1 That the proposed specialty is a well-defined, distinct and legitimate area of medical practice with a sustainable base in the medical profession

1(a) is sufficiently distinct from other specialties, based on substantiated and major new concepts in medical science and health care delivery such that it is not feasible to include it within the current specialty structure;

1(a): Pain Medicine is practised internationally on a multidisciplinary basis informed by the latest developments in neuroscience. It involves the treatment of Acute Pain (pain less than 3 month’s duration) – classically postoperative pain in the hospital setting and chronic pain (pain which persists beyond 3-6 months) in a variety of settings depending on the aetiology of the pain.\(^1,2,3\) This submission will confine itself to medical practitioners who specialise in the management of persistent pain - Pain Medicine.

The multi discipline nature of pain medicine means that a pain medicine specialist could have a foundation specialty training in rheumatology, orthopaedics, anaesthesia or rehabilitation medicine, etc. In Ireland Pain Medicine exists only as a sub specialty of anaesthesia and currently all pain specialists would have trained initially in anaesthesia. However, Pain Medicine has evolved into a distinct entity which can no longer be adequately resourced within the specialty of anaesthesia.

There is a substantial body of science which now supports the concept of chronic pain as a persistent disease in its own right.\(^2\) According to the Compact Oxford English Dictionary, the most common definition of the noun ‘disease’ is “a disorder of structure or function in a human, animal, or plant, especially one that produces specific symptoms.” A more expansive definition includes it being a “cause of discomfort or distress.” In contrast, the definition of syndrome is “a group of symptoms which consistently occur together.” The main distinction here is that in order for something to be a disease there must be an identifiable disorder of structure or function and not just a grouping of symptoms. The factors leading to the disorder of structure or function might vary, as is the case with cancer, but the end result must be a disordered system. In the case of chronic pain, the disorder is found within the nervous system. Historically, chronic pain has been labeled as a syndrome (or group of syndromes), but recent evidence, mainly from neuroimaging studies, strongly suggests that chronic pain could be labeled as a disease.\(^4\) In addition there are molecular mechanisms in the spinal cord to maintain chronicity, distortion of representational areas in the cerebral cortex and an evolving science on the genetics of pain.
Experience to date shows both nationally and internationally that chronic pain management involve a different pool of patients to anaesthesia. These patients expect the same standard of care as patients attending all other full service specialities. There is a very practical volume/quantity issue to be addressed in Ireland in this regard – chronic pain is experienced by more than 13% of the population – 600,000 people. (5) This cannot be serviced by a part time doctor divided between two to three different specialties/sub-specialties (Anaesthesia, Critical Care, and Pain Medicine).

Optimal pain intervention now requires a much more comprehensive system of assessment, treatment, follow-up monitoring surveillance (and frequently further elective and emergency interventions) than was previously the case. Enhanced management requirements now require:

**Assessment**

(a) Out-patient assessment with multidisciplinary input (6) (physiotherapy, occupational therapy & clinical psychology); access to neuro-imaging (MRI, CT, PET, Spect Scanning); neurophysiological assessment and the full range of laboratory services.

(b) In-patient Assessment: This involves diagnostic investigations carried out under both ultrasonography and fluoroscopy frequently under sedation. The overwhelming majority of this cohort can be tested as Day Care Patients. Intrathecal drug testing requires inpatient assessment due to the potential life threatening adverse effects of some of the medications used. Many of these patients who have chronic diseases like cancer or multiple sclerosis require prolonged hospital stays; especially if they proceed to definitive advanced pain therapy surgery (see below).

**Treatment**

(a) Pharmacotherapy: First line treatment for all chronic pain patients which is evidence based and frequently uses supranational protocols e.g. ‘European Federation of Neurological Societies’ (7) algorithm in the treatment of Neuropathic pain or the World Health Organisation’s (WHO) pain ladder for Cancer Pain.

(b) Radiofrequency/Thermal Neural Ablation under Fluoroscopic imaging used in patients who have a positive response (i.e. pain relief greater than 80%) to their diagnostic investigations carried out under both ultrasonography & fluoroscopy.

(c) Pain Management Programmes (PMP): Rehabilitation of 8-10 patients in a multidisciplinary pain management programme based on cognitive behavioural principles over a period 3-4 weeks from 10.00- 16.00 hrs daily.

(d) Advanced Pain Therapies (APT): Performance of pain surgery such as the implantation of spinal cord stimulators, following defined protocols for a variety of chronic pain conditions e.g. Complex Regional Pain Syndrome/Failed Back Surgery Syndrome.

NICE in the UK (8) and NANS (US) (9) have laid down multidisciplinary assessment criteria for these conditions and appropriate setting for the delivery of this service. Intrathecal pumps for drug delivery in patients with chronic diseases like cancer pain or multiple sclerosis need to be surgically implanted following an appropriate testing protocol (See In-patient Assessment)

**Follow-up Monitoring**

(a) All Advanced Pain Therapies patients require rigorous follow-up care. This includes intermittent re-programming in Spinal Cord Stimulator patients -3-4 times per year.
This contrasts with the absolute need to refill Intrathecal (IT) Pumps in patients every 60 -100 days. If their pump has opiates- failure to refill without access to oral opiates is a potentially life threatening emergency.

(b) All patients on oral/intrathecal opiates require long term monitoring of systemic adverse effects which may require treatment like hormone replacement therapy.

(c) All pharmacotherapy patients require follow-up to ensure efficacy of this therapy or whether a change in terms of dose or drug is required.

(d) PMP (pain management programme) patients need follow-up & monitoring of their daily rehabilitation efforts as they may be referred back for a ‘booster week’ to another programme.

(e) Radiofrequency/Thermal Neural Ablation under Fluoroscopic Control- the patient’s pain may recur within 8-12 months- so this cohort needs to be monitored at 3- 6 month intervals after their intervention. When the pain recurs to a level of 50-80% prior to ablation- the procedure is repeated.

**Out of hours care**

All Pain services involved in large scale Advanced Pain Therapies (APT); implanting of IT pumps and spinal cord stimulators need a 24/7 on call service to deal with emergencies like acute device infections which are life threatening clinical situations. The out of hours on call pain physician will be required to surgically explant the pain relief device under general anaesthesia.

It can be seen from these new requirements that a hybrid combination skill set has emerged that involves medical, surgical and rehabilitation skills and this new specialty to deliver quality care will have to interact and involve each of those specialties. It is obviously markedly different from the parent specialty which would see the clinician in theatre dealing with anaesthesia related and medical problems during the peri-operative period but with no long term commitment to individual patients. Therefore in Pain Medicine, there needs to be an additional skill set and training compared to exclusive anaesthesia practice. Conceptually, there is some resonance with the set up in a specialty such as obstetrics and gynaecology – the need for medical and surgical skills with specific areas of expertise in the interventional suite or rehabilitation unit.

The historic association of pain management with anaesthesia evolved out of the practice of regional anaesthesia and the dedication to acute pain management in the perioperative period. This is an invaluable inheritance but the subspecialty has evolved beyond this specific technical nous to a full-care patient-focused service for chronic persistent pain and cancer pain in a population of cancer survivors who do not see their ongoing needs as palliative care.

