Criteria for Accreditation of Training Centres

Indian Academy of Pain Medicine

IAPM

The Academy of the Indian Society for Study of Pain

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INTRODUCTION

Pain is a biopsychosocial experience. The International Association for the Study of Pain has emphasized the importance of the multidisciplinary team in the management of pain to ensure that all facets of the pain experience are addressed. Patients referred to the specialist pain management centre are typically complex with multiple factors impacting on their presentation. Such specialist centres should have a team of key professionals who deliver the highest standard of patient care, research, audit output, teaching, and training in the area of complex pain and pain-associated disability, within a dedicated environment. The centres, furthermore, must be able to provide a whole pathway of care for their patients. This would include assessment, investigation, non-complex interventions, and complex interventions that may be physical or cognitive behavioural.

The IASP has stated that excellence in pain care is dependent on the education of young healthcare providers in the discipline of pain medicine, and that these educational programs should be at all levels attempting to integrate with degree granting institutions as well as post-graduate educational programs. It has, moreover, graded the pain care services as multidisciplinary pain centre, multidisciplinary pain clinic, pain practice and modality-oriented pain clinic depending on the philosophy of the pain centre, administrative structure and staffing, physical components of the facilities, clinical workload and standards, teaching facilities, the presence of programme heads and other activities.

The mission of the Indian Academy of Pain Medicine (IAPM) - the academy of the Indian Society for Study of Pain (ISSP) - is to propagate teaching of pain medicine and to implement quality oriented pain medicine practice across both government and private sectors. The stated objectives of the IAPM in the domains of pain education, as approved by the Governing Council and Annual General Body of the ISSP, were

- To establish structured teaching/training in pain medicine
- Define the characteristics of a physician pain education programme and start such a programme.

Under the title Project **Outline - Working** Protocol, the conception document addresses the issues that are paramount to set up pain education centres such as entry criteria for potential candidates, accreditation of centres, curriculum development, exit criteria and stipend.
Under direction of the Past President of ISSP Dr B.B.Mishra, a three-member committee headed by Dr. R.P. Gehdoo was formed during ISSPCON2016 to study the document and provide direction in each of these domains with a view to start training programs as a priority activity of the ISSP. The committee acknowledges the restraints of the available resources in India. Similarly, it believes that even with limited resources, care should be guided by an understanding that pain is influenced by biomedical, psychological, and social/environmental factors, and treatment should be evidence-based and safe.

To whatever extent possible, treatment should be multidisciplinary and aimed at alleviating pain, as well as improving physical function and psychological distress. In so far as it can be ascertained, there is a wide variation in pain care offered by institutions and clinics in India, and not every pain education programme offered by the centres cover the whole gamut of services.

The committee, therefore, proposes a tiered system of accreditation, where the centres offering pain education programs are categorized into different tiers based on the services offered, physical facilities, clinical workload, teaching faculty and staffing. This document provides a l00-point checklist for accreditation. The intention of this document is not just to provide criteria for accreditation of centres under different tiers, but also to encourage the centres initially accredited under a lower tier, for example as a modality-oriented clinic such as acupuncture-only or spinal injection-only, to work towards obtaining accreditation as a multidisciplinary pain management centre.

The accreditation criteria have been further categorized under general criteria, philosophy of the programme, administrative structure and staffing, physical components of the facilities, clinical workload and standards, accreditation process, teaching facilities and their organisation, the presence of programme heads, stipend and other activities. A standardized application form for the centres to apply for

accreditation has been developed. In addition, a standardised accreditation form that could objectively document the facilities available at the applying centre for use by the accreditation committee has been developed. They are both available as annexures at the end of the document, and also available as separate forms for download from the ISSP website (www.issp-pain.org).

The accreditation criteria that have been set out are approved by the Governing Council of the ISSP. Any changes to the accreditation criteria made by the IAPM in the future should be approved by the Governing Council of the ISSP before it takes effect. Finally, the committee would like to thank the ISSP for entrusting it with the task of setting up accreditation standards for centres offering pain education programs in India.

