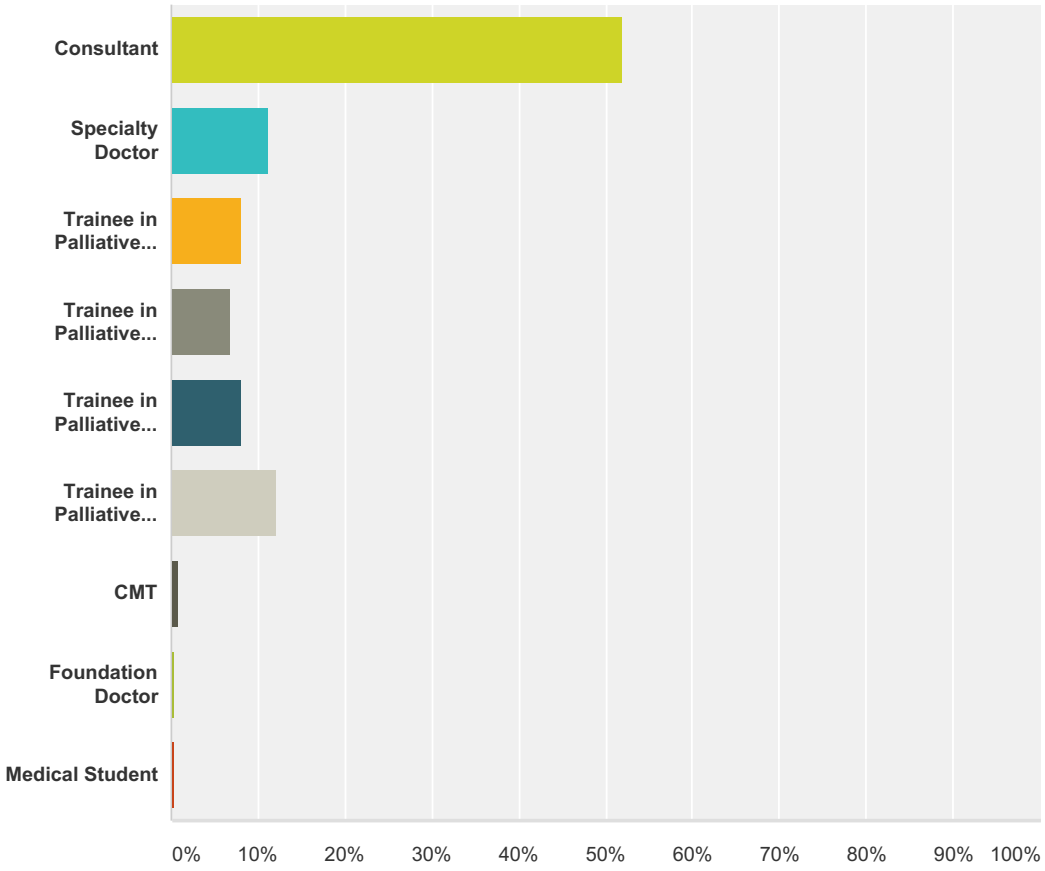
Q1 Position

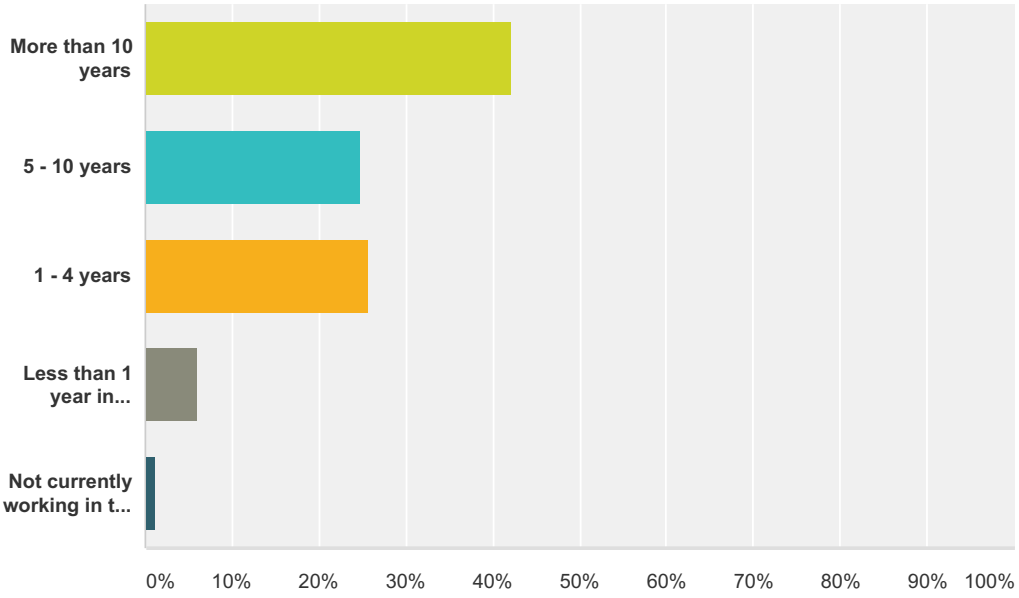
Answered: 248 Skipped: 1



Answer Choices	Responses	
Consultant	**52.02%**	129
Specialty Doctor	**11.29%**	28
Trainee in Palliative Medicine ST3	**8.06%**	20
Trainee in Palliative Medicine ST4	**6.85%**	17
Trainee in Palliative Medicine ST5	**8.06%**	20
Trainee in Palliative Medicine ST6	**12.10%**	30
CMT	**0.81%**	2
Foundation Doctor	**0.40%**	1
Medical Student	**0.40%**	1
Total		**248**

Q2 Length of time working in Palliative Medicine

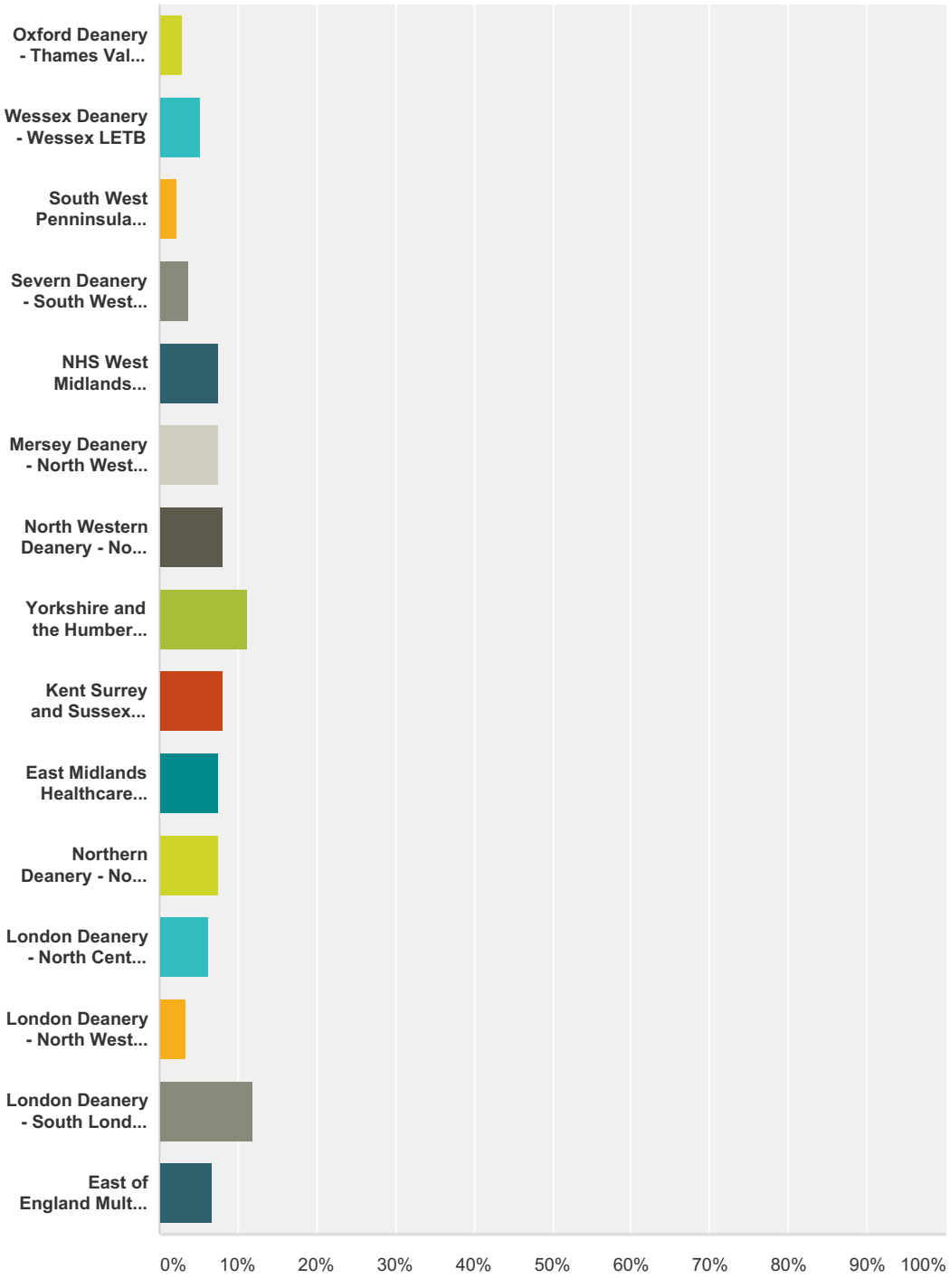
Answered: 249 Skipped: 0



Answer Choices	Responses	
More than 10 years	**42.17%**	105
5 - 10 years	**24.90%**	62
1 - 4 years	**25.70%**	64
Less than 1 year in Palliative Medicine	**6.02%**	15
Not currently working in the Specialty	**1.20%**	3
Total		**249**

Q3 LETB

Answered: 211 Skipped: 38

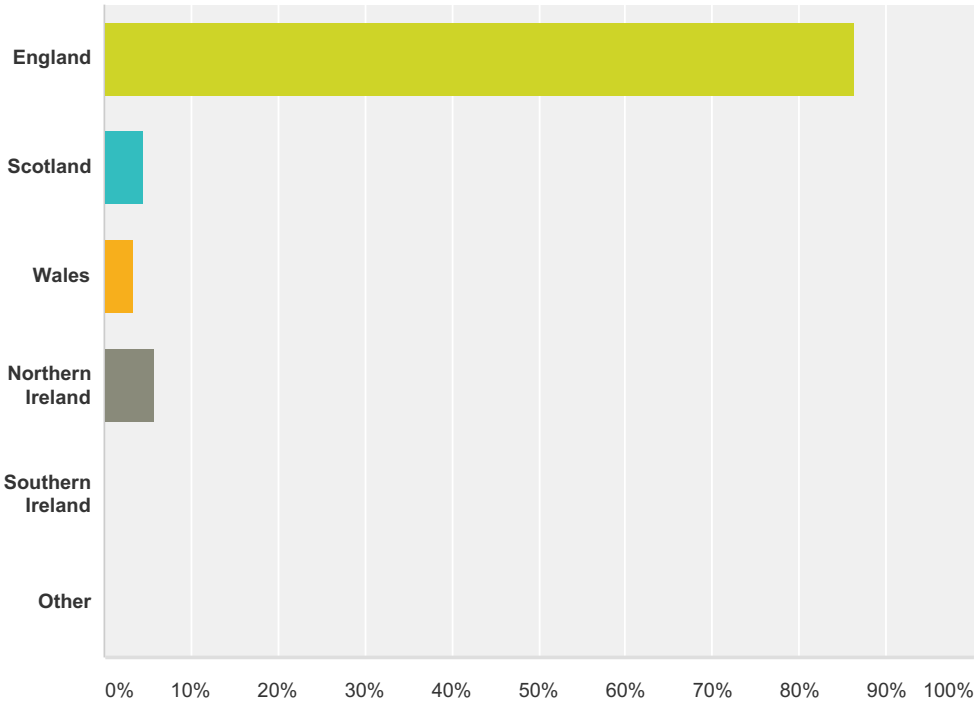


Answer Choices	Responses	
Oxford Deanery - Thames Valley LETB	2.84%	6
Wessex Deanery - Wessex LETB	5.21%	11
South West Penninsula Deanery - South West LETB	2.37%	5

Severn Deanery - South West LETB	**3.79%**	8
NHS West Midlands Workforce Deanery - West Midlands LETB	**7.58%**	16
Mersey Deanery - North West LETB	**7.58%**	16
North Western Deanery - North West LETB	**8.06%**	17
Yorkshire and the Humber Deanery - Yorkshire and the Humber LETB	**11.37%**	24
Kent Surrey and Sussex Deanery - Kent, Surrey and Sussex LETB	**8.06%**	17
East Midlands Healthcare Deanery - East Midlands LETB	**7.58%**	16
Northern Deanery - North East LETB	**7.58%**	16
London Deanery - North Central and East London LETB	**6.16%**	13
London Deanery - North West London LETB	**3.32%**	7
London Deanery - South London LETB	**11.85%**	25
East of England Multi Professional Deanery - East of England LETB	**6.64%**	14
Total		**211**

Q4 Country

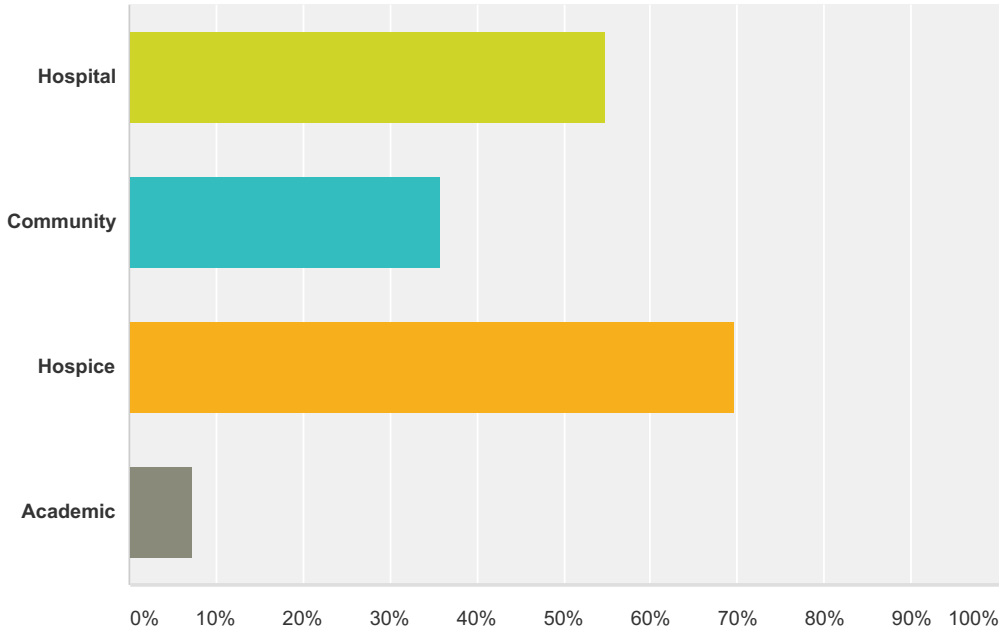
Answered: 243 Skipped: 6



Answer Choices	Responses	
England	**86.42%**	210
Scotland	**4.53%**	11
Wales	**3.29%**	8
Northern Ireland	**5.76%**	14
Southern Ireland	**0.00%**	0
Other	**0.00%**	0
Total		**243**

Q5 Main workplace settings

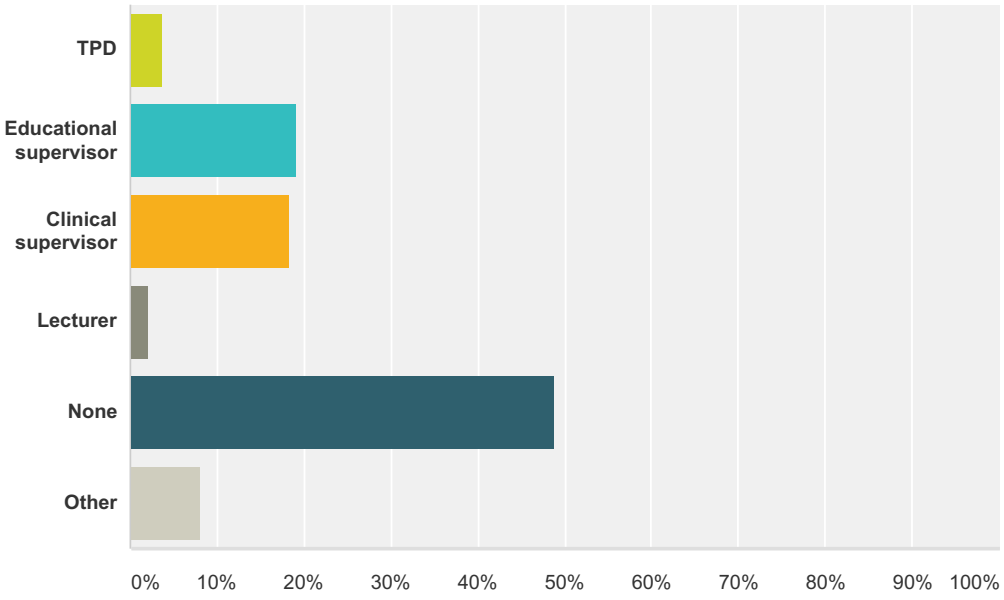
Answered: 248 Skipped: 1



Answer Choices	Responses	
Hospital	**54.84%**	136
Community	**35.89%**	89
Hospice	**69.76%**	173
Academic	**7.26%**	18
Total Respondents: 248		

Q6 Educational rolesPlease indicate which educational/training roles you currently hold

Answered: 246 Skipped: 3



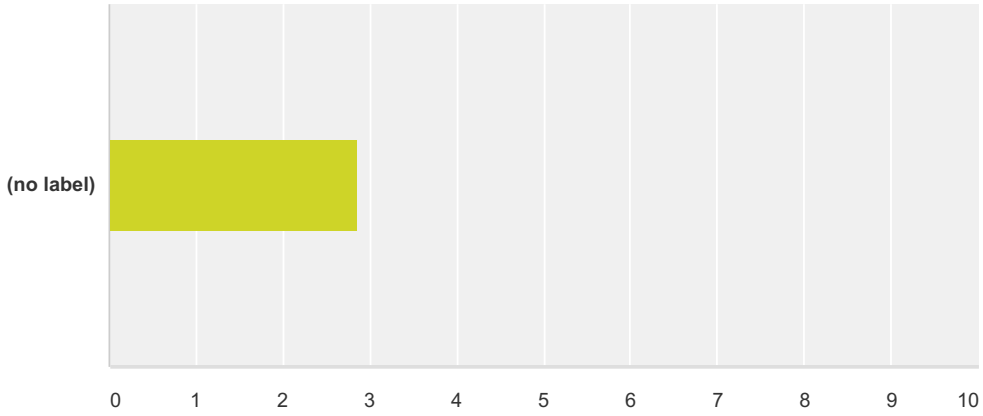
Answer Choices	Responses	
TPD	**3.66%**	9
Educational supervisor	**19.11%**	47
Clinical supervisor	**18.29%**	45
Lecturer	**2.03%**	5
None	**48.78%**	120
Other	**8.13%**	20
Total		**246**

#	Other	Date
1	Internal training role	6/9/2015 12:37 PM
2	Honorary clinical tutor	6/7/2015 2:40 PM
3	Senior Fellow Education and Management	6/2/2015 12:06 PM
4	And lecturer	6/1/2015 10:35 PM
5	Educational and clinical supervisor	5/29/2015 6:53 PM
6	For post grad doctors I am an educational supervisor and clinical supervisor	5/29/2015 3:28 PM
7	Medical Education Fellow	5/29/2015 9:26 AM
8	educational / clinical supervisor and part triumverate tpd	5/28/2015 6:40 PM

9	Due to commence new role as new consultant. Until now, involved in coordinating Regional/local SpR Educational program	5/28/2015 6:35 PM
10	Medical student clinical tutor	5/28/2015 6:23 PM
11	Professor	5/28/2015 4:12 PM
12	Professor	5/28/2015 4:12 PM
13	undergraduate course coordinator	5/28/2015 1:50 PM
14	Honorary clinical tutor	5/28/2015 1:43 PM
15	SAC member / RSA	5/27/2015 3:43 PM
16	Tutor to medical students	5/23/2015 11:44 PM
17	prefer not to say	5/19/2015 7:37 PM
18	lecturer, clincial supervisor and educational supervisor	5/19/2015 8:27 AM
19	Student teaching, other health professional teaching e.g. GPs, nursing staff	5/18/2015 7:42 PM
20	Does not allow you to select more than one option! I am an educational supervisor for StR and clinical supervisor for GPST	5/18/2015 6:36 PM

Q7 Shape of Training changes suggested for pre MRCP part 2 will have a positive impact on the training of doctors in Palliative Medicine.

Answered: 193 Skipped: 56



	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**5.18%** 10	**30.05%** 58	**44.04%** 85	**16.06%** 31	**4.66%** 9	193	2.85

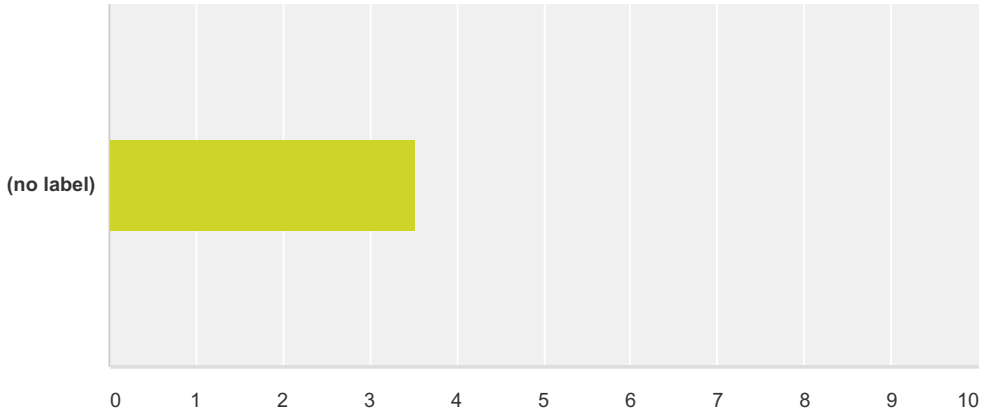
#	Additional Comments	Date
1	I think it is an interesting idea to make CMT a 3 year programme, as a good proportion of people find getting all 3 exams in 2 years a great pressure that sometimes takes away from gaining clinical competencies. I think this may help people gain a solid foundation on which to build from Palliative Medicine. I also think working as a junior registrar in year 3 (moving to manage the acute take) would be beneficial as some people feel a bit stagnant at the end of CT2. However, it remains unclear then how other specialties that are not internal medicine will fit into Palliative Medicine. I've always been proud of the acceptance of other disciplines other than medicine into Palliative Medicine - I think it makes us a more robust specialty and helps us maintain our links with the community and alternative pain management options. I think it would have a negative impact on Palliative Medicine if we lost these additional paths into it.	6/9/2015 10:47 PM
2	I think it is important for doctors training in palliative medicine to have a broad-based general medical experience prior to specialising to inform their specialist practice. I think this would potentially give the opportunity for more junior registrar posts (years 1-3) in palliative medicine, giving more medical trainees experience in palliative care as many of the current 'SHO' posts are now filled by GP trainees rather than medical trainees.	6/9/2015 6:19 PM
3	Don't think this will have any major impact	6/9/2015 4:10 PM
4	While it is good to have a broad exposure to internal medicine specialities, there may be implications for those training outside of acute medicine.	6/9/2015 11:19 AM
5	Having longer periods in each area will allow more time to become confident in the area you are working. Ensuring that all pall med sprs that enter via a core medical route have worked in Gerontology would be helpful.	6/8/2015 5:54 PM
6	These changes seem to force trainees to make decisions about their long term career too early. MMC already started this and Shape pushes it further this direction. When I graduated (2000) I was able to try out several specialities and experience several different hospitals. I would not now be a consultant let alone one in Palliative medicine if I had been forced through this narrow minded training. I feel shortening training will give us a generation of doctors who are stuck in the wrong speciality. Would also need to make significant changes to undergraduate training to allow for safe doctors if allow full registration on graduation.	6/8/2015 5:47 PM
7	But this will depend on availability of palliative medicine posts at this level.	6/8/2015 4:06 PM

8	Potential pros: Additional year (3rd year of internal medicine) spent as medical registrar will improve confidence in general medicine competencies and leadership on general medical problems. Once working in specialist palliative medicine I think this will improve ability to judge which patients would benefit from acute hospital treatment. It will also enhance respect afforded to palliative care trainees (when discussing cases with medical reg on call) as they will have managed acute medical take which, I think is still seen as the pinnacle of general medical competence in the acute hospital. Potential cons: My main concern is the changed perception of palliative medicine as a specialty. There may be some who would make excellent palliative care physicians who are put off palliative medicine as a specialty by the increasing emphasis on acute medical take/training during this time or even through the specialty training. Palliative medicine is already struggling in our specialist units with decisions over how interventional or "medical" to be in the treatment of patients approaching the end of life e.g. IV therapies & TPN, transfusions etc. with the concern (especially of the nursing teams I have worked with) of many being the cost this has on holistic time spent "caring" for patients. The more that palliative medicine trainees are schooled in acute medicine potentially the more likely they are either likely to think how they might manage this patient in hospital (as opposed to in a hospice) or the more likely that those minded to acute medicine will be attracted to the specialty. This may have subtle but seismic effects on the specialist palliative medical provision across all settings. I have often heard it said what a very beneficial thing it is that so many palliative care specialists have traditionally come from a general practice background with all the common sense and balanced perspective this can afford. I agree with comments made in at the recent APM conference that if anything our specialty suffers from lack of community experience rather than further acute medicine training.	6/8/2015 11:10 AM
9	Completion of MRCP part 2 prior to entry for specialist palliative medicine training should be an essential requirement.	6/5/2015 4:51 PM
10	MRCP is not the only way into palliative medicine so shouldn't affect entry to the speciality.	6/4/2015 9:05 PM
11	Extending the length and breadth of internal medicine training to 3 years will give palliative medicine doctors more confidence in managing acute medical problems in hospice & community patients, and more experience in working alongside acute medical teams in hospital support teams.	6/4/2015 12:01 PM
12	A broad basic training will be useful in all specialties and also foster understanding between people working in different care environments to the challenges they face.	6/3/2015 5:16 PM
13	Core medical training to include GIM is essential into the future	6/3/2015 3:35 PM
14	The changes suggested for pre MRCP part 2 do not seem so radically different from present circumstances. Overall I favour as much general medical experience as possible before embarking on higher specialist training.	6/3/2015 1:45 AM
15	There is an advantage to spending one more year gaining experience prior to specialty training. If there are more opportunities for medical rotations to include palliative medicine posts then this will be helpful - but I am not at all certain that this would be the case.	6/2/2015 9:26 AM
16	I think some additional experience at ST1-3 level may be helpful for palliative medicine trainees, but equally this may discourage some who would otherwise have sought out palliative medicine as a specialty	6/1/2015 8:32 PM
17	At the moment I think people who know they want to pursue palliative medicine choose CMT because it is the quickest route to ST3 in palliative medicine. I think if the CMT equivalent were 3 years then it becomes more attractive to pursue palliative medicine via GP training.	5/31/2015 8:34 PM
18	Great grounding (comparably increase experience prior to commencing palliative care training as ST3).	5/30/2015 8:42 PM
19	Good to have more general medicine training before specialisation.	5/29/2015 1:32 PM
20	Use of simulation and gradual increase of responsibilities with competencies good. Not sure where space for community experience will be. Will overly emphasise acute medicine skills, which are unlikely to be used later , risking losing some great doctors for palliative medicine who might be put off the training because they are slower decision makers ,relatively risk adverse , perfectionist individuals with interest in patients as complex people rather than procedural competencies as their motivational driving force. More palliative care will be community based and where will GP trained individuals find a way in?	5/29/2015 8:02 AM
21	It is important for trainees to have a breadth of experience in medicine. Palliative medicine is heavily clinical and hence exposure to acute and General medicine is immensely important	5/28/2015 9:08 PM
22	I do not see how pre MRCP training will significantly impact on training in Pall Medicine as many come through medical rotations anyway. Acute take/medical input at this stage is useful.	5/28/2015 8:06 PM
23	This sounds like a more cohesive approach to building up core medical skills, and a focus on training people up to confidence. I would like to ensure that the demands of running this system do not adversely affect junior doctors in terms of the need to move site of work more than once a year (and therefore moving house or long commutes).	5/28/2015 7:03 PM

24	This focus is all on MRCP Physician route into palliative medicine. It is really important that the GP route into Palliative medicine is maintained. Having only an internal medicine approach to palliative medicine will be detrimental to care delivery	5/28/2015 4:41 PM
25	Rotating through geriatrics, acute take and acute medicine will be of benefit to a Palliative Medicine physician.	5/28/2015 4:41 PM
26	I think a year as a "med reg" in general internal medicine before going into palliative medicine would be an asset for our trainees in terms of confidence and competance in general medicine.	5/28/2015 3:42 PM
27	difficult to say - it looks like it would have positives in increasing the knowledge in general medicine but ? restrict entry from other specialities	5/28/2015 3:40 PM
28	I think the current system of MRCP prior to going into specialty training equips palliative medicine trainees with adequate medical knowledge to manage medical conditions in the palliative care setting. I cannot see how the suggested alteration in training structure benefits the specialty of Palliative Medicine - I think it would only benefit the acute hospital filling gaps in their on-call rotas.	5/28/2015 3:38 PM
29	If increased length of pre mrcp or mrcp training allows more drs to undertake either gpst or cmt palliative medicine attachments eg cmt in uk = approx 30 posts with currently 240 registrars this mis match needs addressing	5/28/2015 3:23 PM
30	personal experience of CMT showed that there is extremely limited choice when it comes to allocations of junior doctor jobs. it is unclear in these "junior registar" posts how much exposure they will get to different specialties ie gastro, cardio, resp and aimed at learning how to manage heart failure, decompensated CLD, COPD etc or whether the bulk of jobs will be used for service provision and on AMAUs managing DVT, PEs, MIs, acute headaches etc which arguably is less useful for palliative care physicians.	5/28/2015 2:30 PM
31	pre-supposes that all doctors entering Palliative Training will be coming through the MRCP route	5/28/2015 2:25 PM
32	This depends on how we are able to influence an updated CMT curriculum	5/27/2015 5:56 PM
33	Overall increasing SHO years to 3 would allow more training before immediate entry in to Palliative Care - especially if this could be broadened to include research, managment or specialist (ie ITU, anesthetics time) time,	5/27/2015 3:50 PM
34	Broader general medicine experience in the form of undertaking 3 years post foundation training in general internal medicine specialties is likely to benefit trainees, the specialty and relationships between specialties	5/26/2015 11:15 AM
35	Candidates need to pass MRCP before applying for Pall Med training. Otherwise, they spend much time and effort preparing for the exam, not in the specialty training.	5/21/2015 2:32 PM
36	Three years of acute/internal medicine + ability to handle general medical take pre-speciality training sounds like a good platform. Need to keep the door open to MRCGP candidates as they bring valualbe balance to a specialty which is not at all a typical medical speciality. In general - the more experience pre- specialist palliative medicine training, the better.	5/19/2015 2:02 PM
37	I do not feel full registration just out of medical school is at all desirable. I work with foundation year doctors and they are not ready for it!	5/18/2015 7:05 PM

Q8 Shape of Training changes suggested for specialty training overall will have a positive impact on the training of doctors in Palliative Medicine.

Answered: 194 Skipped: 55



	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**3.61%** 7	**14.43%** 28	**24.74%** 48	**39.69%** 77	**17.53%** 34	194	3.53

#	Additional Comments	Date
1	Especially if Dual accreditation is part of it.	6/9/2015 9:57 PM
2	It is difficult to say overall as some of the changes will be beneficial but others are likely to have a negative impact.	6/9/2015 6:19 PM
3	Unfortunately can't see that more competencies to achieve in the same time can be achieved without detriment to specialty training. Agree that may be positive having more internal medicine knowledge, but I think this will be to detriment of hospice knowledge and quality end of life care there. I think one of the major learning outcomes from hospice care is when NOT to intervene, and this is beaten out of trainees in acute hospitals- can only see this getting worse.	6/9/2015 4:10 PM
4	As above; plus, consideration needs to be given to how exposure to palliative medicine happens in a timely way: there are already a paucity of appropriate hospice jobs for those planning a career in the specialty. There need to be ways to manage those doctors who don't see a hospice placement as valuable. Also, the service requirements of hospices need to be considered, so that trainees attached to a hospice are protected from extraneous demands of the acute trusts. We also need to be mindful of the impact of the EWTD.	6/9/2015 11:19 AM
5	there should be more community focus in an essentially community job	6/9/2015 8:54 AM
6	Focus on internal medicine looks negative but credentialling may open the speciality to other specialists and allow more flexibility in careers.	6/8/2015 6:29 PM
7	Personally having more general medicine training would be something I personally would be interested in but I would be concerned about the potential to then lose experience in community which is where the focus of the five year forward plan is based. I feel that this is something that is not being addressed in the shape of training review.	6/8/2015 5:54 PM

8	I feel there may be some benefits to Shape in terms of more generic training for all. This would help our trainees better manage acute medical problems. I feel that general medicine has been lost over the last 20 years. However I feel that the remit of shape is too narrow for palliative medicine. Our trainees do not only need to understand the hospital based general medicine but need to have a good grasp of rehabilitation and care of the elderly medicine, other non medical specialities and particularly of general practice. As a speciality we have thrived on having a diverse consultant base with a variety of backgrounds - Medicine/GP/Anaesthetics I am concerned that Shape will adversely affect Palliative Medicine by removing this route to palliative medicine	6/8/2015 5:47 PM
9	Would need to see how this will unfold. I think the "extra" 3rd year post foundation should enhance trainees' knowledge and skills in internal medicine and this should provide a very sound basis for embarking on "Specialty" training. I am not sure that it would be necessary to continue the Internal Medicine training in years ST4 onwards as I think that would detract from the focus of the main specialty chosen by the trainee.	6/8/2015 4:06 PM
10	As we see patients with a broader range of underlying conditions and comorbidities our trainees need good general medical skills	6/8/2015 10:23 AM
11	I think it is difficult to be certain at this point what the impact will be. I think more experience in acute/general medicine will be useful but a reduction in the specialty experience will be detrimental. I think there is limited scope for removing anything from the existing curriculum for post CCT credentialling.	6/8/2015 12:13 AM
12	It depends on the implementation; training depends more on the attitudes of and relationship between trainee and trainer than on the curriculum or organisation of training programme	6/5/2015 9:46 AM
13	Unclear as details still so unclear. I think having a good basis of internal medicine is important but I'm not sure that a palliative care consultant needs to be able to run a medical take.	6/5/2015 9:14 AM
14	I think it would have a negative impact on the speciality. Can't see how the specialty training could be shortened to combine it with internal medicine.	6/4/2015 9:05 PM
15	I am concerned that doctors will be less experienced in core aspects of palliative medicine if they have to undertake dual training.	6/4/2015 5:05 PM
16	This is a risk in both directions both positive and negative depending on the training programme	6/4/2015 2:12 PM
17	If specialty training can be protected the benefit of increased general medical skills could be beneficial	6/4/2015 12:25 PM
18	Taking valuable training time away for specilaity training is harmful. Pre specilaity training we already have acute medical experience and do need not futher to enhance own training	6/4/2015 12:22 PM
19	Both pros and cons	6/4/2015 11:58 AM
20	I think there are some benefits of doing some additional GIM but not if this is at the detriment of some areas of the palliative medicine curriculum. I spent 12 months prior to higher speciality training doing med reg locums and teaching, and I found both experiences invaluable when I entered palliative medicine, and I think they have positively impacted on my ability to stay calm in a crisis and manage evolving situations.	6/3/2015 5:16 PM
21	There would be some specialities in which this was not necessary, but the default should be that all specialist should have a working knowledge of GIM	6/3/2015 3:35 PM
22	Positive impact of continued training in internal medicine. However, concerned about the trade off in terms of reduced time spent in the speciality.	6/3/2015 11:19 AM
23	I agree with the concern identified in AC's report that the priority to create a generalist CST-holder ought not to come at the cost of reduced length of palliative medicine specialist training	6/3/2015 1:45 AM
24	I think the suggested changes reduce the training time available within palliative medicine, and move the focus into hospital and away from home-based care	6/2/2015 5:39 PM
25	This will be detrimental to palliative medicine training - the dovetailing of acute medical take with palliative medicine will lead to major issues with staffing levels ie requiring teams and units to manage an already stretched service with less medical time. Overall time in pall med will diminish for trainees and the emphasis of training will be diluted. This is a politically and financially motivated scheme that is not related to providing better training and experience to junior doctors.This also has implications for trainees coming via general practice. I feel it would be wrong to exclude GP trainees from transferring to pall med - they bring attributes and knowledge that are beneficial to the specialty as a whole. Specialist Palliative Care Services in hospital often have a nurse-led model which is effective, well established and allows for 7 day working with medical on-call support. Hospital palliative care in-patient beds are also unusual and, unless there is a major expansion in medical posts (which we do not have and will not receive the funding for) medical-led services with 7 day working are not going to be possible or desirable.	6/2/2015 9:26 AM

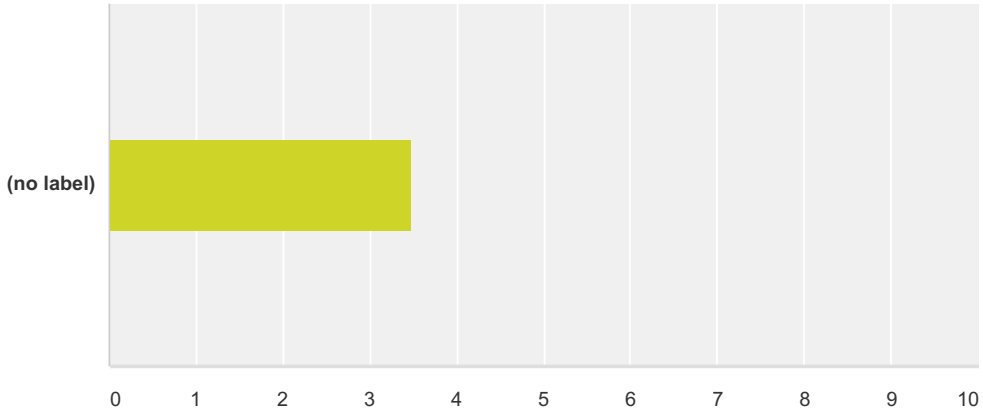
26	less time to gain palliative care competencies. Palliative care will become just another aspect of the general medicine approach, rather than a qualitatively different holistic approach	6/1/2015 8:32 PM
27	acute medical training and specialist palliative training cannot both be done along side each other over the same period of time. the ethos of palliative medicine requires specific specialist training that cannot be shoe horned into a programme along side acute/general medical training. a background of acute medical training prior to entry into specialist palliative medicine is essential, but the two should not be merged into one training job.	6/1/2015 5:02 PM
28	Requirement to dual accredit in internal medicine with palliative medicine seems to be driven purely by service provision and not by training needs for our speciality	5/31/2015 8:34 PM
29	An acute take is a different skill mix to palliative care demands.	5/30/2015 8:42 PM
30	Will reduce the time spent in Palliative Medicine training (as some of the time will be spent doing internal medicine, which is largely irrelevant). Time in training is already insufficient for doctors who have been through the Foundation Programme and CMT, and who have no experience of Palliative Medicine before entering ST3.	5/29/2015 7:06 PM
31	Risk losing specialist skills and approach - we are a specialty that has a strong community focus and we need to be building links with primary care as much as secondary care.	5/29/2015 5:46 PM
32	I agree that there are definitely positive aspects in palliative medicine doctors having a good internal medicine background however I would be concerned that this might be at the expense of their palliative medicine competencies. That being said I think there is a lot of repetition and redundant aspects of the palliative specialist training curriculum.	5/29/2015 3:43 PM
33	Partaking in the acute take is unlikely to provide addityional competencies for palliaitve medicine trainign as a whole	5/29/2015 1:32 PM
34	Acute medical take not necessary for palliative medicine training and will put some people off, especially at a time when there are likely to be extra incentives to draw doctors into general practice training to address shortages there. Team management skills , and judgement of big picture are usually much more important even for hospital palliative care than acute care competencies ... These are the additional value a palliative medicine consultant brings to the care of patients in an increasingly fragmented and acute care focused hospital setting. These skills take time to acquire and will not be helped by shorter training with tacked on credential bits.	5/29/2015 8:02 AM
35	Longer in training will increase experience and expertise. The stand alone 6-12mintu posts were much overlooked and allowed greater experience in a specialty of one's choosing. This will allow this and improve competence and confidence, particularly since on calls have reduced in frequency.	5/28/2015 9:08 PM
36	Palliative medicine relies significantly on the training that is provided through hospice placements and working in the community. There is a risk of losing out on this if the period of training is limited to 4 yrs after ST3 if this would include Internal/acute medicine placements. This structure is less likely to provide sufficient number of professionals capable of covering predominantly hospice/community where Palliative care specialists are highly in need. There is also the difficulty of ensuring sufficient on-call cover for Specialist Palliative Units as the number of seats for STs is finite and unlikely to a compensate for those who get pulled into doing Acute medicine. Palliative trainees need specialty based teaching opportunities which risk being diluted when doing Internal/acute medicine.	5/28/2015 8:06 PM
37	i agree for those coming from a general medicine background - however - if this is the only route by which a trainee can come into pall med then i think that this will be negative	5/28/2015 7:14 PM
38	Palliative medicine specialists need generic skills and a background in general medicine - which will be provided by the 3 years of core training in general medicine. I have no qualms about trainees being involved in unselected take for a fixed period of time eg. year or so (perhaps incorporated with experience in hospital palliative medicine) - but I do not think they should do so for the whole 4 years as this significantly detracts from time and attention being given to developing skills in the hospice and community setting. I think we need to ensure equal weighting and time are given to developing community skills. There may be a role for trainees choosing to shorten or lengthen their time in these areas if they already know they wish to pursue a future career with more hospital/community focus, but without some experience of both we lose part of our ability to think holistically &globally about patient management, about each patient's overall journey, and that is part of what makes our specialty unique.	5/28/2015 7:03 PM
39	very difficult to comment, as on one hand, having a more general background can be nothing but helpful, but at what detriment if this detracts from our palliative care experience	5/28/2015 5:23 PM
40	The risk is that we will create a speciality of Palliative Medicine/Internal medicine that will be focussed on a investigations and procedures but will lack the generalist approach that is so important in managing risk in patients approaching the end of life	5/28/2015 4:41 PM

41	They will be split between palliative medicine and acute medicine which may be in a completely different setting making it difficult to supervise/support and run an on-call rota. It will reduce the time to gain exposure to palliative care.	5/28/2015 4:41 PM
42	I struggle to see how we could deliver the breadth and depth of training that we currently provide with the new model. Consultants would inevitably have had less experience in palliative medicine on appointment.	5/28/2015 3:42 PM
43	major questions exist over amount of time in speciality training that will be in acute medicine so taking time away from speciality training and also over on-call arrangements	5/28/2015 3:40 PM
44	Increase exposure to general/acute /elderly care medicine will enhance palliative care skills especially those with long term conditions bot,h in hospital and community and dealing with medical emergencies in a hospice setting which in some instances can prevent inappropriate medical admissions	5/28/2015 3:23 PM
45	There apears to be no room for experience in general practice or community specialties. With the greater emphasis for shorter stays in hospital, I beleive that ALL those doing an internal medicine specialty should have at least some experience in general practice. I have noted in several consultants that there is a lack of insight into both the problems and abilities of promary care to aid patients. I have been disappointed to see in some the persistence of the outdated notion that GP is either inferior or easier than hospital based medicine. Experience in elderly care, dementia and chronic disorders (e.g. rheumatolgy) is highly desirable.	5/28/2015 3:04 PM
46	feel that taking time away from specialty palliative care training to give to internal medicine will not have a positive impact on training. more useful to have time in community care.	5/28/2015 2:30 PM
47	Changes are likely to erode the time available for palliative medicine trainng in different settings and this will have a negative impact on KSAs oftraines	5/28/2015 2:25 PM
48	- I would worry about the impact on specialty specific skills and training. If committment to the acute take is needed post-ST4, why can't the specialty training period be extended (e.g. to 5 or 6 years in total, allowing 4 years of specialist training to remain within that period).	5/28/2015 2:17 PM
49	I think that the delivery of palliative care over the next 5-10 years will change and we will need a consultant workforce that is comfortable in managing acute medical issues in a range of settings	5/27/2015 5:56 PM
50	It seems very hospital/physician focussed at a time when the general direction of care is moving to community/integrated care.	5/27/2015 5:44 PM
51	pros and cons - more trainees may get exposure to palliative care which should have a positive effect, however it sounds like specialist training will be diluted and that on call may be affected which is a great learning experience	5/27/2015 4:16 PM
52	Overall the feel of the report is that all physicians should be trained for 7 years in general internal medicine - achieving a CST - and then can specialises. Meaning if there are no gaps aged 32 before starting palliative care trianing. Although bare in mind 'gaps' to do masters, MD, PhD, time abroad etc are becoming the normal requirement to get on a training job/consultant role, are probably positives and become more difficult the older and more commitments one builds up - therefore trainees are likely to be older than 32 . So at the age of 32+ one is going to be presented with a choice of a an internal medicine consultant job which one has been striving to acheive or continuing as a trainee of sorts. The consequences of this choice I fear would be a reduction in the number and quality of people who apply to do palliative care training. As many will decide they have done enough time in formal training with all the burderns contained in modern training. While the best candidates will be picked up for internal medicine posts that they have be trained for.	5/27/2015 3:50 PM
53	Beneficial to add to skills in general internal medicine as long as this is not at the expense of specialist palliative medicine experience	5/27/2015 3:04 PM
54	I think it would be useful for the specialty to have more internal medicine expertise but I worry it will detract from the palliative medicine aspect of the job. It is bound to become the dominant feature of the training & more subtle skills such as communication skills might be lost	5/26/2015 5:16 PM
55	My main concern would be lack of opportunity to develop the many skills necessary to providing specialist palliative medicine. In particular, there would be fewer opportunities to undertake out-of-hours sessions in palliative medicine. We currently work 1 in 4 weekends and a week night 6 in 9 weeks. These are a vital learning experience	5/26/2015 11:15 AM
56	Palliative Medicine requires well developed communication skills which would not be developed or encouraged in the same way in an acute take setting. The idea of a general physician with a special interest in palliative medicine would be a regressive step and undermine the work done to have Palliative Medicine recognised as a speciality in its own right.	5/26/2015 9:18 AM
57	Less time in training will produce less skilled physicians	5/23/2015 10:14 PM

