

**SPECIALTY TRAINING CURRICULUM**

**FOR**

**PALLIATIVE MEDICINE**

**MAY 2007**

Joint Royal Colleges of Physicians Training Board

5 St Andrews Place  
Regent's Park  
London NW1 4LB

Telephone (020) 7935 1174  
Facsimile (020) 7486 4160  
e-mail: [ptb@jrcptb.org.uk](mailto:ptb@jrcptb.org.uk)  
website: [www.jrcptb.org.uk](http://www.jrcptb.org.uk)

**INDEX**

**RATIONALE ..... 3**  
**CONTENT OF LEARNING..... 7**  
**MODEL OF LEARNING ..... 31**  
**LEARNING EXPERIENCES..... 34**  
**SUPERVISION AND FEEDBACK ..... 35**  
**MANAGING CURRICULUM IMPLEMENTATION ..... 37**  
**CURRICULUM REVIEW AND UPDATING..... 37**  
**EQUALITY AND DIVERSITY ..... 38**  
**STATUTORY RESPONSIBILITIES ..... 39**  
**APPENDIX 1 ABBREVIATIONS ..... 40**

## RATIONALE

### Purpose of this curriculum

The purpose of this curriculum is to train a specialist in Palliative Medicine. Palliative medicine is the branch of medicine involved in the treatment of patients with advanced, progressive, life-threatening disease for whom the focus of care is maximising their quality of life through expert symptom management, psychological, social and spiritual support as part of a multi-professional team. Palliative medicine specialists may work in hospital, in the community and in hospices or other specialist palliative care units. The curriculum describes the competencies required to complete a Certificate in Training (CCT) and to be registered on the Specialist Register in Palliative Medicine. The CCT specialist will be able to work as a consultant specialist within the National Health Service and charitable sector and will have the knowledge, skills and attitudes required to do this.

### Curriculum development

This curriculum was developed initially by the Curriculum Working Group of the Association for Palliative Medicine of Great Britain and Ireland (APM) in 2001. It has since been modified and updated by the Specialty Advisory Committee (SAC) in Palliative Medicine at the Royal College of Physicians (UK) to comply with the standards set by PMETB.

Members of the Curriculum Working group were as listed:

- Dr Fiona Hicks, Consultant in palliative medicine, Chair of the curriculum working group of the APM, curriculum secretary to the SAC in palliative medicine
- Dr Suzanne Kite, Consultant in palliative medicine
- Dr Rosemary Lennard, Consultant in palliative medicine
- Dr Wendy Makin, Consultant in oncology and palliative medicine
- Dr Karen Simpson, Consultant in anaesthesia and pain management
- Dr Jonathan Adler, Trainee (SpR) in palliative medicine
- Dr Alison Evans, General practitioner and lecturer in medical education.

Members of the SAC in Palliative Medicine are as listed:

- Dr M J Minton
- Dr F M Hicks
- Dr SA Gomm
- Dr HAM Meyer
- Dr ASC Rice
- Dr SE Scragg
- Dr KL Sherry
- Dr PD Martin
- Professor EW Paice
- Dr JM Doyle
- Dr D Waldron
- Dr I N Back
- Dr T A Beynon
- Dr K Forbes
- Dr C M Lewis-Jones

During curriculum development, the following groups were consulted:

- All Regional Specialty Advisors in Palliative Medicine were consulted via workshops and comments on draft documents.
- All Specialist Registrars were consulted through their Association (Doyle Club).
- The Science Committee of the Association for Palliative Medicine for Great Britain and Ireland was consulted for advice on the research section.
- The Executive Committee of the Association for Palliative Medicine for Great Britain and Ireland (APM) was invited to comment on drafts.
- Patient and carer representatives were invited to comment through the Patient Involvement Unit at the Royal College of Physicians, London – specifically their representatives for palliative medicine.

The content of the curriculum was based on a syllabus developed by experts in the field at the inception of palliative medicine as a specialty in 1987. This was enhanced by the group of consultants, who were all educational supervisors working in the specialty, from a variety of regions and from a variety of backgrounds, which comprised the curriculum working group as listed. A trainee representative was also an active member of this group, making a valuable contribution. The chair of the curriculum working group participated in several workshops, alongside other specialties in medicine, to develop the content and style of the curriculum with assistance from the Education Department at the Royal College of Physicians. The content was refined by wide consultation with doctors at all levels within the specialty and from professionals in closely aligned specialties, such as pain medicine and oncology. All educational supervisors in palliative medicine were asked for comment through their Regional Specialty Advisors (RSAs) and all trainees were asked to comment through their association. A workshop was held to which all RSAs, the Executive Committee of the APM and a trainee representative were invited to feed back on the draft curriculum. The curriculum was then approved by the JCHMT at the Royal College of Physicians in 2003.

The content of learning has been in use by SpRs since 2003 and feedback has been sought regularly. Few modifications have been needed during that time.

The curriculum was updated in June 2006 to meet PMETB standards. The consultation process was repeated with the above groups.

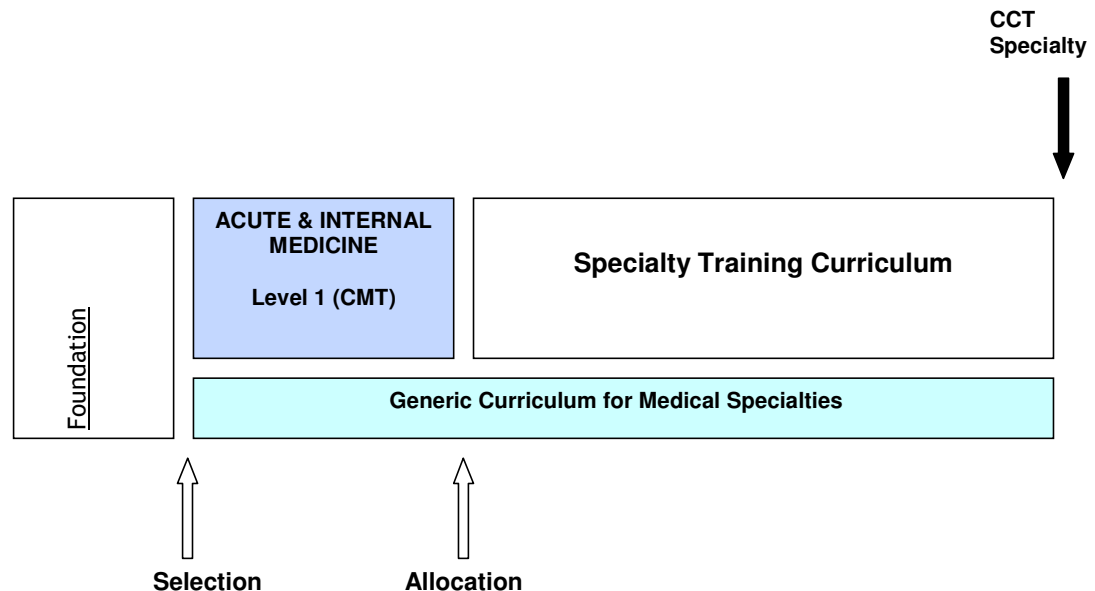
#### Appropriateness of the curriculum to the stage of learning and specialty

This curriculum builds on previous post-graduate learning. This may be undertaken in either general practice or in core training (Core Medical Training (CMT) or Acute Care Common Stem (medicine) (ACCS(M))). This gives the specialty its breadth as palliative medicine is practised in a variety of settings.

For those following the route of the specialty of medicine, the competencies to be achieved as described within this curriculum build on the core medicine training achieved in specialty training years 1 and 2 as outlined in the diagram and labelled “Acute Medicine level 1”. Doctors will then be allocated into palliative medicine

specialty training. It is not anticipated that trainees will progress through acute medicine level 2 but will confine their learning to the specialty curriculum underpinned by the generic curriculum for all physicians.

