

Hospice and Palliative Medicine Core Competencies
Version 2.3
September, 2009

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INTRODUCTION

Hospice and palliative medicine is comprehensive, interdisciplinary care for patients with advanced, progressive, life-threatening illnesses and their families; this model of care is referred to as palliative care. The discipline and model of care aim to help patients and their families achieve the best possible quality of life¹ throughout the course of a life-threatening illness by preventing and relieving suffering, controlling symptoms, providing psychosocial support and preserving opportunities for personal and family development.² As the field continues to develop, palliative care's potential role in the co-management of patients at all stages of disease and in the presence of restorative, curative, and life-prolonging goals is even more important to emphasize.

The domains and structures of high quality palliative care have been comprehensively described in *Clinical Practice Guidelines for Quality Palliative Care, Second Edition*.³ A competent hospice and palliative medicine specialist is equipped to provide the medical aspects of palliative care, in conjunction with the palliative care team and other healthcare providers involved in a patient and family's care, to ensure that:

- Pain and symptom control, psychosocial distress, spiritual issues and practical needs are addressed with patients and families throughout the continuum of care. If present, any conditions are treated based upon current evidence and with consideration of cultural aspects of care.
- Patients and families acquire the information they need in order to understand their condition and realistic, potential treatment options. Their values, goals, and beliefs are elicited over time, with sensitivity to relevant cultural issues. The benefits and burdens of treatment are regularly reassessed; and the decision-making process about the care plan is sensitive to changes in the patient's condition.
- Care is provided within the context of a trusting and respectful physician-patient relationship.
- Coordination of care across settings is ensured through regular and high-quality communication among providers at times of transition or changing needs, and through effective continuity of care.
- Both patient and family are prepared for the dying process and for death, when it is anticipated, insofar as they desire to be prepared. Opportunities for personal growth are supported and bereavement care is available for the family.⁴

While the majority of patients with advanced, progressive, life-threatening illness are adults, and the vast majority of palliative care fellowship training programs are focused on the needs of adult patients and their families, all palliative care specialists need to have some basic competencies in caring for children with palliative care needs.

Basic pediatric palliative care competencies are essential for all palliative care specialists because, in many settings, no pediatric palliative care specialists are available, and adult specialists will be required to provide palliative care for dying children. The level of required competency will vary by setting and location, based on the availability of other pediatric palliative care resources in the community; thus we have not specified a detailed set of pediatric palliative care competencies.

It is likely that, over time, increasing numbers of specialized pediatric palliative care fellowships will develop in response to growing demand. The specific competencies appropriate for a pediatric palliative care specialist, practicing in an exclusively pediatric environment, are not addressed in this document, although some guidance is provided by the general competencies described.

The field of palliative medicine is undergoing rapid evolution. Thus, we anticipate that these competencies will be modified as the field develops. This document, Version 2.3, is the third iteration.

1. PATIENT AND FAMILY CARE

The resident should demonstrate compassionate, appropriate, and effective care, based on the existing evidence base in palliative medicine, aimed at maximizing well being and quality of life for patients with advanced, progressive, life-threatening illnesses and their families, and provide care in collaboration with an interdisciplinary team.

- 1.1. Gathers comprehensive and accurate information from all pertinent sources, including patient, family members, health care proxies, other health care providers, interdisciplinary team members and medical records
 - 1.1.1. Obtains a comprehensive medical history and physical exam, including:
 - Patient understanding of illness and prognosis
 - Goals of care/advance care planning/proxy decision-making
 - Detailed symptom history (including use of validated scales)
 - Psychosocial and coping history including loss history
 - Spiritual history
 - Functional assessment
 - Quality of life assessment
 - Depression evaluation (including stressors and areas of major concern)
 - Pharmacologic history including substance dependency or abuse
 - Detailed neurological exam, including mental status exam
 - 1.1.2. Performs appropriate diagnostic workup; reviews primary source information and evaluation; determines prognosis and appropriate palliative course
 - 1.1.3. Utilizes information technology; accesses on-line evidence-based medicine resources; uses electronic repositories of information, and medical records
- 1.2. Synthesizes and applies information in the clinical setting
 - 1.2.1. Develops a prioritized differential diagnosis and problem list
 - 1.2.2. Develops recommendations based on patient and family values
 - 1.2.3. Routinely obtains additional clinical information (from other physicians, nurses, pharmacists, social workers, case managers, chaplains, respiratory therapists) when appropriate
- 1.3. Demonstrates use of the interdisciplinary approach to develop a care plan that optimizes patient and family goals and reduces suffering
- 1.4. Assesses and communicates prognosis

