Recommended curriculum guidelines for family medicine residents

Palliative and end-of-life care

This document was endorsed by the American Academy of Family Physicians (AAFP).

INTRODUCTION

Each family medicine residency program is responsible for its own curriculum. The AAFP Commission on Education's Subcommittee on Graduate Curriculum has created this guide as an outline for curriculum development, and it should be tailored to the needs of the program.

Through a series of structured and/or longitudinal experiences, the curricula below will support the overall achievement of the core educational competencies defined by the Accreditation Council for Graduate Medical Education (ACGME) and provide guideposts to program requirements specific to family medicine. For updates and details, please refer to the ACGME website at www.acgme.org. Current AAFP curriculum guidelines may be found online at 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.

PREAMBLE

Family medicine is defined by its commitment to whole-person continuity care across a lifespan. These foundational principles align closely with those of palliative and end-of-life care, which emphasize dignity, symptom relief and treatment choices that reflect patients' values and goals. As our population ages, the need for high-quality palliative care for patients with life-limiting illnesses increases.

This curriculum outline aims to provide guidance for integrating palliative medicine competencies into family medicine residency training. It supports the development of family physicians who can initiate timely goals-of-care discussions, manage complex symptoms and advocate for patient autonomy, whether in the context of life-prolonging treatments or hospice care.

Education in palliative care enhances residents' ability to care for seriously ill patients of all ages, including pediatric and adult populations, and to support families through critical health transitions. This blending of competencies and skills enhances communication skills and promotes ethical decision-making and interdisciplinary collaboration.

Embedding these competencies into family medicine residency curricula affirms the role of the family physician as a lifelong advocate and guide, capable of delivering compassionate, evidence-based care at every stage of illness, including at life's end.

PATIENT CARE

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

1. Perform accurate physical assessments, with attention to common findings of the seriously ill patient
2. Demonstrate systematic recognition, assessment and management of commonly encountered symptoms
3. Manage common symptoms using evidence-based pharmacologic and nonpharmacologic treatments, with attention to polypharmacy and potential side effects
4. Identify the primary decision-maker when the patient is unable to communicate and/or make medical decisions
5. Utilize common prognostication tools and recognize their limitations
6. Develop a treatment and management plan for palliative care that includes:
    a. An initial and ongoing symptom management regimen
    b. A comprehensive interdisciplinary assessment of the values, goals and needs for palliative and end-of-life care expressed by the patient and the family
    c. Patient autonomy throughout the continuum of illness by addressing physical, emotional, social and spiritual needs
    d. Demonstrated compassion and understanding for the dying patient's need for comfort, dignity and relief from suffering
    e. Consideration of the family's needs when a patient is imminently dying
7. Assess and treat patients' pain in a logical, systematic and evidence-based manner
    a. Utilize adjuvant or coanalgesic medications for pain relief, when appropriate
        i. Bone-related pain
        ii. Muscular pain
        iii. Neuropathic pain
        iv. Visceral pain
    b. Differentiate and prescribe opioids for severe pain in seriously ill patients
        i. Practice safe prescribing
        ii. Utilize opioid risk assessment tools
        iii. Understand opioid dosages and oral morphine equivalents
        iv. Educate patients and families about risks/benefits of opioid pain treatment, when necessary
        v. Address and alleviate concerns/myths about opioid use in end-of-life pain palliation
    c. Utilize patient- and disease-appropriate routes of analgesia
        i. Oral
        ii. Sublingual
        iii. Intravenous

iv. Subcutaneous
v. Rectal
vi. Transdermal (patches)
vii. Topical (creams/gels)
viii. Nasal
ix. PEG

8. Recognize and treat non-pain symptoms—including, but not limited to, nausea, fatigue, anorexia, insomnia, constipation, depression and anxiety—in seriously ill patients to enable patient comfort
9. Determine patient preferences regarding CPR and appropriately document "code status" in the medical record and physician orders
10. Utilize available hospice admission guidelines, and work with local hospice agencies to determine hospice eligibility and place appropriate hospice referrals
11. Assess for the signs and symptoms of a patient who is imminently dying, and anticipate the needs of the patient and family