Diagrammatic representation of curricula for those entering through core training:



For those entering specialist training from a general practice training route, the competences described in the curriculum will build on general practice training. Where general practice training has not provided adequate experience in the diagnosis and ongoing inpatient management of patients with a broad range of general medical problems, this will need to be completed before this curriculum may be followed to a level equivalent to the experience gained in core training. Doctors must be able to manage concurrent general medical problems in their patients, within the context of advanced, progressive disease, without immediate recourse to other specialists and in isolated units. This will include competence in common practical procedures including:

- Venepuncture
- Cannula insertion
- Pleural tap and aspiration
- Abdominal paracentesis
- Basic cardiorespiratory resuscitation
- Urethral catheterisation
- Nasogastric tube placement

#### Linkages to previous and subsequent stages of training and education

The core training curricula (CMT or ACCS(M)) follow on from the Foundation curriculum. The general practice training curriculum follows on from the Foundation curriculum. Completion of core training will be evidenced by satisfactory

assessments, including success in the MRCP part 1 examination, with the expectation that MRCP part 2 will be completed either before enrolment into specialist training, or soon after. MRCP part 2 must be completed before the Penultimate Year Assessment for doctors following this training route. Completion of general practice training will be evidenced by a CCT in general practice which will include successful completion of the MRCGP. The specialty curriculum follows on from the core 1 training curriculum (CMT or ACCS(M)) and core general practice training curriculum (with caveats above). This will provide the competencies to the level of CCT in palliative medicine. The JRCPTB generic curriculum as applied to palliative medicine, complements both the specialty and core training curricula, and runs through from F2 to CCT. This curriculum will provide the basis for revalidation of consultants in palliative medicine, where it will be adapted to the context of their current practice.

### The training programme

The curriculum will be achieved by completing the necessary specialty posts within training programmes. Until 2007 these posts will be at SHO, GP registrar and specialist registrar level. From August 2007 these will be described as specialty training years 1 through to specialty training year 6 for those following the route of the specialty of medicine.

For those following the general practice route, this will be general practice training years 1-3 followed by specialty training for 4 years as defined in this curriculum (years 4 - 7). Those doctors training via this route who have not had adequate experience of adult general medicine, as defined above, will undertake fixed term specialty training in medicine before embarking on specialty training in palliative medicine (years 4-7). Training via the GP route may therefore take anything between 7 and 8+ years depending on the nature of the posts completed during F2 and GP training.

Following selection into specialist training in palliative medicine, the curriculum will be delivered through a sequence of posts in a training rotation. These will deliver all aspects of the curriculum and be managed by the specialty training committee within a Deanery. Educational approval of each post and of the whole rotational programme will be granted by PMETB. Before this approval is granted, the SAC in palliative medicine will scrutinise the posts and the rotational programme and advise the PMETB accordingly.

Through the rotational programmes, all trainees will occupy posts which provide experience of palliative medicine in a full range of settings (patients' own homes, day hospice, hospices and other inpatient specialist palliative care units, outpatients and general hospitals). Programmes will provide flexibility to meet trainees' needs and attachments to oncology, chronic pain services, primary care and other related specialties will be available in order to meet the competencies as stated in the section on content of learning. Doctors wishing to train less than full time will undergo the same training pro-rata.

Trainees who wish to acquire extensive research competencies, in addition to those specified in the generic element of the curriculum, may undertake a research project as an ideal way of obtaining those competencies, all options can be considered including taking time out of

programme to complete a specified project or research degree. Time out of programme needs prospective approval from the SAC and the support of the Postgraduate Dean. Funding will need to be identified for the duration of the research period. A maximum period of 3 years out of programme is allowed.

## CONTENT OF LEARNING

The content of learning is specified in terms of a generic curriculum for the medical specialties and the specialty curriculum.

The specialty curriculum is of spiral, not modular design, and as such the sequence of clinical posts is not critical to the learning. It is advised however, that where possible, trainees will begin specialist training within a specialist palliative care inpatient unit if they have not had such exposure during earlier stages of training. This will provide concentrated exposure to symptom management and psychosocial issues that will enable them to apply the knowledge and skills they have acquired to the advisory role in hospital and community teams later in training.

### ➤ Index to Specialty curriculum

1. Introduction to Palliative Care
  - 1.1 History, philosophy and definitions
  - 1.2 Personal qualities and attributes of palliative medicine physicians
  - 1.3 Communication between services
  
2. Physical Care
  - 2.1 Disease process and management
    - 2.1.1 Management of life limiting, progressive disease
    - 2.1.2 Specific disease processes
    - 2.1.3 Management of concurrent clinical problems commonly encountered in palliative care
    - 2.1.4 Delivering shared care
  
  - 2.2 Symptoms – understanding and management
    - 2.2.1 General principles of symptom management
    - 2.2.2 Pain
    - 2.2.3 Other symptoms and clinical problems
    - 2.2.4 Emergencies in palliative medicine
    - 2.2.5 Practical procedures
  
  - 2.3 Pharmacology and therapeutics
    - 2.3.1 General
    - 2.3.2 Drug specific
  
  - 2.4 Rehabilitation
  
  - 2.5 Care of the dying patient and their family
  
3. Psychosocial Care
  - 3.1 Social and family relationships
  - 3.2 Communication with patients and relatives
    - 3.2.1 Psychological responses of patients and carers to life-threatening illness and loss

- 3.3 Attitudes and responses of doctors and other professionals
- 3.4 Grief and bereavement
- 3.5 Patient and family finance
  
- 4. Culture, Language, Religious and Spiritual Issues
  - 4.1 Culture and ethnicity
  - 4.2 Religion and spirituality
  
- 5. Ethics
  - 5.1 Theoretical ethics
  - 5.2 Applied ethics in clinical practice of palliative care
  
- 6. Legal Frameworks
  - 6.1 Death
  - 6.2 Therapeutics
  - 6.3 Doctor/patient relationship
  - 6.4 Organisational
  - 6.5 Charity and company law
  
- 7. Teamwork
  
- 8. Learning and teaching
  - 8.1 Learning
  - 8.2 Teaching
  
- 9. Research
  
- 10. Management
  - 10.1 Human resources
    - 10.1.1 Recruitment
    - 10.1.2 Staff development
    - 10.1.3 Disciplinary procedures
  - 10.2 Leadership skills
  - 10.3 Management of work
  - 10.4 Information management
  - 10.5 Structures
  - 10.6 Running a palliative care unit
  - 10.7 Financial management
  - 10.8 Clinical governance
  - 10.9 Audit

## ➤ Introduction to Palliative Care

### 1.1 History, philosophy and definitions

#### Learning outcome

*The trainee will be able to discuss the history, philosophy and definitions of palliative care. The trainee will demonstrate that this knowledge and understanding informs their clinical practice and decision-making, management practice and teaching.*

- Definitions of: palliative care approach; general palliative care; specialist palliative care; hospice; specialist palliative care unit; palliative medicine; supportive care
- Changing role of, and definitions within, palliative care over time (including extension to diseases other than cancer)
- Evolving nature of palliative care over the course of illness, including integration with active treatment, and the significance of transition points
- Re-adaptation and rehabilitation
- Societal expectations and perceptions in progressing and advanced disease, and death
- Differing concepts of what constitutes quality of life (including measurement) and a “good death”

#### Recommended learning experiences

##### *Personal study*

*Study of key papers prepared by professional organisations, notably the NCPC, APM and SPA*

*Participation in clinical, managerial, and strategic planning*

*Discussions with senior staff and multi-professional team*

*Continuity of care of patients throughout their terminal illness*

*Critical appraisal of the media and evidence base*

### 1.2 Personal qualities and attributes of palliative medicine physicians

#### Learning outcome

*The trainee will have developed the personal and professional qualities, skills, and attributes required for the effective practice of palliative medicine.*

- The requirements of good medical practice as described by the GMC including:
  - Tact, empathy, respect and concern for patients and their families
  - Appropriate self confidence tempered by critical self-appraisal and the recognition of one’s limitations.
- The further development of those aspects of good medical practice particularly pertinent to the practice of palliative care:
  - Teamwork
  - Balancing of (often subtle) therapeutic benefits and burdens
  - Liaison with a variety of other multi-professional teams
  - Judgement about when to act swiftly
  - Self-awareness in regard to personal coping strategies and management / leadership style

- Flexible and effective teaching skills
- Reflective practice
- Respect for social and religious values and practices which differ from ones own
- Awareness of the constraints and etiquettes of working in different ways in different environments

Recommended learning experiences

*Studying relevant GMC documents and applying to professional practice*

*Observation of, assisting and discussing with senior staff and other team members*

*Tutored clinical experience*

*Record of reflective practice*

### 1.3 Communication between services

Learning outcomes

*The trainee will demonstrate the knowledge, attitudes and skills required to foster timely and efficient communication between services*

*The trainee will communicate with other professionals, both medical and non-medical, in a timely, effective and appropriate manner necessary for a smooth continuum of patient care*