58	Possibly, with increased knowledge in acute medicine, able to give more in-depth advice to pt.	5/21/2015 2:32 PM
59	As the details aren't yet clear, it is difficult to make a judgment about this.	5/20/2015 9:59 AM
60	Very difficult to assess at this stage.	5/19/2015 3:51 PM
61	Although dual accreditation should be an option for palliative medicine it should not be obligatory and the majority of posts should not be dual-accredited. Palliative Medicine has a neccesarily different approach and culture to internal/acute medicine and needs to maintain its distincitiveness to deliberately challenge the over-medicalization of advanced disease. Palliative Medicine is very different to other medical specialities - it's core area is not defined by system or disease group but by approach and very generalist expertise. There is a real danger that these changes could irreparably diminish the distinctiveness and hence potency of the speciality.	5/19/2015 2:02 PM
62	There appears to be a strong focus on acute medicine as a means to meet the needs of acute medical take and much less emphasis on community focussed, big picture medicine. It is at least as likely that, in 30 years, we will have recognized that most of medical resource is used in the last year of life and developed more effective mechanisms for supporting patients and families using a realistic and community based approach.	5/19/2015 10:15 AM
63	we uniquely sit across hospital and community, there is too much focus on hospital management for our trainees	5/19/2015 8:46 AM
64	Given the current plans, there will be a reduction in Specialist Training overall to try and cover the same key components of training. In addition, the internal medicine rotations will need to have palliative care posts within them to allow individuals to gain experience in this area prior to deciding on specialist training in this area.	5/19/2015 12:35 AM
65	I believe this extra experience could be useful especially as general medical experience in foundation years less than old PRHO/1st year SHO experience (as now can do academic posts, radiology etc etc) Also with EWTD general medical training reduced. Helpful as acute hospital patients have palliative care needs and also many consultants will work in HPCT where knowledge of general medicine required. However I believe palliative medicine training needs to remain as 4 years and any additional internal medicine training needs to be extra to this, not coincide with it or there will be a detrimental effect on pall med skills obtained	5/18/2015 6:52 PM

Q9 A 12 month placement in General Internal Medicine, as part of the four year specialty training in Palliative Medicine, will allow trainees to meet specialty curriculum competencies. (Note: it is still not clear how this will happen. It could be a 12 month placement or a more integrated approach)

Answered: 190 Skipped: 59



	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**3.68%** 7	**20.00%** 38	**17.89%** 34	**40.53%** 77	**17.89%** 34	190	3.49

#	Additional Comments	Date
1	I think our curriculum looks full as it is, and it would be difficult to squeeze it into 3 years, regardless of how the 12 month placement fits in.	6/9/2015 10:47 PM
2	By reducing the length of specialty training I believe it would be difficult to meet the specialty curriculum requirements fully.	6/9/2015 8:12 PM
3	The placement will allow some of the specialty competencies to be met but as palliative medicine is focused more on community practice than other specialties having more hospital experience is unlikely to be as beneficial.	6/9/2015 6:19 PM
4	Broadly- lots of palliative patients on the acute take, and procedural competencies might be easier to obtain in acute setting.	6/9/2015 4:10 PM
5	An integrated approach would be better	6/9/2015 2:09 PM
6	This is an important issue: there needs to be a recognition that doctors working in palliative medicine will need enhanced skills and knowledge in caring for patients with other long term condtions than cancer.	6/9/2015 11:19 AM
7	GIM training should be additional or maybe partly additional and not at the expense of specialist palliative medicine training.	6/9/2015 10:02 AM
8	Potentially. Will depend on whether have Pall Med trainer/ mentor during GIM yr to assist development PM related skills. Also depend on level of Pall Med exposure/ experience prior to ST- although it's prob less likely anyone will have this. I had 3-4 yrs as PM Reg experience pre-speciality training and so less ground to be covered during ST.	6/8/2015 10:21 PM
9	This would not benefit hospice or community work.	6/8/2015 6:29 PM

10	I don't think enough is known to comment but I do think that there are generic competencies which could be developed in GIM. Also the cohort of patients usually admitted under GIM have a huge burden of symptoms which would allow us to develop a larger focus than remaining focussed mostly on cancer patients. I would hope that we might support colleagues to consider more advanced care planning. If rotas are better filled with trainees then they might make the work load significantly better and allow these posts to be more than just a service provision.	6/8/2015 5:54 PM
11	It would not be possible to complete our speciality curriculum in 3 years as very little overlap with acute medicine. Acute medicine would need to be in addition to the 4 years speciality training.	6/8/2015 5:47 PM
12	I would need to understand what this 12 month placement in Internal Medicine would add to what has already potentially been achieved in the 3 CMT years.	6/8/2015 4:06 PM
13	I think it actually fine to add a year to core medical training which would mean a year of acting as medical registrar with acute medical take responsibilities but, speaking as a an ST5 approaching my PYA, I really think that 4 years dedicated palliative specialty training is needed to achieve the important competencies in palliative medicine. A year or even integrated approach with general internal medicine I do not feel would enhance palliative medicine training or the care we are able to offer patients. We have plenty of opportunities to work collaboratively with our acute medical colleagues in the hospital during the 4 years of training. I think the 2 need to be separated. Introducing a year of general internal medicine into the 4 years of specialty training in palliative medicine I think would enhance service delivery in the short term but it would be at the expense of palliative training over the longer term. Palliative medicine also differs considerably from many other medical specialties in that we need to gain competencies in management, leadership and governance in a very different setting that that which we have previously been trained i.e. the hospice (both NHS and independent). We also have a great need for skills in community medicine which I think would only be ill-served by more involvement in the acute medical take.	6/8/2015 11:10 AM
14	I think this would be a very positive development	6/8/2015 10:23 AM
15	I do not think that time n the specialty should be reduced	6/8/2015 12:13 AM
16	In addition to meeting current essential curriculum requirements and completing specialty exam, a significant component of specialty training in palliative medicine involves an essential iterative process, gathering knowledge and experience in the speciality. There is no scope to therefore also include GIM within a 4 year training scheme.	6/5/2015 4:51 PM
17	It depends on how the placement is organised and supervised. If - for example - the trainee was working on an AMU alongside pall med and AMU consultants, this could be a very useful part of training and there are many generic competencies which could be developed	6/5/2015 9:46 AM
18	A more integrated approach would be better to promote the application of different skills and knowledge across bth specialities	6/5/2015 9:14 AM
19	3 years wouldn't be long enough to get palliative medicine speciality training. A shorter placement in medical specialties may be of some benefit but not to result in a consultant in internal medicine .	6/4/2015 9:05 PM
20	I welcome additional gen med experience providing it doesn't dilute time spent in specialty training.	6/4/2015 5:05 PM
21	There is signifcant risk that this will compromise speciality training if the speciality element is shortened	6/4/2015 2:12 PM
22	Many competencies are common to GiM as well as palliative medicine	6/4/2015 12:25 PM
23	it would prevent us gaining competences in palliative medicine	6/4/2015 12:22 PM
24	Will very much depend on the nature of the GIM post	6/4/2015 12:01 PM
25	Think it will really depend on what the placement offers and the supervision received	6/4/2015 11:58 AM
26	Should be in addition. It won't be helpful to reduce training.	6/3/2015 9:17 PM
27	Potentially if this were a separate block of time, so that the time spent a speciality was not interrupted by acute medicine on calls. The converse of this would be where you put that time- if its at the start of specialty training, the chances are you deskill at the end, and if it is mid way through, you loose confidence in your specialty specific skills when you return. In Yorkshire Pall Med registrar training, 8 months is taken out of palliative medicine to spend time time in oncology and chronic pain, and as a trainee returning to palliative medicine after this felt a little strange and my knowledge and skills felt quite rusty for the first month and my clinical confidence was not as good.	6/3/2015 5:16 PM

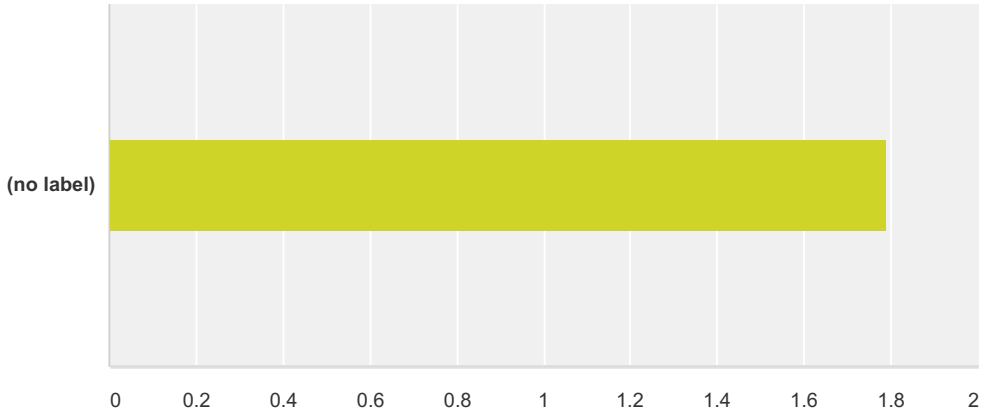
28	I think this is not feasible without sacrificing too much. We are already limiting community training and experience for example.	6/3/2015 3:35 PM
29	In terms of achieving DOPs.	6/3/2015 11:19 AM
30	See my comment for 8	6/3/2015 1:45 AM
31	It depends on what competencies we are asking for. If it is to lead cardiac arrests and trauma calls then yes. We don't have much call for this locally! The first 4 years (ie Foundation/CMT/GP VTS) are much more important in developing the key practical skills needed in pall med.	6/2/2015 9:26 AM
32	It will address medical competencies, but will decrease the amount of time which the trainees spend in specialist palliative care	6/1/2015 11:07 PM
33	I don't see how competencies could be gained in 3 years, nor how 12 months of general medicine would qualify someone to oversee an acute medical take. It strikes me that consultants qualifying from this programme would be underqualified for both areas	6/1/2015 8:32 PM
34	I think that it would not allow the depth and/or range of experience that trainees get currently in different palliative care settings - hospice/community/hospital. Is General Internal Medicine the most relevant other specialty for trainees to spend their time in? As more people want to be supported at home, should the focus not be more on primary/community care?	6/1/2015 6:04 PM
35	time away from specialist palliative medicine training (currently at 4 years post royal college exams MRCP/MRCGP) will only detract from the quality and competency of consultants in palliative medicine. To take a year out for GIM would not be a good move for the specialty - unless the training in palliative medicine is extended beyond 4 years.	6/1/2015 5:02 PM
36	Really not sure, it may help them keep up to date with GIM but may have a negative impact on specialty training or be difficult to combine the two.	5/31/2015 9:54 PM
37	It is already a reasonably short length of training. The focus should be on gathering specialist skills and knowledge on an existing general medicine knowledge base.	5/31/2015 9:26 PM
38	Worried it would not allow enough time for trainee to meet specialty competencies	5/31/2015 4:05 PM
39	Although will allow 'cross-infection' - a palliative care approach to benefit patients and to role model to rest of team	5/31/2015 4:05 PM
40	Primary care placement would be of greater value.	5/30/2015 8:42 PM
41	It will be largely irrelevant, considering the state of internal medicine in acute hospitals currently. There will not be time to role model a pallaitve care approach to others as suggested in the summary document - internal medicine currently is simply fire fighting.	5/29/2015 7:06 PM
42	Whilst there may be benefits in accruing knowledge in GIM, the philosophy and approach to patient management is not aligned.	5/29/2015 5:46 PM
43	Impossible to know without more clarity	5/29/2015 3:44 PM
44	There may be opportunity to gain competencies but I fear the post will become daily acute take as service provision whilst other specialties do procedual comptencies.	5/29/2015 1:32 PM
45	Most doctors will already have spent 3 years in GIM. This is enough to gain the appropriate skills for palliative medicine. To spend one of the 4 years in further training in this area will result in reduced time doing specialty training, which is already short. It is already challenging to get sufficient experience in all elements (hospice, hospital and community) - I think this will be impossible if this needs to be achieved in only 3 years.	5/29/2015 9:49 AM
46	If it was high quality training designed to cover key areas .	5/29/2015 8:02 AM
47	Importance of integrating both specialities is important for 7 day working and increasing need for generalists with specialist knowledge	5/28/2015 9:08 PM
48	Could do with being a bit longer really?	5/28/2015 8:12 PM

49	As above + Work based assessments toward achieving training competencies within the specialty are best carried out with Palliative medicine consultants as Supervisors - there will be a significant reduction in opportunities to liaise/work with peers and Specialty consultants if the 12mths of GIM come within the 4yr period. In addition, I do not think it would be fair on trainees or patient care to integrate GIM placements within Specialist Pall care rotation as the mind set of Palliative management is quite different to that of an acute take - if needs must, the GIM placement should be completed prior to entering specialty training in Pall Med.	5/28/2015 8:06 PM
50	do not feel specialty training should be shortened and am not sure that this proposal allows all competencies to be met	5/28/2015 7:14 PM
51	Will allow the trainee to develop some specialty curriculum competencies, but only a few. Exposure to palliative care trainees may help other trainees to develop their competencies! I think a whole year away from specialty training would be detrimental unless trainees spent enough time (?75% of their work time) within palliative medicine teams rather than in general medical teams.	5/28/2015 7:03 PM
52	The issue for general internal medical competency is not the competency that one has at the point of achieving CCT, but how this is maintained beyond CCT for pall med specialists who are not frequently/regularly exposed to acute medicine eg hospice based consultants. I am out of date on general internal medicine, despite going to update courses and reading BMJ articles on Mx of medical emergencies.	5/28/2015 6:24 PM
53	i think this should be additional year making training 5years total	5/28/2015 5:23 PM
54	It may well do so, but it will not improve the quality of the training for Doctors intending to follow a career in palliative medicine	5/28/2015 4:41 PM
55	There tends to be elements of palliative medicine in most medical specialities, but may not allow development of more specialist skills.	5/28/2015 4:41 PM
56	Not saying that doing it all in 4 years is desirable, but trainees have to manage acutely unwell patients and make appropriate clinical decisions in all settings	5/28/2015 3:45 PM
57	it would be good for general medical knowledge but I do not think would help meet many of the speciality curriculum competencies	5/28/2015 3:40 PM
58	It makes sense for other specialties, such as gastroenterology, to have integrated internal medicine training with a 12 month placement as it will allow them to meet their specialty curriculum competencies during that placement. It will be much more difficult for palliative medicine trainees to meet their competencies in this setting - developing skills in the holistic assessment and management of distressed and dying patients in the setting of an acute take will be impossible.	5/28/2015 3:38 PM
59	Not possible as part of the 4 years	5/28/2015 3:01 PM
60	As above	5/28/2015 2:25 PM
61	It is definitely possible that some of the specialty-specific competencies could be achieved during the acute take (e.g. Managing hypercalcaemia), but it may make it difficult to fit in some of the more specialist skills (e.g. setting up syringe drivers/spinal lines etc).	5/28/2015 2:17 PM
62	Would allow additional competencies to be gained in relevent areas e.g. oncology, heart failure, respiratory, neurology. If flexible could allow for the development of a specialist interest e.g. palliative cardiology.	5/28/2015 9:55 AM
63	It depends on how the training is delivered. There is limited overlap between GIM and palliative medicine competencies, though trainees would gain valuable experience in a range of disease processes and acute management, including management of palliative and oncological emergencies. There might be opportunities for better interface with a range of specialties, including psychiatry, that would support attainment of curriculum competencies, though in a different way to how they may currently be achieved	5/27/2015 5:56 PM
64	I think the current 4 years is the bare minimum already (having just recently qualified)	5/27/2015 5:44 PM
65	already do 4 years so feel this would need to be extended if 1 year GIM included	5/27/2015 4:16 PM
66	I feel this question misses the point. It should not be the smaller question of whether it meets the curriculum but the bigger question of whether that experince helps future palliative care consultants. If it is a general internal medical rotation this then I do not see how this prepares one for being a palliative medicine consultant as that role is currently constituted.	5/27/2015 3:50 PM
67	Again, useful as long as time working in palliative medicine setting is not diminished	5/27/2015 3:04 PM

68	To a certain degree - I think a certain level of GIM training will allow trainees to meet certain specific specialty competencies with a greater depth and understanding that I think will better equip them for the future patients they may encounter within the Palliative Medicine sphere; how we achieve the balance of trainees gaining that training within specific areas of GIM without sacrificing specialty trainee will be key.	5/26/2015 10:12 PM
69	Only if they add an extra year to the speciality training, i.e make it a total of 5 years	5/26/2015 8:24 PM
70	I don't think this will be enough - they might forget again if the placement is at the beginning & it would need to be integrated but how that is done and palliative medicine experience maintained is questionable	5/26/2015 5:16 PM
71	It is possible that it will, since trainees will be exposed to many patients in hospital with specialist palliative care needs as well as general medical problems, that appear on the current curriculum. It is not clear that a clinical supervisor during that placement, not trained in palliative medicine, would be able to recognise and encouragement development of the skills necessary to progress towards fulfilling the palliative medicine curriculum. It is also likely that service provision needs will limit the time allocated for trainees to attend to relevant areas of their curriculum - being required for clincs / acute takes etc instead	5/26/2015 11:15 AM
72	While experience in General Internal Medicine would be useful, arguably placements in oncology, neurology, haematology, pain management would be also be very useful. Shortening the time spent by trainees in a palliative care setting would undermine the development of their communication skills and the reduce their exposure to the many challenging situations encountered in palliative care such as dealing with highly distressed family members, terminal sedation, complex symptom management. These are gained through experience and the trainees would lack these essential skills to the detriment of their patients and future fellow consultant colleagues.	5/26/2015 9:18 AM
73	It would need to be in addition. To suggest that we could just take 1 year out of the training programme is deeply insulting to our specialty and to our patients. Also having an extra year of GIM will not ultimately benefit someone who is going to do Palliative Medicine. All of that stuff gets out of date so quickly that whatever additional things they learn will probably be out of date by the time they become consultants. They should be spending time in the acute setting as I strongly believe Palliative Medicine is an acute specialty (ours do) but this is in the role of a liaison specialist. We have an essential role to play at the front door of the hospital and in the management of the critically ill and I have concerns about how much of this could be learned whilst clerking in folk with chest pain. Who will do this work when our trainees are propping up the acute medical take?	5/25/2015 11:20 PM
74	12 months in addition to the 4 years may be of benefit but not as one of the four years	5/23/2015 10:14 PM
75	The curriculum would need to change	5/20/2015 1:15 PM
76	Internal medicine training can help to cover some part of a very long curriculum.	5/20/2015 12:38 PM
77	Think they may need a longer time of training	5/20/2015 9:59 AM
78	Three years specialty training does not seem enough time to complete all the competencies required, particularly given the need to complete specified periods of time in community and hospital settings.	5/19/2015 3:51 PM
79	No -trainees will get caught up in the service agenda of General Internal Medicine and will not have time or space to address competencies from a palliative medicine perspective. It will provide increased competance in general internal medicine and clinical decision making but no more.	5/19/2015 2:02 PM
80	I don't think there will be enough time and general internal medicine will only fulfil certain competencies. I don't think there are enough generic competencies for us to get some of these completed within internal medicine. However things like breaking bad news can be done in any setting.	5/18/2015 11:18 PM
81	Unless very carefully selected	5/18/2015 8:23 PM
82	It's going to happen, there aren't enough bodies for the rotas	5/18/2015 7:05 PM
83	Palliative medicine curriculum very different to general internal medicine - I did not work as a medical registrar but did do "extra" SHO time. I do not feel that I learnt anything in medicine that helped palliative medicine training!	5/18/2015 6:52 PM

Q10 If trainees are required to complete placements in General Internal Medicine as part of specialty training then the length of specialty training should be increased.

Answered: 192 Skipped: 57



	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**37.50%** 72	**51.04%** 98	**6.77%** 13	**4.17%** 8	**0.52%** 1	192	1.79

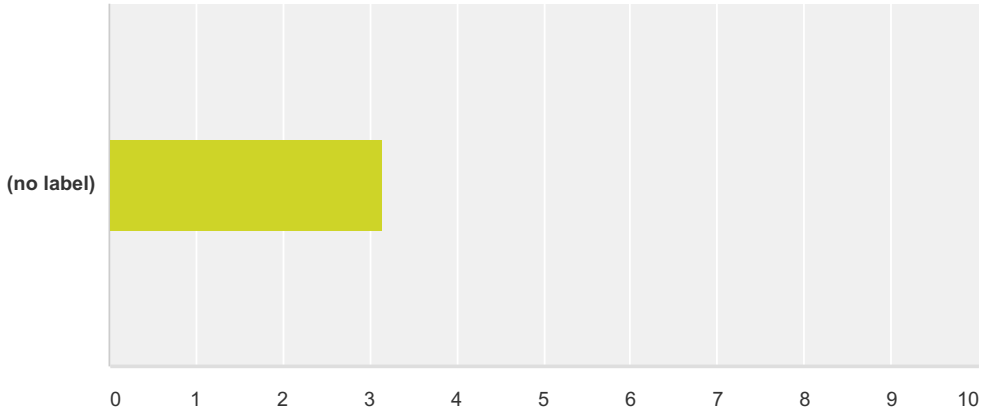
#	Additional Comments	Date
1	I suppose it would be necessary, but I'd rather that Palliative Medicine trainees weren't forced to essentially do dual training.	6/9/2015 10:47 PM
2	I think currently there is a lot to fit into the curriculum in the 4 years already, which would not be achievable in 3 years.	6/9/2015 6:19 PM
3	By at least one year, but perhaps it shouldn't be time based at all, and should be competency based- once you have been signed off in both palliative medicine and internal medicine competencies you can CCT?	6/9/2015 4:10 PM
4	it will depend on whether it is possible for palliative medicine trainees to target the GIM training they do to those patients with more advanced disease in acute areas e.g. cardiac, respiratory, renal where the knowledge and skills learned would overlap with those needed for SPC	6/9/2015 2:09 PM
5	There is such a variety of skills to be learned in specialist palliative medicine, that if a whole year is devoted to GIM, the training programme would have to be extended. However, since so many palliative medicine trainees are flexible, this will have workforce implications.	6/9/2015 11:19 AM
6	Need time in palliative medicine to build competencies and confidence	6/8/2015 6:29 PM
7	I think that this would allow us to develop competancies and experience.	6/8/2015 5:54 PM
8	IF this change comes in, then the 4 years (minimum) for dedicated specialty palliative training should be preserved.	6/8/2015 11:10 AM
9	I think we made our training shorter than many. With a year of GIM Pall Med would effectively be three years, which is not sufficient, particularly as trainees are now more junior coming in to specialty training	6/8/2015 10:23 AM
10	Not necessarily - it depends what we want the 'specialist' is equipped to do. If the 'specialist' needs to be able to take on a post in cancer centre, as a hospice medical director, in the community or in a DGH (nad in any combinations of these as currently) then yes, training length would need to be increased	6/5/2015 9:46 AM
11	This would be the only way we can ensure high standards of experience/competence	6/4/2015 5:05 PM

12	it would need to be to produce competent specilaists	6/4/2015 12:22 PM
13	If the current specialty curriculum remains as it is, then the length of training would need to increase. If trainees were required to spend time in GIM as well, then it would be impossible to achieve specialty competencies in the same time frame as currently.	6/3/2015 7:32 PM
14	Additional year should be added to factor in what is lost.	6/3/2015 5:16 PM
15	Unless there is a proper dual accreditation process, then we will face having even more amateurs. Palliative medicine is clearly more and more important as national demographics changes and we are involved in more complex cases where the skills missing are the palliative care and not the GIM	6/3/2015 3:35 PM
16	Without a doubt. 'Concertinering' of training has been detrimental to all specialties. We have had a system imposed upon us which, to the shame of the profession, we have allowed and collaborated with, where trainees have been expected to do more, learn more and with worse working patterns and no continuity of teams in less and less time. All to satisfy political ends and save money. The language which is used is not honest - training posts are primarily service delivery posts. We have engendered expectations in junior doctors that we just cannot match - rotas that are impossible to complete the work within, curriculum objectives that we cannot provide the opportunities for, training that is a by product of the service that is delivered. Good old experiential learning and apprenticeship style. We need to be more honest in how we describe posts and how trainees will be learning.	6/2/2015 9:26 AM
17	As above there would not be enough specialist palliative care training otherwise	6/1/2015 11:07 PM
18	it would need to be increased	6/1/2015 8:32 PM
19	If a doctor is a well-trained general physician or a geriatrician, specialist palliative emdicine can be completed in less than 2 years.	6/1/2015 11:23 AM
20	We need 4 years of palliative medicine to be ready	5/31/2015 8:34 PM
21	I feel it would be difficult to obtain and develop the specialist knowledge and skills needed without extending training.	5/31/2015 12:33 PM
22	Of course! Current training time is already too short.	5/29/2015 7:06 PM
23	It depends on the duration of the placement and if the curriculum is updated to change more modern requirements and needs.	5/29/2015 3:43 PM
24	I feel that you need to complete 4 years in palliaitve medicine to be sufficiently competent to be a consutlant therefore additional training time will be needed	5/29/2015 1:32 PM
25	This is feasible - as a year of GIM + 4 yrs purely within the specialty.	5/28/2015 8:06 PM
26	Let's see. If they spend more than 50% of their time in any one given year doing something other than palliative medicine, then yes.	5/28/2015 7:03 PM
27	To disinvest Doctors tranined in acute internal medicine time will need to be spent in the real world of palliative care where decision making involved a holistic approach	5/28/2015 4:41 PM
28	almost certainly - as answer to Q9 to have enough time to gain all speciality knowledge	5/28/2015 3:40 PM
29	a year placement in GIM will have a huge negative impact on being able to sign off palliative medicine curriculum competencies.	5/28/2015 3:38 PM
30	I suspect it will be challenging to deliver the full palliative medicine curriculum for the majority of trainees - our experience from academic trainees and some coming from other specialties, is that they value the additional clinical time, in order to gain experience in complex decision making and develop leadership competencies, which develop gradually over the duration of training.	5/27/2015 5:56 PM
31	as above, we need experience in hospital/hospice and community settings	5/27/2015 4:16 PM
32	If anything it feels that as a diverse speciality that is enriched by taking doctors from many different roles/background the training in someways is already short - especially considering we are only expected to have 6/12 community experince). Therefore any time taken would need to be replaced.	5/27/2015 3:50 PM
33	I cannot see how this could take place without increasing length of training - otherwise time spent gaining experience and skills in palliative medicine would surely be diminished	5/27/2015 3:04 PM

34	There is little enough time to meet competencies as it is, while providing the service commitment needed, without adding additional general medical competencies in the same timescale. To identify areas of the curriculum which were only needed for a select part of our patient population, and therefore not needed by every consultant, would be challenging.	5/26/2015 10:04 PM
35	Training programme feels too short already so if undertaking extra placements would need to be extended.	5/26/2015 10:08 AM
36	I fail to see the need for this however. see my previousanswer	5/25/2015 11:20 PM
37	Most likely - but again difficult to say definitively at this stage.	5/19/2015 3:51 PM
38	Agree but I would challenge the premise. Trainees should only be required to complete placements in general internal medicine if they are going to be dual accredited (see my answer above). I would be against obligatory dual accreditation. A placement in General Internal Medicine may however be useful for trainees coming in from MRCGP but ? at a lower grade.	5/19/2015 2:02 PM
39	The 12 month placement will provide increase experience and competencies but ideally shouldn't shorten the current 4 year programme.	5/19/2015 12:35 AM

Q11 There are areas in the current curriculum which would be suitable for undertaking as credentials outside of the current training programme in Palliative Medicine.

Answered: 190 Skipped: 59



	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**3.16%** 6	**28.95%** 55	**27.37%** 52	**30.53%** 58	**10.00%** 19	190	3.15

#	Additional Considerations (Which areas of the curriculum could be moved to post CCT i.e. become part of credentialing? What impact would that have on the training programme?)	Date
1	I don't understand credentialing well enough to answer this question.	6/9/2015 10:47 PM
2	It is difficult to see any areas of the current curriculum which could be delayed until after CCT as all the skills developed during the training are needed once in post as a consultant.	6/9/2015 6:19 PM
3	Not sure I understand this approach despite reading your briefing paper- perhaps research?	6/9/2015 4:10 PM
4	Not really sure about this	6/9/2015 11:19 AM
5	this will create a junior consultant grade - i feel it is better to meet all credentialling within the training programme.	6/9/2015 10:02 AM
6	I don't agree with this credentialing process: seems as if will lead to two tier system. I believe that the Speciality Training should produce doctors with skills necessary to practice as a consultant, as we currently understand the role. Share concern in briefing document that non credentialed Drs could be seen as a cheap option, alternatively, credentialed Drs may end up taking these posts if no alternative. In Republic of Ireland, in recent years, a junior version of consultant was proposed, with very little support from Drs as motivation seemed to be cost containment.	6/8/2015 10:21 PM
7	The only area I could think of is the more practical proceedure such as intrathecals or nerve blocks if someone wanted to develop a service. I think the rest is pretty integral.	6/8/2015 5:54 PM
8	Very few areas and there are already usually completed post CCT eg transition, research, education, interventional pain management	6/8/2015 5:47 PM
9	There are areas where trainees currently gain some experience /exposure such as renal medicine, cardiology & psychiatry. It may be useful to look at immersion by longer/deeper attachments in sub-specialist areas such as those listed above where the outcome, based on credentialing, would be "Consultants in Pall Med with an interest in.. Dementia, Interventional analgesia, End of life care for patients with Cardiac/Respiratory diseases etc.."	6/8/2015 4:06 PM
10	I'm not sure I understand the implications of this well enough	6/8/2015 11:10 AM

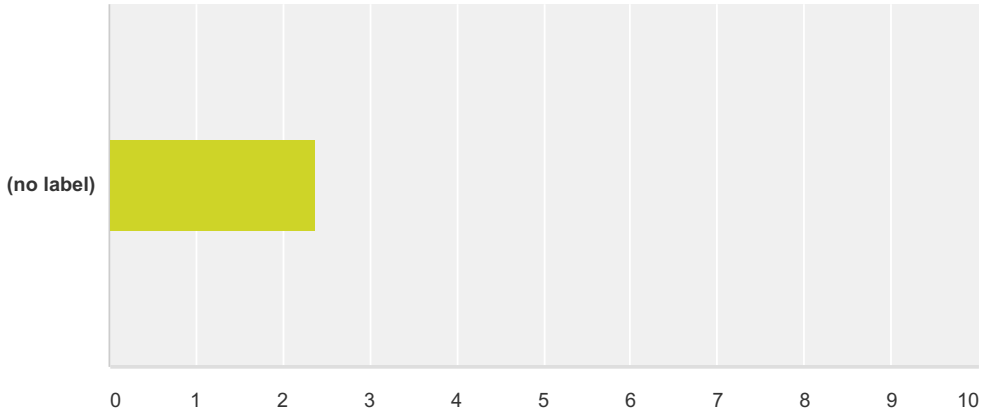
11	Trainees will not be adequately prepared to take on the role of a consultant if curriculum requirements are moved post CCT. This model also assumes that all trainees will move on to a consultant post where there is already a senior consultant and this may not be the case in all units, leaving the new consultant exposed and unprepared.	6/5/2015 4:51 PM
12	Hospice management - this could be a credentialling option for those wishing to take significant leadership roles in hospices (particularly voluntary sector) Palliative oncology and cancer survivorship - for those wanting roles in cancer centres. Would obviously still need some oncology exposure within training but this could be less than currently Interventional pain management Transition	6/5/2015 9:46 AM
13	I think there is very little which could be removed.	6/4/2015 9:05 PM
14	experience in areas such as clinical psychology/psychiatry and possibly management training which is hard to get direct experience of whilst training?	6/4/2015 5:05 PM
15	I think there are areas that could be part of credentialing (renal, heart failure, education etc....) but a degree of knowledge is still required for those not credentialing so I don't think the extent to which they exist in the present curriculum could be removed.	6/4/2015 12:25 PM
16	the curriculm is designed to produced competent consultants with broad know;edge and experience. you cannot remove these from training	6/4/2015 12:22 PM
17	research competencies and some leadership competencies. This would potentially reduce the length of training so it may be possible to undertake GIM placements as well, still within the same timeframe as currently.	6/3/2015 7:32 PM
18	I think some of the management aspects of the curriculum could potentially be done post CCT but this would depend on a trainees destination in the post CCT period and whether they would manage without these until then. The other aspects of the curriculum seem fairly crucial pre- CCT.	6/3/2015 5:16 PM
19	At best these would be practical procedures.	6/3/2015 3:35 PM
20	I wonder that skills currently tested through DOPS might make their way out of a training programme leading to a CCT in palliative medicine, eg. ultrasound skills for paracentesis, or time spent with chronic pain colleagues in order to learn practical skills in nerve blocks, epidurals, intrathecal delivery systems. My concern about taking other 'knowledge and attitude' elements out of the current training programme in Palliative Medicine is that future CCT holders feel they have received a 'diluted' training in comparison to their senior colleagues.	6/3/2015 1:45 AM
21	Research Interventions	6/2/2015 6:11 PM
22	But they are very minor - for example HIV, children's palliative care, interventional pain. The majority of the curriculum is core for a palliative medicine consultant	6/2/2015 5:39 PM
23	Interventional procedures for pain control is an obvious choice.	6/2/2015 9:26 AM
24	Subspecialisation e.g. non-malignant diease, renal medicine, pain techniques.	6/1/2015 9:01 PM
25	yes, but few areas. perhaps some aspects of interventional pain management, but I wouldnt have thought enough areas would fit with this for it to be a useful approach	6/1/2015 8:32 PM
26	all areas of the curriculum need to be currently met to become a consultant - to change this and say trainees can become consultants with fewer competencies dilutes the meaning of a specialist consultant and will undermine public confidence in their abilities. With a speciality like palliative medicine it is essential that trainees are given the time to reshape their thinking and approach to patients from a very medical model learned in medical school/foundation/core training, to a more holistic and patient centred approach. This takes time and should be completed during a training programme rather than after it.	6/1/2015 5:02 PM
27	reserch, paediatrics,	6/1/2015 4:04 PM
28	It depends what CCT is going to mean. If a doctor with CCT is considered a consultant I don't think anything should be moved to post-CCT, however if they will be considered a senior trainee, some of the management and leadership aspects could potentially be moved to post-CCT.	5/31/2015 9:54 PM
29	probably intervention based skills, e.g. nerve blocks	5/30/2015 8:42 PM
30	I am not sure what areas of the current curriculum could be considered unnecessary for a new consultant. None that I am aware of.	5/29/2015 7:06 PM
31	Possibly in areas such as chronic pain, management of the frail elderly, interventional pain.	5/29/2015 5:46 PM
32	These are really hard to clearly describe	5/29/2015 3:44 PM
33	Paediatric pall care. Research	5/29/2015 8:02 AM

34	Having looked through the 2010 Curriculum(prior to the most recent revision), I would say that all of it is relevant within the CCT. Perhaps a research project may not need to be completed within CCT - that aside, I struggle to see anything that can be left for post CCT.	5/28/2015 8:06 PM
35	I can think of things to ADD eg special interest in transition or renal or transplant or respiratory etc, or even competence at performing simple nerve blocks and managing spinal lines. I can't see anything from our curriculum that could be removed without significantly impacting on the quality of training. I think "palliative care" special interest will become a credential for other specialties - and how do we interface with these doctors, do they become part of hospital palliative care teams? I am wary that credentialling will become a means for non-physician providers of care to take on more of the NHS workload at cheaper rates but with a potential impact to safety and continuity of care - I think we need to be sure that anything we put out to credentialling would be 100% safe to be practiced by a trained-up ANP, as this may be 10 years further down the line. ANPs are incredibly clever and skilled people, and something like spinal lines would be very safe in their hands, but will giving away these skills erode the role of doctors, and will the more complex patients suffer?	5/28/2015 7:03 PM
36	I have difficulty in answering this question as the process of credentialing is so foreign to current training	5/28/2015 4:41 PM
37	All areas of palliative care are developed from the outset and increased in confidence and experience, rather than certain areas of training being left until more senior.	5/28/2015 4:41 PM
38	It is hard to know what bit would be subspecialised. A year of subspecialisation in an area of palliative medicine may be a good thing but it would be a new area not an area of existing curriculum	5/28/2015 3:42 PM
39	there are probably some but I do not think there are many - unless we then create an almost 'junior or sub consultant'	5/28/2015 3:40 PM
40	Palliative medicine curriculum is strongly geared towards specialist palliative medicine (as it should be) and I think it would be difficult for credentials to be undertaken outside the training programme.	5/28/2015 3:38 PM
41	Post cct specialisation eg renal ,pain interventions eg spinal etc ie enhancement of existing curriculum	5/28/2015 3:23 PM
42	If palliative medicine moves to become more subspecialised, as has been suggested, then this may lead itself to credentialing - e.g. in developing management skills aligned with a leadership role in the voluntary sector; more broad based community experience or more acute experience.	5/27/2015 5:56 PM
43	I don't really understand the credentialling bit - at what point are you called a consultant? I think you could subspecialise post-CCT (eg gain further tertiary experience or community etc if you wanted to be involved with a very specific service), but the current curriculum seems fairly core	5/27/2015 5:44 PM
44	I am not sure what skills you would only need post CCT	5/27/2015 4:16 PM
45	From the report the balance of credentials and training program appears very unclear. To my mind the training program would be aimed at one gaining credentials and so taking areas out of the training cirriculuim appears illogical.	5/27/2015 3:50 PM
46	I don't believe in the current curriculum there are areas that could be moved into a credentialing programme-perhaps in the future there may be a need for credentialling e.g. in transitional care, chronic pain, interventional pain procedures, clinical leadership etc but these are currently not in sufficient detail in the current curriculum to warrant being separated to post CCT	5/26/2015 10:12 PM
47	Interventional pain services - a level of awareness is needed but these may be provided centrally and therefore detailed knowledge not required for every consultant. Carrying out research may not be essential, although the understanding of the implications of research would be.	5/26/2015 10:04 PM
48	Management experience / possibly research competencies	5/26/2015 5:16 PM
49	Interventions and spinals, management excellence for potential medical directors	5/26/2015 1:47 PM
50	The competencies developed in palliative medicine are different in nature to many other specialities. Whereas for many, there are discrete competencies that can be developed in isolation and easily judged as achieved (e.g. endoscopy, bronchoscopy etc), in palliative medicine most of the competencies in the curriculum are not discrete but intrinsically linked to each other. It is difficult to isolate parts of the curriculum that could be divorced from the rest, since in large part one competency requires the adequate development of the others in order to be fully achieved.	5/26/2015 11:15 AM
51	Time spent in areas such as nephrology, pain management would add to the skill set or give the trainee the opportunity to subspecialise in a particular area. However, it is likely that this subspeciality training would only then be manifest as a palliative medicine consultant with an 'interest in'. This would only have a role as an optional extra and should not be mandatory.	5/26/2015 9:18 AM

52	I think it is a stupid idea. You are either a consultant or you're not as far as the public is concerned. I think this suggestion is not going to do anything other than massage figures and create a sub-consultant grade by stealth	5/25/2015 11:20 PM
53	PhDs, research, leadership	5/21/2015 2:32 PM
54	I think credentialing would actually suit palliative medicine quite well, but in the development of additional training in subspecialties not currently covered in detail (ie hospital non-malignant work, neurodegeneration etc) rather than elements of the current curriculum.	5/19/2015 3:51 PM
55	I think the current program is suitably wide ranging and holistic. There is scope to go into areas in more detail through credentialing or look at additional areas of training but I would not want to remove areas from current CCT curriculum. By the way - "credentialing" is an ugly, clumsy word and the definition given is an example of poorly accessible torture of the english language. Was it written by committee by any chance? What is wrong with "competancies"?	5/19/2015 2:02 PM
56	specific non cancer areas, respiratory, renal, liver, neurology	5/19/2015 8:46 AM
57	I think the training curriculum is quite broad and just expects knowledge in certain areas. Eg Doctors could choose to be pain specialists, but the curriculum only expects you to know what these techniques entail currently.	5/18/2015 11:18 PM
58	Not sure I fully understand credentialing - could you give examples	5/18/2015 8:23 PM
59	I do not agree with credentialling though, it makes us very 'nursey' - 'I've done the phlebotomy course but not the venflon course'.	5/18/2015 7:05 PM
60	Research Some of the management items on the curriculum which I believe would be easier to understand/achieve once in a consultant post e.g.: recruitment, finance etc.… NOT any of the core skills such as symptom control, communication, ethics etc….. A consultant would need to be able to still lead an MDT at the time of CCT I note comments about whether this would lead to a difference in pay between two 'grades' of consultants - i do not think this would be necessary. It may just be that new consultants have a DCC:SPA split which is much more clinical than post credential where SPA component could be increased?	5/18/2015 6:52 PM
61	the 4 years to become a consultant only covers the essentials, i do not feel there is anything i could sacrifice of the last 4 years and be at the same standard as now. we already need to fit more management stuff into current training	5/18/2015 5:15 PM

Q12 Creation of opportunities for dual accreditation with other medical specialties would be a positive development for Palliative Medicine.

