Recommendations of the
European Association for Palliative Care

For the Development of postgraduate Curricula

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Leading to Certification in Palliative Medicine

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Report of the EAPC Task Force on Medical Education

EAPC

Contents

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Foreword

There is a growing awareness by the public in Palliative Medicine and increasing recognition among health care professionals. In many European countries it has been nurtured from pioneer days to a healthy and thriving community. Palliative care in Europe has grown up and is on its way to become a specialty of its own.

In order to do this, specialist training is required. With this curriculum, the Taskforce on Physician Education of the European Association for Palliative Care presents a framework on postgraduate education. It is a logical sequence to the undergraduate curriculum which was presented by the taskforce four years ago.

The taskforce has spent a long time discussing the pitfalls that had to be avoided in the preparation of the European postgraduate curriculum. Differences in the health care systems and the specialist training in the European countries make it hard to find a widely accepted and universally applicable curriculum. Some good examples for postgraduate curricula exist, but the discussion in the group showed that they would not be applicable in other countries. The taskforce wisely chose a loose framework rather than a finalised curriculum, leaving the adaptation of the mandatory contents to the local or national setting and to the individual user. The taskforce took care to link the vertical tier of the specialist education with the horizontal tier of the general palliative care education which should be taught to every medical student and indeed to every health care professional caring for severely ill patients. The taskforce also had to accommodate in the framework the fact that in some European countries palliative medicine is acknowledged as a sub-speciality, or even as a specialty, whereas in other countries it is not. On the other hand, I would strongly support the taskforce's notion that the development of the postgraduate curriculum is a prerequisite for successful campaigning for a medical specialty.

The taskforce points out clearly that a renowned programme for specialist training following an acknowledged curriculum would also have a promotional effect and could be used to educate the next generation of leaders of the field.

As president of the EAPC I am happy to support the postgraduate curriculum. I am confident that it will provide guidance for the palliative care specialists in many European countries who are thriving to promote the field and establish palliative medicine as a medical speciality. I am profoundly grateful to the members of the taskforce who spent much time and energy to complete the curriculum, and especially to the chair of the taskforce Frank Elsner and to Phil Larkin, who both took great pains to moderate the discussion and coax the curriculum towards completion.

The taskforce has provided us with the tool to advance palliative care education to the next level. Now it is up to us to use the tool in all European countries and raise the next generation of well-trained, well-informed and able clinical experts in palliative care.

Prof. Dr. Lukas Radbruch
President of the European Association for Palliative Care

Background

General Background

Palliative Care remains an important public health issue. Although the last decades have seen a rapid growth in concern regarding the need for high quality care, the number of patients with advanced cancer and severe non-malignant diseases still continues to increase (Stjernsward et al.; 2007). International development in many countries has led to the establishment of Palliative Care services across various settings, with guidelines in relation to staff composition and effective quality standards. Key to the development of these quality standards is academic education and training for skilled practitioners to promote leadership and to enable effective and measurable service delivery. This warrants a two-fold approach; a determined programme of public education around the benefits of palliative care within mainstream health care systems and the development of palliative medicine as a recognised medical speciality.

Historically, Palliative Medicine has had specialty status in just two European countries: The United Kingdom and The Republic of Ireland. At the time of writing, the taskforce is aware of ongoing developments regarding specialism in some other European countries. Palliative medicine is considered a sub-specialty, for which additional certification is required, in France, Germany, Latvia, Poland, Romania and Slovakia (Centeno et al.; 2007). Other countries have started the process of certification for palliative medicine, in all cases opting for sub-specialty status that follows full recognition in an established specialty. Across countries there is disparity in the certification criteria followed and considerable variation in the demands that are made in order to achieve certification. Common approaches to establish certification for palliative medicine in different European countries will contribute to improved recognition of palliative care as a discipline.

The importance of this is confirmed by a recent technical report of the European Parliament (Moreno et al.; 2008) that encourages countries to facilitate specialist certification of physicians and other professionals who work in palliative care. This could be accomplished through the establishment of academic chairs in countries with strong general palliative care infrastructures or perhaps scholarships and international partnerships for countries with less development.

EAPC background to palliative medical education

From its initial conception, the European Association for Palliative Care (EAPC) has regarded the education and training of health care professionals as of the highest importance for the promotion and expansion of Palliative Care in Europe. In 1993, an EAPC educational committee, chaired by Derek Doyle, proposed specific recommendations for palliative medical education (Doyle et al.; 1993). In order to meet the interests of diverse professional curricula (medical, nursing, etc.), a further multi-professional meeting was held in Lyon, France in 2000 and specific education projects separated after this initial phase of common goal setting. In 2004, a set of recommendations for palliative nurse education were proposed (De Vlieger et al. 2004). These proposed medical education recommendations are the result of an equivalent project in accordance with the 2003 Council of Europe recommendations on the organisation of palliative care (COE 144/153)

In 2007, the EAPC published the Curriculum in Palliative Care for Undergraduate Medical Education: Recommendations of the European Association of Palliative Care (EAPC), Report of the EAPC Taskforce on Medical Education. The focus of these recommendations was to provide a common curriculum that could be made available across European medical schools. However, on reflection and in light of the inherent developments around specialism and sub-specialisation of palliative medicine in Europe noted earlier, the postgraduate recommendations described here are offered as a standardised template that respective countries can utilise to promote the development of academic palliative medicine nationally.

Goals

Why Palliative medicine should be recognised as a speciality in health care?

