
ET_SP_14	6,8	K S	Perform a gait analysis	Mini-CEX
ET_SP_15	1,6,8	S	Recognise the clinical presentation of symptomatic spinal stenosis	
ET_SP_16	1,6,8	S	Recognise “red flag” pathologies: e.g. cauda equina syndrome and neoplasm	
ET_SP_17	6,8	S	Distinguish between acute and acute-on-chronic episodes of spinal pain	
ET_SP_18	6,8	S	Reinterpret pre-existing investigations and opinions in the light of clinical findings	
ET_SP_19	6,8	K	Know and discuss when to order investigations, including imaging and how to interpret images and reports	

	Domains	KSA	Neck & Back (Spinal) Pain At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD
	Management of Neck and Back Pain			
ET_SP_20	6,8	K	Critically discuss the evidence base for management of acute low back pain with or without radicular pain	
ET_SP_21	6	K	Describe international guidelines for the management of acute and chronic low back pain	
ET_SP_22	6	K A	Discuss the importance of self-management and how it may be implemented	
ET_SP_23	6	K	Discuss the efficacy of psychological therapies in chronic spinal pain including, but not limited to: • CBT • Acceptance Commitment Therapy • Biofeedback • Mindfulness • Relaxation therapies • Hypnosis Combined psychological and physical approaches	
ET_SP_24	4,6,8	K	Discuss principles of activity prescription in the management of neck and back pain	
ET_SP_25	1,4,6 8	K	Discuss the evidence for efficacy and adverse effects of physical therapies in spinal pain, including but not limited to: • Graded exercise exposure • Aerobic exercises • Stretching/strengthening • Posture training • Hydrotherapy • Alexander technique • Feldenkrais technique	

	Domains	KSA	Neck & Back (Spinal) Pain At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD
			• Biofeedback • Manual therapy • Massage • Acupuncture • Electrical stimulation, Transcutaneous and Percutaneous Electrical Nerve Stimulation (TENS, PENS) • Laser therapy	
ET_SP_26	6, 8	K	Critically discuss the evidence base for the efficacy of pharmacological treatment for chronic spinal pain including: • Paracetamol • NSAIDs • Weak opioids, including combination products • Strong opioids • Adjunct medications including antidepressants and anticonvulsants • Antibiotics for Modic disc changes	

ET_SP_27	6, 8	K	Critically discuss the evidence base for the indications efficacy and complications of interventions used for chronic spinal pain, with or without radicular pain including:
			• Injections:
			  ○ Epidural: Lumbar/caudal steroids
			  ○ Medial branch block & Radiofrequency Ablation
			  ○ Prolotherapy
			  ○ Trigger point injections
			  ○ Botulinum toxin	

	Domains	KSA	Neck & Back (Spinal) Pain At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD
			○ Intra-articular steroids (zygapophyseal (facet)and sacro-iliac) • Radiofrequency and electrothermal treatment (including evaluation) ○ Zygapophyseal joint ○ Intervertebral disc ○ Sacro-iliac joint ○ Dorsal Root ganglion • Central neuromodulation including spinal cord stimulation • Peripheral nerve stimulation • Intrathecal drug infusion • Epiduroscopy	
ET_SP_28	6, 8	K	Clinically discuss the evidence base for the indications, efficacy and limitations of surgical interventions for chronic spinal pain with or without radiculopathy • Decompression/laminectomy • Discectomy • Disc replacement • Fusion	
ET_SP_29	1,6,8	K	Critically discuss the evidence base for the efficacy and complications of complementary and alternative medicine in spinal pain, e.g., acupuncture, chiropractic	
ET_SP_30	2,6,8	S	Evaluate efficacy of key interventions through assessment of key clinical and patient reported outcomes	
ET_SP_31	6,8	K S A	Describes and performs a selection of the following interventional pain management techniques, including indications, complications, procedure:	DOPS

	Domains	KSA	Neck & Back (Spinal) Pain At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD
			• Muscle trigger point injections • Caudal, thoracic, cervical and lumbar epidural. Steroid Injection under visualisation (ultrasound or fluoroscopy) • Sympathetic Blocks • Facet (Zygapophyseal) Joint – medial branch blocks • Selective Lumbar Nerve Root Blocks • Radio Frequency Rhizotomy • Pulsed RF lesioning • Spinal Cord Stimulation (see Neuromodulation section 14)	

Minimum Volume of Practice Training Requirements for: Neck & Back (Spinal) Pain		
	Year 1 (Observe only)	**Year 2 (Perform)**
Procedural Skill • **Under Ultrasound control: US** • **Under Fluoroscopic control: FL**		
Muscle trigger point injections	5	5
Selective Nerve root blocks • Lumbar • Thoracic • Cervical	 5 2 3	 5 2 3
Caudal epidural steroid injection (FL / US)	5	5
Transforaminal epidural steroid injection (FL / US) and / or interlaminar epidural corticosteroid injection (FL / US) • Lumbar • Thoracic • Cervical	 5 2 3	 5 2 3

Pulsed radiofrequency lesioning at the level of the dorsal root ganglion (FL / US)	5	5
Lumbar medial branch of the ramus dorsalis block (FL / US)	5	5
Lumbar rhizotomy of the medial branch of the ramus dorsalis (FL / US)	5	5
Cervical medial branch of the ramus dorsalis block (FL / US)	3	3
Cervical rhizotomy of the medial branch of the ramus dorsalis (FL)	3	3
Facet joint injection • Lumbar • Cervical	5 3	5 3
Workplace Based Assessments		
Required WBAs over two years	4	
Available WBAs — CBD	31	
Available WBAs — DOPS	1	
Available WBAs — Mini-CEX	3	

9(a). Musculoskeletal ('MSK') Pain General

	Domains	KSA	Musculoskeletal (MSK) Pain (A) General At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
	MSK Pain Background			
ET_MSA_1	6,8	K	Understand the pathophysiology of joint pain, muscle pain and bone pain	
	MSK Pain Applied Foundation Knowledge			
ET_MSA_2	2,6 8	K	Recognise the stages of acute and chronic MSK pain and discuss	
ET_MSA_3	2,6 8	K	Understand the mechanisms leading to the development of chronicity and its prevention	
ET_MSA_4	2,6 8	K S	Recognise causes and treatments of joint pain	
ET_MSA_5	2,6 8	K S	Recognise causes and treatment of bone pain	

	Domains	KSA	Musculoskeletal (MSK) Pain (A) General At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
ET_MSA_6	6,8	K S	Recognise the role of movement of in causation of MSK pain	
ET_MSA_7	2,6 8	K S	Recognise the influence of repetitive injuries in MSK pain	
ET_MSA_8	2, 6,8	K S	Discuss the role of work and its relationship with MSK pain	
ET_MSA_9	2,6 8	K	Discuss sleep disorders and their relationship to MSK pain	
ET_MSA_10	6,8	K	Recognise the poor correlation between symptoms and imaging findings	
	Clinical Assessment of Musculoskeletal Pain			
ET_MSA_11	6,8	K A	Outline the importance of assessment of function together with pain	
ET_MSA_12	6,8	K S	Differentiate inflammatory and mechanical pain	
ET_MSA_13	3,6 8	K S	Assess the impact of MSK pain on activities of daily living	
	Management of Musculoskeletal Pain			
ET_MSA_14	6,8	K S	Discuss the evidence base for employing the following strategies to manage MSK pain: • Self-management • Exercise • Rehabilitation • Pharmacology • Non-pharmacological approaches	

	Domains	KSA	Musculoskeletal (MSK) Pain (A) General At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
ET_MSA_15	3,8	S	Evaluate efficacy of key interventions, through assessment of key clinical and patient reported outcomes	
ET_MSA_16	2,6 8	K S A	Demonstrate proficiency in carrying out the following procedures: • Shoulder joint corticosteroid injection ultrasound ('US') • Supra scapular nerve block (US) • Knee joint corticosteroid injection (US) • Genicular nerve +/- ablative procedure under imaging • Lateral cutaneous nerve of thigh (US) • Abdominal wall blocks (US) • Greater trochanter bursa injection (US) • Sacro-iliac joint injection (US and FL) • Protein-Rich Plasma (PRP) joint injection of knee/shoulder (US)	DOPS

Minimum Volume of Practice Training Requirements for: Musculoskeletal Pain		
	Year 1 (Observe only)	Year 2 (Perform)
Shoulder joint corticosteroid injection ultrasound (US)	3	3
Supra-scapular nerve block (US)	3	3
Knee joint corticosteroid injection (US)	3	3
Genicular nerve block +/- ablative procedure (US)	3	3
Lateral cutaneous nerve of thigh (US)	2	2
Abdominal wall blocks (US)	3	3
Greater trochanter bursa injection (US)	3	3

Sacro-iliac joint injection (US and FL)		5	5
Protein-Rich Plasma (PRP) joint injection of knee/shoulder (US control)		3	3
Workplace Based Assessments			
Required WBAs over two years		2	
Available WBAs	CBD	16	
	DOPS	1	

9b. Musculoskeletal (MSK) Pain

Fibromyalgia Syndrome (FMS) and Chronic Widespread Pain (CWP)

