POSTGRADUATE COMPETENCIES FOR PALLIATIVE CARE

A GUIDANCE DOCUMENT

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Prepared by the Canadian Society of Palliative Care Physicians
Palliative Approach to Care Education Working Group

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This Guidance Document is intended to describe the palliative care competencies that specialists from disciplines other than palliative medicine should have upon completion of their residency in order to provide a palliative approach to care. This initial list is proposed for all specialties that care for people with life-threatening conditions. Specialties for whom this is likely to be pertinent include:

Specialties:	**Subspecialties:**	**Area of Focused Competence (AFC) Diplomas:**
Anesthesiology	Cardiology	Adolescent and Young Adult Oncology
Emergency Medicine	Colorectal Surgery	Adult Hepatology
Family Medicine	Critical Care Medicine	Advanced Heart Failure and Cardiac Transplantation
General Surgery – see subspecialties	Gastroenterology	Hematopoietic Stem Cell Transplantation
Internal Medicine - see subspecialties	General Internal Medicine	Solid Organ Transplantation
Neurology	Geriatric Medicine	
Neurosurgery	Geriatric Psychiatry	
Otolaryngology – head and neck surgery	Gynecological Oncology Hematology	
Pediatrics	Maternal Fetal Medicine	
Physical and Rehabilitation Medicine	Medical Oncology	
Psychiatry	Neonatal / Perinatal Medicine	
Radiation Oncology	Nephrology	
Urology	Pain Medicine	
Vascular Surgery	Pediatric Hematology/Oncology	
	Respirology	
	Thoracic Surgery	

The Canadian Society of Palliative Care Physicians (CSPCP) encourages the Specialty Committees for these disciplines to review and adapt these competencies as appropriate for their discipline. The CSPCP would be pleased to assist with these discussions.

WHY ARE PALLIATIVE CARE COMPETENCIES NEEDED?

Death and dying are a part of life that affect every person in Canada. Delivering high-quality palliative and end-of-life care is a shared responsibility among all healthcare providers, not just those who specialize in palliative care. It is neither feasible nor necessary that all palliative care is performed by palliative care specialists.

As described in Health Canada's Framework on Palliative Care in Canada (Dec 2018), palliative care is "…an approach that aims to reduce suffering and improve the quality of life for people who are living with life-limiting illnesses through the provision of:

- Pain and symptom management;
- Psychological, social, emotional, spiritual, and practical support; and
- Support for caregivers during the illness and after the death of the person they are caring for."[1]

Access to palliative care in Canada varies widely depending on age, where a person lives, and what he/she is dying from.[2] It is estimated that only between 15 to 30% of Canadians have access to palliative care, and access is least likely in the community, where most people prefer to receive their care: of adults who died in 2016-17, less than one in six received palliative home care services.[3] [4] [5] To improve access, quality and consistency of palliative care in Canada, an appropriately trained workforce is required.[1,3,4] In the case of physicians, "appropriate training" means:

- Basic palliative skills for all physicians to have the ability to provide a palliative approach to care for their patients.
- Additional palliative skills for physicians who:
  a) are a resource for a palliative approach to care to their community of practice.
  b) frequently provide care to patients with end-stage chronic illnesses as part of their practice.
- Expert skills for Consultant Physicians in Palliative Care, Palliative Medicine Subspecialists, and palliative medicine educators and researchers.[6]

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[1] *Framework on Palliative Care in Canada*. Health Canada, December 2018.https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/palliative-care/framework-palliative-care-canada.html#exec

[2] *Highlights from the National Palliative Medicine Survey.* Canadian Medical Association, Canadian Society of Palliative Care Physicians, College of Family Physicians of Canada, Royal College of Physicians and Surgeons of Canada, and the Technology Evaluation in the Elderly Network, 2015. https://www.cspcp.ca/wp-content/uploads/2015/04/PM-Survey-Final-Report-EN.pdf

[3] *Access to Palliative Care in Canada.* Canadian Institute for Health Information, 2018. https://www.cihi.ca/en/access-data-and-reports/access-to-palliative-care-in-canada

[4] *The Way Forward National Framework*. Canadian Hospice Palliative Care Association and the Quality End of Life Care Coalition of Canada, 2015. http://hpcintegration.ca/media/60044/TWF-framework-doc-Eng-2015-final-April1.pdf

