European Association for Palliative Care (EAPC)

REPORT and RECOMMENDATIONS

OF A WORKSHOP ON

PALLIATIVE MEDICINE

EDUCATION AND TRAINING

FOR DOCTORS IN EUROPE

BRUSSELS

MARCH 20th-21st, 1993

under the auspices of :

EC 'Europe Against Cancer' Programm

European School of Oncology (ESO)

Scuola Italiana di Medicina e Cure Palliative (SIMPA)

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1 - INTRODUCTION

A representative group of experts, specialists in palliative medicine and general practitioners from Member States of the European Community and Sweden met under the aegis of the European Association for Palliative Care (EAPC) and the European School of Oncology (ESO), supported by funds from EC 'Europe Against Cancer' Programme in Brussels on March 20th - 21st 1993 (Appendix A).

2 - REMIT

The remit was to study the present state of palliative medicine training for medical students and doctors in the Member States and to make recommendations.

3 - RECOMMENDATIONS

The Workshop strongly endorsed the recommendations of the Report of a Subcommittee on Palliative Care (1992) produced by the EC 'Europe Against Cancer' Programme (Appendix B) and **unanimously recommended** that

1. *palliative medicine should become an obligatory and integral part of the undergraduate curriculum in all medical schools, taught in the clinical years and made an examinable subject*

2. *palliative medicine be included in the training programme of all General practitioners organized where possible by general practitioners for general practitioners with specialist input as appropriate*

3. *palliative medicine be included in the training programmes for hospital doctors whatever their future special interest; that it be multidisciplinary teaching where possible, routinely evaluated and reviewed, and made the responsibility of a doctor or group of doctors with special interest and experience in palliative medicine*

4.1 *Member States keep under review the possibility and potential benefits of doctors undertaking additional training in palliative medicine so that they may practice it as a 'special interest' subject*

4.2 *Member States keep under review the question of palliative medicine being accorded the status of a full specialty subject, with its own advanced training programme for those who elect to make palliative medicine their career specialty*

4.3 *where specialty status and training are approved, the training programme be similar to that devised for the United Kingdom and the Republic of Ireland by the Royal College of Physicians of London and the Association for Palliative Medicine. (Appendix C)*

5. *the curricula for medical student, general postgraduate professional training and special interest specialist training produced by the Association for Palliative Medicine of Great Britain and Ireland be used as a basis for the development of comparable curricula for use throughout the EC. (Appendices D & E)*

6. *English and French language courses in teaching techniques be developed within the EC to enhance the teaching skills of doctors practicing and teaching palliative medicine*

7. *research be encouraged and conducted on such aspects of health care provision, patients' perceived needs and professional education as will influence palliative medicine education in Member States.*

8. *the European Association for Palliative Care should produce a directory of reference books, handbooks, videos, distance-learning material, CD-Is etc. to facilitate professional education in*

palliative medicine.

4 - DEFINITION OF PALLIATIVE MEDICINE

It was noted that in some Member States there appeared still to be uncertainty about the definition of this subject.

The World Health Organization (WHO) states that

"Palliative care is the active, total care of patients at a time when their disease is no longer responsive to curative treatment and when control of pain, or other symptoms, and of psychological, social and spiritual problems is paramount. The overall goal of palliative care is the highest possible quality of life for the patient and family. Palliative care affirms life and regards dying as a normal process. Palliative care emphasizes relief from pain and other distressing symptoms, integrates the physical, psychological and spiritual aspects of patient care, offers a support system to help the patient live as actively as possible until death and a support system to help the family cope during the patient's illness and in bereavement".

The Workshop, whilst accepting this **definition, recommends** that for education purposes throughout the European Community, the acceptable definition should be :

"Palliative medicine is the appropriate medical care of patients with advanced and progressive disease for whom the focus of care is the quality of life and in whom the prognosis is limited (though sometimes may be several years). Palliative medicine includes consideration of the family's needs before and after the patient's death".

5 - SPECIFIC GOALS OF A PALLIATIVE MEDICINE CURRICULUM

(adapted from the Canadian Palliative Care Curriculum)

ATTITUDES

1. to show students and doctors that the therapeutic process involves more than diagnosing and attempting to revert unaltered pathophysiologic process and that illness is a complex state with physical, psychological, social and spiritual elements

2. to demonstrate the multidisciplinary approach of palliative medicine

3. to demonstrate preventive steps to avoid physical, psychological and social problems

4. to emphasize that all intervention should be centred on the patient's needs, desires and beliefs, thus ensuring control by the patients, whenever possible, of decisions which affect them

5. to have students and doctors identify their own attitudes towards death, and to identify and respect family attitudes towards death

6. to enable students and doctors to understand that the unit of care is the family, and to consider the impact of illness upon the family group

7. to demonstrate how the impact and interpretation of illness depends on personal attitudes by providing examples of harmonizing the various European medical models of care with the cultural and spiritual backgrounds of patients and families

8. to involve students in discussions on ethical aspects of providing care, including euthanasia, resuscitation, truthfulness, paternalism, aggressive versus palliative interventional therapy, incompetent patients, fairness in the health care system and strategies for resolving ethical issues

KNOWLEDGE

9. to describe the pathophysiology of common, distressing symptoms in patients with advanced chronic disease and to suggest appropriate pharmacological and non pharmacological techniques to combat these symptoms

10. to have students identify various organizational arrangements for delivery of palliative medicine and the relationship of these organizational structures to the existing health care system, including the community resources available to patients with advanced illness and their families

11. to describe the elements of grief reactions and some techniques to prevent the development of pathological reactions through caring for the patient and bereaved family.

