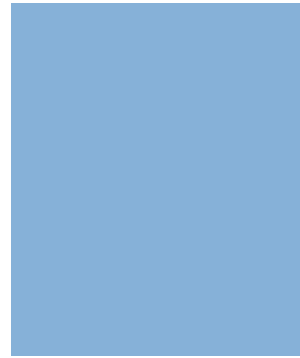


*The Fellowship in Advanced Rural
General Practice*

Advanced Rural Skills Training – Curriculum for Palliative Care



The Fellowship in Advanced Rural General Practice (FARGP)

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We recognise the traditional custodians of the land and sea on which we work and live.

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Introduction

The Fellowship in Advanced Rural General Practice (FARGP) is a qualification awarded by the Royal Australian College of General Practitioners (RACGP) in addition to the vocational Fellowship (FRACGP). The FARGP has distinct pathways for general practice registrars and practising GPs.

The FARGP requirements are:

- completion of the FARGP learning plan and reflection activity
- 12 months in a rural general practice setting
- 12 months of Advanced Rural Skills Training (ARST) in an accredited training post
- completion of a six-month 'working in rural general practice' community-focused project
- completion of the FARGP emergency medicine activities, including satisfactory completion of two advanced emergency skills courses.

A core component of the FARGP is the completion of 12 months of Advanced Rural Skills Training (ARST) in an accredited training post. This is designed to augment core general practice training by providing an opportunity for GPs looking to build, refresh or develop more specialised and/or a broader range of skills and knowledge to meet the needs of their rural or remote community.

For more information on the FARGP or advanced skills training:

- visit the website www.racgp.org.au/fargp
- email fargp@racgp.org.au or
- call RACGP Rural on **1800 636 764**.

Aim

This curriculum is designed to provide GPs and registrars with the skills, knowledge and confidence to provide quality palliative care in rural and remote communities.

Rationale

Skill requirements fluctuate throughout the career of GPs as they respond to changing community needs, address specific disease or population burdens, ensure practice viability and/or adapt to changes in government policy and environment (such as rural hospital closures).¹ GPs may identify a particular area of interest or a specific service gap in their community, or they may seek to broaden their generalist skill set through the acquisition of advanced skills. Undertaking ARST enables GPs to extend their expertise in a particular area and/or expand their generalist skill set, and enhance their capability to provide secondary-level care to their community.

The provision of palliative care services is a significant challenge for the health sector and will become increasingly important as the Australian population ages and demand for these services increase. Rural GPs play an important role in this area, delivering palliative medicine across a number of primary and tertiary care settings and coordinating the broad range of service responses required to meet diverse patient need in rural settings.

Stage of illness, care setting and patient preferences all add to the complexity of palliative care, and it is important that rural GPs have access to the training and support they need to meet patient needs in this challenging context. By undertaking ARST in palliative medicine, registrars and practising rural GPs can build their capacity to address these rural challenges, thus helping to provide high-quality palliative care to their community.

Prerequisites for registrars

The FARGP ARST for palliative medicine candidate must:

- have completed at least 12 months (FTE) of Australian general practice training in a rural general practice setting. (This requirement is to provide a rural general practice context to the learning and provide a better understanding of where the palliative care will be practised. Exemptions on a case by case basis will be considered by the RACGP Rural Censor via application to fargp@racgp.org.au)
- be willing to work as part of a team that includes families of dying patients, and nursing and allied health professionals in the field of palliative care, in both rural and hospital settings.

Duration, setting and supervision

The requirements for this ARST curriculum must be completed in 12 months full-time equivalent (FTE) in an accredited training post, in accordance with the vocational standards and requirements published by the RACGP.

The ARST post must be with a specialist palliative care unit in an appropriate metropolitan or regional setting. The FARGP candidate is required to spend a minimum of six months (FTE) in a hospital/hospice setting in order to avail themselves of the volume of patients and learning opportunities. The remaining six months of the training term can be spent in the same unit, a different location or an alternative setting such as community-based palliative care unit, or a general practice or primary care environment that has GPs providing palliative medicine services.

The training post will be under the direct supervision of a palliative medicine physician who is a Fellow of the Royal Australasian College of Physicians or a Fellow of the Australasian Chapter of Palliative Medicine (RACP). The palliative medicine physician will provide the candidate with a source of clinical expertise, advice and educational support.