[5] *How to Improve Palliative Care in Canada.* Canadian Society of Palliative Care, 2016. https://www.cspcp.ca/wp-content/uploads/2016/11/Summary-How-to-improve-palliative-care-in-Canada-FINAL-Nov-2016.pdf

[6] *Backgrounder: Palliative Care Medical Education in Canada, February 2018*. Canadian Society of Palliative Care Physicians, 2018. https://www.cspcp.ca/wp-content/uploads/2018/02/Palliative-Care-Medical-Education-Feb-2018.pdf

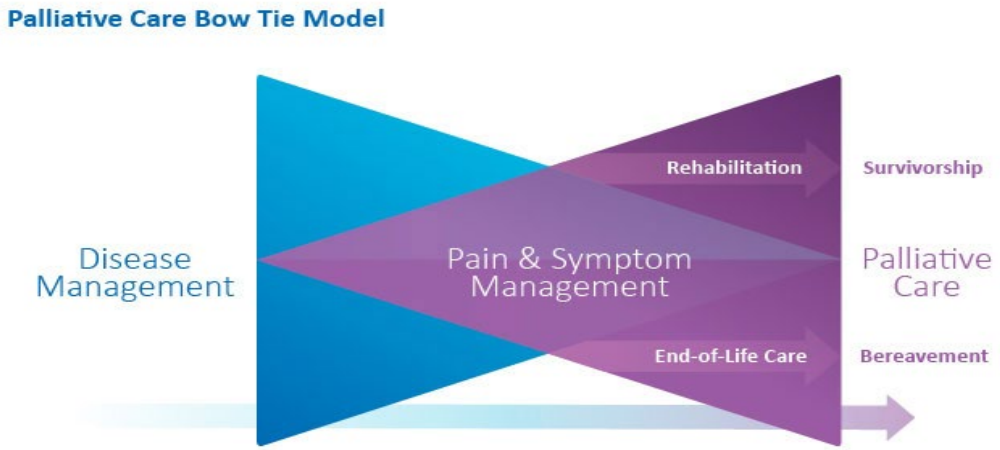
DEFINITION OF PALLIATIVE CARE

The World Health Organization (WHO) defines palliative care as “an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. The full definition is available here: http://www.who.int/cancer/palliative/definition/en/

The WHO notes that palliative care for children represents a special, albeit closely related field to adult palliative care. Their definition of palliative care appropriate for children and their families is here: http://www.who.int/cancer/palliative/definition/en/

MODEL OF PALLIATIVE CARE

The **Bow Tie Model**[7] illustrates the double reality of hoping for cure while facing and preparing for the reality that cure may not be possible. It also illustrates how palliative care should be integrated alongside curative or disease-modifying treatments soon after the diagnosis of a life-threatening condition. Palliative care should be accessible in all levels of the health care system and across all settings of care, including patients’ homes.



[7] **Hawley, P.** *The Bow Tie Model of 21st Century Palliative Care*. J Pain Symptom Manage 2014 January 47(1) e2-e5.

