ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA
COLLÈGE ROYAL DES MÉDECINS ET CHIRURGIENS DU CANADA

Pediatric Palliative Medicine Competencies

2025
VERSION 2.0

Effective for residents who enter training on or after July 1, 2025.

DEFINITION

Pediatric Palliative Medicine is a medical subspecialty concerned with the study and advancement of the knowledge and practice of assessment and medical management of pain, suffering, and quality of life throughout the continuum of illness for children[1] with a life-threatening illness, and through to the bereavement of the children's families.[2]

PALLIATIVE MEDICINE PRACTICE

Pediatric palliative medicine subspecialists provide care for children with a high burden of symptoms or with complex symptoms due to a life-threatening illness or condition, and for their families. This includes children with concurrent complex acute and chronic conditions affecting multiple systems. The aim of the care provided by palliative medicine subspecialists is to reduce suffering and improve quality of life.

Pediatric palliative medicine subspecialists provide consultation, and ongoing follow-up as needed, for relief of suffering and optimization of quality of life. They assess the child and provide comprehensive symptom management, including psychosocial and spiritual support, non-pharmacologic and pharmacologic treatment, and therapeutic procedures. They assist children and families in setting and prioritizing goals in the context of their values and wishes. They anticipate the disease trajectory and possible complications of treatment. They guide children and families in decision-making regarding potential complications of the illness, such as the role of life-sustaining therapies. They prepare children and families for changes in health status, disease progression, and death, including discussing advance care plans and goals of care, arranging transition to other care settings, and providing caregiver support and bereavement counselling. They identify the need for, provide access to, and advocate for existing or additional resources for the child's care and support.

Pediatric palliative medicine subspecialists provide medical leadership to build the health care system's capacity to provide high quality palliative care. They expand the knowledge

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[1] Throughout this document, each reference to "children" includes neonates, infants, children, and youth.
[2] Throughout this document, references to the patient's family are intended to include all those who are personally significant to the patient and are concerned with their care, including, according to the patient's circumstances, family members, partners, caregivers, legal guardians, and substitute decision-makers.

base in the field and develop new tools and treatments. They set standards for the care of common palliative care presentations, disseminate care protocols, and support and educate other health care professionals delivering palliative care. They develop, test, implement, and evaluate new programs for palliative care delivery. They advocate at the local and national level for resources, equitable access, and coordination of palliative care.

Pediatric palliative medicine subspecialists participate in shared decision-making and may share care with the referring physician, including family physicians and specialists with expertise in the child's underlying condition(s). They consult with specialists who perform procedures that alleviate symptoms, including interventional radiologists, pain medicine physicians, physiatrists, and radiation oncologists. Pediatric palliative medicine physicians work within an interprofessional team that includes nurses, child life therapists, mental health professionals, pharmacists, recreation therapists, social workers, and spiritual support services.

Pediatric palliative medicine subspecialists work in academic tertiary and quaternary hospital settings. In addition, they provide support and consultation to other health care professionals to facilitate care to children in community hospitals, hospice settings, the child's home, or remotely via telehealth.

ELIGIBILITY REQUIREMENTS TO BEGIN TRAINING

Royal College certification in Pediatrics

OR

Successful completion of the Transition to Practice stage of training in a Royal College accredited residency program in Pediatrics.[3]

Entry from other specialties may occur but must follow completion of the primary specialty training and must include the prerequisites of twelve months of clinical medicine-based rotations with a minimum of six months at a senior level[4] designed to allow achievement of competencies in the consultation and care of complex pediatric patients, interprofessional care, and effective communication skills.

ELIGIBILITY REQUIREMENTS FOR EXAMINATION[5]

All candidates must be certified in Pediatrics in order to be eligible for the Royal College examination in Pediatric Palliative Medicine.

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[3] Some programs in Quebec may permit eligible trainees to begin subspecialty training before completion of the Pediatrics Transition to Practice stage. However, as with all jurisdictions, trainees in Quebec must achieve all generalist competencies of the Pediatrics specialty prior to certification in Pediatrics. To learn more about the entrance requirements for a specific Palliative Medicine program, speak to the relevant postgraduate medical education office.

[4] Senior level is a resident regularly entrusted with responsibility for direct independent patient care under the supervision of and direct responsibility to a senior subspecialty resident or faculty member.

[5] *These eligibility requirements do not apply to Subspecialty Examination Affiliate Program (SEAP) candidates. Please contact the Royal College for information about SEAP.*

PEDIATRIC PALLIATIVE MEDICINE COMPETENCIES

Medical Expert

Definition:

As *Medical Experts*, pediatric palliative medicine subspecialists integrate all of the CanMEDS Roles, applying medical knowledge, clinical skills, and professional values in their provision of high-quality and safe child- and family-centred care. Medical Expert is the central physician Role in the CanMEDS Framework and defines the physician's clinical scope of practice.

Key and Enabling Competencies: Pediatric palliative medicine subspecialists are able to…

1. Practise medicine within their defined scope of practice and expertise

- 1.1. Demonstrate a commitment to high-quality care of their patients
- 1.2. Integrate the CanMEDS Intrinsic Roles into their practice of Pediatric Palliative Medicine
- 1.3. Apply knowledge of the clinical and biomedical sciences relevant to Pediatric Palliative Medicine

    Psychological, social, spiritual, existential, and cultural concepts

    - 1.3.1. The whole person care framework: integration of psychological, social, spiritual, and cultural components of personhood
    - 1.3.2. Influence of a child's and family's spiritual, religious, or cultural context on their experiences and understanding of wellness and illness
        - 1.3.2.1. Concepts of wellness and illness expressed by First Nations, Inuit, and Métis peoples

    - 1.3.3. Influence of illness, uncertainty, and threat of death on interpersonal relationships, family functioning, body image, sexuality, and life roles
        - 1.3.3.1. Factors, including changing family dynamics, that contribute to distress
        - 1.3.3.2. Needs of siblings of a child with a life-threatening condition
        - 1.3.3.3. Signs of caregiver distress and strategies to provide support
        - 1.3.3.4. Financial issues and losses associated with having a child who is ill and strategies to address them

    - 1.3.4. Spiritual and existential issues related to death and dying as a key dimension of the human experience and the role of spiritual care
        - 1.3.4.1. Differences between spiritual and religious needs and beliefs
        - 1.3.4.2. The importance of nurturing and enhancing hope
        - 1.3.4.3. Factors that contribute to existential distress
        - 1.3.4.4. Strategies to provide support to address existential distress

