CATÓLICA
INSTITUTO DE CIÊNCIAS DA SAÚDE

LISBOA·PORTO

MEDICAL COMPETENCIES IN PALLIATIVE CARE FOR INTERNAL MEDICINE RESIDENCY

Dissertation presented to *"Universidade Católica Portuguesa"* for the Master's Degree in Palliative Care

Manuel Bernardo Clemente Figueira Araújo

Lisbon, 2021

CATÓLICA
INSTITUTO DE CIÊNCIAS DA SAÚDE

LISBOA·PORTO

MEDICAL COMPETENCIES IN PALLIATIVE CARE FOR INTERNAL MEDICINE RESIDENCY

- A Scoping Review -

Dissertation presented to *"Universidade Católica Portuguesa"* for the Master's degree in Palliative Care

By: Manuel Bernardo Clemente Figueira Araújo

Under tutelage by: Professor Manuel Luís Capelas

Lisbon, 2021

Abstract

Objective: The objective of this review is to list the basic palliative competencies that should be acquired throughout the internal medicine residency program in Portugal.

Introduction: Palliative care and the relief of suffering were described as the most neglected dimensions in public health in 2018 and the aging of the population is leading to an increase of chronic diseases. Being the main focus of internists, these are required to develop basic competencies in palliative care in order to assure universal palliative care access. In Portugal the Internal Medicine specialist curriculum is absent regarding palliative care competencies.

Methods: This scoping review is based on JBI methodology. The search was conducted in December 2019. Inclusion Criteria: studies published in international data bases and grey literature in English, Spanish, French and Portuguese languages with no time limit with a clear description of competencies formulated for the internal medicine specialty.

Results: A total of 5032 records from international databases and 15 from grey literature were obtained for analysis. From these 31 articles were included in this review. A total of 1064 competencies were listed from there documents. These competencies were sorted according to 7 domains: 1 Clinical competencies; 2 Psychosocial Issues; 3 Ethical, Legal aspects and Professionalism competencies; 4 Communication competencies; 5 Teamwork competencies; 6 health system network related competencies; 7 Competencies in Education and Evidence Based Medicine. After sorting and simplifying the listing, we obtained a total of 248 competencies.

Conclusion: Internal medicine physicians provide palliative care to patients in their daily practice and have done so since ever. Whether one pursues specialization or not, all internists can, and should use, the growing knowledge of palliative medicine in their medical practice. With the data from this scope we hope to provide a tool that allows the elaboration of a formal curriculum for the internal medicine specialty.

Keywords: Internal Medicine, Internists, Competencies, Palliative Care

Resumo

Objetivo: O objetivo desta revisão é listar as competências básicas que deverão ser adquiridas durante o internato de medicina interna em Portugal.

Introdução: Os cuidados paliativos e o alívio do sofrimento foram descritas como as mais dimensões mais negligenciadas de saúde pública em 2018 e o envelhecimento da população está a dar origem a um aumento das doenças crónicas. Sendo estas um foco primordial na medicina interna, os internistas têm a obrigação de desenvolver competências básicas em cuidados paliativos de forma a proporcionar o acesso universal a estes cuidados. Em Portugal o currículo de medicina interna é omisso relativamente a competências nesta área.

Métodos: Esta *scoping review* foi elaborada com base da metodologia da JBI. A pesquisa foi efetuada em dezembro de 2019. Foram incluídos estudos publicados em bases de dados internacionais e literatura cinzenta em inglês, espanhol, francês e português sem limite de tempo e com uma descrição clara das competências básicas em cuidados paliativos para a especialidade de Medicina Interna.

Resultados: Obtiveram-se para análise, 5032 registos das bases de dados internacionais e 15 de literatura cinzenta. Destes 31 artigos foram incluídos para revisão obtendo-se uma listagem de 1064 competências básicas. Estas competências foram organizadas Segundo 7 domínios: 1 Competências clínicas; 2 Questões psicoexistenciais; 3 Competências em aspetos éticos e legais e profissionalismo; 4 Competências em Comunicação; 5 Competências em trabalho de equipa; 6 Competências relacionadas com os sistemas de saúde; 7 competências em educação e medicina baseada na evidencia. Depois de categorizar a listagem, obtivemos 248 competências básicas.

Conclusão: Os internistas proporcionam cuidados paliativos a doentes na sua prática diária e têm-no feito desde sempre. Independentemente do nível de especialização, todos os internistas podem e devem utilizar o crescente conhecimento em cuidados paliativos na sua prática diária. Com os dados deste *scope*, esperamos proporcionar uma ferramenta que permita a elaboração de um currículo formal para a especialidade de medicina interna.

Palavras-Chave: Medicina Interna, Internistas, Competências, Cuidados Paliativos

"If you want to be successful, don't seek success - seek competence;
do nothing short of the best that you can do."

Jaggi Vasudev

Acknowledgements

Completing this work was only possible with the support of a certain amount of people to whom I owe my sincere thanks:

To professor Manuel Luís Capelas, for helping me throughout the master's course and the present thesis.

To Dr. José Luis Pereira, in obtaining some harder to find articles.

To my dearest wife for all the patience and support. Without her I would not be here.

To my colleagues, in special to Ana Mateus, for her support in taking this project forward.

To my colleagues at Linque for showing me how little we are alone, and how great we can be together.

To my work colleague, Nurse Paula Cruz, my sister in arms, for her daily support. Many were our battles and many more will come but we, as a team, can face them all.

To my patients, my greatest teachers. Thank you for trusting me.

Acronyms

AIIHPC	-	All Ireland Institute of Hospice and Palliative Care
AAFP	-	American Academy of Family Physicians
AAHPM	-	American Academy of Hospice and Palliative Medicine
APCP	-	Associação Portuguesa de Cuidados Paliativos
APMGF	-	Associação Portuguesa de Medicina Geral e Familiar
BC	-	British Columbia
CPR	-	Cardiopulmonary resuscitation
DNR	-	Do not resuscitate
EFPEC	-	Educating Future Physicians in Palliative and End-of-life Care
ERIC	-	Education Resources Information Center
ED	-	Emergency department
EOL	-	End-of-Life
EAPC	-	European Association of Palliative Care
EMBASE	-	Excerpta Medica database
HDG	-	Homogenized Domain Group
HPM	-	Hospice and Palliative Medicine
ICU	-	Intensive Care Unit
IAHPC	-	International Association for Hospice and Palliative Care
JBI	-	Joana Brigs Institute
MAID	-	Medical Assistance In Dying
NHS	-	National Health System
NICE	-	National Institute for Health and Care Excellence
NSAIDS	-	Non-Steroid Anti-Inflammatory Drugs
NIPEC	-	Northern Ireland Practice Education Council
NP	-	Nurse Practitioner
OPCN	-	Ontario Palliative Care Network
PC	-	Palliative Care
SPCI	-	Sociedade Portuguesa de Cuidados Intensivos
SDM	-	Substitute decision maker
UK	-	United Kingdom
USA	-	United States of America
WHO	-	World Health Organization

Index

Images

Tables

Introduction

According to the world health organization, palliative care provides a systematic and humanistic approach in improving the quality of life of patients and their families facing incurable and/or severe diseases and limited prognosis.

Palliative care is the active, total care of patients whose disease is not responsive to curative treatment. Palliative care takes a holistic approach, addressing physical, psychosocial and spiritual care, including the treatment of pain and other symptoms. It is interdisciplinary in its approach and encompasses the care of the patient and their family and should be available in any location including hospital, hospice and community. It affirms life and regards dying as a normal process; it neither hastens nor postpones death and sets out to preserve the best possible quality of life until death (1).

According to the American College of Physicians, internal medicine physicians or internists are specialists who apply scientific knowledge to the diagnosis, treatment, and compassionate care of adults across the whole healthy-complex illness spectrum. They are specially well trained in the diagnosis of puzzling medical problems, in the ongoing care of chronic illness, and in caring for patients with more than one disease. They also specialize in health promotion and disease prevention (2).

Looking closely at the definition, compassionate care is one of the pillars and compassion is inherently related to palliative care and therefore essential for good medical practice and for the specialty.

In Portugal, the definition of internal medicine more commonly used is found In the *Diário da República* where it refers to a specialty that takes charge of the prevention, diagnosis, curative therapeutics and non-surgical management of multisystemic afflictions of teenagers, adults and elders (3). Although edited in 2011, just by comparison of these two definitions we can perceive a completely different approach which can historically contextualize the absence of a specific palliative care curriculum for the specialty in Portugal.

In many countries palliative care curriculum has been introduced into the basic competencies of several medical specialties and, internal medicine, as particularly relevant, due to its generalistic yet complex hospital setting.

Palliative Care and suffering relief were referred to as the most neglected dimensions of public health in 2018 (4) and, with the aging population, we witness an increase in chronic diseases and codependency that weigh on health systems and hospital wards. The fact of the matter is that the mean age of the population in wards in Portugal is situated around 76 years (5), which means that, like oncologists and hematologists, internists are physicians with a constant contact with death and people at end of life. Internists are also physicians that perform in a wide range of services in the hospital, that extend from the emergency department and wards to external consults placing them in front line for detecting palliative care needs and performing palliative approaches (6). Therefore, internists should be competent in evaluating, addressing and implementing said approaches.

Following this line of thought the objective of this study was to develop an integrated taxonomy of the major domains and basic competencies, therefore, the primary question was defined as: What are the basic competencies in palliative care for the internal medicine specialty?

As a secondary question we defined: In which domains should said competencies be grouped?

Since the body of literature regarding this topic has not been comprehensively reviewed and exhibits a large, complex, and heterogeneous nature, we opted to conduct a scoping review based on the Joanna Briggs Institute (JBI) methodology. This scoping review aimed to collect and compile the existing data of basic competencies for internal medicine specialists and has the final objective of proposing the results to the appraisal of specialists in both fields – Internal Medicine and Palliative Care – through a Delphi method study and create a realistic and adequate curriculum for internists in Portugal.

This dissertation is structured in three chapters. The first focusses on the theoretic background, in which an historical context and evolution of competencies are addressed as well as the evolution of medicine and palliative care around this subject. On the second chapter we present the methodology of the scope including, objectives, population, methods, techniques, and data analysis. Lastly, on the third chapter we present and discuss the results as well as the study limitations, biases and strengths.

Chapter I – Theoretic Background

In this chapter we provide an historical context and evolution of the competencies in palliative care as well as view of the competence-based model of teaching in medicine.

Historical context of competence

The term 'competency' has close relationship with a Latin word '*competentia*' that means "is authorized to judge" or "has the right to speak". In the first half of the 20th century, it received a great deal of attention amongst psychologists that yielded many studies about the concept. But it was in the 1970's that McClelland, a Harvard's Psychology professor in the paper – Testing for competence rather than intelligence – defended the thesis that traditional intelligence or aptitude tests and school grades are less accurate in predicting either the job performance or other important life outcomes. He proposed that competencies could be more effective for said prediction. This finding led to a wide application and investigation to human resource management (7).

Defining competence and competency

The very recent work by Wong (7) reviews the evolving definition of competence proposed by many scholars, and clarifies the difference between competence and competency, two different and non-interchangeable concepts that that are frequently used with little distinction and therefore confusion. The sooner being a task oriented and functional approach and the latter a person-oriented behavioral approach. Wong also concludes that throughout the years little consensus towards a universal definition of the term competency has been achieved and is still subject of debate. Nevertheless, competencies can be 'generally' described as a set of observable and measurable 'attributes' or 'success factors' required for individuals for effective work performance. These attributes or factors may include: 1. Knowledge, 2. Skills, 3. Self- concept and values, 4. Personal traits, and 5. Motives (7). It is also mentioned that one can develop or identify specific skills, abilities, behaviors, and knowledge needed for effective performance in a specific profession, work area or job position based on each of these competency classifications.

The competence-based model in medical education

It is evident to any objective observer that the practice of medicine becomes increasingly complex with each passing year. Technological advances and research findings leading to improved methods of disease prevention, diagnosis and treatment produce a constantly changing definition of the competencies a medical student must acquire. Therefore, the student's curriculum model underwent some severe changes attempts in the past 4 decades,

evolving from the subject-centered, to the integrated and lastly to the competence-based curriculum that is currently being widely implemented and gaining popularity. Competency based focuses on learning how to practice medicine, not on accumulating knowledge about medical practices. It differs from the subject-centered and integrated course model in three fundamental ways. First, such curriculum is organized around competencies required for the practice of medicine in a specified setting. Secondly, it is grounded in the empirically validated principle that students of the intellectual quality found in medical schools, when given appropriate instruction, can all master the prescribed basic performance objectives. Thirdly, it views education as an experiment where both the processes of student learning and the techniques used to produce learning are regarded as hypothesis subject to testing (8) and therefore prone to evaluation and improvement over time.

Now comes the important question: What is competent medical practice?

Competence is complex to define as we already addressed. Conceptually there are two approaches: the first defines a competency as an ability to perform a task; the second describes the competencies in terms of a wider concept, considering both a set of dimensions necessary to produce a performance and the performance itself. According to this second approach, a demonstrable and measurable set of attributes (knowledge, skills and behaviors) can be reasonably expected of a practitioner following a determined course of theoretical and clinical learning (9). According to the world health organization competence is defined as a set of cognitive, affective, and psychomotor functions that support the “habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice. Although being somewhat similar, because of the many possible settings in which palliative care is provided across Europe and the need for a clear and meaningful definition for competence, the EAPC proposes the definition by Parry SB, that we used throughout this paper: “a cluster of related knowledge, skills and attitudes that affect a major part of one’s job (a role or responsibility), that correlates with performance on the job, that can be measured against well-accepted standards, and that can be improved via training and development” (10).

Now, how are competencies determined? The desirable attributes of a health professional are determined by many influences: Expert opinions, practice settings, the types of patients or the health care problems, the nature of a discipline or specialty, the stage of socioeconomic

development, and so on… All must be considered, therefore competencies should be adapted to the needs and context where they are applied (11). The description of competencies may emerge from authoritative statements by acknowledged medical leaders, from carefully or casually designed opinion polls, from consensus opinions, from systematic surveys of the professional literature (11) or from scoping reviews. When competence is the goal of an educational program, the first step in program design must be a clear and precise listing of competencies and then identify curricular clusters or Domains. Domains are clusters or pieces of information that fall naturally together in some logical pattern. A subdomain is an additional part of the domain that are created to better organize and classify a listing.

The competence tiers.

Another important topic is the competence level. The continuum of medical education provides the opportunity of having several degrees of mastery or performance.

The EAPC advocates a three tier framework to palliative care, according to which all healthcare professional receive education on the principles and practices of palliative care within their initial training, and those whose work is mainly focused on palliative care move to a specialist level of knowledge (9). The three advocated tiers are:

1. Palliative care approach: a way to integrate palliative care methods and procedures in settings not specialized in palliative care. Should me made available to general practitioners and staff is general hospital, as well as to nursing services and nursing home staff. May be taught through undergraduate learning or through continued professional development.
2. General palliative care: Provided by primary care professionals and specialists treating patients with life-threatening diseases who have good basic palliative care skills and knowledge. Should be made available to professionals who are involved more frequently in palliative care, such as oncologists or geriatric specialist, but do not provide palliative care as the main focus of their work. Depending on discipline, may be taught at an undergraduate or postgraduate level or through continuing professional development.
3. Specialist palliative care: Provided in services whose main activity is the provision of palliative care. These services generally care for patients with complex and difficult

needs and therefore require a higher level of education, staff and other resources. Specialist palliative care is provided by specialized services for patients with complex problems not adequately covered by other treatment options. Usually taught at a postgraduate level and reinforced through continuing professional development.

The focus of this scope is to list the competencies as far as the second tier for it is the level that best represents the focus of internal medicine specialists.

Chapter II – Methods

Study Questions

Although the available data pool is quite extensive, the absence of universal consensus regarding not only the definition of competency, but also a specific listing for said competencies for internal medicine reveals a gap in evidence that we propose to address and therefore formulated the following questions:

Primary question: What are the basic competencies in palliative care for the internal medicine specialty?

Secondary question: In which domains should said competencies be grouped?

Inclusion Criteria

This scoping review includes all articles obtained with the search strategy explained below.

Articles must have a clear, or easily compiled, description and listing of competencies and the tiers proposed.

The articles must be in English, Portuguese, French, or Spanish with no time limit.

This scoping review examined all studies that focus on internal medicine physicians.

To formulate de primary question for this scope, the authors based on the PCC process by JBI. The PCC process (or framework) is a mnemonic used in evidence-based practice (and specifically Evidence Based Medicine) to frame and answer a clinical or health care related question. It is specially designed for scope reviews. The mnemonic stands for Participants, Concept, and Context:

Participants: The review considered studies that included internal medicine search parameters, regardless of level of training or setting.

Concept: This scoping considered studies that mentioned or listed the competencies of palliative care. The search did not define the level of competencies desired, namely the basic competencies, so that the results would not be biased or truncated. This sorting was later sorted by the investigators according to the definition provided in the search strategy.

Context: This scoping review considered studies in the context of palliative care albeit hospital, hospices, or palliative unit setting.

Exclusion criteria

Competencies related to the third tier and not able to be implemented to the second tier of palliative care level.

Competencies that state a specific geographical area or procedure (like euthanasia or medical assistance in dying) outside the target population of this scope

Type of Sources

This scoping review considered quantitative, qualitative, mixed method studies, and systematic reviews. Quantitative designs including any experimental study designs (such as randomized controlled trials, non-randomized controlled trials, or other quasi-experimental studies, including before and after studies), and observational designs (descriptive studies, cohort studies, cross sectional studies, case studies, and case series studies). Qualitative designs include any studies that focus on qualitative data such as, but not limited to, phenomenology, grounded theory, ethnography designs, or discursive analysis. Grey literature was mainly focused on consensus documents elaborated by renown international organizations.

Methods

This scoping review was conducted in accordance with the JBI methodology for scoping reviews.

Search Strategy

The search strategy aimed to find both published and unpublished studies. A three-step search strategy was used in this review. An initial limited search of MEDLINE and CINAHL was undertaken followed by an analysis of the text words contained in the title and abstract, and of the index terms used to describe the articles. A second search using all identified keywords and index terms was undertaken across all included databases. Thirdly, the reference lists of all articles were searched for additional studies. Studies published in English, Spanish, French and Portuguese were included. Studies published in any year were considered for inclusion in this review to capture how it has been addressed in research and in practice over time. The full search strategies and syntax are provided in Appendix I.

Information Sources: The databases searched were: CINAHL complete (by EBSCO) and PubMed. The search for grey literature was conducted using the search term “palliative care competencies” through the following on-line resources:

- web searching through “google search”, “DuckDuckGo”, “DogPile” and “Grey Matters”.
- International/national reference sites
    - SPMI
    - *Ordem dos Médicos*
    - APCP
    - SPCI
    - APMGF
    - EAPC
    - AAFP
    - NICE
- Web based catalogues and databases
    - Ethos.bl.uk
    - http://www.opengrey.eu/
    - http://greylit.org/
    - https://clinicaltrials.gov/
- Grey literature using bibliographic databases.
    - Google scholar
    - Booksc.org
    - B-ok.org
- Databases for conference abstracts
    - ERIC
    - PsycINFO
    - EMBASE

Study selection

Following the search, all identified citations were collated and uploaded into Mendeley v1.19.8 (Mendeley Ltd., Elsevier, Netherlands). The resulting articles were transferred to “Rayyan – Intelligent Systematic Review” where duplicates were removed using the software and double validation by two reviewers. Titles and abstracts were screened by two

independent authors for assessment against the inclusion criteria for the review. Potentially relevant studies were retrieved in full and were analyzed by two independent reviewers. In this phase, studies that did not meet the inclusion criteria were excluded. Disagreements between the two reviewers were resolved through discussion or with a third reviewer, when required.

Data extraction

Data were extracted from papers by two independent authors using a data extraction tool, which was tested to ensure that this tool was clear, and that the information extracted was consistent. The data included study type, year, country of origin and list of domains identified, and list of competencies identified. Similar domains and competencies were discussed and grouped into domains according to mutual agreement and doubts resolved through discussion with a third reviewer when required.

Data presentation

The data was extracted from the included documents, using a Microsoft Excel worksheet based of the preliminary search and review question. This chart was tested for adequacy end reformulated to the present for after the first 5 papers. Two authors independently selected the data, and a third author was involved in case of disagreement.

Chapter III- Results:

On this third chapter we present the results of our scope review

Study inclusion

A total of 5032 citations were identified from systematic research and 15 from grey literature research. After the duplicate removal (n=268), 4764 titles and for analysis based on the inclusion criteria. At this stage 4718 references from the systematic research and 2 from grey literature were excluded. 46 articles from the systematic review and 13 from grey literature search were retrieved in full text for analysis. From these 24 studies of the systematic review and 4 from the grey literature search were excluded and the reasons are presented in Appendix II. A total of 22 articles from systematic review and 9 from grey literature were included in this review. The PRISMA flowchart (Image 1) describes the flow of decisions of this process.