The FARGP candidate will also have indirect supervision from a medical educator to provide a link to the regional training organisation (RTO) to inform the candidate about educational activities and overall training requirements.

The candidate should also have monthly contact (face to face or via teleconference) with a professional mentor/role model such as a rural GP working in the area of palliative care to provide appropriate rural context and additional support throughout the training program.

The clinical placement/attachment to a specialist palliative care unit will include time spent working in all of the following at some stage through the year, preferably in equal measure:

- hospice or specialist inpatient palliative care unit
- community palliative care service
- general hospital consultative service
- work done in a specialist oncology (medical and radiation) unit is also highly desirable.

Recognition of prior learning for practising GPs

The RACGP recognises that doctors who have spent significant time in general practice will already have achieved some of the learning outcomes listed in this curriculum and should therefore be eligible for recognition of prior learning (RPL). A period of three years after FRACGP (full-time equivalent) will qualify a candidate to apply for RPL.

The duration of attachment is six months (full-time equivalent) if RPL is granted. A part-time attachment to a specialist palliative care unit would be acceptable for GPs working in rural or remote practice.

The application for RPL should detail how the candidate has achieved these outcomes with supporting evidence provided. Appropriate documentation could include a letter from a carer or consumer organisation confirming participation, copies of de-identified clinical notes for 20 patients demonstrating involvement in the management of the dying as their general practitioner, statements from consultant supervisors or colleagues confirming experience, and evidence of employment in hospice or palliative care unit etc. The outcomes must have been achieved in the past 10 years.

RPL can be applied for a range of learning outcomes, the following being examples:

- Develop a comprehensive professional referral network. (1.2.3)
- Collaborate with a palliative care consumer organisation. (3.2.1)
- Collaborate with carer organisations. (3.2.2)
- Describe the differing palliative care resources in rural and remote areas. (3.2.4)
- Manage patient confidentiality. (4.1.1)
- Define and describe the use of enduring guardianship and advance care planning and directives. (5.1.2)

Learning outcomes

These learning outcomes are grouped according to the five domains of general practice.

The terms in italics are defined in the Range statement section.

1. Communication skills and the doctor–patient relationship	
Outcome	Performance criteria
1.1 Effective and appropriate communication skills are demonstrated	<p>1.1.1 Establish a <i>therapeutic and supportive relationship</i> with patients and their families based on trust, empathy and confidentiality with an understanding of the importance of family and carer relationships in the context of palliative care</p> <p>1.1.2 Demonstrate focused, flexible and appropriate <i>communication</i> with patients and their families in discussing palliative, prognostic and end-of-life issues</p> <p>1.1.3 In a sensitive manner, explore palliative patients' concerns across the various <i>domains of health</i></p> <p>1.1.4 Modify communication with palliative patients and their families who are from <i>culturally and linguistically diverse</i> backgrounds</p> <p>1.1.5 Modify communication with palliative patients and their families who are from <i>Aboriginal and Torres Strait Islander</i> backgrounds</p> <p>1.1.6 Communicate and consult effectively within and across a <i>multidisciplinary palliative care team</i></p> <p>1.1.7 Educate health professionals involved in the patient's care on palliative and end-of-life care and other associated topics, as appropriate</p> <p>1.1.8 Exhibit a willingness to talk openly about death and dying with patients, family, other health professionals and the general community</p>
1.2 High-quality <i>holistic</i> healthcare is delivered to people accessing palliative care	<p>1.2.1 Work as part of a <i>multidisciplinary team</i> to offer safe palliative healthcare to patients with a terminal illness</p> <p>1.2.2 Manage complex palliative health issues as part of a <i>multidisciplinary team</i></p> <p>1.2.3 Develop a <i>comprehensive professional referral network</i></p> <p>1.2.4 Acknowledge and accommodate the role of spirituality for the patient and the family</p> <p>1.2.5 Discuss end-of-life issues with the patient and their carer(s)/family, including advanced care directives/planning to clarify the patient's wishes</p>

