



# **A RESOURCE GUIDE FOR PALLIATIVE CARE EDUCATION**

## ***Part 3: Communication Skills***

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## **PREFACE**

There is a pressing need to improve palliative care education. This guide was developed to assist medical educators implement educational programs in key palliative care learning domains. The guide is meant to highlight the topics of greatest educational need, as identified by clinicians.

## **DISCLAIMER**

The information in this book is not medical advice. Health care providers should exercise their own independent clinical judgment. Some of the information in this book cites the use of a product in dosage, for an indication, or in a manner other than that recommended in the product labeling. Accordingly, the official prescribing information should be consulted before any such product is used.

## **LEARNING FORMATS USED IN THIS GUIDE**

### **PRE-POST TESTS**

A brief test (5 minutes), (short-answers or fill in the blank) is included at the beginning of each topic domain. Answers are provided at the bottom and can be covered when copies are made for distribution. The test can be administered in one of the following ways:

- Used at the beginning of a teaching session to heighten learner awareness of the topic;
- Used at the conclusion of a teaching session for the learner and/or the teacher to gauge effectiveness of the learning experience and to demonstrate topics for further learning;
- Used at both the beginning and the end of a teaching session for the learner and/or the teacher to gauge effectiveness of the learning experience and to demonstrate topics for further learning; Note: using the same test both pre and post may create re-test bias in the responses.

### **TEACHING OUTLINES**

Each topic domain contains a brief outline containing the essential topic information. The outlines are designed as quick reference guides, suitable for distribution for different types of learning opportunities—either as stand-alone guides, or as written material to accompany an educational experience, such as:

- a didactic lecture—small or large group setting
- teaching time during ward rounds
- a faculty development course
- a self-study guide

### **CASE STUDIES**

The case study format is used to complement the content outlines to help learners:

- express their own feelings toward the attitudinal issues raised in each case (see **Discussing attitudes**, below);

- reveal deficits in knowledge ● reinforce existing knowledge.

The cases are designed for small-group discussions, ideally no more than 12-15 participants, (e.g. ward rounds teaching time, small group conference, faculty development course). Each case can be discussed in 30-45 minutes depending upon the depth of discussion. Case studies are included in the following modules: *Pain; Dyspnea; Delirium; Nausea; Constipation, Artificial Hydration/Nutrition.*

### **SMALL GROUP WORKSHOP-Attitude Discussions**

Small groups are excellent venues to discuss attitudinal issues. To optimally explore the personal attitudes that arise in discussing end-of-life care, it is essential that the small group environment feel comfortable and safe. Have each participant introduce themselves and then set basic small group ground rules. One suggestion to help engage all participants is to break the small group into pairs; have each pair work for 5- 10 minutes on the questions and then re-convene the entire group, asking each pair to report their answers to the questions. Use of a blackboard or flip-chart can be helpful in keeping track of ideas, opinions. Listed below are key teaching points concerning the subject of attitude change (1).

- Exhortation, information and rational argument have a limited role in the learning or changing of attitudes.
- Recognize that attitudes involve ego-involvement.
- Shared group attitudes are more resistant to change
- There must be a willingness to change
- Effective teaching capitalizes on “teachable moments” when the learner is emotionally or intellectually aroused by a question, contradiction, or problem.
- Attitudinal development is fostered in situations in which
- concrete knowledge and skills are taught that relate to the desired attitudes;
- the learner is able to examine personal feelings/attitudes in an open and non-threatening dialog with peers;
- the learner can be active and can engage with others around real problems;
- the learner has an opportunity to practice the new behavior thus making a commitment;
- the learner has the opportunity to reflect on the meaning, difficulties and rewards of attitudinal change.
- Role-playing and role-reversal encourages the learner to take an alternative perspective and may foster an empathic awareness of the other’s experience.
- Role models and mentors are crucial to the process of learning attitudes; especially when the learner is making a transition.
- Feedback about the learners progress towards explicitly desired attitudinal objectives can help promote self-reflection and self-learning.

## **ROLE PLAYING AND EXPERIENTIAL EXERCISES**

Role playing exercises have been designed to help practice critical end-of-life skills, to reinforce knowledge and as learner evaluation tools. The exercises can be done with dyads (doctor and patient/family) or triads (doctor, patient/family and observer/recorder). The exercise can also be used as an example—the facilitator acting as the doctor, showing “how to do it right”.

