UBC Department of Family Practice
Enhanced Skills: Adult Palliative Medicine
Competencies for 3-month Enhanced Skill Experience in Adult Palliative Medicine

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Competencies:

By the end of the 3-month training in adult palliative medicine, the physician will be able to:

1. Function as a palliative care resource for their community
    a. Be a champion and advocate for palliative care
    b. Accept orphaned palliative care patients
    c. Provide consultative support to
        i. Manage common palliative care issues (see below)
        ii. Assist with navigation of resources to provide optimal patient care
        iii. To liaise with tertiary or specialist palliative care providers
    d. Attend to patients admitted to hospice as MRP
2. Assess and manage non-complex pain and other symptoms for patients with palliative needs
3. Recognize and diagnose dying and care for the actively dying patient across care settings:
    a. Home
    b. Hospice
    c. Acute care
    d. Residential care
4. Collaborate with palliative care specialists to care for patients with complex needs
    a. Clearly communicate fulsome palliative care assessments and collaborate on management plans
    b. Determine eligibility for palliative sedation, i.e. determine if a symptom is refractory, and if patient is at end of life.
5. Provide prognostic information – functional and temporal – in those with common life-limiting conditions
6. Adopt a holistic approach to the provision of care, taking into account the patient and family perspectives and across domains of personhood
7. Adopt an integrated approach to the provision of care, considering knowledge of functional and temporal prognoses, medical and psychosocial issues, and patient/family goals
8. Adopt an interdisciplinary approach to care and fully collaborate with team members in care delivery
9. Conduct and facilitate family meetings
10. Engage with patients/families in advance care planning, including serious illness and goals of care conversations
11. Engage with patients who are requesting Medical Assistance in Dying (MAiD) and comprehensively explore issues surrounding requests for hastened death
12. Engage in activities to promote resiliency and self-care

Palliative Care Experiences Tracking

For all these clinical situations, the assumption is that the patient is someone with palliative care needs (not chronic pain or nonlife-limiting diagnoses).

The expectation is NOT that the resident will be able to manage all these situations independently but have exposure to these clinical situations.

If there are no opportunities that arise for a resident to experience these clinical scenarios, then a robust discussion with an attending should take place about these key topics – perhaps after working through a learning module or self-learning tool.

Items marked with * are essential experiences that should have taken place during family medicine training and need to be reinforced during enhanced skills training.

Items marked ** are essential experiences (along with those marked *) during the enhanced skills training.

Other items are recommended experiences and exposure will depend on patient access and opportunity. However, even if there are no opportunities for specific clinical exposure, knowledge of these topics is highly recommended and discussion about these topics with preceptors is encouraged.

Experience	*Date*
Conduct a comprehensive/holistic palliative care assessment – including symptoms, social situation, goals/priorities, functional status*	
Conduct Home Visit(s)*	
Facilitate Family Meeting(s) to discuss goals of care*	
Conduct Serious Illness Conversation(s) with a patient*	
Facilitate Advance Care Planning with a patient*	
Conduct Goals of Care Conversation(s) with a patient/or substitute decision maker*	
Initiate Opioid therapy*	
Conduct Pain Assessment(s)*	
Use the ESAS to assess Symptoms*	
Manage nutrition, hydration, anorexia issues*	
Counsel a patient or family member on Grief and/or Bereavement*	
Manage a patient through final days/hours*	
Complete a BC Palliative Care Program Registration Form*	
Complete a Death Certificate*	
Collaborate with an interdisciplinary team*	
Complete a Notification of Expected Death in the Home Form**	
Rotate from one Opioid to another **	
Manage Nausea and Vomiting**	
Manage Constipation**	
Manage Dyspnea**	

Manage Delirium**
Manage a patient’s request for hastened death, including MAiD**
Manage Depression and Anxiety**
Collaborate with a palliative care specialist for a patient with complex care needs**
Prescribe a palliative kit for the home**
Manage Bowel Obstruction
Manage Hypercalcemia
Manage Spinal Cord Compression
Manage Seizures
Describe indications for Palliative radiation therapy

Other required assignments:

1. Present at Division Journal Club
2. Write a Case Review and Reflection
3. Write a brief report summarizing the palliative care services and resources within the resident's home community and how they integrate with other resources in the province; compare and contrast these resources with another communities

