Objectives of Training in the Subspecialty of Pediatric Palliative Medicine

2016

VERSION 1.0

This document applies to those who begin training on or after July 1st, 2016.

NOTE: Throughout this document the word "family" will include caregivers, legal guardians, and substitute decision-makers. The word "child" or "children" will include infants, children and youth. "Settings of care" includes but is not limited to hospitals, palliative care units, hospices, ambulatory clinics, and the community.

DEFINITION

Pediatric Palliative Medicine is a medical subspecialty concerned with the study and advancement, assessment, and medical management of pain, suffering, and quality of life throughout the continuum of life and death for children with chronic or life threatening illness, and throughout the bereavement of the patients' families.

GOALS

Upon completion of training, a resident is expected to be a competent subspecialist in pediatric Palliative Medicine, capable of assuming a consultant's role in the subspecialty. The resident must acquire a working knowledge of the theoretical basis of the subspecialty, including its foundations in the basic medical sciences and research, as it applies to pediatric Palliative Medicine.

Only candidates certified by the Royal College of Physicians and Surgeons of Canada in Pediatrics may be eligible for certification in pediatric Palliative Medicine. Entry may occur from other specialties/subspecialties may but must follow completion of the primary specialty or subspecialty training and must meet the specific prerequisites detailed in the *Subspecialty Training Requirements* for pediatric Palliative Medicine.

During the course of training, the resident must acquire the medical knowledge, clinical skills, and professional attitudes needed to provide exemplary care throughout the continuum of life, death and bereavement for children with chronic or life threatening illness and patients' families. The resident must acquire an understanding of the basic scientific principles of pain and other common symptoms experienced by the population served, to expertly assess and manage the complex issues associated with chronic and life threatening illness. The resident must develop the ability to function as a consultant in the inpatient, ambulatory, and community settings, as part of an interprofessional team. Expertise in communication to promote the development of supportive respectful, and caring relationships, along with moral and ethical principles, especially related to end of life decision making, are essential.

Residents must demonstrate the requisite knowledge, skills, and behaviours for effective patient-centred care and service to a diverse population. In all aspects of subspecialist practice, the graduate must be able to address moral and ethical issues, and issues of gender, sexual orientation, age, culture, beliefs, and ethnicity in a professional manner.

PEDIATRIC PALLIATIVE MEDICINE SUBSPECIALTY COMPETENCIES

At the completion of training, the resident will have acquired the following competencies and will function effectively as a:

Medical Expert

Definition:

As *Medical Experts*, pediatric Palliative Medicine subspecialists integrate all of the CanMEDS Roles, applying medical knowledge, clinical skills, and professional attitudes in their provision of patient-centred care. *Medical Expert* is the central physician Role in the CanMEDS framework.

Key and Enabling Competencies: pediatric Palliative Medicine subspecialists are able to…

1. **Function effectively as consultants, integrating all of the CanMEDS Roles to provide optimal, ethical and patient-centred medical care**
    - 1.1. Perform a pediatric Palliative Medicine consultation, including the presentation of well-documented assessments and recommendations in oral, written, and/or electronic form, in response to a request from another health care professional
    - 1.2. Demonstrate use of all CanMEDS competencies relevant to the practice of pediatric Palliative Medicine, across settings of care
    - 1.3. Identify and appropriately respond to relevant moral and ethical issues arising from the care of children with chronic or life threatening illness, and the care of patients' families
    - 1.4. Demonstrate the ability to prioritize professional duties effectively when faced with multiple patients and problems
        - 1.4.1. Recognize symptoms, issues, and/or situations that require urgent or emergent palliative care
    - 1.5. Demonstrate compassionate and patient-centred care
        - 1.5.1. Demonstrate skills in developing a shared understanding of patient- and family-centred goals of care with patients and their families
    - 1.6. Recognize and respond to the ethical dimensions in medical decision-making for patients with palliative needs

1.7. Demonstrate medical expertise in situations other than patient care, such as providing expert legal testimony or advising governments, as needed

2. Establish and maintain clinical knowledge, skills and behaviours appropriate to their practice

2.1. Apply knowledge of the clinical, socio-behavioural, and fundamental biomedical sciences relevant to pediatric Palliative Medicine

  2.1.1. Physical symptoms and conditions

    2.1.1.1. Pathophysiology of and management for the following physical symptoms and conditions common to pediatric Palliative Medicine

      2.1.1.1.1. Agitation at the end of life

      2.1.1.1.2. Anorexia and cachexia

      2.1.1.1.3. Bleeding and thrombosis

      2.1.1.1.4. Constipation

      2.1.1.1.5. Cough

      2.1.1.1.6. Delirium

      2.1.1.1.7. Dyspnea

      2.1.1.1.8. Edema

      2.1.1.1.9. Enteral feeding intolerance

      2.1.1.1.10. Nausea and vomiting

      2.1.1.1.11. Oral conditions, including but not limited to candidiasis, stomatitis, and xerostomia

      2.1.1.1.12. Respiratory and oropharyngeal secretions

      2.1.1.1.13. Skin conditions, including but not limited to fistula, lymphedema, malignant wounds, pressure sores, pruritus, wound breakdown and odor

      2.1.1.1.14. Sleep disturbances

      2.1.1.1.15. Weakness and fatigue

  2.1.2. Pain

    2.1.2.1. Common pain syndromes

    2.1.2.2. Neurophysiology of pain transmission

    2.1.2.3. Medications used in the management of pain

      2.1.2.3.1. Opioids

      2.1.2.3.2. Adjuvants, including but not limited to nonsteroidal anti-inflammatory drugs (NSAIDs), anti-depressants, anti-convulsants, glucocorticoids, and N-methyl-D-aspartate (NMDA) receptor antagonists such as ketamine

    - 2.1.2.4. Non-pharmacological approaches to pain management, including but not limited to physical and psychological interventions
    - 2.1.2.5. Indications for, and complications of interventional anesthetic techniques used in pain management, including but not limited to epidural, intrathecal, and neurolytic block

- 2.1.3. Emergencies/urgencies
    - 2.1.3.1. Pathophysiology and management of pediatric Palliative Medicine emergencies/urgencies, including but not limited to
        - 2.1.3.1.1. Biliary, bowel, and urinary obstruction
        - 2.1.3.1.2. Catastrophic bleed
        - 2.1.3.1.3. Delirium
        - 2.1.3.1.4. Hypercalcemia
        - 2.1.3.1.5. Intractable nausea and vomiting
        - 2.1.3.1.6. Pain Crisis
        - 2.1.3.1.7. Seizures
        - 2.1.3.1.8. Severe dyspnea
        - 2.1.3.1.9. Spinal cord compression
        - 2.1.3.1.10. Superior vena cava syndrome

