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A competency-based curriculum for palliative medicine in Canada

Un programme d'études basé sur les compétences pour la médecine palliative au Canada

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The history of subspecialty education in Palliative Medicine in Canada

In October of 2013, the Royal College of Physicians and Surgeons of Canada (the Royal College), passed a motion approving Palliative Medicine as a Royal College Subspecialty. The entry routes to Palliative Medicine include Internal Medicine, Pediatrics, Neurology, Anaesthesia, and any other specialty, including Family Medicine, if a prerequisite of twelve months of clinical medicine with a minimum of six months at a senior level can be met.[1] Palliative Medicine is unique in being the latest subspecialty (as of Oct. 2013) to be created by the Royal College and the only subspecialty that allows entry from Family Medicine.

Following the creation of the subspecialty, we formed a Palliative Medicine Working Group to establish the objectives, training requirements and specific standards for program accreditation of the discipline. With these approved, the Working Group disbanded, and we formed the inaugural Specialty Committee in Palliative Medicine in 2016.[2]

Our specialty committee is made up of Palliative Medicine physicians from across Canada and is comprised of: a chair; vice-chair; representatives from set regions across Canada, community practice and a core specialty area; residency program directors from the universities with Palliative Medicine training programs; and a representative from the national specialty society, the Canadian Society of Palliative Medicine (CPSM).[3] Our specialty committee is responsible for maintaining the subspecialty content expertise in the discipline and making recommendations to the Royal College on specialty-specific issues.[3] Within a year of establishing our specialty committee, The University of Toronto and the University of British Columbia were accredited with new residency training programs in Palliative Medicine (Adult stream) and enrolled their first residents in July 2017.[2]

We also created an Examination Committee to develop certification examinations in adult and pediatric Palliative Medicine and a Practice Eligibility Route (PER) to allow those already in practice to apply to challenge the examination.[1]

In September 2019, we administered the first examination in Palliative Medicine in Canada. This exam resulted in the certification of 34 Palliative Medicine physicians. As of August 2024, we have 98 Canadian exam-certified Palliative Medicine physicians, and there are also six Canadian Palliative Medicine physicians who are recognized as leaders and subspecialists within our discipline, whom have been given the designation of "Founder" by the Royal College.[4]

As of 2024, we have nine training programs in Adult Palliative Medicine, and four training programs in Pediatric Palliative Medicine, that have been accredited by the Royal College.[5] Up until 2023, our residency programs were time-

based, and certification followed the successful completion of an exam after two years of training. In July of 2023, our training programs changed from a time-based model to the Royal College model of time and competency-based medical education (CBME), called Competence by Design (CBD). This paper discusses the process our subspecialty undertook as we transitioned to CBD and our plans for continuous quality improvement going forward.

Competence by Design

To better meet the needs of learners, educators, and the Canadian public, the Royal College moved from a time-based training model to an educational model focusing on the achievements of medical competencies. The competency-based educational model adopted by the Royal College is called Competence by Design (CBD).[6] Under the CBD model, our education of Palliative Medicine residents occurs through frequent and explicit low stakes coaching, with the goal of creating regular and *more in the moment* and *meaningful feedback*. Our learners demonstrate competence in observable skill sets called Entrustable Professional Activities (EPAs). An EPA is a key task of a discipline that an individual can be trusted to perform in a given health care context, once sufficient competence has been demonstrated.[7] As our trainees achieve competency, they are entrusted to independently perform these activities by the residency program committee.[6] There are four stages of residency training in the CBD model including: Transition to Discipline, Foundations of Discipline, Core of Discipline and, Transition to Practice.[8] See Figure 1.

