THE UNIVERSITY OF BRITISH COLUMBIA

Division of Palliative Care

Department of Medicine | Faculty of Medicine

Enhanced Skills Palliative Residency Program Category 1

Department of Family Practice | Faculty of Medicine

HANDBOOK

Last Update June 12, 2024

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INTRODUCTION

Welcome to Palliative Medicine at UBC!

We hope that this guide will help you make the most of your palliative medicine education. It includes a framework for your clinical rotations, resources, policies, responsibilities and opportunities.

Clinical rotations are designed to address the Residency Training Profile for Family Medicine Enhanced Skills in Palliative Care and Priority Topics for competence in palliative care as outlined by the Standards of Accreditation for Residency Programs in Family Medicine. Rotations are scheduled to give you the opportunity to work across several health authorities and care environments, building on your skills from your family medicine training.

Throughout the year, you will have an Academic Day educational series, article and case review presentations, as well as other structured learning opportunities.

There are resident activity funds available to help fund conferences and elective experiences. Information regarding the funds, the opportunities and the specifics of the program are found within this handbook and will be reviewed at the orientation session.

Good luck with your year! We look forward to supporting you in becoming a palliative care consultant to your community. We celebrate your commitment to palliative care advocacy, teaching, research, as well as your role as a lifelong learner.

Sincerely,

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KEY PROGRAM CONTACTS

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A full list of clinical faculty members within the Division of Palliative Care can be found online at the division website.

Further contacts for the Postgraduate Medical Education office (PGME) can be found on the PGME website, including contact information for Dr Ravi Sidhu, the PGME Associate Dean.

Good Links to Bookmark

1. Entrada to Send EPAs
2. One45 to see and submit your Faculty/Academic Day evaluations and ITERS
3. RMS to submit sick days and stat holidays worked
4. PGME Resident Reimbursement Site
5. Entrada Community for How To Guides, Academic Day Resources, RMS Guides, Up to Date Handbooks etc.

RESIDENCY PROGRAM COMMITTEE (RPC)

The Residency Program Committees exist for both the Enhanced Skills in Palliative Medicine Category 1 and Royal College Adult Palliative Medicine Programs. These committees are chaired by their respective Program Directors and meet four times a year. The committees are comprised of:

TBD	Head - UBC Division of Palliative Care
Dr. Shannon Bunn	Program Director, Enhanced Skills Palliative Medicine
Dr. Lauren Daley	Program Director, Royal College Subspecialty Adult Pall Med
Dr. Pippa Hawley	Research Faculty Lead

As well as representatives from the distributed palliative medicine learning sites, oncology, geriatrics, and spiritual care. The lead resident also sits on this committee and serves as a voice and advocate for the residents.

Purpose: The Residency Program Committee is responsible for all educational issues affecting the UBC postgraduate Palliative Medicine Program including but not limited to:

- Overall program direction
- Curriculum plan
- Program objectives
- Practice exams
- Financial issues
- Resident selection
- Faculty development
- Others as deemed appropriate by the program director or raised by the committee

The group will meet at least quarterly as required by the College and may meet as often as monthly if agenda items are sufficient in number or urgency to warrant it. E-mail will facilitate information sharing but not decision making unless an urgent "vote" is needed.

The Committee will function as the focus of academic policy discussion, development and setting for the Program. It will be advisory to the Program Director, but in virtually all situations it will expect that the Program Director will follow that advice unless they feels seriously in disagreement. Whenever possible, it will function in consensus mode, but any member or the Chair can call for a vote on any issue if desired. Simple majority will then decide the matter.

CLINICAL ROTATIONS

There are 13 blocks (4 weeks each) per academic year. A typical schedule is reflected below, but may vary based on resident needs, rotation availability, etc.

Block	Start Date		End Date		Stat Holidays
1	Monday	July 1, 2024	Sunday	July 28, 2024	Monday, July 1 (Canada Day)
2	Monday	July 29, 2024	Sunday	August 25, 2024	Monday, August 5 (BC Day)
3	Monday	August 26, 2024	Sunday	September 22, 2024	Monday, September 2 (Labour Day)
4	Monday	September 23, 2024	Sunday	October 20, 2024	Monday, September 30 (National Day for Truth and Reconciliation) Monday, October 14 (Thanksgiving)
5	Monday	October 21, 2024	Sunday	November 17, 2024	Monday, November 11 (Remembrance Day)
6	Monday	November 18, 2024	Sunday	December 15, 2024	
7	Monday	December 16, 2024	Sunday	January 12, 2025	Wednesday, December 25 (Christmas) Thursday, December 26 (Boxing Day) Wednesday, January 1 (New Year's Day)
8	Monday	January 13, 2025	Sunday	February 9, 2025	
9	Monday	February 10, 2025	Sunday	March 9, 2025	Monday, February 17 (Family Day)
10	Monday	March 10, 2025	Sunday	April 6, 2025	
11	Monday	April 7, 2025	Sunday	May 4, 2025	Friday, April 18 (Good Friday) Monday, April 21 (Easter Monday)
12	Monday	May 5, 2025	Sunday	June 1, 2025	Monday, May 19 (Victoria Day)
13	Monday	June 2, 2025	Monday	June 30, 2025	

Approximate Sequence of Rotations (4 Week Blocks)	
1	Introductory Palliative Medicine
2	
3	Geriatrics
4	Med Onc/Rad Onc
5	PSMPC/Ambulatory
6	Elective/CPO
7	Research Flex/Elective
8	Advanced Palliative Medicine
9	
10	Community Palliative Medicine
11	
12	Elective
13	Elective

1. Palliative Medicine Introduction — 8 weeks
2. Ambulatory Palliative Medicine — 4 weeks
3. Oncology (2 week CPO course) — 6 weeks
4. Geriatrics — 4 weeks
5. Advanced Palliative Medicine — 8 weeks
6. Community Palliative Medicine — 8 weeks
7. Electives/ Flex Research — 14 weeks

52 weeks

Palliative Medicine Rotations

Introductory Blocks*:* Most residents will start their program with an eight-week rotation with a palliative care service in the tertiary setting, including a palliative care unit. The resident is part of the interdisciplinary team, under the direct supervision of palliative physicians. This allows the resident to be well supported in their initial palliative care experiences and also allows an assessment of the resident's current knowledge, skills and vulnerabilities. During this foundational 8-week rotation, there are opportunities to learn about basic principles of pain and symptom management, work with the interdisciplinary team and gain perspective on counseling and facilitating team meetings. Interventional anaesthesia approaches to pain management in palliative patients, palliative care for non-malignant conditions and care for patients with a history of substance use will also be introduced during this time.

