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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

This Curriculum Guideline defines a recommended training strategy for family medicine residents. Attitudes, behaviors, 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), [www.acgme.org](http://www.acgme.org). The family medicine curriculum must include structured experience in several specified areas. Much of the resident's knowledge will be gained by caring for ambulatory patients who visit the family medicine center, although additional experience gained in various other settings (e.g., an inpatient setting, a patient's home, a long-term care facility, the emergency department, the community) is critical for well-rounded residency training. The residents should be able to develop a skillset and apply their skills appropriately to all patient care settings.

Structured didactic lectures, conferences, journal clubs, and workshops must be included in the curriculum to supplement experiential learning, with an emphasis on outcomes-oriented, evidence-based studies that delineate common diseases affecting patients of all ages. Patient-centered care, and targeted techniques of health promotion and disease prevention are hallmarks of family medicine and should be integrated in all settings. Appropriate referral patterns, transitions of care, and the 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 website. Current AAFP Curriculum Guidelines may be found online at [www.aafp.org/cg](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. As patients live longer with chronic debilitating diseases as a result of technological advances, and the aging population continues to grow, it is vital to improve and refine our teaching of palliative and 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. Recognizing that palliative medicine is focused on relieving and improving quality of life 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 physician-patient relationship. Palliative medicine may be combined with other treatments or modalities with a therapeutic goal, or it may be the complete focus, as in hospice care. 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. This care and support can set the stage for very meaningful experiences. The time and care surrounding a loved one's death can have a significant impact. Appropriate teaching and experiences in palliative and end-of-life care throughout residency training will not only provide the necessary knowledge to help ease pain and suffering, but also will inspire family physicians to participate in the ultimate continuity of care: care of the terminally ill.

## Competencies

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

- Identify and manage a plan of care for a terminally ill patient that is based upon a comprehensive interdisciplinary assessment of the patient and family's expressed values, goals, and needs, and be able to effectively communicate the plan to the

patient and family (Patient Care, Medical Knowledge, Interpersonal and Communication Skills)

- Recognize that quality of life is defined by the patient and not by the physician (Patient Care, Interpersonal and Communication Skills, Practice-based Learning and Improvement, Professionalism)
- Identify the primary decision maker when the patient is unable to communicate and/or make medical decisions, and be aware of the ethical and legal issues that may limit or be the basis of a terminally ill patient's preferences and choices (Practice-based Learning and Improvement, Interpersonal and Communication Skills, Systems-based Practice, Professionalism)
- Facilitate patient autonomy, access to information, and choice, and be able to provide palliative care throughout the continuum of illness while addressing physical, emotional, social, and spiritual needs (Patient Care, Medical Knowledge, Interpersonal and Communication Skills, Professionalism)
- Recognize the signs and symptoms of the imminently dying patient, and anticipate the patient's needs (Medical Knowledge, Patient Care, Interpersonal and Communication Skills)
- Demonstrate systematic recognition, assessment, and management of pain syndromes utilizing evidence-based medicine. This should include both pharmacologic (opiate and non-opiate) and non-pharmacologic treatments, as well as possible side effects. (Patient Care, Medical Knowledge, Practice-based Learning and Improvement)

## **Attitudes**

The resident should demonstrate attitudes that encompass:

- The ability to compassionately and empathetically deliver bad news
- Understanding of the psychosocial issues and family dynamics affecting the terminally ill patient
- Understanding of the spiritual and religious issues affecting the terminally ill patient and the family members
- Respect for the cultural beliefs and customs of the patient and the family members in the context of death and dying
- Understanding of the dying patient's need for palliative care, pain relief, control, and dignity
- Understanding of the special issues associated with children, either as terminally ill patients or as family members of a terminally ill patient
- Understanding of the bereavement process for the dying patient and the family members during the continuum of illness and after death

- The ability to function as a member of the interdisciplinary team while respecting the individual goals and beliefs of each team member