2. Applied professional knowledge and skills

Outcome	Performance criteria
2.1 A holistic approach to palliative care is used	<p>2.1.1 Describe the experience of <i>life-limiting illness</i> from the perspective of the patient and their family and the meaning and consequences of illness to the patient and their family</p> <p>2.1.2 Describe the natural history and role of disease-specific treatments in the management of progressive <i>life-limiting illness</i></p> <p>2.1.3 Practice culturally appropriate palliative care</p> <p>2.1.4 Use evidence-based pathophysiology and symptom management, to address the range of physical, psychosocial and spiritual issues relating to life-limiting illness and terminal decline</p>
2.2 Management is appropriate for the person and their symptoms	<p>2.2.1 <i>Develop rapport</i> with the palliative patient, their family and carer(s)</p> <p>2.2.2 Manage <i>challenging circumstances</i></p> <p>2.2.3 Manage concomitant clinical problems and <i>co-morbidities</i></p> <p>2.2.4 Assess risk factors for terminal decline</p> <p>2.2.5 Use the <i>correct phenomenology</i> for palliative and end-of-life care</p> <p>2.2.6 Identify relevant cultural, ethnic and societal issues around death and dying, and their impact on the practice of palliative medicine</p>
2.3 A number of palliative therapies are used appropriately	<p>2.3.1 Assess the patient and their situation to <i>manage symptoms</i>, as well as concurrent and new medical diagnoses</p> <p>2.3.2 Manage pain effectively, utilising both <i>non-pharmacological</i> and <i>pharmacological</i> means</p> <p>2.3.3 Describe the benefits, precautions and common adverse effects of a range of different evidence-based therapies</p> <p>2.3.4 Prescribe medication <i>safely and appropriately</i> based on the known pharmacology and best available evidence</p> <p>2.3.5 Communicate medication issues clearly and concisely to patients, their families and carers</p> <p>2.3.6 Prioritise appropriate investigations and management</p>
2.4 A number of management strategies are developed	<p>2.4.1 Use a model of care that focuses on managing symptoms and optimising <i>quality of life</i></p> <p>2.4.2 Employ pharmacotherapy for the full spectrum of palliative medicine issues</p> <p>2.4.3 Provide <i>supportive counselling</i> to patients and their families</p> <p>2.4.4 Recognise and manage <i>emergencies</i> as they arise in the context of palliative and end-of-life care</p> <p>2.4.5 Manage patients within the <i>context of their life</i></p> <p>2.4.6 Make a plan for managing deterioration and for crisis intervention that falls outside the expected clinical course of the life-limiting illness</p> <p>2.4.7 Demonstrate continuity of care for the long-term health of the patient to ensure optimum quality of life</p> <p>2.4.8 Outline the criteria for transfer of palliative patients to and from hospital</p>

3. Population health and the context of general practice	
Outcome	Performance criteria
<p>3.1 People with a palliative care issue who live in rural and remote areas receive appropriate and timely care</p>	<p>3.1.1 Work effectively with people with palliative care needs within their current social, cultural and economic settings</p> <p>3.1.2 Describe relevant cultural, ethnic and societal issues around death and dying, and their impact on the practice of palliative medicine</p> <p>3.1.3 <i>Advocate</i> for equity of access to multidisciplinary palliative care services</p> <p>3.1.4 <i>Advocate</i> to address the determinants of the experience of illness, dying and bereavement</p> <p>3.1.5 <i>Advocate</i> for access for those from disadvantaged groups and their families/carers</p>
<p>3.2 Health information is disseminated through relevant networks and organisations</p>	<p>3.2.1 Collaborate with relevant organisations involved in the area of palliative care</p> <p>3.2.2 Collaborate with other relevant organisations</p> <p>3.2.3 Promote palliative care services in the health systems in which they work</p> <p>3.2.4 Identify the differing palliative care resources in rural and remote areas</p> <p>3.2.5 Provide ongoing professional development sessions to other rural health professionals, staff, consumers and members of the community</p>
<p>3.3 Health service provision, policies and activities are initiated and undertaken</p>	<p>3.3.1 Use or <i>develop relevant guidelines</i> for health service provision in rural and remote areas that may be missing or in need of reform</p> <p>3.3.2 Involve consumers and consumer groups, and carers and carer groups in developments and initiatives in health service provision</p> <p>3.3.3 Provide information to the community about palliative care issues as a means of reducing the associated stigma and negative connotations</p> <p>3.3.4 Effectively utilise available healthcare resources</p> <p>3.3.5 Describe palliative care budgetary and human resource limitations</p> <p>3.3.6 Negotiate <i>prudent usage</i> of palliative resources</p> <p>3.3.7 Describe and implement, where appropriate, <i>policies and standards for palliative care</i></p>