Community Palliative Care: This rotation allows the resident to provide palliative consultation services to patients in their homes as part of a community palliative care service. It may also involve palliative support for patients in long term care and hospice facilities. During this 8-week period, the resident sees patients at home on a continuing basis. Attendance at community rounds, providing support and care for home deaths, and facilitating transitions of care from acute care to home, home to acute care, and hospice are key to the learning experience. The resident will also learn about other community resources that palliative patients and their families may use, such as visiting a funeral home, meeting with alternative care practitioners and attending grief support groups. This rotation stresses the Palliative Care Clinicians role as lead, support and educator to the Primary Care team and Physician.

**Access to a vehicle is required for most community rotation sites. If you do not have a vehicle for personal use please alert your program director.*

Advanced Palliative Medicine Rotation: The resident works both on a tertiary palliative care unit (TPCU) and provides palliative consultation to other parts of the hospital throughout the rotation. The TPCU experience broadens the resident's scope and solidifies the residents' role as consultant. During the advanced rotation the resident will take on progressive responsibility. Some of the ways this progression may be demonstrated is through increased patient volume, participation in patient triage for admission to the PCU, and ownership of education for junior learners.

Oncology

Oncology is primarily experienced in outpatient clinics, two weeks each of medical and radiation oncology, usually done at one of the provincial BC Cancer locations, plus the two-week Clinician Practitioner in Oncology Course. More information on this course is in the Academic Content portion of this handbook.

Ambulatory Palliative Care

These clinics give the resident the opportunity to participate in medical subspecialty non-cancer clinics with a palliative focus and provide symptom support to outpatients in the Pain and Symptom Palliative Care clinics at the BC Cancer Agency.

Subspecialty areas are: Cardiology, Gastroenterology, Infectious Diseases/HIV, Medical Aid in Dying (MAiD), Nephrology, Neurology, Neuro oncology, Rheumatology and Respirology. The resident will be responsible for arranging the subspecialty clinic days of their choosing.

Geriatrics

The resident gains insight into ethical decision making for patients with dementia and assessing cognitive abilities and decision-making capacity. The resident learns how to effectively manage delirium in the frail elderly.

Electives

Elective experience will be determined by resident learning needs and expressed areas of interest. They may be clinical or non-clinical and can include rotations out of province or out of country.
These must be discussed and approved by the Program Director. Once electives have been scheduled, please update the rotation schedule and inform the Program Administrator so One45 (the electronic evaluation/access platform) may be updated.

Possible electives:

- Chronic Pain Service
- Medical Aid in Dying
- Neuro-oncology
- Neurology and neuromuscular diseases clinic
- Psychiatric issues in palliative care
- Palliative Care Community i.e. Kelowna, Richmond, FHA or Downtown East Side Vancouver.
- St. Paul's Hospital with an emphasis on care for those with HIV/AIDS
- Spiritual Care
- Point of care ultrasound (POCUS) service
- International Electives in Clinical and/or Structural Programs
- Research Projects in Clinical, Economic and/or Operational Issues of Palliative Medicine.

Here is a link to a document that describes various electives in more detail and provides contact information to assist in scheduling.

LEARNING OBJECTIVES AND OUTCOMES

Residency programs across Canada are transitioning to a competency-based system. The CCFP has put forward a Triple C Competence Based Curriculum which has three components:

- Comprehensive education and patient care
- Continuity of education and patient care
- Centred in family medicine

Our rotation structure, which reflects palliative care across the continuum, and academic sessions work to embody these three components of care.

Competency-Based Medical Education is an approach to physician development that focuses on the process and outcomes of training and makes the achievement of competencies more visible and measurable. Entrustable Professional Activities (EPAs) are the work-based assessments specific to a CBME framework, and are used to document completed tasks. This method of assessment conveys more explicit expectations, allows for better capture and understanding of a resident's abilities, and provides more data points for each rotation.

The UBC Enhanced Skills Palliative Care program has developed EPAs specific to your category 1 training. The development of these EPAs was guided by the College of Family Physicians of Canada Residency Training Profile for Family Medicine Enhanced Skills in Palliative Care and Priority Topics for competence in palliative care as outlined by the Standards of Accreditation for Residency Programs in Family Medicine. The EPAs are grounded in the CanMEDS-FM framework of competencies and are a **mandatory part of how you will progress through the year.**

In addition to the EPAs, other forms of resident evaluation are collected in the form of summative evaluations at the end of each rotation block, journal club/ education rounds evaluations, mid-term and end of year written and oral assessments, as well as informal feedback from clinical preceptors and the program director. This collective data is reviewed by the clinical competence committee when making decisions about progression within the program.

Entrustable Professional Activities (EPAs)

Curriculum Mapping

Enhanced Skills - Palliative Care PGY3	July	August	September	October	November	December
	Intro Palliative Care		Geriatrics	Ambulatory Palliative	GPO / Med Onc	Rad Onc / Research
	Scholar Project					
	EPA 1. EPA 2. EPA 3. EPA 6.			EPA 2. EPA 3. EPA 7.		EPA 2.
	January	**February**	**March**	**April**	**May**	**June**
	Elective / Advanced Palliative Care	Advanced Palliative Care	Advanced Palliative Care / Community Palliative Care	Community Palliative Care	Community Palliative Care / Elective	Elective
	EPA 2. EPA 3. EPA 5. EPA 6. EPA 7. EPA 9.			EPA 2. EPA 3. EPA 4. EPA 6. EPA 7 EPA. 9		EPA 2. EPA 9.
	Scholar Project / Exam (JUNE)					

Click [here to see the full EPA Eagle Eye View]()