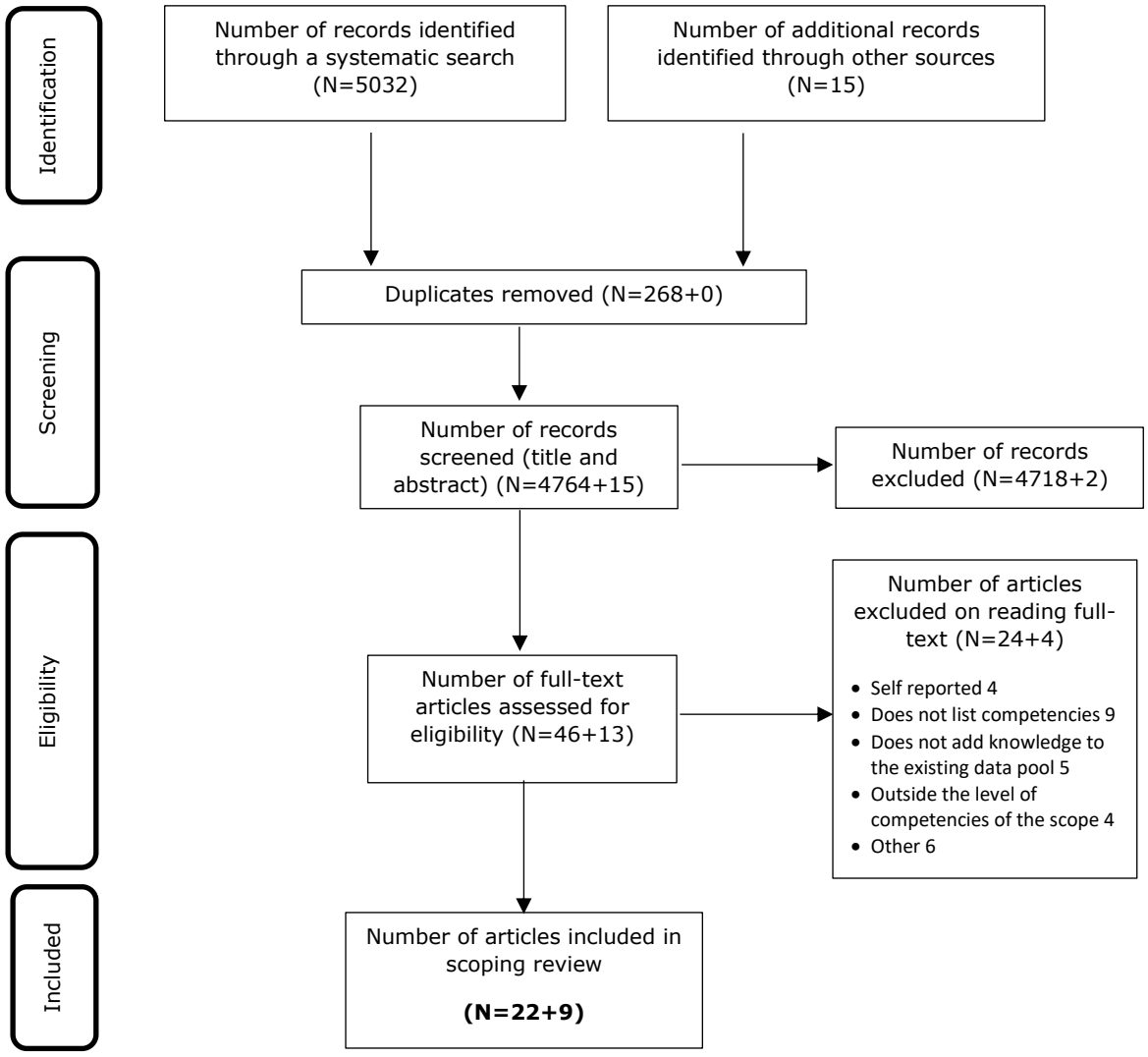

Image 1: PRISMA flowchart[1]

[1] *From:* Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *P*referred *R*eporting *I*tems for *S*ystematic Reviews and *M*eta-*A*nalyses: The PRISMA Statement. PLoS Med 6(6): e1000097. doi:10.1371/journal.pmed1000097

Characteristics of included studies.

Articles selected in this scoping review were published between 1991 and 2018. The majority, 61% (n=14), were published in the last decade. Regarding origin, the United States of America is the most represented country with 63% (n=19). Europe was the second most represented continent with 23% (n=7) of the articles (including Germany, United Kingdom, and Ireland with two articles each). Most were published as journal articles, mainly consensus opinion type articles (n=21, 80%), 3 were literature reviews, 4 were opinion articles, 2 were qualitative studies using focus groups.

The main characteristics of the articles included in this scoping review are additionally reported in Appendix III

Review findings

This review aimed to map the exiting consensus on the basic competencies to any internal medicine specialist. The first approach was to identify the domains in which to include each of the 1064 competencies isolated and listed. 6 competencies were excluded from the list because they mentioned specific guidelines or geographical area outside of a universal setting that was not contemplated on the current scope. By sorting all the domains and listing them it was possible to group the competencies in 8 logical and simplified domains, which we called HDG's for Homogenized Domain Groups: 1 Clinical competencies, 2 Psychosocial issues, 3 Ethical, Legal aspects and professionalism competencies, 4 Communication competencies, 5 Teamwork competencies, 6 Health System Network related competencies, 7 Competencies in Education and Evidence Based Medicine in Palliative Care, 8 Self-care competencies. (table 1)

HDG	N	%
Clinical competencies	292	27
Psychosocial issues	181	17
Ethical, Legal aspects and professionalism competencies	156	15
Communication competencies	150	14
Teamwork competencies	72	7
Health System Network related competencies	75	7
Competencies in Education and Evidence Based Medicine in Palliative Care	93	9
Self-Care	41	4
Total	1059	100

Table 1: Competencies distributed in 8 HDG's

On the second phase, which involved sorting each of the skills to the corresponding domain, there were some competencies that we had trouble to link to a single domain. These were mostly between Teamwork and Self-care which led us to the conclusion that these two could be grouped together for a much logical and natural integration of competencies inside these domains.

The final listing of domains is as in Table 2:

HDG	N	%
Clinical competencies	298	28
Psychosocial issues	175	16
Ethical, Legal aspects and professionalism competencies	155	15
Communication competencies	146	14
Teamwork and self-care related competencies	110	10
Health System Network related competencies	86	8
Competencies in Education and Evidence Based Medicine in Palliative Care	88	8
Total	1059	100

Table 2: Competencies distributed in 7 HDG's

After sorting each of the competencies to a domain, started the job of classifying the competencies inside the domain. We therefore opted to once again sort each of the competencies inside each of the domains into sub-domains that allowed us to find and group similar competencies more accurately.

After further analysis we opted to try and simplify the listing, by eliminating duplicates, pairing similar writings and compiling related competencies together into one single, less specific competence (e.g. "1. Respiratory symptom management; 1.1 managing Dyspnea; 1.2 managing mechanical obstruction; 1.3 secretions management" compiled into "Respiratory symptom management (Dyspnea, mechanical obstruction, secretions management)".

The workflow is charted below (Image 2):

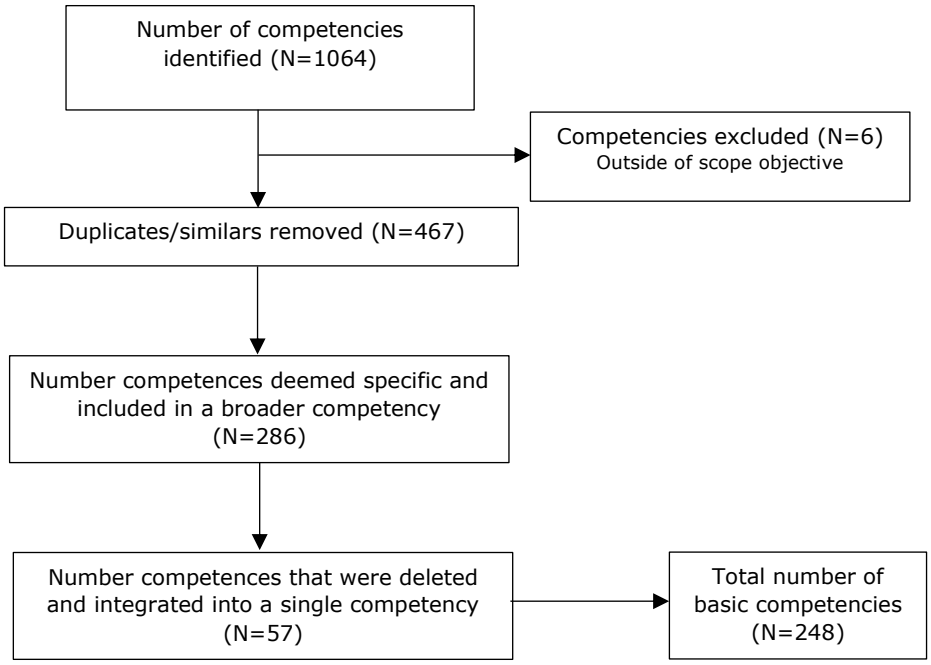

Image 2: Workflow of the decision-making process of the obtained competencies.

The resulting listing is presented on the following tables sorted by each domain (The complete tables, with excluded data and competencies deemed too specific, are provided in appendix IV and V respectively):

Domain 1 – Clinical competencies

In this domain are included all the competencies that are related to clinical practice. It bears similarities with the domain entitled medical Knowledge by Morrison et al. where the resident should demonstrate knowledge about established and evolving biomedical and clinical settings relevant to the care or patients with life threatening illnesses and their families and relate this knowledge to hospice and palliative care practice(12).

Domain	**Subdomain**	**Basic Competence**
Clinical competencies	Symptom management	Respiratory symptom management (dyspnea, mechanical obstruction, secretions management)
		Gastrointestinal symptom management (constipation, diarrhea, nausea, vomiting, obstruction, laxative prescription)
		Oncologic-specific symptom management (Chemotherapy toxicity, preventive approaches)
		Skin, wounds, mucositis and mouth care
		Neurologic symptom management (asthenia, seizures, dementia)
		Nutrition (dehydration, anorexia, cachexia)
		Psychiatric disorders (insomnia, delirium, stress/anxiety, depression, fear)
		Pain (knows the concept of total pain, applies pharmacological and non-pharmacological approaches, knows basis science, pathophysiology of the different types of pain, equianalgesic dosages, opioid proficiency, adjuvant medication & interventions, alternative routes of administration)
	Symptom assessment	Demonstrates a patient and family centered and inter-professional approach to assessing pain and other symptoms in patients with advanced and progressive illness.
		Knows the pathophysiology of each symptom.
		Recognizes potentially associated symptoms.
	Medical Care: Completes a palliative care assessment and plan	prognostication. Applies knowledge of disease trajectories to estimate prognosis in patients
		Obtains a comprehensive palliative care history and physical exam, including Patient understanding of illness and prognosis; functional assessment; neurologic status.
		Provides holistic, person-centered care.
		Bases care on patient and family preferences and goals of care; best evidence, clinical judgment, and input from the interdisciplinary team.
		Seeks to preserve the patient's level of function and improve the quality of life for patients and families.
		Identifies people who would benefit from a palliative approach. Provides basic palliative care; recognizes difficult cases and consults palliative care specialists.
		be able to support the individual retain dignity during symptom management
		Be able to carry out a consultation with a person with a life-limiting condition and recognize the role of palliative care in enhancing that person's care
		Recognizes the refractory symptoms and knows the indications for palliative sedation.

	Special situations: care for imminently dying and their families, end-of-life management in a mass casualty incident/event, spinal cord compression, hypercalcemia, orthopedic catastrophes, increased intra-cranial pressure, bleeding and coagulation disorders, cancer complications, superior vena cava syndrome.
Medical Care: Knowledgeable about medical care	Demonstrate clinical consistency in using complementary diagnostic tests and techniques appropriate to the patient's therapeutic objectives
	Knows the assessment and pathophysiology of physiologic responses
	Skillful management of treatment side effects: opioid intoxication. Chemotherapy, anti-psychotics.
	Appropriately refers the patient to specialists
	Keeps adequate medical records
	Demonstrates knowledge of the indications, contraindications, pharmacology, and side-effects of common psychiatric medications, and appropriate prescribing practice.
	Recommends appropriate treatments
	Is able to recognize potentially reversible causes of clinical deterioration and employ the level of investigation/ assessment that is appropriate to their management

Table 3: List of Clinical competencies domain.

Domain 2 – Psychosocial Issues

This domain addresses the complex interaction between all the components of the Human being, from cultural, spiritual, personality, behavioral and social aspects to physiological susceptibility of even grieving processes. The resident should be able to address and adapt the level of care do these specific needs of the patient.

Domain	**Subdomain**	**Basic Competence**
Psychosocial Issues	Psychosocial issues of death and dying	Collect psychosocial and coping history including loss history
		understand the impact of legal, social, environmental and economic issues on health and wellbeing for individuals and those important to them
		Rituals and meaning at the end of life
		Knows the role of hope, despair, and meaning in the context of severe and chronic illness
		Important factors influencing patient/family decision making (cultural, ethnic, language, institutional, spiritual)
		assist in the evolving process of balancing the benefits with the burdens of various medical interventions
		Describes an approach to defining palliative and end-of-life care needs in indigenous, LGBTQ2S, and vulnerable/marginalized people, as well as various cultural and religious issues in palliative and end-of-life care.
		Describes and recognizes “total pain”, where physical, psychological, social, emotional and spiritual concerns each contribute to the pain experience.
		Identifies patients’ and families’ values, cultural beliefs, and practices related to serious illness and end-of-life care, and integrates these into the care plan
	Anticipates, identifies and addresses supportive care needs of the person and family.	assisting and facilitating the family efforts to resolve: intrafamily relationships
		Helps the family understand what the dying process might be like
		Describes diverse societal perspectives on dying and death
		Understands patient’s and family’s common social problems in end-of-life care and the elements of appropriate clinical assessment and management

	understand the importance of promoting and maintaining the dignity of someone approaching the end of life
	be able to access a Carer's Assessment, identify risk of claudication and provide support
	Identifies spiritual and existential suffering in patients and families.
	Evaluates psychological distress in individual patients and families, and provides support and appropriate referral
	Recognizes and treats the psychosocial and spiritual distress of family members using an interdisciplinary framework
	Be able to assess the person's current understanding of her/his health status
	Shows empathy and compassion
	Assessing loneliness
	Respects patient's choices about alternative/complementary medicine
	Describes people as holistic beings (i.e., with physical, emotional, psychosocial, sexual and spiritual aspects).
Grief and bereavement	Differentiates normal grief from prolonged grief disorder, and makes appropriate referrals
	Supports people and their families in their unique ways of grieving.
	Provides emotional support to the person and family from diagnosis to bereavement
	Describes the impact of developmental stage and cognitive functioning on the understanding of death and manifestations of grief.
	Identifies grief as a common response to loss with multifaceted aspects that affect how it is experienced.
	Understand the process, types and different expressions of loss including: loss, bereavement, grief and mourning
Ethnic & spiritual elements: Ethnic, cultural issues around end-of-life and Death	Recognizes that there are different cultures and beliefs of the patient and family about the dying process.
	Cross cultural encounters in end-of-life care
Ethnic & spiritual elements: Obtains a comprehensive palliative care history and physical exam, including Spirituality	Knows how to perform a basic spiritual/existential/religious evaluation. Identifies spiritual and existential suffering in patients and families. Discuss spiritual considerations. Promotes the expression of the spiritual dimension and directs assistance in case of detecting specific needs and problems.
	be able to distinguish between spirituality and religion
	understand how an individual's awareness of spirituality may change as they approach death
	be able to carry out care after death in a way that promotes dignity and respects the individual's wishes, culture and religious practices, including preparing the body for family and carer visits where appropriate

Table 4: List of psychosocial issues domain.

Domain 3 – Ethical, legal aspects and professionalism competencies

Working with end-of-life situations is very demanding and full of uncertainties. It is highly likely to encounter situations where ethics and even legal aspects are put into question being fundamental that a basic level of knowledge and understanding is acquired. Professionalism is as trait that is closely related with the aforementioned aspects. The resident should be able to demonstrate a commitment to carrying out professional responsibilities, awareness of their role in reducing suffering and enhancing quality of life, adherence to ethical principles, sensitivity to a diverse patient population, and appropriate self-reflection (12).

Domain	Subdomain	Basic Competence
Ethical, legal aspects & professionalism competencies	Ethical analysis and conflict resolution	Basic ethical principles (autonomy, beneficence, nonmaleficence, and social justice)
		Performs his/her practice based on the bioethical principles and legal aspects for the decision-making with the patient, family and the health care team.
		Demonstrates knowledge of ethics and law that should guide care of patients, including special considerations around these issues in adult palliative care, including: Foregoing life-sustaining treatment, Confidentiality, Truth-telling Limits of surrogate decision making, Decision-making capacity, Conflicts of interest, Use of artificial hydration and nutrition, Nurse-physician collaboration, Principal of double effect, Organ donation, refusal of treatment, futility,
		Discloses medical errors in accord with institutional policies and professional ethics
		be able to challenge poor, unethical or discriminatory practice
		understand how to make the individual the focal point of their own care and support, prioritizing individuals' wishes and beliefs to support them to retain independence, choice and dignity
	Legal	Ability to demystify legal situations in terminal situations. Surrogacy, Confidentiality, Equivalency of withholding and withdrawing treatments, Health care power of attorney.
		legal aspects related to informed consents, m wills, advanced care planning, decision-making capacity, artificial nutrition and hydration, surrogate decision-making authority.
		Knows federal, state, and local laws and practices that impact on palliative care practice.
		understand how to access advocacy services for individuals
		understand the concepts, implications and legal status of statements of wishes and preferences, informed consent, best interest decisions, advance care plans and advance decision to refuse treatment
		understand own role in safeguarding individuals
		Be able to provide guidance on issues of organ donation or post-mortems
		understand how to register a death and inform local services/central departments e.g. banks, passport office
		understand what details need to be recorded when caring for and transferring a deceased person, including recording property and valuables
		Opioids and Psychotropics: Knows the national legislation related to the availability, distribution, preparation, dispensing, storage, use and administration of opioids.
	Professionalism: Respectfullness	Avoids keeping the patient waiting without explanation
		Minimizes interruptions and focuses on the patient during visits
		Polite and considerate
		Treats patients (and families) as his/her equal
		Admits when he/she does not know something
		Explores patient and family understanding of illness, concerns, goals, and values, and identifies treatment plans that respect and align with these priorities.
		Demonstrates respect and compassion towards all patients and their families, as well as towards other clinicians
	Professionalism: Dependable	Is prepared for appointments, takes as much time as needed with the patient, ensures to be accessible to the patient and family in a timely manner
	Professionalism: Supportive	Caring for patients under hospice care
		Enlists surrogates to speak on behalf of a patient when making decisions for non-decisional patients
		be comfortable sharing control of the decision-making process with patients.
		Makes the patient feel confident that he/she will not be abandoned prior to death

	Has contact with the family after the patient's death
	Comfortable with people who are dying
	Makes the patient feel unique and special
	Treats the whole person not just the disease
	Takes into account the patient's wishes when treating pain and symptoms
	Lets the patient make decisions about his/her medical care
	Honors the patient's wishes about end-of-life care
	understand and be willing to support the diverse needs and wishes of individuals, that may differ from your own
	be able to encourage and support individuals to make decisions based on their own experience, utilizing professional support and guidance
Professionalism: knowledgeable	Provides treatment options and advice about medical care
	Maintains safe and competent practice, including self-evaluation and continuous learning
	Demonstrates awareness of and adherence to patient safety standards, including appropriate practice in documentation of rationale for clinical decision making
	Understands the rationale for the use of medication formularies
Professionalism: teamplayer	Refers the patient to the specialist when there is inadequate pain control or when risk factors require it.
	Determines, records and implements goals of care through effective communication with patients, families and other caregivers
	Responds appropriately to requests for help from colleagues
	Demonstrates accountability for personal actions and plans
	Fulfills professional responsibilities and works effectively as a team member
Professionalism: Demonstrates accountability to patients, society, and the profession; and a commitment to excellence	Implements best practices for common palliative medicine clinical scenarios across settings
	Maintains comprehensive, timely, and legible medical records
	understand the precautions needed, including use of protective clothing, when undertaking the care and transfer of deceased individuals, including those with specific high risk diseases and conditions
	understand why and how an individual's capacity will affect how assessment and end of life care planning takes place and when a mental capacity assessment may be required
	be able to use communication aids where appropriate to support assessments

Table 5: List of ethical, legal aspects & professionalism competencies domain.

Domain 4 – Communication competencies

Effective communication is essential in palliative care. Communication is also important where circumstances are ambiguous or uncertain or when strong emotions and distress arise. The resident should be able to demonstrate interpersonal and communication skills that result in effective relationship-building, information exchange, emotional support, shared decision-making and teaming with patients, their patients' families, and professional associates(12).

