Choose Palliative Medicine!

#ChoosePallMed
Housekeeping

Please can all attendees

- Turn camera off
- Mute microphones

- Write questions in the Chat: all questions will be taken at the end of the presentations
Overview

▪ Scene setting: the new Palliative Medicine curriculum
▪ What will training programmes look like?
▪ Reflections on a career in Palliative Medicine
▪ Life as a Palliative Medicine trainee
▪ A day in the life of a Palliative Medicine consultant
▪ Future consultant posts
▪ Question and answer session
Why choose Palliative Medicine?

Holistic, diverse clinical care, working within a multidisciplinary palliative care team

- Individualised approach – problem solving; where physical, emotional and spiritual dimensions are equally addressed
- Practice medicine across all settings including hospices, community teams and hospital
- Collaboration between teams to support patients

Consultant career allows flexibility and opportunities for portfolio career; diverse range of responsibilities:

- Leadership & Service development
- Education, Research, Policy
The new training pathway

The physician training pathway

Foundation training (2 Years)

Selection

Internal Medicine Stage 1 training (3 years)
- Mandatory items
  - Acute medicine
  - Acute take
  - Outpatients
  - Geriatric medicine
  - ITU/HDU
  - Simulation

Selection

Medical Registrar

Specialty training (indicative 4 years)

Internal Medicine Stage 2 (in specialty)

Internal Medicine Stage 2 (acute care)

Specialty certification

MRCP(UK)

Workplace-based assessment

SCE/KBA

Royal College of Physicians
Why has Palliative Medicine changed to dual training with Internal Medicine (IM)?

- Palliative care is becoming more complex in all settings
  - Increasing people with multiple long-term conditions, frailty, cancer
  - People living longer with life-limiting illness – more complex needs
  - Increasing treatment options, including multi-system complications from treatment
- Require broader general medical skills to meet changing population need
- Enhanced medical skills will help us deliver services to best meet patient needs, including community and community/hospital interface
Similarities to previous curriculum

- Training across all palliative care settings: hospice inpatient, community, hospital
- Broad approach to training, e.g.
  - Holistic palliative care approach, underpinned by evidence and clinical practice
  - Palliative care approach based on need not diagnosis
  - Core knowledge and skills, e.g. detailed palliative assessment, skilled pharmacology, expert communication
- Flexibility to meet individual trainee needs
- High quality supervision, supportive teams
- SCE (Palliative Medicine only)
The main changes to the curriculum

- 4-year programme after IMS3
  - 25% of training in IM/ 75% of training in Palliative Medicine
- More detail around what we are expecting for trainees to meet capabilities, e.g.
  - Involvement in specialty take/ on call
  - Working in different settings: hospice/ specialist inpatient, community and hospital advisory palliative care
- Enhanced recognition: e.g. Frailty, multi-comorbidity, ageing population, organ failure, supportive care in cancer, transition services
- Public health palliative care
- Looking to the future, e.g. technology
- Self care and resilience
What will training programmes look like?
Integrating Palliative Medicine and IM

- Range of models - interweave Pall Med and IM to maintain skills
- Aim for local links to ease transition between Pall Med and IM
- Early time in Palliative Medicine, often in a hospice
- Must do 3m IM in final year (or 1m immersion in AMU)

- Evolving picture and will need to FLEXIBLE due to LTFT trainees, OOP and dual curricula for a few years
# Example models for Palliative Medicine and IM blocks

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<th>ST4</th>
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<tr>
<td>Entry to HST programme following Stage 1 IM training</td>
<td>Hospice 8m</td>
<td>GIM 4m</td>
<td>Hospital PCT/ Onc 8m</td>
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**IM & Pall Med Training days and KIT days ~ 12/year Pall Med & IM**

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Principles of dual training

- IM training provides experience of patient management delivered in other medical specialities

- Generic and IM capabilities can be acquired during specialty training AND placements labelled as internal medicine
  - Up to 3 months Palliative Medicine training can ‘count’ towards acquisition of IM capabilities
Principles of dual training

- Separate Educational Supervision and IM representation at ARCP as the gold standard.

- TPDs will work with training units and trainees to facilitate ‘Keeping in Touch’ training (Palliative Medicine whilst in IM, IM whilst in Palliative Medicine), e.g.
  - Specialty and IM training days
  - Procedural skills simulation
  - Acute take, AMU and SDEC sessions
  - Outpatient and community experience outside of Palliative Medicine
Additional training opportunities continue

• Out of Programme options (OOPE, OOPT, OOPR)
• Academic training (ACF, OOPR, ACL)
• Leadership and management (Fellowships and Chief Registrar placements)
• Less than full time training (Categories 1,2,3)
• Developing interests e.g. education, ethics, service development
Reflections on a career in Palliative Medicine
Why I still get out of bed and commute to work everyday
Sometimes sad, never depressing....

