

# **Conjoint Palliative Medicine Residency Program at the University of Western Ontario**

## **Introduction:**

The Conjoint Palliative Medicine Residency Program at the University of Western Ontario is a one-year postgraduate program jointly accredited by the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada. The program is designed for physicians seeking training to develop added competency in palliative medicine.

The overall Goal/Objective of the Residency Program is to:

1. To train physicians who will provide primary and consultant palliative care services to have added competency in palliative medicine.
2. To provide clinical and basic academic training for physicians who will be going on to academic careers in palliative medicine.

Entry points to the program include family practice residents who have completed their two-year residency program and residents entering the 4<sup>th</sup> or 5<sup>th</sup> year of their Royal College training program (CCFP or FRCP certified)

## **General Overview:**

The University of Western Ontario has a wide range of palliative care resources and experiences that can be made available to trainees in London, Windsor and Sarnia. Residents will gain experience in hospital-based palliative care, in patient consult teams, acute and long-term palliative care units, home palliative care teams and out patient palliative care clinics. Residents will have the opportunity to work in secondary and tertiary care centers as well in community based hospitals.

There are palliative care consultants from different areas of medicine including family medicine, anesthesia and neurology. Academic palliative medicine physician are actively involved in education and research projects. Residents have access to infrastructure and personnel resources in the Departments of Family Medicine for the purposes of learning about research and education in palliative care, to meet colleagues with similar academic interests and for help with the planning and completion of their scholarly project.

The program is well resourced with multidisciplinary teams in all care settings including a large home based service, the palliative care units, and on the consultation service in both the ambulatory and in-hospital settings. This provides for access to numerous healthcare professionals for teaching and clinical supervision. There are excellent teaching resources from palliative care nurses/nurse practitioners, ethicists, chaplains, and social work many of whom are

full time palliative medicine consultants with academic interests in research and teaching and are available to participate directly and indirectly in the teaching of palliative medicine Residents.

Successful trainees will acquire a broad-based understanding of the principles, core knowledge, skills and attitudes of palliative medicine as well gain basic academic training important for those physicians who may seek academic careers in palliative medicine.

### **Mandatory Content of Training**

Two streams are offered to each incoming resident (London and Windsor) for selection. Choice of stream will entirely be up to resident preferences.

London Stream:

- 4 blocks LHSC (Victoria campus),
- 1 block LHSC (University campus),
- 2 blocks Windsor hospice,
- 1 block Windsor oncology,
- 2 blocks Sarnia,
- 2 blocks elective, and
- 1 block paediatric palliative care selective.

Windsor Stream:

- 2 blocks LHSC (Victoria campus),
- 1 block LHSC (University campus),
- 2 blocks Windsor hospice,
- 2 blocks WRH consult service (Metropolitan Campus, Ouellette Campus, and HDGH PCU),
- 1 block Windsor oncology,
- 2 blocks Sarnia,
- 2 blocks elective, and
- 1 block paediatric palliative care selective.

### **Elective Content of Training**

Description	Duration	Potential Training Sites
According to Resident preference and learning objectives	12 weeks (may be done in 2,4 or 8 week blocks)	At any location within the University of Western Ontario, nationally or internationally at the discretion of the Program Director(s), as long as a suitable preceptor has been identified who has agreed to mentor the Resident for the specified period of time.

## **Narrative Description of the Program**

This is a distributed program where the Resident will spend time in London, Windsor and Sarnia. There are twelve weeks of elective opportunities which can be done at a location of the students' choice.

The year begins with either the Resident at the Hospice (Windsor) or the Palliative Care Unit (London).

The Palliative Care unit at Victoria Hospital in London is a tertiary level, acute care, academic and research oriented unit. The unit has a 14-bed capacity and provides interprofessional care for patients with malignant and non-malignant disease. The resident will work as a full member of the interdisciplinary team to provide care to the patients and their families. He/she is responsible for the daily care of patients including the attendance at team rounds and family meetings. The resident will gain experience in the use of Ketamine, Methadone and CADD Pumps. The resident will also get exposure to treatments offered by interventional radiology and anaesthesiology including such procedures as Vertebroplasty, Blocks and intrathecal pumps.