These recommendations are framed by the 1998 EAPC definition of Palliative care as follows:

"*Palliative care is the active, total care of the patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of social, psychological and spiritual problems is paramount.*

Palliative care is interdisciplinary in its approach and encompasses the patient, the family and the community in its scope. In a sense, palliative care is to offer the most basic concept of care – that of providing for the needs of the patient wherever he or she is cared for, either at home or in the hospital.

Palliative care affirms life and regards dying as a normal process; it neither hastens nor postpones death. It sets out to preserve the best possible quality of life until death".

The already mentioned technical report of the European Parliament (Moreno et al. 2008) highlights the fact that Palliative Care is a model for innovative health care, once medicine makes people survive longer, but sometimes more physically, psychologically and socially handicapped than without the new treatment options.

"*With the well-known demographic changes which are taking place in the EU, palliative care will be of increased importance in providing care for the ageing population. Raised to the policy level, this translates to a need to efficiently use resources (both human and financial) to guarantee the best possible quality of care. Professionals must be trained, care must be* *accessible, and patients must be consulted and respected. In order to achieve these goals in Europe, different aspects of the field must be studied, both at a national and international level*."

A medical specialty contains structured knowledge that can be defined, organised, analysed and transmitted. To be taught, a medical speciality requires evidence based knowledge that is rigorous and ethically sound. Such knowledge shapes a set of principles and standards.

Most specialties are based on specific body organs (i.e. Cardiology, Nephrology, Neurology) or on illness type (i.e. Infectious Diseases, Oncology, Rheumatology). Other specialties focus on general needs of particular groups of patients (i.e. Paediatrics, Obstetrics, Geriatrics, etc). Palliative Medicine is within the latter.

A recent publication from a survey of the EAPC taskforce on development of palliative care in Europe (Centeno et al.; 2007) has identified the lack of recognition of palliative care as a specialisation as one of the specific barriers to its development.

Furthermore, across Europe, there is a disparity in how speciality is defined and who may award specialist status to a physician. As cited earlier there would appear to be two solutions, full specialisation or additionally, sub-specialisation (Centeno et al.; 2007). Since there are numbers of national initiatives in relation to the process of specialisation, the taskforce considers it inappropriate at this time to propose a uniform European curriculum per se at specialist level. Rather, the taskforce prefers to give recommendations for implementing certification at the European level including a proposal of general recommendations for curriculum development (Appendix A) as well as a syllabus proposal (Appendix B).

Just like any other specialty palliative medicine has a set of essential aspects, which are detailed below:

Definition / Specialty Overview: Palliative Medicine is the study and management of patients with active, progressive, far advanced disease whose prognosis is limited and the focus of care is the quality of life.

Palliative medicine involves comprehensive symptom management and support of individuals with life-limiting illness and their families by a palliative care team. Palliative Medicine provides the specific medical competencies based on best available evidence for the management of pain and other symptoms regarding not only physical but as well psychological, social and spiritual problems. Palliative Medicine includes bereavement and family support. Specific competencies for dealing with complex situations at the end of life, e.g. specific communication skills are paramount.

General principles of training: Advanced training in palliative medicine is based on a broad experience in palliative medicine as well as specific experience in cancer medicine and general medicine. The emphasis for the trainee is on clinical aspects of palliative medicine. This includes diagnosis and appropriate management of major symptoms, clinical pharmacology, awareness of a range of pharmacological and non-pharmacological and the psychosocial care of the patients and their families at the end of life. Whenever possible this training must reflect the multi-professional team character.

Population: Any specialty requires a defined population of patients big enough to justify its development as a medical discipline. Palliative Medicine responds to the unique needs of patients with advanced and life-limiting disease and their relatives that represent a large segment of population that is growing in both developed and developing countries. The health care needs of such individuals with advanced and life limiting disease are multiple, complex and urgent.

Acceptance of the general population: A well-defined specialty needs to be appreciated by patients, general public, and other professionals. The increasing demand of the population to improve care of individuals with advanced and life- limiting disease is a current reality that favours the implementation of palliative medicine as a specialty.

Philosophy and mission: The development of a specialty requires that doctors identify a series of principles that form a community with a single common mission within the health services. This was the key for the creation of the hospice philosophy back in the 60s in the United Kingdom, which evolved into the specialty of Palliative Medicine.

Body of knowledge and skills: Any specialty must include a clearly defined structure to be taught. In Palliative Medicine, the body of knowledge is comprised of specialised journals, textbooks, professional societies, congresses, and government commissions and in some countries, syllabi. A specialty must also have a set of skills and technical procedures. In this respect, Palliative Medicine fits into the group of specialties dedicated to specific patient populations. Some of the skills are particular of Palliative Care, such as evaluation, analysis and symptom management of the advanced illness.

Services shared with other specialties: Professionals specialised in palliative medicine must interact with other specialists in order to receive complex patients with advanced disease that require, together with their families, more intensive and specifically focused care. They also need to act as consultants to other specialists when the patient can continue being treated by them. Together they can evaluate and plan the best treatment for the patient and family.

Development of Palliative Care Services: Palliative medicine, as a discipline and body of specialised knowledge, should be responsible for palliative care service delivery to a specific population. Service delivery must include a comprehensive range of services, for instance, in-patient units, hospital based consultation services, specialised out-patient clinics, home care and bereavement support. Palliative care services should be created within the national health system and in collaboration with social health institutions that work in partnership with the national health system.

Career structure: A specialty can develop when a group of doctors are working full- time with patients that need the body of knowledge of such a specialty. Palliative Medicine meets the requirements for medical professionals to work in this area efficiently and is considered attractive to them as a discipline. The EAPC taskforce acknowledges that in Europe there are already many physicians working full-time in this field.