	Domains	KSA	**Musculoskeletal (MSK) Pain (B)** **Fibromyalgia Syndrome (FMS) and Chronic Widespread Pain (CWP)** **At the end of training, the trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)
	Background: Fibromyalgia Syndrome (FMS) & Chronic Widespread Pain (CWP)			
ET_MSB_1	6 8	K	Demonstrate understanding of historical speculations about the nature of pain that is poorly understood, the shortcomings of these speculations and the medical and social outcomes that have arisen as a result of the adoption of these concepts. These include but are not limited to: • Symptoms as psychological by default (DSM 5 and ICD-10) • Symptoms as injury e.g. “repetitive strain injury” • Symptoms as disease entity e.g. “fibromyalgia syndrome” • Symptoms according to different age groups e.g. adolescents, adults and older adults	
ET_MSB_2	6 8	K	Discuss developments in the field of nociceptive signal processing in the brain and descending control systems	
	Applied Foundation Knowledge			

	Domains	KSA	Musculoskeletal (MSK) Pain (B) **Fibromyalgia Syndrome (FMS) and Chronic Widespread Pain (CWP)** **At the end of training, the trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)
ET_MSB_3	6 8	K A	Recognise the potential contributions of sources of somatic and visceral nociception to the experience of widespread pain including CNS processing and descending controls	
	Clinical assessment of FMS and CWP			
ET_MSB_4	6 8	K	Outline the heterogeneity of clinical presentations of CWP	
ET_MSB_5	6 8	K S	Critically interpret the clinical finding of “tenderness”	
ET_MSB_6	6 8	K	Critically evaluate the constructs of “myofascial pain” and “fibromyalgia syndrome”	
ET_MSB_7	6 8	K	Understand the condition of FMS and its historical and more recent definitions including the current American College of Rheumatology definition, revised in 2011	
ET_MSB_8	6 8	K A	Know the incidence, including relative occurrence according to gender, and understand the societal impact of FMS	
ET_MSB_9	6 8	K	Discuss and critique the criteria for diagnosis including: • Widespread pain • Tender points • Fatigue • Sleep problems • Mood disturbance, including depression and anxiety • Cognitive effects, including loss of concentration, memory	

	Domains	KSA	Musculoskeletal (MSK) Pain (B) **Fibromyalgia Syndrome (FMS) and Chronic Widespread Pain (CWP)** **At the end of training, the trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)
			• Associated conditions including irritable bowel syndrome (IBS), headache, cystitis, chronic fatigue syndrome (CFS) • Absence of other conditions to explain symptoms	
ET_MSB_10	6 7 8	K	Discuss the possible aetiologies for FMS and CWP such as: • Chemical changes in the brain • Central sensitisation • Small fibre neuropathy • Altered descending inhibition • Sleep disturbance • Injury (including trauma and litigation) • Viral disorder • Growth hormone deficiency • Genetic predisposition (gene abnormalities) • Immune system disorder • Lyme disease • Arteriovenous shunt (Albrecht)	
	Management of FMS and CWP			
ET_MSB_11	6 8	K	Discuss reasons for the paucity of quality evidence in the management of CWP	
ET_MSB_12	1 to 8	K A	Appreciate the need to provide a multidisciplinary approach including explanation, acceptance, graded activity and social adaptations. Critically review	Mini-CEX

	Domains	KSA	Musculoskeletal (MSK) Pain (B) **Fibromyalgia Syndrome (FMS) and Chronic Widespread Pain (CWP)** **At the end of training, the trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)
			multidisciplinary approach and medications used for FMS (see below)	

ET_MSB_13	6
	8
		K	Discuss treatment of FMS according to international guidelines including the evidence base and the place of:
			• Self-management
			• Graded exercise
			• Medications including:
			  ○ antidepressants
			  ○ pregabalin
			  ○ tramadol
			  ○ simple analgesics only in short-term usage
			  ○ Other than tramadol, opioids should not be used
			• CBT
			• Use of appropriate alternative techniques to reduce symptoms and encourage increased activity and better function
				Mini-CEX

ET_MSB_14	6 8	K	Explain efficacy of key interventions through assessment of key clinical and patient reported outcomes	
ET_MSB_15	6 8	K S	Consider the role of interventional pain management techniques in the management of chronic widespread pain	

Minimum Volume of Practice Training Requirements for: Musculoskeletal Pain (b) - Fibromyalgia Syndrome (FMS) and Chronic Widespread Pain (CWP) Pain			
		Year 1	**Year 2**
Attend multidisciplinary discussions on FMS and CWP		2	5
Workplace Based Assessments			
Required WBAs over two years		2	
Available WBAs	CBD	15	
	Mini-CEX	2	

10. Complex Regional Pain Syndromes

	Domains	KSA	Complex Regional Pain Syndromes At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
	Background			
ET_CRP_1	6, 8	K	Discuss the historical progression of terminology used to describe CRPS Syndromes, type I and II, towards the current use of clinical and research New IASP (Budapest) criteria	
ET_CRP_2	6, 8	K	Discuss sensitivity, specificity and positive predictive value of the current diagnostic criteria	
ET_CRP_3	6, 8	K	Know that there are differences between adult and paediatric CRPS in terms of presentation, disease course, management and prognosis	
	Applied foundation Knowledge			
ET_CRP_4	6, 8	K	Discuss proposed pathophysiological mechanisms of CRPS types I and II	
ET_CRP_5	6	K	Explain the rationale for programmes for: • Desensitisation • Graded mobilisation • Mirror Box Therapy	
	Clinical Identification and Assessment of CRPS			
ET_CRP_6	6,8	K S	Generate a differential diagnosis of more common conditions for a patient with presumed CRPS and know how to use the new IASP criteria	

	Domains	KSA	**Complex Regional Pain Syndromes** **At the end of training, the trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)
ET_CRP_7	2,6,8	K S A	Perform a functional assessment of a CRPS-affected limb including: • Comparison with the contralateral limb • Performance of activities of daily living • Motion analysis, gait analysis, where relevant • Deep somatic structures (bone, joints) • Vasomotor changes, sudomotor changes, trophic changes and sensory changes	Mini-CEX
ET_CRP_8	6	K	Outline the role and elements of the following strategies in achieving improved function and/or recovery in patients with CRPS: • General o Patient information and education • Psychological (CBT) including but not limited to: o Coping skills o Relaxation techniques o Addressing critical life events and abuse o Management of anxiety and/or depression • Physical, including but not limited to: o Graded motor therapy o Mirror visual feedback o Occupational therapy o Graded paced exercise and activity o Desensitisation with tactile and thermal stimuli • Pharmacotherapy depending on the stage of the disease including: o Neuropathic pain medication	

	Domains	KSA	Complex Regional Pain Syndromes At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
			○ Bisphosphonates ○ Steroids • Invasive treatment options in selected patients ○ Neuromodulation ○ Sympathectomy ○ Infusion therapy	
ET_CRP_9	4,6,8	K	Critically discuss preventative strategies employed for CRPS according to the current evidence base (e.g. vitamin C, steroids, ketamine)	
ET_CRP_10	2,6,8	K	Evaluate efficacy of interventions through assessment of clinical and patient reported outcomes	
ET_CRP_11	2,6,8	K S	Demonstrate ability to perform the following blocks: • Stellate ganglion • Lumbar sympathetic	DOPS

Minimum Volume of Practice Training Requirements for: Complex Regional Pain			
		Year 1	Year 2
Attend CRPS physiotherapy and / or OT sessions		2	2
Attend CRPS multidisciplinary discussions		2	2
		(Observe only)	(Perform)
Stellate ganglion block (FL or US)		4	4
Lumbar sympathetic block (FL or US or CT)		2	2
Workplace Based Assessments			
Required WBAs over two years		2	
Available WBAs	CBD DOPS Mini-CEX	11 1 1	

11. Problematic Substance Use

	Domains	KSA	Problematic Substance Use At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
	Background			
ET_PSU_1	6, 8	K A	Define the following concepts: • Tolerance • Physical dependence • Psychological dependence • Problematic substance use • Addiction • Clinical states following psychoactive substance use • Dual diagnosis (problematic substance use co-morbid with physical / mental health problems)	
ET_PSU_2	4,6	K A	Critically discuss the difference in understanding and the use of the terms in standard ET_PSU_1 between the disciplines of pain medicine and addiction medicine	
ET_PSU_3	2,6,8	K S A	Distinguish between inappropriate prescription (inappropriate prescriber behaviour) and unsanctioned use (unsanctioned user behaviour) of drugs	
ET_PSU_4	2, 5 6, 8	K S A	Describe the impact of the following non-prescription substances on health and pain experience: • Caffeine • Nicotine • Alcohol • Cannabis • Methamphetamine and other stimulants	
	Applied Foundation Knowledge			