- 1.5. Assesses and manages patients with the full spectrum of advanced, progressive, life-threatening conditions, including common cancers, common non-cancer diagnoses, chronic diseases, and emergencies
- 1.6. Manages physical symptoms, psychological issues, social stressors, and spiritual dimensions of care for the patient and family
 - 1.6.1. Assesses pain and non-pain symptoms
 - 1.6.2. Uses opioid and non-opioid pharmacologic options
 - 1.6.3. Uses non-pharmacologic symptom interventions
 - 1.6.4. Manages neuropsychiatric disorders
 - 1.6.5. Manages physical symptoms and psychosocial and spiritual distress in the patient and family
 - 1.6.6. Re-assesses symptoms frequently, and makes therapeutic adjustments as needed
- 1.7. Coordinates, orchestrates, and facilitates key events in patient care, such as family meetings, consultation around goals of care, advance directive completion, conflict resolution, withdrawal of life-sustaining therapies, and palliative sedation, involving other team members as appropriate
- 1.8. Provides information and care to patients and families that reflects unique characteristics of different settings along the palliative care continuum to ensure smooth transitions across settings of care
 - 1.8.1. Performs palliative care assessment and management for the home visit, nursing home visit, inpatient hospice unit visit, outpatient clinic visit, and hospital patient visit
 - 1.8.2. Delivers timely and accurate information and addresses barriers to patient and family access to palliative care in multiple settings
 - 1.8.3. Works with families in an interdisciplinary manner to formulate appropriate discharge plans for patients and families
- 1.9. Bases care on patient's past history and patient and family preferences and goals of care, prognostic information, evidence, clinical experience and judgment
 - 1.9.1. Demonstrates a patient-family centered approach to care
 - 1.9.2. Makes recommendations to consulting physician(s) as appropriate
- 1.10. Demonstrates the ability to respond to suffering through addressing sources of medical and psychosocial/spiritual distress, bearing with the patient's and family's suffering and distress, and remaining a presence, as desired by the patient and family

- 1.11. Demonstrates care that shows respectful attention to age/developmental stage, gender, sexual orientation, culture, religion/spirituality, as well as family interactions and disability
- 1.12. Seeks to maximize patients' level of function, and quality of life for patients and families
 - 1.12.1. Evaluates functional status over time
 - 1.12.2. Evaluates quality of life over time
 - 1.12.3. Provides expertise in maximizing patient's level of function and quality of life
 - 1.12.4. Seeks to preserve opportunities for individual and family life in the context of life-threatening illness
 - 1.12.5. Recognizes the potential value to patients and their family members of completing personal affairs/unfinished business
 - 1.12.6. Manages physical symptoms and psychosocial and spiritual distress in the patient and family
- 1.13. Provides patient and family education
 - 1.13.1. Educates families in maintaining and improving level of function to maximize quality of life
 - 1.13.2. Explains palliative care services, recommendations, and latest developments to patients and families
 - 1.13.3. Educates patient and family about disease trajectory, and how and when to access palliation in future
- 1.14. Recognizes signs and symptoms of impending death and cares for the imminently dying patient and their family members
 - 1.14.1. Prepares family, other health care professionals, and caregivers for the patient's death
 - 1.14.2. Provides assessment and symptom management for the imminently dying patient
- 1.15. Provides treatment to the bereaved
 - 1.15.1. Provides support to family members at the time of death and immediately after
 - 1.15.2. Involves interdisciplinary team members in treating the bereaved
 - 1.15.3. Refers family members to bereavement programs
- 1.16. Refers patients and family members to other health care professionals to assess, treat and manage patient and family care issues outside the scope of palliative care practice, and collaborates with them
 - 1.16.1. Recognizes the need for collaboration with clinicians providing disease-modifying treatment

- 1.16.2. Collaborates with and makes referrals to pediatricians with expertise relevant to the care of children with advanced, progressive, and life-threatening illness
- 1.16.3. Accesses specialized pediatric and geriatric palliative care resources
- 1.16.4. Collaborates with other mental health clinicians to meet the needs of patients with major mental health issues

2. MEDICAL KNOWLEDGE

The resident should demonstrate knowledge about established and evolving biomedical, clinical, population science, and social-behavioral sciences relevant to the care of patients with life-threatening illnesses and to their families, and relate this knowledge to hospice and palliative care practice.