## Knowledge

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

1. Palliative and end-of-life care
    - a. Mission
      - i. Improve quality of life
      - ii. Alleviate suffering
      - iii. Autonomy of the patient
      - iv. Patient-family centered care
        - 1) The eight domains of quality hospice and palliative care
          - a) Structure and processes of care
          - b) Physical aspects of care
          - c) Psychological and psychiatric aspects of care
          - d) Social aspects of care
          - e) Spiritual, religious, and existential aspects of care
          - f) Cultural aspects of care
          - g) Care of the imminently dying patient
          - h) Ethical and legal aspects of care
        - 2) Concept of total pain, inclusive of spiritual, physical, and existential components
        - 3) Continuum from palliative care to hospice care
2. Hospice team roles
  - a. Physician
    - i. Identification of appropriate patients for hospice care
      - 1) Cancer-related
      - 2) Non-cancer-related
        - a) Pulmonary
        - b) Cardiovascular
        - c) Neurologic
        - d) Infectious
        - e) Liver
        - f) Kidney
    - ii. Referral process and criteria
    - iii. Insurance and Medicare coverage in various settings
  - b. Nurses
  - c. Family
  - d. Pharmacists

- e. Home health care aides
  - f. Social worker
  - g. Chaplain
  - h. Volunteers
3. Prognostication
- a. Accuracy of prognosis
  - b. Karnofsky Index
  - c. ECOG Scale
  - d. Palliative Prognostic Score
  - e. Mortality Risk Index
  - f. FAST Scale
4. Pain control
- a. Opiates (long- and short-acting)
  - b. Conversion of opiates (equianalgesic table)
  - c. Non-opiates
  - d. Addiction, habituation, and dependence
  - e. Baseline dosing and rescue doses
    - i. Naive
    - ii. Experienced
  - f. Complementary and alternative medicine, including massage and osteopathic manual medicine
  - g. Non-pharmacologic pain control measures
  - h. Side effects of pain control measures
5. Causes and treatment of non-pain 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
  - l. Oral secretions
  - m. Seizures
  - n. Incontinence
  - o. Encopresis
6. Nutrition and hydration in the terminally ill
- a. Artificial feeding
  - b. Intravenous fluids
  - c. Withholding feeding and fluids
7. Care locations
- a. Emergency department
  - b. Inpatient setting
  - c. Outpatient setting
  - d. Extended-care facility
  - e. Home
8. 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. hospital)
9. The bereavement process
- a. Normal grief reaction
  - b. Identify/differentiate characteristics of a dysfunctional grieving process, including depression, anxiety, guilt, substance abuse, and reconciled relationships
10. Legal issues
- a. Patient competency
  - b. Advance directives
  - c. Do-not-resuscitate (DNR) orders
  - d. Durable power of attorney for health care

- e. Living will
- f. Physician Orders for Life-Sustaining Treatment (POLST) forms
- g. Estate planning for patient and family
- h. Withholding and withdrawing life support
- i. Pronouncement of death
- j. Completion of death certificate
- k. Physician-assisted suicide

## **Skills**

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

1. Perform an accurate physical assessment with attention to common findings of the terminally ill patient
2. Facilitate a family meeting using appropriate wording and questioning, and understand the impact of this process on the patient and family
3. Determine patient preferences regarding cardiopulmonary resuscitation and appropriately document “code status” in medical record and physician orders. Complete Physician Orders for Life-Sustaining Treatment (POLST) forms when requested by patient or family.
4. Be in compliance with regulations pertaining to use of controlled substances for the terminally ill patient in and outside hospice care
5. Develop an initial and ongoing analgesic regimen to include the use of morphine-equivalent dosages and other opioid equivalents across the spectrum of palliative and end-of-life patients
6. Use alternative routes of analgesia effectively
  - a. Rectal
  - b. Topical (e.g., creams, gels, patches)
  - c. Nasal
  - d. Subcutaneous
  - e. Sublingual
  - f. Inhaled via nebulizer
7. Refer both patient and family to available social services

8. Counsel family and others effectively throughout the bereavement process
9. Assist families in providing self-care and seeking support when a patient dies
10. Function as a contributing team member of the interdisciplinary team

## Implementation

This curriculum should be taught in a combination of longitudinal and block learning experiences over the three 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. 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 in the care of dying patients and their families. Active learning techniques such as role playing, simulated patients, case discussions, and topic presentations are useful.

## Resources

American Academy of Hospice and Palliative Medicine. *Primer of Palliative Care*. 6<sup>th</sup> ed. Glenview, Ill: AAHPM; 2014.