	Domains	KSA	Problematic Substance Use At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
ET_PSU_5	1,5,7 8	K S A	Describe in detail regulations regarding the prescription, restrictions and monitoring of controlled substances	
ET_PSU_6	4,6,8	K S A	Discuss the current DSM 5 or ICD-10 criteria for diagnosis of mental and behavioural problems due to psychoactive substance use, in particular Opioid Use Disorder discuss the appropriateness of ICD-10 for diagnosis of problematic substance use and dependency for patients receiving opioid therapy.	
ET_PSU_7	6,8	K S	Discuss in detail the use of benzodiazepines in acute pain and chronic non-cancer pain	
	Clinical Presentations and Risk Assessment			
ET_PSU_8	6,8	K S	Recognise the different forms of problematic substance use that may be co-morbid with the experience of chronic pain	
ET_PSU_9	6,8	K S A	Compare and contrast intoxication and withdrawal syndromes from: • Opioids • Alcohol • Benzodiazepines • Amphetamines • Cannabis	
ET_PSU_10	2,4,6 8	K S	Identify patients at risk of problematic substance use when considering opioid prescription for pain using appropriate scoring systems	
ET_PSU_11	6 8	K S	Critically appraise the tools available to assist clinical assessment of suitability for, and monitoring of, prescription of opioids for chronic non-cancer pain	

	Domains	KSA	Problematic Substance Use At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
ET_PSU_12	6,8	K S	Stratify patients into "risk" categories when considering opioid prescription for chronic non-cancer pain	Mini-CEX
ET_PSU_13	6,8	K S	Discuss the uses and limitations of urine drug testing and hair analysis	
	Management of Problematic Substance Use			
ET_PSU_14	6,8	K S	Evaluate the impact of polypharmacy in chronic pain management	
ET_PSU_15	2,4,6 8	K S A	Discuss the impact of opioid diversion on problematic opioid use and strategies to reduce opioid diversion	
ET_PSU_16	6,8	K S	Understand the regimes operated by addiction services of supervised withdrawal from: • Street opioid • Prescribed opioids (including methadone, buprenorphine and others) • Benzodiazepines • Alcohol	
ET_PSU_17	5 6	K A	Demonstrate understanding of controlled opioid substitution therapy programmes	
ET_PSU_18	4,6,8	K S	Demonstrate the assessment and management of patients with problematic substance use in the context of acute on chronic pain, including monitoring, drug therapy and rehabilitation	Mini-CEX
ET_PSU_19	2,3,6 8	K S A	In the context of a multi disciplinary approach, demonstrate skills to counsel patients, their families / carers and GPs / colleagues regarding the conduct of withdrawal of opioids and benzodiazepines in chronic non-cancer pain settings	

	Domains	KSA	Problematic Substance Use At the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
ET_PSU_20	1,3,4 5,6,7 8	K S A	Demonstrate skills to collaborate with GPs / colleagues, families / carers and, where appropriate, employers of patients with co-morbid pain and problematic substance use	

Minimum Volume of Practice Training Requirements for Problematic Substance Use:		
Workplace Based Assessments		
Required WBAs over two years		1
Available WBAs	CBD Mini-CEX	20 2

12. Psychiatry and Chronic Pain

	Domains	KSA	Psychiatry and Chronic Pain At the end of training, a trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
	Background			
ET_PS_1	1,2,6 8	K	Outline the nature and extent of psychiatric morbidity commonly encountered in clinical pain populations	
ET_PS_2	1,2,3 4,5,6	K S A	Describe how psychiatric illness relevant to pain medicine may be modulated through predisposing, precipitating, perpetuating, and protecting factors	
ET_PS_3	1,2,3 4,6,8	K S A	Critically discuss the concept of “maladaptive illness behaviour”	
ET_PS_4	1,2,3 4,6,8	K S A	Discuss the concept of the ‘mind-body connection’ and how it pertains to pain medicine	

	Domains	KSA	**Psychiatry and Chronic Pain** **At the end of training, a trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)
ET_PS_5	1 to 8	K S A	Describe the core psychological symptoms and their course, as well as the diagnostic criteria, for a range of psychiatric disorders, including but not limited to: • Depressive disorders • Anxiety disorders • Trauma and Stressor related disorders • Schizophrenia spectrum and other psychotic disorders • Personality disorders • Somatic symptom and related disorders • Problematic substance use • Neurocognitive disorders, including delirium and dementia	
ET_PS_6	1,2,3 4,6,8	K S A	Describe how biologic predisposition, childhood and early life experiences, including cultural and societal environments, may impact pain perception and pain experience using a bio-psychosocial model	
ET_PS_7	1,2,3 4,5,6	K S A	Explain the psychiatric and psychological impact that medical or surgical treatment, medications or toxins, may have on a person who also requires specialist pain management	
ET_PS_8	6,8	K	Describe common drug toxicity syndromes including opioid toxicity, serotonin syndrome and neuroleptic malignant syndrome	
ET_PS_9	4,5,6	K	Discuss the legislation relating to: • Capacity • Treatment under the Mental Health Act ('MHA') • Treatment under common law	

	Domains	KSA	Psychiatry and Chronic Pain At the end of training, a trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
			• Guardianship/substitute consent • Child safety	
ET_PS_10	4, 6	K A	Discuss the role of psychiatry, including liaison psychiatry, in pain medicine	
	Assessment			
ET_PS_11	1 to 8	K S	Perform an evaluation of patients with pain and undertake a risk assessment (risk to self, others, vulnerability risks) and make an appropriate and timely referral to psychiatry services in both in-patient and out-patient settings	Mini-CEX
ET_PS_12	1,2,3 8	K S A	Identify factors that may lead to refusal of treatment, and implement strategies to help patients make choices that are in their best interests	
ET_PS_13	1,2,3 6	K S	Demonstrate a clear understanding of capacity to consent to treatment and the law as it pertains to same (common law, MHA)	
ET_PS_14	1 to 8	K S A	Discuss the impact of a patient's mental health, including delirium and dementias, on pain presentation.	
ET_PS_15	2,6,8	K S	Discuss the impact of pain on a person's mental health, particularly in relation to delirium and dementia	
ET_PS_16	1,2,3 4,6,8	K S	Differentiate between the different psychiatric disorders such as depression, anxiety disorders, adjustment disorder, problematic substance use, demoralisation, grief and bereavement and recognise each in the pain medicine setting	Mini-CEX
ET_PS_17	1,2,3 4,6,8	K	Differentiate between major psychiatrc and neurocognitive disorders (e.g. delirium, dementia) in the pain medicine setting	

	Domains	KSA	**Psychiatry and Chronic Pain** **At the end of training, a trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)
ET_PS_18	1 to 8	K S	Identify unconscious mental health factors that may influence a patient's symptoms and presentation in the pain medicine setting	
ET_PS_19	3,4,5 6,7,8	K S A	Recognise the impact of distressing situations on staff and clearly identify supports available in such circumstances, both local and national, e.g. GPs, Employee Assistance Programmes, local staff counselling services, etc.	
ET_PS_20	1 to 8	K S A	Recognise the impact of childhood trauma on personality development, complex post-trauma states, psychiatric morbidity, and chronic pain states	
ET_PS_21	2,6,8	K S	Discuss the following conditions: • somatic symptom disorder • illness anxiety disorder • factitious disorder • chronic pain with somatic and psychological factors • psychological factors affecting other medical conditions	
ET_PS_22	6,8	K S	Outline the determinants of somatisation in patients in a pain clinic setting. Discuss the diagnosis of somatoform disorders including disclosure of the diagnosis to a patient and/or their family	
ET_PS_23	1,2,3 4,6,8	K S A	Assess and discuss somatisation symptoms in terms of their impact on function and quality of life in relation to pre-morbid conditions	Mini-CEX
	Management			
ET_PS_24	1,2,3 4,6,8	K	Describe the indications for and use of psychotropic medications in patients with pain	

	Domains	KSA	**Psychiatry and Chronic Pain** **At the end of training, a trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)
ET_PS_25	1,2,3 4,6,8	K	Discuss the use of psychotropic medications, including the impact of unwanted effects in the presence of other medications and in the context of pain medicine	
ET_PS_26	1,2,6 8	K	Demonstrate understanding of abuse potential of commonly prescribed psychotropic medications for treatment of pain including (but not limited to) opioids and analogues, benzodiazepines, gabapentinoids etc.	
ET_PS_27	1 to 8	K S A	Develop a management plan in consultation with psychiatry, in a multidisciplinary setting, for patients with self-harm and suicidal ideation	Mini-CEX
ET_PS_28	1 to 8	K S A	Develop a pain management plan for patients with problematic substance use in consultantation with psychiatry and addiction medicine	Mini-CEX
ET_PS_29	1 to 8	K S A	Discuss the application, in consultation with psychiatry / psychology in a multidisciplinary setting, a range of clinical interventions for patients, including crisis intervention, brief psychotherapy and psychopharmacotherapy	
ET_PS_30	1 to 8	K S A	Identify potentially suitable adult patients for psychotherapy, with special attention to those with cognitive limitations.	
ET_PS_31	1 to 8	K S A	Demonstrate an awareness of transference and countertransference issues that arise between patients and their caregivers in pain medicine settings and how this may lead to interpersonal conflict. Recognise transference and discuss how it may impact on the doctor-patient relationship. Recognise countertransference and discuss how it may impact on the doctor patient relationship	

	Domains	KSA	Psychiatry and Chronic Pain At the end of training, a trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
ET_PS_32	1 to 8	K S A	Undertake a risk assessment (vulnerability risks to self and others on wards and in clinics) Implement risk management plans in response to identified risks (risks to self and others on wards and in clinics)	

