Specialty Training Requirements (STR)

Name of Specialty:	Palliative Medicine
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Scope of Palliative Medicine

Palliative medicine is the branch of medicine involved in the management of patients with progressive, life-threatening disease for whom the focus of care is maximising their quality of life through expert symptom management, psychological, social and spiritual support as part of a multi-professional team.

Purpose of the Residency Programme

The aims of this Palliative Medicine subspecialist training programme are to:

- Train a specialist in Palliative Medicine who may work in hospital-based palliative medicine teams or in the community (inpatient or home hospices, community hospitals or nursing homes)
- Encourage residents to possess habits of life-long learning to build upon their knowledge and skills
- Facilitate residents to be involved in a multidisciplinary working environment where they contribute their particular expertise to situations often in consultation with equally valid opinions from other health professionals
- Ensure that the residents are exposed to the necessary competencies required in Palliative Medicine to complete residency training in this field, and thereby be able to work as consultant specialists in hospitals or the community

Admission Requirements

At the point of application for this subspecialty residency programme:

a) Applicants must be employed by employers endorsed by Ministry of Health (MOH); and
b) Residents who wish to switch to this residency programme must have waited at least one year between resignation from his / her previous residency programme and application for this residency programme.

At the point of entry to this subspecialty residency programme, residents must have fulfilled the following requirements:

a) Hold a local medical degree or a primary medical qualification registrable under the Medical Registration Act (Second Schedule);
b) Have a valid Conditional or Full Registration with Singapore Medical Council (SMC);
c) Be employed by a Singapore Public Healthcare Institute or a Community-based Palliative Care Organisation;
d) Have successfully completed specialty training and pass the exit examination in one of the following base specialties in Singapore:
    - Advanced Internal Medicine or Geriatric Medicine or Medical Oncology or Paediatric Medicine (for the 24-month track residency programme)
    - Family Medicine either via the Family Medicine residency programme or via the College of Family Physician MMed (Family Medicine) Programme, and obtained the degree of Master of Medicine (MMed) in Family Medicine (for the 36-month track residency programme); and

e) Have clinical experience in Palliative Medicine or completed the Graduate Diploma in Palliative Medicine (GDPM) in Singapore within the last 3 years.

Selection Procedures

Applicants must apply for the programme through the annual residency intake matching exercise conducted by MOH Holdings (MOHH).

Continuity plan: Selection should be conducted via a virtual platform in the event of a protracted outbreak whereby face-to-face on-site meeting is disallowed and cross institution movement is restricted.

Less Than Full Time Training

Less than full time training is not allowed.

Non-traditional Training Route

The RAC does not accept application for mid-stream entry to residency programme by an International Medical Graduates (IMG).

Separation

The Programme Director (PD) must verify residency training for all residents within 30 days from the point of notification for residents' separation / exit, including residents who did not complete the programme.

Duration of Specialty Training

The training duration must be 24 months (for residents with base specialty in Advanced Internal Medicine, Geriatric Medicine, Medical Oncology or Paediatric Medicine) or 36 months (for residents with base specialty in Family Medicine).

Maximum candidature: All subspecialty residents must complete the training requirements, requisite examinations and obtain their exit certification from JCST not more than 24 months beyond the usual length of their training programme. The total candidature for Palliative Medicine is:

- *24 months Palliative Medicine residency + 24 months candidature for residents with base specialty in Advanced Internal Medicine, Geriatric Medicine, Medical Oncology or Paediatric Medicine; or*
- *36 months Palliative Medicine residency + 24 months candidature for residents with base specialty in Family Medicine.*

As the residents in Palliative Medicine are already specialists or family physicians, and for parity between residents in the 24-month and 36-month programme, the expected

level of competence and entrustment is based on the resident's Training Phase instead of year in residency:

First Residency Training Phase	*24-month programme: from entry till end of the 12th month* *36-month programme: from entry till end of the 18th month*
Mid-Residency Training Phase	*24-month programme: from the 13th month till end of the 18th month* *36-month programme: from the 19th month till end of the 30th month*
Final Residency Training Phase	*last 6 months of the programme*

