Curriculum in Palliative Care for Undergraduate Medical Education

Recommendations of the European Association for Palliative Care

Report of the EAPC Task Force on Medical Education

Contents

EAPC Onlus: Non profit-making Association
Istituto Nazionale dei Tumori, Via Venezian 1
20133 Milano, ITALY
Tel: +39-02-23903390
Fax: +39-02-23903393
e-mail: e.a.p.c@istitutotumori.mi.it
www.eapcnet.org

ISBN: 978-88-902961-3-0

Foreword

When the EAPC was formed in 1988 many European countries were still without Palliative Care services and few medical schools taught Palliative Care. In those that did, the time allocated to it was small, students were seldom examined in it and many academics saw little reason for change.

Times have changed. Many more people have now heard of Palliative Care and come to expect it to be available and accessible when they, or a loved one, need it. Several governments are acknowledging the need for nationwide Palliative Care services, some even generously funding it. More importantly the relevance of such care for people with non-malignant conditions is being acknowledged, as are the benefits of such care earlier in the patients' care.

Perhaps the biggest change has been the recognition that nearly 50% of deaths in Europe are 'chronic', the patient becoming increasingly frail and dependent with a spectrum of suffering extending over months or years before they die. Every one of those patients needs and will benefit from Palliative Care. Their number is vast and will inexorably increase with ageing populations and medical advances capable of keeping people alive much longer than anyone expected but often with a questionable quality of life. At the same time it has come to be recognised that 90% of these people will (and should) remain under the care of their general practitioners / family doctors. Only if they have suffering of such severity, complexity or rarity that their doctors cannot be expected to look after them will specialist expertise be needed.

It follows that every undergraduate medical student will need to learn about Palliative Care - its challenges, its complexity and its immense professional and personal rewards. He / she will discover that whilst its principles are those of all good clinical care being skilled in it is not an inborn gift. It requires knowledge, compassion, sensitivity and humility. Those who teach it must have those talents in abundance but, in addition, must know how to use appropriately every teaching / tutorial technique. Preferably they should have had formal teacher - training at undergraduate or postgraduate level. Such teachers are now to be found in Palliative Care departments in several universities and it is no surprise that undergraduates are rating their teaching amongst the best in the university and the subject itself amongst the most exciting.

The experts who have produced these recommendations know how easy it is to regard Palliative Care as little more than an exercise in clinical pharmacology, particularly in opioid prescribing and rotation. They know how central to that care is the understanding of the psychosocial and spiritual aspects of the patient's life (so often neglected both in undergraduate years and subsequent specialist training) and the suffering and needs of caring relatives. All have a place in their proposals.

A distinguished professor of surgery, about to retire and looking back on all he had seen and learned in the previous 45 years,, recently said to me that the greatest advance he had seen, the most important thing he had had to learn, was Palliative Care. “We must ensure that never again will young men and women enter our noble profession unable to care for those they cannot cure, not knowing how to listen, not being ready to learn from nurses, and not sensitive to their patients’ greatest needs”.

He, like me, would approve of these EAPC recommendations and commend them to every medical school in Europe and beyond.

Derek Doyle

Chairman of the first EAPC Education Committee

A) Introduction

EAPC background

From its initial conception the European Association for Palliative Care (EAPC) has regarded the education and training of health care professionals as of the highest importance for the promotion and expansion of Palliative Care in Europe. In 1992 an EAPC educational committee chaired by Derek Doyle proposed specific recommendations for training in Palliative Care. Later (2000) and in recognition of ways of working collaboratively in a Palliative Care context, a multi-professional expert group revisited these recommendations for education in Palliative Care.

In order to meet the interests of specific professional curricula (medical, nursing, etc.) the project separated after an initial phase of common goal setting. In 2004 a set of recommendations for palliative nurse education were proposed (EAPC 2004). The curriculum proposed here for undergraduate medical education is the result of an equivalent project for the training in the medical field, both for the basic (undergraduate) and for the specialist (postgraduate) level in accordance with the 2003 Council of Europe recommendations on the organisation of Palliative Care (COE 144/153).

