INDIAN ACADEMY OF PAIN MEDICINE

(The Academy of Indian Society for Study of Pain)

Revised Accreditation Criteria for Pain Medicine Training Centres (FIAPM)

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Introduction

Pain is a complex **biopsychosocial** experience, and effective management requires a multidisciplinary approach. The International Association for the Study of Pain (IASP) emphasizes the importance of a team of professionals to address all facets of the pain experience. Patients referred to a specialist Pain Medicine Centre are often complex, with multiple biological, psychological, and social factors influencing their condition. Such centres must assemble a team of key professionals to deliver the highest standards of patient care, research, audit, teaching, and training in Pain Medicine within a dedicated environment. An accredited Pain Medicine Training Centre should provide a full spectrum of care, including comprehensive assessment, appropriate investigations, non-invasive therapies, and interventional treatments (ranging from basic to advanced).

IASP has categorized pain treatment facilities by scope and complexity – for example,

Multidisciplinary Pain Centres, **Multidisciplinary Pain Clinics**, and other modality-specific clinics. However, in India the Indian Academy of Pain Medicine (IAPM) is adopting a **unified national standard** for accreditation. This means that all Fellowship training centres must meet a single comprehensive set of criteria, rather than being tiered into different levels. Each accredited centre is expected to function as a multidisciplinary Pain Medicine Centre, providing integrated, evidence-based care across specialties. The previous tiered accreditation system (with Tier I/II clinics, etc.) is hereby **abolished** in favor of one national standard of excellence.

The mission of the IAPM – the Academy of the Indian Society for Study of Pain (ISSP) – is to propagate quality pain education and uniform standards of pain practice across India. Under the guidance of ISSP, a structured fellowship program (Fellowship of Indian Academy of Pain Medicine, **FIAPM**) was established. These accreditation criteria define the standards

for centres that offer the FIAPM 12-month Pain Medicine fellowship training. The criteria cover all key domains: general requirements, treatment philosophy, administrative structure and staffing, physical facilities, clinical workload and standards, teaching infrastructure, program leadership, stipend, and other relevant aspects. A standardized application process for accreditation is in place, and the IAPM Accreditation Committee will periodically review approved centres (at least every five years) to ensure continued compliance.

Scope and Definitions: In this document, a **"Pain Medicine Training Centre"** (hereafter **"Centre"**) refers to any hospital department, pain clinic, or healthcare facility that provides multidisciplinary Pain Medicine services and is accredited for FIAPM fellowship training. Each Centre must have FIAPM Qualified Pain Physician as well as allied health professionals (e.g. psychology, physiotherapy, nursing) working together. The Centre should ideally combine both outpatient and inpatient/day-care pain services, and engage in teaching and research activities similar to a multidisciplinary pain centre as defined by IASP. By meeting the criteria below, a Centre is recognized as capable of offering advanced fellowship training in Pain Medicine as a unified national standard (superseding any prior tier-based classification). Stand-alone Pain clinics are not considered appropriate for FIAPM training.

1.0 General Criteria

1.1 These criteria establish the recommended standards for Centres offering fellowship training in multidisciplinary Pain Medicine under the **Fellowship of the Indian Academy of Pain Medicine (FIAPM)**. All accredited Pain Medicine Training Centres must uphold these standards to ensure uniform, high-quality training across India.

1.2 The term **"Centre"** (or **"Pain Medicine Training Centre"**) denotes the organization, and facilities that collectively provide the fellowship training program. A training program may involve more than one Centre (for example, a fellow rotating through two institutions for different exposures), but this must be arranged in advance. If a trainee's program is split across multiple centres, it must be documented in writing to the IAPM Dean and Registrar before the start of training, specifying the additional centre(s), the duration of rotation, and the weekly hours at each site. The Program Head and the fellow are responsible for logistics of such arrangements, and the fellow's logbook must record experiences from all participating centres. (**Note:** IAPM is not responsible for any expenses or logistics in such inter-centre arrangements.)

1.3 The term **"program"** refers to the structured educational experience and clinical exposure designed for the fellow (trainee). The fellowship program at each Centre must be clearly defined. If multiple centres collaborate to provide a comprehensive program, a single Program Head must coordinate the overall training (see **14.0 Program Head and Faculty**) to ensure continuity and that all required competencies are covered.

1.4 An accredited Pain Medicine Centre **must be multidisciplinary** in nature. It should include practitioners from at least two relevant medical specialties, one m ust be FIAPM full- time Qu alified Pain Phys icia n and/o r appropri ate al lied health profession als. The se specialis ts shou ld collabora te in the as sess ment, diagno sis , and mana gement of pa tients with chro nic pain , acu te pa in, and cancer pain. Th e he alth profe ssion als at the Ce ntre mus t have ex pe ri ence working tog ether in a multidisciplin a ry con tex t to address the multifactorial nature of pain.

1.5 Faculty-to-fellow ratios must ensure adequate supervision. As a general rule, **one FIAPM-qualified faculty** can mentor up to **two** fellows per year. If a Centre has additional qualified faculty, each additional faculty may supervise up to two more fellows, **provided the Centre's clinical workload and resources are sufficient** to maintain training quality. *For example:* 1–2 fellows require at least one dedicated faculty; 3–4 fellows require at least two faculty members, and so on. Under no circumstances should a single faculty member be overloaded with excessive number of fellows, to ensure each fellow receives proper guidance and mentorship.

1.6 If a faculty member is supervising a non-FIAPM fellow or a fellow from any other training program (such as an FNB fellow) of one year duration or more, that individual will be consider ed a fellow under the faculty.

1.7 The Centre's accreditation is granted prospectively by IAPM and is subject to periodic review. **Accreditation is valid for five (5) years**, after which the Centre must apply for re-accreditation (or as determined by IAPM policy). **Any significant changes** at the Centre must be reported immediately to IAPM – this includes changes in Program Head, relocation of the facility, or major alterations in faculty or facilities. Failing to inform IAPM of such changes may result in suspension or revocation of the Centre's accreditation. It is the Program Head's responsibility to ensure continuity of training in the event of any change. In particular, if the Program Head leaves or if the Centre faces closure, the Program Head (or institutional management) **must promptly notify IAPM** and make **alternative arrangements** for any current fellow to continue training at same centre under qualified trainer or at any another accredited Centre. Any such arrangement should be made in consultation with the IAPM Dean and Registrar to protect the fellow's training experience. Failure to arrange for a fellow's training continuity in such sc enarios can lead to loss of the Centre's recognition and a disciplinary action against the Program Head.

1.8 All Pain Medicine Centres and their staff are expected to adhere to the highest standards of **medical ethics and professionalism**. Patient care must be conducted in accordance with the NMC code of medical ethics and any relevant regulations. Ethical practice is paramount regardless of the facility or practice setting.

1.9 The fellowship training is a **full-time 12-month program**. Fellows are expected to devote *six days per week* exclusively to Pain Medicine training. A minimum of **36 hours per week** must be spent in fellowship-related activities. This should comprise approximately **30 hours/week** of hands-on clinical work (outpatient clinics, inpatient rounds, procedures, etc.) and **6 hours/week** of structured academic activities. The structured sessions include formal didactics, case discussions, journal clubs, research discussions, and interactive case presentations. All academic sessions and clinical work should be documented in the fellow's logbook, which will be reviewed periodically. Program faculty should ensure a balance such that fellows get ample clinical exposure as well as protected time for academic learning.

*(**Note:** The above time distribution is a minimum requirement. Centres may choose to provide additional hours or days for rotations in related services (e.g., palliative care, neurology, etc.), but any deviation from the standard 12-month timeline or weekly schedule requires prior approval from IAPM.)*

2.0 Treatment Philosophy

2.1 The Pain Medicine service at the Centre must be conducted in accordance with national medical standards and the guidelines of relevant authorities. All patient care must align with evidence-based practices and ethical norms. The goal is to integrate Pain Medicine as an acknowledged specialty in clinical practice, and the Centre's philosophy should reflect this commitment to advancing the field.

