



ROYAL COLLEGE OF
PHYSICIANS OF IRELAND

HIGHER SPECIALIST TRAINING IN PALLIATIVE MEDICINE



This curriculum is currently under review and the new curriculum will be available shortly.

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PALLIATIVE MEDICINE

ENTRY REQUIREMENTS:

Applicants for Higher Medical Training (HMT) should have completed a minimum of two years General Professional Training (GPT) in approved posts and obtained the MRCP(I) / (UK) or should have completed a general practitioner vocational training scheme leading to MICGP or MRCGP. A period of experience in Palliative Medicine at SHO grade is considered desirable, although not essential, before entry to HMT. GPT should provide a minimum of 24 months involved in direct patient care, at least twelve months of which should be concerned with acute unselected medical intake. Graduates of non-Irish/UK medical schools without the MRCP(I)/(UK), or MICGP/MRCGP who compete for HMT posts must provide evidence of knowledge, training and qualifications equivalent to MRCP(I)/(UK) or MICGP/MRCGP standard.

DURATION AND ORGANISATION OF TRAINING:

The duration of HMT in Palliative Medicine is four years. The programmes will be flexible and designed to give opportunity for experience of the various settings in which palliative medicine is practised, i.e. in specialist palliative care units, teaching hospitals or other major centres with academic activity, regional/general hospitals and community based settings. Where individuals lack experience of medical oncology or other relevant disciplines, arrangements should be made to remedy this via rotations and secondments.

It is essential that a period of three years full time is spent in specialist palliative care units or teams where a full range of services are provided in different settings. One year of training may be spent in posts in general medicine or other relevant specialities e.g. medical oncology, radiation oncology, infectious diseases, haematology, geriatric medicine, pain management or general practice, provided such posts are approved for higher medical training.

The programme to which trainees are appointed will have named consultant trainers for each slot in the programme. The ICHMT will appoint a national co-ordinator for training within each speciality (National Specialty Director for Palliative Medicine).

RESEARCH, ACADEMIC AND OUT-OF-PROGRAMME APPOINTMENTS

Research experience is encouraged and supported and can count for up to a year of HMT. Ideally, it should be relevant to Palliative Medicine and undertaken in a department where the trainee has some clinical commitment. It will remain essential to acquire the full balance of clinical training. Trainees wishing to spend a period in excess of one year in research during their HMT training may do so by stepping aside from their clinical training programme. This is perfectly acceptable but no more than twelve months educational credit will accrue.

ASSESSMENT AND TRAINING RECORDS

Assessment for trainees will be based upon a quarterly review with the local consultant trainer and an annual appraisal by the National Specialist Director in Palliative Medicine. The recommendation of the National Specialist Director in Palliative Medicine and the Consultant Trainers will be submitted to the ICHMT which, through the Royal College of Physicians of Ireland retains the final responsibility for advising the Medical Council on Satisfactory Completion of Specialist Training.

A written record of training will be maintained by the trainee to be counter signed by the relevant trainer quarterly. The record will remain the property of the trainee and must be produced at annual assessment and for the final ICHMT decision on certification. At least one of the annual reviews, usually at the end of the penultimate year, will involve external assessment. It will be the responsibility of the assessment panel to indicate where specific deficiencies in the trainees experience exist. If required, remedial action will be recommended. Under these circumstances, the recommendation to issue a Certificate of satisfactory completion of specialist training will be withheld until the assessors are happy that the remedial action has been undertaken.

Objectives Of Higher Training In Palliative Medicine:

The objective of a training programme in Palliative Medicine is to equip individuals to carry the responsibility of a consultant working full time in a specialist palliative care service, with responsibility for substantial numbers of patients with active, progressive and far-advanced disease. The responsibilities include:

- (a) Initial assessment of diagnosis, symptoms and their cause, especially any new symptoms, and treatment of patients with late or end stage disease, particularly malignant disease.
- (b) Regular assessment of the degree to which control of pain and other symptoms has been achieved.
- (c) Mobilising the assistance of specialists in other disciplines for further measures such as interventional therapy, radiotherapy, surgery, chemotherapy and specialised investigations.
- (d) Co-ordinating not only the specialist medical services, but also other professionals, e.g. nurses, social work colleagues, physiotherapists, speech therapists, within an institutional setting, and together with the GP in the patient's own home.
- (e) With other professionals (as in (d) above) working with families as well as patients in the prevention of bereavement morbidity.
- (f) When asked, advising clinical colleagues within hospital or in the community about treatment and management approaches and possibilities for specific patients.