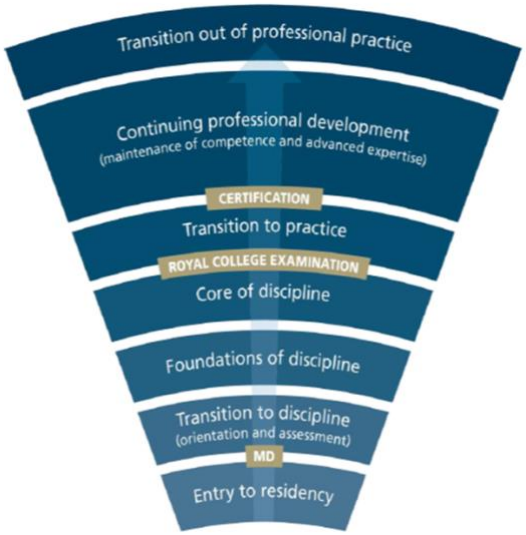

Figure 1. The Competence Continuum. Royal College CBD (Competence by Design) Continuum. Reproduced with permission of the Royal College of Physicians and Surgeons of Canada.

Overview of the Educational Design Process in CBD for Palliative Medicine

Our discipline, Palliative Medicine, started the transition to CBD in May 2021 with the first of three workshops. We invited sixteen palliative care experts to participate in the workshops, and another nineteen invitees came from the Royal College, to help facilitate the process. The palliative care experts were members of our specialty committee for Palliative Medicine including the regional representatives, Chair, Vice-Chair and program directors, a Palliative Medicine resident trainee, a base specialty representative (Neurology), and a Canadian Society of Palliative Medicine (CSPM) representative. We also added a palliative care psychologist to support our development of competencies related to complex psychosocial suffering, a symptom that is commonly seen in palliative medicine practice. The training backgrounds of the palliative care physicians involved in the process varied, and included Internal Medicine, Neurology, Oncology, Pediatrics and Family medicine, as well as a Palliative Medicine subspecialty resident and a Palliative Medicine physician trained in the UK, where Palliative Medicine is a five-year direct entry specialty training program. As the transition to CBD started two years after our first Canadian examination was held, credentialing of the participants also varied. Of the eighteen physicians, four held Palliative Medicine Founder status at the Royal College, seven were Palliative Medicine exam certified, having come from both Royal College and Family Medicine backgrounds, seven held Certificates of Added Competence (CAC) in palliative care through the College of Family Physicians of Canada (CFPC), and one held Royal College certification in the UK. Six of the Family Medicine trained physicians were credentialed with both a Certificate of Added Competence in palliative care and an FRCPC in Palliative Medicine. All non-resident participants had spent many years working clinically in the discipline at a subspecialty-equivalent level.

Workshop 1

In Workshop 1, CBD was introduced, and our group started work to define the scope of practice of a Palliative Medicine subspecialist, to be included as an introduction in the Palliative Medicine Competency document. We then broke into groups, with each group assigned a stage of training to draft EPAs. Many of the Royal College EPAs were felt to be similar for Adult and Pediatric Palliative Medicine, although some important differences did exist. To help ensure the EPAs were appropriate for their patient population the

pediatricians of our working group had an additional meeting and then the Pediatric EPAs were brought back to larger group in time for Workshop 2. The differences are outlined in Tables 1 and 2.

Table 1. Royal College Adult Palliative Medicine Entrustable Professional Activities

Stage of Training	Adult Palliative Medicine Entrustable Professional Activity
Transition to Discipline (TTD)	1. Applying the palliative medicine approach to patient assessment
	2. Sharing information with patients and families
	3. Managing the on-call duties of Palliative Medicine
	4. Supporting patients and families near the time of death
	5. Completing medico-legal responsibilities at time of death
Foundations of Discipline (F)	1. Recognizing and managing patients with an emergent/urgent presentation
	2. Providing consultation for patients with less complex needs
	3. Managing patients with common symptoms
	4. Managing patients with pain
	5. Exploring patient and family suffering
	6. Discussing and documenting goals of care
	7. Facilitating family meetings
	8. Working effectively within an interprofessional team
Core of Discipline(C)	1. Providing consultation for patients with more complex needs
	2. Providing ongoing patient care
	3. Providing contingency plans to manage emergencies and/or acute changes in the patient's condition
	4. Managing patients with complex symptoms
	5. Using advanced pain management strategies
	6. Identifying and addressing existential distress and suffering
	7. Devising management plans regarding potentially life-prolonging or disease-focused interventions in accordance with the patient's goals of care
	8. Providing continuous palliative sedation therapy
	9. Performing the procedures of Palliative Medicine
	10. Leading discussions with patients, their families, and/or other health care professionals in emotionally charged situations
	11. Leading the clinical team
Transition to Practice (TTP)	1. Leading a palliative medicine service

https://www.royalcollege.ca/en/standards-and-accreditation/information-by-discipline/ibd-cbd-documents.html *Copyright © 2023 The Royal College of Physicians and Surgeons of Canada. Referenced and reproduced with permission.*

We also defined training experiences necessary for practice in our discipline that were more experiential in nature and could not be observed as entrustable tasks. These experiential educational requirements went on to become Training Experiences and we discuss them further below.