Answered: 193 Skipped: 56



	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**12.44%** 24	**54.92%** 106	**18.13%** 35	**11.92%** 23	**2.59%** 5	193	2.37

#	Additional Considerations. For which specialties should dual accreditation with Palliative Medicine be supported? This could be just General Internal Medicine or others e.g. Medicine for the Elderly Respiratory Medicine etc.	Date
1	Medicine for the Elderly / Community Geriatrics	6/10/2015 9:00 AM
2	If there was an option to have your 12 months in Internal Medicine be General or another specialty this could be beneficial. I think you could make a case to support this with many other medical specialties - and this would help Palliative Medicine's presence to reach further outside of oncology. However, I don't think we should have to be able to fulfill their whole curriculums. Maybe it could be possible to help us define a (sub)specialty interest in another discipline. But I wouldn't be keen to see us have to complete 2 seperate training programmes. Most of all, I think trainees should have the choice NOT to do dual accreditation.	6/9/2015 10:47 PM
3	But dual accreditation should be an option for those who wish to pursue it rather than the norm for all palliative medicine trainees. Care of the Elderly, Renal Failure, Respiratory, Heart Failure, Neurology may work as dual accreditations.	6/9/2015 8:12 PM
4	I think having dual accreditation may give the possibility of reducing burn-out for those working long-term in palliative medicine, offering the option of changing to a different specialty. Given the changes with palliative care patients expected in the future - increasing frailty, increased age-groups, having the option of dual accreditation for medicine for the elderly may allow different ways of working e.g. community-based palliative medicine consultants could do more work with patients in nursing homes or elderly care community clinics in the future.	6/9/2015 6:19 PM
5	I suspect it would lead to increased argument that palliative medicine no longer required as everyone does it (even if not well!), however, could see benefit for example anaesthetics- pain blocks, elderly care, respiratory, neurology.	6/9/2015 4:10 PM
6	Geriatrics/Medicine for the elderly/Renal/Respiratory	6/9/2015 2:11 PM
7	There is significant crossover between palliative medicine and medicine for the elderly. I think having a palliative medicine presence in the general medicine could be beneficial for patients, and for general medical trainees but I don't think dual accreditation is necessary.	6/9/2015 12:05 PM

8	GIM, elderly care, cardiology, and respiratory medicine. Future development of elderly, frail units (which would encompass surgical care too) are also relevant. We need to remember that hospital care may be very different 10 years down the line. What about the links with community?	6/9/2015 11:19 AM
9	this is a interesting idea and I feel there are close parallels with elderly care - however unlike other specialities with dual accreditation we do not spend prolonged time within the acute sector. However with the addition of an extra year of training and maybe some alterations within the 4 year programme this should be possible.	6/9/2015 10:02 AM
10	I'm unsure whether it dual accreditation is called for. Essentially, supporting development of a special interest would be advantageous for Pall Med and other Specialities, and providing the structure and supports for this within Spec Training and thereafter; for e.g Med for Elderly and Pall Med: obvious synergies, and benefit if trainees in each spent a yr in other ST scheme, or even something less than this, such as regular attendance of OPDs. However, with the emphasis of the changes proposed in Shape of Training being on Acute Medicine, I'm not sure if this would reduce opportunity for sub speciality interest/ training in another medical speciality.	6/8/2015 10:21 PM
11	Elderly care, GP even, neurology, etc, cardiology, nephrology	6/8/2015 7:02 PM
12	General practice, anaesthetics, elderly care, respiratory medicine, renal medicine	6/8/2015 6:29 PM
13	I think this would be positive but as a choice rather than an enforced dual accreditation. I would not want it to stop GPs or different routes to pall care being an option.	6/8/2015 5:54 PM
14	Definate similarites and cross over with COTE and medical oncology. Palliative Medicine has a role in all medical specialities and more widely in GP /clinical oncology/ surgical/ gynae/ITU	6/8/2015 5:47 PM
15	If that is what doctors in training would like to pursue, then there is no harm in having the opportunity. It would be interesting to know what the eventual balance of work/interest is for trainees who already engage in dual accreditation. i.e after the extra years of training & funding, do they truly work in two specialties?	6/8/2015 4:06 PM
16	I do think this would be a positive step but their training in palliative medicine would need to be to a similar high quality for them to be accredited to the same standard as singly accredited palliative care specialists. i.e. their training would need to be longer (perhaps even doubly long) to achieve this accreditation	6/8/2015 11:10 AM
17	GIM, Medicine for Elderly, Respiratory, Cardiology (non-interventional), Hepatology, Renal	6/8/2015 10:23 AM
18	I think there are definitely potential advantages but we need to maintain our identity as a specialty rather than becoming a sideline to other specialties. I do not think it would work for everyone.	6/8/2015 12:13 AM
19	alongside completing 4 years of palliative medicine training, GIM, COTE	6/5/2015 4:51 PM
20	GIM Med for elderly General practice Cardiology Neurology Resp med Nephrology Old age psychiatrists specialising in dementia could dual accredit (or could be a credentialling opportunity)	6/5/2015 9:46 AM
21	Might broaden our scope and experience but at the risk of diluting the specialist workforce unless it was back paid.	6/4/2015 5:05 PM
22	What would the split of the specialist / generalist job and how would this work practically particularly given the instability of some of our patients	6/4/2015 2:12 PM
23	Mixed feelings! In some ways this may be really positive for some but for others there choice of a career in palliative medicine is very specific.	6/4/2015 12:25 PM
24	we are specilaists not generalists	6/4/2015 12:22 PM
25	Palliative medicine would be a useful dual accreditiation with many specialities such as medicine for the elderly	6/4/2015 11:58 AM
26	Respiratory, renal, cardiology, elderly care	6/3/2015 7:32 PM
27	Especially acute medicine, respiratory and geriatrics.	6/3/2015 5:16 PM
28	care of the elderly, respiratory medicine, cardiology	6/3/2015 4:19 PM
29	I am dual accredited and this has only ever been to the patients' advantage. The need for a very specifically tailored curriculum that in now way sacrificed the aspects of pall med that set it apart ie the human aspects, decision making and ability to operate in fluid & extended teams.	6/3/2015 3:35 PM
30	Elderly medicine seems a natural 'twin' specialism, but I would want the SAC to explore closer ties with clinical or medical oncology as well given how these fields are developing. There are not enough palliative medicine consultants in large areas of NHS England (e.g. east and west midlands) still, and I think it is foolish to think that a pool of palliative medicine specialists can be drawn upon to make time to work away from commitments that are largely based in the voluntary/third sector	6/3/2015 1:45 AM

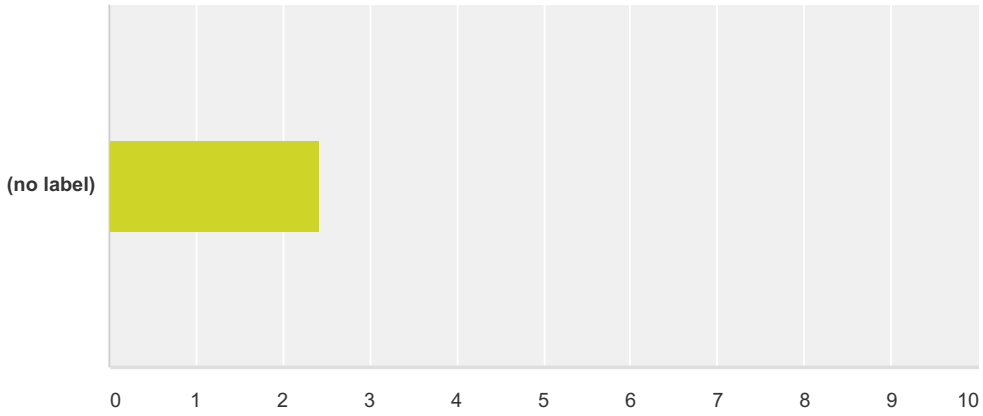
31	Just general medicine	6/2/2015 6:11 PM
32	I think dual accreditation may be helpful for some individuals - but should not be mandatory. Medicine for the elderly, renal medicine, respiratory medicine, oncology may all be appropriate	6/2/2015 5:39 PM
33	This may be helpful not just for individual doctors but the specialty as a whole. We still have an inferiority complex and breaking this down and raising the profile of the specialty may be helped by dual accreditation.	6/2/2015 9:26 AM
34	Respiratory, medicine for the elderly	6/1/2015 11:07 PM
35	Postive benefit with most medical specialties. personally would favour free choice, but those related would be a starting point eg, resp, CoE, cardiology, renal. liver	6/1/2015 10:11 PM
36	Neurology, Oncology, Respiratory	6/1/2015 9:57 PM
37	Medicine for the elderly, respiratory medicine, GIM,	6/1/2015 9:01 PM
38	i can see that care of the elderly/palliative medicine would be useful.	6/1/2015 8:32 PM
39	As long as this does not distract from the quality of Palliative Medicine training and that dual accreditation is optional.	6/1/2015 6:04 PM
40	This could be positive but the length of training for each speciality should not be shortened or trainees will end up being dual accredited but not have the skills necessary to perform as a consultant adequately in either specialty.	6/1/2015 5:02 PM
41	Elderly Care Oncology	6/1/2015 2:06 PM
42	Most pateints die in acute setting or whilst under the care of intermediate care teams. Intergration of palliative emdicine in to general and acute medicine must happen.	6/1/2015 11:23 AM
43	eg care of the elderly; oncology	6/1/2015 9:41 AM
44	Again this would remain to be seen. It might be possible to dual accredit with specialties including elderly care or oncology for example, but at present I would think there are too few palliative medicine consultants to be able to specialise in a subject area (for example renal palliative care), though of course one can have an interest in an area.	5/31/2015 9:54 PM
45	Possibly good specialties to work with- gerontology, oncology, GIM as some examples.Could improve collaboration and research opportunities as well as training of other doctors, more integration. However concern that community and collaboration with primary care will be diluted in the rush to work with the usual hospital specialties	5/31/2015 4:05 PM
46	A positive development not for the specialty itself but to promote a palliative medicine approach in the acute sector.....can we think about dual accreditation with Royal College of GPs too.....don't want to lose sight of the cross-sector working.	5/31/2015 4:05 PM
47	Perhaps, but I feel few trainees would be interested in this option.	5/31/2015 12:33 PM
48	allow career flexibility and lower risk of burnout	5/30/2015 8:42 PM
49	Think there is more overlap between elderly medicine, old age psychiatry than with GIM.	5/29/2015 5:46 PM
50	The increased knowledge base might be a good idea, but I am not sure what the patients might think if they are seeing a Palliative Medicine plus 'something' doctor when they feel their need is the just 'something'. This could well increase patient anxiety.	5/29/2015 4:33 PM
51	With any/all - there are palliative patients in most specialties Dual accreditation should not reduce the training in Palliative Medicine however	5/29/2015 4:07 PM
52	GIM,COE definitely	5/29/2015 3:44 PM
53	May be important if wish to subspecilaise but not sure if as a specialty we shoudl encourage subspecialisation.	5/29/2015 1:32 PM
54	Almonst any!	5/29/2015 1:13 PM
55	Medicine for the Elderly, Respiratory, Renal.	5/29/2015 9:49 AM
56	Only if with General practice as well as with specialties. One of the strengths of palliative care physicians has bee their non specialised approach patient care .. The focus being on this individual not "my area of expertise"	5/29/2015 8:02 AM
57	Medicine for the elderly, resp, cardiology, renal, neurology, community specialism	5/28/2015 9:08 PM

58	Would be a fantastic opportunity and bring not only a bigger range of skills to the discipline but also a lot more interest and opportunities for all	5/28/2015 8:12 PM
59	Care of the Elderly, Renal Medicine, Respiratory Medicine, Cardiology and Renal Medicine.	5/28/2015 8:06 PM
60	agree this option would be positive but feel it should not become a requirement in order to be a pall med specialist	5/28/2015 7:14 PM
61	There will be some specialist services where someone with dual accreditation will be highly valuable. But there will be people who spend time dual accrediting and can't find their niche job, and then only use one set of skills. Matching people to service needs would mean more flexibility for trained physicians to move to the areas they are needed - humans don't work like that. They are not pawns in a larger system. They will prefer not to use their skills than to uproot their families.	5/28/2015 7:03 PM
62	I think GIM, oncology, haematology, neurology, resp med, cardiology, elderly med, renal medicine, would all be good candidates for dual accreditation, as long as the individual's practice was balanced such that both accredited roles were used regularly, so that the doctor's life long learning is not merely theoretical, but up to date in all aspects. And I think the non-pall med specialties would need to take on a more community based practice.	5/28/2015 6:24 PM
63	perhaps link with geriatric medicine, psych, oncology..the list however could go on	5/28/2015 5:23 PM
64	GIM, geriatrics,respiratory	5/28/2015 4:50 PM
65	I think there would be scope for this with specialties which have a similar philosophical outlook to palliative Care such as Elder care, General Practice, Psychogeriatrics	5/28/2015 4:41 PM
66	Rheumatology and neurology could combine but would probably need to be in tertiary centres.	5/28/2015 4:41 PM
67	This potential advantage doesn't seem to outweigh the potential disadvantages	5/28/2015 4:04 PM
68	This is a different issue but may be a good way forward for the speciality. Care of the Elderly and respiratory would seem sensible choices	5/28/2015 3:42 PM
69	certainly knowledge of palliative medicine would be very useful in some other specialities - whether dual accreditation was feasible or not - would also depend on the training time - feel it would have to be significantly increased	5/28/2015 3:40 PM
70	I disagree but if it had to happen, I think medicine for the elderly and oncology would be possibilities.	5/28/2015 3:38 PM
71	Flexibility for dual accreditation eg care of elderly ,acute medicine ,respiratory	5/28/2015 3:23 PM
72	in order to keep up competency in both (without which the dual accreditation is pointless) I feel that we are at risk of watering down our knowledge of each specialty.	5/28/2015 2:30 PM
73	geriatrics, repiratory, oncology	5/28/2015 2:26 PM
74	Most relevant are elderly care respiratory care and oncology but others should be considered if demand exists	5/28/2015 2:25 PM
75	As long as trainees were able to choose to be dual accredited, if all trainees were to complete training as dual accredited then I believe that Palliative Medicine would be watered down as a specialty	5/28/2015 2:25 PM
76	I think it does depend on the specialty - dual accreditation with Oncology or Medicine for the Elderly would seem a more sensible choice.	5/28/2015 2:17 PM
77	Could be positive in terms of better knowledge of general medicine and manageing acute medical problems, but there would need to be an increase in training time as already challenging to meet all competencies in 4 years.	5/28/2015 9:55 AM
78	We already have trainees wishing to dual accredit in acute or GIM, without opportunities at present to do so. I think this would be a welcome development which would move palliative medicine as a specialty more mainstream and allow for increased opportunities for joint working with other specialties. I think the most synergy would be with GIM, acute medicine and care of elderly	5/27/2015 5:56 PM
79	Could dual accredit with Acute med, Oncology, Respiratory etc - or with GP (currently training does not allow you to continue both alongside which seems a shame)	5/27/2015 5:44 PM
80	in some areas e.g renal/cardiology where there are definite patient groups with pall care needs this may be useful	5/27/2015 4:16 PM

81	For some this could be useful. Although I would expect it to be a crediential of palliative care in their speciality - ie respiratory consultants would involve knowledge of respiratory palliative care issues. Although one would hope that this already forms a part of their cirriculum and by making it a special intrest could lose the general palliative medicine knowledge we should expect all physcians to have in their area of expertise. Overall however there still would appear to be a role for specialised palliative care physcians who are comfortable across all disciplines. Partly to provide a wider service that hospices require. Partly so that when conditions combine there is people who can deal with these complex cases.	5/27/2015 3:50 PM
82	Particular benefit for palliative medicine plus neurology/respiratory/renal	5/27/2015 3:04 PM
83	A double edged sword- great to have the interplay between general med and palliative med- bringing a cross-fertilisation in ideas, approaches, understanding. Risk is a dilution and loss of specialism with consequences for development of knowledge within the specialty fields. Dual accreditation would be useful for Respiratory Medicine, Cardiology, Geriatrics, Oncology.	5/26/2015 10:12 PM
84	Any specialty could benefit from having consultants with dual accreditation in palliative medicine, as patients die in every specialty.	5/26/2015 10:04 PM
85	Renal, elderly, oncology, cardiology, stroke	5/26/2015 6:58 PM
86	It has pros and cons as above. It might work for elderly care / respiratory	5/26/2015 5:16 PM
87	GIM, MoE,	5/26/2015 1:47 PM
88	Palliative medicine as a specialty is fundamentally about an approach to the needs of a patient, not a focus on a particular set of diseases / particular body system. As such, it spans specialties, requiring broad general knowledge and in depth specialist knowledge/skills. Dual accreditation risks losing this unique focus of palliative medicine, turning into a 'specialist interest' for phsyicians working in the particular specialities (elderly care, respiratory, general medicine).	5/26/2015 11:15 AM
89	Dual accreditation for other medical specialities is with general internal medicine so it seems sensible to have this as a basis.	5/26/2015 10:08 AM
90	I think that this might be a possibility but you show me a consultant in Palliative Medicine with loads of time on their hands to do Elderly Care on top of the Palliative Medicine. We don't have enough consultants in Palliative Medicine to do the job already and maybe we should concentrate on this first?	5/25/2015 11:20 PM
91	If someone where to choose to dual accredit then this should be supported.	5/23/2015 10:14 PM
92	Med for the elderly	5/21/2015 2:32 PM
93	I think only having some general medicine experience can be enough.	5/20/2015 12:38 PM
94	depending on the choice of specialties e.g. renal or respiratory where there is a natural overlap	5/20/2015 9:59 AM
95	I can see relevant links with all sorts of specialties: GIM, elderly medicine, respiratory, and neurology.	5/19/2015 3:51 PM
96	In hospital palliative care practice I can see this as a positive move. GIM, Elderly, Respiratory, Oncology would be obvious examples..but what about anaesthetics/pain medicine - would that be possible under the new structure? In general palliative medicine should maintain its distinctivieness as a single-accredited speciality.	5/19/2015 2:02 PM
97	oncology, geriatrics, would need to be carefully considered and supported with job opportunities post this	5/19/2015 8:46 AM
98	Opportunity to undertake this would be positive as long as it was not a mandatory requirement	5/19/2015 12:35 AM
99	Dementia care, renal, respiratory, cardiology, neurology.	5/18/2015 11:18 PM
100	Elderly care Medical and clinical oncology	5/18/2015 8:08 PM
101	most of the medical specialties could work well	5/18/2015 7:05 PM
102	Transition medicine Respiratory medicine	5/18/2015 6:52 PM

Q13 Consultants with dual accreditation would benefit the specialty of Palliative Medicine and the delivery of patient care.

Answered: 193 Skipped: 56



	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**12.44%** 24	**51.81%** 100	**19.17%** 37	**14.51%** 28	**2.07%** 4	193	2.42

#	Additional Comments	Date
1	It is without doubt that there are patients on the acute take that have palliative medicine needs, however, I think that this can be supported by having additional Palliative Medicine consultants in hospital roles to help support the acute take. There's also little doubt in my mind that Palliative Medicine consultants are some of the last "generalists" - and would benefit the acute take from that perspective (less tunnel visioned than some other specialities) I do believe that people choose specialties for reasons that suit their personalities. It might be that people have chosen the specialty because they don't enjoy or feel confident in managing the acute take.	6/9/2015 10:47 PM
2	Having other specialties with accreditation in palliative medicine would potentially increase the access for patients to palliative care -eg if care of the elderly consultants were dual-accredited with palliative medicine this may benefit patients.	6/9/2015 6:19 PM
3	As long as speciality training not impacted	6/9/2015 4:10 PM
4	There is value in this, but also need to consider what the role of palliative medicine is in the delivery of patient care in the community, and how will GPs work with hospital colleagues of all persuasions?	6/9/2015 11:19 AM
5	Potential benefit wrt being up to date with gen medical knowledge and key member of medical department. However, due to time constraints and rapidly evolving evidence base, could become jack of all trades and master of none.... Also, this is very hospital medicine focussed, how would we as a group, during training and later develop/maintain skills and focus on community pall care?	6/8/2015 10:21 PM
6	as long as doesn't reduce speciality training and knowledge.	6/8/2015 6:58 PM
7	Dual accreditation would benefit palliative medicine but should not be limited to internal medicine alone. The current siting of palliative medicine as a medical specialty narrows the focus and broader speciality entry eg general practice, anaesthetics (as happened pre specialist training) brings different perspectives and may suit more rural areas who need more generalist workforce willing to work in a variety of settings including community.	6/8/2015 6:29 PM
8	The specialty has always benefited from having people come into it from a range of backgrounds & dual accreditation would potentially facilitate having some people within the specialty with particular expertise, those this would only be in other medical specialties & not in broader areas such as GP, anaesthetics, Oncology.	6/8/2015 5:52 PM
9	Good general medicine knowledge is already essential for palliative medicine. More up to date knowledge of acute medicine would always be useful but unsure how well it could be implemented in a hospice IPU setting.	6/8/2015 5:47 PM

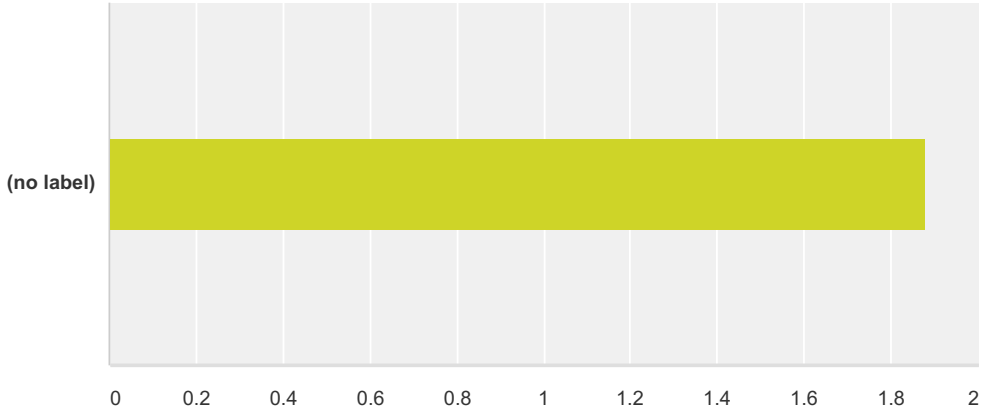
10	I think that several medical specialties would be enhanced by a greater emphasis being placed on delivery of palliative care to their patients, but I do not think that this necessarily requires dual accreditation.	6/8/2015 4:06 PM
11	see my answer to 12	6/8/2015 11:10 AM
12	Particularly their ability to see and prioritise management early in the patients hospital inpatient journey	6/8/2015 10:23 AM
13	I'm sure that there will be benefits given the changes in Palliative Medicine over the last few years. However, I don't see it as essential.	6/8/2015 12:13 AM
14	I agree in principle but am concerned about the detail.	6/4/2015 5:05 PM
15	Depends how the job plans work	6/4/2015 2:12 PM
16	we already use close links with other specialties to use there skils and cooperate in patient care	6/4/2015 12:22 PM
17	Could be both benefts with a broader knowledge/skill base but may 'dilute' the skills in pallitive medicine	6/4/2015 11:58 AM
18	I do worry it would create a hierarchy within the specialty if dual accreditation were optional. Those who had not undertaken it would be considered 'inferior' consultants	6/3/2015 7:32 PM
19	Only if they had credibility as palliative care physicians	6/3/2015 3:35 PM
20	If I had been dually trained in general medicine and in palliative medicine, I would probably 'switch hats' rather than blend the work together seamlessly: the general medicine being high throughput diagnostic work, and the palliative medicine being more holistic. Palliative medicine developed as a response to inadequacies in hospital care once the diagnostic work was done, and it ought to be practised in quite a different 'mode' and 'pace' to general medicine.	6/3/2015 1:45 AM
21	This may be true for some individuals, but I do not feel that it would be generally true. Palliative medicine is broad and delivered in different settings, it is not primarily hospital based as most other medical specialties are, there are a range of skills required in these different settings	6/2/2015 5:39 PM
22	As above! Also, the response to Francis and Neuberger clearly concentrates on hospital care - we have a major role in this and dual accreditation will only assist this.	6/2/2015 9:26 AM
23	Doctors who have more experience in specialist palliative care or any other speciality	6/1/2015 11:07 PM
24	I think many Consultants are part-time in PC; having another clinical area would be no different to having people based at Universities, doing committee work, management or at home	6/1/2015 10:11 PM
25	I think that all medical consultants need to be providing some level of palliative care. There then needs to be an additional specialist level of care for those at greatest need. So all physicians need palliative care exposure, but only a few need full training. The idea of dual accreditation would water down the specialist skills of palliative medicine.	6/1/2015 8:32 PM
26	As above - as long as the same experience and quality of training is received in each speciality.	6/1/2015 6:04 PM
27	if adequate time for training in each specialty is given in training.	6/1/2015 5:02 PM
28	Having dual accrediation wil have a positive impact but overall it could be detrimental if skills acheived elsewhere are not recognised e.g GP training. Concern is the "internal medicalising" of the specialty	6/1/2015 2:09 PM
29	But shouldn't be the sole route	6/1/2015 9:41 AM
30	It is hard to see how consultants could actively practice two specialities and remain up to date	5/31/2015 8:34 PM
31	On the one hand it could improve collaboration and integration and normalise palliative care as part of spectrum of care,also create opportunities for more research; on the other hand danger of "diluting" the specialty and of possible "creep" towards more inappropriate,active interventions in terms of management. Also, as above concern that the whole point of future care is to move care away from acute hospitals so concern about where community fits in and working with GPs/primary care teams	5/31/2015 4:05 PM
32	chronic disease colleagues are already doing this in effect	5/30/2015 8:42 PM
33	For effective palliative care a wider knowledge base is helpful. However, see answer to Q 12.	5/29/2015 4:33 PM
34	There could well be some benefits for employers, but not sure why patients specifically would benefit	5/29/2015 3:44 PM
35	May have quite narrow view on specialty	5/29/2015 1:32 PM
36	Same as previous comment	5/29/2015 8:02 AM

37	Wider experience and different expertise - balance out the speciality and cover weaker spots	5/28/2015 8:12 PM
38	Advantages and disadvantages - Knowledge base and skills advantageous. In my experience, at consultant level, majority tend to get set in their ways. In Palliative care, it's not always about competencies, rather more about personalities... Given that the purpose of dual accreditation is predominantly service provision - I strongly doubt whether Consultants will succeed in doing an acute take one week and then switch to being a purely Palliative care specialist the rest of the month as the mind set is quite different. From that perspective alone, trying to train SpRs to do this is going to be confusing and not really helpful for delivery of patient care. Plus, other medical Specialties already struggle to manage end of life care - taking on the Palliative approach can only be 'taught' to a certain degree as many do not have the patience or softer skills to look at the holistic psycho social/spiritual aspects of care.	5/28/2015 8:06 PM
39	In some scenarios, yes.	5/28/2015 7:03 PM
40	perhaps, but again, not if this limits from their palliative care knowledge/experience	5/28/2015 5:23 PM
41	I find it difficult enough as a consultant in Palliative Medicine ro complete my various clinical and non clinical commitments. I can only imagine that having dual accreditation would make my capacity to deliver consistent palliative care to patients even more difficult as I tried to maintain my CPD requirements into distinct specialities, deliver training to trainees in two distinct specialties and complete other responsibilities	5/28/2015 4:41 PM
42	This potential advantage doesn't seem to outweigh the potential disadvantages	5/28/2015 4:04 PM
43	as above	5/28/2015 3:40 PM
44	With other countries moving towards the UK model of palliative care, why are we considering diluting the skills of palliative medicine consultants via dual accreditation? The skills of UK-trained palliative medicine physicians are highly thought of and sought after by other countries. I can see no benefit to palliative medicine or to the delivery of palliative care to our patients from consultants having dual accreditation.	5/28/2015 3:38 PM
45	Eg acute medicine either credential lingo or dual accreditation ,work with a lead pall med consultant a team in that clinical area would also support 7 day working	5/28/2015 3:23 PM
46	Coming from a hospital post, we are increasingly working jointly with colleagues from care of elderly and general and acute medicine. However dual accreditation, with palliative medicine consultants potentially working in acute medicine and / or participating in acute take, would potentially allow much earlier identification of patients where early palliative care intervention may be helpful, either to support early discharge and linking into community services, or to inform the direction of care. this model already exists in some acute medicine units where consultants use both their specialist and acute medicine skills to drive up quality and safety	5/27/2015 5:56 PM
47	should provide ready access to pall care for more patients but this would depend on how the service is provided	5/27/2015 4:16 PM
48	Many palliative care physcians have a secondary intrest and this clearly benefits patients. For example a palliative COPD clinic. Furthermore this could be be encouraged by dual accreditation. However it should be acknowledged that other palliative care consultants have secondary interests that are outside a sphere that could be accredited - ie research, managment,ethics and law. Therefore while this could be beneficial it needs to not become the expected standard.	5/27/2015 3:50 PM
49	They may benefit the delivery of patient care, in improving palliative care in other specialist settings such as renal medicine or respiratory medicine, however this is likely to be a less specialist level than that seen in consultants with a broad experience of palliative medicine across all specialties.	5/26/2015 10:04 PM
50	I think these consultants with these skills would raise our profile & help reduce the "just palliative care" side	5/26/2015 5:16 PM
51	Although need to consider how to keep up with GIM skills post CCT	5/26/2015 1:47 PM
52	I do think there is some benefit to be gained from increased exposure to general medicine for Palliative Med physicians. It preserves and develops skills in general medicine, which is likely to result in the earlier recognition and more effective treatment of general medical problems within the palliative care patient cohort. This could, however, be better achieved by more collaborative working with GIM colleagues - e.g. palliative physicians joining Post take ward rounds, elderly care rounds, respiratory rounds. This would provide training opportunity for all involved, sharing expertise and improving patient management	5/26/2015 11:15 AM
53	Especially in hospital settings as higher profile, perhaps less so in community settings.	5/26/2015 10:08 AM
54	could be if there were enough Palliative Medicine consultants already to do the job	5/25/2015 11:20 PM
55	Depends on the doctor and the setting and the circunstances	5/23/2015 10:14 PM
56	Could help promote better corss-speciality working	5/20/2015 9:59 AM

57	I think this is likely to be the case.	5/19/2015 3:51 PM
58	Not sure about this. I think Palliative Medicine has already bent over too far backwards to make itself into a "proper medical speciality". Palliative Medicine is very differant by nature from other specialties. We can always learn from interaction with colleagues but I think we should be looking much more towards General Practice and Psychiatry for influence.	5/19/2015 2:02 PM
59	In certain areas this would be clearly advantageous but not for every palliative medicine post and therefore there needs to be flexibility	5/19/2015 12:35 AM
60	As long as their palliative medicine skills maintained!!!	5/18/2015 6:52 PM

Q14 I have concerns about the impact of Shape of Training changes on service delivery in Palliative Medicine.

Answered: 193 Skipped: 56



	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**38.34%** 74	**42.49%** 82	**13.47%** 26	**4.15%** 8	**1.55%** 3	193	1.88

#	Additional Comments	Date
1	We are a small specialty and taking ST4s out of our call schedule / daily routine will stretch our already limited resources. Furthermore in our deanery there are already discussions about having a first and second SHO/StR on call in some posts. Having both occur together would definitely make substantial gaps in our service provision. Reducing our Palliative Medicine training to essentially 3 years will definitely leave gaps in other areas of service provision - like community or academic contributions.	6/9/2015 10:47 PM
2	I am unclear how service and oncall provision could be maintained if trainees are also working on the acute take.	6/9/2015 8:12 PM
3	Given the reliance on trainees for on call cover in hospices and in hospital teams, this could affect service delivery. However, if palliative medicine was included in years 1-3 as hospice posts, this may help with the service delivery.	6/9/2015 6:19 PM
4	We have small on call rota- if trainees were elsewhere on another rota, our first on call rota would not be sustainable. Cover for inpatients and community would also decrease, and support for junior trainees on placement in hospice would differ.	6/9/2015 4:10 PM
5	particularly the difficulty of staffing the acute take and hospice rotas for both trainees and consultants	6/9/2015 2:09 PM
6	These are challenging times ahead, and as patients become frailer, sicker and with more complex conditions there is a real need to address the holistic needs of patients; how we maintain the specialist element of what we do, when more and more teams may be seeking to deliver end of life care, could be potentially difficult.	6/9/2015 11:19 AM
7	taking out registrar level doctors will impact on service delivery at a hospice level - this may be negated by careful consideration of working with other specialiities and swapping appropriate registrar level doctors	6/9/2015 10:02 AM
8	Could be squeezed out of traditional areas of care eg hospice	6/8/2015 7:02 PM
9	this will only affect the areas who have trainees initially, longer term it may be that there are issues with reduced workforce capacity due to internal medicine comitments of the new workforce.	6/8/2015 6:29 PM
10	I am also strongly concerned regarding the evidence base and ability to understand evidence. for palliative medicine doctors to develop in the future they need to have a good ability to read and understand latest evidence. To me the shape of training is too much orientated to cook book medicine, rather than being able to grow and develop.	6/8/2015 6:05 PM

11	It is still difficult to know. If the plan were to go ahead I think they would need to increase numbers of trainees or the service delivery in pall med would be compromised.	6/8/2015 5:54 PM
12	If planned well then shape could offer the ability to produce more rounded person centred doctors but the current plans are too focused on producing consultants quickly rather than producing well rounded and skillful doctors. I am concerned that within current training numbers we would have significant gaps where trainees are not based within hospice and this could severely impact already very stretched services and on call rotas	6/8/2015 5:47 PM
13	Cannot comment until the processes and implications of training/credentialing are clearer.	6/8/2015 4:06 PM
14	I am worried about the detrimental impact shape of training changes will have on trainees choosing to train in palliative medicine (either fewer choosing it or more "acutely minded" trainees choosing it). I am worried that "integrating" general internal medicine in the specialist palliative training will mean inclusion in the acute medical take some of the week and work at hospice/other settings the rest of the week. I think this would be detrimental to patient care in both settings. How will continuity of patient care (which we know is important to patients and doctors) in each setting be prioritised in this system? Who will supervise the palliative trainee on the acute take/post-take ward round and in any real way for on-going general internal medicine if they are also based at a specialist palliative care unit some of the time? The only way I can see it working (& still not ideal as per my comments above) is a dedicated 1 year general medical placement with involvement not only in the take but care of general medical inpatients. And if you are going to do this you may as well just prolong general medical training for the required amount to answer the general medical service provision issues (that have largely driven the shape of training review) and still allow trainees to move into dedicated (minimum 4 years) specialist palliative training after this.	6/8/2015 11:10 AM
15	There are clearly a lot of issues to work out in this respect. Most Palliative a Medicine consultants already work across more than one site. Future models of service delivery will have to be very carefully planned to ensure palliative care services are not disadvantaged. However, if done well, a restructuring of services and careful job planning could be of benefit. On call at hospices could become harder to cover if trainees spend more time in acute medicine.	6/8/2015 12:13 AM
16	Significant detrimental impact on current in and OOH provision of care to patients and also hinder the process of moving toward 7/7 service to patients.	6/5/2015 4:51 PM
17	There are huge implications here for the staffing of voluntary sector hospices in and out of hours and we need to ensure that the implementation of any new curriculum does not lead to hospices opting out of hosting training posts. At the same time we need to 'sell' the advantages of medical trainees in all specialities getting some experience working in specialist pallitive care units as part of their training	6/5/2015 9:46 AM
18	Depends how it is planned and organised	6/5/2015 9:14 AM
19	See above	6/4/2015 2:12 PM
20	Particularly with regard to staffing hospices and out of hours work.	6/4/2015 11:58 AM
21	I think dual accreditation is entirely about filling the gaps in service delivery in the acute sector. Unless the number of .palliative medicine training posts was increased, it would affect service delivery as with EWTD requirements, there would simply not be enough trainees to cover an acute rota and the specialty work and on calls. With days off post on call in the acute sector, I also worry that this would impact detrimentally on specialty training and attainment of specialty competencies.	6/3/2015 7:32 PM
22	Hospice on calls are getting increasingly busy in the region that I work and it is hard to see how trainees could keep a hospice on call rota staffed on top of acute medicine committments.	6/3/2015 5:16 PM
23	The coverage of on call across the three sectors is a big issue and will need to be addressed	6/3/2015 3:35 PM
24	If trainees have to cover acute take, this reduces training time in specialty, and also service provision in often relatively small units. I am not sure that hospices will wish to continue to provide placements to trainees if they cannot rely on them being there.	6/2/2015 5:39 PM
25	Covering services and rotas is already a challenge for many units. This will certainly make this worse. If the government and colleges are truly concerned with how we manage health care with our changing population, which is not a new or unrecognised concern, then we should be expanding the medical, nursing, AHP and social care workforce markedly. Changing the shape of training is, frankly, merely peeing in to the wind and will not in any way solve the issues we face.	6/2/2015 9:26 AM
26	Too soon to know what is actually going to happen and therefore what changes might come as a results.	6/1/2015 9:27 PM
27	this will cause a further split in the speciality with community experience being squeezed	6/1/2015 8:32 PM

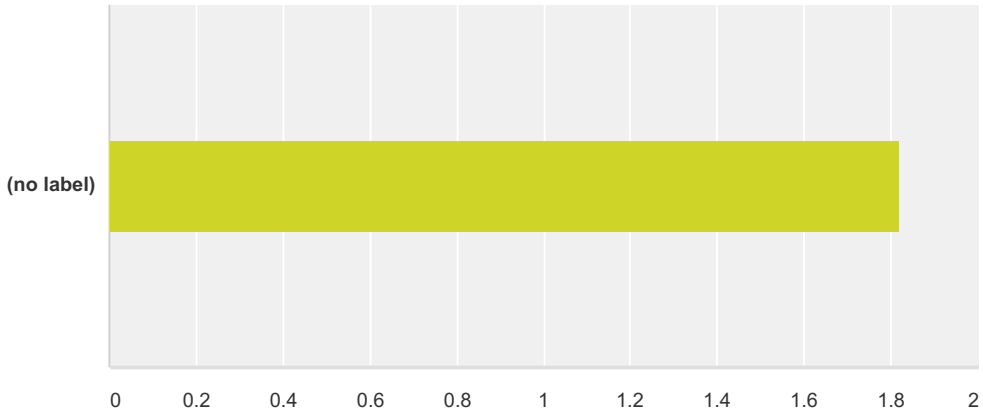
28	trainees in the future if they are GIM and palliative will require educational and clinical supervisors who are qualified in each field, this will complicate their educational training and have impacts on service depending on how the placements work out in the training programme. it would be very difficult for a trainee in palliative medicine to work the acute medical take and then switch modes into palliative thinking again on a frequent basis, the two areas require very different skill sets, so to mix them is not a good idea.	6/1/2015 5:02 PM
29	Largely the impact on non-MRCP routes, as these routes in past have had a major beneficial effect on palliative medicine	6/1/2015 9:50 AM
30	It is the challenge of the on-call commitment to both GIM and palliative care services that would be most difficult to reconcile in all areas in which I have worked.	5/31/2015 9:54 PM
31	Major implications especially for hospices re balancing service with training and of financial costs for them.	5/31/2015 4:05 PM
32	appears speculative as to its endpoint	5/30/2015 8:42 PM
33	It would have a major impact in terms of continuuity of care for patients under the care of Palliative Medicine - in hospices etc, unless there is a corresponding increase in the number of trainig posts in the specialty. Also an impact on on call rotas. Impact on training, with time spent away from palliative medicine (doing nights and other antisocial shifts for internal medicine), and attractiveness of the specialty to potential trainees (absence of night shifts etc is a positive thing now).	5/29/2015 7:06 PM
34	I am not in a position to comment on this as I do not have Palliative Medicine trainees anyway.	5/29/2015 4:33 PM
35	Difficult to see how hospices would maintain specialty training with a doctor contributing to acute take. However, may be a good thing for the earlier broad based training	5/29/2015 3:44 PM
36	There are definite pros and cons to this. Change would need to be considered and monitored.	5/29/2015 3:43 PM
37	It will be difficult top maintain palliaitve care in hospitals if we are covering the acute take rota. Also most of trianing places are within hospices who will lose trainees if this goes ahead.	5/29/2015 1:32 PM
38	I am concerned about entry into Palliative Medicine from outside of GIM training - for example General Practice (which provides an excellent background for palliative medicine). I am concerned about recruitment into Palliative Medicine if GIM training is requried - for many trainees part of the appeal of this specialty is tht the focus in palliative medicine is completely different to GIM. Trainees may simply not want to do it if required to do acute medical takes, particularly as I feel doing further GIM will not help trainees gain the competencies needed to be a good palliative medicine consultant. I think it will be incredibly challenging to maintain staffing levels and rotas if trainees are required to be part of the acute medical take as well as on call for specialist palliative care - a major review of staffing numbers will be requried.	5/29/2015 9:49 AM
39	Access for GpTrainees.	5/29/2015 8:02 AM
40	All points as above answered.	5/28/2015 8:06 PM
41	in order to meet training needs of trainees we often have gaps at units as it is - if 1 year is taken out for GIM then this will mean that the specialist units and teams will have gaps more frequently	5/28/2015 7:14 PM
42	Charities are already struggling to expand services to 24/7; where are the extra people going to come from that cover on calls when the trainees are in hospital? Certainly not from GP surgeries where they are already stretched. This may mean more consultants doing first on calls - and how do we plan for someone who was up all night and has to work the next day?	5/28/2015 7:03 PM
43	Covering hospice on call rotas will become even more of a challenge	5/28/2015 4:50 PM
44	I do not think the implications of these changes have been thought through. The fall in number of GPs coming into Palliative Medicine is changing the ethos of the specialty as is the increasing demands of training, and revalidation. Trainees in Internal medicine currently have a very different experience of training from those going through Palliative Medicine training and I would be disappointed to think that we would end up training our trainees in a similar hands off manner. This feels like it is being lead by pragmatic needs to have more doctors available to be able to participate in general medical on call rotas and very little to do with improving the training that palliative medicine trainees receive.	5/28/2015 4:41 PM
45	Particularly in terms of the very complex patients needing 'specialist' palliative care and also ebing able to run an on-cll rota.	5/28/2015 4:41 PM
46	it is very unclear how the changes will affect cover and on call esp in hospices which are often 'stand alone' and struggle to provide reasonable rot as at present	5/28/2015 3:40 PM

47	The numbers of palliative medicine trainees are small and in the 2 sites that I have worked so far we have struggled to fill gaps in the on-call rota - this will worsen if trainees are pulled out of palliative medicine training to GIM, and this is at a time that there are plans for the NHS to move to 7 day working. The palliative medicine trainees produced by a post-"shape of training" programme may have more skills in GIM but this will not benefit the palliative medicine trainees in their day-to-day job or the palliative patients they are caring for and they will be de-skilled in comparison to current palliative medicine trainees.	5/28/2015 3:38 PM
48	Restrictive entry criteria	5/28/2015 3:29 PM
49	If assumed on call rotas are intertwined ie cover both palmed eg hospice and gen med on call in hospital	5/28/2015 3:23 PM
50	Particular concerns for Hospices who currently have much out of hours provision by registrars who may not be availabel to do this in future.Concern also for registrars who may not get adequate specialist palliative medicine on call experience before becoming a consultatn due to doing mostly GIM on call.	5/28/2015 3:19 PM
51	The hospital based focus of the outline does not adequately prepare for a specialty which should cover both community and hospital causes me much concern.	5/28/2015 3:04 PM
52	moving registrars into acute medical on calls will reduce the palliative medicine on calls that they can provide. we will need additional doctors on already stretched on call rotas and.	5/28/2015 2:30 PM
53	Number of doctors aleady below national recommendations in some areas and with no more money available this development is likely to mean less doctor time for service delivery in palliative medicine	5/28/2015 2:25 PM
54	So much of what is being proposed is unclear. EoLC and GIM whilst having general care of patients at their core are also very different approaches...I think it will be difficult to marry these approaches in training	5/28/2015 2:25 PM
55	Particularly with on-call provision - it is difficult enough as it is to cover this currently...would we be expected to do a higher percentage of on-call coverage to make up for colleagues covering the acute take? Would more consultant posts be funded, or would consultant time be spread more thinly, covering both general and specialist patient cohorts.	5/28/2015 2:17 PM
56	I think there will be significant challenges but they are not insurmountable. This will potentially force us to look at our medical workforce as we will not be able to rely on StRs for service delivery in the same way as may currently be the case - which might be a good thing. The biggest service risk is around on call rotas	5/27/2015 5:56 PM
57	I worry the standard of training and therefore care would be affected	5/27/2015 4:16 PM
58	As above - I believe it could lead to a reduction and quality in the number of doctors becoming palliative care consultants and that they will probably have less palliative care experince.	5/27/2015 3:50 PM
59	It is difficult to see how the current system of on call cover for hospices could be maintained if there were an increased consultant on-call requirement on the hospital acute take, without significant investment in consultant numbers	5/27/2015 3:04 PM
60	I can envisage trainees being unavailable for hospice work as internal medicine takes priority	5/26/2015 5:16 PM
61	What will happen to the doctors who are qualifying now as consultants. Will they be out of a job once pple who have dual accredited qualify?	5/26/2015 3:36 PM
62	How will Palliative Medicine rotas be staffed? what impact would this all have on in hours care? I foresee beds having to close	5/25/2015 11:20 PM
63	Difficult to see how managing two on-call rota commitments would be feasible.	5/19/2015 3:51 PM
64	See above. Obligatory dual accreditation would be a disaster. It is already very difficult covering on call rotas for independent hospices - trainees doing GIM on call would be very difficult to accomodate and would be an inappropirate focus during Palliative Medicine speciality training.	5/19/2015 2:02 PM
65	The loss of alternative routes of entry and change of focus away from community towards supporting acute medical take are concerning	5/19/2015 10:15 AM
66	will trainees do acute take in hospital and hospice on call? this is untenable, I think hospice cover would suffer and hospice work day to day, big part of hospice work is continuity - hard if trainees disappearing to do acute take in the week. I suspect hospices would stop having trainees due to unpredictability of service delivery from them which would be very detrimental to palliative medicine training.	5/19/2015 8:46 AM
67	It remains unclear how internal medicine rotas will effect palliative medicine rotas both in training and as Consultants in the future	5/19/2015 12:35 AM

68	Can barely cover on-call rotas as it is - this will make it much worse	5/18/2015 6:52 PM

Q15 Changes to the delivery of training in Palliative Medicine should be focused on increasing the experience in the community rather than just increasing experience in the acute hospital.Note: This increased experience in the community could be in generic primary care or an increase in specialty training in the community i.e. an increase from the current 6 to 12 months

Answered: 194 Skipped: 55



	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**44.85%** 87	**36.60%** 71	**11.34%** 22	**6.19%** 12	**1.03%** 2	194	1.82

#	Additional Comments	Date
1	Although I would prefer that an increase in specialty training in the community, I would rather have further experience in generic primary care than further hospital training. I think that the better way to move forward with the crisis in secondary care is to move more support into primary care. In just one aspect of our specialty, we are failing to support many patients who would like to die at home. Building stronger support in the community would be helpful and this would put less pressure on admissions to the acute setting which are largely inappropriate.	6/9/2015 10:47 PM
2	Depends on the structure and content of GP training & work	6/9/2015 9:57 PM
3	Generic primary care experience would be helpful for all medical specialties but should not replace specialty training time.	6/9/2015 8:12 PM
4	As palliative medicine has been developing and there is more of a focus of keeping patients out of hospital, there is likely to be an increased need to have doctors working in the commmunity which will need to be experienced doctors.	6/9/2015 6:19 PM
5	Can see advantages of both approaches- more training in GP would be useful in some areas, but lots of GP interactions - worried well and URTIs etc would not be hugely useful. Perhaps psychiatry would be more useful community based specialty? I think specialty training in community is good in our deanery, but from discussions with other consultants might be variable according to where one trains.	6/9/2015 4:10 PM
6	We should consider whether we ar emore of a community speciality rather than secondary care.	6/9/2015 12:27 PM

7	As discussed above; if the RCP's vision for the Future Hospital is realised, there will be a much greater need for real collaboration between community and hospital teams, with joint contracts, shared governance arrangements, and real seamless care, something which GIM is not that well-versed in.	6/9/2015 11:19 AM
8	community palliative care is growing as is partnership working	6/9/2015 10:02 AM
9	I come from a MRCGP training background, and I feel that I have a significant advantage in communication skills training - I used to have one surgery a week where i was videoed and my trainer and I would watch it back and critique my communication skills, and I am amazed that a palliative medicine trainee from an MRCP background would only need to do the advanced communications 2 day course. I feel having community primary care experience allows me to understand better the needs and challenges that patient's face in their home setting.	6/8/2015 8:56 PM
10	this is needed with intergration of healthcare and reduction of focus on hospital care for all Drs.	6/8/2015 6:58 PM
11	This is vital in palliative medicine to help support end of life strategy and support patients in the community with increasingly complex needs. This will be increasingly needed if the trainees train increasingly in internal medicine as they will struggle to manage complex patients in the community- particularly managing uncertainty and benefits/ burdens of secondary care interventions.	6/8/2015 6:29 PM
12	it is where patients want to be, and where we need to be able to keep them for as long as possible. If doctors don't get training there they will never feel confident there.	6/8/2015 6:05 PM
13	The clear focus on NHS england is on more community based care - this is what patients want not just from pall med but other specialities and it seems lacking in foresight to put together a plan for community based working without engaging medical specialities to focus their training more on community based training.	6/8/2015 5:54 PM
14	The future for palliative care is about looking after people in their own homes. I feel the 1 month I spent with a GP practice during my training was the most valuable in helping me as a previously hospital based trainee to better understand that wha is seen in hospital is not the reality that most patients live every day.	6/8/2015 5:47 PM
15	However, in practice, this can be challenging as it depends on the current availability of community input. This can vary greatly from area to area.	6/8/2015 4:06 PM
16	If in future we want to provide more "joined up" care for patients, allowing them to avoid unwanted hospital admission towards the end of their life and build structures in the community that can more effectively adapt to their changing condition and care needs in a way that they are sufficiently supported and cared for then what we need to do is improve our competencies in community and "out of hours" community care, not more experience of acute medical management.	6/8/2015 11:10 AM
17	Both are important	6/8/2015 10:23 AM
18	I think 12 months community palliative care would be invaluable experience. Some experience in primary care may be useful but I would be against a lengthy placement. A longer specialist placement in community will give adequate opportunity to work with and gain a better understanding of primary care.	6/8/2015 12:13 AM
19	I think increased community experience would be beneficial for the majority of trainees	6/5/2015 9:46 AM
20	Both are needed as well as inpatient hospice	6/5/2015 9:14 AM
21	Could see more benefits with gaining further experience in community roles.	6/4/2015 9:05 PM
22	Particularly with the focus of unscheduled care and community delivered care	6/4/2015 2:12 PM
23	with more emphasis on community care we need to drive training in this direction along with the continued need for tertiary expertise	6/4/2015 12:22 PM
24	As long as the training in the community is well supervised and has a good educational component	6/4/2015 11:58 AM
25	I do not feel the general practice training would be at all helpful in palliative medicine specialty training, and again am worried that this suggestion is simply a case of service provision and filling the void in the number of gp posts, rather than improving specialty training.	6/3/2015 7:32 PM
26	This has been my experience and an extensive one with trainees, but both need to increase not one or the other. I would be extremely unhappy to see suspecialisation as a supposed answer	6/3/2015 3:35 PM
27	I couldn't agree more with this statement. Few general medical specialties successfully train doctors to understand how the community 'works' and how to support and improve the knowledge, behaviours and skills of our generalist community clinicians (doctors and DNs, for example). Increasing the amount of time that the palliative medicine trainee spends in the community is wholly in line with RCP Future Hospital thinking, whereas I think the thrust of SHoT is providing manpower for acute hospital care.	6/3/2015 1:45 AM

