THE UNIVERSITY OF BRITISH COLUMBIA

DIVISION OF PALLIATIVE CARE

YEAR OF ADDED COMPETENCY IN PALLIATIVE MEDICINE

HANDBOOK

DEPARTMENT OF FAMILY PRACTICE
FACULTY OF MEDICINE

TABLE OF CONTENTS

INTRODUCTION

Welcome to the Year of Added Competency in Palliative Medicine at UBC

We hope that this guide will help you make the most of the year.

The formal curriculum is presented using CanMEDS principles with movement towards competency based medical education and Entrustable Professional Acts. Please use these as guides for your clinical experience.

Throughout the year, you will also have a weekly academic ½ day educational series, article review and presentations and other structured learning courses.
As each resident's experience may vary, you should take responsibility to ensure that the curriculum is covered to your level of comfort and guided by the Program Objectives.
Please feel free to discuss specific learning needs with the Program Director at any time.

There are also resident activity funds available to help fund your electives experiences.
Information regarding the funds, the opportunities and the specifics of the program are found within this handbook and will be reviewed at the orientation session.
Please connect with Kathryn Inman, Administrator for the YAC Palliative Care at 604 806 9686 ext. 64941 for further assistance.

You will be paid through the Post Grad Office at Family Practice. The R3 salary is currently (2013) $60,702.95 per year plus benefits, which works out to $5058.58 monthly.

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

Sincerely,

Charlie Chen, MD, CCFP-PC, MEd
Program Director, Year of Added Competency of Palliative Care

CONTACT LIST

These are some of the people who will be helping you throughout the year.

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CLINICAL ROTATIONS

1. Palliative Care Introduction	8 weeks
2. BC Cancer Agency	6 weeks
3. Geriatrics	4 weeks
4. Advanced TPCU/Consultation	8 weeks
5. Home Hospice Palliative Care Service	8 weeks
6. Pain & Symp. Mgt. Clinics (malignant and non-malignant)	4-6 weeks
7. Electives	8-10 weeks
8. Holiday	4 weeks
	52 weeks

Introductory Palliative Care

Resident experience: The eight weeks are spent primarily on a palliative care unit. The resident is part of the interdisciplinary team, under the direct supervision of PCU physicians. This allows the resident to be well supported in his/her initial palliative care experiences, and also allows an assessment of the resident's current knowledge, skills and vulnerabilities. Some time may also be spent on the consultation service to the rest of the hospital. During this foundational 8-week rotation, there is the opportunity to learn about basic principles of pain and symptom management, working with the interdisciplinary team and gaining some perspective on counseling and facilitating team meetings. Interventional anaesthesia approaches to pain management in palliative patients, palliative care for AIDS patients and care for patients with a history of substance use will also be introduced during this time.

BC Cancer Agency - Oncology

Resident experience: Resident oncology experiences are reviewed prior to entering the program. Those with an oncology background are able to take an additional elective period in lieu of this oncology rotation, or to work in oncology at a more advanced level. Others undertake a 2 week rotation in medical oncology and 2 weeks in radiation oncology and a two week General Practitioner in Oncology Course. The resident spends two mornings a week with the Pain and Symptom Management/Palliative Care Team seeing patients at the Pain and Symptom Management Clinic, and assists in providing consultation and follow-up support for inpatients.

Home Hospice Palliative Care Service

Resident experience: This rotation allows the resident to provide palliative consultation services to patients in their homes as part of the Home Hospice Palliative Care Service. It may also involve palliative support for patients in long term care facilities and hospice facilities including Canuck Place Children's Hospice. During this 8-week period, the resident sees patients at home on a continuing basis. The resident will also learn about other community resources that palliative patients and their families may use, such as visiting a funeral home, meeting with alternative care practitioners and attending grief support groups. This rotation stresses the Palliative Care Clinicians role as lead, support and educator to the Primary Care team and Physician.

Geriatrics

Resident experience: The resident spends this rotation with consultants in Geriatric Medicine, with particular emphasis on care of the elderly with life-threatening illnesses, and end-of-life issues such as advance directives. The resident becomes more familiar with how palliative care and geriatric medicine complement (and indeed overlap to a large degree), and when geriatric medicine input to the care of palliative patients may be beneficial, and vice versa. The resident gains insight into ethical decision making for patients with dementia, and assessing cognitive abilities and decision-making capacity. The resident learns how to effectively manage delirium in the frail elderly.

Advanced Palliative Care Consultation/TPCU

Resident experience: The resident works both on a tertiary palliative care unit and provides palliative consultation to other parts of the hospital throughout the rotation. The TPCU experience broadens the resident's scope, as the TPCU physician takes a more consultative role to the attending family physician and/or specialist. As part of the 8-week rotation, the resident spends ½ day per week with a consultant psychiatrist seeing cancer patients.

Pain and Symptom Management Clinics and Non-Cancer Clinics

Resident experience: During this rotation, the resident will work both at the BCCA Pain and Symptom Management Palliative Clinic on Tuesdays and Thursdays and non-malignant clinics on Mondays, Wednesday afternoons, and Fridays. The Program Director will work with you to create a schedule for the non-cancer clinics. There will be a variety to choose from: heart failure, COPD, renal, neurology, etc.

Electives

Elective experience will be determined by resident learning needs and expressed areas of interest. These must be discussed and approved by the Program Director.

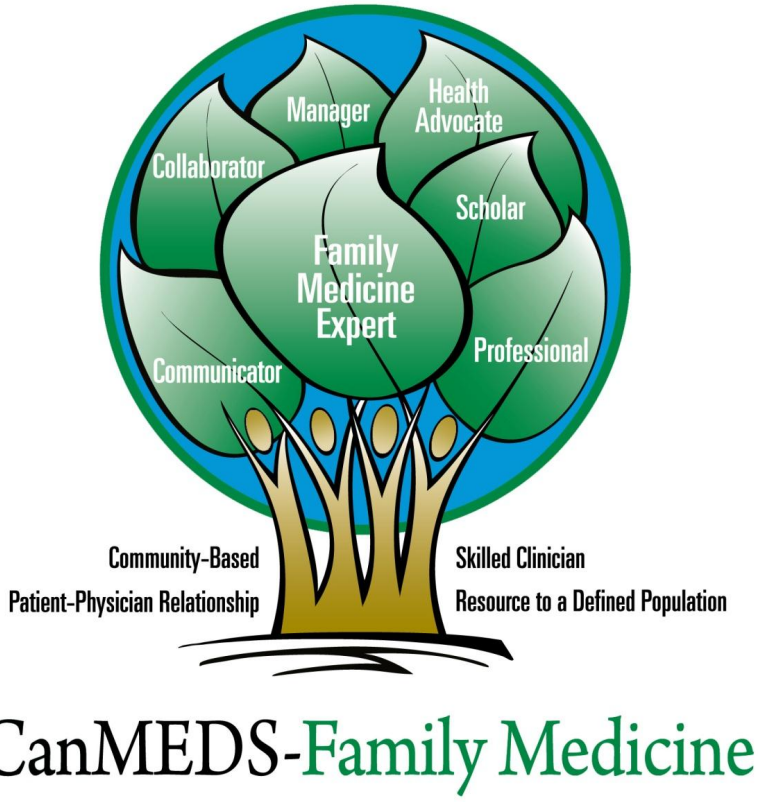
Possible electives:

- Canuck Place Children's Hospice or other Pediatric Facility
- Chronic Pain Service
- Neurology and neuromuscular diseases clinic
- Psychiatric issues in palliative care
- Palliative Care Community i.e. Kelowna, Richmond, FHA or Downtown East Side Vancouver.
- St. Paul's Hospital with an emphasis on care for those with HIV/AIDS
- Pastoral Care Fellowship
- International Electives in Clinical and/or Structural Programs i.e, England, Australia
- Research Projects in Clinical, Economic and/or Operational Issues of Palliative Medicine.

Learning Objectives and Outcomes

In this next section, you will find descriptors, learning objectives, and outcomes for the year. The information is laid out in three formats. The first will be the Guidelines and Objectives as accredited by the College of Family Physicians of Canada. Our last accreditation was in 2013. The second is the Royal College learning objectives as accredited back in 2013. (As of 2017, the Royal College is no longer jointly accrediting this year of added competency program. The RC objectives are listed here for your information.) The third format is based on a 2013 paper published by Meyers et al* which is a national consensus report on Entrustable Professional Activities (or competencies) in preparation for the movement toward competency based medical education.

Format 1:



Family Medicine College Guidelines and Objectives

RATIONALE

- The family physician is a skilled clinician.
- The doctor-patient relationship is central to the role of the family physician.
- The family physician is resource to a defined practice population.
- Family medicine is community based.

*Myers J, Krueger P, Webster F, et al. Development and validation of a set of pallaitive medicine entrustable professional activities: Findings from a mixed methods study. J of Pall Med. 2015; 18(8):682-690

OBJECTIVE
Palliative care specialists with the ability to apply the principles, philosophy, and core knowledge, skills and attitudes of palliative medicine in their practice.

LEARNING OUTCOMES
(Knowledge, Attitude, Skills)

1. Overview of palliative care
    - Review the historical and current Canadian societal attitudes towards death and dying. (K) (A)
    - Define Palliative care, outlining its basic principles and standards, and models of care. (K)
    - Assess the current state of palliative care in Canada, including barriers to providing better care for the dying. (K)
    - Describe the general framework for dealing with pain and symptom issues, psychosocial issues, and spiritual/ existential issues. (K) (A) (S)
    - Consider various approaches to taking a palliative history. (K) (S)

2. Pain Management
    - Appraise prevalence of pain in cancer and other terminal illnesses. (K)
    - Describe the etiology, pathophysiology, classification, and characteristics of pain and incorporate this knowledge into taking a pain history, assessing, and monitoring pain. (K) (S)
    - Explain the basic principles of pain management and apply to using opioids for pain management. (K) (S)
    - Demonstrate knowledge of opioid pharmacology, classification, dosing and titration, routes of administration, side effects and toxicities. (K) (S)
    - Explain use of adjuvant agents in pain management. Consider various approaches and modify treatment to specific pain problems such as neuropathic pain, bony pain, incident pain, and complex pain syndromes. (K) (S)
    - Consider and be able to prescribe non-pharmacological approaches to manage pain, including radiation, surgery, nerve blocks, neurosurgical procedures, and physical methods (e.g. relaxation training). (K) (S)

3. Symptom Management
    - Manage symptoms and employ a preventive approach to symptom management. (K) (S)
    - Utilize appropriate interventions for common symptoms, e.g. nausea/vomiting, constipation, bowel obstruction, dyspnea, sedation, fatigue, cord compression. (K) (S)
    - Employ appropriate interventions for less common symptoms, e.g. cough, urinary obstruction, lymphedema, sleep disorders, sore mouth, wound care. (K) (S)

4. Psychosocial and Spiritual Issues
    - Reflect on the psychosocial and spiritual issues of dying patients and their families. In particular, consider the impact on quality of life, and the nature of suffering. (K) (A)
    - Recognize the importance of a reflective practice by exploring personal experiences of death and dying and in caring for palliative patients. (K) (A) (S)
    - Assess, diagnose and manage anxiety, delirium and depression in a palliative care context. (K) (S)
    - Consider normal and complicated grief in patients and be able to manage grief and bereavement, including utilizing available community resources. (K) (S)
    - Provide educational and supportive counseling for patients and their families. (K) (S)

5. Communication
    - Demonstrate effective communication skills in dealing with seriously ill patients and their families. (K) (S) (A)
    - Demonstrate effective communication skills in specific scenarios, e.g. breaking bad news. (K) (S) (A)