- Recognition of the need for clear, timely communication between different service providers to provide a continuum of care for the patient between different settings e.g. home/hospice/hospital/nursing home
- Shared care with other multi-professional teams, with specialist palliative care taking either the leading or a supportive role in both hospital and community settings
- Communication skills relevant to negotiating these roles

Recommended learning experiences

*Tutored clinical experience in a variety of settings*

*Record of reflective practice*

➤ Physical Care

### 2.1 Disease process and management

Learning outcomes

*The trainee will describe the scientific basis and clinical manifestations of disease processes that are life limiting. The trainee will be able to demonstrate the skill to implement this knowledge in the diagnosis and management of patients with life-limiting progressive disease.*

#### 2.1.1 Management of life limiting, progressive disease

Skills in:

- initial assessment - detailed history and examination; assessment of impact of situation on patient and family
- judgement of prognosis
- consideration of wide range of management options
- judgement of benefits and burdens of investigations, treatments, and intervention or non intervention
- acknowledgement of the need for and skills in reassessment and review
- anticipation and pre-emption of problems

- recognition of transition points during course of illness
- recognition of dying process
- crisis management
- shared care with other specialties – benefits, difficulties, facilitation

### 2.1.2 Specific disease processes

Knowledge of:

- the principles of cancer management
- the presentation, paths of spread and current management of all major malignancies
- the presentation, usual course and current management of other life limiting, progressive illnesses treated within specialist palliative care

### 2.1.3 Management of concurrent clinical problems commonly encountered in palliative care

- infections and infection control measures
- alternative methods of nutrition and hydration
- renal failure
- COPD and common respiratory disorders
- thromboembolic disease
- anaemia, bleeding disorders, coagulopathies
- diabetes mellitus
- hyper and hypothyroidism, adrenal failure, pituitary failure
- ischaemic heart disease, heart failure, arrhythmias, hypotension
- peripheral vascular disease
- peripheral neuropathy
- autonomic neuropathy
- dermatological problems
- liver failure
- anxiety and depression, psychoses
- fractures, osteoporosis, Paget's disease
- pre-existing drug dependence
- pre-existing chronic pain

### 2.1.4 Delivering shared care

Learning outcomes

*The trainee will demonstrate a positive attitude towards shared medical care.*

*The trainee will be able to deliver palliative care whatever the environment (hospital, hospice, nursing homes, daycare and the patient's home).*

- Knowledge of the benefits and difficulties, and skills in facilitation of shared care with other specialities
- Knowledge of services available in each setting and skills needed to give appropriate treatment within each setting

#### Recommended learning experiences

*Tutored clinical experience in a variety of healthcare settings*

*Personal study*

*Lectures*

*Record of reflective practice*

Palliative Medicine May 07

*Grand rounds*  
*Clinical attachments to other specialties*  
*Journal clubs*  
*Multi-source feedback*  
*Mini-CEX*

## 2.2 Symptoms – understanding and management

### Learning outcomes

*The trainee will have the knowledge, understanding and skills to manage symptoms and other clinical problems secondary to life limiting progressive disease*

#### 2.2.1 Principles of symptom management

- history taking and appropriate examination in symptom control assessment
- symptoms as sensory, psychological and social and experience for patients and impact on carers
- need for a diagnosis of the pathophysiology of a symptom (due to concurrent disorders and treatment related as well as cancer related aetiology)
- the wide range of therapeutic options – disease modifying treatments and symptom modifying treatments (palliative surgery, radiotherapy, chemotherapy, immunotherapy, hormone therapy, drugs, physical therapies, psychological interventions, complementary therapies)
- appropriate choice of treatment / non treatment considering burdens and benefits of all options
- management of adverse effects of treatment
- need for regular review of symptom response
- methods of assessment of symptom response
- management of intractable symptoms – recognition and support for patients, carers, multiprofessional teams and self
- referral to other agencies when needed

#### 2.2.2 Pain

- physiology of pain
- history taking, physical examination and investigations in pain assessment
- pain assessment tools – clinical and research
- different types of pain- nociceptive, visceral, neuropathic, incident
- recognised pain syndromes
- drug treatment of pain – WHO analgesic ladder and appropriate use of adjuvant drugs
- range of opioids, relative benefits and indications
- indications for an appropriate use of opioid switching
- management of side effects of drug treatments
- assessment of burdens and benefits of treatments, including radiotherapy
- non- drug treatment – TENS, acupuncture, physiotherapy, immobilisation
- common nerve blocks and other neurosurgical procedures
- principles of spinal delivery of analgesics
- psychological interventions in pain management
- appropriate referral to and shared care with pain management service

### 2.2.3 Other symptoms and clinical problems

- Causes assessment and management of
- sore mouth
- nausea and vomiting
- swallowing problems
- constipation / faecal impaction
- diarrhoea
- tenesmus
- ascites
- intestinal obstruction
- jaundice
- itching
- breathlessness
- cough
- hiccups
- airways/ SVC obstruction
- pleural and pericardial effusion
- haemoptysis
- bladder spasm
- urinary obstructions
- sexual problems
- lymphoedema
- fistulae
- wound breakdown
- bleeding / fungating lesions
- offensive odour
- pressure sores
- pathological fractures
- anorexia, cachexia
- weakness, lethargy
- electrolyte disturbances e.g. hypercalcaemia, hyponatraemia, hypomagnesaemia
- paraneoplastic syndromes
- inappropriate ADH secretion
- neuropathies
- raised intracranial pressure
- communication problems eg difficulties speaking or hearing, English as a second language
- depression and other mood disorders
- anxiety and fear
- insomnia
- confusional states
- hallucinations
- pre-existing drug dependence
- treatment induced symptoms – radiotherapy, chemotherapy, immunotherapy, drugs
- symptoms occurring in the last few days of life

#### 2.2.4 Management of emergencies in palliative medicine

- overwhelming pain and distress
- SVCO obstruction
- hypercalcaemia
- spinal cord compression
- cardiac tamponade
- pathological fractures
- terminal delirium / agitation
- cardiopulmonary arrest
- massive haemorrhage
- epileptic fits
- anaphylaxis
- acute confusional states
- the violent patient
- acute suicidal ideation
- overdose
- alcohol and drug withdrawal
- hypoglycaemia
- acute dystonia, oculogyric and serotonergic crises
- neuroleptic malignant syndrome
- acute urinary retention
- pneumothorax
- pulmonary embolism
- stridor
- bronchospasm
- acute CCF
- acute renal failure
- predictable complications of therapeutic inventions or procedures including advanced life support if appropriate

#### 2.2.5 Practical procedures

Competence in the following

- clinical history taking and examination of patients with advanced illness
- management of stomas
- management of tracheostomies
- managing PEGS
- passing a nasogastric tube
- pleural aspiration
- paracentesis
- management of non invasive ventilation (where available and appropriate)
- urethral catheterisation
- syringe driver set up
- nebuliser setup
- management of epidural / intrathecal catheters (using local guidelines)
- simple nerve blocks
- TENS application

Recommended learning experiences

*Tutored clinical experience, in hours and out of hours*

*Tutorials*

*Personal study*

*Lectures*

*Attachment to pain management service*

## 2.3 Pharmacology and Therapeutics

Learning outcomes

*The trainee will demonstrate knowledge, understanding and experience of treatment methods and use of drugs necessary to treat patients with life limiting progressive disease*

### 2.3.1 General

- the application of evidence based medicine to palliative care
- recommendations, guidelines and protocols – writing, implementation and use
- relevant national guidelines and protocols
- the roles and limitations of drugs, physical therapies, psychological interventions and complementary therapies in palliative care
- the use of appropriate measurement tools when assessing treatment response
- analysis of therapeutic possibilities, weighing up benefits and burdens of treatment or intervention
- communication about therapeutic goals and possible adverse effects with patients and carers; enabling their input to decision making
- communication about the above with others in the clinical team
- compliance and non-compliance with treatments – reasons for non-compliance and ways of increasing compliance

### 2.3.2 Drug specific

- general principles of pharmacodynamics and pharmacokinetics
- pharmacogenetics
- adjustment of dosage in frail, elderly and children
- adjustment of dosage in altered metabolism, disease progression and last few days of life
- the role of hospital and community pharmacy service
- drug formularies in palliative care
- managing a pharmacy budget; issues of cost versus benefit
- prescribing – legal issues, generic prescribing
- legal and ethical issues relating to the prescription of controlled drugs
- use of drugs on a named patient basis
- use of drugs outside their product licence
- use of drugs in clinical trials
- problems of polypharmacy
- helping patients and carers to understand and manage tablets
- reporting adverse drug reactions to CSM