The recommendations are based upon existing medical curricula formulated by the authors with a view to a pan-European perspective. A consultation process was undertaken in which the recommendations were circulated to 30 expert Palliative Care physicians and the final document incorporates the views of this expert group.

Undergraduate training in Palliative Care

The number of patients with cancer and other life-limiting diseases continues to increase. The last decades have seen a rapid growth in the concern for the severely ill and dying patients. The developments in most countries have led to the establishment of Palliative Care services in a variety of settings with diverse staff composition and disparate quality standards.

Palliative Care education at medical schools has also increased in Europe within the last years. However, undergraduate education in Palliative Care in Europe shows wide variation and there is no standardised European core curriculum. Efforts have already been made to standardise undergraduate Palliative Care education by creating curricula for instance in Australia, Canada and the United Kingdom.

The proposed curriculum for undergraduate education in Palliative Care may help medical schools in Europe to improve Palliative Care teaching. The contents are considered essential for all medical graduates. The change in attitude towards the care of severely ill and dying patients and their families is one of the major goals. Another important aspect is to address specific skills in inter-professional team work as well as in the basics of symptom

management. The contents of this undergraduate curriculum refer to the basic principles fixed in the definition of Palliative Care by the World Health Organization (WHO) in 2002.

WHO definition of Palliative Care

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

- *Palliative care provides relief from pain and other distressing symptoms*
- *Affirms life and regards dying as a normal process*
- *Intends neither to hasten or postpone death*
- *Integrates the psychological and spiritual aspects of patient care*
- *Offers a support system to help patients live as actively as possible until death*
- *Offers a support system to help the family cope during the patient's illness and in their own bereavement*
- *Uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated*
- *Will enhance quality of life, and may also positively influence the course of illness*
- *Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.*

(World Health Organisation, 2002)

General recommendations for the curriculum development in Palliative Care

These recommendations provide only a general framework for curricula in Palliative Care as defined by the different medical schools in Europe. The integration of Palliative Care into existing undergraduate curricula is a major challenge. Instruments like the "Palliative Education Assessment Tool" (PEAT) help to detect already existing features of Palliative Care education which often may be found “hidden” in the curricula of medical schools.

In order to meet needs of the different health care systems and the needs of the students some general principles of curriculum planning should be followed (see (E) General Principles of Curriculum Planning).

Specific components of the undergraduate curriculum in Palliative Care

It is the advice of the authors to avoid any overload of the undergraduate curriculum in Palliative Care and to plan any education with the intention and purpose to organize the distribution of the content in the sense of "vertical integration".

The content of the curriculum should comprise seven domains in order to achieve a basic level of competencies in Palliative Care:

- Palliative Care, Palliative Medicine (definitions etc.)
- Pain
- Neuropsychological symptoms (agitation, confusion etc.)
- Management of other symptoms (dyspnoea, nausea, etc.)
- Ethics and law
- Patient/family/ non-clinical caregivers perspectives
- Clinical communication skills

Like a detector PEAT has its place in assessing where Palliative-Care-issues are already located within an existing curriculum and also in defining the best time and place for a new input. It does not specify how and in what detail Palliative Care should be taught.

This assessment tool may help not only to identify relevant contents but also teachers who need to be contacted in order to integrate a new Palliative Care curriculum (mainly oncology, family medicine, geriatrics, pharmacology, psychology, psychiatry). This approach may also keep possible resistance to development low.

Teamwork and recommendations for multi-professional education

The ability to work in and lead a health care team is one of the characteristics of Palliative Care and needs special attention in the planning of the curriculum and the teaching methods adopted. It is considered to be mandatory that some members of the teaching faculty have a professional background different from the medical field (e.g. nursing, pastoral services).

B) Goals

A learning experience has to be promoted which permits students to develop the attitude, knowledge and skills necessary to participate in effective and compassionate Palliative Care.