- Identify barriers to effective communication, and modify approach to minimize these barriers. Realize that empathy and caring can be expressed through both verbal and non-verbal communication. (K) (S) (A)
- Demonstrate effective communication and collaboration among members of the interdisciplinary palliative care team, and other members of the health care team. (K) (S) (A)
- Appraise the elements of a comprehensive and practical palliative care consultation. (K) (S)
- Realize the importance of collaboration and assess the stages of team formation and development. Recognize the unique roles of members of the interdisciplinary palliative care team. (K) (A)
- Demonstrate effective conflict resolution skills, including the ability to identify the nature and causes of the conflict, and utilizing techniques to resolve or mediate the conflict. (K) (S) (A)
- Reflect on the importance of support for caregivers. (A)
- Describe the roles, regulatory frameworks, responsibilities and professional capabilities of members of other professions involved in palliative care. (K)

6. The Last Hours
    - Recognize the physiological changes associated with imminent death. (K) (S)
    - Implement appropriate pain and symptom management interventions in the context of imminent death. (K) (S)
    - Plan for the psychosocial and spiritual changes associated with the last hours and practice comfort measures for patients and their families to address needs and expectations. (K) (S) (A)
    - Implement practical measures such as documentation (and whether a need to report), funeral arrangements, and bereavement counseling at the end of life. (K) (S)

7. Cultural Issues
    - Interpret death and dying, and end of life care in the context of culture, e.g. religious, social, language or ethnic groups. (K) (S) (A)
    - Describe framework for understanding cultural differences. (K) (A)
    - Consider common differences between "western" and "non-western" cultural perspectives. (K) (A)
    - Modify approach to care to reflect differing perspectives of patients and families. (K) (S) (A)
    - Appraise ethical implications of different cultural perspectives. (K) (A)

8. Palliative Care in Different Settings
    - Provide effective palliative care service in a variety of settings including: palliative care units, acute care hospitals, hospices, and community/home settings. (K) (S)
    - Modify approach to care according to site and consider organizational arrangements for the seamless delivery of palliative care in specific settings, e.g. home visits. (K) (S)

9. Oncology
    - Review principles of management of common cancers. (K)
    - Review various therapies in cancer treatment such as use of radiation therapy, chemotherapy/hormonal therapy, and surgery, including the side-effects resulting from such treatments. (K)
    - Describe the role of radiation therapy in bony metastases, spinal cord compression, superior vena cava syndrome, intra-thoracic malignancy, brain metastases, and advanced pelvic malignancy. (K)
    - Describe the role of chemotherapy/ hormonal therapy in breast cancer, non-small cell lung cancer, colorectal cancer, and prostate cancer. (K)
    - Practice good communication skills and team work in managing cancer. (K) (S)

10. Geriatrics
    - Negotiate systems for the care of the frail elderly, including the interface of home, nursing home, and hospital. (K) (S)

- Recognize the role of formal and informal caregivers at home and the impact of hospitalization on the elderly. (K)
- Describe the effects of aging on organ systems and resulting effects on medication use and pharmacology. (K)
- Manage common disorders in the elderly, such as incontinence, dementia, delirium, depression, falls, including assessments and referrals as required. (K) (S)
- Perform functional assessments, both ADLs and IADLs and be able to provide support for failure of functions. (K) (S)

11. Research
    - Describe the unique challenges of palliative care research and strategies to overcome barriers. (K) (S)
    - Explain the principles and techniques of qualitative and quantitative research methodologies and outcome evaluation, including the statistical bases and limitations of current methods to assess the validity of palliative care research. (K) (S)
    - Identify current themes and trends in palliative care research. (K)
    - Demonstrate knowledge of basic grant and proposal-writing techniques and funding sources nationally and provincially. (K) (S)
    - Satisfactorily complete the Scholarly Project (K) (S)

Format 2:
Royal College ROTATION SPECIFIC OBJECTIVES AND CONTENT

ROTATION 1 – Introduction to Palliative Care

By the end of this rotation the resident should be able to:

Role #1 Medical Expert

- Describe current societal attitudes about death and dying;
- Define palliative care and describe its basic principles;
- Describe the elements of a comprehensive and practical palliative care consultation, including approaches to dealing with pain and other symptoms, psychosocial factors, and spiritual/ existential concerns;
- Demonstrate competency in taking a palliative history and performing a complete and appropriate physical examination;
- Identify issues in death and dying relevant to different cultures, spiritual beliefs and traditions;
- Describe the physical, psychological, and social issues of dying patients and their families;
- Demonstrate basic knowledge of the assessment and classification of pain, the neurophysiology of pain, the pharmacology of drugs used in pain and symptom management, and the pathophysiology of other symptoms;
- Describe an approach to management of other physical symptoms and disorders, especially dyspnea, constipation, skin care, mouth care, terminal agitation, delirium, and nausea and vomiting;
- Identify psychological issues associated with life-threatening illness and strategies that may be useful in addressing them;
- Describe the process of normal grief, and the features of atypical grief;
- Seek appropriate consultations from other health care professionals, recognizing the limits of their expertise in areas outside of their special interest.

Role #2 Communicator

- Demonstrate an ability to work with the patient and family to establish common, patient-centered goals of care;
- Produce clear and concise clinical notes, documenting patient assessments and interactions.

Role #3 Collaborator

- Describe the roles of other disciplines in providing palliative care and communicate effectively with other team members;
- Participate in interdisciplinary care of patients, including family conferences;
- Demonstrate skills in learning from members of the interdisciplinary team;
- Understand the role for the neurosurgeon and anesthetist in intractable pain management.

Role #4 Manager

- Describe the models of palliative care delivery and their utilization;
- Assist the Palliative Care Unit staff in educating more junior medical trainees, and members of other professional disciplines on the care team.

Role #5 Health Advocate

- Describe current barriers to providing better care for the dying across different settings;
- Identify the special needs of people living with AIDS, and those who suffer from addiction.

Role #6 Scholar

- Attend and participate actively in all academic sessions including academic half day, journal club and rounds;
- Access the relevant literature in helping to solve clinical problems in Palliative Care;
- Apply critical appraisal skills to relevant literature;
- Participate in Foundations of Palliative Care Research on-line course
- Assist in supervision of junior residents and students on electives or rotations through the Palliative Care Unit.

Role #7 Professional

- Describe his/her concerns about dealing with dying patients and their families;
- Demonstrate an awareness of how his/her own personal experiences of death and dying have influenced attitudes;
- Describe strategies for managing his/her stress in dealing with the dying;
- Demonstrate integrity, honesty, and compassion in the care of patients.

ROTATION 2 – BC Cancer Agency

The overall goal of this rotation is to develop an understanding of the modern practice of oncology, and how to provide appropriate supportive and palliative care consultation support to oncologists, patients, and families dealing with cancer.

By the end of this rotation the resident will be able to:

Role #1 Medical Expert

- Demonstrate a good knowledge of the current principles of cancer, its pathophysiology and management;

- Demonstrate an ability to work with the patient and family to establish common, patient-centred goals of care, especially in transition from a curative to palliative situation;
- Identify psychological issues associated with life-threatening illness, and strategies that may be useful in addressing them;
- Identify sexuality issues related to surgery, cancer itself, and cancer treatments;
- Manage cancer pain effectively, and demonstrate advanced knowledge of the assessment and classification of pain, the pharmacology of drugs used in pain and symptom management including methadone;
- Demonstrate advanced knowledge of the assessment and management of other symptoms and disorders, especially dyspnea, constipation, skin care, mouth care, terminal agitation, delirium, and nausea and vomiting.

Role #2 Communicator

- Demonstrate effective communications skills in dealing with terminally-ill patients and their families, including skills in delivering bad news;
- Communicate effectively with other care team members;
- Produce clear, concise and useful dictated consultation notes.

Role #3 Collaborator

- Describe the roles of other disciplines in providing palliative care in an oncology setting.

Role #4 Manager

- Demonstrate adequate skills in educating and in learning from members of the interdisciplinary team.

Role #5 Health Advocate

- Describe the barriers to delivery of effective care across settings.

Role #6 Scholar

- Access the relevant literature in helping to solve clinical problems in oncology;
- Apply critical appraisal skills to literature in oncology and palliative medicine/supportive care;
- Attend and participate actively in all academic activities, including academic half day, journal club and rounds
- Participate in Foundations of Palliative Care Research on-line course

Role #7 Professional

- Demonstrate effective consultation and communication skills in working with referring physicians;
- Demonstrate integrity, honesty, and compassion in the care of patients.

Learning Activities:

- The Family Practice Oncology Preceptorship (FPOP) program runs a series of lectures on oncology. Palliative Care residents will be invited to participate in these when the subject is relevant.

ROTATION 3 – Community Hospice

Community Rotation Learning Objectives:
The general goal of the Community Rotation is to gain experience and expertise in the assessment, investigation and appropriate management of palliative care patients at home or in other settings outside the Hospice Palliative Care Unit.

Specific goals include:

- Become experienced with accessing community resources and working with full range of team members;
- Become familiar with decision making and family caregiver support at home;
- Develop independent skills in home assessment and interventions, which are practical, effective and appropriate to patient's wishes;
- Develop communication skills with families, community team members and family practitioners regarding on-going patient management at home; and,
- Become experienced in planning and anticipating medical needs for death at home.

The learning objectives for rotations at the two training sites are the same; however there is no hospital consultation component to the Vancouver rotation. This skill is gained by the Vancouver resident during the Advanced Palliative Care rotation (in-patients) and Oncology rotation (in-patients and out-patients).

By the end of this rotation the resident will be able to:

Role #1 Medical Expert

- Identify issues in death and dying relevant to different cultures, spiritual beliefs and traditions;
- Demonstrate skills in working with the families of dying patients and understand the elements comprising good home care;
- Be knowledgeable about and be able to provide home visits to dying patients;
- Describe the community resources available to support patients in their homes;
- Describe an approach to the last hours of caring in the home and the responsibilities of the physician at the time of death;
- Describe the role of family physicians and specialists in the care of the terminally ill in their homes;
- Describe the role of palliative care consultants in supporting the home care team.

Role #2 Communicator

- Demonstrate effective consultation and communication skills in working with general practitioners and other team members, particularly understand the role for a patient-held record.

Role #3 Collaborator

- Demonstrate an ability to work with the patient and family to establish common, patient-centred goals of care;
- Describe the roles of other disciplines in providing palliative care;
- Demonstrate adequate skills in educating and in learning from members of the interdisciplinary team.

Role #4 Manager

- Understand how the home care program is funded and organized for most effective delivery of care;
- Understand the role for free-standing hospices and the need for a close working relationship between them and other health care settings, such as home and the Palliative Care Unit.

Role #5 Health Advocate

- Advocate for the needs of home care patients;
- Demonstrate an ongoing commitment to a patient and family from the time of palliative medicine consultation for a terminal illness until (and after) the patient dies;
- Describe the barriers to effective care across different care settings, and various ways to overcome them.

Role #6 Scholar

- Access the relevant literature in helping to solve clinical problems in Home Hospice;
- Apply critical appraisal skills to literature in palliative care in the home;
- Assist with education of family doctors and home care nurses around the care issues of individual patients.
- Participate in Foundations of Palliative Care Research on-line course

Role #7 Professional

- Demonstrate integrity, honesty, and compassion in the care of patients;
- Demonstrate an ability to manage boundary issues with patients;
- Be aware of the need to maintain a safe working environment, particularly in terms of vulnerability when working alone, outside of a health care setting.