- 2.1. Describes the scope and practice of hospice and palliative medicine, including:
 - Domains of hospice and palliative care
 - Role of palliative care in co-management of patients with potentially life-limiting illness at all stages of disease and in the presence of restorative, curative, and life-prolonging goals
 - History of hospice and palliative medicine
 - Settings where hospice and palliative care are provided
 - Elements of patient assessment and management across different hospice and palliative care settings, including home, nursing home, inpatient hospice unit, outpatient clinic, and hospital
 - The Medicare/Medicaid Hospice Benefit, including essential elements of the program, eligibility, and key regulations for all levels of hospice care
 - Barriers faced by patients and families in accessing hospice and palliative care services
- 2.2. Recognizes the role of the interdisciplinary team in hospice and palliative care
 - 2.2.1. Describes the role of the palliative care physician in the interdisciplinary team
 - 2.2.2. Identifies the various members of the interdisciplinary team and their roles and responsibilities
 - 2.2.3. Recognizes how and when to collaborate with other allied health professionals, such as nutritionists, physical therapists, respiratory therapists, occupational therapists, speech therapists, and case managers
 - 2.2.4. Describes concepts of team process, and recognizes psychosocial and organizational elements that promote or hinder successful interdisciplinary team function

- 2.3. Describes how to assess and communicate prognosis
 - 2.3.1. Identifies what elements of the patient's history and physical examination are critical to formulating prognosis for a given patient
 - 2.3.2. Describes common chronic illnesses with prognostic factors, expected natural course and trajectories, common treatments, and complications
 - 2.3.3. Describes effective strategies to communicate prognostic information to patients, families, and health care providers
- 2.4. Recognizes the presentation and management of common cancers, including their epidemiology, evaluation, prognosis, treatment, patterns of advanced or metastatic disease, emergencies, complications, associated symptoms, and symptomatic treatments
 - 2.4.1. Identifies common diagnostic and treatment methods in the initial evaluation and ongoing management of cancer
 - 2.4.2. Identifies common elements in prognostication for solid tumors and hematological malignancies at various stages, including the natural history of untreated cancers
 - 2.4.3. Describes patterns of advanced disease, associated symptoms, and symptomatic treatments for common cancers
 - 2.4.4. Describes the presentation and management of common complications of malignancy and emergencies in the palliative care setting
- 2.5. Recognizes the presentation and management of common non-cancer life-threatening conditions, including their epidemiology, evaluation, prognosis, treatment, patterns of disease progression, complications, emergencies, associated symptoms, and symptomatic treatments
 - 2.5.1. Identifies markers of advanced disease in common non-cancer life-threatening conditions, such as congestive heart failure, chronic obstructive pulmonary disease, and dementia
 - 2.5.2. Describes patterns of advanced disease, associated symptoms, and symptomatic treatments for common non-cancer life-threatening conditions
 - 2.5.3. Describes the presentation and management of common complications of non-cancer life-threatening conditions and emergencies
- 2.6. Explains principles of assessing pain and other common non-pain symptoms
 - 2.6.1. Describes the concept of "total pain"
 - 2.6.2. Explains the relevant basic science, pathophysiology, associated symptoms and signs, and diagnostic options useful in differentiating among different etiologies of pain and non-pain symptoms

- 2.6.3. Describes a thorough assessment and functional status of pain and other symptoms, including the use of diagnostic methods and symptom measurement tools
- 2.6.4. Names common patient, family, health care professional, and health care system barriers to the effective treatment of symptoms
- 2.7. Describes the use of opioids in pain and non-pain symptom management
 - 2.7.1. Lists the indications, clinical pharmacology, alternate routes, equianalgesic conversions, appropriate titration, toxicities, and management of common side effects for opioids
 - 2.7.2. Describes opioid prescribing, monitoring of treatment outcomes, and toxicity management in chronic, urgent and emergency pain conditions
 - 2.7.3. Describes opioid prescribing in different clinical care settings: home, residential hospice, hospital, long-term care facility
 - 2.7.4. Describes the concepts of addiction, pseudoaddiction, dependence and tolerance, and describes their significance in pain management, as well as approaches to managing pain in patients with current or prior substance abuse
 - 2.7.5. Explains the legal and regulatory issues surrounding opioid prescribing
- 2.8. Describes the use of non-opioid analgesics, adjuvant analgesics, and other pharmacologic approaches to the management of both pain and non-pain symptoms
 - 2.8.1. Identifies the indications, clinical pharmacology, alternate routes, appropriate titration, toxicities, and management of common side effects for: acetaminophen, aspirin, NSAIDs, corticosteroids, anticonvulsants, anti-depressants, and local anesthetics used in the treatment of pain and non-pain symptoms
- 2.9. Describes pharmacologic approaches to the management of common non-pain symptoms
 - 2.9.1. Describes use of common agents used to treat dyspnea, nausea, vomiting, diarrhea, constipation, anxiety, depression, fatigue, pruritus, confusion, agitation, and other common problems in palliative care practice
 - 2.9.2. Identifies the indications, clinical pharmacology, alternate routes, appropriate titration, toxicities, and management of common side effects for: opioids, anxiolytics, antiemetics, laxatives, psychostimulants, corticosteroids, antidepressants, antihistamines, neuroleptics, sedatives and other common agents used in palliative care practice