1.3.5. Influence of children’s and families’ psychological well-being, intense affective responses, and coping styles on decision-making, management of pain and other physical symptoms, and outcomes

1.3.6. Signs of demoralization syndrome

Suffering

1.3.7. Role of suffering as both a universal and unique experience in children facing the end of life and their families

    1.3.7.1. Influence of psychological, social, spiritual, and cultural contexts on an individual’s suffering

    1.3.7.2. Suffering as a potential threat to the experience of personhood

1.3.8. Suffering inherent to the dying process, including multiple losses, death anxiety, and worrying about the survivors’ experience

1.3.9. Role of depression and anxiety in the expression of suffering

1.3.10. Manifestations of suffering and distress in the physical, psychological, social, and spiritual domains, including total pain, emotional distress, demoralization, grief, expression of desire to die, expression of desire for the child to no longer suffer, and requests for hastened death

    1.3.10.1. Concepts of total suffering and total pain

    1.3.10.2. Role of psychological, social, spiritual, and cultural factors on the symptom experience

    1.3.10.3. Impact of pain and intractable symptoms on well-being and quality of life

    1.3.10.4. Expression of desire to die, for the child to no longer suffer or requests for hastened death as an expression of suffering, grief, and loss at end of life that may be ameliorated by palliative care supports

    1.3.10.5. Supports that alleviate, address, or accompany a child and their family in their suffering

    1.3.10.6. Concept that Medical Assistance in Dying (MAID) in Canada includes both assisted suicide and euthanasia

1.3.11. Interventions to address suffering, including

    1.3.11.1. Supportive counselling

    1.3.11.2. Meaning-centred interventions, including legacy work

    1.3.11.3. Play therapy

    1.3.11.4. Psychoeducational interventions

Dying and death

1.3.12. Features of the natural dying process, including physical symptoms, psychological issues, and ethical and moral concerns

1.3.13. Concept that children may appear close to death and then stabilize and live for longer than expected

1.3.14. Concepts of dying well and a good death

1.3.15. Factors that may contribute to a good death across settings of care

1.3.16. Impact of spiritual, religious, and cultural belief systems on the child's and family's approach to dying and death

1.3.17. Features of the terminal phase of an illness and signs of impending death

1.3.18. Concept of brain death and processes for organ and tissue donation

1.3.19. Role of the palliative care team to accompany and support children and families during the last hours and days of life

1.3.20. Spiritual, religious, and cultural beliefs regarding rituals and end-of-life practices pre- and post-death, including care of the body after death

Bereavement, grief, and loss

1.3.21. Concepts of normal, anticipatory, disenfranchised, and complicated grief

    1.3.21.1. Risk factors for disenfranchised and complicated grief

    1.3.21.2. Needs of families dealing with antenatal loss

    1.3.21.3. Needs of siblings in dealing with grief and loss

    1.3.21.4. Complicated nature of guilt often experienced by parents of multiple children with genetic illness

    1.3.21.5. Triggers for anticipatory grief in the child, parent, and sibling, including loss of previous role (e.g., career or role within family unit), loss of sense of identity, and changes in the child's mobility or function

    1.3.21.6. Strategies for dealing with grief and loss to support children and their families, including legacy work

1.3.22. Impact of culture and language on grief and bereavement

1.3.23. Bereavement services available to support children's families

Child development

1.3.24. Developmental stages and their impact on children's concepts of illness and dying

1.3.25. Effect of illnesses on child development, including

    1.3.25.1. Progressive development over atypical trajectories

1.3.25.2. Developmental delay due to central nervous system disease

1.3.25.3. Developmental regression or loss of milestones

1.3.26. Effect of a child’s developmental stage on the assessment of pain and other signs and symptoms

1.3.27. Impact of stages of child development on the provision of palliative care

Chronic, progressive, or life-threatening illnesses

1.3.28. Epidemiology, natural history, pathophysiology, complications, symptom burden, goals of therapy, and principles of management of the following conditions:

Cancer

1.3.28.1. Hematologic cancer

1.3.28.2. Central nervous system

1.3.28.3. Solid tumours

Cardiovascular

1.3.28.4. Arrythmias

1.3.28.5. Cardiomyopathy

1.3.28.6. Congenital cardiac malformations

1.3.28.7. Heart failure

1.3.28.8. Pulmonary hypertension

1.3.28.9. Valvular disease

Gastrointestinal and hepatobiliary

1.3.28.10. Biliary atresia

1.3.28.11. Liver failure

1.3.28.12. Disorders with dependence on parenteral nutrition

Immunological

1.3.28.13. Autoimmune disorders

1.3.28.14. Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS)

1.3.28.15. Primary immune deficiencies

1.3.28.16. Secondary immune deficiencies

Metabolic and genetic

    1.3.28.17. Disorders of protein, lipid, or carbohydrate metabolism
    1.3.28.18. Major chromosomal and genetic abnormalities
    1.3.28.19. Mitochondrial disease
    1.3.28.20. Severe skeletal dysplasias
    1.3.28.21. Rare genetic disorders of unknown prognosis

Neurological

1.3.28.22. Acute brain injury
1.3.28.23. Congenital brain malformations
1.3.28.24. Hypoxic-ischemic encephalopathy
1.3.28.25. Life-threatening epilepsy syndromes
1.3.28.26. Neurodegenerative conditions
1.3.28.27. Neuromuscular diseases

Renal

1.3.28.28. Acute kidney injury
1.3.28.29. Chronic kidney disease
1.3.28.30. Kidney diseases presenting in the perinatal period

Respiratory

1.3.28.31. Bronchopulmonary dysplasia
1.3.28.32. Central hypoventilation syndrome
1.3.28.33. Chronic aspiration pneumonia
1.3.28.34. Cystic fibrosis
1.3.28.35. Hypoplastic lung

Symptoms and other conditions secondary to chronic, progressive, or life-threatening illness and common concurrent medical disorders

1.3.29. Pain, including

  1.3.29.1. Pathophysiology of pain transmission
  1.3.29.2. Types of pain
  1.3.29.3. Common pain syndromes
  1.3.29.4. Pain crisis
  1.3.29.5. Total pain

1.3.30. Pathophysiology and management of the following
    1.3.30.1. Agitation and delirium
    1.3.30.2. Anorexia and cachexia
    1.3.30.3. Anxiety
    1.3.30.4. Biliary obstruction
    1.3.30.5. Bleeding and thrombosis
        1.3.30.5.1. Catastrophic bleed