4. Professional and ethical role

Outcome	Performance criteria
4.1 Ethical practice and behaviour relevant to palliative care are applied	<p>4.1.1 Maintain <i>professional standards of behaviour</i> when managing palliative patients</p> <p>4.1.2 Manage patient wishes to decline treatment</p> <p>4.1.3 Manage <i>ethical issues</i> and conflicts in patient care</p> <p>4.1.4 Recognise, analyse and address <i>ethical issues</i> in clinical practice</p> <p>4.1.5 Discuss the unique emotional and spiritual issues that arise for a palliative patient</p> <p>4.1.6 Advocate strongly for patient needs, including accessing best practice resources</p>
4.2 Appropriate self-care and reflection is practised	<p>4.2.1 Describe the personal stresses involved in caring for the dying</p> <p>4.2.2 Identify strategies for establishing, maintaining and improving self-awareness when interacting with patients with palliative care issues</p> <p>4.2.3 List and discuss <i>self-care strategies</i> that protect and minimise potential personal impacts associated with <i>high levels of disadvantage</i> that occur in a palliative care setting</p> <p>4.2.4 Identify own personal beliefs and those of one's <i>culture</i> and society, and the impact that these have on the ability to deal with death and dying</p> <p>4.2.5 Describe how <i>personal beliefs</i> can impact on the interactions between the doctor, the patients and their families</p> <p>4.2.6 Explain how the losses and grief of patients and their families can influence a doctor's ability to deal with their own losses, and vice versa</p> <p>4.2.7 Learn when to seek personal support for dealing with the emotional and existential issues that inevitably arise when providing palliative care</p> <p>4.2.8 Develop a network of supports that are tailored to the unique needs of the doctor</p>
4.3 The patient's needs are advocated for	<p>4.3.1 Advocate strongly for individual patient needs, including accessing best practice resources</p> <p>4.3.2 Advocate for the needs of social groups and cultures within the community</p> <p>4.3.3 Recognise the value of patients and communities participating fully in decision making regarding palliative care issues</p> <p>4.3.4 Contribute to a 'healthy' and normalising experience of dying and bereavement with patients, families and communities</p>

5. Organisational and legal dimensions	
Outcome	Performance criteria
5.1 Legal and legislative requirements for palliative care are accessed and applied	<p>5.1.1 Apply relevant <i>legislative and administrative requirements</i></p> <p>5.1.2 Define and describe the use of power of attorney, enduring guardian and <i>advance care directives</i> and negotiate these appropriately</p> <p>5.1.3 Identify state legal issues associated with end-of-life care</p> <p>5.1.4 Describe identification and certification of death, and surrounding legal issues</p> <p>5.1.5 Demonstrate professionally acceptable standards of documentation and report writing in the care of patients needing palliative care</p> <p>5.1.6 Undertake regular audits of management practices in dealing with patients needing palliative care and their families/carers</p> <p>5.1.7 Make accurate, comprehensive and contemporaneous patient records</p> <p>5.1.8 Complete relevant documentation as appropriate to the situation</p>
5.2 <i>Palliative care networks</i> are established and supported	<p>5.2.1 Establish a professional palliative care network</p> <p>5.2.2 Access the metropolitan <i>palliative care services</i> for clinical, academic, research, literature, hotline and legal services</p> <p>5.2.3 Develop and use resources and processes to ensure continuity of care for patients with palliative care issues</p> <p>5.2.4 Outline the range of support services for the carers of people with palliative care needs</p> <p>5.2.5 Structure the clinic/practice to accommodate patients with palliative care issues</p>
5.3 <i>Collaborate effectively</i> among multidisciplinary health professionals	<p>5.3.1 Involve team members in interdisciplinary meetings to maximise relevant contributions</p> <p>5.3.2 Organise and implement a treatment plan through collaboration with team members and other colleagues</p>
5.4 Utilise time and resources effectively	<p>5.4.1 Manage time effectively</p> <p>5.4.2 Prioritise tasks and perform tasks in a timely manner</p> <p>5.4.3 Exhibit flexibility in responding to unexpected urgent events</p> <p>5.4.4 Access opportunities for de-briefing or professional supervision</p> <p>5.4.5 Facilitate access to relevant appliances and aids to daily living for patients with palliative care issues</p>

Range statements

These definitions are grouped according to the five domains of general practice.