- 2.1.4. Psychological, social, spiritual and existential issues
    - 2.1.4.1. Psychological
        - 2.1.4.1.1. Issues common to pediatric Palliative Medicine and strategies to address them, including but not limited to
            - 2.1.4.1.1.1. Anxiety
            - 2.1.4.1.1.2. Depression

        - 2.1.4.1.2. Role and application of therapeutic interventions used in the management of psychological issues, including but not limited to behavioural therapy, cognitive therapy, counseling, hypnotherapy, imagery, and visualization
        - 2.1.4.1.3. Responses and emotions expressed by patients and their families, including but not limited to fear, guilt, anger, sadness and despair, and strategies to address them
        - 2.1.4.1.4. Impact of psychological issues and strong affective responses on decision-making, management of pain and other physical symptoms, and outcomes
        - 2.1.4.1.5. Role of patients’ and their families’ coping styles on decision-making and outcomes

  - 2.1.4.1.6. Impact of pain and intractable symptoms on psychological wellbeing and quality of life
  - 2.1.4.1.7. Impact of illness on interpersonal relationships, body image, sexuality, and role

- 2.1.4.2. Social
  - 2.1.4.2.1. Issues common to pediatric Palliative Medicine, including but not limited to child and family relational and financial issues, and strategies to address them
  - 2.1.4.2.2. Changing family dynamics and factors that contribute to distress
  - 2.1.4.2.3. Caregiver distress and strategies to provide support
  - 2.1.4.2.4. Needs of siblings of a child with a life-threatening condition

- 2.1.4.3. Spiritual
  - 2.1.4.3.1. Issues of spirituality related to death and dying, and the role of spiritual care
  - 2.1.4.3.2. Difference between patients’ spiritual and religious needs
  - 2.1.4.3.3. The importance of hope and nurturing hope
  - 2.1.4.3.4. Major cultural and religious practices which relate to medical practice, dying, and bereavement

- 2.1.4.4. Existential
  - 2.1.4.4.1. Existential needs of patients and strategies to provide support
  - 2.1.4.4.2. Factors contributing to existential distress
  - 2.1.4.4.3. Suffering and its impact on patients, their families, and the health care team

- 2.1.4.5. Grief and bereavement
  - 2.1.4.5.1. Normal, anticipatory, atypical, and complicated grief, including identification of risk factors, and strategies for supporting patients and their families
  - 2.1.4.5.2. Bereavement, and strategies and services to support patients’ families
  - 2.1.4.5.3. Needs of siblings in dealing with grief and loss
  - 2.1.4.5.4. Complicated nature of guilt often experienced by parents of children with genetic illness

2.1.5. Therapies
  2.1.5.1. Indications, dose selection, titration, routes of administration, and drug interactions of medications commonly used in pediatric Palliative Medicine
    2.1.5.1.1. Adjuvant pain medications, including but not limited to lidocaine and ketamine
    2.1.5.1.2. Agents that affect bowel function
    2.1.5.1.3. Anticonvulsants
    2.1.5.1.4. Antidepressants
    2.1.5.1.5. Antiemetics
    2.1.5.1.6. Antipsychotics
    2.1.5.1.7. Benzodiazepines
    2.1.5.1.8. Cannabinoids
    2.1.5.1.9. Diuretics
    2.1.5.1.10. Glucocorticoids
    2.1.5.1.11. Opioids, including but not limited to methadone

  2.1.5.2. Medications commonly used in the home setting
  2.1.5.3. Principles of pharmacokinetics and pharmacodynamics of medications commonly used in pediatric Palliative Medicine, including but not limited to the effect of the stages of organ development and changing organ function
  2.1.5.4. Management for side effects of medications commonly used in pediatric Palliative Medicine
  2.1.5.5. Management for opioid neurotoxicity
  2.1.5.6. Tolerance, physical dependence, and addiction to opioids
  2.1.5.7. Safe prescribing, including but not limited to strategies to limit the risk of medication diversion
  2.1.5.8. Alternative and complementary therapies commonly used by patients receiving palliative care, including but not limited to oral agents, therapeutic touch, and reflexology

2.1.6. Disease-specific considerations
  2.1.6.1. Oncologic
    2.1.6.1.1. Epidemiology, natural history, pathophysiology, complications, and symptom burden for childhood cancers
    2.1.6.1.2. Principles of management of childhood cancers
      2.1.6.1.2.1. Goals of therapy including curative, control, and palliative

            - 2.1.6.1.2.2. Role of chemotherapy, immunotherapy, radiation therapy, and targeted therapy
            - 2.1.6.1.2.3. Management of side effects of therapy
        - 2.1.6.1.3. Pain and symptoms related to cancer and its treatment, and management incorporating pharmacological and non-pharmacological strategies
        - 2.1.6.1.4. Indications for and complications of interventions used to manage patients with cancer, including but not limited to
            - 2.1.6.1.4.1. Biliary drainage tubes
            - 2.1.6.1.4.2. Esophageal and colorectal stents
            - 2.1.6.1.4.3. Long-term intravenous lines, including but not limited to peripherally inserted central catheter (PICC), Hickman, Port-a-cath
            - 2.1.6.1.4.4. Renal and bladder drainage tubes
            - 2.1.6.1.4.5. Venting gastrostomy tubes
            - 2.1.6.1.4.6. Ventricular peritoneal (VP) shunt
            - 2.1.6.1.4.7. Vertebroplasty
    - 2.1.6.2. Non-oncologic
        - 2.1.6.2.1. Epidemiology, natural history, pathophysiology, complications, and symptom burden for progressive non-oncologic diseases, including but not limited to
            - 2.1.6.2.1.1. Cardiovascular
                - 2.1.6.2.1.1.1. Arrhythmias
                - 2.1.6.2.1.1.2. Congenital heart disease
                - 2.1.6.2.1.1.3. Congestive heart failure
                - 2.1.6.2.1.1.4. Valvular disease
            - 2.1.6.2.1.2. Gastrointestinal and hepatobiliary
                - 2.1.6.2.1.2.1. Biliary atresia
                - 2.1.6.2.1.2.2. Short gut syndromes
            - 2.1.6.2.1.3. Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS)
            - 2.1.6.2.1.4. Metabolic and genetic
                - 2.1.6.2.1.4.1. Metabolic diseases, including but not limited to defective protein, lipid or carbohydrate metabolism, or mitochondrial disease

