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Choose Palliative Medicine!

#ChoosePallMed

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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

Medical Registrar

Selection

Specialty training (indicative 4 years)

Internal Medicine Stage 2 (in specialty)

Internal Medicine Stage 2 (acute care)

Specialist certification

MRCP(UK)

SCE/KBA

Workplace-based assessment

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

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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

	ST4		ST5		ST6	ST7	
Entry to HST programme following Stage 1 IM training	Hospice 8m	GIM 4m	Hospital PCT/ Onc 8m	GIM 4m	Senior hospice & community	Hospital Pall Med 8m	GIM 4m
	IM & Pall Med Training days and KIT days ~ 12/year Pall Med & IM						

	ST4	ST5		ST6	ST7	
Entry to HST programme following Stage 1 IM training	Hospice 12m	Hospital PCT 6m	GIM 6m	Senior hospice 6m + Community 6m	Hospital PCT/ Senior hospice 6m	GIM 6m

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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

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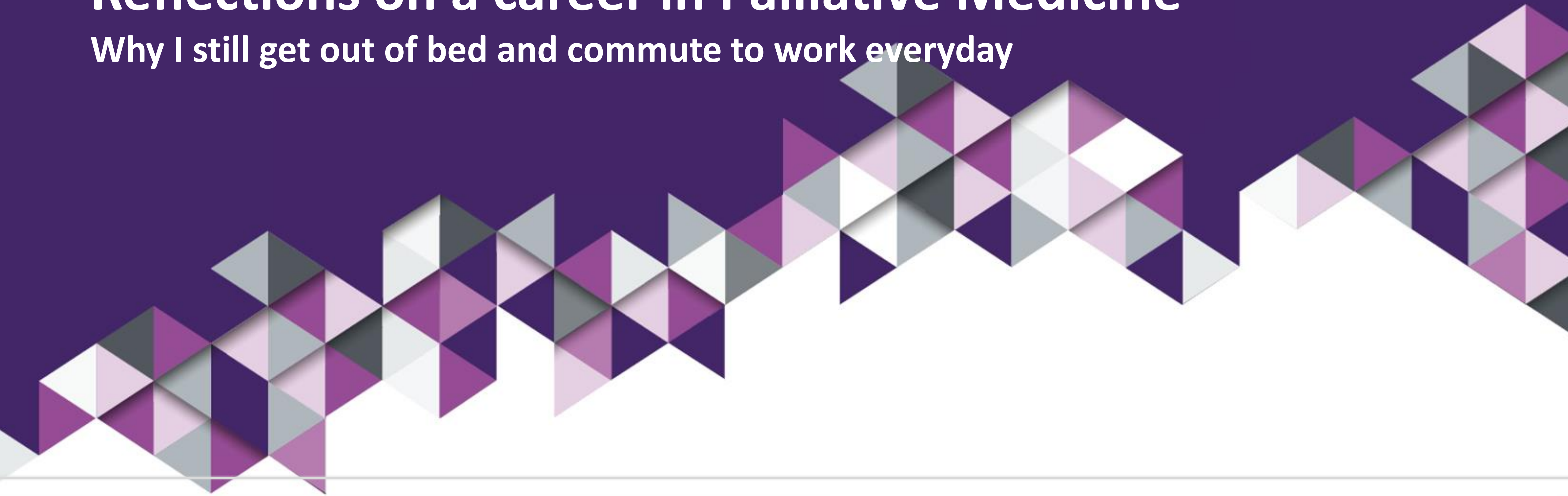
Reflections on a career in Palliative Medicine

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 developed rapidly increasing low back

the fact that she was pregnant, with an elective caesarean section after 24

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

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Life as a Palliative Medicine trainee

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Why we chose Palliative Medicine…