MEDICAL KNOWLEDGE

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

1. Define palliative care, including its appropriateness at any stage of a serious illness (not excluding curative or life-prolonging treatments), and recognize that its duration is dependent on patient needs rather than prognosis
2. Define hospice care, including its appropriateness at the end stage of a serious illness and/or at the end of life when the prognosis is approximately six months or less
3. Differentiate the benefits of palliative care and hospice care
4. Describe the mission of palliative care, including its emphasis on the following:
   a. Quality of life (physical, functional, psychological, practical and spiritual consequences of serious illness)
   b. Alleviation of suffering
   c. Respect for and preservation of patient autonomy and self-determination
   d. Person- and family-centered care
5. Understand the epidemiology of serious illness with respect to the following:
   a. Common chronic illnesses and their trajectories over time
      i. Cardiovascular disease and heart failure
      ii. Pulmonary disease and respiratory failure
      iii. Renal disease and failure
      iv. Hepatic disease and failure
      v. Cerebrovascular disease and stroke
      vi. Neurological disease (neuromuscular, neurodegenerative, dementias)
      vii. Malignancies and complications
   b. Aging populations and the leading causes of death by age group
   c. Cost of care for terminally ill patients in various settings
   d. Survival rates and rates for home discharge after receiving attempts at life-sustaining treatment (CPR, intubation)
6. Recognize the eight domains of quality hospice and palliative care
   a. Domain 1: Structure and processes of care
      i. Care locations
         1) Hospital-based care
            a) Inpatient

b) ICU
c) Emergency department

2) Community-based care
a) Outpatient
b) Extended care facility
c) Home

ii. Interdisciplinary team functions and purpose
1) Physicians
2) Non-physician clinicians
3) Nurses
4) Caregivers
5) Social workers
6) Home health aides
7) Chaplains
8) Pharmacists
9) Volunteers
10) Behavioral health therapists
11) Bereavement/grief counselors
12) Child-life specialists
13) Music therapists

iii. Hospice
1) Eligibility guidelines (adult and pediatric)
2) Certification of terminal illness
3) Services covered and sources of payment
4) Barriers to enrollment/referral
5) Data patterns of use
a) Time enrolled
b) Services used
c) Populations served
d) Disparities

b. Domain 2: Physical aspects of care
i. Pain
1) Physiology
a) Acute vs. chronic
b) Somatic
c) Neuropathic
d) Visceral
e) Total pain (inclusive of spiritual, physical and existential components)

2) Assessment
a) Multidimensional
b) Patient expectations, goals and concerns
c) Review of data (medical records, controlled substance prescription history)

3) Management
a) Opioids
i) Patient/family education
1. Risk assessment
2. Safe prescribing

ii) Overdose precautions
1. Assessment/dose adjustment
2. Reversal agents (naloxone)

iii) Dosing conversions

iv) Formulations (short-acting vs. long-acting)
v) Routes of administration
vi) Pharmacokinetics/metabolism/clearance
vii) Titration and weaning
viii) Rotation
ix) Addiction, tolerance and dependence
x) Side effects
1. Opioid-induced constipation
2. Sedation
3. Confusion
4. Itching
5. Nausea/vomiting
6. Agitation
7. Opioid-induced hyperalgesia
8. Signs of withdrawal
xi) Nonopioid and adjuvant analgesics
b) Nonpharmacologic pain control measures
c) Complementary and integrative treatment modalities