    1.3.30.6. Bowel obstruction
    1.3.30.7. Constipation
    1.3.30.8. Cough
    1.3.30.9. Depression
    1.3.30.10. Dyspnea
    1.3.30.11. Dystonia and spasticity
    1.3.30.12. Edema
    1.3.30.13. Enteral feeding intolerance
    1.3.30.14. Hypercalcemia
    1.3.30.15. Nausea and vomiting
    1.3.30.16. Oral conditions, including candidiasis, stomatitis, and xerostomia
    1.3.30.17. Respiratory and oropharyngeal secretions
    1.3.30.18. Seizures
    1.3.30.19. Severe dyspnea
    1.3.30.20. Skin conditions, including fistulae, lymphedema, malignant wounds, pressure sores, pruritus, and wound breakdown and odour
    1.3.30.21. Sleep disturbances
    1.3.30.22. Spinal cord compression
    1.3.30.23. Superior vena cava syndrome
    1.3.30.24. Urinary obstruction
    1.3.30.25. Weakness and fatigue

1.3.31. Common validated tools used for pain, other symptoms, and functional status assessment

Treatments and interventions

1.3.32. Non-pharmacological approaches to symptom management, including the evidence underlying treatment and indications for

  1.3.32.1. Therapeutic interventions used in the management of psychological issues, including behavioural therapy, cognitive therapy, counselling, creative therapies, distraction techniques, hypnotherapy, imagery/visualization, play therapy, and relaxation/meditation

  1.3.32.2. Physical interventions such as physical therapy, acupuncture, and immobilization

  1.3.32.3. Alternative and complementary therapies commonly used for pain, including oral agents, therapeutic touch, and reflexology

1.3.33. Pharmacologic principles, including pharmacokinetics, pharmacodynamics, indications, dose selection, titration, routes of administration, drug interactions, effect of the stages of organ development and changing organ function, and the management of side effects of medications commonly used in Pediatric Palliative Medicine, including

  1.3.33.1. Medications used in the management of pain

    1.3.33.1.1. Acetaminophen

    1.3.33.1.2. Opioids, including methadone

    1.3.33.1.3. Gabapentinoids

    1.3.33.1.4. Nonsteroidal anti-inflammatory drugs (NSAIDs)

    1.3.33.1.5. Lidocaine

    1.3.33.1.6. N-methyl-D-aspartate (NMDA) receptor antagonists, including ketamine

  1.3.33.2. Agents that affect bowel function

  1.3.33.3. Anticonvulsants, including their adjuvant use for pain

  1.3.33.4. Antidepressants, including their adjuvant use for pain

  1.3.33.5. Antiemetics

  1.3.33.6. Antipsychotics

  1.3.33.7. Benzodiazepines

  1.3.33.8. Cannabinoids

  1.3.33.9. Diuretics

  1.3.33.10. Glucocorticoids, including their adjuvant use for pain

1.3.34. Indications and guidelines for continuous palliative sedation therapy

1.3.35. Management of opioid neurotoxicity

1.3.36. Use of medication in the home setting

    1.3.36.1. Access to medications, including availability, cost, and preloading
    1.3.36.2. Storage and safe disposal
    1.3.36.3. Routes of administration and dosing regimens
    1.3.36.4. Choice of medications with regards to ease of administration and monitoring, caregiver burden, and medication safety

1.3.37. Medication safety

    1.3.37.1. Safe prescribing and disposal of medications, including strategies to limit the risk of medication diversion
    1.3.37.2. Tolerance, physical dependence, and addiction to opioids in the palliative care setting
    1.3.37.3. Regulations governing the prescribing of controlled drugs, including cannabinoids and opioids, and other medications used in children with palliative needs

1.3.38. Interventional techniques used in pain management, including

    1.3.38.1. Cementoplasty
    1.3.38.2. Cryoablation
    1.3.38.3. Epidural and intrathecal catheters
    1.3.38.4. Neurolytic blocks

1.3.39. Role for radiation therapy and systemic therapy in pain and symptom management

1.3.40. Indications for and complications of interventions and devices used to manage the child’s underlying illness and its complications, including

    1.3.40.1. Supportive
        1.3.40.1.1. Mucosal atomization device
        1.3.40.1.2. Subcutaneous infusion pump, including continuous ambulatory delivery devices (CADD pump)
        1.3.40.1.3. Long-term intravenous catheters, including peripherally inserted central catheters (PICC), tunneled venous catheters, and port-a-cath
        1.3.40.1.4. Epidural and intrathecal catheters
        1.3.40.1.5. Regional block catheters

    1.3.40.2. Cancer

        1.3.40.2.1. Bone marrow transplantation
        1.3.40.2.2. Radiation therapy
        1.3.40.2.3. Surgery
        1.3.40.2.4. Systemic therapy
            1.3.40.2.4.1. Chemotherapy
            1.3.40.2.4.2. Immunotherapy
            1.3.40.2.4.3. Targeted cancer therapy

1.3.40.3. Cardiovascular
    1.3.40.3.1. Heart transplantation
    1.3.40.3.2. Implantable pacemakers and defibrillators
    1.3.40.3.3. Ventricular assist devices

1.3.40.4. Gastrointestinal and hepatobiliary
    1.3.40.4.1. Enteric feeding tubes
    1.3.40.4.2. Management of gastrointestinal tract obstruction
        1.3.40.4.2.1. Colostomy
        1.3.40.4.2.2. Ileostomy
        1.3.40.4.2.3. Venting gastrostomy tubes

    1.3.40.4.3. Paracentesis
    1.3.40.4.4. Parenteral nutrition

1.3.40.5. Neurological
    1.3.40.5.1. Ventriculoperitoneal (VP) shunt

1.3.40.6. Renal and urinary
    1.3.40.6.1. Kidney and bladder drainage tubes
    1.3.40.6.2. Hemodialysis
    1.3.40.6.3. Peritoneal dialysis
    1.3.40.6.4. Kidney transplantation

1.3.40.7. Respiratory
    1.3.40.7.1. Oxygen delivery, including high-flow devices
    1.3.40.7.2. Suctioning
    1.3.40.7.3. In/exsufflation device and lung volume recruitment device

            1.3.40.7.4. Invasive and non-invasive ventilation
            1.3.40.7.5. Thoracentesis
            1.3.40.7.6. Chest tubes and pleural drainage catheters
            1.3.40.7.7. Tracheostomy
            1.3.40.7.8. Lung transplantation

