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**Introduction for the Learner (Resident/Fellow)**

**Prior to your evaluation of competency:**

- Complete the web-based palliative care training program “Medical Resident Training in End-of-Life and Palliative Care” before you undergo this competency assessment. The training program is available on the UMMS Intranet, click on Physicians. The course is listed under “Helpful Links.” It is also available via the internet at http://134.192.120.12/canRes/htdocs/login.asp
  - Review Unit II-Management of Symptoms other than Pain (Nausea, Vomiting, Constipation) of the web-based palliative care training program.
  - Review Part 1 (Learning Objectives), Part 2 (Teaching Outline) and Part 3 (Evaluation Checklist) THOROUGHLY so that you are aware of what is required of you.
- When you think you are suitably prepared for testing your competency in this area, ask the attending physician on your inpatient clinical rotation to evaluate the selected competency when the appropriate clinical situation arises.
- Ascertain that the attending/faculty member is certified to conduct the Palliative Care Competency Evaluation.

**Field evaluation of competency:**

- During the course of a clinical rotation, it is anticipated that you will have opportunities to demonstrate your competency in Constipation: Assessment and Management with regard to palliative and end-of-life care during morning work rounds with your attending, and also throughout the day or during times of night call or cross-coverage.
- Identify a faculty member to evaluate your competency – current service attending recommended, if s/he is certified to conduct evaluation. **ASK FACULTY MEMBER TO REVIEW THIS COMPETENCY ASSESSMENT TOOL PRIOR TO YOUR PERFORMING THIS TASK SO THAT THEIR MEMORY WILL BE REFRESHED AS TO THE DESIRED CHARACTERISTICS OF PERFORMANCE THEY WILL BE EVALUATING during the course of the rotation.**
- At the end of the rotation, the Clinical Faculty Evaluator completes the Evaluation Checklist (Part 3) of this document, and shares it with you.
- You will also complete the self-evaluation portion of the checklist as a measure of competency in practice based learning.
- Evaluation Checklist must be signed by faculty and Resident.
- Return Evaluation Checklist to Dr. Susan Wolfsthal, Internal Medicine Residency Director or Dr. Heather Mannuel, Hematology/Oncology Fellowship Director.

**Introduction for the Clinical Faculty Evaluator**

**How to perform this competency assessment:**

A Medical Resident or Oncology Fellow has requested that you assess their competency in a selected palliative care domain during the time you are the attending physician on this service. To assist you with this evaluation, please do the following.

**Preparing for field evaluation of competency:**

- Review this Competency Assessment Tool thoroughly including the Learning Objectives (Part 1), Teaching Outline (Part 2) and Evaluation Checklist (Part 3) prior to pre-discussion counseling with Resident (required).
- Review Unit Unit 2 Module 3 (Nausea, Vomiting, Constipation) of the Web-based palliative care training program, “Medical Resident Training in End-of-Life and Palliative Care.” The training program is available on the UMMS Intranet, click on Physicians. The course is listed under “Helpful Links.” It is also available via the internet at http://134.192.120.12/canRes/htdocs/login.asp (optional).

**Format of competency evaluation:**

**During the clinical rotation**

- Based on the Learning Objectives (Part 1), Teaching Outline (Part 2), and Evaluation Checklist (Part 3) of this document and the content in Unit II, Module 5 of the palliative care training website, assess whether the Resident or Fellow meets the Learning Objectives during the course of this clinical rotation.

**End-of-rotation feedback**

- Review strengths and weaknesses of competency evaluation with Resident/Fellow.
- Provide constructive feedback to improve Residents/Fellows’ performance and patient outcomes.

**Complete Evaluation Checklist (Part 3 of this document)**

- Share with learner; allow learner to make his/her own self-assessment of performance.
- Faculty and Resident/Fellow must sign this Evaluation Checklist (Part 3).
- Learner is responsible for returning Evaluation Checklist to Dr. Wolfsthal (Residents) or Dr. Mannuel (Fellows).
**Part 1: Learning Objectives**

Note to learner and Clinical Faculty Evaluator: The Learning Objectives are listed in terms of fulfilling the six ACGME core competencies, listed below; these are reflected in Evaluation Checklist in Part 3 of this document.