The teacher can reduce the inevitable anxiety that accompanies experiential activities such as role playing by encouraging participants to view the role play as a time for the group to experiment with various approaches to common clinical dilemmas. In the process of experimenting, the learners will discover some approaches that work well, and other approaches that are less effective.

Role playing exercises have been designed to help practice critical end-of-life skills, to reinforce knowledge and as learner evaluation tools.

# DELIVERING BAD NEWS

## LEARNING OBJECTIVES

### **Attitudes**

- Self-reflects on prior good/bad experiences delivering bad news.
- Values the physician's role in delivering bad news in a compassionate, honest, and direct manner.
- Respects the patient's autonomy and right to understand the nature of their medical status.

### **Knowledge**

- Understand the physical setting where a discussion of bad news should be conducted.
- Understand who should be involved in a discussion of bad news.
- Demonstrate knowledge of the first key steps for delivering bad news.
- Demonstrate knowledge of key steps in delivering bad news by telephone.
- Describe key steps in how to follow-up after a discussion of bad news.

### **Skills**

- Demonstrate how to open a discussion when bad news will be presented.
- Demonstrate the ability to deliver bad news with honesty and compassion.
- Demonstrate ability to assess patient/family understand and respond to their needs.
- Demonstrate ability to respond appropriately to strong patient emotions (sadness, fear, anger, etc.).
- Demonstrate how to conclude a discussion of bad news.

## DELIVERING BAD NEWS

### PRE / POST TEST

1. Describe the first three steps in Breaking Bad News after sitting down with a patient: a)

b)

c)

2. Describe the words to use when giving a “warning shot” before giving bad news:

“ \_\_\_\_\_ ”

3. Before giving bad news over the telephone, what two issues must be clarified between yourself and to whomever you are speaking: a)

b)

4. Describe four common patient reactions to receiving bad news: a)

b)

c)

d)

#### **Answers**

1. Determine what the patient knows, give a warning shot, give the bad news. 2. I'm afraid I have some bad news. 3. Each person needs to explain their relationship to the patient (doctor and other person). 4. anger, guilt, grief, denial.

## DELIVERING BAD NEWS -- TEACHING OUTLINE

### **CREATE AN APPROPRIATE CONTEXT**

1. Physical setting: Choose a quiet, comfortable room, turn off beeper, check personal appearance, have participants, including yourself, sitting down.
2. Know the basic information about the patient's disease, prognosis, treatment options.
3. Who should be present?
  - (a) Ask the patient whom they want to participate--clarify relationships to patient. Make sure legal decision-maker is present.
  - (b) Decide if you want others present (e.g. nurse, consultant, chaplain, social worker) and obtain patient/family permission. **Note:** for life-threatening bad news, it is recommended that you have a nurse, social worker, or chaplain present, to assist you and provide additional emotional support to the patient and family.
4. Obtain a skilled medical interpreter if the patient or family do not speak English or are deaf.
5. Think through your goals for the meeting as well as possible goals of the patient.

### **FIRST STEPS**

1. Determine if the patient and family can understand information--are there medical, cognitive or psychological reasons for diminished understanding (e.g. pain, mental retardation, delirium, dementia, emotional upset, etc.).
2. Discover what the patient and family already know-- make no assumptions. For example, ask "What is your understanding of your present condition?" or "What have the doctors told you about your condition?" Shape your discussion to the patient's and family's needs.
3. Before presenting bad news, it is sometimes appropriate to provide a concise (2-4 sentences) narrative overview of the patient's hospitalization, diagnostics procedures, and medical status so that everyone has a common source of information; avoid use of jargon.