Required EPA Numbers for Progression

	Achieved In Intro Blocks	Achieved By Advanced Blocks	Achieved By Community Blocks	TOTAL by June 2025
EPA 1: Manage the care of a dying patient in the last days	2	1	0	**3**
EPA 2: Address difficult symptoms thru comprehensive assessment and management **5 Pain/5 Other Symptoms*	5	3	2	**10***
EPA 3: Complete a comprehensive palliative medicine consultation	4	2	3	**9**
EPA 4: Manage the palliative care needs of a patient in the community setting	0	0	2	**2**
EPA 5: Function as MRP for patients admitted to a palliative care unit	0	3	0	**3**
EPA 6: Identify the need for and conduct a family meeting	2	3	0	**5**
EPA 7: Facilitate transfers of care across the palliative care continuum	0	1	1	**2**
EPA 8: Teaching of junior learners including medical students and residents	0	1	1	**2**
EPA 9: Support patients and families in the psychosocial, spiritual and cultural domains	1	1	1	**3**
	14	**15**	**10**	**39**

EPA 1: Manage the Care of a Dying Patient in the Last Days

- Key Features: The EPA focuses on the last hours and days of life as well as the immediate period after a patient's death. This includes recognizing the clinical signs and symptoms of patients

approaching death, acknowledging and addressing patient and/or family suffering, providing support for anticipatory grief and bereavement, and recognizing risk factors for complicated grief, and recognizing when to consult members of the interprofessional team. It also includes the immediate responsibilities at the time of death such as communicating with family and completing the death certificate.

- Milestones
    - Recognizes the physical signs and symptoms of the dying process
    - Manages common symptoms promptly and effectively with appropriate non-pharmacologic and pharmacologic treatments
    - Discontinues inappropriate interventions
    - Educates caregivers on the common and expected clinical manifestations of an imminently dying person
    - Provides supportive counselling and resources for coping with loss to family and healthcare providers
    - Involves the interdisciplinary team to achieve whole-patient care
    - Recognizes risk factors for complex grief and bereavement
    - Completes a spiritual assessment (ex FICA)
    - Advocates and facilitates cultural/ spiritual practices near and at the time of death
    - Lists medical conditions that require medical examiner/ coroner involvement
    - Prepares the death certificate in a timely, and accurate manner
    - Works within one's own limits, asking for assistance as needed

EPA 2: Address Difficult Symptoms Through Comprehensive Assessment and Management (Pharmacologic and Non-Pharmacologic)

- Key Features: This EPA focuses on the management of symptoms that are common in palliative medicine such as pain, delirium, depression, anxiety, fatigue, nausea, constipation, dyspnea and insomnia. It includes a comprehensive biopsychosocial-spiritual assessment and formulation of a management plan that considers pharmacologic and non-pharmacologic modalities.

  This includes the recognition and timely assessment and management of palliative care emergencies, including consulting with/ referring to other specialties for definitive management. Examples include pain or dyspnea crisis, bowel obstruction, suicidality, bleeding, spinal cord compression, or other acute change in a patient's status.

  As the learner advances in their training this may include methadone, ketamine, lidocaine, interventional techniques and palliative sedation when appropriate.

- Milestones
    - Promptly identifies palliative care emergencies and acts on them
    - Comprehensive assessment of symptom including all domains of suffering
    - Uses validated scales and tools where appropriate
    - Utilize appropriate diagnostic work-up and interpretation of diagnostic tests
    - Clear management approach based on etiology which may include non-pharmacologic, pharmacologic, and/or interventional treatments

- When prescribing considers indications such as age-related changes in pharmacology, benefits, risks and adverse effects, as well as response to previously attempted treatments
- Integrates the patient's beliefs, concerns, expectations, and experiences relevant to the presenting problem in the treatment planning
- Work with the patient and/or family to increase their understanding of their symptoms and health care needs
- Select and prescribe appropriate monitoring strategies
- Recognizes the emotional impact of witnessing suffering on patients, families, and the medical team

EPA 3: Complete a Comprehensive Palliative Medicine Consultation

- Key Features: This EPA includes all aspects of palliative medicine consultation: applying the biopsychosocial-spiritual approach to the assessment, gathering information, working effectively with other members of the palliative team as well the referring service.

  The palliative care resident responds to requests for consultation with explicit recommendations that reflect the patient's prognosis, function, and goals of care. The resident supports and educates the referring and invested team members. This may include communication via telephone or secure electronic means.

- Milestones
  - Performs a complete assessment including:
    - Comprehensive symptom assessment
    - Accurate Palliative Performance Status
    - Comprehensive psychosocial and spiritual assessment
    - Clarification of patient/ family understanding
    - Identification of TSDM
  - Responds to the question posed in the consult
  - Explains the palliative care philosophy to the patient and family
  - Facilitates patient and family access to needed services and resources
  - Collaborates and integrates the assessment and perspectives of other members of the interprofessional team
  - Recommendations consider prognosis, comorbidities and patient/family goals
  - Recommendations are evidence based
  - Recommendations are cost-appropriate
  - Recommendations include anticipatory management plans for emergencies/urgencies when appropriate
  - Recommendations are communicated in a timely manner and convey clinical reasoning and rationale for recommendations
  - Appropriately selects forms of communication based on context (ex. telephone, in-person, medical record)
  - Plans for appropriate follow-up
  - Is able to triage urgent vs routine requests

EPA 4: Manage the Palliative Care Needs of a Patient in the Community Setting

- Key Features: The Palliative Care resident collaborates with the interprofessional members of community-based palliative care team to deliver care in the patient's home

- Milestones
    - Optimizes the environment for patient and family comfort, dignity,
        - privacy, engagement, and safety
    - Gathers an appropriately focused history
    - Performs an accurate physical exam pertinent to the patient visit.
    - Engages the patient, family, and interprofessional team members, inquiring about the patient's concerns and building a therapeutic relationship.
    - Seeks and synthesizes relevant information from other sources (e.g. family, medical record)
    - Is comfortable with ambiguity, manifested as an ability to respond to questions or challenges from the patient in a professional manner
    - In developing care plans uses prognostic tools and guidelines that recognize comorbidity and function
    - In developing care plans considers patient preferences and psychosocial concerns
    - Anticipates changes in the patient's condition and the evolving needs of the patient and their family
    - Respond punctually to requests or calls from patients or other health care professionals
    - Demonstrate an understanding of the scope and expertise of other health care professionals within the specialist palliative care team
    - Communicate effectively with other physicians and health care professionals

EPA 5: Function as MRP for Patients Admitted to a Palliative Care Unit

- Key Features: The Palliative Care resident ensures overall responsibility for a patient admitted to a palliative care bed (for any setting) from the time admission until the time of death, discharge, or transfer of responsibility.