**LEGEND to ACGME core competencies:** http://www.acgme.org/Outcome

| OBJECTIVES – A competent Medical Resident or Oncology Fellow will be able to: | ACGME Competencies |
|---|---|---|---|---|---|---|
| Describe how constipation negatively impacts quality of life. | PC | MK | PBL&I | IPCS | P | SBP |
| List at least two causes of constipation from each of the following categories: 1) mechanical obstruction; 2) drugs; 3) metabolic; 4) neurologic; 5) miscellaneous. | | | | X | | |
| Recognize when to order diagnostic tests in an appropriate and cost effective manner to help establish the cause of constipation. | | | | X | | |
| List the mechanisms of action and common side-effects of drugs from the following categories: 1) bulk laxatives; 2) large bowel stimulants; 3) detergent laxatives; 4) saline laxatives; 5) osmotic laxatives; 6) lubricants; 7) pro-kinetic drugs. | | | | | X | |
| Identify drugs that are not indicated for patients with poor mobility/poor oral intake. | | | | | | X |
| Implement appropriate prophylactic constipation treatment. | | | | | X | |
| Discuss therapeutic options for patients with refractory symptoms. | | | | | | X |
| Engage in an empathetic discussion with the patient with refractory constipation. | | | | | | X |
| Take a thorough history from a patient with constipation. | | | | | | X |
| Construct a differential diagnosis for at least three patients with constipation. | | | | | | X |
| Order abdominal x-rays when appropriate. | | | | | | X |
| Develop an initial treatment plan for at least three patients with constipation. | | | | | | X |
| Choose and titrate an initial drug management plan. | | | | | | X |
| Treat constipation that is refractory to an initial treatment approach. | | | | | | X |
| Prescribe a prophylactic bowel regimen in a patient starting opioid analgesics. | | | | | | X |

**LEGEND:**

PC – Patient Care  
MK – Medical Knowledge  
PBL&I – Practice-Based Learning and Improvement  
IPCS – Interpersonal and Communication Skills  
P – Professionalism  
SBP – Systems-Based Practice

Part 2: Teaching Outline for Learner and Clinical Faculty Evaluator (From Weissman, et al.1)

- Also, recommend reviewing Unit II, Module 3 (Nausea, Vomiting, Constipation) of the Web-based palliative care training program, “Medical Resident Training in Palliative and End-of-Life Care.” The training program is available on the UMMS Intranet, click on Physicians. The course is listed under “Helpful Links.” It is also available via the internet at http://134.192.120.12/canRes/htdocs/login.asp

Definition

- Acute
  - Recent - less than 6 months
  - Decrease in frequency
  - Increase in difficulty initiating a bowel movement.
- Chronic
  - Greater than 6 months
  - Less than 3 BM’s per week.

Associated Symptoms

- Increased passage of gas
- Abdominal pain
- Change in stool caliber
- Oozing of liquid or stool
- Rectal pain
- Anorexia
- Early satiety
- Bleeding with straining

Differential Diagnosis

1. Mechanical obstruction
   - Intraluminal - colon cancer
   - Extraluminal
     - Malignant ascites
     - Peritoneal carcinomatosis (ovarian, colon)
     - Scarring
2. Drug-Induced
   - Opioids
   - Anti-cholinergics, tricyclic antidepressants, neuroleptics, antihistamines
   - Chemotherapy (Vincristine, Vinblastine)
   - Calcium channel antagonists
   - Iron/aluminum containing antacids/barium--contrast agent
   - Laxative abuse
3. Metabolic
   - Hypercalcemia
   - Hypokalemia
   - Diabetes

- Hypothyroidism
- Uremia

4. Neurologic
- Spinal cord damage
- Paraneoplastic autonomic neuropathy
- Polymyositis

5. Miscellaneous
- Dehydration
- Inactivity
- Bed rest
- Confusion
- Depression
- Pain on defecating - hemorrhoids, anal fissure, infection
- Generalized pain
- Irritable bowel syndrome
- Loss of normal bowel routine
- Inadequate privacy/positioning (use of bed pan)

Management

General Measures

- Prophylaxis whenever possible
- Reverse treatable causes
  - Rectal examination to exclude fecal impaction
  - Abdominal exam / x-rays may be needed to exclude bowel obstruction
- Restore daily bowel routine
- Increase fluids and activity as much as tolerated by clinical condition

