Specific Standards of Accreditation for a One Year Program of Added Competence in Palliative Medicine

The College of Family Physicians of Canada | Le Collège des médecins de famille du Canada

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Conjointly Accredited by
The Royal College of Physicians and Surgeons Of Canada and
The College of Family Physicians of Canada

I Introduction

The Canadian Palliative Care Association has defined palliative care as :

> *"Palliative care is aimed at relief of suffering and improving the quality of life for persons who are living with or dying from advanced illness or are bereaved."*

The World Health Organization has defined palliative care as:

> *"The active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount. The goal of palliative care is the achievement of the best possible quality of life of patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness..."*

An accredited program in palliative medicine will provide advanced training at a post-certification level for those physicians who wish to develop added competence in the area. These physicians will be educated to provide secondary, consultant level expertise to support other physicians and their patients, and will receive the basic clinical training required for academic careers in palliative medicine.

II Meeting the Educational Goals and Objectives of Both the CFPC and the RCPSC

A conjoint program in palliative medicine must reflect the basic educational goals and general standards of accreditation of both Colleges.

The educational framework for the CFPC is based on the four principles of family medicine:

1. The doctor-patient relationship is central to family medicine.
2. The family physician is an effective clinician.
3. Family medicine is community-based.
4. The family physician is a resource to a defined practice population.

A full description of these principles is contained in the CFPC *Residency Program Accreditation and Certification*.

The Royal College has established similar broad educational goals as outlined in the *General Standards of Accreditation*. This document also includes reference to the CanMEDS 2000 Roles of Medical Expert, Communicator, Collaborator, Manager, Health Advocate, Scholar and Professional.

III Administrative Structure

There must be an appropriate administrative structure for each residency program.

Interpretation:

1. There must be a program director, with qualifications that are acceptable to the two Colleges, responsible for the overall conduct of the integrated residency program. The program director must be assured of sufficient time and support to supervise and administer the program. The program director is responsible to the head(s) of the sponsoring department(s) and to the postgraduate dean of the Faculty. The Colleges must be informed when a new program director is appointed.

2. There must be a coordinator or supervisor, responsible to the program director, at each institution or agency participating in the program. There must be active liaison between the program director and the coordinators.

3. There must be a residency program committee to assist the program director in the planning, organization, and supervision of the program. This committee:

    a. must include both family physicians and specialists.

    b. should include the coordinators for each major component of the program.

    c. must include representation from the residents in the program, at least one of whom must be elected by his or her peers.

    d. must meet regularly, at least quarterly, and keep minutes.

4. The responsibilities of the program director, assisted by the residency program committee include:

    a. development and operation of the program such that it meets the general standards of accreditation of both Colleges, and the specific standards of accreditation as set forth in this document;

    b. selection of candidates for admission to the program and the evaluation of residents in the program in accordance with policies determined by the faculty postgraduate medical education committee;

    c. maintenance of an appeal mechanism. The residency program committee should receive and review appeals from residents and, where appropriate, refer the matter to the faculty postgraduate medical education committee or faculty appeal committee;

d. establishment of mechanisms to provide career planning and counselling for residents and to deal with problems such as those related to stress;

e. an ongoing review of the program to assess the quality of the educational experience and to review the resources available in order to ensure that maximal benefit is being derived from the integration of the components of the program. The opinions of the residents must be among the factors considered in this review. Appropriate faculty/resident interaction and communication must take place in an open and collegial atmosphere so that a free discussion of the strengths and weaknesses of the program can occur without hindrance. This review must include:

    i. an assessment of each component of the program to ensure that the educational objectives are being met;

    ii. an assessment of resource allocation to ensure that resources and facilities are being utilized with optimal effectiveness;

    iii. an assessment of teaching in the program, including teaching in areas such as biomedical ethics, medicolegal considerations, teaching and communication skills, issues related to quality assurance/improvement, equity issues, and administrative and management issues; and

    iv. an assessment of the teachers in the program.

In addition to the responsibilities of the program director and the residency program committee listed above, the program director must submit, through the office of the postgraduate dean, an annual report to the Colleges providing information on program applicants, individuals in the program, graduates of the program and those who have left the program without completing it. An annual report form will be sent out from the Colleges each fall requesting this information for the current academic year.

IV Goals and Objectives

There must be a clearly worded statement outlining the goals of the residency program and the educational objectives of the residents.

1. Goals of the Program

The overall goals of the program are:

a. to train physicians with added competency in the area of palliative medicine who will provide primary and consultant palliative care services; and

b. to provide clinical and initial basic academic training for physicians who will be going on to academic careers in palliative medicine.

2. Educational Objectives of the Program

Successful residents will acquire a broad-based understanding of the principles, philosophy, and core knowledge, skills and attitudes of palliative medicine.*(**NB-Since the Colleges use different formats for objectives, each general objective that follows has the approved Royal*

College format and has been linked to one of the College of Family Physicians of Canada four principles of family medicine as indicated.)

General Objective 1
(Principle #1 - The Doctor-Patient Relationship)

The resident will be able to describe medical and societal attitudes towards death and dying.