Goals are:

- to show that medical treatment is far beyond diagnostic investigations and healing, the patient is meant to be considered, cared for and treated holistically
- to show how to relieve symptoms (pain and others) by pharmacological and non-pharmacological means
- to show that Palliative Care of patients and their relatives is a process that does not only include crisis intervention but also an anticipatory treatment and attention to need
- to show that care and treatment have to be adopted to the individual needs, wishes and values of a certain patient and his relatives
- to show that the quality of care for the terminally ill patients will only succeed if the attending physician is able to reflect his own attitude towards disease, dying, death and mourning
- to show that the quality of medical treatment cannot only be improved by enlarging knowledge but also by the competence of team-working, communicating and the willingness to discuss ethical issues

C) Educational strategies

Educational technique and process may vary in each medical school but it is recommended that the following aspects should be noted:

- Experiential learning (including the contact to inpatient units, hospital consultative service or community settings and also including patient and family encounters) should be taken into account predominantly. Debriefing should be considered a priority.
- Active rather than passive techniques should be applied (problem based learning, discussion, role play).
- Multi-professional learning should be encouraged to foster cooperation.
- Horizontal integration: Specialists in Palliative Care should be aware of areas of Palliative Care taught by colleagues in other disciplines.
- Repeated occasions for self-reflection and group discussions of difficult situations including family issues, team problems and grief should be arranged.
- Ethical and psychosocial considerations should be integrated into all aspects of teaching.

A total of 40 hours allocated in different years of undergraduate medical education is recommended for achieving the goals of this curriculum. Basics should be taught as early as possible, clinical aspects later on in the medical education. Horizontal and vertical integration must be transparent for the student. Additionally a clinical experience in a Palliative care setting is recommended.

Assessment methods should consider tools to evaluate knowledge, for instance by multiple choice questions, short questions, or case studies and furthermore tools to measure attitudes and skills. It seems crucial to introduce Palliative Care into undergraduate medical examinations.

D) Syllabus

1.	**Basics of Palliative Care**	**5%**
2.	**Pain and Symptom Management**	**55%**
3.	**Psychosocial and spiritual Aspects**	**20%**
4.	**Ethical and legal Issues**	**5%**
5.	**Communication**	**10%**
6.	**Teamwork and Self-reflection**	**5%**

The proposed curriculum is based upon the minimal knowledge and skills which a medical student should obtain during his/her undergraduate education. The content list below must be translated into learning objectives and the educational strategy (learning method) must be defined (see (E) General Principles of Curriculum Planning).

The teaching staff for the items below can and will vary including faculty from other different professional background than medicine.

1. Basics of Palliative Care: 5%

Knowledge	Awareness of
• International development of the idea of hospice and Palliative Care • Definition of Palliative Care	the complexity of the end-of-life the physician's task in terminal care the multiprofessional and interdisciplinary approach of Palliative Care
• Forms of organisation: ➢ outpatient ➢ inpatient ➢ consulting	the necessity of different forms of organisation the necessity of communication between services

2. Pain and Symptom Management: 55%

a) Basic principles of symptom management

Content	Awareness of
• Curative therapy • Palliative therapy • Palliative medicine	the chance of an increase of quality of life by offering Palliative Care early
• Interdisciplinary options ➢ surgery ➢ radiotherapy ➢ pharmacological ➢ non-pharmacological	the necessity of interdisciplinary and multi-professional treatment Balancing diagnostics and treatment with the stage of disease
• Planning and evaluation of treatment • Continuous and on-demand medication • Prevention and rehabilitation • Documentation	the importance of an individual and prospective treatment and care the importance to define goals

b) Pain management:

Knowledge	Comprehension of
• Definition and concepts of pain • Anatomy, pathophysiology • Pathophysiology of somatic and visceral nociception • Mechanisms of neuropathic pain • Recognition of chronic pain features • The concept of "total pain" • Principles of pharmacological treatment, WHO – rules pharmacokinetics ➢ importance of achieving 'steady state' ➢ using the simplest available route ➢ role of titration in opioid ➢ necessity to prescribe rescue medication • Pharmacodynamics of opioids, non-opioids & adjuvant analgesics • Routes of drug administration and their indications, alternative routes when oral is not possible. • Non-pharmacological pain management: ➢ Oncological interventions (chemotherapy, radiotherapy) ➢ Neurolytic procedures (anaesthetic or neurosurgical) ➢ Nursing interventions ➢ Psychotherapy and counselling ➢ Physiotherapy ➢ Alternative therapy • Organisational and legal problems: ➢ Special prescription forms ➢ Driving ability ➢ Travelling	the multidimensional approach of pain management the complexity of pain in terminally-ill patients the fact that there is more to pain relief than drugs. rumours and untruths. Destroy the myth that opioid analgesics are addictive, and that if initiated too early there will be "nothing left for the end".