Drug Therapy — Drug Classification

- Large bowel stimulants - senna, bisacodyl, cascara, casanthranol, phenolphthalein
  - Directly increases bowel motility
  - Requires transformation in liver (phenolphthalein, bisacodyl) or gut (senna, cascara)
  - Abdominal cramps and increased gas are common
  - Senna, available as granules, pills or liquids, is commonly used in “natural” preparations
- Detergent laxatives - docusate, castor oil, also referred to as “wetting agents”
  - Decreases surface tension, allows greater absorption of water/fat into dry stool
  - Decreases mucosal absorption of water and electrolytes
  - Docusate is a weak laxative, available as a sodium salt (Colace), or calcium salt (Surfak)
  - NOTE: Castor oil is not recommended due to expense, bad taste, bowel stimulant effects
- Bulk laxatives - psyllium, methylcellulose, polycarbophil, bran
- soluble and insoluble fiber supplements
- inexpensive
- requires increased fluid intake for activity
  NOTE: when used without increased fluid intake, constipation will worsen
- abdominal cramps
- increased gas
- allergic reactions can occur
- best use in ambulatory pts without bowel obstruction who can take large volumes of liquid

• Saline laxatives - magnesium citrate or phosphate, sodium phosphate
  - increases gastric, pancreas and small bowel secretions and increases bowel motor action
  NOTE: do not use magnesium or phosphate products in renal failure; do not use sodium products in heart/liver/kidney failure

• Osmotic laxatives - lactulose, sorbitol, glycerin, Golytely, Miralax, mannitol
  - non-absorbable sugars - work via osmotic effect in small and large bowel
  - lactulose is expensive, bad tasting, increases abdominal gas; sorbitol is a less expensive alternative
  - GoLytely (Polyethylene Glycol) used as a bowel prep can be given in smaller doses for constipation (MiraLax)
  - glycerin suppositories lubricate hard stool and stimulate defecation within 30 min

• Lubricant - mineral oil
  - can cause malabsorption, perianal irritation, and lipoid pneumonia aspiration;
  NOTE: do not administer with docusate products

• Prokinetic drugs - bethanechol, neostigmine, metoclopramide
  - decreases bowel transit time

• Opioid Antagonists - methylnaltrexone
  - Peripheral opioid mu antagonist indicated for treatment of opioid-induced constipation in patients with advanced illness who are receiving palliative care.

• Enemas/Suppositories
  - bisacodyl suppositories (10 mg) - action in 15-60 minutes
  - glycerin suppositories - action in 30 minutes
  - sodium phosphate enema (Fleet)
  - enemas
    - tap water
    - oil retention
    - soap suds

• “Natural” Laxatives
  Many home recipes and/or natural food stores have products that contain a combination of raisins, prunes, applesauce, figs, dates with or without senna (a.k.a. “Power Pudding”).

• Trade Names - all available over the counter except for lactulose and PEG products
  - Metamucil, Perdiem, Fiberall (psyllium); Citrucel (methylcellulose)
  - Fiberall, Fibercon (calcium polycarboxophil)
  - MOM (magnesium phosphate)
  - Colace (docusate sodium); Surfak (docusate calcium)
  - Senokot (senna); Senokot S (senna and docusate)
  - Peri-Colace (docusate and casanthranol)
  - Ducolox (bisacodyl); Carter’s (bisacodyl)
  - Nature’s Remedy (cascara)
  - Ex-Lax, Feen-a-Mint (phenolphthalein); Correctol, Doxidan (phenolphthalein and docusate)
  - Haley’s MO (mineral oil and magnesium hydroxide)
  - Magnesium citrate (magnesium citrate)
  - Chronulac, Cephulac (lactulose)
  - Fleets Enema (sodium phosphate)
  - Miralax (polyethylene glycol)

Drug Therapy — Management Plan

The following agents should generally be avoided
- mineral oil
- castor oil
- phenolphthalein

1. For prophylaxis - e.g. pt. starting opioids or for recent mild constipation start
  - psyllium product - NOTE: only if patient able to increase fluid intake
  - senna product or MOM; docusate can also be added
  - increase dose of each product as needed (no upper dose limit except MOM in patients with renal failure);
  - if no BM at 8-12 Sennokot/day or 60-80 cc MOM/day go to 2.

2. For constipation refractory to Step 1 - check for fecal impaction (see Step 4)
  - bisacodyl (Ducolax) po 5 mg; up to 3 tabs tid
  - if no response use 1 Ducolax suppository

3. For constipation refractory to Step 2 - check for fecal impaction (see Step 4)
  - magnesium citrate 8 oz. – careful in patients with renal failure
  - lactulose or sorbitol (Miralax) or Fleet enema
  - methylnaltrexone (Relistor)

4. For impacted patients
  - use sedatives/analgesics to relieve stress/pain of disimpaction
  - lubricate rectum - glycerin suppository or oil-retention enema
  - manually disimpact rectum
  - enemas to clear rectum
  - increase daily oral laxative program

soluble and insoluble fiber supplements
inexpensive
requires increased fluid intake for activity
NOTE: when used without increased fluid intake, constipation will worsen
abdominal cramps
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allergic reactions can occur
best use in ambulatory pts without bowel obstruction who can take large volumes of liquid