Education, research and leadership: The EAPC taskforce concurs with the components of the above description and proposes that there are a set of additional advantages in relation to education, research and leadership.

The taskforce is aware that, in general terms, competence in teaching, research and leadership may not always be considered as core components of specialist medical training. However, this group believes that the inclusion of these items is essential for the development of palliative medicine as a speciality.

Recommendations for the development of postgraduate training in Palliative Medicine

Recommendation 1: Formal recognition of training

The taskforce recommends establishing formal specialist or sub-specialty training in Palliative Medicine in each European country.

Recommendation 2: Levels of specialist training in Palliative Medicine

In each country several levels of expertise in palliative medicine should be established over time:

A. Basic training (included in undergraduate training, if not it should be mandatory in postgraduate curricula)
B. Postgraduate diploma for general practitioners and specialists who have interest in palliative care
C. Specialist training in palliative medicine

Recommendation 3: Length of training

For the different levels the taskforce recommends an approximate length of training which may vary due to national conditions:

A. Minimum 40 hours (theoretical training, mostly mono-professional)
B. Minimum 160 hours (theoretical and practical training, partly multi-professional)
C. Minimum 3 years after specialisation in another clinical field (e.g. internal medicine, surgery, paediatrics, neurology, anaesthesiology, etc.)
    - The training may be divided in mandatory and elective training periods
    - The training should be undertaken in at least two different services/ settings (e.g. hospital, community care)
    - The training should include 6 months training in oncology if prior experience has not been adequate
    - Insight into research is strongly recommended; any research term can be awarded up to 1/6 of the specialist training

Recommendation 4: Format of theoretical training

The taskforce recommends that whenever possible multi-professional learning opportunities should be preferred. Common training together with colleagues and students from professionals other than a medical background will enhance team working skills.

Recommendation 5: Curriculum content

The taskforce recommends adhering to the Model of CanMEDS 2005 as a framework for the postgraduate curriculum content planning. This model has been accepted worldwide and has demonstrated its ability to structure curricula in a meaningful way. Furthermore it allows differentiation between different levels of expertise, especially between a diploma (B) and a specialist (C) level. The different roles or competencies encompass

- the role of a **medical expert**
- the role of a **clinical decision maker**
- the role of a **communicator**
- the role of a **collaborator**
- the role of a **manager**
- the role of a **health advocate**
- the role of a **scholar**
- the role of a **professional**

Recommendation 6: Curriculum outcomes

Graduates from a specialist training programme in palliative medicine will be equipped to function effectively within the current and emerging professional, medical and societal contexts. At the completion of their training programme it is expected that a fellow in palliative medicine (adapted from Advanced Training Curriculum, The Royal Australasian College of Physicians):

- has expert knowledge of pathophysiology, symptom management, psychosocial and spiritual issues related to life limiting illness and imminent death
- understands the experience of disease from the perspective of the patient and the meaning and consequences of illness to the patient and their family
- makes appropriate clinical decisions to provide medical care that is structured around the patients' and families' needs, their understanding and priorities, with the aim of

maximising quality of life, relieving suffering, supporting the family and normalising their experiences

- has particular expertise in the management of patients within the home, as well as the hospital and hospice
- understands the natural history and role of disease-specific treatments in the management of advanced cancer and other progressive life-limiting illnesses
- practices culturally responsible medicine with understanding of the personal, historical, legal, cultural and social influences on both health workers and patients and families
- provides expert advice as a consultant
- establishes therapeutic and supportive relationships with patients and their families based on understanding, trust, empathy and confidentiality, understanding that this relationship may cover the time of bereavement
- is an expert in discussing end of life issues with patients and their families as well as with other medical specialists which includes offering support for defining advanced directives and leading decision making conferences together with other medical specialists
- is an expert in discussing requests for euthanasia and in giving advice to any carer on the current legal and ethical framework in his or her country
- is able to sensitively explore the patients' concerns across physical, psychological, social, cultural and spiritual domains
- communicates effectively with patients, their families and other health professionals involved in the patients' care
- manages his or her own time and resources effectively in order to balance patient care, professional development, managerial and administrative duties, learning needs and personal life
- is able to manage human and financial resources, quality assurance, data management and administrative aspects of his or her own practice or palliative care service
- allocates finite healthcare and health education resources effectively

Outcomes for other postgraduate trainings (level A and B) may be derived from this list (with less expert knowledge, more considering principles and ask for specialist advice).

Recommendation 7: Methods

Amongst the usual mix of learning methods postgraduate training should advocate a modular system of theory blocks in order to allow learners to put together their individual programme (nationally or internationally) and create learning opportunities also on an international level especially for clinical training. The STAGE initiative of the EAPC may support this direction, too.

Recommendation 8: Education, research and leadership

Education, research and leadership should play an important role in the postgraduate training as proposed before (p 7). Education, research or leadership activities should be an integrative part of one's assessment portfolio.

Recommendation 9: Assessment

In order to foster the opportunity to train partially in other countries a common or at least similar system of assessment is recommended (see appendix A: KERN curriculum development document)

Whether formative or summative, assessment events should cater for different learning styles and situations. They should be feasible, realistic and cost effective. Wherever practical, assessment activities should be utilised and undertaken within the context of normal workplace activities. A strong international collaboration in the field of education and assessment is recommended.

Recommendation 10: Educational programme coordination

Experiences from other countries demonstrate the need for coordination and special advocacy within main stream medicine through a committee dedicated to the specific challenges (e.g. multi-professional training) in palliative medicine education. These needs may be answered best by a specifically appointed national education committee playing a key role in linking together the different needs of official stakeholders' regulations and students' (learners') expectations.

