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Palliative Medicine—Becoming a Subspecialty of the Royal College of Physicians and Surgeons of Canada

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Abstract

The discipline of palliative medicine in Canada started in 1975 with the coining of the term "palliative care." Shortly thereafter, the provision of clinical palliative medicine services started, although the education of the discipline lagged behind. In 1993, the Canadian Society of Palliative Care Physicians (CSPCP) started to explore the option of creating an accredited training program in palliative medicine. This article outlines the process by which, over the course of 20 years, palliative medicine training in Canada went from a mission statement of the CSPCP, to a 1 year of added competence jointly accredited by both the Royal College of Physicians and Surgeons of Canada (Royal College) and the College of Family Physicians of Canada, to a 2-year subspecialty of the Royal College with access from multiple entry routes and a formalized accrediting examination.

Keywords

Canada, subspecialty, palliative medicine, palliative care

Introduction

The discipline of palliative medicine in Canada started in 1975 when Dr Balfour Mount, a surgical oncologist at The Royal Victoria Hospital of McGill University in Montreal, Canada, coined the term "palliative care."[1] Over the decades, the provision of clinical palliative medicine services expanded to include hospital-based programs, community- and home-based services, and freestanding hospices.[2] However, education in the discipline lagged behind, and by 1991, there were only 2 universities (Ottawa and Alberta) that offered fellowships in palliative medicine. They were designed "to enable a physician to become a clinician, consultant, manager, teacher, and researcher in palliative medicine."[3]

In 1993, the Canadian Society of Palliative Care Physicians (CSPCP) was formed by a small group of physicians, from various provinces and practice locations, who were dedicated to providing palliative medicine services. Their training backgrounds included family medicine and other specialties such as internal medicine, anesthesia, and surgery. The CSPCP mission included the advancement of "competent care of the dying as delivered by family physicians, supported by palliative medicine physicians," and listed the "establishment of palliative medicine as a formalized academic discipline" and the "establishment of palliative medicine as a clinical discipline recognized by Canadian accreditation bodies" within its goals.[4] An editorial in the *Journal of Palliative Care* 1994 urged the CSPCP to pursue specialty designation for palliative medicine stating certification in palliative medicine could significantly, and cost-effectively, diminish the suffering of the terminally ill and their families, strengthen the role of the family physician, and ensure the future development of palliative care.[2]

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In Canada, there are 2 separate colleges that provide certification for physicians—The Royal College of Physicians and Surgeons of Canada (Royal College) and the College of Family Physicians of Canada (CFPC). Each college has different governing committees and administrative structures and uses different educational frameworks to define competencies.

The Early Years

In 1994, members of the CSPCP prepared a document entitled, "Palliative Medicine: Toward Recognition as a Discipline in Canada" to support an application for specialty status (note 1). The document outlined the history of palliative medicine, assumptions, and a case for recognition as a discipline (note 1). It was presented to the executive directors of the CFPC and the Royal College at a joint meeting in May of that year. The document was then revised, based on discussion and comments from both colleges, and a final draft was completed in September 1994. Internal medicine and surgery agreed to be the base specialties for palliative medicine. Although there was initial enthusiasm and support, the application was rejected following concerns over introducing another specialty, the potential of creating conflict between the 2 colleges and with comments that care of the dying was a general competence.[5,6]

Family medicine in Canada was undergoing a shift at this time as well. More family physicians became salaried instead of being paid fee-for-service, and many reduced the scope of their practices to focus on special areas of interest.[7,8] Having a salary made a palliative care practice more attractive, as provincial fee-for-service models did not compensate well for the multiple and often time intensive interactions palliative care patients required.[9] To meet educational needs and ensure competency, the CFPC started the development and accreditation of an extra year of training for family physicians in palliative care.[7,8]

The Year of Added Competence

To develop palliative medicine training for Royal College and family medicine trainees, the CSPCP worked with both colleges over the next 5 years, and in 1999, the Royal College and CFPC agreed to sponsor a jointly accredited, 1 year of training in palliative medicine. The year of added competence (YAC) was recognized as an additional year without special designation at the CFPC and as an accredited program without certification (AWC) at the Royal College. The year of training was comprised of rotations on inpatient tertiary palliative care units, community hospital palliative care units, community home visits, consultative services, outpatient longitudinal clinics, and mandatory rotations in medical and radiation oncology. Trainees also had 3 months of elective time to allow them to mold their own educational experience. There were specific standards for accreditation but no end of year examination. The faculties of medicine, at each of the 13 sponsoring Canadian universities, issued graduates certificates of completion until 2006, when both colleges started issuing attestations of completion to their respective members. This conjoint program was unique in Canada with no other similarly accredited programs.