1. Communication skills and the patient–doctor relationship

Aboriginal and Torres Strait Islander peoples – includes people who are of Aboriginal and Torres Strait Islander descent, who identify as Aboriginal and/or Torres Strait islander, and who are accepted as such by the community within which they associate.

Communication – can include listening, speaking, looking for non-verbal communication, and written, phone and videoconferencing facilities.

Comprehensive professional referral network – a network of the local services, healthcare professionals and specialists, who can be accessed throughout the care of the patient.

Culturally and linguistically diverse communities – can include refugees, visa holders, migrants, people from English and non-English-speaking backgrounds, and people with diverse cultural and religious beliefs and practices that include unfamiliar/unconventional/challenging medical beliefs and practices regarding the roles of children, women, men and others in the community. People who are intellectually or hearing impaired should also be considered.

Develop rapport – with the patient and their family/carer to explore their psychological and emotional concerns and to discuss palliative and end-of-life issues.

Domains of health – the factors that together comprise a person's general health and wellbeing, including physical, psychological, emotional, social, cultural and spiritual factors.

Holistic – a concept that recognises the 'whole' person, rather than merely a person with a disease, integrating a person's mind, body and spirit; and the land, environment and context within which they live; and encompassing all of the domains – physical, psychological, social, emotional, cultural and spiritual – of a person's life, health and wellbeing.

Multidisciplinary team – can include oncologists, surgeons, GPs, palliative care nurses, allied health professionals and other specialists (occupational therapists, psychologists, social workers, etc).

Physical, psychological, social, cultural, spiritual domains of health – the domains of a person's life that influence their health and wellbeing.

Therapeutic and supportive relationship – the collaborative relationship between a healthcare professional and patient and their family in which they can engage with each other.

2. Applied professional knowledge and skills

Challenging circumstances – can make demands on one's abilities, endurance, patience and tolerance. Such patient behaviours may include anger, aggression, violence, agitation and psychiatric symptoms.

Co-morbidity – has implications for aetiology, diagnosis, management and prognosis of palliative conditions. Patients in the terminal phase of their lives often experience pain and develop mental health problems, as well as other medical conditions.

Context of patient's life – the life of the patient outside of the context of healthcare, whether this be in their own home, at a medical practice, in hospital, in a hospice or in a residential care facility.

Emergencies – including, but not limited to, airway obstruction and severe shortness of breath, pain crises, hypercalcaemia, superior vena caval obstruction, spinal cord compression, fractures, haemorrhage, seizures and acute anxiety and depression.

Life-limiting illness – any irreversible disease process or illness where it is expected that death will be a direct consequence of the disease or illness.

Manage symptoms – control symptoms, manage concurrent symptoms and new medical diagnoses through non-pharmacological and pharmacological means such that the patient can enjoy a good quality of life without suffering.

Non-pharmacological means – manage someone's pain without the use of medication, such as by using heat, ice, massage, physical therapy, or psychological therapies.

Personal, historical, contextual, legal, cultural and social influences – the various factors which influence a person's health and behaviour.

Pharmacological means – the use of medications and the various medication delivery methods, including oral analgesia, transdermal patches, 24-hour infusion pumps and intravenous therapies.

Phenomenology – the appropriate description of a patient's medical signs and symptoms in the palliative care context.

Quality of life – tied to the perception of 'meaning', and is a broad multidimensional concept of overall wellbeing that reflects the difference between a person's hopes and expectations and their ability to experience and enjoy life.

Safe and appropriate medication prescription – prescribing only those medications which may benefit the patient in managing their symptoms, so as to allow them to have a good quality of life in a manner that does not put them at harm.

Supportive counselling – provide patients and families counselling that collaboratively and appropriately sets realistic management goals for their concerns.

Therapies – should include both non-pharmacological and pharmacological therapies.

3. Population health and the context of general practice

Advocate – for the needs of social groups and cultures within the community who have specific palliative care needs or do not have effective access to palliative care services. Advocate strongly for patient needs, including accessing best-practice resources.