The Palliative Medicine Consultation Service block can take place in London or in Windsor. At both sites, the resident, under the supervision of a Palliative Medicine Consultant, works as a member of the interprofessional team providing consultation services to patients. Consultations include symptom control as well as psychosocial and spiritual care advice and support.

Both of these rotations provide the Resident a clinical foundation for palliative care knowledge and skills.

The Oncology block and the Community Hospice Block, take place in Windsor.

During the Oncology block the Palliative Medicine resident participates in the care of cancer patients, attending Medical and Radiation Oncology ambulatory clinics. Emphasis is on the most common malignancies seen in the Palliative Care setting including lung, breast, prostate, and colon cancer.

The Community, Home and Hospice Palliative Care block is an 8 week rotation. During this rotation Residents will provide initial consultation and assume ongoing care of community palliative patients. Residents will become familiar with assessing and treating the symptoms of advanced disease at home, and in managing the medical care of patients who are actively dying at home. The Resident will work closely with all the community resources available to terminally ill patients in the home including Home and Community Care Support Services, and Hospice and as such Residents will learn the availability of, indications for, and process for accessing community home care services. During this rotation Residents will also have an opportunity to follow patients in the residential hospice of Windsor and Essex county as well provide palliative medicine consults in Windsor Regional Hospital as well as following patients at the Hotel Dieu Grace Palliative Care unit, a 20 bed unit.

The Inpatient Consult Service at University Hospital takes place in London. A significant number of consults have a primary cardiac, renal, pulmonary, or neurological problem. Residents therefore will learn to care for a diverse group of patients and become expert in understanding and forecasting disease trajectories for a wide range of illnesses.

There are twelve weeks of elective opportunities that may be done in 2, 4 or 8 week blocks. The

electives are to be decided between the Resident and the Program Director(s) individually and may include Paediatric Palliative Care, Geriatrics, ICU, Pain Clinic, or other specialties.

The Integrated Palliative Care block concludes the year and takes place in Sarnia. During this 8 week block, the resident will be expected to function relatively independently and competently in the inpatient, outpatient and community settings. This rotation provides the opportunity for Residents to learn methods to manage their time in the context of multiple different clinical activities and allows for consolidation of knowledge skills and attitudes in an independent manner.

In the latter half of the year the Residents will be expected to function as a junior attending. In this role, the Resident will be expected to take a lead role in patient care, interprofessional collaboration, and resident supervision and teaching with the support and guidance of an attending palliative care physician

It is important to note that during each of the mandatory rotations, Residents interact and work with interprofessional teams and participate in the care of patients and their families. Personal, professional and societal attitudes towards death and dying are discussed and reviewed as part of the daily interactions with these teams. The care of patients in different settings, including the home, are discussed and experienced. The ability to assess and develop standards of care for terminally ill persons in different settings is addressed at every opportunity. Evidence-based decision-making forms the basis of clinical and health service discussions that occur at each of the sites of training.

Residents will also have to complete a scholarly project. The project can involve an exploration of any aspect of palliative care, including clinical care (i.e. symptom control, social support, psychological care, spiritual care, interdisciplinary teams); education (i.e. educational planning or evaluation); Research (i.e. clinical, health services, systematic review, economic evaluation); administration (i.e. needs assessment, quality assurance); or ethics.

Residents have a protected half day per week away from clinical responsibilities for formal teaching, self-directed learning and working on a scholarly project. The academic half-day seminars are front-loaded at the beginning of the year to ensure that core topics of palliative care knowledge are discussed in the first few months of the year. This also allows the Residents more time to work on their scholarly project in the latter part of the year. The Residents also have protected time to attend the monthly, national videoconference for palliative medicine trainees. This allows the resident to connect with other Palliative Medicine Residents across the country.