Priority Topics for the Assessment of Competence: Non-YAC Enhanced Skills Key Features (Adapted from the published Priority Topics from CFPC)

How to use the priority topics and key features

It is important to note that materials in this booklet are intentionally selective and not comprehensive. It is most desirable and useful to assess what will best discriminate between competent and less competent individuals. Priority topics do not represent an extensive list of topics that should be covered in training, but rather a selective list of areas for assessment that can help teachers/assessors to infer overall competence in palliative care. Key features represent the critical or essential steps in the resolution of a clinical situation or problem, so the achievement of underlying competencies can be inferred. All key features refer to observable actions, not knowledge. They do not cover all necessary steps (e.g., history, physical examination, diagnosis, management), but only those that are critical and most likely to be missed.

As such, the priority topics and their features are not meant to be used in a checklist approach when assessing competence. They are best used for guiding assessment efforts (sampling, observation, reflection) over time to build a case for overall competence or the lack thereof. They may also be useful in the following situations:

For trainees:

- Use as a guide for self-reflection on competence and development of a learning plan, particularly prior to and during clinical experiences
- Use as a guide for soliciting feedback from teachers/assessors

For teachers/assessors:

- Compare and contrast materials in this document with your assessment strategies and adjust as necessary
- Use as a guide assessment of your trainees, including soliciting feedback, developing questions to ask trainees, and completing field notes
- Use as a guide to help develop learning plans for your trainees
- Use as a self-reflection guide to assess your teaching

For programs:

- Use as assessment standards when making decisions about residents' successful completion of training
- Use as a guide to develop assessment strategies
- Use as a guide to plan curriculum that can adequately expose trainees to the priority topics and procedures

Priority Topic 1: Advance planning and goals of care

1. Establish a patient's goals of care based on their values and beliefs by:

- Addressing the patient's illness understanding
- Reviewing the pros and cons of the currently offered and potential future treatment options
- Helping the patient to set or change priorities, and to translate these into practical decisions about treatment and other care
- Helping to reframe meaning and hope when facing the end of life

2. For more complex situations (e.g., when there is conflict within the family) help establish goals of care effectively by using patient-centred communication skills (e.g., active listening, being attentive to non-verbal behaviour) to resolve misunderstandings or conflicts and collaborate with or consult palliative care specialist interdisciplinary team members when needed.

3. When there are transitions in a patient's illness (e.g., change of place of care, treatment, patient's wishes), actively review and revisit goals of care with the patient and their family.

4. Always review the currency of advance directives with a patient and family as appropriate before applying them, as situations and preferences change.

5. Recognize when a patient lacks capacity to provide consent for a treatment and be able to follow the legal framework to obtain substitute consent.

Priority Topic 2: Care of Families

1. When facilitating discussion with patients and families:
    - Recognize that pre-existing conflicts may be difficult to resolve
    - Explore management options, considering the patient's wishes and focus on what is best for the patient
    - Assess the potential impact of cultural values and beliefs when different from your own
    - Explore the informational needs of patients and family members, and when these might differ from those of the medical team (e.g. if family members to not want to fully inform patient).

2. Identify family members who are at high risk for severe distress (e.g., suicidal ideation) or complicated grief, and facilitate treatment as appropriate.

3. When withdrawal of some aspect of care is being considered (e.g., intravenous fluids, medications) and it raises concerns amongst family members, address their concerns compassionately (e.g., review the treatments in the context of the patient's goals of care, discuss the options, focus on what will be done rather than not done).

4. When speaking to children about the death of a family member, speak gently and honestly at an age- appropriate level, and provide help and advice to parents/family about how to discuss death and dying with a child.

5. When a child in your care dies or is dying, anticipate a strong emotional reaction from the parents, family, and the health care team, including yourself, and arrange for the appropriate support.

Priority Topic 3: Working as a team

1. As part of an inter-professional team, use communication and professional skills to develop and facilitate team effectiveness including encouraging ongoing engagement of the referring provider (ie. family physician).

2. When team membership changes, invest extra effort in integrating new members, developing healthy team relationships, and optimizing team function.

3. When conflict, discord, and emotions run high in a team context, avoid taking things personally and participate in a calm, constructive, and respectful dialogue to diffuse the situation, involving all team members in the process.