2.2 The Centre's treatment modalities andtrainingexposuresshould exihibit **multidisciplinary approaches.** .Fellow sshouldgain experienceinthe fullrange of P ain Medicine app roaches – includingpharmacotherap y,MIPSIandotherinterventional pain procedures, neuromodulation techniques,physicaltherapyandrehabilitation,orthopedic and neurosurgical paininterventions,psychologicalandbehavioraltherapy, andpalliative care modalities. A multi-professionalteammustcollaborativelyprovidethese treatments. **Interdisciplinarycooperation**isessential;theprogram shoulddemonstratehow physicians, nurses, physiotherapists,psychologists,andotherspecialistsworkinconcerttomanage pain comprehensively. *(Anyreferencetoformer"TierI/II"levelsisnolonger applicable–* ***all*** *accreditedCentresareexpectedtoofferorarrangeexposuretoabroad rangeofmodalities in Pain Medicine.)*

2.3 There must beaculture of **multidisciplinary collaboration** and openness to consultation at the Centre. Fellows should have ready access to other specialty opinions (e.g., neurology, neurosurgery, clinical psychology, psychiatry, oncology, etc.) whenever there is uncertainty about diagnosis or management planning. The Centre should develop an environment where complex cases are reviewed in multidisciplinary team meetings and where input from various specialists is sought to formulate optimal treatment plans.

2.4 Longitudinal care of pain patients is a key part of the training philosophy. Fellows must learn to perform thorough pain assessments, plan and implement treatment plans, and follow patients over time to observe outcomes. The program should provide opportunities for the fellow to follow the progress of patients over an extended period. This may include repeat follow-up visits where the fellow can see the evolution of chronic pain conditions and the impact of interventions. Fellows (with faculty oversight) should maintain detailed logbooks of patient encounters, including initial evaluations, treatment plans, and follow-ups. Logbooks should be regularly reviewed and signed by the Program Head to ensure that fellows are getting the intended breadth of exposure and that data collected can contribute to national Pain Medicine practice statistics and registry.

2.5 Clear lines of **supervision** must be maintained throughout the fellowship. At the start of training, fellows should work under **direct and close supervision** of faculty for most clinical activities. As the fellow demonstrates growing competency and confidence, a graduated increase in responsibility is expected (allowing more independence in routine tasks). However, at all times, fellows must have **immediate access to faculty support**. The Program Head and faculty should ensure that a supervisor (faculty pain physician) is available or on-call at all times when the fellow is involved in patient care, to provide guidance or intervention if needed.

2.6 The Centre must exemplify an **evidence-based approach** to Pain Medicine. Clinical decision-making should be grounded in the *best available evidence and current best*

practices. Fellows should be taught to critically appraise pain medicine literature and to apply research findings to patient care. The program should instill in trainees the principles of lifelong learning – including how to evaluate new treatments, interpret clinical research, and integrate innovations into practice responsibly. If the Centre is involved in research (strongly encouraged), fellows should have opportunities to participate in or observe research projects, which further reinforces evidence-based practice.

2.7 The Centre and its faculty **MUST** use **standardized nomenclature and coding** for pain procedures as approved by ISSP. A national uniform coding system for interventional pain procedures (such as the ISSP Interventional Pain Procedure Coding) is being implemented, and accredited Centres are expected to integrate this into their practice and teaching. This ensures consistency in how procedures are documented and facilitates comparison of data across centres. Fellows should be trained in the proper terminology for diagnoses and procedures, aligning with ISSP and IASP definitions.

*(The **FIAPM Comprehensive Curriculum** is the reference for fellowship training content. It covers core knowledge areas, procedural skills, and competencies in Pain Medicine. Each Centre must adhere to this standardized curriculum framework to ensure all fellows receive equivalent training, regardless of the Centre. Key curriculum domains include Basics of Pain Medicine, Core Topics, Interventional Procedures (with ISSP coding integration), and Knowledge & Skills competency milestones. The fellowship is awarded to those completing the program or meeting alternative criteria for experienced practitioners, as defined by IAPM.)*

3.0 Outpatient Facilities

3.1 The outpatient clinic area of the Centre should be welcoming, accessible, and well-marked. The entrance and reception area must be clearly signposted and easy to navigate for patients. It should convey a professional and patient-friendly atmosphere, as pain patients often have limited mobility or may be visiting a facility for the first time. An accessible, well-designed reception ensures patients feel comfortable and know where to go upon arrival.

3.2 Reception and front-desk staff at the Pain Medicine Centre must be oriented to the needs of chronic pain patients. They should understand the nature of pain services and be trained to handle common inquiries. Reception staff should assist with scheduling appointments and follow-ups, managing referrals, and guiding patients in filling out intake forms or patient-reported outcome questionnaires, as needed. If the Centre collects patient data (e.g. pain scores, disability indexes) as part of outcomes tracking, reception or nursing staff should facilitate patients in completing these forms during visits.

3.3 The **waiting area** should be designed to accommodate pain patients comfortably. Ample seating (including chairs with armrests for those with mobility issues) should be provided. Space should be available for patients to fill out **screening tools and questionnaires** (such as pain inventories, mood scales, etc.) while waiting. If patients or their caregivers need assistance with forms due to literacy or health issues, staff should be available to help. Privacy should be considered even in the waiting area – for example, a space where patients can discuss sensitive information with staff if needed.

3.4 The outpatient facility must be **accessible to persons with disabilities**. This includes wheelchair access (ramps or elevators as needed), wide doorways, and accessible restrooms. Hallways and doors should accommodate wheelchairs or stretchers. Patients with limited mobility should be able to enter, move within, and exit the facility without barriers. Accessibility is not only a regulatory requirement but essential for a pain centre, as many chronic pain patients have mobility impairments.
(Additional note: The outpatient area should ideally also include patient education materials on pain (posters, pamphlets), a comfortable environment with appropriate climate control, and if possible, a separate area for pediatric patients with child-friendly design when pediatric pain patients are seen.)

4.0 Consultation & Examination Room

4.1 Each consultation or examination room should be of adequate size and properly equipped. A room size of around **120–150 square feet** (approximately 12–14 square meters) is recommended for a combined consultation-examination room. If space is constrained, a smaller consulting room can be acceptable *only if* a separate dedicated examination/treatment room is available nearby. The key requirement is that there is sufficient space to examine patients (including maneuvering of wheelchairs, use of examination tables) without crowding.

4.2 The Centre should have provision for **multi-professional clinics and group sessions** within its outpatient suite. This means having a larger room or conference area where multiple providers (for example, a physician and a psychologist, or a physiotherapist) can jointly evaluate or treat a patient, or where group therapy sessions (like chronic pain education classes, support group meetings, etc.) can be held. Such a space should be equipped accordingly (with chairs for group, maybe a projector for education, etc.).

4.3 Certain subspecialty pain services may require **specialized clinic spaces**. For example, a pain psychology counseling room (which should be quiet and private), or a physical therapy area for functional assessments. The Centre should identify if it has specific needs (e.g., a larger area for procedural consent and patient education with device demonstrations) and ensure those needs are met with appropriate space. *In summary:* the physical layout should reflect the range of services – standard consult rooms for routine visits, and suitably larger or specialized rooms for multi-disciplinary sessions or specific therapies.

4.4 Standard examination equipment must be present in each consultation/exam room. This includes an examination couch/table for patient physical exams (with adjustable height if possible for patient ease), adequate seating for at least the doctor and one family member, basic examination tools (stethoscope, reflex hammer, pinwheel, etc.), and facilities for **hand hygiene** (a sink with running water and soap and/or alcohol-based hand sanitizer dispenser). Proper lighting and, if needed, a privacy screen or curtain should be available for physical examinations.