Dr. R. P. Gehdoo
Dr. Pradeep Jain
Dr. P. Vijayanand

Disclaimer: The accreditation of the centres by the Indian Academy of Pain Medicine and the Indian Society for Study of Pain is only for the purpose of training in pain medicine. It does not endorse the centres to perform invasive or non-invasive procedures that may or may not be evidence-based. ISSP and IAPM are not responsible for the legal issues that may arise out of conduct of such procedures.

Revised Criteria for Accreditation of Training Centres - 2020

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Amendments proposed by the appointed Accreditation committee in August 2019.

Reviewed by IAPM and approved by ISSP in 2020.

Revised Criteria for Accreditation of Training Centres -2020

IAPM has been a historical milestone for the ISSP with the initial accreditation criteria laid down by Dr. R P Gehdoo and his able team in March 2016. This was the preliminary step for the apt accreditation of Centres to propagate uniform standards and to promote syllabus -based and structured training of Pain Medicine. The Centres which fulfilled these criteria were selected for the start of the fellowship programme from January 2018. Subsequent to this, there were regular interactions between the IAPM GC Committee members. As the fellowship programme progressed it was deemed necessary to make few practical amendments in the original accreditation criteria document. The need for revision was also mentioned in the original version published in March 2016 as “To be reviewed by IAPM and approved by ISSP in 2020”.

In view of this in February 2019, IAPM Dean, Dr Bibhu Kalyani Das and Registrar, Dr Pradeep Jain formed a committee to revise the original criteria to make them more practical. This committee headed by IAPM GC member Dr Preeti Doshi including three other senior GC members Dr Pratibha Matche, Dr Krishna Poddar and Dr Sunita Lawange was given the responsibility of revision. This committee worked hard to put together all the necessary changes that were finalized and subsequently approved by the ISSP in September 2020. This version of accreditation criteria document will be referred to as the current and valid accreditation criteria until further revision. Any change to the accreditation criteria made by the IAPM in the future should be approved by the ISSP.

Finally, the committee would like to thank the IAPM Dean and Registrar in 2019 for entrusting it with the task of revising accreditation criteria for Centres offering pain education programs in India. It would also like to acknowledge the full support offered by ISSP.

Dr Preeti Doshi
Dr Pratibha Matche
Dr Krishna Poddar
Dr Sunita Lawange

1.0 GENERAL CRITERIA

1.1	These criteria establish the recommended standards for Centres offering training in Multidisciplinary Pain Medicine for **Fellowship of the Indian Academy of Pain Medicine.**
1.2	The term 'Centre' includes the organization, personnel and facilities that together provide all or part of the training programme.
1.3	The term 'programme' refers to the experience and exposure devised for a trainee. A trainee's programme may be pursued through more than one Centre. However, this should be clear in writing with an intimation to IAPM Dean and Registrar before the start of the training with names of each additional center candidate is going to be involved with and likely hours /week and length of rotation at each as applicable. Logbook should have all the data from each Centre mentioned in the list. Logistics related to the same will be the responsibility of programme head and the candidate. IAPM will not be responsible for any expenses incurred in this arrangement.
1.4	A Multidisciplinary Pain Medicine Centre must include practitioners from at least two relevant medical specialties and from relevant allied health professions. These health professionals specialize in assessment, diagnosis and management of patients with chronic pain, acute pain and cancer pain. They should have experience working together in a multidisciplinary context.
1.5	The Pain Medicine trainee fellows must have interaction and experience working in rehabilitation services for chronic pain, cancer and palliative care services, psychological and psychiatric services and acute pain service. Coordination between these services is desirable.
1.6	The Multidisciplinary Pain Medicine Centre must be approved prospectively, and reviewed at regular intervals as determined by the Indian Academy of Pain Medicine for training purposes. With the limited number of centres at present who fulfill all the criteria, one centre can be allotted up to 2 fellows. Reassessment of each centre should be done every five years but if the centre has any changes from the time of assessment including the change of Programme head, it should be intimated to the IAPM Dean and Registrar immediately, failing which the centre can risk losing the recognition.
1.7	Adherence to the highest standards of ethics and professionalism is expected of all pain practitioners, regardless of facility or practice.
1.8	Trainees are expected to spend a minimum of 36 hours/week in Pain Medicine. The trainee may work in their primary specialty (Anaesthesiology) in addition to training requirements, although not in a manner that compromises training opportunities. The training is for a period of 12 months. The 36 hours can be split into 30 hours of practical training in OPD, Ward, Procedures and 6 hours per week spent on formal teaching, presentations, interactive case discussions which should be recorded in the logbook.