        2.1.6.2.1.4.2. Major chromosomal conditions and genetic abnormalities

      2.1.6.2.1.5. Neurological and neuromuscular
        2.1.6.2.1.5.1. CNS dysgenesis
        2.1.6.2.1.5.2. Hypoxic-ischemic encephalopathy
        2.1.6.2.1.5.3. Neurodegenerative conditions, including but not limited to adrenoleukodystrophy, juvenile Huntington’s disease, and Menke’s disease
        2.1.6.2.1.5.4. Neuromuscular conditions, including but not limited to Duchenne’s Muscular Dystrophy, and spinal muscular atrophy
        2.1.6.2.1.5.5. Stroke

      2.1.6.2.1.6. Renal dysfunction
      2.1.6.2.1.7. Respiratory
        2.1.6.2.1.7.1. Bronchopulmonary dysplasia
        2.1.6.2.1.7.2. Chronic aspiration pneumonia
        2.1.6.2.1.7.3. Cystic fibrosis
        2.1.6.2.1.7.4. Hypoplastic lung
        2.1.6.2.1.7.5. Pulmonary hypertension

    2.1.6.2.2. Management of patients with end-stage non-oncologic diseases, including but not limited to medical, surgical, and rehabilitative therapies
    2.1.6.2.3. Symptom management of patients with progressive non-oncologic diseases incorporating pharmacological and non-pharmacological strategies
    2.1.6.2.4. Indications for and complications of interventions used to manage patients with progressive non-oncologic diseases, including but not limited to
      2.1.6.2.4.1. Chest tubes
      2.1.6.2.4.2. Cough assist devices
      2.1.6.2.4.3. Enteric feeding tubes
      2.1.6.2.4.4. Esophageal and colorectal stents
      2.1.6.2.4.5. Hemodialysis and peritoneal dialysis
      2.1.6.2.4.6. Implantable pacemakers and defibrillators
      2.1.6.2.4.7. Invasive and non-invasive ventilation
      2.1.6.2.4.8. Left ventricular assist devices (LVAD)

2.1.6.2.4.9. Oxygen
2.1.6.2.4.10. Paracentesis
2.1.6.2.4.11. Pleurodesis
2.1.6.2.4.12. Renal and bladder drainage tubes
2.1.6.2.4.13. Suctioning
2.1.6.2.4.14. Thoracentesis
2.1.6.2.4.15. Tracheostomy
2.1.6.2.4.16. Transplantation
2.1.6.2.4.17. Venting gastrostomy tubes
2.1.6.2.4.18. Ventricular peritoneal (VP) shunt

2.1.7. Child development
    2.1.7.1. Impact of stages of child development on provision of palliative medicine
    2.1.7.2. Developmental stages and their impact on children's concepts of illness and dying
    2.1.7.3. Effect of illnesses on child development, including but not limited to:
        2.1.7.3.1. Arrested development due to encephalopathy
        2.1.7.3.2. Developmental regression/loss of milestones
        2.1.7.3.3. Progressive development over atypical trajectories, including but not limited to autism spectrum disorders

    2.1.7.4. Effect of a child's developmental stage on the assessment of pain and other symptoms

2.1.8. Specific patient populations
    2.1.8.1. Neonatal & perinatal palliative care
        2.1.8.1.1. Life threatening congenital and acquired conditions that present antenatally or in the neonatal period
        2.1.8.1.2. Complications of extreme prematurity
        2.1.8.1.3. Challenges of working with families with prenatal diagnoses implying severe morbidity or mortality
        2.1.8.1.4. Planning for delivery, advance directives and comfort care methods at the time of delivery as appropriate for neonates with life-threatening conditions
        2.1.8.1.5. Methods for medication delivery in neonates requiring palliative symptom management, including but not limited to intranasal route

        - 2.1.8.1.6. Planning for post-delivery care for neonates with life threatening conditions, including but not limited to discharge home, provision of appropriate normal newborn care, and anticipated symptom needs
        - 2.1.8.1.7. Care requirements for the mother's post-partum physical and mental health
        - 2.1.8.1.8. Care and resources for both parents and siblings of neonates with life limiting conditions

    - 2.1.8.2. Transition to adult care of youth with life limiting conditions
        - 2.1.8.2.1. Principles of transition of care for youth between pediatric and adult services
        - 2.1.8.2.2. Evolving needs including sexual and reproductive health, emotional well-being, social support and services, spirituality, and advance care planning
        - 2.1.8.2.3. Evolving needs for additional community support in caring for a young adult with a complex life limiting condition with aging primary caregivers
        - 2.1.8.2.4. Issues of achieving and maintaining independence for youth with typical or atypical development, including but not limited to:
            - 2.1.8.2.4.1. Independent living
            - 2.1.8.2.4.2. Meaningful occupation/employment
            - 2.1.8.2.4.3. Independent mobility
            - 2.1.8.2.4.4. Friendship
            - 2.1.8.2.4.5. Sexuality
            - 2.1.8.2.4.6. Transition of responsibility from parents

- 2.1.9. Prognostication
    - 2.1.9.1. Different trajectories common in chronic or life threatening illnesses and their relevance to prognostication
    - 2.1.9.2. Use of prognostication for recognizing transition points in illness and access to appropriate palliative care resources, including but not limited to hospice palliative care
    - 2.1.9.3. Disease-specific prognostic indicators, including clinical signs, symptoms, and medical investigations
    - 2.1.9.4. Common validated tools used to assist in prognostication in adult Palliative Medicine, including but not limited to the Eastern Cooperative Oncology Group (ECOG) scoring system, Karnofsky Scoring System, the Palliative Performance Score (PPSv2), and the Palliative Prognostic Index (PPI)

- 2.1.9.5. Limitations of using adult indicators and tools to prognosticate in children

2.1.10. Rehabilitation

- 2.1.10.1. Rehabilitation needs common to pediatric Palliative Medicine including but not limited to physical function and social issues
- 2.1.10.2. Maintenance of function through exercise and therapy throughout the disease trajectory to improve quality of life
- 2.1.10.3. Strategies and services to address rehabilitation needs