Furthermore, it is worth pointing out that the specialty would not fit into the specialty of palliative care medicine, although there is much shared medical knowledge. This is primarily because our patients live a full life expectancy with their chronic illness and they will require our skills in acute pain, regional anaesthesia, advanced surgical techniques and the full range of rehabilitation inputs necessary to sustain their quality of life.
1 (b) represents a new well-defined and widely accepted field of medical practice (e.g. as demonstrated by a comprehensive and developing body of international research and scholarly literature to support evidence-based clinical practice; significant representation within academic medicine; number of meetings held annually; the existence of a national and/or international society with a principal interest in the proposed specialty; formal recognition as a medical specialty (or other relevant category) in comparable countries;)

1 (b): Pain Medicine is a multidisciplinary field of specialist medical practice. The area of interest includes acute pain, cancer pain and chronic or persistent pain. The latter encompasses more than 200 conditions described in the IASP Taxonomy of Chronic Pain 2nd Edition \(^{[10]}\) and includes, for example, post herpetic neuralgia, mechanical low back pain, complex regional pain syndromes, phantom limb pain to name but a few.

The International Association for the Study of Pain (IASP) was set up in 1973 to provide a framework for the expansion of clinical knowledge and science to manage pain. At its most recent biennial congress in Montreal in August 2010, the refresher course designed to offer state of the art education covered 18 key topics with 44 individual lectures. *Pain 2010* – an updated review edited by the chairman of the scientific program committee, Dr Jeffrey Mogil, contains 2,881 high quality scientific references from a full range of peer review journals. This is just a small and current example of how the field of Pain Medicine has a “comprehensive and developing body of international research and scholarly literature to support evidence – based clinical practice. Another compelling example is the Bandolier website on pain at [http://www.medicine.ox.ac.uk/bandolier/](http://www.medicine.ox.ac.uk/bandolier/) which has been maintained for more than ten years by the Oxford Pain group, led by Professors Henry McQuay and Andrew Moore.

In 1974, the IASP launched the journal *Pain*. It has become the leading journal in this field, publishing high quality multidisciplinary basic and clinical science with a significant impact factor – 6 plus. Other journals devoted to this area of medicine include *Anaesthesia and Analgesia*, whose stand-alone section on Pain Medicine began in 2001; *Regional Anaesthesia and Pain Medicine*; *Pain Medicine, the Journal of the American Academy of Pain Medicine*; the *Clinical Journal of Pain*; *European Journal of Pain*; *Journal of Pain and Symptom Management*; *Der Schmerz*; *Douleur et Analgésie*; and *Neuromodulation*. The IASP has also facilitated the assembly of scientific evidence by the publication of monographs edited by world leaders in the field through the IASP Press in Seattle. More than thirty of these clinical reference books have been published to date.

The IASP has chapters in every country with a functioning health service, including Ireland. Since the late seventies and up until 2000, Irish pain clinicians formed part of the second largest international chapter – Great Britain and Ireland. Since forming our own chapter in 2001, we have held an annual scientific meeting every year. Our inaugural meeting at Dublin Castle was opened by Junior Health Minister Mary Hanafin TD. In 2007, the Minister for Health Mary Harney TD launched the meeting emphasising the need for research and development and co-operation between academic, pharmaceutical and technological stakeholders to ensure that Ireland takes up a place at the cutting edge of this rapidly emerging discipline for the benefit of all our patients.

In 2002, the first Diploma in Pain Medicine was launched in Ireland at a ceremony by the then Minister for Health, Micheal Martin TD. It was the first such exam launched in the European Union. Each year, the invited extern examiner rotates between the UK, USA and
the EU and the feedback is always excellent. This exam was run at inception by the Board of Pain Medicine but, more recently, the Faculty of Pain Medicine within the College of Anaesthetist of Ireland took up a management role. This reflected the Board of Pain Medicine becoming the foundation Faculty of Pain Medicine in 2007. In this manner, Ireland followed the example of the Australian and New Zealand College of Anaesthetics who launched their faculty a number of years previously. Contemporaneously with the Irish launch in Dublin, the Royal College of Anaesthetists in London also launched their Faculty of Pain Medicine. Currently the London faculty is launching its fellowship exam which is modelled on our established diploma exam. This will offer full fellowship to trainees who complete 6 months of training in pain medicine and who pass the exam. International candidates successful in the exam will be offered a diploma not fellowship.

In the United States, an Academy of Pain Medicine exists which includes all the specialty bodies with an interest in Pain Medicine. The Academy conducts specialist examinations in Pain Medicine. The American Board of Anaesthesiologists has conducted an examination in Pain Medicine for some years.

It is worth noting that, in 2002/2003, the Australian and New Zealand Faculty of Pain Medicine applied successfully to their medical council for specialty recognition. Many would consider that the standard of Pain Medicine in these jurisdictions is among the best in the world. Since 2001, a major policy objective of the European Federation of IASP chapters has been to achieve recognition of chronic pain as a disease in its own right across various member jurisdictions. This has achieved success in Norway where the condition has been accepted as a major healthcare condition in its own right. Pain, and the need for optimal intervention, was prioritised by the Chief Medical Officer in the UK in his annual report in 2009. There is a very strong campaign for disease status recognition in both the US and Australian healthcare systems which appears to be close to success. In 2009, the new Irish faculty was invited to meet the Minister for Health, Mary Harney TD and make a submission on the pathway forwards in terms of meeting Ireland’s pain management challenges. The following is an extract on Chronic Pain from the document presented by the Faculty to the Minister (for full document, see Appendix 1)

- Unrelieved chronic pain represents a major problem for individual patients and a massive socio-economic burden for the health service and the community at large.
- Unrelieved chronic pain may lead to depression, psychological dysfunction, prolonged disability and dependency on drugs.
- It leads to significant overuse of medical services and increased costs to the taxpayer through social security payments and unemployment.
- The identified prevalence of chronic pain in Ireland is 13% of the adult population. It is estimated that there are approximately 585,000 chronic pain sufferers in Ireland with 36% of all households affected. The cost of low back pain in Ireland is enormous: disability payments from the Department of Social and Family Affairs amounted to €348 million in 2003 and insurance payments cost €10.5 million.
- These figures are replicated throughout the world with a prevalence rate of 17.5% of males and 20% of females in Australia. In Australia, the total cost of chronic pain was estimated at $34.3 billion dollars or $10,847 per person with chronic pain. The prevalence rises with advancing age reaching a peak of 31% in the 80-84 year old group.
• Optimal management of chronic / neuropathic pain requires a multifaceted approach using pharmacological / psychological and interventional techniques in a concerted effort to restore mental and physical function.

• Effective chronic pain management should be based upon interdisciplinary cooperation of specialist Pain Medicine doctors, primary care physicians, specialist nurses, clinical psychologists, physiotherapists, occupational therapists and pharmacists.

• Pain Medicine has been one of the leading specialties in the rigorous pursuit of evidence of effectiveness of treatments by analysis of systematic reviews and randomized controlled trials.

