

CanMEDS Goals and Objectives

To train pain physicians with added competency in the areas of physical medicine, rehabilitation and rheumatology who will provide primary and consultant pain management services to pain patients; and to provide clinical and initial basic academic training for physicians who will be going on to academic careers in pain medicine including cancer pain.

Educational Objectives of the Program

Successful residents will acquire a broad-based understanding of the principles, philosophy, and core knowledge, skills and attitudes of physical medicine & rehabilitation and rheumatology.

The resident will complete one block made up of two weeks of rheumatology and two weeks of physical medicine & rehabilitation rotations. The first two weeks (10 days) will consist of various physical medicine outpatient clinics including:

- GF Strong Rehabilitation Centre Outpatient Clinics: Dr. Rajiv Reebye, Dr. Russ O'Connor, Dr. Daniel DeForge, Dr. Rhonda Wilms
- Community Based Physiatry Pain Clinic: Dr. Rajiv Reebye, Dr. Anibal Boroquez, Dr. Kay Kshitja, Dr. Eric Hui

The final two weeks (10 days) will consist of various rheumatology community based outpatient clinics including:

1. Dr. Kam Shojania, Head of Rheumatology UBC who sees a diverse range of mainly inflammatory Rheumatologic Disorders, near Providence Health
2. Dr. Rhonda Shuckett, Rheum representative to the Pain Fellowship who sees a diverse range of inflammatory, regional and diffuse chronic pain conditions such as fibromyalgia and spine pain in her practice near Providence Health
3. Dr. Max Sun Rheumatologist who has a special interest in Chronic Pain Management and Interventional Procedures for Chronic Pain at Artus Health Rheumatology Clinic near VGH
4. Dr. Jon Chan Rheumatologist who sees diverse conditions, but who has a special interest in Seronegative Spondyloarthropathies/ Ankylosing Spondylitis and Psoriatic Arthritis. Artus Health Rheumatology Clinic near VGH.
5. Dr. Maz Badii Rheumatologist who has a specialist interest in Spine problems
6. Dr. David Collins a Rheumatologist, who see a host of rheumatology problems and who uses ultrasound in his office

At the completion of the rotation in Pain Medicine, the pain resident will gain the following knowledge and understanding:

- 1) Taking a thorough history and physical examination as well as optimal use of laboratory blood tests and radiology image techniques to assess presentation by patients with musculoskeletal (MSK) pain.
- 2) Within the history, the Rheumatology Review of Systems, to look for extra-articular features will be stressed. Also taking a functional history of impact of pain on activities of daily living (ADL) is important in the MSK history
- 3) Distinguishing clinically between soft tissue pain or non-articular MSK pain from articular (arising from the joints) MSK pain
- 4) Pattern Recognition to distinguish non inflammatory (Osteoarthritis) joint pain and physical signs from inflammatory (RA, and other conditions) joint pain.
- 5) Approach to various spinal condition and when to refer for injection therapy.
- 6) Approach to Complex Regional Pain Syndrome

- 7) Work up of Rheumatic Disease, use of the lab and X-ray
- 8) Approach to Treatment of Various Common Rheumatologic Conditions.

The overall goals of this musculoskeletal rotation for the Pain resident are in the following domains:

Medical Expert

1. To demonstrate examination of the joints of the axial spine and peripheral joints
2. To take a functional history to help in the management of chronic pain patient
3. Demonstrate knowledge of diagnosis with emphasis on history and physical exam and management of common axial spine pathology including the following:
 - a. Mechanical Neck Pain acute and chronic
 - i. Soft tissue neck pain
 - ii. Facet or zygapophyseal joint neck pain and injury
 - iii. Discogenic pain and neuroforaminal and spinal stenosis
 - iv. when to refer to the interventional pain specialist.
 - b. Mechanical low back pain
 - i. Musculoligamentous pain including sacroiliac ligament pain
 - ii. facet pain and the role of facet block
 - iii. Discogenic pain and neuroforaminal stenosis
 - iv. Spinal stenosis
 - v. Approach to diagnosis and acute treatment of osteoporotic compression fractures
 - vi. neuroforaminal stenosis and role of nerve block
 - vii. sacroiliac (SI) joint/ligament dysfunction and injections for
 - viii. Inflammatory axial spine conditions such as seronegative spondyloarthritis (SSpA) (see below in section E)
4. Demonstrate knowledge of red flag symptoms
 - a. Red Flags in Low back pain: Night Pain, Bladder/Bowel Saddle sensation problems/Abdominal Aortic Aneurysm
 - b. Red flag: The Unstable Rheumatoid Neck: things to know
5. **Soft Tissue Disorders and Regional Pain Syndromes which commonly present to the Rheumatologist.**
 - a. Regional soft tissue pain and myofascial pain, acute and chronic
 - b. Diffuse, widespread soft tissue pain and the criteria and treatment of fibromyalgia.
 - c. Assessment and injection of the painful shoulder