Berger AM, Shuster JL, VonRoenn JH. *Principles and Practice of Palliative Care and Supportive Oncology*. 4<sup>th</sup> ed. Philadelphia, Pa: Lippincott Williams & Wilkins; 2013.

Booth S, Edmonds P, Kendall M. *Palliative Care in the Acute Hospital Setting*. New York, NY: Oxford University Press; 2010.

Bruera E, Higginson IJ, von Gunten CF, Morita T, eds. *Textbook of Palliative Medicine and Supportive Care*. 2<sup>nd</sup> ed. Boca Raton, Fla: CRC Press; 2015.

Carter BS, Levetown M, Friebert SE, eds. *Palliative Care for Infants, Children, and Adolescents: A Practical Handbook*. 2<sup>nd</sup> ed. Baltimore, Md: Johns Hopkins University Press; 2011.

Cherny N, Fallon M, Kaasa Stein, Portenoy RK, Currow DC, eds. *Oxford Textbook of Palliative Medicine*. 5<sup>th</sup> ed. New York, NY: Oxford University Press; 2015.

Esper P, Kuebler KK. *Palliative Practices from A to Z for the Bedside Clinician*. 2<sup>nd</sup> ed. Pittsburgh, Pa: Oncology Nursing Society; 2008.

Fitzgibbon DR, Loeser JD. *Cancer Pain: Assessment, Diagnosis, and Management*. Philadelphia, Pa: Lippincott Williams and Wilkins; 2010.

Kübler-Ross E. *On Death and Dying*. Classics ed. New York, NY: Simon and Schuster; 2014.



Lo B. *Resolving Ethical Dilemmas: A Guide for Clinicians*. 5<sup>th</sup> ed. Philadelphia, Pa: Lippincott Williams & Wilkins; 2013.

Lynn J, Schuster JL, Wilkinson AM, Simon LN. *Improving Care for the End of Life: A Sourcebook for Health Care Managers and Clinicians*. 2<sup>nd</sup> ed. New York, NY: Oxford University Press; 2008.

Meier DE, Isaacs SL, Hughes RG, eds. *Palliative Care: Transforming the Care of Serious Illness*. San Francisco, Calif: Jossey-Bass; 2010.

Mitchell G. *Palliative Care: A Patient-Centered Approach*. Abingdon, UK: Radcliffe; 2008.

O'Reilly K, Watson M, Simon C. *Pain and Palliation*. New York, NY: Oxford University Press; 2010.

Papadakis MA, McPhee SJ. *Current Medical Diagnosis and Treatment 2015*. 54<sup>th</sup> ed. New York, NY: Lange Medical Books/McGraw-Hill; 2015.

Walsh TD, Caraceni AT, Fainsinger R, et al. *Palliative Medicine*. Philadelphia, Pa: Saunders; 2009.

Watson M, Lucas CF, Hoy AM, Wells J. *Oxford Handbook of Palliative Care*. 2<sup>nd</sup> ed. New York, NY: Oxford University Press; 2009.

## **Website Resources**

National Consensus Project for Quality Palliative Care (NCP).  
[www.nationalconsensusproject.org/](http://www.nationalconsensusproject.org/)

Palliative Care Network of Wisconsin (PCNOW). Fast Facts and Concepts.  
[www.mypcnow.org/#!/fast-facts/c6xb](http://www.mypcnow.org/#!/fast-facts/c6xb)

## **Journal Titles**

*Advances in Palliative Medicine*

*American Journal of Hospice and Palliative Care*

*BMC Palliative Care*

*Journal of Pain and Palliative Care Pharmacotherapy*

*Journal of Pain Symptom and Management*

*Journal of Palliative Medicine*

*Pain Research and Management*

*Palliative & Supportive Care*

*Palliative Care: Research and Treatment*

*Palliative Medicine*

*Progress in Palliative Care*

## **Recommended Reading**

*Being Mortal: Medicine and What Matters in the End* by Atul Gawande, MD

*Dying Well: Peace and Possibilities at the End of Life* by Ira Byock, MD

*The Best Care Possible: A Physician's Quest to Transform Care Through the End of Life* by Ira Byock, MD

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