Conclusion

With the increasing challenges and internationalisation of health care a global perspective for clinical training is now required in our field.

The EAPC taskforce proposes these recommendations to formally recognise the need for the integration of palliative medical education in both undergraduate and postgraduate programmes.

Appendix A

Educational Strategies

General recommendations for curriculum development in Palliative Medicine

The objective of a training programme in Palliative Medicine is to equip physicians to carry the responsibility for substantial numbers of patients with active, progressive and far advanced disease.

Given that the craft of Medicine requires the candidate to be able to apply theoretical skills in a practical clinical context, these recommendations offers two separate, yet integrated parts for consideration:

a. The theoretical components required to achieve specialist knowledge in the field
b. The clinical practice required to supplement knowledge and to ensure a broad range of expertise in the speciality.

It is suggested that proposed levels of education should be adapted to everyday practice. The "advanced" level might be subject to variable definition since it depends on organisational structure of health care in each country.

Innovation in teaching and learning

The demonstration of the complexity of palliative care cannot only be taught through didactic methods such as lectures and seminars. The preparation of a curriculum must be responsive to the needs of mature students who are technologically competent with competing demands of work-life balance. E-learning as a method of technological development within education has the capacity to reach a broader range of students and offers flexibility in learning. The use of audio-visual technologies can compliment group work and personal reflective work around the psychosocial dynamics of palliative care. The availability of such methods will inevitably vary between countries. However, this should not deter educators from seeking robust methods of teaching and learning that reflect the breadth of learning needed to understand palliative care fully.

Duration of theoretical programme

Although it may be possible to dictate a specific range of training hours in a structured undergraduate curriculum [see EAPC taskforce report on undergraduate curriculum in palliative medicine], the diversity of opportunities of postgraduate education across Europe at the moment means that it is difficult to suggest minimum hours as mentioned in recommendation 3. However, the EAPC taskforce does suggest that a candidate for postgraduate training (B or C) should already have completed a palliative medicine education programme commensurate with that proposed in the current undergraduate curriculum [i.e. 40 hours approximately]

Accreditation of Prior Learning

The concept of accreditation of prior learning is widely understood in educational theory to reflect the need to be responsive to those people who may have extensive practical experience in a particular field of study, but have been unable to complete formally recognised training. As palliative care is already developing in many European countries, there is a need to provide an accreditation process which respects this experience and values it in terms of ongoing achievement of academic learning. In other disciplines, portfolios of clinical experience can be used as one method of accreditation. Such methods may have merit for the experienced clinician seeking academic validation.

Teamwork and recommendations for multi-disciplinary education

The ability to work in or even lead a team is one characteristic of palliative care that needs to be reflected in physician training. Since it holds special importance in palliative care, the planning of a curriculum and the teaching methods adopted should demonstrate the role and function of the physician in relation to the team and team dynamics.

General Principles of Curriculum Planning

The taskforce suggests that a framework such as that devised by Kern et al. (1998) should be utilised in the preparation of a curriculum and adapted to the needs of each respective country keeping in mind that this framework by Kern originally was developed for undergraduate palliative care education.

Step 1: Identification of general needs and problems

In Palliative Care this might include statistical information of the number of severely ill patients and causes, preference and actual place of death, deficiencies in hospital care and home care, current ethical discussion in public, health insurance issues and so on.

This kind of analysis should enable to identify key differences between the current and an ideal approach. An assessment of the potential number and qualification of teachers when identifying the ideal approach is warranted.

Step 2: Identification of specific needs of different target groups

Content

In Palliative Care this might include orientation towards practical needs of physicians regarding Palliative Care in different settings (hospital, home care, hospice, general practice, other medical specialists in private practice etc.) Specific needs should be defined by an analysis of deficiencies.

There should be a clear distinction between the undergraduate and postgraduate level. Palliative Care is in danger of accumulating an enormous number of topics within one course or curriculum. We recommend to focus on the vertical integration of learning content relative to time in continuous medical education (exposure to concrete clinical practice will lead to other needs in postgraduate training). This approach might prevent the creation of overloaded Palliative Care curricula in the undergraduate level.

A detailed analysis of characteristics of the learners' environment regarding barriers, enabling and reinforcing factors will help to implement any curriculum more easily.

Methods

Preferences and experiences regarding different learning strategies might differ enormously not only among the targeted learners but also to different cultures and countries. The same is true for the resources available to learners (e.g. computers, audiovisual equipment, role models, simulated patients, teachers etc.).

Step 3: Setting of goals and objectives

Goals are of a general character and define the ideas what should be generally achieved by a course or curriculum.

Objectives are defined specifically for the measurement of outcomes taking into consideration three major fields of achievement:

- knowledge (cognitive)
- skills (psychomotor)
- attitude (affective)

The more precisely objectives are formulated the easier evaluation (see step 6) becomes. The formulation of a learning objective needs the definition of

• Who will perform?	(e.g. "the student")
• Which level of activity?	(e.g. "should be able to rank")
• What level of achievement?	(e.g. "3 most frequent symptoms…”)

- When should objective be reached? (e.g. "at the end of the course")
-

Step 4: Educational strategies

The question is what content may be presented and learnt best. Content and method must be congruent. For instance to improve decision making skills a small group discussion (problem based learning) might be more effective than having a faculty member analyse the case for the learners. Content should include all three areas of objectives: cognitive ("knowledge"), psychomotor ("skills") and affective objectives ("attitude").

The use of multiple educational methods during a course or programme does not only provide a more vivid atmosphere and enhanced participation but also takes into account the different learning styles of the learners. Some learn best while reading an article, others prefer role play or creating a concept for their learning (see Learning Styles Model by Kolb).