CURRICULUM SUMMARY

Demonstrable competencies at appropriate level will be expected in the following fields:

- (a) Assessment and consulting skills in the context of late or terminal illness due to a variety of causes. This will involve knowledge of: a wide spectrum of illness and diseases (particularly malignant disease) characterised by multiple symptoms; prognosis, options for management and treatment including treatment in various settings; the role of the multi-professional team in the care and support of patients and their families.
- (b) Detailed appreciation of patients' problems at the end of life, including spiritual pain, and knowledge of symptom control including non-drug approaches, the place of intervention procedures, which may be surgical, anaesthetic, radiotherapeutic, etc., and complementary therapies, the management of common emergencies in late stage disease.
- (c) Appreciation of the scope and limitations of rehabilitation.
- (d) The pharmacology of drugs commonly used in symptom control in terminal illness.
- (e) The science and art of the palliative approach including the use of appropriate measurements such as quality of life indices in treatment evaluation.
- (f) The principles of good communication and how these can be taught in the context of direct patient care and how used to support and enable teamwork.
- (g) Understanding of the processes of bereavement, grief and loss; effects of disease on body image and sexuality, psychological problems faced by patients and their families, the role of colleagues in psychiatry and psychology – normal and abnormal grief reactions.
- (h) Knowledge of the possibilities and limitations of care in the community for these patients including awareness of the various statutory and voluntary organisations involved.
- (i) Understanding of general management issues and responsibilities, which are part of the duties of Consultants including personnel and contract issues, relationship between the Department of Health, Health Board/Authorities and Voluntary Bodies.
- (j) Ability to undertake clinical audit and to take the appropriate actions arising from the audit exercise.
- (k) Ability to contribute to professional education. This is likely to be for the benefit of undergraduates, postgraduates and other health care personnel in specialist and non specialist fields who are working with patients with late stage disease.

CURRICULUM DETAILS:

A. Physical Aspects

1. Disease Process

The doctor should:

- Know the meaning of "terminal illness" and of "palliative medicine".
- Be aware that cancer may be curable and does not always mean a terminal illness.
- Understand that the principles of palliative medicine are also applicable to people with a wide variety of life threatening illnesses.
- Understand the concept of clinical re-evaluation as the disease progresses.
- Be able to anticipate likely potential problems, caused either by the disease or by treatments.
- Have skills in diagnosis and management of common concurrent conditions.
- Know the benefits of shared care between palliative medicine and other specialities, notably medical oncology and radiation oncology.
- Know the natural history, markers of progression and range of treatments available at each stage for active, progressive and far-advanced diseases.

2. Symptom Control:

The doctor should know that symptoms may be:

- Caused by the disease itself.
- Caused by treatment.
- Related to the disease or associated debility.
- Caused by a concurrent disorder.

3. Common Emergencies & Complications in Practice

The doctor should:

- Be able to manage each symptom appropriately.
- Understand the place of palliative surgery, radiotherapy, chemotherapy and hormone therapy.

Specific symptoms to be considered are:

- Pain
- Taking a pain history, including the use of pain charts and pain scores.
- Diagnosis of different types of pain including the differentiation between nociceptive and neuropathic pain.
- Factors influencing pain (physical, psychological, social, spiritual).
- Sore mouth
- Candidiasis
- Mouth care
- Anorexia

- Nausea and vomiting
- Constipation
- Diarrhoea
- Intestinal obstruction
- Dysphagia
- Pruritus
 - Jaundice
- Dyspnoea
 - Cough
 - Hiccups
- Anxiety and fear
 - Depression
 - Acute confusional states (delirium)
- Weakness and lethargy
- Sexual problems
 - Incontinence
 - Bladder and rectal spasms
- Smell
- Lymphoedema

The doctor should be able to manage common emergencies in Palliative Medicine:

- Hypercalcaemia
- Spinal cord compression
- Superior vena caval obstruction
- Massive haemorrhage
- Fitting
- Severe agitated confusion

The doctor should be able to manage:

- Fungating lesions, including choice of dressings.
- Pressure area care.
- Stoma care.
- Raised intracranial pressure.
- Restlessness in the last days of life.
- Fistulae.
- Malignant effusions.
- Iatrogenic disease.