The Canadian Society of Palliative Medicine (CSPM) was actively involved in the development of the document suite through workshop participation and regular reporting to the CSPM board throughout the process. Following Workshop 1, we created a survey outlining the draft EPAs and Training Experiences, which was sent to the CSPSM for feedback, and no edits were recommended.

In between the first two workshops, and with the goal of decreasing the time spent for each virtual meeting, the Royal College also took us through several short webinars, covering additional material that was important to the CBD process.

Table 2. Royal College Pediatric Palliative Medicine Entrustable Professional Activities

Stage of Training	Pediatric Palliative Medicine Entrustable Professional Activity
Transition to Discipline (TTD)	1. Applying the palliative medicine approach to assessment
	2. Sharing information with children and families
	3. Managing the on-call duties of Palliative Medicine
Foundations of Discipline (F)	1. Providing consultation for children with less complex needs
	2. Managing children with common symptoms
	3. Managing children with pain
	4. Exploring suffering
	5. Discussing and documenting goals of care
	6. Supporting children and families near the time of death
	7. Completing medico-legal responsibilities at time of death
	8. Facilitating family meetings
	9. Working effectively within an interprofessional team
Core of Discipline(C)	1. Providing consultation for children with more complex needs
	2. Providing ongoing care
	3. Providing contingency plans to manage emergencies and/or acute changes in the child's condition
	4. Managing children with complex symptoms
	5. Using advanced pain management strategies
	6. Identifying and addressing existential distress and suffering
	7. Devising management plans regarding potentially life-prolonging or disease-focused interventions in accordance with goals of care
	8. Recognizing and managing children with an emergent/urgent presentation
	9. Leading discussions with children, families, and/or other health care professionals in emotionally charged situations
	10. Leading the clinical team
Transition to Practice (TTP)	1. Leading a palliative medicine service

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Workshop 2

Workshop 2 occurred in December of 2021, and at this workshop we focused on reviewing the EPAs created several months earlier. We worked on defining and creating the number of observations and contextual variables needed to ensure learner competencies within the EPAs, and on defining and creating additional residency training experiences. Our discussions determined that our Objectives of Training document needed updating to reflect a change in practice, and the evolving Canadian landscape, before it was transitioned to the CBD Competencies document format. We therefore created a small group to more fully explore, edit, and write additional educational standards. Once these new standards were created, the Royal College educational consultants helped us to convert these to the draft discipline specific Competencies. While the working group provided discipline specific content expertise, the Royal College consultants provided educational expertise and ensured the competencies were worded with preset stems and according to Royal College educational standards, which reflect Bloom's taxonomy.[9] These were then sent back for review and were approved by the larger working group.

Workshop 3

In our last workshop, in the Spring of 2022, we finalized the EPAs, assessment plans, Training Experiences, and the Competencies. The Standards of Accreditation were updated to the CBD format by the Royal College just prior to Workshop 3 and we also discussed and finalized these standards. These documents went back to the Royal College for editing and translation and then became our full specialty CBD document suite.

Entrustable professional activities and other training experiences

Entrustable Professional Activities

In 2014, a group of palliative care physicians from across Canada had already developed a set of EPAs for palliative care. These EPAs were developed based on input obtained from surveys and focus groups with members of the CPSM, and twelve EPAs were published in a paper by Myers et al. in 2015.[10]

Between 2015 and 2023, several universities unofficially adopted the EPAs published by Myers et al. into assessment metrics for their Palliative Medicine trainees, while still following a time-based curriculum. This was done as a complementary assessment method and proactive measure to assist with the transition to CBME, in anticipation of the full launch of CBD that would occur a few years later. This important work laid the foundation that helped introduce the culture of CBME to the palliative care community and likely helped ease the transition to CBD eight years later.