It is also important to note that while the general content and organization of the Palliative Medicine program is the same for each Resident, it is recognized that individual Resident's needs may differ, depending on previous educational experiences and future goals. Every effort will be made to individualize the Resident program within the scope of the specific and general program requirements.

## **Evaluation:**

The following methods are used to evaluate the Resident:

1. The clinical supervisor will complete and review with the Resident an end of rotation ITER for summative feedback. All ITERs will be articulated via the CanMEDS and CanMEDS-FM roles. All program ITERs will be managed through the web based One45 program at the University of Western Ontario.
2. At the mid-point in each rotation, the resident reviews a mid-point ITER with the clinical supervisor as a self-evaluation. The midpoint ITER reflects the final ITER, allowing resident and supervisors to modify the final part of the rotation if necessary to meet the resident's learning needs
3. Field Notes are used to assess the overall effectiveness of the resident's clinical skills (both practical and attitudinal), communication skills, and knowledge. The resident will need to complete at least 50 in a year with a minimum of 5 per service, and 6 must be direct observation. These should be done in the Core palliative care blocks.
4. A formative written evaluation at mid-year (written exam)
5. A summative oral evaluation close to the end of year (Case Based Oral Exam)
6. The final in-training evaluation report (FITER) will be completed by the Program Director, with input from the Residency Training Committee, based on a summation of all ITERs, feedback from interprofessional team members, Mini CEX, summative oral examination, and the scholarly project

## **General Educational Objectives/Competencies**

### MEDICAL EXPERT/ FAMILY MEDICINE EXPERT

*The Family Physician is a skilled clinician.*

*Family Medicine is a Community Based Discipline.*

*The patient-physician relationship is central to the role of the Family Physician.*

#### **General Objective #1:**

*The resident will demonstrate skills in performing a palliative care consultation.*

Specific objectives: The resident will be able to:

- 1.1 perform a complete palliative care consultation, including assessing the physical, social, psychological, spiritual and functional parameters for a palliative care patient.
- 1.2 communicate the findings both written and verbally.

#### **General Objective #2:**

*The resident will be able to demonstrate advanced knowledge, skill, and attitudes in managing pain in advanced illness.*

Specific objectives: The resident will be able to demonstrate the knowledge of:

- 2.1 Assessment of pain, including the use of validated assessment tools, history taking skills, physical examination skills, and appropriate ordering and interpretation of investigations;
- 2.2 the common and less common cancer pain syndromes;
- 2.3 the neurophysiology of pain transmission;
- 2.4 the pharmacology (pharmacokinetics and dynamics) of medications used in pain control;
- 2.5 the special issues in assessment of pain in patients with cognitive impairment and with communication difficulties;
- 2.6 dose selection, titration, routes of administration and effectiveness of pain medications. Medications include:
  - 2.6.1 opioids, including methadone;
  - 2.6.2 adjuvants; NSAIDS, anti-depressants, anti-consultants, steroids, ketamine, etc.
- 2.7 side-effects and management of side-effects;
- 2.8 the indications for, management of and complications of interventional anaesthetic techniques such as epidurals, intrathecal route, and neurolytic blocks;

- 2.9 the role of radiotherapy and chemotherapy in cancer pain control;
- 2.10 the level of evidence in the literature regarding pain management.

