PS16(PM) Scope of clinical practice for Specialist Pain Medicine Physicians

Background paper 2026

Short title: Scope of practice for SPMPs BP

Preamble

The Faculty of Pain Medicine (FPM/faculty) of the Australian and New Zealand College of Anaesthetists (College) was established in 1998 [1]. The faculty is a binational organisation representing the specialty of pain medicine in the jurisdictions of Australia and Aotearoa New Zealand, although it has accredited training institutions in Hong Kong, Singapore, and Canada on a case-by-case basis. Previous work outlining scope of practice for specialist pain medicine physicians (SPMPs) was undertaken at the time of recognition as a principal specialty in Australia between 2004-2005. With many changes to the curriculum and the state of medical knowledge, as well as evolution of the regulatory environment in both jurisdictions, it is timely to revisit and articulate the scope of practice for FPM fellows.

SPMPs practice the specialty of pain medicine. The term 'pain management' is often employed in casual reference to healthcare endeavours that aim to reduce or mitigate pain (i.e. provide 'pain relief'), whether it be acute, persistent or in the context of palliative care. Pain medicine is a systematized body of knowledge and practice that provides expert pain management, along with additional responsibilities appropriate to a principal medical speciality in the binational jurisdiction.

This document outlines the scope of practice of specialist pain medicine physicians trained and recognised by the faculty with regard to their qualifications and particular areas of expertise, their location and types of practice, and some of the treatments which form part of the pain management armamentarium, which are specific to the skills and knowledge of SPMPs (the 'who, where and how' of SPMP practice).

A unique feature of the FPM training program and fellowship is that unlike other jurisdictions internationally, proficiency in performance of procedures is not required for fellowship. The ability to lead a multidisciplinary team is not formally examined in other curricula. The distinct nature of the specialty in Australia and Aotearoa New Zealand has led to it being described as a 'supraspecialty rather than a subspecialty' by Professor Bart Morlion, former President of the European Pain Federation in his 2022 Michael Cousins lecture. Such a complex and multifaceted specialty is therefore in need of clear governance to ensure that fellows, medical administrators, colleagues, and the community are all able to understand what specialist practitioners of pain medicine can offer.

Purpose and background

This document outlines the scope of practice for SPMPs in Australia and Aotearoa New Zealand and may also be applied in jurisdictions such as Singapore and Hong Kong where FPM-trained SPMPs practice and provide training within the FPM Fellowship Training Program. The faculty is dedicated to setting the highest standards for the multidisciplinary management of complex pain, aiming to reduce the burden of pain on society through education, advocacy, and research. This summary clarifies for clinicians, health administrators, and the wider community the distinctive, team-based, and culturally safe approach that defines SPMP practice in this region.

Whilst aspects of pain treatment are widely practiced by many health care professionals, the role of the SPMP is in providing specialist pain medicine care and management that encompasses the broadest

and highest level of care, at an individual and societal level.

1. A unique scope of practice

Pain medicine in Australia and Aotearoa New Zealand is grounded in an interdisciplinary model. SPMPs within FPM must hold another specialty fellowship before being granted FFPMANZCA status (referred to as a primary specialty), and a wide range of primary specialties may be eligible for acceptance by the FPM Board [2]. This stipulation has created a fellowship within SPMP which is professionally diverse, and which reflects that pain is a universal human experience encompassing the breadth of medical endeavor. Expert management of pain therefore benefits from having a universality of medical experience within the fellowship in addition to the body of knowledge and training that defines the FFPMANZCA qualification.

Professionally distinct aspects of the FFPMANZCA qualification are enumerated as follows:

• *A sociopsychobiomedical framework, prioritising the complex interplay of biological, psychological, and social factors in pain.*

The term 'sociopsychobiomedical' was introduced by Carr and Bradshaw in 2014 as part of a proposal to reconceptualise how pain education was conceived and taught [3]. Although a more euphonious term would have perhaps been preferable, the word arises when the commonly used term 'biopsychosocial' is reversed to emphasise that pain should be understood as primarily a social phenomenon in terms of its interpersonal and societal consequences, before individualisation to the psychology of the person experiencing the pain, and finally to the biological events which create the pain experience within that person. Specifically, Carr and Bradshaw were referring to the idea of 'flipping the pain curriculum' for healthcare professionals and using the strategy of inverting a cliched word (the term 'biopsychosocial' was introduced by Engels [4] into the medical literature in 1977, almost 4 decades before their paper) to surface the implicit bias against social and psychological factors in clinical practice. This usage was adopted by FPM to continue the work of reversing expectations among our colleagues who continue to give biological factors primacy in clinical care, when the literature holds several decades' worth of research which suggests the primary factors influencing pain experience are social and psychological in nature.