(c) Symptom management:

Knowledge	Comprehension for
• Gastrointestinal symptoms ➢ Constipation, diarrhoea o Anatomy and physiology of normal defaecation and bowel continence. o Mechanisms of constipation in a terminal illness (drugs, particularly opioids, altered diet) o weakness ➢ Ileus • Nausea and vomiting o Pathophysiology of nausea and vomiting: where are the sites, receptors? o Pharmacology of antiemetics, particular sites of drug action o The role of the route of drug administration o How to deal with bowel obstruction • Pulmonary symptoms ➢ Dyspnoea o Pathophysiology of respiratory symptoms o Relevant pharmacology (opioids, anxiolytics, steroids) o Principles of oxygen therapy o How to deal with "death rattle" ➢ Cough	the physical, psychological, social and spiritual aspects of symptom management in Palliative Care

- Neuropsychiatric symptoms
  - Delirium
  - Insomnia
  - Depression and other mood disorders
  - Anxiety and fear
  - Hallucinations
  - Confusional states
- Anorexia, cachexia
  - Loss of appetite
  - Fatigue
  - Weakness, lethargy
- Thirst, dry mouth
  - Sore mouth
  - Swallowing problems
- Dermatologic symptoms
  - Wound breakdown
  - Lymphoedema
  - Itching
- Terminal care

3. Psychosocial and spiritual Aspects: 20%

Knowledge	Comprehension for
• Psychological reactions to chronic illness, grief and loss • Impact on patient and family of loss of independence, role, appearance, sexuality and perceived self worth during a terminal illness • Family dynamics • Ethnic, social and religious differences • How to help patients and families to deal with practical, financial and legal issues where appropriate. In particular to arrange for social work and legal briefing to assist with will-making or revision and compensation claims, which sometimes arise as matters of urgency close to the end of life • Facilitation of work leave and travel arrangements for relatives and friends to come to visit a dying person from within the country and overseas	the patient's autonomy the meaning of truth the patient's individuality the patient's vulnerable self-respect the meaning of vitality and sexuality cherishing the patient's and relatives' feelings cherishing the patient's and relatives' needs the complexity of the patient's social circumstances the idea of a "Unit of Care" the important role of the family in terms of the patient's quality of life the specific needs of children
• coping strategies	the difficulties you may encounter when dealing with severe illness and closing death the importance and meaning of quality of life in Palliative Care
• Grief and bereavement as a process of each concerned person • Anticipatory mourning • Risk factors for difficult mourning	identification of helpful and not helpful strategies when working with the patient's and relatives' mourning, including children. ➢ at the beginning of the disease ➢ during disease ➢ when patient is dying ➢ after patient's death
• Spirituality ➢ hope ➢ review of one's life ➢ belief	the differences between spirituality and religion one's own spirituality the patient's spirituality

4. Ethical and legal Issues: 5%

Knowledge	Comprehension for
• Discussion of decision-making at the end of life, particularly the abatement, withdrawal or withholding of a treatment • The proper ways of negotiating and placing 'Do-not- resuscitate'-orders (DNR's) • Exploration of proxy decision-making and advance directives	ethical aspects in medical decision-making the reflection of one's own ethical attitude the reflection of one's own attitude towards death and dying
• Distinction between accepted Palliative Care practice and euthanasia • Ethical and legal differentiation in the national and international context ➢ euthanasia ➢ physician assisted suicide	the reflection about the physician's role in treatment of end-of-life patients

5. Communication: 10%

Knowledge	Comprehension for
• Models of communication • Differentiation: ➢ verbal vs. non-verbal communication • Special situations of communication ➢ patient's information, prognosis ➢ decision-making ➢ conflict and conflict resolution ➢ talking with relatives	the perception of the patient's attitude towards his disease one's own shortcomings and strong points in perception and communication