- 2.10. Describes the use of non-pharmacologic approaches to the management of pain and non-pain symptoms
 - 2.10.1. Identifies indications, toxicities, and appropriate referral for interventional pain management procedures, as well as surgical procedures commonly used for pain and non-pain symptom management
 - 2.10.2. Identifies indications, toxicities, management of common side effects, and appropriate referral for radiation therapy
 - 2.10.3. Identifies indications, toxicities, and appropriate referral for commonly used complementary and alternative therapies
 - 2.10.4. Explains the role of allied health professions in pain and non-pain symptom management
- 2.11. Describes the etiology, pathophysiology, diagnosis, and management of common neuropsychiatric disorders encountered in palliative care practice, such as depression, delirium, seizures, and brain injury
 - 2.11.1. Recognizes how to evaluate, and treat common neuropsychiatric disorders
 - 2.11.2. Describes how to refer to neurological and mental health professionals
 - 2.11.3. Describes the indications, contraindications, pharmacology, appropriate prescribing practice, and side-effects of common psychiatric medications
 - 2.11.4. Recognizes the diagnostic criteria and management issues of brain death, persistent vegetative state, and minimally conscious state
- 2.12. Recognizes common psychological stressors and disorders experienced by patients and families facing life-threatening conditions, and describes elements of clinical assessment and management
 - 2.12.1. Recognizes psychological distress
 - 2.12.2. Describes concepts of coping styles, psychological defenses, and developmental stages relevant to the evaluation and management of psychological distress
 - 2.12.3. Describes how to provide basic supportive counseling and to strengthen coping skills
 - 2.12.4. Recognizes the needs of minor children when an adult parent or close relative is seriously ill or dying, and provides appropriate basic counseling or referral
 - 2.12.5. Recognizes the needs of parents and siblings of children who are seriously ill or dying and provides appropriate basic counseling or referral

- 2.12.6. Explains appropriate utilization of consultation with specialists in psychosocial assessment and management
- 2.13. Recognizes common social problems experienced by patients and families facing life-threatening conditions and describes elements of clinical assessment and management
 - 2.13.1. Able to assess, counsel, support, and make referrals to alleviate the burden of caregiving
 - 2.13.2. Able to assess, provide support, and make referrals around fiscal issues, insurance coverage, and legal concerns
- 2.14. Recognizes common experiences of distress around spiritual, religious, and existential issues for patients and families facing life-threatening conditions, and describes elements of clinical assessment and management
 - 2.14.1. Describes the role of hope, despair, meaning, and transcendence, in the context of severe and chronic illness
 - 2.14.2. Describes how to perform a basic spiritual/existential/religious evaluation
 - 2.14.3. Describes how to provide basic spiritual counseling
 - 2.14.4. Identifies the indications for referral to chaplaincy or other spiritual counselors and resources
 - 2.14.5. Knows the developmental processes, tasks, and variations of life completion and life closure
 - 2.14.6. Describes processes for facilitating growth and development in the context of advanced illness
- 2.15. Able to recognize, evaluate, and support diverse cultural values and customs with regard to information sharing, decision making, expression and treatment of physical and emotional distress, and preferences for sites of care and death
 - 2.15.1. Recognizes major contributions from non-medical disciplines, such as sociology, anthropology, and health psychology, in understanding and managing the patient's and family's experience of serious and life-threatening illness
- 2.16. Recognizes the components of management for the syndrome of imminent death
 - 2.16.1. Identifies common symptoms, signs, complications and variations in the normal dying process and describes their management
 - 2.16.2. Describes strategies to communicate with patient and family about the dying process and to provide support
- 2.17. Recognizes the elements of appropriate care of the patient and family at the time of death and immediately thereafter
 - 2.17.1. Describes appropriate and sensitive pronouncement of death

