# *AST Programme*

# PALLIATIVE MEDICINE

## (A) INTRODUCTION

**Definition**

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual (World Health Organization)

Palliative medicine is the branch of medicine involved in the treatment of patients with advanced, progressive, life-threatening disease for whom the focus of care is maximizing their quality of life through expert symptom management, psychological, social and spiritual support as part of a multi-professional team.

Emphasis is placed on excellent communication skills both with patients and with their families. Clinical skills in history taking and examination are essential; investigations are carried out only if the result will contribute to the patients' management. Active emphasis is placed on involving patients and their families in decision making regarding treatment options and care.

**Objective(s) of Training**

The aims of this Palliative Medicine subspecialist training programme are:

- To train a specialist in Palliative Medicine who may work in hospital-based palliative medicine teams or in the community (inpatient or home hospices, community hospitals or nursing homes)
- To encourage trainees/residents to possess habits of life-long learning to build upon their knowledge and skills.
- To facilitate trainees/residents to be involved in a multidisciplinary working environment where they contribute their particular expertise to situations often in consultation with equally valid opinions from other health professionals.
- To ensure that the trainees/residents are exposed to the necessary competencies required in Palliative Medicine to complete advanced subspecialty training (AST)/residency training in this field, and thereby be able to work as consultant specialists in hospitals or the community.

## (B) PROGRAMME OVERVIEW

### Trainee/Residency Duration

1. **2-Year Track**

   The traineeship/residency programme for Palliative Medicine Subspecialty Training is conducted for a period of 2 years.

2. **3-Year Track**

   The traineeship/residency programme for Palliative Medicine Subspecialty Training is conducted for a period of 3 years.

### Duration of Core Postings and Electives

| **Before AY2023 cohort:** | **From AY2023 cohort onwards:** |
|---|---|
| 1. **2-Year Track**<br>This training comprising of at least:<br>• 9 months in hospital-based Palliative Medicine units<br>• 9 months in community hospice units, of which at least 6 months will be in hospice home care;<br>• 6 months elective postings | 1. **2-Year Track**<br>This training comprising of at least:<br>• 9 months in hospital-based Palliative Medicine units<br>• 12 months in community-based Palliative Medicine units, of which 6 months will be in hospice home care and 6 months will be in inpatient hospice care;<br>• 3 months elective postings |
| 2. **3-Year Track**<br>This training comprising of at least:<br>• 12 months hospital-based Palliative Medicine Unit<br>• 12 months in community hospice units, of which 6 months will be in hospice home care and 6 months in inpatient hospice care;<br>• 12 months elective posting with the following conditions: 6 months compulsory posting in Medical Oncology and 6 months elective postings | 2. **3-Year Track**<br>This training comprising of at least:<br>• 15 months hospital-based Palliative Medicine units<br>• 15 months in community-based Palliative Medicine units, of which 9 months will be in hospice home care and 6 months will be in inpatient hospice care;<br>• 6 months elective posting with the following conditions: 3 months compulsory posting in Medical Oncology and 3 months in other elective postings |

**List of Elective Postings**

| **Before AY2024 cohort:** | **From AY2024 cohort onwards:** |
|---|---|
| • Medical Oncology<br>• Internal Medicine,<br>• Geriatric Medicine,<br>• Paediatric Medicine and Paediatric Oncology,<br>• Radiation Oncology,<br>• Anaesthesiology - Pain Management Centre/Pain services,<br>• Rehabilitation Medicine,<br>• Psychiatry,<br>• Haematology,<br><br>• Electives for other specialties or services will be considered on a case-by-case basis by SSTC<br><br>• Approval of elective posting to these centres must be obtained from -Palliative Medicine SSTC prior to commencement of the posting. | • Medical Oncology (3 months compulsory for residents in a 3-year Track),<br>• Radiation Oncology,<br>• Anaesthesiology - Pain Medicine<br>• Rehabilitation Medicine,<br>• Pyscho-oncology[1],<br>• Palliative Care for Critically Ill and/or Ventilated Patients – ICU Palliative Care (2 weeks) and Home Ventilation and Respiratory Support (2 weeks)<br>• Paediatric Palliative Care - Star PALS (Paediatric Advanced Life Support) under HCA Hospice – only for residents who are intending to work in Paediatric Palliative Care long term<br><br>• Approval of elective posting to these centres must be obtained from Joint Coordinating Committee (JCC) prior to commencement of the posting.<br><br>• Electives for other specialties or services will be considered on a case-by-case basis by JCC and SSTC / RAC. This apply to candidates who require specific electives to acquire the relevant competencies for completion of AST training, with the possibility of extension of duration of training if needed) |