Carer organisations – includes Palliative Care Australia.

Community services – including nursing, allied health, domiciliary services and pastoral care. Coordination of community services can include care of the patient, health beyond that of the individual patient, and advocacy regarding community needs, needs of disadvantaged groups, and cross-cultural partnerships.

Ethical issues – including advanced medical planning, family involvement in medical planning, treatment of concurrent medical problems with limited life expectancy, and balancing symptom management with adverse drug events. Recognise, analyse and address issues relating to truth-telling, informed consent, advance directives, confidentiality, end-of-life care, conflicts of interest, resource allocation and research ethics.

Policies and standards for palliative care – including, for example, the Standards for providing quality palliative care for all Australians, as well as the policies specific for health districts and hospitals.

Prudent usage – using good judgement in the use of palliative resources; for example, the utilisation of in home services/house calls for patients who are too unwell to attend your practice, the use of infusion pumps for pain and symptom control.

Relevant guidelines – including end-of-life care and decision-making guidelines, guidelines for syringe driver management in palliative care and eTG guidelines for palliative care.

4. Professional and ethical role

Boundaries – the relationship between a doctor and a patient for the purposes of providing and obtaining treatment; this is commonly referred to as a doctor–patient relationship. This relationship has boundaries around it and within it as defined by medical regulatory authorities and common law.

Ethical issues – including the core ethical principles of autonomy of the patient; non-maleficence, which is the doctor’s duty to avoid inflicting physical or emotional harm on the patient; beneficence, which is to prevent or remove harm and promote wellbeing; and justice, which does not operate in a vacuum, but responds to the ever-changing social, political, religious and legal mores of the moment.

Personal and family boundaries – can include personal boundaries around disclosing personal information, socialising and forming relationships; family boundaries can be around issues of disclosing confidential work-related information, protecting your family against unwanted attention from patients; and professional boundaries around treating friends, family members, colleagues or acquaintances.

Professional standards of behaviour – can include negotiating and agreeing on treatment modalities, priorities and goals of treatment in partnership with patient/family/carers; resource allocation to best serve the health needs of the population on the basis of need and equity of access to care and support; recognition of personal emotional stress and seeking assistance appropriately; understanding of patient and community perspectives on a ‘good death’; the need to complete ‘unfinished business’; and the issues surrounding relief of suffering versus euthanasia.

Self-care strategies – activities that ensure the doctor remains well physically, spiritually and emotionally.

5. Organisational and legal dimensions

Advance care directive – a statement derived from discussion with a patient and others they considers significant, outlining their values and goals of care in certain circumstances. It may be specific (for example, not for intubation) or more general in nature.

Barriers to the provision of coordinated services – including intra-practice issues, time management and financial constraints.

Collaborate effectively – be a team player and openly support team activity. Exhibit a willingness to contribute to the interdisciplinary team. Demonstrate awareness and respect for the roles, expertise and limitations of multidisciplinary team members.

Community services – can include nursing, allied health, domiciliary services and pastoral care. Coordination of community services can include care of the patient, health beyond that of the individual patient, advocacy regarding community needs, needs of disadvantaged groups and cross-cultural partnerships.

Legislative and administrative requirements – can include death certificates, advance care directives, medical powers of attorney, enduring guardianship requirements, carer’s allowance applications, will preparation and testamentary capacity.

Palliative care services – including clinical, academic, research, literature, hotline and legal services.

Professionally acceptable standards – including those that are involved with the issue that medical records are not used by doctors alone, but also by regulatory agencies, by court-ordered subpoena, in malpractice litigation and by patients under the Freedom of Information Act 1982.

Resources and processes – can include written and recorded notes, copies of referrals, involvement. Utilise time and resources effectively in order to balance patient care, management duties, professional development, outside activities and personal life.

Structure – can include accommodating home visits for patients needing palliative care, when appropriate, arranging adequate clinical handover to partners or preferred after-hours providers to ensure continuity of care at all hours for patients requiring palliative care and their families.

Assessment

General practice registrars and practising GPs

Summative assessment comprises a logbook which includes a statement by the supervising palliative medicine physician, and two case reports, one of which must be about a patient with a non-cancer need for palliative care (for example, chronic kidney disease, chronic obstructive pulmonary disease, advanced cardiac failure) and the other about a patient with cancer.