4. Use a team/collaborative approach proactively (e.g., anticipated changes in a patient's clinical status, psychosocial issues) whenever possible (i.e., do not limit use only to problematic or difficult cases).

5. When other teams or individuals are involved in the care of a patient, reduce mixed messages by clarifying and clearly documenting treatment plans.

Priority Topic 4: Community Resources

1. Use available community resources to support patients and families in an optimal, integrated, and effective fashion.

2. When planning for a patient's end-of-life care at home, anticipate that care in another facility (e.g., hospice, palliative unit, hospital) may be necessary,to ensure a smooth transition and minimize the patient's and/or family's discomfort.

3. When caring for a patient at home, ensure that the roles, tasks, and the responsibilities of the various health care providers are appropriate for the designated providers, and clearly understood by the patient, family, and providers.

4. When planning a home death, ensure that the family and caregivers are aware of and have access to available grief and bereavement services.

Priority Topic 5: Non-malignant illness

1. For patients with chronic progressive non-malignant illness, (e.g., cardiac, pulmonary, renal, neurological):
   - recognize that the disease trajectory and prognosis are more variable and may be harder to predict than for malignant diseases.
   - initiate early advance care planning and goals of care discussions, and facilitate access to available palliative care resources.

2. When caring for a patient nearing the end of life with nonmalignant illness:
   - continue to optimize management of the underlying illness (e.g., some medication should be continued, some may be discontinued)

- appropriately prescribe palliative symptom management such as opioids for pain and dyspnea, adjusting as needed for the underlying disease (e.g., renal or hepatic failure, nausea in Parkinson disease).

Priority Topic 6: Nausea/vomiting/bowel obstruction

1. For a patient with nausea and vomiting, use an organized and thorough approach to look for the cause(s)based on pathophysiology, being careful not to miss commonly overlooked causes (e.g., anxiety, candidiasis, neurological and other non-gastrointestinal causes).

2. Assess the contribution of nausea and vomiting to the total suffering experience for the patient and family.

3. Distinguish a bowel obstruction from constipation, by appropriate history, physical exam, and investigations.

4. Treat to reverse the causes (of nausea and vomiting) if possible and manage the symptoms using anti-emetics and other medications, based on the pathophysiological cause(s) and the patient's overall condition (e.g., considering comorbidities, interactions with other medications, available routes of administration).

5. For bowel obstruction:
   - Look for and recognize the indications and the contraindications for surgical treatment
   - Include the patient and family in the discussions of the available options and the expected outcomes
   - Involve the surgical team as necessary
   - Use appropriate medications (e.g., prokinetics, antispasmodics, corticosteroids) and strategies according to the pathophysiology, (e.g., gastric outlet, small bowel, large bowel), if the obstruction is not managed surgically.

6. Screen for, prevent, and treat constipation by appropriate use of laxatives.

Priority Topic 7: Pain

1. Complete a comprehensive pain assessment including:
   - The intensity, character, descriptors, and impact on function, using appropriate pain assessment tools
   - The type and origins of the pain (e.g., cancer-related visceral pain, bone pain from metastases, neuropathic pain)
   - The total suffering experience (physical, psychological, spiritual, social, cultural) related to the pain of the patient and family
   - Follow up in a timely manner and adjust doses, plan appropriately.

2. Identify patients with risk factors (e.g., history of substance abuse, cognitive impairment, communication difficulties), who may require a more complex management plan.

3. Recognize a pain crisis and plan urgent specific treatment taking into consideration the underlying cause(s).

4. Consider the use of opioids, including methadone; be choose appropriate route of administration

5. Look for and recognize the side effects and complications of opioid use, including neurotoxicity/opioid-induced hyperalgesia, when needed collaborate with a palliative care specialist and refer accordingly

6. For cases of complicated pain (e.g., bone pain from metastases, neuropathic pain, complex pain syndrome, intractable pain, and incident pain), collaborate with a palliative care specialist and refer accordingly

Priority Topic 8: Breathlessness

1. For a patient in palliative care who is breathless, assess the:
   - Underlying cause(s) of the breathlessness, paying attention to those that might be reversible within the clinical context and the patient's goals of care
   - Total suffering experience, of the patient, family, and caregivers, related to the breathlessness

2. Look for and recognize degrees of distress from dyspnea that require immediate intervention, constant attention or frequent reassessment.