The Conjoint Advisory Committee on Palliative Medicine (CACPM) was established to advise both colleges on specialty-specific accreditation standards, evaluations, and credentials. In addition, the CSPCP developed a postgraduate education committee to coordinate the efforts of the program directors, support individual programs, train palliative care physicians, and help advance the academic standing of palliative medicine across Canada. The committee was to ensure trainees were educated within a competency framework that was acceptable to both colleges.

At the CSPCP annual general meeting in 2006, the need for specialty recognition was reintroduced. Although the YAC was providing additional clinical training in palliative medicine, there was concern that it was not adequate to address the growing complexity of the patient population.

Palliative medicine in Canada had been gradually changing to include patients earlier in their disease course and patients with chronic diseases, end-stage organ failure, and frailty. With these shifts, palliative providers required expertise in the management or comanagement of patients taking numerous medications, having medical devices, and sometimes undergoing life-sustaining treatments. This was similar to trends noticed in other countries, where the aggressiveness of end-of-life care was increasing[10] and where the proportion of the dying population who received palliative care had increased from 37% to 63%.[11,12] Moreover, the demand for palliative care was expected to continue to rise, as in other countries, due to increases in the incidence of dementia and cancer.[13]

In order to address the evolving needs of the population, Canada also needed leaders who would create better access to care, improve advocacy and consultation for family physicians, and address the lack of evidence in order to support best practice.[1] Despite improved involvement in palliative care teaching and research by YAC graduates, it was felt that the training needed to create leaders in education, research, program development, and advocacy was limited and would not be sufficient to address the anticipated future needs (note 2).

Following extensive discussion, the membership endorsed a motion "to form a working group within the CSPCP to discuss and move forward the specialty status of palliative care" (note 2). In May 2007, the terms of reference for an ad hoc Committee on Specialty Status was approved with its mandate to produce a discussion paper for the November 2007 annual general meeting.

Changing the Terminology From Specialty to Subspecialty

At the first meeting of the ad hoc Committee on Specialty Status, the Royal College definitions of "specialty" and "subspecialty" were reviewed. A specialty was defined as "an area of medicine with a broad-based body of knowledge that is

relevant in both community and tertiary settings and is a foundation for additional competencies (such as subspecialties).''[14] It had a broad and foundational scope, admission from medical school, and was typically 4 or 5 years in length.[14] A subspecialty was defined as ''an area of medicine with a more focused or advanced scope that builds upon the broad-based knowledge defined in a parent specialty.''[14] It was less broad in scope, built on the primary specialty, and had entry from that specialty. A subspecialty was typically 1 to 2 years in length.[14]

The ad hoc committee determined that, based on the Royal College definitions, the training program and recognition desired by the CSPCP was best defined as a subspecialty. Following this, it set out to fulfill its mandate of identifying the benefits, risks, and general considerations associated with moving forward as a subspecialty.

The Benefits of Subspecialization

In their 1994 document, the CSPCP proposed 3 categories for physicians who provide medical care for the dying in Canada: (1) family physicians occupying the central role in the framework and providing most of the care of the dying, who would have a general knowledge of palliative from medical school and family medicine residency training; (2) physicians with a heavy burden of terminal illness in their practice, who would focus part of their practice on the care of the dying, with expertise from some additional formal or informal training, and who would become local resources for their communities; and (3) subspecialists in palliative medicine who had formal fellowship training and would serve as clinical consultants and staff academic programs.[15] As palliative medicine evolved, these categories became the framework for the concept of primary, secondary, and tertiary levels of care.