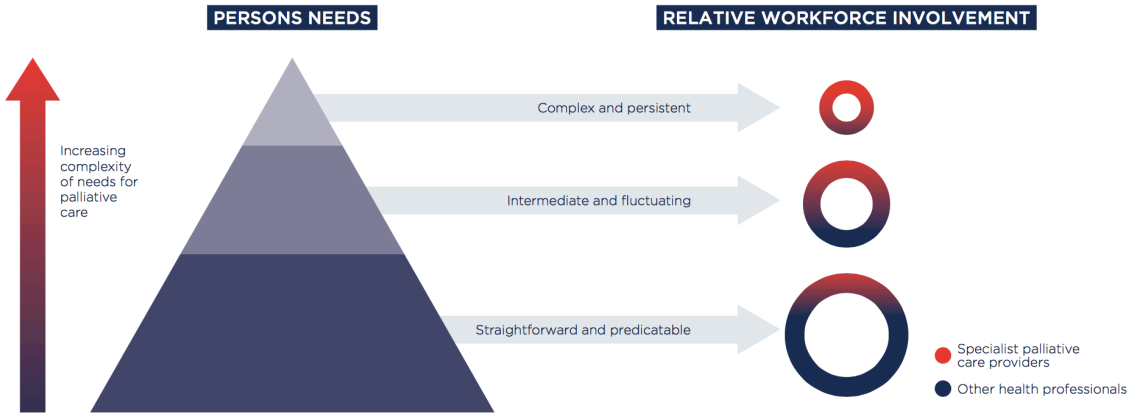
PALLIATIVE APPROACH TO CARE

Most palliative care can and should be provided by primary care providers with basic training and competencies in providing a Palliative Approach to Care, with access to Specialist Palliative Care as needed for more complex needs. [1 5 8 9]

The lexicon of terms from *The Way Forward* project defines the Integrated Palliative Approach to Care as "care that focuses on meeting a person's and family's full range of needs – physical, psychosocial and spiritual – at all stages of a chronic progressive illness. It reinforces the person's autonomy and right to be actively involved in his or her own care – and strives to give individuals and families a greater sense of control. It sees palliative care as less of a discrete service offered to dying persons when treatment is no longer effective and more of an approach to care that can enhance their quality of life throughout the course of their illness or the process of aging. It provides key aspects of palliative care at appropriate times during the person's illness, focusing particularly on open and sensitive communication about the person's prognosis and illness, advance care planning, psychosocial and spiritual support and pain/symptom management. As the person's illness progresses, it includes regular opportunities to review the person's goals and plan of care and to make referrals, if required, to expert palliative care services."[10]

The palliative approach to care is a shared responsibility of everyone who supports patients and families through serious illness, death and bereavement.

Alignment of need for palliative care with provider expertise[9]



[8] Krakauer EL, Kwete X, Verguet S, et al (2018). Palliative care and pain control. In: Jamison DT, Gelband H, Horton S, Jha P, Laxminarayan R, Mock CN, Nugent R, eds. Disease Control Priorities, 3rd Edition, Volume 9: Improving Health and Reducing Poverty. Washington, DC: World Bank, 235-246

[9] *Palliative Care Service Development Guidelines.* Palliative Care Australia, January 2018

[10] http://www.hpcintegration.ca/media/53072/TWF-lexicon-eng-final.pdf

WHAT IS THE PURPOSE OF THIS DOCUMENT?

This Guidance Document is intended to describe the palliative care competencies that specialists from disciplines other than palliative medicine should have upon completion of their residency in order to provide a palliative approach to care. This initial list is proposed for all specialties that care for people with life-threatening conditions. Specialties for whom this is likely to be pertinent are listed on the cover page.

The Canadian Society of Palliative Care Physicians encourages the Specialty Committees for these disciplines to review and adapt these competencies as appropriate for their discipline. The Canadian Society of Palliative Care Physicians would be pleased to assist with discussions.

HOW WAS THIS GUIDANCE DOCUMENT CREATED?

In 2017, the Canadian Society of Palliative Care Physicians formed a Palliative Approach to Care Education working group with the goal of establishing a set of core palliative competencies for non-palliative postgraduate training programs of both the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada. Working group members were selected on the basis of their expertise with post-graduate palliative medicine education, as well as clinical experience with palliative medicine and other specialty areas.

The proposed post-graduate competencies for palliative care were created as an extension of recently updated palliative care competencies for undergraduate medical students in Canada, which underwent a multi-step validation process with 60 individuals prior their release in June 2018.[11] The undergraduate and postgraduate competencies are organized using the CanMEDS framework developed by the Royal College of Physicians and Surgeons of Canada.[12]

Key steps

1. The competencies were prepared and reviewed by the Working Group over a 6-month period, after completion of a comprehensive literature search
2. The resulting draft was reviewed by five key organizations in summer 2018:
    a. Association of the Faculties of Medicine of Canada (postgraduate deans)
    b. College of Family Physicians of Canada
    c. Collège des médecins du Québec
    d. Medical Council of Canada
    e. Royal College of Physicians and Surgeons of Canada
3. Input was incorporated into a new draft in fall and winter 2018.
4. The new draft was reviewed and endorsed by CSPCP Board (February 22, 2019).
5. The Document was translated into French and reviewed by the Collège des médecins du Québec and a bilingual palliative care physician from the University of Montréal.
6. The competencies were endorsed by the CSPCP Postgraduate Education Committee in August 2019. The committee includes a representative from the 13 medical schools in Canada that offer postgraduate palliative care programs (Appendix).
7. The final step is dissemination of the Guidance Document to the Specialty Committees listed on the cover page and to stakeholders involved in palliative care medical education (September 2019 and beyond). Specialty Committees are encouraged to review and adapt these competencies as appropriate for their discipline. The Canadian Society of Palliative Care Physicians would be pleased to assist with discussions.