4.5 There should be an **adequate workstation** in each exam room for documentation and other tasks. A desk or workstation with a computer (electronic medical record access or for viewing imaging), phone, and internet connectivity is ideal. This workstation will be used by faculty and fellows to review investigations (like MRI images) with patients and to document

clinical notes. Additionally, space should be allocated for secretarial tasks if a nurse or assistant is helping with documentation or scheduling. Fellows should have access to the IT systems to enter or retrieve patient data as part of their training.

4.6 The clinic environment must ensure **patient privacy and dignity** at all times. The design and usage of each room should allow for private conversations and examinations. This includes having doors or curtains that can be closed during exams, ensuring the room is soundproof enough to maintain confidentiality (so other patients in corridor cannot overhear consultations). Measures such as using examination gowns, sheets, and screens for patients to change clothes or for modesty during exams are required. Attention to details like acoustics (so patients feel comfortable discussing sensitive issues) is important.

4.7 A **chaperone** policy must be in place. A staff member (nurse or appropriate attendant) should be available to be present as a chaperone during physical examinations when needed or requested, especially for sensitive examinations or opposite-gender situations. The availability of a chaperone not only protects patient comfort but also provides an added layer of professional accountability.

4.8 If the Centre caters to **pediatric pain patients**, the consultation/exam environment should be child-friendly. This may include having some pediatric equipment (e.g., smaller blood pressure cuffs), distraction tools (toys or visuals) for children, and an ambience that reduces anxiety (colors, murals, etc.). The staff should be trained in pediatric communication and minor procedures if applicable. Though not all centres see children, those that do must ensure the environment addresses the unique emotional and physical needs of children in pain.

5.0 Operating Theatre / Pain Procedure Room

5.1 The Centre must have access to a properly equipped **procedure room or operating theatre** for performing interventional pain procedures. All standard monitors and resuscitation aids must be available at any site where procedures are performed. This includes, at minimum: non-invasive blood pressure monitor, ECG, pulse oximeter, oxygen supply, airway management tools (ambu bag, masks), and suction apparatus. If sedation or any anesthesia is used, capnography and deeper monitoring may be required. Essentially, the procedure room must be capable of safely monitoring the patient and handling any emergency during a pain procedure.

5.2 Full resuscitation equipment and emergency drugs must be immediately available in or adjacent to the procedure area. This should align with up-to-date resuscitation guidelines (e.g., American Heart Association or Indian Resuscitation Council standards) and the hospital's policy. A fully stocked emergency crash cart with defibrillator, emergency medications (like ACLS drugs, naloxone, etc.), airway equipment (intubation kit), and IV fluids should be present. The staff should regularly check and document that emergency equipment is functional and drugs are within expiry dates.

5.3 A formal **procedure safety checklist** must be implemented for all interventions. This can be adapted from the WHO Surgical Safety Checklist or the APSF (Anesthesia Patient Safety Foundation) procedural checklist. It should include verifying patient identity, procedure site/side (marking if applicable), allergies, equipment readiness, antibiotic prophylaxis if

needed, etc. The fellow should be trained to perform or participate in these safety checks as part of good practice.

5.4 For any interventions that may require sedation, regional, or general anesthesia, appropriate anesthesia provision must be ensured. An anesthesia machine and the ability to administer general anesthesia or deep sedation must be present at the site of procedures. Even if a particular pain procedure is typically done under local anesthesia or mild sedation, the facility must be prepared for conversion to general anesthesia in case of patient discomfort or emergency. An additional qualified anesthesiologist (not the one performing the pain procedure) should be available to administer anesthesia if needed.

5.5 All anesthetic, monitoring, and surgical equipment must meet current standards (such as NABH – National Accreditation Board for Hospitals – standards, if applicable). Equipment must be maintained and calibrated; there should be protocols for regular servicing. During any procedure, the patient's vital parameters (heart rate, BP, SpO_2, etc.) must be continuously monitored and documented at appropriate intervals. Fellows should be taught to interpret these monitors and respond to changes under guidance.

5.6 Infection control policies must be strictly observed in procedure areas. The Centre must have equipment and protocols to prevent cross-infection: sterile technique for all invasive procedures, proper handwashing/scrubbing facilities, use of sterile gowns, gloves, and drapes as required, and safe disposal systems for sharps and biohazardous waste. Autoclaving or high-level disinfection should be done for all reusable equipment. There should be defined cleaning protocols for the procedure room between cases. Staff must be trained in infection control practices, and these should be audited periodically.

5.7 Where fluoroscopy (X-ray) is used for interventional procedures, the procedure room must comply with **radiation s afety** standards. This means walls or shields with appropriate lead
equivalence, or portable lead screens. All X-ray equipment must be registered and comply with Atomic Energy Regu latory Board (AERB) regulations. Warning signs ("X-Ray in use") should be posted on doors when fluoroscopy is active. The Centre should have a radiation safety policy, including mo nitoring of staff exposure via dosimeter badges and regular equipment quality checks.

5.8 Personal protective equipment for radiation must be available in sufficient numbers. Lead aprons (full body, 0.5 mm Pb equivalent or per norms) and thyroid shields are mandatory for all staff (including fellows) who are present during fluoroscopic procedures. Additionally, if staff are regularly exposed, lead goggles can be considered. Each staff member who works with fluoroscopy should have a **dosimeter badge** to track cumulative exposure, and these should be analyzed as per regulatory guidance (usually monthly or quarterly).

5.9 Facilities should ensure patient **privacy and comfort** around the procedure. There must be a provision for private pre-procedure discussions and obtaining informed consent (*Refer ISSP Uniform Consent form for Interventional Pain procedures*). A counseling room or simply ensuring the procedure room is free of other people during consent can achieve this. Patients should have modest attire (hospital gowns) and proper draping during procedures to maintain dignity.

5.10 The Centre should provide **separate changing areas** for patients (especially if procedures require them to change into a gown). Ideally, male and female patients should

have access to separate changing rooms or areas with secure lockers for their clothing and valuables.

5.11 Patients undergoing procedures should have a secure place to store personal belongings (clothes, jewelry, etc.) while in the procedure room. Lockers or supervised storage should be available, and a clear policy should exist so that patients' items are safely kept until they recover.

5.12 All interventional procedures must be performed under strict **aseptic precautions(***Refer ISSP Aseptic guidelines***)**. The Centre must use disposable sterile supplies whenever possible (needles, syringes, catheter kits, etc.). Pre-packaged procedure kits that contain essential items (drape, needle, catheter, etc.) are desirable to maintain consistency and sterility – additional items can be added as needed. Fellows should be trained in maintaining sterile technique, including proper skin prepping, draping, and avoidance of breaks in sterility.

5.13 Sharps disposal containers must be present in every procedure area. Needles and other sharps should be immediately disposed of in puncture-proof containers. There should be protocols for handling needle-stick injuries for staff. Also, for certain procedures like peripheral nerve blocks, appropriate equipment like nerve stimulators and ultrasound machines should be available to increase safety and efficacy. Fellows should gain familiarity with all such adjunct equipment.

5.14 Centres that perform interventional pain procedures must have imaging capabilities and an archive system. **Imaging equipment** could be fluoroscopy and/or ultrasound. The Centre should be able to **store and retrieve images** for documentation and teaching. Usually, this means a C-arm with digital storage or an ultrasound machine with image save function. Keeping procedure records with images is important for both clinical follow-up and medicolegal documentation. Fellows should learn how to use imaging properly and document findings.

5.15 The **operating table** or procedure table used for interventions should be **fluoroscopy-compatible** (radiolucent) to allow clear imaging if using X-ray. Additionally, it should be able to accommodate patients safely (weight capacity) and be adjustable for height and tilt as needed for various procedures.