- d. Assessment and injection of tennis elbow and deQuervains' tenosynovitis
 - e. Assessment and injection of trochanteric bursitis
 - f. Assessment of CRPS (Complex Regional Pain Syndrome)
6. Widespread Soft tissue pain: Approach to diagnosis and management of fibromyalgia syndrome
 7. Various forms of regional tendonitis and bursitis
 8. Assessment of the Painful Shoulder Assessment
 9. Acute articular problems
 - a. Septic joint, and importance of joint arthrocentesis
 - b. Analgesia of septic joints in IV drug user
 - c. Crystal Arthritis and out and Pseudogout approach to diagnosis and treatment and what pitfalls to avoid
 - d. Traumatic joint presentations
 10. Chronic articular problems:
 - a. An Overview of Basic Approach to diagnosis and treatment of inflammatory arthropathies such as RA
 - b. An Approach to polymyalgia rheumatic and temporal arteritis
 - c. Approach to inflammatory back pain
 - i. Inflammatory joint disease eg: RA, lupus, psoriatic arthritis, seronegative spondyloarthropathies (SpA)
 - d. Non inflammatory joint disease such as osteoarthritis and treatment including cortisone injections and/or viscosupplementation with hyaluronic acid.
 11. To be exposed to treating chronic pain and MSK disorders in patients with complex medical background (i.e. spinal cord injury, Stroke, multi-trauma injuries) in the outpatient setting)
 12. Prevention and approach to diagnosis and treatment of osteoporotic compression fractures
 13. Describe indications and limitations of various diagnostic imaging modalities.
 - a. Describe the choice of imaging studies
 - b. To be exposed to the indications and limitations of electrodiagnostic testing in patients with MSK disorders.
 14. Role of diagnostic and therapeutic blocks:
 - a. acupuncture, trigger point injections, Botox injections for myofascial pain syndrome (injection treatment modalities handled by Physical Medicine and Rehabilitation)
 - b. SIJ blocks and epidural steroid injections
 - c. Facet pain and role of facet block
 - d. Indications for referral for injection therapy including facet block and nerve block
 - e. soft tissue injection
 - f. injection of tennis elbow and deQuervains' tenosynovitis and Trochanteric bursitis
 - g. Assessment and injection of trochanteric bursitis
 - h. Joint injection techniques particularly the shoulder and knee
 - i. Osteoarthritis with role of cortisone and viscosupplementation injections of the knee joint
 - j. To be exposed to ultrasound guided injections in pain and spasticity management
 - k. Joint injection techniques, particularly of the shoulder and knee (hopefully many joint injection techniques will be covered but Dr. Shuckett will also provide a self learning power point module on this.

Communicator

1. Be able to convey patient's diagnosis, prognosis and management plan in a comprehensive and empathetic fashion
2. Accurately answer patient questions within the residents comfort level, and defer to staff when beyond the resident's level of training
3. Establish therapeutic relationships with patients/families

Collaborator

1. Consult appropriately with other physicians and health care professionals
2. Contribute effectively to other interdisciplinary team activities.

Manager

3. Utilize resources effectively to balance patient care, learning needs, and outside activities
4. Demonstrate understanding of need to allocate finite health care resources responsibly

Health Advocate

1. Identify important determinants of health affecting pain clinic patients
2. Recognize and respond to those issues where advocacy is appropriate

Scholar

1. Reads around cases
2. Able to critically appraise sources of medical information as they relate to pain medicine

Professional

1. Deliver the highest quality care with integrity, honesty and compassion
2. Exhibits appropriate personal and interpersonal professional behaviours
3. Practices medicine ethically consistent with the obligations of a physician