Domain	**Subdomain**	**Basic Competence**
Communication competencies	Communication and therapeutic relationship	Establishes an empathic and compassionate therapeutic relationship that favors the comprehensive care of the patient and his family. Uses empathic and facilitating verbal behaviors such as: naming, affirmation, normalization, reflection, silence, listening, and humor
		Uses age and culturally appropriate concepts and language when communicating with families and patients

	Effective communication: Knows and uses the basic tools of effective communication with the patient and family. Explains consultation needs and results to patients and families. Translates consultant recommendations to the palliative care setting. Negotiates how much information and decision-making input a patient/family want. Discusses issues in identifying and treating pain and other symptoms across the spectrum of developmental, cognitive and physical abilities. Communicates new knowledge to patients/families adjusting language and complexity of concepts based on the patient/family's level of sophistication and values, as well as on developmental stage of patient Identifies patients/families who may benefit from a language translation service or interpreter. Gives a concise verbal history and physical presentation for a new palliative care patient
	Talking about spiritual or existential suffering
	be able to use active listening skills and open questions to support individuals and those important to them to express their feelings, preferences and needs alongside their strengths and abilities
	Be able to facilitate key events in the care of the person with a life-limiting condition, such as family meetings and advance care planning, involving other team members as appropriate
	be able to manage conflict where it arises between the individual and those important to them regarding end-of-life care or advance care planning choices, work sensitively with all parties regarding end of life care or advance care planning choices, work sensitively with all parties towards a resolution and access mediation and advocacy services where appropriate
Giving Bad news	Demonstrates effective patient-centered communication when giving bad news or prognostic information, discussing resuscitation preferences, and coaching patients through the dying process
	Introducing option of palliative care (discussing enrollment to hospice, assessing place of death, seek advice about difficult and complex situations)
	Withholding and withdrawing of life-sustaining therapy and sedation therapy (artificial hydration, nutrition, renal support, ventilation and euthanasia)
	Goals of care discussions: review therapeutic options, inform about the illness impact, elucidate about illness and treatments, honor patient wishes, promote consensus between parties, advance care planning.
Barriers to communication	Facing external barriers: understand the different barriers to communication at end of life, including where someone has additional care, support or communicational needs e.g. learning disabilities, cognitive impairment, sensory impairment, or where a situation makes it difficult to communicate effectively e.g. noisy, distressing, emergency environments, and have strategies in place to overcome these barriers
	Facing internal barriers: honesty, self-concerns, accepting different values and beliefs of others

Table 6: List of Communication competencies domain.

Domain 5 – Teamwork competencies

Working in teams has been an integral part of the philosophy of palliative care since its early days, enshrined in its standards and embedded in its practice(13). Palliative care embraces a number of different frameworks and approaches to meet the needs of the "whole" person. As soon as we speak about the many dimensions of dying, and aim to provide maximum comfort and support, we are engaged in broad endeavors. Moreover, the origins of palliative care lie in the areas of religious care and nursing, rather than medicine, and palliative care draws heavily on a broad spectrum of disciplines, knowledge, skill, experience and creative thought. To achieve this level of care it is important to know how a team works and potentiates care, being beneficial for patient, practitioners and carers alike.

Domain	Subdomain	Basic Competence
Teamwork competencies	Demonstrate leadership in the delivery of general palliative care in your local work environment	team management skills: decision making, delegation of functions, organizational skills, Teambuilding theory
	Collaboration: Works interdisciplinary to perform the necessary interventions.	Recognizes and integrates members of different disciplines as part of the team.
		Treats the physical symptoms, and psychosocial and spiritual distress of the patient using an interdisciplinary framework
		Obtains additional clinical input (from other physicians, nurses, social workers, case managers, chaplains) when appropriate
		Describes the roles of and collaborates with members of an interdisciplinary care team when creating a palliative patient care plan
		Demonstrates an inter-professional care approach with formal and informal teams
		Works effectively with others as member or leader of Interdisciplinary Team. Accepts feedback from Interdisciplinary team members
	Collaboration: Includes interdisciplinary team members in formulating the best discharge plan for patient and families	Develops effective relationships with referring physicians, consultant physicians, and other health care providers
		Identifies issues affecting quality of life and collaborates with the inter-professional team to develop and implement a care plan.
		Recognizes psychosocial and organizational features that promote successful interdisciplinary team function and collaboration
		Use effective Communication in interdisciplinary teamwork
		Collaborates with the inter-professional team, person and family to ensure care plans are consistent with goals of care, preferences and advance care plans (ACPs), which may change throughout the life-limiting condition(s).
		Contributes effectively to the holistic inter-professional management plan for a patient with palliative care needs.
		Works toward consensus building about treatment plans and goals of care
	Collaboration: interact with other specialties and other fields of expertise	Summarizes the active palliative care issues for a known patient in signing out to or updating a colleague
		Communicates with referring and consultant clinicians about the care plan/recommendations for the patient and family
		Demonstrates appropriate referral, consultation and communication with the other disciplines and professionals involved in caring for patients with palliative care needs.
		Communicates with health care providers when there is disagreement about treatment plans
		Supports and empowers colleagues in leading family meetings.
	Roles: Group dynamics	Lets the patient know who to call for different problems
		Helps the patient and family get consistent information from the entire health care team
		Definition and role of multidisciplinary team members
		Describes the roles of members of an interdisciplinary palliative care team, including nurses, social workers, case managers, chaplains, and pharmacists.
	Conflicts & team health: Conflict resolution	Knows how to set appropriate boundaries with colleagues and with patients and families
		Appropriately addresses concerns about quality of care and impaired performance among colleagues
	Conflicts & team health: Support of self and others	Identifies the causes and manifestations of burnout in self and team members and takes action for management.
		Demonstrates awareness that the care and decision-making provided by physicians, Nurse Practitioners, and other team members may be influenced by their ongoing experiences of loss, both personal and professional.

	be able to provide support for colleagues to develop their skills and confidence when working with individuals at the end of life and those important to them
	understand how own experiences, views and beliefs relating to death, dying, loss and bereavement may affect the care provided to individuals.
	Treats co-workers with respect, dignity, and compassion
	Recognize the need for support for self and others in palliative and end of life care and utilize appropriate support systems
	Responds to requests to participate in spiritual or religious activities and rituals, in a manner that preserves respect for both the patient and family, as well as one's own integrity
	Achieves appropriate balance between needs of patients/family/team, while balancing one's own need for self-care
Conflicts & team health: self-evaluation and awareness	Practices self-reflection to understand personal and systemic biases.
	Recognizes his/her own limitations and performs a personal reflection related to issues such as pain, suffering, disease and death.
	Knows effective strategies for self-care, including balance, emotional support, and dealing with personal loss. know how to access support to help oneself and others involved in caring for the person at end of life, including accessing a caring network
	Reflects on emotions after event, Discusses how personal attitudes may potentially impact the care provided to a dying patient and their family.

Table 7: List of teamwork competencies.

Domain 6 – Health system network related competencies

Care planning in palliative care is characterized by coordinating and integrating person-centered care to promote quality of life for patients and families. It involves assessing needs, goals and wishes, promoting and preserving choice, predicting likely problems and planning for the future, in the context of a changing and deteriorating disease trajectory(12). Patients and families should be actively engaged in the care planning process to the extent that they are able and wish to be involve. For this it is crucial to know the existing health care network services and provide an adequate continuum of care after hospital discharge.

Domain	**Subdomain**	**Basic Competence**
Health system network related competencies	PC healthcare network: Different modes of delivery	Knows the spectrum of services, and the benefits and barriers to providing end of life care in the following settings: home care, assisted living, long-term care, acute hospital medical unit, intensive care unit, long term acute care, palliative care unit, hospice unit
		Inform and provide access to resources available in the hospital and the community to ensure a transition from hospital to effective and adequate home care.
		Discusses the important supporting role the physician or NP has in the management of dying patients and their families in community care.
		Communicates with care managers/discharge planners across sites to enable seamless transitions between settings
		Helps patients and families in discharge planning decision-making
		Communicates with clinicians at time of discharge to clarify and coordinate care plan across settings
		Recognizes the existence and technical capacity of palliative care services in hospitals, ambulatory and home care models, articulated in a network of health care services.
		understand the huge potential the community has to offer in providing end of life care support, e.g. how the community can enable individuals to stay in, or return to, their own home, and the various support services the community has to offer
		understand that individuals should be seen within the context of their own community and be supported to participate and contribute to this as they wish

	Recognize the limitations of one's own expertise in Palliative and end of life care and indications for onward referral to Specialist Palliative Care or other appropriate disciplines and agencies
	Be able to refer the person with a life-limiting condition and their family members to other health care professionals to assess, treat and manage individual and family care issues outside the scope of palliative care practice and collaborate with them.
	Management of hospice patients/palliative care systems referrals
PC healthcare network: Quality improvement	Understands hospital and palliative medicine program continuous quality improvement programs and their goals and processes
	Partners with health care managers and health care providers to assess, coordinate, and improve patient safety and health care, and understands how these activities can affect system performance
	Evaluates and implements systems improvement based on clinical practice or patient and family satisfaction data, in either personal practice, team practice, or within institutional settings
	Understands own role and the role of the system in medical error
PC healthcare network: Administrative issues	Adequately completes the special prescription forms according to the protocols of each hospital, institution and insurance agencies.
	Documents, shares, implements, evaluates and provides feedback to the surveillance program for appropriate prescription and adherence to treatment involving the patient-family-health team.
	Know who to contact regarding legal, ethical or safeguarding issues
	Understands the various settings and related structures for organizing, regulating, and financing care near the end of life, and their interaction with hospice and palliative care
	understand local and national policy relating to medicines management
	understand which organizations should be contacted following an individual's death, and the purpose of such contact
Carer support: Family interaction and community support	understand that carers may need support to recognize they have taken on a caring role
	Advocates for quality patient and family care and assists patients and families in dealing with system complexities
	understand that the support needs of individuals and those important to them are wide ranging and extend far beyond the care, support and treatment provided by health and care professionals
	be able to develop the practical skills of individuals and those important to them to enhance networks, including: saying yes to offers of help and learning how to ask
	be able to use networks and partnerships to identify resources, information and support for carers in their community, and make referrals where appropriate
	Discusses patient and family education regarding self-management techniques for controlling pain and other symptoms
Carer support: Risk management	be able to recognize where a child or young person has taken on a caring role and refer to appropriate support services
	understand the impact of, and different factors that may affect carers' response to, death grief, loss and bereavement
	understand how to access support for family conflicts
Financial & insurance issues	Knows how to assess, provide support, and make appropriate referral around fiscal issues and insurance coverage
	Reimbursement and economic issues
	Understands basic concepts and patterns of physician billing and reimbursement across settings
	Communicates and supports patient and family decision-making about discharge planning – including settings of care, service options, and reimbursement/payer systems

Table 8: List of health care system network related competencies domain.

Domain 7 – Competencies in education, evidence base medicine & quality control

This domain encompasses the basic concepts around palliative care, as well as the obligation to pursue and implement practices based on evidence-based medicine, educate the patient, carers and the community and disseminate the message of palliative care in every setting.

Domain	Subdomain	Basic Competence
Competencies in Education, evidence base medicine & quality control	Diagnosis	Who to consider for palliative care
		Screening for palliative care needs
	Concepts	Palliative Care Definition. Goals of medicine
		Rapid palliative care assessment; Interprets, applies and transmits the basic concepts of palliative care; Identifies the individual realities based on a clinical and social analysis to generate intervention strategies in patients with palliative care needs.
		Understands the scope and practice of palliative care, including the relationship to hospice. Has knowledge of the domains of palliative care, setting where palliative care is provided, history of the hospice and palliative medicine fields, barriers to accessing palliative care
		The hospice/interdisciplinary-team approach to palliative care
		Medical vs. biopsychosocial model of illness
		Describes a palliative approach to care; benefits of early collaborative approach;
		Understands the scope and practice of hospice care. Has knowledge of the structure, setting and barriers to hospice care.
		understand what it means to be a 'carer'
		be aware of current guidance and evidence to inform assessment and decision making
		be aware of local and national end of life policy and where to find additional information about this
		Developing self and others
		Describes the incidence and diagnosis of depression and other mood disturbances in a patient with palliative care needs.
		Describes disease trajectories for common serious illnesses in adult and pediatric patients.
		Describes common signs of the natural dying process.
	Evidence based medicine	Discusses appropriate/relevant investigations of pain and other symptoms.
		Demonstrates knowledge of and commitment to continuing professional development and life-long learning
		Demonstrates knowledge of the roles and responsibilities of the trainee/mentor
		Demonstrates the ability to reflect on his/her personal learning style and use different opportunities for learning
		Demonstrates the ability to actively seek and utilize feedback
		Demonstrates the ability to develop an effective learning relationship with members of the faculty
		Accesses, analyzes and applies the evidence base to clinical practice in palliative care
		Demonstrates knowledge of, and understands limitations of evidence-based medicine in palliative care
		Actively seeks to apply the best available evidence to patient care and encourages others to do so
		Shows ability to apply evidence-based medicine to facilitate safe, UpToDate palliative clinical practice
		know where to obtain information about policy and evidence-based practice
		be able to judge the value of information e.g. according to its source or evidence base

	Lead, facilitate or engage in research in palliative care and in the context of your local work environment.
Educate: Caregiver education	Demonstrates the ability to educate patients/families about the medical, social and psychological issues associated with life-limiting illness
	Care for the Caregiver and Family, Identifies and empowers the capabilities of the caretaker and his family. • Promotes self-care in the patient and family / caregiver in the context of palliative care.
Educate: Communicates effectively about palliative care to the community at large	Uses opportunities to educate health care professionals and the public about palliative care when they arise
	Describes how to prepare and educate the patient, family and caregivers when death approaches, and care of the body after death.
	Communicates accurate and relevant information on hospice and palliative medicine to the community at large
	Effectively communicates the mission of palliative medicine to hospital administrators, clinicians, and community at large
	Participate in education and learning to improve outcomes for patients with generalist palliative and end of life care needs
Service improvement / Quality control	Contribute to audit, evaluation and research in order to improve practice in palliative and end of life care
	Understands common approaches to quality and safety assurance
	Demonstrates an openness and willingness to evaluate and participate in practice and service improvement
	Knows relative costs of medications and other therapeutics/interventions
	Reviews pertinent clinical or patient/family satisfaction data about personal, team, or institutional practice patterns
	be able to empower and support individuals manage their care and support and to make decisions based on their own experience, utilizing professional support and guidance
	be able to participate in reviews, research and surveys, including service satisfaction surveys
	be able to reflect on practice and learn from experiences
	understand how to use the national end of life intelligence network data and other data sources to determine population needs
	Audit, research and practice development
	Participate in processes of clinical governance and quality assurance to maintain and improve clinical practice in palliative care.
	be able to support individuals to identify and manage risk

Table 9: List of Competencies in education, evidence base medicine & quality control domain

Discussion

Firstly, addressing domains, we found a significant variability in the listing. Some authors contemplated the existence of only 4 (14) or 5 domains (15–20) but, on the other hand, others contemplated as many as 13 (21). This lack of consensus was our first concern which we tried to address. Focusing on the existing data, we firstly formulated 8 possible domains and then, due to similarities between some competencies and due to the low number of competencies in some domains we were able to downsize to 7 as was addressed on the results section of this paper. This step seems to us of great importance since it feels important to simplify the existing data into a more concise yet taxonomically accurate listing.

Sub domain were also an important aspect of the taxonomic effort that we endeavored. These sub-domains, that were most selected from existing competencies in the listing, allowed us to achieve two objectives: simplify the existing data, making it easier to understand, and identify mistakes that could have been made in the sorting process.

This study shows that chronologically there was an attempt to be oversimplistic at first and then progressively more exhaustive in describing the competencies, some of which became excessively specific to certain contexts losing their universality. We tried to address this situation by removing or including these competences into those with a vaguer definition that fitted this premise. Our aim was to simplify the results and make them more easily operable.

This study has several limitations that need to be addressed:

- Possible Methodological Limitations:
  - Quality of available data: It is important to mention that most of the papers obtained where based on consensus-based opinions which are placed at a low level of evidence. However due to the empirical nature of the subject it is hard to obtain a higher level of evidence. To limit this impact, we tried to perform a wide search and include the most articles possible for this scope. Another relevant aspect is the context the competencies are to be implemented, which, as mentioned before, are intricately linked to the population and cultural context. Some competencies, like the ones related to euthanasia/MAID, or insurance related topics which are a main concern in other settings, do not apply at this moment, to the Portuguese reality and therefore to a universal setting. Since there are no Portuguese publications on this subject this an area that warrants further research.
  - Measure used to collect the data: we tried to be as transparent as possible while extracting data, limiting as much as possible to the already existing listings, but the size of the data lead us

to firstly attempt to lists all the competencies under a massive list that was then sorted according to the defined domains. This methodology has its limitations because we fall into the error of possibly eliminating relevant data or be biased by subjective reasoning, although we tried to keep this aspect to a minimum through discussion and mutual agreement between investigators.

- Possible Limitations of the Researchers
  - Longitudinal effects: The subject of this study, competency, is limited to a certain time, place and context and we chose to study with no time limit and no geographical constraints. We tried to take these factors into consideration, and although most were easy to interpret as adequate, once again, subjective reasoning and even cultural aspects must be highlighted as possible biases. For example, competencies that may seem adequate in 1991 may not seem to be at the present time in Portugal but be adequate in other settings at the present time.
  - Fluency in a language: although the investigators are fluent in all the languages included in this scope, the articles included were not in their main language, and although the bias originated by this factor, albeit translation or interpretation, is considered minimum, it should be enunciated.

As for Strengths we tried to obtain unbiased data, with no time limit. This scope provides an overview of the state of evidence in this subject, includes published literature as well as grey literature and includes a wide range of study designs and methodologies. Another strength was that the search was exhaustive with a total of 5032 articles + 15 in grey literature being revised for content. A total of 1064 competencies were identified and sorted into a final number of 7 domains and 248 basic competences. To our knowledge, there is no such study in the current literature.

The competencies listed are intended to be used as they are, solely for the mentioned purpose and the population they are targeted for, which are for doctors in the setting of internal medicine.

Conclusion

Medical education is perpetually reconfiguring itself in response to the need of constantly changing scientific knowledge, technology, and health care delivery systems (22) and palliative care is an essential yet often-neglected part of medical education. Several authors, like Ellen Fox or Billing and BlocK, mentioned that the curative model of education predominates, with the palliative model occurring only when there is failure of the first (23,24). However, studies are starting to suggest that formal education in EOL/palliative care is expanding during clinical experience and is changing the way palliative care is being provided. Therefore it should be taught at the level of internal medicine residencies (25).

Internal medicine physicians provide palliative care to patients in their daily practice and have done so since ever. Whether one pursues specialization or not, all internists can use the growing knowledge of palliative medicine in their medical practice. The incorporation of palliative medicine competencies to internists basic formation will warrant quality practice not only for patients and their families but also a new way to perceive life and self-care which are fundamental for healthy professionals.

With the competencies and structure provided in this scope we aimed at providing the scientific community with a tool that enables any researcher to work towards a more universal and structured curriculum for internists and their perception of palliative care. This information could also be used as a foundation, not only for the population of this study, but to anyone interested in implementing a competence-based curriculum albeit with the necessary adjustments to their context.

Recommendations for research

With the data collected from this scope, our list of competencies should be evaluated, sorted and adapted to Portugal internists. A valid approach could be through a panel of Portuguese palliative care experts using in e.g., a Delphi approach. Following this step a way to implement and evaluate the outcome of the implementation of said competencies in the Portuguese internal medicine residency program should be studied.

Funding

None to declare.

Conflicts of interest

None to declare.

References:

1. EAPC. What We Do [Internet]. 2021 [cited 2021 Apr 15]. Available from: https://www.eapcnet.eu/about-us/what-we-do/

2. ACP. What is a Doctor of Internal Medicine, or Internist? [Internet]. [cited 2021 Apr 15]. Available from: https://www.acponline.org/acp-newsroom/what-is-a-doctor-of-internal-medicine-or-internist-0

3. Portaria nº 614/2010 de 03 de Agosto. Diário da República. Ministério da Saúde; 2010. 3163–3165 p.

4. Horton R. A milestone for palliative care and pain relief. Lancet [Internet]. 2018 Apr;391(10128):1338–9. Available from: https://linkinghub.elsevier.com/retrieve/pii/S0140673617325606

5. Vilas Boas A. Who are our patients? - Characterization fo Internal Medicine Wards in Portugal. In: 15th European Congress of Internal Medicine Amsterdam. 2016.

6. Plano Estratégico para o desenvolvimento dos Cuidados Paliativos: Biénio 2019-2020. Comissão Nacional de Cuidados Paliativos; 2019.

7. Wong S-C. Competency Definitions, Development and Assessment: A Brief Review. Int J Acad Res Progress Educ Dev. 2020;9(3).

8. McGaghie WC, Miller GE, Sajid AW, Telder T V. Competency based curriculum development in medical education: An introduction. WHO [Internet]. World Health Organization 1978; 1978. Available from: https://apps.who.int/iris/handle/10665/39703

9. Gamondi C, Larkin P, Payne S. Core competencies in palliative care: an EAPC White Paper on palliative care education - part 1. Eur J Palliat Care. 2013;20(2):86–91.

10. Scott B. Parry. The Quest for Competencies. Training. 1996;48–54.

11. McGaghie WC, Miller GE, Sajid AW, Telder T V. Competency based curriculum development in medical education: An introduction. WHO. World Health Organization 1978; 1978.

12. LJ M, JO S, SD B. Developing initial competency-based outcomes for the hospice and palliative medicine subspecialist: phase I of the hospice and palliative medicine competencies project. J Palliat Med [Internet]. 2007 Apr;10(2):313–30. Available from: http://search.ebscohost.com/login.aspx?direct=true&db=rzh&AN=105848265&lang=pt-pt&site=ehost-live

13. Crawford GB, Price SD. Team working: Palliative care as a model of interdisciplinary practice. Med J Aust. 2003;179(6 SUPPL.):32–4.

14. Ross DD, Shpritz DW, Wolfsthal SD, Zimrin AB, Keay TJ, Fang H-B, et al. Creative solution for implementation of experiential, competency-based palliative care training for internal medicine

residents. J Cancer Educ. 2011 Sep;26(3):436–43.

15. Bulkin W, Lukashok H. Training physicians to care for the dying. Am J Hosp Palliat Med. 1991;8(2):10–5.

16. Mularski RA, Bascom P, Osborne ML. Educational agendas for interdisciplinary end-of-life curricula. Crit Care Med. 2001 Feb;29(2 Suppl):N16-23.