4. Additional Experience

The doctor should be able to:

- Recognise the limits of attainable symptom control.
- Give permission to other carers to fail in their attempts to achieve complete symptom control.

The doctor should demonstrate skills in the appropriate use of:

- Aids to daily living.
- Indwelling epidural catheters.
- Local anaesthetic and corticosteroid injections.

The doctor should demonstrate an understanding of the role of complementary therapies.

5. Pharmacology

The doctor should know:

- The classification of analgesics (as defined by the World Health Organisation) and their use.
- Which drugs are commonly used for the control of symptoms, usual frequency of administration, typical doses and common adverse effects.
- The various routes for drug administration and when each is appropriate.
- The indications for a syringe driver.
- The compatibility and miscibility of drugs used in syringe drivers.
- How to set up a syringe driver.
- The effects of renal and liver failure on drugs commonly used in palliative medicine.
- The importance of the pharmacokinetics of drugs used to control symptoms.
- How to weigh up benefits and risks of different drugs for symptom control, being aware that these may change as a patient's condition deteriorates.
- The equivalent doses of different opioids.
- Be able to recognise the less common adverse effects of drugs used in palliative care.

B. PSYCHOSOCIAL ASPECTS

1. Family and social background

The doctor should:

- Be able to assess the differing perceptions and expectations of disease and treatment among the various family members.
- Be able to draw up a family tree (genogram) and understand its uses.
- Understand the importance of meeting with the family.
- Be aware of the psychodynamics of interpersonal relationships and the changes which can occur in illness.

2. Communications skills

The doctor should demonstrate skills in:

- Listening.
- Assessing the patient's knowledge of the diagnosis and prognosis.
- Giving information about the diagnosis and/or deterioration sensitively to both patient and family ('breaking bad news').
- Imparting an appropriate amount of information to a patient at appropriate times.
- Dealing with 'difficult questions'.
- Eliciting and responding to the fears of patients and their family.
- Empowering the patient to exercise autonomy.

3. Psychological responses

The doctor should:

- Understand responses to loss and that these manifest normally at various times and are a form of grief.
- Understand the importance of hope; and that this may have other goals other than cure.
- Be aware of the special needs of children and other vulnerable groups, including those with learning difficulties.
- Recognise and handle appropriately the normal responses to bad news and loss, including:
 - Anger
 - Guilt
 - Collusion and conspiracy of silence
 - Denial
 - The unrestrained expression of grief.

The doctor should have insight into:

- Transference
- Personal limitations
- Specialist limitations

4. Sexuality

The doctor should understand:

- The patient's perception of his/her sexuality, including body image, and the effect of disease on this.
- The need for privacy to allow the patient and family to express affection.
- How alterations in libido affect the relationship between patient and partner.

5. Grief

The doctor should know the common pattern of responses to bereavement.

The doctor should be able to:

- Support a bereaved person.
- Help prepare the family for bereavement.
- Anticipate and identify a complicated grief reaction.
- Support the person with complicated grief.
- Assess the need for referral to other agencies.
- Recognise the special needs of bereaved children.
- Provide staff support to the bereaved team.
- Recognise and support the individual team member who is bereaved.
- Support people involved in bereavement counselling.
- Know about bereavement counselling methods, including the organisation of services.
- Recognise the counsellor who is in need of additional support.

6. Awareness of professional and personal feelings

The doctor should be able to:

- Recognise and respond to emotional stress in self and others in the team.
- Recognise the value of asking for help with personal feelings.
- Identify where support is available.
- Recognise the sources of personal opinions and belief systems and the danger of projecting these feelings onto others.
- Cope with guilt-feelings in self and others arising from deficiencies in care.
- Recognise the impact of personal loss and grief on the delivery of care.
- Understand the ways of providing and using staff support.
- Perceive the effect of chronic exposure to grief and loss, distinguishing between normal emotions and 'burn out'.
- Recognise the syndrome of the compulsive carer.
- Recognise in self and others the danger of trivialising and denying personal needs by always putting patient's needs first. This implies adequate personal supervision of the trainee on a regular ongoing basis.