2.1.11. Community-based care

- 2.1.11.1. Definition of community-based care and its various settings of care
- 2.1.11.2. Differences in community-based palliative care, including
    - 2.1.11.2.1. Availability and access to lab and investigative services, therapies, and interventions, as well as medical, nursing, and support services
    - 2.1.11.2.2. Level of expertise of palliative care providers
    - 2.1.11.2.3. Family structure, dynamics, and ability to cope with providing care and experiencing a death in the home
    - 2.1.11.2.4. Issues of personal safety and the safety of other health care providers and patients
    - 2.1.11.2.5. Economic and social costs
    - 2.1.11.2.6. Time commitment
    - 2.1.11.2.7. Providing care in patients’ homes and in rural communities

2.1.12. Care of the dying

- 2.1.12.1. Recognition of the dying phase of illness
    - 2.1.12.1.1. Recognition that children often have repeated cycles of apnea and hypopnea followed by spontaneous recovery over weeks preceding death

- 2.1.12.2. Specific issues associated with dying, including but not limited to physical symptoms, psychological issues, and ethical and moral concerns
- 2.1.12.3. Concept of a good death and factors that contribute to a good death across settings of care

2.1.13. Epidemiology

2.1.13.1. Describe the spectrum of disease conditions encountered in pediatric palliative care, ranging from curable but life threatening, through non-curable, non-treatable, and static conditions

2.1.13.2. Recognize how the spectrum of conditions impacts families' and health care professionals' expectations of pediatric palliative care and the timing of consultation or interventions

2.1.13.3. Understand the evolving epidemiology of youth with life limiting conditions of childhood living into young adulthood

2.2. Describe the CanMEDS framework of competencies relevant to pediatric Palliative Medicine

2.3. Apply lifelong learning skills of the Scholar Role to implement a personal program to keep up to date, and enhance areas of professional competence

2.4. Integrate the available best evidence and best practices to enhance the quality of care and patient safety in pediatric Palliative Medicine

3. Perform a complete and appropriate assessment of a patient

3.1. Identify and effectively explore issues to be addressed in a patient encounter, including the patient's context and preferences

3.1.1. Demonstrate understanding of the disease experience from the perspective of a patient, and the meaning and consequences of illness to patients and their families

3.2. Elicit a history that is relevant, concise, and accurate to context and preferences for the purposes of diagnosis, prognosis, management, health promotion, and disease prevention

3.2.1. Review physical, psychological, social, spiritual, and functional domains

3.2.2. Engage and assess verbal and non-verbal children through the use of play, art, and music

3.2.3. Describe how various modalities provide insight into the child's world and avenues for therapeutic intervention or assistance

3.2.4. Use validated age-appropriate tools in the assessment of pain and other symptoms, functional status, and prognosis

3.2.5. Recognize and accommodate for patients' diversities and differences, including but not limited to state of disease, disabilities, gender, sexual orientation, age, developmental stage, culture, ethnicity, religion, and socio-economic status

3.2.6. Assess level of distress and resiliency in patients and their families

3.3. Perform a focused physical examination that is relevant and accurate, for the purposes of diagnosis, prognosis, management, health promotion, and disease prevention

3.4. Select medically appropriate investigative methods in a resource-effective and ethical manner

  3.4.1. Select investigative methods appropriate to stage of disease and concomitant with patient- and family-centred goals of care

  3.4.2. Select appropriate investigations for the purpose of prognostication

3.5. Demonstrate effective clinical problem solving and judgment to address patient problems, including interpreting available data and integrating information to generate differential diagnoses and management plans

  3.5.1. Develop a management plan throughout the disease trajectory that balances disease modifying treatments and symptom management in accordance with patient- and family-centred goals of care and in settings where availability of investigations is limited

  3.5.2. Develop management plans for the following physical symptoms and conditions common to pediatric Palliative Medicine:

    3.5.2.1. Agitation at the end of life

    3.5.2.2. Anorexia and cachexia

    3.5.2.3. Bleeding and thrombosis

    3.5.2.4. Constipation

    3.5.2.5. Cough

    3.5.2.6. Delirium

    3.5.2.7. Dyspnea

    3.5.2.8. Edema

    3.5.2.9. Enteral feeding intolerance

    3.5.2.10. Nausea and vomiting

    3.5.2.11. Oral conditions, including but not limited to candidiasis, stomatitis, and xerostomia

    3.5.2.12. Pain

    3.5.2.13. Respiratory and oropharygeal secretions

    3.5.2.14. Skin conditions including but not limited to fistulae, lymphedema, malignant wounds, pressure sores, pruritus, wound breakdown, and odor

    3.5.2.15. Sleep disturbances

    3.5.2.16. Weakness and fatigue

3.5.3. Develop management plans for pediatric Palliative Medicine emergencies/urgencies, including but not limited to

3.5.3.1. Biliary, bowel and urinary obstruction

3.5.3.2. Catastrophic bleed

3.5.3.3. Delirium

3.5.3.4. Hypercalcemia

3.5.3.5. Intractable nausea and vomiting

3.5.3.6. Obstruction of VP shunt

3.5.3.7. Pain crisis

3.5.3.8. Seizures

3.5.3.9. Severe dyspnea

3.5.3.10. Spinal cord compression

3.5.3.11. Superior vena cava syndrome

3.5.4. Develop management plans for psychological, social, spiritual and existential issues in pediatric Palliative Medicine

4. Use preventive and therapeutic interventions effectively

4.1. Implement a management plan in collaboration with patients and their families

4.1.1. Work with patients and their families to establish common, patient-and family-centred goals of care, ensuring responsiveness to patients' and their families' needs, values, beliefs, and wishes

4.1.2. Identify relevant priorities for management based on the patient's and family's perspective, medical urgency and the clinical context

4.2. Demonstrate appropriate and timely application of preventive and therapeutic interventions relevant to pediatric Palliative Medicine

4.2.1. Develop a proactive approach to managing the expectations and needs of patients and their families by anticipating symptoms and issues, and identifying appropriate services and resources

4.2.2. Address advance care planning with specific discussion of the indications, use, and discontinuation of therapeutic interventions, including but not limited to hydration, nutritional therapies, supplemental oxygen, and non-invasive ventilation

4.2.3. Provide medical care that is structured around patients' and their families' needs, their level of understanding, and their priorities, with the aim of relieving suffering, maximizing quality of life, and providing support

4.2.4. Select pharmacological and non-pharmacological approaches to address physical symptoms and conditions, and psychological, social, spiritual and existential issues that are evidence based and concomitant to patient- and family-centred goals of care

