(I) OBJECTIVES

1. To provide a broad-based training and in-depth experience at a level sufficient for trainees to acquire competence and professionalism required of a specialist in Palliative Medicine, so as to be able:

   1.1 To provide consultative and advisory service to physicians and surgeons in general hospitals regarding the palliative care of patients and their significance, the modalities of palliative care service available and the appropriateness of referral.

   1.2 To provide specialist palliative care service in palliative care and non-palliative care wards, clinics, day settings and residences.

2. To cultivate compassion, and to enhance critical thinking, self-learning and a commitment to continuing medical education in Palliative Medicine.

3. To encourage contributions which aim at advancement of knowledge in Palliative Medicine and the teaching of trainees.

4. To develop a sense of responsibility and leadership in the service development of palliative care.

5. To acquire professional competence in training future trainees in Palliative Medicine.

(II) STRUCTURE

1. This period consists of three years of supervised and accredited training in Palliative Medicine. The three-year training programme comprises two years of core training in Palliative Medicine as described below (with a minimum of 12 months of core training to be undertaken in training units that have been formally accredited by the College), plus one year of training in any of the following:

   1.1 The same specialty which may be accredited for a maximum of 12 months, AND/OR

   1.2 A broad-based specialty, defined as Advanced Internal Medicine, which may be accredited for a maximum of 12 months, AND/OR

   1.3 Overseas training in Palliative Medicine, which may be accredited for a maximum of six months, with prior approval by the specialty board, AND/OR

   1.4 Research in Palliative Medicine which may be accredited for a maximum of six months, with prior approval by the specialty board.

2. The structures of dual training programmes in Palliative Medicine and AIM approved by the College include the following and trainees must clearly indicate the programme chosen at the time of application as Higher Physician Trainee of the College:

   2.1 Concurrent training: A minimum of four years of supervised training is required. The training programme comprises 24 months (cumulative) of core training in AIM and 24 months (cumulative) of core training in Palliative Medicine.
2.2 Sequential training: A minimum of five years of supervised training is required. The training programme comprises 36 months training in either Palliative Medicine or AIM followed by 24 months of core training in the remaining specialty.

3. Trainees in Palliative Medicine must have completed training and passed the Exit Assessment in AIM before they are eligible to be College Fellows. Trainees who opt to take the Exit Assessment in Palliative Medicine at the end of three years of Higher Physician Training (i.e. as the first specialty) are thus eligible to be admitted as College Fellows only after they have also completed training and passed the Exit Assessment of AIM, i.e. at least four years after commencement of Higher Physician Training. Should Trainees in Palliative Medicine wish to become College Fellow three years after commencing Higher Physician Training, they may opt to take the Exit Assessment with dissertation in AIM as the first specialty. It should be noted that such Trainees would still be required to submit a second dissertation for their subsequent Exit Assessment in Palliative Medicine.

(III) CONTENTS

(1) Knowledge

1.1 Pharmacology of drugs used for symptoms control.

1.2 Understanding symptoms in terms of:

1.2.1 Prevalence, complexity and progression along the trajectory of disease, including those prevalent at end-of-life (EOL).

1.2.2 Symptom as multidimensional in nature and symptom distress as unique experience of patients.

1.2.3 Elucidation of underlying causes and mechanisms of various symptoms.

1.2.4 Methods of assessment, diagnosis and management of various symptom complexes.

1.2.5 Development of appropriate management strategies taking into consideration the personal priorities of the patient.

1.2.6 Identification of potential refractory symptoms.

1.3 Management of common emergencies encountered in palliative care.

1.4 The role of disease-specific treatments in the practice of Palliative Medicine for cancer (such as palliative surgery, radiotherapy, chemotherapy, hormonal therapy, anaesthetic techniques) and non-cancer chronic debilitating diseases including end-stage renal, respiratory, heart and neurological diseases.

1.5 Psychological response of the patients and their families to terminal illness, including psychological morbidities and grief reactions.
1.6 Understanding of the spiritual element as an integral part of palliative care.