The new Faculty of Pain Medicine was formally launched in late 2008 and held its first annual scientific meeting in Dublin Castle in 2009 at which it invited leading pain clinicians from Australia – Prof Michael Nicholas (Psychology), Dr Fiona Blythe (Epidemiology) and Dr Stephan Schug (Acute Pain). The meeting was launched by the Minister for Health, Ms Mary Harney TD.

In 2010, we joined up with our colleagues in Obstetrics and Gynaecology at the annual Charter Day lecture of the National Maternity Hospital (Holles Street). This lecture was given by Professor Eisenach, Editor in Chief of Anesthesiology. It was the first time a pain topic had been the subject of an annual Charter Day lecture. This pioneering address allowed exploration of the theme “Pain in Women” and produced a highly successful interdisciplinary meeting.

In 2011, the theme for the Faculty of Pain Medicine’s Annual Scientific Meeting was pain management in cancer survivors. At this meeting we awarded our first honorary fellowships to Professor Harald Breivik Norway, Professor Emeritus Tess Cramond Australia and Professor John Loeser USA. As a surgeon Professor Loeser has the distinction of becoming the first non anaesthesia trained fellow in our new faculty. In 2012 our theme was the science of spinal pain to reflect Dublin’s title in 2012 of City of Science. On this occasion we awarded honorary fellowships to 3 distinguished Americans Professor Elliot Krames and Professor Robert Levy Editor and immediate past editor of the Journal Neuromodulation and Dr Ken Aloe. Of note Professor Levy is a neurosurgeon by training and gave the inaugural Dr Francis Rynd Lecture. Dr Francis Rynd was the inventor in 1844 of the forerunner to the hypodermic syringe and more importantly the first patient he treated as a Dublin surgeon in the Meath Hospital was a patient suffering from chronic pain. Our scientific programmes have included speakers from Rheumatology, Palliative Care, General Practice, Orthopaedic surgery, neurosurgery, Psychology physiotherapy and Epidemiology, Obstetrics, and Oncology. Therefore, on an ongoing basis, the faculty is endeavouring to interact with different medical specialties for the benefit of the patient in chronic pain.

The Faculty of Pain Medicine holds an annual education course for trainees undertaking the Diploma in Pain Medicine exam and run ongoing educational programmes for fellows (Autumn, Winter and Spring lecture series). In addition we have launched a National Training Scheme in Pain Medicine. We are steadfastly resolved to progress specialty and disease recognition and in that context we set up a seminar last year on this topic with input from leading faculty fellows. This discussion forum was led by Professor Rollin Gallagher, recent past President American Academy of Pain Medicine (AAPM) and Editor in Chief of Pain
*Medicine*, the official Journal of the American Academy of Pain Medicine. He reported to us directly from the US’s first National Pain Medicine Summit. A final report on this initiative was published in *Pain Medicine* last year (2010, 11; 1447 – 1468). Outlining their goals for this key event, the organisers stated: “[We desire] excellence in the delivery of high quality cost effective pain care to the patients we serve. One way of achieving this includes the development of Pain Medicine as a distinct specialty with ACGME accreditated residency programmes and ABMS certification”. A representative of the Irish Medical Council was invited to join Prof Gallagher as a speaker. We were delighted that Dr Anne Keane attended and was most helpful in outlining the application process for specialty recognition in Ireland which resulted in this submission.

**I (c) has a demonstrable and sustainable base in the medical profession (e.g. as demonstrated by a sufficient number of practitioners with the capacity to meet existing clinical need, who possess the knowledge and skills to practice in the specialty, and who practice predominantly in the specialty);**

1(c): Currently in Ireland there are approximately 26 doctors who spend more than three sessions (nine hours) in the practice of Pain Medicine. This is the minimum level of practice set out in the Faculty of Pain Medicine’s Foundation Fellow criteria document. Some practitioners are full time and many spend a major portion of their sessions in Pain Medicine. The total number of dedicated Pain Medicine sessions makes up 14 whole time equivalents approximately. The recommendations for pain specialist to patient ratios are approximately one per 100,000 of the population. On this basis there is room for expansion on the absolute numbers. This is more so if one allows for the fact that many of the current practitioners are part-time and would be expected to practice anaesthesia and cover intensive care medicine also. The goal for a national training programme over a ten year period would be to produce 30 pain specialists. In that context a training programme would need to produce three trained doctors per year. To allow this to happen, we would need to have a minimum of six doctors in training at any one time. In the context of our current financial difficulties as a nation it is useful to point out that we currently have five funded posts across five hospitals (two in Cork, three in Dublin). We have a reasonable expectation that at least one of four other major hospitals will be able to rezone a currently unnumbered (not on a training scheme) but funded post. We have launched a national training scheme in pain medicine. The first trainee will commence in St Vincent’s University Hospital in the summer of 2012. We have available posts for training in St James, Tallaght, Mercy University Hospital in Cork and Cork University Hospital. Our programme is a two year post CST design with an exit exam. If a candidate has one year’s experience in pain medicine and a part one diploma in pain management exam they can complete this training in one year post CST in their parent specialty. We envisage access from other specialities as follows – post CST they can join the two year national programme and gain a dual CST on completion of their training and passing the exit exam. Or they can sit the part one exam after a period of 6 months training in pain medicine on release from their parent specialty in a manner not dissimilar to the current access to ICU training and diploma from other disciplines. Furthermore, there is an excellent network of dedicated pain clinics in Ireland. They exist in all major teaching hospitals and regional centres. In addition there are also a significant number of pain physicians in smaller hospitals such as Portlaoise, Letterkenny, Ballinasloe and Sligo. Multidisciplinary resources are also thin on the ground nationally in terms of access to physiotherapy, occupational therapy and psychology. A 2010 community based pain management pilot project funded by the HSE delivered by clinical psychologists using a Canadian manualised approach was an imaginative approach to this problem. However, with re-organisation of existing services in innovative ways and changes in work practices to
reallocate more support services to chronic diseases that affect large numbers of patients, we are confident that it is possible to achieve greater access to the preferred multidisciplinary model of pain clinics. The Faculty has publicly advocated for a national strategy in this regard and outlined the need for a national strategy for chronic pain in Ireland. This process has involved documenting the current resources available to the service in Ireland (Appendix 2).

1(d) can sustain activities such as vocational training and assessment and continuing professional development.

1(d): We have demonstrated by the launch of the Pain Medicine Fellowship and diploma, our capacity to set the standards for the next generation of Pain Medicine doctors. In the future, this will involve other medical specialties in a similar manner to the current ICU Medicine Training Programme, which allows access from medical and surgical specialties as described above. The first year of training will be broad based and include all key components of the IASP core education curriculum. Candidates will be expected to be proficient in patient assessment, clinical examination, with a capacity to investigate where appropriate, to work in a multidisciplinary environment, to initiate pharmacotherapy from a sound knowledge base, include key rehabilitation principles etc. During this year the trainee would be expected to pass the broad based diploma in pain management. After such a year the trainee may elect to return to their core parent discipline and to continue to have an interest in pain management. This could be nurtured by membership of the faculty of pain medicine. Alternatively the trainee could proceed to the second year where the emphasis is on competencies and pass the exit exam which would lead to independent practitioner status and Dual CST and fellowship of the Faculty of Pain Medicine.