- 4.2.5. Monitor and modify the plan of care in response to side effects, toxicity, or efficacy of therapeutic interventions

4.3. Obtain appropriate informed consent for therapies

- 4.3.1. Assess decision-specific capacity to consent for treatment
- 4.3.2. Recognize the need for, and the role of the substitute decision maker in treatment decisions for a child

4.4. Ensure patients and their families receive appropriate end-of-life care consistent with the standards of pediatric Palliative Medicine practice

5. Demonstrate proficient and appropriate use of procedural skills, both diagnostic and therapeutic

5.1. Demonstrate effective, appropriate, and timely performance of diagnostic procedures relevant to pediatric Palliative Medicine

- 5.1.1. Perform diagnostic thoracentesis and paracentesis

5.2. Demonstrate effective, appropriate, and timely performance of therapeutic procedures relevant to pediatric Palliative Medicine

- 5.2.1. Perform therapeutic thoracentesis and paracentesis
- 5.2.2. Insert subcutaneous access
- 5.2.3. Use a Mucosal Atomization Device (MAD) for intranasal medication administration
- 5.2.4. Initiate and manage continuous ambulatory delivery devices (CADD pumps)
- 5.2.5. Manage the following existing therapeutic interventions
  - 5.2.5.1. Biliary drainage tubes
  - 5.2.5.2. Chest tubes
  - 5.2.5.3. Cough assist devices
  - 5.2.5.4. Enteric feeding tubes
  - 5.2.5.5. Epidural, intrathecal, and regional block catheters
  - 5.2.5.6. Implantable cardiac defibrillators
  - 5.2.5.7. Long term intravenous lines, including but not limited to PICC, Hickman, Port-a-cath
  - 5.2.5.8. Non-invasive ventilation
  - 5.2.5.9. Renal and bladder drainage tubes
  - 5.2.5.10. Tracheostomy tube

      - 5.2.5.11. Venting gastrostomy tubes

  - 5.3. Obtain appropriate informed consent for procedures
  - 5.4. Document and disseminate information related to procedures performed and their outcomes
  - 5.5. Ensure adequate followup is arranged for procedures performed

6. **Seek appropriate consultation from other health professionals, recognizing the limits of their own expertise**
  - 6.1. Demonstrate insight into their own limits of expertise
    - 6.1.1. Practice self-reflection as a tool to understanding personal limitations of expertise
  - 6.2. Demonstrate effective, appropriate, and timely consultation of another health professional as needed for optimal patient care
  - 6.3. Arrange appropriate followup services for patients and their families/caregivers

Communicator

Definition:

As *Communicators*, pediatric Palliative Medicine subspecialists effectively facilitate the doctor-patient relationship and the dynamic exchanges that occur before, during, and after the medical encounter.

Key and Enabling Competencies: pediatric Palliative Medicine subspecialists are able to…

1. **Develop rapport, trust, and ethical therapeutic relationships with patients and their families**
  - 1.1. Recognize that being a good communicator is a core clinical skill for physicians, and that effective patient-physician and family-physician communication can foster patient and family satisfaction, physician satisfaction, adherence, and improved clinical outcomes
    - 1.1.1. Demonstrate skills in eliciting concerns across physical, functional, psychological, social, and spiritual domains
  - 1.2. Establish positive therapeutic relationships with patients and their families that are characterized by understanding, trust, respect, honesty, and empathy
    - 1.2.1. Recognize the value of maintaining hope when working with patients with palliative needs and their families
    - 1.2.2. Provide supportive counseling and resources to those coping with loss

1.3. Respect patient and family confidentiality, privacy, and autonomy

1.4. Listen effectively

   1.4.1. Demonstrate skills in empathetic listening to establish patient- and family-centred goals of care and identify extent of awareness about illness and prognosis

1.5. Be aware of and responsive to nonverbal cues

   1.5.1. Recognize that emotions, empathy and caring can be expressed through both verbal and nonverbal communication

1.6. Facilitate a structured clinical encounter effectively

   1.6.1. Organize, participate in, and, when appropriate, lead clinical encounters structured to achieve predetermined goals, including but not limited to advance care planning, while respecting patient and family autonomy, and maximizing the involvement of patients and their families

2. Accurately elicit and synthesize relevant information and perspectives of patients and families, colleagues, and other professionals

2.1. Gather information about a disease and about a patient’s and family’s beliefs, wishes, hopes, concerns, expectations, and illness experience as relevant to palliative and end-of-life care

2.2. Seek out and synthesize relevant information from other sources, such as other professionals, while respecting individual privacy and confidentiality

3. Convey relevant information and explanations accurately to patients and their families, colleagues, and other professionals

3.1. Deliver information to a patient and family, colleagues, and other professionals in a humane and compassionate manner, and in such a way that it is understandable and encourages discussion and participation in decision-making

   3.1.1. Identify challenges to and modify approach to ensure effective communication, including but not limited to anger, confusion, culture, denial, educational level, developmental stage, and language

   3.1.2. Adapt the communication style to accommodate patients and their families

   3.1.3. Explain treatment options, both pharmacological and non-pharmacological, including but not limited to benefits, risks, side effects, and effectiveness

   3.1.4. Exchange information effectively with colleagues and other health care professionals to ensure consistent messages are delivered to patients and their families

4. **Develop a common understanding on issues, problems, and plans with patients, their families, and other professionals to develop a shared plan of care**
    - 4.1. Identify and effectively explore problems to be addressed from a patient encounter, including the patient's and family's context, responses, concerns, and preferences
        - 4.1.1. Explain a palliative care philosophy to patients and their families
    - 4.2. Respect diversity and differences, including but not limited to the impact of gender, religion, and cultural beliefs on decision-making
    - 4.3. Encourage discussion, questions, and interaction in the encounter
    - 4.4. Engage patients, their families, and relevant health professionals in shared decision-making to develop a plan of care
        - 4.4.1. Discuss palliative and end-of-life issues skillfully with patients and their families, including but not limited to advance care planning, location of care, palliative sedation, prognosis, treatment choices, and withholding or withdrawal of life-sustaining treatment
        - 4.4.2. Participate in and facilitate family meetings to discuss issues, including but not limited to goals of care and discharge planning
        - 4.4.3. Educate patients, their families, and health care professionals regarding common symptoms, conditions, and issues, and emergencies/urgencies encountered by patients with palliative needs and strategies for management across settings of care
        - 4.4.4. Educate patients, their families, and health care professionals regarding the differences in providing community-based palliative and end-of-life care, including but not limited to home and rural communities
    - 4.5. Address challenging communication issues effectively, including but not limited to obtaining informed consent, delivering bad news, and addressing anger, confusion, and misunderstanding
        - 4.5.1. Respond to requests from a youth or from the family of a child for euthanasia and physician assisted suicide, incorporating knowledge of professional responsibilities
        - 4.5.2. Explain the concept of brain death, and organ and tissues donation
        - 4.5.3. Demonstrate skills in discussing emotionally difficult topics with children, adolescents, and their families