1.3.41. Role of rehabilitation
    1.3.41.1. Maintenance of function through exercise and therapy
    1.3.41.2. Common rehabilitation needs, including physical function and social issues
    1.3.41.3. Strategies and services to address rehabilitation needs

Prognosis

1.3.42. Trajectories common to chronic, progressive, or life-threatening illnesses and their relevance to prognosis

1.3.43. Determining prognosis to recognize transition points in illness and facilitate access to appropriate palliative care resources, including hospice

1.3.44. Disease-specific prognostic indicators, including clinical signs, symptoms, and results of medical investigations

1.3.45. Common validated tools used to assess prognosis, including
    1.3.45.1. Eastern Cooperative Oncology Group (ECOG) scoring system
    1.3.45.2. Karnofsky Performance Scale
    1.3.45.3. Lansky Scoring System
    1.3.45.4. Palliative Performance Score (PPSv2)
    1.3.45.5. Palliative Prognostic Index (PPI)
    1.3.45.6. Phase of Illness (POI)

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

Perinatal and neonatal care

1.3.47. Life-threatening congenital and acquired conditions that present antenatally or in the neonatal period

1.3.48. Complications of extreme prematurity

1.3.49. Challenges of working with families with prenatal diagnoses when severe morbidity or mortality is anticipated

1.3.50. Planning for delivery, advance directives, and comfort care methods at the time of delivery as appropriate for neonates with life-threatening conditions

1.3.51. Methods for medication delivery in neonates requiring palliative symptom management

1.3.52. Planning for post-delivery care for neonates with life-threatening conditions, including discharge home, provision of appropriate normal newborn care, and anticipated symptom management

1.3.53. Provision of care to support the mother's post-partum physical and mental health

1.3.54. Care and resources for both parents and siblings of neonates with life-threatening conditions

Adolescents and young adults

1.3.55. Evolving patterns of youth with life-threatening conditions of childhood living into young adulthood and implications for management and support

1.3.56. Transition to adult care for youth with life-threatening conditions

1.3.57. Evolving needs, including sexual and reproductive health, emotional well-being, social support and services, spirituality, and advance care planning

1.3.58. Evolving needs for additional community support in caring for a young adult with a complex life-threatening condition and aging primary caregivers

1.3.59. Considerations for achieving and maintaining independence for youth with typical and atypical development, including

    1.3.59.1. Education and vocation or work

    1.3.59.2. Financial and legal

    1.3.59.3. Friendship and social support

    1.3.59.4. Housing

    1.3.59.5. Mobility and transportation

    1.3.59.6. Responsibility for medical care

    1.3.59.7. Sexuality

Delivery of palliative care services

1.3.60. Models of palliative care delivery and their utilization, advantages, and disadvantages

    1.3.60.1. Impact on the health care system, including human resources and resource allocation

    1.3.60.2. Resources available in different settings, including for populations supported through federal health care programs, including the Non-Insured Health Benefits (NIHB) program for First Nations and Inuit

    - 1.3.61. Team management frameworks
    - 1.3.62. Community-based care and its settings of care, including
        - 1.3.62.1. Availability and access to medical, nursing, and support services as well as laboratory and investigative services, therapies, and interventions
        - 1.3.62.2. Availability and access to different levels of palliative care expertise
    - 1.3.63. Providing care in children's homes, in both urban and rural communities, including
        - 1.3.63.1. Influence of family structure, dynamics, and ability to cope with a death in the home
        - 1.3.63.2. Issues of personal safety and the safety of other health care professionals
        - 1.3.63.3. Economic and social implications
        - 1.3.63.4. Practical advantages and disadvantages for a family member to be at home during the course of the child's illness

- 1.4. Perform appropriately timed clinical assessments with recommendations that are presented in an organized manner
- 1.5. Carry out professional duties in the face of multiple competing demands
- 1.6. Recognize and respond to the complexity, uncertainty, and ambiguity inherent in Pediatric Palliative Medicine practice
    - 1.6.1. Use a whole person care framework, integrating psychological, social, spiritual, and cultural components of personhood with physical aspects of the illness experience to promote healing and alleviate suffering

2. Perform a child- and family-centred clinical assessment and establish a management plan

- 2.1. Prioritize issues to be addressed in a patient encounter
    - 2.1.1. Recognize symptoms, issues, and situations that require urgent or emergent palliative care
    - 2.1.2. Identify relevant priorities for management based on the child's and family's perspective, medical urgency, and the clinical context
- 2.2. Elicit a history, perform a physical exam, select appropriate investigations, and interpret their results for the purpose of diagnosis and management, disease prevention, and health promotion

  - 2.2.1. Elicit information about the child's and family's understanding of the illness
  - 2.2.2. Review physical, functional, cognitive, psychological, social, spiritual, and cultural domains
  - 2.2.3. Engage and assess verbal and non-verbal children through the use of play, art, and music
  - 2.2.4. Use validated age-appropriate tools in the assessment of pain and other symptoms, functional status, phase of illness, and prognosis
    - 2.2.4.1. Take into account the effect of language and cultural differences on pain and symptom assessment
  - 2.2.5. Assess the presence, nature, and sources of suffering, including underlying depression and anxiety
  - 2.2.6. Assess level of distress, resiliency, and coping strategies in children and their families
  - 2.2.7. Select investigative methods appropriate to stage of disease and concomitant with child- and family-centred goals of care
  - 2.2.8. Select appropriate investigations to determine prognosis

- 2.3. Establish goals of care in collaboration with children and their families, which may include slowing disease progression, treating symptoms, achieving cure, improving function, and palliation
  - 2.3.1. Work with children and their families to establish shared, child- and family-centred goals of care, ensuring responsiveness to their needs, values, beliefs, and wishes

- 2.4. Establish a child- and family-centred management plan
  - 2.4.1. Provide supportive counselling and resources to children and families coping with losses associated with the dying process
    - 2.4.1.1. Recognize and acknowledge the anticipatory grief children and families experience as they deal with increasing losses associated with the dying process
    - 2.4.1.2. Recognize and validate caregiver distress
    - 2.4.1.3. Identify children's and families' strengths and resources in dealing with suffering

  - 2.4.2. Develop management plans to address developmental, psychological, social, spiritual, cultural, and existential issues necessary for providing whole person care
  - 2.4.3. Develop management plans throughout the disease trajectory that balance disease-modifying treatments and symptom management in accordance with child- and family-centred goals of care