17. Weissman DE, Blust L. Education in palliative care. Clin Geriatr Med. 2005 Feb;21(1):165–75, ix.

18. Meier DE. Palliative care in hospitals. J Hosp Med. 2006 Jan;1(1):21–8.

19. Carey EC, Paniagua M, Morrison LJ, Levine SK, Klick JC, Buckholz GT, et al. Palliative Care Competencies and Readiness for Independent Practice: A Report on the American Academy of Hospice and Palliative Medicine Review of the U.S. Medical Licensing Step Examinations. J Pain Symptom Manage. 2018 Sep;56(3):371–8.

20. de Bruin J, Verhoef M-J, Slaets JPJ, van Bodegom D. End-of-life care in the Dutch medical curricula. Perspect Med Educ. 2018 Oct;7(5):325–31.

21. McCallum M, Carver J, Dupere D, Ganong S, Henderson JD, McKim A, et al. Developing a palliative care competency framework for health professionals and volunteers: The Nova Scotian experience. J Palliat Med. 2018;21(7):947–55.

22. Saidi F. American medical education 100 years after the flexner report. Arch Iran Med. 2007;10(1):131–3.

23. Billings JA. Palliative Care in Undergraduate Medical Education. Jama. 1997;278(9):733.

24. Fox E. Predominance of the curative model of medical care: A residual problem. J Am Med Assoc. 1997;278(9):761–3.

25. Shaheen AW, Denton GD, Stratton TD, Hoellein AR, Chretien KC. End-of-life and palliative care curricula in internal medicine clerkships: a report on the presence, value, and design of curricula as rated by clerkship directors. Acad Med. 2014 Aug;89(8):1168–73.

Appendices

Appendix I: Search Strategy

In the following table we present the search methodology and syntax for PubMed:

	PUBMED		
	Participants	Concept	Context
	Internal medicine physicians	Competencies	Palliative Care
Terms used	GENERAL Physicians MESH Doctor)- 12 Geriatricians- 1396 (MeSH term) Oncologists – 17260 (MeSH term) MEDICINA INTERNA Hospitalists – 2724 (MesH term) Internal medicine – 107122 (MeSH term)	Palliative Care education – 8802 - palliative care - MeSH Terms - education - MeSH Terms - educational status - MeSH Terms Competencies (competenc*) 78 405 Skills - 175054 Expertise - 43483 Professional Competence –110961 - MeSH Terms Generalization of Expertise - 113988 Technical Expertise - 116743 Capability - 91271 Capacity - 507700 Ability (ies): Ability: 807980; Abilities: 81170 Aptitude(*): 7684 - MeSH Terms Know-how - 5898 Knowledge – 638605 MeSH Terms Health Knowledge, Attitudes, Practice - 103213 MeSH Terms Accomplishment – 4109 Academic performance MeSH Terms Clinical Competence - 88 351 Clinical Competency - 87 847 Clinical Competencies - 87 769 Clinical competencies (Clinical Skill*) - 5610 Cultural Competency – 5666 MeSH Terms (todos vêm parar a este) Cultural Competence – 6264 Cultural Competencies –5002 Social Skills – 30864 / 5589 **(MesH term)** Social Abilities – 1648 MesH term social skills Social Ability – 59009 / 1491 MesH term social skills Interpersonal Skills – 35168 / 3091 MesH term social skills Interpersonal Skill – 31711 / 1462 MesH term social skills Social Competence – 44293 /3544 MesH term social skills Talent (*) - 1403 / 4527 Mesh term Aptitude Competence areas: Advance care planning -MESH Communication -MESH Symptom control Team work Bereavement; grief; mourning Hope Ethics Spirituality - 10239 Last days and hours of life - 630	Palliative care (MESH) Palliative medicine (MESH) Terminal care (sem eutanásia) (MESH) End-of-life care Supportive care Terminally ill (MESH) Hospice care (MESH) Generalist palliative care Palliative care approach Comfort care Palliation Patient Comfort (MESH)

		Minorities 21318 --> Minority Groups (MeSH Term); Sexual and Gender Minorities (MeSH Term) Withdrawal – 94607 / 86792 (MesH term) Withholding Treatment **(MesH term)** Witholding Life-supportive care - 7 DIGNITY SUFFERING HOMELESS HOMELESS PERSONS (MESH) PAIN –MESH NAUSEA-MESH VOMITING-MESH CONSTIPATION-MESH DYSPNEA-MESH DELIRIUM-MESH DEPRESSION-MESH DEPRESSIVE DISORDERS-MESH ANOREXIA-MESH CACHEXIA-MESH FATIGUE-MESH ASTHENIA - MESH ANXIETY-MESH MEDULLAR COMPRESSION-MESH INTESTINAL OBSTRUCTION –MESH BOWEL OBSTRUCTION COGNITIVE DYSFUNCTION-MESH COGNITIVE IMPAIRMENT SYMPTOM* MUCOSITIS-MESH Search ((((((((((((((((((((((((((((((((((((PAIN[MeSH Terms]) OR PAIN[Title/Abstract]) OR NAUSEA[MeSH Terms]) OR NAUSEA[Title/Abstract]) OR VOMITING[MeSH Terms]) OR VOMITING[Title/Abstract]) OR CONSTIPATION[MeSH Terms]) OR CONSTIPATION[Title/Abstract]) OR DYSPNEA[MeSH Terms]) OR DYSPNEA[Title/Abstract]) OR DELIRIUM[MeSH Terms]) OR DELIRIUM[Title/Abstract]) OR DEPRESSION[MeSH Terms]) OR DEPRESSION[Title/Abstract]) OR DEPRESSIVE DISORDERS[MeSH Terms]) OR DEPRESSIVE DISORDERS[Title/Abstract]) OR ANOREXIA[MeSH Terms]) OR ANOREXIA[Title/Abstract]) OR CACHEXIA[MeSH Terms]) OR CACHEXIA[Title/Abstract]) OR FATIGUE[MeSH Terms]) OR FATIGUE[Title/Abstract]) OR ASTHENIA[MeSH Terms]) OR ASTHENIA[Title/Abstract]) OR ANXIETY[MeSH Terms]) OR ANXIETY[Title/Abstract]) OR MEDULLAR COMPRESSION[MeSH Terms]) OR MEDULLAR COMPRESSION[Title/Abstract]) OR INTESTINAL OBSTRUCTION[MeSH Terms]) OR INTESTINAL OBSTRUCTION[Title/Abstract]) OR COGNITIVE DYSFUNCTION[MeSH Terms]) OR COGNITIVE DYSFUNCTION[Title/Abstract]) OR MUCOSITIS[MeSH Terms]) OR MUCOSITIS[Title/Abstract]) OR BOWEL	

		OBSTRUCTION[Title/Abstract]) OR COGNITIVE IMPAIRMENT[Title/Abstract]) OR SYMPTOM*[Title/Abstract] 2 300 924	
Sintaxes	GERAL (((((((Physicians[MeSH Terms]) OR Physicians[Title/Abstract]) OR Geriatricians[MeSH Terms]) OR Geriatricians[Title/Abstract]) OR Oncologists[MeSH Terms]) OR Oncologists[Title/Abstract]) OR Doctor[Title/Abstract]) OR Doctors[Title/Abstract] – 422234 MED INT (((Hospitalists[MeSH Terms]) OR Hospitalists[Title/Abstract]) OR Internal medicine[MeSH Terms]) OR Internal medicine[Title/Abstract] – **109732**	((((((((((((((((((((((((((((((((((((education[MeSH Terms]) OR education[Title/Abstract]) OR educational status[MeSH Terms]) OR educational status[Title/Abstract]) OR Professional Competence[MeSH Terms]) OR Professional Competence[Title/Abstract]) OR Aptitude[MeSH Terms]) OR Aptitude[Title/Abstract]) OR Knowledge[MeSH Terms]) OR Knowledge[Title/Abstract]) OR Health Knowledge, Attitudes, Practice[MeSH Terms]) OR Health Knowledge, Attitudes, Practice[Title/Abstract]) OR Academic performance[MeSH Terms]) OR Academic performance[Title/Abstract]) OR Cultural Competency[MeSH Terms]) OR Cultural Competency[Title/Abstract]) OR Social Skills[MeSH Terms]) OR Social Skills[Title/Abstract]) OR Competencies[Title/Abstract]) OR Competenc*[Title/Abstract]) OR Skills[MeSH Terms]) OR Skill*[Title/Abstract]) OR Expertise[Title/Abstract]) OR Generalization of Expertise[Title/Abstract]) OR Technical Expertise[Title/Abstract]) OR Capability[Title/Abstract]) OR Capacity[Title/Abstract]) OR Ability[Title/Abstract]) OR Abilities[Title/Abstract]) OR Know-how[Title/Abstract]) OR Accomplishment[Title/Abstract]) OR Clinical Competence[Title/Abstract]) OR Clinical Competency[Title/Abstract]) OR Clinical Competencies[Title/Abstract]) OR Clinical Skill*[Title/Abstract]) OR Cultural Competence[Title/Abstract]) OR Cultural Competencies[Title/Abstract]) OR Social Abilities[Title/Abstract]) OR Social Ability[Title/Abstract]) OR Interpersonal Skills[Title/Abstract]) OR Interpersonal Skill[Title/Abstract]) OR Social Competence[Title/Abstract]) OR Talent*[Title/Abstract] **3 030 340** ((((((((((((((((((((((((((((Advance care planning[Title/Abstract] OR Communication[Title/Abstract]) OR Symptom control[Title/Abstract]) OR Team work[Title/Abstract]) OR Bereavement[Title/Abstract]) OR grief[Title/Abstract]) OR mourning[Title/Abstract]) OR Hope[Title/Abstract]) OR Ethics[Title/Abstract]) OR Spirituality[Title/Abstract]) OR (Last days[Title/Abstract] AND hours of life[Title/Abstract])) OR Minorities[Title/Abstract]) OR Minority Groups[Title/Abstract]) OR	((((((((((((((((Palliative care[MeSH Terms]) OR Palliative care[Title/Abstract]) OR Palliative medicine[MeSH Terms]) OR Palliative medicine[Title/Abstract]) OR Terminal care[Mesh:NoExp]) OR Terminal care[Title/Abstract]) OR Terminally ill[MeSH Terms]) OR Terminally ill[Title/Abstract]) OR Hospice care[MeSH Terms]) OR Hospice care[Title/Abstract]) OR End-of-life care[Title/Abstract]) OR Supportive care[Title/Abstract]) OR Generalist palliative care[Title/Abstract]) OR Palliative care approach[Title/Abstract]) OR Comfort care[Title/Abstract]) OR Palliation[Title/Abstract]) OR Patient Comfort[MeSH Terms]) OR Patient Comfort[Title/Abstract] **114 878**

		(Sexual[Title/Abstract] AND Gender Minorities[Title/Abstract])) OR Withdrawal[Title/Abstract]) OR Withholding[Title/Abstract]) OR Life-supportive care[Title/Abstract]) OR DIGNITY[Title/Abstract]) OR SUFFERING[Title/Abstract]) OR "advance care planning"[MeSH Terms]) OR "communication"[MeSH Terms]) OR "bereavement"[MeSH Terms]) OR "grief"[MeSH Terms]) OR "ethics"[MeSH Terms]) OR "hope"[MeSH Terms]) OR "spirituality"[MeSH Terms]) OR "minority groups"[MeSH Terms]) OR "sexual and gender minorities"[MeSH Terms]) OR "withholding treatment"[MeSH Terms]) OR "respect"[MeSH Terms]) OR RESPECT[Title/Abstract]) OR "homeless persons"[MeSH Terms] **1 281 707** **AND** **287 891**	
Global Syntax used - on the 19/12/19	MED INT ((((((((((((((((((((Palliative care[MeSH Terms]) OR Palliative care[Title/Abstract]) OR Palliative medicine[MeSH Terms]) OR Palliative medicine[Title/Abstract]) OR Terminal care[Mesh:NoExp]) OR Terminal care[Title/Abstract]) OR Terminally ill[MeSH Terms]) OR Terminally ill[Title/Abstract]) OR Hospice care[MeSH Terms]) OR Hospice care[Title/Abstract]) OR End-of-life care[Title/Abstract]) OR Supportive care[Title/Abstract]) OR Generalist palliative care[Title/Abstract]) OR Palliative care approach[Title/Abstract]) OR Comfort care[Title/Abstract]) OR Palliation[Title/Abstract]) OR Patient Comfort[MeSH Terms]) OR Patient Comfort[Title/Abstract])) AND ((((((((((((((((((((((((((((((((((((((education[MeSH Terms]) OR education[Title/Abstract]) OR educational status[MeSH Terms]) OR educational status[Title/Abstract]) OR Professional Competence[MeSH Terms]) OR Professional Competence[Title/Abstract]) OR Aptitude[MeSH Terms]) OR Aptitude[Title/Abstract]) OR Knowledge[MeSH Terms]) OR Knowledge[Title/Abstract]) OR Health Knowledge, Attitudes, Practice[MeSH Terms]) OR Health Knowledge, Attitudes, Practice[Title/Abstract]) OR Academic performance[MeSH Terms]) OR Academic performance[Title/Abstract]) OR Cultural Competency[MeSH Terms]) OR Cultural Competency[Title/Abstract]) OR Social Skills[MeSH Terms]) OR Social Skills[Title/Abstract]) OR Competencies[Title/Abstract]) OR Competenc*[Title/Abstract]) OR Skills[MeSH Terms]) OR Skill*[Title/Abstract]) OR Expertise[Title/Abstract]) OR Generalization of Expertise[Title/Abstract]) OR Technical Expertise[Title/Abstract]) OR Capability[Title/Abstract]) OR Capacity[Title/Abstract]) OR Ability[Title/Abstract]) OR Abilities[Title/Abstract]) OR Know-how[Title/Abstract]) OR Accomplishment[Title/Abstract]) OR Clinical Competence[Title/Abstract]) OR Clinical Competency[Title/Abstract]) OR Clinical Competencies[Title/Abstract]) OR Clinical Skill*[Title/Abstract]) OR Cultural Competence[Title/Abstract]) OR Cultural Competencies[Title/Abstract]) OR Social Abilities[Title/Abstract]) OR Social Ability[Title/Abstract]) OR Interpersonal Skills[Title/Abstract]) OR Interpersonal Skill[Title/Abstract]) OR Social Competence[Title/Abstract]) OR Talent*[Title/Abstract])) AND ((((((((((Physicians[MeSH Terms]) OR Physicians[Title/Abstract]) OR Geriatricians[MeSH Terms]) OR Geriatricians[Title/Abstract]) OR Oncologists[MeSH Terms]) OR Oncologists[Title/Abstract]) OR Doctor[Title/Abstract]) OR Doctors[Title/Abstract])) OR ((((Hospitalists[MeSH Terms]) OR Hospitalists[Title/Abstract]) OR Internal medicine[MeSH Terms]) OR Internal medicine[Title/Abstract])) – **4131**		

In the following table we present the search methodology and syntax for CINAHL:

	CINAHL PLUS WITH FULL TEXT		
	Participants	Concept	Context
	Internal medicine physicians	Competencies	Palliative Care

Terms used	GERAL Physicians - SUBJECT HEADING Doctor (*) Geriatricians - SUBJECT HEADING Oncologists - SUBJECT HEADING Hospitalists - SUBJECT HEADING Internal medicine - SUBJECT HEADING	Palliative Care education educational status- SUBJECT HEADING Competencies (competenc*) Skills Clinical Competence- SUBJECT HEADING Communication Skills Training- SUBJECT HEADING Communication Skills- SUBJECT HEADING Communication Skills Training- SUBJECT HEADING Competency Assessment- SUBJECT HEADING Expertise Professional Competence generalization of Expertise Professional Competence- SUBJECT HEADING Professional Development- SUBJCT HEADING Technical Expertise Capability Capacity Ability (ies) Aptitude(*)- SUBJECT HEADNG Know-how Knowledge- SUBJECT HEADING Health Knowledge, Attitudes, Practice Accomplishment Academic performance- SUBJECT HEADING Clinical Competence - SUBJECT HEADING Clinical Competency Clinical Competencies Clinical competencies (Clinical Skill*) Cultural Competency – SUBJECT HEADING Cultural Competence – SUBJECTHEADING Cultural Competencies Social Skills – SUBJEC HEADING Social Skills Training- SUBJECT HEADING Social Abilities Social Attitudes- SUBJECT HEADING Social skills- SUBJECT HEADING Social Ability Interpersonal Skills Interprofessional Relations- SUBJECT HEADING Interpersonal Skill Social Competence Talent (*) Áreas de competências Advance care planning-SUBJECT HEADING Communication-SUBJECT HEADING Symptom control Teamwork-SUBJECT HEADING Bereavement SUBJECT HEADING Grief-SUBJECT HEADING mourning Hope- SBJECT HEADING Ethics-SUBJECT HEADING Bioethics- SUBJECT HEADING Codes of Ethics- SUBJECT HEADING Spirituality -SUBJECT HEADING Last days and hours of life Minorities Minority Groups - SUBJECT HEADINGS Sexual and Gender Minorities Withdrawal	Palliative care - SUBJECT HEADING Palliative medicine Terminal care - SUBJECT HEADING --Terminal care (Saba ccc) - SUBJECT HEADING End-of-life care Supportive care Terminally ill --Terminally ill patients – SUBJECT HEADING Hospice care – SUBJECT HEADING Generalist palliative care Palliative care approach Comfort care --Comfort care (Saba CCC) - SUBJECT HEADING Palliation Patient Comfort

		Withholding Treatment – não é um subject heading, mas aparece associado ao termo eutanásia --EUTHANASIA, PASSIVE – SUBJECTIVE HEADING Withholding - não é um subject heading, mas aparece associado ao termo eutanásia Life-supportive care Dignity --Human Dignity – SUBJECT HEADING Suffering – SUBJECT HEADING Homeless Homeless persons – SUBJECT HEADING Pain - SUBJECT HEADING Nausea - SUBJECT HEADING Vomiting - SUBJECT HEADING --Nausea and vomiting - SUBJECT HEADING --Anticipatory nausea and vomiting - SUBJECT HEADING Constipation - SUBJECT HEADING Dyspnea - SUBJECT HEADING Delirium - SUBJECT HEADING Depression - SUBJECT HEADING Depressive Disorders Anorexia - SUBJECT HEADING Cachexia - SUBJECT HEADING Fatigue - SUBJECT HEADING --Cancer fatigue - SUBJECT HEADING Asthenia - SUBJECT HEADING Anxiety - SUBJECT HEADING Medullar compression Bowel obstruction --Intestinal obstruction – SUBJECT HEADING Cognitive dysfunction Cognitive impairment Symptom* --Symptoms – SUBJECT HEADING Mucositis - SUBJECT HEADING	
Sintaxes	Geral MM Physicians OR TI Physicians OR AB Physicians OR TI Doctor OR AB Doctor OR MM Geriatricians OR TI Geriatricians OR AB Geriatricians OR MW Oncologists OR TI Oncologists OR AB Oncologists - **171336 – S1** Internal Medicine MM Hospitalists OR TI Hospitalists OR AB Hospitalists OR MM Internal medicine OR TI Internal medicine OR Internal medicine - **10560 – S8**	TI Palliative Care education OR AB Palliative Care education OR MM educational status OR TI educational status OR AB educational status OR TI competenc* OR AB competenc* OR TI Skills OR AB Skills OR MM Clinical Competence OR TI Clinical Competence OR AB Clinical Competence OR MM Communication Skills Training OR MM Communication Skills OR TI Communication Skills OR AB Communication Skills OR MM Competency Assessment OR TI Competency Assessment OR Competency Assessment OR TI Expertise OR AB Expertise OR TI Professional Competence OR AB Professional Competence OR MM Professional Competence OR MM Professional Development OR TI Professional Development OR AB Professional Development OR TI Technical Expertise OR AB Technical Expertise OR TI Capability OR AB Capability OR TI Capacity OR AB Capacity OR TI Ability OR AB Ability OR MM Aptitude OR TI Aptitude OR AB Aptitude OR TI Know-how OR AB Know-how OR MM Knowledge OR TI Knowledge OR AB	MM Palliative care OR TI Palliative care OR AB Palliative care OR TI Palliative medicine OR AB Palliative medicine OR MM Terminal care OR TI Terminal care OR AB Terminal care OR TI End-of-life care OR AB End-of-life care OR TI Supportive care OR AB Supportive care OR MM Terminally ill patients OR TI Terminally ill OR AB Terminally ill OR MM Hospice care OR TI Hospice care OR AB Hospice care OR TI Generalist palliative care OR AB Generalist palliative care OR TI Palliative care approach