5. **Convey oral, written, and/or electronic information effectively about a medical encounter**
    - 5.1. Maintain clear, concise, accurate, and appropriate records of clinical encounters and plans, including physical, functional, psychological, social, and spiritual domains
    - 5.2. Present oral reports of clinical encounters and plans

   - 5.3. Communicate effectively by telephone and other electronic media with patients, their families, and health care providers
   - 5.4. Convey medical information appropriately to ensure safe transfer of care

6. **Present medical information to the public or media about a medical issue**

Collaborator

Definition:

As *Collaborators*, pediatric Palliative Medicine subspecialists work effectively within a health care team to achieve optimal patient care.

Key and Enabling Competencies: pediatric Palliative Medicine subspecialists are able to…

1. **Participate effectively and appropriately in an interprofessional health care team**
   - 1.1. Describe the pediatric Palliative Medicine subspecialist’s roles and responsibilities to other professionals in assessment and management of patients with palliative needs and their families throughout the disease trajectory and across settings of care, and in consultative, shared care, and primary care
   - 1.2. Describe the roles and responsibilities of other professionals within the health care team
     - 1.2.1. Discuss the importance of role clarity in the provision of palliative and end-of-life care
   - 1.3. Recognize and respect the diverse roles, responsibilities, and competencies of other professionals in relation to their own
     - 1.3.1. Recognize the roles, expertise, and limitations, including overlap and complementary nature, of each member of the interprofessional team
     - 1.3.2. Respect the role of primary care physicians, and the importance of continuity of care for patients with palliative needs
   - 1.4. Work with others to assess, plan, provide, and integrate care for individuals and groups of patients
     - 1.4.1. Participate in the interprofessional and multidisciplinary care of patients with palliative needs and their families throughout the disease trajectory and across settings of care
     - 1.4.2. Coordinate with appropriate adult-based teams and services to develop a plan for ongoing care for youth with complex, life threatening conditions as they transition from pediatric to adult care

    - 1.4.3. Establish with the referring team how patient care will be delivered: as consultative, primary, or shared care

- 1.5. Work collaboratively in other activities and tasks, including but not limited to research questions, educational work, program review, or administrative responsibilities
- 1.6. Participate effectively in and, when appropriate, lead family conferences and interprofessional team rounds and meetings
- 1.7. Enter into interdependent relationships with other professions for the provision of optimal interprofessional palliative and end of life care
- 1.8. Describe the principles of team dynamics
    - 1.8.1. Assess the stages of team formation and development, and describe elements of an effective interprofessional team
    - 1.8.2. Describe common causes for team dysfunction and conflict, and different types of team management frameworks
- 1.9. Respect team ethics, including confidentiality, resource allocation, and professionalism
- 1.10. Demonstrate leadership in a health care team, as appropriate
- 1.11. Recognize and respect an individual's right to object to performing and participating in acts on the basis of moral conscience

2. Work with other health professionals effectively to prevent, negotiate, and resolve interprofessional conflict

- 2.1. Demonstrate a respectful attitude towards other colleagues and members of an interprofessional team
- 2.2. Work with other professionals to prevent conflicts
- 2.3. Respect difference and the scopes of practice of other professions
- 2.4. Reflect on their own differences, misunderstandings, and limitations that may contribute to interprofessional tension
    - 2.4.1. Practice self-reflection as a tool to enhance team function and support resolution of team conflict
    - 2.4.2. Receive and incorporate feedback from colleagues, other health care providers, and patients, and their families
- 2.5. Reflect on interprofessional team function
    - 2.5.1. Promote team reflection as a tool to enhance team function and support resolution of team dysfunction
- 2.6. Identify the nature and cause(s) of conflict, and employ strategies to resolve or mediate conflict

Manager

Definition:

As *Managers*, pediatric Palliative Medicine subspecialists are integral participants in health care organizations, organizing sustainable practices, making decisions concerning the allocation of resources, and contributing to the effectiveness of the health care system.

Key and Enabling Competencies: pediatric Palliative Medicine subspecialists are able to…

1. **Participate in activities that contribute to the effectiveness of their health care organizations and systems**
    - 1.1. Work collaboratively with others in their organizations, and in institutional and/or community-based settings
    - 1.2. Participate in systemic quality process evaluation and improvement, including patient safety initiatives
    - 1.3. Describe the structure and function of the health care system as it relates to pediatric Palliative Medicine, including the roles of physicians
        - 1.3.1. Describe the models of palliative and end-of-life care delivery and their utilization, advantages and disadvantages
        - 1.3.2. Discuss how palliative and end-of-life care fits within the broader health care system
    - 1.4. Describe principles of health care financing, including physician remuneration, budgeting, and organizational funding

2. **Manage their practice and career effectively**
    - 2.1. Set priorities and manage time to balance patient care, practice requirements, outside activities, and personal life
    - 2.2. Manage a practice, including finances and human resources
    - 2.3. Implement processes to ensure personal practice improvement
        - 2.3.1. Implement a process to incorporate evidence-based decision-making and evolving standards of care
        - 2.3.2. Monitor practice by applying the principles of self-reflection
        - 2.3.3. Demonstrate awareness of specific skills required for different career paths in pediatric Palliative Medicine
    - 2.4. Employ information technology appropriately for patient care

3. **Allocate finite health care resources appropriately**
    - 3.1. Demonstrate an understanding of the importance of just allocation of health care resources, balancing effectiveness, efficiency, and access with optimal patient care
        - 3.1.1. Promote timely advance care planning and goals of care discussions to ensure appropriate use of health care resources
        - 3.1.2. Describe the resources available to support patients with palliative needs across settings of care
        - 3.1.3. Describe how the various models of palliative and end-of-life care delivery affect the health care system, including but not limited to human resources and resource allocation
    - 3.2. Apply evidence and management processes for cost-appropriate care

4. **Serve in administration and leadership roles**
    - 4.1. Participate effectively in committees and meetings
    - 4.2. Lead or implement change in health care
        - 4.2.1. Describe theories associated with facilitating change within organizations
        - 4.2.2. Describe characteristics essential to the provision of effective leadership within a team or organization
        - 4.2.3. Develop and maintain institutional and/or community-based standards of care
    - 4.3. Plan relevant elements of health care delivery, such as work schedules

Health Advocate

Definition:

As *Health Advocates*, pediatric Palliative Medicine subspecialists use their expertise and influence responsibly to advance the health and well-being of individual patients, communities, and populations.