[11] https://www.cspcp.ca/information/efppec-competencies/
[12] http://canmeds.royalcollege.ca/en/framework

COMPETENCIES

Medical Expert

Upon completion of residency, physicians will be able to:

1. Provide a *palliative approach to care.*[13]

Enabling competencies

1.1 Identify when to initiate a palliative approach to care in all settings.

	Specific Objectives
1.1.1	Recognize common trajectories, natural histories of functional decline, and transition points to trigger early initiation of a palliative approach to care.
1.1.2	Describe the benefits of an early palliative approach to care.

2. Assess and manage pain and other common symptoms in their patient populations.

Enabling Competencies

2.1 Assess and manage pain in a palliative context.

	Specific Objectives
2.1.1	Conduct a thorough pain history and perform an appropriate physical exam for a patient presenting with pain.
2.1.2	Demonstrate a patient- and family-centered and interprofessional approach to assessing pain in patients with life-threatening illness.
2.1.3	Describe and recognize “total pain”, where physical, psychological, social, emotional and spiritual concerns each contribute to the pain experience.
2.1.4	Describe and use standardized tools for pain assessment.
2.1.5	Choose appropriate/relevant investigations of pain.
2.1.6	Choose an appropriate analgesia regimen, including non-pharmacological and pharmacological elements.

[13] Care that focuses on meeting a person’s and family’s full range of needs – physical, psychosocial and spiritual – at all stages of a chronic progressive illness. It reinforces the person’s autonomy and right to be actively involved in his or her own care – and strives to give individuals and families a greater sense of control. It sees palliative care as less of a discrete service offered to dying persons when treatment is no longer effective and more of an approach to care that can enhance their quality of life throughout the course of their illness or the process of aging. It provides key aspects of palliative care at appropriate times during the person’s illness, focusing particularly on open and sensitive communication about the person’s prognosis and illness, advance care planning, psychosocial and spiritual support and pain/symptom management. As the person’s illness progresses, it includes regular opportunities to review the person’s goals and plan of care and referrals, if required, to expert palliative care services. http://www.hpcintegration.ca/media/53072/TWF-lexicon-eng-final.pdf

Enabling Competencies

2.2 Use opioids effectively to manage pain and other symptoms in a palliative context.

	Specific Objectives
2.2.1	Write an appropriate opioid prescription for an opioid-naïve patient, including breakthrough dosing.
	2.2.1.1 Manage common routes of opioid administration and their effect on bioavailability and dosing frequency.
	2.2.1.2 Manage relevant pharmacokinetic and pharmacodynamics properties of opioids, including patient-specific considerations such as age, weight, prior exposure and renal and hepatic function.
2.2.2	Demonstrate appropriate opioid titration.
2.2.3	Manage common side effects of opioids and anticipate and prevent side effects such as nausea and constipation.
2.2.4	Address patient and family concerns or myths about opioids.
2.2.5	Explain the concepts of tolerance, physical dependence and addiction as they relate to the use of opioids.
2.2.6	Identify potential risk factors for opioid misuse, abuse, addiction and/or diversion, and describe approaches for managing these issues.
2.2.7	Recognize opioid-induced neurotoxicity (OIN) and distinguish OIN from opioid overdose.

Enabling Competencies

2.3 Use adjuvant modalities and medications for pain management in a palliative context.

	Specific Objectives
2.3.1	Use adjuvant analgesics appropriately, including but not limited to corticosteroids, non-steroidal anti-inflammatory drugs and neuropathic agents.
2.3.2	Recognize the potential role for adjuvant modalities, including but not limited to chemotherapy, radiation therapy, surgery and interventional analgesia in the management of pain and other symptoms, and refer when appropriate.