Specific Objectives

The resident will be able to:

1.1 describe current societal attitudes about death and dying;
1.2 identify issues in death and dying relevant to different cultures, spiritual beliefs and traditions;
1.3 describe current barriers in providing better care for the dying; and
1.4 define palliative care and describe its basic principles.

General Objective 2
(Principle #1 - The Doctor-Patient Relationship)

The resident will be able to demonstrate a whole person (person-centered) approach to caring for dying patients and their families.

Specific Objectives

The resident will be able to:

2.1 describe the physical, psychological, social and spiritual issues of dying patients and their families;
2.2 demonstrate an ability to work with the patient and family to establish common, patient-centred goals of care;
2.3 demonstrate effective communications skills in dealing with terminally-ill patients and their families, including skills in delivering bad news;
2.4 demonstrate a systematic approach to working with the families of dying patients including bereavement counselling; and
2.5 demonstrate an ongoing commitment to a patient and family from the time of palliative medicine consultation for a terminal illness until a patient dies and to the family after a patient dies.

General Objective 3
(Principle #1 - The Doctor-Patient Relationship)

The resident will demonstrate awareness of his/her personal issues and concerns in the area of death and dying.

Specific Objectives

The resident will be able to:
3.1 describe his/her own concerns about dealing with dying patients and their families;
3.2 demonstrate an awareness of how his/her own personal experiences of death and dying have influenced attitudes; and
3.3 describe strategies for managing his/her own stress in dealing with the dying.

General Objective 4
(Principle #2 - Effective Clinician)

The resident will be able to demonstrate effective knowledge, skills and attitudes in dealing with the complex interplay of the physical, psychological, social and spiritual needs of dying patients and their families.

Specific Objectives

The resident will be able to:

4.1 demonstrate consultant level diagnostic and therapeutic skills for ethical and effective patient care;
4.2 manage pain effectively;
4.3 demonstrate advanced knowledge of the assessment and classification of pain, the neurophysiology of pain, the pharmacology of drugs used in pain and symptom management, and the pathophysiology of other symptoms;
4.4 manage other physical symptoms especially dyspnea, constipation, skin care, mouth care, terminal agitation, delirium, and nausea and vomiting;
4.5 demonstrate a good knowledge of the current principles of cancer, its pathophysiology and management;
4.6 identify psychological issues associated with life-threatening illness and strategies that may be useful in addressing them;
4.7 describe the process of normal grief and the features of atypical grief;
4.8 demonstrate skills in working with the families of dying patients;
4.9 demonstrate skills in providing educational counselling to dying patients and their families; and
4.10 identify the social and existential needs confronting the patient and families, and strategies that may be useful in addressing them.

General Objective 5
(Principle #2 - Effective Clinician)

The resident will be able to collaborate as an effective member of an interdisciplinary team.

Specific Objectives

The resident will be able to:

5.1 describe the roles of other disciplines in providing palliative care;
5.2 participate in interdisciplinary care of patients, including family conferences;
5.3 communicate effectively with other team members;
5.4 demonstrate adequate skills in educating and in learning from members of the interdisciplinary team;
5.5 act as a role model for other residents and physicians; and
5.6 demonstrate effective consultation and communication skills in working with referring physicians.

General Objective 6
(Principle #3 -Community-Based)

The resident will be able to demonstrate requisite knowledge and skills in managing patients across different care systems.

Specific Objectives

The resident will be able to:

6.1 describe the models of palliative care delivery and their utilization;
6.2 describe the societal and environmental factors relevant to the care of the dying;
6.3 describe the barriers to effective care across settings;
6.4 describe the role of family physicians and specialists in the care of the terminally ill; and
6.5 demonstrate the ability to work effectively in institutional and community-based palliative care programs.

General Objective 7
(Principle #3 - Community-Based)

The resident will demonstrate skills in managing patients in their homes.

Specific Objectives

The resident will be able to:

7.1 describe the elements comprising good home care;
7.2 be knowledgeable about and able to provide home visits to dying patients;
7.3 describe the community resources available to support patients in their homes;
7.4 describe an approach to the last hours of caring in the home and the responsibilities of the physician at the time of death;
7.5 describe the physician's role in managing patients in their homes;
7.6 describe the role of palliative care consultants; and
7.7 advocate for the needs of home care patients.

General Objective 8
(Principle #4 - Resource to a Defined Patient Population)

The resident will be able to demonstrate the ability to incorporate accepted standards of palliative care into their practices.

Specific Objectives

The resident will be able to:

8.1 become a role model by demonstrating skillful care of the dying;
8.2 develop a proactive approach to managing patient and family expectations and needs; and
8.3 assist institutional and community palliative care programs in developing standards of care consistent with accepted standards.

General Objective 9
(Principle # 4 - Resource to a Defined Patient Population)

The resident will be able to incorporate evidence based decision making in caring for dying patients and their families.

Specific Objectives

The resident will be able to:

9.1 access the relevant literature in helping to solve clinical problems; and
9.2 apply critical appraisal skills to literature in palliative medicine.

General Objective 10
(Principle #1- The Doctor-Patient Relationship)

The resident will be able to discuss the ethical issues confronting dying patients, their families and their physicians including end of life decision-making, advance directives, care planning, competency, euthanasia and assisted suicide.