Key and Enabling Competencies: pediatric Palliative Medicine subspecialists are able to…

1. **Respond to individual patient health needs and issues as part of patient care**
    - 1.1. Identify the health needs of an individual patient
        - 1.1.1. Describe the physical, functional, psychological, social, and spiritual issues of an individual patient with palliative needs and the associated needs of the patient’s family

- 1.1.2. Define the elements of suffering experienced by an individual patient with palliative needs and by the patient's family
- 1.1.3. Identify the needs of, and the challenges experienced by a family with a child living with a life threatening condition
- 1.1.4. Recognize that families of children with life threatening conditions often adopt a combined approach of potentially curative interventions, along with palliation and focused symptom management

1.2. Identify and reflect upon opportunities for advocacy, health promotion, and disease prevention with individuals to whom they provide care

- 1.2.1. Manage expectations and needs of an individual patient and the their family
- 1.2.2. Reduce suffering and improve quality of life through identification of the psychological, social, and spiritual issues experienced by an individual patient and their family
- 1.2.3. Address risk factors associated with atypical and complicated grief

1.3. Demonstrate an appreciation of the possibility of competing interests between individual advocacy issues and the community at large

2. Respond to the health needs of the communities that they serve

2.1. Describe the practice communities that they serve

2.2. Identify opportunities for advocacy, health promotion, and disease prevention in the communities that they serve, and respond appropriately

- 2.2.1. Describe current and evolving societal attitudes about death and dying
- 2.2.2. Describe societal, environmental, financial and political factors relevant to the provision of palliative and end-of-life care in Canada
- 2.2.3. Identify and advocate for children with palliative needs and their families
- 2.2.4. Identify issues related to palliative and end-of-life care relevant to different cultures, beliefs, and traditions
- 2.2.5. Describe the societal benefits of organ and tissue donation
- 2.2.6. Demonstrate awareness of local, regional, provincial, national, and international organizations, including but not limited to the Canadian Hospice Palliative Care Association, Canadian Network of Palliative Care for Children (CNPCC), International Children's Palliative Care Network (ICPCN), and Canadian Society of Palliative Care Physicians (CSPCP) that advocate for palliative and end-of-life care at all levels of government

2.3. Demonstrate an appreciation of the possibility of competing interests between the communities served and other populations

3. Identify the determinants of health for the populations that they serve

- 3.1. Identify the determinants of health of the populations, including barriers to access to palliative care and resources
  - 3.1.1. Availability of primary care, interprofessional teams, and specialized medical services
  - 3.1.2. Delayed or lack of identification of patient populations who would benefit from palliative care
  - 3.1.3. Availability of resources for supporting children with rare diseases
  - 3.1.4. Availability of community-based resources, including but not limited to homecare and pharmaceuticals
  - 3.1.5. Geographic inequities
  - 3.1.6. Inequities in vulnerable and marginalized populations
  - 3.1.7. Poverty
  - 3.1.8. Cost of dying at home

- 3.2. Identify vulnerable and marginalized populations within those served and respond appropriately
  - 3.2.1. Identify barriers to evidence-based palliative and end-of-life care for vulnerable or marginalized populations, including but not limited to homeless, Indigenous Peoples, those who are incarcerated, and those living in rural, northern, and remote communities

4. Promote the health of individual patients, communities, and populations

- 4.1. Describe an approach to implementing a change in a determinant of health of the populations they serve
  - 4.1.1. Promote advance care planning
  - 4.1.2. Develop interprofessional care
  - 4.1.3. Identify organizational issues that affect the delivery of palliative and end-of-life care, including but not limited to the lack of community resources for those who wish to die at home
  - 4.1.4. Participate as a member of the Canadian Society of Palliative Care Physicians (CSPCP), the Canadian Network of Palliative Care for Children (CNPCC), and other organizations to advocate for equitable, accessible, safe, and quality palliative and end-of-life care for all Canadians

- 4.2. Describe how public policy impacts on the health of the populations served
  - 4.2.1. Describe how changes in legislation could affect the health of patients with palliative needs and their families
  - 4.2.2. Describe how changes in the funding and structure of the health care system affect the delivery of palliative and end-of-life care

- 4.3. Identify points of influence in the health care system and its structure
  - 4.3.1. Describe the role of the Canadian Hospice Palliative Care Association (CHPCA), the Canadian Network of Palliative Care for Children (CNPCC), provincial palliative care associations, the Canadian Society of Palliative Care Physicians (CSPCP), and palliative sections of provincial medical associations in advocating for patients with palliative needs and their families

- 4.4. Describe the moral, ethical, and professional issues inherent in health advocacy, including altruism, social justice, autonomy, integrity, and idealism
- 4.5. Demonstrate an appreciation of the possibility of conflict inherent in their role as health advocate for a patient or community with that of manager or gatekeeper
- 4.6. Describe the role of the medical profession in advocating collectively for health and patient safety

Scholar

Definition:

As *Scholars*, pediatric Palliative Medicine subspecialists demonstrate a lifelong commitment to reflective learning, and the creation, dissemination, application, and translation of medical knowledge.