### **BREAKING BAD NEWS**

1. **Speak slowly, deliberately and clearly** . Provide information in small chunks. Check reception of news frequently; closely observe patient body language.
2. **Give fair warning** --"I am afraid I have some bad news for you" then pause for a moment.
3. **Present the bad news in a succinct manner** . Be prepared to repeat information and present additional information in response to patient and family needs.
4. **Sit quietly and listen to the patient** . Allow the patient time to absorb the news. You may wait for the patient to respond, or you may offer support (e.g. "I'm so sorry"), but avoid the common mistake of rushing forward and talking because you are anxious.
5. **Anticipate common reactions to bad news** :
  - overwhelming emotion--anger, fear, sadness, crying, isolation, guilt, relief, helplessness, anxiety
  - numbness, often presenting as an absence of emotion
  - denial
  - collusion--request to withhold information from patient or family members

6. **Listen carefully and actively. Pick up clues. Acknowledge and validate the patient's and family's reactions and thoughts.** "This is very difficult news", "This must be very hard."
7. **Recognize and reflect the patient's emotions.** For example, when a patient begins to cry the physician may be quiet at first and then say "I see that you are crying." If a patient shouts in anger "This is unfair" the physician might say "You are feeling very angry" or "This feels very unjust."
8. **Give an early opportunity for questions and comments.**
9. **Present information at the patient's and family's pace.** Do not overwhelm with detailed information at the first setting. The discussion is like peeling an onion. Provide an initial overview, then assess understanding and answer questions. Then provide the next level of detail, assess understanding and answer questions. Provide additional detail, or move back to the overview in response to the patient's and family's needs.
10. **Be flexible and responsive.** Allow the patient's and family's concerns and needs to mold the discussion.
11. **Be mindful** of your own feelings, thoughts and reactions. Don't allow your reactions to derail you, offer false reassurance, over-talk, or commit other communication errors.
12. **Ask** "How can I help."
13. **Assess thoughts of self-harm.** Based on how the patient/family reacts, ask questions to assess risk of self-harm/suicide.
14. **Agree on a follow-up plan** (e.g. "I will return later today, write down any questions you have") and make sure this meets the patient's needs. Involve other team members in the follow-up plan.

### ***DOCUMENT THE CONFERENCE IN THE CHART***

Who was present? What information was discussed? What actions need to be taken now? What follow-up is planned?

### ***ASSESS YOUR OWN FEELINGS AND NEEDS.***

1. Guilt ("This is my fault. I missed his early symptoms. I'm not supposed to cause emotional pain.")
2. Anger ("I wouldn't be in this situation if she had come for regular checkups...")
3. Fear ("They are going to blame me for this. This same thing could happen to me.")
4. Sadness ("How can this happen to this person?")

### ***GIVING BAD NEWS BY TELEPHONE***

1. Avoid when possible—consider home or office visit. If you expect an important test result, schedule an office visit in advance to review results.
2. Make sure you have time to talk.
3. Clarify who you are speaking to and their relationship to the patient.
4. Introduce yourself and your role in the patient's care.
5. Verify that they can talk now.
6. Give fair warning --"I am afraid I have some bad news."
7. In some cases you may want to offer to meet with the individual at the hospital or your office to present and discuss the bad news.
8. Offer to contact others--family members, clergy, neighbors



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## DELIVERING BAD NEWS

### TEACHING WORKSHOP / ROLE PLAYING EXERCISE

#### Faculty Guide

1. Ask students to generate one or several case examples of real clinical situations in which they had to break bad news to a patient.
2. Review and discuss the **Breaking Bad News** teaching outline using the cases for illustration.
3. Ask students to form pairs or triads (patient/physician/observer).
4. Select one of the two role-playing exercises (see below).
  - Students should spend 5-7 minutes role-playing.
  - Encourage students who role-play the family member or patient to adopt one of the various potential emotional reactions to receiving bad news: angry or hysterical or profound sadness or disbelief
  - Following the role-play have the "patient" or "family member" complete the evaluation form and discuss this with their "physician" partner.
5. Depending on time, students can reverse roles and/or use the second case.
6. Debrief the student experience--what worked well, what didn't, what was hard, what was easy?
7. Faculty may wish to demonstrate their own technique at delivering bad news, either at the start or conclusion of the student role-playing.

#### Role Playing Cases

#1 Death in emergency department (AMI) in a previously healthy person.

#2 New diagnosis of metastatic stomach cancer.