[1] Pyscho-oncology refers to Psychiatry services with special interest in palliative care mental health issues or Services run by Psychologists/ Medical Social Workers who work predominantly with patients with serious life limiting illness.

| | |
|---|---|
| | For the 2-year programme, each resident will do 3 elective postings and each elective posting is of 1-month duration.<br><br>For the 3-year programme, each resident will do a compulsory 3-month elective posting in Medical Oncology and 3 other elective postings of 1-month duration each. |

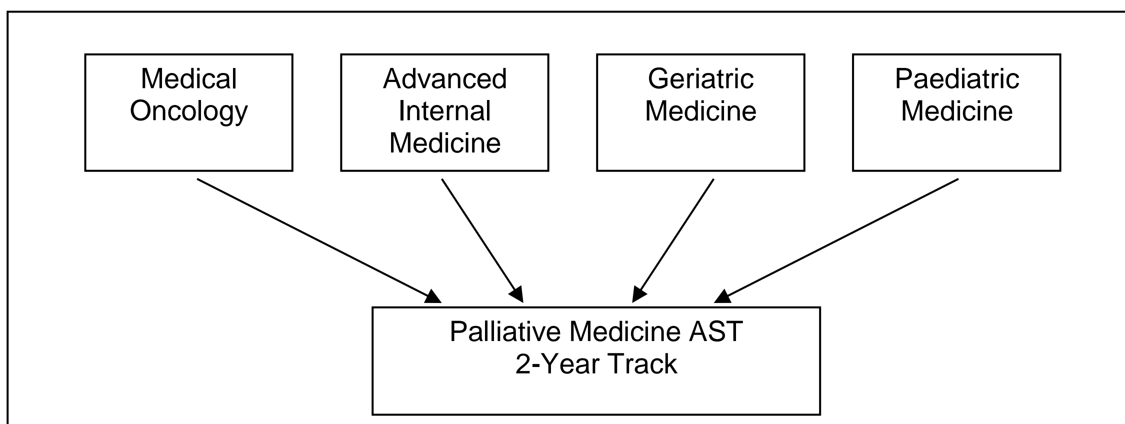
## (C) ADMISSION REQUIREMENTS

**Entry Criteria / Pre-requisites**

**1. 2-Year Track**

To be eligible for the Palliative Medicine Subspecialty Training Programme, candidates need to have fully completed and exited from any one of the four following base advanced specialty trainings:

- Advanced Internal Medicine,
- Geriatric Medicine,
- Medical Oncology,
- Paediatric Medicine.




**2. 3-Year Track**

To be eligible for the Palliative Medicine Subspecialty Training Programme, candidates are required to have acquired Master of Medicine in Family Medicine.

Candidates who fulfill the entry criteria for either 2-year or 3-Year track but do not have prior experience in Palliative Medicine, should have completed the Graduate Diploma in Palliative Medicine (GDPM) within the last 3 years.

## (D) TRAINING SYLLABUS

**Detailed Syllabus**

Refer to **Annex A** for more details

1. Introduction to Palliative Care
    - 1.1 History, philosophy and definitions
    - 1.2 Communication between services
2. Clinical Care
    - 2.1. Management of life limiting, progressive disease
    - 2.2 Cancer care
    - 2.3 Non –malignant life limiting, progressive illnesses
    - 2.4 Management of concurrent clinical problems
    - 2.5 Functional assessment and rehabilitation
3. Symptom Control
    - 3.1 Principles of symptom management
    - 3.2 Pain
    - 3.3 Other symptoms
4. Emergencies in Palliative Care and Practical procedures
    - 4.1 Management of palliative care emergencies
    - 4.2 Practical Procedures
5. Pharmacology and Therapeutics
    - 5.1 Drug Specific
    - 5.2 Care of the dying patient and family
6. Psychosocial Care
    - 6.1 Social and Family relationships
    - 6.2 Communication with patients and relatives
    - 6.3 Psychological responses of patient and relatives to life-threatening illness
    - 6.4 Care of self and team
    - 6.5 Grief and Bereavement
    - 6.6 Financial issues
7. Culture, Religion and Spirituality
    - 7.1 Culture and ethnicity
    - 7.2 Religion and spirituality