ii. Non-pain symptom assessment and management
1) Respiratory
a) Dyspnea
b) Cough
c) Secretion management
d) Oropharyngeal rales
e) Hiccups
2) Gastrointestinal
a) Nausea/vomiting
b) Acid reflux
c) Xerostomia/stomatitis
d) Dysphagia/odynophagia
e) Diarrhea vs. overflow incontinence
f) Constipation vs. obstruction
g) Anorexia/cachexia
3) Genitourinary
a) Urinary retention/polyuria
b) Incontinence
4) Behavioral/psychiatric
a) Depression
b) Anticipatory grief/demoralization
c) Anxiety
d) Delirium
i) Hypoactive vs. hyperactive vs. mixed
ii) Reversible vs. terminal
5) Constitutional
a) Sleep disturbance
i) Insomnia/hypersomnia
ii) Sleep apnea
iii) Nightmares
b) Fatigue/asthenia
c) Fever/chills
d) Neurological symptoms
e) Seizures

f) Paralysis/immobility
6) Hematological
a) Hypercoagulability/blood clots/deep vein thrombosis/pulmonary embolism
b) Bleeding
c) Bruising
7) Integumentary
a) Wound care
i) Assessment
ii) Pressure sores
iii) Cancer wounds
iv) Infections
b) Pruritus/xerosis
iii. Polypharmacy and deprescribing
iv. Prognostication
1) "Surprise question" (SQ)
2) Palliative Prognostic Score (PaP)
3) Palliative Performance Scale (PPS)
4) Mortality Risk Index (MRI)
5) ePrognosis (Lee/Schonberg indices)
6) Disease-specific scoring systems
a) Functional Assessment Staging Tool (FAST) scale
b) Eastern Cooperative Oncology Group (ECOG) scale
c) Karnofsky index
d) Model for End-stage Liver Disease (MELD) 3.0

c. Domain 3: Psychological and psychiatric aspects of care
i. Bereavement process
1) Normal grief reaction
2) Adjustment disorder or complicated grief
3) Clinician grief, self-care and wellness

d. Domain 4: Social aspects of care

e. Domain 5: Spiritual, religious and existential aspects of care
i. Spiritual assessment
1) FICA tool
2) HOPE tool

f. Domain 6: Cultural aspects of care
i. Empathic communication
1) Patient-centered goals
2) Shared decision-making
3) Estimation of prognosis
4) Barriers to communication
a) Language
b) Family dynamics
c) Preconceptions
d) Clinician anxiety/inexperience

g. Domain 7: Care of the imminently dying patient
i. Recognize and acknowledge signs of impending death
ii. Treat discomforts associated with impending death
iii. Prepare families for "what to expect" (physiological changes, etc.)
iv. Encourage patient-family discussions regarding postmortem disposition
v. Understand the complexity of patient-family medical decision-making with respect to applicable state laws and regulations

h. Domain 8: Ethical and legal aspects of care
    i. Competency vs. capacity
    ii. Hierarchy of surrogate decision-making
    iii. Advance directives
        1) Durable power of attorney for health care (state dependent)
        2) Medical power of attorney (state dependent)
        3) Directive to physicians
        4) Living will
    iv. Physician orders
        1) Out-of-hospital do-not-resuscitate (DNR) orders
        2) Physician Orders for Life-Sustaining Treatment (POLST) forms
    v. Guardianship issues
    vi. End-of-life care options
        1) Palliative sedation
        2) Withdrawal of life-sustaining treatment
        3) Physician aid in dying (state dependent, ethical issues)
        4) Artificial nutrition and hydration (pros and cons)
    vii. Patient care and legal requirements upon the death of a patient, including:
        1) Pronouncement of death
        2) Notification of next of kin
        3) Disposition of remains
            a) Cremation vs. burial
            b) Transportation of remains
        4) Death certification

INTERPERSONAL COMMUNICATION

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

1. Demonstrate basic communication skills in serious illness discussions and goals-of-care conversations, including use of empathic, patient-centered language that is sensitive to the impact of cultural and/or religious beliefs on patient care decisions
2. Facilitate a family meeting to elucidate goals of care and quality-of-life expectations for both the patient and caregiver(s) by setting expectations, sharing values, and identifying cross-cultural and spiritual issues that can drive decision-making
3. Deliver bad news compassionately and empathically to both patients and family members
4. Communicate prognoses and their limitations to patients and family members
5. Develop and communicate palliative care plans and end-of-life care plans to patients and family members effectively
6. Discuss expectations, signs of change and transitions of care points with patients and family members
7. Communicate patient and family goals regarding care plans to other members of the patient care team
8. Counsel family members and others effectively throughout the bereavement process, and refer them to additional help in complicated grief situations
9. Discuss internet safety and protection of health information
10. Discuss risks and benefits of social media use for a medical practice and for a health care professional