5.16 If the Centre offers radiofrequency ablation (RFA) treatments, it must have a functional **radiofrequency generator** with a maintenance log. Adequate supplies of appropriate RF needles, electrodes, and cables should be on hand. The RF machine must have documented regular service (including calibration and safety checks). Fellows should be trained in the safe use of RFA, understanding settings, and verifying equipment function.

5.17 For centres performing neuromodulation (such as spinal cord stimulation or intrathecal pump implantation), access to specialized equipment is required. If general anesthesia is required for implanting such devices, an additional qualified anesthesiologist (not the pain physician performing the implant) must administer it. This ensures patient safety by separating the roles of implanter and anesthetist. Fellows should be given exposure to neuromodulation cases; if a particular Centre does not perform these advanced procedures regularly, arrangements should be made (through rotations or affiliations) for fellows to observe or assist in such procedures at another centre (see also 12.7, 12.9).

(Additional note: Many of these requirements align with standard OT practice and NABH guidelines. The Centre should ideally have NABH or equivalent accreditation for its theatre complex. Fellows must also be taught all aspects of procedural safety, including patient positioning, radiation safety, sterile technique, and emergency readiness.)

6.0 Recovery Room

6.1 Any facility performing day-case or in-patient pain procedures must have a **Recovery Room** with appropriate equipment and trained staff. After interventional procedures (especially those done under sedation or anesthesia), patients must recover in a monitored setting. The recovery area should be fully equipped (monitors, oxygen, suction) and staffed by nurses or anesthesia technicians trained in recovery care. Recovery staff must meet defined competency standards (e.g., able to manage airways, recognize post-procedure complications, and perform basic life support). Typically, a patient can be transitioned from the immediate post-procedure stage to a step-down area when they are awake, airway is secure, oriented (if GA was given), and hemodynamically stable.

6.2 After **complex pain interventions** (e.g., neurolytic procedures,MisEpp, implanted devices, etc.), patients must recover in a specially designated area under close observation. These patients might require longer observation or special monitoring (for instance, neurological checks after neuraxial procedures or MisEpp, or motor/sensory exams after nerve blocks). The Centre should have protocols for extended recovery or even short inpatient observation if needed for certain high-risk procedures (like intrathecal pump trials, etc.).

6.3 The Centre must have **written discharge criteria** for patients post-procedure. Typically, discharge criteria will include stable vital signs, pain controlled, minimal nausea, ability to ambulate (if applicable), intact sensation/movement after regional blocks, etc. These criteria should be in line with standard ambulatory surgery protocols. Fellows should be familiar with these criteria and take part in evaluating patients against them as part of their training (under supervision).

6.4 Every patient must be provided a **24/7 contact mechanism** for any post-procedure issues. The recovery/discharge process must include giving the patient (and their attendant) a phone number to call for advice or help in case of complications after they go home. This could be a dedicated pain nurse line or the on-call pain physician's contact. The patient should also receive written instructions on what to watch for and when to seek urgent care. Fellows should learn to formulate safe discharge plans including patient education.

6.5 The Centre should have arrangements for **escalation of care** if a patient cannot be discharged as planned. There must be easy access to inpatient hospital beds if a day-care patient requires admission due to complications. Ideally, these beds would be in a ward where nursing staff are familiar with pain patients or post-anesthesia care. For example, a surgical ward or ICU step-down that frequently manages post-op pain patients could be utilized. The Centre's affiliation or hospital privileges should ensure that in an emergency or unexpected event, a pain procedure patient can be admitted and cared for appropriately. Fellows should understand the chain of escalation (who to call, how to arrange admission) for any adverse events.

(In summary, the recovery setup should mirror that of any accredited day-surgery unit: proper staffing, monitoring, protocols, and safety nets. This protects patients and also provides a learning experience for fellows in managing immediate post-procedure recovery and complications.)

7.0 Equipment

7.1 All **medical devices and equipment** used in the Pain Medicine Centre must be managed according to applicable laws and manufacturer guidelines. This means any equipment (like monitors, infusion pumps, RF generator, ultrasound, etc.) should be officially procured (with maintenance contracts if possible), and maintained in good working order. The Centre should keep an inventory of equipment with purchase and service dates. There should be no use of unapproved or substandard devices; all must have the necessary certifications (e.g., CE marked, FDA-approved, or per Indian standards).

7.2 The Centre must have clear **accountability and policies** for equipment maintenance. A responsible person or team (such as a biomedical department or the pain program coordinator) should be assigned to oversee device maintenance schedules, calibration, and safety testing. Policies should cover what to do if equipment fails (backup devices, etc.) and how often preventive maintenance is done. *Fellows should be made aware of the importance of checking equipment before use (for safety) and reporting any malfunctions*.

7.3 Operation of specialized medical equipment must only be by **trained personnel**. For example, only those trained in ultrasound use should operate the ultrasound machine; only trained staff should calibrate infusion pumps, etc. If fellows are to use equipment (like C-arm or ultrasound for procedures), they must receive appropriate training and supervision until proficient. Certificates or training records for staff handling equipment (radiographers for C-arm, etc.) should be maintained.

7.4 All critical equipment (anesthesia machine, monitors, fluoroscopy units, ultrasound machines, radiofrequency lesion generators, etc.) must undergo **regular servicing** as per manufacturer recommendations. Service records must be kept and be up-to-date, readily available during inspections or accreditation visits. Preventive maintenance at scheduled intervals (e.g., annual calibration of the fluoroscope, electrical safety check for RF generator) is essential for patient and staff safety. The Centre should also maintain logs of any repairs and ensure that equipment is re-certified safe after any major service.

(In addition, the Centre should have policies for introducing new equipment or technology – e.g., trialing new devices in a supervised manner. Fellows should gain familiarity with all common equipment in Pain Medicine, including patient-controlled analgesia pumps, spinal cord stimulator programming devices, etc., even if not all are available on-site, through demonstrations or rotations.)

8.0 Staff Training

8.1 All staff involved in Pain Medicine procedures must maintain current competency in **resuscitation techniques**. Regular attendance at Basic Life Support (BLS) and Advanced Cardiac Life Support (ALS) or equivalent courses is **mandatory**. The Centre should conduct or sponsor refresher training at recommended intervals (typically every 1–2 years for ALS).

This applies to doctors, fellows, nurses, and technicians who participate in procedures. Documentation of staff certification should be kept. *Fellows themselvesshouldideallyobtain anALScertificationduringtrainingifnotalreadycertified.*

8.2 Staff in the procedure room (including fellows) must be fully **compliant with the WHO Surgical Safety Checklist** or similar safety protocols. This implies training sessions and drills on how to perform time-outs, sign-ins, and sign-outs for procedures. It also includes practicing adherence to protocols like the "Stop Before You Block" (to prevent wrong-site nerve blocks) or other safety steps specific to pain interventions.

8.3 The Centre should encourage a culture of **team briefings and debriefings** around procedure lists. Regular team briefings (e.g., a morning huddle before starting the day's procedures to discuss each case and assign roles) are required for smooth and safe operations. Similarly, debriefing after sessions (to discuss what went well or any issues) should be routine. Such practices enhance communication and safety. Fellows should actively participate in these as part of their leadership training.

8.4 Adequate number of experienced staff must be present to handle patient needs, including patient transfers and positioning. Staff should have **manual handling** training to safely move patients with limited mobility. Necessary equipment like patient transfer devices, hoists, or sliding boards should be available to avoid injury to patients or staff. If a patient is bariatric or has severe mobility issues, the Centre must ensure appropriate resources (both equipment and personnel) are in place to manage them safely.

8.5 The Centre should have access to or include **trained staff** or imaging technicians to support procedures that require imaging. Using C-arm fluoroscopy safely and effectively often needs a radiographer; if the pain physician or fellow or OT Staff is operating the C-arm themselves, they must have received training in its use and radiation safety.