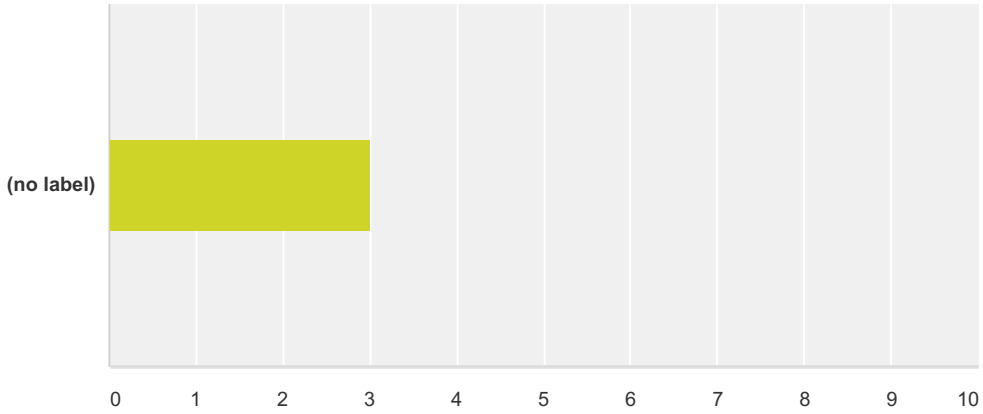
28	The focus is for all settings but the major area of poor practice is in hospital. The community issues are markedly different and relate more to lack of practical help from carers and nurses rather than medical input. Palliative medicine training is already training across hospital, hospice and community and has a large percentage of GP trained doctors in the workforce. I hope that this will continue.	6/2/2015 9:26 AM
29	Would be better if it was part of the speciality training	6/1/2015 11:07 PM
30	Suggest a high level of nursing home exposure, in partnership with GPs.	6/1/2015 9:57 PM
31	much palliative care takes place in the community. If shape of training goes ahead as planned I see a split in the speciality - hospital trained medical/palliative care consultants vs community and hospice consultants - it would make more sense for hospice/community consultants to train via the GP route. in fact it might make more sense for palliative care to be a GP based speciality, and to have a palliative care/medicine dual accreditation for hospital work only	6/1/2015 8:32 PM
32	As the focus of care is being shifted to the community I think that this would be more valuable than further acute hospital experience.	6/1/2015 6:04 PM
33	I feel all palliative medicine trainees should have at least 6 months in general practice.	6/1/2015 2:06 PM
34	Care is moving into the community and with most patients still wanting to remain at home for as long as possible an increasing focus on providing palliative care to patients at home is required.	5/31/2015 9:54 PM
35	More important looking forward as the vast majority of trainees will come from an acute medical background/ training. A significant proportion of our work is in the community setting and working closely with our GP colleagues.	5/31/2015 9:26 PM
36	My 6 month FY2 job in general practice has proved as useful to me in my palliative medicine training as 2 years of CMT	5/31/2015 8:34 PM
37	yes- see comments to Qs 12 and 13	5/31/2015 4:05 PM
38	especially given focus on care outside of hospital setting	5/30/2015 8:42 PM
39	Generic primary care experience is not Palliative Medicine training. I think trainees get adequate community experience certainly in the training scheme locally.	5/29/2015 7:06 PM
40	I think that community experience needs to be specialty focused rather than generic primary care.	5/29/2015 5:46 PM
41	Doctors need to know how things work in the community rather than the somewhat closeted DGH.	5/29/2015 4:33 PM
42	But community models are generally more disparate,	5/29/2015 3:44 PM
43	I agree to this based on practical considerations of the likely future of patient care rather than based on the 'best training'.	5/29/2015 3:43 PM
44	Community experience is crucial to allow patients to die at home. Therefore we should have 12 months at least in dedicated community teams. Currently the 6 months split up in parts is not sufficent and not seen as important for our training by hospices.	5/29/2015 1:32 PM
45	Our current training programme is very much hospice based, with a small component of both community and acute hospital SPECIALIST palliative care training. I do not think this should change.	5/29/2015 9:49 AM
46	The loss of entrance from General practice to palliative medicine and the management of simple ailments (impacted ear wax, eye complaints to name but a few) could improve provision of holistic care and the diversity of our medical management	5/28/2015 9:08 PM
47	There needs to be a fine balance - many GPs in primary care are capable of providing good palliative care with appropriate support and education. Currently, it would help to increase Palliative care input within hospitals to provide holistic care, encourage and empower junior doctors to generate sensible plans for palliative patients to return to the community. 12 months training within the community would be advantageous for both trainees and the primary care teams as they would learn from each other.	5/28/2015 8:06 PM
48	i think experience in community is essential for pall med and it would be good to be in a position to increase this area	5/28/2015 7:14 PM
49	I think we could do with a review of how we work in the community alongside our GP colleagues. There is huge overlap and duplication in some services - so not just increasing the TIME in the community but looking at what value we add to community teams and embedding better within these (?palliative clinics in surgeries, bi-weekly rounds at nursing homes?).	5/28/2015 7:03 PM

50	i am aware that not all my colleagues have exposure to so much community work - also, ?the impact upon GPs - they are already swamped with work and we often help take the burden of this	5/28/2015 5:23 PM
51	Palliative medicine is likely to be much more community facing in the future.	5/28/2015 4:41 PM
52	Potentially. There should be a minimum experience of community based specialist palliative care to reach minimum competencies; but any extra time probably best down to the individual trainee based on their ultimate career aspiration. Some may want to be hospital team based.	5/28/2015 4:04 PM
53	Increase experience in community if there is justification but not simply because training might be extended to accommodate acute medicine.	5/28/2015 3:45 PM
54	a lot of palliative medicine consultants will work at least partly in the community and this is a very different environment to hospitals	5/28/2015 3:40 PM
55	Community experience should be pall med only not as a substitute for lack of gps ie focused to care homes and at home by leading a community pall care team	5/28/2015 3:23 PM
56	End of life care at home is being developed nationally and so this is going to be increasingly important to our regsitrars	5/28/2015 3:19 PM
57	I think that we get a good amount of community experience as part of the current training programme.	5/28/2015 2:17 PM
58	Would support experience of integration of services and caring for patients across differnt care settings. Also helpful in terms of education for all HCPs.	5/28/2015 9:55 AM
59	The majority of patients seen by palliative care services, in terms of actual numbers, are already in hospital and community, so this is not inappropriate. the national drive is for more integration between acute and community settings and palliative medicine may be well placed, along with care of elderly, to test new models of service delivery to support admission avoidance	5/27/2015 5:56 PM
60	care should be provided more in the community so this is an area that needs expanding and careful consideration	5/27/2015 4:16 PM
61	One of the biggest things missing from the report was a clear vision of what the NHS will look like in 10-20 years time - when the first new consultants will be arriving. To my mind this will be more community based medicine and the challanges will be very different to those we currently face and so additional community experince is essential. Unfortunatley it feels that the report is trying to solve todays problems with a 10-20 year plan and so has overlooked this point.	5/27/2015 3:50 PM
62	As a consultant who barely managed 6 months community experience in training due to lack of opportunities, but has a largely community focused consultant post, I think there should be more community experience, but acknowledge that this is managed better in some training programmes than others depending on service design.	5/26/2015 10:04 PM
63	I think there is a clear argument for both, since the speciality spans several locations for the delivery of care. Indeed, this unique scope and perspective is a huge strength for the specialty and the NHS as a whole. It is essential that Palliative Medicine Physicians in a secondary care setting are aware of the services available and challenges faced in the primary care setting and vice versa. This provides for the ability to deliver individualised care, continuity of care and excellence in communication between service, as well as reducing hospital admissions and length of stay (thereby reducing cost). The answer is not more hospital experience to the detriment of community, nor more community experience to the detriment of hospital but continuing to develop exposure to both settings. We must be producing physicians that are not fixed to particular locations but able to develop regional services providing excellent palliative care in primary and secondary care contexts.	5/26/2015 11:15 AM
64	Experience in acute take would not add in any way to the training of a palliative medicine trainee. This suggestion is one which has been put forward to address service provision and not to enhance the palliative medicine trainees skill set. Time separately spent in Medicine for the Elderly would be preferable.	5/26/2015 9:18 AM
65	Specialty traing in community amplified from 6 months cumulative expereience not as a substitute service for primary care	5/25/2015 6:17 PM
66	I think there needs to be more focus on Palliative medicine from those already in the community e.g. GP training and this should be promoted further.	5/20/2015 9:59 AM
67	It is difficult enough to find enough community placements already so increasing it would present a challenge in some areas. Not sure I agree with either statement.	5/19/2015 3:51 PM

68	Palliative Medicine consultants have to understand and work with the community setting - there is a strong drive now to provide hospice at home/community based care. the amount of community expereince necessary will depend on whether the trainee has come from MRCP or MRCGP and there should be flexibility to accomodate this.	5/19/2015 2:02 PM
69	we are unique in where we sit across all care settings our training should reflect this, community, hospital and hospice, acute medicine is one small part of what we do, I think w are better suited to thinking about dualling up with geriatric medicine than acute medicine	5/19/2015 8:46 AM
70	This is key. I would almost want GP to play a more prominent part than hospital practice as so much work is in primary and care and yet trainees coming through have so little experience in this	5/18/2015 8:23 PM
71	I believe that working in GP would be much more useful than working in acute medicine	5/18/2015 6:52 PM

Q16 The current curriculum in Palliative Medicine equips doctors at CST level to manage acute and emergency patients appropriately if required

Answered: 193 Skipped: 56



	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**3.63%** 7	**36.27%** 70	**26.42%** 51	**23.32%** 45	**10.36%** 20	193	3.01

#	Additional Comments	Date
1	This depends on previous experience prior to SpR training and also depends on what is meant by acute and emergency patients. There is currently a need to manage acute / emergency patients in hospices but this is very different from managing acute medical patients in the hospital setting which currently the curriculum is not designed to cover.	6/9/2015 6:19 PM
2	I think managing common emergencies is done well in palliative medicine. Escalation plans are sensible.	6/9/2015 4:10 PM
3	The palliative medicine curriculum equips trainees for emergencies in the palliative care setting e.g. Hypercalcaemia and NOT in the acute medical take/resus setting e.g. Massive GI bleed/CPR. Palliative care trainees are not ALS up to date and would need to be to cope with an acute hospital take.	6/9/2015 2:11 PM
4	The only way for doctors to be fully equipped to manage emergency and acute patients is for them to have regular working experience in these areas. Knowing the theory is necessary but not sufficient.	6/9/2015 12:05 PM
5	I'm not sure that current trainees or newly appointed Consultants in Palliative Medicine could lead acute takes. Maybe the whole system needs to change with more shared care between acute and non-acute specialities.	6/9/2015 11:19 AM
6	yes in palliative care emergencies	6/9/2015 10:02 AM
7	Question unclear. If referring to pts admitted to hospital acutely, then no. If pall med emergencies/ pts admitted acutely to hospice, then yes.	6/8/2015 10:21 PM
8	I'm assuming this means general acute and emergency patients, not just acute palliative care situations.	6/8/2015 8:56 PM
9	My experience of newly qualified consultant level is that they do not have enough experience generally of medicine; it takes several years to build this up	6/8/2015 7:02 PM
10	I would not currently feel confident in a cardiac arrest situation. I am able to recognise and manage an acutely sick patient in an emergency but would very rapidly require support from other teams.	6/8/2015 5:54 PM
11	I think it equips people to manage acute problems in the hospice setting but wouldn't be sufficient to manage acute patients in the hospital setting.	6/8/2015 5:52 PM

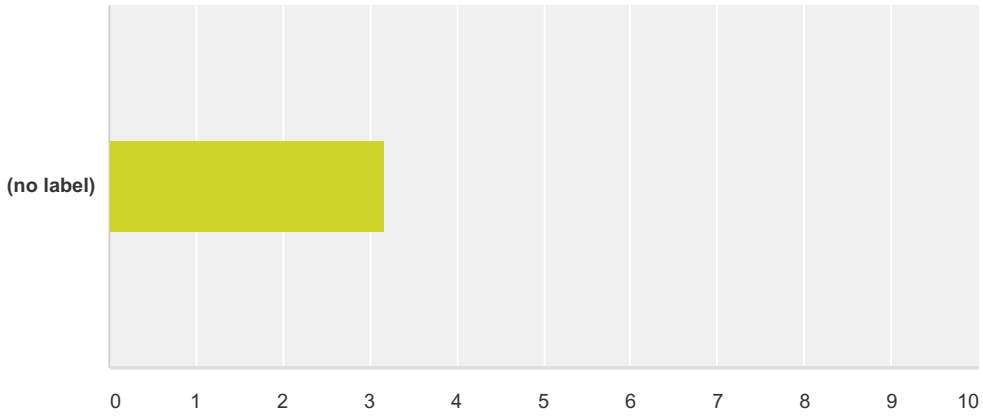
12	The current curriculum equips doctors to manage emergencies in patients with palliative care needs. They need to be able to identify problems, know if it can be managed in the setting the patient is in, treat where appropriate, transfer where appropriate and link with appropriate specialist if any doubt.	6/8/2015 5:47 PM
13	I think that there is generally a very good standard of experience in managing acute & emergency patients appropriately in pall care setting. Clearly this can be influenced by the previous posts held by the trainees. I think the extra 3rd year of core training will enhance this knowledge and help to develop skills in this area. There is currently significant emphasis placed on management of emergency patients throughout the pall med specialty curriculum.	6/8/2015 4:06 PM
14	Clearly it does not. Although in section 2.5 Management of Concurrent Clinical Problems most organ systems are mentioned the subheading states: "describe the scientific basis and clinical manifestations of concurrent clinical problems presenting in patients with life limiting illness and to diagnose and manage them in the context of patients with life-limiting progressive disease." The last phrase in this heading "in the context of patients with life-limiting progressive disease" is very important. The management of patients approaching the end of their life is very different from patients who need acute, emergency, curative medical care and potentially escalation to intensive care treatment. The curriculum would need significant amendment to be fit for purpose if palliative care trainees are expected to be able to do both by the end of their training.	6/8/2015 11:10 AM
15	This is not our experience for most CST trainees	6/8/2015 10:23 AM
16	Most are equipped to manage palliative care emergencies but I think some of the less experienced doctors can struggle in difficult situations.	6/8/2015 12:13 AM
17	Badly worded question hence the 'neither agree nor disagree' answer - it equips them to manage acute / emergency patients in a pall care setting but does not equip them to manage acute medical patients at specalist level	6/5/2015 9:46 AM
18	There may be some benefit in gaining further experience in acute medicine but not in place of palliative medicine training.	6/4/2015 9:05 PM
19	Only those within our comfort zone however - my trainees would not feel confident managing an acute MI for example.	6/4/2015 5:05 PM
20	Not if part of acute unselected take	6/4/2015 2:12 PM
21	If you mean general medical acute and emergency patients then I disagree.	6/4/2015 12:25 PM
22	As long as this is referring to acute and emergency patients within the palliative care setting. I'm not sure I could still effectively manage a patient in A&E resus.	6/4/2015 12:01 PM
23	Often, the level of medical intervention may be limited by the setting. May be fine for hospital but less so for hospices and the community	6/4/2015 11:58 AM
24	Well equipped to manage acute and emergency patients in palliative medicine, but not those in general medicine (eg generic medical emergencies etc)	6/3/2015 7:32 PM
25	But with the proviso that whilst people can deal with the emergencies in theory, by the end of a 4 year training programme, it is fairly common that trainees will not have dealt with any emergencies in a practical situation for a number of years and therefore their theoretical knowledge may no longer translate into practical skills.	6/3/2015 5:16 PM
26	This needs strengthening aside form the radical proposals of shape of training	6/3/2015 3:35 PM
27	Those relevant to the specialty.	6/3/2015 11:19 AM
28	If you mean the acute general medicine take, I would disagree. If you mean how to manage common acute and emergency presentations in the third sector, then yes.	6/3/2015 1:45 AM
29	To manage acute and emergency palliative patients- yes	6/2/2015 5:39 PM
30	Yes but only within the context of palliative medicine. If patients need intensive monitoring and interventions, the correct path is to transfer to the appropriate acute specialty. As I have noted, most services do not have in-patient hospital beds, therefore management of acute medical problems in hospital is shared with an appropriate team.	6/2/2015 9:26 AM
31	Does not equip to manage acute medical emergencies -may have been 4 years since managing a pneumothorax, septic shock etc. they are equipped to manage palliative emergencies	6/1/2015 11:07 PM
32	the focus on diagnostic skills allows doctors to recognise an emergency situation, and transfer them appropriately to an acute setting, but doesn't necessarily equip them to manage these patients	6/1/2015 8:32 PM

33	well equipt to manage palliative emergencies and general medical emergencies - if patients are in a hospice unit and requiring further acute or emergency treatment for other issues then they should be transferred out to the appropriate acute specialty as GPs would do at home.	6/1/2015 5:02 PM
34	I have found some of those who have chosen to do palliative medicine is not for their love for the specialty, but because they do not want to do acute or general medicine.	6/1/2015 11:23 AM
35	I'm not sure this question is clear. They are not equipped to manage acute medical emergencies in all patients, however it does equip them to recognise and manage acute emergencies in palliative care patients, and to recognise when escalation of treatment or calling for specialist expertise is necessary.	5/31/2015 9:54 PM
36	Especially if doing via MRCP route.	5/31/2015 9:26 PM
37	Acute and emergency situations within a palliative medicine setting only	5/31/2015 8:34 PM
38	Especially with regard to unselected take and performing procedures	5/31/2015 4:05 PM
39	Only acute emergencies relevant to palliative care.	5/31/2015 12:33 PM
40	acute and emergency patients within palliative care; but not for a general take - I would feel deskilled in the latest management of a number of presentations as the responsible consultant	5/30/2015 8:42 PM
41	New consultants do not now have adequate experience.	5/29/2015 7:06 PM
42	Palliative care emergencies are covered but less so other types of emergencies	5/29/2015 3:43 PM
43	It allows us to make judgments on condition but would need additional support from specialties.	5/29/2015 1:32 PM
44	within the specialty	5/29/2015 1:13 PM
45	I would not feel comfortable to manage an actuely unwell general medical patient - I think patient safety may be compromised.	5/29/2015 9:49 AM
46	With rapidly changing acute medicine it is more appropriate to have ongoing updates available to all practising pall med doctors than increase acute medicine training in specialty training. MUch of the 1st on call in pallmed is done by gp,s or specialty doctors and we can access acute medical advise from hospital colleagues when necessary.	5/29/2015 8:02 AM
47	Not for unselected general medical acute & emergency situations. Not too same level as gained through internal medicine training for example.	5/28/2015 11:37 PM
48	Should have a longer stint in A&E to see and know what happens when pts in the community are sent in or taken in unexpectedly and so help manage their care better at home pre (so hopefully preventing) and post having a better understanding of whats been going on.	5/28/2015 8:12 PM
49	The current curriculum does equip trainees at CST level to manage most acute/emergency events happening to PURELY Palliative patients. Given that palliative training varies from region to region in the level of expertise provided within hospices and that hospital palliative specialists to date have more of an advisory role, the practical aspects of handling acute emergencies is limited (knowledge base will be there).	5/28/2015 8:06 PM
50	Mostly, but is very dependant on what happens to come in while you're in the hospice -so levels of experience will vary considerably depending on where you worked, how big your unit is and how each unit deals with an emergency.	5/28/2015 7:03 PM
51	It equipped me to deal with palliative care emergencies. I do not feel it equipped me to manage an acute reversible illnesses actively.	5/28/2015 6:24 PM
52	not enough refreshing of general medicine unless you pay yourself to attend a course	5/28/2015 5:23 PM
53	It equips them to manage them in a community and hospice setting - and enables decisions about transferring to acute trusts to be made. If the question is asking whether they could/should run the acute medical take then no.	5/28/2015 4:50 PM
54	if i had my first heart attack I would not want to be looked after by a Doctor who was not up to date with the latest acute protocols. Equally I would not want my palliative needs to be looked after by a Doctor who only understood the acute response to disease.	5/28/2015 4:41 PM
55	But only in the context of working in the community/hospice, not running an acute take.	5/28/2015 4:41 PM
56	Depends what you mean. In terms of selected palliative care acute and emergency patients then yes; in terms of unselected general medicine acute and emergency patients then no.	5/28/2015 4:04 PM

57	depends on what is meant by 'manage appropriately' but if full medical interventions then I would say definitely not	5/28/2015 3:40 PM
58	Senior decision making experience is not gained after cst	5/28/2015 3:23 PM
59	no mandatory ALS.	5/28/2015 2:30 PM
60	It depends - trainees can rapidly lose their acute / general medicine skills and most by ST5/6 would not be able to manage an acute take. I think our curriculum allows trainees to manage acute patients to the level required in a non-acute setting, but not to necessarily hold management, e.g. of an acutely unwell patient in the community	5/27/2015 5:56 PM
61	As long as it is not shortened....	5/27/2015 5:44 PM
62	if this is regarding GIM patients I would be concerned about some procedures e.g. central line insertion, chest drain as not performed for some years.	5/27/2015 4:16 PM
63	It does not - but the underlying question is should it. Why do you want a palliative care consultant in a hospice to be able to run an acute take? Why do you want to fund him/her to be trained to do so?	5/27/2015 3:50 PM
64	For common presentations in palliative care patients	5/27/2015 3:04 PM
65	CST level doctors currently manage acute and emergency patients within the palliative care setting appropriately - they do not have the skills to manage all acute and emergency patients across all settings, however a physician will not have the skills to manage all acute surgical patients - how broad does this training expect to be?	5/26/2015 10:04 PM
66	The curriculum does equip doctors for the emergencies most commonly affecting our specific cohort of patients. It does not necessarily equip doctors for dealing with more general medicine emergencies, though courses such as ALS and IMPACT could become a core part of the curriculum to rectify this to the degree necessary (since ultimately the role of palliative medicine doctors at CST level will be to correctly diagnose and initiate appropriate management for such emergencies until an appropriate transfer/appropriate specialist help arrives). I undertook 2 years as a specialty Doctor in acute medicine before entering the palliative medicine training program, which was a valuable experience.	5/26/2015 11:15 AM
67	As general medicine advances/changes may become easy to be "left behind" with regard to specific management of emergencies (eg drugs for ACS etc)	5/26/2015 10:08 AM
68	Mine did. However attention needs to be paid to the experience breadth for trainees and they need to have experience of services that admit 24/7 and spend time in all settings including assessment and critical care areas of the hospitals	5/25/2015 11:20 PM
69	Exposure is limited in acute and general medicine and often as optional modules only	5/25/2015 6:17 PM
70	Depends what you mea. Managing acutely ill palliative patients admitted to hospitals or hospices or in community- yes, agree strongly. If managing acute takes in hospital as consultant on call- disagree strongly.	5/24/2015 10:09 AM
71	Yes, speciality specific emergencies	5/20/2015 12:38 PM
72	I presume this is talking about the general acute take and not "pallaitive medicine emergences". Of course it doesn't equip trainees to manage acute general medical emergencies and it shouldn't be trying to.	5/19/2015 2:02 PM
73	Although I agree with this, this may be around acute management rather than leading or managing an internal medicine rotation as a Consultant or senior medic.	5/19/2015 12:35 AM
74	I've worked with some ready & some not.	5/18/2015 7:05 PM

Q17 Shape of Training will help support trainees to develop the skills to deliver acute palliative care in hospital, community and hospice settings, and to support the national requirement for more integrated care and avoidance of acute admissions.

Answered: 192 Skipped: 57



	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**5.21%** 10	**21.88%** 42	**33.33%** 64	**28.65%** 55	**10.94%** 21	192	3.18

#	Additional Comments	Date
1	Potentially....	6/10/2015 9:00 AM
2	I think it will only help with delivering acute palliatve care in the hosptial, but this does not provide more integrated care and avoidance of acute admissions. I think increasing the component of our training in the community is the better way to support this national requirement.	6/9/2015 10:47 PM
3	I am unsure if trainees with more general medical training would have the necessary skills to deliver hospice-based palliative care which often sees patients with very complex symptom control issues, but increasing palliative care knowledge would be helpful for doctors delivering medical care in hospitals and the community settings.	6/9/2015 8:12 PM
4	Potentially - if this means including more palliative care in other specialty curriculums and trainees having at least 6 months palliative care placements during their medical training.	6/9/2015 6:19 PM
5	Don't think that it will alter this- patient and family expectations are driving the demand on acute admissions, not doctors	6/9/2015 4:10 PM
6	I think the current training achieves that	6/9/2015 2:09 PM
7	If done well, there is a real opportunity to help shape a new healthcare delivery system: the boundaries need to be broken down between primary and secondary care, something which palliative medicine has traditionally done well. But we can't cut the time involved to achieve this.	6/9/2015 11:19 AM
8	community and gp training is not detailed in how this would change	6/9/2015 8:54 AM
9	Yes wrt hospital settings. No wrt community or avoidance acute admissions.	6/8/2015 10:21 PM
10	Perhaps, not sure how it will be put into practice	6/8/2015 7:02 PM
11	Too much focus on internal medicine at the expense of community and hospice.	6/8/2015 6:29 PM

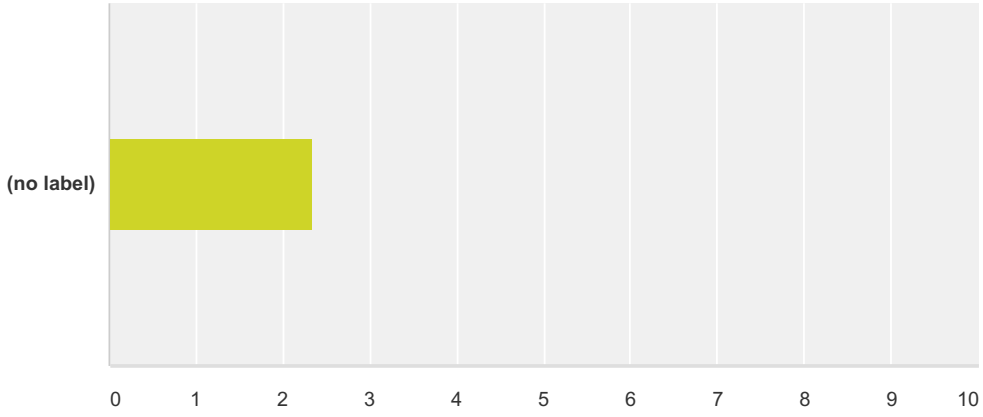
12	The emphasis in SHOT is on increased experience in Acute Medicine for those training in medical specialties, & I think improved skills in managing patients with acute medical problems in hospice or community would be achieved better by spending more time working in those settings.	6/8/2015 5:52 PM
13	I do not feel Shape directly will do this. Service development and education would be able to acheive this.	6/8/2015 5:47 PM
14	Depends on what resources are found to underpin further training & experience in community for example.	6/8/2015 4:06 PM
15	We need to accept that 'hospice' is changing (and the name may even be undesirable?) More and more hospices are acute palliative medicine units, in my view appropriately	6/8/2015 10:23 AM
16	I'm really not sure if it will! If we get it right...	6/8/2015 12:13 AM
17	Yet again, it depends on the implementation. It could do this, it could be a complete disaster	6/5/2015 9:46 AM
18	I don't think it would help palliative medicine doctors. I think it could distract from the holistic care we provide at present and may change the focus to more acute medical interventions instead of helping patients and families accept that patients are dying. I think it would result in more hospital admissions and more investigations and treatments.	6/4/2015 9:05 PM
19	Not sure we have sufficient detail to know...	6/4/2015 5:05 PM
20	Potentially depending on the training programme and the ability to influenec other speciality training	6/4/2015 2:12 PM
21	by ditracting for comminuty care and service provision i believe this would increase hospital addmsions at great cost to the individual and NHS	6/4/2015 12:22 PM
22	Not sure what evidence there is that shape of training will do this.	6/4/2015 12:01 PM
23	I think it will maintain service provision in the acute sector rather than improve specialty training.	6/3/2015 7:32 PM
24	only porviding there is a sensible balance struck and at least another year of training. I feel that most consultants exit training only barely able to be experts and are not rounded.	6/3/2015 3:35 PM
25	It's not entirely clear that it will. If all the internal medicine is at year 4, before you've had any specialty training, then I can't see how you can 'model' palliative care skills to the acute take team.	6/3/2015 11:19 AM
26	I don't think SHoT has been the prime thrust behind more cross-boundary care. If SHoT recommendations are fully implemented, then perhaps we will, in future, have a pool of doctors who are dually trained in general medicine and palliative medicine, who then go on to influence generalist colleagues in ways perhaps current hospital palliative medicine physicians cannot. My hunch is that because of needing to 'switch hats' as mentioned earlier, this 'influencing' role will not be as strong when it is based on shortened specialty training.	6/3/2015 1:45 AM
27	It focusses attention much more on in hospital care than on admission avoidance	6/2/2015 5:39 PM
28	Shangri-Lah! We can dream. It will equip trainees with knowledge but to achieve this aim, we require a significant investment in other staff - doctors alone will not prevent admissions, increase the ability of patients to die at home and integrate care. This is a much broader issue and medics are probably the least important aspect. Changing the shape of training will not mange this.	6/2/2015 9:26 AM
29	Not sure it will do either will dilute palliative care and not enough acute medicine to do either properly	6/1/2015 11:07 PM
30	I think it will rather result in underskilled palliative care physicians. doing acute medicine won't improve the quality of palliative care we provide.	6/1/2015 8:32 PM
31	I do not think that it is clear one way or another whether this would be the case as there is not sufficient information about how exactly the training will take place.	6/1/2015 6:04 PM
32	changes in training will dilute the trainees exposure and learning of palliative medicine, with distractions on GIM learning needs that are very different to palliative ethos. If trainees are to learn how to deliver palliative care in hospital, community, and hospice, then trainees need to soley focus on learning these skills as part of palliative medicine training in all 3 sites as currently happens.	6/1/2015 5:02 PM
33	Moving the hub of palliative care services outside the hospices and more inetegration with community and hospital teams will help. Whether anything will prevent acute admissions is a different area as far as I am concerned.	6/1/2015 11:23 AM
34	But needs care to ensure time and settings to acquire the palliative medicine skills to sufficient level	6/1/2015 9:50 AM
35	I think the current system already does that, what we need in order to prevent acute admissions is greater access to palliative medicine specialists out of hours.	5/31/2015 8:34 PM

36	Need to wait to see more detail first before being able to answer this.	5/31/2015 4:05 PM
37	We'll have to wait and see!	5/31/2015 4:05 PM
38	Difficult to tell at this stage. I suspect it will not add anything.	5/31/2015 12:33 PM
39	The impact of S o T will be that trainees have less community experience and therefore less confidence in integrating care/admission avoidance.	5/29/2015 5:46 PM
40	Although I hope this would be the case, I suspect palliative medicine would lose out to the other specialities.	5/29/2015 4:33 PM
41	No it is aimed to provide more generalists support.	5/29/2015 3:43 PM
42	I fear extra competencies will not be gained as we will become clerking patients wo help support the acute take withlittle extra knowledge. The MRCP and core medical training equips us with sufficient medical knowledge to manage acutely ill patients.	5/29/2015 1:32 PM
43	There is insufficient empahsis on specialist palliative care training. Whilst the Shape of Training may improve GIM trainees skills in palliative care, it will reduce the skills of those who have gained CST.	5/29/2015 9:49 AM
44	go trainees make superb pall med consultants ,as they are used to focusing on big picture and individuals in that big picture. wE should enable the right sort of personalities to train in pall med, otherwise there will be lots of frustrated specialty doctors being managed by acute medicine focused consultants.	5/29/2015 8:02 AM
45	The current shape of training as it stands appears to be hospital focused(at risk of taking trainees away from the hospices/community) - so will not do much for avoidance of acute admissions. Acute emergencies are unlikely to be manageable in hospices or the community - these will need to come into hospital as appropriate - Avoidable admissions can only be reduced by changing the mindset of the public (to get comfortable in managing end of life at home) and GPs getting supported enough to feel confident enough to manage palliative patients at home.	5/28/2015 8:06 PM
46	Surely the only way to do that would be to divert more doctors into general practice so that each GP has more time and attention for a smaller set of patients who they look after? I'm not at all sure how SoT is planning to avoid admissions when it is just re-designing hospital based training.	5/28/2015 7:03 PM
47	SPending more time in a community setting would do this, not increasing experience in the acute setting itself.	5/28/2015 4:50 PM
48	I am not sure what acute palliative care is. If the national requirement is for more integrated care then surely the ficus needs to be on improving general practice not into creating a new tier of Hospital Partialists	5/28/2015 4:41 PM
49	Not if they don't include GPs and there isn't time in the training for registrars to spend much time in the community/hospice.	5/28/2015 4:41 PM
50	This potential advantage doesn't seem to outweigh the potential disadvantages.	5/28/2015 4:04 PM
51	The phrase acute palliative care is a new one! Where did that come from? I would say just good palliative care.	5/28/2015 3:45 PM
52	Much of our work in admission avoidance is about looking at alternatives to acute medicine rather than delivering a watered down version in another setting.	5/28/2015 3:42 PM
53	it will in some degree	5/28/2015 3:40 PM
54	This should occur already with the current curriculum and experience gained whilst training. The opposite could occur with consultants having had less experience in managing situations at home resulting in more acute admissions occuring.	5/28/2015 3:19 PM
55	avoidance of acute admissions stems from good advanced care planning and community care provision. neither of these will be developed as well as they are currently if there is a change to shape of training.	5/28/2015 2:30 PM
56	Acute skills/dual accreditation will be very useful for palliative medicine but positive effect could be exceeded by loss of time for training and reduction in doctor time for service delivery, both of which are needed to provide integrated care and avaiod admissions	5/28/2015 2:25 PM
57	I don't see improvement on the way things are done right now	5/28/2015 2:25 PM
58	But only if trainees are given the time to develop the specialty skills needed to do this (ie extra specialty training time in addition to the time spent managing the acute take).	5/28/2015 2:17 PM
59	The demographic of our patient population is changing and we need to take the opportunity to evolve our training to meet the population needs.	5/27/2015 5:56 PM

60	As above - the focus appears to be on hospital based acute internal medicine. Therefore will lead to a lose in palliative care training overall, especially in the non-hospital setting.	5/27/2015 3:50 PM
61	There is not enough palliative medicine time in it to do this.	5/26/2015 10:04 PM
62	All doctors need to be able to work with a palliative approach - not sure this is the way to do this	5/26/2015 5:16 PM
63	I think this is the specific area in which the shape of training recommendations most clearly falls down. It risks making palliative medicine either a hospital only specialty, or multiple sub-specialties with either a community/hospice or hospital focus. This will threaten integrated care goals and likely fail to reduce admissions / length of stay	5/26/2015 11:15 AM
64	Will help in hospital setting but less so in community settings if no community/general practice element to the changes.	5/26/2015 10:08 AM
65	I think they will be less experienced in Palliative Medicine	5/25/2015 11:20 PM
66	Not more so than current training	5/23/2015 10:14 PM
67	Difficult to know until details are further clarified.	5/20/2015 9:59 AM
68	Impossible to say!	5/19/2015 3:51 PM
69	I havn't seen anything to suggest why this should be the case with shape of training any more than it is under the current system. Shape of training is about improving the care of general acute medicine patients - there is nothing about it that has been aimed at improving training in palliative medicine. Palliative Medicine needs to maintain its standard of training in spite of of shape of training.	5/19/2015 2:02 PM
70	no the focus on shape of training is all about the acute hospital take	5/19/2015 8:46 AM
71	Acute medicine will not - more work in GP may	5/18/2015 6:52 PM
72	difficult to visualise honestly how training will actually look, hence hard to answer this question	5/18/2015 5:15 PM

Q18 The current curriculum for Palliative Medicine meets the objective of producing doctors in the specialty who are equipped in terms of their knowledge, capability, experience, attitudes and behaviour to meet the changing needs of the patient population and flexibility to continue to meet those needs as they evolve?

Answered: 192 Skipped: 57



	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**14.06%** 27	**53.65%** 103	**18.75%** 36	**12.50%** 24	**1.04%** 2	192	2.33

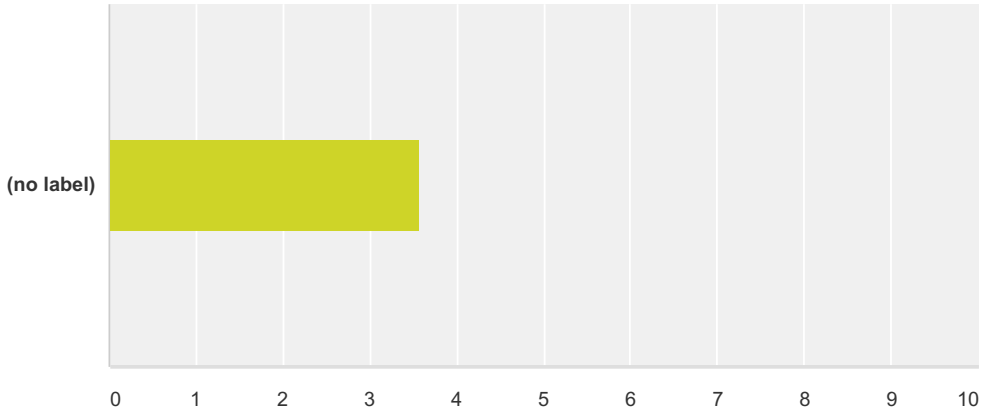
#	Additional Comments	Date
1	Personal experience only, but what I see makes me feel that potentially long periods spent in "independent hospice" culture during training does not prepare individuals for the "rough and tumble" of realities in Primary care or Hospital practice of Palliative Medicine	6/9/2015 9:57 PM
2	There is currently more of a hospital / in-patient unit focus to the training which is likely to need adjusting as the needs of the population are changing.	6/9/2015 6:19 PM
3	Although the curriculum does require a considerable proportion of hoop jumping at present.	6/9/2015 4:10 PM
4	looking ahead there will need to be more focus on management of chronic conditions	6/9/2015 2:09 PM
5	Not sure that we have caught up with the changing patient demographic, and am not sure that all hospices are on course to change radically what they do. The hospice I work in runs a 7 day service, including out of hours admissions, and increasingly is delivering care to patients with non-malignant disease. Many others don't, and if they don't, there won't be enough units to train the doctors in the way they need to be trained.	6/9/2015 11:19 AM
6	more medical training is needed, more partnership working and more community experience - complex often elderley patients needing holistic assessment and management	6/9/2015 10:02 AM
7	CESR should be protected to allow SAS doctors to progress. There are areas in the country who struggle to recruit and this is then a vicious circle as this impacts on ability to train and "grow" future workforce.	6/8/2015 6:29 PM
8	I think there are a lot of weaknesses in our current curriculum.	6/8/2015 6:05 PM
9	I think it would be good to have a clearer focus on community than the current curriculum has.	6/8/2015 5:54 PM

10	At this point it does. The curriculum needs to continue to change with the times as it has in recent years to meet the need.	6/8/2015 5:47 PM
11	I think the curriculum goes a long way to doing this already. There is always room for improvement. More guidance on how to gain competencies in meeting the changing needs of the patient population would be helpful.	6/8/2015 11:10 AM
12	Probably we need more of a public health focus	6/8/2015 10:23 AM
13	The majority of trainees currently want hospital posts rather than community ones; if we look at the needs of a future population this needs to change.	6/5/2015 9:46 AM
14	I think this varies beteween training programmes	6/5/2015 9:14 AM
15	I think there should be more in the curriculum supporting working in the community and also in acute palliative care ie AMU, A&E, 7 day responsive service	6/4/2015 12:01 PM
16	I suspect that management will be increasingly complex and patients may expect more intervention than currently	6/4/2015 11:58 AM
17	Whether there is sufficient funding within the system to enable them to do this is another matter....	6/3/2015 7:32 PM
18	I think it does need some more acute medicine to reflect the changing population in hospices and the interventions that hospices now offer.	6/3/2015 5:16 PM
19	Refinement is needed, but it is fundamentally good.	6/3/2015 3:35 PM
20	The changes need to be developed post CCT/CST also, otherwise your newly trained dual accredited doctors will coon be out-of-date on acute medical care.	6/3/2015 11:19 AM
21	I think the current curriculum for Palliative Medicine does indeed produced a group of doctors with the necessary skills to provide valuable opinions for patients whilst the clinical landscape evolves. The demand for this value will surge as the population ages, because the thrust of general medicine is to 'save' life at all cost.	6/3/2015 1:45 AM
22	and obviously we all need to continue to learn throughout our careers after training	6/2/2015 5:39 PM
23	The reality is that these doctors have been medical students seeing all the same issues, they have only practised with the current demographics and are very well versed in the issues of an ageing and increasingly frail, disabled population. It is patronising and arrogant of those in the colleges and other institutions to believe that the next generation are not up to the task of developing services and improving care. Just like some of them have done themselves with no specific training for the task to boot. I sometimes wonder if the people who produce these plans are actually in the same world as the rest of us. Please do not allow another massive reorganisation that is politically motivated and does not address the real problems.	6/2/2015 9:26 AM
24	It does depend on their rotations and what their exact experience is	6/1/2015 11:07 PM
25	Training needs to change to allow for the changing needs of our patients	6/1/2015 9:01 PM
26	Some can only survive in hospices.	6/1/2015 11:23 AM
27	I think more focus needs to be given to primary care and also management of long term conditions (non malignant disease). This experience will not be gained from doing acute takes.	5/31/2015 9:26 PM
28	Curriculum and training need review and I would support more community training.	5/31/2015 4:05 PM
29	The current curriculum does not ask trainees to think about how our jobs might look in the future - to meet the changing needs of our patient population - we learn about non-malignant and malignant disease - need to embrace chronic disease including transition/young adults and prepare trainees for new models of care - MAJOR focus on community services	5/31/2015 4:05 PM
30	Since the introduction of MMC CCT holders are much less able to take on all the responsibilities of being a consultant - they simply do not have the necessary experience.	5/29/2015 7:06 PM
31	I feel the curriculum does need to be evolved.	5/29/2015 3:43 PM
32	a bit unclear; the curriculum is fine, but doesn't 'produce' anything - it's the training / experience / monitoring that does or doesn't do that! We need to get away from 'paper' education and back to patients	5/29/2015 1:13 PM
33	More equal focus on community and hospital needed , also team management , service provision and planning. experTise in education also vital as upskilling others a vital role.	5/29/2015 8:02 AM

34	There needs to be much more focus on quality improvement, service innovation and management during the training scheme - not just going on courses, but being immersed in these things in a way that is something beyond a neat little audit project - senior trainees need to be allowed to come to senior management and governance meetings, and to shadow and support consultants who are trying to develop innovative models of care.	5/28/2015 6:24 PM
35	4years without any time out is quite quick to suddenly be expert in all things palliative care i think we need more cross specialty working/shadowing	5/28/2015 5:23 PM
36	If we can't produce consultants capable of dealing with change we have truly failed.	5/28/2015 4:04 PM
37	We have to be prepared to constantly revise light of changing roles and opportunities - which might widen access by a different group of patients.	5/28/2015 3:45 PM
38	to a large degree but I feel patients are becoming more complex and as we take on more non-cancer pts we need to expand our skills	5/28/2015 3:40 PM
39	And if it didn't, the curriculum needs to flexible to meet those changing needs	5/28/2015 2:25 PM
40	I think it depends on the trainee - for some yes but for others no. I think trainees moving forward will need to have more acute experience to be able to help lead the service changes required to meet the needs of the population	5/27/2015 5:56 PM
41	I do feel with the increasing move to community care that 6/12 experince is insufficent to become a community palliative care consultant and this should be reviewed. Indeed could this setting based approach be a possible target for crediationing?	5/27/2015 3:50 PM
42	I think there needs to be a more structured approach to ensure that trainees are definitely gaining the necessary depth of experience and insight into the medical changes that are occurring in other general medical fields e.g. respiratory, geriatric - at the moment it is too variable according to your personal experience in the placements you've had.	5/26/2015 10:12 PM
43	I think the curriculum is good if the trainees get appropriate clinical experience to gain their competencies. I have my reservations about the DOPS they have to do	5/25/2015 11:20 PM
44	Emphasis on long term conditions needs increasing still remains too cancer focused especially in hospices	5/25/2015 6:17 PM
45	In the right training programme, in my experience, the curriculum delivers	5/23/2015 10:14 PM
46	The current curriculum is pretty good. It falls down on areas which are harder to define and measure e.g Maturity of clinical decision making, complex/poorly sighted decision making and "working with the gray", complex communication skills. This is where I think we are better off collaborating with General Practice/Psychiatry in developing educational models.	5/19/2015 2:02 PM
47	don't know!	5/18/2015 7:05 PM
48	although if we move more towards chronic disease management then this should be looked at incorporated - eg respiratory clinics/rotations etc	5/18/2015 5:15 PM

Q19 The current Undergraduate programme and Foundation programme prepare doctors very well for entry to Palliative Medicine?