3. Manage breathlessness as appropriate to the clinical context and the patient's goals of care by:
   - Providing symptomatic relief for the breathlessness using pharmacologic and non-pharmacologic means, including psychosocial support for the patient and family
   - Treating the underlying cause(s) or condition(s) (e.g., heart failure, anxiety and comorbidities)
   - Continuing underlying medical treatment if the treatment is still of benefit to the patient

4. Using opioids appropriately to manage breathlessness; including negotiating any concerns/anxiety of the patient, family, or colleagues about using opioids in this situation

5. For a breathless patient (both acute and chronic), manage anxiety appropriately, using pharmacological and nonpharmacological means.

Priority Topic 9: Delirium

1. For a patient who has changing cognitive function, assess to distinguish between delirium (hyperactive, hypoactive, or mixed), dementia, and depression, and recognize superimposed presentations (e.g., delirium superimposed on a pre-existing dementia).

2. For a patient who has decreasing cognitive function (e.g., responding less, quiet, sleeping more), look for and recognize hypoactive delirium, distinguishing it from depression or underlying disease progression.
   - Investigate to establish the cause and potential reversibility of delirium appropriate to the context and the patient's goals of care:
   - Do not under-investigate by assuming the patient's delirium is terminal, before ruling out reversible causes
   - Do not over-investigate when the patient's delirium has been established as a terminal event

3. Manage symptoms of delirium effectively by:
   - Considering the total suffering experience of the patient, family, and the caregiver team caused by the delirium

4. Treating symptomatic hyperactive delirium in an urgent manner, to avoid further harm (e.g., aggression, risk for falls, psychological distress)

Priority Topic 10: Anorexia/cachexia/nutrition/fatigue

1. Assess early for the presence of unreported anorexia or cachexia and their possible contributing factors, as this may be a source of significant distress to the patient and their family/health care providers.

2. For a patient who has anorexia, cachexia, and/or fatigue, develop a management plan consistent with goals of care that includes:
   - Investigation to rule out reversible causes
   - Education of the patient and caregivers about its normalcy in these circumstances
   - Reconciliation, as much as possible, of patient and caregiver expectations to reduce guilt and tension about food intake
   - Nutritional advice and symptomatic treatment
   - Clarification that symptomatic therapy will continue to be offered to patients with severe end-stage illness, although aggressive management to attempt to reverse the anorexia/cachexia/fatigue is usually not helpful or indicated in this situation

3. Routinely encourage and facilitate regular activity as tolerated (including non-weight bearing) as a strategy to prevent or reduce fatigue.

4. For patients with anorexia and cachexia at the end of life, use a patient-centered approach to discuss when to stop the use of supplements, artificial nutrition, and parenteral feeding.

Priority Topic 11: Anxiety and Depression

1. Routinely assess for the presence of anxiety or depression, paying attention to non- classical symptoms or presentations, such as somatization, increasing medication needs, or behavioural change.

2. When a patient appears to be depressed:
   - Do not assume this to be an unavoidable response to theend of life
   - Assess methodically to determine if a clinical diagnosis of depression is present
   - Rule out alternative diagnoses such as hypoactive delirium, hypothyroidism, adjustment disorder, or existential distress
   - Assess for suicidal risk

3. Start treatment for depression early, using nonpharmacologic and pharmacologic means as indicated.

4. Select pharmacologic treatment considering:
   - Its likely effects (beneficial or aggravating) on the patient’s other symptoms (e.g., anxiety, neuropathic pain, nausea, anorexia)
   - The indications and contraindications of the use of psychostimulants

5. When a patient appears to be anxious:
   - Rule out alternative diagnoses, such as uncontrolled physical symptoms

- Assess methodically to determine a clinical diagnosis of an underlying anxiety disorder (e.g.,general anxiety disorder, panic disorder, obsessive compulsive disorder)

6. When a patient is experiencing severe or persistent physical symptoms (e.g., pain, nausea, dyspnea), assess for anxiety as a potential contributor to the patient's symptoms.

7. When selecting pharmacological treatment for anxiety:
    - Consider the use of selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), atypical antipsychotics, and benzodiazepines, depending on the clinical situation and goals of care

8. Be judicious if using benzodiazepines:
    - To avoid complications associated with excessive and long-term use
    - In high-risk populations (e.g., elderly, dementia)

Priority Topic 12: Emergencies

1. Anticipate likely emergencies (e.g., delirium, spinal cord compression, seizure, major bleeding), and plan measures in consultation with the patient and/or family to deal with these possible emergencies.