- 2.17.2. Identifies the standard procedural components and psychosocial elements of post-death care
- 2.17.3. Recognizes the potential importance and existence of post-death rituals and describes how to facilitate them
- 2.18. Describes the basic science, epidemiology, clinical features, natural course, stages, and management options for normal and pathologic grief
 - 2.18.1. Demonstrates knowledge of normal grief and elements of bereavement follow-up, including assessment, treatment, and referral options for bereaved family members
 - 2.18.2. Recognizes the risk factors, diagnostic features, epidemiology, and management of depression and prolonged grief disorder
 - 2.18.3. Appreciates risk of suicide in the bereaved and carries out initial assessment for suicide risk
- 2.19. Describes common issues in the palliative care management of pediatric and geriatric patients and their families, that differ from caring for adult patients, in regard to physiology, vulnerabilities, and developmental stages
 - 2.19.1. Describes the epidemiology of pediatric life-threatening conditions
 - 2.19.2. Appreciates developmental perspectives on illness, grief, and loss
 - 2.19.3. Describes pharmacologic principles applicable to the management of symptoms in infants, children, adolescents, and geriatric patients
- 2.20. Describes ethical and legal issues in palliative care and their clinical management
 - 2.20.1. Discusses ethical principles and frameworks for addressing clinical issues
 - 2.20.2. Describes federal, state, and local laws and practices that impact on palliative care practice
 - 2.20.3. Consults clinical ethicist when necessary
 - 2.20.4. Describes professional and institutional ethical policies relevant to palliative care practice

3. PRACTICE-BASED LEARNING AND IMPROVEMENT

The resident should be able to investigate, evaluate, and improve their practices in caring for patients and families, and appraise and assimilate scientific evidence relevant to palliative care.

- 3.1. Maintains safe and competent practice, including self-evaluation and continuous learning
 - 3.1.1. Demonstrates an ability to self-reflect on personal learning deficiencies and develop a plan for improvement

- 3.1.2. Demonstrates knowledge of and commitment to continuing professional development and life-long learning
- 3.1.3. Demonstrates knowledge of the roles and responsibilities of the trainee/mentor
- 3.1.4. Demonstrates the ability to reflect on his/her personal learning style and use different opportunities for learning
- 3.1.5. Demonstrates the ability to actively seek and utilize feedback
- 3.1.6. Demonstrates the ability to develop an effective learning relationship with members of the faculty and other professionals
- 3.2. Accesses, analyzes, and applies the evidence base to clinical practice in palliative care
 - 3.2.1. Demonstrates knowledge of, and recognizes limitations of, evidence-based medicine in palliative care
 - 3.2.2. Actively seeks to apply the best available evidence to patient care to facilitate safe, up-to-date clinical practice, and encourages others to do so
- 3.3. Develops competencies as an educator
 - 3.3.1. Recognizes the importance of assessing learning needs in initiating a teaching encounter
 - 3.3.2. Describes the importance of defining learning goals and objectives as a basis for developing educational sessions
 - 3.3.3. Reflects on benefits and drawbacks of alternative approaches to teaching, and the role of different teaching techniques to address knowledge, attitudes, and skills
 - 3.3.4. Demonstrates the ability to supervise clinical trainees (e.g., medical students, residents, and other health care professionals) and give constructive feedback
 - 3.3.5. Shows respect towards learners
- 3.4. Demonstrates knowledge of the process and opportunities for research in palliative care
 - 3.4.1. Recognizes and values the importance of addressing ethical issues in palliative care research
 - 3.4.2. Is realistic about the benefits and challenges of palliative care research and supports research as appropriate to the setting
 - 3.4.3. Recognizes and values the use of data to demonstrate clinical, utilization, and financial outcomes of palliative care
- 3.5. Describes common approaches to quality and safety assurance
 - 3.5.1. Demonstrates an openness and willingness to evaluate and participate in practice and service improvement

- 3.5.2. Demonstrates knowledge of palliative care's clinical, financial, and quality-of-care outcome measures
- 3.5.3. Demonstrates awareness of and adherence to patient safety standards

4. INTERPERSONAL AND COMMUNICATION SKILLS

The resident should be able to demonstrate interpersonal and communication skills that result in effective relationship-building, information exchange, emotional support, shared decision-making and teaming with patients, their patients' families, and professional associates.