Enabling Competencies

2.4 Assess and manage common symptoms, including but not limited to constipation, nausea and vomiting, dyspnea, delirium, and insomnia.

	Specific Objectives
2.4.1	Conduct a thorough history and perform an appropriate physical exam for a patient presenting with common symptoms.
2.4.2	Demonstrate a patient- and family-centered and interprofessional approach to assessing symptoms in patients with life-threatening illness.
2.4.3	Describe and use validated tools for symptom assessment as appropriate for the patient population.
2.4.4	Choose appropriate/relevant investigations for identified symptoms.
2.4.5	Initiate appropriate first-line therapy to manage identified symptoms, including non-pharmacological and pharmacological interventions.

Enabling Competencies

2.5 Appropriately assess and describe the elements of suffering for patients receiving a palliative approach to care and their families.[14]

	Specific Objectives
2.5.1	Integrate diverse societal perspectives on dying and death.
2.5.2	Identify and describe issues contributing to suffering in patients requiring a palliative approach to care and their families.

Enabling Competencies

2.6 Provide a supportive approach to suffering.

	Specific Objective
2.6.1	Demonstrate a supportive approach to address multidimensional sources of suffering in patients with palliative care needs and their families.

3. Participate in the care of the dying patient and their family in uncomplicated cases.

Enabling Competencies

3.1 Participate in the care of the dying patient and their family in uncomplicated cases.

	Specific Objectives
3.1.1	Identify signs of approaching death.
3.1.2	Describe common signs of the natural dying process.
3.1.3	Prepare and educate the patient and family when death approaches.
3.1.4	Prescribe medications for symptom control in the dying phase.
3.1.5	Pronounce a patient's death and complete a death certificate.

4. Participate in providing care for the child requiring a palliative approach to care and their family, if provision of pediatric care is applicable to scope of practice.

Enabling Competencies

4.1 Participate in the management and support of a child with palliative care needs and their family.[14]

	Specific Objectives
4.1.1	Describe the similarities and differences in providing palliative care to children and adults, including the impact of grief and loss on the family.
4.1.2	Identify the challenges (societal, professional and personal) which arise when caring for a child with palliative care needs and their family.
4.1.3	Describe the multidisciplinary approach to care which benefits the child and family when life-limiting illness is present.

[14] In this document, the term "family" refers to family, friends and/or caregivers who are deemed to be important to the patient.

5. Address psychosocial and spiritual needs of patients requiring a palliative approach to care and their families.

Enabling Competencies

5.1 Address psychosocial and spiritual issues that patients with life-threatening illness and their families encounter.

	Specific Objectives
5.1.1	Identify, assess and plan for the psychosocial and spiritual needs that patients and their families encounter across the illness trajectory.
5.1.2	Recognize the level of demand and stress of caregivers and identify risk factors for caregiver burnout.
5.1.3	Demonstrate the ability to screen, diagnose and initiate treatment for patients experiencing depression and/or anxiety.
5.1.4	Identify risk factors for complicated grief.
5.1.5	Identify patients and caregivers who have complex psychosocial needs who would benefit from referral to expert resources.
5.1.6	Describe the relationship between psychosocial, spiritual and cultural issues with respect to total suffering and total pain.
5.1.7	Describe an approach to provide or refer for supportive care for someone experiencing anticipatory grief and someone experiencing bereavement.

Enabling Competencies

5.2 Develop and propose a care plan in collaboration with other disciplines.

	Specific Objectives
5.2.1	Collaborate in the development of an interprofessional care plan to meet the psychosocial and spiritual needs of patients and families facing life-threatening illness.
5.2.2	Actively involve primary care providers and other community-based supports in the psychosocial and spiritual support of patients and families facing life-threatening illness.

Enabling Competencies

5.3 Create an environment of cultural safety, demonstrating sensitivity to spiritual, religious and cultural considerations, and to life context.

	Specific Objectives
5.3.1	Demonstrate cultural humility and describe how diversity impacts decision making, to provide patient and family centered care.
5.3.2	Recognize when the values, biases or perspectives of patients, physicians or other health care professionals may have an impact on the quality of care and modify the approach to the patient and family accordingly.