2.0 TREATMENT PHILOSOPHY

2.1	The pain service must be conducted in accordance with the Medical Council of India's code of medical ethics**.** Efforts will be proactively made to obtain upon MCI approval for Pain Fellowship and thereby get the specialty formal recognition in clinical practice.
2.2	The assessment and treatment modalities on offer in the various components of the training programme must be truly multidisciplinary in nature so as to encompass pharmacological medicine, neural blockade, stimulation techniques, physical therapies, surgical techniques (including orthopedic surgery and neurosurgery), neuromodulation, rehabilitation and psychological approaches in all patient groups. Multi-professional staff must provide the treatment especially in Tier I and II a centres.
2.3	There must be a culture of multidisciplinary co-operation with ready access to other specialist opinion in the hospital or hospitals, particularly when there is any doubt about diagnosis or the formulation of a management plan.
2.4	Trainees must learn to assess, examine, investigate and plan treatments for a variety of different pain patients in different settings. There must be an opportunity for the trainee to follow the progress of patients over an extended period. This can be implemented by logbooks checked and countersigned by the programme head. This can help us also to build up our own Indian statistics about practice and trends.
2.5	There should be clear lines of supervision. Initially very close supervision will be needed and as competencies develop more independent working should be possible. However, trainees must always be able to access support from their programme heads at all times.
2.6	The centre or institution should be able to demonstrate an evidence-based approach to pain medicine and should be able to instill in the trainees an understanding of critical appraisal of research publications in pain medicine.

3.0 OUT PATIENT FACILITIES

3.1	The entrance and reception should be well sign-posted, accessible and welcoming**.**
3.2	The reception staff should understand the nature of pain medicine services and its patients. They should be able to help with enquiries and outpatient bookings, as well as with the collection of any outcome data where needed.
3.3	The waiting area should allow for the completion of any screening tools and questionnaires and any help required by the patient or caregivers in completing this material should be provided.
3.4	Access should be available for wheelchair users.

4.0 CONSULTATION / EXAMINATION ROOM

4.1	A room size of 125 sft or more is considered suitable for a consulting room with examination facilities. A smaller consulting room is acceptable if the examination room is different.
4.2	There should be space for multi-professional clinics as well as for group sessions. This often requires larger space provision.
4.3	Specialized pain services may have specific needs requiring different and larger specialist clinical spaces.
4.4	The necessary equipment to examine patients must be available, including examination couch, adequate seating, examination tools and clinical hand washing facilities.
4.5	Adequate workstation/desk space and communications/IT provision should be provided for the trainee and the secretarial staff.
4.6	The setup of the clinical area should be tailored to preserve the patient's privacy, modesty and dignity: this includes consideration of the acoustics of the space, the use of screens and covers, and hospital gowns to dress/undress.
4.7	A chaperone should be available when needed.
4.8	Where more numbers of pediatric patients are seen, the ambience should be suitable for the emotional and physical needs of the child.