ROTATION 4 – Geriatrics

The geriatrics rotation offers an opportunity to develop competence in ethical and legal issues relevant to end of life decision making, especially with respect to competency assessment. It also specifically offers in-depth teaching about non-cancer terminal diseases and their management.

By the end of this rotation the resident will be able to:

Role #1 Medical Expert

- Describe the effects of aging on organ systems;
- Describe the effects of aging on medication use and pharmacology;
- Describe the concept of frailty;
- Medically manage illnesses commonly seen in the elderly, i.e. CHF, COPD, pneumonia;
- Recognize the side effects of commonly used drugs, i.e. neuroleptics, cardiac meds, etc.;
- Recognize the features of end-stage disease;
- Recognize and differentiate dementia, delirium and depression;
- Adequately manage these syndromes;
- Assess and manage common geriatric syndromes, i.e. incontinence, falls;
- Recognize when referral to a sub specialist is required for atypical presentations of geriatric syndromes;
- Demonstrate ability to make a functional assessment with respect to ADLs and iADLs;

- Recognize the contribution of medical diagnosis to evaluation of functional loss;
- Describe the societal and environmental factors relevant to the care of the elderly;
- Assess the role of advance directives and levels of intervention;
- Recognize the impact of dementia on decision making;
- Describe the fundamental concept of competency with regard to decision making on health care issues;
- Be able to perform an assessment of competency in differing situations;
- Describe the concept of futile treatment;
- Be able to manage ethical problems at the end of life, including withdrawing or withholding therapy, advance directives, euthanasia and assisted suicide.

Role #2 Communicator

- Demonstrate an ability to work with the patient and family to establish common, patient-centred goals of care;
- Communicate effectively with other team members;
- Demonstrate ability to write clear and concise consultation notes.

Role #3 Collaborator

- Describe the roles of other disciplines in providing care of the elderly;
- Recognize the roles of informal and formal caregivers;
- Demonstrate ability to put systems in place to support function failure, i.e. home care, home making, aids;
- Demonstrate ability in working with a multi-disciplinary team to effectively manage functional losses.

Role #4 Manager

- Recognize the changing demographics of our society, and its implications for future health care provision needs;
- Describe the systems of care in place for the care of frail elderly, i.e. long term care, home care, etc;
- Explain the impact of hospitalization on the elderly;
- Describe the interface of nursing home, hospital and home.

Role #5 Health Advocate

- Recognize the role of the physician as an advocate for care of the elderly;
- Recognize the role of the physician in supporting family care givers.

Role #6 Scholar

- Access the relevant literature in helping to solve clinical problems in geriatrics;
- Apply critical appraisal skills to literature in geriatrics and palliative care.
- Participate in Foundations of Palliative Care Research on-line course

Role #7 Professional

- Demonstrate integrity, honesty, and compassion in the care of patients.

Learning Activities:

- Topic reviews and discussions
- Case-based problem solving discussions
- Small and large group discussions

- Rotation observations, modeling and practice
- Teaching opportunities suitable for the Palliative Care resident may be made available to the resident at times other than during the geriatrics rotation

ROTATION 5 – Advanced Palliative Care

By the end of this rotation, residents should be able to:

Role #1 Medical Expert

- Describe issues in death and dying relevant to different cultures, spiritual beliefs and traditions;
- Demonstrate consultant level diagnostic and therapeutic skills for ethical and effective patient care;
- Demonstrate advanced knowledge of the assessment and classification of pain, the neurophysiology of pain, the pharmacology of drugs used in pain and symptom management, and the pathophysiology of other symptoms;
- Demonstrate competence in advanced pain management, including an understanding for the role of interventional techniques such as neuraxial infusion, neurolytic blocks and cementoplasty;
- Manage other physical symptoms especially dyspnea, constipation, skin care, mouth care, terminal agitation, delirium, and nausea and vomiting;
- Describe the process of normal and atypical grief, and a systematic approach to working with the families of dying patients including bereavement counselling;
- Identify the social and existential needs confronting patients and families, and strategies that may be useful in addressing them.

Role #2 Communicator

- Demonstrate an ability to work with the patient and family to establish common, patient-centred goals of care;
- Communicate effectively with other palliative care team members;
- Communicate effectively with referring physicians and care teams on the hospital wards;
- Demonstrate ability to write clear and concise consultation notes.

Role #3 Collaborator

- Demonstrate the ability to work effectively in institutional multidisciplinary palliative care program;
- Demonstrate an understanding of the different perspectives of various medical specialties, and how to resolve inter-disciplinary conflict around goals of care;
- Describe the roles of other disciplines in providing palliative care;
- Participate in interdisciplinary care of patients, including family conferences.

Role #4 Manager

- Teach junior trainees on Palliative Care rotations and electives;
- Assist institutional and community palliative care programs in developing standards of care.

Role #5 Health Advocate

- Describe the barriers to effective care across different settings;
- Advocate for the needs of dying patients who are in hospital but not in a Palliative Care bed;
- Act as an effective advocate for the rights of the patient and family in clinical situations involving serious ethical considerations;

- Understand the issues related to provision of adequate bed availability in a general hospital, how to integrate with home care services, and the role for free standing hospices in resource management.

Role #6 Scholar

- Demonstrate skills in providing educational counselling to dying patients and their families;
- Demonstrate skills in educating and in learning from members of the interdisciplinary team.
- Participate in Foundations of Palliative Care Research on-line course

Role #7 Professional

- Describe his/her concerns about dealing with dying patients and their families;
- Demonstrate an awareness of how his/her own personal experiences of death and dying have influenced attitudes;
- Describe strategies for managing his/her stress in dealing with the dying;
- Demonstrate integrity, honesty, and compassion in the care of patients;
- Act as a role model for other residents and physicians.

Learning Activities:

- Topic reviews and discussions
- Case-based problem solving discussions
- Small and large group discussions
- Rotation observations, modeling and practice

RESEARCH SEMINARS

Royal College Objectives:
The resident will be able to:

Role #6 Scholar

- Access the relevant literature in helping to solve clinical problems;
- Apply critical appraisal skills to literature in palliative medicine;
- Participate in Foundations of Palliative Care Research on-line course
- Recognize inadequacy of literature for addressing some palliative care issues.

GENERAL

The resident will be able to:

Role #7 Professional

- Describe his/her concerns about dealing with dying patients and their families;
- Demonstrate an awareness of how his/her own personal experiences of death and dying have influenced attitudes; and,
  Describe strategies for managing his/her stress in dealing with the dying.

*Format 3: Entrustable Professional Activities**

Appendix 1. Palliative Medicine EPAs

EPA title	*Summary*	*Observable and measurable tasks*
1. Complete a palliative medicine consultation	Multidimensional assessment and synthesis of information to formulate an individualized management plan for a patient with serious life-limiting illness and his or her family	• Assesses physical, social, psychological, spiritual, and functional domains (including appropriate use of assessment tools) • Communication skills used to develop a therapeutic relationship • Facilitates a goals-of-care discussion (includes illness understanding) • Decision-making processes are based on care goals • Assesses caregiver distress and resiliency • Selects and interprets tests and interventions • Communicates effectively using oral, written, and electronic methods
2. Manage the care of a dying patient in the last days, and final hours	Recognize clinical signs and symptoms of patients approaching death. Bereavement practices, identifying caregivers at risk for pathological grief, and when possible, advocacy for any cultural or spiritual practices near and at the time of death	• Appropriately uses interventions as well as educates around the inappropriate use of other interventions (e.g., blood work, vital signs) • Supports and effectively educates informal and formal caregivers on common and expected clinical manifestations of an imminently dying person • Facilitates the diverse range of grief reactions and responses
3. Conduct a family conference or meeting	Lead a meeting with a family/caregivers and/or the patient and often includes colleagues and members of the interprofessional team	• Ensures perspective of all participants is heard • Communicates using conflict resolution skills • Facilitates a goals of care discussion (includes illness understanding) • Develops a plan of care
4. Address difficult to manage symptoms through pharmacological and non-pharmacological modalities appropriate for the palliative medicine setting	Comprehensive assessment and formulation of a symptom management plan considering medications, routes of administration and therapeutic and interventional procedures	Symptoms to include (but not limited to): Pain, nausea, vomiting, breathlessness, cough, constipation, diarrhea, anorexia, cachexia, weakness, fatigue, edema, bleeding, thrombosis, anxiety, depression, spiritual or existential distress; at end-of-life: agitation, respiratory and oropharyngeal secretions, and the constellation of symptoms associated with delirium • Therapeutic symptom management procedures (e.g., paracentesis) • Clinical processes associated with palliative sedation therapy (PST)
5. Collaborate as a palliative medicine physician with referring health care teams	Effective working relationships with and education of members of referring health care teams when either direct or indirect consultation is being sought	• Negotiates to determine how the care of the patient will be shared with the referring team • Direct consultations represents direct involvement in assessing the patient/family • Indirect consultations represents discussing clinical issues with colleagues from a different service • Educates referring team members with the aim of building capacity in the provision of quality primary level palliative care
6. Educate about ''palliative care'' as an approach or philosophy	Educate patients, family, informal caregivers, formal health care providers/teams, and the public	• Incorporates the principles of health literacy, adult learning, and best practices in patient and family member education • Advocates for palliative care provision as appropriate
7. Integrate into an interprofessional specialized palliative care team	Communicate with and advocate for interprofessional team members	• Advocates for the contribution of each profession comprising an interprofessional palliative care team • Active contributes to palliative care team function • Appropriately participates in resolving team conflict

(*continued*)

*Myers J, Krueger P, Webster F, et al. Development and validation of a set of pallaitive medicine entrustable professional activities: Findings from a mixed methods study. J of Pall Med. 2015; 18(8):682-690

Appendix 1. (Continued)

EPA title	*Summary*	*Observable and measurable tasks*
8. Manage the palliative care of a patient in the community setting	Collaborate with interprofessional members of community-based palliative care teams	• Documents the care plan • Informs caregivers of changes in status • Identifies care needs for the patient as well as his or her caregivers • Appropriately utilizes community resources • When appropriate facilitates decision making re: transfers in care setting
9. Maintain resiliency in practice as a palliative medicine physician	Maintain an individualized approach to resiliency (i.e., self-care) aimed at enhancing both the well-being of the clinician him or herself as well as the individuals with whom he/she interacts within a professional context	• Applies continuously throughout training program • Incorporates measures to attempt to achieve balance between the physical, emotional, intellectual, relational, and spiritual aspects • Method should have a self-awareness-based approach (e.g., reflective writing and mindfulness meditation) • Exposure to and experience with a variety of self-care practices to facilitate determining which ones work best for him or her for ongoing maintenance
10. Provide palliative medicine telephone advice and management	Communicate by telephone with patient, family member, caregiver, or clinical colleague for the purpose of addressing clinical issues, symptoms, or practical concerns	• Gathers relevant clinical information/history • Provision of information/advice • Arranges appropriate resources and follow-up • Documents the encounter • Communicates to other team members involved in the care of the patient as required • Telephone advice constitutes the clinical management of the patient and equates to the provision of direct patient care
11. Serve as Most Responsible Physician for a patient admitted to a designated palliative care bed	Maintain overall responsibility for a patient admitted to a palliative care bed (for any setting) from the time admission until the time of death, discharge, or transfer of responsibility	• Manages the clinical, operational, and administrative elements of the patient's care • Discharge or care transition planning • Appropriately utilizes institutional resources • Accountable for operational and clinical quality indicators
12. Describe an approach to managing a controversial palliative medicine ethical issue for a patient	Articulate how he/she ''should'' proceed for a given context, involves consideration of the relevant laws, policies, and ethical principles that govern medical practice in the jurisdiction	''Controversial'' ethical issues include (but not limited to): • Nondisclosure (diagnoses, prognoses) • Discordance or confusion about a patient's autonomous wishes • Withholding or withdrawing medical therapies or artificial nutrition/hydration • Patient/family requests: euthanasia, assisted suicide

EPA, entrustable professional activities.