		Knowledge OR TI Health Knowledge, Attitudes OR AB Health Knowledge, Attitudes OR TI Practice Accomplishment OR AB Practice Accomplishment OR MM Academic performance OR TI Academic performance OR AB Academic performance OR MM Clinical Competence OR TI Clinical Competence OR AB Clinical Competence AND TI Clinical Competenc* OR AB Clinical Competenc* OR TI Clinical Skill* OR AB Clinical Skill* OR MM Cultural Competency OR MM Cultural Competence OR TI Cultural Competenc* OR AB Cultural Competenc* OR MM Social Skills OR TI Social Skills OR AB Social Skills OR MM Social Skills Training OR TI Social Abilit* OR AB Social Abilit* OR TI Interpersonal Skill* OR AB Interpersonal Skill* OR MM Interprofessional Relations OR TI Interprofessional Relations OR AB Interprofessional Relations OR TI Social Competenc* OR AB Social Competenc* OR TI Talent OR AB Talent OR TI Talent* OR AB Talent* - **511414-S20=S13+S14+S15+S16+S17+S18+S19**	OR AB Palliative care approach OR MM Comfort care OR TI Comfort care OR AB Comfort care OR TI Palliation OR AB Palliation OR TI Patient Comfort OR AB Patient Comfort – **64037 – S24=S21+S22+S23**
Global Syntax used - on the 19/12/19	(MM Physicians OR TI Physicians OR AB Physicians OR TI Doctor OR AB Doctor OR MM Geriatricians OR TI Geriatricians OR AB Geriatricians OR MW Oncologists OR TI Oncologists OR AB Oncologists OR MM Hospitalists OR TI Hospitalists OR AB Hospitalists OR MM Internal medicine OR TI Internal medicine OR Internal medicine) AND (TI Palliative Care education OR AB Palliative Care education OR MM educational status OR TI educational status OR AB educational status OR TI competenc* OR AB competenc* OR TI Skills OR AB Skills OR MM Clinical Competence OR TI Clinical Competence OR AB Clinical Competence OR MM Communication Skills Training OR MM Communication Skills OR TI Communication Skills OR AB Communication Skills OR MM Competency Assessment OR TI Competency Assessment OR Competency Assessment OR TI Expertise OR AB Expertise OR TI Professional Competence OR AB Professional Competence OR MM Professional Competence OR MM Professional Development OR TI Professional Development OR AB Professional Development OR TI Technical Expertise OR AB Technical Expertise OR TI Capability OR AB Capability OR TI Capacity OR AB Capacity OR TI Ability OR AB Ability OR MM Aptitude OR TI Aptitude OR AB Aptitude OR TI Know-how OR AB Know-how OR MM Knowledge OR TI Knowledge OR AB Knowledge OR TI Health Knowledge, Attitudes OR AB Health Knowledge, Attitudes OR TI Practice Accomplishment OR AB Practice Accomplishment OR MM Academic performance OR TI Academic performance OR AB Academic performance OR MM Clinical Competence OR TI Clinical Competence OR AB Clinical Competence AND TI Clinical Competenc* OR AB Clinical Competenc* OR TI Clinical Skill* OR AB Clinical Skill* OR MM Cultural Competency OR MM Cultural Competence OR TI Cultural Competenc* OR AB Cultural Competenc* OR MM Social Skills OR TI Social Skills OR AB Social Skills OR MM Social Skills Training OR TI Social Abilit* OR AB Social Abilit* OR TI Interpersonal Skill* OR AB Interpersonal Skill* OR MM Interprofessional Relations OR TI Interprofessional Relations OR AB Interprofessional Relations OR TI Social Competenc* OR AB Social Competenc* OR TI Talent OR AB Talent OR TI Talent* OR AB Talent*) AND (MM Palliative care OR TI Palliative care OR AB Palliative care OR TI Palliative medicine OR AB Palliative medicine OR MM Terminal care OR TI Terminal care OR AB Terminal care OR TI End-of-life care OR AB End-of-life care OR TI Supportive care OR AB Supportive care OR MM Terminally ill patients OR TI Terminally ill OR AB Terminally ill OR MM Hospice care OR TI Hospice care OR AB Hospice care OR TI Generalist palliative care OR AB Generalist palliative care OR TI Palliative care approach OR AB Palliative care approach OR MM Comfort care OR TI Comfort care OR AB Comfort care OR TI Palliation OR AB Palliation OR TI Patient Comfort OR AB Patient Comfort) – **1783-S31=S27+S20+S24** Search Link: http://search.ebscohost.com/login.aspx?direct=true&db=rzh&bquery=(((TI+Palliative+Care+education)+OR+(AB+Palliative+Care+education)+OR+(MM+educational+status)+OR+(TI+educational+status)+OR+(AB+educational+status)+OR+(TI+competenc*)+OR+(AB+competenc*)+OR+(TI+Skills)+OR+(AB+Skills)+OR+(MM+Clinical+Competence)+OR+(TI+Clinical+Competence)+OR+(AB+Clinical+Competence))+OR+(MM+Communication+Skills+Training+OR+MM+Communication+Skills+OR+TI+Communication+Skills+OR+AB+Communication+Skills+OR+MM+Competency+Assessment+OR+TI+Competency+Assessment+OR+Competency+Assessment+OR+TI+Expertise+OR+AB+Expertise+OR+TI+Professional+Competence+OR+AB+Professional+Competence+OR+MM+Professional+Competence)+OR+((MM+Professional+Development)+OR+(TI+Professional+Development)+OR+(AB+Professional+Development)+OR+(TI+Technical+Expertise)+OR+(AB+Technical+Expertise)+OR+(TI+Capability)+OR+(AB+Capability)+OR+(TI+Capacity)+OR+(AB+Capacity)+OR+(TI+Ability)+OR+(AB+Ability))+OR+((MM+Aptitude)+OR+(TI+Aptitude)+OR+(AB+Aptitude)+OR+(TI+Know-how)+OR+(AB+Know-	

	how)+OR+(MM+Knowledge)+OR+(TI+Knowledge)+OR+(AB+Knowledge)+OR+(TI+Health+Knowledge%2c+Attitudes)+OR+(AB+Health+Knowledge%2c+Attitudes))+OR+(TI+Practice+Accomplishment+OR+AB+Practice+Accomplishment+OR+MM+Academic+performance+OR+TI+Academic+performance+OR+AB+Academic+performance+OR+MM+Clinical+Competence+OR+TI+Clinical+Competence+OR+AB+Clinical+Competence+AND+TI+Clinical+Competenc*+OR+AB+Clinical+Competenc*)+OR+((TI+Clinical+Skill*)+OR+(AB+Clinical+Skill*)+OR+(MM+Cultural+Competency)+OR+(MM+Cultural+Competence)+OR+(TI+Cultural+Competenc*)+OR+(AB+Cultural+Competenc*)+OR+(MM+Social+Skills)+OR+(TI+Social+Skills)+OR+(AB+Social+Skills)+OR+(MM+Social+Skills+Training)+OR+(TI+Social+Abilit*)+OR+(AB+Social+Abilit*))+OR+((TI+Interpersonal+Skill*)+OR+(AB+Interpersonal+Skill*)+OR+(MM+Interprofessional+Relations)+OR+(TI+Interprofessional+Relations)+OR+(AB+Interprofessional+Relations)+OR+(TI+Social+Competenc*)+OR+(AB+Social+Competenc*)+OR+(TI+Talent)+OR+(AB+Talent)+OR+(TI+Talent*)+OR+(AB+Talent*)))+AND+(((MM+Palliative+care)+OR+(TI+Palliative+care)+OR+(AB+Palliative+care)+OR+(TI+Palliative+medicine)+OR+(AB+Palliative+medicine)+OR+(MM+Terminal+care)+OR+(TI+Terminal+care)+OR+(AB+Terminal+care)+OR+(TI+End-of-life+care)+OR+(AB+End-of-life+care))+OR+((TI+Supportive+care)+OR+(AB+Supportive+care)+OR+(MM+Terminally+ill+patients)+OR+(TI+Terminally+ill)+OR+(AB+Terminally+ill)+OR+(MM+Hospice+care)+OR+(TI+Hospice+care)+OR+(AB+Hospice+care)+OR+(TI+Generalist+palliative+care)+OR+(AB+Generalist+palliative+care)+OR+(TI+Palliative+care+approach)+OR+(AB+Palliative+care+approach))+OR+((MM+Comfort+care)+OR+(TI+Comfort+care)+OR+(AB+Comfort+care)+OR+(TI+Palliation)+OR+(AB+Palliation)+OR+(TI+Patient+Comfort)+OR+(AB+Patient+Comfort)))+AND+(((MM+Physicians)+OR+(TI+Physicians)+OR+(AB+Physicians)+OR+(TI+Doctor)+OR+(AB+Doctor)+OR+(MM+Geriatricians)+OR+(TI+Geriatricians)+OR+(AB+Geriatricians)+OR+(MW+Oncologists)+OR+(TI+Oncologists)+OR+(AB+Oncologists))+OR+((MM+Hospitalists)+OR+(TI+Hospitalists)+OR+(AB+Hospitalists)+OR+(MM+Internal+medicine)+OR+(TI+Internal+medicine)+OR+(Internal+medicine)))&cli0=LA99&clv0=eng%7efre%7epor%7espa&lang=pt-pt&type=1&searchMode=Standard&site=ehost-live

Appendix II: Studies Excluded

Systematic search excluded results and reason for exclusion

Author	Year	Title	Reason
Roen	1988	A curriculum in Palliative care for internal medicine housestaff	Outdated. Does not add new information to the knowledge pool
Weissman	1995	A survey of competencies and concerns in end-of-life care for physician trainees	Self-reported data inconclusive
Ury	2000	A needs assessment for a palliative care curriculum	Self-reported data inconclusive
Weissman, gunten	2001	End-of-Life Graduate Education Curriculum Project	Mentions five domains that are based on other publications
Rawlinson	2002	Assessing education in palliative medicine: development of a tool based on the Association for Palliative Medicine core curriculum	States some skills by importance but don't add new information to the already existing knowledge pool
Mullan	2002	End-of-Life Care Education in Internal Medicine Residency Programs: An Interinstitutional Study	Self-reported data inconclusive
Gunten	2002	End-of-Life Curriculum Reform: Outcomes and Impact in a Follow-Up Study of Internal Medicine Residency Programs	Does not provide a comprehensive listing of domains and skills. It does not contribute to the current scope data
Ferris	2003	Competency in end-of-life Care: Lasts hours of life	Does not lists competencies. Describes the process of dying and frequent scenarios
Warm	2003	Introducing End-of-Life Care into the University of Cincinnati Internal Medicine Residency Program	Does not provide a comprehensive listing of domains and skills. It does not contribute to the current scope data
Olthuis	2003	Professional Competence and Palliative Care: an Ethical Perspective	Does not provide a comprehensive listing of domains and skills. It does not contribute to the current scope data
Ahmedai	2004	A new international framework for palliative care	Inconclusive
Morrison	2007	Developing initial competency-based outcomes for the hospice and palliative medicine subspecialist: Phase I of the hospice and palliative medicine competencies project	Based on studies already included
Smith	2007	Leadership roundtable. A competency-based approach to	Does not list competencies.

		expanding the cancer care workforce.	
Pereira	2008	Compétences en soins palliatifs: Que faut-il savoir faire en tant que médecin?	Does not list competencies.
Williams	2010	"Medicine in the 21st Century: Recommended Essential Geriatrics Competencies for Internal Medicine and Family Medicine Residents"	Geriatric competencies
Lubimir	2011	Towards cultural competency in end-of-life communication training.	Does not list competencies. Does not add data to information gathered so far
Kang	2013	Developing competencies for multidisciplinary hospice and palliative care professionals in Korea	Competencies for palliative care professionals. Too specialized for the current scope
Puchalski	2013	Integrating spirituality into patient care: an essential element of person-centered care.	Unrelated with the scope theme
Yamamoto	2013	The Palliative Care Knowledge Questionnaire for PEACE: Reliability and Validity of an Instrument To Measure Palliative Care Knowledge among Physicians.	Does not lists competencies
Head	2014	The Interdisciplinary Curriculum for Oncology Palliative Care Education (iCOPE): meeting the challenge of interprofessional education.	aims undergraduates
Hom	2017	A high value care curriculum for interns: a description of curricular design, implementation and housestaff feedback.	Does not list competencies.
Connolly	2018	Development and Initial Psychometric Properties of a Questionnaire to Assess Competence in Palliative Care: Palliative Care Competence Framework Questionnaire.	Focuses on the scales of competencies rather than structuring competencies and domains
Forbat	2019	"Defining 'specialist palliative care': findings from a Delphi study of clinicians"	For specialists in palliative care
Atreya	2019	Primary palliative care competency framework for primary care and family physicians in India-Collaborative work by Indian Association of Palliative Care and Academy of Family Physicians of India.	For family physicians

Grey literature excluded results and reason for exclusion.

Author	Year	Title	Reason
AAHPM	2009	Hospice and Palliative Medicine Core Competencies	- based on the work of Morrison et al and Weissman. - Too specialized
OPCN	2019	The Ontario Palliative Care Competency Framework	Skills are not related to specific domains. Hard to implement
NIPEC	2016	Palliative and End of Life Care competentency assessment Tool	For Nurses
AAFP	2015	Palliative and end-of-life care	Family physicians

Appendix III: Characteristics of included studies.

Articles included from the Systematic search with Domains.

Paper	Year	Title & Context	Origin	Type	Domains
Bulkin Wilma	1991	"Training Physicians to care for the dying" - propose a five-pronged curriculum in terminal care to be ongoing from medical Pschool through postgraduate training.	USA	Opinion/hypothesis	1 Clinical skill 2 Communication skills 3 Psychosocial issues 4 Administrative/ management and team interaction 5 Bioethical issues.
Forbes John	1994	"Towards an optimal teaching programme for supportive care" -development of an oncology/palliative-care curriculum	Austrália	Opinion/hypothesis	1 Symptom control especially pain relief 2 Support for dying patients: the patients' needs, family needs, optimal environments, bereavement processes 3 Interacting with family and community-support people 4 Reversible problems for dying patients 5 Team management in palliative care 6 Comunication
Weissman	1999	"Recommendations for incorporating palliative care education into the acute care hospital setting."	USA	Consensus based opinion	1 Symptomatic control 2 Communication 3 End-of-life technology 4 Ethics 5 Patient and family needs and values 6 Other situations 7 Legal issues
Curtis	2001	"Understanding physicians skill at providing end of life care" - Perspectives of patients, families and Health Care Workers	USA	Qualitative study using focus groups and content analysis based on grounded theory	1 Communication with patients 2 Emotional support 3 Accessibility and continuity 4 Competence 5 Respect and humility 6 Team communication and coordination 7 Patient education 8 Personalization 9 Pain and symptom management 10 Inclusion/recognition of the family

					11 Attention to patient's values 12 Support of patient decision making
Mularski	2001	"Educational agendas for interdisciplinary end-of-life curricula" Curriculum for interdisciplinary teams. ICU related	USA	Opinion/hypothesis	1 Approaches to end-of-life care and organization 2 Ethical and legal constraints 3 Symptom management 4 Specific end-of-life syndromes/palliative crises 5 Development of communication skills for trusting relationships
Montagnini	2004	"Palliative Care Education Integrated into a Geriatrics Rotation for Resident Physicians"	USA	consensus based guidelines	1 Prognostication 2 Pain 3 Delirium 4 Depression 5 Anxiety 6 Dyspneia and cough 7 Nausea and vomiting 8 Anorexia 9 Constipation 10 Bowel Obstruction
Gunten	2005	Evidence of improved knowledge and skills after an elective rotation in a hospice and palliative care program for internal medicine residents.	USA	Opinion/hypothesis	1 Hospice and palliative medicine 2 Breaking bad news 3 Cancer pain 4 Nausea and vomiting 5 Symptoms of advanced illness 6 Advance directives 7 Diagnostic and therapeutic procedures 8 Terminal illness: The process of dying 9 Managing personal stress
Weissman	2005	"Education in Palliative Care" - Review about the state of palliative care education so far	USA	Consensus based opinion	1 Pain assessment and management 2 Nonpain symptom assessment and management 3 Communication skills, ethics, and law 4 Psychosocial care 5 Health systems
Meier	2006	"Palliative care in hospitals" - Review about the state of palliative care education so far	USA	Literature review	1 assessment and treatment of pain and other symptom distress, including psychiatric symptoms 2 Communication Skills 3 Psychological support

					4 Care coordination and continuity 5 Bereavement support
Quest	2009	Hospice and Palliative Medicine: New Subspecialty, New Opportunities	USA	consensus based opinion	
Ross	2011	Creative Solution for Implementation of Experiential, Competency-Based Palliative Care Training for Internal Medicine Residents"	USA	consensus based opinion	1 Communication 2 Pain and symptom management 3 Ethical and legal aspects of care 4 Psychosocial/ cultural/ spiritual aspects of care; hospice care and referrals
Sanchez	2012	"Hospice and Palliative Medicine: Curriculum Evaluation and Learner Assessment in Medical Education"	USA	consensus based opinion	1 Patient and family care 2 Medical knowledge 3 Practice-based learning and improvement 4 Interpersonal and Communication Skills 5 Professionalism 6 Systems-based practice
Ahia	2014	"Primary Palliative Care for the General Internist: Integrating Goals of Care Discussions into the Outpatient Setting"	USA	consensus based opinion	1 Pain/symptom assessment 2 Social/spiritual assessment 3 Illness/prognosis understanding 4 Treatment options understanding 5 Identification of patient-centered goals of care 6 Transition of care postdischarge
Schaefer	2014	"Raising the Bar for the Care of Seriously Ill Patients: Results of a National Survey to Define Essential Palliative Care Competencies for Medical Students and Residents"	USA	consensus based opinion	
Shaheen	2014	End-of-Life and Palliative Care Curricula in Internal Medicine Clerkships	USA	Qualitative study using focus groups and content analysis	
Mendoza	2015	"Competencies in Palliative Care for Cardiology Fellows"	USA	literature review	1 Prognostication 2 Communication

					3 Discussing goals of care, end-of life care, and resuscitation status 4 Understanding what palliative care actually is 5 Timely referrals to palliative care 6 Symptom palliation 7 Deactivation of rhythm control devices
Pastrana	2016	"Consensus-Based Palliative Care Competencies for Undergraduate Nurses and Physicians: A Demonstrative Process with Colombian Universities"	Germany, Argentina, USA	consensus based opinion	1 Definition and principles of PC 2 Identification and control of symptoms 3 End-of-life care 4 Ethical and legal issues 5 Psychosocial and spiritual issues 6 Teamwork
Carey	2018	"Palliative Care Competencies and Readiness for Independent Practice: A Report on the American Academy of Hospice and Palliative Medicine Review of the United States Medical Licensing Step Examinations"	USA	consensus based opinion	1 Pain and Symptom Management 2 Communication 3 Psychosocial, Spiritual and Cultural Aspects of Care 4 Terminal Care and Bereavement 5 Palliative Care Principles and Practice
De Bruin	2018	"End-of-life careinthe Dutchmedical curricula" - Medical students	Germany	consensus based opinion	1 Psychological, sociological, cultural and spiritual aspects 2 Communication and conversational techniques 3 Pathophysiology and treatment of symptoms 4 Juridical and ethical aspects 5 Self-reflection on personal and professional experiences with death and loss
Lio	2018	"Exploring Palliative Care Competency Standards for Medical Education	China	consensus based opinion	

		in China: A Survey of National Hospice Service Program Providers" - Based on the article by Schaefer			
McCallum	2018	"Developing a Palliative Care Competency Framework for Health Professionals and Volunteers: The Nova Scotian Experience" - select, tailor, or create palliative care education programs for health professionals and volunteers	Canada	literature review	1 Principles of palliative care 2 Cultural safety 3 Communication 4 Optimizing comfort and quality of life 5 Care planning and collaborative practice 6 Last days and hours 7 Loss, grief, and bereavement 8 Professional and ethical practice 9 Self-care 10 Education 11 Evaluation 12 Research 13 Advocacy
Shoenberger	2018	"Development of Hospice and Palliative Medicine Knowledge and Skills for Emergency Medicine Residents: Using the Accreditation Council for Graduate Medical Education Milestone Framework" - Emergency medicine	USA	consensus based opinion	1 provider skill set (primary level) 2 recognition of Hospice and Palliative Medicine needs in ED patients 3 logistic understanding related to Hospice and Palliative Medicine in the ED

Articles included from the Grey Literature search with Domains

Paper/Origin	Year	Title & Context	Origin	Type	Domains
Scottish partnership for palliative care	2007	A guide to using palliative care competence frameworks	Scotland	consensus based opinion	1 communication skills 2 quality issues clinical practice 3 education and training

		- presents a methodology of how to build a set of competencies for palliative care health providers			4 management and leadership 5 research and development 6 ethical and legal Issues 7 grief, loss and bereavement spirituality 8 rehabilitation/maximizing potential. 9 family care.
BC center for palliative care	2019	"BC Centre for Palliative Care Inter-Professional Palliative Competency Framework - Physicians & NP	UK	consensus based opinion	1 Principles of palliative care and palliative approach 2 Cultural safety and humility 3 Communication 4 Comfort and quality of life 5 Care planning and collaborative practice 6 Loss, grief and bereavement 7 Professional and ethical practice 8 Self-care
IAHPC	2014	Palliative care competencies in undergraduate education	USA	consensus based opinion	1 definition and principles of palliative care 2 identification and control of symptoms 3 end of life 4 ethical and legal 5 psychosocial and spiritual aspects 6 teamwork
University of Colorado	2011	Inpatient Palliative Medicine Consultation Residency Rotation University of Colorado Denver Curriculum and Core Competencies 2010-11	USA	consensus based opinion	1 Patient and Family Care 2 Medical Knowledge 3 Practice Based Learning and Improvement 4 Interpersonal and Communication Skills 5 Professionalism 6 Systems Based Practice
EAPC	2013	Core competencies in palliative care: an EAPC White Paper on	EUROPE	consensus based opinion	1. Apply the core constituents of palliative care in the setting where patients and families are based

		palliative care education – part 1			2. Enhance physical comfort throughout patients' disease trajectories 3. Meet patients' psychological needs 4. Meet patients' social needs 5. Meet patients' spiritual needs 6. Respond to the needs of family carers in relation to short-, medium- and long-term patient care goals 7. Respond to the challenges of clinical and ethical decision-making in palliative care 8. Practise comprehensive care co-ordination and interdisciplinary teamwork across all settings where palliative care is offered 9. Develop interpersonal and communication skills appropriate to palliative care 10. Practise self-awareness and undergo continuing professional development
NHS	2017	End of Life Care Core Skills Education and Training Framework	UK	consensus based opinion	1 Person-centred end of life care 2 Communication in end of life care 3 Equality, diversity and inclusion in end of life care 4 Community skills development in end of life care 5: Practical and emotional support for the individual approaching the end of life 6 Assessment and care planning in end of life care 7 Symptom management in end of life care 8 Working in partnership with health and care professionals and others 9 Support for carers

					10 Maintain own health and wellbeing when caring for someone at the end of life 11: Care after death 12 Law, ethics and safeguarding 13 Leading end of life care services and organisations 14 Improving quality in end of life care through policy, evidence and reflective practice
AIIHPC	2012	A Review of Palliative Care Competence Frameworks Revision of previous works	Ireland	consensus based opinion	Generalist 1 Overarching values and knowledge 2 Communication skills 3 Assessment and care planning 4 Symptom management, maintaining comfort and wellbeing 5 Advance care planning ---------- Medicine The HPM core competencies report details the headline core competencies for medics: 1. Patient and family care 2. Medical knowledge 3. Practice based learning and improvement 4. Interpersonal and communication skills 5. Professionalism 6. Systems based practice ---------- 2.2 The Royal Australian College of General Practitioners Curriculum for Australian General Practice (2011) – Palliative Care 1. Communication skills and the patient-doctor relationship 2. Applied professional knowledge and skills 3. Population health and the context of general practice

					4. Professional and ethical role 5. Organisational and legal dimensions ---------- 2.3 Educating Future Physicians in Palliative and end of Life Care (EFPPEC) (2006) Canada Over-arching competencies: 1 address and manage pain and symptoms. 2 address psychosocial and spiritual needs. 3 end of life decision making and planning using basic bioethical and legal framework 4 communicate effectively 5 collaborate as a member of an interdisciplinary team. 6 attend to suffering
Palliative Care Competence Framework Steering Group	2014	Palliative Care Competence Framework	Ireland	consensus based opinion	1 principles of palliative care 2 communication 3 optimising comfort and quality of life 4 care planning and collaborative practice 5 loss, grief and bereavement 6 professional and ethical practice in the context of palliative care

Appendix IV: Listing of removed competences.