The Faculty of Pain Medicine is a resource that affords us the opportunity to set up a national training programme with comprehensive competence assurance structures to maintain standards in professional development. The complexity of skills needed by the modern pain physician will continue to increase with the expansion of our knowledge base. It is no longer tenable with this explosion in knowledge for a modern pain physician to function also as a full time anaesthetist and/or intensive care doctor though by definition as dual CST holders they may elect to do so allowing for some flexibility in the context of prevailing local circumstances. Furthermore, it would still be possible for practitioners to hold single specialty status but with an interest in pain management so that, for example, in smaller to medium sized hospitals there would be a role for an anaesthetist with a special interest in Pain Management or a rheumatologist or neurologist with such an interest.
II: That specialisation in this area of medicine is demonstrably contributing to substantial improvements in the quality and safety of healthcare
Please describe (using examples):

II (a) Whether the proposed specialty has improved the quality of healthcare in Ireland (by increased effectiveness of health care as defined by improved health outcomes; increased appropriateness of health care as defined by providing care relevant to patients’ needs and based on established standards; increased safety of care and / or significant reduction of harm experienced as a result of receiving healthcare):

II (a): The existence of a pain service in a hospital improves health care outcomes. Optimal acute Pain Medicine allows speedy discharge from day wards with less re-admission subsequently. With regard to inpatients, it is well established in the literature by Professor Henrik Kehlet and others that good pain relief allows a more rapid recovery with less need for drains, and traditional surgical practices. This fosters a culture of early mobilisation and discharge. Many international accreditation bodies now insist on measuring pain as the fifth vital sign in all patients so that those needing attention can be matched with a pain service provider. Better pain management facilitates physiotherapy leading to less respiratory complications. Furthermore, there is ample evidence that badly treated acute pain proceeds to chronic pain – a persistent condition that once established has no cure. In the future, prevention of this evolution of acute into chronic pain will be important. There are also interesting developments in neuroscience and genetics that are likely to enable those concentrating in these areas to help deliver significant improvements in patient outcomes.

We now have considerable success with cancer treatments so that we are no longer offering care to a cohort of patients on a pathway towards hospice care. Many of these survivors will have pain problems due to a combination of the disease process, surgery, chemotherapy and radiotherapy. Good pain relief will make a significant impact on their quality of life.

There are studies indicating that the quality of life for patients suffering chronic pain is worse than those with significant cancers and cardiovascular disease. So, our efforts at modern pain management and intervention will pay dividends for this massive patient cohort in terms of quality of life. For example, there is level-one evidence that multidisciplinary pain management programmes based on cognitive behavioural principles improve quality of life. This important health outcome will also have an impact on family members and other social partners including work colleagues.

The provision of specialty status for Pain Medicine will allow greater access and transparency in this area for the benefit of the patient. It is well established in the international literature that most patients with chronic pain never get a referral to a pain clinic. Those who do make it to the clinic have often spent many years moving between multiple specialities in an attempt to get a treatment or a better quality of life. Some of these patients will have been harmed by that process and damage will have been caused by unnecessary surgeries, excess medication including problems of addiction, excessive medical tests, loss of work, diminished status, income loss (not to mention the psychological turmoil generated by the persistent ongoing pain without any explanation and a constant succession of medical and alternative opinion). It will also help address a significant patient safety issue in terms of the harm that can be done to members of the public by untrained doctors and unregulated alternative practitioners.
A specialty of Pain Medicine would offer a substantial improvement in quality of care for all these neglected patients. If one was to adopt a provocative position on this subject of neglect, the following might be argued: Despite comprising 13% of the population there is no official recognition of the condition chronic pain. Despite enormous associated socio-economic and medical costs, this chronic disease does not appear in H.I.P.E data. There is no national policy for Pain Medicine at present. There is no official in the HSE with responsibility for service or policy in this area. There is poor education both at undergraduate and post graduate levels (and this is well-documented in the Irish medical literature). The existence of all this follows on directly from two interrelated key factors: 1) The lack of disease recognition; and 2) The lack of specialty status for Pain Medicine. The Irish Medical Council now has an opportunity to redress this inequality for the benefit of patients and in so doing may offer dramatic improvements in healthcare in Ireland over the next 10 years based on the sheer volume of numbers of chronic pain patients alone.

II (b) That specialisation is not and will not adversely affect the quality of healthcare in Ireland by promoting the unnecessary fragmentation of medical knowledge and skills and / or medical care, including that it should be broadly available nationally; the unnecessary deskilling of other medical practitioners (e.g. GPs and other primary health care providers); inequitable access to health care as defined by socioeconomic status, geography or culture;

II (b) The existence of a specialty of Pain Medicine will be a great resource to general practice. At present GPs receive little formal post graduate education on the topic and have large numbers of patients who they seem to be referring to multiple clinics but with little patient satisfaction. The availability of a specialist to make the diagnosis and guide the management plan will improve efficiencies for both patient and GP. This care, for the most part, will be joint care and the simple cases may need some diagnostic confirmation but no further specialist input. Complex cases will probably be managed in the multidisciplinary pain clinic but the GP will remain an essential partner. Most cases will be joint care as pain is a chronic relapsing condition. Thus, from time to time, there will be a need for specialist input.

Anaesthesia will also benefit by bringing to fruition a subspeciality that it has nurtured, promoted and developed. There will continue to be shared training as the majority of Pain Medicine specialists will probably graduate from anaesthetic training programmes. However, the Specialty will proactively attempt to recruit trainees from other Specialty areas as well.

Shared care will be facilitated in other areas, for example in terms of acute pain in the peri-operative period and in terms of the chronic pain which may evolve out of a surgical or trauma incident. There will be ongoing shared research opportunities to unravel the molecular biology of pain. The existence of the specialty will also be a benefit to palliative care and other medical specialities. We aspire to opening up the Faculty to all medical and surgical specialities with an interest in this clinical area. This cannot currently happen as we are a sub-speciality of anaesthesia. Receiving specialty recognition would allow us to offer training in Pain Medicine and Dual CST to other specialties so, for example, one could be a rheumatologist or neurologist with an interest in Pain Medicine or a full pain specialist with such a parent speciality. Palliative care would also have the opportunity to join us in the faculty if they have an interest in pursing this option.
II (c) That where the specialist medical services are already provided or could be provided by practitioners in a recognised specialty or a combination of recognised specialty groupings, provision of these services by this new specialty enhances the quality and/or efficiency of healthcare.

II (c): It is true that we already have pain clinics which are managed by anaesthetists with allocated sessions in Pain Medicine. However, unlike general anaesthesia where the commitment to the patient at most will be a few days during the perioperative period, the pain commitment is full-time in terms of the patient who presents with it as a chronic disease. It is not fair to the patient that their specialist doctor cannot make him or herself available throughout the working week due to their anaesthesia commitments and that the trainees from anaesthesia whom patients may see from time to time can only offer a two month commitment to their ongoing care.

