FPM
Faculty of Pain Medicine
ANZCA

11 June 2025

Professor Ian Martin Symonds
RANZCOG
c/o Rutu Dhavan
Coordinator, curriculum development

Faculty of Pain Medicine ANZCA response to RANZCOG PPP SIM curriculum review

Dear Professor Symonds,

Thank-you for the opportunity to comment on RANZCOGs Special Interest Advanced Training module (SIM) – Persistent Pelvic Pain curriculum. The opinions expressed below have been informed by dual fellows of the Faculty of Pain Medicine, ANZCA with a primary specialist qualification of FRANZCOG who have not be involved in the drafting of this document.

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.

Overall, I think this document appears to be very thorough in addressing an advanced training curriculum in the area of persistent pelvic pain. It has been suggested that given the prevalence and importance of persistent pelvic pain in society that perhaps RANZCOG could consider incorporating elements of this into their basic Fellowship training undertaken by all trainees in addition to an 'elective' advanced unit.

The overarching document suggests that there will not be much assessment of knowledge, skills and behaviours occurring within the context of this curriculum and yet when considering the detail there appears to be many more assessment episodes. MsF's have been used extensively as an assessment instrument especially in assessing counselling and explanation competencies. These episodes of care lend themselves to focussed mini-CEXs where the trainee is observed and aspects of communication, professionalism and cultural safety can be incorporated to the assessment rubric, in addition to those of the medical expert. The advantage of using multiple mini-CEXs compared to a single MsF is in the provision of feedback on each occasion, thereby facilitating learning, rather than waiting for the 3 or 6 month meeting (3MA or 6MA). Assessors from multiple healthcare professions could still be used in this situation without compromising the validity of the instrument.

Is this learning outcome "demonstrate an understanding of the principles of choosing wisely" (p.36) related to the recommendations around opioid and gabapentinoid prescribing made in the "Choosing Wisely" campaign that was run by the NPS MedicineWise?

The only other concern that we would have relates to the assessment rubric and specifically to level of supervision for procedures, 1a. It is unclear how an assessor concludes that a trainee can do something in a simulated environment but be incapable of doing it in a clinical situation without giving them the opportunity to demonstrate what they can do. This is an assumption on the part of the assessor that requires a narrative description of what the identified issues in the simulated situation were that allow for a level of competency, that is not translatable to a clinical environment.

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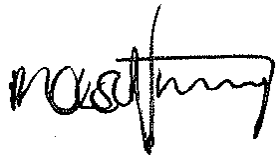
Yours sincerely,



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