    - 2.4.3.1. Adapt management plans in situations in which availability of investigations is limited

- 2.4.4. Develop management plans, including contingency plans for emergencies and urgencies, for the following
    - 2.4.4.1. Biliary obstruction
    - 2.4.4.2. Bowel obstruction
    - 2.4.4.3. Catastrophic bleeding
    - 2.4.4.4. Increased intracranial pressure
    - 2.4.4.5. Intractable nausea and vomiting
    - 2.4.4.6. Obstruction of a VP shunt
    - 2.4.4.7. Pain crisis
    - 2.4.4.8. Seizures
    - 2.4.4.9. Severe dyspnea
    - 2.4.4.10. Severe dystonia
    - 2.4.4.11. Spinal cord compression
    - 2.4.4.12. Superior vena cava syndrome
    - 2.4.4.13. Urinary obstruction

- 2.4.5. Develop management plans for the following symptoms and conditions
    - 2.4.5.1. Agitation and delirium
    - 2.4.5.2. Anorexia and cachexia
    - 2.4.5.3. Anxiety
    - 2.4.5.4. Bleeding and thrombosis
    - 2.4.5.5. Constipation
    - 2.4.5.6. Cough
    - 2.4.5.7. Depression
    - 2.4.5.8. Dyspnea
    - 2.4.5.9. Dystonia and spasticity
    - 2.4.5.10. Edema
    - 2.4.5.11. Enteral feeding intolerance
    - 2.4.5.12. Nausea and vomiting
    - 2.4.5.13. Oral conditions, including candidiasis, stomatitis, and xerostomia
    - 2.4.5.14. Pain
    - 2.4.5.15. Respiratory and oropharyngeal secretions

        - 2.4.5.16. Skin conditions, including fistulae, lymphedema, malignant wounds, pressure sores, pruritus, and wound breakdown and odour
        - 2.4.5.17. Sleep disturbances
        - 2.4.5.18. Weakness and fatigue

3. Plan and perform procedures and therapies for the purpose of assessment and/or management

- 3.1. Determine the most appropriate procedures or therapies
- 3.2. Obtain and document informed consent, explaining the risks and benefits of, and the rationale for, a proposed procedure or therapy
    - 3.2.1. Assess decision-specific capacity to assent or consent for treatment
    - 3.2.2. Recognize the need for, and the role of, the substitute decision-maker in treatment decisions for a child
- 3.3. Prioritize procedures or therapies, taking into account clinical urgency and available resources
- 3.4. Perform procedures in a skilful and safe manner, adapting to unanticipated findings or changing clinical circumstances
    - 3.4.1. Insertion of subcutaneous catheter device
    - 3.4.2. Initiate and manage
        - 3.4.2.1. Subcutaneous infusion pump, including continuous ambulatory delivery devices (CADD pump)
        - 3.4.2.2. Mucosal atomization device

    - 3.4.3. Manage the following existing therapeutic devices and interventions
        - 3.4.3.1. Chest tube and pleural drainage catheter
        - 3.4.3.2. In/exsufflation device and lung volume recruitment device
        - 3.4.3.3. Enteric feeding tube
        - 3.4.3.4. Epidural and intrathecal catheters
        - 3.4.3.5. Kidney and bladder drainage
        - 3.4.3.6. Long-term intravenous catheter
        - 3.4.3.7. Non-invasive ventilation
        - 3.4.3.8. Peritoneal drainage tube
        - 3.4.3.9. Regional block catheter
        - 3.4.3.10. Tracheostomy
        - 3.4.3.11. VP shunt

4. **Establish plans for ongoing care and, when appropriate, timely consultation**
    - 4.1. Implement a child- and family-centred care plan that supports ongoing care, follow-up on investigations, response to treatment, and further consultation
        - 4.1.1. Monitor and modify the plan of care in response to efficacy, side effects, or toxicity of therapeutic interventions
        - 4.1.2. Anticipate symptoms and the evolving needs of children and their families, and identify appropriate services and resources
        - 4.1.3. Address advance care planning with specific discussion of the indications, use, and discontinuation of therapeutic interventions, including hydration, nutritional therapies, supplemental oxygen, and ventilatory support
        - 4.1.4. Provide education and support near the time of and following death
            - 4.1.4.1. Counsel children and families on potential factors that may contribute to a good death
            - 4.1.4.2. Be present to family members at the bedside during the dying process
            - 4.1.4.3. Recognize that the quiet time before death, sometimes referred to as a bedside vigil, can be uncomfortable and distressing for family members
            - 4.1.4.4. Integrate rituals and end-of-life practices pre- and post-death in keeping with a child’s and family’s spiritual, religious and cultural beliefs, including care of the body after death
            - 4.1.4.5. Identify and address risk factors associated with atypical and complicated grief
            - 4.1.4.6. Recommend bereavement services to support children’s families

5. **Actively contribute, as an individual and as a member of a team providing care, to the continuous improvement of health care quality and patient safety**
    - 5.1. Recognize and respond to harm from health care delivery, including patient safety incidents
    - 5.2. Adopt strategies that promote patient safety and address human and system factors
        - 5.2.1. Adhere to policies and advocate for safe dispensing and storage of opioids in high-risk situations

Communicator

Definition:

As *Communicators*, pediatric palliative medicine subspecialists form relationships with children and their families that facilitate the gathering and sharing of essential information for effective health care.

Key and Enabling Competencies: Pediatric palliative medicine subspecialists are able to…

1. **Establish professional therapeutic relationships with children and their families**
    1.1. Communicate using a child- and family-centred approach that encourages trust and autonomy and is characterized by empathy, respect, and compassion
        1.1.1. Identify and respond to emotions expressed by children and their families, including fear, guilt, anger, sadness, and despair

    1.2. Optimize the physical environment for child and family comfort, dignity, privacy, engagement, and safety
    1.3. Recognize when the perspectives, values, or biases of children, their families, physicians, or other health care professionals may have an impact on the quality of care, and modify the approach to the child accordingly
        1.3.1. Demonstrate understanding of the disease experience from the perspective of a child, and the meaning and consequences of illness to children and their families
        1.3.2. Maintain and reframe hope when working with children with palliative needs and their families
            1.3.2.1. Recognize that hope in palliative care is both a universal and individual experience
            1.3.2.2. Explore the child’s and family members’ personal experiences of hope
            1.3.2.3. Develop and use hope-enhancing strategies that are unique to each child’s experiences
            1.3.2.4. Recognize the duality of hope, acknowledging it sometimes improves coping and other times complicates anticipatory grieving by preventing children and families from speaking freely about their feelings
                1.3.2.4.1. Explore hopes, including hopes for miracles