For example:

	Jul – Dec 2024	*Jan – Jun 2025*	*Jul – Dec 2025*	*Jan – Jun 2026*	*Jul – Dec 2026*	*Jan – Jun 2027*
24-month Programme	*First Residency Training Phase*	*First Residency Training Phase*	*Mid-Residency Phase*	*Final Residency Phase*		
36-month Programme	*First Residency Training Phase*	*First Residency Training Phase*	*First Residency Training Phase*	*Mid-Residency Phase*	*Mid-Residency Phase*	*Final Residency Phase*

"Make-up" Training

Make-up" training must be arranged when residents:

- Exceed days of allowable leave of absence / duration away from training or
- Fail to make satisfactory progress in training.

The duration of make-up training should be decided by the Clinical Competency Committee (CCC) / Joint Coordinating Committee (JCC) and should depend on the duration away from training and/or the time deemed necessary for remediation in areas of deficiency. The CCC / JCC should review residents' progress at the end of the "make-up" training period and decide if further training is needed.

Any shortfall in core training requirements must be made up by the stipulated training year and/or before completion of residency training.

Learning Outcomes: Entrustable Professional Activities (EPAs)

Residents must achieve level **4b** of the following EPAs by the end of residency training:

	Title
EPA 1	Managing pain in patients with life-limiting illnesses
EPA 2	Managing non-pain symptoms in patients with life-limiting illnesses
EPA 3	Managing palliative care emergencies
EPA 4	Managing imminently dying patients
EPA 5	Supporting patients and families in the psychosocial and spiritual domains
EPA 5.1	Provide support to patients and families in the psychosocial and spiritual domains
EPA 5.2	Facilitate the provision of grief and bereavement support to families
EPA 6	Facilitating transitions across the palliative continuum of care
EPA 6.1	Facilitate transitions across palliative care settings
EPA 6.2	Facilitate terminal discharge for imminently dying patients
EPA 7	Providing palliative medicine consultation and team support

The levels of entrustment for the EPAs are defined below:

Level	Descriptors
1	**Not allowed to practice EPA**
2	**Allowed to practice EPA only with full supervision** With supervisor in the room, either as a co-activity, or providing step-by-step guidance
3	**Allowed to practice EPA only under reactive / on-demand supervision** 3a. With supervisor distantly available (including by phone or text), all key findings and decisions presented, discussed, and checked by the supervisor before implementation.
	3b. With supervisor distantly available (including by phone or text), selected key findings and decisions discussed and endorsed by the supervisor before implementation.
4	**Allowed to practice EPA unsupervised** 4a. With remote review e.g., supervisor receives updates and reports by the end of the day.
	4b. Without review.
5	**Allowed to supervise others in practice of EPA**

Learning Outcomes: Core Competencies, Sub-competencies and Milestones

The programme must integrate the following competencies into the curriculum, and structure the curriculum to support resident attainment of these competencies in the local context.

Residents must demonstrate the following core competencies:

1) Patient Care and Procedural Skills

Residents must demonstrate the ability to:

- Gather essential and accurate information about the patient
- Counsel patients and family members
- Make informed diagnostic and therapeutic decisions
- Prescribe and perform essential medical procedures
- Provide effective, compassionate and appropriate health management, maintenance, and prevention guidance

Residents must demonstrate the ability to:

- Perform comprehensive assessment of the patient, including psychosocial and spiritual assessment
- Counsel patients and family members as well as address suffering and distress
- Make informed diagnostic and therapeutic decisions
- Facilitate shared decision making; anticipate and plan for withholding or withdrawal of life sustaining therapy in patients with end stage illnesses
- Weigh the risks and benefits of medical procedures in accordance with the patient's condition and values
- Provide effective and compassionate care to improve patient's quality of life through optimisation of symptom control and provision of appropriate support

2) Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioural sciences, as well as the application of this knowledge to patient care

Residents must demonstrate knowledge of:

- Disease trajectories and formulation of prognosis in serious illness
- Palliative management of pain and non-pain symptoms