Methods for achieving cognitive objectives (Knowledge)

- Problem based learning (PBL)
- Small group work
- Lectures
- Role plays

Methods for achieving psychomotor objectives (Skills)

- Supervised clinical experience
- Simulations (e.g. simulated patients, role plays)
- Audio or visual review of skills

Methods for achieving affective objectives (Attitude)

- Exposure (experiential learning) followed by discussion
- Role models
- Role plays
- Individual and group supervision: promote openness, introspection and reflection.

These methods rely on trust, continuity and trained teachers in order to facilitate self-reflection and feed-back on a personal level. In Palliative Care these types of methods need to be integrated into each course or curriculum since self- reflection is of major importance for the field.

Specific to Palliative Care are methods to promote teamwork. Teamwork can be used as a collaborative learning experience (any task or problem experienced and resolved in a group), team-teaching (teaching by two, three, etc.) and team-exercise (e.g. to solve a case together). Several models for enhancing teamwork (knowledge, skills and attitude) exist from management courses in the industry and can be transferred to field of Palliative Care.

Step 5: How to implement the course or curriculum

The following checklist facilitates the successful establishment of a curriculum in Palliative Care:

- Identify resources (personnel, time, faculties, funding)
- The programme leader must be qualified to supervise and educate trainees in Palliative Care. Thus, the leader should have appropriate experience in Palliative Care and teaching
- Identify multi-professional teaching staff to meet training needs
- Develop administrative mechanisms to support the curriculum for
    - repartition of responsibilities
    - continuous communication and adaptation
    - permanent evaluation
- Find partnerships with the clinical Palliative Care services, other specialities, other health care professionals.

Step 6: Evaluation and Feedback

Evaluation and feedback close the loop in the curriculum development cycle. Two questions are asked:

1. How did the participants perform? (Assessment of the individual)

Usually two different assessment strategies are used in order to evaluate the achievement of the learning objectives formulated in Step 3:

Formative assessment: The change in achievement or performance over a time period, mostly monitored by a tutor or supervisor, using self-assessment tools. The exam itself is part of the educational process.

Summative assessment: The level of achievement. You must pass this exam to progress. Several assessment methods are commonly used, including written or computer-interactive tests, oral examination, questionnaires (MCQ or open questions) and direct observation.

2. How did the curriculum perform? (Assessment of the curriculum)

In Palliative Care as a relatively young discipline permanent attention should be drawn to the increasing basic knowledge of the targeted groups. Therefore Step 6, 1 and 2 need to be administered carefully and repetitively. The assessment of the curriculum usually focuses on the content level as well as on the methods.

To test the impact of a curriculum on the population level (consumers' health) might be of special interest and can be administered best in clearly described environments (e.g. nursing home, community level).

The results of step 6 should be disseminated to regional, national and international groups in Palliative Care and across a multi-professional spectrum.

Appendix B

SYLLABUS - overview

1. Introduction to Palliative Care
1.2 History, philosophy and definitions
1.3 Personal qualities and attributes of palliative medicine physicians
1.4 Communication between services

2. Physical care and treatment
2.1 Management of life limiting, progressive disease
2.2 Specific disease processes
2.3 General principles of symptom management
2.4 Pain
2.5 Other symptoms and clinical problems
2.6 Emergencies in palliative care
2.7 Practical procedures
2.8 Pharmacology and therapeutics
2.9 Rehabilitation
2.10 Care of the dying patient and their family

3. Psychosocial Care and interventions
3.1 Social and family relationships
3.2 Communication with patients and relatives
3.3 Psychological responses of patients and carers to life-threatening illness and loss
3.4 Attitudes and responses of doctors and other professionals
3.5 Grief and bereavement
3.6 Patient and family finance

4. Culture, Language, Religious and Spiritual Issues
4.1 Culture and ethnicity

4.2 Religion and spirituality

5. Ethics

5.1 Theoretical ethics

5.2 Applied ethics in clinical practice of palliative care

6. Legal frameworks

6.1 Death

6.2 Treatment

6.3 Doctor/patient relationship

7. Teamwork

8. Teaching and Learning

8.1 Teaching

8.2 Learning

9. Research

10. Management

10.1 Human resources

10.1.1 Recruitment

10.1.2 Staff development

10.2 Leadership skills

10.3 Management skills

10.4 Information management

10.5 Health care system in relation to palliative care

10.6 Audit

10.7. Documentation

1. Introduction to Palliative Care

1.1 History, philosophy and definitions

- History of palliative care
- Definition of: palliative care; hospice; specialist palliative care unit; palliative medicine; supportive care
- Evolving nature of palliative care over the course of illness, including integration with active treatment, and the significance of transition points
- Re-adaptation and rehabilitation
- Societal expectations and perceptions in progressing and advanced disease and death
- Differing concepts of what constitutes quality of life (including measurement) and a good death
- Development and state of the Art of palliative care in an International context

1.2 Personal qualities and attributes of palliative medicine physicians

- The requirements of good medical practice including:
  - Tact, empathy, respect and concern for patients and their families
  - Appropriate self confidence tempered by critical self-appraisal and recognition of limitations
- The further development of those aspects of good medical practice particularly pertinent to the practice of palliative care:
  - Teamwork
  - Balancing of (often subtle) therapeutic benefits and burdens
  - Liaison with a variety of other multi-professional teams
  - Judgement about when to act swiftly
  - Self awareness in regard to person coping strategies and management / leadership style
  - Flexible and effective teaching skills
  - Reflective practice
  - Respect for social and religious values and practices which differ from ones own
  - Awareness of the constraints and etiquettes of working differently in different environments
  - Communicate effectively and appropriately