SKILLS

12. to enable students and doctors to integrate knowledge from other health care professions and critically to appraise clinical data, diagnostic tests and the literature in order to assist with decisions to initiate or stop various investigations and therapy

13. to demonstrate various techniques for communication with patients and families, as well as how and why these techniques should be modified, based on the personal, educational and

cultural background of the patient and family

SUMMARY OF WORKSHOP

6 - DOCUMENTATION

Delegates attending the Workshop were furnished with

1. a report on the current state of palliative medicine provision and education (under- graduate, general post-graduate, general practice and specialist) for each of the twelve Member States and Sweden

2. the Report of the European Association for Palliative Care on Education in Europe (1992)

3. the Report of a Subcommittee on Palliative Care (1992) of the EC 'Europe Against Cancer' Programme

4. Palliative Medicine Curriculum for Medical Students, General Professional Training and Higher Specialist Training (Association for Palliative Medicine of Great Britain and Ireland)

5. the curriculum of Scuola Italiana Di Medicina E Cure Palliative (SIMPA, Italy)

6. the Outline of a Training Programme for General Practitioners on Palliative Care for the Patient with Cancer (Netherlands)

7. the Canadian Palliative Care Curriculum.

7 - DETAILED OBSERVATIONS

1. <u>Undergraduates</u>

Wide variations were noted in respect of time allocated and importance attached, to palliative medicine input in undergraduate curricula, up to one week being allocated in one and nothing in many other medical schools. Whether it was taught appeared to be more related to individual initiatives than medical school or national policy.

There was **unanimous and strong agreement** that palliative medicine be introduced into the curriculum of each medical school as a matter of urgency. It should be:

- taught in the clinical years
- taught as a module, either in a single block or in parts over three years
- taught by a multiprofessional faculty if possible
- organized or supervised by a doctor expert and experienced in palliative medicine
- taught making use of all audio-visual materials and other modern techniques known to be widely available in the subject
- based on modern health care and educational research, the results of which are readily available in specialist journals and books devoted to palliative medicine
- made **examinable** to emphasize its importance.

2. General Practitioners

The widely differing patterns of health care provision and organization were acknowledged and, in particular, the standing of general practice and its training programmes in Member States.

It was recognized that general practitioners have a key role to play in the provision of palliative care, both for those who die at home and for the many who wish to spend as long as possible at home before being admitted to a hospital, hospice or nursing home. The need for improved palliative medicine training for general practitioners was regarded as a matter or urgency.

It was **unanimously agreed** that this need for improved palliative medicine education and training be addressed as a priority, using the basic curriculum already devised and accepted for the United Kingdom and the Republic of Ireland, making use of general practitioners themselves for its organization with input where appropriate from palliative medicine specialists.

3. Hospital Doctors and Specialization

The emergence of palliative medicine as a 'special interest' subject for some doctors and as a full specialist career for others (as in the United Kingdom and the Republic of Ireland at present) were seen as something which might develop in the future but was not regarded as a matter of immediate priority. Nevertheless, the potential for such specialization both to further the subject and to enrich medical education throughout the EC was acknowledged, without in any way denying the considerable financial implications.

4. Training the Teachers

It was agreed that the quality of education and training is largely dependent on the teaching skills of the educators and that there were few trained teachers in the field of palliative medicine at present.

4.1 It was accordingly **recommended** that courses be run in English and French speaking centres on modern educational techniques, methods, materials, evaluation and assessment. Such courses, without the necessity for any examination or the award of Diploma or Certificate, might be a responsibility of the EAPC.

4.2 It was agreed that a European Diploma in Palliative Medicine or a Diploma in Palliative Medicine Teaching were not appropriate at this stage but could be pursued later.

5. Research

The need to base education on well-conducted research on health care provision and patients' perceived needs was accepted. The EAPC and its members are **urged** to encourage such research.

APPENDIX A

List of Participants

Workshop Chairmen:

Dr. Derek Doyle	(EAPC, National Council of Hospices and PC Services)
Dr. Robert Twycross	(International School for Cancer Care)

Experts:

Dr. Chantal Couvreur	(Consultant for P.C. "Europe against Cancer)
Dr. Franco De Conno	(SIMPA, EAPC)
Dr. Xavier Gomez-Batiste	(WHO Demonstration Project, Catalonia)
Dr. Jean Nicola Ormsby	(Specialist for education "Europe against Cancer")
Prof. Vittorio Ventafridda	(Chairman EAPC, SIMPA)
Prof. Robert Zittoun	(ESO)

	Palliative Care Specialists	**General Practitioners**
Belgium :	Dr. Catherine Markstein	Dr. Diderik Hemans
Denmark:	Dr. Ivar Ostergaard	
France :	Prof. René Schaerer	Dr. Jean-Marie Gomas
Germany :	Dr. Raymond Voltz	Dr. Martina Weiss-Plumeyer
Great Britain :	Dr. Anthony Smith	Dr. D.G. Millar
Greece :	Dr. Kiriaki Mistakidou	Dr. George Bellos
Ireland :	Dr. Tony O'Brien	Dr. Seamus Cryan
Italy :	Dr. Michele Gallucci	
Luxembourg :	Dr. B. Till	Dr. Martine Stein
Netherlands :	Dr. Zbigniev Zylicz	Prof. E. Schade
Portugal:	Dr. Luis Portela	Dr. Isabel Galrica Neto
Spain :	Prof. Jaime Sanz Ortiz	Dr. Rogelio Altisent
Sweden:	Dr. Carl Johan Fürst	Dr. Anne-Marie Gravgaard

Observers :

Germany:	Dr. Detlev Zech
The Netherlands:	Dr. Ruthmarijke Smeding

APPENDIX B

Report of a Sub-Committee on Palliative Cancer Care (1992):

EUROPE AGAINST CANCER

(I) University hospitals and national cancer institutes should have a palliative care department or team to facilitate the education and training of all doctors in this field

(II) Health care workers should be taught the essential components of palliative care in a way that is relevant to their profession. Pain management should be given priority and should be an integral part of basic and continuing education for health care professions.

(III) Palliative care should be a compulsory part of under-graduate courses leading to basic professional qualification for nurses, doctors and other health care workers

(IV) Post-graduate courses and research opportunities in palliative care should be established, with priority for those responsible for nursing and medical education and training ('training the trainers')

(V) Continuing education and training should be provided for doctors and nurses practicing palliative care; and updating courses should be provided regularly for other doctors and nurses involved in the care of cancer patients.

APPENDIX C

Curriculum and Guidelines for Teaching of Palliative Medicine [at all grades]

including recommended syllabus content for

A - Medical students

B - General professional medical training

C - Higher specialist training in palliative medicine

ACKNOWLEDGEMENTS

These guidelines were prepared by a working party of the Association for Palliative Medicine of Great Britain and Ireland, 11 Westwood Road, Southampton, Hants, S02 lDL, U.K.