  This includes fostering relationships with colleagues in the interprofessional team to coordinate, expedite and optimize care, as well as supporting and enhancing well-being within the team. It may include other responsibilities of the attending physician, such as supervising junior learners.

- Milestones
    - Demonstrates understanding of the admission criteria for a palliative care bed and recognizes who would benefit from admission
    - Manage time and prioritize tasks
    - Communicate effectively with other physicians and health care professionals
    - Respond punctually to requests or calls from patients or other health care professionals
    - In developing care plans, considers patient comorbidity, function, and prognosis
    - In developing care plans, considers the evidence base, and age-related changes in physiology, pharmacology, treatment efficacy and response
    - In developing care plans, considers patient preferences and psychosocial concerns.

    - Ensures that members of the interprofessional team have had adequate input in the development and implementation of care plans.
    - Consistently engages the patient, and family, with the goal of building a therapeutic relationship.
    - Actively plans for continuity of care for the patient, and makes discharge and follow-up plans that integrate appropriate use of community resources or other health providers.
    - Provide junior learners with teaching and clinical supervision
    - Documents care on the patient chart, completes discharge summaries and ensures these are sent to appropriate recipients.

EPA 6: Identify the Need For and Conduct a Family Meeting: Including the Skilled Communication of Prognosis, Aid in Medical Decision Making, and Establishing Goals of Care

- Key Features: This EPA focuses on leading meetings for the purpose of discussing complex issues related clinical status, patient and family expectations, illness trajectory, and/or possible complications. This includes creating a safe space, providing information, and eliciting patient and family concerns and values while attending to meeting flow. Facilitating shared decision making in prioritizing and setting goals of care. Summarizing and documenting decisions reached. This may include the use of conflict resolution skills to address difficult situations.

- Milestones
    - Prepares for a meeting, reviewing its purpose, and background information
    - Identifies necessary participants for the meeting
    - Demonstrates empathy and respect for patient, family, and interprofessional team members
    - Identifies the focus of the meeting
    - Seeks permission from patient and/or their family to talk about their values and wishes for care
    - Assesses for patient or caregiver understanding prior to sharing information
    - Provides information about the disease trajectory and possible complications that are clear, accurate, and void of medical jargon
    - Responds to non-verbal behaviours to enhance communication
    - Provides empathy, maintains and reframes hope, and is able to recognize and attend to strong emotions
    - Elicits patient/ family values, concerns, and wishes for their care effectively uses conflict management skills
    - Attend to meeting flow, organization, and time management
    - Summarizes and clarifies key points and discussions
    - Aligns patient's values and goals with treatment options in the recommendation of a personalized care plan
    - Accurately documents the contents and results of the meeting

EPA 7: Facilitate Transfers of Care Across the Palliative Care Continuum

- Key Features: The palliative care resident demonstrates an understanding of the varying priorities of care in different care settings ranging from intensive to acute, ambulatory,

community (patient home, long term care, hospice) and is able to navigate with the patient the type of care setting that is in line with their care needs and goals of care.

- Milestones
    - Proactively communicates with appropriate team members, including the family physician.
    - Seeks and incorporates the input of the interprofessional care team.
    - Correctly identifies the need for a goals of care discussion when appropriate
    - Assess prognosis using disease specific indicators, including clinical signs, symptoms, validated tools, and investigations
    - Is able to predict likely future care needs and plans accordingly.
    - Applies knowledge of the resources and/or services available in other care settings in formulating recommendations for a safe and appropriate care plan
    - Summarizes and documents patient issues for the accepting physician providing rationale for key decisions and recommendations for management
    - Communicates with the appropriate team members when a patient transitions from one care setting to another, including the patient's family physician.
    - Work with other health care professionals to address barriers to access resources and services

EPA 8: Teaching of Junior Learners Including Medical Students and Residents

- Key Features: This EPA focuses on evaluation of teaching skills including bedside, patient related and didactic sessions

- Milestones
    - Introduces teaching topic and assesses learner's prior knowledge base
    - Speaks in a slow pace, appropriate volume
    - Creates opportunities for learner interaction and reflection
    - Assesses learner emotional well-being when teaching topics that may evoke emotional response
    - Summarizes key points at end of teaching session
    - Provides didactic teaching using clinically relevant examples

EPA 9: Support Patients and Families in the Psychosocial, Cultural and Spiritual Domains

- Key Features: This EPA focuses on the recognition of distress and suffering in patients and families. This includes being a witness to and normalizing their suffering, and supporting and guiding as appropriate with the assistance of the interprofessional team. The learner uses open and empathic communication skills to explore physical, psychological, socio-cultural, and/or spiritual aspects of care. It may involve participating in legacy/memory making, or responding to requests for hastened death.

- Milestones
    - Recognizes, sits with, and validates the patient and/or family member suffering
    - Uses empathic listening, and appropriate non-verbal communication to demonstrate attentiveness, empathy, respect and compassion
    - Invites the patient and/or family to share what they are experiencing

- Explores requests for hastened death
- Assesses the presence, nature, and source of an individual's suffering, exploring underlying depression or anxiety
- Applies FICA/ HOPE/ FIFE tools in their assessment and development of a care plan
- Seeks and incorporates the input of the interprofessional care team in the development of a care plan.
- Has an understanding of referral patterns, and utilizes the skills of the interprofessional team to support the patient and family.

Periodic Reviews

The resident and program director meet at minimum twice a year to review the resident experience within the program. This includes academic sessions, rotations, wellness and safety. Resident progress is reviewed, areas of success are highlighted, and areas in need of increased focus are identified.