1.3 Communication between services

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

2. Physical Care and treatment

2.1 Management of life limiting, progressive disease

- Initial assessment – detailed history and examination; assessment of impact of situation on patient and family
- Complexity of prognostication
- Consideration of wide range of management options
- Judgement of benefits and burdens of investigations, treatments and non intervention
- Acknowledgement of the need for and skills in reassessment and review
- Anticipation and pre-emption of problems (see section 2.6)
- Recognition of transition points during course of illness
- Recognition of dying process
- Crisis management
- Shared care with other specialities – benefits, difficulties, facilitation
- Recognition of limitations of individual knowledge and experience

2.2 Specific disease process

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

2.3 General principles of symptom management

- Symptoms as physical, psychological, social and spiritual experience
- History taking and appropriate examination in symptom control – including the use of modern diagnostic technology, such as MRI, PET scan, invasive procedures, etc.
- Need for diagnosis of pathophysiology of a symptom (due to concurrent disorders and treatment related as well as cancer related aetiology)
- The wide range of therapeutic options – disease modifying treatments and symptom modifying treatments (palliative surgery, radiotherapy, chemotherapy, immunotherapy, hormone therapy, drugs, physical therapies, psychological interventions, complementary therapies)
- Appropriate choice of treatment or non-treatment considering burdens and benefits of all options
- Management of adverse effects of treatment
- Need for regular review of symptom response
- Methods of assessment of symptom response
- Management of intractable symptoms – recognition and support for patients, carers, multi-professional teams and self
- Referral to other agencies when needed

2.4 Pain assessment and management

- Pain as physical, psychological, social and spiritual experience
- Physiology of pain
- History taking, physical examination and investigations in pain assessment
- Pain assessment tools – clinical and research
- Different types of pain – nociceptive, neuropathic, breakthrough
- Recognised pain syndromes
- Drug treatment of pain – WHO analgesic ladder and appropriate use of adjuvant drugs
- Range of opioids, relative benefits and indications
- Indications for an appropriate use of opioid switching
- Management of side effects of drug treatments
- Assessment of burdens and benefits of treatments, including radiotherapy and chemotherapy

- Non-drug treatment – TENS, acupuncture, physiotherapy
- Common nerve blocks and other neurosurgical procedures
- Principles of spinal delivery of analgesics
- Psychological interventions in pain management
- Appropriate referral to and shared care with pain management service

2.5 Assessment and management of other symptoms and clinical problems

- Sore mouth
- Nausea and vomiting
- Swallowing problems
- Constipation/faecal impaction
- Diarrhoea
- Tenesmus
- Ascites
- Intestinal obstruction
- Jaundice
- Itching
- Breathlessness
- Cough
- Hiccups
- Airways obstruction
- Pleural and pericardial effusion
- Haemoptysis
- Bladder spasm
- Urinary obstructions
- Sexual problems
- Lymphoedema
- Fistulae
- Wound breakdown
- Bleeding / fungating lesions
- Smell

- Pressure sores
- Pathological fractures
- Anorexia, cachexia
- Weakness, lethargy
- Electrolyte disturbances such as hypercalcaemia, hyponatraemia, hypomagnesaemia
- Paraneoplastic syndromes including inappropriate ADH secretion
- Neuropathies
- Raised intracranial pressure
- Depression and other mood disorders
- Anxiety and fear
- Insomnia
- Confusional states / Delirium
- Hallucinations
- Pre-existing, drug dependence
- Nutrition and hydration
- Treatment induced symptoms – radiotherapy, chemotherapy, immunotherapy, drugs
- Symptoms occurring in the last few days of life

2.6 The approach in palliative medicine to management of emergencies

- Overwhelming pain and distress
- Superior vena cava obstruction
- Hypercalcaemia
- Spinal cord compression
- Cardiac tamponade
- Pathological fractures
- Terminal delirium / agitation
- Cardiopulmonary arrest
- Massive haemorrhage
- Epileptic fits
- Anaphylaxis
- Acute confusional states

- The violent patient
- Acute suicidal ideation
- Overdose
- Alcohol and drug withdrawal
- Hypoglycaemia
- Acute dystonia, occulogyric and serotonergic crises
- Neuroleptic malignant syndrome
- Acute urinary retention
- Pneumothorax
- Pulmonary embolism
- Stridor
- Bronchospasm
- Acute CCF
- Acute renal failure
- Predictable complications of therapeutic interventions or procedures including advanced life support if appropriate

2.7 Practical procedures / Competencies

- Clinical history taking and examination of patients with advanced illness
- Management of complications of
    - stomas
    - tracheostoma
    - PEG-tubes (Percutaneous endoscopic gastroscopy tubes)
    - nasogastric tubes
    - non invasive ventilation
- Pleural aspiration
- Paracentesis
- Syringe driver set up
- Nebuliser set up
- Management of epidural / intrathecal catheters and infusions (using local guidelines)

2.8 Pharmacology and therapeutics

- General principles of pharmacodynamics and pharmacokinetics
- Pharmacogenetics
- Adjustment of dosage in frail, elderly and children
- Adjustment of dosage in altered metabolism, disease progression, organ failure and last few days of life
- The role of hospital and community pharmacy service
- Drug formularies in palliative care
- Managing a pharmacy budget; issues of cost versus benefit
- Prescribing - legal issues relating to the prescription of controlled drugs
- Use of drugs on a named patient basis
- Use of drugs outside their product licence
- Use of drugs in clinical trials
- Problems of poly-pharmacy
- Helping patients and carers to understand and manage tablets
- Reporting adverse drug reactions to CSM
- Recommendations, guidelines and protocols – writing, implementation and use
- Compliance and non-compliance with treatments – reasons for non-compliance and ways of increasing compliance
- Principles of homeopathy including indications and potential side effects
- Principles of complementary therapies including indications and possible complications