Revisiting the issue of applying for subspecialty status 12 years later, the CSPCP once again recognized the need for 3 levels of palliative care expertise in Canada. This was similar to what the CSPCP had previously articulated and what had been described in the United Kingdom,[16] and the United States.[17] The CSPCP reaffirmed there was a need for primary palliative care to be practiced by all physicians. Secondary palliative care would now be practiced by those with some additional training or years of expertise. These physicians would serve as a resource for their communities by providing consultation to colleagues and serving in the roles of teaching, research, and administration within the model of distributed medical education. However, it was the role of the tertiary subspecialists that needed considerable revision to more accurately reflect the demands of a growing and evolving subspecialty. Tertiary palliative care physicians required more than just the skills to provide good clinical care and staff specialized tertiary palliative care units.[17] They also needed to assume leadership in teaching, research, and administration and possess the skills necessary to design and manage palliative care programs to meet current and anticipated future societal needs.[17]

The expectation was that the creation of a subspecialty would lead to an increase in skill level, particularly among tertiary subspecialists. In the United Kingdom, subspecialization had helped palliative medicine gain credibility and acceptance among physicians and government. It had also led to more teaching, research, and higher expectations.[16] Having received advanced training, graduates were often inspired to take additional courses in counseling, management, education, and teaching, further enhancing the quality of care they provided.[16] It was hoped that the creation of a subspecialty in Canada would lead to similar changes, improving standards, leadership, and fostering research and innovation.

Risks of Subspecialization

There was an acknowledgment of the risks that might come along with the creation of a subspecialty in palliative medicine. Critics of subspecialization in Canada worried that subspecialists in palliative medicine would work predominantly in an academic tertiary care centers and that more patients would be admitted to these units under the care of the subspecialist.[2,18] This would disrupt continuity of care, disaffect physicians and inter-professional teams already doing good end-of-life care, and lead to increased cost, hospitalizations, and testing.[2,18] They worried that palliative care would become the realm of the specialist, with palliative care physicians taking on most routine end-of-life and chronic care.[2,18] These risks were almost identical to those voiced when palliative medicine became a subspecialty in the United States.[17]

After careful consideration of the issues, outcomes in other countries, and outcomes following the creation of other subspecialties in Canada, the ad hoc committee presented a document called ''More Questions than Answers,''[19] at the 2007 CSPCP annual general meeting. It outlined many of the challenges that would be faced if the CSPCP continued to pursue subspecialty status. After the presentation and subsequent discussion, the CSPCP board concluded that the benefits outweighed the risks and decided to go ahead with the continued exploration of becoming a subspecialty. Risks would be mitigated with careful planning, stakeholder feedback, and ongoing collaboration.

Ongoing Discussions With the Colleges (Why Not Continue a Conjoint Program?)

Initially, the goal was to continue a conjoint Royal College and CFPC program that would be recognized by both colleges and allow all trainees, regardless of their primary specialty, to pursue 1 or 2 years of additional training.

In 2007, the CFPC recognized family medicine as a specialty and subsequently established a section of family physicians with special interests or focused practice. At that time, the Royal College, following a review of existing training programs, decided to consolidate AWC programs into subspecialties requiring examinations. Although both colleges continued to support palliative medicine, they had different approaches to recognizing areas of medicine. The Royal College was content to train subspecialists who would serve as consultants and

advocates for a broad range of patients, while the College of Family Physicians allowed areas of enhanced skills to be obtained by its trainees with a goal of developing a focus, often within an individual family practice. In subsequent discussions with the CACPM, the colleges explored the option of palliative medicine being recognized separately as an area of focused competence for family medicine and a subspecialty of the Royal College (notes 3 and 4). The CACPM expressed the desire for palliative medicine to remain a conjoint program and sought feedback from the CSPCP.

When it became evident that a single conjoint training program may not be possible, the CSPCP membership voted at its 2009 annual general meeting to affirm its support for the continuation of the YAC and also continue to pursue subspecialty status collaboratively with the CFPC and the Royal College (note 5). A joint working group comprised of members of the CSPCP and CACPM was established. It reviewed relevant national and international literature and produced a discussion paper designed to promote dialogue as to the future of palliative medicine in Canada. It was entitled ''Postgraduate Education for Palliative Medicine Physicians'' (note 6).