6. Teamwork and Self-reflection: 5%

Knowledge	Comprehension for
• How to work in a team	the necessity of teamwork the danger of role-conflicts the process of decision-making the possibility of debriefing each other in a team
• Networking ➢ support systems ➢ partners	The importance of delegation
• ”Burn-out” -avoidance and -prophylaxis	one’s own way how to manage burdens one’s own way how to manage personnel concern the chance of debriefing oneself by supervision

E) General Principles of Curriculum Planning

The educational programme in Palliative Care should be organised in each country taking into consideration the six-step approach for curriculum development for medical education formulated by Kern et al. (1998):

Step 1: Identification of general needs and problems

In Palliative Care this might include statistical information of the number of severely ill patients and causes, preference and actual place of death, deficiencies in hospital care and home care, current ethical discussion in public, health insurance issues and so on.

This kind of analysis should enable to identify key differences between the current and an ideal approach. An assessment of the potential number and qualification of teachers when identifying the ideal approach is warranted.

Step 2: Identification of specific needs of different target groups

Content

In Palliative Care this might include orientation towards practical needs of physicians regarding Palliative Care in different settings (hospital, home care, hospice, general practice, other medical specialists in private practice etc.) Specific needs should be defined by an analysis of deficiencies.

There should be a clear distinction between the undergraduate and postgraduate level. Palliative Care is in danger of accumulating an enormous number of topics within one course or curriculum. We recommend to focus on the vertical integration of learning content relative to time in continuous medical education (exposure to concrete clinical practice will lead to other needs in postgraduate training). This approach might prevent the creation of overloaded Palliative Care curricula in the undergraduate level.

A detailed analysis of characteristics of the learners' environment regarding barriers, enabling and reinforcing factors will help to implement any course or curriculum more easily.

Methods

Preferences and experiences regarding different learning strategies might differ enormously not only among the targeted learners but also to different cultures and countries. The same is true for the resources available to learners (e.g. computers, audiovisual equipment, role models, simulated patients, teachers etc.).

Step 3: Setting of goals and objectives

Goals are of a general character and define the ideas what should be generally achieved by a course or curriculum.

Objectives are defined specifically for the measurement of outcomes taking into consideration three major fields of achievement:

- **knowledge** (cognitive)
- **skills** (psychomotor)
- **attitude** (affective)

The more precisely objectives are formulated the easier evaluation (see step 6) becomes. The formulation of a learning objective needs the definition of:

- Who will perform? (e.g. "the student")
- Which level of activity? (e.g. "should be able to rank")
- What level of achievement? (e.g. "3 most frequent symptoms…")
- When should objective be reached? (e.g. "at the end of the course")

Step 4: Educational strategies

The question is what content may be presented and learnt best. Content and method must be congruent. For instance to improve decision making skills a small group discussion (problem based learning) might be more effective than having a faculty member analyse the case for the learners. Content should include all three areas of objectives: cognitive ("**knowledge**"), psychomotor ("**skills"**) and affective objectives ("**attitude**").

The use of multiple educational methods during a course or program does not only provide a more vivid atmosphere and enhanced participation but also takes into account the different learning styles of the learners. Some learn best while reading an article, others prefer role play or creating a concept for their learning (see Learning Styles Model by Kolb).

Methods for achieving cognitive objectives (Knowledge)

- Problem based learning (PBL)
- Small group work
- Lectures
- Role plays

Methods for achieving psychomotor objectives (Skills)

- Supervised clinical experience
- Simulations (e.g. simulated patients, role plays)
- Audio or visual review of skills

Methods for achieving affective objectives (Attitude)

- Exposure (experiential learning) followed by discussion
- Role models
- Role plays
- Individual and group supervision: promote openness, introspection and reflection.

These methods rely on trust, continuity and trained teachers in order to facilitate self-reflection and feed-back on a personal level. In Palliative Care these types of methods need to be integrated into each course or curriculum since self- reflection is of major importance for the field.

Specific to Palliative Care are methods to promote teamwork. Teamwork can be used as a collaborative learning experience (any task or problem experienced and resolved in a group), team-teaching (teaching by two, three, etc.) and team-exercise (e.g. to solve a case together). Several models for enhancing teamwork (knowledge, skills and attitude) exist from management courses in the industry and can be transferred to field of Palliative Care.