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Ducolox (bisacodyl); Carter’s (bisacodyl)
Nature’s Remedy (cascara)
Ex-Lax, Feen-a-Mint (phenolphthalein); Correctol, Doxidan (phenolphthalein and docusate)
Haley’s MO (mineral oil and magnesium hydroxide)
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lubricate rectum - glycerin suppository or oil-retention enema
manually disimpact rectum
enemas to clear rectum
increase daily oral laxative program
References


Part 3: Evaluation Checklist

<table>
<thead>
<tr>
<th>Learner name:</th>
<th>Evaluator/Attending:</th>
</tr>
</thead>
</table>

- [ ] Resident PGY Level: [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5
- [ ] Fellowship Year: [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5

Rotation Site: [ ] Inpatient Cancer Center [ ] Inpatient GIM [ ] Oncology Clinic [ ] Continuity GIM clinic [ ] Other

Please rate the trainee's competency/skills/knowledge/attitude using the following scales:

<table>
<thead>
<tr>
<th>For competency/skills</th>
<th>For knowledge and attitudes (e.g. Medical Knowledge)</th>
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<tbody>
<tr>
<td>4 = Competent to perform independently</td>
<td>4 = Superior</td>
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<td>3 = Competent to perform with minimal supervision</td>
<td>3 = Satisfactory</td>
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<tr>
<td>2 = Competent to perform with close supervision / coaching</td>
<td>2 = Below average</td>
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<td>1 = Needs further basic instruction</td>
<td>1 = Insufficient – needs further learning</td>
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<td>n/o = not observed</td>
<td>n/o = not observed</td>
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OBJECTIVES

**Patient Care**

- 4 3 2 1 n/o
  - Described how constipation negatively impacts quality of life.
- 4 3 2 1 n/o
  - Implemented appropriate prophylactic constipation treatment.
- 4 3 2 1 n/o
  - Discussed therapeutic options for patients with refractory symptoms.
- 4 3 2 1 n/o
  - Constructed a differential diagnosis for at least three patients with constipation.
- 4 3 2 1 n/o
  - Developed an initial treatment plan for at least three patients with constipation.
- 4 3 2 1 n/o
  - Chose and titrated an initial drug management plan.
- 4 3 2 1 n/o
  - Treated constipation that is refractory to an initial treatment approach.
- 4 3 2 1 n/o
  - Prescribed a prophylactic bowel regimen in a patient starting opioid analgesics.

**Overall Performance:**

<table>
<thead>
<tr>
<th>Cannot Evaluate</th>
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<th>7 to 9 Superior</th>
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**Medical Knowledge**

- 4 3 2 1 n/o
  - Stated the prevalence of constipation as a common end-of-life symptom.
- 4 3 2 1 n/o
  - Listed at least two causes of constipation from each of the following categories: 1) mechanical obstruction; 2) drugs; 3) metabolic; 4) neurologic; 5) miscellaneous.
- 4 3 2 1 n/o
  - Recognized when to order diagnostic tests in an appropriate and cost effective manner to help establish the cause of constipation.
- 4 3 2 1 n/o
  - Listed the mechanisms of action and common side-effects of drugs from the following categories: 1) bulk laxatives; 2) large bowel stimulants; 3) detergent laxatives; 4) saline laxatives; 5) osmotic laxatives; 6) lubricants; 7) pro-kinetic drugs.
- 4 3 2 1 n/o
  - Identified drugs that are not indicated for patients with poor mobility/poor oral intake.
- 4 3 2 1 n/o
  - Ordered abdominal x-rays when appropriate.

**Overall Performance:**

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**Interpersonal and Communication Skills**

- 4 3 2 1 n/o
  - Engaged in an empathetic discussion with the patient with refractory constipation.
- 4 3 2 1 n/o
  - Took a thorough history from a patient with constipation.

**Overall Performance:**

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Part 3: Evaluation Checklist (Continued)

**Resident/Fellow strengths:**


**Resident/Fellow areas for improvement:**


**Overall impression:** Did the Resident/Fellow demonstrate competency in a manner so as to do no harm?

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**Resident/Fellow self-evaluation of performance:** May comment on any of the above checklist items or other reflections on performance; perceived strengths, and need for improvement and learning.

__________________________________________

__________________________________________

Clinical Faculty Evaluator/Attending

Resident/Fellow

Clinical Faculty Evaluator/Attending – PRINTED NAME/DATE

Resident/Fellow – PRINTED NAME/DATE