Answered: 193 Skipped: 56



	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**0.52%** 1	**13.47%** 26	**26.42%** 51	**47.67%** 92	**11.92%** 23	193	3.57

#	Additional Considerations: How would these programmes need to be developed to incorporate aspects of the Palliative Medicine curriculum should the length of training be shortened?	Date
1	In terms of medical knowledge doctors are adequately prepared, but there is often little exposure to the specialty prior to applying for specialty training meaning that trainees may not consider palliative medicine as a career option or understand what the job entails.	6/9/2015 8:12 PM
2	Undergraduate training in palliative medicine is very variable at present with some areas having a few weeks of training, other areas only a couple of days. There are also very few foundation programmes including palliative care experience - this would need to be adjusted considerably to allow the length of training to be shortened.	6/9/2015 6:19 PM
3	Not enough consideration given to the option of doing nothing, or to holistic care or to symptom control or to care of dying patients at present- I think Francis report indicates this.	6/9/2015 4:10 PM
4	in the North East	6/9/2015 1:48 PM
5	In our region, and within our Deanery, there is excellent recognition of and exposure to palliative medicine principles, including communication skills and role of hospices. Even if this is made the norm across the country, junior doctors still will need exposure post-registration to the elements involved.	6/9/2015 11:19 AM
6	not sufficiently trained in time management, autonomous practice, pain control/opioids, general medical managment of patients	6/9/2015 10:02 AM
7	depends on the Trust and medical school	6/9/2015 9:55 AM
8	Drs frequently minimal experience PM before training scheme.	6/8/2015 10:21 PM
9	there needs to be more training at the undergraduate level in palliative care.	6/8/2015 8:56 PM
10	Not enough time spent	6/8/2015 7:02 PM
11	our local medical school is reducing palliative care teaching to a minimum.	6/8/2015 6:58 PM
12	There is insufficient palliative medicine in foundation training	6/8/2015 5:54 PM

13	Not enough integration of Palliative care into training - seen as an extra few days rather than actually making patient centred holistic care the core of all training	6/8/2015 5:47 PM
14	Include more pall med training in early years of training. Increase the number of opportunities to have working attachments in palliative care/medicine, from foundation through CMT.	6/8/2015 4:06 PM
15	I think it depends on the medical school. Many students get very good UG training, some very little, the problem is that much of this training is reversed/ignored once students meed the hidden curriculum within their acute hospital trust foundation programme work	6/8/2015 10:23 AM
16	Undergraduate palliative medicine training could be better if spread out throughout training rather than 1 week block.	6/5/2015 4:51 PM
17	Currently students and foundation trainees get too little exposure to following patients through a hopsital stay - this makes it difficult for them to learn symptom control or to gain confidence in communication.	6/5/2015 9:46 AM
18	Probably need a little more general experience prior to entry	6/5/2015 9:14 AM
19	I think doctors should have a very broad range of experience, knowledge and skills. More experience in general practice and psychiatry could be useful along side medical experience.	6/4/2015 9:05 PM
20	In my experience those who have an interest develop the experience but am not sure that we currently educate enough when we are not 'preaching to the converted'. Generalist palliative care knowledge should be integral to all specialties and be mandatory at undergraduate and foundation level.	6/4/2015 5:05 PM
21	There is an agrument for incorporating more palliative care training into undergrad and foundation programme irrespective of how the specialist curiculm changes	6/4/2015 2:12 PM
22	Most undergraduate and foundation programmes have minimal exposure to specialist palliative care.	6/4/2015 12:01 PM
23	My experience is that more exposure to acute medicine is needed in the early years of training. I am not sure how that could be achieved if training is shortened.	6/4/2015 11:58 AM
24	Communication. ACP. EOLC	6/3/2015 9:17 PM
25	More rotations in, and exposure to, palliative medicine needed at undergraduate and foundation level. Community posts eg hospice etc would be useful	6/3/2015 7:32 PM
26	There needs to be far more exposure from the beginning of medical school for there to be any chance of the medical culture changing for the better.	6/3/2015 3:35 PM
27	Need a sound medical knowledge and experience. More communication skills training is needed however.	6/3/2015 11:19 AM
28	The current UG and Foundation programmes ought not to be shortened themselves!	6/3/2015 1:45 AM
29	Pall med has to compete with larger and conceivably more important specialties for undergrad curriculum time. How we change this is another challenge. Shape of Training will not influence this. Postgrad time in pall med has diminished with the establishment of F1/F2 and CMT. There are very few opportunities for junior docs to chose to do pall med to find out if it is for them. Shape of Training will not help unless more rotational posts are funded within pall care teams or units. And I will believe that when I see it!	6/2/2015 9:26 AM
30	In merseyside we have a 4 week undergraduate programme for undergraduates this includes advanced communication skills training. We also have final year 7 week attachments when they can spend the time doing more palliative care - they choose this option if they wish. We have had several trainees who have decided to palliative care via this route. We are also part of foundation year and core medical rotations and trainees will ask to do those rotations if they are considering this as a speciality.	6/1/2015 11:07 PM
31	The artificial split between community and hospital work makes the transition to palliative care training difficult. I suggest that a higher proportion of community work should be incorporated into early training	6/1/2015 8:32 PM
32	very little input into these programmes	6/1/2015 5:02 PM
33	Foundation programme probably helps, but for undergradute programme to be helpful, palliative medicine needs to have a larger weightage in final undergraduate exams.	6/1/2015 11:23 AM
34	Palliative medicine is not well integrated into the undergraduate curriculum largely through the culture of death avoidance in many specialties outside of palliative medicine. I believe palliative care trainees are often best to have wider experience prior to entering the training programme.	5/31/2015 9:54 PM
35	There are insufficient numbers of foundation year/ ST1-2 posts in the speciality. I think many trainees either know little about the speciality or are concerned about committing to a speciality in which they have never worked.	5/31/2015 9:26 PM

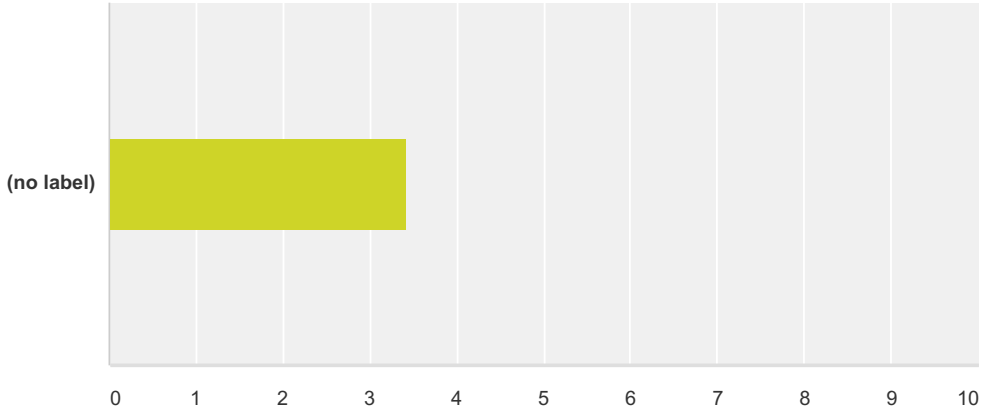
36	On my CMT curriculum there was not one competency to do with end of life care, recognising dying, or symptom management.	5/31/2015 8:34 PM
37	Potentially would need to adjust undergraduate and foundation programme to provide more integrated training eg in community (already happening in some areas).	5/31/2015 4:05 PM
38	Depends on specialities covered in CMT eg geriatrics, oncology useful.	5/31/2015 12:33 PM
39	There is good grounding but it does not seem to be reinforced at a ward / team level; so the skills are often lost.	5/30/2015 8:42 PM
40	Trainees entering ST3 nowadays often do not have any experience of worknig in Palliative Meidcine -s o are sometimes not well suited to this specialty, or have unrealistic expectations about the specialty. It was better in the olden days when doctors could take standalone jobs before entering SpR training to gain some expereicne nd check that it was the specialty for them.	5/29/2015 7:06 PM
41	It seems better than it was but if the undergraduates and foundation doctors are not exposed to specialist palliative care, they can have a distorted view of what it actually involves.	5/29/2015 4:33 PM
42	Entry is not from foundation is it??	5/29/2015 3:44 PM
43	There are few training options currently though this might be increasing.	5/29/2015 3:43 PM
44	No- need core medical training in addition.	5/29/2015 1:32 PM
45	The current literature show that newly qualified doctors feel unprepared to manage end of life care. There needs to be much more integrate teaching and placements in palliative medicine for both undergraduate and Foundation doctors.	5/29/2015 9:49 AM
46	Fragmentation of training a problem - it is hard for juniors to follow patients through, take responsibility for decision making and see the outcomes , learn to work effectively in a team. Those who most need pall med experience are least likely to select it, but in my experience do learn a lot and have attitudes changed by hospice/pall medicine training attachments. Core medicine And surgical trainees might well benefit from pall med fort nights.	5/29/2015 8:02 AM
47	Only limited foundation opportunities	5/28/2015 11:37 PM
48	Regular experience, rather than ad hoc ward rounds. Single days with palliative Care nurse; attendance at outpatient clinic; observing admissions to hospices, shadowing a registrar or consultant for the day	5/28/2015 9:08 PM
49	Some medical schools do a lot - Cambridge under Stephen Barclay being one example - however I have spoken to many other medical students at different universities who have had a very different experience	5/28/2015 8:12 PM
50	I believe this is dependent on regional training programs - some areas(eg South west) have been way ahead than others in preparing doctors for Palliative medicine. Provision of taster sessions / hospice placements at foundation levels help.	5/28/2015 8:06 PM
51	it is improving but feel more could be done during foundation programme to allow exposure/ experience in working in pall med unit / team	5/28/2015 7:14 PM
52	If the palliative team were able to support the 'home' team for each end of life care case, if monthly self-reflection/ethics case-based learning were held, and if juniors sat in on palliative outpatient clinics, they would learn the skills faster.	5/28/2015 7:03 PM
53	I spent a lot of time in medicine before I knew I wanted to do palliative care - I feel lucky to have had this experience - I see other people come through with much less general medical experience pre specialising, and I think there is a gap. That doesn't mean I think we need dual training in GIM necessarily - it means that I think the training period before specialising is too short.	5/28/2015 6:24 PM
54	not enough focus during medical school	5/28/2015 5:23 PM
55	Senior doctors need to be better trained so that they are taught as part of their general medical experience.	5/28/2015 4:41 PM
56	The loss of flexibility whereby additional time could be spent as an SHO for up to 12 months testing out palliative medicine before applying for specialist training has been a disadvantage. On the other hand the 'absorption' of such stand alone posts into existing general medical rotations (CT1/CT2, perhaps some F posts though?) has already meant that a broader range of doctors with a wide range of career aspirations are being exposed to palliative care and can take forward this experience into their future roles.	5/28/2015 4:04 PM
57	Most new entrants have had to look at ways to develop their palliative care skills and it is not core business for CMT	5/28/2015 3:42 PM

58	I don't feel they have enough teaching/exposure to palliative medicine	5/28/2015 3:40 PM
59	I agree although there were few palliative care jobs available where I trained (NC/NE London)- so increasing opportunities to work in palliative care at foundation and core training level would be beneficial.	5/28/2015 3:38 PM
60	Additional gpst and cmt posts needed	5/28/2015 3:23 PM
61	Ideally all docotrs should have a placement in palliative medicine when in junior roles to prepare them for delivering end of life care in whichever speciality they choose long term.Few such placements are available locally.	5/28/2015 3:19 PM
62	Very variable still. Some areas of excelent practice.	5/28/2015 3:04 PM
63	Not unless they have an interest and seek opportunites out	5/28/2015 3:01 PM
64	personal experience: 5 years medical school. 2 days palliative care. foundation programme is variable depending on where it happens. length of training should not be shortened. why are we trying to patch potential holes in SPECIALTY training through modules in undergraduate and foundation training. increase the amount of palliative care teaching in uni and foundation programme because it is required, not because training is shortened.	5/28/2015 2:30 PM
65	I do not believe increasing training of undergraduates can compenstae for eduction of time for training of specilist registrars	5/28/2015 2:25 PM
66	There is widespread variation in the amount of teaching both at undergrad and at Foundation....these need to be more robustly described and assessed	5/28/2015 2:25 PM
67	I still think that the current CMT (what would be internal medicine)/GP/Anaesthetic rotations are what prepare doctors for entry to palliative medicine, rather than (for the most part) experience gained through the Undergraduate or Foundation programmes.	5/28/2015 2:17 PM
68	Often very little exposure to palliative medicine in foundation training, and CMT.	5/28/2015 9:55 AM
69	Many programmes have only limited exposure to palliative medicine. In our experience Foundation doctors are a very valuable workforce and there may be increased opportunities for training opportunities outside of acute hospitals.	5/27/2015 5:56 PM
70	from personal experience (which is a few years ago) there is not enough under grad exposure but this is changing	5/27/2015 4:16 PM
71	Overall UG and FY doctors (in my locality) appear to recieve little palliative care training.	5/27/2015 3:50 PM
72	Main issues really are communication skills, and retaining a holistic sense of a patient and appreciation of disease trajectories changing.	5/26/2015 10:12 PM
73	Trainees coming straight from cmt currently do not have the breadth of experience needed- previous trainees had experience from a wide range of specialties and had frequently worked in a variety of settings over a number of years prior to coming into training. You cannot replace experience - both clinical and life experience- with education.	5/26/2015 10:04 PM
74	There is very little opportunity for theme to experience palliative care (especially hospices) prior to applying for a ST3 post	5/26/2015 5:16 PM
75	At medschool I had essentially no teaching about palliative care. Need to get it into the med school curriculum in a big way.	5/26/2015 3:36 PM
76	Little exposure to the speciality included unless sought out by individuals - at the start of speciality training there is a lack of familiarity with common drugs used etc. Little/no choice in selection of rotations which would be useful for palliative medicine (eg oncology/haematology).	5/26/2015 10:08 AM
77	Time spent in palliative medicine settings	5/26/2015 9:18 AM
78	IN our area yes, they get a good experience as students (4 weeks) and all the local hospitals are well staffed with Palliative Care teams so they get a fair bit of exposure. However I think that there should be more flexibility in the system for people to step off the training conveyor belt and get some staff grade experience in Palliative Care before they decide whether it is for them. MMC has been particularly bad for forcing them down paths they are not that sure about.	5/25/2015 11:20 PM
79	very variable across undergraduate training	5/25/2015 6:17 PM
80	Depends which medical school, which hospital, which F jobs	5/24/2015 10:09 AM

81	They need more experience either of GP or medicine	5/23/2015 10:14 PM
82	Depends on junior doctor's own initiative to find placements, specialty doctor jobs, attend study days.	5/21/2015 2:32 PM
83	I would say, core medical training makes the doctors ready to enter palliative medicine	5/20/2015 12:38 PM
84	Hardly any access to experience of palliative medicine in current undergraduate/foundation programme currently.	5/19/2015 3:51 PM
85	The wider range of experience in foundation years is wecome but this may be at the expense of reaching lower levels of maturity in clinical decision making because of less responsibility taken in each clinical area. In general, Palliative Medicine trainees benefit from having as much clinical and life experience as possible before starting Palliative Medicine training. They need emotional maturity and maturity in decision making and taking responsiblility in situations which are complex and messy and often without easy answers.	5/19/2015 2:02 PM
86	this depends a lot on the medical school, there is great variety in what is taught and the importance that is placed on palliative medicine, similarly this applies to foundation training	5/19/2015 8:46 AM
87	This is dependent on which posts that they have undertaken at FY and CMT currently - as palliative medicine experience already is very beneficial. If speciality training is shortened then there needs to be increased capacity to gain palliative medicine experience and training at a more junior level.	5/19/2015 12:35 AM
88	Most doctors have poor knowledge of palliative medicine!	5/18/2015 11:18 PM
89	I think it is the commonest area that F1s struggle with and amazes me how little medical students that we get from Kings and St George's have covered	5/18/2015 8:23 PM
90	Many have had no exposure at all to pall med now before applying after CMT. If pall med training was to be shortened then there has to be a move for some elements of the curriculum to CMT (perhaps ethics, communication etc which would benefit all doctors whatever the speciality) However this would then need to be lengthened	5/18/2015 6:52 PM

Q20 Palliative Medicine should support the changes to training outlined in Shape of Training.

Answered: 194 Skipped: 55



	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**2.58%** 5	**17.53%** 34	**32.47%** 63	**29.90%** 58	**17.53%** 34	194	3.42

#	Additional Comments	Date
1	There are some aspects which should be supported - considering integrating acute medicine into the training, but if this meant shortening the palliative medicine training this shouldn't be supported. Increasing the training in palliative medicine for other specialties should be encouraged as this would be likely to improve the quality of generalist palliative care leaving the specialists to focus more on the more complex care.	6/9/2015 6:19 PM
2	Training would need to be longer	6/9/2015 6:12 PM
3	With caveats, it could be helpful, but considerable anxiety about effect on speciality training	6/9/2015 4:10 PM
4	Yes, we cannot ignore this important development, but we need to be sure that hospices across the country are aware of the implications and of their responsibilities.	6/9/2015 11:19 AM
5	As long as it recognises the need for flexibility of experience. I come from Gp background and have not been able to get experience in hospital or community medicine as am not part of training programme	6/8/2015 7:02 PM
6	I do not feel as it currently stands that shape of training would be good for Palliative medicine. There are elements that could improve medical training but too much focus on shortening time rather than producing rounded experienced quality consultants.	6/8/2015 5:47 PM
7	We should support: - An additional year (or more) of general internal medicine training at the end of core medical training when the individual would act as medical registrar on the acute medical take. This would have some benefits for acute medical take service delivery (increased number of medical registrars) and the general medical competencies of that physician. - After this a dedicated palliative specialty training programme of a minimum of 4 years with no "integration" with general medicine if this means involvement in the acute medical take as this would be to the cost of achieving competence in palliative medicine and potentially jeopardise good patient care. - Specialist palliative care training would benefit from more community experience in preference to more acute hospital experience (which can be gained prior to commencement of specialist palliative care training). - Specialist palliative physicians need to maintain their general medical competencies throughout their specialist career through CPD, involvement with hospital patients and collaboration with their general medical colleagues. General medical training prior to specialist palliative training should be sufficient to form the foundation on which to build this lifelong learning.	6/8/2015 11:10 AM

8	I think training needs to change but I think we need to have some further negotiations in Palliative Medicine to maximise the potential benefits and limit any detrimental effects.	6/8/2015 12:13 AM
9	A difficult one! Probably not as they stand but a broad principle of increasing general internal medicine knowledge is good but I think training would need to be extended	6/5/2015 9:14 AM
10	Change is necessary due to the current crisis but all proposals need to be reflected on before action is taken and as ever the devil is in the detail.	6/4/2015 5:05 PM
11	I think that they will happen it is the ability to influence the trainig to ensure that there is adequete specialist training to deliver the service	6/4/2015 2:12 PM
12	There are some changes which will benefit the speciality and others which need to be more clearly defined- such as time in GIM during the 4 year training programme.	6/4/2015 12:01 PM
13	We need to think about the impact to the speciality	6/4/2015 11:58 AM
14	Subjec to my suggestions, yes, withou them, no, hence my neutrality	6/3/2015 3:35 PM
15	I agree with the need to change to meet the needs of the population and the need for palliative medicine physicians to retain general medical skills. However, the proposed model appears to be structured around service delivery in the acute sector.	6/3/2015 11:19 AM
16	FOI requests have exposed the bias inherent within the SHoT report.	6/3/2015 1:45 AM
17	I think there are huge concerns about the current SoT thinking for palliative medicine	6/2/2015 5:39 PM
18	I think it is another ill-thought and ill-planned major change to an already restrictive and narrow training structure that pays lip service to training and education and is based on the entirely hypocritical basis that there is such a thing as a training post. If we were honest, we would call these posts service delivery with some opportunities for training. The language is wrong and leads to unrealistic expectations and discontent as a consequence. We are forcing our junior colleagues to choose sooner, apply centrally with no knowledge of where they will be working or living, to not have choice of switching specialties or locations and to do it all more quickly with more and more curriculum demands. All administered and coordinated by a generation who had none of this to cope with. We should be ashamed.	6/2/2015 9:26 AM
19	The future of palliative care lies in the positive influence we can have on other physicians/doctors in primary, secondary and tertiary care settings, and breaking down the distinction between 'active care' and 'palliative care',. Greater involvement in general medicine will facilitate this.	6/1/2015 9:57 PM
20	Agree in principle, but with amendments to ensure training needs are met	6/1/2015 9:01 PM
21	I think that shape of training is likely to result in palliative care consultants who are partially equipped to manage acute admissions, but to a lower standard than current care - this will result in more referrals to specialist care and poorer outcomes for patients. Equally palliative care consultants will lack the experience to robustly provide expert palliative care input to their patients - these changes will make palliative training something that produces consultants who are partially trained in two areas, but not fully trained in either. Palliative care is broader than general medicine in its focus on person centred care. To truly broaden the base of training, I suggest that all physicians undertake basic palliative care training and the palliative care approach can thus be integrated into the acute take with expert support from fully specialist trained palliative care consultants	6/1/2015 8:32 PM
22	It is a golden opportunity to try somethings that may work as current system is not fit for the purpose.	6/1/2015 11:23 AM
23	But with caveats to ensure maintaining palliative care standards to sufficient level while increasing Acute Medicine training which will be helpful	6/1/2015 9:50 AM
24	Hard to suggest supporting them as the details of how it will affect our specialty are so sketchy.	5/31/2015 9:54 PM
25	I think that many people who want to pursue palliative medicine (and are likely to make good consultants) would not choose the speciality if they had to also do internal medicine. These people are likely to end up in general practice, or in non-training posts in palliative medicine, where there is no requirement to do the acute take. I think in the end this would reduce the quality of trainees who would end up as palliative medicine consultants.	5/31/2015 8:34 PM
26	Need to see more detail. Biggest concern would be that the agenda is simply to train more senior doctors to deliver unselected medical take and this could lead to reduced morale in the profession as a whole. However I do think there is room for more integrated training with care of the elderly and primary care. Individual doctors training in palliative medicine have attempted to dually accredit but have struggled to achieve this and for doctors who wish to dually accredit is currently very difficult. .	5/31/2015 4:05 PM
27	Need more detail on how it will affect our speciality.	5/31/2015 12:33 PM

28	Need to see what the endpoints to the thinking are; linking to primary care elements (excepting obstetrics, paeds...) seems more sensible.	5/30/2015 8:42 PM
29	Absolutely not. It will be a disaster for Palliative Medicine, and medicine in general.	5/29/2015 7:06 PM
30	It is important to be at the table to discuss changes, but I do not feel I am in a position to agree with this statement as such agreement might dilute any push to keep palliative medicine more specialist.	5/29/2015 4:33 PM
31	No reduction in training should be considered acceptable	5/29/2015 4:07 PM
32	I think the changes are interesting and should be considered but not adopted without more information about what such a curriculum would look like.	5/29/2015 3:43 PM
33	Palliative medicine as a specialty is too different from General Internal Medicine to compbine the two for specialty training. I am conerned that attempts to do this will result in poor quality specialist palliative medicine training and poor quality care for patients in both specialities. I have significant concerns about including palliative medicine trainees in the acute take - both for service provision, recruitment and patient care. There also needs to be provision to attract trainees from other specialties such as general practice and oncology in addtion to just GIM.	5/29/2015 9:49 AM
34	There is increasing chronic diseases including survivors of cancer which require an integrated model of care that includes the specialist palliative care. If within a few years the care of mnd patients has significantly improved morbidity and mortality, this should be available to all patients with a life limiting illness.	5/28/2015 9:08 PM
35	As most big changes are ultimately politically driven and unavoidable, the way forward is probably to be very clear about how Shape of Training should change to the advantage of our specialty.	5/28/2015 8:06 PM
36	can support those that wish to come through General medicine route	5/28/2015 7:14 PM
37	I don't think not supporting them will get us anywhere. I do think we ought to argue that we are a special case as we are a predominantly community based specialty, and that we cannot have our trainees joining general medical acute takes regularly over 4 years and pretend that is somehow going to make them better palliative medical specialists - it won't. But they could do their bit while learning hospital palliative care skills, and develop opportunities for a palliative approach within existing services, and develop stronger links with the community teams (eg better facilitated quick turnaround admissions, for instance).	5/28/2015 7:03 PM
38	Either way they need to stay engaged to ensure decisions aren't made without Palliative Medicine's input.	5/28/2015 4:41 PM
39	with a caveat about not compromising existing training	5/28/2015 3:45 PM
40	would like the extra year pre registrar training but not the integration during training	5/28/2015 3:42 PM
41	change happens and as with most changes there are some good suggestions and some worrying ones	5/28/2015 3:40 PM
42	No shortening of specialty training	5/28/2015 3:23 PM
43	It depends on how it affects length of training as 4 years is quick already for palliative medicine training	5/28/2015 3:01 PM
44	much more information is required about what it will actually involve, and whether "broad based training" is a genuine attempt to increase breadth of exposure to different specialties or whether merely a way to increase service provision in busy specialties like AMAU and geriatrics.	5/28/2015 2:30 PM
45	credentialing is fundamentally wrong CCT should remain as the final sign off not a sub consultant grade	5/28/2015 2:03 PM
46	Increased exposure and experience in general medicine would enhance training and experience, but there would need to consideration of extending training time to allow for this.	5/28/2015 9:55 AM
47	the majority of trainees do come through the CMT route and I agree there needs to be some changes in training so support the change in demand on acute services but I am concerned how this will affect our training and standard of care. as we do work in the community it would be unfair to not allow trainees to come via the GP route as their skills are needed	5/27/2015 4:16 PM
48	For all the above reasons the shape of training report does not appear to be a positive way forward.	5/27/2015 3:50 PM
49	Not in current form; if dual accreditation with GIM is considered necessary then I feel that the specialty training programme should be extended to achieve this, so that palliative medicine time/experience is not diminished	5/27/2015 3:04 PM
50	Although some of the changes outlined are laudable, there are too many concerns at the moment on the lack of independance of a supposed independant review carried out by Greenaway.	5/26/2015 10:12 PM

51	I think introducing more collaborative work with general internal physicians (shared ward rounds / clinics etc) is to be welcomed and could be reflected within the curriculum / ARCP requirements. However, it is vital that palliative medicine is clear about it's identity as a specialty service, spanning locations, providing individualised and integrated care with expertise.	5/26/2015 11:15 AM
52	Not overall but there are components such as dual accreditation which have a potential role or additional experience in an area such as pain management/nephrology/heart failure	5/26/2015 9:18 AM
53	No, no and no again. I think we should vehemently oppose this half-baked notion. It is designed to prop up the acute medical take not enhance the training experience of anyone.	5/25/2015 11:20 PM
54	There are potentially positive aspects - but the limited clarity about aspects makes it difficult to support at present.	5/20/2015 9:59 AM
55	I am an SAS doctor	5/19/2015 8:12 PM
56	palliative medicine training would need to be extended to support the changes	5/19/2015 7:39 PM
57	I have mixed feelings - I think it could potentially be an exciting new direction for the specialty but there is so little detail and it is a very different path to the historical background of palliative medicine. I have concerns that trainees from different backgrounds (ie general practice) would now be excluded, but I don't know how may people come from this background at the moment or whether the new requirements to complete 18 months in medical specialities is excluding them anyway.	5/19/2015 3:51 PM
58	The changes outlined in Shape of Training are there to benefit patients under General Medicine. The increased ability of physicians in general to handle acute general medicine may be a good thing but Palliative Medicine is not just another medical specialty and has very different needs. There is a danger that Palliative Medicine will be swept up in changes that are inappropriate and damaging to the speciality even if the changes may be beneficial to acute general medicine. We should position ourselves firmly on the outside to, an exception from these changes as much as possible and argue that we are not just another medical specialty.	5/19/2015 2:02 PM
59	too much focus on acute hospital, need to also consider community and hospice. I think the training needs to change and we need more acute skills for our hospices but not through the shape of training review.	5/19/2015 8:46 AM
60	I think the changes should be supported but only if the speciality training is preserved as well	5/19/2015 12:35 AM
61	Not sure - would need to know more	5/18/2015 8:23 PM
62	Dual accreditation does not make sense as consultants in palliative medicine are unlikely to be able to keep their acute skills up once working in palliative care unless a significant amount of their consultant job is continuing to see patients on an unselected acute take. If this does not happen then after a couple of years their ability to manage acute problems will reduce/be forgotten.	5/18/2015 6:52 PM

Q21 Service requirements

Answered: 126 Skipped: 123

Answer Choices	Responses	
(1.1) What is your perception of the future patient and service needs in Palliative Medicine?	**96.03%**	121
(1.2) How will this affect the role of doctors in Palliative Medicine and the type of care they provide?	**84.13%**	106
(1.3) What should doctors in Palliative Medicine be trained to do?	**88.10%**	111

#	(1.1) What is your perception of the future patient and service needs in Palliative Medicine?	Date
1	Increasing intensity and support needs for older frailer more complex patients as the norm	6/9/2015 11:16 PM
2	More focus on nonmalignant palliative conditions. Moving more care into the community, hospital avoidance.	6/9/2015 11:10 PM
3	will increase	6/9/2015 10:29 PM
4	Ongoing symptom control, advance care planning, more access for more patients.	6/9/2015 4:14 PM
5	More community based care, more symptom control management, better end of life care outside the hospital, more access to palliative care services	6/9/2015 2:38 PM
6	It will need to be a more consultant-led service	6/9/2015 2:03 PM
7	Increased requirements to deliver palliative care in the community and hospice. Open to all diagnoses. See patients earlier in their training.	6/9/2015 12:42 PM
8	We need an increase in the ability to assess patients at home out of hours, and a better presence in the acute sector.	6/9/2015 12:11 PM
9	Much more involvement in the care of patients with non-malignant disease, in hospital and in community. Hospices will also need to ensure that they have a workforce equipped to meet the demands.	6/9/2015 11:33 AM
10	More co morbidities wih an aging population and graeter input to patients with diagnoses other than cancer	6/9/2015 10:38 AM
11	LIkely to be seeing patients earlier in trajectory therefore with more acute medical needs	6/9/2015 10:33 AM
12	more community patients, older patients, more complex needs and multiple co-morbidities	6/9/2015 10:11 AM
13	Need to reach a wider range of patients (esp. non-malignant), earlier in illness.	6/9/2015 9:28 AM
14	community experience is at the for and we fail in the amount of this that is provided for	6/9/2015 8:55 AM
15	Need for greater input wrt services and education at community level to meet needs of population. Lack of comprehensive SPC ooh services creating greater demand for inpatient care	6/8/2015 10:42 PM
16	Needs to be expanded in community and hospital roles	6/8/2015 7:14 PM
17	Increasing comorbidities being managed at a distance from tertiary centres. Needs more community specialists and a number of spcialised teams supporting specialist centres	6/8/2015 6:35 PM
18	ageing and multi morbity, need to manage complexity	6/8/2015 6:13 PM
19	wider range patient groups e.g. more supportive care and neurology/respiratory patients than cancer, a focus on supporting community teams/care homes and nursing homes.	6/8/2015 6:06 PM
20	More patients will have multiple co-morbidities. More patients will need to be cared for in community settings.	6/8/2015 6:06 PM
21	More diverse patient population with multiple comorbidities	6/8/2015 10:30 AM
22	Increasing non-cancer workload. Service will need to be available to more patients with limited resources.	6/8/2015 12:35 AM
23	Increased care to be delivered in the community. Support in acute settings will continue - focus may be on discharge.	6/7/2015 2:58 PM
24	More community based pallaitve care and 7 day working	6/5/2015 5:01 PM

25	Ageing population, increase in frail elderly with multiple pathology	6/5/2015 9:54 AM
26	More community based	6/5/2015 8:03 AM
27	I think there will be an increased need for all doctors to be able to provide general palliative care to patients with long term non malignant conditions so I see a greater role for palliative medicine physicians in education and support for other specialities. .	6/4/2015 9:13 PM
28	Increaing complexity, polymorbidity and community focus	6/4/2015 2:21 PM
29	More collaborative working	6/4/2015 12:38 PM
30	continued emphaisis on community care balaanced with tertiary specilalist care	6/4/2015 12:31 PM
31	Increasingly complex with more numbers of frail, elderly with multiple co-morbidities and social needs	6/4/2015 12:10 PM
32	Increasing workload from non-cancer specialities; increasing pressure from commisioners to avoid acute hospital admissions; .	6/4/2015 12:10 PM
33	More complex. Increased burden. Limited resources	6/3/2015 9:20 PM
34	considerable and sustained rise, but the spectre of assisted suicide is very troubling	6/3/2015 3:53 PM
35	More patients with multiple complex co-morbidities, to manage them better in community	6/3/2015 11:29 AM
36	Present needs are unmet in my part of NHS England because of a lack of specialist manpower	6/3/2015 2:12 AM
37	It is increasing rapidly. Ongoing need to develop services for non-cancer patients. The frail elderly are a particular challenge	6/2/2015 5:49 PM
38	Major need is not more medical staff but greater resources for community care - carers and community nurses in particular.	6/2/2015 9:38 AM
39	Need to work more cross sector for the good of the patients. Also non malignant disease management. See patients earlier in their disease process as per New England journal of medicine article on small cell carcinoma of the lung	6/1/2015 11:21 PM
40	There is a great need in nursing homes and in supporting GPs with Nursing Home patients. Should all nursing home patients be under palliative care? GPs often do not have the time or inclination to address their complex needs	6/1/2015 10:25 PM
41	more flexible, more chronic disease management	6/1/2015 10:14 PM
42	Could stay as it is i.e. mainly cancer EOLC. Or could expand more into non-malignant conditions.	6/1/2015 9:31 PM
43	palliative patients will have more need for acute management of concurrent medical problems.	6/1/2015 9:04 PM
44	increasing non malignant conditions with patients living for many years with palliative care needs. Increased need to upskill generalists in principles of palliative care especially when looking after patients with multimorbidity	6/1/2015 8:55 PM
45	With an ageing population, I think that the demand for Palliative Care services will increase. I think that more focus needs to be placed on developing community based services to meet the needs of the changing population.	6/1/2015 6:10 PM
46	this will increase as cancer survivorship increases and the population ages	6/1/2015 5:08 PM
47	reiquires increasing decision making related to acute/general medical conditions, especially when deciding on hospital vs community treatment options and supporting informed decisions in advance care planning, complex and mulitple co-mrbidities, incresaingly frail and complex patient group we are caring for, with changing expectations of role of palliative care	6/1/2015 4:44 PM
48	Increasing emphasis on community care, also taking care to the patient	6/1/2015 2:16 PM
49	Generic care of the elderly using pallitaive principles.	6/1/2015 2:09 PM
50	Will probably increase	6/1/2015 11:30 AM
51	More patients, and with greater complexity of needs due to multiple conditions - this is already happening	6/1/2015 9:55 AM
52	more non-cancer and older	6/1/2015 9:46 AM
53	Increasing involvement with care of older people with multiple conditions, avoiding and shortening unwanted admissions, currently unmet need needs in other groups eg transition, homelessness	5/31/2015 4:39 PM

54	I would like to see Palliative Medicine poised at the front line of acute services (rather than remain in wings for too long as we do at the moment) - a community based approached with a very proactive 'in-reach' or liaison service into secondary/tertiary care	5/31/2015 4:29 PM
55	Need to develop community service and integration with hospital services.	5/31/2015 12:42 PM
56	increase in number and breadth of condition. also expectation of care provided.	5/30/2015 8:54 PM
57	Increasing and more complex needs due to demographic changes, longevity, and increrasing treatment options for all kinds of illness.	5/29/2015 7:09 PM
58	Needs will increase, possibly exponentially	5/29/2015 5:49 PM
59	There will be an increasing need for Palliative medicine with an aging and frail population.	5/29/2015 4:43 PM
60	likely to increase and become more complex due to the increasing dementia and lone persons burden, and lack of GPs or GPS with time to support these patients properly	5/29/2015 4:13 PM
61	less focus on cancer an more on frailty and elderly and multi morbididty	5/29/2015 3:51 PM
62	There will be increasing numbers with increased complexity (aging population with increased numbers of co-existing conditions). Due to current and likely future funding limitiations increasing amount of care will need to be facilitated in the community setting.	5/29/2015 3:49 PM
63	conflict between palliative care versus end-of-life care agendas and specialist versus generalist agedas	5/29/2015 1:36 PM
64	There needs to be ongoing development in non-malignant disease in palliative care and investment in support avilable in the community.	5/29/2015 9:53 AM
65	More community based care with beds not for symptom control but rather for complex respite and intermediate care as hospital care becomes more centralised at a greater distance from patient homes. Rapid turnover of patients in acute hospitals making palliative care input 7 days a week vital and the importance of working across boundaries paramount.	5/29/2015 9:09 AM
66	Increasing levels of patient complexity. Increased need for palliative care services to work in close collaboration with other specialities.	5/28/2015 11:41 PM
67	End of life care is currently a big agenda - whilst it deserves to be recognised, the current workforce is significantly inadequate in numbers to be able to meet the needs of patients identified with palliative care needs.	5/28/2015 8:50 PM
68	As the specialty broadens to incorporate more non-malignant disease, and cover more services eg nursing homes, there will either be a need for ALL doctors to develop better palliative skills and palliative medicine to have LESS specialists who are only called upon in difficult scenarios, or or MORe palliative specialists who do clinics/ward rounds/regular sessions within different services and work alongside other specialties. The patient population will expand not only through ageing population, but also the increasing demand of patients themselves for more holistic and personalised care.	5/28/2015 7:30 PM
69	nicreasing need for community provision of care, increasing need for care for people at the end stage of long term conditions	5/28/2015 6:41 PM
70	Increased demand	5/28/2015 6:20 PM
71	ever increasing numbers, especially with ageing population and non malignant conditions et dementia	5/28/2015 5:27 PM
72	Less hospice ,more community, more coordinating care in collaboration with other partners	5/28/2015 4:58 PM
73	More complex, including more co-morbidities and difficult social situations.	5/28/2015 4:52 PM
74	More community, more liaision with GP, more shared care	5/28/2015 4:48 PM
75	Likely to be more general in the sense of cancer/non-cancer diagnoses	5/28/2015 4:26 PM
76	Cannot just provide the Rolls Royce for some. What proportion of patients have care influenced by us (and then only at end)?	5/28/2015 3:55 PM
77	Likely to increase and include more elderly long term conditions and more community work	5/28/2015 3:49 PM
78	will increase and become more varied	5/28/2015 3:48 PM
79	I think the specialty will become increasingly outpatient based and efforts should be made to focus training on skills to meet these needs. It is difficult for trainees where I work (NC/NE London) to get blocks of community training - it would be good to have more opportunities to do dedicated community jobs.	5/28/2015 3:45 PM

80	Expansion of trainees and consultant posts to meet increase in elderly mortality both in hospital ,care home and own homes	5/28/2015 3:35 PM
81	More care at home will be needed.More consultant support 7 days per week and out of hours will be needed	5/28/2015 3:24 PM
82	Increasing emphasis on non-cancer, including multiple morbidities and dementia, as well as organ failure.	5/28/2015 3:21 PM
83	community	5/28/2015 2:41 PM
84	increased community working	5/28/2015 2:37 PM
85	workloads willl increase	5/28/2015 2:34 PM
86	Many more patients with non-malignant conditions (e.g. heart failure/dementia). A large increase in the older population, and therefore an increasing need for palliative medicine.	5/28/2015 2:29 PM
87	Flexible doctors who can handle multimorbidity as well as specialist issues.	5/28/2015 2:21 PM
88	flexibility ability to assess patients / situations holistically and on individualised basis ability to work seamlessly with coleagues / other services	5/28/2015 2:11 PM
89	Greater integration and co-ordination of care across care settings. Incaresed work with patients witha non-cancer diagnosis.	5/28/2015 10:05 AM
90	Increasing elderly population, increasing complexity and comorbidity - need to develop new models of service delivery that better meets these needs	5/27/2015 6:10 PM
91	More community care, but there will always be a need for both hospuital and hospice IP care	5/27/2015 5:48 PM
92	more patients will be seen early in their disease trajectory.more demand in hospital post LCP removal	5/27/2015 4:23 PM
93	Increasing community work. Increasing symptom control.	5/27/2015 3:53 PM
94	Likely to increase both in number and 'complexity' and be increasing demand in the community in particular	5/27/2015 3:22 PM
95	Increased community needs	5/27/2015 9:12 AM
96	Need is greatest in areas outwith those which have a 24/7 service- community and acute hospital, and this will continue to grow. Need to work collaboratively with colleagues from other specialties, promoting good general end of life care, but also to identify the complex patients who could benefit from specialist input.	5/26/2015 10:24 PM
97	Patients who have comorbid general medical conditions, more complex decision making regarding appropriateness of treatments that could/should be offerred	5/26/2015 10:17 PM
98	Higher expectations on palliative care to provide good quality generalist care to older patients in terms of their medical needs. Increasing expectation that a specialty such as palliative medicine will plug the service gap for this population.	5/26/2015 8:52 PM
99	More focus on integration of community care with hospital discharges.	5/26/2015 8:31 PM
100	More patients will need us. Likely to need to train more non specialists	5/26/2015 7:15 PM
101	Increasing requirement to manage multiple end stage comorbidites. Increasingly patients will be referred to us in earlier stage of their disease trajectory, this should stimulate more out patient clinic being created.	5/26/2015 5:44 PM
102	more patients, older patients, more co-morbidities	5/26/2015 5:17 PM
103	There has been increasing media attention given to the need to develop palliative and end of life care services in the UK, with multiple examples of bad care cited. We have an ageing population with increasing comorbidities, causing many to live longer in a state of suffering that requires expert symptom management and individualised care. Developing a specialised, integrated palliative medicine service, delivered by Physicians with expert knowledge and skill, as well as ability to develop services regionally (not just locally) is essential to meeting this recognised need.	5/26/2015 11:28 AM
104	Many but main issue is that more resources need to be directed towards community and caring for people at home/avoiding inappropriate hospital admissions. More long-term conditions in an ageing population needs to be recognised and model of service delivery may need to adapt.	5/26/2015 10:25 AM
105	Patients are getting older with more chronic progressive conditions so demand will increase	5/26/2015 9:30 AM
106	2 ASPECTS CANCER PATIETS INCLUDING THE LONG TERM SURVIVORS .Elderly patiets with multiple comorbidities, working in hospital and communityand hospice	5/25/2015 6:39 PM

107	Generalism will be very important	5/24/2015 10:12 AM
108	They will increase	5/23/2015 10:23 PM
109	Seven Day Working	5/21/2015 2:44 PM
110	more community focus as GPs disappear	5/20/2015 10:02 PM
111	that patent needs will be more complex balancing long term conditions with life limiting illnesses	5/20/2015 5:19 PM
112	more community based care is needed	5/20/2015 12:47 PM
113	7 day service	5/19/2015 8:17 PM
114	Likely to include patients with an awful lot more non-malignant disease, and also patients with multimorbidity.	5/19/2015 4:00 PM
115	increasingly complex non malignant chronic conditions, need flexible seamless delivery across all settings, needs strong leaders to think about the overal health economy rather than one specific setting	5/19/2015 8:50 AM
116	7/7 if not 24/7 availability across settings including community with increased experience of non-malignant as well as cancer. We are likely to be asked to support acute management and decision making around palliative care patients	5/19/2015 12:42 AM
117	24/7 service, access to emergency hospice admissions overnight, consultant follows the patient into any care setting	5/18/2015 11:29 PM
118	Greater knowledge of dying from non-cancer conditions, increased ability to work effectively in the community, major role in educating and influencing other professionals. Skills on ethical decision making and communication skills	5/18/2015 8:33 PM
119	Increased focus on very specialist palliative care as generalists take on more of the general palliative care needs of patients	5/18/2015 8:02 PM
120	24/7 access, more need for medical assessment and review and generalist medical skills alongside spc skills	5/18/2015 7:44 PM
121	alot more community work, increasing interventions, broader patient population	5/18/2015 7:14 PM
#	**(1.2) How will this affect the role of doctors in Palliative Medicine and the type of care they provide?**	**Date**
1	will need more doctors	6/9/2015 10:29 PM
2	I think we need to invest more in palliative medicine as a speciality and allow consultants to be service leaders	6/9/2015 4:14 PM
3	More doctors are needed in this specialty, longer community based training is required	6/9/2015 2:38 PM
4	more face to face	6/9/2015 2:03 PM
5	Work across all care settings - review patient in hospital and offer advice but maintain our bridge between primary and secondary care.	6/9/2015 12:42 PM
6	We will still have a vital role to play in the delivery of care, but also in the education of non-specialists (at least 25% of my work load is education of doctors, nurses, paramedics, etc). Having the right skills and working relationships with other physicians (in the same way that historical links have been forged with oncology) is crucial.	6/9/2015 11:33 AM
7	The care will be the same but more co working with specialists. It is less about managing acute take rather chronic illness and exacerabations. I am not sure it is possible to be come expert in all of these. having areas for credentails may help but not withe the workforce we are likely to have when one will need to know about multiple conditions and where to get expert advice from.u	6/9/2015 10:38 AM
8	Will need to have skills and knowledge to manage acute and internal medicine problems to some level	6/9/2015 10:33 AM
9	more general palliative care, increased education, more holistic care and decision making, complex ethics	6/9/2015 10:11 AM
10	Not sure - likely to have to work more collaboratively with colleagues for patients still receiving active treatment.	6/9/2015 9:28 AM
11	Emphasis on liaison and supporting generalists as impt as providing SPC for those that need more than generalist care.	6/8/2015 10:42 PM
12	Need larger role, so. Many people need this care and currently not able to access it	6/8/2015 7:14 PM
13	Increasing need for skills in general practice/ elderly care in managing comorbidities and uncertainty	6/8/2015 6:35 PM