8. Ethics
    - 8.1 Theoretical ethics
    - 8.2 Applied ethics in palliative care
9. Legal Issues at the end-of-life
    - 9.1 Death
    - 9.2 Therapeutics
    - 9.3 Doctor/patient relationship
    - 9.4 Organisational
10. Teaching
11. Research
12. Teamwork and Service development
    - 12.1 Teamwork
    - 12.2 Service development

## (E) INSTITUTIONAL REQUIREMENTS (FACILITIES & RESOURCES)

**Requirements for facilities for study and training**

- Facilities to accomplish the overall educational programme must be available and functioning.
- Training will only be conducted in accredited training centres which are either hospital-based palliative care units/services, in-patient hospices or hospice home-care services.
- Access to a good resource library, secretariat & logistic assistance must be available.

## (F) SUPERVISION OF TRAINEES

All AST trainees will be supervised by a designated consultant/ supervisor but in general all the consultant staff will be duty bound to take an active part in teaching. Designated supervisor at each posting should submit a training report to SSTC every 6 months. In addition to the posting supervisors, SSTC will appoint a main supervisor who is responsible for the whole period of the training the trainee.

1 Full-time Associate Consultant/Consultant may supervise up to a maximum of 2 junior residents or 1 junior resident and 1 AST (with minimum of 2 years training gap. e.g. First year Associate Consultant may supervise 1$^{st}$ year AST)

In a hospital-based palliative care unit/service, the trainee will be supervised by a Palliative Medicine Specialist. The service will include in-patient consultations and their subsequent follow-up and ambulatory service at outpatient clinics. In an in-patient hospice, the trainee will be supervised by a Palliative Medicine Specialist in daily ward round and management of palliative care patients.

In a hospice home care service, the trainee will be supervised by a Palliative Medicine Specialist. The service will include medical support to a team of community hospice nurses who are looking after palliative care patients in their homes.

In the elective posting, the trainee will be supervised by a specialist in the respective specialty.

## (G) ASSESSMENT AND FEEDBACK

### Logbook

**Before AY2023 cohort**

All trainees are expected to keep a log book which will be reviewed on a monthly basis by the main supervisor. The log book will have a record of cases managed or consulted. Notes should be made regarding difficult or complicated cases. CME activities should also be recorded.

All other teaching experiences e.g. conferences, seminars, papers presented should also be recorded.

**From AY2023 cohort onwards**

All residents will adopt the EPA framework.

### Feedback

Six-monthly interviews with the trainees should be conducted to ensure that the training objectives for each rotation have been adequately met, as well as to monitor for any difficulties in workload and training activities. Feedback forms should also be provided at the end of each posting, and SSTC is responsible for collating the results and instituting the appropriate changes to the training programmes.

## (H) EXIT EXAMINATION

The examinations are held annually, not earlier than 3 months before end of training.

**Eligibility**

A candidate may be admitted to the examination provided he / she has:

- Completed the requisite periods of training.

Completed a minimum of 4 patient case studies, with in-depth discussions on pain, other symptoms, psychosocial and bioethical issues. (AY 2023 cohort onwards will no longer be required to complete the minimum of case studies)

**Exit Examination Format**

- Clerking of a case (1 hour) & case discussion (30 minutes)
- Conducting an interdisciplinary patient case conference (30 minutes)
- Viva voce (30 minutes)

Palliative Medicine SSTC will organise exit examinations in the current format until all trainees from the AY2022 cohort exit or leave because maximum candidature duration is exceeded.

Please note that Palliative Medicine training will transition to the APMES (Accreditation of Postgraduate Medical Education Singapore) Model from July 2024.

The new Programme of Assessments will start from AY2023 cohort.