8.6 Nursing or technical staff assisting in procedures should be specifically trained in any specialized equipment, such as the **radiofrequency generator**. They should know how to set up the machine, test it, and handle cables and probes safely. The Centre should conduct

periodic in-service training sessions to keep everyone's skills current. *Fellows,as partof the team,should attendthese andcanevenbeaskedtopresenttopics(goodfortheir learning and teaching experience).*

(Overall, staff education is continuous. The Centre might also facilitate staff attending external workshops like pain CME programs, ISSP workshops, etc., to update their knowledge. A well-trained staff enhances the training environment for fellows by modeling best practices.)

9.0 Staff Facilities

9.1 The Pain Medicine Centre must provide adequate **office and support space** for its staff. There should be a designated office area for secretarial and administrative personnel to carry out scheduling, record-keeping, and correspondence. Ideally, this includes desks, computers, telephones, and storage for files. A **permanent designated office space** ensures that support staff (e.g., program coordinator, secretary, billing personnel, TPA staff) have an organized work area and that patients have a clear point of contact for queries.

9.2 Adequate **workspace for fellows (trainees)** is required. There should be a room or area where fellows can sit to do their academic work, prepare presentations, or write case notes. This space should have access to computers with internet (for literature search, online logbook entries, etc.) and ideally access to hospital information systems for looking up results. If possible, a small library or reading area can be part of this space (see also 13.4 regarding library facilities). Information technology resources are important – fellows should have access to email, online journals (if available), and the ability to prepare documents. A comfortable workspace encourages learning and productivity when not seeing patients.

9.3 The Centre should provide basic **amenities for staff** such as rest areas and meeting space.

A staff pantry or break room is recommended, especially for long working days. Access to clean washrooms (separate for staff if possible) is expected. Moreover, if the pain clinic is part of a larger hospital, fellows and staff should have access to hospital facilities (canteen, on-call rooms if overnight call is expected, etc.). While not an official criterion, these contribute to a conducive working environment, indirectly benefiting training quality by reducing stress and fatigue.

(Staff facilities might also include a discussion room for multidisciplinary team meetings or a small conference room. Depending on the size of the Centre, these facilities can be shared with another department, but the key is that the pain faculty and fellows have a reliable space for their academic and administrative work.)

10.0 Faculty/ Consultant Responsibilities

10.1 Pain Medicine is inherently multidisciplinary – **no single physician working in isolation in a pain clinic** can provide the full spectrum of care or run a comprehensive Pain Medicine service. Therefore, an accredited Centre must have a team of consultants (or consulting specialists) rather than a lone practitioner. This criterion underscores that a solo practice clinic is not sufficient for fellowship training; a fellow must be exposed to team-based practice. Every consultant or specialist involved should collaborate as part of the pain team.

10.2 All consultants/faculty in the Pain Medicine Centre must have appropriate **professional indemnity insurance** coverage. This is to protect both providers and patients in case of medico-legal events. *The Centre shouldverifythat each doctor's indemnitypolicy is valid andsufficient for interventional painwork. Additionally, itis the responsibility of the Program Head to ensure thateach fellow (trainee) isproperly registeredwith the state medical council fortheduration of training* . The fellow's medical licensing and any indemnity or malpractice coverage for them should be addressed. Some centres include fellows in their institutional indemnity; others require the fellow to obtain their own – in either case, it should be settled before clinical work begins.

10.3 Faculty physicians in the training program should be **full-time Pain Physicians** at the Centre. Anesthesiologists ~~(or other specialists)~~ who practice pain management only part-time or intermittently do **not qualify as faculty** for the fellowship. This criterion ensures that fellows are mentored by dedicated pain physicians who are immersed in the field daily. The Centre should not appoint someone as core faculty if their primary commitment is elsewhere. This also means that the training centre should ideally have at least one or more full-time Pain Medicine consultants to provide continuous learning opportunities.

10.4 Each pain faculty member should allocate a **minimum of 30 hours per week** specifically to Pain Medicine Centre/ department duties at the main Centre. This ensures that throughout the working week, fellows always have supervised clinical activity available. In practice, this translates to essentially full-time presence in pain centres, procedure days, rounds, etc., by the faculty. If a faculty has other hospital roles (like anesthesia), those should not encroach beyond a day or so, so that 30+ hours weekly are protected for pain service.

10.5 Any consultants from other specialties who are involved in the fellowship (for cross-disciplinary exposure) must be familiar with the fellowship training goals and objectives. For example, if a neurosurgeon or psychiatrist is giving a fellow some training experience, they should understand what the fellow is expected to learn and coordinate with the Program Head. The aim is to maximize focused Pain Medicine exposure while still allowing some enriched learning from related fields, within limits.

10.6 All core faculty at an accredited Centre **must themselves be FIAPM-qualified**. A minimum of **two years of post-FIAPM experience** is required to serve as faculty. This ensures that those teaching the fellows have substantial practical experience beyond their own training period. The Program Head, in particular, must be a senior pain physician (FIAPM) with leadership capability. (See section 14 for Program Head specific requirements.)

10.7 Each medical practitioner involved in the pain unit must practice within the scope authorized by their primary institution and specialty qualifications. In other words, **credentials and privileges** for every procedure or duty must be in place. If a pain faculty is performing neurolytic blocks, for example, the base hospital must have credentialed them for that procedure. This is to ensure patient safety and institutional accountability. The Centre should keep a file of what each faculty is credentialed to do and ensure no one operates outside their competency. Fellows, under supervision, are covered by the faculty's oversight and by being part of the program.

10.8 When advanced pain therapies like MisEpp, Vertebral Augmentation or **neuromodulation** (spinal cord stimulators, etc.) are offered, the consultant performing them must be appropriately trained and experienced. If an implant is being done, the clinician (or surgical team member) in charge should have documented training in that specific procedure. They must operate strictly within their competence and the guidelines provided by the device manufacturers and professional bodies. If an aspect of care is beyond the local team's expertise, referrals or visiting specialists should be utilized rather than compromising on quality. Fellows may observe these procedures, but direct performance should only be under the guidance of experienced implanters.

(In summary, the consultants at the Centre must form a committed, qualified team with clearly defined roles. They must model multidisciplinary teamwork and uphold the program's academic standards. Their responsibilities span clinical care, teaching, and administration of the fellowship.)

11.0 Members of the Multidisciplinary Team

*(Note: Section 11 outlines the **additional team members** beyond physician faculty who are integral to a multidisciplinary pain training program.)*

11.1 Psychology/Psychiatry: Access to a clinical psychologist (or psychiatrist) with expertise in pain management is **essential**. Psychological evaluation and therapy (such as cognitive-behavioral therapy for pain) are critical components of chronic pain care. The Centre should ensure that during the fellowship, the fellow spends a significant period (recommended ~2 weeks cumulative) engaging with pain psychology services – whether through direct patient co-management or observation. A Centre should, at minimum, have a referral or consultative arrangement so that every fellow is exposed to psychological pain management approaches in practice.

11.2 Nursing: There must be **senior nursing staff** specialized or at least experienced in chronic pain management on the team. These could be pain nurse specialists or nurses from anesthesiology background with pain training. Their roles include patient education (e.g., explaining use of patient-controlled analgesia), monitoring patients, triaging calls, and sometimes conducting follow-up clinics (like nurse-led follow-ups). The presence of skilled nursing staff is also vital for continuity of care when physicians are unavailable. Fellows should learn from nurses about aspects of pain care like patient counseling, medication titration follow-ups, etc.