The Joint Statement on the Palliative Medicine content of Vocational Training for General Practice was prepared in association with the Royal College of General Practitioners and that for Higher specialist training in association with the Royal College of Physicians of London.

o INTRODUCTION

In 1991, the Regional Educational Representatives of the Association for Palliative Medicine established a Working Party to produce a syllabus for teaching palliative medicine at all levels.

The working party identified three desired levels of knowledge:

A = medical student

B = general practitioner and hospital doctor

C = registrar and senior registrar in palliative medicine

The syllabus sets standards for training doctors in palliative medicine. The list of topics is not exhaustive, and can be developed further at local level. Topics relevant to medical student teaching (level A) are included as a separate section within this document.

The syllabus is designed to be appropriate for teachers and learners alike. The format enables the document to be used as a means for evaluating educational programmes.

The syllabus is compatible with the curriculum for vocational trainees of the Royal College of General Practitioners (1991), as cross-referenced at level 'B'. This curriculum is included as a separate section within this document.

The higher professional training syllabus, cross referenced at level 'C', is compatible with the report of the Joint Committee on Higher Medical Training (1991).

The working party used the following definition of palliative medicine:

> *Palliative medicine is the appropriate medical care of patients with advanced and progressive disease for whom the focus of care is quality of life and in whom the prognosis is limited (although sometimes it may be several years). Palliative medicine includes consideration of the families' needs before and after the patient's death.*

'Family' refers to those closest to the patient. Often this will be the patient's kin; sometimes it will mean a close friend or friends.

SYLLABUS

* PHYSICAL ASPECTS

.Disease process

The doctor should:

know the meaning of "terminal illness" and of "palliative medicine"A

be aware that cancer may be curable and does not always mean a terminal illness A

understand that the principles of palliative medicine are also applicable to people with a wide variety of life threatening illnesses A

understand the concept of clinical re-evaluation as the disease progresses A

be able to anticipate likely potential problems, caused either by the disease or by treatments B

have skills in diagnosis and management of common concurrent conditions B

know the natural history, markers of progression and range of treatments available at each stage of the following: B

- malignant diseases
- acquired immune deficiency syndrome (AIDS)
- chronic debilitating neurological conditions; in particular, motor neurone disease (amyotrophic lateral sclerosis)

know the benefits of 'shared care' between other specialities and palliative medicine, notably radiotherapy and oncology C

.Symptom control

The doctor should know that symptoms may be: A

- caused by the disease itself
- caused by treatment
- related to the disease or associated debility
- caused by a concurrent disorder

The doctor should:

be able to manage each symptom appropriately B

understand the place of palliative surgery, radiotherapy, chemotherapy and B

hormone therapy

Specific symptoms to be considered are:

pain - taking a pain history, including the use of pain charts and pain scores A

diagnosis of different types of pain including the differentiation between nociceptive and neurogenic pain A

factors influencing pain (physical, psychological, social, spiritual) A

response and non-response to opioids and other analgesics A

monitoring response to treatment A

appropriate referral to pain clinic, oncology or radiotherapy services B

non-drug treatments C

common nerve blocks C

sore mouth	A
candidiasis	A
mouth care	B
anorexia	A
nausea and vomiting	A
constipation	A
diarrhoea	A
intestinal obstruction	B
dysphagia	B
pruritis	B
jaundice	B
dyspnoea	A
cough	A
hiccups	A
anxiety and fear	A
depression	A
acute confusional states (delirium)	A
weakness and lethargy	B
sexual problems	B
incontinence	B
bladder and rectal spasms	C
smell	B
lymphoedema	C

The doctor should be able to manage common emergencies in palliative medicine: B

hypercalcaemia
spinal cord compression
superior vena caval obstruction

massive haemorrhage

The doctor should be able to manage:

fungating lesions, including choice of dressings B
pressure area care B
stoma care B
raised intracranial pressure B
restlessness in the last days of life B
fistulae C
malignant effusion C
iatrogenic disease C

The doctor should be able to: C

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 B
indwelling epidural catheters C
local anaesthetic and corticosteroid injections C
nebulised local anaesthetics and opioids. C

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

.**Pharmacology**

The doctor should know:

the classification of analgesics (as defined by the World Health Organisation) and their use A

which drugs are commonly used for the control of symptoms, usual frequency of administration, typical doses and common adverse effects A

the various routes for drug administration and when each is appropriate A

the indications for a syringe driver A

the compatibility and miscibility of drugs used in syringe drivers B

how to set up a syringe driver B

the effects of renal and liver failure on drugs commonly used in palliative medicine B

the importance of the pharmacokinetics of drugs used to control symptoms B

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 B

the equivalent doses of different opioids B

be able to recognise the less common adverse effects of drugs used in palliative care B

* **PSYCHOSOCIAL ASPECTS**

.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 A

be able to draw up a family tree (genogram) and understand its uses A

understand the importance of meetings with the family B

be aware of the psychodynamics of interpersonal relationships and the changes which can occur in illness. B

.Communication skills

The doctor should demonstrate skills in:

listening A

assessing the patient's knowledge of the diagnosis and prognosis A

giving information about the diagnosis and/or deterioration sensitively to both patient and family ('breaking bad news') A

imparting an appropriate amount of information to a patient at appropriate times A

dealing with 'difficult questions' A

eliciting and responding to the fears of patients and their family A

empowering the patient to exercise autonomy A

.Psychological responses

The doctor should:

understand responses to loss and that these manifest normally at various times and are a form of grief A

understand the importance of hope; and that this may have other goals than cure A

be aware of the special needs of children and other vulnerable groups, including those with learning difficulties B

recognise and handle appropriately the normal responses to bad news and loss, including:

- anger B
- guilt B
- denial B
- collusion and conspiracy of silence B
- the unrestrained expression of grief C

have insight into:

- transference B
- personal limitations C
- specialist limitations C

.Sexuality

The doctor should understand:

the patient's perception of his/her sexuality, including body image, and the effect of disease on this A

the need for privacy to allow the patient and family to express affection A

how alterations in libido affect the relationship between patient and partner B

.Grief

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

The doctor should be able to:

support a bereaved person A

help prepare the family for bereavement B

anticipate and identify a complicated grief reaction B

support the person with complicated grief B

assess the need for referral to other agencies B

recognise the special needs of bereaved children B

provide staff support to the bereaved team C

recognise and support the individual team member who is bereaved C

support people involved in bereavement counseling C

know about bereavement counseling methods, including the organisation of services C

recognise the counselor who is in need of additional support C

.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 A

recognise the value of asking for help with personal feelings A

identify where support is available A

recognise the sources of personal opinions and belief systems and the danger of A projecting these feelings onto others

cope with guilt-feelings in self and others arising from deficiencies in care A

recognise the impact of personal loss and grief on the delivery of care B

understand the ways of providing and using staff support C

perceive the effect of chronic exposure to grief and loss, distinguishing between C normal emotions and 'burn out'

recognise the syndrome of the compulsive carer C

recognise in self and others the danger of trivialising and denying personal needs C by always putting patient's needs first

* **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 A

recognise the importance of religious and cultural influences, including language, on all aspects of palliative care A

recognise the importance and effect of the beliefs of the patient, carers and the doctor on the process of care B

be aware of the attitudes and practices of the major religions relating to illness and death C

* **ETHICAL ASPECTS** A

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

The doctor should show 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 judgements 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')

* **TEAMWORK**

The doctor should:

appreciate the skills and contributions of others, both medical and non-medical, to A

palliative care

understand the concept of teamwork A

be aware of the role of statutory and voluntary organisations involved in patient care B

demonstrate an ability to work in a multi-disciplinar,v team, understanding boundaries and professional rivalries B

be sensitive to the dynamics of the team in different situations C

be able to chair team meetings C

be aware of the different forms of team support C

understand strategies which facilitate team functioning C

recognise that conflict in a team is inevitable and handle this constructively C

be able to consider the 'skill-mix' of the team, particularly when appointing new team members C

* **ORGANISATIONAL ASPECTS**

.Statutory regulations

The doctor should know about:

certification of death A

liaison with the coroner's office and regulations concerning statutory notification to the coroner A

cremation regulations A

procedures for relatives following a death and how cultural influences affect this A

grants, funds and allowances available to the terminally ill A

the role of the undertaker B

controlled drugs regulations and local policy B

.Practical support for the patient and family

The doctor should know about the quality of care available in different settings (i.e. home, hospital, hospice and other places) and how to obtain access to this care B

The doctor should know how to obtain:

appliances e.g. commodes, wheelchairs, cushions and mattresses B

assessment by an occupational therapist for modifications to the home B

physiotherapy B

support services available to care for the person dying at home, e.g. home help, day and night sitting services, volunteers help with shopping, meals on wheels and specialist nursing (Marie Curie and Macmillan) B

the services of a Disablement Services Centre for artificial limbs and appliances C

The doctor should:

understand the principles of rehabilitation C

know of facilities available for rehabilitation C

be aware of the specific skills of breast counselor, prosthetic advisors and stoma care therapists C

* **NON CLINICAL ISSUES**

.Management C

The doctor should know about:

recruiting and staff selection, including person specifications, job descriptions and interviewing techniques

appraisal systems and staff development, counseling and disciplinary procedures

NHS reforms and the funding of independent hospice services

budgetary systems

annual accounts including the balance sheet and profit and loss account

the principles of fund raising

the preparation of strategy and the principles of business planning

the role of the administrator

the administration of the National Health Service and Health Authorities, including committee structures

organisation of health care within the National Health Service

effects of manpower strategies on staffing levels

principles of management structures

differentiation between clinical and management issues

various committee structures in the charitable sector

the different major charities involved in palliative care

the legal status of charitable trustees and the responsibilities of employees to the trustees

local regional strategy for care of the dying

laws and regulations relating to registered nursing homes

different ways in which palliative care is organised in different districts, their advantages and disadvantages

.Research C

The doctor should:

have the opportunity to undertake research: this implies adequate time (at least 2 sessions per week) and adequate supervision

understand how to apply for a research grant

know how to manage a research budget

.Audit B

Through involvement in regular audit, the doctor should understand:

the principles of audit

the application of audit in palliative care

.Teaching

The doctor should: C

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 Regional Postgraduate Dean

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

APPENDIX D

Palliative Medicine Syllabus for Medical Students

Association for Palliative Medicine of Great Britain and Ireland

INTRODUCTION

This syllabus provides a summary of the topics in palliative medicine which should be covered during medical student training.

It is recommended that a designated member of the medical school staff takes responsibility for implementing the syllabus and coordinating teaching to ensure a systematic approach to the subject.

Individual course organisers and tutors may wish to expand on specific items. Teaching methods are not discussed. An interactive approach is encouraged, supported by suitable written material e.g. lecture notes.

Throughout the syllabus the term 'family' refers to those closest to a patient. Often this will be the patients kin; sometimes, however, it will mean a close friend or friends.

The broad framework of physical, social, emotional, and spiritual components to each patient's symptoms can be used as a teaching model. The aims of the syllabus are to allow the student to develop:

- *An understanding of the principles of the palliative approach and its relationship to diagnosis and care*
- *The concept of clinical re-evaluation as disease progresses*
- *An understanding of the strengths of teamwork in this field and the contribution of other professions*
- *Confidence to cope with difficult questions*
- *The need for application of clinical skills and evaluation of the patient to ensure the best possible quality of life for patient and family*

SYLLABUS

* PHYSICAL ASPECTS

.Disease process

The medical student should learn:

the meaning of 'terminal illness' and 'palliative medicine'

that cancer may be curable and does not always mean a terminal illness

that the principals of palliative medicine are also applicable to people with a wide variety of life- threatening illnesses

the concept of clinical re-evaluation as the disease progresses

the differing patterns of advanced HIV infection

Symptom control

The medical student should learn that symptoms may be:

caused by the disease itself

caused by treatment

related to the disease or associated debility

caused by a concurrent disorder

The medical student should learn that:

the incurably ill patient may have minimal symptoms

pain is not synonymous with cancer all symptoms

require attentive treatment

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 neurogenic pain
- factors influencing pain (physical, psychological, social, spiritual)
- response and non-response to opioids
- monitoring response to treatment.