## **ROLE PLAY CASE #1**

**Purpose of Case:** Giving Bad News

**Training Level:** Medical students, post-graduate trainee or faculty

**Simulated patient name:** Mr./Mrs. Jones

**Diagnosis:** Acute Myocardial Infarction

**Setting:** Quiet room for family meetings in an emergency room

**Time allotted:** 7 minutes

## **ROLE PLAY CASE #1**

### **FAMILY MEMBER PROFILE**

#### **MEDICAL HISTORY**

Your spouse, Mr./Mrs. Jones, is a 54 y/o high school teacher with no history of any medical problems. This morning at 5 am he/she woke up with crushing chest pain. He/she took some antacids, was no better 30 minutes later, and finally woke you up and you brought him to the emergency room. You have been waiting in the waiting room and you have not met the doctor. You did see a nurse who said "your husband is having some problems; the doctor will be out to talk with you soon".

#### **SOCIAL HISTORY**

You have three children, ages 25, 22 and 17. Your parents are deceased, you have no siblings. You work as a new car salesperson.

#### **SETTING**

You are alone, in a quiet waiting room, located in the emergency room, sitting on a chair.

#### **TASK**

Your partner, in the role of the ER physician, will break the bad news to you. Some questions/comments you may wish to pose (or any you think are appropriate to the situation) include:

\*How can this be, he/she was fine when I brought him in!

\*He/she's never been sick a day in his/her life! \*What should I tell the children?

## **ROLE PLAY CASE #1**

### **INFORMATION FOR PHYSICIAN**

#### **MEDICAL HISTORY**

You are on duty one early morning when a 54 y/o with chest pain is brought to the emergency room. While you are seeing another patient the ER nurse informs you about the patient's arrival, and tells you that he "looks stable and has normal vital signs". You ask the nurse to get an electrocardiogram and you tell her you'll be done in 5-10 minutes. Five minutes later the nurse runs in to say the patient has suffered a cardiac arrest. You supervise a 30 minute attempt at cardiopulmonary resuscitation that fails and you pronounce the patient dead. The nurse tells you that the spouse is in the waiting room and does not know about the cardiac arrest.

#### **SETTING**

The patients' spouse is sitting alone in a waiting room in the ER, sitting in a chair.

#### **TASK**

You are the Emergency Room physician--tell the husband/wife that their spouse has died.

## **ROLE PLAY CASE #2**

**Purpose of Case:** Giving Bad News

**Training Level:** Medical students, post-graduate trainee or faculty.

**Simulated patient name:** Mr./Mrs. Phillips

**Diagnosis:** Metastatic stomach cancer

**Setting:** Outpatient clinic office

**Time allotted:** 7 minutes

## **ROLE PLAY CASE #2 PATIENT PROFILE**

### **MEDICAL HISTORY**

You are Mr./ Ms. Phillips, 72 y/o, with a new problem of mid-epigastric pain. You have been very healthy until one month ago when you started to have some mild mid-epigastric pain. You saw your doctor who told you it was most likely gastritis and prescribed an over-the-counter medication. The pain persisted and when you returned to see the doctor he seemed a bit more concerned, but said the pain was most likely from an ulcer or gallstones and scheduled you to have a CT scan of the abdomen. You are now returning to the doctor's clinic to hear the results of the CT scan.

### **SOCIAL HISTORY**

You are divorced, have two children, ages 40 and 38. You live alone but have a "significant other" you have been seeing for two years. You are a retired commercial artist. Both your parents are deceased and you have one sister who lives in the area.

### **SETTING**

Outpatient clinic office of your primary physician.

### **TASK**

Your partner, in the role of the physician, will break the bad news to you. Your demeanor should be mildly anxious. Once told that you likely have cancer you may adopt one of several emotional reactions (quiet-introspective or disbelieving or angry or other). Some questions/comments you may wish to pose--or any other you think are appropriate include:

- What does this mean?
- What can be done if it is cancer?
- Am I going to die?
- How can you be sure?
- Maybe the radiologist made a mistake
- I want another opinion ● Will I be in pain?