Logbook

Description

A logbook of cases should be kept by each trainee during the training program. The purpose of the logbook is not to maintain a list of the palliative care cases seen during the program, but for the trainee to reflect on the subsequent learning from experiencing those cases. It is recommended that the trainee review a wide variety of different experiences (for example, a range of issues, symptoms, presentations, diagnoses and treatments). These can, and should, include examples of symptom/problem management from a 'biopsychosocial' model of care.

Each candidate will be supplied with a logbook at the commencement of this training program. It is strongly recommended that candidates have this logbook with them during each clinical placements and that it is updated on a weekly basis.

Section A

These activities must be recorded in the logbook and signed off by the candidate's clinical supervisor:

- Hospice/Inpatient facility:
 - three teaching ward rounds with supervising palliative medicine physician
 - six admissions (clinical clerking) of new patients with reasons for admission and plans for care
 - three multidisciplinary meetings with nursing and allied health professional staff
 - three family conferences in both the home setting and/or hospital/hospice.
- Community palliative care service:
 - two home visits
 - two discussions (and completion if appropriate) of advance care directives
 - three referrals to other specialists which could include oncology, inpatient palliative care, general hospital admission (ED, surgery, etc).
- Hospital consultative service:
 - two teaching consultations, of patients with cancer, with supervisor
 - one teaching consultations, of patients with non-cancer diagnoses, with supervisor
 - three interdisciplinary meetings with other specialties (for example oncology, surgery, cardiology, renal, ICU) regarding patients with advanced illness
 - at least one presentation at a multidisciplinary clinical meeting (for example, medical grand rounds).

- Oncology meetings and ward rounds:
 - two patients undergoing chemotherapy or radiotherapy
 - two complications of chemotherapy or radiotherapy
 - three meetings/interviews with a patient/family and cancer services in which cessation of active treatment is discussed.

All patients seen during the clinical placement should be noted in the logbook. Where ongoing care/visits occur with the same patients, this should also be noted. The logbook should be available to the candidate's medical educator, supervising palliative medicine physician and rural general practitioner for review during the ARST attachment.

The logbook will be reviewed by the rural censor at the completion of the attachment.

Statement by supervising palliative medicine physician

On completion of the attachment, the supervising palliative medicine physician must sign a document stating the candidate has met all curriculum requirements.

Case studies

Two case studies (in grand round report format), each of approximately 1200 words, will be completed as part of the final assessment. One case should be about patients with cancer and one about a patient with non-cancer condition requiring palliative medicine input. They should include detailed analyses of the most pertinent aspects of that case (rather than necessarily being all encompassing), referencing reasons why the patient was managed in a certain way. They should reflect on the learning each of the cases provided.

Reference

1. Royal Australian College of General Practitioners. New approaches to integrated rural training for medical practitioners – Final report. East Melbourne, Vic: RACGP, 2014. Available at <http://www.racgp.org.au/yourracgp/faculties/rural/projects/doh/>

Recommended resources

The following list of resources is provided as a suggested guide to resources relevant to palliative medicine in Australasia.

Books and other useful documents

Cherny N, Fallon M, Kaasa S, Portenoy R, Currow D. Oxford textbook of palliative medicine. 5th edn. Oxford: Oxford University Press, 2015.

The above is considered to be the definitive text and an essential source of information.

Palliative Care Australia. Standards for providing quality palliative care for all Australians. Deakin West, ACT: Palliative Care Australia, 2005.

Royal Australasian College of Physicians. 2015 PREP Clinical diploma in palliative medicine program requirements handbook; 2014.

Royal Australian College of General Practitioners. Palliative care: The nitty gritty handbook. Rev edn. South Melbourne, Victoria: Royal Australian College of General Practitioners, 2003.

Therapeutic Guidelines: Palliative care: version 3. Melbourne: Therapeutic Guidelines Limited, 2010.

Woodruff R. Palliative medicine. 4th edn. Melbourne: Asperula Press, 2003.

Journals

Palliative Medicine

Journal of Palliative Care

Progress in Palliative Care

Journal of Pain and Symptom Management

Societies

Australian and New Zealand Society of Palliative Medicine www.anzspm.org.au

Palliative Care Australia <http://palliativecare.org.au/>