- Enhanced Viva voce -3 stations (25 minutes per station)
- Summative portfolio based on Entrustable Professional Activities (EPAs)

Trainees/residents are required to pass both components (i.e., viva voce and summative portfolio) before they are allowed to exit from the training programme.

**Re-Examination**

Unsuccessful candidates shall be required to repeat the entire examination or component of the examination as determined by the Board of Examiners or SSTC. Any additional training requirements must be completed prior to the re-examination.

For repeating the entire examination, the candidate shall be re-examined at the next exit examination for the subsequent cohort of trainees/residents completing their training. For repeating only each component of the examination, the candidate may be re-examined at an appropriate time to be determined by SSTC. The number of attempts at each component will be considered independently and will be based on the maximum candidature duration.

## (I) GENERAL GUIDELINES

Please refer to Annex 1 for general guidelines on the following:

- Leave Guidelines
- Training Deliverables
- Changes to Training Period
- Overseas Training
- Maximum Candidature
- Withdrawal of Traineeship
- Exit Certification

**ANNEX A**

# CURRICULUM OF PALLIATIVE MEDICINE AST TRAINING

## 1. INTRODUCTION TO PALLIATIVE CARE

### 1.1 History, philosophy and definitions

- Definitions of palliative care and changing role of palliative care over time (including extension to diseases other than cancer)
- Evolving nature of palliative care over the course of illness, including integration with active treatment, and the significance of transition points
- Dying in Singapore- epidemiology, access to palliative care services, historical aspects

### 1.2 Communication between services

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

## 2. CLINICAL CARE

### 2.1 Management of life-limiting, progressive disease

Skills in:
- initial assessment -detailed history and examination; assessment of impact of situation on patient and family
- judgement of prognosis
- consideration of wide range of management options
- judgement of benefits and burdens of investigations, treatments, and intervention or non-intervention
- reassessment and review
- recognition of transition points during course of illness
- recognition of dying process
- crisis management

### 2.2 Cancer care

Knowledge of:
- the principles of cancer management
- the presentation, paths of spread and current management of all major malignancies

### 2.3 Non–malignant life limiting, progressive illnesses

Knowledge of the presentation, usual course and current management of

- End-stage renal failure
- End-stage heart failure
- End-stage respiratory failure e.g. from advanced COPD, fibrosing alveolitis
- End –stage liver failure including Child's C cirrhosis
- Motor neuron disease/ advanced dementia/ advanced Parkinson's disease/ Multi-system atrophy

### 2.4 Management of concurrent clinical problems commonly encountered in palliative care

- Malignant intestinal obstruction
- Pleural and pericardial effusion
- Electrolyte disturbances e.g. hypercalcaemia, hyponatraemia, hypomagnesaemia
- Paraneoplastic syndromes
- Inappropriate ADH secretion
- Raised intracranial pressure
- Infections and infection control measures
- Nutrition and hydration – methods, indications, and controversies
- Common respiratory disorders
- Thromboembolic disease
- Anaemia, bleeding disorders, coagulopathies
- Diabetes mellitus, hyper/hypothyroidism,
- Ischaemic heart disease, heart failure, arrhythmias, hypotension
- Peripheral vascular disease
- Common dermatological problems
- Anxiety, depression, delirium and psychoses
- Fractures
- Pre-existing drug dependence
- Pre-existing chronic pain

## 3 SYMPTOM CONTROL

### 3.1 Principles of symptom management

- History taking and appropriate examination in symptom control assessment
- Diagnosis of the pathophysiology of a symptom
- The wide range of therapeutic options – disease-modifying treatments and symptom-modifying treatments (palliative surgery, radiotherapy, chemotherapy, immunotherapy, hormone therapy, drugs, physical therapies, psychological interventions, complementary therapies)
- Appropriate choice of treatment / non-treatment considering burdens and benefits of all options
- Management of adverse effects of treatment
- Regular review of symptom response
- Assessment of symptom response
- Management of intractable symptoms – recognition and support for patients, carers, multi-professional teams and self
- Referral to other disciplines when needed