14	need good physicians, with good general knowledge and able to review evidence and keep up to date well	6/8/2015 6:13 PM
15	More of an education/supportive role. More people are going to die in care homes/nursing home and people want to die at home we should be focusing on this and bring the hospice model more into people' homes and care homes.	6/8/2015 6:06 PM
16	More knowledge & skills in caring for patients in community & those with cognitive impairment will be needed.	6/8/2015 6:06 PM
17	need to focus on all long term conditions rather than cancer being the primary focus	6/8/2015 10:30 AM
18	I think we are all getting busier and this is likely to continue. The desire to take time over patients will continue but we will be more pressured. Whilst this may be less satisfying for individual patient encounters, I believe we will benefit more patients.	6/8/2015 12:35 AM
19	Need to be flexible and to follow patients up across care settings.	6/7/2015 2:58 PM
20	Need to consider different models of working to provide 7 day service	6/5/2015 5:01 PM
21	Need more generalist approach and more community exposure	6/5/2015 9:54 AM
22	Need for confidence to work outside of acute settings	6/5/2015 8:03 AM
23	access to packages of support will become an increaing issue	6/4/2015 2:21 PM
24	may be asked to specilaise in sub specilties or comminty based care wityh less broad skills	6/4/2015 12:31 PM
25	Closer working with other specialities.	6/4/2015 12:10 PM
26	incresing expectation and need for 7 days consultant lead services both in hospital and community to deliver the first two points	6/4/2015 12:10 PM
27	More flexible. Increased education. Supporting other teams	6/3/2015 9:20 PM
28	There needs to be very much more training and explicit support to colleagues embedded and contracted in jobs	6/3/2015 3:53 PM
29	Need to keep up-to-date on general medicine. Development of community services, integrated with generalists/elderly medicine physicians	6/3/2015 11:29 AM
30	I remain convinced that the specialty is not developed or old enough to be able to support general medicine work. My colleagues in other parts of the UK may disagree.	6/3/2015 2:12 AM
31	Need to continue to develop the specialty and broaden access - therefore broaden skills and knowledge	6/2/2015 5:49 PM
32	There should be country wide availability of medical pall care advice 24 hours.	6/2/2015 9:38 AM
33	Will need experience in elements of this care	6/1/2015 11:21 PM
34	Greater working in partnership with GPs. Should we be doing clinics based at GP surgeries rather than bringing them to hospitals or outpatients?	6/1/2015 10:25 PM
35	more mainstream specialty	6/1/2015 10:14 PM
36	They will need to be able to manage acute medical conditions	6/1/2015 9:04 PM
37	increasing role in advising other specialties. Increasing role in managing non malignant disease. Increasingly long period of palliative care support for patients	6/1/2015 8:55 PM
38	I think that Palliative Medicine doctors need to have an open mind about the structure of services and be flexible to cope with changing need and demands so that access is more equitable.	6/1/2015 6:10 PM
39	increased care of frail elderly with multiple co-morbidities	6/1/2015 5:08 PM
40	More community experience e.g GP	6/1/2015 2:16 PM
41	More focus on community care.	6/1/2015 2:09 PM
42	Doctors in palliative medicine need to be able to provide care in acute setting, including A&E	6/1/2015 11:30 AM
43	More care of elderly skills needed, as well as good acute medicine skills	6/1/2015 9:55 AM
44	will need more general medicine and community expereience	6/1/2015 9:46 AM

45	May need broader range of general medical/care of elderly knowledge and possibly practical skills, more time in community, ability to provide 7 days/week	5/31/2015 4:39 PM
46	Much greater profile in the acute sector - will be aided with the Shape of Training reforms? Emphasis also on cross-sector working - a more consultative or collaborative approach involving importantly GPs	5/31/2015 4:29 PM
47	Uncertain. More work with PCTs?	5/31/2015 12:42 PM
48	more supportive and educational than direct care	5/30/2015 8:54 PM
49	Cross-setting working is important, rathe than isolated work in hospice, hospital or community.	5/29/2015 4:43 PM
50	Need more in hospitals and integrated or community and less ' hospice' consultants	5/29/2015 3:51 PM
51	The work will increase and get more complex.	5/29/2015 3:49 PM
52	too big a question for a survey item: it depends!	5/29/2015 1:36 PM
53	Pall med doctors need to be able to work across boundaries and be generalists, with a few further specialising to lead new developments/do research	5/29/2015 9:09 AM
54	Palliative Medicine drs will be required to see many more patients(inclusive of inappropriate referrals) and be pulled in to educate and support professionals from primary and secondary care. With 7 day week /24hr care being pushed for, the workload will increase.	5/28/2015 8:50 PM
55	as above	5/28/2015 7:30 PM
56	I think they will be asked to take on more long term condition work from medical specialties - I think it should be shared care, rather than "take-over"	5/28/2015 6:41 PM
57	Will work across borders	5/28/2015 6:20 PM
58	ever stretched	5/28/2015 5:27 PM
59	Less ivory tower protection. The care they provide will continue to need to be focussed on he individual patient	5/28/2015 4:58 PM
60	Need to be well versed in medical specialities and working with other consultant specialities.	5/28/2015 4:52 PM
61	More leading of MDTs, working in partnership and understanding of primary care	5/28/2015 4:48 PM
62	We will need to retain a focus on the last 12 months of life and dealing with patients with specialist needs; otherwise how will we differ from other groups, e.g. geriatricians etc.	5/28/2015 4:26 PM
63	It may change or be more versatile!	5/28/2015 3:55 PM
64	We will need to do more community work	5/28/2015 3:49 PM
65	need wider knowledge but also more specialised knowledge	5/28/2015 3:48 PM
66	as above.	5/28/2015 3:45 PM
67	Ability to deliver a 7 day service with face to face contact ,need to support hospices also with increase specialty dr posts,/ sessions	5/28/2015 3:35 PM
68	More doctors will be needed to provide care 7 days per week.	5/28/2015 3:24 PM
69	Increased need to work in parralel with specialties where treatment is needed right to near the end of life. Also/or increased teaching and devlopment of nurse links to enable specialists to provide such palliative care. May well be greater need for community based palliative specialists, who will require a different skill set to in-patient based ones.	5/28/2015 3:21 PM
70	more community based services, day hospice, OP clinics, Domi visits, nursing homes	5/28/2015 2:41 PM
71	roles will need to adapt	5/28/2015 2:37 PM
72	they should try and offer more community based care for broader population	5/28/2015 2:34 PM
73	More doctors in palliative medicine working in community settings (e.g. nursing homes/more closely integrated with GP services)	5/28/2015 2:29 PM
74	Providing general medicineand palliative medicine.	5/28/2015 2:21 PM
75	improve patient care family support and improve job satisfaction	5/28/2015 2:11 PM

76	More joint working, and working in new settings e.g primary care based clinics.	5/28/2015 10:05 AM
77	Our holistic skill set can be invaluable in supporting frail older people towards the end of life. We are already becoming more involved in giving 2nd opinions in complex clincal and ethical sitations and in considering acute interventiuons that can safely be delivered in community settings. this will develop and evolve.	5/27/2015 6:10 PM
78	Won't - but could subspecialise within the specialty	5/27/2015 5:48 PM
79	increased work load, more teaching of other professionals	5/27/2015 4:23 PM
80	Likely to require more 24/7 working pattern both in hospital and hospice	5/27/2015 3:22 PM
81	Need to be flexible across settings, comfortable with dealing with complex comorbidities (both medical and surgical) and with an ageing population.	5/26/2015 10:24 PM
82	Pall Med doctors will need to aquire a better understanding of the changes that are occurring in medical specialties and understand these well enough and enough detail to have a meaningful conversation with patients	5/26/2015 10:17 PM
83	It will redefine the specialty and will have a big impact on the palliative curriculum	5/26/2015 8:52 PM
84	Increase numbers of palliative care doctors within community to enable more patients to be at home	5/26/2015 8:31 PM
85	Can become a very busy job	5/26/2015 7:15 PM
86	Constant updating of knowledge and wide berth of experience in a variety of settings.	5/26/2015 5:44 PM
87	More generic care	5/26/2015 5:17 PM
88	The care should be cross-location and available to many more patients than currently receive it. This requires more palliative medicine doctors	5/26/2015 11:28 AM
89	More consultatory approach and a "dip in/out" model.	5/26/2015 10:25 AM
90	Patient presentations will be complex with patients living longing with more complex needs and a higher demand on palliative care services	5/26/2015 9:30 AM
91	Greater involvement in hospital and community care and enhaced 7 day working	5/25/2015 6:39 PM
92	We will continue to have this role	5/24/2015 10:12 AM
93	More limited resource, doctors will deal with the very complex cases	5/23/2015 10:23 PM
94	workload will be more spreadout throughout the week, continuity of care and team working may be affected	5/21/2015 2:44 PM
95	Will need a range of levels of experience in palliative medicine- from generalists managing straight-forward symptom issues or end of life care to specialists for the more complex situations.	5/21/2015 12:04 PM
96	more community, less hospital	5/20/2015 10:02 PM
97	may need more breadth of scope	5/20/2015 5:19 PM
98	We need more workforce in community	5/20/2015 12:47 PM
99	Same role and type of care	5/19/2015 8:17 PM
100	Will need a lot more disease specific knowledge not just symptom control knowledge.	5/19/2015 4:00 PM
101	must be able to fill the gaps, be happy in acute, community and hospice settings	5/19/2015 8:50 AM
102	role will be fairly similar as we work across care settings currently. however workforce needs to increase. remove the titles of hospice consultant vs hospital consultant.	5/18/2015 11:29 PM
103	Will need greater understanding of natural history of non-cancer conditions, better training in community care, ethics and communication skills. Will need to have greater availability 7 days a week to meet increasing need	5/18/2015 8:33 PM
104	Need even more specialist skillls	5/18/2015 8:02 PM
105	Should enhance, but worry will take trainees away from palliative medicine	5/18/2015 7:44 PM
106	will need more numbers	5/18/2015 7:14 PM
#	**(1.3) What should doctors in Palliative Medicine be trained to do?**	**Date**
1	holistic care in hospice, hospital and community	6/9/2015 10:29 PM

2	Symptom control, psychological support, communication, managing emergencies, advance care planning, service development, research...	6/9/2015 4:14 PM
3	Give excellent symptom control alongside other specialties I.e. Dual clinics, be providers of outstanding end of life care in all settings.	6/9/2015 2:38 PM
4	be clinicians	6/9/2015 2:03 PM
5	To care for patients according to the curriculum 2010.	6/9/2015 12:42 PM
6	Be equipped to deliver a specialist service across different healthcare sectors - community, hospice, hospital.	6/9/2015 12:11 PM
7	Same as we've always been trained to do; the challenge will be in bringing hospices along with them, and ensuring that there are more opportunities for shared contracts/jobs, etc.	6/9/2015 11:33 AM
8	To be experts in the speciality with liason skills to support multiple conditions.	6/9/2015 10:38 AM
9	Have specialty expertise in managing palliative care problems, with some general level knowledge on how to manage aute and internal medicine issues	6/9/2015 10:33 AM
10	complex ethical decision making and partnership working, managing multiple co-morbidities	6/9/2015 10:11 AM
11	They will need to have a better understanding and up-to-date knowledge in general internal medicine.	6/9/2015 9:28 AM
12	community and understand the worl of gp	6/9/2015 8:55 AM
13	Specialist Pall medicine as it is currently defined, plus education/ training of generalists, possibly with special interest sub specialisation for some	6/8/2015 10:42 PM
14	Holistis and patient centred care	6/8/2015 8:21 PM
15	Manage commonest situations, know how to collaborate, expertise in Pain management, additional training in non-cancer areas	6/8/2015 7:14 PM
16	Support generalist colleagues in community and hospitals and provide specialist care for a smaller number of the nost complex patients	6/8/2015 6:35 PM
17	assess and manage physical, emotional, social and spiritual need,s work in teams, lead evidence understanding and generation, teach, communication, develop services	6/8/2015 6:13 PM
18	Care for patients with complex problems arising from progressive life-limiting illness, & support for their families.	6/8/2015 6:06 PM
19	assess, manage and support pts with palliative care needs, whatever their circumstances or prognosis	6/8/2015 10:30 AM
20	I think training is pretty comprehensive now. However, increasing knowledge if the management of long term conditions and medical emergencies would be beneficial.	6/8/2015 12:35 AM
21	To place the patient at the centre of clinical practice. To identify acute medical needs and those patients who would benefit from further investigation / treatment.	6/7/2015 2:58 PM
22	Holistic care, complex symtom control, leadership, service design and delivery, teaching	6/5/2015 5:01 PM
23	Manage complex patients and educate and support others to mange the less complex	6/5/2015 9:54 AM
24	Diagnose reversible conditions and work with relevant specialities when identified but focus on delivery of specialist palliative care	6/5/2015 8:03 AM
25	deliver pal med, provide leadership and advice	6/4/2015 2:21 PM
26	provide specialist palliative care for patients and support other healthcare professionals through joint working and education	6/4/2015 12:38 PM
27	depends on the individual. we provide service no other speialty can provide, experts in communication, education, pharmacology, research, pain managment who else provides this holistic patitnt centres expert care	6/4/2015 12:31 PM
28	Be expert in symptom control but also look at bigger picture for patients and maybe influence how care is co-ordinated.	6/4/2015 12:10 PM
29	Specialist palliative care across hospital, hospice and community settings with a good grounding in general internal medicine	6/4/2015 12:10 PM
30	Expert symptom control. Educate. Develop plan	6/3/2015 9:20 PM

31	reason and analyze, teach, mediate, communicate as much as be experts in symptom management and general diagnostics	6/3/2015 3:53 PM
32	To bring medical support and leadership to a multi-disciplinary team that works largely with the cancer population in three different settings: acute Trust, inpatient hospice and community/home settings	6/3/2015 2:12 AM
33	To provide holistic care to patients with life limiting conditions, to influence service delivery, to train others, to engage in research	6/2/2015 5:49 PM
34	What we do now! Expertise in symptom control and end of life care. Ability to asit in the ethical dilemmas that frequently come up in hopsital.	6/2/2015 9:38 AM
35	Manage symptoms and of life care in patients with complex needs	6/1/2015 11:21 PM
36	Other than the obvious symptom control and psychological support, our most challenging role is recognising where patients are in their illness trajectory, sharing that info sensitively with other professionals and the patient and family, and as issues arise recognising what is and is not reversible	6/1/2015 10:25 PM
37	comfortable with the idea of PC specialists having general skills also	6/1/2015 10:14 PM
38	End of life care for all conditions.	6/1/2015 9:31 PM
39	Manage medical problems without the need to transfer patients to the care of a different specialism	6/1/2015 9:04 PM
40	1. support and educate generalists. 2. care for patients in the advanced stages of illness and address their priorities including comprehensive knowledge and skill in symptom management	6/1/2015 8:55 PM
41	.	6/1/2015 6:10 PM
42	palliative medicine! hospital/hospice/community care	6/1/2015 5:08 PM
43	Confidence at managing complex patients at home	6/1/2015 2:16 PM
44	To work alongside GPs to manage the elderly at home and in residential care.	6/1/2015 2:09 PM
45	General andf acute medicine in addition to palliative medicine	6/1/2015 11:30 AM
46	As currently but with strengthening of geriatric medicine skills	6/1/2015 9:55 AM
47	offer specialist advice regardless of diagnosis	6/1/2015 9:46 AM
48	earlier intervention, eg. involvement in outpatient clinics of other specialities earlier in disease trajectory	5/31/2015 8:38 PM
49	Diagnose and treat potentially reversible deteriorations within context of incurable illness, diagnose dying,communicate and collaborate with other colleages, lead MDTs especially community, deliver flexible response 7 days per week, train other colleagues as well as trainees,lead on strategic health delivery especially as expertise in community, hospice and acute Trusts.	5/31/2015 4:39 PM
50	Have a detailed understanding and be able to work across the interfaces between voluntary/statutory, community and hospital services	5/31/2015 4:29 PM
51	What we already do! Support patients and families to maximise their quality of life when living with terminal illness and die with comfort and dignity.	5/31/2015 12:42 PM
52	more team management	5/30/2015 8:54 PM
53	Too big a question to answer properly. However they will need to be generalists with a specific skillset and mindset.	5/29/2015 3:49 PM
54	Palliative Medicine! The medical component of a specialist palliative care, multi-professional team - able to look after patients and their familes with life-threatening illnesses that are facing complex, unsual or refractory quality of life or end-of-life issues	5/29/2015 1:36 PM
55	Manage teams, train others, be knowledgable about holistic care and good at making difficult decisions as well as core pall med stuff such as symptom control, acute medical situations management is largely limited to recognising when patients might benefit from acute services and a few cor topics such as thrombosis,diabetes management at end of life	5/29/2015 9:09 AM
56	To identify and manage patients with specialist palliative care needs, network with other specialties to the benefit of palliative patients, support end of life care in the acute and primary settings, support and educate colleagues in provision of generalist palliative care and educate the public about death and dying.	5/28/2015 8:50 PM

57	Manage pts in and out of hospital. Work within a larger hospital team and communicate with community services efficiently	5/28/2015 8:16 PM
58	manage physical symptoms, communicate well, manage difficult psychological symptoms, think through ethical scenarios and guide others, lead teams, work with other teams, knowledge of health systems, teach well, support colleagues, and deliver some practical skills eg ascitic drainage, nerve blocks, pleural aspirations preferably at the patient's place of care if possible!	5/28/2015 7:30 PM
59	Symptom control, psychological support of patients with life-threatening disease, good communication, ethics, helping medical specialties and GPs identify patients who would be eligible for palliative care, develop expertise in certain specific diseases and share these various skills wihtin a gruop or network, educate non specialists in palliative care knowledge and skills, develop services, manage teams including overarching management roles in organisations and not just management of junior doctors, governance	5/28/2015 6:41 PM
60	Manage patient with untreatable conditions / end of life	5/28/2015 6:20 PM
61	i personally would relish more general medicine teaching - perhaps more joint study days/shadowing weeks	5/28/2015 5:27 PM
62	To provide high quality symptom control, to communicate well, to manage risk, to work in teams and to be patient centred.	5/28/2015 4:58 PM
63	Work as specialists. Deal with the most complicated of patients and leave general palliative care to the GPs, case managers, geriatricians.	5/28/2015 4:52 PM
64	Work collaboratively with hospitals and primary care	5/28/2015 4:48 PM
65	To provide specialist palliative care! So we have a clear role/contribution to make for when generalists and 'general' palliative care is insufficient	5/28/2015 4:26 PM
66	cannot answer this in a few words.	5/28/2015 3:55 PM
67	Care for patients in multiple settings and have competance to know when conditions are not reversible	5/28/2015 3:49 PM
68	medical management of patients in hospice and community setting; management of emergencies; management of pain crisis; psychosocial/spiritual skills; communciation skills	5/28/2015 3:45 PM
69	Care of dying,meet needs of long term cancer survivors widen experience in multiple comorbidities including dementia	5/28/2015 3:35 PM
70	The current curriculum covers the main things needed	5/28/2015 3:24 PM
71	In one line? Good general medicine. Good genral practice. Teaching skills from early on. Dilpkmacy.	5/28/2015 3:21 PM
72	hospice patients, communication, hospital advisory service, community	5/28/2015 2:41 PM
73	assess, investigate and manage patients in line with modern medicine and with patients wishes	5/28/2015 2:37 PM
74	manage dying (particulary at home), complex pain and symptoms and psychological and spirital problems	5/28/2015 2:34 PM
75	To look after all patients (with malignant and non-malignant diagnosese) with complex symptom control needs, at whatever stage of their diagnosis this help is needed.	5/28/2015 2:29 PM
76	Palliative medicine first and foremost - general medicine also would be useful.	5/28/2015 2:21 PM
77	assess complex situations and agree priorities with patients / families improve education of generalist colleagues strive for quality symptom management and end of life care	5/28/2015 2:11 PM
78	Provide specialist palliative care to patients across all care settings, reagrdless of diagnosis. Significant training needed in terms of leadership, education role, and service development.	5/28/2015 10:05 AM
79	Need to have excellent broad medical knowledge, with specialty skills that allow us to give an expert opinion and to manage the care of the most complex patients. We need a workforce taht is trained to be critical, flexible and imaginative, building on excellent general knowledge and with an ability to manage complex symptoms and psychosocial issues as part of MP teams.	5/27/2015 6:10 PM
80	All current curriculum	5/27/2015 5:48 PM
81	holistic end of life care, complex symptom management, teaching	5/27/2015 4:23 PM
82	Increased Palliative care experince	5/27/2015 3:53 PM

83	Clinically: True holistic assesment, symptom management, coordination of medical care in patients with palliative care needs, psychological assessment and management/referral for patients with malignant and non-malignant diagnoses. Non-clinically: Play a key role in shaping the palliative care services of the future, engage with commissioners and management to provide well coordinated and sustainable services which across care settings. Engage in research to expand evidence-base for practice.	5/27/2015 3:22 PM
84	Increased oncology experience	5/27/2015 9:12 AM
85	Provide specialist palliative care in a variety of settings, and support others to provide good generalist palliative care.	5/26/2015 10:24 PM
86	Deliver specialist palliative medicine, educate non-specialists on the principles and how they might apply in specialty fields,	5/26/2015 10:17 PM
87	Should be trained to deliver good quality end of life care with good communication skills in a compassionate and team-focused way.	5/26/2015 8:52 PM
88	Be able to recognise and Treat the treatable/reversible conditions. Symptom manage. Be equipped to work in the community by exposure to more gp training.	5/26/2015 8:31 PM
89	manage distress. Be able to manage medical emergencies. Use discussion to make progmatic decisions.	5/26/2015 7:15 PM
90	Make decisions in an acute setting, facilitate difficult circumstances/communication with other teams and service users, facilitate/make EOL decisions and symptom control. Educate colleagues, patients and the public.	5/26/2015 5:44 PM
91	Be patient-centred above all else	5/26/2015 5:17 PM
92	Manage complex symptom burdens, communicate with excellence and model individualised care planning, develop regional services, collaborate more effectively with colleagues from other specialties (joint clinics, joint ward rounds), develop research in the area, support community services	5/26/2015 11:28 AM
93	As per current curriculum but experience in general practice and community settings needs to be expanded.	5/26/2015 10:25 AM
94	To manage non-malignant conditions in a shared manner with their colleagues in other specialities	5/26/2015 9:30 AM
95	Trained in theri specialty needs for cancer and long term conditions but with knowledge and skills of general internal medicine incresed ie integrated higher training to 5 years	5/25/2015 6:39 PM
96	A variety of approaches and roles are appropriate but acute on call in hospital general medicine is not one for most palliative doctors	5/24/2015 10:12 AM
97	The answer to this is extensive. They need to be trained to deliver palliative medicine	5/23/2015 10:23 PM
98	Pall med, good knowledge of gen med	5/21/2015 2:44 PM
99	Complex symptom control, management of complex end of life care	5/21/2015 12:04 PM
100	provide specialist pall care in a range of setting s but not acute medical cover	5/20/2015 10:02 PM
101	the same - complex symptom management	5/20/2015 5:19 PM
102	community experience which we do get during training	5/20/2015 12:47 PM
103	Life saving interventions, when appropriate and what pt wants, and good symptom management	5/19/2015 8:17 PM
104	To manage holistically complex/difficult scenarios, to advise on difficult symptom control, to educate inside and outside speciality	5/19/2015 2:16 PM
105	care for all patients in last year of life, improve service delivery across areas, lead on integrating services, be experts in symptom management	5/19/2015 8:50 AM
106	Need to have breadth of palliative care experience in all settings but also need to have a good background experience in general medicine or community	5/19/2015 12:42 AM
107	assess patients, manage symptoms, teach other HCPs, lead a large MDT team, be able to manage most gen med problems, co-ordinate care, be specialist advice to other teams	5/18/2015 11:29 PM
108	Provide hands on specialist palliative medicine. Up skill all professionals in general palliative care skills. Influence society and government to improve care of the dying	5/18/2015 8:33 PM
109	Provide specialist palliative care	5/18/2015 8:02 PM

110	Manage symptoms, complex decision making, ethical decision making, advice to other professionals, communication, ability to recognise when acute intervention appropriate or not and management of	5/18/2015 7:44 PM
111	it remains important for them to have a wide experience of the specialty	5/18/2015 7:14 PM

Q22 More generic training - generalism and areas for joint work and training

Answered: 124 Skipped: 125

Answer Choices	Responses
(2.1) What are the clinical pathways/areas in Palliative Medicine which require or will require cross medical specialty working? This may be particularly relevant to the boundaries between primary and secondary care.	**66.13%** 82
(2.2) Which other specialty (ies) could or should Palliative Medicine be combined with?	**83.87%** 104
(2.3) What is the overall scope for more generic training in Palliative Medicine and with whom?	**51.61%** 64
(2.4) Which other specialties could Palliative Medicine usefully collaborate with to produce quality training?	**75.00%** 93
(2.5) What role could dual accreditation of specialties play?	**54.84%** 68
(2.6) What specific parts of the Palliative Medicine curriculum need to be shared with or exported to other specialties? i.e. what elements of the Palliative Medicine curriculum do you believe doctors from other specialties need to understand to provide the best care for their patients	**70.16%** 87
(2.7) What specific parts of curricula from other specialties need to be imported to the curriculum in Palliative Medicine? i.e. What elements of the curricula of other specialties do you believe doctors in Palliative Medicine need to better understand to provide the best care for patients?	**55.65%** 69

#	(2.1) What are the clinical pathways/areas in Palliative Medicine which require or will require cross medical specialty working? This may be particularly relevant to the boundaries between primary and secondary care.	Date
1	chronic neurological, respiratory and cardiac conditions, renal too to some extent	6/9/2015 11:16 PM
2	Outpatient clinics, referral processes between specialties, primary/secondary care	6/9/2015 2:38 PM
3	all areas	6/9/2015 2:03 PM
4	Cross medical speciality working in acute settings - acute admissions of dying patients, patients with ned stage diseases. However if we expanded and broadened our hospice type and community services we could manage these patients outside of an acute care setting.	6/9/2015 12:42 PM
5	Joint care in non-malignant disease, and earlier access to palliative care eg MND, MS, renal failure, liver failure.	6/9/2015 12:11 PM
6	Much more involvement in working with older frailer people; working in teams which straddle hospital and primary care (admission avoidance, case management in care homes, etc). Closer working in acute settings with colleagues in respiratory, cardiology and gastro-enterology.	6/9/2015 11:33 AM
7	integrated care	6/9/2015 10:38 AM
8	management of multi-morbidity	6/9/2015 10:33 AM
9	elderly complex patients, complex decision making in both acute sector and community	6/9/2015 10:11 AM
10	Medical Admissions Unit, Oncology (acute oncology services), Care of the elderly wards	6/9/2015 9:28 AM
11	How gpo works how ccgs work	6/9/2015 8:55 AM
12	End of life care ,Transition care ,survivorship	6/8/2015 8:21 PM
13	More GP training to involve palliative care in community settings/ hospice etc, currently very little exposure	6/8/2015 7:14 PM
14	General practice training	6/8/2015 6:35 PM
15	discharge, admission, home care, elderly care,	6/8/2015 6:13 PM
16	more support of primary and secondary care and more community working.	6/8/2015 6:06 PM
17	1ry/2ndry care interface and working with GIM, HCoE, Resp, Renal, Hepatology etc	6/8/2015 10:30 AM

18	Transplant, end stage lung and heart failure, neurological conditions.	6/7/2015 2:58 PM
19	Community medicine, acute medicine	6/5/2015 5:01 PM
20	I don't understand the question - sorry	6/5/2015 8:03 AM
21	Patients with non maligannt diseases.	6/4/2015 9:13 PM
22	all	6/4/2015 2:21 PM
23	in admissions mamngement and preventing repeat admissions. in more down streamning of services in terms of input to patitents	6/4/2015 12:31 PM
24	Advance care planning	6/4/2015 12:10 PM
25	longterm conditions and elderly care, but intensive care and transisition into adulthood is alwasy missed	6/3/2015 3:53 PM
26	renal conservative care, medical/clinical oncology, pain management, psychiatry	6/3/2015 2:12 AM
27	Pretty much everything! - Elderly care is a key area for development	6/2/2015 5:49 PM
28	Interesting question when one of the likely outcomes is that General Practice trainees may not be able to switch to pall med.	6/2/2015 9:38 AM
29	Primary care, oncology, medicine of the elderly,respiratory medicine	6/1/2015 11:21 PM
30	Stroke, Dementia care, Renal, COPD,	6/1/2015 10:25 PM
31	i think most conditions are becoming about chronic disease management and so greater confidence in managing those conditions is crucial	6/1/2015 10:14 PM
32	Non-malignant disease e.g. joint management of patients with cardiologists or renal physicians	6/1/2015 9:04 PM
33	community work - preventing hospital admission - work with GPs. Management of chronic disease in outpatient settings - role to promote advance care planning	6/1/2015 8:55 PM
34	no different to current - working closely with whatever other specialty team that we are involved with in patient care.	6/1/2015 5:08 PM
35	Acute admissions, the very elderly	6/1/2015 2:16 PM
36	Palliative medicine is nothing but practice of general medicine taht puts patient at centre and involves good communication	6/1/2015 11:30 AM
37	Geriatric Medicine especially but also better awareness of Primary Care	6/1/2015 9:55 AM
38	renal; cardiac; respiratory; care of theelderly; psychogeriatrics; general pracitcie	6/1/2015 9:46 AM
39	Referrals out of hours ie expert triaging working with primary care includng out of hours, avoiding unwanted acute admissions, facilitating rapid sicharges eg home to die	5/31/2015 4:39 PM
40	Non-malignant chronic illness, care for young people/adolescents, disability services, complex medical technological support.	5/31/2015 4:29 PM
41	Primary care, acute medicine (preventing inappropriate admissions/tests)	5/31/2015 12:42 PM
42	care homes, rehab	5/30/2015 8:54 PM
43	as a cross-cutting specialty the question is redundant - we span all specialties, all setting (community, day and inpatient - both hospice and hospital) and all levels (primary, secondary and tertiary care)	5/29/2015 1:36 PM
44	All -this is absolutely at the core of patients troubles	5/29/2015 9:09 AM
45	Medical admissions unit and primary care(community)	5/28/2015 8:50 PM
46	All	5/28/2015 8:16 PM
47	elderly care medicine, the interface between primary and secondary care and developing systems to streamline a patient's movement from one to another, symptom control and future planning for patients within larger medical specialties eg respiratory, renal	5/28/2015 7:30 PM
48	neurology, respiratory, cardiology, oncology, haematology, renal medicine, elderly medicine, old age psychiatry for improved dementia care	5/28/2015 6:41 PM

49	Work closely with rehabilitation medicine, acute sector and community.	5/28/2015 6:20 PM
50	all patients who are still receiving active treatment	5/28/2015 5:27 PM
51	Organ failure, dementia care, frail elderly.	5/28/2015 4:52 PM
52	Management of chronic illness,	5/28/2015 4:48 PM
53	Volume wise it will always be oncology; other patient groups are relevant but proportion fulfilling criteria 'per clinic' /'per session of clinical experience' will be less; so harder to select other specialties so clearly	5/28/2015 4:26 PM
54	acute care pathways, interface between community and acute care; nursing homes; supporting those with chronic conditions but buredned by symptoms	5/28/2015 3:55 PM
55	Mainly between primary care and palliative care	5/28/2015 3:49 PM
56	neurological issues, old age. dementia	5/28/2015 3:48 PM
57	There is a limitation to what is feasible. Lare hospitals with specialities, such as cardiology and or respiratory medicine, would beenfit from this.	5/28/2015 3:21 PM
58	heart failure, COPD, shared GP MDTs.	5/28/2015 2:41 PM
59	non-malignant diseases in particular, community care	5/28/2015 2:37 PM
60	end of life care	5/28/2015 2:34 PM
61	We are likely going to need to work more closely with Care of the Elderly teams, with community teams (including GPs).	5/28/2015 2:29 PM
62	General medicine - care of the multimorbid - community care.	5/28/2015 2:21 PM
63	symptom management emergencies in palliative medicine support for patients undergoing oncology treatments / MDTs etc.. support for long term conditions heart failure copd renal degenrative conditions dementia	5/28/2015 2:11 PM
64	Work within primary care but as a SPC doctor rather than as a GP. Early integration and involvement with oncology patients. Joinyt working with e.g. heart failure teams, COPD etc.	5/28/2015 10:05 AM
65	Opportunity to be involved in models for delivering more integrated care in community and in delivering acute interventions in community - with the abilty to assess for reversibility whilst ensuring robust plans are in place if ongoing deterioration. Palliative medicine may also need to becoem more embedded in acute medical units to earlier identify those patients where early intervention can shorten admission, prevent readmissions or change forcus of care, as clinially appropriate	5/27/2015 6:10 PM
66	Community work for all palliative medicine areas	5/27/2015 3:53 PM
67	Increased joint working and training in specialties other than oncology which have large numbers of patients approaching end of life with significant symptom burden- respiratory, renal, neurology, cardiology, vascular.	5/26/2015 10:24 PM
68	Oncology/haematology/psychiatry, patients with chronic conditions, interventional pain techniques	5/26/2015 8:52 PM
69	all non malignant disease, oncology, acute medicine	5/26/2015 7:15 PM
70	Acute scenarios. More team working with oncologists. Education and support for GPs.	5/26/2015 5:44 PM
71	elderly care	5/26/2015 5:17 PM
72	All medical specialities (particularly haem/onc, elderly medicine, renal) and general practice	5/26/2015 10:25 AM
73	Care of acuteky unwell patient and care of dying patient	5/25/2015 6:39 PM
74	Community	5/24/2015 10:12 AM
75	Elderly medicine and general practice in the main. On going oncology as well.	5/23/2015 10:23 PM
76	many! elderly care, resp, neurology, primary care, social services	5/21/2015 2:44 PM
77	General medicine	5/20/2015 12:47 PM
78	Acute admissions/acute medical problems; discharges from the acute sector	5/19/2015 4:00 PM
79	patients in the community with GP, hospitals with all specialities, hospices	5/19/2015 8:50 AM

80	Primary care would be most important. Dementia. Respiratory. Heart failure. Neurology. Renal	5/18/2015 8:33 PM
81	Not sure	5/18/2015 8:02 PM
82	Elderly care	5/18/2015 7:44 PM
#	**(2.2) Which other specialty (ies) could or should Palliative Medicine be combined with?**	**Date**
1	Respiratory, Cardiology, Health Care of the Elderly, Neurology, Gastroenterology.	6/9/2015 11:10 PM
2	As mentioned previously, palliative medicine could be linked to care of the elderly training, there is also scope to have more palliative medicine training for GPs.	6/9/2015 6:25 PM
3	Geriatrics, Respiratory, General Practice	6/9/2015 2:38 PM
4	acute and general medicine, geriatrics	6/9/2015 2:03 PM
5	Can be most!	6/9/2015 12:42 PM
6	none	6/9/2015 12:11 PM
7	Elderly Care; orthogeriatrics; acute frailty units.	6/9/2015 11:33 AM
8	general practice and possibly psychiatry	6/9/2015 10:38 AM
9	medicine for the elderly	6/9/2015 10:33 AM
10	elderly care	6/9/2015 10:11 AM
11	Respiratory Medicine, Care of the elderly, Oncology&Haematology, Renal	6/9/2015 9:28 AM
12	I think that combination should be avail to those who wish it and not for all. Most specialities relevant.	6/8/2015 10:42 PM
13	InternalMedicine,Elderly Care, Paediatrics,Respiratorii Medicine,Oncology	6/8/2015 8:21 PM
14	See above	6/8/2015 7:14 PM
15	General practice and anaesthetics	6/8/2015 6:35 PM
16	not sure combine is the right answer, work with many,	6/8/2015 6:13 PM
17	care of the elderly, renal and respiratory, also cardiology and a focus on heart failure as such a significant number die of this. Also more support for dementia although I don't think this should be the focus of our service	6/8/2015 6:06 PM
18	elderly care, general practice	6/8/2015 11:16 AM
19	GIM, HCoE, Renal, Resp, Hepatology ?cardiologu	6/8/2015 10:30 AM
20	Respiratory medicine, elderly care, oncology	6/8/2015 12:35 AM
21	My opinion is that palliative medicine as a stand alone specialty is well placed to deliver high quality patient care. If it is to be combined with another specialty that should be the choice of the individual not mandated by the training scheme.	6/7/2015 2:58 PM
22	COTE/GP	6/5/2015 5:01 PM
23	Medicine for elderly; oncology	6/5/2015 9:54 AM
24	Geriatrics, primary care	6/5/2015 8:03 AM
25	None	6/4/2015 9:13 PM
26	in terms of dual acreditation could make an arguement for any medical speciality, oncology or haematology.	6/4/2015 2:21 PM
27	GIM, Medicine for older people, medical oncology, respiratory medicine etc..	6/4/2015 12:38 PM
28	continued cooperative working with all specilaities but we are a specilty in own right.	6/4/2015 12:31 PM
29	Medicine for the elderly, cardiology and respiratory medicine, oncology	6/4/2015 12:10 PM
30	Care of the elderly/ respiratory	6/4/2015 12:10 PM
31	None	6/3/2015 9:20 PM
32	primary care, GIM, elderly care	6/3/2015 3:53 PM

33	Elderly Medicine/Oncology/Renal/cardiology/respiratory/rehab	6/3/2015 11:29 AM
34	Elderly care, psychiatry, pain medicine, medical/clinical oncology	6/3/2015 2:12 AM
35	Pain interventional work - with anaesthetists.	6/2/2015 9:38 AM
36	As above	6/1/2015 11:21 PM
37	Care of the Elderly, Neurology, Oncology, Respiratory,	6/1/2015 10:25 PM
38	most of the inpatient based medical specialties	6/1/2015 10:14 PM
39	Old Age Psychiatry.	6/1/2015 9:31 PM
40	GP, geriatrics.	6/1/2015 8:55 PM
41	none	6/1/2015 5:08 PM
42	Acute Medicine, Care of the the Elderly,	6/1/2015 2:16 PM
43	general medicine, geriatrics, acute medicine	6/1/2015 11:30 AM
44	Geriatric Medicine, Primary Care	6/1/2015 9:55 AM
45	oncology; care of the elderly	6/1/2015 9:46 AM
46	General practice, care of elderly.	5/31/2015 4:39 PM
47	Care of the elderly, rehabilitation, renal, cardiac, respiratory.....any that it shouldn't be?!	5/31/2015 4:29 PM
48	GP, geriatrics	5/31/2015 12:42 PM
49	COTE, chronic conditions, ?psych	5/30/2015 8:54 PM
50	It could be combined with several (eg neurology, respiratory, renal, care of the elderly) but at the risk of dilution of both.	5/29/2015 4:43 PM
51	all - should depend on the interests of the trainee	5/29/2015 4:13 PM
52	acute general, geriatrics, GP	5/29/2015 3:49 PM
53	all or none - it is more nuanced; to what degree, in what context etc...	5/29/2015 1:36 PM
54	General practice	5/29/2015 9:09 AM
55	Oncology / neurology	5/28/2015 11:41 PM
56	With all areas /specialties where patients develop life - limiting illnesses - mainly, Cardiology, respiratory, renal, neurology	5/28/2015 8:50 PM
57	All - not fully combined but every specialty needs to have an insight into what Palliative Medicine is so that when they have a patient who could benefit from such services they know who and how to contact the Palliative team	5/28/2015 8:16 PM
58	Oncology, Pain Medicine, Elderly Care, Cardiology/Respiratory/Neurology (some), Psychiatry (very occasional)	5/28/2015 7:30 PM
59	neurology, respiratory, cardiology, oncology, haematology, renal medicine, elderly medicine,	5/28/2015 6:41 PM
60	Rehabilitation Medicine	5/28/2015 6:20 PM
61	GP, elderly care, psychiatry, oncology, neurology....	5/28/2015 5:27 PM
62	General Practice, Elder care, Psychogeriatrics, Oncology, neurology,Cardiology and Respiratory medicine	5/28/2015 4:58 PM
63	community geriatrics, clinical oncology	5/28/2015 4:52 PM
64	primary care, GIM, MOE	5/28/2015 4:48 PM
65	Do not agree with this.	5/28/2015 4:26 PM
66	Ther is synergy with a range eg oncology, renal, neurology- but in main workinfgg alongside not combined	5/28/2015 3:55 PM
67	Care of the elderly and respiratory	5/28/2015 3:49 PM
68	think it should be a separate speciality	5/28/2015 3:48 PM

69	General.acute ,elderly care medicine and primary care experience	5/28/2015 3:35 PM
70	General Practice/Elderley care	5/28/2015 3:24 PM
71	None. However, some specialities could benefit from combining with palliative medicine - respiratory, renal, heart failure in particular	5/28/2015 3:21 PM
72	GP	5/28/2015 2:41 PM
73	Old age / gerontology / old age psychiatry / end stage issues in cardiac, renal, chest etc	5/28/2015 2:37 PM
74	geriatrics, resp, oncology, GP	5/28/2015 2:34 PM
75	Oncology, Care of the Elderly.	5/28/2015 2:29 PM
76	General medicine, acute medicine, GP possibly clinical pharmacology and medical oncology	5/28/2015 2:21 PM
77	geriatrics paediatrics oncology general practice	5/28/2015 2:11 PM
78	Should be a stand alone specialty.	5/28/2015 10:05 AM
79	Care of elderly, GIM, acute medicine	5/27/2015 6:10 PM
80	GP, oncology, GIM, Respiratory, COE etc	5/27/2015 5:48 PM
81	Respiratory, Neurology, Renal, Pain	5/27/2015 3:22 PM
82	Oncology/ care of elderly/ respiratory	5/27/2015 9:12 AM
83	Respiratory, renal, cardiology, neurology, oncology, elderly medicine, paediatrics, vascular surgery, general practice.	5/26/2015 10:24 PM
84	Geriatrics, General practice,	5/26/2015 10:17 PM
85	Oncology, pain medicine, care of the elderly	5/26/2015 8:52 PM
86	GP. In theory, any medical specialty: resp, cardio, COTE, renal. But it changes your focus and it is not clear if this would be beneficial in the long run.	5/26/2015 5:44 PM
87	neurology, oncology, geriatrics, respiratory, cardiology, renal, gastro (the list can go on)	5/26/2015 11:28 AM
88	General medicine	5/26/2015 10:25 AM
89	This is too board - Palliative Medicine trainees need experience in managing and understanding conditions such as heart failure, pulmonary fibrosis, end stage neurlogical conditions so that they can engage with colleagues in these specialities as future consultants in a shared care approach. To identify what specialties need to be combined with palliative medicine is to miss the point. What benefit is it to a palliative medicine trainee to be provicient in managing MIs, acute pneumothorax etc. when they can't manage a pain crisis, terminal agitation or psychological distress?	5/26/2015 9:30 AM
90	Elderly care, respiratory medicine and acute medicine ,medical and clinical oncology	5/25/2015 6:39 PM
91	In general, none	5/24/2015 10:12 AM
92	None	5/23/2015 10:23 PM
93	eld care, gen med	5/21/2015 2:44 PM
94	Care of the Elderly, Medical Oncology, Chronic Pain (although obviously these two are not currently internal medicine specialties)	5/21/2015 12:04 PM
95	elderly care	5/20/2015 10:02 PM
96	respiratory	5/20/2015 5:19 PM
97	Elderly care, respiratory, neurology,	5/19/2015 4:00 PM
98	General Practice, Pain Medicine	5/19/2015 2:16 PM
99	geriatrics, oncology	5/19/2015 8:50 AM
100	Collaboration with elderly medicine but there are distinct roles and skills that should remain	5/19/2015 12:42 AM
101	geriatric, renal, respiratory, cardiology, neurology.	5/18/2015 11:29 PM

102	?geriatric medicine	5/18/2015 8:02 PM
103	Elderly care, respiratory, neurology	5/18/2015 7:44 PM
104	C of the E, GIM, respiratory medicine, cardiology, gastroenterology,	5/18/2015 7:14 PM
#	**(2.3) What is the overall scope for more generic training in Palliative Medicine and with whom?**	**Date**
1	by exchange of trainees	6/9/2015 2:03 PM
2	I would like to see palliative medicine develop as a community speciality more than as an acute - we are generalists and should be proud of that badge.	6/9/2015 12:42 PM
3	Needs to be opportunity for all doctors to be exposed to EOLC training.	6/9/2015 11:33 AM
4	general practice	6/9/2015 10:38 AM
5	rotational posts with medicine for the elderly	6/9/2015 10:33 AM
6	elderly care and acute medicine	6/9/2015 10:11 AM
7	Training earlier in career (ie- at current CMT level, or in years 1-3 of proposed training days)	6/9/2015 9:28 AM
8	GPs- some GP training schemes in ROI include rotation through hospice/CSPCT, oncology, haematology, respiratory, cardiology, Med Elderly, etc	6/8/2015 10:42 PM
9	Best and appropriate patient care	6/8/2015 8:21 PM
10	General medicine and geriatrics , possibly neurology	6/8/2015 7:14 PM
11	Expand training schemes to more rural areas	6/8/2015 6:35 PM
12	all specialties to some extent, especially ageing, oncoloyg, respiratory, neuro, cardio, renal. liver	6/8/2015 6:13 PM
13	Particularly GIM and HCoE	6/8/2015 10:30 AM
14	All specialties require generic training in palliative medicine.	6/7/2015 2:58 PM
15	With most medical specialties	6/5/2015 9:54 AM
16	all	6/4/2015 2:21 PM
17	GP shoudl have more ediuaction to support primary care	6/4/2015 12:31 PM
18	medicine for the elderly especially with the changing demographic	6/4/2015 12:10 PM
19	??Time in general practice?? In acute settings time with Care of the Elderly teams	6/4/2015 12:10 PM
20	there is only scope if training is lengthened	6/3/2015 3:53 PM
21	Limited scope, but perhaps some months spent with care of the elderly colleagues	6/3/2015 2:12 AM
22	There is scope for increased palliative medicine training in all medical specialties, especially elderly care, oncology, respiratory	6/2/2015 5:49 PM
23	limited	6/1/2015 8:55 PM
24	not required - will dilute the skills of future consultants in our own specialty	6/1/2015 5:08 PM
25	oncology, cardiology, hepatology, renal respiratory, care of elderly (although this patient group will increasingly be the norm rather than specialist)	6/1/2015 4:44 PM
26	GP	6/1/2015 2:16 PM
27	A huge with general medicine, acute medicine and geriatrics	6/1/2015 11:30 AM
28	Geriatric Medicine, Primary Care	6/1/2015 9:55 AM
29	undergraduate and foundation curricula in all specialties but difficult to resource currently from available pool of pall med doctors-may be scope for combined learning/teaching with nonmedical colleagues	5/31/2015 4:39 PM
30	GPs have a lot to teach us	5/31/2015 4:29 PM
31	Depends if future palliative care physicians want it. As above.	5/31/2015 12:42 PM