This document provided the background for a special meeting in May 2010 to discuss the future training options for palliative medicine physicians. In attendance were members of the working group, the CACPM, the CSPCP board, and representatives of the Royal College and the CFPC. Participants acknowledged the need to train physicians with added competence in palliative medicine to meet secondary and tertiary levels of clinical services.

This special meeting focused on the following key considerations: (1) the expanded and more complex population served by palliative medicine, (2) the recognition that 1 year of training may not provide adequate time or depth of training to meet current and future societal needs and advance palliative medicine, (3) the previous ''AWC'' designation held by palliative medicine at the Royal College was being phased out and another designation was required, (4) confirmation that the designation of subspecialty was the most appropriate within the Royal College, and (5) the ability of the CFPC to support only 1 year of additional training in palliative medicine as an enhanced skill following their 2 base years of training (note 7).

Following considerable discussion, the meeting concluded with a unanimous decision to develop a 2-year subspecialty in palliative medicine through the Royal College and, in parallel, maintain the 1-year enhanced skills training program in palliative medicine through the CFPC. The CFPC was aware that formal recognition, upon completion of an enhanced skills program, was very important and set about creating a special designation for its members. While these transitions were occurring, the YAC would be maintained (note 7). Although the hope had been to continue a conjoint program, this did not seem possible. However, participants emphasized the special nature of the YAC and the need for the future CFPC and Royal College programs to remain collaborative, although not conjoint. This decision was endorsed by the CSPCP at its 2010 annual general meeting.

Becoming a Subspecialty at the Royal College of Physicians and Surgeons of Canada

Approval of an application for a new subspecialty is a 5-step process. It consists of a 2-part review by the Committee on Specialties (COS), a review by the Education Committee, consideration by the Executive Committee of Council, and final endorsement by the Royal College Council. It took 3 years for palliative medicine to go through this process and be granted subspecialty status through the Royal College.

In January 2011, the CSPCP submitted a formal application to the Royal College for a 2-year subspecialty in palliative medicine. Recognizing the increasingly complicated medical management of palliative patients, internal medicine and pediatrics were selected as the sponsoring specialties with the knowledge that other entry training routes would also be necessary.

Although supportive of palliative medicine as a subspecialty, the COS deferred the part I application, from their meeting in March 2010 until the fall of that year, to allow for further clarification of entry routes. The CSPCP requested a further extension to solicit feedback from the palliative community. A revised application adding anesthesiology and neurology as entry routes to the adult stream was submitted in early 2012 and considered by the COS March 2012. Although surgery was initially an entry route when the idea of specialization was first considered, it was omitted in the 2012 application. The increasing complexities of the palliative population were predominantly due to complexities in the medical management of cancer, organ failure, dementia, and chronic disease. It was felt a base background in surgery would not equip a trainee with the necessary skills to manage this population with only 2 additional years of subspecialty training.

The application received part I approval, and a national consultation followed, before part II was presented in September 2012. Although the national consultation raised concerns about the bifurcation of the current conjoint training program, the COS endorsed the proposal and recommended the education committee approves the application. In a Royal College memorandum, Dr Jason Frank, director, Specialty Education, Strategy and Standards, Office of Education, noted that the COS felt ''both family doctors and specialists involved in palliative medicine will continue to work together in a collaborative and collegial manner and that those with the additional training via the 2-year subspecialty route will provide additional consultative services to family physicians and other specialists for complex palliative patients'' (note 8). This was to be similar to models of care currently in existence in Canada, with examples such as geriatrics, emergency medicine, sports medicine, or anesthesia, and in the United States, with examples such as pain, geriatrics, sleep, and sports medicine.[20-22] The Education Committee approved the application in November 2012.