*Myers J, Krueger P, Webster F, et al. Development and validation of a set of pallaitive medicine entrustable professional activities: Findings from a mixed methods study. J of Pall Med. 2015; 18(8):682-690

ACADEMIC CONTENT

Victoria Hospice Palliative Care Medical Intensive Course

As part of your core content, you are required to take the one-week course of the Victoria Hospice Palliative Care Medical Intensive Course (PCMI) unless taken in the prior 18 months of the date of the course. This inter-professional course covers basic and some advanced aspects of palliative care.

A second course through Victoria Hospice, The Psychosocial Care of the Dying and Bereaved is also recommended. This 5-day course has 28 hours CME credits and is offered twice a year in Victoria.

In the Spring, the Residents will be expected to present and teach at the Richmond Victoria Hospice PCMI course.

General Practice Oncologist (GPO) Didactic Course

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

You will NOT be certified to be a GPO at the end of the course. In order to become a GPO, you need to find a community which is in need of a GPO to sponsor you and complete the six (6) week practicum in addition to the 2-week lecture series. Please talk to the Program Director if you are interested in becoming a GPO.

Scholarly Project

You will be required to complete a scholarly project during your year. There will be several academic half day sessions related to research. Further information about the scope of the scholarly project will be provided during these sessions. Many past residents have conducted systematic literature reviews or qualitative research projects. Very few have successfully completed a quantitative research project due to the limited amount of time. However, if you have interest in conducting quantitative research or prospective studies, we will encourage you to pursue these interests. Understanding that one year is not enough time for this type of work, submission of an Research Ethics Board application (which includes a robust literature review, full description of methodology, along with any documents pertaining to consent) as your scholarly project will be acceptable.

Academic Half-days, Article Review and Journal Club

In each rotation, you have one-half day/week as protected academic time. The Academic half-day has designated topics you need to know in depth. These sessions will be led by a palliative care physician or clinician. Some weeks, the first hour will consist of an article review where one of you will be expected to present an article. The following 2 hours will consist of a small-group seminar either web based or

teleconferenced. Some sessions will be 3 hours long. There will be several in person sessions throughout the year as well. Travel expenses will be able to be claimed for these sessions.

These half days will be set up with your learning needs paramount, but rotating residents from other programs doing Palliative Care electives will also be invited to attend. Your attendance and participation is required for all sessions unless you are on vacation. You should be prepared for each topic by reading relevant material. Please see the current Academic half-day schedule for details. You can find the latest schedule on our website.
http://palliativecare.med.ubc.ca/education/postgrad/schedule-resources/

The Division of Palliative Care holds a monthly Journal Club. These usually fall on the same day as our academic half days. We often substitute the article review and attend the journal club. Each of you will be expected to present at one of these meetings during the year. The coordinator will be in touch with you at the beginning of the year to create a schedule.
The Journal Club is not sponsored by Pharmaceutical Companies as per UBC policy. Please see the UBC Department of Family Practice Guidelines regarding involvement with the Pharmaceutical Companies.
http://policybase.cma.ca/dbtw-wpd/Policypdf/PD08-01.pdf

Case Studies – Formal write-ups

Case studies are usually included as core content in each of your rotations. Some will be more formal than others in terms of presentation. For example, during the BCCA Pain and Symptom Management Palliative Care clinic rotation you will be required to present a case at one of the rounds Palliative Care Team. For article review, the presenting resident is encouraged to contextualize their article choice and discussion with a brief case presentation.

You will be required to submit four (4) formal case studies during the year. The Program Director will alert you when each one is due. Please follow the following format:

Part 1: The Case
Patient Information
History of Present Illness
Past Medical History
Social History
Functional History

Medical Review of Diagnostics/Investigations
Medical Review of Therapeutics/Treatments

Medical Issue(s)
Treatment Approach
Evidence Based Critique
Research Support
Outcomes/Learnings

Part 2: The Reflection
There will be a different reflection for each of the 4 case studies. For example, one will require a selection of a piece of art that resonates with the case and a brief reflection on why you choice

that artwork. Another will require you to do a little research into the historical development of a particular palliative care topic related to your case.

The Program Director will inform you of the reflection component at the time of each assignment.

The Case Studies are meant to be a brief exercise to develop critical thinking, literature review and help differentiate between clinical practice and evidence based medicine.

Ideally, I would suggest that you also should review a case weekly with your attending on each rotation.

Rounds

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

Recommended but not required rounds include:
Vancouver Hospital - Research Rounds
St Paul's Hospital - Research Rounds
St Paul's Hospital – AIDS Rounds
Other rounds as appropriate (Psychiatry, Oncology, and Geriatrics)

Conferences

Recommended:

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

Evaluations

Evaluations are the primary tool for assessing your progress and will be important when you apply for hospital privileges on completion of your training. Without proper documentation, providing a reference letter or letter of confirmation of training, especially a few years after the completion of training, becomes a much more onerous task and may result in less than desirable outcomes. Likewise, it is also important to document the educational objectives that demonstrate the effectiveness of the training, which in turn will help to ensure future government and university support of the R3 Enhanced Skills Program.

We expect that residents will complete their training having confidence in a new set of skills to be able to serve their community. We expect that training will be done in such a way that the College of Physicians and Surgeons of British Columbia will acknowledge the appropriateness of the training at the skill level of the individual involved so that credentialing will not be a problem. For this reason, the program and the individual will be well evaluated throughout the course of training.

YAC Evaluation

1. Case Review (4 per year Intro, Home Health, Advanced and Elective)
2. Scholarly Project +/- Presentation/Survey/Poster
3. Article Review Presentations during AHD
4. Evaluations Individual Preceptor/In Time Interview
5. Journal/Diary (Optional)
6. Self-Assessment Tools (Workbook)
7. Consultant Letter Assessments (Advanced Rotation)
8. Examination Written/Oral (June)

Completion

At the end of the training period, a UBC Diploma of Completion will be presented to residents who have completed a one-year residency. A Letter of Completion outlining the training taken will be presented to residents completing a shorter residency and submitting a list of objectives and all evaluations. These do not imply certification in a particular set of skills but is recognition that the individual has completed the training program.

For certificants of the College of Family Physicians of Canada, upon completion of the year, you will be qualified to use the Certification of Competency (CAC) designation PC representing Palliative Care. I.E., CCFP-PC.

Texts and Resources

- Oxford Textbook of Palliative Medicine (4th edition). G. Hanks, N. Cherny, N. Christakis, M. Fallon S. Kaasa, R. Portenoy Oxford University Press: New York.

Palliative Medicine, a case based manual, 3rd Edition. N. MacDonald, D.Oneschuk, N. Hagen, Oxford University Press: New York

- Medical Care of the Dying. Fourth Edition. Victoria Hospice Society. 1900 Fort Street, Victoria, BC V8R 1J8. (This is included with course registration.)

- Evidence –Based Practice of Palliative Medicine: Expert Consult: Online and Print
  N.E. Goldstein, R.S. Morrison

- Demystifying Opioid Conversion Calculations: A Guide for Effective Dosing –M.L. McPherson
  Medicine: A case-based manual – D. Oneschuk, N. Hagen, N. MacDonald

- Spirituality in Hospice Palliative Care –P. Bramadat, H. Coward, K. Stayduhar

- Palliative Care: A case-based guide – C. Sinclair, J. Loitman, M. Fisch

- Palliative Care for Advanced Alzheimer's and Dementia Guidelines and Standards for Evidence-based Care – G. Martin, M. Sabbagh

- Pain in Older People – P.Crome, C. Main, F. Lally

- Cancer-related Bone Pain – A Davies

- Neuropathic Pain – M. Bennett

- Cancer-related Breakthrough Pain – Andrew Davies

- Acute Pain – L. Bromle, B. Brandner

- Opioids in Cancer Pain – K. Forbes

-Opioids in Non-Cancer Pain – D. Stannard, M. Coupe, T. Pickering

-Canadian Palliative Care Formualry (CPCF) –R. Twycross, A. Wilcock, M. Dean, B. Kennedy

Other useful resources

1 Indigenous Cultural Competency Training Program
Provincial Health Services Authority in BC
http://www.culturalcompetency.ca/training/core-icc-health

2 Abrahm, Janet. (2005) A Physician's Guide to Pain and Symptom Management in Cancer Patients, 2nd edition. John Hopkins University Press.

3 Ian Anderson Continuing Education Program in End-of-Life Care
http://www.cme.utoronto.ca/endoflife/Modules.htm

4 Canadian Virtual Hospice http://www.virtualhospice.ca/en_US/Main+Site+Navigation/Home.aspx

5 EPERC
http://www.eperc.mcw.edu/

6 Fraser Health Palliative Symptom Guidelines
http://www.fraserhealth.ca/professionals/hospice_palliative_care/hospice_palliative_care_symptom_guidelines/

RESIDENCY EDUCATION COMMITTEE

The Residency Education Committee is chaired by the Year of Added Competency in Palliative Medicine Program Director and meets four times a year. The committee is comprised of:

Dr. Pippa Hawley	Head - UBC Division of Palliative Care
Dr. Charlie Chen	Program Director YAC
Dr. Julia Ridley	Research Director and BC Cancer Agency
Dr. Janet Kow, FRCPC	Geriatrics
Dr. Gil Kimel	St. Paul's Hospital
Dr. Jody Anderson	Victoria Hospice
Dr. Steve Mitchinson	Fraser Health Authority, Abbotsford
Dr. Shalini Nayar	Fraser Health Authority, Surrey
Dr. Susan Germain	Fraser Health Authority, Burnaby
Dr. Aleco Alexiadis	Vancouver Coastal Health, Richmond
Dr. Mo Yeung	Vancouver General Hospital and Vancouver Home Hospice Palliative Care Service
Kathryn Calzavarra	Spiritual Care Consultant – FH Palliative Care
Residents	All YAC residents are expected to attend committee meetings if possible.

Purpose: The YAC Residency Committee is responsible for all educational issues affecting UBC Year of Added Competency in Palliative Medicine Program including but not limited to:

- Overall program directions
- Curriculum plan
- Program objectives
- Practice exams
- Financial issues
- Resident selection
- Evaluation of faculty and residents
- Faculty development
- Others as deemed appropriate by the program director.

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

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

ACADEMIC AND PRACTICAL ISSUES

Please see the UBC Post Grad Website for more information.
http://postgrad.med.ubc.ca

Support

There is a particular challenge to entering the Program from practice rather than straight out of residency. It is the "culture shock" effect. Practicing physicians come from a practice where they are in charge, have autonomy, have established a reputation and are trusted and well known. They enter into a situation where they are residents – a pressured, learning culture in which they may not be known and have to re-establish themselves. It is important that YAC Residents coming from long experience in rural communities be prepared for this change and be ready to address it. We will be working to establish a support system for our residents, but it is important that the resident themselves have developed their own personal support system, in respect to their families and friends, or in some other way.

Mentor and Faculty Advisor

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

The Program Director will also serve as your Faculty Advisor. This is feasible due to the small size of the program. However, if you would like to work with another faculty advisor, this will be arranged. Please let the Program Director know of this preference. If at any time during the year you experience any academic difficulties or concerns, a faculty advisor may be assigned to you that matches your learning needs.

Resident Wellness and Wellness Faculty Member

Starting in 2017, there will also be a Wellness Faculty member who will provide you with information and support. Academic Half Day sessions will be devoted to resident wellness.