For drugs commonly used in palliative medicine or commonly taken by patients presenting to palliative care:

- routes of administration
- absorption, metabolism, excretion
- half-life, usual frequency of administration
- adverse effects and their management
- use in syringe drivers stability and miscibility
- interactions with other drugs
- possibility of tolerance, dependence, addiction and discontinuation reactions
- availability in the community

Recommended learning experiences

*Personal study*

*Lectures*

*Tutored clinical experience*

*Journal clubs*

*Discussion with pharmacist*

## 2.4 Rehabilitation

Learning outcomes

*The trainee will demonstrate knowledge of the principles of rehabilitation in progressive illness and the skills to appropriately initiate rehabilitation for patients receiving palliative care*

- principles of rehabilitation related to illnesses with gradually increasing disability
- concept of maintenance of function through exercise and therapies
- recognition of changing goals during the course of an illness
- dealing with patient / family conflict in relation to unrealistic goals
- facilities available for rehabilitation
- specific skills of AHPs and disease/cancer site specific specialist nurses in rehabilitation
- appliances available in the home
- use of disablement centre for artificial limbs and appliances
- support services available in the home

Recommended learning experiences

*Exposure to rehabilitation units and services; Discussion / visits with specialist nurses*

*Tutored clinical experience*

## 2.5 Care of the dying patient and their family

Learning outcomes

*The trainee will have the knowledge, understanding and skills to provide optimal care for the dying patient and their family*

- recognition of the dying phase
- initial assessment of the dying patient
- providing ongoing care for dying patients and their families:
  - assessment of required medications
  - recognising when to discontinue further investigations and treatment

- managing symptoms in the dying phase – pain, agitation, nausea and vomiting, respiratory tract secretions, delirium, massive haemorrhage
- management of mouth care and bowel care
- psychological care of the family
- knowledge of major cultural and religious customs which relate to medical practice, dying and bereavement
- understanding of ethical dilemmas in the dying phase
- understanding pharmacology in dying patients, adjustment of drug dosage in organ failure and use of a syringe driver
- understanding the role environment plays in caring for the dying patient and being able to adapt accordingly eg hospital, home, hospice
- understanding the role of care pathways in improving care of the dying.

Recommended learning experiences

*Tutored clinical experience.*

*Reflective practice*

*Personal study*

*Tutorials*

➤ Psychosocial Care

### 3.1 Social and Family Relationships

Learning outcomes

*The trainee will demonstrate skills in assessing the ill person in relation to family, work and social context. The trainee will undertake this assessment with tact and compassion.*

*The trainee will have acquired the skills to adapt their approach to care to meet the patients' individual and family needs*

- Appreciation of the ill person in relation to his/her family, work and social circumstances
- Impact of illness on interpersonal relationships
- Impact of illness on body image, sexuality and role
- Construction and use of genograms in taking a family history and understanding family relationships
- Assessment of the response to illness and expectations among family members
- When and how to use family meetings
- Ways to accommodate needs of partners and families in provision of palliative care in both an inpatient unit or home setting
- Palliative care provision in relation to the homeless and those in custody
- Understanding of family dynamics and the use of concepts such as resonance
- Awareness of transference and counter-transference in professional relationships with patients and family members

Recommended learning experiences

*Participation in multi-disciplinary assessment and review*

*Personal study*

*Participation in family meetings*

*Appropriately supervised role play*

*Experience working with social work colleagues*

*Attendance at case conferences*

### 3.2 Communication with patients and relatives

#### Learning outcomes

*The trainee will demonstrate good communication skills and use of reflective practice to ensure these skills are maintained.*

*The trainee will be able to identify obstacles to communication and demonstrate skills in overcoming these.*

*The trainee will demonstrate a professional attitude to confidentiality.*

- Skills in active listening, open questioning and information giving to:
  - elicit concerns across physical, psychological, social and spiritual domains
  - establish extent of awareness about illness and prognosis
  - manage awkward questions and information giving sensitively and as appropriate to wishes and needs of the individual
  - facilitate decision making and promote of autonomy of the individual patient
  - ensure that the patient is appraised of arrangements for the continuity of their care and who to contact in case of need.
  
- Knowledge of theories and evidence base for communication practice
- Awareness and practice of a range of structures and styles of consultation
- Critical evaluation of own consulting skills
- Awareness of common barriers to communication for both patients and professionals
- Awareness of common communication problems: deafness, expression and learning disabilities
- A professional understanding of the ethical and legal aspects to confidentiality

#### Recommended learning experiences

*Tutored clinical experience*

*Formal communication skills course*

*Reflective practice*

*Personal study*

*Audio and / or videotaping where available*

*Case reviews*

*Multi-disciplinary meetings*

*Work with speech and language therapist*

### 3.3 Psychological Responses of Patients and Carers to Life-threatening Illness and Loss

#### Learning outcomes

*The trainee will demonstrate knowledge and understanding of psychological responses to illness in a range of situations, and skills in assessing and managing these in practice*

- Recognition of the different responses and emotions expressed by the patient and others, including fear, guilt, anger, sadness and despair
- Psychological impact of pain and intractable symptoms
- Responses to uncertainty and loss at different stages in the illness
- Illness in people with dementia or pre-existing psychological or psychiatric problems
- Identification of psychological responses as a source of additional problems for patient and family and as potentially obstructing the goals of care
- Dealing with
  - anger and strong emotions
  - anxious preoccupation

- transference
  - collusion and conspiracy of silence
  - denial
- Responses and needs of children (including siblings) at different developmental stages
  - Responses and needs of children and adults with learning difficulties
  - Distinction between sadness and clinical depression

Learning outcomes

*The trainee will have knowledge of and skills in recognising and managing psychiatric illness and the trainee will use psychological / psychiatric services appropriately*

- Knowledge and application of therapeutic interventions including:
  - counselling
  - behavioural therapy
  - cognitive therapy
  - group activities
- Roles of relaxation/hypnotherapy, imagery and visualisation, creative therapies
- Role and availability of the specialist psychological/psychiatric services and indications for referral

Learning outcomes

*The trainee will be able to deal with violent/suicidal individuals, and demonstrate this directly or indirectly*

- Dealing with violent/suicidal individuals; use of compulsory treatment (Mental Health Act)

Recommended learning experiences

*Working contact with and formal teaching by Psychiatric/Psychological Service*

*Personal study*

*Tutored clinical experience*

### 3.4 Attitudes and Responses of Doctors and other Professionals

Learning outcomes

*The trainee will demonstrate an attitude of self awareness and insight*

- Awareness of personal values and belief systems, and how these influence professional judgements and behaviours
- Awareness of own skills and limitations, and effect of personal loss or difficulties
- Ability to ask for help or hand over to others where necessary

Learning outcomes

*The trainee will demonstrate the skills and attitudes necessary to deal with difficulties in doctor-patient relationship*

- Potential sources of conflict in the doctor-patient relationship and how to deal with these including:
  - over-involvement
  - personal identification
  - negative feelings/personality clash

- demands which cannot be met
- Recognition and management of the emotional and psychological impact of palliative care on oneself, the team and other colleagues

#### Learning outcomes

*The trainee will demonstrate responsible support of professional colleagues*

- Being a supportive colleague to other members of staff
- Recognition of individuals who are having difficulties and understanding of when, and how, to take action if this adversely affects patient care
- Recognition of ways staff support can be offered / co-ordinated
- Assessment of personal and team member safety when conducting visits in the community

#### Recommended learning experiences

*Role play - experience of conflict*

*Teamwork*

*Reflective practice*

*Tutored clinical experience*

*Attachment to a clinical psychology/liaison psychiatry service*

### 3.5 Grief and Bereavement

#### Learning outcomes

*The trainee will demonstrate the skilful application of knowledge and understanding to prepare individuals for bereavement, to support the acutely grieving person/family. This will include the ability to anticipate / recognise abnormal grief and access specialist help*

- Theories about bereavement including the process of grieving, adjustment to loss and the social model of grief
- Grief and bereavement in children
- Recognition of multiple losses and effects on the individual
- Preparation of carers and children for bereavement
- Support of the acutely grieving individual or family
- Anticipation and identification of abnormal and complicated bereavement in adults
- Knowledge of bereavement support and organisation of support services
- Identification of appropriate bereavement support for an individual or family
- Epidemiological impact of bereavement
- Risk factors for adverse outcomes of bereavement