• *Expertise in the assessment and management of acute, subacute and persistent pain arising from nociceptive, neuropathic and nociplastic mechanisms. This includes but is not limited to perioperative surgical, cancer-related and non-traumatic pain conditions.*

The field of pain medicine recognises differences between pain types based on their time course (acute, subacute or persistent), mechanistic descriptor (as recognised by the International Association for the Study of Pain and amended in the light of ongoing research from time to time), or underlying cause (cancer, injury, disease or primary pain syndrome). While these can be useful ways to classify pain types for the purpose of discussion, the underlying recognition is that pain is a unitary, conscious experience [5], and SPMPs are trained to assess it and direct management in all possible clinical circumstances.

• *A recognition that all medical interventions, from medications to complex surgery, have limitations as well as benefits. Where there are clear indications of benefit which justify any risks involved, they should be delivered in the context of a sociopsychobiomedical framework.*

All medical endeavours involve the fundamental calculation of risk against benefit for the good of the patient. In many areas of pain medicine, rigorous scientific understanding of the condition and many of the treatments applied are lacking, and in many cases cannot ever ethically be obtained. This lack of

complete evidentiary certainty does not prevent pain care from being provided based on an ethical and well-reasoned framework of clinical understanding. Using the sociopsychobiomedical paradigm, higher-risk or more resource-intensive interventions such as the use of implantable pain management devices or pain management programs can be justified where the confluence of potential benefit, judgement of the adversity of the natural history of the patient's situation if no treatment is provided, and local logistic considerations is favourable and ethical.

• *An unapologetic emphasis on interdisciplinary, function-focused, and rehabilitative care, supported by procedural and pharmacological interventions.*

A fundamental tenet of pain medicine as understood and advocated by FPM is that the best societal-level results and the most resource-effective approach is to provide care that encompasses a holistic perspective rather than a narrowly biomedical approach. This does not mean that a purely biomedical approach is not sometimes appropriate, but more that a prescription or injection should not be all that is available to a patient from a pain service if their treatment goals are not met easily. SPMPs will practice mainly in secondary or tertiary care settings where primary care has not been sufficient to prevent disabling pain from occurring. Particularly where pain has become persistent, the provision of medication or procedures alone is unlikely to be enough to optimise the ability of the patient to fulfil their potential. The short-to-medium gains that can be produced by medical interventions can be parlayed into long-term quality of life gains with improved mental and physical wellbeing if care is provided which educates, challenges, engages and supports the patient to achieve mastery of their healthcare journey.

• *A societal approach to pain management that includes research, training, education and prevention of pain conditions as part of the breadth of the specialty.*

FPM has initiated and collaborated with external stakeholders, such as the peak sector bodies Painaustralia and Chronic Pain Australia, the Australian Pain Solutions Research Alliance (APSRA), the Better Pain Management Program, The Online Pain Education Network (OPEN) initiative, the National Standards for Health Practitioner Education in Pain project, and the spinal implant device registry in fulfillment of its mission to facilitate and promote a greater understanding of the impact of pain conditions and the urgent need to take a societal approach to reducing the burden of pain in the communities which we serve.

This holistic, physician-led approach makes pain medicine as conceived and practised by fellows of FPM unique among our colleagues internationally. It is distinct from pain specialty training and practice in jurisdictions such as the UK, Ireland and US, where the treatment approach remains largely biomedical in context with a training emphasis on procedures and medications, and less time dedicated to the mastery of multidisciplinary team-based care. The diversity of specialist medical craft groups completing training through FPM is also in contrast to the programs developed for pain medicine training in other jurisdictions where recruitment has been tilted towards anaesthesia.

FPM has been a world leader in standard setting, curriculum development for pain professionals and broadening the awareness of pain within the medical profession, healthcare more generally and with the general public through support and collaboration with consumer peak bodies and other allies.

2. Collaboration With Other Specialties

Pain care should ideally be integrated into care plans in all areas of healthcare practice, so it is incumbent on SPMPs to be supportive colleagues and work as seamlessly as possible with specialists in other areas of the system.