**General Objective #3:**

*The resident will be able to demonstrate advanced knowledge, skill and attitude in managing symptoms in advanced illness.*

Specific objectives: The resident will be able to:

- 3.1 perform an assessment of each symptom (including performing a history using validated assessment tools, a physical exam and ordering/interpreting appropriate investigations);
- 3.2 understand the pathophysiology of each symptom;
- 3.3 propose an etiology of each symptom; and
- 3.4 propose a management strategy for each symptom. Symptoms include, but are not limited to:
  - 3.4.1 nausea and vomiting;
  - 3.4.2 dyspnea;
  - 3.4.3 delirium;
  - 3.4.4 constipation;
  - 3.4.5 skin and mouth care;
  - 3.4.6 pruritis;
  - 3.4.7 insomnia;
  - 3.4.8 anorexia; cachexia;
  - 3.4.9 weakness and fatigue;
  - 3.4.10 edema; and
  - 3.4.11 bleeding and thrombosis.
- 3.5 demonstrate an understanding of the role for hydration and nutritional therapies in palliative care patients.
- 3.6 be sensitive to the needs of patients and families for complimentary and unorthodox therapies.

**General Objective #4:**

*The resident will be able to demonstrate effective knowledge, skills and attitudes in assessing and managing palliative patients suffering from non-malignant illnesses.*

Specific objectives: The resident will be able to:

- 4.1 demonstrate knowledge of the assessment and management of patients with advanced non-malignant diseases including: COPD; CHF; CVA; CRF; Dementias; ALS, other progressive neuromuscular diseases;

**General Objective #5:**

*The resident will understand principles of oncologic management of common cancers and the role of treatment in the palliative patient.*

Specific objectives: The resident will be able to:

- 5.1 demonstrate knowledge of cancer, with focus on breast, lung, colon, prostate, pancreatic and hematologic cancer. Understand the principles of cancer epidemiology, the natural history of the above cancers, complications of the above cancers, and basic principles of management;
- 5.2 demonstrate knowledge of the role of radiation and chemotherapy in the management of cancer patients. Demonstrate a basic understanding of radiation and chemotherapy in the non-palliative patient and an in-depth understanding of radiation and chemotherapy for palliative patients;
- 5.3 demonstrate knowledge of side-effects of radiotherapy and chemotherapy in the palliative care patient and basic management of these side-effects;
- 5.4 demonstrate knowledge of interventional techniques relating to the care of patients with cancer, specifically, the indication for, complications of and methods of obtaining consult for placement of:
  - 5.4.1 parenteral lines – Hickman catheters, PICC lines, porta-cath
  - 5.4.2 interventional radiological procedures, such as g-tubes, nephrostomy tubes, esophageal stents, colorectal stents, biliary drainage procedures, vertebroplasty.
- 5.5 recognize, describe the pathophysiology of and management of the following palliative care emergencies/urgencies, including any potential surgical, radiological, and oncological therapy if appropriate:
  - 5.5.1 airway obstruction;
  - 5.5.2 catastrophic bleeding;
  - 5.5.3 spinal cord compression;
  - 5.5.4 SVC syndrome;
  - 5.5.5 biliary, urinary and bowel obstruction; and
  - 5.5.6 hypercalcemia.

**General Objective #6:**

*The resident will have advanced skill in managing pain, symptoms and psychosocial care of patients in the last days to weeks of life.*

Specific objectives: The resident will be able to:

- 6.1 demonstrate knowledge of symptoms and issues arising in the last days and hours of life. Demonstrate skills in management of these symptoms and in caring for patients and families during this time.
- 6.2 identify legal aspects of certification of death, regulations concerning



statutory notifications to the coroner and procedures for families following death.

**General Objective #7:**

*The resident will be able to demonstrate knowledge, skill and attitude in managing the psychosocial aspects of advanced illness.*

Specific objectives: The resident will be able to:

- 7.1 identify psychological, social and spiritual issues associated with life-threatening illnesses and strategies for management;
- 7.2 understand the role of coping styles in dealing with life-threatening illnesses;
- 7.3 identify and manage anger, fear, and strong affective responses to life-threatening illness;
- 7.4 demonstrate an approach to requests to die in a palliative care population;
- 7.5 identify and manage depression and anxiety;
- 7.6 describe the process of normal grief and features of atypical grief;
- 7.7 describe a basic approach to bereavement work;
- 7.8 demonstrate skills in working with and caring for the families of dying patients;
- 7.9 demonstrate skills in providing education to patients and their families around illness, symptom management and end-of-life decision-making; and
- 7.10 identify the existential needs of dying patients and their families and the strategies for managing them.
- 7.11 perform a spiritual assessment
- 7.12 explore opportunities for spiritual self-assessment
- 7.13 understand how a volunteer service is organized.