Other specialties could not provide this specialist care. They do not have the necessary interventional skills set which range from regional anaesthesia to pain surgery. Where relevant medical skills exist, such as palliative care, the primary focus is on cancer. While there is a great need for palliative care to move beyond the cancer remit, this is proving difficult due to sheer volume of increasing numbers in the cancer care system and limited resources. Rheumatology, neurology and rehabilitation medicine are overstretched by the needs of their own expanding disciplines. While it is expected in due course to have interested specialists from these disciplines involved in the Faculty of Pain Medicine, it is unrealistic to expect any such group to take on a chronic condition that afflicts so many patients in addition to their current commitments.
III: That specialisation in this area of medicine is demonstrably contributing to substantial improvements in the standards of medical practice

The pain and suffering of millions of people since the advent of modern surgery has been well documented \(^{(15)}\) – however, despite the existence of surgical colleges England (11th century) and Ireland (18th century), neither of these august bodies concerned themselves with the modern day epidemic that is post-surgical pain. In 1979, following on from a number written communications from a slew of enlightened colleagues describing the pain and suffering that was the typical experience of day of the postoperative patient, the original anaesthetic based Acute Pain Service was born \(^{(15)}\). Pioneers in this regard were the University of Washington Healthcare Centre in Seattle, USA. Their work in this regard is just one of many examples that can be chosen to demonstrate the contribution of ‘Pain Management’ to the well being of millions of people worldwide going about their daily business in the hours and days after surgery

Please describe whether / how:

III (a) There is a professional body that is responsible for setting the requirements and standards for training, assessment and certification in the specialty; that is capable of defining, promoting, maintaining and improving standards of medical practice to ensure high quality health care, and capable of engaging stakeholders, including health consumers, in setting standards; that has guidelines and procedures for determining who will be Fellows/Members of the body; that has appropriate processes for determining the standard of education, training and experience of medical practitioners trained in the discipline overseas;

As outlined earlier in this submission, the Faculty of Pain Medicine was formally launched in 2008. It existed in shadow form from 2007 and was preceded by a Board of Pain Medicine from 1999 at the College of Anaesthetists of Ireland. The College of Anaesthetists in Ireland is the recognised training body for anaesthesia which currently includes the subspecialties of Pain Medicine and Intensive Care Medicine (ICM). The latter ICM faculty is shared in a conjoint manner with the Royal Colleges of Physicians of Ireland and the Royal College of Surgeons in Ireland. As a constituent faculty of the College, we share in its governance structures with due recognition of the authority of the President and Council of the College. We participate in all its committees. The Dean of the Faculty of Pain Medicine sits on the Council of the College and all decisions of the faculty board are sanctioned by Council. We follow the high standards set by the College in all domains – training, examination, education, credentials and competence assurance.

As a board, and more recently as a faculty, we have been proactive in training issues. For example, we set up the first Diploma in Pain Medicine in Europe. This exam has taken place every year since 2002. It is rotated nationally between three centres Dublin, Cork and Belfast. We have consistently invited externs to our annual exam from the UK, Europe and North America in rotation. To sit the diploma one needs to gain a minimum of six months training in Pain Medicine within the framework of anaesthesia training. In fact, before sitting the diploma one needs to have achieved success in the two-part fellowship exam of the College. In this context, the diploma is targeted at senior trainees. From 2012, access to become a fellow of the faculty will be on the basis of a two-part examination and participation in a two year national training programme.
We are currently moving to a two year model which is emerging as the best international standard. From 2012, we will have a two part exam integrating the existing diploma as part one of that exam sequence. This can be taken during the first year of training. It will consist of a written paper, a set of MCQs and a viva (verbal interview examination). Part Two an exit exam can be taken on completion of the two-year national training programme. This will be a comprehensive clinical exam which will include assessment of interventional Pain Medicine procedures. So, in this context, the candidate will be post-CST (Certificate on the Completion of Specialist Training) in their parent discipline and will be required to satisfy the faculty that he/she is capable of independent safe practice in the specialty of Pain Medicine in addition. The following is proposed - a doctor with one year’s experience in pain medicine and who has passed the diploma exam in pain management will be entitled to have pain management as a special interest whatever their core specialty and could elect to continue their interest as members of the Faculty of Pain Medicine. Independent practitioners in pain medicine need to be in possession of a dual CST – their parent specialty and a CST in pain medicine. The latter is awarded after completion of two years dedicated training in pain medicine and success in the exit exam which offers full fellowship of the Faculty

Currently, the Hospital Accreditation Committee of the College of Anaesthetists (which visits all hospitals) includes a representative from the Pain Medicine Faculty. This individual’s role includes evaluating Pain Medicine training for anaesthesia. We have set up a national training scheme using five existing funded posts with a possibility of up to three additional posts due to a reorganisation of funded non-training posts in three hospitals. The intention is to produce three-to-four trainees per year for ten years. This will allow us to produce the correct number of consultants per head of population – approximately one per 100,000. Currently there are 14 whole time equivalents in Pain Medicine. Some 26 physicians currently have some practice in Pain Medicine which ranges from a minor input of three sessions to the full time practice of Pain Medicine. Our target, to be negotiated and agreed with the HSE, is for 30 pain physicians nationally to be delivered over the coming decade. The Faculty will be responsible for Hospital accreditation in Pain medicine. The faculty will stand over its fellows as competent practitioners in pain medicine provided they have maintained their skills through the CPD process as outlined by the Medical Council and set up by our training body the College of Anaesthetists. Interventional pain competencies in particular are the preserve of full fellowship of the faculty and it is important that those who have a diploma or membership of the faculty do not work beyond their scope of practice.

We have not yet established equivalence for our examination internationally but this will be a part of our planned training programme. It will be robust and established to the best international standards, featuring good procedures for hospital accreditations, and a comprehensive education programme for fellows which includes a good competence assurance programme. When it is in place, we will be able to evaluate doctors who train in other jurisdictions in terms of credentials, equivalence and reciprocity.

We are currently a ‘trans–national’ faculty containing fellows from five different health care systems: Ireland, Northern Ireland, Scotland, England and Australia. We enjoy particularly good relations with the Australian and New Zealand Faculty of Pain (ANZFP), arguably the most progressive international body in Pain Medicine. Sydney-based Professor Michael Cousins addressed our national meeting in 2007 on the subject of chronic pain as a disease in its own right. His landmark 2006 paper in *Anesthesia and Analgesia* is the leading contribution to the international literature in this area. The ANZFP’s former Dean, Dr Roger Gouke, visited our annual scientific meeting in 2007 whilst their leading professor emeritus, Professor Tess Cramond (nee Brophy), is an honorary fellow of the
College of Anaesthetists of Ireland. Prof Cramond became the first international honorary fellow of our faculty at our 2011 Annual Scientific Meeting. We recently received a letter of appreciation from the Current Dean, Dr David Jones, regarding our intention to honour Professor Cramond. This correspondence contained an offer of further help to our faculty from colleagues in Australia and New Zealand. The current Vice-Dean of the ANZFP, Dr Brendan Moore, trained in Ireland whilst two active members of our faculty board trained in Australia. The Irish Faculty recently endorsed our antipodean counterparts’ key publication *Acute Pain: The Scientific Evidence (Third Edition)* and are actively encouraging the use of this handbook as a resource to improve the quality of Pain Medicine in Ireland in the peri-operative period.