1.7 Effects of religious beliefs and cultural influences.

1.8 Ethical principles including beneficence, non-maleficence, the principle of double effect, equity, privacy and confidentiality, respect for autonomy, respect for life, and issues related to request to hasten death, physician assisted suicide and euthanasia.

1.9 Familiarity with Drug Ordinances related to the use of controlled or dangerous drugs.

1.10 Familiarity with the various modes of palliative care provision, including inpatient care, outpatient care, home care, day care and consultative services.

1.11 Functions of the multidisciplinary team, including the role of rehabilitation in palliative care.

1.12 Characteristics of a palliative care team, team dynamics and conflict resolution.

1.13 Knowledge concerning staff stress and burnout.

1.14 Knowledge in research and evaluation methods relevant to palliative care.

(2) Skills

2.1 Ability to use drugs for symptom relief, including strong opioids, in a safe and effective manner; and to formulate a care plan for potentially refractory symptoms.

2.2 Ability to perform bedside diagnostic and therapeutic interventions, e.g. thoracocentesis and abdominal tapping for symptom relief.

2.3 Communication skills with respect to other health care professionals in palliative care consultation: regarding information and knowledge transfer to facilitate on-site management, and facilitation of patient's psychological transition from curative to palliative care.

2.4 Ability to develop therapeutic relationship and communicate with empathy and compassion in breaking bad news and prognosis telling to patients and families.

2.5 Counselling skills to enhance the patient’s and the family’s coping with terminal illness, to facilitate communication among family members including holding family conferences.

2.6 Ability to elicit the values and preferences of patients and families, balance between benefits and burdens of treatments, and take into consideration the prognosis in advance care planning and in making Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and difficult treatment decisions.

2.7 Ability to apply sound ethical and legal decision making to situations arising from symptom management and withholding and withdrawing life-sustaining treatment.
2.8 Ability to resolve conflicts over futility and requests for hastening death, assisted suicide and euthanasia.

2.9 Ability to guide the family during the patient’s final hours and provide support for anticipatory grief.

2.10 Ability to identify family members who are at risk of complicated grief and to refer for appropriate professional service.

2.11 Ability to work in a multi-disciplinary team to handle team dynamics and team conflicts, and to support the team in crisis.

2.12 Ability to undertake clinical audit and take appropriate actions arising from the audit exercise.

2.13 Ability to manage staff stress and burnout arising from the provision of palliative care, including self care and support of other team members.

3.1 To recognise that all days of human life are deserving of dignity, meaning and concern and that dying is a normal phase of life.

3.2 To recognise that when cure is not possible, active total care of the patient and the family is central to patient management, and quality of life is more important that quantity.

3.3 To recognise the limits of medicine, including symptom control measures.

3.4 Awareness of the importance of assessing cost-effectiveness and risk-benefits of various treatments based on best evidence and the patient’s values and preferences.

3.5 To recognise that hastening and artificial termination of life should not be the intention of care or as a method of symptom control.

3.6 To respect and observe the privacy and confidentiality of patients.

3.7 To be empathic and to have self awareness.

3.8 To be willing to advocate for the dying.

(IV) INSTITUTIONAL REQUIREMENTS

1. Presence of a trainer who possesses specialist accreditation in Palliative Medicine recognised by the Hong Kong College of Physicians with a trainer to trainee ratio should not be less than 1:2 at any one time.
2. Sufficient numbers of regular referrals of patients with incurable cancers and non-cancers.

3. Presence of a multidisciplinary team comprising medical, nursing and allied health professionals, in particular clinical psychologists, social workers, counsellors and workers from religious sectors to assist the trainer in the training of junior doctors, in communication skills and family and bereavement care.

4. Presence of home care and out-patient clinic facilities in addition to designated in-patient facilities.

5. Designated time for regular academic activities and evaluation.

6. Presence of regular interdisciplinary activities including inpatient and home care conferences.

7. Adequate educational facilities including library and audio-visual facilities.

8. Maintenance of high quality medical records with easy and prompt accessibility.