The application proceeded to the Executive Committee of Council for consideration at its January 2013 meeting. Its decision was deferred following considerable discussion. In a letter

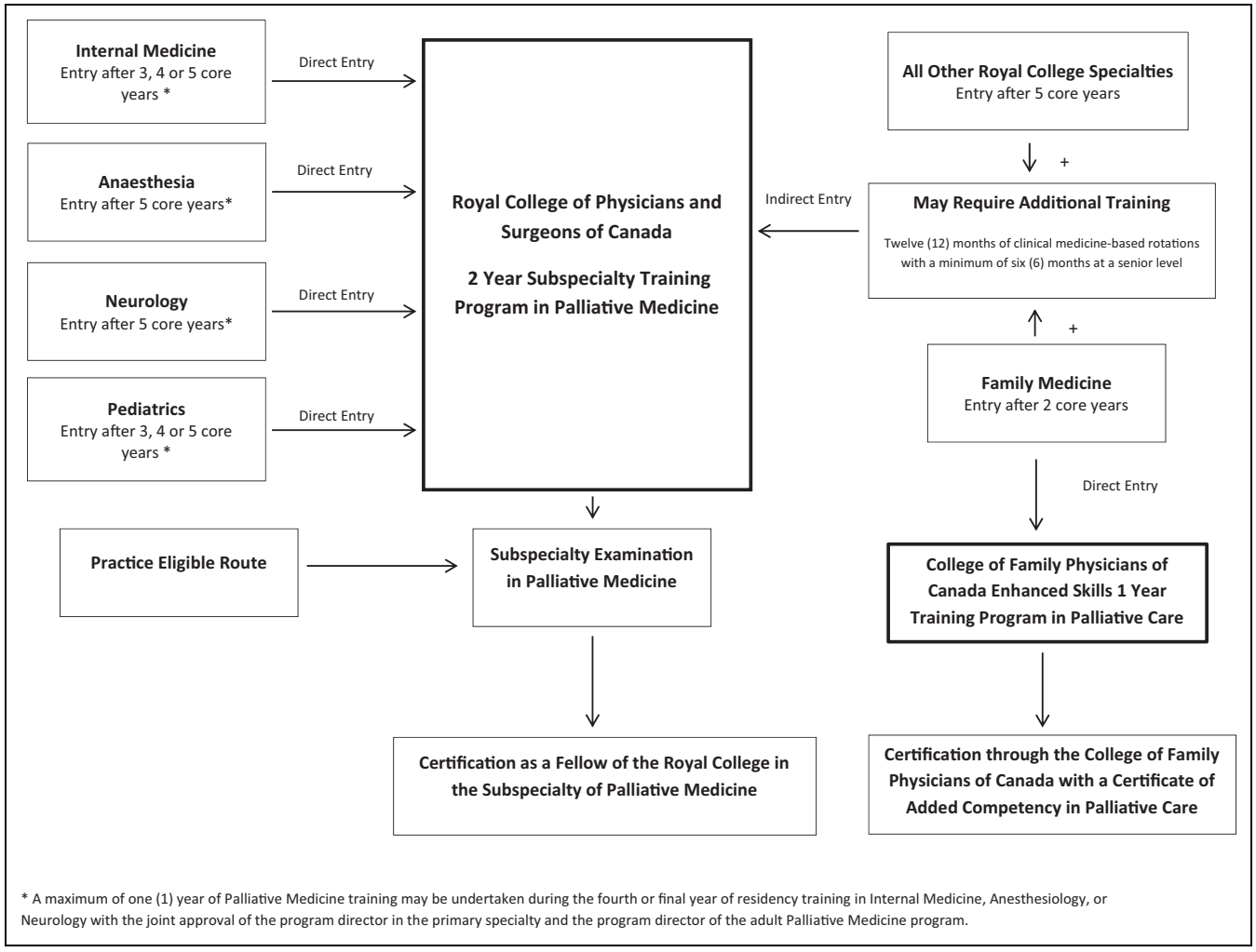

Figure 1. Entry routes into the Royal College of Physicians and Surgeons of Canada 2-year training program in palliative medicine and the College of Family Physicians of Canada 1-year enhanced skills training program in palliative care.

from Dr Kevin Imrie, vice president education and chair, Royal College Education Committee, the reasons for deferral were the ''significantly narrower routes of entry than the current conjoint program'' and the need for a practice eligible route (PER) to ''accommodate access by specialists from all other disciplines, including family medicine, should they be able to demonstrate the necessary competencies and wish to pursue certification in palliative medicine'' (note 9). Further discussions involving the CACPM, Royal College, CFPC, and postgraduate deans occurred with the hope of a solution that included both a 1- and 2-year competency-based training program accessible by either college. However, the CFPC had concerns that the addition of a second year to the YAC would be opposed to the fundamental principle of family physicians providing comprehensive care, incorporating enhanced skills training where appropriate.