2.1 Acute inpatient admissions to hospital

Acute inpatient pain services frequently collaborate with specialist anaesthetists, perioperative physicians and surgeons for acute postoperative pain, although SPMP's are able to also provide consultative services to other specialties for acute non-surgical pain conditions. Ideally, acute pain services should be led by a SPMP particularly if the hospital is a tertiary service, as this better equips the service to deal with complex acute presentations, and facilitates professional alignment with best practice in the field. In regions where this is not the case, SPMPs may provide support to anaesthetist or nurse specialist acute pain clinicians to manage cases where the level of complex decision-making requires the highest level of training and expertise.

It is not an acceptable level of care for acute pain services to decline to provide management of complex patients' persistent pain conditions because of an arbitrary distinction between 'acute' and 'chronic' pain, when pain is a unitary experience unique to the individual concerned. Part of the training and induction to working in an acute pain team should be an appreciation of the sociopsychobiomedical paradigm and how it applies in an acute setting. Pain in the postoperative or acute disease setting may be predominantly nociceptive but psychosocial considerations are no less important to the formulation of treatment choices, and only SPMPs have the training and experience to provide expertise in their application in routine care.

SPMP's can be the admitting primary treating specialty for inpatient care, where the condition and/or treatment provided is primarily pain related or focused on functional gains, such as inpatient infusion therapy, inpatient treatment of complications of procedures, or inpatient pain rehabilitation programs.

2.2 Outpatient and community services

SPMP's work collaboratively with other healthcare professionals in a primary or secondary care setting to provide expert management of pain conditions.

Examples of roles where SPMPs may provide valuable expertise include transitional pain clinics (which bridge the gap between acute and community services), multidisciplinary pain clinics staffed by a team of clinicians and led by SPMPs, private clinics which may vary from solo practitioner to FPM-approved training units, and hospital outpatient services. SPMPs may provide community outreach such as residential aged care facility visitation or telehealth services.

SPMPs may be valuable team members in a consultation/liaison role in outpatient clinics with addiction specialists, orthopaedic subspeciality clinics, rehabilitation centres, and perioperative clinics where ready access to pain medicine expertise may enhance provision of the associated primary service.

2.3 Pain in the palliative care setting

The speciality of palliative medicine encompasses medical, psychosocial and spiritual needs of the person approaching the end of their life. SPMPs can provide pain management expertise as part of a consultative service with patients in such settings to provide optimal medical and/or procedural management of pain. Palliative care practitioners may work closely with SPMPs in hospital or community clinic settings, and exposure to palliative care settings is an essential part of FPM training.

2.4 Pain-related procedures

SPMPs may have a procedural scope of practice endorsed under the Procedures Endorsement Program (PEP) [6]. PEP does not provide an exhaustive accreditation for every possible procedure, but concentrates on a core curriculum of procedures with established evidentiary basis and circumscribed

techniques. Expansions of procedural skills beyond the scope of PEP endorsement is a matter for the CPD program of the SPMP concerned and should take into account the primary speciality e.g. neurosurgery or gynaecology when deciding on expansion of scope of procedures performed.

As many SPMPs practice in teams where there may not be a proceduralist, or where their hospital may not provide theatre access, SPMPs can provide expert assessment and follow up for procedures performed by interventional radiologists or surgeons working in collaboration with the pain team to ensure that the procedures are linked to functional outcomes. Procedures undertaken by non-FPM specialists should be done to the same standards as outlined in *PS11(PM)* [7], as patients should have equitable access to the highest standard of pain care.

2.5 Paediatric pain

There is no formal qualification in paediatric pain medicine at this time, although the framework of such a subspecialty will be the subject new faculty professional document '*Position statement on the provision of pain medicine care to children and adolescents' (to come 2026).* SPMPs are expected to have sufficient knowledge to be able to advise paediatricians regarding management of conditions such as complex regional pain syndrome (CRPS) or neuropathic pain in children and adolescents including when referral to a specialist paediatric pain service is advisable.

3. Core role of specialist pain medicine physicians

3.1 Medical expert

3.1.1 Advanced diagnostic expertise

SPMPs have specialist diagnostic skills in assessing pain and its impact on the individual, particularly in cases where multiple pain conditions coexist. They are trained to:

- Differentiate between neuropathic, nociplastic, and nociceptive pain.
- Understand the role of specialised tests for diagnosing pain conditions as adjuncts to history and clinical examination.
- Recognise overlapping pain conditions (e.g., fibromyalgia coexisting with osteoarthritis or CRPS and anxiety) and distinguish primary pain syndromes from inflammatory or structural causes.
- Identify central sensitisation and its contribution to pain persistence.
- Identify psychiatric conditions and substance misuse that impacts on pain management.
- Identify and triage patients based on clinical urgency and risk factors.
- Recognise and address red flags (pathology) and yellow flags (psychosocial risk factors for chronicity).