## **ROLE PLAY CASE #2 INFORMATION FOR PHYSICIAN**

### **MEDICAL HISTORY**

You are caring for a previously healthy 72 y/o, Mr./Ms. Phillips, with a new problem of abdominal pain. He/she has been a patient of yours for over 5 years and came to see you one month ago with mid-epigastric pain. You thought it was most likely gastritis and prescribed an over-the-counter H2 blocker. One week ago, he/she returned saying the pain was getting worse and on examination you noted left supraclavicular adenopathy. You ordered an outpatient CT scan of the abdomen, suspicious of an abdominal malignancy. You reviewed the CT scan with the radiologist yesterday. It showed a focal mass with ulceration in the body of the stomach and numerous (more than 10) densities in the liver compatible with liver metastases. The radiologist feels that the findings are absolutely typical of metastatic stomach cancer. You decide the easiest way to confirm the diagnosis is a percutaneous liver biopsy of the one of the larger liver nodules-- but you need to discuss the CT results first with the patient when he/she returns to your office.

### **SOCIAL HISTORY**

Your patient is divorced, has two children, ages 40 and 38. The patient lives alone but mentioned to you that he/she has a "significant other". He/she is a retired commercial artist; both parents are deceased, he/she has one sister who lives in the area.

### **SETTING**

An examination room in your outpatient clinic.

### **TASK**

Present the CT scan information to your patient who has returned to your office to discuss the test results.



## GIVING BAD NEWS LEARNER ASSESSMENT FORM

**Content Checklist:** Make an “X” if the resident did this without prompting; “√√” if the resident did this only after prompting, and leave blank if this was not done.

- \_\_\_\_\_ Greet the patient and introduce self
- \_\_\_\_\_ Explain the purpose of the meeting
- \_\_\_\_\_ Ask the patient their understanding of the issue
- \_\_\_\_\_ Give advanced warning of bad news
- \_\_\_\_\_ Describe the bad news in plain language, no jargon
- \_\_\_\_\_ Allow the patient to digest the information, use silence
- \_\_\_\_\_ Offer an opportunity for the family member to ask questions
- \_\_\_\_\_ Respond to questions using plain language, no jargon
- \_\_\_\_\_ Offer a plan for next steps to follow meeting

**Communication Skills - Please check ONE box per question using the following rankings: 3=Excellent, 2=Good, 1=Marginally Satisfactory, or 0=Unsatisfactory (either poorly done or not done at all)**

	3	2	1	0
Assures comfort and privacy				
Assumes a comfortable inter-personal communication distance				
Maintains an open posture				
Reflects patient's emotions				
Displays empathy through words, expression or touch that was appropriate to situation				
Reflects patient's thoughts and concerns				

**Please provide your overall assessment:**

- \_\_\_ Competent to perform independently
- \_\_\_ Needs close supervision
- \_\_\_ Needs basic instruction

**Do you believe the physician able to present bad news with compassion in a manner so as to do no harm? YES OR NO**

**If you feel additional training is needed, please indicate what problems need to be addressed (circle all that apply):**

- basic communication skills (eye contact, rate of speech, excessive use of jargon, personal space)
- professional attitude (sullen, not empathic, angry, giggles) other: please describe:
- other:

# GOALS OF CARE CONDUCTING A FAMILY CONFERENCE

## LEARNING OBJECTIVES

### **Attitudes**

- Values the physician's role in convening a family conference.
- Values the patient's and family's role in working with the health care team.
- Aspires to enhance professional skills in conducting a family conference.
- Respects the patient's autonomy.

### **Knowledge**

- Describes the physical setting where a family conference should be held.
- Understands who should be involved in a family conference.
- Understands the concepts of decision-making capacity and surrogate decision-maker.
- Describes the key steps in running a family conference.
- Describes strategies for working with families when there is disagreement or indecision.
- Describes how to follow-up after a family conference.

### **Skills**

- Demonstrates how to open a family conference.
- Demonstrates how to describe the concept of a surrogate decision-making and health care power of attorney.
- Demonstrates how to guide a discussion of the patient's medical status.
- Demonstrates how to moderate a discussion of treatment decision making.
- Demonstrates how to conclude a family conference.
- Writes a complete note summarizing a family conference.