32	lots or none - it is more nuanced	5/29/2015 1:36 PM
33	Should be compulsory part of training for GPs, med for elderly,oncology, and pain consultants.	5/29/2015 9:09 AM
34	Generic training would be useful - particularly with Elderly care as this population is on the rise.	5/28/2015 8:50 PM
35	You mean that other specialties should get training in palliative medicine? Its a pity it's not listed alongside geriatrics, MRCP and simulation as part of the core competences.	5/28/2015 7:30 PM
36	not within current time frame of 4yrs - often also, our time is spent in service provision rather than education/training	5/28/2015 5:27 PM
37	General Practice, Elder care, Psychogeriatrics, Oncology, neurology, Cardiology and Respiratory medicine	5/28/2015 4:58 PM
38	I think it would benefit palliative care, especially with something like geriatrics or oncology, but only as long as it doesn't dilute the palliative care training which is all about experience.	5/28/2015 4:52 PM
39	More generic training would be beneficial to understand and learn from other specialties with less excluvisity	5/28/2015 4:48 PM
40	Do not agree with this.	5/28/2015 4:26 PM
41	As above	5/28/2015 3:49 PM
42	important as long as does not dilute the specialist training	5/28/2015 3:48 PM
43	More community based training. Palliative medicne in dementia is a whole new paradigm, yet to be established.	5/28/2015 3:21 PM
44	GP training	5/28/2015 2:41 PM
45	foundation drs and cmt equivalent/ Gp STs could benefit from more generic training	5/28/2015 2:34 PM
46	Unclear - not in the way shape has offered.	5/28/2015 2:21 PM
47	Oncology, respiratory, primary care,	5/28/2015 10:05 AM
48	Increased broad medicial knowledge of disease processes, in order to manage acute problems and assess for reversibility	5/27/2015 6:10 PM
49	year fellowships with another speciality	5/27/2015 4:23 PM
50	Minimal	5/27/2015 3:53 PM
51	GP's	5/26/2015 7:15 PM
52	I feel training in palliative medicine is already quite generic if you fulfill the training requirements.	5/26/2015 5:44 PM
53	Limited but elderly care and general practice seem to be the most interested. Perhaps build in placements with palliative medicine into all medical speciality training.	5/26/2015 10:25 AM
54	as above	5/26/2015 9:30 AM
55	generic training should be comparable thro genrel in trenal medicine irrespective of specialty training ie communication skills , leadership ethical and legal aspects of medical care	5/25/2015 6:39 PM
56	GP, oncology, elderly medicine, cardiology(heart failure), nephrology, hepatology. Lots of specialities.	5/23/2015 10:23 PM
57	elderly care - comprehensive geriatric assessment	5/20/2015 10:02 PM
58	additional to the 4 years rather than instead of	5/20/2015 5:19 PM
59	Some experience in general medicine	5/20/2015 12:47 PM
60	Huge scope - it could become a more significant part of training for medical students and junior doctors.	5/19/2015 2:16 PM
61	I think there is scope between all medical specialities but care of the elderly and GP would seem the most relevant	5/18/2015 8:33 PM
62	Not sure	5/18/2015 8:02 PM
63	Not sure I understand question	5/18/2015 7:44 PM
64	we are such a broad based specialty the scope is wide	5/18/2015 7:14 PM

#	(2.4) Which other specialties could Palliative Medicine usefully collaborate with to produce quality training?	Date
1	psychiatry, anaesthetics/pain interventional radiology, education, ethics, law, psychology	6/9/2015 11:16 PM
2	Possibly care of the elderly.	6/9/2015 6:25 PM
3	As above	6/9/2015 2:38 PM
4	medicine, geriatrics, respiratory, cardiology, neurology	6/9/2015 2:03 PM
5	General paractice, HCOP	6/9/2015 12:42 PM
6	Many acute medical specialties (see above)	6/9/2015 12:11 PM
7	As above.	6/9/2015 11:33 AM
8	oncology, renal, respiratory, cardiac, neurology but elements of these only.	6/9/2015 10:38 AM
9	medicine for the elderly	6/9/2015 10:33 AM
10	elderly care and acute medicine	6/9/2015 10:11 AM
11	GP training, Care of the Elderly, Respiratory Medicine	6/9/2015 9:28 AM
12	geriatirucs gp neurology	6/9/2015 8:55 AM
13	oncology, haematology, respiratory, cardiology, Med Elderly, etc but SUSPECT DUAL ACCREDITATION IS OVERKILL.	6/8/2015 10:42 PM
14	Same as 2.2	6/8/2015 8:21 PM
15	As above	6/8/2015 7:14 PM
16	as above, better to collaborate than combine	6/8/2015 6:13 PM
17	As for 2.2 + primary care	6/8/2015 10:30 AM
18	Chronic Pain, neurology, cardiology	6/8/2015 12:35 AM
19	I am not convinced that increased collaboration is required but if it is mandated respiratory medicine or care of the elderly.	6/7/2015 2:58 PM
20	COTE	6/5/2015 5:01 PM
21	Care of elderly / GIM	6/5/2015 9:54 AM
22	Care of the elderly, GP, psychiatry.	6/4/2015 9:13 PM
23	as for 2.2	6/4/2015 2:21 PM
24	GIM, medicine for older people, medical oncology, respiratory medicine, renal medicine, cardiology	6/4/2015 12:38 PM
25	all. we have always worked collaeratively woth GP, onc, Resp, Haem, GI , surgery. we provide support advice and cooperative team working	6/4/2015 12:31 PM
26	Medicine for the elderly, cardiology and respiratory medicine, oncology	6/4/2015 12:10 PM
27	primary care and any acute medical specialty	6/3/2015 3:53 PM
28	As above	6/3/2015 11:29 AM
29	I think it depends on the aims of such training, but see my answers to 2.2	6/3/2015 2:12 AM
30	All above	6/2/2015 5:49 PM
31	Care of the elderly	6/2/2015 9:38 AM
32	As above	6/1/2015 11:21 PM
33	Care of the Elderly, Neurology, Oncology, Respiratory,	6/1/2015 10:25 PM
34	Old Age Psychiatry.	6/1/2015 9:31 PM
35	GP, geriatrics	6/1/2015 8:55 PM

36	none unless a trainee wants to undertake 2 four year programmes	6/1/2015 5:08 PM
37	Respiratory medicine	6/1/2015 2:16 PM
38	General practice, Oncology, Elderly care	6/1/2015 2:09 PM
39	not sure if collaboration alone works	6/1/2015 11:30 AM
40	Geriatric Medicine, Primary Care	6/1/2015 9:55 AM
41	all above	6/1/2015 9:46 AM
42	as for 2.2 but also oncology, general internal medicine	5/31/2015 4:39 PM
43	GPs - Care of the elderly	5/31/2015 4:29 PM
44	As above.	5/31/2015 12:42 PM
45	pain teams for intervention; oncology for less aggressive / futile treatment	5/30/2015 8:54 PM
46	all or none - it is more nuanced	5/29/2015 1:36 PM
47	Oncology, medicine for the elderly, psychiatry, respiratory and renal	5/29/2015 9:53 AM
48	As above and psychiatry,psychology	5/29/2015 9:09 AM
49	Oncology	5/28/2015 11:41 PM
50	Respiratory medicine - given significant proportion of COPD/ Malignancy/ Pulmonary fibrosis	5/28/2015 8:50 PM
51	All - as above	5/28/2015 8:16 PM
52	Oncology, Pain Medicine, Elderly Care, Cardiology/Respiratory/Neurology/Renal (some), Psychiatry (very occasional)	5/28/2015 7:30 PM
53	neurology, respiratory, cardiology, oncology, haematology, renal medicine, elderly medicine, old age psychiatry for improved dementia care	5/28/2015 6:41 PM
54	as above	5/28/2015 5:27 PM
55	General Practice, Elder care, Psychogeriatrics, Oncology, Cardiology and Respiratory medicine, anaesthetics	5/28/2015 4:58 PM
56	MOE and primary care	5/28/2015 4:48 PM
57	Do not agree with this.	5/28/2015 4:26 PM
58	care of elderly	5/28/2015 3:55 PM
59	Oncology may have something else to offer also	5/28/2015 3:49 PM
60	as above	5/28/2015 3:48 PM
61	Psychiatry/psychology. If hospital based chronic pain services.	5/28/2015 3:21 PM
62	GP	5/28/2015 2:41 PM
63	elderly care, as above...cardiology, respiratory, renal, neurology when EoLC issues begin to arise	5/28/2015 2:37 PM
64	GP, pain (anaethetics)	5/28/2015 2:34 PM
65	See above.	5/28/2015 2:29 PM
66	The above	5/28/2015 2:21 PM
67	respiratory cardiology haematology gastroenterology renal	5/28/2015 2:11 PM
68	Oncology, respiratory, primary care.	5/28/2015 10:05 AM
69	Care of elderly, GIM, acute medicine	5/27/2015 6:10 PM
70	COE, GP esp	5/27/2015 5:48 PM
71	geriatrics/renal	5/27/2015 4:23 PM
72	Respiratory, Neurology, Renal, Pain	5/27/2015 3:22 PM

73	Geriatrics, Cardiology, Resp	5/26/2015 10:17 PM
74	Oncology	5/26/2015 7:15 PM
75	Doing joint days with resp, COTE, renal, cardio might be useful	5/26/2015 5:44 PM
76	As above	5/26/2015 11:28 AM
77	Oncology/haematology, elderly medicine, general practice, renal medicine, chest medicine, cardiology, neurology, intensive care.	5/26/2015 10:25 AM
78	as above	5/26/2015 9:30 AM
79	Elderly care, respiratory medicine and acute medicine ,medical and clinical oncology	5/25/2015 6:39 PM
80	See above	5/23/2015 10:23 PM
81	eld care	5/21/2015 2:44 PM
82	Oncology, Pain, Neurology, Respiratory	5/21/2015 12:04 PM
83	geriatrics	5/20/2015 10:02 PM
84	geriatrics.	5/20/2015 5:19 PM
85	Respiratory, Renal, Cardiology, Geriatrics	5/20/2015 12:47 PM
86	Elderly care	5/19/2015 8:17 PM
87	Elderly care	5/19/2015 4:00 PM
88	General Practice and Psychiatry. The internal medicine paradigm is not adequate to cover the holistic complexity of the specialty and the advanced communication and skills required	5/19/2015 2:16 PM
89	as above and neurology, respiratory, cardiology, renal, liver.....	5/19/2015 8:50 AM
90	As above	5/18/2015 8:33 PM
91	All medical specialties	5/18/2015 8:02 PM
92	Elderly care, respiratory, neurology	5/18/2015 7:44 PM
93	all of the above	5/18/2015 7:14 PM
#	**(2.5) What role could dual accreditation of specialties play?**	**Date**
1	no much	6/9/2015 10:29 PM
2	Production of consultants with an advisory role in 2 areas leading to better patient care	6/9/2015 2:38 PM
3	crossing boundaries	6/9/2015 2:03 PM
4	Improve standards of care across all care settings.	6/9/2015 12:42 PM
5	limited	6/9/2015 10:33 AM
6	community care of complex patients and collaberation with GP practice	6/9/2015 10:11 AM
7	Joint clinics	6/9/2015 9:28 AM
8	As above, think is overkill. Desirable outcomes could be achieved by agreeing curriculum competencies for 'sub speciality interest'	6/8/2015 10:42 PM
9	Don't know	6/8/2015 7:14 PM
10	increased ability to work across boundaries	6/8/2015 6:13 PM
11	Important	6/8/2015 10:30 AM
12	Within the acute setting I can see this being a bonus. Whilst experience may be a bonus in other settings there would be challenges to working in the current models if palliative care and incorporating a role in another specialty.	6/8/2015 12:35 AM

13	If required to dual accredit consultants should be able to utilise all of their skills (rather than merely while training). Acute medical ward rounds with a focus on symptom control would be beneficial but sufficient time would be required to perform such assessments.	6/7/2015 2:58 PM
14	Dual accreditation should be to enhance particular interests outside of palliative medicine	6/5/2015 5:01 PM
15	Huge - could dual accedit with most med specialties	6/5/2015 9:54 AM
16	same as dual now	6/4/2015 2:21 PM
17	depending on individual should not be the norm	6/4/2015 12:31 PM
18	Useful in the hospital setting	6/4/2015 12:10 PM
19	very provided training was adequate	6/3/2015 3:53 PM
20	An adverse role. I think there will be greater demand for the general medicine medic than for the palliative medicine medic	6/3/2015 2:12 AM
21	Individuals with particular interests could dual accredit which gives them great opportunities to develop better care pathways for particular groups	6/2/2015 5:49 PM
22	I feel that having care of the elderly trainees accrediting in palliative medicine is the more logical way round.	6/2/2015 9:38 AM
23	May be particularly relevant in some subspecialties, e.g. a lung cancer specialist dual accredited in palliative medicine	6/1/2015 10:25 PM
24	-	6/1/2015 8:55 PM
25	none	6/1/2015 5:08 PM
26	could have an out-patient cohort of patients who have palliative care needs in the end stages of the specific dual specialty eg respiratory, renal, hepatology	6/1/2015 4:44 PM
27	Managing LTC	6/1/2015 2:16 PM
28	It may improve delivery of palliative care in in any setting	6/1/2015 11:30 AM
29	Strengthen the community awareness and context of training, plus also develop better care of older people skills and experience	6/1/2015 9:55 AM
30	oncolgoy and care of the elderly	6/1/2015 9:46 AM
31	Feel it should be optional rather than compulsory	5/31/2015 4:39 PM
32	'Cross-infection', raising profile	5/31/2015 4:29 PM
33	Enhance knowledge and experience.	5/31/2015 12:42 PM
34	COTE in community hospitals and care homes	5/30/2015 8:54 PM
35	all or none - it is more nuanced	5/29/2015 1:36 PM
36	I would like to see option for GPs and other specialty dual accreditations with no restrictions to specialty training other than an aptitude test and the right personal attributes at aan assessment 6 month post	5/29/2015 9:09 AM
37	May enhance skills for those who wish to have additional skills.	5/28/2015 8:50 PM
38	More experience, broader knowledge, team building and better well rounded care	5/28/2015 8:16 PM
39	To be honest, I just don't see that there are enough posts that need this to warrant it becoming a regular thing - there are some, in larger trusts perhaps, or research centres, but i think it is really only appropriate for people pursuing a particular interest.	5/28/2015 7:30 PM
40	always beneficial, especially if good teachers	5/28/2015 5:27 PM
41	Very limited	5/28/2015 4:58 PM
42	helpful in understanding level of trainign achieved by individual dr	5/28/2015 4:48 PM
43	I suspect limited; its already an option that few have taken up.	5/28/2015 4:26 PM

44	Small posts in specialist servioces where enough numbers to jsutify post dedicated to one diagnostic group such as a cancer centre	5/28/2015 3:55 PM
45	specialists who can work in either area	5/28/2015 3:49 PM
46	have to be careful does not dilute specialist knowledge in both specialities	5/28/2015 3:48 PM
47	Some in large hospitals. Not in small town/rural areas.	5/28/2015 3:21 PM
48	i feel none or GP	5/28/2015 2:41 PM
49	may be helpful in cardiology, respiratory, renal, neurology, elderly medicine	5/28/2015 2:37 PM
50	Being more flexible for our patients and sharing our skills	5/28/2015 2:21 PM
51	Training Drs with a broader knowledge and experience, but could lead to doctors with less SPC experience.	5/28/2015 10:05 AM
52	Early specialty input to acute medicine units, care homes, support for 'virtual ward' teams in community	5/27/2015 6:10 PM
53	I do not know	5/26/2015 8:52 PM
54	useful one	5/26/2015 7:15 PM
55	I think only dual accreditation would be suitable in Primary care	5/26/2015 5:44 PM
56	As an option for those who wish to, it has a place and could help develop greater collaboration between specialist services	5/26/2015 11:28 AM
57	Better links with other speciality trainees and as careers progress consultants. A greater understanding of the challenegs within each area. More up to date knowledge of acute medicine.	5/26/2015 10:25 AM
58	perhaps with Medicine for the Elderly as there is overlap and this would benefit both specialties	5/26/2015 9:30 AM
59	For some trainees this could be an option especialaly those who wish to be based in secondary care only	5/25/2015 6:39 PM
60	Unclear really. I suspect dual accreditation would be of more benefit to a geriatrician for example than for someone doing pure palliative medicine	5/23/2015 10:23 PM
61	for registrars who wish to work in hospitals	5/21/2015 2:44 PM
62	limited	5/20/2015 10:02 PM
63	i don't fully see a need unless someone was clear they wanted to do hospital pall med potentially	5/20/2015 5:19 PM
64	Not sure, may be not much	5/20/2015 12:47 PM
65	See above	5/19/2015 2:16 PM
66	Would help to influence practice of peers	5/18/2015 8:33 PM
67	Not sure	5/18/2015 8:02 PM
68	Sub specialty expertise within specialty	5/18/2015 7:44 PM
#	**(2.6) What specific parts of the Palliative Medicine curriculum need to be shared with or exported to other specialties? i.e. what elements of the Palliative Medicine curriculum do you believe doctors from other specialties need to understand to provide the best care for their patients**	**Date**
1	Recognition of end of life care in nonmalignant conditions, help to support patients in EHCP, communication skills, appropriate first steps in symptom management.	6/9/2015 11:10 PM
2	I think a lot of the aspects of symptom control (more basic) and more basic communication skills should be shared across all specialties.	6/9/2015 6:25 PM
3	The patient as the main focus, communicating effectively with patients and carers, time to do this properly	6/9/2015 2:38 PM
4	mainly around symptom control and the drugs. Hopefully they will now understand end of life issues including advance care planning	6/9/2015 2:03 PM
5	Pain control and use of strong analgesics. Communication skills.	6/9/2015 12:42 PM
6	Listening to the patient	6/9/2015 12:11 PM
7	basic symptom control, MDT working, ethics, holistic assessment, communication skills	6/9/2015 10:38 AM

8	basic symptom management, communication skills	6/9/2015 10:33 AM
9	holistic assessment, communication, indivdual patient/family needs - the bigger picture	6/9/2015 10:11 AM
10	Recognition of dying patient. Advanced communication skills. Ethical and legal considerations of withdrawal or withholding of medical interventions, Pharmacological understanding of analgesia, esp opioids.	6/9/2015 9:28 AM
11	Principles of holistic care and pain control,Recognising the limits within speciality and the need for MDT working	6/8/2015 8:21 PM
12	Comminication skills and pain management	6/8/2015 7:14 PM
13	lots - where to start - symptom management, communicaiton, ethics, etc	6/8/2015 6:13 PM
14	pain and symptom control and end of life care	6/8/2015 10:30 AM
15	End of life care	6/8/2015 12:35 AM
16	Communication skills, care of the family, social and financial support, bereavement care.	6/7/2015 2:58 PM
17	Basic symptom contro, communication skills, ethics	6/5/2015 5:01 PM
18	Communication, care of dying, management of common symptoms, ethics	6/5/2015 9:54 AM
19	Basic symptom control following holistic assessment	6/5/2015 8:03 AM
20	EoL care, symptom management and commuication	6/4/2015 2:21 PM
21	communication skills, symptom control at end of life, ethics, care across different care settings	6/4/2015 12:38 PM
22	comminucation edication patiient at the centre of care	6/4/2015 12:31 PM
23	advance care planning	6/4/2015 12:10 PM
24	Recognising dying patients, good end of life care	6/4/2015 12:10 PM
25	communication skills, ethics and clinical reasoning,	6/3/2015 3:53 PM
26	General palliative care - discussions re future/ACP. Prognostication and use of GSF. Understanding of services in local area and referral.	6/3/2015 11:29 AM
27	The best bit of my job is the time I can give to patients. Exporting elements of a specialty curriculum will never fully change the working practices of docs from other specialties.	6/3/2015 2:12 AM
28	Communication, advance care planning, management of last days of life,	6/2/2015 5:49 PM
29	Basic symptom management, end of life care and advanced communication skills to deal with advance care planning, recognising dying and talking about this	6/1/2015 11:21 PM
30	General philosophy of patient centred care	6/1/2015 10:25 PM
31	role of holistic care. patient centred approach focusing on patient priorities. Recognition of limits of appropriate treatment. Advanced communication skills. Ability to manage symptoms concurrently with diseases	6/1/2015 8:55 PM
32	communication skills, end of life care, ethics, palliative ethos	6/1/2015 5:08 PM
33	ethics, communication skills, patient centred goals and information preferences	6/1/2015 4:44 PM
34	Core skill set in palliative and end of life care, communication skills training	6/1/2015 2:16 PM
35	Communication , symptom control and ACP	6/1/2015 2:09 PM
36	As I say above, palliative medicine is nothing but practice of general medicine in last 1-2 years of ;life	6/1/2015 11:30 AM
37	There are components which all need, but it is the approach, awareness, attitutes and detail which is so valuable, not just components	6/1/2015 9:55 AM
38	how to diagnose dying, communication skills, symptom control	5/31/2015 8:38 PM
39	Diagnosing dying, communication skills, team working, ethical knowledge and skills, basic symptom managment and basic understanding of injectable medications	5/31/2015 4:39 PM
40	Communication section - patients and families, bereavement, what actually happens in the community - other specialties need to understand in order to manage expectations about community services available for palliative medicine	5/31/2015 4:29 PM

41	Care of dying patient, communication with patients and families.	5/31/2015 12:42 PM
42	Communicating diagnosis of dying aspects	5/29/2015 3:51 PM
43	all specialites (except possibly plastic surgey and dermatology) but to varying degrees and assessed each year rather than just once. Symptomatology mangaement training should be increased for undergraduate doctors.	5/29/2015 3:49 PM
44	all or none - it is more nuanced	5/29/2015 1:36 PM
45	End of life care	5/29/2015 9:53 AM
46	Holistic care, symptom control, team working,care of a dying patient and family, how to use specialist pall care services well	5/29/2015 9:09 AM
47	COMMUNICATION SKILLS!!	5/28/2015 8:50 PM
48	All - give them an idea of what Palliative care does and you what they do	5/28/2015 8:16 PM
49	ethics, communication skills, care of the dying patient, basic symptom management, emergencies, an understanding of spiritual and psychological care, an understanding of what services exist and what can be provided	5/28/2015 7:30 PM
50	communication skills!!	5/28/2015 5:27 PM
51	Communication, managing risk, symptom control advance care planning	5/28/2015 4:58 PM
52	Advance care planning, symptom control	5/28/2015 4:52 PM
53	Care of the dying, communication with others, management of pain,	5/28/2015 4:48 PM
54	Generic probably already contains the more relevant. The management of the dying patient either needs to be flagged higher or taught better to all trainees	5/28/2015 4:26 PM
55	generic palliative care approcah, EOLC, ethics	5/28/2015 3:55 PM
56	Too long to answer! - team working; symptom management communication skills - all generic	5/28/2015 3:49 PM
57	communication, and basic symptom control	5/28/2015 3:48 PM
58	Oncology/Haematology.	5/28/2015 3:45 PM
59	Communication training	5/28/2015 3:24 PM
60	Diagnosis of dying (but is this really a palliative skill?). Communication skills. What nurses and therapists do (yes, really).	5/28/2015 3:21 PM
61	basic symptom control, end of life care and communication about this.	5/28/2015 2:41 PM
62	basic symptom management, EoLC in particular	5/28/2015 2:37 PM
63	Management of patients at the end of life, advance care planning.	5/28/2015 2:29 PM
64	communication skills - symptom management	5/28/2015 2:21 PM
65	End of life care, symptom control, ACP.	5/28/2015 10:05 AM
66	Palliiative medicine doctors have a totally different focus in terms of their assessment and approach compared to othe4r specialties. Care of elderly is also holistic, but with a different focus. There are overlapping curriculum competencies but it is the application and interpretation of these competencies that is subtely different. For the largest impact, we need to deliver more quality end of lfie care training across a range of other specialties, with more hands on experience	5/27/2015 6:10 PM
67	improved communication	5/27/2015 4:23 PM
68	End of life care, communication skills, basic symptom management.	5/26/2015 10:24 PM
69	I have not thought about his in any detail	5/26/2015 8:52 PM
70	Communication, respecting decision making, ethics, spiritual aspects	5/26/2015 7:15 PM

71	I think the role of palliative input and the recognition that things don't always have to be black and white e.g. often people think there are only the options of 'dying' thus stop all drugs and put up syringe driver and make not for resus or full active treatment with resus. Also the support to enable room for reflection on when patients are being actively treated for 'us' rather than the benefit of the patient.	5/26/2015 5:44 PM
72	Interface between community/hospital (a lot of time goes into explaining this to colleagues). Ethics and law section of curriculum. Psychological/spiritual aspects.	5/26/2015 10:25 AM
73	Pain crisis, terminal agitation or psychological distress - so that they know that these need palliative medicine input	5/26/2015 9:30 AM
74	communication skills , leadership ethical and legal aspects of medical care	5/25/2015 6:39 PM
75	Care of the dying, principles of symptom control, patient centred care.	5/23/2015 10:23 PM
76	pt-centred care, co-ordinating and handing over care from primary care to hospice and hospital seamlessly	5/21/2015 2:44 PM
77	Doctors from other specialities need to know the definition of palliative care and what actually our role is. They need to know that palliaitive care is not just about EOLC	5/20/2015 12:47 PM
78	All medical specialities	5/19/2015 8:17 PM
79	Communication and reflective practice;	5/19/2015 4:00 PM
80	Symptom control essential. Advance care planning. Communciation skills around end of life care	5/19/2015 2:16 PM
81	basic recognition of dying patient and how to manage them, able to recognise and have timely advance care planning discussions	5/19/2015 8:50 AM
82	communication, dealing with uncertainty, recognising and managing the dying patient, ceilings of care	5/18/2015 11:29 PM
83	Basic end of life care and treating the patient holistically	5/18/2015 10:42 PM
84	Communication skills, end of life care and basic symptom control	5/18/2015 8:33 PM
85	General palliative care and high quality end of life care	5/18/2015 8:02 PM
86	Communication, decision making, symptom management, viewing the wider picture	5/18/2015 7:44 PM
87	pain control, communication, ethics	5/18/2015 7:14 PM
#	**(2.7) What specific parts of curricula from other specialties need to be imported to the curriculum in Palliative Medicine? i.e. What elements of the curricula of other specialties do you believe doctors in Palliative Medicine need to better understand to provide the best care for patients?**	**Date**
1	Possibly more of the aspects of caring for patients with frailty as there is likely to be an increasing link between frailty / palliative care.	6/9/2015 6:25 PM
2	I think our trainees need to go out and work in these specialties, not just putting it into a notional curriculum to be rubber stamped	6/9/2015 2:03 PM
3	Better understanding of the advances in interventional medicine.	6/9/2015 12:42 PM
4	not familiar with other curricula so unable to comment.	6/9/2015 10:38 AM
5	managing medical patients generally - increased knowledge	6/9/2015 10:11 AM
6	Basic understanding of oncological interventions. How to use NIV effectively. Specialist management of chronic diseases, such as COPD, heart failure, pulmonary fibrosis, diabetes	6/9/2015 9:28 AM
7	For End stage Organ failure intrface with relevant speciality	6/8/2015 8:21 PM
8	More gastrointestinal medicine and respiratory would be useful	6/8/2015 7:14 PM
9	more rehabilitation needed I think, and much more approach, like in oncology, to research evidence, for which we are weak	6/8/2015 6:13 PM
10	management of long term conditions	6/8/2015 10:30 AM
11	Unsure.	6/7/2015 2:58 PM
12	More knowledeg on specific conditions such as Parkinson's Disease, dementia - maily COTE elements	6/5/2015 5:01 PM
13	I don't know	6/5/2015 8:03 AM

14	Some experience in management of long term conditions such as COPD, dementia Heartfailure.	6/4/2015 9:13 PM
15	primary care	6/4/2015 2:21 PM
16	nil is far reaching	6/4/2015 12:31 PM
17	Better understanding of various chronic conditions that would help provide best control of symptoms	6/4/2015 12:10 PM
18	The role of acute interventions offered by other teams invovled eg oncologists/anaesthetists/cardiologists- when these are appropriate and when they are not	6/4/2015 12:10 PM
19	therapeutic principles in ederly care, acute diagnostics	6/3/2015 3:53 PM
20	Elderly medicine	6/3/2015 11:29 AM
21	More chronic pain training. The patients who fail to be served well in an acute Trust focussed on diagnostic work are those with chronic pain who are living longer	6/3/2015 2:12 AM
22	None.	6/2/2015 9:38 AM
23	Basic management of those conditions which specialit palliative care are most likely to manage heart failure, COPD etc	6/1/2015 11:21 PM
24	Greater exposure to management of chronic conditions e.g. COPD, CCF	6/1/2015 10:25 PM
25	Dementia.	6/1/2015 9:31 PM
26	community skills from GP. Expereince in oncology. Knowledge of management of advanced stages of illnesses in all specialities.	6/1/2015 8:55 PM
27	rotation in oncology is useful in training	6/1/2015 5:08 PM
28	managing multiple comorbidities eg GP or care of the elderly	6/1/2015 2:16 PM
29	it is too broad a question to be answered in short	6/1/2015 11:30 AM
30	Geriatric assessment and intervention skills	6/1/2015 9:55 AM
31	Optimisation of respiratory and cardiac medications for long term conditions eg COPD and heart failure, managment of multiple conditions and pharmacological issues for older people, microbiology (emerging infections, HIV,TB)	5/31/2015 4:39 PM
32	Not sure.	5/31/2015 12:42 PM
33	Old age psychiatry, elderly care medicine, psychology	5/29/2015 5:49 PM
34	all or none - it is more nuanced	5/29/2015 1:36 PM
35	mental health-cbt, anxiety management, emergencies, oncology - metastatic disease management options, how oncology services are organised,general practice- how out of hours is delivered, communication skills, community services available	5/29/2015 9:09 AM
36	Difficult to answer as the specialty is quite broad in itself inclusive of a fair amount of GIM. Psychiatry/ managing depression/mood disorders may be useful to include.	5/28/2015 8:50 PM
37	All - as above	5/28/2015 8:16 PM
38	I think we should have a few more practical skills (wouldn't it be useful to be able to put in a PICC rather than repeat cannulations when we've decided to hydrate someone? why can't we manage epidurals in the community?), and a better understanding of organ-specific treatments for end-stage patients in eg cardiology, renal, and more experience with artificial hydration/nutrition teams - it's embarrassing to have to ask for help constantly when we are trained doctors too.	5/28/2015 7:30 PM
39	management of general medicine - DM, dementiam psychiatry	5/28/2015 5:27 PM
40	Interventional pain management techniques, basic oncology, Dementia care, etc	5/28/2015 4:58 PM
41	I don't know the curricula of other specialties	5/28/2015 4:48 PM
42	Don't know	5/28/2015 4:26 PM
43	Acute medicine, care of elderly	5/28/2015 3:55 PM

44	knowledge of basic oncology and neurology would be helpful	5/28/2015 3:49 PM
45	dementia, longterm conditins and 'survivorship	5/28/2015 3:48 PM
46	psychiatry/psychology	5/28/2015 3:45 PM
47	Some less - I think communication skills are more importnat than the ability to insert and mainatin a spinal line, for example. Radiology - especially ultrasound - is becoming more bedside possible, and could help many. Specifically management of behavioural and psychological symptoms of dementia.	5/28/2015 3:21 PM
48	medications management	5/28/2015 2:41 PM
49	managing angina/chest pain, COPD, common infections, basic GP presentations, depression and anxiety	5/28/2015 2:34 PM
50	I can't answer this question, as I don't have enough knowledge about the curricula in other specialties.	5/28/2015 2:29 PM
51	general medicine	5/28/2015 2:21 PM
52	More experience of management of organ failure, oncology treatments.	5/28/2015 10:05 AM
53	Not sure - would probably be most useful to look carefullly at care of elderly	5/27/2015 6:10 PM
54	I think all the appropriate areas are listed in the palliative medicine curriculum but the degree to which trainees explore different specialties and the needs of those patients is variable depending on local training opportunities.	5/26/2015 10:24 PM
55	principles as they apply to anaethetasing patients, the role and goals of ITU	5/26/2015 7:15 PM
56	Perhaps an opportunity to witness procedures that our patient may undergo (not be able to carry them out) e.g. PTC, ERCP, nerve block	5/26/2015 5:44 PM
57	Acute medicine (keeping up to date with specific management). Elderly medicine - long-term conditions eg Parkinson's, dementia.	5/26/2015 10:25 AM
58	management of certain chronic progressive conditions such as heart failure as there where these patients are admitted to a hospice setting and there is poor understanding how to manage the medications, the patients may be made more symptomatic rather then less.	5/26/2015 9:30 AM
59	elderly care	5/25/2015 6:39 PM
60	Dementia, heart failure, chronic liver disease	5/23/2015 10:23 PM
61	potentially some chronic disease management areas - eg heart failure, COPD	5/20/2015 5:19 PM
62	I think current curriculum covers everything	5/20/2015 12:47 PM
63	Falls, all elderly care symptoms	5/19/2015 8:17 PM
64	Management of uncertainty from General Practice. Psychological approaches from psychiatry	5/19/2015 2:16 PM
65	I don't know enough about other curricula. management of end stage organ failure without needing to ask for input, unless complex.	5/18/2015 11:29 PM
66	I suspect it is more about what should be put into other specialities curricula. This should include the common end of life events in disease common in the speciality. ACP is key in all curricula	5/18/2015 8:33 PM
67	Chronic conditions - COPD, heart failure, neurological (MS, MND), Chronic renal disease	5/18/2015 8:02 PM
68	Oncology - cancer types and treatment and patterns of progression. Long term conditions	5/18/2015 7:44 PM
69	acute management of emergency presentations (but I don't know what the other curricula include, sorry)	5/18/2015 7:14 PM

Q23 Sub-specialty training

Answered: 68 Skipped: 181

Answer Choices	Responses
(3.1) How do you envisage the training of sub-specialists in Palliative Medicine?	**97.06%** 66
(3.2) Are there areas of the sub-specialty/special interest curricula that could be applicable to generalists within Palliative Medicine or other specialties? What are these?	**51.47%** 35

#	(3.1) How do you envisage the training of sub-specialists in Palliative Medicine?	Date
1	theme running through particular training programmes - perhaps for last two year of training with post CCT training in addition.	6/9/2015 11:16 PM
2	PLease don't- why would you want more subspeciality training if trying to train generalists?	6/9/2015 4:14 PM
3	Pro - more in depth knowledge in a certain area. Con - less generalist could lead to consultants becoming deskilled	6/9/2015 2:38 PM
4	It depends on the local expertise	6/9/2015 2:03 PM
5	Not positively!	6/9/2015 12:42 PM
6	limited to those working in highly specialist tertiary centres	6/9/2015 10:38 AM
7	limited. possibly interventional pain managment	6/9/2015 10:33 AM
8	extra training within current curriculum eg. elderly care	6/9/2015 10:11 AM
9	Post-CCT	6/9/2015 9:28 AM
10	'Exchanges' or transfer of ST Drs, for 6-12 mths, e.g between training schemes. Alternatively regular Pall Med OPD attendance	6/8/2015 10:42 PM
11	Should still be on several years course, need experience of life as well as medicine	6/8/2015 7:14 PM
12	difficult, currently we are too small for many sub specialities and also not really in patients interests	6/8/2015 6:13 PM
13	maybe sub-specialism in renal palliative care, perhaps hepatology, I don't think other areas	6/8/2015 10:30 AM
14	I think with current consultant numbers and the existing service models sub-specialisation is difficult. Most of us do a bit of everything. I think there is a role for a small number of consultants to sub specialise but not for everyone.	6/8/2015 12:35 AM
15	Unsure.	6/7/2015 2:58 PM
16	Detrement to specialty and will disadvantage patients	6/5/2015 5:01 PM
17	Could sub-specialise in most other med specialties and many condiitons (eg oncology/ cardiology/ dementia) but could also sub-specialise in particular settings eg AMU/community/cncer centre/ hospice management	6/5/2015 9:54 AM
18	Concerned about lack of ability to take holistic view / risk of inequities of service	6/5/2015 8:03 AM
19	could be beneficial providing core specialty experience is maintained	6/4/2015 5:08 PM
20	depends on the role that they undertake. if as speciality doctors fine but not as replacements for consultants	6/4/2015 2:21 PM
21	up to the individual to find sub specility and work in a team within a department	6/4/2015 12:31 PM
22	Special interests in renal/respiratory/cardiology/haematology	6/4/2015 12:10 PM
23	a waste of time unless part of broad palliative care practice. subspecialisation as a principle and a preference has killed good meidicne and to repeat it is foolish.	6/3/2015 3:53 PM
24	I don't know	6/3/2015 2:12 AM
25	Pursing a specific area of care - eg renal palliative care, transitional care etc	6/2/2015 5:49 PM

26	I have no idea and I suspect nobody else does either.	6/2/2015 9:38 AM
27	Not sure.	6/1/2015 9:31 PM
28	Palliative medicine is a generalist speciality because it focuses on the care of all patients at the end of life. I hope that it will remain so and that subspecialisation will be limited. I envisage some specialisation post CCT in hospital vs community settings, or in specific procedures.	6/1/2015 8:55 PM
29	unsure	6/1/2015 5:08 PM
30	Research/Academia	6/1/2015 2:16 PM
31	don't udnertsand the question	6/1/2015 11:30 AM
32	Should not become cheap consultant substitutes - require clinical skilss, not leadership/developmental	6/1/2015 9:46 AM
33	My concern would be that the need is for palliative physicians who can work with multiple conditions especially in older people so that palliativ ephysicians who subspecialise eg in single diseases might lose skills in other areas.IN certain catchement areas/populations there may be a role eg for transition palliative care or possibly palliative care for homeless or prisoners but these would be very "niche" and general. There may be a role for care home palliative physicians esp re dementia but unclear how this would link with changes in gerontology moving back to community	5/31/2015 4:39 PM
34	Driven by local service needs	5/31/2015 4:29 PM
35	Part of GP/speciality training eg 1 additional year with separate curriculum.	5/31/2015 12:42 PM
36	Sub-specialty interests could be gained after CCT/CST. Training should provide basic competence needed by all consultants.	5/29/2015 7:09 PM
37	same as specialists	5/29/2015 1:36 PM
38	Paediatrics , not sure about value of others as we are too few to have tertiary referral and I prefer the model of co operative working with other specialties rather than sub specialising ourselves which will create inequalities of access and miss the opportunity of ups killing our colleagues and ourselves through joint working	5/29/2015 9:09 AM
39	Subspecialists in Palliative Medicine may wish to choose just Oncology/ respiratory medicine	5/28/2015 8:50 PM
40	Very similar to dual accreditation - helping broaden knowledge and scope of palliative care	5/28/2015 8:16 PM
41	6 month long supernumerary attachments to other specialties?	5/28/2015 7:30 PM
42	I think all cons in pall med should have some knowledge of management of all the subspecialties of illness groups, with some consultants developing a deeper knowledge and practice that can be shared within a geographical area, but not such that some pall med cons don't know how to start managing the pall care aspects of all patients' disease.	5/28/2015 6:41 PM
43	with caution	5/28/2015 5:27 PM
44	For Palliative medicine Doctors who are attached to particular units such as ENT units who need to specialise in ENT pal care	5/28/2015 4:58 PM
45	Time in the hospice, spending time with the hospital liason team	5/28/2015 4:52 PM
46	Do not agree with this.	5/28/2015 4:26 PM
47	I disagree with sub specialists	5/28/2015 3:55 PM
48	Some palliative medicine consultants will specialist in a specific area eg heart failure; renal etc	5/28/2015 3:49 PM
49	not clear in how these would fit in and to what status	5/28/2015 3:48 PM
50	Post cct eg renal or plain interventions or old age psychiatry	5/28/2015 3:35 PM
51	I can conceive that there may be a division between specialist inpatient palliative care units and district based services - "Hen and Chickens".	5/28/2015 3:21 PM
52	do not believe this is useful."broad based" training then sub specialising makes no sense.	5/28/2015 2:41 PM
53	I don't see it happening for a while	5/28/2015 2:37 PM
54	As they currently are - with opportunities to dual accredit	5/28/2015 2:21 PM

55	A year spent working in palliative medicine for those with an interest e.g. GPs, oncology trainees.	5/28/2015 10:05 AM
56	Subspecialisation could relate to setting (hospital / community / hospice); could also relate to some disease processes, e.g. dementia	5/27/2015 6:10 PM
57	Additional time in training programme to focus on specialty for joint accreditation with expectation to complete SCE in other relevant specialty in addition to palliative medicine SCE	5/27/2015 3:22 PM
58	through self sought systems	5/26/2015 7:15 PM
59	I can see that (as is already happening) some doctors will focus on more niche areas but ideally the majority will remain general palliative medicine doctors	5/26/2015 5:44 PM
60	May become too sub-specialised within one of the only generalist specialities. Clinicians already have their own particular interests which happen naturally.	5/26/2015 10:25 AM
61	time spent in pain management, management of particular subspecialites in other areas of medicine e.g. heart failure, pulmonary fibrosis, cystic fibrosis that are relevant to palliative medicine would be a great opportunity to add to one's skill base	5/26/2015 9:30 AM
62	Only as post CCT we do not have eough consultants in hospital and community on a 7 day basis yet	5/25/2015 6:39 PM
63	PhDs	5/21/2015 2:44 PM
64	?	5/20/2015 12:47 PM
65	One year fellowship might work well	5/19/2015 4:00 PM
66	Don't believe this is a good idea	5/18/2015 8:02 PM
#	**(3.2) Are there areas of the sub-specialty/special interest curricula that could be applicable to generalists within Palliative Medicine or other specialties? What are these?**	**Date**
1	Looking after end of life care should be in the generalists curriculum.	6/9/2015 12:42 PM
2	management of secretions in MND, management of breathlessness for resp and cardiac	6/9/2015 10:38 AM
3	elderly care, possibly neuro/resp/cardiac but small numbers	6/9/2015 10:11 AM
4	Not sure	6/9/2015 9:28 AM
5	Principles of symptoms control	6/8/2015 8:21 PM
6	See above	6/8/2015 7:14 PM
7	sub specalities is a problem for patients with multimorbidity, which is the future	6/8/2015 6:13 PM
8	Unsure.	6/7/2015 2:58 PM
9	Dementia/MND but the list is endless, therefore supporting palliative medicine as specialist rather than generalist	6/5/2015 5:01 PM
10	yes; non-cancer subspecialties might actual help to reduce inequality in those who access our services	6/4/2015 5:08 PM
11	No - stop splitting hairs	6/3/2015 3:53 PM
12	I don't know	6/3/2015 2:12 AM
13	-	6/1/2015 8:55 PM
14	unsure	6/1/2015 5:08 PM
15	Managment of long term conditions, more focus on dementia, more focus on transitional care (working with paediatrics but also other adult speialties as this is a growing population of young adults)	5/31/2015 4:39 PM
16	Not sure.	5/31/2015 12:42 PM
17	lots or none - it is more nuanced	5/29/2015 1:36 PM
18	Paediatric pall med for paediatricians	5/29/2015 9:09 AM
19	Oncology/ Respiratory Medicine/ Cardiology/Renal/ Learning disabilties in Psychiatry/ MND , Dementia and other Palliative neurological conditions	5/28/2015 8:50 PM
20	can't think of any	5/28/2015 7:30 PM

21	Most of these areas could provide generalist overviews of the particular palliative care issues from these areas.	5/28/2015 4:58 PM
22	Do not agree with this.	5/28/2015 4:26 PM
23	All of the above	5/28/2015 3:49 PM
24	I belive that palliative dementia care has sufficent differences form the existing model to justify it becoming a (sub) specialty in its own right.	5/28/2015 3:21 PM
25	no	5/28/2015 2:41 PM
26	dying patients, pain control, communication	5/28/2015 2:34 PM
27	unknown	5/28/2015 2:21 PM
28	Additional training in palliative medicine I think would be very attractive to some trainees in GP, care of elderly, acute medicine	5/27/2015 6:10 PM
29	I don't understand this question.	5/26/2015 5:44 PM
30	Neurology, elderly medicine, renal, chest, cardiology (eg heart failure).	5/26/2015 10:25 AM
31	communication skills	5/26/2015 9:30 AM
32	dont understand question	5/25/2015 6:39 PM
33	?	5/20/2015 12:47 PM
34	Hospital palliative care; non-malignant disease (renal, heart failure, COPD, neurodegeneration)	5/19/2015 4:00 PM
35	Not sure	5/18/2015 8:02 PM

Q24 Academic training

Answered: 50 Skipped: 199

Answer Choices	Responses	
(4.1) What is the scope for more generic academic training across the specialties?	100.00%	50

