

So you want a career in pain medicine

The treatment of patients in pain is a fundamental skill of all doctors. From the junior doctor to the senior GP all will require an ability to manage the commonest presenting symptom. So why would you want to specialize in pain medicine? Well, the burden of pain is huge. Surveys estimate that almost 20% of adults in Britain are suffering from significant long-term painful symptoms. The consequences both to health of the nation and the economy are huge. But all is not lost – pain is rarely intractable and it is seldom that ‘nothing can be done’.

Today patients can benefit from evidence-based treatment delivered in a variety of settings – primarily general practice but also the clinic, theatre, the hospice, even the psychiatrist’s couch. The predominant speciality that provides pain specialists is anaesthesia, but those who embark on it as a career will need to develop far wider skills than those seen in the operating theatre.

Skills required

Pain medicine requires a broad mind and a broader skill-set. Most important is the ability to communicate effectively – often in very trying (and tearful) situations. Clinicians need to be able to discuss, diagnose and treat this most difficult of patient groups (the classic ‘heart-sink’ patient is greatly over-represented in this group). Many patients have conditions where many previous treatments have been unsatisfactory, leaving the patient disappointed, in pain and on occasion damaged. Explaining the limits of medical treatment, establishing boundaries of care and personal responsibility all require a quick brain, sympathetic ear and often a big box of tissues.

Pain doctors also require good technical skills to perform pain management procedures like nerve root injections or

implantation of a drug infusion pump. Finally they need to be good managers; in these difficult times the ability to lead and develop a service for the benefit of patients is probably the most challenging of all.

Career pathway

Most pain symptoms are managed in primary care. The majority of hospital-based specialists come from anaesthesia although rheumatologists and palliative care physicians also have a significant interest in pain medicine.

The first step is to secure a post on an anaesthetic training scheme. As is often the case competition here is fierce and any additions to your CV that show enthusiasm and leadership in the anaesthetic or pain field will only advance your cause. Initial training in anaesthesia covers all the areas necessary to become an anaesthetist including basic training in pain management (e.g. prescribing, regional anaesthesia basics).

To progress further the first anaesthetic examination is usually taken (the primary FRCA). Successful doctors will progress to intermediate anaesthetic training within the anaesthetic syllabus (during this time the final FRCA exam is taken). Here the pain training experience extends out of the theatre and includes pain clinics, intervention lists and hospice visits. There is also more practical experience (and with it responsibility) in the perioperative environment. There will be opportunities to perform practical procedures such as ultrasound-guided nerve blocks, epidurals and spinal injections.

Those who want to specialize in pain medicine will then do approximately 15 months pain training (higher and advanced modules) in the final 2 years of anaesthetic training. This time is spent entirely in the pain management department (except on calls) and it will equip the trainee with the necessary skills to be able to practice pain medicine as a consultant.

At the end there is, inevitably, an exam, where successful candidates will then be eligible for the Fellowship of the Faculty of Pain Medicine at the Royal College of Anaesthetists. This qualification is essential for anyone wishes to pursue a career in pain medicine.

Sub-specialization

Specialists in pain management see patients with acute, chronic non-malignant and cancer pain. A variety of techniques are used – pharmacological, physical, interventional and psychological strategies – often in combination. Some pain clinicians sub-specialize in complex interventions such as spinal cord implantation (inserting electrodes into the spine) while others concentrate on running psychology-based rehabilitation courses. Then there are cancer pain commitments with close liaison with the palliative care team or teaching roles. Most pain doctors most will have a variety of responsibilities in clinics, theatre and on the wards, in addition to anaesthetic commitments.

The future

Like many specialities pain management is undergoing great change. The drive to reduce health-care costs may mean delivering pain services in the community. Specialists of the future must be prepared to engage with commissioners and trusts to ensure high quality care.

Conclusions

Relieving pain and distress is a great privilege – despite its challenges. It requires good technical and diagnostic skills and those who are able to communicate effectively often in areas of great uncertainty. To find out more visit the Royal College of Anaesthetists website (www.rcoa.ac.uk) and follow the links to the Faculty of Pain Medicine. **BJHM**

Conflict of interest: none.

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KEY POINTS

- All clinicians need an understanding of how to assess and treat pain.
- Many specialists manage pain – notably anaesthetists and palliative care doctors as well as GPs.
- The training pathway to be a specialist in pain management is via anaesthesia.