FPM
Faculty of Pain Medicine
ANZCA

Dean
Faculty of Pain Medicine
Australian and New Zealand
College of Anaesthetists

16 February 2023

Erin Micali
Education Development Officer | Curricula Development | RACP

Via email: curriculum@racp.edu.au

Dear Ms Micali,

Thank you for the opportunity to comment on the RACP's proposed (Adult) Rehabilitation Medicine Advanced Training Curriculum renewal project.

The Faculty of Pain Medicine (FPM), Australian and New Zealand College of Anaesthetists (ANZCA) is the professional organisation for specialist pain medicine physicians (fellows) and specialist pain medicine physicians in training (trainees). FPM is responsible for the training, examination and specialist accreditation of specialist pain medicine physicians and for the standards of clinical practice for pain medicine in Australia and New Zealand. Formed in 1998, we were the first multidisciplinary medical academy in the world to be devoted to education and training in pain medicine. The Faculty of Rehabilitation Medicine (RACP) was amongst those medical specialties which participated in the initial memorandum of understanding resulting in the establishment of the Faculty of Pain Medicine, ANZCA.

In its own curriculum for training, the Faculty has 'flipped' the biopsychosocial paradigm of pain to sociopsychobiomedical in order to emphasise the importance of the psychosocial aspects of pain in both its assessment and management. The Faculty encourages the working group to consider chronic pain in a similar manner to many of the other conditions nominated where functional goals within a psychosocial context are emphasized more broadly (especially where "cure" of the underlying problem is unlikely).

The Faculty notes that the Rehabilitation Medicine Curriculum Renewal working group has adopted a more contemporary approach to trainee learning, supervisory responsibilities and assessment with a hybrid arrangement between time and competence at the core of these activities. However, it also notes there is a considerable burden of assessment within the program. Single, point-in-time examinations persist within the curriculum, and it will be very interested to understand how the Progression Committee will manage these in the context of a competency-based assessment framework. The curriculum framework appears to take account of the core knowledge, skills and behaviours necessary in an (adult) rehabilitation medicine practitioner of today and tomorrow in a pyramidal structure. Specifically, it has also adopted the standard expected by the MCNZ and AMC around culturally safe medical practice and training for Maori, Aboriginal and Torres Strait Islander communities and trainees and, more generally, other culturally and linguistically diverse communities, thereby acknowledging differing needs of diverse Australian and New Zealand communities. Whilst not described in the curriculum framework, these competencies are articulated in the document, "Advanced Training in Rehabilitation Medicine, Curriculum Standards".

In terms of the curriculum detail, we will restrict our comments to Knowledge Guide 11 - Pain. The Faculty notes that the painful conditions nominated are a very small number that affect patients. Some of these conditions conform to a conventional diagnostic category whilst others fall under broader terms e.g. musculoskeletal disorders encompassing osteoarthritis, soft tissue injuries and even fractures. "Chronic pain syndrome, including psychological and behavioural dysfunction", "myofascial pain" and "failed back surgery syndrome" are somewhat vague and outdated terms and do not exist within the current international classification system, namely ICD-11. Likewise, 'visceral hyperalgesia' is not a condition per se but rather a finding on assessment. Painful conditions associated with visceral hyperalgesia might be chronic pancreatitis or irritable bowel syndrome. Indeed, we might suggest that these "conditions" and the "types of pain" listed elsewhere could be presented in a more contemporaneous way from the point of view of the rapidly evolving discipline of Pain Medicine (and its recent incorporation into ICD-11), along the following lines:

ANZCA House
630 St Kilda Road, Melbourne VIC 3004
+61 3 9510 6299
fpmdean@anzca.edu.au

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A. Major dichotomies
- acute pain vs chronic pain
- chronic non-cancer pain vs chronic cancer-associated pain

B. Somatic descriptors of pain
- nociceptive (such as fractures, soft tissue injuries, arthritis, ischaemia, some cases of post operative pain)
- neuropathic (including central pain due to spinal cord and brain damage, nerve root and peripheral nerve syndromes, including nerve entrapment, post-stroke pain, phantom pain and some case of post-operative pain)
- nociplastic (such as “fibromyalgia”, conditions characterised by visceral hyperalgesia such as chronic pancreatitis or irritable bowel syndrome)

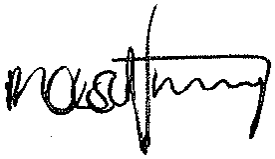
C. Special understanding
- incident pain vs “breakthrough” pain vs background pain
- end-of-life pain

We note that the Entrustable Professional Activities articulated in the curriculum would appear to codify generic consultant competencies across the domains in medical practice. Amongst these is “Plan, prepare for, *perform*, (italicized for emphasis) and provide after care for important practical procedures”. This suggests there appears to be an emphasis on the role of interventional techniques in the management of pain (at least for some trainees and specialists) and we query whether undertaking procedures is an essential skill for Rehabilitation Medicine physicians. In contrast we do consider that Rehabilitation Medicine Physicians have an important role in championing “opioid stewardship” and, believe that the curriculum would benefit from its inclusion. This is especially so given the role opioid analgesics frequently have in initial phases of rehabilitation following surgery or trauma and, the responsibilities that all doctors have in ensuring the appropriate prescription (and de-prescribing) of this class of drug.

Our final comment relates to experiential training in pain medicine which we acknowledge occurs across a range of the suggested learning environments nominated in supplied documents however, exposure to a broad range of both inpatient and outpatient acute, chronic and cancer-related pain can best be undertaken from within a multidisciplinary pain management unit. These units are staffed by Fellows of the Faculty of Pain Medicine (many of whom are dual qualified in Rehabilitation Medicine), other physicians, psychiatrists and a range of allied health staff and nursing staff. They undergo regular accreditation by the Faculty to ensure they meet the standards for training of specialist pain medicine physicians. The Faculty acknowledges that pain is ubiquitous in medicine and that all doctors should be qualified to undertake assessments and management of common, painful conditions. As such it would support trainees in rehabilitation medicine undertaking specialist training placements in pain medicine, either short term or, for dual training and qualification.

Should you wish clarification of any of these comments, please do not hesitate to contact me.

Yours sincerely,



Dr Kieran Davis
Dean, Faculty of Pain Medicine

Dr Melissa Viney
DPA FPM Education