5.0 OPERATING THEATRE / PAIN PROCEDURE ROOMS

5.1	Facilities for monitoring, airway and respiratory support and resuscitation, including defibrillation, must be available at all sites.
5.2	Full resuscitation equipment and drugs must be provided as specified by up-to-date resuscitation guidelines and hospital policy.
5.3	Check list should be verified before the procedure.
5.4	Anaesthesia machine and facilities for general anaesthesia and resuscitation must be available at all sites where patients are undergoing pain intervention procedure, even when no sedation or anaesthesia is being administered.
5.5	All anaesthetic and monitoring equipment must comply with standards set by NABH. Patients' physiological parameters must be adequately monitored throughout intervention procedures.
5.6	Policies and equipment must be in place to protect patients and staff from cross-infection, including safe disposal of sharps.
5.7	The operating and anaesthetic rooms must conform to radiological protection specifications where designated. All X-Ray equipment must conform to AERB rules. External door signs should indicate when X-Ray/fluoroscopy is in use.
5.8	Staff must have access to lead aprons of the appropriate thickness, along with thyroid shields. Members of staff who are in close vicinity to fluoroscopy equipment must wear x-ray dosimeter badges.
5.9	Facilities are required to allow for patient privacy and confidentiality during the pre-procedure discussion and examination.
5.10	There should be separate male and female changing facilities.
5.11	Patients should have access to secure storage for their personal belongings whilst undergoing their procedure.
5.12	The procedure to be done under strict aseptic precautions. Disposable equipment like syringes, needles, mask and gloves to be used. Basic pre-packed kits may be provided which contain the essentials to which additional equipment may then be added.
5.13	Sharps disposal units should be available. Equipment for nerve identification has to be available when performing peripheral nerve blocks (nerve stimulator, ultrasound or both).
5.14	All pain services that use interventional techniques need to have access to appropriate imaging equipment and the ability to store and retrieve images.
5.15	The operating table should be fluoroscopy compatible.
5.16	Where radiofrequency lesioning is provided, clinicians need to have access to the necessary lesion generator and appropriate needles and leads. The generator must be have a clear and up-to-date service record.
5.17	Where neuromodulation is provided, clinicians need to have access to the required equipment to insert, maintain and program such devices. Where general anaesthesia is required for insertion of the neuromodulation device, this must be provided by an additional trained anaesthesiologist and not by the anaesthesiologist inserting the neuromodulation device.
5.18	For all the pain interventions where anesthesia is required, it must be provided by an additional trained anesthesiologist present throughout for providing MAC, GA or RA as necessary.

6.0 RECOVERY ROOM

6.1	Each day-surgery unit must have a fully equipped recovery area, staffed by Recovery personnel trained to defined standards. Transfer from the immediate recovery area to a second stage (ambulatory) recovery area may take place when the patient is awake, in control of their airway, oriented (if GA is given) and hemodynamically stable.
6.2	After complex pain intervention procedures, patients must recover in a specially designated area.
6.3	Written discharge criteria must be available.
6.4	A contact telephone number for specialist advice must be supplied so that every patient knows whom to contact in case of post-operative complications.
6.5	There must be easy access to inpatient beds in the event of perioperative complications. Normally such beds should be located on a ward where the nursing staff is familiar with the management of these patients.

7.0 EQUIPMENT

7.1	Medical devices and clinical equipment must be purchased, managed, maintained and used in accordance with legislation and manufacturers' guidance.
7.2	Accountability for the management of such devices must be transparent and clearly defined. Policies must be in place to ensure that this occurs.
7.3	The management and use of medical devices and equipment must be by designated staff who have been appropriately trained and certified.
7.4	All anaesthetic and monitoring equipment, fluoroscopy or ultrasound equipment and radiofrequency lesion generators must be fully serviced at regular intervals designated by the manufacturer, and a service record must be maintained.

8.0 STAFF TRAINING

8.1	All staff must regularly attend mandatory resuscitation training. They should be trained to ALS standards.
8.2	All staff in theatre must be compliant with the use of a WHO surgical safety checklist.
8.3	Regular team briefing is a must to aid the smooth and safe running of a procedure list.
8.4	A sufficient number of experienced staff with appropriate manual-handling skills and access to patient hoists and transfer equipment is required to safely manage and treat patients with limited mobility.
8.5	Trained radiographers should support imaging activity.
8.6	Theatre staff should be trained in the operation of the radiofrequency generator.

9.0 STAFF FACILITIES

9.1	The main pain management facility should have permanent designated office space, for the secretarial. Administrative and other support staff.
9.2	There should be appropriate space for trainees with access to computers and information technology.