### 3.2. Pain

- Physiology of pain
- History taking, physical examination and investigations in pain assessment
- Pain assessment tools – clinical and research
- Pain syndromes
- Drug treatment of pain – WHO analgesic ladder and appropriate use of adjuvant drugs
- Range of opioids, relative benefits and indications
- Indications and appropriate use of opioid switching
- Management of side effects of drug treatments
- Assessment of burdens and benefits of treatments in relieving pain eg radiotherapy
- Non-drug treatment – TENS, acupuncture, physiotherapy, immobilisation
- Common nerve blocks and principles of spinal delivery of analgesics
- Appropriate referral to and shared care with pain management service
- Psychological interventions in pain management

### 3.3 Other symptoms

Causes, assessment and management of

- oral problems eg mucositis, oral thrush, mouth ulcers
- nausea and vomiting
- swallowing problems
- constipation, faecal impaction, diarrhoea
- tenesmus
- ascites
- jaundice
- itch
- breathlessness , cough , hiccups , haemoptysis
- bladder spasm, urinary symptoms
- sexual problems
- lymphoedema
- fistulae, wound breakdown, bleeding / fungating/ odourous lesions, pressure sores
- anorexia, cachexia
- fatigue
- communication problems, eg, difficulties speaking or hearing
- sleep disturbances
- treatment induced symptoms – radiotherapy, chemotherapy, immunotherapy, drugs

## 4 EMERGENCIES IN PALLIATIVE MEDICINE AND PRACTICAL PROCEDURES

### 4.1 Management of emergencies:

- Overwhelming pain and distress
- SVCO obstruction
- Hypercalcaemia
- Spinal cord compression
- Cardiac tamponade
- Pathological fractures
- Terminal delirium / agitation
- Massive haemorrhage
- Seizures
- Pleural effusion
- Delirium
- Acute suicidal ideation
- Drug overdose
- Alcohol and drug withdrawal
- Hypoglycaemia
- Oculogyric and serotonergic crises
- Acute urinary retention
- Pneumothorax
- Pulmonary embolism
- Stridor, bronchospasm
- Acute congestive cardiac failure
- Acute renal failure, obstructive uropathy

### 4.2 Practical procedures

Competence in the following
- Management of stomas
- Management of tracheostomies
- Managing percutaneous gastrostomies and jejunostomies
- Insertion of nasogastric tube
- Abdominal paracentesis
- Management of non invasive ventilation (where available and appropriate)
- Urethral catheterisation
- Syringe driver set up
- Nebuliser setup
- Management of spinal catheters in the community (with support from Pain Teams)

## 5. PHARMACOLOGY AND THERAPEUTICS

### 5.1 Drug specific

- General principles of pharmacodynamics, pharmacokinetics and pharmacogenetics
- Adjustment of dosage in the elderly ,children, altered metabolism, disease progression and last few days of life
- Use of drugs outside their product licence
- Helping patients and carers to understand and manage tablets

For drugs commonly used in palliative medicine:
- Routes of administration
- Absorption, metabolism, excretion
- Half-life, frequency of administration
- Adverse effects and their management
- Use in syringe drivers- stability and miscibility
- Interactions with other drugs
- Possibility of tolerance, dependence, addiction and discontinuation reactions
- Availability in the community

### 5.2 Care of the dying patient and their family

- Recognition of the dying phase
- Assessment of the dying patient
- Providing ongoing care for dying patients and their families
  -managing symptoms in the dying phase
  -psychological care of the family
  -knowledge of major cultural and religious norms regarding death and dying
  -understanding of ethical dilemmas in the dying phase
- Understanding the role of care pathways in improving care of the dying.

## 6. PSYCHOSOCIAL CARE

### 6.1 Social and Family Relationships

- Appreciation of the ill person in relation to his/her family, work and social circumstances
- Construction and use of genograms in taking a family history and understanding family relationships
- Assessment of the response to illness and expectations among family members
- When and how to conduct family meetings

- Ways to accommodate needs of patients and families in provision of palliative care in different settings
- Understanding of family dynamics
- Awareness of transference and counter-transference in professional relationships with patients and family members

**6.2 Communication with patients and relatives**

- Skills in active listening, open questioning and information giving to:
  -elicit concerns across physical, psychological, social and spiritual domains
  -establish extent of awareness about illness and prognosis
  -managing awkward questions and giving information sensitively and appropriately
  -facilitate decision making, negotiating goals of care
- Awareness of common barriers to communication