sore mouth
candidiasis

anorexia
nausea and vomiting
constipation
diarrhoea
dyspnoea
cough
hiccups

anxiety and fear
depression
acute confusional states (delirium)

The student should develop an understanding of:

the frustration and disability caused by weakness

ways to prevent the development of pressure sores

management of long-term indwelling urinary catheter and other devices

.Pharmacology

The medical student should learn:

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

* **PSYCHOSOCIAL ASPECTS**

.Family and social background

The medical student should learn:

to assess the differing perceptions and expectations of disease and treatment among the various family members

to draw up a family tree (genogram) and understand its uses

.Communication skills

The medical student should learn the skills of:

listening

assessing the patient's knowledge of the diagnosis and prognosis

giving information about 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

.Psychological responses

The medical student should learn to understand:

responses to loss and that these manifest normally at various times and are a form of grief

the importance of hope and that this may have other goals than cure

.Sexuality

The medical student should learn to understand:

the patient's perception of his/her sexuality, including body image, and the effect of disease on this

the need for privacy for the patient and family to express affection

.Grief

The medical student should learn to recognise:

the common pattern of responses to bereavement

ways to support a bereaved person

abnormal grief reactions which may benefit from further professional help

.Awareness of personal and professional feelings

The medical student should learn 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 opinion 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

* **RELIGIOUS AND CULTURAL ISSUES**

The medical student should learn:

the importance of seeking appropriate help in responding to the spiritual needs and questions of the patient

to recognise the importance of religious and cultural influences, including language, on all aspects of palliative care

* **ETHICAL ASPECTS**

The student should learn how doctors can 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 the third party

fulfilling the patient's need for information about any treatment

respecting the patient's wish to decline treatment

The medical student should learn to show respect for life and acceptance of death and that:

treatment should never have the specific induction of death as its aim

a doctor has neither right nor duty, legal or ethical, to prescribe a lingering death

The medical student should learn to:

understand the issues which surround requests for euthanasia

recognise the dangers of professionals making judgements 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

understand decisions involved in the allocation and use of resources

* **TEAMWORK**

The medical student should learn to:

appreciate the skills and contributions of others, both medical and non-medical, to palliative care

understand the concept of teamwork

* **STATUTORY REGULATIONS**

The medical student should learn about:

grants, funds and allowances available to the terminally ill

procedures for relatives following a death and how cultural influences affect this

certification of death

liaison with the coroner's office and regulations concerning statutory notification to the coroner

cremation regulations

APPENDIX E

ROYAL COLLEGE OF GENERAL PRACTITIONERS

ASSOCIATION FOR PALLIATIVE MEDICINE

Joint Statement on Palliative Medicine
Content of Vocational Training

Guidelines for Vocational Training in Palliative Medicine

Introduction

A joint working party of the Royal College of General Practitioners and Association for Palliative Medicine was established, at the request of the Education Division of the RCGP Council, in April 1991. The remit of the group was to devise guidelines for postgraduate training in palliative medicine for vocational training for general practice.

The membership of the working group was as follows: Drs. Ilora Finlay, Anthony Smith and Nigel Sykes from the Association for Palliative Medicine, and Drs. Carolyn Chew, Roger Chapman and Huw Lloyd from the Royal College of General Practitioners.

1. Remit of the Working Party

The working group agreed that the following definition of Palliative Medicine be used: palliative medicine is the medical care of patients with advanced and progressive disease for whom the focus of care is quality of life and in whom the prognosis is limited, but may be a number of years. Palliative Medicine includes consideration of the families' needs before and after the patient's death.

The group also felt that their discussion should extend to include other aspects of death and bereavement.

The subjects covered in the syllabus (Appendix I) are applicable to all forms of illness in their palliative and terminal phases, especially HIV infection and neurological diseases, as well as patients with malignancy.

The term family refers to those closest to the patient, both the patient's actual kin and a close friend or friends.

2. Place of Training

It was agreed that experience of, and thus training in, palliative medicine may occur in hospital, hospice and general practice. The main opportunity for training, however, was felt to be the general practice trainee year. As this is undertaken by all prospective GPs, some

consistency can be achieved.

3. Training Objectives

The aim of specific training in palliative medicine is to enable all general practitioners to obtain the knowledge and the skills to promote the highest quality of life for each individual patient and their family and carers. The minimum standards towards this aim will be achieved by implementation of the core curriculum and the other recommendations outlined in this report.

A core curriculum in palliative medicine has been compiled for general practitioner vocational training and is applicable throughout general practitioner vocational training. It is anticipated that the trainee, trainer and course organiser can use the curriculum to identify areas not already covered in the hospital component of training and to build on knowledge, skills and attitudes already acquired.

The curriculum (Appendix I) has been defined to ensure that doctors understand, and gain experience in, all aspects of care. The curriculum outlines (1) the physical aspects of care including the disease process and symptom control, (2) psycho-social aspects of care including communication skills, psychological responses, grief, sexuality and dealing with one's own feelings. (3) Cultural and (4) ethical issues are discussed and (5) the importance of teamwork is stressed. (6) Practical aspects including regulations relating to palliative medicine are also listed.

Many issues covered in this document are highlighted in palliative medicine, but provide educational opportunities to develop skills which are widely applicable to other aspects of general practice. The development of communication skills and the effect of terminal illness on all members of the family provide examples for training.

Appendix II looks at the commonest posts approved for hospital training, and identifies specific training opportunities from these posts.

This curriculum accords with recommendations of the General Medical Council: Education Committee (1987) on the attributes of the independent practitioner (Appendix III).

4. Educational Context and Methods

Educational Context

During the years of vocational training for general practice there should be a continuing programme of education in palliative medicine based on the core curriculum.

During the hospital component of training the Course Organiser should:

- retain overall management of the educational programme
- monitor the educational content of hospital posts and feedback to teachers
- meet appropriate needs through the half-day release course
- encourage adoption by consultants of a wide range of educational methods appropriate to the task.