3.1.2 Provision of comprehensive care

SPMPs oversee comprehensive pain care that includes:

- Development and implementation of individualised, evidence-based management plans using pharmacological, physical, psychological and interventional strategies.
- Multidisciplinary assessment of pain and mental health interactions.
- Psychologically informed pain management, incorporating:
    - Cognitive behavioural therapy (CBT)-based pain strategies.
    - Acceptance and commitment therapy (ACT) and mindfulness-based approaches.
- Optimisation of pain treatments to minimise psychiatric risk, including:

    - Avoiding or deprescribing high-risk medications (opioids, benzodiazepines).
- Managing high-risk legacy patients who have challenging co-morbidities or high-dose opioid regimens.
- Allied health interventions including physiotherapy, occupational therapy, dietetics.
- Medical optimisation including surgical, medical, psychiatric and addiction medicine.
- Pharmacological interventions for pain and underlying conditions that cause pain.
- Appropriately selected procedural treatments.
- Leading or participating in multidisciplinary teams, facilitating the team approach through case conferences.
- Educating patients and the community on pain mechanisms, treatment options and realistic expectations.
- Follow up and outcome monitoring – monitor progress and assess outcomes using validated assessment tools

3.1.3 Procedures

Procedures must be integrated into a holistic patient centred approach and should in all circumstances be provided in an evidence-informed and ethical manner. The Professional document *PS11(PM) Procedures in pain medicine clinical care standard* [7] sets out the clinical standard required in this regard. Not all SPMP's will perform procedures but FPM expects that they maintain an awareness of current evidence and practice regarding the role of procedures in pain management.

SPMP's may perform interventional procedures within their level of specialist training. These procedures can include but not be limited to those specified by the Procedures Endorsement Program of FPM.

3.1.4 Health advocate

FPM Board has been the primary source of formal activity for advocacy according to the strategic plans and purpose of the College. However, each SPMP can advocate locally at service and community level for equity of access and provision of high-quality care. Regional and National Committees are tasked to develop issues in their jurisdiction for communication to the board and hence incorporation into formal strategic planning. Individual fellows can raise advocacy concerns with their relevant regional or national committee to initiate this process. FPM staff can assist SPMPs who have the opportunity to pursue local advocacy with media training and assistance with ensuring alignment with FPM advocacy strategy goals.

Part of advocacy can include becoming involved with external partners who need pain medicine expertise but who may not be part of daily care delivery. Some examples of this type of advocacy include medicolegal practice, where pain medicine expertise is made available to courts to inform decisions made by judges, advocacy to jurisdictional bureaucracy such as ministerial departments, local or regional statutory bodies who fund and oversee healthcare provision.

3.1.5 Scholar

SPMPs are experts in the basic and clinical science of pain and its management. Pain management is a field of healthcare where outdated knowledge, and even frank pseudoscience remain prominent. Sufferers of persistent pain are uniquely vulnerable to promises of easy cures and encouragement of unrealistic expectations. The absolute bedrock of pain medicine, and by extension the faculty, is a rigorous and serious scientific approach which underpins the humanistic clinical implementation of this knowledge. Scientific and scholarly integrity is fundamental to differentiating pain medicine from the

legion of unscientific and ineffective treatments that can exhaust pain patients of their hope and resources.

Practical facets of the scholar role that all SPMPs will encounter may include:

To provide ongoing education to medical students, nurses, allied health care professionals (HCP) and other doctors in relation to the diagnosis and treatment of pain conditions. The formulation of an enormous amount of basic and clinical research into actionable protocols and clinical insights is both a formal and informal task. FPM has developed National Standards for Health Practitioner Education in Pain Management in pursuit of its purpose at a strategic level, but there are innumerable opportunities in a less formal setting to share information with HCP colleagues to improve pain care within other specialty areas and more generally in primary care and undergraduate settings.

To support ongoing research into the basic science and clinical treatment of pain conditions, underlying causes of persistent pain, and prevention strategies for persistent pain. FPM has facilitated the establishment of the Australian Pain Solutions Research Alliance (APSRA) to bring together scientists, clinicians, consumers and industry at a macro scale. In everyday practice, clinical audit activities and clinician-led research projects can add significant value to health services and patient care more generally.

Incident reporting and quality improvement activities. Participating in quality and governance activities is an aspect of the scholar role which is particularly prominent in hospital settings but does not need to be confined to this arena. Safe systems help many more patients than are harmed to learn the lessons which inform safe practice.