2. Identify clinical elements (e.g., symptoms, signs, appropriate investigations) that may suggest an early emergency situation that may require a change in management.

3. When a palliative care emergency or crisis has been identified, manage the situation effectively and compassionately, considering the reversibility/irreversibility of the underlying cause(s) and the patient's goals of care.

Priority Topic 13: Imminent death

1. For the patient whose condition is deteriorating, look for and recognize the signs of imminent death (e.g., changed patterns of breathing, varying levels of consciousness including being unresponsive, decreased urine output, peripheral mottling).

2. When death is imminent, collaborate with family and other health care providers to modify the treatment plan by:
    - Reviewing all medications that the patient is no longer able to swallow, discontinuing those that are no longer necessary, and providing alternatives appropriate to the context
    - Addressing symptoms that cause distress and suffering (e.g., upper airway secretions, pain, delirium)

3. Prepare the family and other health care providers for the various signs and symptoms that may be disturbing and intermittent during the dying process

4. For a patent who is dying at home, ensure the available resources and documentation (e.g., DNR, arrangements for transfer of the body after death) are in place.

5. Support the family throughout in an appropriate fashion, honouring their cultural rituals prior to and after death, and assisting them with the grieving process according to their preferences and needs (e.g., physician presence may or may not be desirable).

Priority Topic 14: Palliative sedation therapy

1. When palliative sedation therapy is being considered:
    - Collaborate with a palliative care specialist to determine if the symptom is difficult versus refractory
    - Educate the patient, family, and health care team about the differences between palliative sedation therapy and medical assistance in dying seek a second opinion from an appropriate source to review the decision and make sure that there has not been an inadvertent oversight (e.g., missed reversible cause of delirium, untreated depression).
    - Ensure all care elements (e.g., code status, hydration, nutrition) and goals of care are aligned.

2. When palliative sedation has been determined to be the most appropriate management strategy, and consent by the patient or substitute decision maker has been given:
    - Use and titrate sedating antipsychotics and benzodiazepines proportionately to achieve the desired level of sedation required to effectively treat the intolerable and refractory symptoms
    - Avoid using inappropriate medications (e.g., opioids and haloperidol) for the purposes of sedating
    - Regularly monitor the patient and review the plan with the health care team and family to address all concerns
    - Continue appropriate symptom management (e.g., opioids for pain or dyspnea)

Priority Topic 15: Medical Assistance in Dying

1. When a patient or family member asks about and/or requests hastened death), explore in detail the reasons behind the request and help reach common ground by:
    - Clarifying all the elements of the total suffering experience (patient and family)
    - Assessing for depression
    - Assigning priority to the wishes of the patient while still recognizing family concerns

2. When concerns are raised—by the patient, family members, or members of the health care team—that the palliative treatment may be hastening death, either intentionally or inadvertently, explore the reasons for the concerns and seek common ground with the ongoing management by:
    - Reviewing the total suffering experience, including particular fears or perceptions about the current treatment.
    - Reviewing the goals of care, based on the patient's wishes in order to facilitate their understanding of the intention of the treatment plan, including palliative sedation

3. When a patient requests a discussion about Medical Assistance in Dying (MAID), conduct an in-depth discussion with the patient and/or family or, depending on personal beliefs, refer the patient to a colleague for this discussion.

Priority Topic 16: Maintaining the clinician's well-being

1. Demonstrate self-care while mindfully choosing the times when it is important to put a patient's needs ahead of personal needs. personal needs.

2. Self-assess regularly, and seek and accept constructive feedback from peers regarding observed behaviours that may indicate stress or becoming overwhelmed.

3. If your own mood or behaviours indicate a risk of burnout or stress, seek help and implement wellness strategies (e.g., share with colleagues and team, adjust your schedule).

4. When experiencing a distressing reaction to a situation maintain composure and consider that your response(s)may be influenced by your personal experiences of death and dying.

5. Following a major incident that could threaten your wellbeing (e.g., death of a child, major conflicts, perceived failures), actively seek support and guidance.

6. When a colleague's or other team member's behaviour or mood suggest stress or being overwhelmed, initiate a constructive and supportive exchange that may help them address the situation.

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