Residents will also meet with the overarching Enhanced Skills Program Directors at minimum once a year (towards the end of the year) to provide feedback specific of the palliative residency program and team.

Clinical Competence Committee

The Competency Committee (CC) provides regular, systematic and transparent review of each residents' performance. The committee consists of 4-5 faculty advisors, and the Program Director. Each faculty advisor is responsible for one resident. The advisors meet with their respective residents through the year, review evaluations, and assist in the development of individualized learning plans with the resident. The committee reviews in-training evaluation reports (ITERS), EPAs, scholarly project progress, journal/education rounds evaluations, and all other evaluations for each resident.

The competency committee meets at minimum twice a year and provides a summative report to each resident as well as the program director, after each meeting. These reports advise on the residents' progression through the program, identify areas requiring focused attention, and areas of strength.

ACADEMIC CONTENT

Academic Days, Case Review, Article Review and Journal Club

Approximately every two weeks, you have a full day of protected academic time. The Academic Days will alternate (mostly) every other Wednesday. Residents attend the academic seminars with the Year 1 Adult Palliative Medicine Subspecialty program residents, and these sessions will have designated topics you need to know in depth. These sessions will be led by a palliative care physician, other speciality staff physician or allied health. Most Academic Days will have an alternating Case Review in where each resident will take turns presenting an interesting patient case or an Article Review, where one resident will be expected to present an article. The following 2-3 hours in each morning and afternoon will consist of small-group seminars. In person attendance is encouraged when possible, however, most will be available via video conferencing.

These Academic Days will be set up with your learning needs prioritized, but rotating residents from other programs doing Palliative Care electives will be invited to attend some sessions. Your attendance and participation are required for **all** sessions unless you are on vacation or sick. You should be prepared for each topic by reading relevant material.

Please see the current Academic Day schedule for details.

Division of Palliative Care Biweekly Education Rounds

These are also considered mandatory educational sessions. Residents are expected to present at one of these meetings during the year. The Education Rounds Lead will be in touch with you at the beginning of the year to create a schedule. The Education Rounds are not sponsored by pharmaceutical companies as per UBC policy.

Clinician Practitioners in Oncology (CPO) Didactic Course

We have collaborated with the Family Practice Oncology Network of BC Cancer and the CPO training program and secured seats for palliative medicine residents to participate in the 2-week CPO didactic course in the fall of each year. This intensive lecture and workshop series is intended to familiarize you with common oncology systemic and radiation therapies for various malignancies, as well as common side-effects of treatment. Novel approaches to cancer treatment will also be explored. This is also an opportunity for you to liaise with oncological clinicians and develop relationships.

For 2024, this will be held online for ¾ of a day. Residents are expected to have ALL One45 evaluations completed during this time and use the remainder of the ¼ day to work on their research.

Ultrasound Guided Palliative Care Procedures Course

This is a half-day hands on workshop to learn and practice ultrasound guided palliative care procedures, such as thoracentesis, paracentesis, and DVT detection. Please see the current Academic Day schedule for details.

Resident as Teacher Curriculum

There will be several opportunities for you to teach during the residency. To assist you with your education duties, the UBC PGME office and our program facilitate numerous Resident as Teacher topics which explore best practices and theories pertaining to medical education.

All residents who are new to UBC and have not previously done any RaT training **are required** to do a 2-part introductory module on teaching.

The modules will be available between July 1, 2024-August 15, 2024 and can be found on Entrada. For more information please visit this PGME website.

Please notify the Enhanced Skills Manager, Lindsay Gowland – lindsay.gowland@familymed.ubc.ca – when you have completed the module. If you are unsure whether you need to complete the training, please contact Lindsay.

Scholarly Project

You will be required to complete a scholarly project over the course of the residency program. There will be several academic sessions related to research. Scholarly projects can be collaborative, and qualitative or quantitative in nature. Each resident is expected to take on a primary role in development and implementation of a project, with the goal of publication or presentation if possible. Further information about the scope of the scholarly project will be provided during these sessions.

In process and completed projects are presented at the annual Division Research Day in June.

Purpose:

The purpose of this mandatory scholar project is for you to demonstrate competence in a scholarly activity relevant to palliative care. Activities engaged in during your scholarly project will demonstrate various CANMEDS competencies in the scholar, professional, health advocate, collaborator, communicator and expert role. It is hoped that this endeavour will inspire you to continue similar academic pursuits during your career. There is a great need for good quality palliative care research, reflection, and innovation.

> ***completion of the scholar project is required to complete your residency. The program director is obligated to withhold submitting your final evaluation (FITER) of palliative training until completion (i.e. submitted written report and presented at Resident Scholar Day). If you anticipate difficulties in completing on time, please ask for help from the faculty research advisor well before the end of the academic year.

Types of Scholarly Projects:

-Quantitative Research Studies (case-control, small prospective observational pilot study, small control trial, secondary analysis of data)
-Survey-based studies (cross sectional study)
-Qualitative Research Studies (focus groups, one-on-one interviews)
-Systematic Review
-Program Innovation (Pilot study of unique or new patient care program if includes outcomes)
-Educational Intervention (if includes outcomes)
-Quality Improvement initiatives

Key Steps

1.Pick topic area and identify research supervisor
2.Form research question
3.Write research proposal
4.Apply for ethics approval
5.Collect data / implement project
6. Analyze data
7.Present project at research day
8.Write manuscript

Timeline

There are at minimum three academic sessions devoted to the scholarly project:
July-Aug: Introduction to research and brainstorm potential topics/supervisors/questions
March: Present work-in-progress
June: Submit written report and present completed project at the division research day

Support

The research lead in the Division of Palliative Care is responsible for facilitating the resident scholarly projects. This individual is not the project supervisor, but will meet regularly with the residents about their projects to ensure a suitable supervisor has been found and that the project is moving ahead.

Research Supervisor

You are encouraged to seek out local palliative care physicians, UBC faculty or allied health professionals who share your interests to support your project as your research supervisor. Alternatively, you may approach someone who is already involved in research of their own. If, during your palliative care residency, you make a substantial contribution to an existing faculty/staff research project, such that you would be listed by them as an author, then you may write this up and present it as your Scholar Project. Your research supervisor can serve as the "Principal Applicant" (PI) on your ethics proposal, or if they do not meet requirements for this role then the Divisional representative can be the official PI.