The case study masterclass

Each masterclass comprises a detailed case history followed by a series of questions that are designed to give you food for thought at the key stages in the history. A discussion of this case study will be given in the next issue of the *European Journal of Palliative Care.*

**Case 30  And baby came too: Lucy’s story**

*When Lucy was 25 years old and in the early stages of an unplanned pregnancy, she developed hyperemesis. An abdominal ultrasound revealed an ovarian mass. Repeat scanning a fortnight later showed that the mass had doubled in size. At laparotomy, the mass was removed; histology revealed a poorly differentiated adenocarcinoma probably of ovarian origin. A further tumour deposit was removed from the anterior abdominal wall. At this stage, Lucy was well. Limited staging investigations were performed and were normal. After much deliberation, Lucy and her oncologist decided to withhold chemotherapy and follow an expectant ‘watch and wait’ policy. She had a staging MRI.*

She remained generally well but usually slept well and was at times pain-free. Her clinical course was complicated by a severe bout of *Clostridium difficile* diarrhoea and an episode of potentially life-threatening neutropenic sepsis and pneumonia.

*It was decided to deliver the baby at 29 weeks by elective caesarean. The day before, you met Lucy’s midwife on the ward before seeing her. It became apparent that the question of guardianship had not been discussed with Lucy. It fell to you to raise this issue with her; she made it seem much easier to discuss this topic than you had feared and arrangements were made for a legal document detailing...*
Palliative Critical Care

• Quality Improvement Project 2016

• Palliative and end of life now seen as an important, integral and normal part of ICU care – complex issues referred to palliative care team
Life as a Palliative Medicine trainee
Why we chose Palliative Medicine...

Our stories so far...
Reasons we chose Palliative Medicine

❖ The new curriculum (!)
❖ Principles of Palliative Medicine
❖ Opportunities – The sky is the limit!
❖ Personalised
❖ Supported
❖ Never stop being a Palliative Medicine Registrar

Each deanery is unique in terms of rotations so we would encourage you to contact the TPD of an area to find out further information about the training in that region.
A day in the life - the Palliative Medicine consultant
Clinical Teaching
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<th>Monday</th>
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<tr>
<td>Post 1 Hospice IPU Ward Round am Governance</td>
<td>Medical director meetings am Clinic pm</td>
<td>Hospice MDT Journal Club lunchtime ES supervision Audit pm</td>
<td>Hospice IPU Ward Round MEM lunchtime Core SPA pm</td>
<td>Medical Examiner</td>
<td>Integrated Huddle</td>
<td>Hospital Inpatient Unit WR am Hospice Inpatient WR pm</td>
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<td>Post 2 Hospital Team Reviews</td>
<td>Hospital MDT &amp; WR am Clinical Governance pm</td>
<td>SPA am Journal Club lunchtime Hospital Team Reviews pm</td>
<td>Advanced Liver MDT Weekly Safety Meeting Hospital Reviews PM</td>
<td>Time off in Lieu post weekend</td>
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<td>Post 3 Clinic am Wellbeing MDT Rotas / admin</td>
<td>Hospital MDT am Homelessness MDT Home visit</td>
<td>Non-Working Day</td>
<td>Community MDT and education am ES / audit pm</td>
<td>Home visit Community meetings Senior review</td>
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<td>Post 4 Non Working Day</td>
<td>Hospital MDT am Management meetings pm</td>
<td>Integrated Care Hub</td>
<td>Integrated MDT Educational Management pm</td>
<td>Hospital Inpatient Unit Round am SPA pm</td>
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Future consultant posts
# Contact Emails for TPDs

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<td>London</td>
<td><a href="mailto:nicholas.gough@gstt.nhs.uk">nicholas.gough@gstt.nhs.uk</a></td>
<td>Yorkshire &amp; Humber</td>
<td><a href="mailto:s.kyeremateng@hospicesheffield.co.uk">s.kyeremateng@hospicesheffield.co.uk</a></td>
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<td>KSS</td>
<td><a href="mailto:cathygleeson@stch.org.uk">cathygleeson@stch.org.uk</a></td>
<td>Yorkshire &amp; Humber</td>
<td><a href="mailto:hannah.zacharias@st-gemma.co.uk">hannah.zacharias@st-gemma.co.uk</a></td>
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<td>Scotland</td>
<td><a href="mailto:ruth.isherwood@nhs.scot">ruth.isherwood@nhs.scot</a></td>
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<td>Northern</td>
<td><a href="mailto:t.morgan@nhs.net">t.morgan@nhs.net</a></td>
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<td>Thames Valley</td>
<td><a href="mailto:Matthew.Carey@ouh.nhs.uk">Matthew.Carey@ouh.nhs.uk</a></td>
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<td>East of England</td>
<td><a href="mailto:koakley@sthelena.org.uk">koakley@sthelena.org.uk</a></td>
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**Note:** The table above provides contact emails for Training Programme Directors (TPDs) across various Deaneries. Each entry includes the name of the Deanery, followed by the TPD email address. For clarity, some entries have been abbreviated to fit within the column width.
Questions?