During the practice year GP teachers should:

- undertake assessment on entry to define the trainee's remaining learning needs,

based on the core curriculum

- set objectives on the basis of this assessment

- reassess attainment of the objectives set.

Educational Methods

The teaching and learning of palliative medicine lends itself to a particularly wide range of educational methods:

(1) Reading - both technical (e.g. therapeutics) and experiential

(2) Experiential learning through
- one to one tutorials
- small group discussions
- project work
- portfolio learning

(3) Case studies

(4) Computer assisted learning

(5) Multi-disciplinary conferences

(6) Hearing experiences of patients, carers and patient groups; discussing these with the patient and with other doctors

(7) Demonstration of equipment and techniques, through video and hands on practice

(8) Auditing
- care
- learning

(9) Bedside teaching

(10) Lectures

In addition, first class consulting and communication skills are a sine qua non of good palliative medicine. The development of such skills through role play, video and observation should be a continuing process throughout vocational training.

Any or all of the above may be appropriate to either the hospital component of vocational training
or the year in practice. Adoption of appropriate educational methods should result from the auditing process.

The half day release course of general practice training allows the use of many of the above methods.

5. Needs of Learners

The specific needs of learners should be addressed, in particular:

- help and support is required for individuals to develop their own techniques for handling these particularly emotionally charged situations and the feelings resulting from involvement in

such situations

- educational programmes should be developed with the needs of adult learners clearly in mind
- adequate time must be made for the assessment of learners needs
- time for study leave must be arranged
- job descriptions should emphasise educational content and objectives and the educational responsibilities of consultant/trainer.

6. Teaching Resources

Resources to assist in teaching are listed in Appendix IV.

7. Local Policy

Local policy should include explicit recommendations about:

- assessment of trainees' needs at the beginning of the general practice trainee year
- definition of the roles of Trainers, Course Organisers, Associate Advisers, Regional Advisers and Postgraduate Deans
- need for method of assessment and feedback from trainees
- teaching time, study leave arrangements and half-day release
- monitoring of training
- provision for involvement in all aspects of audit.

8. Approval of Posts/Joint Hospital Visits

These should reinforce the recommendations contained in local policy.

Evaluation of educational needs at the start of each post and trainee feedback from each post should be available to joint hospital visitors and directly attributable to each post.

The working group firmly believe that posts with no educational value should not be approved for training in general practice.

APPENDIX I

TRAINING OBJECTIVES: CORE CURRICULUM

This curriculum defines minimum standards for trainees in general practice. The list is not necessarily exhaustive, and may be developed further by Regional Advisers, Course Organisers, Trainers or Trainees.

(1) PHYSICAL ASPECTS OF CARE

The disease process

The doctor should:

know the definitions of terminal illness and of palliative medicine

be aware that cancer is not always a terminal illness

understand that care of persons with a potentially life-threatening illness which may be curable, but in which there is uncertainty (e.g. Hodgkins disease), requires many aspects involved in palliative medicine

know the patterns of disease, markers of disease progression and the range of treatments available at each stage of disease, for the following range of diseases:

malignant diseases

acquired immune deficiency syndrome (AIDS)

chronic debilitating neurological conditions; in particular, motor neurone disease (amyotrophic lateral sclerosis)

understand that patients with other diseases e.g. cardio-respiratory failure, may be terminally ill

be able to critically assess and re-evaluate the clinical situation as the disease progresses

be able to anticipate likely potential problems caused either by the disease or by treatments

have skills in diagnosis and manage incidental conditions and iatrogenic illness.

Pharmacology

The doctor should:

know what drugs are commonly used for the control of symptoms, their usual frequency of administration, typical dose-range and common adverse effects

know the various routes by which drugs can be administered and when each is appropriate

know the indications for a syringe driver

know how to set up a syringe driver

know the compatibility and miscibility of drugs used in syringe drivers

know the effects of renal or liver failure on metabolism and elimination of drugs commonly used in palliative medicine

understand the importance of the pharmacokinetics of drugs when prescribing to control persistent symptoms

be able to weigh up benefits and risks of different drugs for symptom control; be aware that these may change as a patient's condition deteriorates

know the equivalent doses of different opioids

know and be able to recognise the less common adverse effects of drugs used in terminal care.

Symptom control

The doctor should be able to:

determine the cause of individual symptoms which may be:

caused by the cancer itself

caused by anti-cancer and other treatments

related to the cancer and/or debility

caused by a concurrent disorder

manage each of the symptoms appropriately

understand the place of palliative surgery, radiotherapy, chemotherapy and hormone therapy

Specific symptoms to be considered are:

(a) Pain - diagnosis of different types of pain including:

the differentiation between nociceptive and neurogenic pain

responsiveness and resistance to opioids

taking a pain history and monitoring response to treatment, including the use of pain charts

non-drug treatment

common nerve blocks

the range of treatments for difficult pain problems

(b) Anorexia
Nausea and vomiting
Constipation
Intestinal obstruction
Hiccups
Dysphagia

(c) Sore mouth
Candidiasis
Mouth care

(d) Cough
Dyspnoea

(f) Depression and appropriate sadness
Fears and anxieties
Acute confusional states (delirium)

(g) Pressure area care
Indications for different topical dressings
Managing fungating wounds, including controlling smell and local bleeding

(h) Stoma care

(i) Incontinence
bladder spasm and rectal tenesmus
smell, including the management of fungating lesions

(j) Sexual problems

(k) Lymphoedema

(l) Infections in the immuno-compromised patient especially

(1) HIV infected patients
(2) post chemotherapy

The doctor should be able to manage common emergencies in palliative care:

hypercalcaemia
spinal cord compression
superior vena caval obstruction
massive haemorrhage

The doctor should be able to manage:

fungating lesions including malodour and choice of dressings
fistulae
restlessness in the last days of life
raised intracranial pressure
malignant effusion
iatrogenic disease

The doctor should be able to:

recognise the limits of attainable symptom control
give permission to other carers to fail in attempts to achieve complete symptom control

The doctor should demonstrate skills in the appropriate use of:

syringe drivers
aids to daily living
an indwelling epidural catheter
local anaesthetic and steroid injections

nebulised local anaesthetics and opioids

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

The doctor should demonstrate an understanding of the place of palliative surgery, radiotherapy and hormone manipulation.