    1.4. Respond to a child’s non-verbal behaviours to enhance communication
        1.4.1. Recognize that emotions, empathy, and caring can be expressed through both verbal and nonverbal communication

    1.5. Manage disagreements and emotionally charged conversations

1.5.1. Identify communication challenges, including anger, confusion, culture, denial, educational level, and language, and modify approach to ensure effective communication

1.6. Adapt to the unique needs and preferences of each child and to their clinical condition and circumstances

1.6.1. Recognize and accommodate for children's diversities and differences, including state of disease, disabilities, gender, sexual orientation, age, developmental stage, culture, ethnicity, religion, language needs, and socio-economic status

1.6.2. Adapt communication style to accommodate children and their families

2. Elicit and synthesize accurate and relevant information, incorporating the perspectives of children and their families

2.1. Use child- and family-centred interviewing skills to effectively gather relevant biomedical and psychosocial information

2.1.1. Use empathetic listening to establish child- and family-centred goals of care and identify the extent of awareness about illness and prognosis

2.2. Provide a clear structure for and manage the flow of an encounter

2.3. Seek and synthesize relevant information from other sources, including the child's family

3. Share health care information and plans with children and their families

3.1. Share information and explanations that are clear, accurate, and timely, while assessing for child and family understanding

3.1.1. Explain the palliative care philosophy to children and their families

3.1.2. Explain treatment options, both pharmacological and non-pharmacological, including potential benefits, effectiveness, risks, and side effects

3.1.3. Educate children and their families about

3.1.3.1. Common symptoms, conditions, and issues, and emergencies/urgencies encountered by children with palliative needs and strategies for management across settings of care

3.1.3.2. Differences in providing community-based palliative care, including in homes and in rural communities

3.1.3.3. Signs of impending death

3.1.3.4. The concept of brain death, and processes for organ and tissue donation

3.1.4. Validate and normalize suffering that is inherent to the dying process

3.1.5. Provide supports to alleviate, address, or accompany a child and their family in their suffering

3.2. Disclose harmful patient safety incidents to children and their families

4. Engage children and their families in developing plans that reflect their health care needs and goals

4.1. Facilitate discussions with children and their families in a way that is respectful, non-judgmental, and culturally safe

4.1.1. Participate in and facilitate family meetings to discuss issues, including goals of care and discharge planning

4.1.2. Facilitate discussions about advance care plans, location of care, palliative sedation, prognosis, treatment choices, and non-initiation or withdrawal of life-sustaining treatment

4.1.3. Explore, fully and sensitively, the child's desire to die and family requests for suffering to end

4.1.4. Respond to requests for euthanasia and physician assisted suicide, from a child or their family, in accordance with professional responsibilities

4.1.4.1. Explain that, in Canada, MAID includes both assisted suicide and euthanasia

4.1.4.2. Explain the legal framework that regulates MAID

4.2. Assist children and their families to identify, access, and make use of information and communication technologies to support their care and manage their health

4.3. Use communication skills and strategies that help children and their families make informed decisions regarding their health

4.3.1. Respect autonomy and maximize the involvement of children and their families in shared decision-making

5. Document and share written and electronic information about the medical encounter to optimize clinical decision-making, patient safety, confidentiality, and privacy

5.1. Document clinical encounters in an accurate, complete, timely, and accessible manner, in compliance with regulatory and legal requirements

5.1.1. Document advance care planning and goals of care conversations

5.1.2. Document anticipatory palliative care management plans

5.2. Communicate effectively using a written health record, electronic medical record, or other digital technology

5.3. Share information with children, families, and others in a manner that enhances understanding and that respects patient privacy and confidentiality

Collaborator

Definition:

As *Collaborators*, pediatric palliative medicine subspecialists work effectively with other health care professionals to provide safe, high-quality, child- and family-centred care.

Key and Enabling Competencies: Pediatric palliative medicine subspecialists are able to…

1. **Work effectively with physicians and other colleagues in the health care professions**
    - 1.1. Establish and maintain positive relationships with physicians and other colleagues in the health care professions to support relationship-centred collaborative care
    - 1.2. Negotiate overlapping and shared responsibilities with physicians and other colleagues in the health care professions in episodic and ongoing care
        - 1.2.1. Recognize the roles, expertise, and limits of each member of the interprofessional team, including overlapping and complementary skills
        - 1.2.2. Demonstrate an understanding of the importance of role clarity both within and between teams in the provision of palliative care
        - 1.2.3. Exchange information effectively with colleagues and other health care professionals to ensure consistent messages are delivered to children and their families
        - 1.2.4. Work effectively with other health care professionals throughout the course of the child’s illness and across settings of care
    - 1.3. Engage in respectful shared decision-making with physicians and other colleagues in the health care professions
        - 1.3.1. Establish with the referring team how pediatric palliative care will be delivered: as consultative, primary, or shared care
        - 1.3.2. Support and educate others in the provision of primary palliative care through formal consultation, informal coaching and mentoring, and ongoing education

2. **Work with physicians and other colleagues in the health care professions to promote understanding, manage differences, and resolve conflicts**
    - 2.1. Show respect toward collaborators
        - 2.1.1. Respect the role of primary care physicians, and the importance of continuity of care for children with palliative needs
    - 2.2. Implement strategies to promote understanding, manage differences, and resolve conflict in a manner that supports a collaborative culture
        - 2.2.1. Assess the stages of team formation and development and describe elements of an effective interprofessional team
        - 2.2.2. Identify common causes for team dysfunction and conflict and apply different types of team management frameworks

    - 2.2.3. Practice self-reflection as a tool to enhance team function and support resolution of team dysfunction
    - 2.2.4. Promote team reflection as a tool to enhance team function and support resolution of team dysfunction

3. **Hand over the care of a child to another health care professional to facilitate continuity of safe patient care**
  - 3.1. Determine when care should be transferred to another physician or health care professional
    - 3.1.1. Coordinate with other physicians and services to develop a plan for ongoing care for youth with complex, progressive, or life-threatening conditions as they transition from pediatric to adult care
  - 3.2. Demonstrate safe handover of care, using both oral and written communication, during a transition to a different health care professional, setting, or stage of care
    - 3.2.1. Provide guidance for anticipated changes in a child's status and needs

Leader

Definition:

As *Leaders*, pediatric palliative medicine subspecialists engage with others to contribute to the development of a high-quality health care system and take responsibility for the delivery of excellent patient care through their activities as clinicians, administrators, scholars, or teachers.