#### Recommended learning experiences

*Personal study*

*Multi-disciplinary team work*

*Reflective practice*

*Tutored clinical experience*

*Formal teaching*

### 3.6 Patient and Family Finance

#### Learning outcomes

*The trainee will demonstrate an ability to assess the patient and family finances and find solutions to issues raised*

- Financial assessment
- Accessing benefits, grants and allowances available to patients and families
- The role of the social worker and/or welfare benefits officer

Recommended learning experiences

*Contact with social worker/welfare benefits officer.*

*Personal study*

*Tutored clinical experience*

➤ Culture, language, religion and spirituality

4.1 Culture and ethnicity

Learning outcomes

*The trainee will demonstrate an awareness of, and respect for, the social and cultural values and practices of others*

*The trainee will recognise differences in beliefs and personal values. The trainee will be able to deal with conflicts in the beliefs and values in the clinical team, and recognise and deal with conflict of beliefs and values within a team*

- Recognition of cultural influences on the meaning of illness for patient and family
- Acknowledgement and accommodation of differences in belief and practice to ensure thorough assessment and acceptable care
- Use and support of interpreters
- Awareness of personal beliefs and attitudes and the importance of not imposing these on others
- Ability to recognise and deal with conflicts of beliefs and values within the team

Recommended learning experiences

*Case review*

*Tutored clinical experience*

*Multi-disciplinary teamwork*

*Tutored clinical experience*

*Personal study*

*Reflective practice*

4.2 Religion and spirituality

Learning outcomes

*The trainee will have the knowledge and skills to elicit spiritual concerns, recognise and respond to spiritual distress and demonstrate respect for differing religious beliefs and practice and accommodation of these in patient care*

- Ability to distinguish between an individual's spirituality and religious needs
- Ability to elicit spiritual concerns appropriately as part of assessment
- Spirituality issues in relation to life-threatening physical illness and the role of spiritual care
- Recognition of the importance of hope and ability to nurture hope in palliative care
- Ability to acknowledge and respond to spiritual distress, including referral to others

- Knowledge of pastoral systems within different religious groups and work with their representatives within the multidisciplinary team
- Knowledge of the major cultural and religious practices that relate to medical practice, dying and bereavement.

*Recommended learning experiences*

*Reflective practice*

*Communication skills teaching*

*Tutored clinical experience*

*Spend time with pastors/leaders of different religious groups*

*Work with chaplains / pastors within multi-disciplinary team at hospital/hospice*

➤ Ethics

5.1 Theoretical ethics

Learning outcomes

*The trainee will demonstrate an understanding of the theoretical basis for applied ethics in clinical practice, and be able to evaluate personal attitudes, beliefs and behaviours.*

- History of medical ethics, with emphasis on evolving philosophy and codes of practice, and with particular regard for current GMC guidance and BMA guidelines
- Critical analysis of current theoretical approaches to: medical ethics, including ‘four principles (beneficence, nonmaleficence, justice and respect for autonomy) with attention to scope’ with acknowledgement to: Raanan Gillon, Medical ethics: four principles plus attention to scope, *BMJ* 1994; 309: 184-188; futility; virtues and rights and the place of narrative analytical approaches.

5.2 Applied ethics in clinical practice of palliative care;

Learning outcomes

*The trainee will demonstrate skills in ethical reasoning and decision-making in end-of-life care, at consultant level, both for their own patients and for those that are referred to them in an advisory capacity.*

*The trainee demonstrates the skills and ability to justify their own ethical position in relation to palliative care practice using sound philosophical arguments.*

- Acknowledgement of ethical issues in daily clinical practice and teamwork
- Consent
- Giving information
- Confidentiality
- Competence to make particular decisions
- Non-autonomous or incompetent individuals
- Best interest judgements
- Conflicts of interest between patient and their relatives
- Responsibility for decisions (doctors, patients & teams)
- Resource allocation (including of oneself)
- Withholding and withdrawing of treatment (including hydration / non-hydration)
- Euthanasia
- Physician-assisted suicide
- Doctrine of double effect
- DNAR decisions
- Research / clinical trials

Recommended learning experiences

*Personal study*

*Appropriate postgraduate education courses*

*Reflective practice within multi-professional team*

*Formal teaching*

*Case presentations and discussion*

*Tutored clinical experience*

## ➤ Legal Frameworks

### Learning outcomes

*The trainee will demonstrate the skills and knowledge to:*

*1. Make decisions and practice palliative medicine within a legal/lawful framework*

*2. Access appropriate legal help and advice when necessary*

- Common law, Parliamentary law Scottish and European law in relation to end of life medical care including euthanasia and physician assisted suicide
- Knowledge of appropriate guidelines produced by BMA, GMC, Royal Colleges and defence bodies

### 6.1 Death

- Certification of death procedures, including definition and procedure for confirming brain death
- Cremation regulations
- Procedures for relatives following a death
- The role of the undertaker
- Procedures around post mortems

### 6.2 Therapeutics

- Definitions of treatment
- Refusal of treatment by patients
- Responsibilities of prescriber /pharmacist/nurses
- Controlled drugs/ storage
- Non licensed use of drugs
- Withdrawal/withholding of treatment from competent & incompetent patients
- Drugs and situations where the doctrine of double effect is relevant in clinical practice
- Obligations to treat/ not to treat
- Resuscitation guidelines

### 6.3 Doctor/patient relationship

- Consent
- Autonomous/non-autonomous/ partially autonomous patients
- Capacity/competency
- Power of attorney
- Record taking and patient access to records including the provisions of the Data Protection Act and Freedom of Information Act
- The role of the Caldicott Guardian within an institution
- Confidentiality and its limits
- Assault/battery/manslaughter as applied to medicine
- Care of minors
- Wills

### 6.4 Organisational

- Corporate law relating to charities/trusts e.g responsibilities/liabilities of trustees and employers
- Laws & regulations relating to nursing homes
- Employment law, including equal opportunities
- Discrimination – gender, race, disability, age

## 6.5 Charity and company law

- Corporate governance
- Trusteeship
- Charity acts and charity commissioners
- The company limited by guarantee

### Recommended learning experiences

*Personal study*

*Appropriate postgraduate education courses*

*Subject specific discussion /examples in daily practice*

*Tutored clinical experience*

### ➤ Teamwork

### Learning outcomes

*The trainee will demonstrate effective membership and leadership of multi-professional specialist palliative care teams.*

- Ability to work in a team
- Theories of teamwork, e.g. psychological, psychodynamic, managerial
- Identification of oneself in relation to these differing theoretical models of teamwork
- Role and responsibilities of doctors in multi-professional teams (GMC, *Good Medical Practice*)
- Skills and contributions of other members of the multi-professional team
- Nature of roles within teams: sometimes overlapping, others professionally distinct, with the boundaries sometimes unclear
- Team dynamics in different situations and over time
- Forms of team support
- Strategies that facilitate team functioning, and those which do not.
- The inevitability of conflict within a team, and strategies to manage this
- Skill mix of a team, particularly in relation to the appointment of new members
- Chairing of team meetings
- Balancing the needs of the different or overlapping teams of which the doctor may be a member at any one time
- Wide application of teamwork to include all the professionals and organisations involved in the care of a particular patient, including specialist nurses, statutory and voluntary organisations
- The impact on patients and carers of the number of professionals who may be involved in their care

### Recommended learning experiences

*Working within a number of different multi-professional teams*

*Tutored clinical experience, including chairing of clinical meetings/ward rounds*

*Personal study*

*Appropriate postgraduate education courses*

*Observation and/or participation in interviews for junior staff*

*Providing consultant cover for short periods of absence, with feedback*

*Preparation and discussion of cases in portfolio*

*Clinical attachments to other teams, eg GP practices, other hospital specialists*

➤ Learning & Teaching

## 8.1 Learning

### Learning outcomes

*The trainee will demonstrate the attitudes and skills to maintain a safe, contemporary and competent practice and will demonstrate an understanding of postgraduate education and supervision*

- Principles of adult and life-long learning, personal learning style and reflective practice
- Concept of continuing professional development
- Roles and responsibilities of trainee and trainer
- Role of supervision, mentoring, learning contracts, critical appraisal and feedback, experiential learning
- Planning learning aims, objectives, methods and outcomes
- Role of the Postgraduate Deanery, Royal Colleges of Physicians and PMETB in postgraduate education