(2) PSYCHOSOCIAL ASPECTS OF CARE

Social and Family

The doctor should:

be able to assess the differing perceptions and expectations of disease and treatment amongst the various family members

be able to draw up a family tree (genogram) and understand its uses

understand the importance of family meetings

understand the psychodynamics of interpersonal relationships and the changes that can occur in illness.

Communication skills

The doctor should demonstrate skills towards both patient and family in the following:

empowering the patient to exercise autonomy

active listening

assessing the patient's level of awareness

informing of the diagnosis and/or deterioration gently and sensitively

imparting appropriate information about illness and its management

breaking bad news

dealing with difficult questions

eliciting and dealing with fears.

Psychological responses

The doctor should recognise the following in both patient and family:

anger
guilt
transference
collusion and conspiracy of silence
the special needs of children
response to loss (grief) that are manifest at various stages of illness

The doctor must understand that the patient's perception of hope may not be for a "cure", but instead, for example, a pain free death, honesty or the chance to see a longed-for grandchild.

Sexuality

The doctor should understand:

the patient's perception of his/her sexuality, including body image and personal appearance, and the effect of disease on this

how alterations in libido affect the emotional health of the relation ship between a patient and his/her partner

the need for privacy for the patient and family to express affection.

Grief

The doctor should demonstrate an ability to:

understand the normal process of grief

recognise the patient's response to loss e.g. of health, of limb, of role in life

help prepare carers for bereavement

support the person in grief

anticipate and identify the complicated grief reaction

support and manage the person with a complicated grief reaction

assess the need for the support of the other agencies

recognise children's special needs in bereavement.

Dealing with own feelings

There is a need for all doctors to:

recognise and deal with emotional stress in oneself and others in the primary care team

identify where GPs can obtain support appropriate to their own needs and the value of asking for help

recognise the sources and effects of one's own opinions and judgements

recognise the danger of transposing one's own opinions or judgements onto patients or families

consider how to deal with the guilt feelings arising from perceived deficiencies in care

have insight into one's own personal and professional limitations.

(3) CULTURAL ISSUES

Religious Beliefs

The doctor should recognise and consider the importance of, and the effect of:

the beliefs of the patient, the carers and the doctor on any process of care

the practices of the major religions as related to death

helping to meet spiritual needs either personally or by referral.

Cultural Influences

The doctor should recognise and consider the important effect of cultural influences including language on all aspects of palliative care.

(4) ETHICAL ISSUES

The doctor should demonstrate, in practice, respect for the patient as a person, autonomy', which involves:

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

The doctor should show respect for life and acceptance of death by understanding that:

treatment should never have the specific induction of death as its 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 judgements based on factors such as pre-morbid disability or the age of the dying person (e.g. death of a handicapped child, death of an elderly person)

aim to do good, (beneficence), and avoid harm, 'non-maleficence'
assess the risks versus the benefits of each clinical decision

The doctor should understand:

the right of the individual patient to the highest standard of care within the resources available

the decisions involved in the allocation and use of resources.

(5) TEAMWORK

The doctor must:

demonstrate an ability to work in a multi-disciplinary team

be aware of skills in others e.g. specialist and non-specialist nurses, occupational

therapists, social workers

understand the value of team support mechanisms

be aware that effective leadership of the team may on occasions be best devolved to others

be sensitive to the difficulties involved in teamwork e.g. understanding boundaries and inter-professional rivalry

be aware of the role of other organisations, including self help and support groups.

(6) PRACTICAL ISSUES

Interface between GP and consultant specialists

The doctor should understand:

the relationship and responsibilities of the specialist towards the patients

the relationship between primary care team and the hospital based team

the signs that communication between these services is in jeopardy

the action needed to ensure clear role definition

the need for the patient and family to understand the different roles and when and how to contact the most appropriate individual.

Practical support

The doctor should know how to obtain the following:

appliances, such as a commode

occupational therapist assessment for modifications to the home to assist with activities of daily living

physiotherapy services

support services available to care for the person dying at home, especially home help, sitter services (day and night), volunteer help with shopping, meals on wheels and specialist nursing

assessment for and provision of wheelchairs and cushions

the services of a Disablement Services Centre for artificial limbs and appliances

relevant grants, funds and allowances.

Organisational Issues

The doctor should know about:

controlled drugs procedures - national regulations and local policy

identification and certification of death

cremation regulations

procedures for relatives following death (& how cultural influences may affect this)

the role of the undertaker

facilities provided by different places of care:
home/hospital/hospice/other.

APPENDIX II

TRAINING OPPORTUNITIES FOR PALLIATIVE CARE IN HOSPITAL POSTS COMMONLY APPROVED FOR TRAINING IN GENERAL PRACTICE

Experiences and opportunities for teaching on aspects of palliative care can be found in most hospital posts suitable for general practice training. This appendix looks at the commonest posts most often approved for hospital training and identifies specific training objectives for these posts. The list is not exhaustive and other opportunities for training which may arise should not be ignored.

Accident and Emergency

The doctor should be competent in the practical aspects of resuscitation, but also have the ability to recognise when resuscitation is inappropriate or has failed. The doctor should demonstrate a working knowledge of legal issues surrounding sudden death and certification of death.

The doctor should have experience in dealing with aspects of sudden or traumatic death including sudden infant death syndrome, road traffic accidents and suicide. The way bad news is given and the way the immediately-bereaved are supported should be considered.

Obstetrics and Gynaecology

This post provides opportunities for learning about issues concerned with loss. These include infertility and loss of sexuality, miscarriage, still-birth and the birth of an abnormal baby.

Paediatrics

The doctor should gain an understanding of:

the effect of protracted childhood illness/handicap on a family

the effect of a terminally ill child on a family

responses of a child to illness
the impact of a childhood death on a family

the support required for parents and surviving children when a cot death or other bereavement occurs.

Medicine/Geriatric Medicine

The doctor should gain an understanding of:

issues of ageism and euthanasia

the principles of rehabilitation

the diagnosis and management of non-malignant death (end stage renal failure, cardiac failure or liver failure)

identifying and overcoming problems in communication due to sensory deficit, e.g. deafness, visual impairment, and motor dysfunction, e.g. dysarthria.