Our Royal College Palliative Medicine CBD Working Group did not use the Myers et al. EPAs in our development of our subspecialty EPAs, as the Royal College was clear that the working group process needed to independently create the EPAs as per their usual process, ensuring the integrity of the process and decreasing bias.

However, when we compare the Myers et al. EPAs with our current Royal College EPAs, they are complementary but differ in important ways. Myers et al. defined an EPA as a core task or responsibility for which a learner must become sufficiently competent that an assessor would trust the learner to perform the activity unsupervised, and that required both the acquisition and integration of multiple competencies to result in a measurable outcome.[10]

Although both sets of EPAs encompass core skills necessary for the practice of specialty palliative care, our Royal College Palliative Medicine CBD Working Group added additional EPAs which are defined according to stages of training, include additional skills and competencies, and explicitly lay out the steps for achievement and assessment. Specifically, the Royal College EPAs contain contextual variables that specify where we must observe each EPA, what disease processes or symptoms we need to observe, who are appropriate observers, whether our learners can be observed during simulation, and how many times our learners must be observed to complete the skill satisfactorily. The Royal College EPAs are specified to have a specific start and a specific end and contain milestones to help break them down into discreet and separate learning steps.[11]

Although almost all the EPAs identified by Myers et al. were included in some form in our new Royal College documents, one EPA identified by Myers et al. called "Maintain resiliency in practice as a palliative medicine physician" was not. While maintaining resiliency was recognized as being extremely important in Palliative Medicine, we felt this skill was too difficult for us to observe and assess within the EPA format. See Table 3.

Table 3. Comparison of Previously Defined Entrustable Professional Activities by Myers et al.[10] and the Royal College Adult Palliative Medicine Entrustable Professional Activities 2023

Entrustable Professional Activities Myers et al 2015[10]	Entrustable Professional Activities Royal College of Physicians and Surgeons of Canada 2023
Complete a palliative medicine consultation	TTD1 Applying the palliative medicine approach to assessment F2 Providing consultation for patients with less complex needs C1 Providing consultation for patients with more complex needs
Manage the care of a dying patient in the last days, and final hours	TTD4 Supporting patients and families near the time of death
Conduct a family conference or meeting	F7 Facilitating family meetings C10 Leading discussions with patients, their families, and/or other health care professionals in emotionally charged situations
Address a difficult to manage symptom using medications and appropriate route of administration specific to the palliative medicine setting	F3 Managing patients with common symptoms F4 Managing patients with pain F5 Exploring patient and family suffering C4 Managing patients with complex symptoms C5 Using advanced pain management strategies C6 Identifying and addressing existential distress and suffering
Collaborate as a palliative medicine physician with referring health care teams	F8 Working effectively within an interprofessional team C10 Leading discussions with patients, their families, and/or other health care professionals in emotionally charged situations C11 Leading the clinical team
Educate patients, families, and colleagues about ''palliative care'' as an approach or philosophy	TTD2 Sharing information with patients and families F6 Discussing and documenting goals of care F8 Working effectively within an interprofessional team C7 Devising management plans regarding potentially life-prolonging or disease-focused interventions in accordance with the patient's goals of care C11 Leading the clinical team
Integrate into an interprofessional specialized palliative care team	F8 Working effectively within an interprofessional team C10 Leading discussions with patients, their families, and/or other health care professionals in emotionally charged situations C11 Leading the clinical team TTP1 Leading a palliative medicine service
Manage the palliative care of a patient in the community setting	F1 Recognizing and managing patients with an emergent/urgent presentation F2 Providing consultation for patients with less complex needs F3 Managing patients with common symptoms F4 Managing patients with pain C2 Providing ongoing patient care C3 Providing contingency plans to manage emergencies and/or acute changes in the patient's condition C4 Managing patients with complex symptoms (These EPAs all include a contextual variable indicating that they must be observed in the community as well as in other clinical areas)
Maintain resiliency in practice as a palliative medicine physician	Not included as an EPA
Provide palliative medicine telephone advice and management	C2 Providing ongoing patient care (This EPA includes a contextual variable indicating it must be observed virtually as well as in person)
Serve as Most Responsible Physician for a patient admitted to a designated palliative care bed	C11 Leading the clinical team TTP1 Leading a palliative medicine service
Describe an approach to managing a controversial palliative medicine ethical issue for a patient	C7 Devising management plans regarding potentially life-prolonging or disease-focused interventions in accordance with the patient's goals of care C8 Providing continuous palliative sedation therapy C10 Leading discussions with patients, their families, and/or other health care professionals in emotionally charged situations