Research Proposal

This is a key document for your scholarly project (appendix 1). Every resident needs to fill out a research proposal for submission to their supervisor and the Divisional representative prior to commencing their project. This proposal will also be submitted as part of your ethics proposal.

Ethics

All Projects involving humans must have UBC Ethics Board approval before starting. This includes educational interventions, interviews, photos, video and simple surveys. Projects using clinical data from patient charts also need Ethics Board approval.

Ethics Board Application

1. Complete a research proposal.
2. Submit the research proposal to your supervisor and the Divisional representative.
3. Once proposal is finalized, go to https://www.rise.ubc.ca/ Complete the relevant UBC Ethics Board application. There are many details on the website which will help you complete this.

Statistical and Data Analysis

If advanced statistical analysis is needed for quantitative projects and you are not experienced in doing this yourself, help is available. Contact the Divisional representative if you wish to enlist the help of a statistician.

Written Report

The written report should follow the ICMJE recommendations (http://www.icmje.org/recommendations/browse/manuscript-preparation/preparing-for-submission.html). We strongly encourage you to submit your research to a journal for consideration for publication.

Work In Progress Presentation

This is a chance for you to rehearse your oral presentation in front of your fellow residents and staff. It is a great opportunity to receive feedback on your work to date and suggestions for going forward.

Research Day

Each resident must present their scholarly project at the palliative care research day held in June. You will have 15-20 minutes for your presentation. Your written work and presentation will be reviewed and evaluated by the Divisional representative prior to Scholarship day and your presentation will be evaluated on Scholarship day.

Rounds

Attending palliative care rounds is mandatory for residents at each site/rotation. Each palliative care unit holds rounds throughout the week.

Conferences

Recommended with funding available through DOPC/PGME:

- UBC Palliative Medicine CME Conference (Fall)
- CSPM Annual Course – Advanced Learning in Palliative Medicine (Spring)

Suggested:

BC Hospice Palliative Care Association Annual Conference May
Annual Forum on Death and Dying: Finding Comfort in Serious Illness - October
Canadian Pain Society Annual Meeting - May
Canadian Hospice Palliative Care Association Annual Meeting - September
American Academy of Hospice and Palliative Medicine Assembly - Spring
International Congress of Palliative Care - Fall

Texts and Resources

- Oxford Textbook of Palliative Medicine
- Palliative Medicine: A Case Based Manual
- Oxford Textbook of Palliative Care for Children
- Care Beyond Cure: Management of Pain and Other Symptoms
- Journal of Palliative Medicine
- Journal of Pain and symptom Management
- Textbook of Interdisciplinary Palliative Pediatric Care
- Supportive Care in Cancer Journal
- UpToDate

Other Resources:

- 50 Studies Every Palliative Care Doctor Should Know David Hui, Akhila Reddy, Eduardo Burera, Oxford University Press, April 2018
- Medical Care of the Dying. Fourth Edition. Victoria Hospice Society. 1900 Fort Street, Victoria, BC V8R 1J8. (This is included with course registration.)
- Evidence –Based Practice of Palliative Medicine: Expert Consult: Online and Print N.E. Goldstein, R.S. Morrison
- Demystifying Opioid Conversion Calculations: A Guide for Effective Dosing –M.L. McPherson Medicine: A case-based manual – D. Oneschuk, N. Hagen, N. MacDonald
- Canadian Palliative Care Formualry (CPCF) –R. Twycross, A. Wilcock, M. Dean, B. Kennedy

Online Resources

1. BC Cancer Symptom and Side Effect Management Resource Guide
2. Indigenous Cultural Competency Training Program
3. Canadian Virtual Hospice
4. Palliative Fast Facts and Concepts (Previously EPERC)
5. Fraser Health Palliative Symptom Guidelines
6. BC Centre for Palliative Care – includes symptom management guidelines
7. Ian Anderson Continuing Education Program in End-of-Life Care

EVALUATIONS

Evaluations are the primary tool for assessing your progress through the program. Without proper documentation, providing a reference letter or letter of confirmation of training, especially a few years after the completion of training, becomes a much more onerous task and may result in less than desirable outcomes. Likewise, it is also important to document that the educational objectives have been met, which demonstrate the effectiveness of the training. This in turn will help to ensure future government and university support of postgraduate palliative medicine education.

Evaluations and progression of each resident through the program is completed by a competence committee, which will review evaluations and provide feedback to each resident at a minimum of twice a year.

Evaluation of the Learner

1. Entrada Entrustable Professional Activity (EPA) forms
    a. These are ongoing, low stakes feedback, based on direct/indirect observation, elicited by the resident on performance of tasks integral to the discipline of palliative care.
    b. These are a mandatory part of your evaluation and a minimum number of EPAs are required for each rotation to advance through the program.

2. Rotation In-Training Evaluation Reports (ITERS)
    a. These are summative evaluations specific to each rotation, and should be reviewed regularly on One45, UBC's evaluation system
    b. See a copy of the blank ITERS here.

3. Scholarly Project +/- Presentation/Survey/Poster
4. Journal Club Presentations
5. Quarterly Personal Learning Plans
6. Year End Assessment Written (June)

Minimum Requirements for Completion

1. Resident must pass all core rotations.
2. Resident must meet all minimum EPA numbers as required
3. Resident must have successfully completed their presentations including Case Review(s), Article Review(s), Educational Rounds Presentation.
4. Resident must have successfully completed and presented their scholarly project.
5. Resident should have successfully completed the year end assessments

Evaluation of the Program

1. Evaluation of each rotation and site
2. Evaluation of clinical preceptors
3. Evaluation of individual academic day seminars
4. End of residency evaluation of program
5. Opportunity for feedback during periodic reviews

WELLNESS, SAFETY, ACADEMIC AND PRACTICAL ISSUES

Please see the UBC Post Grad Website and Resident Doctors of BC for further information.

For the most up to date Policies and Procedures, please see UBC PGME policies and procedures.