Step 5: How to implement the course or curriculum

The following checklist facilitates the successful establishment of a curriculum in Palliative Care:

- Identify resources (personnel, time, faculties, funding)
- The program leader must be qualified to supervise and educate trainees in Palliative Care. Thus, the leader should have appropriate experience in Palliative Care and teaching
- Identify multi-professional teaching staff to meet training needs
- Develop administrative mechanisms to support the curriculum for
    - repartition of responsibilities
    - continuous communication and adaptation
    - permanent evaluation
- Find partnerships with the clinical Palliative Care services, other specialities, other health care professionals.

Step 6: Evaluation and Feedback

Evaluation and feedback close the loop in the curriculum development cycle. Two questions are asked:

1. **How did the participants perform? (Assessment of the individual)**

Usually two different assessment strategies are used in order to evaluate the achievement of the learning objectives formulated in Step 3:

- **Formative** assessment: the change in achievement or performance over a time period, mostly monitored by a tutor or supervisor, using self-assessment tools. The exam itself is part of the educational process.
- **Summative** assessment: the level of achievement. You must pass this exam to progress. Several assessment methods are commonly used, including written or computer-interactive tests, oral examination, questionnaires (MCQ or open questions), direct observation

2. **How did the curriculum perform? (Assessment of the curriculum)**

In Palliative Care as a relatively young discipline permanent attention should be drawn to the increasing basic knowledge of the targeted groups. Therefore Step 6, 1 and 2 need to be administered carefully and repetitively. The assessment of the curriculum usually focuses on the content level as well as on the methods.

To test the impact of a curriculum on the population level (consumers' health) might be of special interest and can be administered best in clearly described environments (e.g. nursing home, community level).

The results of step 6 should be disseminated to regional, national and international groups in Palliative Care and across a multi-professional spectrum.

F) References

1. Kern DE, Thomas PA, Howard DM. Curriculum Development for Medical Education: A Six-Step Approach. Johns Hopkins University Press (1998)
2. Kolb D. Experiential Learning. Experience as the Source of Learning and Development. Prentice Hall International (1985)
3. Hillier R. Palliative medicine: a new specialty. Br Med J (1988) 297: 873-874
4. Calman K. Education and training in palliative medicine. In: Doyle D, Hanks G, Cherny N, Calman K. Oxford Textbook of Palliative Medicine. Oxford University Press. 3rd edition (2004)
5. James CR, MacLeod RD. The problematic nature of education in Palliative Care. J Pall Care (1993) 9(4): 5-10
6. MacDonald N, Mount B, Boston W, Scott J. The Canadian Palliative Care undergraduate curriculum. J Cancer Education (1993) 8(3): 197-201
7. Ferris FD, Cummings I. Palliative care: Towards a consensus in standardised principles of practice. Canadian Palliative Care Association. Ottawa (1995)
8. Smith A. Continuing education and short courses. Pall Med (1996) 10: 105-111
9. Sheldon F, Smith P. The life so short, the craft so hard to learn: a model for post-basic education in Palliative Care. Pall Med (1996) 10: 99- 104
10. Doyle D. Education in palliative medicine. Pall Med (1996) 10: 91 -92
11. Doreen Oneschuk. La formation Universitaire et professionnelle en soins palliatifs. EJPC 1999 ; 6(6)
12. Meekin SA, Klein JE, Fleischman AR, Fins JJ. Development of a palliative education assessment tool for medical student education. Acad Med (2000) 75(10):986-92.
13. Vlieger M de, Gorchs N, Larkin PJ, Porchet F. Palliative nurse education: towards a common language. Palliative Medicine (2004) 18: 401-03
14. Palliative Oncology Education Section. AACE "Cancer pain education: Objectives for medical students and residents in primary care specialties" J Cancer Educ (1996) 11: 7-10
15. The Irish committee on Higher Medical Training. Curriculum for Higher Specialist Training in Palliative Medicine. Dublin: RCPI (1997).
16. Joint committee on higher medical training. Curriculum for higher specialist training in palliative medicine. (2003) www.jchmt.org.uk
17. Basic recommendations for training in Palliative Care. SECPAL (Spanish society for Palliative Care) (1999)
18. Curriculum for the university diploma. French association for Palliative care SFAP (2001)
19. Guidelines for Palliative Care education. EAPC educational network (2000)
20. Raccomandazioni generali per lo sviluppo delle cure palliative in Italia, Allegato N° 2. La formazione nelle cure palliative. SIPC (Italian Society for Palliative Care) FCP (Italian Federation of Non profit associations in Palliative Care) (2002)