10.0 CONSULTANT RESPONSIBILITIES

10.1	No sole practitioner acting in isolation can claim to run a pain management clinic or service.
10.2	Specialist supervision appropriate to the level of clinical experience of the trainee must be available at all times.
10.3	The mandatory training time of 36 hours/week should be provided by a minimum of two different Pain medicine Consultants who have substantial hours of commitment to pain medicine (required because of the need for peer support and cross cover), along with other specialties.
10.4	Pain medicine consultant should devote a minimum of 25 hours/week to acute, chronic and cancer pain in the main centre so that there is supervision and training available throughout the whole working week.
10.5	Consultant time in other specialties such as palliative care, neurology, orthopaedics, rheumatology, rehabilitation medicine and psychiatry must not exceed 20% of the mandatory training time. Consultants in the other specialties must be familiar with the aims and objectives of advanced training of the fellow in pain medicine.
10.6	A maximum of 8 hours per week allocated to the Acute Pain Service can be counted. At least 20 hours per week should be conducted by medical practitioners holding Fellowship of the Indian Academy of Pain Medicine.
10.7	All medical practitioners involved in the Unit must be accredited by their institutions for the duties and procedures they perform.
10.8	When providing neuromodulation services, the clinician implanting the device must be suitably trained and experienced in the particular part of the assessment and procedure they undertake, and operate within their scope of practice and competency.
10.9	The Director / Clinical Lead / Programme Head of a Multidisciplinary Pain Centre must be a Fellow of the Indian Academy of Pain Medicine. He/ She has the responsibility for coordination and oversight of the trainee's programme, including where that programme is pursued in more than one unit.

11.0 OTHER MEMBERS OF THE MULTIDISCIPLINARY PAIN TEAM

11.1	Clinical input to the pain service from a psychologist with expertise in pain medicine is essential. It is desirable for this to be a significant aspect for at least 8 weeks of training**.**
11.2	There must be appropriate provision of senior registered nurse/nurses in both acute and chronic pain.
11.3	There must be links with necessary clinical support services e.g. physiotherapy, occupational therapy, social work, pharmacy and orthotics.
11.4	There must be access to other allied health disciplines such as rehabilitation, counseling and dietetics.
11.5	There must be full time/part time secretarial, administrative and clerical support staff
11.6	There must be a well-defined management structure for the pain service.

12.0 CLINICAL WORKLOAD

12.1	The clinical workload of the pain management service should be large enough to provide a breadth and depth of clinical experience.
12.2	For acute pain, chronic non-cancer pain and cancer pain there would be a minimum of 1000 new patients managed by the service per annum.
12.3	There should be a minimum of five outpatient consultant half-day sessions per week within the pain service devoted to pain medicine consultations and treatments.
12.4	In main training centres there should be a minimum of five in-patient ward rounds for acute, chronic and cancer pain (conducted by medical and/or nursing staff) each week.
12.5	The overall number of therapeutic interventions such as neural blockade and other major procedures should total at least 250 per annum. These interventions should cover a wide range of procedures performed for acute. chronic and cancer pain.
12.6	Interventional therapy such as neural blockade must not be the sole treatment modality offered by the institution and must be used in the context of a balanced, rational, multidisciplinary approach to pain medicine.
12.7	If specialised procedures such as intrathecal drug delivery and spinal cord stimulation are not performed in the institution, then there must be an opportunity for the trainee to gain an understanding of these techniques in another institution.
12.8	Trainees should gain adequate exposure to observe and perform assessment interviews, cognitive assessments, substance use assessments, self harm assessments, subsequent interviews, brief simple interventions, family assessments, crisis interventions (where feasible).