### Learning outcomes

*The trainee will demonstrate skills and knowledge to access, analyse and apply the evidence base to clinical practice*

- Evidence based medicine including skills to search electronic databases and the worldwide web
- Critical appraisal of literature including qualitative and quantitative research
- Critical application of the available evidence to patient care

### Recommended learning experiences

*Self directed private study*

*Appropriate post graduate education courses*

*Developing evidence-based clinical guidelines and introducing them into every day clinical practice*

*Journal clubs*

*Reflective practice*

*Case studies incorporating literature searches, critical appraisal of evidence and discussion of application to clinical practice*

## 8.2 Teaching

### Learning outcomes

*The trainee will be an effective and confident teacher, with the ability to improve their students' learning*

- Teaching ability in different contexts (eg large/small group, undergraduate/postgraduate, medical/non medical)
- Knowledge of different teaching methods and structure, including lecturing, problem based learning, role play, bedside teaching and their applicability in different settings
- Selection, preparation and presentation of teaching materials
- Presentation skills
- Methods of assessment including OSCE, observed long case, modified essay questions, project reports and case studies

Recommended learning experiences

*Teaching practice in as many different situations and with as many different methods as appropriate*

*Feedback from observer/student assessment forms*

*Peer/tutor feedback on teaching skills*

*Appropriate post graduate education courses*

*Self directed private study*

*Participation in student assessments*

➤ Research

Learning outcomes

*The trainee will demonstrate an understanding of the scope of healthcare research in general, and palliative care research in particular*

*The trainee will demonstrate the ability to evaluate published research and understand implications for current practice*

*The trainee will demonstrate the ability to initiate and see through to completion, a project based on sound research principles, eg small study, literature review, audit project.*

- The scientific basis of medicine and its limitations applied in the field of palliative care
- Research topics and trends in palliative care and allied disciplines e.g. oncology, pain management, rehabilitation
- Legal and ethical dimensions of research, including standards such as the GMC Guide to Good Medical Practice (1998), Declaration of Helsinki, European Union Clinical Trials Directive, guidelines for pharmaceutical companies
- Research ethics, design and methods in the specific context relevant to palliative care
- Knowledge of the research process
  - Formulation of original research questions
  - Development of ideas by reading and using local peer group and appropriate research supervision
  - Application of appropriate study designs e.g. randomised controlled trials, single centre or multi-centre studies, n of 1 trials, qualitative techniques
    - The appropriate use and limitations of pilot studies
    - Statistical input to sample size calculation in planning research
  - Statistical analysis, appropriate to the research question
  - Supervised production of protocols
  - Sources of funding and supervised writing of grant applications
  - Patient information consent forms and informed consent
  - Patient safety and actions to be taken if an adverse event occurs

- Research ethics committee applications
- Ability to work within collaborative research teams
- Data analysis
- Presentation of research findings in a relevant format e.g. critical review, original research paper in a peer-reviewed journal, poster or oral presentation at a scientific meeting.

Recommended learning experiences

*Personal study, including relevant journals and databases*

*Journal clubs*

*Participation in the development of ideas at local research groups*

*Attendance and participation in scientific meetings*

*Supervised personal research*

*Observation and assistance of other researchers within the multi-professional team*

*Collaborative research with other disciplines*

*Attendance at postgraduate courses in statistics, research methods etc, as appropriate to trainee's interests and needs*

*Participation in the formulation of clinical guidelines and protocols*

➤ Management

10.1 Human resources

Learning outcomes

*To provide the trainee with the skills and knowledge to manage the human resources in a specialist palliative care in patient unit and palliative care team*

10.1.1 Recruitment

- Writing a job description and person specification
- Short-listing and interviewing skills
- Writing a reference
- Contract negotiation

10.1.2 Staff development

- Induction and training
- Mentoring skills
- Appraisal
- Assessment of trainees/junior colleagues

10.1.3 Disciplinary procedures

- Key issues in employment law
- When and how to institute disciplinary procedures

Recommended learning experiences

*Personal study*

*Involvement in recruitment task*

*Role-play simulation and/or observation with one to one teaching*

*Tutored experience*

*Direct observation*

*Appropriate postgraduate course*

*Deanery equal opportunities training course*

## 10.2 Leadership skills

### Learning outcomes

*The trainee will demonstrate the skills needed to lead a clinical team effectively*

- Motivating and leading a team
- Management styles
- Goal setting
- Short and long term strategic planning
- Negotiating skills
- Strategic implementation of audit
- Directing and delegating

### Recommended learning experiences

*Lectures*

*Group work*

*Role-play*

*Personal study*

*Involvement in projects within attachment*

*Tutored experience*

## 10.3 Management of work

### Learning outcomes

*The trainee will manage their work effectively and efficiently*

- Time management
- Working with a secretary
- Planning, implementing and evaluating change

### Recommended learning experiences

*Tutored experience*

*Appropriate management courses*

## 10.4 Information management

### Learning outcomes

*The trainee will demonstrate knowledge and skills in using information systems*

- Patient data collection including the NCPC minimum data set
- Data Protection Act, including rights of access for patients to information held on them
- Computer security and backup systems
- NHS net and communication systems

### Recommended learning experiences

*Use of local computer systems and databases*

*Practical experience*

*Private study*

*Formal teaching*

## 10.5 Structures

### Learning outcomes

*The trainee will demonstrate knowledge of organisational structures*

- The organisation of the NHS

- Management structures of hospices
- The structures and roles of:
  - PCTs
  - NHS provider units
  - Strategic Health Authorities
  - NHS Executive and NHS frameworks
  - Department of Health/Scottish Executive Health Department
  - Major organisations and charities involved in palliative care
  - Deputising services and co-operatives

Recommended learning experiences

*Lecture*

*Personal study*

*Tutored experience*

*Tutorials*

*Management course*

## 10.6 Running a palliative care unit

Learning outcomes

*The trainee will demonstrate knowledge and skills necessary to run a palliative care unit*

- Supply of drugs to hospices / palliative care units, stock lists, financing and regulations for controlled drugs
- Storage and retrieval of case notes
- Health and safety legislation
- Equipment safety and maintenance
- Nursing home registration
- Hospice security
- Role and management of volunteers
- Disposal of bodies

Recommended learning experiences

*Lecture*

*Involvement in running a unit in 3<sup>rd</sup>/4<sup>th</sup> year*

*Tutored experience*

*Tutorials*

## 10.7 Financial management

Learning outcomes

*The trainee will understand the principles of financial management in relation to organisations and budgets and will act with probity*

- Public and charitable health funding structure
- Understanding accounts
- Interacting with fundraisers
- Formulating business plans
- Budget setting and management

Recommended learning experiences

Lecture

Personal study

Attachments at units

Tutorials

## 10.8 Clinical Governance

Learning outcomes

*The trainee will demonstrate knowledge and skills in the methodology of clinical governance.*

- Responsibilities of doctors; professional and organisational goals
- Quality assurance in relation to service and organisation
- Service review and accreditation of palliative care services
- Role of NICE
- Role of clinical standards board for Scotland
- Expectations of GMC
- Outcome measures and performance indicators
- Risk management in relation to palliative care
- Application of SIGN guidelines ( for trainees in Scotland)

Recommended learning experiences

Lectures

Personal study

Attendance at clinical governance meetings

Diary of critical incidents

## 10.9 Audit

Learning outcomes

*The trainee will demonstrate knowledge and skill in conducting audit in practice*

- Methods of auditing structure, process and outcome applied to palliative care
- Clinical, organisational and multi-professional audit
- Collection of activity data, including NCPC or SIGN data sets
- Setting standards in relation to palliative care

Recommended learning experiences

Tutored experience

Participation in audit

## MODEL OF LEARNING

Adults learn by

- reflecting and building upon their own experiences
- identifying what they need to learn
- being involved in planning their education and training
- evaluating the effectiveness of their learning experiences

For trainees to maximise their experiential learning opportunities it is important that they work in a 'good learning environment'. This includes encouragement for self-directed learning as well as recognising the learning potential in aspects of day to day work and generally adopting a positive attitude to training.

Learning from peers should also be encouraged. Active involvement in group discussion is an important way for doctors to share their knowledge and experiences. Lectures and formal educational sessions make up only a small part of the postgraduate training in palliative medicine. The bulk of learning occurs as a result of clinical experience (experiential learning) and self-directed study. The degree of self-directed learning will increase as trainees become more experienced.