Leader and Professional

Upon completion of residency, physicians will be able to:

6. Actively engage in advance care planning, goals of care and decision making with patients who would benefit from a palliative approach to care, using bioethical and legal frameworks.

Enabling Competencies

6.1 Establish advance care plans with patients and families in accordance with provincial / territorial regulations and terminology.

	Specific Objectives
6.1.1	Discuss the common ethical issues that arise throughout the illness trajectory such as decision making, withdrawing or withholding therapy, and resuscitation orders.
6.1.2	Demonstrate respect for differing family structures, roles, and cultural issues when sharing information and arriving at decisions, including care plans.

6.2 Demonstrate the use of advance care planning.

	Specific Objectives
6.2.1	Demonstrate an effective approach to advance care planning.

6.3 Distinguish between Medical Assistance in Dying (MAiD), palliative sedation, withholding or withdrawing therapy in accordance with provincial/territorial/federal regulations and terminology.

	Specific Objectives
6.3.1	Demonstrate the ability to respond to patients and families when discussing MAiD, palliative sedation and withholding or withdrawing therapy.
6.3.2	Compassionately explore and address patient and family suffering in these contexts.
6.3.3	Involve specialized palliative care services when appropriate.

6.4 Demonstrate self-reflection and self-care in working with patients requiring a palliative approach to care and their families.

	Specific Objectives
6.4.1	Identify common factors contributing to personal and professional stress in caring for patients who require a palliative approach to care and their families.
6.4.2	Develop a plan to cope with personal and professional stress that may arise in caring for patients who require a palliative approach to care and their families.
6.4.3	Exhibit self-reflective capacity in analyzing one's own values, beliefs and reactions when faced with dying and death.
6.4.4	Demonstrate awareness when personal reactions may impact the ability to provide a palliative approach to care and seek help to mitigate.

Communicator

Upon completion of residency, physicians will be able to:

7. Communicate effectively with patients, families and other informal caregivers.

Enabling Competencies

7.1 Communicate honestly and compassionately about life-threatening illness and prognosis from the time of diagnosis and throughout the illness trajectory.

	Specific Objectives
7.1.1	Elicit the patient's and family's understanding of their illness and readiness for information sharing.
7.1.2	Demonstrate the ability to discuss an individualized estimation of survival and disease trajectory.

7.2 Independently facilitate patient and family meetings.

7.3 Communicate with patients and families in order to determine, record, and implement a care plan aligned with the patient's values and goals of care.

7.4 Demonstrate the ability to educate patients and families receiving a palliative approach to care about matters related to advancing disease.

7.5 Communicate with health care providers, including the primary care team, about the natural history of the illness, what to monitor, when to refer, prognostication, and suggestions around "community-based action plans".

Collaborator

Upon completion of residency, physicians will be able to:

8. Collaborate as members of an interprofessional team.

Enabling Competencies

8.1 Work effectively with interprofessional colleagues to provide a palliative approach to care throughout the illness trajectory.

8.2 Make effective referrals for patients with complex needs requiring specialized palliative care expertise; including but not limited to: reasons for consultation, pertinent investigations, pain management, medication list, opioid toxicity.

8.3 Ensure the continuity of a palliative approach to care across different settings by collaborating with the most responsible clinician.

8.4 Demonstrate the ability to collaborate with other disciplines regarding which serious illness conversations have occurred and share the patient and family's reactions.

Health Advocate

Upon completion of residency, physicians will be able to:

9. Identify determinants of health and address barriers impacting palliative care provision for an individual patient and the population served.

Enabling competencies

9.1 Identify determinants of health & address barriers impacting access to palliative care resources.

	Specific Objectives
9.1.1	Identify and, where possible, address barriers for availability and accessibility of palliative care, including but not limited to: geography, stigma associated with receiving palliative care, lack of recognition of people who would benefit, availability of community resources, availability of specialized palliative care services.
9.1.2	Identify and work in partnership with allies among vulnerable and marginalized populations to address the inequities in their access to palliative care, including but not limited to: homeless, Indigenous peoples, incarcerated individuals and those in rural/remote communities.

APPENDIX

Members of the Canadian Society of Palliative Care Physicians Postgraduate Education Committee

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Dr. Samir Azzaria – University of Laval
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