21. Nordic specialist course in Palliative Medicine (2003 – 2005)
22. Corso residenziale di medicina palliativa SFAMP (2002)
23. Área de Capacitación específica. Medicina Paliativa Propuesta Curricular. Versión 6.3: Documento de trabajo. Recommendations for specialist training in Palliative Care. Spanish society for Palliative Care (2005)
24. Nordic Cancer Union: Steering Committee for Patient Support 'A Curriculum for Palliative Care Education in the Nordic countries' (in press)
25. Association for Palliative Medicine of Great Britain and Ireland: Palliative Medicine: Curriculum for Medical Students, General Professional Training, Higher Specialist Training
26. Working Group on Education of the German Association of Palliative Medicine (DGP). Curriculum: Palliativmedizin für Studierende. www.dgpalliativmedizin.de
27. Working Group on Education of the Swiss Association of Palliative Medicine Aus- und Weiterbildung in Palliative Care – Nationale Empfehlungen. www.palliative.ch
28. The Royal Australasian College of Physicians, Adult Medicine Division 'Australasian Chapter of Palliative Medicine: Training Manual'. Sydney, 4th edition (2004)
29. World Health Organization: Cancer Pain Relief. Geneva (1986)
30. Palliative Care Education: Joint Committee on Higher Medical Training Guidelines for higher specialist training in palliative medicine. London: Royal College of Physicians (1991) www.jchmt.org.uk
31. Recommendations de la SFAP pour l'enseignement des soins palliatifs dans le cursus des études médicales. (1995) www.sfap.org
32. MacLeod RD. Teaching postgraduate palliative medicine. University of Dundee. Scotland (1992)
33. Report and recommendations of a workshop on palliative medicine education and training for doctors in Europe. EAPC (1993)
34. Association for Palliative Medicine of Great Britain and Ireland: Palliative Medicine Curriculum. Southampton (1992)
35. National Cancer Control Programmes Policies and managerial guidelines. 2nd edition. WHO (2002) p 84 Lloyd-Williams M, Macleod RD, A systematic review of teaching and learning in palliative care within the medical undergraduate curriculum.Med Teach 2004;26;683-690

G) Authors and Acknowledgements

Members of the EAPC taskforce on medical education:

- Marilène Filbet (France), *Chair of the taskforce*
- Carlos Centeno (Spain)
- Franco De Conno (Italy)
- John Ellershaw (United Kingdom)
- Frank Elsner (Germany)
- Steffen Eychmuller (Switzerland)
- Stein Kaasa (Norway)
- Phil Larkin (Ireland)

The Taskforce on Medical Education especially wish to acknowledge the contribution of Prof Dr. José Pereira, Switzerland and Prof Dr. Mari Lloyd-Williams, United Kingdom for their review of this curriculum and assistance in the preparation of this final version.

The meeting expenses were supported by "Accompagner" GRESP CHLS 69495 Pierre-Bénite Lyon (France) and Université C.Bernard, Lyon (France)

H) Advisory Board

Advisory board members for the revision of the underlying curriculum:

- Wee Bee (UK)
- Snezana Bosnjak (Serbia)
- Benoit Burucoa (France)
- Ilora Finlay (UK)
- Karen Forbes (UK)
- Holli Kaija (Finland)
- Daniele Leboul (France)
- Kiriaki Mistakidou (Greece)
- Maria Nabal (Spain)
- Antonio Pascual (Spain)
- Lukas Radbruch (Germany)
- Athina Vadalouka (Greece)
- Zbigniew Zylicz (Poland)