**General Objective #8:**

*The resident will be able to describe medical and societal attitudes towards death and dying.*

Specific objectives: The resident will be able to:

- 8.1 describe current societal attitudes about death and dying;
- 8.2 identify issues in death and dying relevant to different cultures, faiths and traditions;
- 8.3 describe current barriers to providing improved care for the dying.

**General Objective #9:**

*The resident will be able to discuss ethical issues confronting dying patients, their families and healthcare providers, including end-of-life decision-making, advance directive, competency, euthanasia and assisted suicide.*

Specific objectives: The resident will be able to:

- 9.1 outline a general framework for ethical decision-making;

- 9.2 describe an approach to addressing particular ethical issues at the end-of-life, including withdrawal or withholding therapy, advance directive, euthanasia and assisted suicide.
- 9.3 describe the legal aspects of capacity and competency.

**General Objective #10:**

*The resident will be able to demonstrate skills in managing patients in their homes.*

Specific Objectives: The resident will be able to:

- 10.1 describe the community resources available to support dying patients in their homes;
- 10.2 describe the physician's role in the care of the dying patient at home;
- 10.3 describe the various roles of a palliative care consultant in the care of palliative patients at home;
- 10.4 describe an approach to the care of the dying patient at home – specifically addressing anticipating needs, using alternative routes of medication and understanding the role of the physician at the time of death; and
- 10.5 demonstrate skill in providing home visits to patients.
- 10.6 appreciate the role of family caregivers- their burden of care, emotional experiences; and perceptions of illness and economic and social costs
- 10.7 assess the indications for an infusion device/ syringe driver; discuss the compatibility and miscibility of drugs used in such devices.
- 10.8 list the useful medications in the doctor's/ nurse's bag to help provide for care in the home.

**General Objective #11:**

*The resident will be able to demonstrate effective knowledge, skills and attitudes in assessing and managing issues specific to pediatric palliative care patients.*

Specific Objectives: The resident will be able to:

- 11.1 explore the various causes of life-limiting/ threatening illnesses of childhood;
- 11.2 identify when and who to include / introduce palliative care for children;
- 11.3 explore the impact of developmental stage on illness and communication;
- 11.4 explore the psychosocial and spiritual issues unique to pediatric palliative care including school and peer-related issues;
- 11.5 identify unique and comparable issues between pediatric and adult palliative care;
- 11.6 compose a genogram (family tree) and understand its uses;
- 11.7 explore issues around communication with dying children, parents and siblings
- 11.8 discuss the ethical considerations relating to a child with significant illness;
- 11.9 identify methods for pain assessment in young verbal, older verbal and non-verbal children;
- 11.10 be familiar with opioid use in children;

- 11.11 explore methods for non-pharmacologic pain management in children;
- 11.12 discuss common myths and beliefs with pain and the use of opioids in children;
- 11.13 identify common and / or distressing symptoms in pediatric palliative care;
- 11.14 explore methods to assess and manage pharmacologically and non-pharmacologically symptoms in children and
- 11.15 explore pharmacologic options for end-of-life sedation for children.