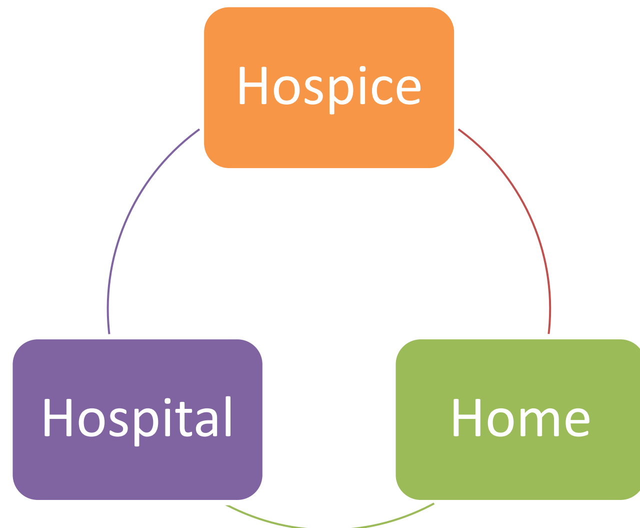
Our stories so far…

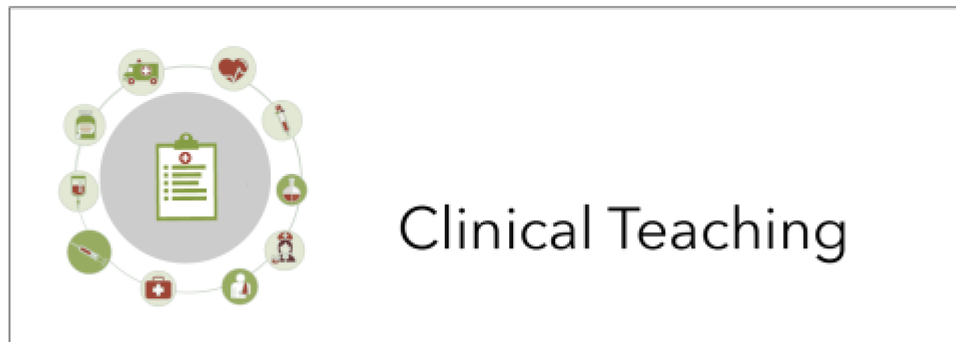
Reasons we chose Palliative Medicine

- 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


Hospice
Hospital
Home


Clinical Teaching

Clinical Governance Pillars
Education and training
Openness and candour
Risk management
Clinical Effectiveness
Research and development
Clinical audits

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Integrated Posts (4 of 8)

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Post 1	Hospice IPU Ward Round am Governance meetings pm Senior review	Medical director meetings am Clinic pm	Hospice MDT Journal Club lunchtime ES supervision Audit pm	Hospice IPU Ward Round MEM lunchtime Core SPA pm	Medical Examiner Weekend handover	Integrated Huddle On Call	Hospital Inpatient Unit WR am Hospice Inpatient WR pm
Post 2	Hospital Team Reviews	Hospital MDT & WR am Clinical Governance pm	SPA am Journal Club lunchtime Hospital Team Reviews pm	Advanced Liver MDT Weekly Safety Meeting Hospital Reviews PM	Time off in Lieu post weekend		
Post 3	Clinic am Wellbeing MDT Rotas / admin	Hospital MDT am Homelessness MDT Home visit	Non-Working Day	Community MDT and education am ES / audit pm	Home visit Community meetings Senior review		
Post 4	Non Working Day	Hospital MDT am Management meetings pm	Integrated Care Hub	Integrated MDT am Educational Management pm	Hospital Inpatient Unit Round am SPA pm		

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Future consultant posts

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Contact Emails for TPDs

Deanery	TPD email	Deanery	TPD email
London	nicholas.gough@gstt.nhs.uk	Yorkshire & Humber (south)	s.kyeremateng@hospicesheffield.co.uk tpd@hospicesheffield.co.uk
KSS	cathygleeson@stch.org.uk	Yorkshire & Humber (north)	hannah.zacharias@st-gemma.co.uk
Northwest	Andrew.Fletcher@stcatherines.co.uk	Scotland	ruth.isherwood@nhs.scot
Mersey	andrew.khodabukus@nhs.net	Northern	t.morgan@nhs.net
Wessex	Catherine.Webb@uhd.nhs.uk	Northern Ireland	Sinead.Hutcheson@belfasttrust.hscni.net
West Midlands	Milind.Arolker@uhb.nhs.uk	Peninsula	shuman@nhs.net
East Midlands	Fiona.Wiseman@nhft.nhs.uk	Thames Valley	Matthew.Carey@ouh.nhs.uk
Wales	margred.capel@cityhospice.org.uk		
Seven	Candida.Cornish@stpetershospice.org.uk	East of England	koakley@sthelena.org.uk

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Questions?