Key and Enabling Competencies: Pediatric palliative medicine subspecialists are able to…

1. **Contribute to the improvement of health care delivery in teams, organizations, and systems**
  - 1.1. Apply the science of quality improvement (QI) to systems of patient care
    - 1.1.1. Develop and implement QI strategies and programs for palliative care services
  - 1.2. Contribute to a culture that promotes patient safety
  - 1.3. Analyze patient safety incidents to enhance systems of care
  - 1.4. Use health informatics to improve the quality of patient care and optimize patient safety
2. **Engage in the stewardship of health care resources**
  - 2.1. Allocate health care resources for optimal patient care

        - 2.1.1. Promote timely advance care planning and goals of care discussions to ensure appropriate use of health care resources

    - 2.2. Apply evidence and management processes to achieve cost-appropriate care

3. **Demonstrate leadership in health care systems**
    - 3.1. Demonstrate leadership skills to enhance health care
        - 3.1.1. Demonstrate characteristics essential to the provision of effective leadership within a team or organization
        - 3.1.2. Act in the role of the leader on an interdisciplinary palliative care team, identifying and working with the roles and capabilities of individual team members to ensure optimal team function and clinical service delivery
        - 3.1.3. Demonstrate support for building capacity in primary palliative care
            - 3.1.3.1. Support other health care professionals in providing a palliative approach to care for their patients through formal and informal education, mentorship, and coaching

        - 3.1.4. Work with managers, team leads, and leads from other disciplines to develop programs that meet the needs of the population served
        - 3.1.5. Develop protocols for incorporating palliative care into existing and novel interprofessional patient care teams

    - 3.2. Facilitate change in health care to enhance services and outcomes
        - 3.2.1. Describe theories associated with facilitating change within organizations
        - 3.2.2. Set evidence-based standards and best practice guidelines for palliative care
        - 3.2.3. Develop and implement policies and clinical pathways for palliative care provision based on evidence-based standards and best practices
        - 3.2.4. Identify gaps and needs for care in underserved areas/populations using outcomes data
        - 3.2.5. Develop, plan, and implement palliative care programs that meet the needs of the population served

4. **Manage career planning, finances, and health human resources in personal practice(s)**
    - 4.1. Set priorities and manage time to integrate practice and personal life
    - 4.2. Manage personal professional practice(s) and career
    - 4.3. Implement processes to ensure personal practice improvement

Health Advocate

Definition:

As *Health Advocates*, pediatric palliative medicine subspecialists contribute their expertise and influence as they work with communities or patient populations to improve health. They work with those they serve to determine and understand needs, speak on behalf of others when required, and support the mobilization of resources to effect change.

Key and Enabling Competencies: Pediatric palliative medicine subspecialists are able to…

1. Respond to an individual child's health needs by advocating with the child and family within and beyond the clinical environment

- 1.1. Work with children and families to address determinants of health that affect them and their access to needed health services or resources
    - 1.1.1. Recognize how access to palliative care is affected by determinants of health that lead to inequality in health status and access to resources, including
        - 1.1.1.1. Age
        - 1.1.1.2. Culture
        - 1.1.1.3. Disability
        - 1.1.1.4. Geography
        - 1.1.1.5. Poverty
        - 1.1.1.6. Underhousing, vulnerable-housing, and homelessness
    - 1.1.2. Facilitate access to needed services and resources
    - 1.1.3. Apply Jordan's Principle, and other national programs, to facilitate access to care and resources
- 1.2. Work with children and their families to increase opportunities to adopt healthy behaviours
- 1.3. Incorporate disease prevention, health promotion, and health surveillance into interactions with individual children and families

2. Respond to the needs of the communities or populations they serve by advocating with them for system-level change in a socially accountable manner

- 2.1. Work with a community or population to identify the determinants of health that affect them

- 2.1.1. Identify barriers to access to palliative care and resources
    - 2.1.1.1. Availability of primary health care, interprofessional teams, and specialized medical services
    - 2.1.1.2. Availability of community-based resources, including home care and pharmaceuticals
    - 2.1.1.3. Availability of resources for supporting children with rare diseases
    - 2.1.1.4. Delay in or lack of identification of patient populations who would benefit from palliative care
    - 2.1.1.5. Expense of dying at home
    - 2.1.1.6. Geographic inequities
    - 2.1.1.7. Poverty
    - 2.1.1.8. Structural inequities and discrimination impacting vulnerable and marginalized populations

2.2. Improve clinical practice by applying a process of continuous quality improvement to disease prevention, health promotion, and health surveillance activities

- 2.2.1. Identify organizational issues that affect the delivery of palliative care, including the lack of community resources for those who wish to care for their child at home

2.3. Contribute to a process to improve health in the community or population they serve

- 2.3.1. Understand the role of, and work with, provincial, territorial, and national palliative care organizations, including the Canadian Hospice Palliative Care Association (CHPCA), Canadian Network of Palliative Care for Children (CNPCC), provincial palliative care associations, the Canadian Society of Palliative Care Physicians (CSPCP), and palliative care sections of provincial medical associations in advocating for children with palliative needs and their families
- 2.3.2. Advocate for equitable, accessible, safe, and quality palliative care for all Canadian children through participation as a member of the CNPCC, CSPCP, and other organizations
- 2.3.3. Promote advance care planning
- 2.3.4. Contribute to community-based education to promote improved understanding of palliative care, including normalizing natural death and dying and dispelling myths about death and dying
- 2.3.5. Apply a public health approach to palliative care to advance understanding and acceptance of a palliative approach to care

Scholar

Definition:

As *Scholars*, pediatric palliative medicine subspecialists demonstrate a lifelong commitment to excellence in practice through continuous learning, and by teaching others, evaluating evidence, and contributing to scholarship.