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

Housing

Housing is your responsibility to organize. To assist you we will provide some phone numbers that you may try that will give you opportunity to locate reasonable accommodation.

For those residents who are with us for a year, or who have organized programs in which they will be moving from community to community, housing can be a major difficulty. It's not insurmountable but you need to be prepared for accommodation problems as you go. We will do our best to give you some assistance in finding accommodation, though we can't provide you with any guarantees.

A great place to start your search for accommodation in the Lower Mainland is by searching the UBC Alternative Housing page. The website address where you may find this valuable information is: www.housing.ubc.ca . This site also contains links to additional websites that are comprised of other off campus and non-Lower Mainland housing information (like www.rentbc.com or http://www.homes4students.ca/.) For short term rentals: www.makeyourselfathome.com. The properties listed are quite nice, slightly high-end. If you look, the area that would be nice is Kitsilano on the west side of Vancouver - near the water and a fun neighbourhood.

Some additional accommodation listings that are not included on the UBC Housing website include the following (Taken from "UBC Reports" classified section):

Tina's Guest House – Elegant accommodation in Point Grey area. Minutes to UBC. On main bus routes. Close to shops and restaurants. Includes TV, tea and coffee making, private phone/fridge. Weekly rates available. Call (604) 222-3461. Fax (604) 222-9279.

Camilla House – Bed and Breakfast. Best accommodation on main bus routes. Includes TV, private phone and bathroom. Weekly reduced rates. Call (604) 737-2687. Fax (604) 737-2586.

B&B by Locarno Beach – Walk to UBC along the ocean. Quiet exclusive neighbourhood. Near buses and restaurants. Comfortable rooms with TV and private bath. Full breakfast. Reasonable rates. Non-smokers only please. Call (604) 341-4975.
In addition there is a University-run Rentsline at (604) 714-4848 that may also be of use.

Resident Mandated Travel and Reimbursement Policy

Policy
- The Ministry of Health has mandated that postgraduate resident training occur at distributed sites throughout the province.
- The Ministry of Health provides funding to support the travel and accommodation of residents mandated to undertake training at Faculty of Medicine identified distributed sites.
- Where possible, the Health Authorities, with the assistance of the Faculty of Medicine, has procured long term leases of appropriate furnished accommodation for residents undertaking training at distributed sites.
- Where accommodations are not provided, residents will be reimbursed for commercial accommodations rented at mandated distributed sites at the rates specified below.
- Residents are responsible for booking all travel arrangements, including accommodations, where no prepaid accommodations are available.
- Residents should make travel arrangements well in advance of rotation dates in order to take advantage of savings available by booking early.

Procedures for Reimbursements

Claims for reimbursement of travel expenses must be submitted on the Resident Reimbursement Form, and ideally be submitted within 30 days of return from rotation
Claims must have
- Purpose and duration of the rotation
- Clearly detailed expenses supported by original dated receipts
- Original signature of resident and original signature of Program Director/Program Assistant

Receipts

Original itemized dated receipts MUST be submitted – photocopies, cancelled cheques, and credit card statements are not acceptable. All receipts must coincide with dates of rotation.

- Airline Tickets : Electronic tickets – a copy of the itinerary/receipts is acceptable. Receipt must show ticket number, breakdown of cost and form of payment.
- Hotel/Apartment/B&B Rental - Original receipt from commercial properties only.
- Toll fees/Ferry/Bus/Taxi – original dated receipts only

Expenses covered

Travel

- To and from site to a maximum of $700 economy airfare return or mileage ($.50/km)
- Return trip to program base at the end of every four week block or a return trip for the resident's partner to a maximum of $700 economy airfare return or mileage from program base ($.50/km)
- Return trip to program base for educational activities deemed mandatory by the program director and with PRIOR written approval by the postgraduate deans' office to a maximum of $700 economy airfare return or mileage ($.50/km)
- Allowable travel expenses are:

- Economy Airfare - Bus Fare to and from site
- Mileage – to and from site - Taxi to and from airport/bus depot
- Ferry - Public transit to and from air/bus depot
- Ferry Reservation Fee - Bridge tolls (Port Mann Bridge)

Accommodation

- Subject to this policy, if housing is not in place, $1300 per month (commercial properties). Accommodation exceeding $1300/month must be pre-approved by the postgraduate deans' office.

Expenses not covered

Expenses that are not reimbursable (this list is not exhaustive and the Postgrad Dean's office reserves the right to reject other expenses not itemized below):
- Interest charges on outstanding charge card balances
- Loss or damage to personal possessions
- Parking and traffic fines
- Automobile rental
- Expenses to change or cancel transportation or accommodation reservations
- Excess baggage fees
- Assured Boarding fee (BC Ferries)
- Airline Seat Selection Fees
- Meals and grocery supplies
- Travel Agent Fees

January 16, 2013
Amended and approved by FRC on January 22, 2013

Pay and Benefits

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

Should you have any problems regarding your pay cheque, your queries may be directed to Lois Moen in the Postgraduate Medical Education Office at (604) 875-4834 or the VGH Payroll Department at (604) 875-4738.

If you have any questions regarding benefits, please contact the Resident Benefits Coordinator, at (604) 875-5306.

Expenses

Please keep receipts for any expenses incurred due to participation in the YAC. Some expenses may be reimbursed through the Resident Activity Fund (see below). There is also an endowment resource which may be accessed through the Division of Palliative Care. This funding, however, varies year to year and is not guaranteed.

UBC
Division of Palliative Care
Residents Motor Vehicle Expenses Policy

During some rotations, you will be required to conduct home visits or provide patient care at locations other than a primary work site (PWS). Usually, your PWS for a particular rotation will be an acute care site, ambulatory clinic, or home health office. If you are required to leave the PWS to go to another location to assess and care for a patient, the following expenses will be reimbursed for local travel in the Lower Mainland/Fraser Valley area:

Private Vehicles

- Reimbursed at the kilometre (KM) rate (currently $0.53/km) in effect at the time of travel. This rate is charged when travelling from the PWS to another location of care on the same day, travelling the shortest distance route. Traffic fines will not be reimbursed. If you proceed from home directly to a care location other than your PWS and the location is further than your PWS, you may claim only kilometres travelled which exceed the distance between your primary residence and your PWS. If you proceed directly home at the end of the day from a location other than the PWS, you may only claim kilometres travelled which exceed the distance from the PWS and your home.

- If you need to use a private vehicle for travel in these situations, but usually take public transit, you will be reimbursed for the travel based on the current KM rate minus the usual cost of public transit to and from your PWS.

- Parking - Actual costs at locations other than the PWS will be reimbursed. Parking fines will not be reimbursed. If you are using a private vehicle only for these situations but usually take public transit, parking at the PWS and other locations of care will be reimbursed.

- Bridge Tolls - Will be reimbursed at the toll rate in effect at the time of travel. Tolls will be reimbursed when travelling from the PWS to another care location on the same day, travelling the shortest distance route. Financial consequences of unpaid tolls will not be reimbursed.

*** IMPORTANT:

- ❖ A BCIRPA form needs to be completed showing the mileage (use google map)
- ❖ Parking receipts need to be attached. All receipts need to be original or copies of the online receipts to prove payment.

Resident Change Form

This form must be used to notify the Postgrad Deans' Office (Lois Moen) of any changes to a resident's training. Memos and emails are no longer acceptable.

Resident Activity Fund

As a YAC resident, you are entitled to some reimbursement for expenses related to course and conference registration fees. Please use the reimbursement of expenses form provided when submitting the original receipts to us for reimbursement.

There are also funds available from Foundational Support for Palliative Medicine.
These funds are variable and will be made available during the year for educational pursuits.

Pagers

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

Malpractice Insurance

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

Prescription Writing

Any residents who are writing prescriptions must get prescription privileges and pads through the Vancouver Acute HSDA office

The Health Authority MAC has reiterated the longstanding VA policy that physician orders must be accompanied by a signature, a printed name, and a unique physician identifier. The Health Authority MAC and VA MAC have endorsed the BC College requirement that BC College numbers be used on all prescriptions. Residents are required to append their printed name and their BC College training license.

Immunizations

Residents doing rotations in a Vancouver Coastal Health facility are required to provide a record of immunization. Please find a form on our website Postgrad education.

Vacation Scheduling

Entitlement is 10 consecutive working days, plus the weekend between and the weekend either before or after the 10 days, per six-month period. In addition, five consecutive days, including the official holidays, may be taken over Christmas. If vacation is taken during Block 7 STAT days are forfeited.

Every Resident shall be entitled to at least five (5) consecutive days off during the twelve (12) day period that encompasses Christmas, New Year's Day and two (2) full weekends. Those five (5) days off are to account for the three (3) statutory holidays, Christmas Day, Boxing Day, New Year's Day, and two (2) weekend days.
- See more at: http://www.par-bc.org/collective-agreement-constitution/collective-agreement/article-11/#sthash.wRYVJ1Hv.dpuf

Residents are entitled to take time off for statutory holidays if service on their rotation is not disrupted. Please make arrangements with your rotation supervisor. If you are asked to work on a stat holiday, you are entitled to double time pay, plus a paid day off in lieu – to be arranged at a mutually agreeable time with the preceptor. A Statutory Holiday Reimbursement Form must be submitted to the Residency Office within two weeks of stat holiday worked for reimbursement of double time pay.

Vacation Requests: should be submitted to ideally at the start of the year, so that rotations can be scheduled. Any change requests must be discussed with the Program Director a soon as possible. Due to the need to accommodate elective residents, and having limited training sites, we cannot always guarantee we can accommodate changes.

Call Schedules

As a resident, you may be expected to be on call. This is to enable you to gain experience in the working conditions you can expect to be moving to after you finish your program. You must honor the call schedule set up on your behalf.

Staying in Touch

It is important that you keep your contact information with the Program up to date. The difficulty with a de-centralized program such as this is that when it is imperative to reach a resident immediately, it may take hours to track them down and may even be impossible. Please help in maintaining the point of contact throughout your training by notifying the Palliative Care Program Office and Residency program Director of any change in your mailing address, phone number or email. If you do not have your own email account when you start the program, but you will have access to a computer hooked to the internet, we strongly suggest that you at least sign up for one of the various free web-based email accounts (Hotmail, Yahoo, Lycos etc.) as it only takes a few minutes of your time to do so, but could potentially save you many more later on. If you have a cell phone or pager, please make sure the Program Office has your number(s).

EVALUATION/ YAC COMPLETION

Minimum Requirements for Completion:

1. Resident must pass all core rotations.

2. Resident must have successfully completed his/her presentations.

3. Resident must have successfully completed his/her scholarly project.

4. Resident should have successfully completed the in-training and final examinations.

PRINCIPLES FOR THE LEARNER

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

A. Principles for the learner

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

B. Context of learning for the faculty

Effective instruction of a learner occurs best if:

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

"Imagination is more important than knowledge."

- A. Einstein

CHARACTERISTICS OF A SELF-DIRECTED LEARNER

- Takes the initiative, with or without the help of others, in diagnosing or assessing his/her own learning needs;

- Selects appropriate resources and, when necessary, temporarily surrenders some measure of independence for the sake of expedience in learning;

- Develops, through inquiry and reflection, appropriate criteria by which to evaluate specific learning goals;

- Asks for justification of rules, procedures, principles and assumptions which it might otherwise by natural to take for granted;

- Refuses to agree or comply with what others state or demand where this seems critically unacceptable;

- Is aware of alternative choices, both as to learning strategies and to interpretations or value position being expressed, and makes reasoned choices about a preferred course of action;

- Continually reviews his/her approach to learning and makes strategic and tactical adjustments in order to optimize learning;

- Conceives of goals, policies and plans independently of pressures from others to do so, or not to do so;

- Independently forms opinions and clarifies beliefs, yet is willing to relinquish beliefs or to alter opinions when relevant contrary evidence is presented, and does so irrespective of the presence or absence of external rewards or pressures;

- Clarifies what is of personal value or in one's interests, as distinct from what may be expedient, or what may be convenient; and,

- Is willing and able to accept alternative points of view as legitimate and is able to deal with objections, obstacles, and criticisms or one's point of view without becoming defensive, threatened or angry.