Minimum Volume of Practice Training Requirements For: Psychiatry and Chronic Pain			
		Year 1	Year 2
Attend psychiatry clinics		2	4
Workplace Based Assessments			
Required WBAs over two years		1	
Available WBAs	CBD Mini-CEX	32 5	

13. Rheumatology and Pain

	Domains	KSA	Rheumatology and Pain At the end of training the training will be able to:	Assessment (in addition to FFPMCAI/CBD)
	Background			
ET_RH_1	1,2,3 6,8	K A	Compare and contrast the current definition of • Rheumatoid Arthritis/juvenile RA • Axial Spondyloarthritia • System Lupus Erythematosus (SLE) • OsteoArthritis • Fibromyalgia syndrome	
ET_RH_2	1,6,7 8	K S	Discuss controversies in diagnostic terminology in rheumatology	

	Domains	KSA	Rheumatology and Pain At the end of training the training will be able to:	Assessment (in addition to FFPMCAI/CBD)
		A		
ET_RH_3	1,2,4 5,6,8	K S A	Discuss the public health dimensions of the problem of pain in Rheumatology including but not limited to: • Prevalence • Demography • Personal and community costs	
	Applied Foundation Knowledge			
ET_RH_4	6,8	K	Describe the joint structure and function and identify potential structures that may be associated with pain	
	Clinical assessment of Pain in Rheumatology			
ET_RH_5	1 to 8	K S A	Broadly discuss the prevalence and aetiology of Rheumatoid Arthritis and the relationship between genetic and environmental factors leading to a breakdown of immune tolerance, immune system dysregulation and synovial inflammation in a characteristic symmetric pattern.	
ET_RH_6	1,2,3 4,6,8	K S	Describe the clinical components of the Beighton Score, the advantages and limitations of this score.	
ET_RH_7	1,2,3 4,6,8	K S	Critically interpret commonly used physical examination tests, for example, Beighton score, Brighton criteria for hypermobility and myofascial pain syndrome tests.	
ET_RH_8	1,2,3 4,6,8	K S A	Perform a full musculoskeletal examination of patient with rheumatological condition (including a Beighton score).	
ET_RH_9	1 to 8	K S A	Interpret investigations in the light of clinical findings	
	Management of Pain in Rheumatological diseases			

	Domains	KSA	**Rheumatology and Pain** **At the end of training the training will be able to:**	Assessment (in addition to FFPMCAI/CBD)
ET_RH_10	5,6,8	K S A	Critically discuss the evidence base for management of acute and chronic pain in rheumatological disease.	
ET_RH_11	4,6,8	K S	Discuss the efficacy of psychological therapies in chronic musculoskeletal pain in rheumatological disease, including but not limited to: • Cognitive • Behavioural • Acceptance and Commitment	
ET_RH_12	1,2,3 4,5,6 8	K S	Discuss principles of activity prescription and occupational therapy in the management of pain in rheumatological conditions	
ET_RH_13	1,2,4 6,8	K S	Generally discuss the evidence base for efficacy and adverse effects of physical therapies in chronic rheumatology pain, including but not limited to: • Graded exercise exposure • Stabilization/strengthening • Dynamic exercises • Posture training, proprioceptive training • Hydrotherapy • Feldenkrais technique • Manual therapy • Massage • Acupuncture • Biofeedback • TENS	
ET_RH_14	4,6,8	K S	Critically discuss the mechanism of action, efficacy in modifying disease and providing pain relief, and	

	Domains	KSA	**Rheumatology and Pain** **At the end of training the training will be able to:**	Assessment (in addition to FFPMCAI/CBD)
			complications of pharmacological treatments of rheumatologic diseases including: csDMARDs (Conventional Synthetic Disease-modifying Anti-Rheumatic Agent e.g. Methotrexate) bDMARDs ("Biologics" biological drugs licenced for RA) including: • TNF-a inhibitors e.g. Infliximab, • Anti-interleukin-1 inhibitors e.g. Anakinra • Anti-Interleukin-6 inhibitors e.g. Tocilzumab • T-Cell deactivators e.g. Abatacept • B-cell inhibitors e.g. Rituximab • JAKi (Janus kinase Inhibitors) e.g. Tofacitinib	

ET_RH_15	5,6,8	K
		S
			Critically discuss the evidence base for the indications, efficacy and complications of interventions used for chronic rheumatology pain, including:
			• Injections
			• Epidural/caudal steroids
			• Medial branch injections
			• Trigger point injections
			  ○ Botulinum toxin
			  ○ Intra-articular steroids	

ET_RH_16	4,6,8	K S	Broadly appreciate the evidence base for the efficacy and the complications of complementary and alternative medicine for management of chronic pain in rheumatological conditions e.g. acupuncture	

Minimum Volume of Practice Training Requirements For: Rheumatology and Pain			
		Year 1	Year 2
Attend rheumatology clinics		5	5
Workplace Based Assessments			
Required WBAs over two years		1	
Available WBAs	CBD	16	

14. Pelvic Pain

	Domains	KSA	Pelvic Pain At the end of training the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
	Background			
ET_PP_1	6,8	K A	Describe epidemiology and natural history of pelvic pain in women and men	
ET_PP_2	6,8	K A	Discuss the psychological sequelae of persistent pelvic pain and the implications it may have on medical management.	
ET_PP_3	2,3,6 8	K S A	Discuss persistent pelvic pain that usually presents with multiple issues and is likely to have four components: • Pelvic organ contributions or causes of nociception • Somatic nociception • Peripheral and central sensitisation cross-sensitisation between organs • Patient's adaptation to chronic pain	
ET_PP_4	2,3,6 8	K S A	Recognise the lifestyle, posture, exercise and obstetric issues that predispose to the development of pelvic pain	
ET_PP_5	2,3,6 8	K S	Identify nociception involving the pelvic floor muscles and ligaments, their presenting symptoms, examination findings and management options	

	Domains	KSA	**Pelvic Pain** **At the end of training the trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)
ET_PP_6	6,8	K	Discuss in detail the concept of neuroplasticity, i.e. sensitisation or neuropathic mechanisms in persistent pelvic pain Outline the mechanisms of pain in: • Surgical nerve injury e.g. ilioinguinal/hypogastric, obturator, pudendal • Irritable bowel syndrome • Painful Bladder Syndrome • Pudendal Neuralgia	
ET_PP_7	6,8	K	Describe the mechanisms by which menstrual suppression may have an effect on pain control	
ET_PP_8	6,8	K	Outline the mechanisms of pain in: • Dysmenorrhoea • Endometriosis • Vulvodynia • Menstrual migraine • Chronic candidiasis	
	Assessment			
ET_PP_9	2,6,8	K S A	Elicit a history from the patient with pelvic pain to evaluate the pain and its impact on physical and social functioning including: • Bladder function • Bowel function including “bloating” • Food intolerances • Surgical history • Cognitive factors such as fear-avoidance beliefs and coping styles	

	Domains	KSA	**Pelvic Pain** **At the end of training the trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)
			• Precipitating neural injury • Pain, or relief of pain through exercise and activity • Sexual history • Abuse history	
ET_PP_10	1,2,3 6,8	K S	Distinguish clinically conditions that are suggestive of: • Inflammatory and neuropathic sources of pelvic pain • Nociception from pelvic muscles including pubococcygeus and obturator internus • Central sensitisation • Symptoms and signs that reflect convergence	
ET_PP_11	2,3,6 8	K S	Elicit the presence of pelvic pain muscle allodynia by both history and appropriate examination	
ET_PP_12	6,8	K	Describe the possible causes of acute exacerbations of pain in the context of persistent pelvic pain	
ET_PP_13	6,8	K S	Evaluate the relationship between pain and the menstrual cycle, including the effect of hormonal changes	
ET_PP_14	2,3,6 7,8	K S A	Perform a thorough physical examination to exclude infection and diagnose the causes of pelvic pain.	
	Management of Pelvic Pain			
ET_PP_15	5,6,8	K	Discuss treatment options for: • Bladder symptoms of frequency, nocturia or urgency • Irritable bowel and food intolerance • Pudendal neuralgia	
ET_PP_16	3,4,5 6,7,8	K	Discuss the management of pelvic muscle pain, including the contribution of obturator internus, pubococcygeus,	

	Domains	KSA	**Pelvic Pain** **At the end of training the trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)
			piriformis, mechanical allodynia and the role of physiotherapy	
ET_PP_17	1,2,3 4,5,6 8	K S A	Describe the role of psychological measures in the management of pelvic pain Describe the role of neuropathic medications and pharmacological combinations of therapy, including but limited to: • Amitriptyline • Anti-convulsants including pregabalin and gabapentin • SNRI medications including duloxetine • Describes gender specific risks and consequences of long-term pharmacotherapy including hormonal therapies used in the treatment of pelvic pain	
ET_PP_18	3,4,6 8	K S	List the allied health professionals that may be involved in the care of persistent pelvic pain and outline their respective contributions to management	
ET_PP_19	1 to 8	K S A	Discuss the importance of psychological support strategies in conjunction with other treatment	
ET_PP_20	1 to 8	K S A	Explain the role of multidisciplinary management i.e. combinations of pharmacotherapy and non-pharmacological treatments in the management of persistent pelvic pain.	
ET_PP_21	1 to 8	K S A	Discuss specific treatment options for: • Dysmenorrhoea • Endometriosis	