3) Systems-based Practice

Residents must demonstrate the ability to:

- Work effectively in various health care delivery settings (acute hospital, intermediate and long-term care facilities as well as home care services) and systems relevant to Palliative Medicine
- Coordinate patient care within the health care system, ensuring safe and effective transitions of care / hand-offs within and across health care delivery systems, including outpatient settings
- Incorporate considerations of cost awareness and risk / benefit analysis in patient care
- Advocate for quality patient care and optimal patient care systems
- Work in inter-professional teams to enhance patient safety and improve patient care quality
- Participate in identifying systems errors and in implementing potential systems solutions

4) Practice-based Learning and Improvement

Residents must demonstrate a commitment to lifelong learning.
Residents must demonstrate the ability to:

- Investigate and evaluate patient care practices
- Appraise and assimilate scientific evidence for evidence-based and informed practice
- Improve the practice of medicine
- Reflect, identify learning needs and perform appropriate learning activities for personal growth

5) Professionalism

Residents must demonstrate a commitment to professionalism and adherence to ethical principles including the SMC's Ethical Code and Ethical Guidelines (ECEG).

Residents must:

- Demonstrate professional conduct and accountability
- Demonstrate humanism and cultural proficiency
- Maintain emotional, physical and mental health, and pursue continual personal and professional growth
- Demonstrate an understanding of medical ethics and law
- Recognise and utilise appropriate resources for managing and resolving ethical dilemmas as needed

6) Interpersonal and Communication Skills

Residents must demonstrate ability to:

- Effectively exchange information with patients, their families and professional associates
- Establish therapeutic relationships with patients and families, with attention to patient / family concerns and context
- Align patient / family values, goals and preferences with treatment options to make a personalised care plan
- Acknowledge as well as address uncertainty and conflict
- Work effectively as a member or leader of a health care team
- Maintain accurate medical records

Other Competency: Teaching and Supervisory skills.

Residents must demonstrate ability to:

- Teach others
- Supervise others

The competencies and sub-competencies are mapped to the EPAs. Refer to ***Annex C.R4*** for the Core Competencies, Sub-competencies and Milestones

Learning Outcomes: Others

Residents must attend the Medical Ethics, Professionalism and Health Law course conducted by Singapore Medical Association (SMA).

Refer to ***Annex C.R5*** for the Learning Outcomes – Others

Curriculum

The curriculum and detailed syllabus relevant for local practice must be made available in the Residency Programme Handbook and given to the residents at the start of residency.

The PD must provide clear goals and objectives for each component of clinical experience.

Adequate information on the programme of assessments, core conditions to be assessed and expectations on performance during residency must be made available to all residents and faculty members.

Learning Methods and Approaches: Scheduled Didactic and Classroom Sessions

The programme must set aside dedicated time for educational activities and teaching sessions.

The programme must organise teaching activities on a regular basis, including but not limited to:

- Topic review / teaching
- Case-based discussion / teaching
- Journal club / Journal critique

The teaching sessions must cover at least the following:

- Symptom management in palliative care
- Palliative care emergencies
- Care of the imminently dying patient
- Psychosocial, spiritual, religious and cultural issues
- Communication and ethical issues
- Overview of cancer and non-cancer conditions in palliative care practice

Residents must attend a minimum of 70% of the tracked teaching activities.

In the event of a protracted outbreak or other public health emergency resulting in restrictions in face-to-face meetings and restriction of cross institution movement, teaching sessions must be conducted in a safe environment according to prevailing outbreak measures, moved to virtual platforms, or if necessary, postponed until normal operations resume.

Learning Methods and Approaches: Clinical Experiences

Residents, in the respective training tracks, must complete the following rotations.

24-month Track

- 9 months in hospital-based Palliative Medicine units including a rotation in a different sponsoring institution;
- 12 months in community-based Palliative Medicine units, of which 6 months must be in hospice home care and 6 months in inpatient hospice care; and
- 3 months of elective rotations (each month must be in a different rotation).