13.0 OTHER ESSENTIAL REQUIREMENTS

13.1	There must be provision of diagnostic services e.g. laboratory, radiology and neurophysioloqy.
13.2	Regularly scheduled educational sessions for all staff - multidisciplinary case conferences are mandatory (minimum fortnightly). These are in addition to regular journal clubs, topic reviews or guest lectures.
13.3	Regularly scheduled quality improvement and peer review activities are essential.
13.4	There should be library facilities with subscription to at least one pain journal in addition to Indian Journal of Pain, and textbooks, monographs and other reference material in pain medicine.
13.5	A comprehensive patient record system is a must.
13.6	There must be documentation of treatment protocols and procedures for patients together with a statement of their rights and responsibilities.
13.7	Secretarial assistance is essential.
13.8	There should be an active research programme related to Pain Medicine.
13.9	It is essential for the trainee as well as the trainer to be members of ISSP and desirable also of IASP to facilitate exchange of information and to maintain high standards.
13.10	There must be a well-defined weekly timetable in which the day-to-day training opportunities are clearly apparent.
13.11	The pain service should document and respond to critical incidents and must be able to demonstrate that risk management strategies are in place.
13.12	Pain services should keep a record of complaints and compliments.
13.13	Compliance with all current IAPM/ISSP Professional Documents is essential. The centre should use the coding system and approved nomenclature by ISSP.
13.14	An audit system is a must for both diagnosis and treatment outcomes.

14.0 PROGRAMME HEAD

14.1	A programme head is assigned for the complete duration of training.
14.2	The programme head for the programme will be appointed by the IAPM & ISSP and must be a Fellow of Indian Academy of Pain Medicine.
14.3	Centres may combine to create a comprehensive training programme, when the individual centres offer training in only one particular aspect of pain medicine. Such a programme must have a single named programme head. Details of the centres involved should be clearly conveyed in writing to the IAPM Dean and Registrar.
14.4	Each training post is expected to strictly adhere to the curriculum produced by the IAPM and ISSP, and should cover the required competencies during the training period.
14.5	When the programme involves several centres a Regional Advisor (appointed by the IAPM board) has the overall responsibility for the supervision of training but may choose to delegate aspects of supervision, as appropriate, to programme heads.
14.6	Training across regions should be approved by the IAPM board and agreed upon by the Regional Advisors as well as the Programme Heads at both the current programme and the programme where additional training is sought.
14.7	In an unforeseen circumstance if programme head is not able to continue service to the centre, an alternate head with appropriate eligibility can act as a locum till the one-year fellowship of a candidate is complete. It will be mandatory to inform the IAPM Dean and Registrar urgently in order to maintain the validity of the training programme**.**

15.0 STIPEND

15.1	Funding for a training programme(s) remains the responsibility of the Centre(s) involved.
15.2	The ISSP has resolved that a minimum stipend of Rs. 30.000/month should be paid to the trainee throughout the twelve months programme.
15.3	When a Centre does not have the funds to pay the stipend, it should explicitly state and make the applicant aware that it is a self-funded programme. The training duration of such programme should also be stated. The IAPM board has the right to determine the duration of self-funded programs.

16.0 ACCREDITATION PROCESS

16.1	The accreditation process is determined by the Registrar and Accreditation Committee (AC) of the IAPM and centre should apply for re-accreditation before completing five years. Travel Expenses towards inspection for the accreditation and reaccreditation process will be borne by the IAPM and local hospitality to be taken care by the centre.
16.2	All documentation regarding accreditation visits must be received by the IAPM-AC at least 10 working days prior to the anticipated visit or the visit may be suspended.
16.3	It is the responsibility of the Centre Director/ Programme Head to notify the IAPM-AC of any difficulties likely to impact the required time lines for accreditation.
16.4	IAPM-AC has the right to suspend accreditation, pending a decision of the IAPM Board, if the Centre fails to respond to requests for documentation or a suitable date for visit.

TIERED ACCREDITATION

The objective of the IAPM is to establish training programs in pain management and develop methods of evaluation and certification of individual health care providers to the highest standards. In a rapidly changing health care delivery system, the IAPM is careful not to propose standards that prevent innovation and progress. At the same time, the IAPM recognizes the complexity of pain and its management, and the benefits that an interdisciplinary team, with its multiple skills and knowledge would offer.