General Surgery

The doctor should gain an ability to:

recognise when curative treatment should be stopped and palliative medicine takes over.

evaluate the place of palliative surgery

manage inoperable symptoms.

Psychiatry

The doctor should gain an understanding of the stigma of disease.

The doctor should be able to demonstrate an ability to identify and manage:

normal and complicated grief reactions

psychiatric symptoms associated with terminal illness

organic psychoses, including drug related psychoses

depression and adjustment disorder, including appropriate sadness.

The doctor should have the opportunity to develop his/her communication skills, in particular the skill of active listening.

APPENDIX III

Attributes of the Independent Practitioner

(General Medical Council: Education Committee (1987))

The General Medical Council's Education Committee published its recommendations on the training of specialists in October 1987. These identified the attributes of the independent practitioner which are presented here to provide the background against which the specific recommendations for general practitioner vocational training in palliative medicine should be considered.

"All doctors share a common role in the prevention or alleviation of disease or distress through appropriate intervention. Education and training for specialities should not only include acquisition of the technical knowledge and skills of a particular speciality or its branches, but also development of the attributes set out below; together they contribute to a doctor's professional development"

(1) The ability to solve clinical and other problems in medical practice, which involves or requires:

(a) an intellectual and temperamental ability to change, to face the unfamiliar and to adapt to change;
(b) a capacity for individual, self-directed learning; and

(c) reasoning and judgment in the application of knowledge to the analysis and interpretation of data, in defining the nature of a problem, and in planning and implementing a strategy to resolve it.

(2) Possession of adequate knowledge and understanding of the general structure and function of the human body and workings of the mind, in health and disease, of their interaction and of the interaction between man and his physical and social environment. This requires:

(a) knowledge of the physical, behavioural, epidemiological and clinical sciences upon which medicine depends;
(b) understanding the aetiology and natural history of diseases;
(c) understanding the impact of both psychological factors upon illness and of illness upon the patient and the patient's family;
(d) understanding of the effects of childhood growth and of later aging upon the individual, the family and the community; and
(e) understanding the social, cultural, and environmental factors which contribute to health or illness, and the capacity of medicine to influence them.

(3) Possession of consultation skills, which include:

(a) skills in sensitive and effective communication with patients and their families, professional colleagues and local agencies, and the keeping of good medical records;
(b) the clinical skills necessary to examine the patient's physical and mental state and to investigate appropriately;
(c) the ability to exercise sound clinical judgment to analyse symptoms and physical signs in pathophysiological terms, to establish diagnoses, and to offer advice to the patient taking account of physical, psychological, social and cultural factors; and
(d) understanding of the special needs of terminal care.

(4) Acquisition of a high standard of knowledge and skills in the doctor's speciality, which include:

(a) understanding of acute illness and of disabling and chronic diseases within that speciality, including their physical, mental and social implications, rehabilitation, pain relief, and the need for support and encouragement; and
(b) relevant manual, biochemical, pharmacological, psychological, social and other interventions in acute and chronic illness.

(5) Willingness and ability to deal with common medical emergencies and with other illness in an emergency.

(6) The ability to contribute appropriately to the prevention of illness and the promotion of health,which involves:

(a) understanding of the principles, methods and limitations of preventative medicine and health promotion;
(b) understanding of the doctors role in educating patients, families and communities, and in generally promoting good health; and
(c) the ability to identify individuals at risk and to take appropriate action.

(7) The ability to recognise and analyse ethical problems so as to enable patients, their families, society and the doctor to have proper regard to such problems in reaching decisions; this comprehends:

(a) knowledge of the ethical standards and legal responsibilities of the medical profession;

(b) understanding of the impact of medico-social legislation on medical practice; and
(c) recognition of the influence upon his or her approach to ethical problems of the doctor's own personality and values.

(8) The maintenance of attitudes and conduct appropriate to a high level of professional practice, which includes:

(a) recognition that a blend of scientific and humanitarian approaches is required, involving a critical approach to learning, open mindedness, compassion, and concern for the dignity of the patient and, where relevant, of the patient's family;
(b) recognition that good medical practice depends on partnership between doctor and patient, based upon mutual understanding and trust; the doctor may give advice, but the patient must decide whether or not to accept it;
(c) commitment to providing high quality care; awareness of the limitations of the doctor's own knowledge and of existing medical knowledge; recognition of the duty to keep up to date in the doctor's own specialist field and to be aware of the developments in others; and
(d) willingness to accept review, including self-audit, of the doctor's performance.

(9) Mastery of the skills required to work within a team and, where appropriate, assume the responsibilities of team leader, which requires:

(a) recognition of the need for the doctor to collaborate in prevention, diagnosis, treatment and management with other health care professionals and with the patient themselves;
(b) understanding and appreciation of the roles, responsibilities and skills of nurses and other health care workers; and
(c) the ability to lead, guide and co-ordinate the work of others.

(10) Acquisition of experience in administration and planning, including:

(a) efficient management of the doctor's own time and professional activities;
(b) appropriate use of diagnostic and therapeutic resources, and appreciation of the economic and practical constraints affecting the provision of health care; and
(c) willingness to participate, as required, in the work of bodies which advise, plan and assist the development and administration of medical services, such as NHS authorities, Royal Colleges and Faculties, and professional associations.

(11) Recognition of the opportunities and acceptance of the duty to contribute, when possible, to the advancement of medical knowledge and skill, which entails:

(a) understanding of the contribution of research methods, and interpretation and application of other's research in the doctors own speciality; and
(b) willingness, when appropriate, to contribute to research in the doctor's specialist field, both personally and through encouraging junior colleagues.

(12) Recognition of the obligation to teach others, particularly doctors in training, which requires:

(a) acceptance of responsibility for training junior colleagues in the speciality, and for teaching other doctors, medical students and other health care professionals, when required;
(b) recognition that teaching skills are not necessarily innate but can be learned, and willingness to acquire them; and
(c) recognition that the example of the teacher is the most powerful influence upon the standards of conduct and practice of every trainee."