- 4.1. Initiates informed relationship-centered dialogues about care
 - 4.1.1. Assesses patient/family wishes regarding the amount of information they wish to receive and the extent to which they want to participate in clinical decision-making
 - 4.1.2. Determines, in collaboration with patient/family, the appropriate participants in discussions concerning a patient's care
 - 4.1.3. Assesses patient's and family members' decision-making capacity, and other strengths and limitations of understanding and communication
 - 4.1.4. Enlists legal surrogates to speak on behalf of a patient when making decisions for a patient without decision-making capacity
 - 4.1.5. Recognizes differences between relationship-centered dialogues in adult and pediatric palliative care based on physiology, vulnerabilities, and developmental stages
- 4.2. Demonstrates empathy
 - 4.2.1. Uses empathic and facilitating verbal behaviors such as: naming, affirmation, normalization, reflection, silence, listening, self-disclosure, and humor in an effective and appropriate manner
 - 4.2.2. Employs empathic and facilitating non-verbal behaviors such as: touch, eye contact, open posture, and eye-level approach in an effective and appropriate manner
- 4.3. Demonstrates ability to recognize and respond to own emotions and those of others
 - 4.3.1. Expresses awareness of own emotional state before, during, and after patient and family encounters
 - 4.3.2. Reflects on own emotions after patient and family encounter or related event
 - 4.3.3. Processes own emotions in a clinical setting in order to focus on the needs of the patient and family

- 4.3.4. Responds to requests to participate in spiritual or religious activities and rituals, in a manner that preserves respect for both the patient and family, as well as one's own integrity, and personal and professional boundaries
- 4.3.5. Self-corrects communication miscues
- 4.3.6. Responds effectively to intense emotions of patients, families and colleagues
- 4.4. Demonstrates the ability to educate patients/families about the medical, social and psychological issues associated with life-limiting illness
 - 4.4.1. Demonstrates self-awareness and ability to recognize differences between the clinician's own and the patient and family's values, attitudes, assumptions, hopes and fears related to illness, dying, and grief
 - 4.4.2. Recognizes the importance of serving as an educator for patient/family
 - 4.4.3. Identifies gaps in knowledge for patients/families
 - 4.4.4. Communicates new knowledge to patients/families, adjusting language and complexity of concepts, based on the patient/family's level of sophistication, understanding, and values, as well as on developmental stage of patient
 - 4.4.5. Educates patients/families about normal developmental processes, completion of practical affairs and relationships, achievement of a satisfactory sense of life completion and closure, and for the possibilities for growth and healing at the end-of-life
 - 4.4.6. Recognizes the importance of ambivalence about care and uses appropriate strategies to address it
 - 4.4.7. Identifies patients/families who may benefit from a language translation service or interpreter
 - 4.4.8. Educates legal surrogates in preparation for role as medical decision-makers
- 4.5. Uses age, gender, and culturally-appropriate concepts and language when communicating with families and patients
 - 4.5.1. Routinely assesses patients/families to identify individuals who might benefit from age, gender, and culturally-appropriate interventions or support
 - 4.5.2. Shows sensitivity to developmental stages and processes in approaching patients/families
 - 4.5.3. Appreciates the need to adjust communication strategies to honor different cultural beliefs

- 4.6. Demonstrates the above skills in the following paradigmatic situations with patients or families and documents an informative, sensitive note in the medical record:
- Giving bad news
 - Discussing transitions in goals of care from a curative and/or life prolonging focus to palliative care
 - Dealing with family members who want to protect the patient from distressing information
 - Discussing patient wishes for inappropriate or “futile” care at the end-of-life
 - Addressing patient/family emotional distress about talking about death and dying, and end-of-life issues
 - Introducing option of palliative care consultation
 - Discussing goals of care including advance care planning and resuscitation status
 - Discussing appropriate care settings
 - Discussing the end-of-life care needs of a dying child with parents
 - Discussing the needs of minor children of dying adults
 - Withholding or withdrawing of any life-sustaining therapy
 - Continuing life-sustaining therapy with focus on palliation
 - Discussing enrollment into hospice
 - Dealing with requests for physician aid in dying
 - Discussing palliative sedation
 - Discussing artificial hydration and nutrition
 - Discussing severe spiritual or existential suffering
 - Referring to tasks of life review, completion of personal affairs, including relationships and sexuality, and social and spiritual aspects of life completion and closure
 - Saying good-bye to patients or families
 - Pronouncing death in presence of patient’s family
 - Writing condolence notes and making bereavement calls
- 4.7. Organizes and leads or co-facilitates a family meeting
- 4.7.1. Identifies when a family meeting is needed
 - 4.7.2. Identifies appropriate goals for a family meeting
 - 4.7.3. Demonstrates a step-wise approach in leading a family meeting