	Domains	KSA	**Pelvic Pain** **At the end of training the trainee will be able to:**	Assessment (in addition to FFPMCAI/CBD)
			• Vulvovaginal irritation • Chronic candidiasis • Menstrual migraine	
ET_PP_22	1,6,8	K S A	Describe the indications, effectiveness and adverse effects of pharmacotherapies used to suppress ovarian and uterine function	
ET_PP_23	1,4,5 6,8	K S	Discuss the evidence base for the indications, effectiveness and adverse effects of surgical interventions as a treatment for pelvic pain, including but not limited to laparoscopy and hysterectomy	
ET_PP_24	1 to 8	K S A	Outline the treatment options available for women with persistent pelvic pain who are trying to conceive	
ET_PP_25	1 to 8	K S A	Critically discusses the treatment options for management of persistent pelvic pain during pregnancy, the postpartum period and breastfeeding	

Minimum Volume of Practice Training Requirements For: Pelvic Pain			
		Year 1	**Year 2**
Attend multidisciplinary discussions on Pelvic Pain			2
Workplace Based Assessments			
Required WBAs over two years		1	
Available WBAs	CBD	25	

15. Neuromodulation

(Ref 1: Development of an Educational Curriculum for Spinal Cord Stimulation, Abd-Elsayed A et al, Neuromodulation 2020; 23: 555–561
Ref 2: . Guidance on competencies for Spinal Cord Stimulation, Faculty of Pain Medicine, Royal College of Anaesthetists, July 2020.)

	Domains	KSA	Neuromodulation : Spinal Cord Stimulation (SCS) and Peripheral Nerve Stimulation (PNS) By the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
			BACKGROUND	
ET_NM_ 1	1 to 8	K S A	Demonstrate knowledge of the science related to SCS & PNS including: • general principles of neuromodulation • neurophysiology/potential mechanisms of action of neuromodulation • Physics relevant to SCS & PNS including electrical safety • spinal cord anatomy/physiology & fluoroscopic appearance • Infection control	
ET_NM_ 2	1 to 8	K S A	Demonstrate knowledge of evidence base for SCS & PNS in different pain conditions • In adults • In children	
ET_NM_ 3	1 to 8	K S A	Demonstrate knowledge of indications and contra-indications of SCS & PNS, and their evidence base, • In adults • In children	
ET_NM_ 4	1 to 8	K S A	Demonstrate knowledge of the practical use of SCS & PNS devices and interactions with other devices/equipment including: • medical/electrical/magnetic equipment e.g. diathermy, physiotherapy equipment, • MRI scanners	

	Domains	KSA	Neuromodulation : Spinal Cord Stimulation (SCS) and Peripheral Nerve Stimulation (PNS) By the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
			• Other implanted devices e.g. cardiac pacemakers	
ET_NM_ 5	1 to 8	K S	Demonstrate knowledge of the range of SCS and PNS stimulator systems available, including range of leads	
ET_NM_ 6	1 to 8	K S	Demonstrate knowledge of local referral pathways for patients being considered for SCS or PNS therapy	
ET_NM_ 7	1 to 8	K S A	Demonstrate knowledge of indications for trial of SCS and PNS and evaluation of trial outcome	
ET_NM_ 8	2,3	A	Demonstrate effective communication with patients/carers	
ET_NM_ 9	1 to 8	K S A	Demonstrate effective communication with other healthcare professionals in primary and secondary care e.g., surgical specialties for assessment and treatment of urgent complications and communication with specialist teams offering SCS therapy	
ET_NM_ 10	1 to 8	KSA	Practice safe tunnelling techniques including: • Identify optimal generator location • Adopt secure anchoring systems • Ability to select optimal lead insertion and target sites • Ability to identify satisfactory lead placement Ability to demonstrate system circuit integrity	DOPS
			ASSESSMENT for Neuromodulation	
ET_NM_ 11	1 to 8	K	Demonstrate accurate assessment of pain in the context of neuromodulation and patient selection,	

	Domains	KSA	Neuromodulation : Spinal Cord Stimulation (SCS) and Peripheral Nerve Stimulation (PNS) By the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
			screening as well as preparation for therapy including physical and social assessment	
ET_NM_ 12	1 to 8	K	Participate in accurate assessment of pain in the context of neuromodulation and patient selection, screening as well as preparation for therapy including psychological assessments specifically for implantation of device	DOPS
ET_NM_ 13	1 to 8	KSA	Demonstrate knowledge relating to: • Balanced assessment of benefits/risks • Comprehensive understanding of alternatives to SCS therapy • Management of patient expectations • Provision of rehabilitative support following SCS insertion	
			MANAGEMENT of patients requiring Neuromodulation	
ET_NM_ 14	1 to 8	KSA	Demonstrate ability to perform necessary practical procedures for safe, effective evidence-based practice, including the surgical skills appropriate to SCS	DOPS
ET_NM_ 15	1 to 8	KSA	Demonstrate ability to provide follow-up care to patients with SCS and PNS in-situ including: • Ability to recognise and manage symptoms including increased pain that may indicate the requirement for reprogramming or revision • Ability to recognise early symptoms and signs of complications (infection, loss of efficacy and neurological dysfunction)	Mini-CEX

	Domains	KSA	Neuromodulation : Spinal Cord Stimulation (SCS) and Peripheral Nerve Stimulation (PNS) By the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
			• Ability to perform work-up for loss of efficacy (progression of disease vs. malfunction of stimulator • Ability to recognise when further investigation may be required either in relation to new symptoms, exacerbation of old symptoms or SCS device problems • Ability to recognise pulse generator end-of-life • Ability to manage wound complications • Ability to safely explant stimulator when indicated	
ET_NM_ 16	1 to 8	KSA	Demonstrate knowledge of multi-disciplinary teamwork and liaison with spinal and neurosurgeons, as well as other professionals including those working in radiology and microbiology	
ET_NM_ 17	1 to 8	KSA	Demonstrate skills in: • patient positioning • asepsis and infection control (hand hygiene, MRSA screening, antibiotic prophylaxis, surgical asepsis) • familiarity with implanted SCS and PNS components • techniques of access to epidural space for SCS • fluoroscopic placement of single/multiple electrodes	DOPS
ET_NM_ 18	1, 8	KSA	Interpret hardware migration/malfunction on radiographic imaging	DOPS

	Domains	KSA	Neuromodulation : Spinal Cord Stimulation (SCS) and Peripheral Nerve Stimulation (PNS) By the end of training, the trainee will be able to:	Assessment (in addition to FFPMCAI/CBD)
ET_NM_ 19	1 4,5,6,7 8	KSA	Define use of lead manipulation for optimal results (repositioning, steering, angle of entry etc.) and isolate component malfunction through sequential troubleshooting	
ET_NM_ 20	1,6,8	KSA	Demonstrate proficiency in carrying out the following procedures: • Spinal cord stimulation – trial • Spinal cord stimulation – implant	DOPS
ET_NM_ 21	1,6	K	Demonstrate knowledge of: • Peripheral Nerve Stimulator – trial • Peripheral Nerve Stimulator - implant	

Minimum Volume of Practice Training Requirements for: Neuromodulation			
		Year 1	Year 2
Attend programming sessions		5	5
		(Observe only)	(Perform)
Spinal cord stimulation – trial		5	5
Spinal cord stimulator - implant		5	5
Workplace Based Assessments			
Required WBAs over two years		2	
Available WBAs	CBD DOPS Mini-CEX	21 6 1	

16. Intrathecal Drug Delivery Systems

(Ref 1: Intrathecal drug delivery systems, Lynch L, Continuing Education in Anaesthesia, Critical Care & Pain 2014; 14:1, 27-31
Ref 2: Intrathecal drug delivery for the management of pain and spasticity in adults; recommendations for best clinical practice British Pain Society, December, 2015.)