1.1 Pain and symptom management,
1.1 Pain
1.2 Anxiety and depression
1.1 Pain
1.2 Nausea and vomiting
4.2 Takes the patient's symptoms seriously
9.1 Is not afraid to prescribe pain medications when needed
9.4 Acknowledges and treats anxiety and depression
1.2 Relief of symptoms
4.5 Delirium
4.1 Learn how to assess depression in terminally ill patients.
1.1 pain assessment
6. Management of pain/nonpain symptoms
2.1 Pain assessment and management
3 Symptom control (e.g., pain and nausea)
2.1 Pain control
2.2 Respiratory symptoms
2.3 Gastrointestinal symptoms
2.4 Insomnia
2.5 Delirium
3.1 Pain
3.2 Dyspnoea
3.4 Depression
3.5 Delirium
1.1 Pain control
1.2 Treating other distressing symptoms (e.g., nausea/vomiting, dyspnea)
4.3.2 Addresses and manages pain and other symptoms in patients with advanced illnesses (cancer and non-malignant disease)
4.3.12 Assesses and manages other common symptoms in advanced illness including fatigue, cachexia and anorexia constipation, dyspnea, nausea and vomiting, delirium, anxiety and depression
4.3.14 Systematically assesses symptoms in patients with palliative care needs and participates in the evidence-based holistic and inter-professional management of these symptoms.
2.1 Symptom Management
Pain Knows the definition of total pain and its prevalence in palliative care. Recognizes PAIN as the 5th vital sign.
2.6. Understands the management of common cancers, their presentation, patterns of metastatic disease, common complications, and symptomatic treatment
2.7. Understands the management of common non-cancer life-threatening conditions, including their presentation, evaluation, prognosis, associated symptoms, and symptomatic treatment
2.8. Understands basic principles of pain assessment
2.8.4. Knows the critical role of functional assessment in pain management
2.9. Understands common approaches to treating each type of pain

2.10.2. Knows the etiology, pathophysiology, diagnosis, and management of urgent non-pain symptoms and clinical problems
2.11.1. Knows common symptoms, signs, complications and variations in the normal dying process and their management
2.17. Understands the etiology, pathophysiology, diagnosis, and management of common psychiatric disorders encountered in palliative care practice
2.17.1. Knows how to recognize, evaluate, and treat these common psychiatric disorders
6.8. Understands common high-risk scenarios in palliative care and how to prevent them (e.g., under-dosing of opioids, misuse of methadone, overdosing with naloxone)
b) understand how different factors can alleviate or exacerbate pain and discomfort
d) understand the range of therapeutic options available including practical support or psychological therapy , for symptom management available to them and any potential risks and benefits
h) understand the importance of, and know how to, provide regular symptom relief and measure its effectiveness
3.3 Develop, implement and evaluate a management plan
4.1 Symptom management
3.3 Pain assessment and management
2 Assesses and manages nonpain symptoms and conditions
4.3.3 Assesses pain and symptoms effectively by conducting a thorough pain history, appropriate physical exam and relevant investigations
5.1.5 Develops a person-centred, holistic symptom management plan
Gastrointestinal symptoms
1.1.2. Obtains a comprehensive palliative care history and physical exam, including: 1.1.2.8 Observed pain behavior
b) know who to contact if symptoms or pain are not being managed well
1.4 nausea
1.5 vomiting
1.6 anorexia
1.7 sleep disturbance
1.4 Constipation
1.5 Delirium
1.8 Dyspnea
2.1 Learn how to perform a basic pain assessment
3.2 Describe nonpharmacologic interventions for delirium.
5.1 Learn how to assess anxiety in terminally ill patients.
5.2 Understand the role of anxiolytics for treatment of anxiety in terminally ill patients.
5.3 Describe non-pharmacological interventions for anxiety
6.3 Describe non-pharmacological interventions for dyspnea
7.1 Learn how to assess nausea and vomiting in terminally ill patients.
7.3 Understand the role of non-pharmacological treatment of nausea.
8.1 Learn how to assess anorexia.
8.2 Know the indications of common drugs utilized for treatment of anorexia in terminally ill patients.
9.2 Understand the indications, mechanisms of action and common side effects of different classes of laxatives

3.3 Adjuvant analgesics
3.4 Barriers to cancer pain management
2.2 Dyspnea: assessment and management
2.3 Delirium: assessment and management
2.4 Nausea: assessment and management
2.5 Constipation: assessment and management
3 Assesses pain systematically and treats pain effectively with opioids, non-opioid analgesics, and non-pharmacologic interventions
14 Assesses and manages non-pain symptoms and conditions including, but not limited to, dyspnea, nausea, bowel obstruction, and cord compression using current best practices
1.1 Assesses pain systematically and distinguishes nociceptive from neuropatic pain syndromes.
1.3 Assesses non-pain symptoms and outlines a differential diagnosis, initial work-up and trearment plan.
1.4 Describes an approach to the diagnosis of anxiety, depression and delirium
4.1 Identifies common signs of the dying process and describes treatments for common symptoms at the end of life.
3 Diagnoses anxiety, depression, and delirium, and provides appropriate initial treatment and referral
7 Assesses pain systematically and effectively uses opioids, nonopioid analgesics, and nonpharmacologic interventions
4.3.8 Outlines the WHO approach to the management of cancer pain.
4.3.16 Monitors the efficacy of treatment plans for pain and other symptoms
3.7 Acquired immune deficiency syndrome symptom management
2.9.5. Knows the common indications and contraindications for interventional pain management procedures
2.9.6. Knows the appropriate use of commonly applied non-pharmacologic approaches to pain control
2.9.7. Knows common barriers to the effective treatment of pain
e) understand that symptoms have many causes and that different causes may require different approaches to treatment, care and support
4.1 Superior vena cava syndrome
Sleep disorders
4.2 Dilemmas on the treatment of pain
2.10.1. Knows the etiology, pathophysiology, diagnosis and management of common non-pain symptoms and clinical problems from both a disease-specific and organ systems approach
4.3.11 Describes the potential role for chemotherapy, radiation therapy, surgery and procedures, and interventional analgesia in the management of pain and other symptoms.
6.2 Understand the role of opioids, benzodiazepines, and steroids in managing terminal dyspnea and cough.
7.2 Know the indications and mechanisms of action of different classes of antiemetics.
4.2 Know the indications and mechanisms of action of common antidepressants in terminally ill patients
1.4 prescription writing
2. Basic formulation of prognosis
2.2 Prognostication
Knows and provides information to patients and caregivers on the procurement of medications.
1.1.1. Obtains a basic medical history

1.3.1. Understands and utilizes patient- and family-centered approach to care
1.3.2. Makes recommendations to consulting physician(s) as appropriate
1.6.1. Adjusts care plan according to the patient's care setting
2.17.2. Refers appropriately to psychiatry
b) be able to ascertain from an individual what would make them comfortable and respond to this appropriately
3.1 Holistic assessment
3.4 Be able to recognise and provide immediate care of emergencies that may arise in palliative care (e.g. spinal cord compression, hypercalcaemia, major haemorrhage)
Manages and monitors oxygen in accordance with the patient's requirements.
Prevents and treats opioid side effects, including signs and symptoms of opioid intoxication.
Recognizes complications of uncontrolled pain and impact on the patient (personal, family, work, social) and on the health system
1.2. Synthesizes and applies information in the clinical setting
• Integrates physiological and semiological elements in the clinical exam to determine cause and type of pain.
3.10 Understand the role of the coroner and know when to report a death to the coroner.
3.9 Be able to verify and pronounce death
i) be able to support an individual to eat and drink as long as they wish and are able to, and take appropriate action to rectify problems individuals may have with eating and drinking
c) understand the importance of a holistic understanding and assessment of the individual's perception of their symptoms and the impact this may have on their choices
4.2 Demonstrate ability to recognise that the person with a life-limiting condition may lose capacity to make decisions towards end-of-life
1.2 Expertise in prescribing
3.2 Disease-modifying managements
1 Assessment of illness trajectory decline
15 Applies the evidence base and knowledge of disease trajectories to estimate prognosis in individual patients
2.1 Trajectories of dying
4.3.18 Applies techniques for the assessment of pain and other symptoms on a longitudinal basis and identify opportunities to modify the management strategy according to effectiveness, side-effects, patient preferences and the stage of disease.
1.1.2. Obtains a comprehensive palliative care history and physical exam, including: 1.1.2.2 Goals of care/advance care planning
2.5.1. Knows common chronic illness diagnoses with expected natural course, trajectories, prognostic factors and treatments
1.1 Understand and be able to recognise common trajectories of life-limiting conditions, including prognostic factors, common symptoms and problems
1.1 Demonstrate in-depth understanding of the full spectrum of trajectories of life-limiting conditions in the context of your specialty or local work environment
1.5 development of a comprehensive treatment plan
1.1 Routine and repeated formal assessment
4.1 Responding to complex end-of-life situations
3.15 Terminal phase and events
8. Management of the imminently dying
4.5 Care of the actively dying patient

16 Managing sedation
3.1 Palliative sedation
3.2 End-of-life care
11 Identifies and manages common signs and symptoms at the end of life
1.7 Treating common end-of-life symptoms
4.3.32 Identifies signs of approaching death.
5.2.1 Participates in appropriate care for the dying patient and their family
1.11. Recognizes signs and symptoms of impending death and appropriately cares for the imminently dying patient and family members
2.11. Understands how to manage the syndrome of imminent death
a) know how to offer support to someone who is dying
d) understand that the needs of individuals approaching the end of life in relation to food and drink may significantly reduce, especially within the last days of life
a) understand common symptoms associated with the approach of end of life
2. Interpret clinical data to inform diagnosis and decision making in palliative or end of life care
3. Develop, implement and evaluate a management plan to meet identified needs in palliative or end of life care
4. Apply appropriate judgement to inform pharmacological and non-pharmacological management, in meeting the Palliative and End of life care needs of the patient
3.5 Be able to anticipate (where possible) and recognise a need for change in the focus of care and treatment goals at critical decision points in the course of a life-limiting condition
3.1 Demonstrate an ability to assess and manage common symptoms associated with life-limiting conditions
4.3.36 Describes the steps needed to pronounce a patient's death and to complete a certificate confirming death.
4.7 Knowledgeable about the care needed by patients during the dying process
3.1 Learn how to assess delirium in terminally ill patients.
3.3 Learn the indications and pharmacology of drugs utilized for terminal delirium.
6.1 Learn how to assess dyspnea and cough in terminally ill patients.
9.1 Learn how to assess constipation in terminally ill patients.
10.1 Learn how to assess and treat bowel obstruction in terminally ill patients.
8 Identifies and manages common signs and symptoms at the end of life
4.3.35 Lists common medications used for control of symptoms in the dying phase.
2.10.3. Knows the diagnosis and management of brain death and persistent vegetative state
3.2 Opioid pharmacology and use
4 Defines and applies principles of opioid prescription, including equianalgesic dosing and common side effects, and demonstrates na understanding that appropriate use of opioids rarely leads to respiratory depression or addiction when treating cancer-related pain
6 Defines and applies principles of opioid prescription, including equianalgesic dosing and common side effects
4.3.9 Utilizes adjuvant modalities and medications for pain management in patients with palliative care needs
4.3.15 Describes the potential role for chemotherapy, radiation therapy, other oncological therapies, surgery, and interventional procedures in the management of symptoms.
4.3.20 Proposes evidence-based opioid therapies, including effective prescribing, titration, breakthrough dosing and prevention of side-effects

4.3.21 Describes how pharmacokinetics & pharmacodynamics impact the choice of opioids, including patient-specific considerations such as age, weight, frailty, prior exposure, and renal and hepatic function.
4.3.22 Describes common side effects of opioids & an approach to their management that includes anticipation & prevention of side effects.
4.3.24 Explains the concepts of tolerance, physical dependence, & addiction as they relate to the use of opioids in palliative care.
4.3.25 Identifies potential risk factors for opioid use disorder, including topics such as abuse, addiction and/or diversion.
4.3.28 Describes and explains an appropriate prescription for an opioid naïve patient including breakthrough dosing.
4.3.29 Describes appropriate approaches to opioid titration for patients with palliative care needs.
4.3.30 Identifies and describes strategies to manage opioid-induced neurotoxicity vs. overdose.
Administers medications keeping in mind general and specific precautions and recommendations based on the different levels of control and surveillance.
Knows the equianalgesia of opioid medications and their rotation.
Knows the risk factors in patients, family and environment related to the abuse and diversion of medications and the control.
Knows the difference between addiction, pseudo-addiction and tolerance.
2.9.1. Knows the indications, relevant clinical pharmacology, alternate routes, equianalgesic conversions, and management of common side effects for opioids
2.9.2. Knows the concepts of addiction, pseudoaddiction, dependence and tolerance, their importance in pain management, and the complexities of managing pain in patients with current or prior substance abuse
1.2 Counselling
6.3 Counselling
2.14.3. Knows how to provide supportive counseling
2.15.1. Knows how to assess, counsel, support, and make appropriate referrals to strengthen the family's coping skills, of the family and alleviate the burden of caregiving
2.15.2. Knows how to assess the needs of minor children when an adult parent or close relative is dying, and how to provide counseling and referral when appropriate
2.15.3. Knows how to assess the needs of parents and siblings of children who are dying and is able to provide appropriate care
4.2.2. Uses empathic and facilitating non-verbal behaviors such as touch, eye contact and open posture, in an effective, appropriate, and flexible manner
4.2.3. Uses empathic curiosity effectively
h) understand why silence is an important part of communication in end of life care, and feel confident in the value of silence
2.1 Open and sensitive communication
2.16.2. Knows how to provide basic spiritual counseling
6.1 verbal and non-verbal comunication
5.4 Basic counseling techniques
a) be able and willing to listen to an individual describing their symptoms and know how to direct the them for more help
d) be able to communicate effectively with carers to support them express themselves freely
2.2 Be able to communicate diagnosis and likely prognosis in an accurate and compassionate manner, taking account of the person's needs and wishes

a) understand the importance of discussing dying, death and bereavement, and expressing wishes and preferences associated with this
4.6.9 Saying good-bye to patients or families
7.1.15 Describes an approach to responding to suffering expressed by patients and families.
e) understand how different customs and preferences, including religious and cultural customs, may impact on communication
2.2 Demonstrates patient-centered communication techniques when giving bad news and discussing resuscitation preferences.
4.3.31 Manages the care needs of a dying patient, communicating with and supporting their family members
4.2. Demonstrates empathy and compassion
3.1.6 Describes an approach to discussing prognosis with patients facing a life-limiting illness, and their families.
1.11.1. Effectively prepares family for the patient's death
5.2 Show respect for the patient's relationship with the family, family doctor, caregivers and foster shared decision-making
3.1.6 Describes an approach to discussing prognosis with patients facing a life-limiting illness, and their families.
5.2 Show respect for the patient's relationship with the family, family doctor, caregivers and foster shared decision-making
5.5 Communication and therapeutic relationship
5.5 Conflict resolution skills
4.3.23 Describes and manages patient and family concerns or myths about opioids at the end of life.
5.1 Delivering bad news
2.1 bad news communication
3. Difficult communications. Breaking bad news/death disclosure
1.1 Delivering bad or sad news
6 Describes and performs communication tasks effectively at the time of death, including pronouncement, family notification and support, and request for autopsy
4 Communicarion: breaking bad news
4.2 Describes the communication tasks of a physician when a patient dies, such as pronouncement, family notification and support, and request for autopsy.
9 Performs the communication tasks of a physician when a patient dies, such as pronouncement, family notification, and support
1.3 Difficult communication
3.1.2 Communicates information about the illness effectively including bad news
3.1.4 Describes an approach to the communication of information about the illness, including bad news.
3.1.5 Demonstrates an ability to communicate bad news with a palliative care patient and his/her family.
7.1.19 Discusses some of the moral and cultural issues raised when MAiD is requested or advocated.
4.6.1 Giving bad news
3.1.1 Communicates effectively with patients, families and other caregivers
1.1 Listens to patients
1.3 Talks with patients in an honest and straightforward way
2.1 Listening to the impact of disease on the patient's life

6.2 listening techniques.
1 Communication: palliative care options
1.3.3. Makes recommendation to patient and family based on prognostic information and patient and family and goals
1.12.1. Delivers accurate information to patients and families about palliative care treatment settings to facilitate choices
2.5.2. Knows strategies to communicate with patient and family about prognosis
2.11.2. Knows strategies to communicate with patient and family about these varied manifestations
4.1. Initiates informed relationship-centered dialogues about care
The learner will: a) be able to engage in conversation with an individual nearing the end of life b) understand and respect that individuals are experts in their own lives
i) be able to use communication skills to ensure end of life care plans, and advance care plans, are understood and shared
j) be able to share information about the illness, its prognosis and support available to make informed decisions in a way that is accessible and uses appropriate language
6.1 Use open and sensitive Communication with patients and those who matter to them, to facilitate expression of needs including those of diverse cultural groups and those with special needs in palliative and end of life care
1.3 Establishing treatment goals: conducting a family conference
2.1 Explores patient and family understanding of illness, concerns, goals, and values that inform the plan of care
4.2 Incorporates quality of life, as defined by the person, as a key focus of care.
3.2.2 Describes the role of family meetings with a patient with palliative care needs and their families.
3.2.3 Participates in family meetings with patients with palliative care needs, their family and the inter-professional team.
4.1.2. Determines, in collaboration with patient/family, the appropriate participants in discussions concerning a patient's care
4.7. Organizes and leads a family meeting
1.3 Establishing treatment goals: conducting a family conference
2.1. Guidelines for the interview
2.5 Discuss referral for specialized palliative care
1.5 Communication among caregivers
2.4 Be able to recognise and address the immediate manifestations of conflict in decision-making in the context of palliative care.
4.3.43 Addresses psychosocial and spiritual needs
6.1.1 Assesses psychosocial and spiritual issues in end-of-life care including grief
Understands the different interventions in palliative care for patients and their families, within an epidemiological, demographic, economic, and cultural and public policy.
3.3 Stress management
2.2 Family needs
12 Demonstrates effective approaches to exploring and handling strong emotions in patients and families facing serious illness
5.1 Emotional issues
17 Identifies spiritual suffering in patients and families and provides appropriate support and referral
1.5 Identifies who the family is for the person and includes family in care.