Despite the ongoing challenges, Dr Jason Frank, advised that the Executive Committee of Council expressed commitment to moving the application forward at its May 2013 meeting ''pending the development of a PER or similar convention which will allow access to the training program by a physician who can demonstrate the competencies required to serve this complex patient population ''(note 10). The entrance criteria for the subspecialty was subsequently expanded to allow entry from other specialties to occur provided trainees had completed their primary specialty and the prerequisites of 12 months of clinical medicine-based rotations with a minimum of 6 months at a senior level. A PER to examination was also introduced, with criteria to be set by the Royal College Subspecialty Committee in palliative medicine when that committee was formed.

There seemed to be no solution that allowed continued collaboration between the colleges as a conjoint program, and these concerns were acknowledged and shared with the Royal College. The application passed the Executive Committee of Council in January 2013.

In October 2013, the Royal College Council passed a motion introducing palliative medicine as the newest Royal College subspecialty. Just a few weeks later, the Royal College passed another motion allowing trainees from the CFPC,

Table 1. Comparison of the YAC in Palliative Medicine and the Royal College Subspecialty in Palliative Medicine.

	YAC in Palliative Medicine	Subspecialty Adult Palliative Medicine	Subspecialty Pediatric Palliative Medicine
College overseeing education	College of Family Physicians, Royal College of Physicians and Surgeons	Royal College of Physicians and Surgeons	Royal College of Physicians and Surgeons
Prerequisite training	Family medicine, Royal College specialty	Internal medicine, neurology, anesthesia, or any other specialty provided prerequisite training requirements met	Pediatrics or any other specialty provided prerequisite training requirements met
Length of training	1 year	2 years	2 years
Certification upon completion	Attestation of completion (Royal College), certificate of added competence (CFPC)	Subspecialty certification	Subspecialty certification
National examination	No	Yes	Yes
Rotations on acute tertiary/quaternary palliative care unit	Yes	Yes	Yes
Rotations in subacute/chronic palliative care in the community	Yes	Yes	Yes
Rotations in ambulatory palliative care	Yes	Yes	Yes
Rotations in consultative palliative care	Yes	Yes	Yes
Rotations in rural palliative care	Optional	Optional	Optional
Rotations in oncology	Yes	Yes	Yes (hematology/oncology)
Rotations in other subspecialties	No	Critical care, cardiology, respirology, neurology, geriatrics, nephrology, infectious diseases, gastroenterology	Respirology, gastroenterology, metabolics and genetics, neurology, pediatric critical care, neonatal and perinatal medicine
Rotations in pediatric palliative care	Optional (as elective)	Yes	Yes and rotations in adult palliative care
Rotations in scholarly work	No	Yes	Yes
Electives/selectives	3 months	1-3 months	1-3 months

Abbreviations: CFPC, College of Family Physicians of Canada; YAC, year of added competence.

who met the entrance criteria, to be eligible for the Royal College Palliative Medicine Residency program. They would also be allowed to sit the Royal College Palliative Medicine examination, through the same PER as their Royal College trained colleagues (see Figure 1).

The Royal College Working Group and Subspecialty Committee in Palliative Medicine

At the end of 2013, with the recognition of the new subspecialty in palliative medicine, the Royal College established a working group on palliative medicine (WGPM). The mandate of the WGPM was to develop the standards documents for both the adult and pediatric training streams.

The WGPM met for the first time in the spring of 2014 and monthly through to the end of 2015. Over the course of 2 years, it created the objectives of training, subspecialty training requirements, specific standards of accreditation, and the final in-training evaluations for both the adult and pediatric palliative medicine programs. The complete version of these documents can be accessed on the Royal College website,[23] but a summary and comparison of some of the subspecialty training requirements and the specific standards of accreditation are presented in Table 1.