Key and Enabling Competencies: Pediatric palliative medicine subspecialists are able to…

1. **Engage in the continuous enhancement of their professional activities through ongoing learning**
    - 1.1. Develop, implement, monitor, and revise a personal learning plan to enhance professional practice
        - 1.1.1. Use information technology to optimize learning
    - 1.2. Identify opportunities for learning and improvement by regularly reflecting on and assessing their performance using various internal and external data sources
    - 1.3. Engage in collaborative learning to continuously improve personal practice and contribute to collective improvements in practice

2. **Teach students, residents, the public, and other health care professionals**
    - 2.1. Recognize the influence of role modelling and the impact of the formal, informal, and hidden curriculum on learners
    - 2.2. Promote a safe and respectful learning environment
    - 2.3. Ensure patient safety is maintained when learners are involved
    - 2.4. Plan and deliver learning activities
    - 2.5. Provide feedback to enhance learning and performance
    - 2.6. Assess and evaluate learners, teachers, and programs in an educationally appropriate manner

3. **Integrate best available evidence into practice**
    - 3.1. Recognize practice uncertainty and knowledge gaps in clinical and other professional encounters and generate focused questions that can address them
    - 3.2. Identify, select, and navigate pre-appraised resources
    - 3.3. Critically evaluate the integrity, reliability, and applicability of health-related research and literature
    - 3.4. Integrate evidence into decision-making in their practice

4. **Contribute to the creation and dissemination of knowledge and practices applicable to health**
    4.1. Demonstrate an understanding of the scientific principles of research and scholarly inquiry and the role of research evidence in health care
        4.1.1. Identify current themes and trends in palliative care research

    4.2. Identify ethical principles for research and incorporate them into obtaining informed consent, considering potential harms and benefits, and considering vulnerable populations
        4.2.1. Describe the unique challenges of palliative care research and strategies to overcome them

    4.3. Contribute to the work of a research program
    4.4. Pose questions amenable to scholarly investigation and select appropriate methods to address them
    4.5. Summarize and communicate to professional and lay audiences, including children and their families, the findings of relevant research and scholarly inquiry

Professional

Definition:

As *Professionals*, pediatric palliative medicine subspecialists are committed to the health and well-being of individual patients and society through ethical practice, high personal standards of behaviour, accountability to the profession and society, physician-led regulation, and maintenance of personal health and well-being.

Key and Enabling Competencies: Pediatric palliative medicine subspecialists are able to…

1. **Demonstrate a commitment to patients by applying best practices and adhering to high ethical standards**
    1.1. Exhibit appropriate professional behaviours and relationships in all aspects of practice, demonstrating honesty, integrity, humility, commitment, compassion, respect, altruism, respect for diversity, and maintenance of confidentiality
        1.1.1. Demonstrate an ongoing commitment to a child and their family throughout their illness trajectory
        1.1.2. Demonstrate sensitivity and responsiveness to a diverse patient population

- 1.2. Demonstrate a commitment to excellence in all aspects of practice
  - 1.2.1. Incorporate current standards of pediatric palliative care in clinical practice
  - 1.2.2. Act as a role model by demonstrating skilful care of children with palliative needs and their families

- 1.3. Recognize and respond to ethical issues encountered in practice
  - 1.3.1. Apply an ethical approach when discussing issues related to the care of children with palliative needs and their families
    - 1.3.1.1. Describe the availability of and access to resources to support ethically complex decision-making, including ethics consultations
    - 1.3.1.2. Recognize and respect differences in conscience and moral distress experienced by children, their families, and members of the palliative care team
    - 1.3.1.3. Identify moral and ethical issues commonly encountered in pediatric palliative care and describe similarities and differences with adult palliative care

  - 1.3.2. Demonstrate strategies to resolve conflicts of interest related to provision of palliative care, including autonomy, goals of care, and resource allocation

- 1.4. Recognize and manage conflicts of interest
- 1.5. Exhibit professional behaviours in the use of technology-enabled communication

2. Demonstrate a commitment to society by recognizing and responding to societal expectations in health care

- 2.1. Demonstrate accountability to patients, society, and the profession by responding to societal expectations of physicians
- 2.2. Demonstrate a commitment to patient safety and quality improvement

3. Demonstrate a commitment to the profession by adhering to standards and participating in physician-led regulation

- 3.1. Fulfil and adhere to professional and ethical codes, standards of practice, and laws governing practice
  - 3.1.1. Apply relevant protocols at the time of death, including the appropriate notification of the medical examiner or coroner and completion of documentation
  - 3.1.2. Apply legislation that relates to patient care, including care directives and role of substitute decision-makers

- 3.1.3. Identify different approaches in caring for children with respect to moral, ethical, and legal roles of substitute decision-makers, including
  - 3.1.3.1. Rights accorded during pregnancy and how these change after birth
  - 3.1.3.2. Parental rights
  - 3.1.3.3. Guardianship
  - 3.1.3.4. Consent and assent
  - 3.1.3.5. Role of a mature minor in decision-making
  - 3.1.3.6. Court rulings regarding children's decision-making
  - 3.1.3.7. Involvement of agencies, such as social services

- 3.1.4. Adhere to regulations governing the prescribing of controlled substances
- 3.1.5. Describe the medical, legal, moral, and ethical issues surrounding organ and tissue donation and transplantation

3.2. Recognize and respond to unprofessional and unethical behaviours in physicians and other colleagues in the health care professions

3.3. Participate in peer assessment and standard setting

- 3.3.1. Develop and maintain standards for care delivery

4. Demonstrate a commitment to physician health and well-being to foster optimal patient care

4.1. Exhibit self-awareness and manage influences on personal well-being and professional performance

- 4.1.1. Recognize the importance of incorporating self-reflection in all aspects of practice
- 4.1.2. Reflect on one's own beliefs, culture, and personal experiences with death and how they impact on the response to grief, dying and death, and suffering of children and families
- 4.1.3. Reflect on the personal impact of providing care for children who are suffering and their families
- 4.1.4. Demonstrate strategies for managing personal stress associated with caring for children with palliative needs and their families
- 4.1.5. Recognize risk factors for moral distress, moral injury, and burnout, and develop strategies to mitigate the impact of these on personal well-being and professional performance
- 4.1.6. Seek and accept feedback and assistance from others related to personal and professional issues

4.2. Manage personal and professional demands for a sustainable practice throughout the physician life cycle

    4.2.1. Demonstrate strategies for resolving conflicts and role strain

4.3. Promote a culture that recognizes, supports, and responds effectively to colleagues in need

    4.3.1. Identify individuals and teams at risk for or demonstrating moral distress, moral injury, and burnout, and strategies and resources to assist them

This document is to be reviewed by the Specialty Committee in Palliative Medicine by December 31, 2027.

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