An interdisciplinary team is an integrated working group where each individual has a high level of expertise in different aspects of management of patients with complex pain. The team should include: physicians, psychologists, physiotherapists and specialist nurses, with access to others such as pharmacists and occupational therapists. Cross cover should be available indicating that there must be at least two persons able to provide any specific aspect of care.

A multidisciplinary service involves several members from various health care professional backgrounds, such as medicine, nursing, physiotherapy, occupational therapy and psychology. A multispecialty service is a close collaboration and liaison between several medical specialties' in assessing and managing a specific patient, and usually involves combined clinics.

The centres are encouraged to apply for accreditation after careful consideration of their strengths and weaknesses. The centres would be accredited based on whether they are interdisciplinary, multispecialty. Multidisciplinary. and single or modality oriented. The duration of training that can be offered in these centres, and the specific requirements of the centres to be accredited in the different tiers are detailed below. Also detailed below are the essential and desirable criteria for accreditation of the centres.

Tiers	**Duration of training accredited**	**Facilities**
Tier I	Maximum 12 months	Interdisciplinary center
Tier II A	Maximum 12 months	Multispecialty, multidisciplinary centre
Tier II B	Maximum 12 months	Multidisciplinary centre
Tier II C	Maximum 1 month	Modality-oriented clinic

Note:

a) Tier II C accreditation is for centres applying to be recognized as centres for the four weeks ISSP-IASP Observership (formerly Fellowship). The centres that have a higher accreditation (Tier I. Tier II A and Tier II B) are eligible automatically to take ISSP-IASP Observers, provided they could accommodate them along with other trainees who are in a longer training programme.

b) Tier II C centres and other centres that take in ISSP-IASP Observers, as selected by the ISSP Governing Council, do not have to pay a stipend to the Observers.

c) The IAPM committee acknowledges that very few centres would be accredited as Tier I in the first few years of existence of the academy. The intention is to introduce objectivity and transparency in the accreditation process, so that deficiencies are identified and centres are encouraged to aim for the highest accreditation by improving their interdisciplinary pain services.

THE 100-POINT CHECKLIST

The criteria from 1.0 to 13.0 constitute a 100-point checklist for centres applying for accreditation by IAPM and ISSP for advanced training in Pain Medicine.

Tier I - should satisfy all criteria. If there are deficiencies, they should be minor and immediately rectifiable.

Tier II A - should satisfy most criteria. These are centres that typically have two or more consultants providing pain service, but only ad hoc support from other specialties and allied-health professionals like psychologists from within the hospital i.e. they are employed by the hospital, but are not full-time at the pain centre or do not hold combined clinics with the pain consultants. The centres should have acute, chronic and cancer pain services, and in-patient beds. The centre should also be able to arrange competency-based training modules in psychology, palliative care, radiology etc., within the hospital. The centre might have minor, rectifiable deficiencies in staffing, staff training, policies, facilities, equipments etc.

Tier II B - should satisfy majority of the criteria. These are centres that typically have two or more consultants providing pain service, but could refer their patients outside for specialist consultations including allied-health. They may not have in-patient beds in their centre, but will have the necessary arrangements when such a need arises. They should have in-house cancer pain and chronic pain services, and should make arrangements for the trainee to be exposed to acute pain service in a larger hospital. The centre should also be able to arrange competency-based training modules in psychology, palliative care, radiology etc., in another hospital. The centre might have minor deficiencies in staffing, staff training, policies, facilities, equipments etc.

Tier II C - these are centres run by one or more pain consultants, but do not or could not provide a multidisciplinary, multispecialty service due to local constraints. These may be based in a hospital or exist as a separate clinic. They may not be able to support the trainee's stipend. Typically, they are accredited for the 4 weeks Observership of ISSP/IASP.

Note:

When centres are accredited as Tier II A or Tier II B, arrangements should be made for additional training outside the programme to satisfy the training requirements. The trainee stipend during the out-of-programme training is the responsibility of the named Programme Head. Mutual arrangements for exchange of trainees between accredited centres could be made to solve this issue. The IAPM must be notified of the arrangement. The IAPM could assist centres in making such arrangements, but does not guarantee or take responsibility for such trainee exchange arrangements.