36-month Track

- 15 months in hospital-based Palliative Medicine units including a rotation in a different sponsoring institution;
- 15 months in community-based Palliative Medicine units, of which 9 months must be in hospice home care and 6 months in inpatient hospice care;
- 3 months in Medical Oncology; and
- 3 months of elective rotations (each month must be in a different rotation)

Residents must only do elective rotations in the following:

1. Medical Oncology
2. Radiation Oncology
3. Anaesthesiology-Pain Medicine
4. Rehabilitation Medicine
5. Psycho-oncology: Psychiatry services with special interest in palliative care mental health issues or services run by Psychologists / Medical Social Workers who work predominantly with patients with serious life-limiting illness
6. Palliative care for critically ill and / or ventilated patients: ICU palliative care (2 weeks) and Home Ventilation and Respiratory Support (2 weeks)
7. Paediatric Palliative Care: Star PALS (Paediatric Advanced Life Support) under HCA Hospice – only for residents who are intending to work in Paediatric Palliative Care long term.

Other electives beyond the approved list must be submitted for RAC's review on case-by-case basis should it be deemed necessary for a resident to acquire the relevant competencies, even if this meant extending the training. JCST's approval must be sought if the other elective posting(s) are meant to replace the compulsory elective postings under the approved list.

Refer to *Annex C.R8* for the Samples of rotation schedule

In the event of a protracted outbreak or other public health emergency resulting in restriction of cross institution movement, the sequence of postings should be rearranged to comply with prevailing outbreak measures whereby core postings should be prioritised.

Learning Methods and Approaches: Scholarly / Teaching Activities

Residents must complete the following scholarly / teaching activities:

	Name of activity	Minimum number to be achieved, when it is attempted
1.	Teaching of healthcare students and juniors, presentations during journal club / journal critique, topic review, peer review learning, case-based teaching etc.	Frequency: at least once every 3 months
2.	Conference Presentation (poster / oral presentation at local / overseas conferences)	Frequency: at least 1 abstract / poster / oral presentation accepted before exit from the programme

In the event of a protracted outbreak or other public health emergency resulting in restrictions in face-to-face meetings and restriction of cross institution movement, online presentation, virtual conference and e-posters should be completed.

Learning Methods and Approaches: Documentation of Learning

Residents must maintain a case log of patients seen, as part of the portfolio of learning; the record should include not only the important clinical details, but what was learnt from managing each case.

Residents must log at least 1 case for each *core clinical encounter / presentation / condition, and a minimum of 15 cases every 6 months The case log must be reviewed by the rotation supervisor / trainer before the end of every core rotation.

(* The following are the core clinical encounters / presentations / conditions.)

A.	**MEDICAL CONDITIONS** **A1. Cancer Conditions** 1. Breast cancer 2. Colorectal cancer 3. Gastric cancer 4. Hepatocellular carcinoma 5. Lung cancer 6. Prostate cancer 7. Pancreatic cancer 8. Head and Neck cancer including NPC
	A2. Cancer-related Conditions 1. Ascites 2. Brain Metastasis(es)

	3. Intestinal Obstruction
	A3. Non-Cancer Conditions 1. End-stage Organ Failure • End-stage Renal Failure • End-stage Heart Failure • End-stage Respiratory Failure • End-stage Liver Failure 2. Progressive Neurodegenerative Disease • Advanced Dementia
B.	**PHYSICAL SYMPTOMS AND RELATED ENCOUNTERS** This applies across the trajectory of the illness, inclusive of the phase when the patient is imminently dying. **B1. Pain (Cancer Pain and Pain associated with Life-limiting Non-Cancer Conditions)** 1. Nociceptive Pain, including Bone Pain 2. Neuropathic Pain 3. Complex Pain Syndromes 4. Pain crisis & Rapid Titration of Analgesics
	B2. Other Key Symptoms 1. Gastrointestinal Symptoms a) Nausea / vomiting b) Constipation and diarrhoea 2. Respiratory Symptoms a) Dyspnoea b) Cough 3. Anorexia, Cachexia, Fatigue 4. Neurological / Psychological / Psychiatric Symptoms a) Delirium b) Depression c) Anxiety
C.	**PALLIATIVE CARE EMERGENCIES** This applies across the trajectory of the illness, inclusive of the phase when the patient is imminently dying and the use of sedation. 1. Massive haemorrhage 2. Acute malignant spinal cord compression 3. Seizures 4. Acute airway obstructions and dyspnoeic crisis 5. High suicide risk 6.
D.	**IMMINENTLY DYING PATIENTS**