C. RELIGIOUS AND CULTURAL ASPECTS

The doctor should:

- Know the importance of seeking appropriate help in responding to the spiritual needs and questions of the patient.
- Recognise the importance of religious and cultural influences, including language, on all aspects of palliative care.
- Recognise the importance and effect of the beliefs of the patient, carers and the doctor on the process of care.
- Be aware of the attitudes and practices of the major religions relating to illness and death.

D. ETHICAL ASPECTS

1. Patient Autonomy

The doctor should demonstrate respect for the patient ('autonomy') by:

- Agreeing priorities and goals with the patient and carers.
- Discussing treatment options with the patient and jointly formulating care plans.
- Not withholding information desired by the patient at the request of a third party.
- Fulfilling the patient's need for information about any treatments.
- Respecting the patients wish to decline treatment.
- Showing respect for life and acceptance of death by understanding that treatment should never have the induction of death as its specific aim.
- A doctor has neither right nor duty, legal or ethical, to prescribe a lingering death.

The doctor should:

- Understand the issues which surround requests for euthanasia.
- Recognise the dangers of professionals making judgement based on factors such as pre-morbid disability or age.
- Weigh up the benefits and burdens of treatment ('beneficence').
- Assess the risks versus the benefits of each clinical decision ('non-maleficence').
- Understand the right of the individual patient to the highest standard of care within the resources available.
- Be able to evaluate the decisions involved in the allocation and use of resources ('justice').

2. Teamwork**The doctor should:**

- Appreciate the skills and contributions of others, both medical and non-medical, to palliative care.
- Understand the concept of teamwork.
- Be aware of the role of statutory and voluntary organisations involved in patient care.
- Demonstrate an ability to work in a multi-disciplinary team, understanding boundaries and professional rivalries.
- Be sensitive to the dynamics of the team in different situations.
- Be able to chair team meetings.
- Be aware of the different forms of team support.
- Understand strategies which facilitate team functioning.
- Recognise that conflict in a team is inevitable and handle this constructively.
- Be able to consider the 'skills-mix' of the team, particularly when appointing new team members.

E. ORGANISATIONAL ASPECTS**Statutory regulations****The doctor should know about:**

- Certification of death.
- Liaison with the coroner's office (regulations concerning statutory notification).
- Cremation regulations.
- Procedures for relatives following a death and how cultural influences affect this.
- Grants, funds and allowances available to the terminally ill.
- The role of the undertaker.
- Controlled drugs regulations and local policy.
- Practical support for the patient and family.
- The doctor should know about the quality of care available in different settings (i.e. home, hospitals, hospice and other places) and how to obtain access to this care.

The doctor should know how to obtain:

- Appliances e.g. commodes, wheelchairs, cushions and mattresses.
- Assessment by an occupational therapist for modifications to the home.
- Physiotherapist.
- Support services available to care for the person dying at home, e.g. home help and night sitting services.

The doctor should:

- Understand the principles of rehabilitation.
- Know of facilities available for rehabilitation.
- Be aware of the specific skills of breast counsellor, prosthetic advisors and stoma care therapists.

F. NON CLINICAL ISSUES**1. Management****The doctor should know about:**

- Recruiting and staff selection, including person specifications, job descriptions and interviewing techniques.
- Appraisal systems and staff development, counselling and disciplinary procedures.
- The funding of independent hospice services.
- Budgetary systems.
- Annual accounts including the balance sheet and profit and loss account.
- The preparation of strategy and the principles of business planning.
- The role of the administrator.
- Knowledge of the structure within the Department of Health and Local Health Boards.
- Knowledge of funding by the Department of Health and Local Health Boards.
- Knowledge of local management structure.
- Principles of management structure.
- The different major charities involved in palliative care and the interface between statutory and voluntary bodies.
- Knowledge of national and regional policies that are relevant to delivery of palliative care services.
- Knowledge of the different models of delivery of palliative care services.