**6.3 Psychological responses of patient and relatives to life-threatening illness**

- Distinction between sadness and clinical depression
- Role of the psychiatric services and indications for referral
- Role of medical social worker and indications for referral
- Role of counselling, behavioural therapy, cognitive therapy, support groups
- Roles of relaxation therapies and art therapy
- Sexuality and body image issues

**6.4 Care of self and team**

- Awareness of personal values and belief systems, and how these influence professional judgements and behaviours
- Awareness of own skills and limitations, and effect of personal loss or difficulties
- Ability to ask for help or hand over to others where necessary
- Potential sources of conflict in the doctor-patient relationship and how to deal with these (eg over-involvement, personal identification, negative feelings/personality clash, demands which cannot be met)
- Recognition and management of the emotional/ psychological impact of palliative care on oneself, the team and other colleagues
- Recognition of ways staff support can be offered / co-ordinated
- Assessment of personal and team member safety when conducting visits in the
- Community

**6.5 Grief and Bereavement**

- Theories about bereavement
- Grief and bereavement in children
- Preparation of carers and children for bereavement
- Anticipation and identification of abnormal and complicated bereavement in adults
- Knowledge of bereavement support and organisation of support services
- Risk factors for adverse outcomes of bereavement

**6.6 Finances**

- Basic understanding of the healthcare financing system in Singapore (Medisave, Medishield, Medifund etc) and how it impacts patients and families in accessing healthcare

## 7. CULTURE, RELIGION AND SPIRITUALITY

### 7.1 Culture and ethnicity

- Recognition of cultural influences on the meaning of illness for patient and family
- Accommodation of differences in beliefs to ensure acceptable care
- Ability to recognise and deal with conflicts of beliefs and values within the team

### 7.2 Religion and spirituality

- Ability to elicit spiritual concerns appropriately as part of assessment
- Understand importance of spiritual care and role of pastoral worker
- Recognition of the importance of hope and ability to nurture hope in an appropriate manner
- Ability to acknowledge and respond to spiritual distress, including referral to relevant sources

## 8. ETHICS

### 8.1 Theoretical ethics

- Critical analysis of current theoretical approaches to: medical ethics, including 'four principles (beneficence, nonmaleficence, justice and respect for autonomy)
- Current SMC guidelines relevant to palliative care

### 8.2 Applied ethics in palliative care:

- Consent
- Confidentiality
- Best interest judgements
- Conflicts of interest between patient and their relatives
- Responsibility for decisions (doctors, patients & teams)
- Resource allocation (including of oneself)
- Withholding and withdrawing of treatment
- Assisted dying practices including Euthanasia / Physician-assisted suicide
- Doctrine of double effect
- DNR decisions
- Ethics of research in palliative care

## 9. LEGAL ISSUES AT THE END-OF-LIFE

### 9.1 Death

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

### 9.2 Therapeutics

- Responsibilities of prescriber /pharmacist/nurses
- Storage of Controlled drugs
- Non licensed use of drugs

### 9.3 Doctor/patient relationship

- Capacity/competency
- Power of attorney
- Confidentiality and its limits
- Advance directives
- Wills

### 9.4 Organisational

- Corporate governance

## 10. TEACHING

- Teaching ability in different contexts (eg large/small group, medical students, medical/ nursing/ auxiliary health)
- Knowledge of different teaching methods
- Presentation skills

## 11. RESEARCH

- Knowledge of the research process (design, methods, statistics, grant applications, IRB applications)
- Initiate and see through to completion, a project based on sound research principles, e.g. small study, literature review, audit.
- Presentation of project findings in a relevant format e.g. publication in a peer-reviewed journal, poster or oral presentation at a scientific meeting

## 12. TEAMWORK AND SERVICE DEVELOPMENT

### 12.1 Teamwork

- Ability to work in a team
- Recognition of skills and contributions of other members of the multi-professional team
- Nature of roles within teams
- Team dynamics in different situations and over time
- Forms of team support
- Strategies that facilitate team functioning and those which do not.
- The inevitability of conflict within a team, and strategies to manage this
- Chairing of team meetings

### 12.2 Service Development

- Funding issues
- Setting up a palliative care service