TTD – Transition to Discipline; F – Foundations of Discipline; C – Core of Discipline; TTP- Transition to Practice

Training experiences

EPAs are only one element of training assessment within our subspecialty. There are skills our learners must acquire to be able to practice in Palliative Medicine, that do not easily fit within the model of an EPA. These training experiences are equally important, and are required for certification, but are listed separately within our document suite.[3] Several of these required Training Experiences speak specifically to how our learners develop and maintain resiliency. These include required experiences in the "Benefits of Self-care and Self-reflection as a Strategy to Promote Resiliency," "Teaching around Reflective Practice," and "Meetings with a Mentor."[3] Our training programs are also encouraged to develop other assessment methods to capture these important competencies.

Milestones

Within each EPA, we have milestones which represent the more discreet aspects of the skill that our learners must achieve to determine whether they can be entrusted to perform the professional activity. The Royal College helped us map the milestones to the CanMEDS competencies to highlight which competencies are needed within each EPA.[11]

Bringing EPAs into the teaching environment

Designing the EPAs set the standard for knowledge and skills in our discipline, and defined what it means to practice Palliative Medicine, at a subspecialist level, in Canada. In CBD, each EPA is explicitly presented to learners and faculty. This helps the residents to better understand which specific skills need to be achieved to progress to the next stage of residency. The milestones help our residents focus on the skills necessary to achieve entrustability for a professional activity and help our evaluators focus on individual steps to simplify teaching and evaluation. Multiple evaluations are considered by our competence committees, which report and give recommendations to our Residency Program Committees. Our competence committees include individuals with interest and expertise in assessment and medical education, who have a mandate to review our resident's progress towards competence through the synthesis of assessment data.[11]

Potential pitfalls, challenges and the way forward

While 70% of all Royal College program directors across Canada found the transition to CBD went well, significant challenges were also identified.[12-15] Although the literature suggested that CBME could be problematic if it caused an objectivist approach to learning or a reduction of complex skills to discrete measurable tasks as opposed to a more holistic view,[16,17] implementational concerns that centred on readiness to change, fidelity and integrity of implementation, e-portfolios and platforms, and concerns over wellness of resident trainees turned out to be bigger challenges for many programs.[12,14,14517,18]

Palliative Medicine is fortunate to be in one of the last cohorts to undergo transition to CBD and, in doing so, we could learn from the experiences of other specialties.

Palliative Medicine was ready for change

Our Royal College subspecialty of Palliative Medicine is closely affiliated with a complementary one-year enhanced skills training program in palliative care offered by the CFPC.[19] As the CFPC transitioned to CBME in 2011 with its Triple C Curriculum,[19] many of our palliative care physicians were already familiar with competency based medical education and they had been giving feedback in the form of "field notes," which are similar to EPA observations, for many years. In fact, several of our training programs had already started implementing their own EPAs based on the work by Myers et al.,[10] and Queen's University had developed their own entire set of subspecialty EPAs when the whole University adopted CMBE, before our standardized EPAs were created by the Royal College. Most training programs had already created competence committees by the time we started workshop 1 and varied interdisciplinary faculty had already taken on competency and advisory roles.

For us, as a new subspecialty, challenges about having adequate numbers of faculty to fill educational requirements were not attributed to CBD, per se, but more to the creation of our entirely new Royal College training programs. As our discipline was created at the same time as CBD was being rolled out for other programs, and after the CFPC had already transitioned to CBME, not only did Palliative Medicine "grow up" alongside a culture of CBME from the CFPC enhanced skills in palliative care , but the pending Royal College transition to CBD for the subspecialty of Palliative Medicine was known to be on the horizon throughout our discipline's existence. Most new training programs anticipated the faculty requirements for CBD ahead of time, even as they created their time-based curricula, and some universities that did not think they had the faculty to support the anticipated transition to CBD, never started training programs at all.