## COMMUNICATOR

*The Family Physician is a skilled clinician.*

*The patient-physician relationship is central to the role of the Family Physician.*

### **General Objective #1:**

*The resident will develop rapport, trust and ethical therapeutic relationships with patients and families.*

Specific objectives: The resident will be able to:

- 1.1 understand the impact of good patient-physician communication on patient care, patient satisfaction, and clinical outcome.
- 1.2 demonstrate skills in patient-physician communication, including active listening, reflection, use of non-verbal cues, etc.;
- 1.3 demonstrate skill in discussing end-of-life issues with patients and families, such as treatment choices, location of care and resuscitation decisions;
- 1.4 demonstrate skill in breaking bad news to patients and families;

### **General Objective #2:**

*The resident will be able to demonstrate skill in developing a shared understanding of a patient's goals of care and demonstrate an ability to communicate these goals to all the caregivers in the health care team. Goals of care refer to a patient's beliefs, hopes, expectations and concerns regarding their illness experience.*

Specific objectives: The resident will be able to:

- 2.1 participate in and facilitate family meetings to discuss relevant issues such as goals of care and future planning;
- 2.2 understand the importance of patient confidentiality; and
- 2.3 demonstrate skill in addressing challenging communication issues such as anger, misunderstanding and grief reactions.
- 2.4 respect diversity and difference, including but not limited to the impact of gender, religion and cultural beliefs on decision-making.

### **General Objective #3:**

*The resident will be able to convey effective oral and written information about a medical encounter.*

**Specific objectives:** The resident will be able to:

- 3.1 maintain clear, accurate, and appropriate records (e.g. written or electronic) of clinical encounters and plans; and
- 3.2 effectively present verbal reports of clinical encounters and plans.

## COLLABORATOR

*Family Medicine is a Community Based Discipline.*

### **General Objectives #1:**

*The resident will be able to collaborate as an effective member of an interdisciplinary team.*

**Specific objectives:** The resident will be able to:

- 1.1 describe the roles of other disciplines in the provision of palliative care;
- 1.2 be able to describe the role of palliative care to other health care providers;
- 1.3 participate in the interdisciplinary care of patients, including family conferences and team meetings;
- 1.4 communicate effectively with interdisciplinary team members;
- 1.5 communicate effectively and work cooperatively with interdisciplinary teams in a home setting, palliative care unit and acute care institution;
- 1.6 understand team function and methods to resolve conflicts within teams.

### **General Objective #2:**

*The resident will be able to consult effectively with other physicians and health care professionals.*

**Specific objectives:** The resident will be able to:

- 2.1 demonstrate effective consultation and communication skills when working with referring physicians and services; and
- 2.2 effectively communicate their assessments and plans to referring physicians and services.

## MANAGER

*Family Medicine is a Community Based Discipline.*

*The Family Physician is a resource to a defined practice population.*

### **General Objective #1:**

*The resident will understand the importance of activities that contribute to the effectiveness of the healthcare organization within which they work.*

**Specific objectives:** The resident will be able to:

- 1.1 describe the different models of palliative care delivery and their utilization;
- 1.2 describe how the models of palliative care delivery fit into the broader healthcare system;

- 1.3 describe the roles of the family physician and the specialist in the provision of palliative care;
- 1.4 demonstrate effective use of resources across the healthcare system, demonstrating awareness of the just allocation of healthcare resources;
- 1.5 participate in quality assessment and improvement initiatives;
- 1.6 demonstrate an ability to work with others in the location of practice, whether it is community or hospital-based; and
- 1.7 be introduced to the role of administrator and leader.
- 1.8 develop skills for building effective teams in varied circumstances.

**General Objective #2:**

*The resident will demonstrate an ability to manage their practice in palliative medicine.*

Specific objectives: The resident will be able to:

- 2.1 manage time in order to balance the demands of practice requirements as well as non-clinical activities and personal life.

HEALTH ADVOCATE

*Family Medicine is a Community Based Discipline.*

*The Family Physician is a resource to a defined practice population.*

**General Objective #1:**

*The resident will be able to demonstrate knowledge and skills in managing the palliative care patients in their community.*

Specific objectives: The resident will be able to:

- 1.1 describe the societal, environmental and resource allocation factors that are relevant to the care of the dying;
- 1.2 develop a proactive and therefore preventive approach to the dying patient's and family's needs throughout the course of illness;
- 1.3 describe the practice communities that they serve;

**General Objective #2:**

*The resident will be able to demonstrate the ability to act as an advocate within the health care system.*

Specific objectives: The resident will be able to:

- 2.1 act as an effective advocate for the rights of the patient and family in clinical situations involving serious ethical considerations;
- 2.2 advocate for the needs of patients receiving care throughout the health care system; and
- 2.3 identify the ethical and professional issues inherent in health advocacy,

Including altruism, social justice, autonomy, integrity and idealism.