- 4.7.4. Demonstrates techniques for mediating intra-family or family-health care team conflict
- 4.7.5. Documents the course and outcome of a family meeting in the medical record
- 4.8. Collaborates effectively with others as member or leader of an interdisciplinary team (IDT)
 - 4.8.1. Facilitates efficient team meetings
 - 4.8.2. Accepts and solicits insights from IDT members regarding patient and family needs in developing the patient's plan of care
 - 4.8.3. Manages and recognizes the need for conflict resolution in IDT meetings
 - 4.8.4. Provides constructive feedback to IDT members
 - 4.8.5. Accepts feedback from IDT members
- 4.9. Develops effective relationships with referring physicians, consultant physicians, and other health care providers
 - 4.9.1. Provides a concise verbal history and physical exam presentation for a new palliative care patient
 - 4.9.2. Summarizes the active palliative care issues and treatment recommendations for a known patient in signing out to or updating a colleague
 - 4.9.3. Communicates with referring and consultant clinicians about the care plan/recommendations for the patient and family
 - 4.9.4. Communicates with health care providers when there is disagreement about treatment plans
 - 4.9.5. Works toward consensus building about treatment plans and goals of care
 - 4.9.6. Supports and empowers colleagues to lead and participate in family meetings
 - 4.9.7. Elicits concerns from and provides emotional support and education to staff around difficult decisions and care scenarios
- 4.10. Maintains comprehensive, timely, and legible medical records
 - 4.10.1. Documents legible notes in the medical record in a timeframe consistent with individual program and institutional requirements and regulatory agencies
 - 4.10.2. Adapts documentation to different medical record formats available or required in different settings
 - 4.10.3. Addresses the major domains of palliative care, (as per the National Consensus Project) as appropriate, in the initial history and physical exam

- 4.10.4. Consistently includes all relevant domains of palliative care (as per the National Consensus Project) in progress notes and follow-up documentation
- 4.10.5. Documents death pronouncement in the medical record and completes death certificate in a correct and timely

5. PROFESSIONALISM

The resident should be able to demonstrate a commitment to carrying out professional responsibilities, awareness of their role in reducing suffering and enhancing quality of life, adherence to ethical principles, sensitivity to a diverse patient population, and appropriate self-reflection.

- 5.1. Achieves balance between needs of patients/family/team, while balancing one's own need for self-care
 - 5.1.1. Recognizes the signs of fatigue, burnout, and personal distress, and makes adjustments to deal with it
 - 5.1.2. Describes effective strategies for self-care, including balance, emotional support, and dealing with burn-out and personal loss
 - 5.1.3. Contributes to team wellness
 - 5.1.4. Explains how to set appropriate boundaries with colleagues and with patients and families
- 5.2. Recognizes own role and the role of the system in disclosure and prevention of medical error
 - 5.2.1. Assesses personal behavior and accepts responsibility for errors when appropriate
 - 5.2.2. Discloses medical errors in accord with institutional policies and professional ethics
- 5.3. Demonstrates accountability to patients, society, and the profession; and a commitment to excellence
- 5.4. Describes role of hospice medical director in terms of quality of care, compliance, and communication with other professionals
- 5.5. Fulfills professional commitments
 - 5.5.1. Responds in a timely manner to requests from patients and families for medical information
 - 5.5.2. Responds to requests for help from colleagues
 - 5.5.3. Demonstrates accountability for personal actions and plans
 - 5.5.4. Fulfills professional responsibilities and works effectively as a team member