	1. Physical Symptoms 2. Palliative Care Emergencies 3. Psychosocial, Religious and Spiritual Issues 4. Ethical and Legal Issues 5. Difficult / Complex Conversations and Discussions 6. Terminal Discharge
E.	**PSYCHOSOCIAL, CULTURAL, RELIGIOUS AND SPIRITUAL ISSUES** **E1. Patient** 1. Demoralisation, Anxiety, Depression 2. Suicide and Desire for Hastened Death 3. Cultural, Religious and Spiritual / Existential Concerns
	E2. Family / Caregivers 1. Family Dynamics 2. Caregiver Stress 3. Cultural, Religious and Spiritual Concerns 4. Grief and Bereavement
F.	**ETHICAL AND LEGAL ISSUES** **F1. Ethical Issues / Dilemmas** 1. Non-Disclosure / Collusion 2. Informed Decision and Autonomy 3. Best Interest Judgements 4. Withholding and Withdrawing of Treatment 5. Palliative Sedation 6. DNR Decisions
	F2. Legal Issues 1. Decision-making Capacity / Competency 2. Informed Consent 3. Power of Attorney, Advance Directives, Wills 4. Procedures Following Death, including Death Certification, Coroner's Case, Procedures for Relatives
G.	**COMPLEX COMMUNICATION ENCOUNTERS** 1. Breaking Bad News 2. Goals of Care Discussion including ACP / PPC, End-of-Life Care Concerns 3. Discussion on Withdrawal / Withholding of Interventions 4. Managing Partial / Non-Disclosure 5. Managing Misaligned Expectations 6. Family Conference 7. Transition of Care Discussion

Residents must maintain a list of formal teaching sessions attended, and scholarly / teaching activities performed.

Summative Assessments

The current exit examination consisting of (1) Viva Voce, (2) Case clerking and discussion and (3) Multidisciplinary Round (MDR) will be phased out when all residents from intakes before AY2023 have exited or finished their candidature.

From AY2023 onwards, the exit assessment will be (1) Summative Portfolio anchored on EPAs and (2) Summative oral exam / viva voce. This table illustrates the changes in the components in the exit exam:

Year of training	**Residents from intakes before AY2023**	**Residents from AY2023 intake onwards**
Final Year of residency, which is second year for 24-month track and third year for 36-month track	**Cognitive Component** (1) Viva Voce: 1 station, 30 minutes	**Cognitive Component** (1) Viva Voce: 3 stations, 25 minutes each, including reading time
	Clinical Component (2) Case Clerking (1 hour) and Discussion (30 minutes) (3) Multi-Disciplinary Round: 30 minutes	**Clinical Component** (2) Summative Portfolio Review based on EPAs

EPA S/N	**Learning outcomes**	**Summative assessment components**	
		Viva voce	Summative portfolio review
1	Managing pain in patients with life-limiting illnesses	✓	✓
2	Managing non-pain symptoms in patients with life-limiting illnesses	✓	✓
3	Managing palliative care emergencies	✓	✓
4	Managing imminently dying patients	✓	✓
5	Supporting patients and families in the psychosocial and spiritual domains	✓	✓
5.1	Provide support to patients and families in the psychosocial and spiritual domains	✓	✓
5.2	Facilitate the provision of grief and bereavement support to families	✓	✓
6	Facilitating transitions across the palliative continuum of care	✓	✓
6.1	Facilitate transitions across palliative care settings	✓	✓
6.2	Facilitate terminal discharge for imminently dying patients	✓	✓
7	Providing palliative medicine consultation and team support	✓	✓