- Daniel D. Pratt

HARASSMENT POLICY

TOWARDS A HOSPITABLE POLICY IN UBC FAMILY PRACTICE

Throughout universities in North America there has been concern about the academic climate in which students, staff and faculty work. It is essential that the Department of Family Practice and the UBC Faculty of Medicine ensure that our climate is supportive for all its members.

This document outlines principles derived from the work of other academic departments struggling with similar issues. They are intended to foster a climate in which all feel safe, respected and free to pursue their academic work.

Faculty, students and staff all share responsibility for the climate within the department. At the same time faculty are identified as enjoying relatively more power and privilege within the university, and in particular, as responsible for evaluating the work of students. Consequently it is essential that faculty agree to behave in a manner consistent with these principles as a condition of working within the department.

These principles are complemented by formal procedures which exist for responding to some of the situations described in this document. Individuals are encouraged to know and utilize these procedures as appropriate.

Harassment

The UBC Department of Family Practice affirms the UBC policy which prohibits harassment based on race, national or ethnic origin, colour, religion, age, sex, sexual orientation, marital or family status, or disability. Harassment means any conduct, comment, gesture or contact that is likely, on reasonable grounds, to cause offence or humiliation to any person, or that might be perceived as placing a condition on employment or any opportunity for training or promotion, work assignment or compensation. Allegations of harassment in the workplace will be treated with confidentiality and sensitivity.

The University of British Columbia has a detailed policy document on sexual harassment that defines terms, explains procedures for laying complaints, and describes the adjudication process and, most importantly, suggests how to avoid behaving in a way that could be interpreted as sexual harassment.

It should be noted that sexual harassment does not include accepted social banter between adults. As well, a finding of sexual harassment is not necessarily confined to supervisor/subordinate or male/ female relationships.

Conflict of Interest

The University has a conflict of interest policy that concerns the activities of employees that may place them in a position where their interests may conflict with the interests of the University.

Members of the departmental community have the right and responsibility to inform one another when they believe a conflict of interest is occurring. Those who believe they have been harmed by a conflict of interest should make full use of the policy and procedures to lodge a complaint.

Sexist Language

Responsible academic work requires that we use gender-inclusive language whenever possible in classes, in our writing, and in informal interactions. Using gender-inclusive forms is a sign of respect and should be encouraged in a supportive manner whenever outdated forms are used.

Physical Contact

Touching, kissing, hugging and other forms of physical contact in public are means of nonverbal communication that can be very effective at expressing friendships, caring and joy. But there are substantial cultural and individual differences in the use of physical contact for communication. In some cultures and for some people, physical contact is an expected form of communication while for others it is neither offered nor welcomed. We believe that genuine expressions of friendship, caring and joy through physical contact are a healthy part of our community when they are clearly welcome and reciprocal and in a context where they will not be misinterpreted. It is the obligation of the person who initiates physical contact to make sure it is welcome. If the situation is unclear or there is any indication that it is not welcome, physical contact is not acceptable.

Demeaning Comments

Faculty and students have an obligation to avoid making demeaning comments about people and groups, to intervene in a respectful way when such comments are made, and to point out statements that can be interpreted as demeaning or callous.

Scheduling Classes, Meetings and Other Academic Events
Scheduling activities so that they are accessible to faculty and students is a challenge. The department is committed to scheduling events so no single group of faculty or students (e.g., single parents) is consistently prevented from attending, while trying to make classes, events and meetings accessible to the greatest number of individuals possible.

If rescheduling or relocation of classes is necessary, faculty shall make every opportunity to inform students and shall make acceptable arrangements for those who cannot attend at the new time location.

Favouritism
Faculty and students have an obligation to make opportunities to participate in academic life and to acquire resources known to all eligible students.

Faculty has an obligation to assure that all students have opportunity to participate in class discussion.

Faculty is on occasion and often with little or no advance notice asked to recommend students for particular tasks or projects. Students who are known to the faculty member to have skills matching the task will often be recommended. Whenever possible, these opportunities should be open to application by all who wish to apply to avoid the appearance of favouritism.

Advising Relationships

Students have the right to timely, accurate and respectful advising. Students can request a change of advisor at any time for any reason.

Meetings should take place in locations that are mutually agreeable to both the faculty member and student. Students and faculty are jointly obligated to clarify expectations and responsibilities in the advising relationship and to hold one another accountable for commitments made in that relationship.

Procedural Guidelines
An individual who believes these policies have been contravened should bring this complaint to the attention of their immediate supervisor; Course Director; or Residency Site Director. Notwithstanding, individuals have the right to utilize preferentially the policies of the University of British Columbia with respect to procedures in the case of conflict of interest or sexual harassment.

If bringing the complaint as outlined does not resolve the matter, the complaint may be directed to the Head of the UBC Department of Family Practice.

In a context of strict confidentiality, the complainant and Department Head will review the episode and discuss alternative courses of action.

It is expected that supervisors, course directors and Residency Site Directors will deal promptly and responsibly with complaints.

Carol P. Herbert, Professor and Head
UBC Department of Family Practice
Policy Statement Passed by Department March 1, 1995
Acknowledgement: The earlier work of Alison Tom and Tom Sark in the Faculty of Education is very much appreciated

COMPLAINT MANAGEMENT SYSTEM

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

1. Your Preceptor
2. The Program Director
3. The Department Head
4. Resident Doctors of BC
5. Associate Dean, Postgraduate Education
6. Associate Dean, Equity
7. College of Physicians and Surgeons of B.C.

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

EVALUATIONS

In-Training Evaluation Report (ITER) - Introductory Rotation

Resident Name: _____

Rotation Dates: _____

Rate the resident's performance in the objectives listed below using the following scale:
A – outstanding B – above average C – meets expectations
D – below expectation E – unsatisfactory N/A – not applicable/assessed

Role #1 Medical Expert						
Describe current societal attitudes about death and dying	A	B	C	D	E	n/a
Define palliative care and describe its basic principles	A	B	C	D	E	n/a
Describe the elements of a comprehensive and practical palliative care consultation, including approaches to dealing with pain and other symptoms, psychosocial factors, and spiritual/ existential concerns	A	B	C	D	E	n/a
Demonstrate competency in taking a palliative history and performing a complete and appropriate physical examination	A	B	C	D	E	n/a
Identify issues in death and dying relevant to different cultures, spiritual beliefs and traditions	A	B	C	D	E	n/a
Describe the physical, psychological, and social issues of dying patients and their families	A	B	C	D	E	n/a
Demonstrate basic knowledge of the assessment and classification of pain, the neurophysiology of pain, the pharmacology of drugs used in pain and symptom management, and the pathophysiology of other symptoms	A	B	C	D	E	n/a
Describe an approach to management of other physical symptoms and disorders, especially dyspnea, constipation, skin care, mouth care, terminal agitation, delirium, and nausea and vomiting	A	B	C	D	E	n/a
Identify psychological issues associated with life-threatening illness and strategies that may be useful in addressing them	A	B	C	D	E	n/a
Describe the process of normal grief	A	B	C	D	E	n/a
Seek appropriate consultations from other health care professionals	A	B	C	D	E	n/a
Role #2 Communicator						
Demonstrate an ability to work with the patient and family to establish common, patient-centered goals of care	A	B	C	D	E	n/a
Produce clear and concise clinical notes, documenting patient assessments and interactions	A	B	C	D	E	n/a
Role #3 Collaborator						
Describe the roles of other disciplines in providing palliative care and communicate effectively with other team members	A	B	C	D	E	n/a
Participate in interdisciplinary care of patients, including family conferences	A	B	C	D	E	n/a
Demonstrate skills in learning from members of the interdisciplinary team	A	B	C	D	E	n/a
Understand the role for the neurosurgeon and anesthetist in intractable pain management	A	B	C	D	E	n/a
Role #4 Manager						
Describe the models of palliative care delivery and their utilization	A	B	C	D	E	n/a
Assist the Palliative Care Unit staff in educating more junior medical trainees, and members of other professional disciplines on the care team	A	B	C	D	E	n/a
Role #5 Health Advocate						
Describe current barriers to providing better care for the dying across different settings	A	B	C	D	E	n/a
Identify the special needs of people living with AIDS, and those who suffer from addiction	A	B	C	D	E	n/a
Role #6 Scholar						
Attend and participate actively in all academic sessions including academic half day, journal club and rounds	A	B	C	D	E	n/a
Access the relevant literature in helping to solve clinical problems in Palliative Care	A	B	C	D	E	n/a
Apply critical appraisal skills to relevant literature	A	B	C	D	E	n/a
Develop ideas for research project	A	B	C	D	E	n/a
Assist in supervision of junior residents and students on electives or rotations through the Palliative Care Unit	A	B	C	D	E	n/a
Role #7 Professional						
Describe his/her concerns about dealing with dying patients and their families	A	B	C	D	E	n/a
Demonstrate an awareness of how his/her own personal experiences of death and dying have influenced attitudes	A	B	C	D	E	n/a

Describe strategies for managing his/her stress in dealing with the dying	A	B	C	D	E	n/a
Demonstrate integrity, honesty, and compassion in the care of patients	A	B	C	D	E	n/a

Motivation: Shows enthusiasm, displays initiative, and works hard	A	B	C	D	E	n/a
Interpersonal Skills: Interacts effectively with staff	A	B	C	D	E	n/a
Empathizes with patients and respects patient confidentiality	A	B	C	D	E	n/a
Learning: Self directs learning based on patient encounters	A	B	C	D	E	n/a
Presents thorough, organized, and well-researched rounds	A	B	C	D	E	n/a

The following sources of information were used for this evaluation.