Key UBC PGME Policies (as of June 27, 2024):

1. PGME Wellness Policy
2. PGME Fatigue Risk Management Policy
3. Fatigue Risk Management Handout
4. PGME Resident Health and Safety

Mentor and Faculty Advisor

It is encouraged that each resident establish a formal mentor for the year. The Program Director will provide names of appropriate individuals upon request and will endeavor to make a good match for you. You will be encouraged to connect with the mentor on a regular basis. Some past residents have elected to work with multiple individuals as mentors. Whether you choose to engage with a mentor(s) is voluntary.

A member of the Competency Committee will serve as your Faculty Advisor. You are expected to meet with your advisor a minimum of 3 times a year. During these meetings you may discuss challenges and successes from your recent rotations and formulate learning plans for upcoming blocks. Information from these meetings will inform the decisions of the Competency Committee as they determine progression of the resident through the program.

Resident Wellness and Wellness Faculty Member

Wellness is important for all residents, but particularly for Palliative Medicine residents, clinical and personal circumstances may lead to significant stress, distress and potential burnout. You are encouraged to talk to your mentor, program director, peers, faculty, whenever needed. Formal supports are also available, including Resident Wellness Co-Leads.

Academic Day and other sessions will also be devoted to resident wellness.

UBC PGME office also has a Resident Wellness Centre which provides various resources, including counselling support. Please have a look at their webpage:
http://postgrad.med.ubc.ca/resident-wellness/

Palliative Medicine Resident Wellness Policy

Preamble
The Postgraduate Medical Education (PGME) Office recognizes that residents require a safe, positive, and healthy learning environment to thrive.

The Division of Palliative Care (DOPC) aims to support this by creating, promoting, and sustaining a culture of wellness and resilience.

Key Responsibilities
The UBC Faculty of Medicine PGME Office and all PGME Residency Programs, including the Year of Added Competency in Palliative Medicine and the Palliative Medicine Subspecialty Program, have a duty to promote the wellness of residents, provide resources to support physical, emotional and mental wellbeing, and to strive to assist residents in identifying and obtaining support at times that they are struggling in their physical, emotional and/or mental wellbeing.
Residents are responsible for reporting fit for duty, and recognizing their own impairments, if present, and being familiar with the PGME Wellness Policy.

A. PGME Resources
UBC PGME provides several resources to support resident wellness. Palliative Medicine residents are encouraged to access the Resident Wellness Office (RWO) for support when needed, and utilize workshops and online resources offered by the RWO. Recommendations and resources provided by the RWO and Resident Wellness Advisory Group will be relayed to Palliative Medicine residents, and supported/enacted by the Program Director, RPC and clinical faculty.

B. Division of Palliative Medicine Resources
The Division of Palliative Medicine and Palliative Medicine Residency Programs offer additional supports to their residents, in recognition of the specific emotional demands that training in palliative medicine can place on learners. These supports include:

- Wellness Workshops included in the academic curriculum
- Balint groups incorporated into the academic curriculum
- Upon Request Formal Mentorship with a mentor in a non-evaluative role offered to each resident
- A Wellness Faculty Advisor to oversee the above

C. Program Responsibilities

The Program Director will include wellness and address any concerns about mental, physical or emotional wellbeing of each resident at periodic reviews. The Program Director is accessible by email and phone to clinical faculty and residents to discuss any concerns regarding resident wellness on a continual basis; when one Program Director is away, the Program Directors for the Year of Added Competency and Subspecialty Program provide cross coverage.

D. Resources
UBC Resident Wellness Office (http://postgrad.med.ubc.ca/resident-wellness)
Employee & Family Assistance Program (http://www.efap.ca)
Physician Health Program (https://www.physicianhealth.com)
PGME Fatigue Risk Management Policy

Housing

Housing is your responsibility to organize.

For residents doing mandatory rotations outside of the Lower Mainland, e.g. Victoria, housing assistance will be requested from PGME and the Housing Accommodation for Mandated Rotations Policy.

Resident Mandated Travel and Reimbursement Support and Policy

Many expenses related to *mandatory* rotations and academic sessions are reimbursed. For current policy, and reimbursement forms, please see the Resident Mandated Travel and Reimbursement Policy

Pay and Benefits

As a resident, you will receive a salary, plus benefits for you and your dependents, at the level of a third-year resident (unless otherwise specified). This involves the completion of the required university forms and establishing precise start/stop dates of your training. It is strongly recommended that residents use the direct deposit method of payroll.

Should you have any problems regarding your pay cheque, your queries may be directed PHSA payroll, the central paying agency for all residents. Please see the Resident Doctors of BC website for contact information regarding payroll.

If you have any questions regarding benefits, please contact the Resident Benefits Coordinator, employeeRBsupport@phsa.ca; information regarding benefits can be found at the Resident Doctors of BC website.

Expenses

Please keep receipts for any expenses incurred due to participation in your palliative medicine training. Some expenses may be reimbursed through the Resident Activity Fund (see below).

Resident Activity Fund

As a Palliative Medicine resident, you are entitled to some reimbursement for expenses related to course and conference registration fees. Please consult with the Program Coordinator for details on available funds and use the reimbursement of expenses form provided when submitting the original receipts to us for reimbursement.

Pagers/Cell Phones

Pagers are no longer used during the year. You are expected to provide your cell phone as contact information during each rotation.

Malpractice Insurance

In addition to the coverage provided by the University and affiliated hospitals, residents are required to obtain their own individual malpractice insurance through the Canadian Medical Protective Association, P.O. Box 8225, Ottawa, Ontario, K1G 3H7 (phone: 1-800-267-6522).

Prescription Writing

Duplicate pads are required in BC for opioid and controlled medications. Please ensure these are ordered for your use, as they are used on many palliative medicine rotations. Please liaise with the Program Coordinator for details.

Immunizations

Residents are required to report immunization status prior to beginning of training, this will be/should have been part of your registration process.

Vacation Scheduling

Please see the Resident Doctors of BC website for details beyond what is below.