SYSTEMS-BASED PRACTICE

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

1. Refer patients and caregivers to available services related to:
   a. Financial or social needs
   b. Legal needs (e.g., advance directives, surrogate decision-makers, guardianship)
   c. Psychological needs, including bereavement
2. Assist patients in effectively navigating complex health systems, with particular focus on transitions from curative care to palliative care to hospice care
3. Comply with regulations pertaining to use of controlled substances for terminally ill patients in and out of hospice care
4. Reflect on special issues associated with children, either as terminally ill patients or as family members of a terminally ill patient (i.e., resources for specific needs of children)

PRACTICE-BASED LEARNING

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

1. Incorporate patient and family feedback to adapt and refine care plans, ensuring alignment with the patient's evolving goals, values and definitions of quality of life
2. Engage in ongoing self-assessment and seek feedback from peers, mentors and interdisciplinary team members to enhance competence in delivering palliative and end-of-life care
3. Utilize evidence-based guidelines and current literature to inform symptom management strategies, including management of pain and non-pain symptoms commonly encountered in palliative care
4. Recognize personal biases and emotional responses related to caring for terminally ill patients, and develop strategies that promote self-care and resilience in order to maintain professional effectiveness

PROFESSIONALISM

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

1. Identify and accept a patient's individual definition of quality of life and facilitate incorporation of the patient's definition into care planning
2. Respect a patient's autonomy and dignity, avoiding assumptions about their care preferences, including their decisions regarding code status, life-sustaining treatments, hospitalizations and comfort care
3. Demonstrate respect for the psychosocial, cultural, spiritual and religious issues affecting seriously or terminally ill patients and their family members
4. Function as a contributing member of the interdisciplinary team by understanding the roles and expectations of other team members, including social workers, chaplains, nurses, respiratory therapists, behavioral health professionals and other physicians
5. Appreciate the complexities of the bereavement process for the dying patient and

family members throughout the progression of illness and after death
6. Engage in self-care and seek support for personal well-being as a health care professional
7. Demonstrate awareness of implicit bias, particularly in relation to race and ethnicity

IMPLEMENTATION

This curriculum should be taught in a combination of longitudinal and block learning experiences throughout residency training. The curricular content should be integrated into the core didactic schedule on a recurring basis. The content should include instruction regarding palliative and hospice care and how to discuss them with families; ways to identify goals of care and quality-of-life expectations in various care settings as part of an interdisciplinary team; and bereavement counseling, when possible. Clinical exposure could include rotations with inpatient and outpatient palliative and hospice care teams, home visits and opportunities to lead family meetings. Relevant literature should be regularly reviewed and integrated into the curriculum. Patients who have terminal illnesses should be included in all resident patient panels. Faculty members should function as role models for residents in the care of dying patients and their families. Active learning techniques such as role-playing, patient simulations, case discussions and topic presentations are preferred.

RESOURCES

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Coda Alliance. Go Wish cards. https://codaalliance.org/go-wish

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Dignity in Care. The patient dignity question. https://dignityincare.ca/en/the-patient-dignity-question.html

EPEC: Education in Palliative and End-of-Life Care. www.bioethics.northwestern.edu/programs/epec/index.html

ePrognosis. https://eprognosis.ucsf.edu

GeriPal: A geriatrics and palliative care podcast for every healthcare professional. https://geripal.org

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The Patient Preferences Project. Best case/worst case scenario communication tool. www.youtube.com/watch?v=oXfXr7koz_A

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REVISIONS

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