11.3 Clinical Support Services: The Centre must have established links with key allied health services such as physiotherapy, occupational therapy, social work, pharmacy, and orthotics. Pain often requires physical rehabilitation – hence a physiotherapist knowledgeable in pain exercises and pacing techniques should be available for consultation or referrals. Occupational therapists can help with functional restoration and adaptive strategies for patients to regain daily activities. Social workers are important for addressing the social support and community resources (especially for patients with disability due to pain). Pharmacists can assist in complex medication management (e.g., opioid stewardship, drug interactions) which the fellow should learn about. Orthotists may help with braces or supports (for spine, etc.) if needed for certain pain conditions. Fellows should ideally have observational sessions or discussions with each of these professionals to understand their role in pain management.

11.4OtherAlliedHealth: The Centre should ensure access (either on-site or via referral) to services like **rehabilitation medicine**, **clinical counseling**, and **dietary consultation** when theseare relevant.
*(In summary, "team" is not just doctors. An accredited Pain Medicine Centre functions as a **multidisciplinary unit**. For the fellow, this means their training will involve learning from and collaborating with various professionals – reflecting real-world best practices in pain management.)*

12.0 Clinical Workload

12.1 The Centre's **clinical workload** must be sufficient to provide a broad and deep experience for the fellow. This means a high enough volume of patients across different pain conditions. A centre with a very low patient load would not allow the fellow to see the variety of cases needed. As a guideline, the pain training centres should manage a large number of cases annually so that fellows routinely see common and uncommon pain syndromes.

12.2 Minimum patient numbers:

WORK LOAD PER ANNUM (Minimum 2 Years of Record at the time of application)

	1-2 Fellows One Faculty	3-4 Fellows Two Faculties
1. OPD	1200	1800
2. **Joints, Bursa, Tendons, Ligaments, Muscles** Major, intermediate, minor joint interventions (e.g., knee, hip, shoulder, sacroiliac, facet joints). Sacroiliac joint denervation, arthrograms **MIPSI A**	60	90
3. **Nerves and Ganglia including RFA** Peripheral nerve Infiltration (e.g., occipital, suprascapular, intercostal, ilioinguinal) Sympathetic Neurolysis (stellate ganglion, celiac plexus, hypogastric plexus, ganglion impar) Pulsed and thermal radiofrequency ablation (RFA) **MIPSI B**	60	90
4. **Epidural Procedures** Interlaminar, transforaminal, caudal epidural Neuroplasty Adhesiolysis (mechanical, chemical) **MIPSI C**	60	90
5. **Vertebral Augmentation** Vertebroplasty, kyphoplasty, sacroplasty (with/without balloon, unipedicular or bipedicular) **MIPSI D**	**Compulsory** Each fellow is expected to observe or assist 5 Procedures in one year of training	
6. **Neurostimulation** Spinal cord stimulation (trial and permanent)	**Desirable** Each fellow is	

Dorsal root ganglion stimulation, peripheral nerve stimulation **MIPSI E**	expected to observe or assist 1-2 Neuromodulation in one year of training	
7. **Intrathecal Drug Delivery** Intrathecal pumps, ports, neurolysis **MIPSI F**	**Desirable** Each fellow is expected to observe or assist 1-2 Inrathecal drug delivery in one year of training	
8. **Intradiscal Procedures** Discography, ozonucleolysis, nucleoplasty, annuloplasty, IDET, biacuplasty **MIPSI G**	**Compulsory** 5	30
9.**Minimally Invasive Spine Endoscopic Pain Procedures (MisEpp)** Endoscopic lumbar Decompression, Transforaminal and Interlaminar Techniques, UBE, Percutaneous Endoscopic Laminotomy and Foraminotomy. **MIPSI H**	**Compulsory** Each fellow is expected to observe or assist 5 MisEpp in one year o f training.	
10. **Pain Biologics** PRP, bone marrow, adipose-derived injections for major, intermediate, and minor joints and bursa **MIPSI I**	20	30
11. **Other Therapies** Botulinum toxin injections, acupuncture, dry needling, diathermy, TENS, shock wave therapy. **MIPSI J**		

12.3 The pain service should operate regular clinics throughout the week. Fellows thus have clinic exposure daily. If the service has multiple simultaneous clinics (with different faculty) the fellow might alternate or attend specialty ones (e.g., one day for cancer pain, one for headache, etc. if applicable). The key is consistent, frequent outpatient experience.

12.4 If certain advanced procedures or services are **not available** at the Centre (for example, if a centre does not perform MisEpp, Vertebral augmentation, spinal cord stimulation or intrathecal pumps), the program **must arrange exposure elsewhere** so the fellow gains at least an understanding of these techniques. This could be a short observational rotation at a larger centre that offers them, or sending the fellow to attend specific cases. Documentation of such an arrangement is needed in the training plan communicated to IAPM (refer back to 1.2 and 14.5 on multi-centre programs). *The goalis thatthefellowdoesn'tmissoutonkey domainsofpainmedicinepurelyduetothe centre's limitations.*

12.5 Fellows should also receive training in the **evaluation and management of special populations and scenarios**. This includes performing comprehensive pain assessments (including psychosocial aspects), cognitive and mental health screenings (like identifying depression, anxiety, risk of opioid misuse, etc.), and crisis intervention for patients expressing self-harm or severe distress. The Centre should have protocols to teach fellows how to handle situations like suicidal ideation in chronic pain patients, or acute exacerbations requiring rapid intervention.

12.6 If the training centre lacks a particular **sub-specialty pain clinic or service** (for instance, say the centre doesn't have a pediatric pain clinic or a headache clinic), then it must ensure the fellow can spend time at a facility that does, or at least attend specialty clinics in another department, to gain exposure. For example, a fellow might sit in on a palliative care clinic for cancer pain if the pain centre itself doesn't manage many cancer pain patients, or attend a rheumatology fibromyalgia clinic for exposure to that condition. The program should formalize these cross-specialty learnings so that upon completion, the fellow has a well-rounded experience covering all common pain conditions even if some were seen via rotations outside the primary centre.

*(Overall, the clinical workload criteria ensure that any accredited Centre is busy enough and diverse enough to train a fellow in all aspects of Pain Medicine. It should function as a **centre of excellence** in pain management, handling high patient volumes and complex cases, thereby providing a rich training ground.)*

13.0 Other Essential Requirements

13.1 The Centre must have access to basic **diagnostic services** that pain physicians commonly need. At a minimum, facilities for imaging (X-ray, MRI, CT, ultrasound) and laboratory tests should be readily available (onsite or via referral) to support patient evaluation. If the Centre doesn't house these (for example, a standalone centres without its own MRI), there should be a Memorandum of Understanding (MOU) or established tie-up with diagnostic centers so that fellows can get required investigations for their patients in a timely manner. This ensures that diagnostic workups (like nerve conduction studies, if needed, or specialized blood tests) can be done and that the fellow learns how to utilize these in forming a diagnosis.

13.2 There should be **regular educational meetings** within the Centre for continuous learning. Multidisciplinary case conferences are **mandatory**, at least once every two weeks (fortnightly). In these meetings, complex or interesting cases are discussed by the whole team (doctors, psychologists, physiotherapists, etc.), which teaches the fellow team-based problem solving. In addition to case conferences, the fellows are required to attend IAPM Lecture

series. These educational sessions are in addition to the routine daily teaching and should be structured and scheduled. Fellows should actively participate – presenting articles or cases as assigned – to develop their academic skills.

13.3 Quality improvement (QI) and peer review activities must be regularly conducted. Examples include morbidity/mortality meetings (to review any complications or adverse outcomes in pain treatments), audit presentations (like an audit of infection rates after procedures, or audit of outcomes for a specific therapy), and patient feedback reviews. These activities instill a culture of self-improvement and accountability. The fellow should take part in at least one QI project or audit during the fellowship, as this is an important learning outcome (how to systematically evaluate and improve practice).