#	(4.1) What is the scope for more generic academic training across the specialties?	Date
1	trainees doing research within other academic (non-palliative) departments	6/9/2015 2:03 PM
2	I would like to see Palliative Medicine develop a research base in the UK with a standard amount of time required in the curriculum.	6/9/2015 12:42 PM
3	should be incorporated into foundation training or core medical training	6/9/2015 10:33 AM
4	unsure about this	6/9/2015 10:11 AM
5	Poor, unless given a chunk of dedicated time during training. It is very difficult to do meaningful academic training in a post with a clinical emphasis.	6/9/2015 9:28 AM
6	Would increase potential for research collaboration across specialities.	6/8/2015 10:42 PM
7	Better doctors better patient care, Better awareness of Palliative and End of life care general public other healthcare professionals, Better Strategies for care delivery	6/8/2015 8:21 PM
8	Currently is very narrow, GP training is ignored at present, could be based more on other experience, porfolio careers, etc	6/8/2015 7:14 PM
9	to some extent, but we have specific research methods and issues and study designs. Also it is much easier to learn if the examples of studies and assignments are specific to palliative care, so I would be doubt full as to how much is useful. Running a phase III chemo trial is very different to running a trial of a medicine in palliative care. Outcomes, proceudres, pateints, concerns are different.	6/8/2015 6:13 PM
10	Academic training still not well developed and could be more so across specialties	6/8/2015 10:30 AM
11	Academic training should be a positive choice rather than mandated. All trainees should have an awareness of academia and be able to perform literature searches and critically appraise documents however not all trainees should have to undertake research.	6/7/2015 2:58 PM
12	good idea	6/4/2015 2:21 PM
13	The generic academic skills can be acquired at any stage in training they are rarely specific to specialties.	6/4/2015 12:38 PM
14	already has a role, priovides reasrch and education opportunies relevant to specilaty	6/4/2015 12:31 PM
15	enormous and to be encouraged	6/3/2015 3:53 PM
16	It should be kept flexibly available as outlined in AC's report. Conveyor-belt style clinico-academic jobs are worth holding onto at junior doctor level, but research interests can develop much later in a career	6/3/2015 2:12 AM
17	I think the emphasis on more academic training is nonsense. Give those who wish it the opportunities. Do not force everyone to do it. Acknowledge the wide range of interstes and abilities that exist.	6/2/2015 9:38 AM
18	Training in research and educAtion would be helpful	6/1/2015 11:21 PM
19	Why should academic training be generic? I think there is scope for cross specialty collaboration in terms of learning about research methods and areas of research as is often the case in the Academic Clinical Fellowship programmes in some institutions,	6/1/2015 8:55 PM
20	could be improved	6/1/2015 5:08 PM
21	don't know	6/1/2015 11:30 AM
22	YES - this is sadly lacking.	6/1/2015 9:55 AM

23	Could be positive development and increase cross-fertilisation and collaboration but concern will be how this will be balanced against other training needs, service delivery and also how academic we want palliative medicine to be?	5/31/2015 4:39 PM
24	Not sure.	5/31/2015 12:42 PM
25	lots!	5/29/2015 1:36 PM
26	Good idea -esp oncology, chronic neurology and general practise	5/29/2015 9:09 AM
27	Dependant on trainees with interest and resources to release trainees.	5/28/2015 8:50 PM
28	i'm in two minds - i think it should be available but not mandatory. Some of us want to be clinical and don't find research interesting, some of us only find academia interesting when a particular topic has arisen. My immunology lecturer told me you can't be an excellent clinician and an excellent researcher - one has to suffer - why don't we let people be one and not the other; i think that's wise. I find research interesting, but I can't see how it helps my practice given I already had critical appraisal skills and knew how to practice evidence based medicine.	5/28/2015 7:30 PM
29	if appropriate and clinicians keen	5/28/2015 5:27 PM
30	unclear	5/28/2015 4:58 PM
31	Only if it didn't dilute the training still further or people are allowed to take OOPE, which trainees already do.	5/28/2015 4:52 PM
32	A better understanding of principles of carrying out research, statistics and critique of evidence would be helpful, scope for collaborative projects across specialties	5/28/2015 4:48 PM
33	I am unsure what you are asking here? I thought that is what we are already providing with the current Pall Med curriculum? There may be some economies of scale in providing more structured generic training by combing multiple specialties	5/28/2015 4:26 PM
34	I cannot answer this one	5/28/2015 3:55 PM
35	Yes	5/28/2015 3:49 PM
36	Don't know	5/28/2015 3:35 PM
37	Establish a better minimum in undergraduate training. Ensure that palliative medicine basics are part of the curriculum for all bed based specialties, both medical and surgical.	5/28/2015 3:21 PM
38	I would definitely welcome more opportunities to get involved in academic training as part of palliative medicine.	5/28/2015 2:29 PM
39	Should be core for all doctors	5/28/2015 2:21 PM
40	Standard 6 month researtch/audit block acros all specailaities could be of benefit.	5/28/2015 10:05 AM
41	Need for more generic training in education and for this to be valued alongside research.	5/26/2015 10:24 PM
42	Plenty	5/26/2015 7:15 PM
43	There needs to be more funding and support for trainees interested. I hadn't been aware there was an academic palliative training job until I met the person doing it. Currently too many of the academic trainees end up doing oncological research causing dwindling interest and enthusiasm having a knock on effect on inspiring others.	5/26/2015 5:44 PM
44	Probably limited by funding but does already happen in certain places (eg Cicely Saunders Institute)	5/26/2015 10:25 AM
45	time spent out in research to allow the trainee understand how to interpret and conduct research would be very useful so that even non academicallly orientated trainees wouldn't have a fear of research. They might then be more open to be involved in research to a greater extent as consultants	5/26/2015 9:30 AM
46	onkly in out of programme experience eg MD or PhD	5/25/2015 6:39 PM
47	curriculum is full already	5/21/2015 2:44 PM
48	We do have ACF tarinees	5/20/2015 12:47 PM
49	Possible in terms of generic knowledge and skills, but difficult to see how engaging/relevant this will be in practice.	5/19/2015 4:00 PM
50	Find it hard to believe there is possibly time in training to try and get a decent amount of knowledge across all medical specilaties/	5/18/2015 8:02 PM

Q25 Length of training

Answered: 106 Skipped: 143

Answer Choices	Responses
(5.1) How long do you think it should take to acquire the competences to meet the overall training requirements in Palliative Medicine? Should there be a prescribed length of training or an overall average length of training?	**91.51%** 97
(5.2) Is there scope for shortening the length of training? Why or why not?	**91.51%** 97
(5.3) If the length of training was shortened what impact would that have? What components of the Palliative Medicine curriculum could not be delivered if training was shortened to the arbitrary time scale of a maximum of 6 years as suggested in the Shape of Training Review?	**73.58%** 78

#	(5.1) How long do you think it should take to acquire the competences to meet the overall training requirements in Palliative Medicine? Should there be a prescribed length of training or an overall average length of training?	Date
1	I think there should be an average length of training. If it really is competency based, people should be allowed to exit the programme when they've completed the curriculum.	6/9/2015 11:10 PM
2	5 years	6/9/2015 10:29 PM
3	with the current curriculum, 4 years is sufficient, is this was to include general medicine this would need to be increased to 5 years.	6/9/2015 6:25 PM
4	average length of training, but competency based- average I think would be 4 years for speciality, 5-6 years for dual training	6/9/2015 4:14 PM
5	4 years is not long enough. Palliative medicine trainees need longer in hospital and in the community. 5 years would be better to accomplish this.	6/9/2015 2:38 PM
6	3 years	6/9/2015 2:03 PM
7	5 years if SoT is introduced	6/9/2015 12:42 PM
8	4 years is appropriate	6/9/2015 12:11 PM
9	It took me 11 years from qualifying to get my Consultant post (old-style training back then with a lot of DIY posts!). Realistically, and from a maturity point of view, I think 8-9 years is a given; certainly shouldn't be rushing people through in 6 or 7 years.	6/9/2015 11:33 AM
10	minimum 4 years	6/9/2015 10:38 AM
11	prescribed four years	6/9/2015 10:33 AM
12	overall average length of training as this allows for potential sub speciality interest	6/9/2015 10:11 AM
13	At least 7 years (after foundation years)	6/9/2015 9:28 AM
14	6 years	6/9/2015 8:55 AM
15	As per now, 4 y	6/8/2015 10:42 PM
16	7 yrs +	6/8/2015 7:14 PM
17	average	6/8/2015 6:13 PM
18	I think 4 years is about right.	6/8/2015 6:06 PM
19	Should be competency based, but minimum 4, and would probably take most 5yrs with a year of GIM	6/8/2015 10:30 AM
20	4 years specialty training is about right. An extra year of medicine would be useful. Average length of training would be reasonable.	6/8/2015 12:35 AM
21	Training should be competency based.	6/7/2015 2:58 PM
22	4 years	6/5/2015 5:01 PM

23	Depends what you want specialist to be able to do.	6/5/2015 9:54 AM
24	Overall average	6/5/2015 8:03 AM
25	4-5 years	6/4/2015 9:13 PM
26	should be competency driven, not time-driven	6/4/2015 5:08 PM
27	there needs to be 4 year as a minimum specifically to palliative medicine if additional other general training required this should lengthen the training. Particularly if looking at the breadth of areas covered i.e. acute / community / hospice. No other specialisty in reaches into so many different areas	6/4/2015 2:21 PM
28	I think it should be competency based rather than time spent, however I do not imagine competency in all areas of palliative medicine could be gained in much less than the present length of training, but it does depend on trainees previous experience.	6/4/2015 12:38 PM
29	5 years overall with mpre flexibility for individual developement	6/4/2015 12:31 PM
30	May vary with differnet trainees but on average needs to be increased if including dual accreditation	6/4/2015 12:10 PM
31	I think currently 4 years as a minimum, with opportunities to expand this with research or clinical leadership posts	6/4/2015 12:10 PM
32	should be complete when the person is competent and this cannot be in under 7 years	6/3/2015 3:53 PM
33	A prescribed length of training is very important. Shortening it risks producing CCT holders with 'less' experience. After broad-based medical training up to ST2, I think 4 years higher specialist training (pro-rata) is sufficient	6/3/2015 2:12 AM
34	There has been a trend to competency based training, but I do think there is value in spending time in a specialty, getting a broad experience. I think 4 years is about right, although for some people who work part time and have a lot of experience in different units etc, I do not think they always need to do exactly equivalent time in training	6/2/2015 5:49 PM
35	4 years from ST3 (or ST4) is about right given the opportunity to experience all settings.	6/2/2015 9:38 AM
36	Maybe a bit longer, but there should be a minimum length and it could be extended if needed	6/1/2015 11:21 PM
37	Prescribed length.	6/1/2015 9:31 PM
38	I don't know	6/1/2015 8:55 PM
39	4 years of specialty palliative medicine, 8 years in total after medical school	6/1/2015 5:08 PM
40	no, a competency based curriculum - no minimum, an average length of 6-7 years	6/1/2015 4:44 PM
41	4 years, prescribed minimum with opportunity to extend	6/1/2015 2:16 PM
42	If one is a well-trained general physician or a geriatrician, maximum of 2 years should be enough	6/1/2015 11:30 AM
43	4 to 5 years	6/1/2015 9:55 AM
44	average - minimum 6 years	6/1/2015 9:46 AM
45	4 years as a norm, but greater flexibility to shorten training for people with prior experience or who progress quickly	5/31/2015 8:38 PM
46	Overall average as some trainees may need some extra support but still be excellent physicians by ned of training- even 4 years can feel very short to some people	5/31/2015 4:39 PM
47	4 years, prescribed	5/31/2015 4:29 PM
48	4 years seems appropriate.	5/31/2015 12:42 PM
49	SCE now dominates a significant proportion of time, undoubtedly limiting other learning opportunities over that time.	5/30/2015 8:54 PM
50	Should be prescribed minimum, but training should be flexible above this to allow trainees time to gain adequate competence and confidence.	5/29/2015 7:09 PM
51	4 years mixed experience	5/29/2015 3:51 PM
52	minimum of 4 years dedicated to palliative medicine - competency as measured now, without the accompanying experience, is a receipe for disaster	5/29/2015 1:36 PM
53	Prescribed as a lot is judgement acquisition which needs exposure to situations, 4 years	5/29/2015 9:09 AM

54	4-5 yrs of just Palliative medicine training - preferably prescribed length. Otherwise, the training is unlikely to be valid and reliable or accountable.	5/28/2015 8:50 PM
55	4+years (minimum)	5/28/2015 8:16 PM
56	4 years seems adequate.	5/28/2015 7:30 PM
57	It depends on what additional competencies we are going to be expected to have - I think 4 years is about right for the current curriculum but needs to focus more on management,service development and governance skills, and would need to be longer if adding any GIM competencies,	5/28/2015 6:41 PM
58	5yrs - yes to the prescribed length, especially for those who have not taken any time out of training, being a consultant at 32yo is very young	5/28/2015 5:27 PM
59	After basic training four years	5/28/2015 4:58 PM
60	Definitely no less than is already being undertaken.	5/28/2015 4:52 PM
61	5 - 4 is very short for people with no previous experience in PM, an average may be a better way of individualising training	5/28/2015 4:48 PM
62	4 years; there is already flexibility for individual trainee in terms of additional training if required through ARCP process.	5/28/2015 4:26 PM
63	would add 6-12 months if incoprparting acute medicine	5/28/2015 3:55 PM
64	4 years has worked well for some time!	5/28/2015 3:49 PM
65	I think the current 4 years of specialist training is correct	5/28/2015 3:48 PM
66	overall average length	5/28/2015 3:45 PM
67	7 years don't know	5/28/2015 3:35 PM
68	4 years at least	5/28/2015 3:24 PM
69	Overall average, depending on previous experience.	5/28/2015 3:21 PM
70	5	5/28/2015 2:41 PM
71	4-5 years at ST level	5/28/2015 2:37 PM
72	An average length, as I think different people develop at different rates, and some will need longer to meet the comptencies than others.	5/28/2015 2:29 PM
73	4-5 years single CCT - 7- if dual accrediting	5/28/2015 2:21 PM
74	4 years sufficient, but if more training in general medicine, this should eb extended.	5/28/2015 10:05 AM
75	5 years if include a min year of GIM	5/27/2015 6:10 PM
76	Current system about right (4 years at reg level)	5/27/2015 5:48 PM
77	prescribed	5/27/2015 4:23 PM
78	I think the 4 years in current form is adequate though with any additional requirement time should be increased accordingly	5/27/2015 3:22 PM
79	Average length of training but with a minimum period - perhaps 6-7 years minimum however I would envisage 7 years being the norm if training only in palliative medicine, and longer if combined with acute medicine.	5/26/2015 10:24 PM
80	5 years (but possibly longer) 7 (from Foundation)	5/26/2015 7:15 PM
81	I think it is important that there is time prior to speciality training for junior doctors to experience a wide range of specialties as often the reality varies from the experience as a medical student. If people do not have the space to work out what they really want to do, time and money will be wasted in training people who end up changing specialities.	5/26/2015 5:44 PM
82	Overall average training would be better - approx 5 years	5/26/2015 11:28 AM
83	5 years of specialist training. Many trainees train flexibly so a minimum of 4 years with an average length of training may work better as long as curriculum competencies achieved.	5/26/2015 10:25 AM

84	at least 4 years. Palliative Medicine is unique in that excellent communication skills are essential and these take time to be developed.	5/26/2015 9:30 AM
85	3 yrs pre MRCP and 5 yrs higher medical training ie 4 yrs pallaitive medicine and 1 yr gerneral internal medicine	5/25/2015 6:39 PM
86	4 years in specialist training, which should follow 4 years core training.	5/23/2015 10:23 PM
87	Overall ave length of training. Depends on competency, life events.	5/21/2015 2:44 PM
88	4 years feels right	5/20/2015 5:19 PM
89	4years	5/20/2015 12:47 PM
90	4 years seems reasonable, but surely with competency based assessments we should not be prescribing this...	5/19/2015 4:00 PM
91	There needs to be a minimum length (see below) Four years seems reasonable.	5/19/2015 2:16 PM
92	I think current speciality training length is about correct. An increased year of internal medicine or equivalent prior to this would be useful compared to the current system	5/19/2015 12:42 AM
93	4 years	5/18/2015 11:29 PM
94	4 years	5/18/2015 10:42 PM
95	As it is currently seems fine.	5/18/2015 8:02 PM
96	4-5 years of specialty trainng	5/18/2015 7:44 PM
97	prescribed length, 5 years minimum full time	5/18/2015 7:14 PM
#	**(5.2) Is there scope for shortening the length of training? Why or why not?**	**Date**
1	no - more time needed not less	6/9/2015 11:16 PM
2	no	6/9/2015 10:29 PM
3	If you did, it would reduce experience- acceptance of this would be important prior to it happening	6/9/2015 4:14 PM
4	No. It's too short as it stands. Longer is needed to attain the competencies required to be an excellent consultant.	6/9/2015 2:38 PM
5	not if they're going to do a year's acute	6/9/2015 2:03 PM
6	No - even at the moment STs struggle to meet all their requirments and there is always the conflict between training and service provision.	6/9/2015 12:42 PM
7	no	6/9/2015 12:11 PM
8	No	6/9/2015 11:33 AM
9	No trainees already feel training is too short and extend it by taking OOPEs etc. 4 years is needed to train in the different settings in a more junior and then more senior role. Many trainees feel that they are not prepared for the management role of a consultant as it is difficult to get this in the 4 years.	6/9/2015 10:38 AM
10	no. much of palliative medicine knowledge and skills comes from experience, not just achieving competencies	6/9/2015 10:33 AM
11	no - cannot acquire knowledge or skills in less time as experience dependent	6/9/2015 10:11 AM
12	No - too much to cover when leadsership / management / research / experience in all settings is included. Need to be confident in skills and knowledge when become a consultant	6/9/2015 9:28 AM
13	No- the time is needed to help people mature	6/9/2015 8:55 AM
14	No, as Drs freq relatively jr and inexperienced at time entry ST.	6/8/2015 10:42 PM
15	Overall average length measured by competencies achieved	6/8/2015 8:21 PM
16	No, too much time wasted already on going through the motions for exams, probably is not long enough.	6/8/2015 7:14 PM
17	most trainees I know want longer, especially if they do any academic time	6/8/2015 6:13 PM

18	I think shortening training would risk having CST holders who are not equipped to deliver what is required from them. In Palliative Medicine, many consultants work single-handed or with just one other colleague, so need to take significant leadership responsibilities from the start of a consultant post. Hence a greater amount of general & life experience is helpful to equip one for these challenges. I think this is different from someone taking up a consultant post within a large dept with 6 or 8 more senior colleagues.	6/8/2015 6:06 PM
19	No - we are already shorter than many. Credibility of specialty important also	6/8/2015 10:30 AM
20	No. The current curriculum gives a good grounding for consultant working. Nothing lends itself to being removed.	6/8/2015 12:35 AM
21	Yes, if a person is demonstrably competent in all areas of the curriculum and feels ready to finish. For example, if the individual transferred from another specialty many of the competencies may have already been achieved. Similarly, if a trainee is having difficulty attaining competency training should be lengthened.	6/7/2015 2:58 PM
22	No	6/5/2015 5:01 PM
23	Depends what you want specialist to be able to do	6/5/2015 9:54 AM
24	No	6/4/2015 9:13 PM
25	yes for some who meet competencies more quickly than others	6/4/2015 5:08 PM
26	No as above	6/4/2015 2:21 PM
27	Definitely not if the intention is to train in GIM and palliative medicine	6/4/2015 12:38 PM
28	no. already hard to achive suck specilism within short time	6/4/2015 12:31 PM
29	Not as it stands currently. May be scope in trainees who have swapped speciality and already have many generic skills	6/4/2015 12:10 PM
30	No, our skills are learned by habituation and mentorship, not factual absorption because we are a philosophy ahead of being a technology	6/3/2015 3:53 PM
31	It can be difficult to achieve all curriculum competencies as it stands, alongside service delivery	6/3/2015 11:29 AM
32	I don't think it is wise to shorten length of training. Palliative medicine is more than the list of items put together in a document called a curriculum, from which one might pick, choose and prioritise elements. The amount of publications on it is testament to its standing as a discipline that can 'rightly' inform and influence the 'ethos' behind diagnostic general medicine	6/3/2015 2:12 AM
33	Perhaps for some individuals, for example if they come to training having had a long experience in other areas of medicine which would equip them for some of the leadership/management role etc of a consultant	6/2/2015 5:49 PM
34	Preferably longer - doctors are becoming consultants at a younger age with less clinical and life experience. they are working in an increasingly pressured environment that is often too much to cope with. We are not looking after our next generation.	6/2/2015 9:38 AM
35	No, not if we want to have consultants who are adequately trained to manage patients with delivering excellent care	6/1/2015 11:21 PM
36	No - current model works well.	6/1/2015 9:31 PM
37	I think that palliative care training requires a degree of reflective practice and that it takes a certain amount of exposure to really develop and cement views ont eh most improtant issues. I struggle to see how this can be rushed	6/1/2015 8:55 PM
38	I do not think that there is cope for shortening the training. I think that a shorter period of time would not permit for the development of skills and broad range of experience required to practice competently and safely as a specialist consultant.	6/1/2015 6:10 PM
39	no - it takes this time to build up adequate experience and confidence to function as a consultant	6/1/2015 5:08 PM
40	No, needs life experience	6/1/2015 2:16 PM
41	Training in palliative medicine can be shortened, but not overall dual accreditation traing - 7 years look reasonable.	6/1/2015 11:30 AM
42	Hard to justify this with expanding needs for skills/experience	6/1/2015 9:55 AM
43	no - life experience required too!	6/1/2015 9:46 AM

44	I would be concerned that a shorter training would not allow for a wide enough range of exposure to different situations, develop maturity and confidence especially in manaing difficult ethical situations unsupervised	5/31/2015 4:39 PM
45	Depends what end product is required e.g. in the acute sector - if a consultant can challenge decision making, stop futile diagnostic and therapeutic interventions, prevent unecessary admissions, provide symptom control advice, communicate effectively and refer back into community services, ask for more specialist palliative medicine support where necessary then yes length of training could be shortened. However if a specialist who can work across sectors and support specialist symptom control services is required then I think it would be difficult to shorten training time.	5/31/2015 4:29 PM
46	No - need the experience.	5/31/2015 12:42 PM
47	No. Need to gain experience in variety of settings (community, hospital liasion service, hospice) so shorter training will compromise breadth of experience	5/30/2015 8:54 PM
48	No - current training is already too short.	5/29/2015 7:09 PM
49	No. Being able to work effectively in the specialty requires sufficient exposure as a trainee.	5/29/2015 4:43 PM
50	No - need to ensure consultants are adequately trained to work in potentially isolated roles e.g in hospices	5/29/2015 4:13 PM
51	For some, but not across the board	5/29/2015 3:51 PM
52	No - competency as measured now, without the accompanying experience, is a receipe for disaster	5/29/2015 1:36 PM
53	No - it is very short to gain the required competencies already.	5/29/2015 9:53 AM
54	No - judgement, team leadership, teaching skills, and broad range of things to cover - settings, diseases, management and clinical skills. Also may be relatively isolated and senior in first consultant post.	5/29/2015 9:09 AM
55	Absolutely No scope of shortening. Shortening the length of training will definitely jeopardise workplace based learning - given the high risk of service provision taking over meeting learning needs.	5/28/2015 8:50 PM
56	No - need to gain experience and knowledge of different areas. it should not be a race to be a consultant, it's not about 'knowledge', its about being rich with experience and communication abilities	5/28/2015 8:16 PM
57	Yes but only if training is more focused and there is less time for service provision; i.e. more time set aside for one on one training with consultants.	5/28/2015 7:30 PM
58	no. If we were all given better management training, service dev't and governance training, this would make the 4 years a tight fit, but achievable.	5/28/2015 6:41 PM
59	NO	5/28/2015 5:27 PM
60	Yes, provided trainees have completed full training, for example in General Practice, and or have had considerable palliative care experience prior to starting training. Not for Doctors who are inexperienced in medicine and life.	5/28/2015 4:58 PM
61	No, because Palliative medicine is all about bredth of experience rather than number of patients seen or procedures done. This can only been gained with time.	5/28/2015 4:52 PM
62	No - requires at least the current length if not longer to have experience of complexity of patients seen in PM and adequate experience in other specialties	5/28/2015 4:48 PM
63	No. 4 years is the minimum based on my experience of the trainees coming through, particularly as it is no longer the norm that they have 6-12 months experience as an SHO in palliative care	5/28/2015 4:26 PM
64	No- short enough already	5/28/2015 3:55 PM
65	No - I think trainees would struggle to develop the maturity they need to take up a consultant post in less time.	5/28/2015 3:49 PM
66	no as there is a lot in the curriculum and also need to experience different areas etc	5/28/2015 3:48 PM
67	No - quite difficult to meet competencies in less than 4 years.	5/28/2015 3:45 PM
68	No	5/28/2015 3:35 PM
69	No - experience of working in several diffiernet settigns is needed (ie. hospital,hospice,community)	5/28/2015 3:24 PM
70	Where doctors wish to transfer from other specialties or general practice, the previous experience obtained should be examined and recognized.	5/28/2015 3:21 PM

71	no	5/28/2015 2:41 PM
72	No...particularly if entering training in ones 20s....Yes if someone is training having been in GP etc	5/28/2015 2:37 PM
73	no- only just prepared after 4 years ST with current scheme	5/28/2015 2:34 PM
74	No - competencies do not provide experience and time to mature	5/28/2015 2:21 PM
75	No - need time to gain competencies and also develop leadership and management skills.	5/28/2015 10:05 AM
76	No - I don't think that trainees would be a ble to develop the suble attitudinal and leadership skills in less time	5/27/2015 6:10 PM
77	No - it is full!!	5/27/2015 5:48 PM
78	no - need to cover all pall care settings	5/27/2015 4:23 PM
79	No - not able to gain sufficient knowledge/experience in time less than currently taken	5/27/2015 3:22 PM
80	To provide the range of experience across different clinical settings, with enough time to settle into each and learn within these, I do not think training should be shortened	5/26/2015 10:24 PM
81	no (would be good to have a broader experience e.g. other medical specialities	5/26/2015 7:15 PM
82	I don't think so. With the EWTD and increasing consultant led services there is less opportunity to gain experience in more challenging and complex scenarios.	5/26/2015 5:44 PM
83	No - already too short.	5/26/2015 10:25 AM
84	no, as above	5/26/2015 9:30 AM
85	No	5/25/2015 11:22 PM
86	NO we all ready produce trainees who are not ready for the Consultant role	5/25/2015 6:39 PM
87	No. Skills, practical knowledge, experience takes at least this long to acquire.	5/23/2015 10:23 PM
88	no, StRs already have lots to do	5/21/2015 2:44 PM
89	no	5/20/2015 5:19 PM
90	No. 4 years are needed to acquire competencies	5/20/2015 12:47 PM
91	Would be difficult to fit in community and hospital placements plus gaining all relevant competencies and attendance at suggested courses if training were any shorter.	5/19/2015 4:00 PM
92	No - time needed for maturity in compex decision making.	5/19/2015 2:16 PM
93	No - needing increased experience in community palliative medicine - not less	5/19/2015 12:42 AM
94	No, some aspects already not covered in much detail eg research.	5/18/2015 11:29 PM
95	No - I think there is too much to cover in the curriculum for shortening the training.	5/18/2015 8:02 PM
96	No trainees need at least 4 years to develop	5/18/2015 7:44 PM
97	no - there's enough to fit in as it is	5/18/2015 7:14 PM
#	**(5.3) If the length of training was shortened what impact would that have? What components of the Palliative Medicine curriculum could not be delivered if training was shortened to the arbitrary time scale of a maximum of 6 years as suggested in the Shape of Training Review?**	**Date**
1	I think a lot of it is the exposure to patients in different settings at different stages of competency which are currently achieved through the 4 years of training. Shortening the training would reduce the frequency of seeing very complex patients and managing at a junior level then a senior level.	6/9/2015 6:25 PM
2	Very detrimental. Palliative medicine would be compromised severely. Community and hospice experience would be overshadowed by hospital, which would be a problem.	6/9/2015 2:38 PM
3	The level of experience needed to be safe caring for patients.	6/9/2015 12:42 PM
4	Not sure that people would have had the right exposure after only 6 years.	6/9/2015 11:33 AM
5	Difficult to identify what could be removed. The curriculum does not have any redundant areas	6/9/2015 10:38 AM
6	difficult to attain adequate experience in general	6/9/2015 10:33 AM

7	less able to make complex ethical decisions, less able to work collaberatively and poor communicators	6/9/2015 10:11 AM
8	Research competencies, leadership and management.	6/9/2015 9:28 AM
9	I would strongly believe that skills and competencies achievement more important than length of training	6/8/2015 8:21 PM
10	Inexperienced doctors, poor leadership and management skills	6/8/2015 7:14 PM
11	I am most concerned that academic would suffer, and probabaly also community and hospice rotations	6/8/2015 6:13 PM
12	I think CST holders would feel less confident & less likely to take on a consultant post unless they had other Palliative Medicine colleagues in the same unit to support them.	6/8/2015 6:06 PM
13	Research and management would fall by the wayside - they are always left to the end anyway	6/8/2015 10:30 AM
14	Lack of the experience that can only be gained through time. I think managing patients at a senior level would become harder for trainees even if on paper they have covered the curriculum. I suspect management experience will be reduced and in palliative medicine this would definitely be detrimental. Research could become an OOP experience only. However, it would still need to be covered to some extent.	6/8/2015 12:35 AM
15	It depends on the trainee and the rotations available.	6/7/2015 2:58 PM
16	Loss of experience, especially that gained through an iterative process	6/5/2015 5:01 PM
17	Hospice management	6/5/2015 9:54 AM
18	Management skills	6/5/2015 8:03 AM
19	i would worry that we would need to lose useful but non-essential experience e.g. in oncology/pain services	6/4/2015 5:08 PM
20	care compromised	6/4/2015 2:21 PM
21	Experience and "wisdom" through working. A good range of all areas (hospice, hospital and community), opportunities to gain experience in education, management research are likely to be lost with the need to get core clinical skills to an adequate level.	6/4/2015 12:38 PM
22	Risk that trainees do not have time to develop leadership and management skills	6/4/2015 12:10 PM
23	Significantly shortening training would reduce the exposure to complex patients who benefit most from the pallaitive medicine specialist approach.	6/4/2015 12:10 PM
24	the key ones - ie the development of sound judgment and communicate in complex and often hostile and hazardous environments	6/3/2015 3:53 PM
25	Might be difficult to find time to attend management meetings/ non-clinical exposure. Probably find you have clinically excellent physicians that have no idea about management/running hospices/development of services etc at the point of CCT/CST	6/3/2015 11:29 AM
26	I foresee less time spent in hospices. I suspect less time will be devoted to leadership and management. This would be detrimental to our general medical colleagues who look to the specialists in palliative medicine as gatekeepers to the beds in the third sector, and as leaders to influence the standard of EOL care in acute Trusts	6/3/2015 2:12 AM
27	I think it would result in consultants who struggled hugely with the multiple demands on them - not just clinical but management/training etc	6/2/2015 5:49 PM
28	I think this is detrimental and should not be done. It is not just about the curriculum which is over-long and rather ridiculous, it is about good old fashioned experience and maturity.	6/2/2015 9:38 AM
29	Large	6/1/2015 11:21 PM
30	Community expereince likely to be lost. Exposure to the range of conditions may be limited. Less scope for subspecialty interests.	6/1/2015 8:55 PM
31	less experienced consultants with fewer competencies, potentially impacting on patient care.	6/1/2015 5:08 PM
32	Too big a question to be answered here.	6/1/2015 11:30 AM
33	The main concern would be as per my answer to 5.2- otherwise post-CST holder might lack confidence to manage situations as above	5/31/2015 4:39 PM
34	Cross sector working would be omitted whilst secondary care/acute medicine/service requirements were being met - critical area for the new models of care that are set to develop	5/31/2015 4:29 PM

35	Less experienced consultants.	5/31/2015 12:42 PM
36	Dr would be unable to support full spct	5/30/2015 8:54 PM
37	Even less well trained consultants in the future.	5/29/2015 7:09 PM
38	Cannot be shortened - competency as measured now, without the accompanying experience, is a receipe for disaster	5/29/2015 1:36 PM
39	It would be too difficult to gain experience in all areas of palliative medicine - hospice, hospital and community	5/29/2015 9:53 AM
40	as above. The only way I can see of shortening it would be to cut out medicine for Mrcp route trainees and go for Mrcgp route trainees.	5/29/2015 9:09 AM
41	Compromise on training time in the community, breadth of experience of dealing with complex cases. There is the undeniable aspect of understanding managerial responsibilities (again different from other General Medical Specialties as the hospice sector is distinctive) within the specialty which comes with a certain level of maturity. A mature attitude needs time to develop and cannot always be 'taught'. Particularly as Consultants are now pushed to take on far more managerial roles early on in their career compared to 5 yrs ago.	5/28/2015 8:50 PM
42	experience	5/28/2015 8:16 PM
43	management competencies would suffer - you need to be confident with clinical work before you can really grasp these	5/28/2015 7:30 PM
44	I would be concerned that trainees would not have enough general med knowledge and may miss out on important aspects of specialist training and mangement role experience and training. I think having someone come out as a "consultant" who has had less training and experience presents the public with a lower standard for the same title, and is likely to devalue to role.	5/28/2015 6:41 PM
45	less experience - more risk	5/28/2015 5:27 PM
46	It would very much depend on the trainee. With so many fertile trainees going through training it might be hard for a proportion to complete training within six years.	5/28/2015 4:58 PM
47	Would that be full time equivalent, because many of us take more than six years due to maternity leave etc!	5/28/2015 4:52 PM
48	More complex pain management including interventional pain, drug misuse. Level of knowledge and experience required for management of hospice	5/28/2015 4:48 PM
49	I disagree strongly that it should be shortened	5/28/2015 4:26 PM
50	I guess would try to cove all but shorter exposure to fewer cases	5/28/2015 3:55 PM
51	a junior consultant grade - suspect community would lose out	5/28/2015 3:49 PM
52	I don't think you could produce a fully functioning specialist ESP if there was more acute medicine involved - and would produce a junior/sub consultant grade	5/28/2015 3:48 PM
53	Hospice experience and service would be disadvantaged	5/28/2015 3:35 PM
54	Consultants would have less experience when starting in post	5/28/2015 3:24 PM
55	i think all aspects of the curriculum are important to have gained before CST	5/28/2015 2:41 PM
56	If shorter I believe that there would be less understanding of the holistic nature of assessment and care	5/28/2015 2:37 PM
57	psychosocial, complex pain, management, research	5/28/2015 2:34 PM
58	I think it would depend on the locality, but I am sure that there would be some part of the training (e.g. experience in hospices, acute hospitals, and community) that would be reduced if the length of training was shortened.	5/28/2015 2:29 PM
59	Negative - less experience.	5/28/2015 2:21 PM
60	Less experience overall in all areas - e.g. symptom control. Would also impact on development of necessary leadership and management skills - although this could be developed rom earlier in training.	5/28/2015 10:05 AM
61	I think trainees would struggle to make transition into consultant posts and particularly to bring experience to consultant level complex decision making	5/27/2015 6:10 PM
62	Less experienced clinicians, less able to make independent decisions	5/27/2015 5:48 PM
63	as above	5/27/2015 4:23 PM

64	Likely that non-clinical experience in particular would suffer; particularly research, audit and managment/leadership requirements which are key in a cohort of consultants who may well have a significant organisational leadership role in the hospice setting	5/27/2015 3:22 PM
65	To deliver meaningful community and research opportunities within that timescale would be impossible if combined with a commitment to the acute take.	5/26/2015 10:24 PM
66	Ethics, benefit and burden, management, prioritisation and management plans	5/26/2015 7:15 PM
67	The recent ombudsman report demonstrated a reinforcement of previous thought that end of life care significantly accounts for many complaints which can reflect distress and subsequent difficult bereavements. As 'experts' in this complex and often emotionally charged time it is vital we have the knowledge and experience to make difficult decisions confidently (over a wide variety of diseases) and to communicate these complex decision making processes to patients and their families. This specific job has a high burn out rate and doctors are already under pressure to tick boxes, jump through hoops and pass exams within a relatively short period of time. Shortening training means less time for these additional requirements which are already usually done in personal time and will result in poor work life balance, an already stressed work force at breaking point and a generation of consultants ill-equipped to cope with the increasingly complex demands of an already intricate and senstive patient group. To conclude this will result is poor decision making, increase burn out rate of doctors, a reduction in quality of health care and subsequently a less efficient approach to patient care.	5/26/2015 5:44 PM
68	Less experienced trainees becoming consultants. Working at a more senior level within a team and the management competencies would be harder to achieve. Research component would also be difficult.	5/26/2015 10:25 AM
69	Trainees would struggle with complex cases with challenging communication issues as they would lack the experience to deal with these to the detriment of patient care	5/26/2015 9:30 AM
70	Doctore swould not gain the competencies and service experoence required and specifically maintaining 2 yrs Core experience in hospice pallaitive medicine which underpins training in hospigtal and community	5/25/2015 6:39 PM
71	Worse care, worse doctors. Breadth of symptomatology, skill with complex communication, experience with dangerous medications all take time.	5/23/2015 10:23 PM
72	4 years training would be fine with good community experience	5/20/2015 12:47 PM
73	See above.	5/19/2015 4:00 PM
74	Consultants may not have adequate maturity in complex decision making to cope with the nature of the specialty.	5/19/2015 2:16 PM
75	The non-clinical components of research for instance are likely to be reduced as well as time spent within other specialities that are not palliative medicine - this experience may be gained in other elements of shape of training - but i think this needs to be confirmed	5/19/2015 12:42 AM
76	Experience across all settings needed to practice in palliative medicine	5/18/2015 8:02 PM
77	Maturity and experience	5/18/2015 7:44 PM
78	you'd get second rate consultants, and as the impetus is to move to a consultant led service, patients, and the whole service, will suffer	5/18/2015 7:14 PM

Q26 Additional Comments

Answered: 32 Skipped: 217

#	Responses	Date
1	I think that providing full registration from the time of completion of graduate training will need to be supported by a national examination, and more involvement of undergraduates in clinical care of patients (like clerkship in Canada). With lengthening training, I think it will be more difficult to encourage people to take part of academic training. I think the perception of Palliative Medicine is going to be another stumbling block in us taking part of the Shape of Training. My Educational Supervison (and TPD) was reluctant to allow me to do some procedures as I wouldn't ever have to do them as a Pallative Medicine trainee (ie - central lines). I've also been met with StRs on the acute take when I was finishing my CT2 year (I'd passed MRCP in CT1) when finding out I was going into palliative medicine told me "he'd take care of me" on the acute take. I worry that our decision making will be questioned if people know what our chosen discipline is.	6/9/2015 11:10 PM
2	Palliative Medicine as a speciality is unique and we should fight to maintain what makes us special! Otherwise I am concerned we will end up being incorporated into other specialities and lose what we have worked so hard to improve over the last few decades.	6/9/2015 12:42 PM
3	I'm not sure that participating in the medical take would benefit the trainee much, but could benefit the patients and model a different approach to staff. In this times of crisis in the acute take it is arguable that we should be prepared to 'help out'. I don't think more exposure to the acute take can be a bad thing, as long as it is matched by exposure to community and hospice care.	6/9/2015 12:11 PM
4	Sorry, not entirely au fait with all the current curriculum. It is vital that independent hospices wake up to the challenges ahead; too many are ivory towers, unaware of what's happening in acute settings, or within primary care. We need to adapt our services to a changing population, who have a very different view of life and death. To do this well needs appropriate resources, and proper recognition of the existing medical staff working in a lot of them.	6/9/2015 11:33 AM
5	I believe it is a good thing for all specialists, including palliative medicine specialists, to have more generalist knowledge and skills. Therefore I would agree with increasing CMT to three years. However I would have concerns about palliative medicine specialty trainees, or indeed consultants, having to contribute to acute medical take cover as this would have an impact on specialty cover.	6/9/2015 10:33 AM
6	Sorry I have not been able to answer all of this as I don't feel I know enough to answer it all.	6/8/2015 6:06 PM
7	I think there are already too many people in our specialty moving to Australia because of the demands of being a Consultant in Palliative Medicine in the UK. I think this would only increase if the implementation of SHOT means they feel less well-equipped to be consultants. I think more people who are interested in Palliative Medicine will do General Practice & then SSAS posts, rather than enter specialty training, as the requirement to do so much acute medicine as part of specialty training would be very unattractive to them. I think overall there is the potential that it will make it easier to recruit to SSAS posts & more difficult to fill Specialty Training posts in Palliative Medicine.	6/8/2015 6:06 PM
8	I haven't completed this section as currently do not have sufficient time to do it justice and compared to many of your experienced consultant respondents am relatively junior (ST5), thanks for the questionnaire & the opportunity to respond.	6/8/2015 11:16 AM
9	I have concerns about the shape of training review. There is a need to increase the number of medical registrars but I am not sure that this proposal provides an adequate answer.	6/7/2015 2:58 PM
10	The whole project is a good one, but we can't have it both ways - the cost simply has to be longer training. Like all things if the time in construction or the materials are compromised, then the product will be poor, short-lasting and dangerous.	6/3/2015 3:53 PM
11	This was a challenging questionnaire for two reasons: I think many elements of SHoT are unsupported by the RCP; and many of my responses here are based purely on speculation.	6/3/2015 2:12 AM
12	I think we will be a more useful, influential and respected specialty if we embrace these changes.	6/1/2015 10:25 PM

13	I have a CCT in old age psychiatry hence focus on this area in some answers. I think we do need to be more able to cross specialty boundaries but I think this shouldn't come at the expense of changing and diluting existing training (i.e., I needed three years as an old age psych reg to become good enough to be a consultant psychiatrists, if I had done two years psych and one year pall med it wouldn't have been enough).	6/1/2015 9:31 PM
14	I worry that if palliative care is diluted into general medicine that we will end up with palliative care consultants who are just about competent in general medicine, but who are almost certainly not competent to supervise medical registrars from other specialties. A consultant in palliative & general medicine may have 2 or 3 years less experience of running the acute take than a senior registrar in a general medical specialty eg geriatrics. It would be difficult for the consultant to supervise the registrar in this situation. They will equally have less expereince in palliative care. I don't see how a partly trained general medic would be particualrly beneficial to the running of the acute take. Whilst they would undoubtedly provide benefit by bringing palliative care into the acute take, they would be underskilled in general medicine, resulting in risks to patient care. If the aim is to integrate palliative care, then all physicians should undertake palliative care placements. If the aim is to fill the medical take, then it would be better to have fully trained consultants to do so.	6/1/2015 8:55 PM
15	SCE is another hoop imposed on Palliative Medicine. It does not translate, or correlate, to the real world. Is this a similar grand idea that will be of limited benefit to Pall Med?	5/30/2015 8:54 PM
16	I am sorry I have not answered all the questions. As I do not have Palliative Medicine trainees and only very limited medical support I do not have the time nor the need to know the details of the curriculum, and I do not want to skew the results because of my uncertainty in this area.	5/29/2015 4:43 PM
17	In my observation doctors in palliative medicine take on a disproportionate number of managerial (med director etc roles) than other physiciany specialties	5/29/2015 3:51 PM
18	Sorry, but for me section 2 doesn't work in this format - the questions are too big / too important; risks unhelpful, clichéd sound-bite responses, instead it needs informed debate / detailed preparation etc...	5/29/2015 1:36 PM
19	Please enable Gp trainees to access pall med specialist training - the acute medicine bit is easier to learn during specialist training than all the skills and knowledge gained from community experience, so general practice trainees are just as good if not better in the end. Palliative medicine is needed in hospitals and community but in both settings home care is the goal usually and requires skills focused towards community care with best use of brief hospital /hospice .	5/29/2015 9:09 AM
20	There will be a significant impact of what happens with Shape of Training - I do believe that if carefully thought through, we can achieve significant advantages for the Specialty in the long run... Good luck to us all!	5/28/2015 8:50 PM
21	Thanks	5/28/2015 6:20 PM
22	I am worried a lot of this reform is looking at needs of acute medicine and not the requirements of the speciality	5/28/2015 3:48 PM
23	I think the question that has not been asked is whether or not it is appropriate for palliative care consultants to take part in acute medical take in hospital. if the answer is no then shape of training has no purpose as competencies gained in training will be quickly lost if not an active part of job after this. if as a specialty we are to partake in management of acute patients in hospital setting then the shape of training period should be extended to give time to achieve all the competencies needed and we will also need to find ways to populate our on call rotas and increase the numbers of registrars to fill the gaps	5/28/2015 2:41 PM
24	A huge amount of work by Dr Coackley to have summarised the issues and implications...thanks you	5/28/2015 2:37 PM
25	We need to push for EOL care being made a core for pre-specialisty and speciality training	5/28/2015 2:26 PM
26	Vagueness of credentially worries me a lot - should not be left to emplyers to do - this must be college based as with present system	5/27/2015 5:48 PM
27	This review does not take into account those doctors who choose a less acute specialty for family or health reasons, who may well be lost to future consultant posts for which they would be very suited due to a need to participate in the acute take. It does not allow for those changing from other specialties who broaden the specialty and improve the care our patients receive.	5/26/2015 10:24 PM

28	I feel strongly that junior doctors should not feel they have to pigeon hole themselves into one speciality early on. I had decided to specialise in neurology as an F1 but following an oncology and then acute medicine job as a CT1 realised my calling without a doubt was palliative medicine. If I hadn't had the opportunity to experience a variety of roles I would have most likely dropped out once in training or as a doctor all together, disappointed I hadn't found my niche. Perhaps this might have been different if I had received education of the presence and role of palliative medicine as an undergraduate. I feel it is disappointing that end of life is the one thing that will affect nearly every doctor no matter their speciality yet this is so neglected. Poor communication often comes from a fear of saying the wrong thing; why is it that every health care professional is obliged to carry out some form of life support training when only 1% are required to use their skills a year but there is no formal or mandatory training communicating about the very thing that reflects who we are as a society.	5/26/2015 5:44 PM
29	Don't shorten training. It will be a disaster.	5/23/2015 10:23 PM
30	None	5/20/2015 12:47 PM
31	Sorry - no time for any more!	5/19/2015 2:16 PM
32	I would like to be dual trained but I am told I cannot at present. I do not like the current training system as little generic skills. I welcome the future shape of training but I cannot see how it can implemented given the tutors are not generically trained.	5/18/2015 10:42 PM