We also have good relations with Professor Rollin Mac Gallagher, former President of the American Academy of Pain and author of the Flexner report on training in the USA. Our College in Ireland is currently in discussion the Royal College of Anaesthetists and GMC in London about the reciprocity and equivalence of anaesthetic training in Ireland. When this process is complete we hope to meet with our colleagues in the Faculty of Pain Medicine in the Royal College to develop a working relationship that reflects the proximity of our two islands and their long-established historic medicine relationship.

### IIIB Governance:

The Faculty of Pain Medicine is structured to adhere to the accepted principles of good governance (i.e. the structure and policies for decision making), in keeping with the OECD Principles of Corporate Governance (2004). With these principles in mind, The Faculty will adopt a Joint Faculty/Board model. The Board of the Joint Faculty will operate under the following principles:

- Should act in good faith, with due diligence and care, and in the best interest of the Joint Faculty and Fellows and Members,
- Must protect, respect, and facilitate respect the exercise of the rights of all Fellows Members and Trainees of the Joint faculty.
- Must review and guide corporate strategy.
- Set clear performance targets and provide the appropriate supports for Joint Faculty Officers and Secretariat to achieve these goals.
- Should ensure that timely and accurate disclosure is made on all material matters regarding the Joint Faculty, not only with regard to financial and organizational matters, but also in relation to all programmes, courses and examinations under the auspices of the Joint Faculty.
- Establish appropriate financial and operational control, in compliance with the relevant requirements set in Irish and EU law and regulatory requirements.
- Trainees should be represented at all levels of the governance structure.

### IIIB(i) The Board

The Board is the body that directs and manages the Joint Faculty, and shall apply the principles of good governance as described above.
IIIB(ii) Membership of the Board:

12 fellows by election including the office of Dean and Vice Dean. In addition there will be a trainee representative, a lay representative and co-opted will be the President of the IASP Chapter in Ireland. If there are no board members by election from specialities other than anaesthesia 2-3 interested physicians/surgeons will be co-opted to represent a broader range of opinion.

IIIB(iii) Election to the Board:

- All Fellows of the Faculty of not less than two years standing on the date fixed for the election and being in good standing shall be eligible for the election to the Board on complying with the Standing Orders.

IIIB(iv) Terms of Office:

- Each Member of the Board shall serve for a term of five years, at the end of which period, he/she shall retire and shall be eligible for re-election to the Board for one further term.
- A Board member who has served for two consecutive five year terms shall not be eligible for re-election until after a lapse of one year.
- The Dean shall be appointed for a period of Three years and thereafter shall not ordinarily be eligible for re-election as Dean. The Vice-Dean will be elected by the board and succeed as Dean so shall be appointed for a period of 3 years. On the expiry of his/her term of office as Dean, the Dean shall continue as a Member of the Board for one year. He/she shall then retire and shall not be eligible for re-election to the Board until after the lapse of one year.

IIIB(v) Committees:

- The Board shall set up the following Standing Committees: Competence Assurance, Training, education, exams, Credentials as a minimum

IIIB(vi) Meetings of the Board:

- Unless otherwise ordered by the Board, meetings shall be held quarterly, with an annual AGM for all fellows

III (C) The specific body of knowledge and skills is sufficiently complex or extensive to require a comprehensive and distinct training programme;

III (C): As stated earlier, there is a rapid expansion of knowledge in our discipline due to key developments in neuroscience, genetics, immunocytochemistry and neuroimaging techniques. Furthermore, a clinician practising in this area needs to have a comprehensive and contemporary knowledge of medical assessment across a diverse range of relevant areas including neurology; rheumatology; rehabilitation medicine; occupational medicine; liaison psychiatry; psychology and physiotherapy; oncology; and palliative care. This knowledge will not flow from the field of peri-operative medicine within an anaesthetic training programme. However Anaesthesia training is beneficial will in the areas of acute medicine, surgical techniques, managing Chronic Pain in acute situations. In addition,
anaesthesia skills in regional anaesthesia including ultrasound bring additional technical expertise. However, many skills in the area of pain intervention will be shared more with neurosurgery than anaesthesia – basic surgical skills, neuroablation techniques, the implantation of spinal cord stimulators and intrathecal drug delivery systems for example.

Chronic pain fits into the model of a chronic disease and as an emerging new discipline has worked the multidisciplinary model well on an international basis for the last 30 years. Thus, training needs to share the assessment space with physiotherapy and psychology and be able to interact with these disciplines to produce a rehabilitation plan for the patient, often based on cognitive behavioural principles so that the patient can manage their condition on an ongoing basis.

**III (d) There is or will be a programme of education, training and assessment that will enable practitioners to:**

- **undertake unsupervised, comprehensive, safe and high quality medical practice in the relevant specialty, including in the general roles and competencies that apply to all professional medical practice;**

III (d): The training programme will include an exit exam that will involve patient assessment and management. Furthermore, it will establish the existence of core competencies for procedures. Within the fellowship of the faculty there will be an ongoing education and competence assurance programme. In this context, the faculty is happy to stand over the competencies of all its fellows in good standing and who participate in the competence assurance programme. It is hoped that, by granting specialty status, that the current situation where a physician can do procedures on patients without any training, qualification, commitment to education or participation in a competence assurance programme will end. This will therefore ensure a safe environment for patients.

- **demonstrate the requisite knowledge, skills and professional attributes through exposure to a broad range of clinical experience and training in the relevant specialty;**

This document identifies a hybrid specialty which requires a core entry discipline that can draw on relevant knowledge and skills from a range of interrelated disciplines in order to develop a unique knowledge base and skill set of its own.

In addition to knowledge, there is the requirement for experience. Currently all major hospitals have a pain clinic. Many smaller hospitals also have such a facility. Some of the larger centres come up to the full international standards others need additional resources and are considered to be work in progress. Training in Pain Medicine reflects this variation with three tracks – some hospitals sanctioned for two months training, others for six and a few for 12 months.

- **contribute to providing high standards of medical education;**

The Faculty see this is as a critical function due to the lack of visibility of special recognition within Irish Medical Schools. With specialty status, the opportunity to provide knowledge and understanding of pain medicine will be increased and will allow easier access to undergraduate education. Our faculty has documented the poor standard of pain education
in medical schools both at the undergraduate and post graduate levels. This is unacceptable for a chronic condition that afflicts 13% of the population. An internationally-accepted core curriculum on Pain Medicine is available from the International Association for the Study of Pain. We welcome the opportunity to join with the various medical schools in opening a dialogue this current deficit. Indeed, Professor Dominic Harmon at the University of Limerick’s Graduate Entry Medical School has taken a national lead in this regard.

In Limerick, the primary focus is the Australian model of post-graduate entry medical education. This contains several conditions with Pain Medicine as the primary focus. Pain Medicine is built into case scenarios that are used for problem based learning in years one and two. The students in preclinical years also get eight invited guest lectures on Pain Medicine topics. In the clinical years (year 3 and 4) Pain Medicine is also significantly covered. The medical school has accepted the curriculum for medical student pain education from the International association for the study of pain. The university has established the post of adjunct professor of Pain Medicine.