Key and Enabling Competencies: pediatric Palliative Medicine subspecialists are able to…

1. Maintain and enhance professional activities through ongoing learning

- 1.1. Describe the principles of maintenance of competence
- 1.2. Describe the principles and strategies for implementing a personal knowledge management system
  - 1.2.1. Design, implement, document and monitor a personal plan for continuing education
  - 1.2.2. Use information technology to optimize learning

- 1.3. Recognize and reflect on learning issues in practice
  - 1.3.1. Practice self-reflection as a learning tool

- 1.4. Conduct personal practice audits
- 1.5. Pose an appropriate learning question related to the care of patients with palliative needs and their families
- 1.6. Access and interpret the relevant evidence
- 1.7. Integrate new learning into practice

1.8. Evaluate the impact of any change in practice

1.9. Document the learning process

2. Critically evaluate medical information and its sources, and apply this appropriately to practice decisions

2.1. Describe the principles of critical appraisal

2.2. Critically appraise retrieved evidence in order to address a clinical question

2.3. Integrate critical appraisal conclusions into clinical care

3. Facilitate the learning of patients, their families, students, residents, other health professionals, the public, and others

3.1. Describe principles of learning relevant to medical education, including but not limited to adult learning theory, personal learning styles, and reflective practice

3.2. Identify collaboratively the learning needs and desired learning outcomes of others

3.3. Select effective teaching strategies and content to facilitate others' learning

3.4. Deliver effective lectures or presentations

3.4.1. Demonstrate effective teaching in a variety of contexts, including but not limited to undergraduate, postgraduate, continuing professional development, and public forums

3.5. Assess and reflect on teaching encounters through self-reflection and assimilation of feedback

3.6. Provide effective feedback

3.7. Describe the principles of ethics with respect to teaching

4. Contribute to the development, dissemination, and translation of new knowledge and practices

4.1. Describe the principles of research and scholarly inquiry

4.1.1. Identify current themes and trends in palliative and end-of-life care research

4.1.2. Describe the unique challenges of palliative and end-of-life care research and strategies to overcome them

4.2. Describe the principles of research ethics in the context of palliative and end-of-life care

4.3. Pose a scholarly question related to the care of patients with palliative needs, including but not limited to clinical care, basic science, population health, education, and systems

4.4. Conduct a systematic search for evidence

4.5. Select and apply appropriate methods to address the question

4.6. Disseminate the findings of a study

4.7. Complete a scholarly research, quality assurance, or educational project relevant to pediatric Palliative Medicine that is suitable for peer reviewed publication or presentation at an academic meeting

Professional

Definition:

As *Professionals*, pediatric Palliative Medicine subspecialists are committed to the health and well-being of individuals and society through ethical practice, profession-led regulation, and high personal standards of behaviour.

Key and Enabling Competencies: pediatric Palliative Medicine subspecialists are able to…

1. Demonstrate a commitment to their patients, profession, and society through ethical practice

1.1. Exhibit appropriate professional behaviours in practice, including honesty, integrity, commitment, compassion, respect, and altruism

1.1.1. Demonstrate an ongoing commitment to a patient and their family, as appropriate from the time of consultation until the patient dies, and to the family after the patient dies

1.2. Demonstrate a commitment to delivering the highest quality care and maintenance of competence

1.2.1. Incorporate current standards of palliative and end-of-life care in clinical practice

1.2.2. Act as a role model by demonstrating skillful care of patients with palliative needs and their families

1.2.3. Demonstrate sensitivity and responsiveness to a diverse patient population

1.3. Recognize and appropriately respond to moral and ethical issues encountered in practice, including but not limited to advance directives, advance care plans, confidentiality, conflict of interest, consent and capacity, palliative sedation, physician assisted suicide and euthanasia, substitute decision-making, truth-telling, and withdrawal or withholding of life-sustaining therapy

1.3.1. Identify moral and ethical issues commonly encountered in pediatric palliative care, and describe similarities and differences with adult palliative care

1.3.2. Recognize and respect differences in conscience and moral distress experienced by members of the palliative care team, patients, and their families

- 1.3.3. Describe the availability of and access to resources to support ethically complex decision-making, including but not limited to ethics consultations

1.4. Identify, declare, and manage perceived, potential, and actual conflicts of interest

- 1.4.1. Demonstrate strategies to resolve conflicts of interest related to palliative and end-of-life care, including but not limited to autonomy, goals of care, and resource allocation

1.5. Recognize the principles and limits of patient privacy and confidentiality, as defined by the law and professional practice standards

1.6. Maintain appropriate boundaries with patients and their families, including but not limited to over involvement and personal identification

2. Demonstrate a commitment to their patients, profession, and society through participation in profession-led regulation

2.1. Demonstrate knowledge and an understanding of professional, legal, moral, and ethical codes of practice related to advance directives, advance care plans, palliative sedation, and withdrawal and withholding of life-sustaining therapies

- 2.1.1. Describe the medical, legal, moral, and ethical issues surrounding organ and tissue donation and transplantation

2.2. Fulfil the regulatory and legal obligations required of current practice

- 2.2.1. Apply relevant legislation that relates to patient care including but not limited to advance directives and power of attorney for personal care
- 2.2.2. Apply relevant protocols at the time of death, including but not limited to the appropriate notification of the medical examiner/coroner and completion of relevant documents
- 2.2.3. Identify different approaches in caring for children with respect to moral, ethical, and legal roles of substitute decision-makers, including but not limited to
  - 2.2.3.1. Rights accorded during pregnancy and how these change after birth
  - 2.2.3.2. Parental rights
  - 2.2.3.3. Guardianship
  - 2.2.3.4. Role of a mature minor in decision making
  - 2.2.3.5. Court-rulings regarding children's decision-making
  - 2.2.3.6. Specific involvement of agencies such as social services
- 2.2.4. Demonstrate advanced knowledge of regulations governing the prescribing of controlled drugs, including but not limited to cannabinoids

and opioids, and other medications used in the management of pain and symptoms in patients with palliative needs

- 2.3. Demonstrate accountability to professional regulatory bodies
- 2.4. Recognize and respond appropriately to others' unprofessional behaviours in clinical practice or in the context of teaching or research
- 2.5. Participate in peer review

3. Demonstrate a commitment to physician health and sustainable practice

- 3.1. Balance personal and professional priorities to ensure personal health and a sustainable practice
  - 3.1.1. Demonstrate strategies for managing personal stress associated with caring for patients with palliative needs and their families
  - 3.1.2. Demonstrate strategies for resolving conflicts and role strain

- 3.2. Strive to heighten personal and professional awareness and insight
  - 3.2.1. Recognize the importance of incorporating self-reflection in all aspects of practice
  - 3.2.2. Reflect on the personal effect of providing care for patients who are suffering and their families
  - 3.2.3. Recognize compassion fatigue and develop a strategy to mitigate that risk
  - 3.2.4. Seek and receive feedback and assistance from others related to personal and professional issues
  - 3.2.5. Demonstrate self-awareness and self-care

- 3.3. Recognize other professionals in need and respond appropriately
  - 3.3.1. Identify individuals at risk for or demonstrating compassion fatigue, and strategies and resources to assist them

REVISED – Specialty Standards Review Committee – October 2015