13.4 The Centre should provide **library facilities or access to medical literature**. At minimum, the fellow must have access to the **Indian Journal of Pain** (the ISSP's official journal) and at least one international pain journal (like *Pain*, *Pain Medicine*, etc.) either via subscription or through online access. Key textbooks and reference monographs in pain medicine should be available. If a physical library is not present, online access to journals or a digital resource collection is acceptable. The idea is to enable fellows to study and reference up-to-date knowledge for case discussions and research. The Centre should encourage use of ISSP's educational resources.

13.5 A comprehensive **patient record system** is **essential**. Whether electronic or paper-based, the Centre must maintain detailed records of all patient evaluations, treatments, and follow-ups. Good record-keeping is important for continuity of care, research, and medicolegal reasons. The records should include initial assessment notes, pain scores, treatment plans, procedural details (with consent forms and procedure notes), and follow-up outcomes. Fellows should be trained to write proper consultation and procedure notes. If an Electronic Medical Record (EMR) is used, fellows should receive access and training to input data.

13.6 There must be documentation of **treatment protocols and patient care policies**. This includes having **written Standard Operating Procedures (SOPs)** or protocol documents for common procedures and therapies (e.g., an SOP for epidural Neuroplasty, or a protocol for opioid rotation). Additionally, the Centre should have a clear **patient rights and responsibilities** statement available (many hospitals post these publicly), aligning with hospital or ISSP guidelines. Pain patients should be informed of their rights (to appropriate assessment and management, to be informed, to consent or refuse treatments, etc.) and responsibilities (e.g., adhere to treatment plans, safe use of medications, follow-up compliance). Fellows should be aware of these protocols and help enforce them.

13.7 Secretarial assistance is considered **essential**. As mentioned, having dedicated administrative support is not optional – someone must handle the scheduling, communication (like coordinating referrals or scheduling pain procedures, sending reports to referring physicians), billing if applicable, and maintaining training program paperwork. This allows the clinical faculty and fellows to focus on medical training and care.

13.8 The Centre should actively engage in **pain-related research**. An **active research program** is highly desirable. This could range from clinical case reports to retrospective studies or even basic science collaborations. While not every Centre will have large research infrastructure, an accredited Centre should at least contribute to scholarly activities – e.g.,

publishing case reports, conducting surveys or audits (which can be considered research for improvement), or participating in multi-centre studies. Fellows benefit greatly from research exposure: ***each fellow is required to publish research in Indexed Journal during their fellowship***. The Program Head should encourage and facilitate this (ethics committee approvals, mentoring in research methodology, etc.).

13.9 Both fellows and faculty are expected to be active members of professional bodies.

Membership in IASP (International Association for Study of Pain) is also **strongly recommended** (desirable) to stay connected with international developments. Being part of these societies facilitates exchange of knowledge, attendance at conferences, and upholding high standards. The Centre should support fellows in obtaining these memberships (often the cost is minimal for trainees or can be included as part of program benefits). Additionally, membership in ISSP ensures the fellow gets the Indian Journal of Pain and other educational materials regularly.

13.10 A system to record and address **critical incidents** must be in place. If any adverse event or complication occurs (like a case of local anesthetic toxicity, or an infection after a procedure, or even a serious patient complaint), the Centre should document it and convene a review to learn and improve. Fellows should be involved in these reviews to learn safety practices. The Centre must also have **risk management strategies** documented – for example, consent processes to mitigate legal risk, checklists to reduce procedural risk, etc. Evidence of such strategies (like a risk register or incident log) should be present.

13.11 The pain service should keep a log of **patient feedback – complaints and compliments**. Handling complaints in a systematic way is important for service improvement and public accountability. If a patient complains about any aspect (e.g., long wait, a side effect not addressed, etc.), there should be a mechanism to formally record and respond. Likewise, positive feedback (compliments) can be recorded as it boosts morale and indicates what is working well. Fellows can be taught to value patient feedback and maybe help in patient satisfaction surveys as part of their project.

13.12 The Centre must comply with all current **IAPM/ISSP professional guidelines and documents**. This means if ISSP or IAPM has issued position statements (for example, guidelines on opioid use agreements, or any standard of care guidelines for certain procedures), the Centre should implement those. Being an accredited Centre comes with the responsibility to lead by example in following the standards set by the pain professional community. The Program Head should stay updated on any new guidelines from IAPM/ISSP and integrate them into practice and training promptly. The program heads, should use only ISSP approved nomenclature for the procedures.

*(Collectively, these "other requirements" ensure that an accredited Centre is not just clinically active, but also academically oriented, quality-conscious, and well-organized. They transform a pain clinic into a true **Pain Medicine Training Centre** that cultivates competent specialists. These requirements also fulfils the NABH requirements as even he day care centres can go for NABH accreditation.)*

14.0 Program Head and Faculty

14.1 Every accredited Centre must have a designated **Program Head** (Fellowship Program Director) who will oversee the fellowship for its entire duration. The Program Head should ideally be identified at the time of accreditation application. They are expected to serve for the whole training year to provide continuity. In the **unforeseen event** that the Program Head is unable to continue (due to health, resignation, etc.), the Centre must immediately install an **alternate qualified program head** (meeting all eligibility criteria) as an interim or locum Program Head. The IAPM Dean and Registrar must be notified urgently of this change, and the replacement Program Head will assume responsibility to ensure the fellow's training is completed without disruption. *This contingency plan is critical; a fellow should not be left without leadership. Failure to arrange a suitable replacement could invalidate the training program for that period, hence the emphasis on urgent communication with IAPM*. Failure to comply with this may invite a disciplinary action against the program head.

14.2 Collaboration between centres is allowed and even encouraged to enrich training, but it must be well-coordinated. If two or more centres within same city (each perhaps with different strengths) wish to combine resources to ~~create a comprc~~hensive fellowship program, they can do so provided that they appoint a **single unified Program Head**. This Program Head will be responsible for orchestrating the training across all involved centres. The details of such an arrangement — which centres are involved, what components of training each will provide, schedules of rotation — must be clearly laid out in advance and communicated in writing to the IAPM Dean and Registrar. Each participating centre would be subject to accreditation to ensure they contribute meaningfully. This model can allow, for instance, a smaller centre that excels in one area to partner with a larger centre to cover all fellowship requirements.

14.4 Each fellowship training post (position) at the Centre must adhere to the official **FIAPM Curriculum** set by IAPM. The Program Head and faculty are responsible for ensuring that the fellow is taught all required competencies (knowledge, clinical skills, procedural skills, professionalism, etc.) during the training period. The curriculum is comprehensive – covering everything from basic pain mechanisms to advanced interventions – and the Centre should have a plan (a curriculum map or schedule) of how those topics and skills will be covered. Periodic assessments (formative) should be conducted to see that the fellow is meeting learning milestones. *Deviationsfrom thecurriculum are not permitted unless approvedby IAPM(and typicallythecurriculum is standardized, so this is mostly to ensure consistency nationwide).*

14.5 If training is happening **across different regions or states**, it requires explicit approval by the IAPM Registrar. Both the sending and receiving Program Heads, must agree to the arrangement and communicate effectively. For instance, if a fellow from a North India centre is to spend 2 months in a South India centre for a particular training module, the IAPM Board

should vet and approve this plan to ensure it's justified and beneficial. Proper agreements (perhaps MOUs between institutions) should be in place. All such arrangements must prioritize the fellow's learning and not be for convenience of centres alone.

14.7 The **Program** holds ultimate responsibility for coordinating and overseeing the fellowship training. This includes planning the fellow's rotations (even if multiple centres are involved), ensuring all learning objectives are met, and that the fellow's progress is monitored. If the fellowship is delivered across more than one site (satellite centres), the Program Head must maintain oversight of the entire program and liaise with any other site supervisors to track the fellow's experience.

14.8 It is mandatory for the Program head or the faculty or some representative from the accredited centre to attend the Program Head meeting with Dean and Registrar during ISSPCON

(Collectively, Section 14 ensures that the fellowship program's leadership and structure are solid. The Program Head is essentially the cornerstone – they must be qualified, stable in position, and proactive in managing the fellow's journey. Multi-centre arrangements increase training opportunities but require additional oversight, hence the structure of Program Head is defined to maintain quality control.)