4.3.51 Identifies issues contributing to suffering in patients requiring palliative and end-of-life care and their families/caregivers.
4.4 Supports people in self-management of their life-limiting condition(s), involving the family as appropriate.
5.1 Emotional Aspects Recognizes the needs and emotional problems and provides support to the patient and family.
6.1.1 Assesses psychosocial and spiritual issues in end-of-life care including grief
5.1 Emotional Aspects Recognizes the needs and emotional problems and provides support to the patient and family.
1.1.2. Obtains a comprehensive palliative care history and physical exam, including: 1.1.2.9 Other areas of major concern (e.g. stressors)
1.1.2. Obtains a comprehensive palliative care history and physical exam, including: 1.1.2.10 Attitude toward, and use of, complementary and alternative medicine
2.14.1. Knows how to anticipate and recognize psychological distress
2.14. Understands patient's and family's common psychological stresses and disorders in end-of-life care, and the elements of appropriate clinical assessment and management.
d) be able to undertake initial risk assessment of mental health and emotional needs including signs of depression
g) be able to recognise and respond to individuals' concerns, fears and anxiety
d) be able to recognise and understand the changes that occur in the dying process
5.1 Demonstrate understanding of normal and pathological responses to the diagnosis/prognosis of a life-limiting condition and an ability to address the immediate management of such responses
11 Assesses and diagnoses anxiety, depression, and delirium and provides appropriate initial treatment and referral
3.1 Identifies psychosocial distress in patients and families
3.2 Support the burden on family caregivers (often struggle with anxieties about doing the wrong thing, difficulty traveling to physicians' offices, social isolation, and a high prevalence of preventable suffering of all types)
4.3.48 Describes the features of dignity conserving care.
2.3 Provides comfort through touch
Takes the patient and the family as a unit of care. Models and Components of Care
3.8 Be able to provide guidance and support to the individual and their family preparing them for what to expect during the normal dying process
8.3 Considers the patient's social situation when making treatment plans
4.3.44 Describes the psychosocial and spiritual issues that a dying patient and their family may experience.
2.13. Understands major contributions from sociology, anthropology, and health psychology in appreciating the patient's and family's experience of serious and lifethreatening illness
12 Demonstrates effective approaches to exploring and handling strong emotions in patients and families facing serious illness
5.1 Emotional issues
17 Identifies spiritual suffering in patients and families and provides appropriate support and referral
1.5 Identifies who the family is for the person and includes family in care.
4.3.51 Identifies issues contributing to suffering in patients requiring palliative and end-of-life care and their families/caregivers.
4.4 Supports people in self-management of their life-limiting condition(s), involving the family as appropriate.

5.1 Emotional Aspects • Recognizes the needs and emotional problems and provides support to the patient and family.
6.1.1 Assesses psychosocial and spiritual issues in end-of-life care including grief
5.1 Emotional Aspects • Recognizes the needs and emotional problems and provides support to the patient and family.
1.1.2. Obtains a comprehensive palliative care history and physical exam, including: 1.1.2.9 Other areas of major concern (e.g. stressors)
1.1.2. Obtains a comprehensive palliative care history and physical exam, including: 1.1.2.10 Attitude toward, and use of, complementary and alternative medicine
2.14.1. Knows how to anticipate and recognize psychological distress
2.14. Understands patient's and family's common psychological stresses and disorders in end-of-life care, and the elements of appropriate clinical assessment and management.
d) be able to undertake initial risk assessment of mental health and emotional needs including signs of depression
g) be able to recognise and respond to individuals' concerns, fears and anxiety
d) be able to recognise and understand the changes that occur in the dying process
5.1 Demonstrate understanding of normal and pathological responses to the diagnosis/prognosis of a life-limiting condition and an ability to address the immediate management of such responses
11 Assesses and diagnoses anxiety, depression, and delirium and provides appropriate initial treatment and referral
5.9 Grief and bereavement of patient
5.10 Grief and bereavement of family
4.3 grieving processes: identifying and preventing pathological grief and depression.
1.1 Suffering
1.2 Loss
1.3 Mourning
1.9 Bereavement and grieving
Management of Grief • Recognizes the manifestations and normal grief, and risk factors of pathological grief.
1.13. Provides treatment to the bereaved
1.13.1. Involves interdisciplinary team members in treating the bereaved
1.13.2. Appropriately refers family members to bereavement programs
2.18. Understands the basic science, epidemiology, natural course, and management options for normal and complicated bereavement
2.18.1. Demonstrates knowledge of elements of bereavement follow-up, including assessment, treatment, and referral options for bereaved family members
a) understand how bereavement and the grieving process may affect individuals differently
f) be able to recognise where grieving and bereavement is complex and know who to refer to relevant services
b) be able to support individuals with thoughts associated with death and dying
f) be able to offer support to someone who is bereaved and grieving
2.3 Understanding grief
5.1 Care of the patient after death
8. Identify the range of Grief responses to appropriately assess and support those dealing with loss and bereavement in palliative and end of life care

1.3 Understand, recognise and address the immediate management of pathological responses to loss which may impact on the mental health and decision-making of the person with a life-limiting condition and their family
1.2 Understand, recognise and address the management of pathological responses to loss which may impact on the mental health and decision-making of individuals and families, referring to specialists where appropriate.
5.1 Demonstrate an ability to identify those experiencing complicated grief and utilise resources to support them
5.2 Appreciate the nature of disenfranchised grief in individuals, families, and carers and appropriate methods of addressing this grief.
3.3 Bereavement counselling and support
2.4 Grieving processes
16 Differentiates normal grief from prolonged grief disorder and makes appropriate referrals
1.13.4. Identifies individuals at high risk of complicated grief
4.3 Describes normal grief and bereavement, and risk factors for prolonged grief disorder.
8.3 Spiritual issues
5. Family presence during resuscitation
11. Spiritual/cultural competency
5.3 Spirituality
17 Identifies spiritual suffering in patients and families and provides appropriate support and referral
6.1.1 Assesses psychosocial and spiritual issues in end-of-life care including grief
Spirituality • Recognizes and respects different manifestations of spirituality of the patient and his family, understanding religion as one of these.
5.8 Spirituality
5.11 Cultural issues
2.16. Understands patients' common experiences of distress around spiritual, religious, and existential issues in end-of-life care, and elements of appropriate clinical assessment and management
2.16.3. Knows the indications for referral to chaplaincy
1.7. Recognizes and treats the psychosocial and spiritual distress of family members using an interdisciplinary framework
7. Be able to identify spiritual and religious needs of patients and those who matter to them, receiving palliative and end of life care and how they may be addressed
8.2 Family responses
4.1 knowledge about family, spirituality, values and personal experiences
5.4 Caregiver and family
3.3 Identifies patients and families cultural values, beliefs and practices related to serious illness and end-of-care.
15 Identifies patient and family values, beliefs, and practices related to end-of-life care, and integrates them into the treatment plan
2.2.1 Demonstrates sensitivity to cultural/religious considerations and to indigenous, LGBTQ2S, and vulnerable / marginalized people, in addressing palliative and end-of-life care needs
4.3.45 Assesses the psychosocial and spiritual needs of a dying patient and their family.
4.3.49 Attends to multi-dimensional sources of suffering
4.3.53 Describes a supportive approach to addressing multi-dimensional sources of suffering in patients with palliative care needs and their families/caregivers.

2.12. Understands how to recognize, evaluate, and support cultural values and customs, particularly in minority populations, with regard to information sharing, decision making, expression of physical and emotional distress, and preferences for site of care and death.
c) be able to assess the needs, concerns and priorities of individuals and those important to them in a person-centred way, and support them to meet these needs
a) understand the significance of diversity, including the impact that an individual's beliefs, customs, faith, life circumstances, religion, social norms, spirituality, sexuality and values can have on their preferences, their choices and the care provided, and be able to assess and support these needs and preferences
c) understand that different personal skills, qualities and experiences could be valuable to individuals and those important to them in meeting their social, intellectual, spiritual, emotional, psychological or physical needs
13. Be able to care for the patient's body after death, respecting any wishes expressed by the family, taking into account any legal, cultural/religious or health and safety requirements in palliative and end of life care
4.1 Be able to participate in key events in the care of the person with a life-limiting condition, such as family meetings and advance care planning
5.2 Work in partnership with parents, guardians and other family members in order to prepare and support children and vulnerable adults for the loss of loved ones
3.4 Advise on alternative medicines.
3.14 Complementary medicine
1.5 Leadership
2.2 Teamwork
1.4 Demonstrate leadership in the delivery of palliative care education in your local work environment
12 Interprofessional delivery of care
1.2.2 Discusses inter-professional collaboration in palliative and end-of-life care as a fundamental concept.
4.3.19 Discusses the role of other team members in assessing and managing pain.
5.1.1 Assists in the development of an inter-professional care plan to meet the psychosocial and spiritual needs of a patient with palliative care needs and their family.
5.1.7 Identifies the components of a holistic inter-professional record of a patient with palliative care needs and records the physician's or NP's components.
5.1.13 Discusses the importance of routine, inter-professional monitoring of the treatment care plan for patients with palliative care needs.
5.1.14 Demonstrates the ability to communicate the perspective of the physician's or Nurse Practitioners discipline and elicit those of other professionals while providing palliative and end-of-life care.
5.1.15 Identifies the components of a holistic, inter-professional management plan for a patient with palliative care needs.
Works in an interdisciplinary way during the decision and the sedation, integrated to the network of support.
e) be able to work with individuals and others to develop a person-centred end of life care plan that balances disease-specific treatment with care and support needs and wishes of the individual
a) know who is involved in an individual's end of life care and be able to work in partnership with them to deliver care in a coordinated way organised around the individual's needs, knowing who to contact with any issues or questions

a) be able to work in partnership with others, exploring and integrating the views of wider multidisciplinary teams to deliver care in a co-ordinated way, showing an understanding the role of others, to meet the needs of the individuals and those important to them
b) be able to share information, including that which relates to an individual's wishes, in a timely and appropriate manner with those involved in an individual's end of life care, taking into account issues of confidentiality and ensuring that where information is already available, the person is not asked to provide the same information repeatedly
c) be able to facilitate workers to offer support and guidance to each other regarding caring for individuals at the end of life
1. Undertake a Holistic Assessment of the patient with palliative or end of life care needs, and those who matter to them, in collaboration with the interdisciplinary team
f) understand the part you play in the individual's end of life care and know where to seek support
6.2 Makes sure there is someone available to help the patient when the physician is not available
5.4 Role of the doctor and other health workers in end of life care
10 Describes the roles of and collaborates with members of an interdisciplinary care team
3.3 Multidisciplinary team and support systems (understanding team roles and system resources)
1.2 Describes the role and function of the inter-professional team in palliative care.
5.1.8 Describes the role of the physician or Nurse Practitioner in providing end-of-life care.
5.1.9 Describes the key roles of other professionals in caring for a person at the end of life.
5.2.2 Describes the complementary roles of physicians, Nurse Practitioners and other formal caregivers in end-of-life
f) understand own role and the limits of own knowledge and competence, and know where to seek support
5.1.2. Contributes to team wellness
d) understand the potential emotional impact of death and dying upon others and provide support
a) understand the importance of caring for yourself and others providing caring roles
b) understand the importance of making good use of the support available (for example through formal supervision or informally from colleagues), reflecting on practice, identifying learning needs and accessing further support for such needs
c) be able to offer support to colleagues
5.1.2. Contributes to team wellness
4.1 Personal awareness and self-care
10 Reflects on his or her own emotional reactions, models self-reflection, and acknowledges team distress when caring for dying patients and their families
5.4 Reflects on personal emotional reactions to patients' dying and deaths.
5.1 Personal experience with death
5.2 View on the hereafter
18 Reflects on one's own emotional reactions and recognizes team distress when caring for dying patients and their families
1.12 Coping and self-care
4.3.7 Describes the effect of the physician's or NP's personal experiences and beliefs on the assessment and management of pain and other symptoms.
7.1.6 Demonstrates awareness of personal fears and attitudes towards dying and death and how to access a support system.
7.1.8 Discusses the importance of the physician/NP-patient relationship in end-of- life decision making.

8.1.1 Demonstrates self-awareness and self-care in caring for terminally ill patients
8.1.2 Self-assesses personal attitudes and beliefs in caring for dying patients and their families
8.1.3 Identifies common factors contributing to personal and professional stress in caring for patients who are dying, and their families.
8.2.1 Identifies and demonstrates use of effective strategies to cope with personal and professional stress that arises in caring for patients who are dying, and their families
4.3.3. Deals with own emotions in clinical setting in order to focus on the needs of the patient and family
5.2.1. Assesses personal behavior and accepts responsibility for errors when appropriate
b) understand the potential emotional impact of death and dying on oneself and others involved in caring for the person at end of life
a) understand the potential impact the death of an individual may have on own feelings
d) understand what is mean by 'emotional resilience' and be able to access support to build this
8 Dealing with emotions (patients and themselves)
4.2 Applying basic ethical principles in decision-making
3.1 Principles of Ethics
7. Withdrawal/withholding nonbeneficial treatments
1.2 Establishing treatment goals for patients near the end of life: the DNR discussion
3.1 Establishing treatment goals: advance directives and advance care planning
3.2 Withdrawal of life-sustaining medical treatments
3.3 Artificial nutrition and hydration in terminally ill patients
7 Describes and applies ethical and legal principles that inform decision-making in serious illness, including: a) the right to forgo or withdraw life-sustaining treatment; b) decision-making capacity and substituted judgment; and c) physician-assisted death
5 Understanding advance directives
10 Patient preferences
11 Ethical dilemmas
14 When and how to write "Do Not Resuscitate" orders
15 Withdrawal or withholding of care
2.5 Discuss advanced care planning
4.1 Not-starting/stopping treatment and euthanasia
1.6 Noninitiation or stopping of nonbeneficial interventions
3.1 Advance directives
3.2 Ethical and legal issues
7.1.9 Discusses common ethical issues at the end of life such as decision making, withdrawing or withholding therapy, and resuscitation orders.
7.1.10 Describes the practical clinical application of the principles of medical ethics in palliative and end-of-life care.
7.1.11 Proposes Advance Care Plans, including developing and discussing Advance Directives with patients and families, in accordance with B.C. regulations
7.1.12 Describes the components of advance care planning in patients with palliative and end-of-life care needs.
7.1.13 Describes the role ofSubstitute Decision Makers in palliative and end-of-life care planning.
7.1.14 Distinguishes between Medical Assistance in Dying (MAiD), palliative sedation and withholding and withdrawing therapy, in accordance with B.C. regulations and terminology
7.1.17 Identifies why patients at the end of life may request MAiD.

2.19.1. Knows ethical principles and frameworks for addressing clinical issues
5.6.1. Is aware of sensitivities regarding age, ethnicity, sexual orientation, culture, spirituality and religion, and disability
a) understand the importance of assessment and care planning being a 'holistic' and person centred process
b) understand the content of individuals' care plans and advance care plans and the impact this has on care and support offered
c) understand when an end of life or advance care plan would be appropriate and be able to identify individuals who may benefit from these plans early
d) understand that individuals and those important to them have a choice in who they choose to discuss assessment and care planning with
j) understand why assessments and care plans need to be reviewed regularly and in partnership with others, including the individual and those important to them taking account of the changing needs and wishes of individuals
l) be able to support and record decisions about advance care planning, understanding the difference between advanced decisions and advance statements
n) be able to communicate and share information in an individual's care plan or advance care plan effectively with their permission with appropriate others, including ensuring that individuals' decisions, including advance care plan status and do not attempt cardiopulmonary resuscitation (CPR) instructions, can be seen 'at a glance'
1.2 Ethical understanding
9. Collaborate with others in the use of an ethical framework which guides decision making in the context of palliative and end of life care
3.3 Demonstrate an ability to appropriately manage decisions about withholding or withdrawing treatment
6.2 Demonstrate an understanding of the difference between managing a life-limiting condition and providing end-of-life care.
10. Ethical/legal issues
3.4 Conflict resolution: managing requests for medically ineffective treatments
4.4 Describes ethical principles and inform decision-making in serious illness, including the right to forgo or withdraw life-sustaining treatment and the rationale for obtaining a surrogate decision maker.
4.3 Non-abandonment of the patient
3.3 giving bad news, discussing prognosis, treatment withdrawal options, resuscitation orders, and the use of artificial hydration/feeding
4. Advance care planning
7.1 Identifies and addresses ethical and/or legal issues in collaboration with the inter-professional team
f) be able to provide information on advance decision planning for individuals and those important to them and check understanding
k) be able to sensitively support those important to the individual when individuals are making advance care planning decisions
b) understand and follow legal and ethical requirements, agreed ways of working, processes and procedures following death
d) understand the legal and ethical requirements and agreed ways of working that protect the rights of individuals at the end of life, and know how to access expert advice regarding these
2.19. Understands common ethical and legal issues in end-of-life care and their clinical management
3.2 Informed decision making

e) be able to contribute to the assessment of a variety of needs individuals and those important to them may present in a person-centred, holistic, private and dignified way, using role-appropriate assessment tools, understanding the advantages and disadvantages of such tools
2.9.3. Knows the legal and regulatory issues surrounding opioid prescribing
b) understand what is meant by 'informed consent'
4.2 Working with the hospice team when one of your patients is in hospice
3.6 Continues to be involved with the patient after referral to hospice
5.4.1. Responds in a timely manner to requests from patients and families for medical information
a) understand the importance of having the individual's experiences, wishes and priorities included at all stages of assessment, planning and decision making, and be able to support individuals to express those wishes and beliefs at all stages of assessment, planning and decision making, and be able to support individuals to express those wishes and beliefs
i) know the importance of taking into account and acting on the observations and judgements of family and carers when planning end of life care, integrating their observations into assessment and care plans
4.10.1. Writes in a manner which can be read by a normal person
4.10.2. Writes notes within 24 hours of seeing the patient
7.2 promoting and implementing advanced care directives
2.5 Self-determination
5.2 ability to work collaboratively with the diverse group of health professionals to provide timely support to meet changing goals
4.3 Hospice care and referrals
2.3.2. Knows local resources both in the hospital and in the community, for patients requiring transition out of the hospital
2.4. Understands the role of the interdisciplinary team in hospice and palliative medicine
2.4.1. Knows the members of the hospice interdisciplinary team and their roles
6.3. Integrates knowledge of health care system in developing plan of care
6.3.1. Understands policies and procedures of pertinent health care systems
6.6.2. Coordinates and facilitates dialogue between patients/families and service provider representatives (e.g. hospice liaison nurses, nursing home administrators, etc.)
d) be able to engage in local community support schemes that offer services to individuals and those important to them – either to offer or access support
e) understand what is meant by a 'caring network' (family, friends and others around an individual), and the value a caring network can bring
f) be able to develop the practical skills of enhancing networks: saying yes to offers of help and learning how to ask
g) be able to support individuals and those important to them to consider their network of support (referred to as a 'caring network') which may extend beyond immediate family and friends
i) understand the value of multi-disciplinary teams involving and including people from outside health and social care, e.g. community development workers, community leaders, individuals and their caring networks
b) understand what support, services and resources are available, including practical and emotional support services, and know how to access them
j) understand the duty of local authorities to undertake carer's assessments
d) be aware of local and national policies shaping the delivery of end of life care and how these influence service delivery
3.4 Appropriate referral

1.5 Take cognisance of the potential role of specialist palliative care services in supporting staff in other agencies to provide a palliative care approach to persons with a life-limiting condition.
7.3 Guides patient and family to helpful resources
1.3 Access to care
e) be able to find and facilitate access to specialist services or support groups to support individuals' diverse needs
7 Hospice requirements and placement
5.1.3 Describes local resources in palliative care and hospice care and participates in the appropriate utilization of these resources.
6 Understanding the difference between hospice versus palliative care
5.1 Defines the philosophy and role of palliative care across the life cycle and differentiates hospice from palliative care
1.1.3 Describes models of end-of-life care
1.1.4 Describes the principles and models of palliative care and hospice care.
1.3.3 Describes common trajectories of functional decline.
1.1 History of hospice
1.1 Definition and principles of PC
1.2 Models of PC
1.1 Describes key elements of palliative care and a palliative approach.
4.3.5 Describes standardized tools for pain assessment.
1.4 Provide education to people with life-limiting conditions, their carers and colleagues in the context of your role and at an appropriate level
3.2.5 Educates patients and family about end-of-life care issues and pain and symptom management
4.3.13 Describes the prevalence and impact of major symptoms in patients with palliative care needs.
1.4. Provides patient and family education
4.3.37 Participates in the appropriate care for the pediatric patient with palliative care needs and their family
4.3.38 Demonstrates an understanding of pediatric palliative care which can start at diagnosis (including antenatal diagnosis) and continue throughout the life of the child (alongside acute care interventions) and into bereavement for the family.
4.3.39 Describes the differences between pediatric and adult palliative care.
4.3.40 Describes the multidisciplinary and inter-professional approach to care which benefits the child and family when life-threatening illness is present.
4.3.41 Describes elements of support to families in deciding the best treatment option(s), including non-intervention, for their child and demonstrates the ability to respect the choice(s) made. Identifies the challenges (societal, professional and personal) which arise when caring for a dying child.
4.3.42 Manages the care needs of a pediatric dying patient, communicating with and supporting their family members, liaising with pediatric specialists when needed

Appendix V: Listing of specific competences.

Defines dyspnea, identifies its causes and makes a differential diagnosis. Applies non-pharmacological and pharmacological treatment for dyspnea. Understand the role of opioids, benzodiazepines, and steroids in managing terminal dyspnea and cough.
Applies an established protocol to keep the airway unobstructed, ensuring autonomy and independence.
Evaluates and appropriately manages the patient with respiratory secretions, according to the disease stage.
Constipation Prevents constipation, especially the one induced by opioids.
Diarrhea Recognizes diarrhea, especially the one induced by chemotherapy. • Recognize strategies for the management of diarrhea associated with disease progression (basic management ileostomy, colostomy).
Nausea and vomiting Recognizes and performs the initial treatment of nausea and vomiting, including those induced by chemotherapy and / or disease progression. Applies mechanic approaches to the management of nausea and vomiting. Manages antiemetic medications in the proper way (e.g. subcutaneous).
Identifies, assesses and performs the initial treatment of intestinal obstruction.
Knows the pharmacology and indications of different laxatives available in the market.
Recognizes drug interactions that could lead to or worsen constipation.
Knows the pharmacology and indications of different antidiarrheal medications available in the market.
1.7 Asthenia
4.4 Seizures
3.3 Dehydration
1.3 Anorexia
Caquexia
Insomnia Recognizes the different types and causes of insomnia and implements pharmacologic and non-pharmacologic strategies to address it.
Delirium Recognizes precipitating and predisposing factors and clinical manifestations of delirium. Applies pharmacological and non-pharmacological treatment strategies and/or refers to specialist when necessary.
1.3 stress/anxiety
1.6 Depression
3.6 Fear
Knows and applies non-pharmacological and pharmacological therapies for pain management (type of drug, formulation, dosage, side effects, and drug interactions), including the World Health Organization (WHO) analgesic ladder.
2.8.1. Knows the concept of “total pain”
2.8.2. Knows the relevant basic science, pathophysiology, symptoms, and signs necessary to differentiate among different types of pain as the etiology of discomfort
1.2 Describes key issues and principles of pain management with opioids, including equianalgesic dosing common side effects, addiction, tolerance and dependence
4.3.10 Describes the use of adjuvant medications in pain management.
Knows the essential medicines in palliative care based on evidence-based recommendations, and prescribes them rationally and responsibly.
2.2 Describe the indications, pharmacology, side effects, and costs associated with oral opioids.