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

- Routes of administration
- Absorption, metabolism, excretion
- Half-life, usual frequency of administration
- Adverse effects and their management
- Use in syringe drivers stability and miscibility
- Interactions with other drugs
- Possibility of tolerance, dependence, addiction and discontinuation reactions

- Availability to the community

2.9 Rehabilitation

- Physical training – including physiotherapy, etc.
- Principles of rehabilitation related to illness with gradually increasing disability
- Concept of maintenance of function through exercise and therapies
- Recognition of changing goals during the course of an illness
- Dealing with patient/family conflict in relation to unrealistic goals
- Facilities available for rehabilitation
- Specific skills of allied health care professionals, eg physiotherapist, occupational therapist
- Support services available in the home

2.10 Care of the dying patient and their family

- Recognition of the dying phase
- Initial assessment of the dying patient
- Providing ongoing care for dying patients and their families
- Assessment of required medications
- Recognising when to discontinue further investigations and treatment
- Managing symptoms in the dying phase
- Psychological care of the family
- Knowledge of major cultural and religious customs which relate to medical practice, dying and bereavement
- Understanding of ethical dilemmas in the dying phase
- Understanding pharmacology in dying patients, including use of a syringe driver
- Understanding the role of care pathways in improving care of the dying
- Sedation – indications and contraindications

3. Psychosocial Care and interventions

3.1 Social and family relationships

- Appreciation of the ill person in relation to his/her family, work and social circumstances

- Impact of illness of interpersonal relationships
- Impact of illness on body image, sexuality and role
- Construction and use of genograms
- Assessment of the response to illness and expectations among family members
- When and how to use family meetings
- Ways to accommodate needs of partners and families in provision of palliative care in both an inpatient unit or home setting
- Palliative care provision in relation to the homeless and those in custody
- Understanding of the concepts of resonance, family scripts, homeostasis in families and the impact of illness and loss on the family system
- Awareness of transference and counter-transference in professional relationships with patients and family members

3.2 Communication with patients and relatives

- Skills in empathetic listening and open questioning to:
    - elicit concerns across physical, psychological, social and spiritual domains
    - establish extent of awareness about illness and prognosis
- Common barriers to communication for both patients and professionals
- Management of difficult questions and information giving sensitively and as appropriate to wishes and needs of the individual
- Facilitation of decision making and promotion of patient autonomy
- Recognition and management of conflicts between confidentiality and the need to share information with others
- Common communication problems: deafness, expression and learning disabilities (see also section 4)
- Theories and evidence base for communication practice
- Awareness and practice of a range of structures and styles of consultations
- Critical evaluation of own consulting skills

3.3 Psychological responses to life-threatening illness and loss

- Recognition of the different responses and emotions expressed by the patient and others, including fear, guilt, anger, sadness and despair
- Psychological impact of pain and intractable symptoms

- Responses to uncertainty and loss at different stages in the illness
- Illness in people with dementia or pre-existing psychological or psychiatric problems
- Identification of psychological responses as a source of additional problems for patient family and as potentially obstructing the goals of care
- Dealing with
  - anger and strong emotions
  - anxious preoccupation
  - transference
  - collusion and conspiracy of silence
  - denial
- Responses and needs of children (including siblings) at different developmental stages
- Responses and needs of children and adults with learning difficulties
- Distinction between sadness and clinical depression
- Knowledge and application of therapeutic interventions including
  - counselling
  - behavioural therapy
  - cognitive therapy
  - groupwork approaches
  - family therapy
- Roles of relaxation / hypnotherapy, imagery and visualisation, creative therapies
- Role and availability of the specialist psychological / psychiatric services and indications for referral
- Dealing with violent/suicidal individuals; use of compulsory treatment(within the laws of country)

3.4 Attitudes and responses of doctors and other professionals

- Awareness of personal values and belief systems, and how these influence professional judgements and behaviours
- Awareness of own skills and limitations and effect of personal loss or difficulties
- Ability to ask for help or hand over to others where necessary
- Potential sources of conflict in the doctor-patient relationship and how to deal with these including:

  - over-involvement
  - personal identification
  - negative feelings / personality clash
  - demands which cannot be met
- Recognition and management of the emotional and psychological impact of palliative care on oneself, the team and other colleagues
- Being a supportive colleague to other members of staff
- Recognition of individuals who are having difficulties and understanding of when and how to take action if this adversely affects patient care
- Recognition of ways staff support can be offered / co-ordinated
- Assessment of personal and team member safety when conducting visits in the community

3.5 Grief and bereavement

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

3.6 Patient and family finance

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

4. Culture, language, religion and spirituality

4.1 Culture and ethnicity

- Recognition of cultural influences on the meaning of illness for patient and family
- Acknowledgement and accommodation of differences in belief and practice to ensure thorough assessment and acceptable care
- Use and support of interpreters
- Awareness of personal beliefs and attitudes and the importance of note imposing these on others
- Ability to recognise and deal with conflicts of beliefs and values within the team

