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Recommended Curriculum Guidelines for Family Medicine Residents

# End-of-Life Care

*This document was endorsed by the American Academy of Family Physicians (AAFP), the Association of Departments of Family Medicine (ADFM), the Association of Family Medicine Residency Directors (AFMRD) and the Society of Teachers of Family Medicine (STFM), and was developed in cooperation with the North Oakland Family Residency Program.*

## Introduction

This Curriculum Guideline defines a recommended training strategy for family medicine residents. Attitudes, knowledge and skills that are critical to family medicine should be attained through longitudinal experience that promotes educational competencies defined by the Accreditation Council for Graduate Medical Education (ACGME) http://www.acgme.org. The curriculum must include structured experience in several specified areas. Most of the resident's knowledge will be gained by caring for ambulatory patients who visit the family medicine center. Structured didactic lectures, conferences, journal clubs and workshops must be included in the curriculum with an emphasis on outcomes-oriented, evidence-based studies that delineate common and chronic diseases affecting patients of all ages. Targeted techniques of health promotion and disease prevention are hallmarks of family medicine. Appropriate referral patterns and provision of cost-effective care should also be part of the curriculum.

Program requirements specific to family medicine residencies may be found on the ACGME Web site. Current AAFP Curriculum Guidelines may be found online at http://www.aafp.org/cg. These guidelines are periodically updated and endorsed by the AAFP and, in many instances, other specialty societies as indicated on each guideline.

Each residency program is responsible for its own curriculum. ***This guideline provides a useful strategy to help residency programs form their curricula for educating family physicians.***

## Preamble

Caring for dying patients is inseparable from our efforts as physicians to improve our patients' lives. The increasingly large number of patients who are part of our aging population along with technologic advancements make it vitally important to improve and refine our teaching of end-of-life care.

One of medicine's most important missions is to allow terminally ill patients to die with as much dignity, comfort and control as possible. In patients for whom a cure is not possible, there is still an enormous amount of care and support that can and should be provided for patients and their families. Many of the tenets embodied in family medicine are very important in the care of the dying. A holistic approach to the patient's physical and psychosocial well-being, a focus on the family, continuity of care and an emphasis on quality of life are four important principles that make the family physician uniquely suited to care for the terminally ill.

The end of life is one of the most critical times in the doctor-patient relationship. A family physician providing and coordinating hospice or other team care for a dying patient can ease physical symptoms and provide social, emotional and spiritual support. The care and support provided can set the stage for some of the most meaningful experiences in which human beings participate. The time and care surrounding a loved one's death are not just remembered for days or weeks but often lifetimes. Appropriate teaching and experiences in end-of-life care during residency training will not only provide necessary information to help ease pain and suffering, but it will also inspire family physicians to participate in the ultimate continuity of care: that of the terminally ill.

## Competencies

At the completion of residency training, a family medicine resident should:

- Be able to identify a plan of care for terminally ill patients, which is based upon a comprehensive interdisciplinary assessment of the patient and family's expressed values, goals and needs, and communicate the plan to the patient and family. (Patient Care, Medical Knowledge, Interpersonal Communications)
- Optimize treatment plans for terminally ill patients via integrating knowledge of local palliative and hospice care resources, as well as state and federal resources. (Practice-based Learning, Systems-based Practice)
- Recognize the signs and symptoms of the imminently dying patient. (Medical Knowledge)
- Demonstrate systematic recognition, assessment and management of pain syndromes utilizing evidence-based medicine. This should include both pharmacologic (opiate and non-opiate) and nonpharmacologic treatments as well as possible side effects. (Patient Care, Medical Knowledge, Practice-based Learning)
- Be aware of the ethical and legal issues from which the terminally ill patient's preferences and choices may be based upon and/or limited within. Further, skillfully negotiate treatment decisions with terminally ill patients and his or her family within this context. (Professionalism, Interpersonal Communications)

## Attitudes

The resident should demonstrate attitudes that encompass:

- The process of “breaking bad news,” including choice of setting, talking with the patient and family members, summarizing, using appropriate wording and questioning and the impact of this process on the patient and family.
- An understanding of the psychosocial issues and family dynamics affecting the terminally ill patient.
- An understanding of the spiritual and religious issues affecting the terminally ill patient.
- An understanding of the family cultural issues and particular customs in the context of death and dying.
- An understanding of the dying patient’s need for palliative care, pain relief, control and dignity.
- An understanding of the special issues associated with children, either as terminally ill patients or as family members of a terminally ill patient.
- An understanding of the impact of attitudes and experiences about death and dying in relation to caring for terminally ill patients.