Direct observations	Yes	No
Discussion of consultations	Yes	No
Review of written consultations	Yes	No
Chart reviews	Yes	No
Feedback from other physicians/health care professionals	Yes	No

Strengths:

Weaknesses:

Please rate this rotation Fail Pass

Comments:

Did you have the opportunity to meet with this trainee to discuss their performance:
Yes
No

(For the evaluee to answer)

Did you have an opportunity to discuss your performance with your preceptor/supervisor
Yes
No

Date:

Resident signature_____

Rotation supervisor:

Supervisor signature: _____

In-Training Evaluation Report (ITER) - BC Cancer Agency–Medical Oncology/Radiation Oncology

Resident Name: _____

Rotation Dates: _____

Rate the resident's performance in the objectives listed below using the following scale:
A – outstanding B – above average C – meets expectations
D – below expectation E – unsatisfactory N/A – not applicable/assessed

Role #1 Medical Expert						
Demonstrate a good knowledge of the current principles of cancer, its pathophysiology and management	A	B	C	D	E	n/a
Demonstrate an ability to work with the patient and family to establish common, patient-centred goals of care, especially in transition from a curative to palliative situation	A	B	C	D	E	n/a
Identify psychological issues associated with life-threatening illness, and strategies that may be useful in addressing them	A	B	C	D	E	n/a
Identify sexuality issues related to surgery, cancer itself, and cancer treatments	A	B	C	D	E	n/a
Manage cancer pain effectively, and demonstrate advanced knowledge of the assessment and classification of pain, the pharmacology of drugs used in pain and symptom management including methadone	A	B	C	D	E	n/a
Demonstrate advanced knowledge of the assessment and management of other symptoms and disorders, especially dyspnea, constipation, skin care, mouth care, terminal agitation, delirium, and nausea and vomiting	A	B	C	D	E	n/a
Role #2 Communicator						
Demonstrate effective communications skills in dealing with terminally-ill patients and their families, including skills in delivering bad news	A	B	C	D	E	n/a
Communicate effectively with other care team members	A	B	C	D	E	n/a
Produce clear, concise and useful dictated consultation notes	A	B	C	D	E	n/a
Role #3 Collaborator						
Describe the roles of other disciplines in providing palliative care in an oncology setting	A	B	C	D	E	n/a
Role #4 Manager						
Demonstrate adequate skills in educating and in learning from members of the interdisciplinary team	A	B	C	D	E	n/a
Role #5 Health Advocate						
Describe the barriers to delivery of effective care across settings	A	B	C	D	E	n/a
Role #6 Scholar						
Access the relevant literature in helping to solve clinical problems in oncology	A	B	C	D	E	n/a
Apply critical appraisal skills to literature in oncology and palliative medicine/supportive care	A	B	C	D	E	n/a
Attend and participate actively in all academic activities, including academic half day, journal club and rounds	A	B	C	D	E	n/a
Role #7 Professional						
Demonstrate effective consultation and communication skills in working with referring physicians	A	B	C	D	E	n/a
Demonstrate integrity, honesty, and compassion in the care of patients	A	B	C	D	E	n/a

Motivation: Shows enthusiasm, displays initiative, and works hard	A	B	C	D	E	n/a
Interpersonal Skills: Interacts effectively with staff	A	B	C	D	E	n/a
Empathizes with patients and respects patient confidentiality	A	B	C	D	E	n/a
Learning: Self directs learning based on patient encounters	A	B	C	D	E	n/a
Presents thorough, organized, and well-researched rounds	A	B	C	D	E	n/a

The following sources of information were used for this evaluation.

Direct observations	Yes	No
Discussion of consultations	Yes	No
Review of written consultations	Yes	No
Chart reviews	Yes	No

Feedback from other physicians/health care professionals	Yes	No

Strengths:

Weaknesses:

Please rate this rotation Fail Pass

Comments:

Did you have the opportunity to meet with this trainee to discuss their performance:
Yes
No

(for the evaluee to answer)

Did you have an opportunity to discuss your performance with your preceptor/supervisor
Yes
No

Date:

Resident signature_____

Rotation supervisor:

Supervisor signature: _____

In-Training Evaluation Report (ITER) - Community Hospice

Resident Name: _____

Rotation Dates: _____

Rate the resident's performance in the objectives listed below using the following scale:
A – outstanding B – above average C – meets expectations
D – below expectation E – unsatisfactory N/A – not applicable/assessed

Role #1 Medical Expert						
Identify issues in death and dying relevant to different cultures, spiritual beliefs and traditions	A	B	C	D	E	n/a
Demonstrate skills in working with the families of dying patients and understand the elements comprising good home care	A	B	C	D	E	n/a
Be knowledgeable about and be able to provide home visits to dying patients	A	B	C	D	E	n/a
Describe the community resources available to support patients in their homes	A	B	C	D	E	n/a
Describe an approach to the last hours of caring in the home and the responsibilities of the physician at the time of death	A	B	C	D	E	n/a
Describe the role of family physicians and specialists in the care of the terminally ill in their homes	A	B	C	D	E	n/a
Describe the role of palliative care consultants in supporting the home care team	A	B	C	D	E	n/a
Role #2 Communicator						
Demonstrate effective consultation and communication skills in working with general practitioners and other team members, particularly understand the role for a patient-held record	A	B	C	D	E	n/a
Role #3 Collaborator						
Demonstrate an ability to work with the patient and family to establish common, patient-centred goals of care	A	B	C	D	E	n/a
Describe the roles of other disciplines in providing palliative care	A	B	C	D	E	n/a
Demonstrate adequate skills in educating and in learning from members of the interdisciplinary team	A	B	C	D	E	n/a
Role #4 Manager						
Understand how the home care program is funded and organized for most effective delivery of care	A	B	C	D	E	n/a
Understand the role for free-standing hospices and the need for a close working relationship between them and other health care settings, such as home and the Palliative Care Unit	A	B	C	D	E	n/a
Role #5 Health Advocate						
Advocate for the needs of home care patients	A	B	C	D	E	n/a
Demonstrate an ongoing commitment to a patient and family from the time of palliative medicine consultation for a terminal illness until (and after) the patient dies	A	B	C	D	E	n/a
Describe the barriers to effective care across different care settings, and various ways to overcome them	A	B	C	D	E	n/a
Role #6 Scholar						
Access the relevant literature in helping to solve clinical problems in Home Hospice	A	B	C	D	E	n/a
Apply critical appraisal skills to literature in palliative care in the home	A	B	C	D	E	n/a
Assist with education of family doctors and home care nurses around the care issues of individual patients	A	B	C	D	E	n/a
Role #7 Professional						
Demonstrate integrity, honesty, and compassion in the care of patients	A	B	C	D	E	n/a
Demonstrate an ability to manage boundary issues with patients	A	B	C	D	E	n/a
Be aware of the need to maintain a safe working environment, particularly in terms of vulnerability when working alone, outside of a health care setting	A	B	C	D	E	n/a
Describe the barriers to effective care across different care settings, and various ways to overcome them	A	B	C	D	E	n/a

Motivation: Shows enthusiasm, displays initiative, and works hard	A	B	C	D	E	n/a
Interpersonal Skills: Interacts effectively with staff	A	B	C	D	E	n/a
Empathizes with patients and respects patient confidentiality	A	B	C	D	E	n/a

Learning: Self directs learning based on patient encounters	A	B	C	D	E	n/a
Presents thorough, organized, and well-researched rounds	A	B	C	D	E	n/a

The following sources of information were used for this evaluation.

Direct observations	Yes	No
Discussion of consultations	Yes	No
Review of written consultations	Yes	No
Chart reviews	Yes	No
Feedback from other physicians/health care professionals	Yes	No

Strengths:

Weaknesses:

Please rate this rotation Fail Pass

Comments:

Did you have the opportunity to meet with this trainee to discuss their performance:
Yes
No

(for the evaluee to answer)

Did you have an opportunity to discuss your performance with your preceptor/supervisor
Yes
No

Date:

Resident signature_____

Rotation supervisor:

Supervisor signature: _____

Please return to Garnette McCue, Program Assistant – Division of Palliative Care
UBC Department of Family Practice, c/o 1081 Burrard Street, Vancouver, BC V6Z 1Y6
Phone: 1.604.740.5711 Fax:1. 604.740-5737 Email: gmccue@familymed.ubc.ca

In- Training Evaluation Report (ITER) - Geriatrics

Resident Name: _____

Rotation Dates: _____

Rate the resident's performance in the objectives listed below using the following scale:

A – outstanding B – above average C – meets expectations
D – below expectation E – unsatisfactory N/A – not applicable/assessed

Role #1 Medical Expert						
Describe the effects of aging on organ systems	A	B	C	D	E	n/a
Describe the effects of aging on medication use and pharmacology	A	B	C	D	E	n/a
Describe the concept of frailty	A	B	C	D	E	n/a
Medically manage illnesses commonly seen in the elderly, i.e. CHF, COPD, pneumonia	A	B	C	D	E	n/a
Recognize the side effects of commonly used drugs, i.e. neuroleptics, cardiac meds, etc.	A	B	C	D	E	n/a
Recognize the features of end-stage disease	A	B	C	D	E	n/a
Recognize and differentiate dementia, delirium and depression	A	B	C	D	E	n/a
Adequately manage these syndromes	A	B	C	D	E	n/a
Assess and manage common geriatric syndromes, i.e. incontinence, falls	A	B	C	D	E	n/a
Recognize when referral to a sub specialist is required for atypical presentations of geriatric syndromes	A	B	C	D	E	n/a
Demonstrate ability to make a functional assessment with respect to ADLs and iADLs	A	B	C	D	E	n/a
Recognize the contribution of medical diagnosis to evaluation of functional loss	A	B	C	D	E	n/a
Describe the societal and environmental factors relevant to the care of the elderly	A	B	C	D	E	n/a
Assess the role of advance directives and levels of intervention	A	B	C	D	E	n/a
Recognize the impact of dementia on decision making	A	B	C	D	E	n/a
Describe the fundamental concept of competency with regard to decision making on health care issues	A	B	C	D	E	n/a
Be able to perform an assessment of competency in differing situations	A	B	C	D	E	n/a
Describe the concept of futile treatment	A	B	C	D	E	n/a
Be able to manage ethical problems at the end of life, including withdrawing or withholding therapy, advance directives, euthanasia and assisted suicide	A	B	C	D	E	n/a
Role #2 Communicator						
Demonstrate an ability to work with the patient and family to establish common, patient-centered goals of care	A	B	C	D	E	n/a
Communicate effectively with other team members	A	B	C	D	E	n/a
Demonstrate ability to write clear and concise consultation notes	A	B	C	D	E	n/a
Role #3 Collaborator						
Describe the roles of other disciplines in providing care of the elderly	A	B	C	D	E	n/a
Recognize the roles of informal and formal caregivers	A	B	C	D	E	n/a
Demonstrate ability to put systems in place to support function failure, i.e. home care, home making, aids	A	B	C	D	E	n/a
Demonstrate ability in working with a multi-disciplinary team to effectively manage functional losses	A	B	C	D	E	n/a
Role #4 Manager						
Recognize the changing demographics of our society, and its implications for future health care provision needs	A	B	C	D	E	n/a
Describe the systems of care in place for the care of frail elderly, i.e. long term care, home care, etc	A	B	C	D	E	n/a
Explain the impact of hospitalization on the elderly	A	B	C	D	E	n/a
Describe the interface of nursing home, hospital and home	A	B	C	D	E	n/a
Role #5 Health Advocate						
Recognize the role of the physician as an advocate for care of the elderly	A	B	C	D	E	n/a
Recognize the role of the physician in supporting family care givers	A	B	C	D	E	n/a
Role #6 Scholar						
Access the relevant literature in helping to solve clinical problems in geriatrics	A	B	C	D	E	n/a
Apply critical appraisal skills to literature in geriatrics and palliative care	A	B	C	D	E	n/a

Role #7 Professional						
Demonstrate integrity, honesty, and compassion in the care of patients	A	B	C	D	E	n/a

Motivation: Shows enthusiasm, displays initiative, and works hard	A	B	C	D	E	n/a
Interpersonal Skills: Interacts effectively with staff	A	B	C	D	E	n/a
Empathizes with patients and respects patient confidentiality	A	B	C	D	E	n/a
Learning: Self directs learning based on patient encounters	A	B	C	D	E	n/a
Presents thorough, organized, and well-researched rounds	A	B	C	D	E	n/a

The following sources of information were used for this evaluation.