4.2 Religion and spirituality

- Ability to distinguish between an individual's spirituality and religious needs
- Ability to elicit spiritual concerns appropriately as part of assessment
- Spirituality issues in relation to life-threatening physical illness and the role of spiritual care
- Recognition of the importance of hope and ability to nurture hope in palliative care
- Ability to acknowledge and respond to spiritual distress, including referral to others
- Knowledge of pastoral systems within different religious groups and work with their representatives within the multidisciplinary team
- Knowledge of the major cultural and religious practices which relate to medical practice, dying and bereavement

5. Ethics

5.1 Theoretical ethics

- History of medical ethics, with emphasis on evolving philosophy and codes of practice
- Critical analysis of current theoretical approaches to: medical ethics, including 'four principles (beneficence, non-maleficence, justice and respect for autonomy)

5.2 Applied ethics in clinical practice of palliative care

- Acknowledgement of ethical issues in daily clinical practice and teamwork

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

6. Legal Frameworks

- Knowledge of law in relation to end of life medical care including euthanasia and physician assisted suicide
- Knowledge of appropriate guidelines produced by EAPC and national organisations

6.1 Death

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

6.2 Therapeutics

- Definitions of treatment
- Refusal of treatment by patients

- Legal aspects of opioid prescribing
- Responsibilities of prescriber / pharmacist/nurses
- Controlled drugs/storage
- Non licensed use of drugs
- Withdrawal / withholding of treatment from competent and incompetent patients
- Obligations to treat/not to treat
- Resuscitation guidelines

6.3 Doctor/patient relationship

- Consent
- Autonomous/non-autonomous/partially autonomous patients
- Capacity/competency
- Power of attorney
- Record taking & patient access to records
- Confidentiality and its limits
- Assault/battery/manslaughter as applied to medicine
- Care of minors (children)
- Wills

7. Teamwork

- Experience of working in at least two palliative care services
- Ability to work in a multi-professional team
- Theories of teamwork (psychological, psychodynamic, managerial)
- Identification of oneself in relation to these differing theoretical models of teamwork
- Role and responsibilities of doctors in multi-professional teams
- Skills and contributions of other members of the multi-professional team
- Nature of roles within teams: some overlapping, others professionally distinct, with the boundaries sometimes unclear
- The role of volunteers in palliative care services
- Team dynamics in different situations and over time
- Forms of team support

- Strategies which facilitate team functioning and those which do not
- The inevitability of conflict within a team and strategies to manage this
- Skill mix of a team, particularly in relation to the appointment of new members
- Chairing of team meetings
- Balancing the needs of the different or overlapping teams of which the doctor may be a member at any one time
- Wide application of teamwork to include all the professionals and organisations involved in the care of a particular patient, including specialist nurses, statutory and voluntary organisations
- The impact on patients and carers of the number of professionals who may be involved in their care

8. Learning and Teaching

8.1 Learning

- Principles of adult and life-long learning, personal learning style and reflective practice
- Roles and responsibilities of trainee and trainer
- Role of supervision, mentoring, learning contracts, critical appraisal and feedback, experiential learning
- Planning learning aims, objectives, methods and outcomes
- Concept of continuing professional development
- Evidence based medicine including use of electronic databases and worldwide web
- Critical appraisal of literature including qualitative and quantitative research
- Application of evidence to patient care

8.2 Teaching

- Teaching contexts (large / small group, undergraduate / postgraduate, medical / non-medical, multi-professional)
- Teaching methods and structure, including lecturing, problem based learning, role play, bedside teaching
- Selection, preparation and presentation of teaching materials
- Presentation skills

- Methods of assessment including OSCE, observed long case, modified essay questions, project reports and case studies

9. Research

- The scientific basis of medicine and its limitations applied in the field of palliative care.
- Research topics and trends in palliative medicine and allied disciplines eg oncology, pain management, rehabilitation
- Legal and ethical dimensions of research, including standards such as the Declaration of Helsinki, guidelines for pharmaceutical companies
- Research ethics, design methods in the specific context relevant to palliative care
- Knowledge of the research process
    - Formulation of original research questions
    - Development of ideas by reading and using local peer group and appropriate research supervision
    - Application of appropriate study designs such as randomised controlled trials, qualitative techniques, single centre or multi-centre studies
    - The appropriate use and limitations of pilot studies
    - Planned statistical analysis, appropriate to research question
    - Supervised production of protocols
    - Sources of funding and supervised writing of grant applications
    - Patient information and informed consent
    - Patient safety and actions to be taken if an adverse event occurs
    - Research ethics committee applications
    - Ability to work within collaborative research teams
    - Data analysis
    - Presentation of research findings in a relevant format eg writing a critical review, writing an original research paper for a peer-reviewed journal, presenting a poster or oral presentation at a scientific meeting

10. Management

10.1 Human resources

10.1.1 Recruitment

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

10.1.2 Staff development

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

10.2 Leadership skills

- Motivating and leading a team
- Management styles
- Goal setting
- Short and long term strategic planning
- Negotiating skills
- Strategic implementation of audit
- Awareness of own need for support and guidance
- Directing and delegating

10.3 Management skills

- Time management
- Working with a secretary
- Formulating business plans

- Budget setting and management
- Planning, implementing and evaluating change
- When and how to institute disciplinary procedures

10.4 Information management

- Patient data collection
- Data Protection Act, including rights of access for patients to information held on them
- Computer security and backup systems
- To utilise medical informatics and awareness of the role of telemedicine

10.5 Health care systems in relation to palliative care

- Management structures of hospices
- The structures, funding and roles of the major components of the health care system within the European Union
- Quality assurance in relation to service and organisation
- Service review and accreditation of palliative care services
- Outcome measures and performance indicators
- Risk management in relation to palliative care

10.6 Audit

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

10.7 Documentation

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