Please fill in this Qualtrics form for any vacation requests. The process for vacation:

1. Get Program Director's Approval
2. Get Site Lead's Approval
3. Update Google Schedule (RC) or (ES)
4. Inform Program Admin (fill in the Qualtrics form where you will need to upload a copy of the approval of the first two points)

You have 20 working days (M-F) of vacation to use during the year as per your Collective Agreement.

Call Schedules

As a resident, you will be expected to be on call on some, not all rotations. This is to enable you to gain experience in the working conditions you can expect to be moving to after you finish your program. You must honor the call schedule set up on your behalf. You should contact your preceptor for each rotation 6 weeks in advance of the rotation should there be any weekends or days that you do not wish to be on call.

While in most cases call should be determined a month in advance, on many rotations residents do not provide coverage on a regular basis, therefore call days/weekends can be determined in discussion with the site faculty.

Sick Days

Residents must inform the Program Director and their rotation supervisor or supervising staff, and the Program Coordinator when taking sick days. Additionally, the resident is required to update RMS. Residents sick for longer than 5 consecutive days, must contact their Program Director to discuss their situation and, at the Program Director's discretion, may be required to follow the procedures for medical leaves (short or long term).

Staying in Touch

It is important that you keep your contact information with the Program up to date. The difficulty with a de-centralized program such as this is that when it is imperative to reach a resident immediately, it may take hours to track them down and may even be impossible. Please help in maintaining the point of contact throughout your training by notifying the Palliative Care Program Office and Residency Program

Director of any change in your mailing address, phone number or email. You will be given a UBC email address, and are strongly encouraged to use this address, or forward it to your regular email address, as it will be used routinely by the PGME office.

PRINCIPLES FOR THE LEARNER

Learning to be and remain competent as a physician is an ongoing developmental process if acquiring wise judgment, attentive compassion, precise skills, and accurate information. While change is constant, and uncertainty exists with every patient encounter, the principles of learning to become and be this effective physician remain constant. Reflection and self-assessment are fundamental to becoming such a self-directed learner. The following description addresses some of the principles:

A. Principles for the learner

- Learning is a consequence of clinical experience and that experience is not altered without altering the person;
- Learning is an experience which occurs inside the learner and is activated by the learner; thus no one directly teaches anyone anything of significance;
- Learning is the discovery of the personal meaning and relevance of ideas;
- Learning is a co-operative and collaborative process;
- Learning is an evolutionary process;
- Learning may be painful;
- One of the richest resources for learning is the learner him/herself;
- The process of learning is emotional as well as intellectual.

B. Context of learning for the faculty

Effective instruction of a learner occurs best if:

- The individuality of the resident is recognized;
- There is active participation of the learner(s);
- There is immediate and frequent feedback;
- Clinical preceptors/faculty are most effective facilitators of learning when in a professional relationship, where they might integrate five distinct educational roles as:
    - An instructional designer (goals, plans, implementation, & evaluation);
    - A role model;
    - A resource;
    - A supervisor;
    - A mentor, a relationship that fosters professional and personal development by believing in the learner, helping them refine, support and attain their dream.

"Imagination is more important than knowledge."

- A. Einstein

CHARACTERISTICS OF A SELF-DIRECTED LEARNER

- Takes the initiative, with or without the help of others, in diagnosing or assessing his/her own learning needs;
- Selects appropriate resources and, when necessary, temporarily surrenders some measure of independence for the sake of expedience in learning;
- Develops, through inquiry and reflection, appropriate criteria by which to evaluate specific learning goals;
- Asks for justification of rules, procedures, principles and assumptions which it might otherwise by natural to take for granted;
- Refuses to agree or comply with what others state or demand where this seems critically unacceptable;
- Is aware of alternative choices, both as to learning strategies and to interpretations or value position being expressed, and makes reasoned choices about a preferred course of action;
- Continually reviews his/her approach to learning and makes strategic and tactical adjustments in order to optimize learning;
- Conceives of goals, policies and plans independently of pressures from others to do so, or not to do so;
- Independently forms opinions and clarifies beliefs, yet is willing to relinquish beliefs or to alter opinions when relevant contrary evidence is presented, and does so irrespective of the presence or absence of external rewards or pressures;
- Clarifies what is of personal value or in one’s interests, as distinct from what may be expedient, or what may be convenient; and,
- Is willing and able to accept alternative points of view as legitimate and is able to deal with objections, obstacles, and criticisms or one’s point of view without becoming defensive, threatened or angry.

- Daniel D. Pratt

COMPLAINT MANAGEMENT SYSTEM

WHERE CAN *POSTGRADUATE* STUDENTS GO TO DEAL WITH COMPLAINTS?

1. Your Preceptor/Education Site Lead
2. The Enhanced Skills Palliative Program Director
3. The Enhanced Skills Program Director
4. The Division Head
5. Resident Doctors of BC
6. PGME Faculty Lead for Educational Environment
7. Associate Dean, Postgraduate Education
8. Associate Dean, Equity
9. College of Physicians and Surgeons of B.C.

In turn any or all of these resources may contact the Associate Dean, Equity to coordinate the process.

Please see this section on the PGME website for appropriate links:

Dr. Henry Broekhuyse is the PGME Faculty Lead for the Educational Environment. Although multiple policies and portals of entry for concerns currently exist, PGME feels that it is important to have a dedicated faculty who is in a non-evaluative role available for our learners. Any concerns regarding mistreatment or learning environment can be confidentially discussed with Dr. Broekhuyse who is in a position to support and advise on next steps (if any). Dr. Broekhuyse can be reached at: **Pgme.educational.environment@ubc.ca**

PGME Trainee Mistreatment and Learning Environment Reporting Process

Professional Standards fo aculty Members and Learners' in the Faculties of Medicine and Dentistry

Policy and Processes to address unprofessional behavi r (including harassment, intimidation) in the Faculty of Medicine

UBC Policy # 3 - Discrimination and Harassment

UBC Policy # SC17 - Sexual Misconduct and Sexualized Violence Policy

UBC Statement on Respectful Environment for Students, Faculty and Staff

CMA Code of Ethics and Professionalism

CMA Guidelines for Physicians for Interaction with Industry

UBC Policy # SC3 - Conflict of Interest and Conflict of Commitment