A supportive, open atmosphere should be cultivated and questions welcomed.

The list of learning opportunities below offers guidance only - there are other opportunities for learning that are not listed here. Trainees will learn in different ways according to their level of experience. Those likely to be used by more experienced trainees are marked with an asterisk.

#### **A. Experiential learning opportunities**

1. Every patient seen, on the ward, in their own home or in outpatients, provides a learning opportunity which will be enhanced by following the patient through the course of their illness. Patients seen should provide the basis for critical reading around clinical problems.
2. Every time a trainee observes another doctor, consultant or fellow trainee, seeing a patient or their relatives there is an opportunity for learning.
3. Ward-based learning includes ward rounds and multiprofessional team meetings. These should be led by a consultant, or the trainee may lead the ward round and be observed by a consultant, and include feed-back on clinical and decision making skills.
4. Trainees should have the opportunity to assess both new and follow-up patients in outpatient clinics and discuss each case with the supervisor so as to allow feedback on diagnostic skills and gain the ability to plan investigations. Trainees should have the opportunity to discuss on-call clinical activity and receive feedback from their supervisor.
- 5\*. Trainees need to learn to make increasingly independent decisions on diagnosis, investigations and treatment consistent with their level of experience and competence and with maintaining patient safety. These decisions should be reviewed with their supervising consultant.
6. There are many situations where clinical problems are discussed with clinicians in other disciplines, such as radiology, pathology and multidisciplinary meetings. These provide excellent opportunities for observation of clinical reasoning.

#### **B. Small group learning opportunities**

1. Case presentations and small group discussion, particularly of difficult cases, including presentations at clinical and academic meetings. This should include critical incident analysis.

2. Small group bedside teaching, particularly covering problem areas identified by trainees.
3. Small group sessions of data interpretation, particularly covering problem areas identified by trainees.
4. Local resuscitation skills review by a resuscitation training officer including simulation with manikins. This may be gained by attending an ALS course.
5. Participation in audit meetings, journal clubs and research presentations.
6. Video consultation with subsequent small group discussion.

#### **C. One-to-one teaching**

1. Review of out-patients, ward referrals or in-patients with supervising consultant.
2. Review case presentations with educational supervisor including selected notes, letters and summaries.
3. Critical incident analysis.
4. Discussion between trainee and trainer of knowledge of local guidelines.
5. Video consultation with subsequent individual discussion with trainer.
6. Feedback following a mini-CEX and DOPS assessment.
7. Feedback following the completion of a Record of Reflective Practice) providing an opportunity to reflect in detail on a patient's case or other scenario.

#### **D. Regular teaching and external courses etc**

1. Lectures and small group teaching as part of the regional training programme supervised by the Deanery to provide opportunities for more formal learning with peers.
2. Formal training in communication skills.
3. Study days organised by the Association for Palliative Medicine.

#### **E. Personal study**

1. Personal study including computer-based learning.
2. Practise examination questions and subsequent reading.
3. Reading journals.
4. Writing reviews and other teaching material.

#### **F. Teaching others**

1. Increasing exposure to teaching undergraduate medical students, students and practitioners from allied health professions and postgraduate doctors provides excellent learning opportunities for the teacher.
2. Presenting cases at grand rounds or similar clinical meetings provides the opportunity to review the literature relating to the clinical case. This provides the opportunity for in depth study of one clinical problem as well as learning important critical thinking skills.
3. Increasing exposure to journal club presentations allows development of critical thinking and in depth study of particular areas.

#### **G. Research**

1\*. Research provides the opportunity to develop critical thinking and the ability to review medical literature. This is an essential skill for effective clinical practice as well as for the pursuit of more academic research.

2\* Clinical research allows development of particular expertise in one area of palliative medicine allowing more in depth knowledge and skills and helping to focus long term career aims and interests.

## H. Audit and guidelines

1. Participation in audit: trainees should be directly involved and expect to undertake a minimum of one in-depth audit during every year of training.

2. Guideline generation\*/review.

Adapted from 'A Core Curriculum for Senior House Officers', Federation of the Royal College of Physicians; 4<sup>th</sup> edition.

## LEARNING EXPERIENCES

The curriculum will be delivered by tutored clinical experience in all settings (hospice/specialist palliative care inpatient unit, day hospice, hospital, outpatients and community) including multidisciplinary team meetings, ward rounds and clinical governance meetings. This is not a modular curriculum and it will be delivered via rotational training posts building on experience and training at each stage. The doctor will be given increasing responsibilities for patient management during the course of the curriculum. A variety of learning methods will be employed as outlined in the previous section, allowing a richness of experience to suit individual learners' styles.

The majority of the curriculum will be delivered through work-based experiential learning with protected time for independent learning and appropriate tutored study leave. This will amount to a total of up to 30 days per year, the nature and organisation of which can be determined by local Deaneries and specialty training committees. Study leave will be granted to enable the trainee to achieve their educational objectives as set out at the beginning of each training post, and through regular appraisal, by agreement between the trainee and their educational supervisor in accordance with the curriculum and in agreement with the post-graduate dean. The trainee will have several educational supervisors during the course of their training. The educational supervisor will oversee the learning in each post on the rotation and specific teaching will be delivered both by consultants and other members of the multi-professional team as outlined in section 2.

Within the hospice/inpatient specialist palliative care unit environment, doctors will learn to deliver specialist palliative care to patients with the most complex problems in addition to managing concurrent general medical problems in inpatients in the context of advanced disease. This will include developing and applying admission and discharge criteria to such units and liaison with hospital teams and primary care. The management of emergencies in palliative care will be covered, both during the working day and out of hours. Doctors will be involved with complex discharge planning arrangements and be exposed to a variety of models for bereavement care.

Within day hospice, doctors will experience the differences/tensions between medical and social models of care and deliver specialist palliative care within a multi-professional team in this environment with close liaison with primary care.

Within hospital, doctors will work with clinical nurse specialists in palliative care and others within the multi-professional team in an advisory role. This will develop skills in decision-making and working with a variety of hospital-based specialist teams to enhance the palliative care of hospital inpatients with specialist palliative care needs. Doctors will be involved with complex discharge planning arrangements from the hospital setting.

Within outpatients, doctors will manage specialist palliative care problems in conjunction with primary care colleagues and will enhance their skills in symptom management and advanced care planning.

In the community, doctors will work with clinical nurse specialists and other members of the multi-professional team to advise primary care teams in the specialist aspects of palliative care for patients in their own homes and in nursing homes. This will involve accessing drugs and equipment in community settings, advanced care planning and the use of pathways of care.

Practical procedures will be learnt in any of the above settings as appropriate. Doctors will learn to manage emergencies in palliative care through working on call for a minimum of 20 weekends during the delivery of this curriculum, for units and teams who accept out-of-hours admissions and/or referrals. They will also provide out of hours advice to non-specialist colleagues.

Having experienced the delivery of specialist palliative care in all these settings, the trainee will be able to understand the strengths and limitations of palliative care delivery in different environments, weigh up the merits of care in different settings with individual patients, be in a position to redesign or develop services for populations of patients and work with colleagues in primary, secondary and tertiary care to deliver the best possible palliative care to patients.

## SUPERVISION AND FEEDBACK

Each specialist training programme in palliative medicine will have a Programme Director and named consultant trainers who will undertake educational supervision of individual trainees. Upon enrolment with the JRCPTB the trainee will receive a copy of the Curriculum for Training in Palliative Medicine and the Training Record. A written record of training will be maintained by the trainee, and counter-signed by the relevant trainer and postgraduate dean at least annually. It will remain the property of the trainee but must be produced at the annual review. The Programme Directors' responsibility is to ensure that the JRCPTB requirements are met, to structure and coordinate rotations in liaison with the Postgraduate Dean, to facilitate where possible the educational needs of the trainees and, at each annual review, to suggest any future modifications in training or experience that may be necessary.

Training under the supervision of several trainers and in two or more different centres with a broad range of learning opportunities is strongly encouraged. All elements of work in training posts must be supervised with the level of supervision varying depending on the experience of the trainee and the clinical exposure and case mix undertaken. This supervision must routinely include the opportunity to personally discuss all cases if required.

## Training Record and Appraisal

It is the responsibility of the trainee to keep their training record up to date with clear documentation of all generic and specific training experience, all assessments undertaken, reports from trainers and other required information. During any research period or other out of programme module the training record will include an account of work undertaken.