2. Research

- Knowledge of the principles of clinical research, and the ability to evaluate medical literature pertinent to the speciality.
- The ability to promote, supervise or take part in research appropriate to the speciality of Palliative Medicine should be demonstrable.
- Before the end of training the successful completion (and communication) of a research project or programme should be demonstrated.
- The trainees work programme should show the equivalent of two sessions weekly of protected, non-clinical time for formal teaching, private reading, audit and research.

3. Audit

Through involvement in regular audit, the doctor should understand:

- The principles of audit.
- The application of audit in palliative care.

4. Teaching

The doctor should:

- Be aware of different teaching methods.
- Develop teaching skills appropriate to the groups and subjects to be taught.
- Undertake supervised teaching sessions.
- Understand how to evaluate a teaching programme.
- Understand the role of the Royal Colleges in monitoring training.
- Be aware of the organisation of medical training in palliative medicine and related specialities.
- Understand the organisation and content of training of other professional groups in palliative care.

Comparison of Higher Medical Training Programmes in Palliative Medicine

	IRISH	U.K.
Entry Requirements	Minimum of two years GPT. MRCPI or UK ; Or Vocational training scheme leading to MICGP or MRCGP. Minimum of 1 year acute unselected medical take.	As pre Irish requirements but also FRCR and FRCA.
Length of Training	Four years	Four years
Training Settings	Specialist Palliative Care Units University/Teaching/ Regional Hospitals. Community based settings. Minimum of three years full time in specialist palliative care unit or team.	As pre Ireland, except a minimum period of two years in a specialist unit or team.
Curriculum	As pre curriculum produced by Assn. For Pall Med GB & I.	As per curriculum produced by A.P.M. GB & I.
Research	Relevant research may contribute up to twelve months of HMT	Relevant research may contribute up to twelve months of HMT
Continuous Assessment	Training record maintained by trainee. Quarterly review with local trainer; annual review with National Specialist Director	Training record maintained by trainee. Annual Review.

There is no UEMS curriculum in respect of Palliative Medicine
AM/JB
1/12/98

Curriculum Requirement	Required/Desirable	Minimum Requirement	Reporting Period	Form Name
Section 1 - Training Plan				
Personal Goals Plan (Copy of agreed Training Plan for your current training year signed by both Trainee & Trainer)	Required	1	Training Post	Form 052
Weekly Timetable (Sample Weekly Timetable for Post/Clinical Attachment)	Required	1	Training Post	Form 045
On Call Rota	Required	1	Training Post	Form 064
Section 2 - Training Activities				
Outpatient Clinics				
Palliative Medicine (minimum 40 over training)	Required	40	Training Programme	Form 001
Medical Oncology (minimum 20 over training)	Required	20	Training Programme	Form 001
Radiology Oncology (minimum 10 over training)	Required	10	Training Programme	Form 001
Specialist Pain Clinic (minimum 5 over training)	Required	5	Training Programme	Form 001
Interventional Pain Clinic (minimum 5 over training)	Required	5	Training Programme	Form 001
Ward Rounds/Consultations				
Consultant led (minimum 2 per week)	Required	80	Year of Training	Form 002
SpR led (1 per week)	Required	40	Year of Training	Form 002
Consultations	Required	1	Year of Training	Form 002
Emergencies/Complicated Cases	Desirable	1	Training Programme	
Procedures/Practical Skills/Surgical Skills				
Syringe driver (e.g case where you setup syringe driver under supervision) (minimum 10 per year)	Required	10	Year of Training	Form 004
Paracentesis (minimum 10 over training)	Required	10	Training Programme	Form 004
Thoracentesis (minimum 5, 10 observed)	Required	15	Training Programme	Form 004
Spinal infusion systems (minimum 5 over training)	Required	5	Training Programme	Form 004
ECG (minimum 10 per year performing and interpreting)	Required	10	Year of Training	Form 004