**General Objective #3:**

*The resident will be able to identify the determinants of health for the populations that they serve.*

Specific objectives: The resident will be able to:

- 3.1 identify the barriers to adequate palliative care for vulnerable or marginalized patients in their patient population;
- 3.2 describe the barriers to the effective care of dying patients in different care settings across a community.

SCHOLAR

*The Family Physician is a resource to a defined practice population.*

**General Objective #1:**

*The resident will be able to develop a strategy for life-long learning.*

Specific objectives: The resident will be able to:

- 1.1 design, implement and monitor a personal plan for continuing education;
- 1.2 understand and practice reflective practice as a learning tool.

**General Objective #2:**

*The resident will be able to incorporate evidence-based clinical decision-making in caring for palliative care patients.*

Specific objectives: The resident will be able to:

- 2.1 access the relevant literature to address a specific clinical question; and
- 2.2 apply critical appraisal skills to the evidence and integrate it into clinical care.

**General Objective #3:**

*The resident will facilitate the learning of patients, students and other health care professionals when appropriate.*

Specific objectives: The resident will be able to:

- 3.1 describe the principles of medical education, specifically with reference to adult education principles; and
- 3.2 act as an educator to patients and their families around end of life issues.
- 3.3 demonstrate an effective lecture or presentation;
- 3.4 provide effective feedback; and
- 3.5 assess and reflect on a teaching encounter.

**General Objective #4:**

*The resident will contribute to the creation, dissemination, application and translation of new medical knowledge and practices.*

Specific objectives: The resident will be able to:

- 4.1 describe the principles of research and scholarly activity;
- 4.2 describe the principles of research ethics;
- 4.3 pose a scholarly question;
- 4.4 conduct a systematic search for evidence;
- 4.5 select and apply appropriate methods to address the question; and
- 4.6 appropriately disseminate the findings of a study.

PROFESSIONAL

**General Objective #1:**

*The resident will demonstrate a commitment to patient, their profession and society through ethical practice.*

Specific objective: The resident will be able to:

- 1.1 demonstrate appropriate professional behaviour, such as honesty, integrity, commitment, compassion, respect and altruism;
- 1.2 demonstrate a commitment to delivering the highest quality of care;
- 1.3 recognize and manage ethical issues in their practice;
- 1.4 appropriately manage conflict of interest;
- 1.5 maintain appropriate relations with patients.

**General Objective #2:**

*The resident will demonstrate a commitment to participate in profession-led regulation.*

Specific objective: The resident will be able to:

- 2.1 appreciate the professional, legal and ethical codes of practice;
- 2.2 fulfill the regulatory and legal obligations required of current practice;
- 2.3 demonstrate accountability to professional regulatory bodies;
- 2.4 recognize and respond to others' unprofessional behaviours in practice;
- 2.5 participate in peer review.

**General Objective #3:**

*The resident will demonstrate a commitment to physician health and sustainable practice.*

Specific objective: The resident will be able to:

- 3.1 describe his or her own concerns about caring for dying patients and their families;
- 3.2 demonstrate how his or her own personal experiences of death and dying influence his or her attitudes;
- 3.3 discuss methods of managing his or her own stress associated with caring

for dying patients; and  
3.4 recognize and respond to other professionals in need.

Developed by: Dr. Gordon Giddings, Dr. Anita Singh, Dr. Daniel Grushka & the Palliative Care Program  
Subcommittee

Last reviewed: Oct. 2019