## Knowledge

In the appropriate setting, the resident should demonstrate the ability to apply knowledge of:

1. The philosophy of palliative care
    a. Home-based approach
    b. Family-as-care unit
    c. Pain control
    d. Symptom control
2. Hospice team roles
    a. Physician
        i. Identification of appropriate patients for hospice care
            1). Cancer-related
            2). Noncancer-related
                a). Pulmonary
                b). Cardiovascular
                c). Neurologic
                d). Infectious
        ii. Referral process and criteria
        iii. Insurance and medicare coverage
        iv. Cost of care for terminally ill in various settings
    b. Nurses

   c. Social worker
   d. Pharmacists
   e. Home health care aides
   f. Volunteers
   g. Family

3. Prognosis of terminal illness
   a. Accuracy of prognosis
   b. Clinical indicators of time until death
   c. Value of medical therapies
   d. Psychosocial stages of the dying process for patient and family
4. Major pain syndromes
   a. Neuropathic
   b. Bone pain
   c. Visceral pain
   d. Nonphysiologic pain

5. Pain control
   a. Opiates (long- and short-acting)
   b. Nonopiates
   c. Addiction, habituation and dependence
   d. Baseline dosing and rescue
   e. Complementary and alternative medicines
   f. Nonpharmacologic pain control measures
   g. Side effects of pain control measures

6. Causes and treatment of nonpain symptoms
   a. Nausea
   b. Shortness of breath
   c. Loss of appetite
   d. Vomiting
   e. Sleeplessness
   f. Depression
   g. Anxiety
   h. Cough
   i. Constipation
   j. Diarrhea

   k. Xerostomia

7. Nutrition and hydration in the terminally ill
   a. Artificial feeding
   b. Intraveneous fluids
   c. Withholding feeding and fluids

8. Care locations
   a. Emergency department
   b. Inpatient
   c. Outpatient
   d. Extended-care facilities
   e. Home

9. Data related to end-of-life care in the United States
   a. Aging population
   b. Most common chronic illnesses
   c. Most common causes of death by age
   d. Cost of care for the terminally ill in various settings
   e. Where people die (home vs in hospital)

10. The bereavement process
    a. Normal grief reaction
    b. Differentiate grief reaction from depression

11. Legal issues
    a. Patient competency
    b. Advance directives
    c. Do-not-resuscitate (DNR) orders
    d. Power of Attorney for health care
    e. Living will
    f. Estate planning for patient and family
    g. Withholding and withdrawing life support
    h. Pronouncement of death
    i. Completion of death certificate

## Skills

In the appropriate setting, the resident should demonstrate the ability to independently perform or appropriately refer:

1. Physical assessment with attention to common findings of the terminally ill patient
2. Correct compliance with regulations pertaining to use of controlled substances in the terminally ill patient in and outside hospice care
3. Development of an initial and ongoing analgesic regimen to include the use of morphine-equivalent dosages and other narcotic equivalents
4. Effective use of alternative routes of analgesia
   a. Rectal
   b. Topical (e.g., creams, gels, patches)
   c. Nasal
   d. Subcutaneous
5. Correct use of pain scales to adjust medication dosage
6. Effective referral of available social services for both patient and family
7. Effective counseling of family and others
   a. The process of the death and dying of a loved one via direct communication, family conferences and creation of a multidisciplinary team for resolution
   b. Grief reaction
   c. Continuing relationships with family members after a loss
8. Self-care and seeking support when patients die

## Implementation

This curricular segment lends itself to a combination of longitudinal and block learning experiences over the 3 years of residency training. The curricular content should be integrated into the core conference schedule and should include exposure to hospice care, home visits and bereavement counseling whenever possible. Relevant literature should be available in the resident library. An attempt should be made to include patients who have terminal illnesses in all resident-patient panels. The faculty should function as role models for residents dealing with dying patients and their families. Active learning techniques such as role playing, simulated patients, case discussions and topic presentations are useful.

## Resources

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End of Life/Palliative Education Resource Center.
www.eperc.mcw.edu

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