	Domains	KSA	**Intrathecal Drug Delivery Systems** **At the end of training, the trainee is able to:**	Assessment (in addition to EEPMCAI/CBD)
ET_IDD_1	1 to 8	K	Discuss the value of Intrathecal Drug Delivery ('ITDD') systems, including the nature and purpose for patients with pain associated with: • terminal cancer • progressive cancer-related pain • intractable pain of either malignant or non-malignant aetiology	
ET_IDD_2	1,2,3 4,5,6 8	K S A	Discuss the groups of patients that may benefit from ITDD including: • those with spasticity • those with refractory pain	

ET_IDD_3	1, 6 8	K S A	Discuss the types and advantages/disadvantages of ITDD systems that are available including
			• percutaneous catheter (tunnelled or non-tunnelled) with an external pump
			• fully implanted catheter with subcutaneous injection port attached to an external pump
			• fully implanted catheter and pumps
			  ○ fixed rate
			  ○ programmable	

ET_IDD_4	1,2,3 3,6,8	K S A	Discuss recommendations for maximising efficacy and minimizing toxicity of intrathecal (IT) drugs including but not limited to:	

	Domains	KSA	**Intrathecal Drug Delivery Systems** **At the end of training, the trainee is able to:**	Assessment (in addition to EEPMCAI/CBD)
			• minimizing local concentrations of drug against neural tissue by appropriate catheter placement • high flow rates • using lowest concentration of drug possible • using more complex dosing • using on-demand or activity-based dosing • using variable flow rates • using intermittent bolus delivery	
ET_IDD_5	6	K	Describe CSF dynamics and how it affects IT drug delivery	
ET_IDD_6	1,6,8	K	Discuss the factors that affect CSF drug spread including but not limited to: • buoyancy • streaming • injection rate • enhanced diffusion • physico-chemical properties (eg ionised vs non-ionised) • pharmacokinetics (eg lipid solubility)	
ET_IDD_7	1,6,8	K	Discuss the efficacy of drugs delivered through ITDD including: • morphine • hydromorphone • ziconitide • baclofen • clonidine • fentanyl • sufentanil • bupivacaine (or levo-bupivicaine)	

	Domains	KSA	**Intrathecal Drug Delivery Systems** **At the end of training, the trainee is able to:**	Assessment (in addition to EEPMCAI/CBD)
ET_IDD_8	1,6,8	K	Discuss drugs that have demonstrated neurotoxicity and are not generally recommended for ITDD including • some opioids including pethidine, methadone, tramadol • tetracaine • dexmedetomidine • droperidol • midazolam • methylprednisolone • ondansetron	
ET_IDD_9	1,5,6 8	K	Discuss drugs that appear to be safe but for which ITDD has not been demonstrated for chronic pain including: • gabapentin • baclofen • octreotide • ropivacaine	
ET_IDD_10	1 to 8	K A	Discuss the principles of patient selection for ITDD in patients with chronic non-cancer pain (CNCP) including: • diagnostic groups e.g.: ○ back and leg pain not responsive to spinal surgery or spinal cord stimulation ○ complex regional pain syndrome non-responsive to spinal cord stimulation ○ pain from multiple vertebral fractures secondary to osteoporosis ○ neuropathic pain secondary to pre-ganglionic nerve injury eg brachial plexus avulsion, post	

	Domains	KSA	**Intrathecal Drug Delivery Systems** **At the end of training, the trainee is able to:**	Assessment (in addition to EEPMCAI/CBD)
			cauda equina syndrome where spinal cord stimulation has failed ○ patients with chronic visceral pain eg chronic pancreatitis • psychological assessment • CBT • presence of spasticity	
ET_IDD_11	1,2,3 4,6,8	K S A	Discuss the principles of patient selection for ITDD in patients with cancer pain including: • failure of conventional routes of analgesic administration despite escalating doses of strong opioids and/or other analgesics • the malignancy must be investigated with appropriate imaging techniques • epidural route may be more appropriate • neurolytic or neuroablative techniques may be appropriate alternative interventions • presence of spasticity	
ET_IDD_12	1 to 8	K S A	Discuss and demonstrate the procedure and aftercare of ITDD insertion including: • preoperative preparation • theatre procedure • inpatient management • discharge and ongoing care	DOPS
ET_IDD_13	1,2,5 6,8	K S A	Discuss and demonstrate test dosing and trials of intrathecal drugs	DOPS

	Domains	KSA	Intrathecal Drug Delivery Systems At the end of training, the trainee is able to:	Assessment (in addition to EEPMCAI/CBD)
ET_IDD_14	1,2,5 6	K S	Describe the complications from ITDD system implantation including: • infection including meningitis, epidural abscess • IT granulomas • CSF leakage • device complications including catheter kinking, disconnection, dislodgement or pump failure, programme error and overfill or incorrect refill • pump movement or scar thinning • MRI scanning • leg oedema	
ET_IDD_15	8	K S	Understand principles of best practice and describe the potential complications associated with pump refill and programming	Mini CEX DOPS

Minimum Volume of Practice Training Requirements for: Intrathecal Drug Delivery systems			
		Year 1 (Observe only)	Year 2 (Perform)
Intrathecal pump - test			5
Intrathecal pump - implant			5
Intrathecal pump - refill		2	5
Workplace Based Assessments			
Required WBAs over two years		1	
Available WBAs	CBD DOPS Mini-CEX	15 3 1	

17. Pain Management Programmes ('PMPs') and Pain Management Education Programmes ('PMEPs')

(Ref: Core standards for Pain Medicine in the UK, (2015), Faculty Pain Medicine, Royal College of Anaesthetists, UK.)

	Domains	KSA	**Pain Management Programmes (PMPs) and Pain Management Education Programmes (PMEPs)** At the end of training, the trainee will be able to;	**Assessment (in addition to FFPMCAI/CBD)**
ET_PMP_1	2,3,4, 5,6,7,8	K S A	Describe the concept of PMPs and the standards they should aim for, including but not limited to the following: • Standard and intensive PMPs should be undertaken by multi-disciplinary pain management teams which contain specialist healthcare professionals including doctors, psychologists, physiotherapists and ideally, nurses and occupational therapists. Access to pharmacists is very useful. Clinical support workers and an administrator is also required. • Access should be timely • A group format should be available, but individual sessions with team members may be required • Proper resourcing with qualified personnel, time and facilities should be in place • There should be no discrimination on the basis of age, literacy, litigation or judgement of motivation • PMP should be delivered by a suitably-qualified highly-skilled multi-disciplinary team • Standard practice should include evaluation of outcomes, including assessment of changes in physical function, psychological wellbeing, healthcare use, quality of life, and work practice where relevant. • Interventions to return to work should be viewed as an important component and be integrated with other treatment offered.	

	Domains	KSA	Pain Management Programmes (PMPs) and Pain Management Education Programmes (PMEPs) At the end of training, the trainee will be able to;	Assessment (in addition to FFPMCAI/CBD)
			• High-quality leadership and effective team working should be aimed for • Adequate time for training opportunities and continued professional development should be provided	
ET_PMP_2	2, 6, 8	K S A	Describe the cohort of patients who should be considered for PMP including but not limited to patients with persistent pain which adversely affects their quality of life and where there is significant impact on physical, psychological and social function	
ET_PMP_3	1 to 8	K S A	Describe the typical time-allocation of PMPs (minimum of 12 half-day periods generally)	
ET_PMP_4	1 to 8	K S A	Discuss the principles of cognitive behavioural therapy (CBT) including but not limited to: • Graded activation guided by participant goals – a process of goal-setting, identification and management of barriers to activity, and the practice of specific practical and psychological skills in order to produce integrated and sustainable patterns of healthy activity • Cognitive behavioural methods to identify, examine, and change the impact of distressing, misleading, or restrictive thoughts and beliefs • Graded exposure to reduce fear or to increase willingness to experience fear, in order to reduce avoidance and increase activity • Methods to enhance acceptance, mindfulness and psychological flexibility through a process of "psychological flexibility".	

	Domains	KSA	**Pain Management Programmes (PMPs) and Pain Management Education Programmes (PMEPs)** At the end of training, the trainee will be able to;	**Assessment (in addition to FFPMCAI/CBD)**
			• Skills training and activity management to provide an opportunity for direct practice in the use of skills for changing behaviour, pursuing goals and dealing with barriers to the achievement of these goals. Typical skills taught include: ○ Methods for altering the adverse impacts of thoughts and feelings on healthy behaviours ○ Methods for identifying, setting, and planning and pursuing goals ○ Strategies for co-ordinating, scheduling and managing the rate and pattern of goal-directed activity ○ Skills for communication and social interaction ○ Sleep management methods ○ Explicit methods for generalising and integrating new skills and behaviour change into daily life and maintaining these over the longer term. • Physical exercise to change behaviour patterns around physical sensations – including pain, to increase willingness to engage the body in movements and to expand patterns of activity, Exercise also aims to increase movement, to enable increased goal-directed therapy, and to eventually improve fitness and physical health	
ET_PMP_5	1 to 8	KSA	Discuss the concept of education to improve knowledge and understanding which may improve behaviour change or improve daily functioning. Education can include information on:	

	Domains	KSA	**Pain Management Programmes (PMPs) and Pain Management Education Programmes (PMEPs)** At the end of training, the trainee will be able to;	**Assessment (in addition to FFPMCAI/CBD)**
			○ Pain anatomy, physiology and mechanisms ○ Pain psychology ○ Safety and risk in relation to increased activity ○ Advantages and disadvantages to using aids, treatments and medication ○ Self-management approaches to flare-ups and setbacks • Lifestyle and lifestyle changes issues for improving or maintaining general health ○ Supports to facilitate return to work	
ET_PMP_6	3,4,5,6	K S	Discuss the concept that individual pain rehabilitation physiotherapy and/or psychology treatment sessions may be required for some patients before, during and after PMPs	
ET_PMP_7	2,3,4,6	K	Discuss the expertise and contribution required of the different members of the PMP team including: • Medical Practitioner • Psychologist • Physiotherapist • Occupational Therapist • Nurse	

	Domains	KSA	Pain Management Programmes (PMPs) and Pain Management Education Programmes (PMEPs) At the end of training, the trainee will be able to;	Assessment (in addition to FFPMCAI/CBD)
ET_PMP_8	2,4,5,6	K A	Discusses the effectiveness of PMPs: • cost-effectiveness • ability to reduce healthcare consumption and enable more appropriate use of healthcare resources. • Ability to reduce presentation with pain-related issues to primary care and accident and emergency departments, reduce onward referrals to specialist services, and reduce the need for medication. • That PMPs are recognised and established as a core part of pain treatment	

Minimum Volume of Practice Training Requirements for: PMP			
		Year 1	Year 2
Pain Management Programme			
Attend Multidisciplinary PMP Assessment Clinics		3	3
Follow at least one Pain Management Programme from beginning to end		1	1
Attend Pain Management Patient Education sessions		3	3
Workplace Based Assessments			
Required WBAs over two years		2	
Available WBAs	CBD	8	

Appendix 1 - Training Diary and E-Portfolio

Maintenance of the College approved e-Portfolio is mandatory for trainees on the Specialist Training Programme in Pain Medicine. The purposes served by the e-Portfolio are to:

- Record the trainee's profile and rotations;
- Provide for the electronic capture of volume of practice and generation of volume of practice reports;
- Record trainee and tutor interactions, including workplace based assessments;
- Record professional activities including training diary;
- Record clinical reflection;
- Provide access to learning resources.