Direct observations	Yes	No
Discussion of consultations	Yes	No
Review of written consultations	Yes	No
Chart reviews	Yes	No
Feedback from other physicians/health care professionals	Yes	No

Strengths:

Weaknesses:

Please rate this rotation Fail Pass

Comments:

Did you have the opportunity to meet with this trainee to discuss their performance:
Yes
No

(For the evaluee to answer)

Did you have an opportunity to discuss your performance with your preceptor/supervisor?
Yes
No

Date:

Resident signature_____

Rotation supervisor:
Supervisor signature: _____

In-Training Evaluation Report (ITER) - Vancouver General Hospital–Advanced Palliative Care

Resident Name: _____

Rotation Dates: _____

Rate the resident's performance in the objectives listed below using the following scale:
A – outstanding B – above average C – meets expectations
D – below expectation E – unsatisfactory N/A – not applicable/assessed

Role #1 Medical Expert						
Describe issues in death and dying relevant to different cultures, spiritual beliefs and traditions	A	B	C	D	E	n/a
Demonstrate consultant level diagnostic and therapeutic skills for ethical and effective patient care	A	B	C	D	E	n/a
Demonstrate advanced knowledge of the assessment and classification of pain, the neurophysiology of pain, the pharmacology of drugs used in pain and symptom management, and the pathophysiology of other symptoms	A	B	C	D	E	n/a
Demonstrate competence in advanced pain management, including an understanding for the role of interventional techniques such as neuraxial infusion, neurolytic blocks and cementoplasty	A	B	C	D	E	n/a
Manage other physical symptoms especially dyspnea, constipation, skin care, mouth care, terminal agitation, delirium, and nausea and vomiting	A	B	C	D	E	n/a
Describe the process of normal and atypical grief, and a systematic approach to working with the families of dying patients including bereavement counselling	A	B	C	D	E	n/a
Identify the social and existential needs confronting patients and families, and strategies that may be useful in addressing them	A	B	C	D	E	n/a
Role #2 Communicator						
Demonstrate an ability to work with the patient and family to establish common, patient-centered goals of care	A	B	C	D	E	n/a
Communicate effectively with other palliative care team members	A	B	C	D	E	n/a
Communicate effectively with referring physicians and care teams on the hospital wards	A	B	C	D	E	n/a
Demonstrate ability to write clear and concise consultation notes	A	B	C	D	E	n/a
Role #3 Collaborator						
Demonstrate the ability to work effectively in institutional multidisciplinary palliative care program	A	B	C	D	E	n/a
Demonstrate an understanding of the different perspectives of various medical specialties, and how to resolve inter-disciplinary conflict around goals of care	A	B	C	D	E	n/a
Describe the roles of other disciplines in providing palliative care	A	B	C	D	E	n/a
Participate in interdisciplinary care of patients, including family conferences	A	B	C	D	E	n/a
Role #4 Manager						
Teach junior trainees on Palliative Care rotations and electives	A	B	C	D	E	n/a
Assist institutional and community palliative care programs in developing standards of care	A	B	C	D	E	n/a
Role #5 Health Advocate						
Describe the barriers to effective care across different settings	A	B	C	D	E	n/a
Advocate for the needs of dying patients in hospital but not in a Palliative Care bed	A	B	C	D	E	n/a
Act as an effective advocate for the rights of the patient and family in clinical situations involving serious ethical considerations	A	B	C	D	E	n/a
Understand the issues related to provision of adequate bed availability in a general hospital, how to integrate with home care services, and the role for free standing hospices in resource management	A	B	C	D	E	n/a
Role #6 Scholar						
Demonstrate skills in providing educational counselling to dying patients and their families	A	B	C	D	E	n/a
Demonstrate skills in educating and in learning from members of the interdisciplinary team	A	B	C	D	E	n/a
Role #7 Professional						
Describe his/her concerns about dealing with dying patients and their families	A	B	C	D	E	n/a
Demonstrate an awareness of how his/her own personal experiences of death and dying have influenced attitudes						
Describe strategies for managing his/her stress in dealing with the dying	A	B	C	D	E	n/a

Demonstrate integrity, honesty, and compassion in the care of patients	A	B	C	D	E	n/a
Act as a role model for other residents and physicians	A	B	C	D	E	n/a

Motivation: Shows enthusiasm, displays initiative, and works hard	A	B	C	D	E	n/a
Interpersonal Skills: Interacts effectively with staff	A	B	C	D	E	n/a
Empathizes with patients and respects patient confidentiality	A	B	C	D	E	n/a
Learning: Self directs learning based on patient encounters	A	B	C	D	E	n/a
Presents thorough, organized, and well-researched rounds	A	B	C	D	E	n/a

The following sources of information were used for this evaluation.

Direct observations	Yes	No
Discussion of consultations	Yes	No
Review of written consultations	Yes	No
Chart reviews	Yes	No
Feedback from other physicians/health care professionals	Yes	No

Strengths:

Weaknesses:

Please rate this rotation Fail Pass

Comments:

Did you have the opportunity to meet with this trainee to discuss their performance?
Yes
No

(for the evaluee to answer)
Did you have an opportunity to discuss your performance with your preceptor/supervisor?
Yes
No

Date:

Resident signature_____
Rotation supervisor:
Supervisor signature: _____

In-Training Evaluation Report (ITER) - Elective Rotation

Resident Name: _____

Rotation Dates: _____

Rate the resident's performance in the objectives listed below using the following scale:
A – outstanding B – above average C – meets expectations
D – below expectation E – unsatisfactory N/A – not applicable/assessed

Resident Objectives

		A	B	C	D	E	n/a
		A	B	C	D	E	n/a
		A	B	C	D	E	n/a
		A	B	C	D	E	n/a
		A	B	C	D	E	n/a
		A	B	C	D	E	n/a
		A	B	C	D	E	n/a
		A	B	C	D	E	n/a

Motivation: Shows enthusiasm, displays initiative, and works hard	A	B	C	D	E	n/a
Interpersonal Skills: Interacts effectively with staff	A	B	C	D	E	n/a
Empathizes with patients and respects patient confidentiality	A	B	C	D	E	n/a
Learning: Self directs learning based on patient encounters	A	B	C	D	E	n/a
Presents thorough, organized, and well-researched rounds	A	B	C	D	E	n/a

The following sources of information were used for this evaluation.

Direct observations	Yes	No
Discussion of consultations	Yes	No
Review of written consultations	Yes	No
Chart reviews	Yes	No
Feedback from other physicians/health care professionals	Yes	No

Strengths:

Weaknesses:

Please rate this rotation Fail Pass

Comments:

Did you have the opportunity to meet with this trainee to discuss their performance:
Yes
No

(for the evaluee to answer)

Did you have an opportunity to discuss your performance with your preceptor/supervisor
Yes
No

Date:

Resident signature_____

Rotation supervisor:

Supervisor signature: _____

SITE EVALUATION – Year of Added Competency in Palliative Care
For resident to complete.

Date: _____

Rotation Site	
Name of Resident	

Instruction
In the spaces below, please write in the names of the instructor(s) with whom you have had the most contact during this experience. List only those faculty instructors for whom you can give a reliable assessment of their abilities as clinical teachers.

1.	4.
2.	5.
3.	6.

Breadth
The instructor has a strong command of his or her area and discusses different approaches to patients and treatment.

Instructors	Strongly Disagree						Strongly Agree
1.	1	2	3	4	5	6	7
2.	1	2	3	4	5	6	7
3.	1	2	3	4	5	6	7
4.	1	2	3	4	5	6	7
5.	1	2	3	4	5	6	7
6.	1	2	3	4	5	6	7

Clarity
The instructor explains him/herself clearly and identifies the important aspect about patients and treatment.

Instructors	Strongly Disagree						Strongly Agree
1.	1	2	3	4	5	6	7
2.	1	2	3	4	5	6	7
3.	1	2	3	4	5	6	7
4.	1	2	3	4	5	6	7
5.	1	2	3	4	5	6	7
6.	1	2	3	4	5	6	7

Interaction

The instructor is friendly towards the resident and encourages resident questions and discussion.

Instructors	Strongly Disagree			Moderately Agree			Strongly Agree
1.	1	2	3	4	5	6	7
2.	1	2	3	4	5	6	7
3.	1	2	3	4	5	6	7
4.	1	2	3	4	5	6	7
5.	1	2	3	4	5	6	7
6.	1	2	3	4	5	6	7

Supervision

The instructor provides suitable practice opportunities for the resident and objectively identifies strengths and deficiencies in resident performance.

Instructors	Strongly Disagree			Moderately Agree			Strong Agree
1.	1	2	3	4	5	6	7
2.	1	2	3	4	5	6	7
3.	1	2	3	4	5	6	7
4.	1	2	3	4	5	6	7
5.	1	2	3	4	5	6	7
6.	1	2	3	4	5	6	7

Enthusiasm

The instructor seems to enjoy teaching and stimulated interest for this field.

Instructors	Strongly Disagree			Moderately Agree			Strongly Agree
1.	1	2	3	4	5	6	7
2.	1	2	3	4	5	6	7
3.	1	2	3	4	5	6	7
4.	1	2	3	4	5	6	7
5.	1	2	3	4	5	6	7
6.	1	2	3	4	5	6	7

Summary Assessment

Considering all aspects of instruction, how would you rate each instructor in terms of overall effectiveness as a teacher?

Instructors	Strongly Disagree			Moderately Agree			Strongly Agree
1.	1	2	3	4	5	6	7
2.	1	2	3	4	5	6	7
3.	1	2	3	4	5	6	7
4.	1	2	3	4	5	6	7
5.	1	2	3	4	5	6	7
6.	1	2	3	4	5	6	7

Rotation Organization and Content

Please indicate your agreement or disagreement with each of the following statements as they apply to this rotation.

	Statements	Strongly Disagree			Moderately Agree			Strongly Agree
A.	The rotation was well organized with efficient use of time.	1	2	3	4	5	6	7
B.	The opportunities for a resident to participate in patient care were meaningful and sufficient.	1	2	3	4	5	6	7
C.	The major learning objectives were clearly described and followed.	1	2	3	4	5	6	7
D.	A variety of patient problems representative of the discipline were seen.	1	2	3	4	5	6	7
E.	The rotation yielded returns in proportion to its time allocation in the curriculum.	1	2	3	4	5	6	7
F.	Were made to feel part of this experience, an integrated member of a team rather than a "fifth wheel".	1	2	3	4	5	6	7
G.	The assessments were a fair and valid evaluation of your competence.	1	2	3	4	5	6	7
H.	The teaching was effectively delivered	1	2	3	4	5	6	7
I	The teaching content was useful and relevant	1	2	3	4	5	6	7
J	Considering all components, how would you rate the overall organization and content of this experience?	1	2	3	4	5	6	7

Overall Summary Assessment

Considering all aspects of this experience, how would you rate its overall effectiveness as a learning experience?

Poor			Satisfactory			Excellent
1	2	3	4	5	6	7

Comments

Please comment on strengths or weaknesses that particularly apply to this experience.

Please return to Kathryn Inman, UBC Division Of Palliative Care Program Administrative Assistant
6389 Stadium Road, Vancouver BC
Fax (604) 806-9643; Email: ksinman@mail.ubc.ca

Academic Half-Day Feedback Form

****

Date:

Speaker:

Topic:

Were learning objectives clearly stated?

What did you learn from the session?

Is there anything else that you could suggest to add to this session for next year (i.e. any specific additional learning objectives)?

Please comment re: the quality of the speaker.

Positive feedback:

Suggestions for improvement:

(Optional):

Residency Training Program and Year:

a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA

UBC Palliative Medicine
Direct/Indirect observation feedback form

Name of resident: _____ Date of feedback: _____

Name of preceptor: _____ Current rotation: _____

Setting: _____
- [ ] Inpatient - Acute
- [ ] Inpatient - Hospice
- [ ] Outpatient/ambulatory
- [ ] Community
- [ ] Other

Activity observed: _____

Plus (what was done well and why):

_____

_____

_____

Delta (what could be changed and rationale for the change proposed):

_____

_____

_____

Plan (how to encourage the changes):

_____

_____

_____