Small training programs in our subspecialty acknowledge they may be challenged, for many years, to ensure they have enough faculty to meet the training requirements, but despite this, our training programs embraced the change to CBD. The CBD model of training aligns with the CFPC teaching model which many were used to, and with the other Royal College training programs whose trainees were also rotating through palliative care. Indeed, the feeling at our specialty committee was that Palliative Medicine was "more than ready" for the transition to CBD when it was our turn.

Our subspecialty will need to have continued dialogue to best address the potential challenge of faculty numbers at

each university for our small training programs. Our hope is that we will be able to encourage more trainees to enter and complete the training programs, while also encouraging existing faculty to become exam certified through the practice eligibility route.

Palliative Medicine strove to reduce variability and increase integrity in implementation

Our Royal College workshops highlighted the theory of CBD and our need for faculty education, which was embraced by our Specialty Committee in Palliative Medicine. Many of our schools were already using Competency Committees, and by the time we were was ready to launch CBD, there had already been departmental initiatives and faculty education for many other Royal College disciplines. Challenges experienced by others had often already been identified and ironed out. Our specialty committee took an active role in providing extra workshops and guidelines, such as how to create a curriculum map, and how to navigate residency entry routes in CBD for our program directors. Ongoing dialogue between our specialty committee and our program directors helped to address common challenges and we expect this to continue in the future.

E-portfolios, and E-platforms continue to be a concern for all programs, including Palliative Medicine

Palliative Medicine is not immune to the challenges other training programs have with a malalignment between desired functionality and electronic capacity.[12] While each university is working to improve their platforms, the Royal College is also identifying leading practices and innovations during university accreditations that they hope can serve as models for other programs in the future. (Personal communication with Ashley Ronson, Education Standards Unit and Royal College Accreditation, 11-05-2024)

Many electronic platforms are now available on phones, which facilitates in-the-moment assessment. As they are developed, innovative ideas and technologies that improve residency education should be considered by Palliative Medicine.

Concerns over reduction of complex skills into measurable steps are also warranted in Palliative Medicine

The Royal College anticipated that there might be concerns over the reduction of complex skills into measurable steps, and so our EPAs were explicitly created with the intention of capturing the varied contextual variables within the real clinical work of the specialty.[21] EPAs are broad in scope and are intended to cover a broad and holistic skill, but challenges with reductionism still exist.[12,20] To address this challenge, our Palliative Medicine programs need to acknowledge that EPAs are only one type of training requirement in the new curriculum, and all training programs need to incorporate other training experiences and metrics into learner assessment. Narrative comments and written concerns outside of EPAs have been found to be helpful in gauging learner progress and need to be encouraged. These allow competence committees to triangulate assessments between the EPAs, other assessment metrics, and "real" world feedback from preceptors and other members of the interdisciplinary team to get a more complete and holistic, picture of resident capability.[23] Additional narrative comments can also decrease bias by residents who aim to "game the system" by deliberately choosing EPA observers that they know to be lenient in their assessments.[23]

Palliative Medicine is concerned about resident wellness

Concerns have been raised about the negative impact CBD has had on resident wellness.[14,15,24] The residents have identified that they need: onboarding and training in CBD; clarity around EPAs, assessments and promotion; sharing the burden of getting assessments done with the faculty; and approachable faculty who are willing to supervise and complete assessments for the trainees.[14] Additional helpful approaches include: mapping EPAs to each rotation, setting expectations with faculty and trainees about the timeliness of completing assessments,[28] increasing transparency and communication around competence committees, and ongoing faculty education for CBD.[15,24] Interestingly, a paper by Ahn showed that resident perspectives on the value of EPAs was related to messaging from program administration and faculty buy-in.[29] Methods to mitigate and monitor potential negative health impact on our trainees must be undertaken by all Palliative Medicine residency programs, with help and collaboration from the universities and the Royal College. The transition for each Palliative Medicine training program to CBD should start and continue with positive messaging.