The Medical Council's Professional Competence Schemes ('PCS') are formal structures to ensure that all doctors registered and working in Ireland maintain their education, knowledge and skills (competence) at an acceptable level. All registered medical professionals have a legal duty to maintain professional competence, however, trainees registered on the Trainee Specialist Division of the Medical Council Register are NOT required to be enrolled on a PCS. This is because trainees on a formal training programme are recognised as undergoing consistent work in education and skills.

However, although trainees on the Faculty's specialist training programme are not required to be enrolled on a PCS, the CAI utilises the concept of Professional Competence to promote self-directed and practice-based learning activities, as well as activities that maintain and develop professionalism, knowledge, skills and attitudes in their trainees. The Eight Domains of Good Professional Practice recommended by the Medical Council and referred to in Section One of this document describe a framework of competencies applicable to all doctors and the training diary, which is located in the trainee's e-Portfolio, maps learning activities to each of these domains. These domains should be used by trainees to assess professional development needs.

With this structure in mind, trainees are required to complete a training diary which reflects all elements of learning. Mandatory documentation of attendance at learning activities is required which mirror those outlined in the PCS.

The points accrued in the training diary are a reflection of the Medical Council's Eight Domains of Good Professional Practice. Specialist pain medicine trainees are expected to demonstrate professionalism, this will be documented in the training diary, and reviewed by the Faculty at the trainee's Progression Review at the end of Year 1.

Expected annual requirements include:

50 Continuing Professional Development ('CPD') credits annually comprising (minimum):

- External 20 credits (minimum)
- Internal 20 credits (minimum)
- Personal Learning 5 credits (minimum)
- Research, Postgraduate Examining and Teaching - total 2 credits desirable

Training Diary Activity Categories

External:

- Attending Consultant Session Outside Base Hospital; CAI Meetings; International Meetings; National Meetings; Training Courses; Live video conference teaching with participant interaction

Internal:

- Mortality & Morbidity Meetings; Journal Clubs; Grand Rounds; Appraisal Training; Hospital Lectures; Attending Consultant Session in Base Hospital

Personal:

- Recorded Internet Lectures; Independent Study; Verified Distance Learning; Verified Computer Assisted Learning; Verified Educational Video; Verified MCQ's in Medical Journey

Research or Teaching:

- Research Meetings; Presentation of Research Findings; Publication in Recognised Medical Journal (5 credits per publication); Publication of Chapter or Book (5 credits per publication); College or University Examinations; Faculty on CAI course; Preparation of a Lecture (5 credits per lecture); Conducting Supervisorial; Faculty on other course.

Audit:

Clinical Audit can be defined as the "systematic review and evaluation of current practice with reference to research based standards to improve patient care." The setting of standards, measurement of practice compared to 'gold standard', identification of deficiencies and addressing deficiencies (closing the loop) is an accepted model of clinical audit. Audit may include Departmental Audit Meetings; Critical Incident Meetings; Personal Clinical Audit; Measurement of individual compliance with guidelines protocols; Pain Medicine Workshop; Skills Analysis; Department/Practice Audit; Directly Observed Procedures (DOPS); Individual Practice Review; Evaluation of individual risk incidents/ complaints; Patient satisfaction; Self-assessment; Peer review.

Protected Training Time:

Trainees are required to also keep a record in their training diary of any additional protected training time. This is described as "the time a trainee spends on-site in the hospital that is reserved for training purposes only, with no bleeps or obligations to attend work duties during the training session". Under the Organisation of Working Time Act, trainees are entitled to protected training time and in compliance with HSE regulations, trainees need to be in a position to provide proof of same.

Non-Clinical Time:

Trainees are required to keep a record of their activities during allocated non-clinical time, where appropriate. Where it can be accommodated, non-clinical time is factored into a trainee's working schedule to promote participation in academic and research activities. These activities must be recorded in the trainee's e-Portfolio and provided at Exit Interview.

Reflective Practice

Doctors need to think critically and to engage themselves in reflection upon their professional activities to improve their performance. This is a deliberate practice which calls for the doctor to reflect on their own practice, identify areas for improvement (especially if difficulties or unexpected problems were encountered) and develop a plan to improve their overall performance. The reflection can relate to both positive and negative experiences and the recorded learning outcomes and action plans should serve to provide a valuable learning experience for the trainee. Opportunities for reflective practice could be at the end of a module, at the end of a rotation, at the end of a training period (theatre on-call, senior on-call), after a challenging clinical experience or after an academic session. These reflections should be recorded in the trainee's e-Portfolio.

A simple model for reflection has been described by Borton*, and may be useful as a guide to learning through reflection.

1) What: Describe the event, the facts
2) So What: What did this experience mean to me? What is the interpretation, lessons and feelings?
3) Now what: What are the next steps? How can I use this experience to plan for the future?

*Reference: Borton, T. (1970) Reach, Touch and Teach. London: Hutchinson.

The trainee's reflective practice may be discussed at either an In-Training Assessment ('ITA') or progression interview. Ideally the trainee should complete at least one reflection per year of training. Evidence of critical reflection will be required prior to award of CSCST.

Appendix 2 - Workplace Based Assessments

Workplace based assessments provide an opportunity for trainees to obtain feedback and for skill, knowledge and progression to be documented. There are three types of workplace based assessments, each with a different focus of knowledge, skill or behaviour.

A Case Based Discussion (CBD) involves a consultant and trainee reviewing a selected routine clinical case or an aspect of patient care, in which the consultant participated. The discussion is focused on the application of the trainee's clinical knowledge, and on their diagnostic ability and patient management skills.

Direct Observation of Procedural Skills (DOPS) involves a trainee being observed by a consultant whilst performing a specific clinical technical procedure. DOPS are completed with patients, in real time, as part of routine clinical work. DOPS are an indicator of clinical skill and proficiency. For the purposes of this curriculum, to broaden the choice of assessment tool options, DOPS has been chosen for use outside its normal remit to move from "a specific technical procedure" to also include a piece of "routine clinical work".