- 5.5.5. Addresses concerns about quality of care and impaired performance among colleagues
- 5.5.6. Treats co-workers with respect, dignity, and compassion
- 5.6. Demonstrates knowledge of ethics and law that should guide care of patients, including special considerations around these issues in pediatric, adult, and geriatric palliative care, including:
 - Informed consent
 - Confidentiality
 - Decision-making capacity
 - Decision-making for children and adolescents, and older patients with dementia
 - Limits of surrogate decision-making
 - Truth-telling
 - Foregoing life-sustaining treatment
 - Medical futility
 - Use of artificial hydration and nutrition
 - Physician-assisted suicide
 - Euthanasia
 - Principle of double effect
 - Organ donation
 - Research ethics
 - Nurse-physician collaboration
 - Indications for referring to an ethics consultant
 - Conflicts of interest
- 5.7. Demonstrates respect and compassion towards all patients and their families, as well as towards other clinicians
 - 5.7.1. Demonstrates willingness and ability to identify own assumptions; individual and cultural values; hopes and fears related to life-limiting illness and injury, disability, dying, death and grief
 - 5.7.2. Displays sensitivity to issues surrounding age, ethnicity, sexual orientation, culture, spirituality and religion, and disability
 - 5.7.3. Communicates the mission of palliative care to hospital administrators, clinicians, and community at large

- 5.8. Demonstrates the capacity to reflect on personal attitudes, values, strengths, vulnerabilities, and experiences to optimize personal wellness and capacity to meet the needs of patients and families

6. SYSTEMS-BASED PRACTICE

The resident should be able to demonstrate an awareness of and responsiveness to the larger context and system of health care, including hospice and other community-based services for patients, including children and families, and the ability to effectively call on system resources to provide high-quality care.

- 6.1. Demonstrates care that is cost-effective and represents best practices
 - 6.1.1. Recognizes relative costs of medications and other therapeutics/interventions
 - 6.1.2. Implements best evidence based practices for common palliative medicine clinical scenarios across settings
 - 6.1.3. Explains the rationale for the use of medication formularies
 - 6.1.4. Identifies similarities and differences between reimbursements for palliative medicine, hospice, hospital, home health, and long term care
 - 6.1.5. Describes basic concepts and patterns of physician billing, coding and reimbursement across settings
- 6.2. Evaluates and implements systems improvement based on clinical practice or patient and family satisfaction data; in personal practice, team practice, and within institutional settings
 - 6.2.1. Reviews pertinent clinical or patient/family satisfaction data about personal, team, or institutional practice patterns
- 6.3. Integrates knowledge of health care system in developing plan of care
 - 6.3.1. Describes policies and procedures of pertinent health care systems
 - 6.3.2. Describes philosophy, admissions criteria, range of services, and structure of hospice care
 - 6.3.3. Recognizes resources and barriers relevant to the care of specialized populations in hospice and palliative medicine, and has basic knowledge of how to mobilize appropriate support for these populations (e.g. pediatric patients, HIV patients, etc.)
- 6.4. Demonstrates knowledge of the various settings and related structures for organizing, regulating, and financing care for patients at the end-of-life
 - 6.4.1. Describes differences in admission criteria for various settings such as hospitals, palliative care units, skilled-nursing and assisted-living facilities, acute/sub-acute rehab facilities, and long-term acute care settings as well as traditional home hospice

- 6.5. Collaborates with all elements of the palliative care continuum, including hospitals, palliative care units, nursing homes, home and inpatient hospice, and other community resources
 - 6.5.1. Utilizes members of interdisciplinary team to create smooth and efficient transitions across health care settings for patients and families
 - 6.5.2. Communicates with care managers/appropriate staff across sites to enable seamless transitions between settings
 - 6.5.3. Communicates with clinicians at time of care transitions to clarify and coordinate care plan across settings
- 6.6. Advocates for quality patient and family care, and assists patients and families in dealing with system complexities
 - 6.6.1. Communicates and supports patient and family decision-making about discharge planning – including settings of care, service options, and reimbursement/payer systems
 - 6.6.2. Coordinates and facilitates dialogue between patients/families and service provider representatives (e.g. hospice liaison nurses, nursing home administrators; and inter-hospital departments including but not limited to ICU, intermediate care, emergency department)
- 6.7. Partners with health care managers and health care providers to assess, coordinate, and improve patient safety and health care; and understands how these activities can affect system performance
 - 6.7.1. Describes hospital and palliative care program continuous quality improvement programs, and their goals and processes
 - 6.7.2. Demonstrates ability to work with managers of varying disciplines to improve patient safety and system-based factors that affect care delivery

¹The term family is used broadly to encompass all those persons of importance to the patient, as defined by the patient.

² National Hospice Organization Standards and Accreditation Committee. (1997). *A pathway for patients and families facing terminal disease*. Arlington, VA: National Hospice Organization

³ National Consensus Project for Quality Palliative Care (2009). *Clinical practice guidelines for quality palliative care, second edition*. <http://www.nationalconsensusproject.org>

⁴ *Clinical practice guidelines for quality palliative care, second edition*. pp. 5-6.