The deficit in Pain Medicine education in postgraduate training is particularly acute. Once again, speciality recognition and support from the Medical Council will help to improve this situation. There is a general belief in society that pain relief is a human right – this also needs to be reflected in medical education. The Faculty is fully committed to contributing to and encouraging high standards in Pain Medicine education in Ireland. We await the intervention of other stakeholders to help us make this a reality.

The College of Anaesthetists of Ireland are developing expertise in medical education and as a Faculty we will have access to that expertise.

- provide leadership in the complex health care environment, working collaboratively with patients and their families and a range of health professionals and administrators;

Once again, the current situation means that there is no one with responsibility for Pain Medicine in the HSE, nor is there a national policy for Pain Medicine within the Department of Health. We have made this point to the former Minister for Health, Mary Harney TD who appointed the Deputy Chief Medical Officer as the liaison with our faculty. The patient support group CPI have made a similar point to the new Minister Dr James Reilly who met with them. The awarding of specialty status would increase our visibility within the HSE and the Department of Health. This would directly assist patients suffering from Chronic Pain. An international campaign by EFIC (European Federation of IASP Chapters) has been ongoing since 2001 to have chronic pain declared a disease in its own right) [11]. Norway, China and Pakistan have achieved this objective to date. Australia and New Zealand are on the brink of such recognition. In America, the American Medical Association has recognised the condition as a distinct disease entity. The greatest help to patients and families in our complex environment would be recognition of the specialty status for Pain Medicine and disease recognition for persistent pain. Please also see the attached Pain Proposal document which represents a recent patient-based initiative on the need to have a more rigorous concentration on pain and its impact on society. Many of our faculty members contributed to this document, which formed part of a Pan-European initiative. The Irish document (Appendix 3), in common with others, highlighted the need for recognition of the specialty of Pain Medicine as a number one priority in terms of improving patient outcomes.
• *demonstrate a knowledge and understanding of the issues associated with the delivery of safe, high quality and cost-effective health care within the Irish health system.*

We are fully cognisant of the complexities of the Irish health care system. Within our parent specialty of anaesthesia, we deliver a safe, high quality, cost-effective health care service. We will bring this expertise into the new specialty of Pain Medicine. We are particularly concerned with the safety of patients and the lack of regulation at a professional level of interventional Pain Medicine procedures. In this application, we are offering the Medical Council a mechanism to ensure that those performing such procedures are properly trained in the future and that they participate in an appropriate competence assurance programme that is transparent and relevant to the specialty of Pain Medicine.

**III (e) There is or will be a programme of continuing professional development that assists participants to maintain and develop knowledge, skills and attitudes essential for meeting the changing needs of patients and the health care delivery system, and for responding to scientific developments in medicine**

III (d): We are, as a faculty, represented on the College of Anaesthetists competence assurance committee by our Vice Dean. We are fully committed to this programme and, alongside maintaining general professional standards plan to adapt the core principles more specifically to the needs of our specialty without dissipating the core structure of the programme envisaged by the College of Anaesthetists of Ireland. We have taken the advice and guidance from Professor John McAdoo as Chair of the Competence Assurance Committee within the College. As a previous President of the College, he has a good working knowledge and relationship with the Medical Council in the domain of competence assurance.

**III (f) The professional body can demonstrate experience in all or some of the following:**

• *health policy development*

III (e): Currently, there is no national strategy for addressing chronic pain. Our faculty members have long been proactive in advocating publicly with all stakeholders for the development of such a policy and present our 2006 paper the Irish Journal of Medical Science (Appendix 2) (17) and briefing document presented to the former Minister for Health Mary Harney TD in 2009 as evidence of our good intention in this regard (Appendix 1). A process is also under way in terms of active liaison with the HSE.

• *health promotion and advocacy*

In many of our departments, we have ensured good acute pain management following surgery or trauma so that we can prevent the development of chronic pain. We support the international campaign to have pain measurement declared as the fifth vital sign. Professor Harmon in Limerick has worked diligently to include pain as a key part of the early warning system for high risk patients being launched by the HSE. The existence of pain management programmes are designed to return people to an active life, including work. When we use advanced pain technologies, such as spinal cord stimulation, it is also with the intention of
promoting a return to a more active life. As core pain management principles, we encourage daily exercise, relaxation and the concept of pacing to achieve desired goals for all our patients so that their quality of life will be better.

- **research activity and facilitation**

Ireland has a rich supply of pharmaceutical and technology-based industry. As a faculty, we have identified the need to develop this further and harness opportunities that are presented in the field of pain. Following a meeting with the IDA in July 2010, we began a process of setting up clinical networks. We have enclosed our initial consultation document with key stakeholders (Appendix 4, Irish Pain Clinician Network, August 2010). It is our intention to actively contribute to the development of this sector because patients with chronic pain need better treatment and Ireland, as a first world country, should be playing its part. Also, the area of pain represents a rich vein of research, particularly in neuroscience, genetics and neuro-imaging. There is no comprehensive research programme currently underway in Pain Medicine in Ireland but there are pockets of research activity that need support – University College Dublin: Dr Brona Fullen in the area of rehabilitation, plus collaborations with the Conway Institute and St James’s Hospital, Dublin: Dr Connall Mc Crory in the area of intrathecal NSAIDS; Galway Institute of Technology: Dr David Finn in the area of cannabinoids and Dr Brian Maguire (Psychology) University College Galway; University College Cork: Cork Professor George Shorten in the area of acute pain; and University of Limerick: Professor Dominic Harmon in the area of ultrasound in Pain Medicine.

- **the development and dissemination of the discipline’s evidence base**

We support the work of the Irish Pain Society, which is a chapter of the International Association for the Study of Pain (IASP). This body has more than has 30 associated publications, including the research journal *Pain*. We encourage all our trainees and fellows to be members. We also support the work of patient support groups such as Chronic Pain Ireland, Arthritis Ireland and other patient support groups. We hope in time to build a broad based coalition between such partners. We took some advice in this regard from Professor Rollin Gallagher at our recent seminar – he chairs just such a broad based advocacy group in the US. We also note the success of our faculty colleague in Northern Ireland, Dr Pamela Bell, on this topic. She has forged an alliance with patient groups and doctors and politicians including Lord Magennis on behalf of patients with Chronic Pain.

We hold a high-profile scientific meeting each spring with professional organisation and extensive advertising, including dedicated public relations expertise to maximise impact. This year’s gathering is scheduled for the College of Anaesthetists and the RCPI. There is a dedicated website featuring the agenda and facilitating convenient booking. Discounted admission for is available for students. Our scientific meetings feature an international panel of speakers who speak to a central, relevant theme each year. In 2010 we addressed ‘Pain in Women’, in 2011 ‘Pain in Cancer Survivors’ and in 2012 “The science of spinal pain”. We also contribute a pain-related module to the annual scientific meeting of the College of Anaesthetists. The IASP designated 2011 as ‘The Year of Acute Pain Management’ and this was reflected at the event in May.

- **the education of other medical and health professionals**

Recognition of our specialty will allow us to open up the faculty on an equal basis to other interested disciplines in medicine and surgery, thus allowing a pathway to pain fellowship
from these disciplines in due course. Our commitment to other health care professionals is reflected in our support of the Irish Pain Society, a multidisciplinary umbrella group for healthcare professionals including physicians, nurses, physiotherapists, occupational therapists, and clinical psychologists. The President of IPS is co-opted onto the faculty board. All the meetings outlined above, and our own educational programme, are made available to all medical and health professionals interested in the area of chronic pain.