Maintain up to date knowledge and skills, required CPD and regular review of practice. In both countries within the jurisdiction of FPM, mandatory CPD activities require completion of practitioner-directed activities within domains which include practice review and clinical audit. Without thoughtful input these can be simple compliance but with some scholarly introspection they can provide professional growth and new learning. SPMPs should aim to be lifelong learners with curiosity and intellectual integrity to make changes to their practice in the light of ongoing research and evidence.

4. SPMP's provide pain management in a culturally safe manner
Australian and Aotearoa New Zealand health frameworks

4.1 The Aotearoa New Zealand health framework

In Aotearoa New Zealand, pain management approaches align with Te Tiriti o Waitangi principles and the Māori health framework, which emphasises the holistic care model. This includes:

- Recognising the spiritual, physical, psychological, and social dimensions of health and wellbeing following the Te Whare Tapu Wha model of health(8) and the Meihana Model of assessment(9).
- The importance of whanau (extended family) in the healing process and providing culturally appropriate support.

These models recognise and aim to address:

1. Tinana: physical wellbeing
2. Hinengaro: consciousness and awareness

3. Iwi Katoa: wider support

4. Wairua: spiritual wellbeing

5. Taiao: environmental wellbeing

4.2 The Australian health framework

In Australia, SPMPs engage with both mainstream health services and Aboriginal and Torres Strait Islander health frameworks, which prioritise culturally safe care. Pain management involves:

- Understanding the historical, social, and cultural context of health for First Nations peoples.
- Incorporating holistic care approaches in partnership with Aboriginal and Torres Strait Islander healthcare providers, ensuring culturally competent and inclusive care.

First Nations cultures on both sides of the Tasman have embedded within their philosophy of health a sociopsychobiomedical approach to pain management, recognising the unique social determinants of health and cultural factors that influence pain perception and treatment, and wellbeing more broadly.

4.3 Addressing Barriers to Mainstream Pain Care

Barriers that limit access to, and engagement with, mainstream pain medicine services include:

- Culturally unsafe or insensitive healthcare environments [10]
- Under-recognition and under-treatment of pain [11]
- Limited access to Indigenous led health services and practitioners [10]
- Communication gaps, such as reliance on biomedical pain scales that may not capture expressions of pain in Māori, Aboriginal and Torres Strait Islander people. [11]
- Experiences of stigma, racism, and distrust of healthcare services due to historical and ongoing trauma [12]

Recognising and addressing these barriers is central to delivering equitable care, and the faculty aspires to respond both at the systems level via advocacy, and at the level of individual fellows via CPD activities.

4.4 Ongoing collaboration and consumer input

The SPMP recognises that improving pain care for Aboriginal, Māori and Torres Strait Islander peoples (and indeed for all consumers) requires continuous consultation, collaboration, and meaningful consumer input. Effective approaches must operate at the individual, system, and societal levels to ensure sustained improvements in access to culturally safe pain management.

5. Conclusion

Fellows of FPM practice pain medicine and have a unique scope of practice. This includes:

- Diagnosing and managing acute, subacute, persistent, end-of-life and complex pain conditions.
- Leading and working within interdisciplinary teams in the management of pain conditions.
- Working collaboratively with other stakeholders and allies in the pain sector to advocate for appropriate standards of pain management in all pain conditions, including the creation of accessible, sustainable and clinically effective pain services in primary, secondary and tertiary care settings.

- Implementing pain management strategies that include psychological, social, and functional components as well as best- practice medical care.
- Diagnosing and treating predisposing, perpetuating and resulting co-morbid and/or secondary conditions (with clear exclusion for management unless this is within the specialist pain medicine physicians' primary scope of practice).
- Preventing disability and secondary harm by skillful negotiation of the interface between pain, mental health and addiction care.
- Advocating for, and translating into systematic practice, high-quality research regarding pain conditions.

This scope of specialist practice ensures optimal patient outcomes within a holistic, physician-led model, distinct from international pain medicine structures, and tailored to the needs of communities in Aotearoa New Zealand, Australia and Asia Pacific.

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Faculty of Pain Medicine professional documents

POLICY – A document that formally states principle, plan and/or course of action that is prescriptive and mandatory.

STATEMENT – A document that describes where the college stands on a particular issue. This may include areas that lack clarity or where opinions vary. A statement is not prescriptive.

GUIDELINE – A document that offers advice on a particular subject, ideally based on best practice recommendations and information, available evidence and/or expert consensus. A guideline is not prescriptive.

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