Curriculum Requirement	Required/Desirable	Minimum Requirement	Reporting Period	Form Name
Lumbar puncture (minimum 5 during training)	Required	5	Training Programme	Form 004
TENS (observation desirable)	Desirable	1	Training Programme	Form 004
Additional/Special Experience Gained	Desirable	1	Training Programme	Form 005
Relatively Unusual Cases	Desirable	1	Training Programme	Form 019
ICU/CCU				
AMU	Required	1	Year of Training	Form 090
Oncology Day Ward	Required	1	Year of Training	Form 090
Chronic Cases/Long term care (record a minimum 5 cases per year)	Required	5	Year of Training	Form 066
Family Meetings (observe or participate in 40 per year; lead 10 per year)	Required	40	Year of Training	Form 102
Record of Offsite Activities				
Daycare Hospice (minimum 10 during training)	Required	10	Training Programme	Form 082
Medical Day Wards (minimum 10 during training)	Required	10	Training Programme	Form 082
Domiciliary visits (minimum 15 over training)	Required	15	Training Programme	Form 082
Management Experience	Desirable	1	Training Programme	Form 110
Section 3 - Educational Activities				
Mandatory Courses				
Mastering Communications (Year 1)	Required	1	Training Programme	Form 006
Audit (Year 1)	Required	1	Training Programme	Form 006
Leadership Skills (Year 3+)	Required	1	Training Programme	Form 006
Ethics I: Professionalism	Required	1	Training Programme	Form 006
Ethics II: Ethics & Law	Required	1	Training	Form 006

Curriculum Requirement	Required/Desirable	Minimum Requirement	Reporting Period	Form Name
			Programme	
Ethics III: Research	Required	1	Training Programme	Form 006
Ethics IV: End of Life	Required	1	Training Programme	Form 006
ACLS	Required	1	Training Programme	Form 006
Advanced Skills course	Required	1	Training Programme	Form 006
Non – Mandatory Courses	Desirable	1	Training Programme	Form 007
Study days	Required	6	Year of Training	Form 008
In-House Activities/Hospice:				
Grand rounds (minimum 1 per week)	Required	40	Year of Training	Form 011
Journal Club (2 per month)	Required	20	Year of Training	Form 011
Radiology MDT meeting (minimum 1 per week)	Required	40	Year of Training	Form 011
Pathology conference	Required	1	Year of Training	Form 011
MDT palliative medicine meeting (minimum 1 per week)	Required	40	Year of Training	Form 011
Seminar	Required	1	Year of Training	Form 011
Lecture	Required	1	Year of Training	Form 011
Oncology tumour board meeting(minimum 1 per month)	Required	10	Year of Training	Form 011
Psychosocial meetings (minimum 1 per week)	Required	40	Year of Training	Form 011
Bereavement services (minimum 2 per year)	Required	2	Year of Training	Form 011
Examinations	Desirable	1	Training Programme	Form 012
Formal Teaching Activity (minimum 1 formal session per month)				
Lecture	Required	4	Year of Training	Form 013
Tutorial	Required	4	Year of Training	Form 013
Bedside Teaching	Required	4	Year of Training	Form 013

Curriculum Requirement	Required/Desirable	Minimum Requirement	Reporting Period	Form Name
Research (minimum 2 literature reviews during training cycle. At least one submission of research proposal for ethical approval)	Required	3	Training Programme	Form 014
Audit activities (1 per year either to start or complete audit cycle and present at least 1 audit at national or international meeting during training)	Required	1	Year of Training	Form 015
Publications	Desirable	1	Year of Training	Form 016
Presentations (minimum of 1 oral or poster presentation per year)	Required	1	Year of Training	Form 017
National/International meetings	Required	1	Year of Training	Form 010
Additional Qualifications	Desirable	1	Training Programme	Form 065
Committee Attendance	Desirable	1	Training Programme	Form 063
Section 4 - Assessments				
DOPS				
Management of Stomas	Required	1	Training Programme	Form 021
Managing PEGS	Required	1	Training Programme	Form 021
Management of tracheostomies	Required	1	Training Programme	Form 021
Paracentesis	Required	1	Training Programme	Form 021
Syringe driver set -up	Required	1	Training Programme	Form 021
Management of epidural/ intrathecal catheters	Required	1	Training Programme	Form 021
Urethral catheterisation	Required	1	Training Programme	Form 021
Nebuliser set-up	Required	1	Training Programme	Form 021
Management of non invasive ventilation	Required	1	Training Programme	Form 021
TENS application	Required	1	Training Programme	Form 021

Curriculum Requirement	Required/Desirable	Minimum Requirement	Reporting Period	Form Name
CBD	Required	1	Year of Training	Form 020
Mini-CEX (At least two Mini-CEX assessments)	Required	2	Year of Training	Form 023