As part of the training record, trainees in palliative medicine will complete a Record of Reflective Practice. A minimum of two cases per year should be submitted to their educational supervisor for structured feedback on their learning. The cases may relate directly to patient management or to other aspects of the curriculum, depending on their learning needs and stage of training.

The trainee should have regular (at least three monthly) appraisal meetings with their educational supervisor to review progress, discuss strengths and weaknesses and set agreed targets for the next training period. Trainees will meet their Programme Director at least once each year and submit the training record for approval through the annual review process. The Programme Director, Postgraduate Dean (or representative), and external assessor/other educational supervisor will certify the training and assessments undertaken and, if necessary, advise the trainee and his/her trainer about any shortcomings of the trainee or the training posts, with suggestions how to remedy these in the coming year. The trainee will also undertake a Penultimate Year Assessment (PYA) in the presence of an external assessor nominated by the SAC in palliative medicine, to ensure that their training needs are being met by the programme and that they are progressing satisfactorily through training. Written, agreed objectives will be set in the light of this assessment, for the final year of training. A successful annual review (currently RITA) will be required in each year of before a CCT can be recommended.

Trainees are expected to be highly motivated in self-directed learning through reading, planning and organizing (in discussion with their trainers) clinical attachments, attendance at appropriate meetings and courses and specific projects. A proactive approach to such activities is an essential part of training for lifelong learning through Continuing Professional Development after Specialist Registration. Similarly a positive and proactive approach to appraisal, assessments and annual review documentation throughout training is essential and constitutes an important element in preparation for ongoing revalidation as a Specialist.

#### Assessment

Assessments of a) knowledge and understanding b) clinical skills and competencies c) attitude and conduct will be undertaken throughout training as recommended and updated from time to time by the SAC. Confirmation of satisfactory completion of these assessments will be through the annual review process. The assessment process will be expected to demonstrate knowledge and competence across a range of specific and generic curricular topics. MRCP part 2 **must** be completed before the Penultimate Year Assessment for those doctors entering specialist training in palliative medicine through the specialty of medicine route. The range of assessment methods is set out below.

Evaluations of should be frequent, broadly based, should involve multiple trainers, should cover clinically important areas of the curriculum on several occasions, should incorporate learning and feedback for the trainee and should be documented. It is not anticipated that every component of the curriculum be evaluated but that a sampling approach be adopted to ensure satisfactory performance across each educational domain in a broad range of topics.

The domains of Good Medical Practice will be assessed using an integrated package of workplace-based assessments and examination of knowledge and clinical skills, which will

sample across the domains of the curriculum (e.g. knowledge, skills and attitudes). The assessments will generate structured feedback for trainees within Core training and Specialist Training. Assessment tools will be both formative and summative and will be selected on the basis of their fitness for purpose.

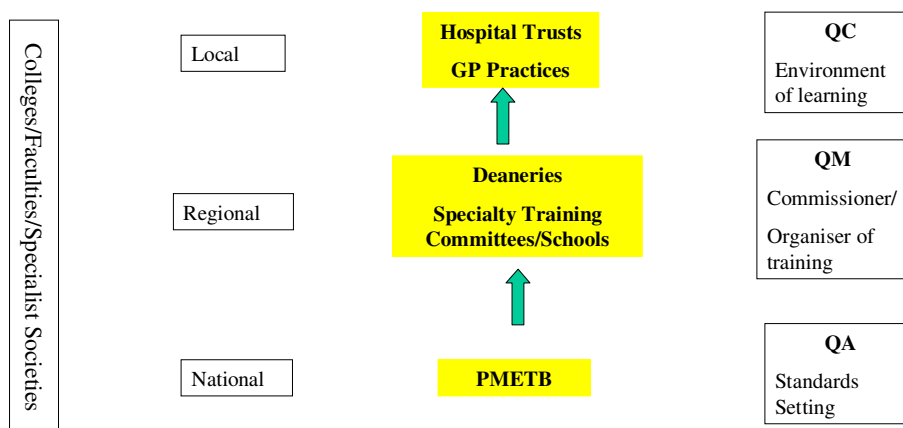
It is likely that the workplace-based assessment tools will include mini-CEX (mini-Clinical Examination Exercise), DOPS (Direct Observation of Procedural Skills) and MSF (multi-source feedback). The Federation of the Royal Colleges of Physicians has piloted these methods and has demonstrated their validity and reliability. It is proposed that the examination and assessment of knowledge will utilise elements of the MRCP(UK) examination, relevant to the level of training.

An assessment blueprint will be developed which will map the assessment methods on to the curriculum in an integrated way. The blueprint will ensure that there is appropriate sampling across the curriculum. It is expected that the blueprinting exercise will have been completed by November 2006.

## MANAGING CURRICULUM IMPLEMENTATION

Deaneries are responsible for quality management, PMETB will quality assure the deaneries and educational providers are responsible for local quality control, to be managed by the deaneries. The role of the Colleges in quality management remains important and will be delivered in partnership with the deaneries. The College role is one of quality review of deanery processes and this will take place within the SACs on a regular basis.

### The Organisation and Quality Assurance of PG Training



## CURRICULUM REVIEW AND UPDATING

Curriculum review will be informed by a number of different processes. For instance the SAC will be able to use information gathered from specialty heads, specialty deans and the National Health Service. It will have available to it results of the trainee survey, which will include questions pertaining to their specialty. Interaction with the NHS will be particularly important to understand the performance of specialists within the NHS and feedback will be required as to the continuing need for that specialty as defined by the curriculum. It is likely that the NHS will have a view as to the balance between generalist and specialist skills, the development of generic competencies and, looking to the future, the need for additional specialist competencies and curricula.

## EQUALITY AND DIVERSITY

In the exercise of these powers and responsibilities, the Royal Colleges of Physicians will comply, and ensure compliance, with the requirements of relevant legislation, such as the:

Race Relations (Amendment) Act 2000

Disability Discrimination Act 1995 (Amendment) 2004 and Special Educational Needs and Disabilities Act 2001

The Disability Discrimination Act 1995 (amendment) (further and higher education) Regulations 2006

Data Protection Acts 1984 and 1998

Age Discrimination Act October 2006

The Federation believes that equality of opportunity is fundamental to the many and varied ways in which individuals become involved with the Colleges, either as members of staff and Officers, as advisers from the medical profession, as members of the Colleges' professional bodies or as doctors in training and examination candidates. Accordingly, it warmly welcomes contributors and applicants from as diverse a population as possible, and actively seeks to recruit people to all its activities regardless of race, religion, ethnic origin, disability, age, gender or sexual orientation.

Deanery quality assurance will ensure that each training programme complies with the equality and diversity standards in postgraduate medical training as set by PMETB.

Compliance with anti-discriminatory practice will be assured through:

- Monitoring of recruitment processes
- Ensuring all College representatives and Programme Directors have attended appropriate training sessions prior to appointment or within 12 months of taking up post
- Ensuring trainees have an appropriate, confidential and supportive route to report examples of inappropriate behaviour of a discriminatory nature
- Monitoring of College examinations
- Ensuring all assessments discriminate on objective and appropriate criteria and do not unfairly disadvantage trainees because of gender, ethnicity, sexual orientation or disability (other than that which would make it impossible to practise safely as a physician). All efforts shall be made to ensure the participation of people with a disability in training.

## STATUTORY RESPONSIBILITIES

The Royal Colleges of Physicians will comply, and ensure compliance, with the requirements of legislation, such as the:

Human Rights Act 1998  
Freedom of Information Act 2001  
Data Protection Acts 1984 and 1998

## APPENDIX 1 ABBREVIATIONS

AHP	-	Allied health professional
APM	-	Association for Palliative Medicine of Great Britain and Ireland
BMA	-	British Medical Association
CSM	-	Committee for Safety of Medicines
DOPS	-	Directly Observed Procedural Skills
GMC	-	General Medicine Council
Mini-CEX	-	Mini Clinical Examination
NCPC	-	National Council for Palliative Care
NICE	-	National Institute of Clinical Excellence
OSCE	-	Objective, Structured Clinical Examination
PCT	-	Primary Care Trust
PMETB	-	Postgraduate Medical Education and Training Board
SPA	-	Scottish Partnership Agency for cancer and palliative care
SIGN	-	Scottish Intercollegiate Guidelines Network