Specific Objectives

The resident will be able to:

10.1 outline a general framework for ethical decision-making;
10.2 describe an approach to managing the particular ethical issues at the end of life including withdrawing or withholding therapy, advance directives, euthanasia and assisted suicide;
10.3 demonstrate integrity, honesty, and compassion in the care of patients; and
10.4 act as an effective advocate for the rights of the patient and family in clinical situations involving serious ethical considerations.

V Content and Organization of the Program

There must be an organized program of rotations and other educational experiences, both mandatory and elective, designed to provide each resident with the opportunity to fulfil the educational requirements and achieve competence in the program.

Residents must be provided with increasing individual responsibility, under appropriate supervision, according to their level of training, ability and experience.

The following are the minimum educational requirements in palliative medicine. Additional experience may be required by the program director.

1. Pre-requisite

   a. Completion of the educational requirements for certification by the CFPC

      or

   b. Completion of the educational requirements for certification by the RCPSC

2. Program Requirements

   One year of palliative medicine. This program must include:

   a. a core component of at least nine months in supervised clinical experience in palliative care;

b. oncology educational experience unless previously done;
c. a blend of institutional and community experience;
d. opportunity for continuity of experience across home and institutional care throughout the program;
e. interdisciplinary care and teaching;
f. three months of electives designed to complement core experience, taking into account previous experience and the learning needs of the resident; and
g. a scholarly project.

3. For satisfactory completion of the CFPC/RCPSC requirements in palliative medicine a resident must:

   a. have successfully completed a one year program in palliative medicine accredited by the CFPC and the RCPSC in which the resident has been enrolled for the full year;

   b. have completed a mandatory scholarly project such as a published case report, a review of the literature, or participation in a research project; and

   c. have attained certification by the CFPC or the RCPSC.

VI Resources

There must be sufficient resources including teaching faculty, the number and variety of patients, physical and technical resources, as well as the supporting facilities and services necessary to provide the opportunity for all residents in the program to achieve the educational objectives and receive full training in the program.

Learning environments must include experiences that facilitate the acquisition of knowledge, skills and attitudes relating to aspects of age, gender, culture, and ethnicity appropriate to palliative medicine.

The program must include the following:

1. A full scope of palliative care programs:
   - institutional (acute and chronic) palliative care units
   - community-based
   - ambulatory care

Teaching sites should be evaluated regularly.

2. Patient experience that:
   - is not specific to cancer care only
   - includes responsibility for patients at consultant and direct care levels
   - includes sufficient numbers of patients in each setting

3. Interdisciplinary faculty including:
   - experienced, academic palliative medicine faculty with university appointments
   - palliative medicine consultant physicians (both family medicine and specialty medicine based)
   - experienced teachers from other medical specialties and other disciplines such as nursing, social work and theology

4. Support Services
   - appropriate administrative support for the program
   - access to appropriate diagnostic resources including ultrasound, MRI and CT to provide pathophysiologic correlates to symptoms
   - access to interventional radiologists for such procedures such as biliary stent insertion and venous stents
   - access to anesthetists who perform nerve blocks and epidural procedures
   - palliative care counselling resources such as social workers, psychiatrists or psychologists with special expertise in caring for dying patients and their families
   - computer technology for the purposes of literature searching, data base management, production of teaching materials and other educational uses

VII Academic and Scholarly Aspects of the Program

The academic and scholarly aspects of the program must be commensurate with the concept of university postgraduate education. The quality of scholarship in the program will, in part, be demonstrated by a spirit of enquiry during clinical discussions, seminars, rounds, and conferences. Scholarship implies an in-depth understanding of basic mechanisms of normal and abnormal states and the application of current knowledge to practice.

Interpretation:

1. Organized scholarly activities such as journal clubs, research conferences and seminars must be a regular part of every program.

2. The academic program must include organized teaching in the basic and clinical sciences relevant to palliative medicine.

3. There must be a faculty member with the responsibility to facilitate the involvement of residents in research and other scholarly work.

4. All programs must promote development of skills in self-assessment and self-directed life-long learning. To promote this end, the program should provide opportunities for residents to attend conferences outside their own university.

VIII Evaluation of Resident Performance

There must be mechanisms in place to ensure the systematic collection and interpretation of evaluation data on each resident enrolled in the program.

There should be an evaluation process that meets the criteria of the two Colleges and that is timely, relevant and congruent with the objectives of the program.

As there is no summative evaluation at a national level, it is particularly important that the evaluation of residents in the program be rigorous and well documented. Programs must have a comprehensive assessment plan including assessment criteria and methods, based on the objectives of the program. Assessments of the performance of individual residents in the program are to be kept on file in the office of the postgraduate dean for review at the time of on-site surveys. The final evaluation will also include the mandatory scholarly project completed by the resident.

For each resident deemed by the program director to have completed the program, an "Attestation of Program Completion" form on University letterhead must be filed with the Colleges. These forms will be sent to the program for each resident reported on the Annual Report to be completing the required one year in the program.

Approved by the Executive Committee 99 06 04