2.3 Describe the indications, pharmacology, side effects, and costs associated with parenteral opioids.
2.4 Describe the indications, pharmacology, side effects, and costs associated with adjuvant analgesics
1.3 equianalgesic dose conversion
4.3.26 Describes safe storage of opioids, responsible prescribing and disposal.
4.3.27 Discusses routes of opioid administration.
3.16 Adjuvant pain interventions (radiation, chemotherapy, nerve blocks and ablation, transcutaneous electrical nerve stimulation, surgical interventions, and rehabilitative strategies)
Applies pharmacologic and non-pharmacologic measures based on available evidence, according to the symptom and its intensity.
Identifies and manages symptoms (physical and emotional) as well as other aspects in the end of life.
2.8.3. Knows how to use tools and strategies for pain diagnosis and assessment
1.1.2. Obtains a comprehensive palliative care history and physical exam, including: Detailed symptom history (including use of scales)
1.8. Re-assesses pain and other symptoms on a frequent basis, and makes therapeutic adjustments as needed
2.10. Understands how to approach common and urgent non-pain symptoms, and clinical problems encountered in palliative care practice
3.2 Demonstrate an ability to assess and manage uncomplicated symptoms associated with life-limiting conditions using standard guidelines or protocols of care
f) understand that symptom and pain management should be organised around the needs of the individual, and delivered in a co-ordinated manner
i) understand when to refer concerns about an individual's symptoms to specialist colleagues
8 Applies knowledge of disease trajectories to estimate prognosis in patients
1.1.2.1 Patient understanding of illness and prognosis
1.1.2.6 Functional assessment
1.1.2.7 Detailed neurological exam, including mental status exam
1.1. Gathers comprehensive and accurate information from all pertinent sources, including patient, family members, health care proxies, other health care providers, interdisciplinary team members and medical records
1.14. Refers patients to non-palliative care physicians to assess, treat and manage patient and family care issues
1.2.1. Develops a prioritized differential diagnosis and problem list, based on patient and family values
1.1.4. Utilizes information technology, by accessing on-line evidence-based medicine resources, electronic repositories of information, and medical records
1.1.3. Performs appropriate diagnostic workup; makes use of diagnostic workup information already completed
1.1 Emphasis on quality of life
1.9.1. Evaluates level of function and functional decline
1.9.2. Provides expertise in improving and maintaining patient's level of function and quality of life
1.3 Identifies people who would benefit from a palliative approach.
3.6 Be able to help the person with a life-limiting condition and their family adapt to a transition from life prolonging treatment to a focus on palliative care, where appropriate

3.2 Demonstrate an ability to consider the benefits, burdens and risks of investigations and treatments and make decisions regarding the appropriateness of these for each person living with a life-limiting condition
Knows the medications used in palliative sedation, indications, dosage, prescription properly adjusted to regulations, routes of administration, adverse effects and contraindications.
Knows the 'operational' aspects: who, when, how and where to formulate a sedation.
1.8 Care for the imminently dying (expected death within hours to days) or recently deceased patient and their family members
1.13 End-of-life management in a mass casualty incident/event
4.2 Spinal cord compression
4.3 Hypercalcemia
4.6 Orthopedic catastrophes
4.7 Increased intracranial pressure
4.8 Bleeding and coagulation disorders
2.5 Complications of cancer
4.1 Superior vena cava syndrome
3.1 Assessment and pathophysiology
1.14.1. Recognizes the need for referral in order to deliver good medical care
4.7.5. Clearly documents the course and outcome of a family meeting in the medical record
4.4 Has good technical skills
Knows the different medications formulations, dilutions and conversions for treatment individualization.
2.9.4. Knows the indications, relevant clinical pharmacology, alternate routes, and management of common side effects for the following agents: acetaminophen, aspirin, NSAIDS, and adjuvant medications
3.4 Demonstrate an ability to appropriately modify the management of co-morbidities in the context of life-limiting conditions.
4.8 Knows when to stop treatments that are no longer helpful
4.2.1. Uses empathic and facilitating verbal behaviors such as: naming, affirmation, normalization, reflection, silence, listening, and humor
2.3 Demonstrates basic approaches to handling emotion in patients and families facing serious illness.
4.5.1. Routinely assesses patients/families to identify individuals who might benefit from age-appropriate interventions or support
4.5.2. Demonstrates an informed understanding of developmental stages in approaching patients/families
4.5.3. Appreciates the need to adjust communication strategies to honor different cultural beliefs
3.1.7 Discusses issues of truth-telling for patients with palliative care needs, including the influence of cultural issues.
f) be able to communicate appropriately across the age spectrum with people facing bereavement
Knows and uses the basic tools of effective communication with the patient and family.
1.4.2. Explains consultation needs and results to patients and families
1.14.2. Translates consultant recommendations to the palliative care setting
4.1.1. Negotiates how much information and decision-making input a patient/family want
4.3.4 Discusses issues in identifying and treating pain and other symptoms across the spectrum of developmental, cognitive and physical abilities.

4.4.3. Communicates new knowledge to patients/families adjusting language and complexity of concepts based on the patient/family's level of sophistication and values, as well as on developmental stage of patient
4.4.4. Identifies patients/families who may benefit from a language translation service or interpreter
4.9.1. Gives a concise verbal history and physical presentation for a new palliative care patient
Communicates with the patient and the caregiver about the process of death and grief.
g) understand that sensitive communication includes the need to respect wishes of those who do not want to have open discussions about their condition or end of life and that the ability and desire of individuals and those important to them to discuss end of life care issues may change over time
a) be able to communicate sensitively and respecfully with individuals and those important to them on a range of complex matters relating to end of life care, in a non-judgemental, empathetic, genuine, collaborative and supportive manner that is appropriate to them and the situation
c) be able to talk about death, dying and bereavement and actively listen to others
2.3 Builds relationships by listening without judgement and being open to learning from others.
1.2 Encourages questions from the patient
1.3 Talks with patients in an honest and straightforward way
2.1 Listening to the impact of disease on the patient's life
10.1 Openly and willingly communicates with the family
5.3 Family-centered approaches
3.2 Asks the person and family what is important to them and, with permission, shares that information with the inter-professional team.
3.2.1 Leads effective meetings with patients and their families
4.7.1. Identifies when a family meeting is needed
4.7.2. Identifies appropriate goals for a family meeting
4.7.3. Follows a step-wise approach in leading a family meeting
2.4 address and resolve disagreements and conflicts between patients, families and carers
2.2 Be able to mediate conflict in decision-making in the palliative care setting and work towards consensus building in care planning.
4.7.4. Effectively deals with family conflict
2.1 Discussion of diagnoses and prognosis
1.4 Gives bad news in a sensitive way
1.5 Willing to talk about dying
1.6 Sensitive to when patients are ready to talk about death
7.4 Talks with patients about what their dying might be like
1 Demonstrates effective patient-centered communication techniques and helps patients and families face the process of dying
3.1.3 Identifies the specific issues that may interfere with communication of news or bad news to dying patients and their families.
Informs the patient and family about the process of palliative sedation.
d) know how to be a good listener in relation to end of life discussions
3.7 Be able to recognise when a person with a life-limiting condition is actively dying and communicate to family and staff the expectation of imminent death
1.11.1. Effectively prepares family for the patient's death
4.6.6 Discussing enrollment into hospice

d) know where to seek advice about difficult and complex matters or situations
7.1.18 Discusses withholding and withdrawing of therapies such as artificial hydration, artificial nutrition, renal support and ventilation and the differences between these and euthanasia
7.1.21 Discusses the role of palliative sedation therapy (sedation for refractory symptoms at the end of life), its ethical implications, and how it differs from euthanasia
2.4 Discuss suspension of therapeutic measures and DNR
4.6.7 Talking about artificial hydration and nutrition
2.3 Review therapeutic options
7.1 Gives enough detailed information so that patient understands his/her illness and treatments
7.2 Tells patient how this illness may affect his/her life
2.2 elucidating patient wishes for future care
2.3 promote communication and consensus about care goals.
2.5. Understands how to assess and communicate prognosis in end-of-life care
13 Explores patient and family understanding of illness and goals of treatment, and identifies treatment plans that align with these considerations
7.1.20 Discusses how to avoid prolongation of the dying process while respecting the goals of care.
1.10. Coordinates, orchestrates, and facilitates key events in patient care, such as family meetings, consultation around goals of care, advance directive completion, conflict resolution, withdrawal of life-sustaining therapies, and palliative sedation
4.1.3. Assesses patient's and family members' decision making capacity, and other limitations on understanding and communication
4.6.2 Discussing transition from curative therapies to a focus on palliative care
4.6.4 Discussing goals of care including advance care planning and code status
2.3 Understand that the communication of information which fundamentally changes the person's understanding of their situation and/or influences their decision-making or planning is an on-going process and not a single event
c) understand the different barriers to communication at end of life, including where someone has additional care, support or communicate needs e.g. learning disabilities, cognitive impairment, sensory impairment, or where a situation makes it difficult to communication effectively e.g. noisy, distressing, emergency environments, and have strategies in place to overcome these barriers
4.3.5. Self-corrects communication miscues
3.2.4 Describes how personal concerns about caring for patients and families at the end of life and/or personal experiences of death and dying influence patient-physician/NP communication.
b) know how to talk about own beliefs and values and recognise that they may differ from those of others
c) be able to listen to and support individuals who may hold different beliefs and values, or have had different life experiences
e) be able to discuss and listen to others' feelings and recognise and accept these may be different to your own
b) know how to communicate own worries and concerns and assert own wishes about dying and the care provided, and be able to engage in activities to support this
k) be able to manage conflict where it arises between the individual and those important to them regarding end of life care or advance care planning choices, work sensitively with all parties regarding end of life care or advance care planning choices, work sensitively with all parties towards a resolution and access mediation and advocacy services where appropriate

2.14.2. Integrates concepts of coping styles, psychological defenses, and developmental stages into the evaluation and management of psychological distress
3.1.2 assisting and facilitating the family efforts to resolve: financial concerns
3.1.3 assisting and facilitating the family efforts to resolve: legal maters
2.2 Maintains hope and a positive attitude
4.4 Discussing and assessing spiritual issues; maintaining hope
2.2 Explore hope, helplessness and fear in depth
Identifies timely caregiver fatigue and the risk of claudication.
14 Identifies psychosocial distress in patients and families and provides appropriate assistance.
5 Recognizes emotion in patients and families facing serious illness, and demonstrates effective approaches to handling emotion
4.3.50 Describes the elements of suffering in end-of-life care for patients, families and caregivers
4.3.52 Describes a supportive approach to suffering
4.3.46 Develops and proposes a care plan to address psychosocial and spiritual issues in collaboration with other disciplines
16 Identifies spiritual and existential distress in individual patients and families, and provides support and appropriate referral
5.3 Facilitate the person with a life-limiting condition and their carers to express their thoughts and feelings relating to illness and loss
h) be able to support those important to the individual to maintain their relationships
f) be able to assess when individuals need to be alone
11.1 Acknowledges and respects patient's personal beliefs
a) understand that supporting someone at the end of life and those important to them goes beyond health and social care intervention
2.2 Incorporates the uniqueness of each person, family and community into all aspects of care.
2.2.3 Demonstrates respect for differing family structure, roles and cultural issues when sharing information and arriving at decisions, including treatment care plans.
4.3.17 Describes the role of the patient, family and inter-professional care team in monitoring treatment plans.
d) understand that person-centred care includes all elements of an individual's life that are important to them, not just their symptoms
c) understand the factors that could affect an individual's view of dying, including their physical, emotional, psychological, spiritual, cultural and religious needs emotional, psychological, spiritual, cultural and religious needs
h) be able to provide emotional, physical and psychological support to individuals to maintain comfort and well-being
k) understand the importance of relationships as a person nears the end of life, and be able to support a dying person to maintain these relationships
l) understand the need to be sensitive to the individual's changing circumstances, and adapt care and support accordingly
1.2Understand the impact that psychological responses, social stressors and spiritual dimensions to loss, may have on the mental health and decision making of the person with a life-limiting condition and their family and take this into account when planning care
14 Identifies psychosocial distress in patients and families and provides appropriate assistance.
5 Recognizes emotion in patients and families facing serious illness, and demonstrates effective approaches to handling emotion
4.3.50 Describes the elements of suffering in end-of-life care for patients, families and caregivers
2.3 Provides comfort through touch

h) be able to support those important to the individual to maintain their relationships
3.8 Be able to provide guidance and support to the individual and their family preparing them for what to expect during the normal dying process
6.2.2 Describes the features of anticipatory grief, normal grief and atypical grief as defined by current Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria, including risk factors for atypical grief.
2.18.2. Knows the diagnostic features, epidemiology, and natural course of normal and complicated grief and depression and the risk factors for complicated grief
1.13.3. Recognizes complicated bereavement among family members of patients with life-threatening illnesses
2.3 Discuss loss and mourning
e) be able to demonstrate an awareness of the impact of dying
Provides initial support, promotes normal grieving process, and refers promptly in case of pathological grief.
e) understand how the physical changes after death may affect laying out or moving someone, and act accordingly
5.3 decision-making
5.4 Delegation of functions
5.6 Organizational skills
5.7 Team-building theory
2.10.4. Knows the role of physical therapy, occupational therapy, Physical Medicine and Rehabilitation, and other allied health professions in the management of patients with life-threatening illnesses and above symptoms
6.3 Respects and uses the expertise of nurses, social workers, and other nonphysician team members
2.1 Demonstrate an ability to enlist the skills of the multidisciplinary team/colleagues to enhance and support communication with the person with a life-limiting condition and their family
b) be able to provide effective supervision and support regarding end of life care, enabling team members to manage their own feelings, reflect on practice and improve service delivery
8.2 Supports colleagues as they address personal well-being in relation to challenges and complexities of this work.
4.9.7. Elicits concerns and provide emotional support and education to staff around difficult decisions and care scenarios
8.1 Reflects on, and addresses, own well-being.
4.3. Demonstrates ability to effectively recognize and respond to own emotions
4.3.1. Is aware of own emotional state during patient and family encounters
c) know how to access support to help oneself and others involved in caring for the person at end of life, including accessing a caring network
7.1.7 Discusses how personal attitudes may potentially impact the care provided to a dying patient and their family.
5.2 honoring living wills
2.4 Informed consent
5.1.2 Assists in the development and discussion of goals of care, including discussing and developing advance directives with patients with palliative care needs and their families.
7.1.1 Addresses end-of-life decision-making and planning using a basic bioethical and legal framework
2.9 Proportionate care
2.11 Allocation of scarce resources

2.8 Advanced directives
2 Establishing goals of care
2.4 Advocates for culturally safe practices that are free of racism and discrimination.
12 Ensures the right of the patient in serious illness to forgo or withdraw life-sustaining treatment and to designate a surrogate decision maker, and assesses decisionmaking ability
1.5. Demonstrates care that shows respectful attention to age, gender, sexual orientation, culture, religion/spirituality, and disability
6.1. Demonstrates care that is cost-effective and represents best practices
2.6 Refusal of treatment
2.13 Double effect
2.12 Loyalty
5.1 DNR decision making
2.14 Nonabandonment
2.16 Futility
2.17 Persistent vegetative state and brain death
2.18 Artifical hydration and nutrition
2.19 Truth telling
2.20 Aid-in-dying
1.10 Family witnessed resuscitation
3.1 Palliative Sedation • Knows the definition of palliative sedation and the differences with euthanasia and assisted suicide as well as the medical, bioethical and legal aspects.
7.1.2 Describes an approach to addressing ethical issues. Describes different ways that patients and families cope with illness and death.
7.1.4 Describes the hierarchy for Substitute Decision Making for a patient who lacks capacity.
7.1.5 Participates with the health care team to assist the patient, and if appropriate, the Substitute Decision Maker (SDM) or family, in the development of a treatment care plan in alignment with the goals of care, collaborating with other team members and using appropriate resources.
7.1.16 Describes an approach to respond to a patient's or family's request for hastened death.
c) understand that the individual has a right to change their mind regarding the sort of care they want
d) understand the importance of choice, and the options available in, planning for end of life care and future care needs e.g. where care will take place, decisions to refuse some treatments, funeral planning, organ donation, mental capacity, lasting power of attorney
g) understand how an individual's beliefs, customs, faith, lifestyle, religion, social norms, spirituality and values may affect assessment and end of life care planning
k) understand that some individuals will not wish to be involved in the care planning process, and respect this decision
2.7 Surrogacy
2.10 Confidentiality
2.15 Equivalency of withholding and withdrawing treatments
13 Health care power of attorney
Knows the concepts of wills, advance directives and their implications in medical decisions.
3.1 Takes as much time as needed with the patient
3.4 Ensures that he/she is accessible to the patient and family in a timely manner
e) understand who is important to the individual and who they see as 'leading' their care

5.5 Does not view death as a medical or personal failure
2.3 Assessment of decision-making capacity
3.1.1. Demonstrates an ability to self-reflect on personal learning deficiencies and develop a plan for improvement
5.4. Fulfills professional commitments
6.5. Collaborates effectively with all elements of the palliative care continuum, including hospitals, nursing homes, home and inpatient hospice, and other community resources
6.1 to know the particularities of the various types of continuing care and to recognize their potentials and limitations
6.4. Knows differences in admission criteria for various settings such as skilled-nursing and assisted-living facilities, acute/sub-acute rehab facilities, and long-term acute care settings as well as hospice
1.12. Provides appropriate information about all settings of the palliative care continuum, including hospital, home and inpatient hospice, nursing home, and other community resources, to ensure smooth transitions across settings
c) know how to support an individual to access medicines or other treatment, especially at weekends and holidays
e) understand how to plan for end of life care and future care for self or others, and how to access specialist support services
6.5.1. Effectively utilizes members of interdisciplinary team to create smooth and efficient transitions across health care settings for patients and families
4.4.5. Refers patients/families with special needs to appropriate resources
6.7.2. Demonstrates ability to work with managers of varying disciplines to improve patient safety and system-based factors that affect care delivery
g) understand importance of a caring network from which the individual and those important to them may benefit
d) be able to recognise, assess and respond to the end of life care needs for individuals with a variety of diagnoses and in a variety of service and community environments
d) understand how local community schemes could benefit individuals and those important to them
e) understand and be able to map the community assets available and how to access these to inform own practice, other staff and individuals and those important to them
f) be able to support individuals and those important to them to access local community groups and services and to understand the benefit this could bring
f) know where to direct an individual for more support
5.1 match existing resources with patient objectives
6.5 Guides patient or family to hospice in a timely manner
1.4 Patient eligibility and referral availability
3.4 Transitions across care settings, e.g., inpatient vs. home hospice, palliative care unit
6.3.2. Understands philosophy, admissions criteria, and services, and structure of hospice care
c) understand referral criteria and processes for referral to specialist services to meet the needs of individuals and those important to them
i) be able to offer assessment to carers
b) understand the importance of recognising the expertise of carers and important others and support them to continue performing tasks should they wish to do so
f) understand the need to be sensitive to carers' changing circumstances and needs, and adapt care and support accordingly

j) be able to provide individuals, through the use of networks and partnerships, with information on a range of resources, information and support available, how they might be accessed, and the potential risks and benefits
5.1 Recognizing physical, psychological and spiritual needs
1.3.1 Identifies when to initiate a palliative approach to care across various diagnoses and care settings.
1.3.2 Describes and identifies patients who would benefit from a palliative care approach early in their illness trajectory.
5 Defines and explains the philosophy and roles of palliative care and hospice
2.1.1. Domains of palliative care
2.1.2. Settings where palliative care is provided
2.1.3. History of the hospice and palliative medicine fields
2.1.4. Barriers to accessing palliative care
1.2.1 Describes the benefits of an early collaborative palliative approach to care.
2.2.1. Structure of the Medicare Hospice Benefit
2.2.2. Settings where hospice is provided
2.2.3. Basic elements of a home visit
2.2.4. Barriers to accessing hospice care
4.4.1. Recognizes the importance of serving as an educator for patient/family
4.4.2. Effectively identifies gaps in knowledge for patients/families
9.3 Helps patients and families understand how to provide symptom and pain control
Designs an educational program for the patient, the primary caregiver and the family, for storing, preparation and the administration of medicines used in palliative care.
Identifies and anticipates timely manifestations of the dying process and educates the caregiver
1.4.1. Educates families in maintaining and improving level of function in order to preserve quality of life
g) be able to develop the practical skills of caring e.g. how to lift and move an individual in a safe way
l) be able to offer guidance and/or training to carers on practical aspects of care