- engagement with health consumers.

We are supportive of the patient support groups operating in the area of pain. These include Chronic Pain Ireland and Arthritis Ireland. Both organisations have actively promoted the need to recognise chronic pain as a disease with a specialty dedicated to its management (Appendix 3). As stated above, it is the intention of the faculty to facilitate a broad-based coalition to further enhance the specialty of Pain Medicine so that it can be of increased service to our patients.

We are fully supportive of the need to declare persistent pain a disease in its own right, a major health care problem. We believe that Ireland should lead on this and follow Norway’s example and so become the first country in the EU to do so and are in the process of engagement with legislators and the HSE in this regard.

The Irish media campaign that formed part of the recent EU-wide Pain Proposal initiative in October 2010 serves as a timely and useful measurement of overall public interest and engagement in the area of improved pain management. As mentioned earlier, this outreach urged policy makers, the medical profession and society in general to reassess attitudes to chronic pain and a reappraisal of the often unnecessary costs incurred by a failure to optimally prioritize and treat the condition. Indeed, a central plank of the Pain Proposal involved the need to recognize and promote the work of pain clinicians as a distinct medical specialty in its own right (Appendix 3, P11). This argument was made to medical councils and healthcare regulators in 15 European countries. The public response to the Pain Proposal – through the good offices of journalists, broadcasters and patient organizations (including Arthritis Ireland and Chronic Pain Ireland) – demonstrates and reflects the significant massive resonance improved treatment of chronic pain has with Irish citizens. The report’s launch was reported the news programmes of two national television broadcasters and print coverage was carried in numerous national newspapers. The editors of many local newspapers and radio stations also viewed the subject worthy of communication with readers. Many individual patients, passionate that the outcomes of those accessing pain services be improved, volunteered to speak about their experiences and were subsequently interviewed on television, radio and in the press by reporters who felt this issue resonated with their varied audiences. In all, it is estimated that through the media (using verifiable measurement indices) more than 3,000,000 Irish citizens engaged with this campaign.
IV: That recognition of the specialty would be a wise use of resources

Recognition of the specialty would be a wise strategic response to the management of a significant cohort (13%) of the population whose service provision is currently under-resourced. Professor Maguire’s group in Galway in conjunction with Professor Charles Normand (Edward Kennedy Chair of Health Policy) at TCD have published the Prime study in the journal Pain (17) (impact factor 6) which estimates the cost of chronic pain in Ireland to be of the order of 4 to 5 billion euro per year. This figure should focus the mind on the wise use of resources. Recognition of the specialty would also impact on Ireland’s position as a State where large scale clinical research projects in Pain Medicine were possible via the ‘Irish Pain Clinician Network’. Finally, a strategic move like this would be seen by the pharmaceutical and medical device industries as a vote of confidence in Ireland’s Clinical Medicine & Medical Research communities by the Irish Medical Council. The IDA have already strongly backed the Irish Pain Clinician Network and stated their belief that it could, in time, help Ireland become a global test bed for pain research and treatment development.

Please demonstrate:

IV (a) That recognition of the proposed specialty is of significance to health as defined by a significant burden of disease, incidence, prevalence or impact on the community which is relevant to the proposed specialty;

(IV (a): Given that 13% of the Irish population suffer from persistent pain, the illness represents Ireland’s most widespread chronic disease. This 2009 annual report of the UK’s Chief Medical Officer in 2009 explicitly recognised this staggering disease burden and advocated a strategic response. Chronic Pain’s impact has been lucidly assessed in Ireland – and across 14 other European States – in the Pain Proposal initiative (See Appendix 3). In financial terms, it is now known that chronic pain costs the EU €300 billion annually. Although we have no official current figures for Ireland due to lack of recognition, the socio economic cost in Ireland is estimated as stated above to be over 4 billion (17).

IV (b) That this significance is coupled with a demonstrated capacity of members of the proposed specialty to influence it;

IV (b): It is the primary aim of the faculty, alongside its partners in the Irish Pain Society, to improve the health and quality of life of the patient who is suffering from chronic pain and thereby make significant in-roads into reducing the burden of this chronic disease on society.

IV (c) That there is significant professional and consumer support for the recognition of the medical specialty;

IV (c): The public response to the recent ‘Pain Proposal’ initiative (Appendix 3), outlined above, emphatically demonstrated public interest in improving pain outcomes. The document was supported by the Irish Pain Society, Chronic Pain Ireland and Arthritis Ireland patient groups. Significantly, specialty recognition was the document’s number one request.

IV (d) That the resource implications for health care providers and consumers are justified on the basis of benefit to the community inherent in the recognition of the specialty.
IV (d): “Pain is more of a lord of mankind than even death itself” Dr Albert Schweitzer (1931). The provision of medical care has moved on considerably since Dr Schweitzer made his famous philosophical commentary on pain. There is no civilised society that could argue against the provision of state-of-the-art pain management to its citizens. It is well documented that there is a poor quality of life in these patients (Appendix 5). We have a duty of care to ensure sensible use of resources to offer good care to all our citizens trapped in a cycle of chronic pain. The Pain Proposal document states that 20% of this cohort whose pain is so bad and so persistent that they want to die and it is certainly not unknown for Irish patients to take their own lives (Appendix 5).

We already have a national network of pain clinics. It includes 26 specialists with 14 whole time equivalents between them. More than five fully-funded Pain Medicine posts are waiting training designation that would follow specialty recognition. Nationally, all main therapies are available. As always, there is need for greater streamlining of scarce resources and further planned development is needed. In the College of Anaesthetists we have an excellent parent training body whilst the Faculty of Pain Medicine offers the potential to streamline all training, examinations, research and competence assurance programmes. Our members have already made a significant investment in promoting the need to reassess age-old approaches to pain and its management. To bring this process to its best possible outcome, we require specialty recognition from the Medical Council. This can facilitate innovative policy initiatives that will not only service the needs of vast numbers of suffering patients but allow us to develop a comprehensive research and development strategy at a time when we need such an initiative to build on the excellent pharmaceutical and technological device production in our country over the past 20 years. In this context we believe that the recognition of the specialty of Pain Medicine by the Medical Council will in time be seen as a seminal effect that will pay dividends for patients and their families for many years to come.
Appendix 1: National Pain Medicine Strategy Document presented to the Minister of Health, Mary Harney TD in 2009
Appendix 2: IMJ paper on the need for a national strategy
Appendix 3: Pain Proposal Document
Appendix 4: Irish Pain Clinician Network, Inaugural Meeting Report
Appendix 5: Quality of Life and Suicide in Chronic Pain, Surveys
References

11. EFIC (European Federation of IASP Chapters). Declaration on chronic pain as a major healthcare problem, a disease in its own right. EFIC Publications 2001.
17. The Economic Cost of non cancer pain in Ireland: results from the Prime study part 2. Raftery MN, Ryan P, Normand C, Murphy AW, de la Harpe D, Mc Guire BE. J Pain 2012 (feb; 13(2)) 139-45

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