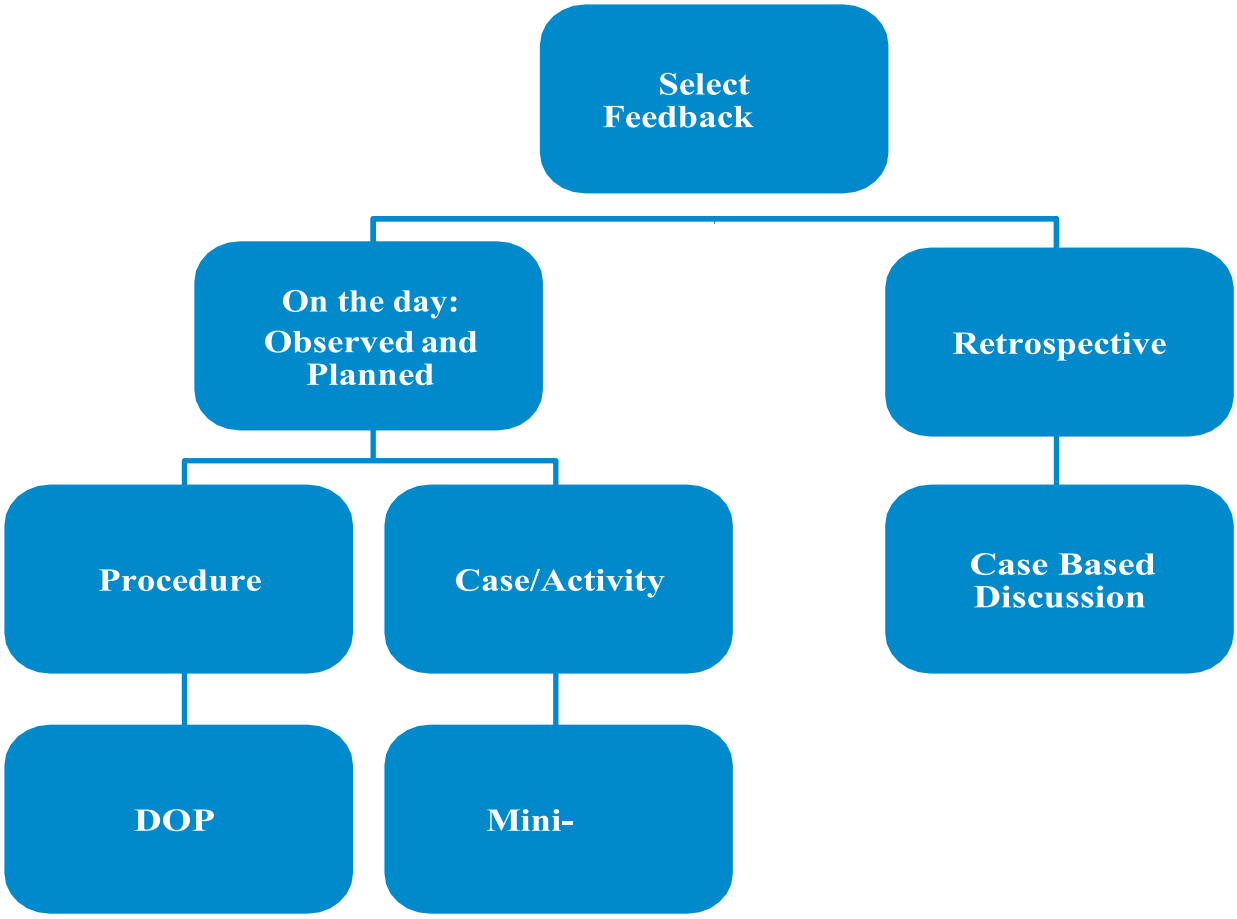
A Mini Clinical Evaluation Exercise (Mini-CEX) involves the consultant directly observing the trainee completing a more extended activity and can be used to observe a wider range of competencies. A Mini-CEX is carried out in real time as part of routine clinical work. A Mini-CEX is an appropriate assessment tool for assessment of professionalism, including the behaviour and attitude of a trainee, and their interaction with their colleagues.

The trainee should seek feedback with each WBA. Feedback is designed to offer the trainee an insight into their performance on one procedure, case or event on one occasion only, and does not reflect or predict the trainee's overall ability. The feedback should be focused on highlighting aspects of the trainee's performance in a constructive manner and on the trainee's response and should be 'low stakes' in nature. A level of proficiency may be assigned to the specific WBA which demonstrates a trainee's proficiency on that single interaction. This is a formative assessment of the trainee's performance. However the overall trend may demonstrate the trainee's progress.

Level	Milestone for WBA	Level of Proficiency
1	Pre-practice	Trainee has acquired knowledge and skills but insufficient to perform: not allowed to enact the activity.
2	Requires direct supervision	Trainee performs under full, proactive supervision: the supervisor is in the room.
3	Requires indirect supervision	Trainee performs under qualified, reactive supervision: the trainee asks for supervision or advice.
4	Ready for Independent practice	Trainee performs independently with backstage, mainly informal supervision.
5	Experienced practitioner	Trainee may provide supervision and instruction to junior learners.

Trainees have primary responsibility for ensuring that they seek feedback and gather evidence, across a range of domains and for the range of competencies. The process generally involves a consultant observing and reporting on:

- Details of the case/procedure/event
- The competencies which were actually observed
- The feedback provided by a consultant to the trainee
- The response from a trainee, with a specific action/learning plan.
- It is the responsibility of the trainee to record the interaction on their e-Portfolio. The template below reflects the template available on the trainee's e-Portfolio.
- The following diagram highlights the key factors trainees and consultants consider in selecting which one to use in different circumstances.


Select Feedback
On the day: Observed and Planned
Retrospective
Procedure
Case/Activity
Case Based Discussion
DOP
Mini-

Workplace Based Assessment Template		
Trainee's Name		
College ID		
Hospital		
Year of Training		Date:
Observer's Name		
Observer's MC number		
Type of Workplace Based Assessment		
DOPS (Direct observation of a procedural skill) ☐ Mini-CEX (Mini clinical evaluation exercise) ☐ CBD (Case Based Discussion) ☐		
Expected standard assessed		
Details of Case		
Feedback from Consultant	**Level of Proficiency (2-5)**	
Aspects of good performance		
Suggested areas for development		
Trainee response to feedback		
Specific learning plan		
Trainee Signature		Date:
Consultant Signature		Date:

Appendix 3 - In-Training Assessment Template

In-Training Assessment Process	Start and Mid Point Sections
Start of Rotation Date: Agreed Goals: **Supervisor confirmation:** **Trainee acknowledgement:**	

Mid Rotation Date: Update on progress and revised goals: Consultants involved: **Supervisor confirmation:** **Trainee acknowledgement:**

In-Training Assessment Process	To be completed at end of each six month rotation
Heading **Knowledge** Knowledge appropriate to level of training Exam Preparation Ability to plan care Record Keeping **Academic** Interest in academic activities Participation in department meetings Attendance at meetings and courses Engagement in research Use of non-clinical time	**Rating** *Select from Satisfactory / Requires Improvement / Unsatisfactory*

Participation in teaching

Behaviour
Punctuality
Reliability
Enthusiasm
Initiative
Ability to cope with stress
Commitment to patient care
Concern for colleagues

Clinical Skills
Clinical Judgement
Manual Dexterity
Vigilance
Safety awareness
Knowledge of drugs
Knowledge of equipment

Overall Rating

Has this assessment been discussed with the trainee?	**Yes / No**
Sources of Information	
Personal Observation	Yes / No
Departmental Feedback	Yes / No
WBA Forms	Yes / No
Logbook	Yes / No
e-Portfolio	Yes / No

Comments:

Trainers Involved:

Supervisor sign off:
Date:

Trainee Acknowledgement:
Date:

Appendix 4 - List of Hospitals Accredited for Pain Medicine Training Programme

As at date of this Curriculum, the following sites are approved for Pain Medicine Training:

- Beaumont Hospital
- Cork University Hospital
- Mater Misericordiae University Hospital
- St James's Hospital
- St Vincent's University Hospital
- Tallaght University Hospital

Glossary of Terms

'CAI / College'	College of Anaesthesiologists of Ireland
'CAT'	Committee of Anaesthesiology Trainees
'CBD'	Case Based Discussion
'CBT'	Cognitive Behavioural Therapy
'CSCST'	Certificate of Satisfactory Completion of Specialist Training
'Council'	Council of the College
'CNS'	Central Nervous System
'CPD'	Continuing Professional Development
'CRPS'	Complex Regional Pain Syndrome
'CSF'	Cerebrospinal fluid
'Curriculum'	Curriculum for the Specialist Training Programme in Pain Medicine
'CWP'	Chronic Widespread Pain
'EFIC'	European Pain Federation
'Department Chair'	Chair of the Hospital Department
'Director/s'	Directors of Post Graduate Training
'DOPS'	Direct Observation of Procedural Skills
'DSM'	Diagnostic and Statistical Manual of Mental Disorders
'FMS'	Fibromyalgia Syndrome
'FPM / Faculty'	Faculty of Pain Medicine CAI
'FPM ANZCA'	The Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine
'FFPMCAI'	Fellowship of the Faculty of Pain Medicine of CAI
'Hospital Department'	Department of Pain Medicine within Anaesthesiology Department in an accredited training site
'HSE NDTP'	Health Service Executive National Doctors Training & Planning
'IASP'	International Association for the Study of Pain
'ICD'	International Classification of Diseases
'ICF'	International Classification of Functioning, Disability and Health
'ICM'	Intensive Care Medicine
'ITA'	In-Training Assessment
'ITDD'	Intrathecal Drug Delivery
'K/S/A'	Knowledge, Skill or Attitude
'Mini-CEX'	Mini Clinical Evaluation Exercise
'MHA'	Mental Health Act'
'MRI'	Magnetic Resonance Imagery
'MSK'	Musculoskeletal
'NMDA'	N-methyl-D-aspartate
'NNH'	Numbers needed to harm
'NNT'	Numbers needed to treat
'NSAIDs'	Non-steroidal anti-inflammatory drugs
'PCS'	Professional Competence Scheme
'PENS'	Percutaneous Electrical Nerve Stimulation
'PMPs'	Pain Management Programmes
'PMEPs'	Pain Management Education Programmes
'PNS'	Peripheral Nerve Stimulation

‘Rotations’	Approved Hospital Posts
‘SAT’	Specialist Anaesthesiology Training
‘SBA’	Single Best Answer Questions
‘SCS’	Spinal Chord Simulation
‘SNRIs’	Serotonin-noradrenaline reuptake inhibitors
‘SOE’	Structured Oral Exam
‘Supervisor’	Faculty appointed Supervisor of Training
‘TENS’	Transcutaneous Electrical Nerve Stimulation
‘Trainee/s’	Specialist/s in training on the Pain Medicine Programme
‘Training Programme / Programme’	Specialist Training Programme in Pain Medicine
‘Training Department’	Training Department of the College
‘US’	Ultrasound
‘VOP’	Volume of Practice
‘WBA/s’	Workplace Based Assessment/s
‘WHO’	World Health Organisation