The next step was to transition the WGPM to a Royal College Specialty Committee. The Specialty Committee in Palliative Medicine met for the first time in September 2016. This committee is responsible for advising the Royal College on subspecialty-specific issues including standards, credentials, evaluation, and accreditation and is tasked with determining the criteria for the PER and approving applications from the faculties of medicine to sponsor the programs. An additional examination committee has been established to set the new credentialing examination. There is considerable interest with many universities developing training programs, and the first class of trainees was enrolled in July 2017. The YAC will continue until all residents who started their YAC prior to the new subspecialty training programs have

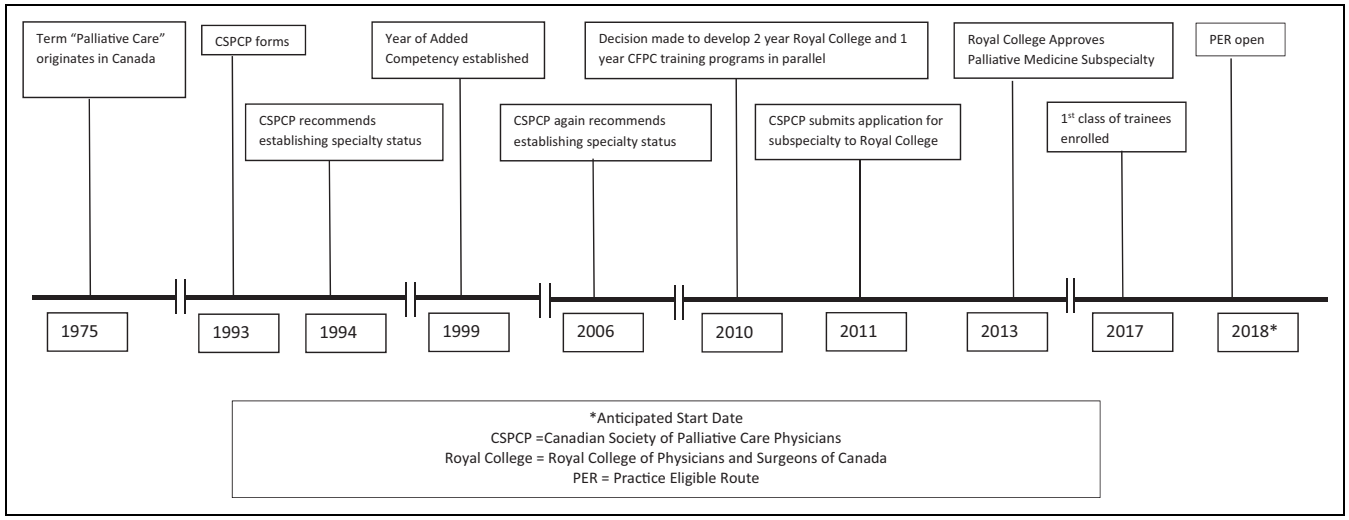

Figure 2. Important milestones in the time line of the development of the Royal College of Physicians and Surgeons of Canada subspecialty of palliative medicine.

completed their training. For a time line that highlights the important milestones on the path to developing the subspecialty training programs, see Figure 2.

Certificates of Added Competence From the CFPC

To acknowledge advanced training in palliative medicine, and also to acknowledge that not all trainees will wish to pursue 2 additional years of training, the CFPC announced in 2014 that they would award certificates of added competence (CACs) to family medicine graduates completing 1 year of added training in palliative medicine. These are very similar to the certificates of added qualifications that are given to US family physicians after 12 months of additional training in fields of adolescent medicine, pain, sleep, sports, geriatrics, and hospice/palliative medicine.[22]

Certificates of added competence are available to new and future graduates of accredited programs, who can demonstrate the achievement of the required competencies, and also to previous graduates depending on their present scope of practice. There will also be a PER to attain the certificate by demonstration of competence for physicians who work within the field of palliative care but did not undergo formal training.[24]

Conclusion

After many years, palliative medicine has become a subspecialty in Canada through the Royal College. Simultaneously, palliative medicine CFPC CAC training has also evolved. These programs complement each other and, collaboratively, though the CSPCP Postgraduate Education Committee, they are being designed to advance palliative care expertise in Canada to meet the increasing demands of society. Despite some challenges in creating a training program that would be available and acceptable to both Royal College and CFPC trainees, the final product is a testament to the ongoing collaboration, flexibility, and innovation of Canadian palliative medicine physicians.

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Notes

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