15.0 Stipend

15.1 Funding for the fellowship program is primarily the responsibility of the participating Centre(s). IAPM does not centrally fund fellowship positions; thus, each accredited Centre (or group of centres running a joint program) must ensure they have the financial resources to support the fellow's training needs – including salary (stipend), educational materials, and any other training-related costs. This could come from the hospital's budget, departmental funds, or external grants, but it needs to be arranged in advance.

15.2 The IAPM Governing Council has resolved that a **minimum stipend of f30,000 per month** should be paid to each fellow during the 12-month program. This is a baseline to ensure fellows receive some financial support, considering they will be working full-time and likely not earning from other sources.

The stipend should be provided on a regular monthly schedule. The term "minimum" indicates that under no circumstance should a fellow be unpaid or paid a token amount lower than this guideline.

15.3 If a Centre genuinely lacks the funds to provide the recommended stipend, this must be **declared upfront**. The Centre's accreditation application (or renewal application) should explicitly state if it is unable to offer a stipend, and under what conditions. Importantly, any prospective fellow must be made fully aware **before joining** that the position is **unpaid or self-funded**. This transparency is critical to avoid misunderstandings or financial hardship for the fellow. ~~Ideally, even if the Centre cannot pay, they might assist the fellow in obtaining scholarships or paid duties elsewhere in the hospital. However, IAPM strongly prefers centres to arrange stipends as per 15.2 because offering a stipend reflects the value of the fellow's contributions and makes the fellowship accessible to talented physicians from all economic backgrounds, not only those who can afford a year without salary.~~

(In summary, while education is the primary goal, financial aspects cannot be ignored. A fair stipend policy helps maintain the fellowship's attractiveness and viability. IAPM may verify that fellows are indeed receiving the stated stipend during accreditation reviews or by direct feedback from fellows.)

16.0 Accreditation Process

16.1 Accreditation of a Centre is governed by the IAPM **Accreditation Committee (AC)**. The process for initial accreditation and subsequent re-accreditation is determined by this committee's policies. Once accredited, a Centre holds that status for a finite term (currently five years) after which it must apply for renewal to continue hosting the fellowship. A Centre should plan ahead to submit a renewal application before the five-year term lapses to avoid any gap in accreditation (which could affect ongoing fellows). IAPM-AC may update accreditation criteria over time; Centres are expected to comply with any new requirements at re-accreditation.

16.2 When an accreditation site visit is scheduled, **all required documentation** must be submitted to the IAPM-AC at least 10 working days (two weeks) prior to the visit. This documentation typically includes the completed application form, self-study report, supporting evidence of meeting criteria (e.g., faculty CVs, case logs, facility photographs or floor plans, equipment lists, etc.). If the documentation is incomplete or delayed, the IAPM-AC reserves the right to **postpone or cancel the visit**. This rule ensures the visiting assessors have time to review materials beforehand for an efficient and effective evaluation. Centres should be proactive in preparing these documents and responding to any queries from IAPM-AC ahead of time.

16.3 It is the duty of the Centre's leadership (Centre Director or Program Head) to promptly inform the IAPM-AC of any **challenges** that might impact the accreditation timeline or process. For example, if a hospital merger or a natural disaster or a pandemic surge temporarily affects the pain clinic operations or the timing of a scheduled inspection, the Centre should communicate this as soon as possible to IAPM. Transparent communication can allow rescheduling or provisional measures. Essentially, if the Centre anticipates difficulty in complying with any accreditation requirement or timeline, they must not wait in silence; they should engage the committee for guidance or extension. This helps maintain trust and can prevent punitive actions.

16.4 The IAPM-AC (with IAPM Board authority) holds the right to **suspend or revoke accreditation** if a Centre fails to cooperate with the accreditation process or meet standards. If the Centre does not respond to requests for required documentation, or is unable to accommodate a site visit within a reasonable period, the AC can recommend suspension of accreditation. Similarly, if serious deficiencies are found (during a visit or via reports, or if unreported changes like loss of Program Head are discovered), the IAPM Board can be asked to suspend accreditation until issues are rectified. Suspension means the Centre cannot enroll new fellows until resolved, and revocation means the Centre is no longer accredited. These actions are to uphold the quality of the program nationally. The Centre would usually be given notice and a chance to correct issues, but non-responsiveness is viewed seriously.

16.5 **The inspector reserves the right to verify the accuracy and authenticity of all procedures reported by the centre.** The Centre Head must ensure availability of complete

printed records of all procedures, including UHID, diagnosis, and details of the procedure performed. Prior permission to access these documents must be obtained from the Medical Records Department (MRD) before the inspection. Failure to adequately verify the number of cases performed may result in disqualification of the centre from future accreditation.

(The accreditation process is essentially a partnership between the Centre and IAPM to ensure quality. Centres should treat it as an ongoing commitment to excellence, not just a one-time inspection. Maintaining records, updating IAPM on major changes, and continuous compliance with criteria will make the re-accreditation smoother. IAPM-AC often also provides feedback and guidance, which Centres should utilize for improvement.)

Concluding Note & Disclaimer

The Indian Academy of Pain Medicine and the Indian Society for Study of Pain are committed to ensuring the highest quality of pain management education through these accreditation standards. By adhering to this unified criteria, Pain Medicine Centres across the country will help create a uniformly trained workforce of pain specialists capable of providing advanced, compassionate care to patients in need. It is expected that centres will not only meet the **minimum standards** outlined but will strive for excellence and innovation in pain management, serving as models for others.

Clinical Responsibility Disclaimer: Accreditation by IAPM/ISSP certifies that a Centre has the facilities, faculty, and program structure to train pain specialists; **however, it is NOT an endorsement or guarantee of any specific clinical practices or outcomes** at that Centre. Each accredited Pain Medicine Centre and its practitioners remain individually responsible for the care they deliver and must practice within the bounds of medical ethics and law. The IAPM and ISSP do **not assume liability** for clinical decisions, procedures, or interventions performed at an accredited Centre, whether they are evidence-based or experimental. Any invasive or non-invasive procedure carried out is under the auspices of the treating practitioners and the hosting institution. The Centre must obtain proper informed consent from patients for all treatments and is accountable for maintaining patient safety and managing any complications or legal issues that arise from patient care.

In essence, accreditation is an educational quality mark – it signals that a Centre can provide good training – but **ultimate responsibility** for patient care and clinical conduct lies with the Centre's professionals. All fellows and faculty are expected to adhere to professional guidelines and statutory regulations. Should any incident of misconduct or deviation from standard of care occur, the Centre must address it through its clinical governance mechanisms and, where appropriate, report to regulatory authorities. IAPM/ISSP will cooperate as needed (for example, providing training records or clarifying standards) but cannot be held liable for the independent clinical actions of an accredited Centre's staff.

Conclusion: With these revised criteria in effect, we look forward to elevating the standard of Pain Medicine education nationwide. Centres are reminded that **accreditation is a continuing journey** – compliance must be maintained at all times, not just for inspections. By doing so, each Centre contributes to the mission of delivering safe, effective, and multidisciplinary pain relief to the people of India, and to advancing the field of Pain Medicine. The IAPM Governing Council, with the endorsement of ISSP, congratulates all

stakeholders on this milestone and anticipates fruitful outcomes as these standards are implemented. Let this document serve as both a guide and a pledge – a guide for what is expected, and a pledge of our collective dedication to excellence in Pain Medicine training.

Critical Points for discussion

- Workload
- Arrangements for Inter Centre Rotations
- Responsibility of completion of fellowship in case of discontinuation
- Program head meeting ISSPCON
- Accreditation of Primary centre in case of two or more centres combine resources