Continuous quality improvement of training requirements

Although our Palliative Medicine training programs officially launched their CBD curriculum in July 2023, this is just one step in the continuous quality improvement process. It is the responsibility of our specialty committee to uninterruptedly review the training curricula, and it is anticipated that the CSPM will continue to be involved in reviewing all training revisions, as a process for broader consultation. Taking a page from other subspecialties that

have already gone through a process of re-evaluation, it is anticipated that our specialty committee will be reviewing the curriculum within the next few years and might ask the following questions previously outlined by Pinsk et al:

- Do the current EPAs and milestones describe the practice of Palliative Medicine and define training that creates an employable palliative medicine physician in Canada? If not, what tasks or skills have been overlooked or minimized, and what tasks or skills have been embedded in the documents that do not reflect current clinical and academic practice?
- Do the current required training experiences provide adequate learning for comprehensive training in Palliative Medicine? If not, what is missing and/or what is overemphasized?
- Is the number of EPAs, milestones, and training experiences feasible in the context of providing sufficient clinical structures and assessment of Palliative Medicine trainees? If not, what training experiences or assessments will be untenable to require?[31]

Although initial implementation occurred quickly, full implementation and change in culture is likely to take many years with the need for ongoing adjustments and flexibility.[31]

Reflections on the Palliative Medicine CBD development process

The workshops started in 2021 during the COVID-19 pandemic and thus were held online, by a process that had been developed and tweaked by the Royal College over the preceding year. While this educational model achieved the goal, and decreased the time and cost associated with travel, we think that having the workshops in person, would have allowed more networking and the ability for us to meet other subspecialty palliative care educators in person. This would have been of particular benefit for our subspecialty which was new and had only been running subspecialty residency programs for, at most, four years. As we review the documents in the future as a Specialty Committee, it will be helpful to ensure that some meetings are held in person.

As a CBD working group, we found ourselves challenged to put some of our Palliative Medicine knowledge and skills into the EPA format. Despite having a full explanation and definition of EPAs, to determine why some competencies didn't fit the EPA model was challenging for us, particularly as we explored how to teach resiliency. It took time for the working group to determine that developing competency in resiliency - which is individual led, different for each person and life-long - could not be assessed through a standardized EPA. A more fulsome discussion of why putting some educational concepts that are broad, longitudinal and multi-faceted, such as resiliency, into an EPA format would be reductionist, would be beneficial when the CBD document suite is reviewed again in the future. We will need to ensure that skills that are not well suited to the EPA format are not excluded, are still acknowledged as being integral to the discipline, and do not take a reduced priority to the EPAs within the training programs.

We feel that our transition to CBD was a relativity easy one. Our subspecialty is unique in that our faculty are also often involved with teaching in the complementary enhanced skill in in palliative care through Family Medicine which transitioned to CBME in 2018.[19] As well, some of our training programs were already adopting the EPAs by Myers et al., [10] and we were one of the later CBD cohorts at the Royal College. These three things meant there was a lot of exposure for our faculty to CBME years before we started it ourselves. It will be interesting to see if other Royal College disciplines who are in later CBD cohorts have a similar experience and if, as the amount of time spent in CBD increases, the challenges faced by some of the other Royal College disciplines lessens.

The process of creating the document suite was challenging but also very important to our subspecialty that is still young and evolving. The workshops allowed us to take on the dual role of being both learners and educators and to come together with a common goal of really "nailing down" what it meant to practice subspecialty Palliative Medicine in Canada. The CBD development process for our discipline was not just important for how it defined our training standards, but it was at least equally as important in defining, unifying and solidifying our identity as a young subspecialty.

Conclusion

As Palliative Medicine continues to evolve, our EPAs may need to be streamlined, and contextual variables will need to be continuously reevaluated.[24] We will need to ensure all training and evaluative metrics are relevant or practical to practice,[14,17] and continue to be committed to ensuring our trainees are provided with high quality education. With

the leadership and guidance of the Royal College and the CSPM, online educational material, meetings and conferences, the CBD rollout should be successful within our discipline. In the end, longitudinal evaluations of CBD, and the use of EPAs within our subspecialty of Palliative Medicine will need to be based on whether our trainees are ready to practice when they have completed training[12,13] and it is up to our discipline to ensure this happens.

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