## GOALS OF CARE/ CONDUCTING A FAMILY CONFERENCE

### PRE / POST TEST

1. Describe three common reasons for convening a family conference concerning a non-decisional patient:
  - a)
  - b)
  - c)
2. Write the phrase you would use when asking family members or patient their understanding of the patient's medical conditions:

“ \_\_\_\_\_ ”

3. List two key points when summarizing the medical condition.
  - a)
  - b)
4. List three steps to take when there is no clear family consensus about decisions:
  - a)
  - b)
  - c)

#### **Answers**

1. Share information sharing, set goals, resolve differences of opinion, support family coping . 2. “Can you tell me what the doctors have told you?” or “Can you tell me what your understanding is of <patient name>'s condition and treatment plan?” 3. Present big picture, succinctly, no jargon, solicit questions. 4. Set time limited goals, arrange a follow-up meeting, remind family members of the concept of surrogate decision making and ask them to think about what decision the patient would make if they could speak for themselves, offer and recruit support for the family (chaplain; social worker; psychologist).

## GOALS OF CARE/ CONDUCTING A FAMILY CONFERENCE TEACHING OUTLINE

Establishing goals of care for patients near the end of life is a critical physician skill. Such discussions can occur in the inpatient or outpatient setting, and often occur during a family meeting. Convening a family conference is necessary whenever there is a need for discussion between key members of the health care team, the patient, the patient's family, and other essential family support people such as a member of the clergy or a close personal friend. A successful family conference is more likely to occur if key steps are completed, in the correct order--a ten step process is outlined below. These 10 steps are not a cookbook or blue-print which can be followed in a rigid sequence, but a list of principles and tasks that the physician should consider incorporating into the family meeting. Because each patient and family has a unique history and needs, it is important that the physician assess and respond to the family's needs during the meeting.

### 1. Pre-Meeting Planning

#### **Determine the reasons for convening a family conference.**

- review medical condition, set treatment goals, decide future level of care/treatments;
- establish surrogate decision maker;
- resolve patient, family and/or staff conflicts.

**Decide what is medically appropriate:** what tests/procedures/interventions do you believe will improve or worsen function, longevity and quality of life?

**Review Medical History:** review all pertinent medical facts including treatment options, prognosis, with and without treatment, and consultant opinions.

**Coordinate opinions:** contact consultants to coordinate message to patient/family.

**Advance Directives:** review any advance directive documents and bring to the meeting.

**Psychosocial data:** obtain all available information about the patient and family system. psychosocial status/issues.

**Attendees:** Determine who you wish to have present from the medical team and invite the family to bring whomever they wish to the meeting. Determine whether there is a need for an interpreter for the patient or family members.

**Meeting leadership:** designate one person from the medical team to serve as meeting leader.

#### **Determine if the patient has decision-making capacity**

- a) Decision-making capacity refers to the capacity to make medical decisions and to provide informed consent to treatment. This is different from competence, a legal term; competence is determined by a court, not by a physician.
- b) Key elements of decision-making capacity--A patient must meet three criteria to demonstrate decision-making capacity:
  - Ability to Understand information about diagnosis and treatment;
  - Ability to Evaluate deliberate, weigh alternatives, compare risks and benefits;
  - Ability to Communicate a Choice verbally, in writing, or with a nod or gesture.

2. **Environment** —find a quiet, private room; arrange chairs in a circle so each participant has a “front-row” seat; make sure the patient, if participating, will be as comfortable as possible.

3. **Introductions** — ask all participants to introduce themselves and their relationship to the patient. For large groups, set ground rules: everyone can speak, no interruptions. Identify the legal surrogate decision maker if available. Review your goals & purpose of the meeting; ask participants for their goals. Write names down if this is helpful to you.

4. **Determine what the patient/family already knows.** "What is your understanding of \_\_\_\_\_ 's present condition" or "What have you been told about \_\_\_\_\_ 's condition". For patients with chronic diseases, ask about function and quality over the preceding 3-6 months and any changes or trends. Invite all participants to share their impressions.
5. **Medical Review.** Provide a short synopsis of the current medical condition and how the current condition fits within the larger illness trajectory (for chronic disease patients). The synopsis should be very brief, focusing on the large overall condition ("your father has pneumonia and kidney failure; despite 3 days of antibiotics, his condition is getting worse").
6. **Avoid medical jargon.** Use the word "dying" if appropriate to the situation; "Despite the chemotherapy, the cancer is growing, I believe your mother is dying".
7. **Allow silence,** respond to questions and emotional reactions.

**When the medical review has indicated that no further treatments are likely to reverse the disease process/the patient is dying, there are two common reactions:**

A. **Acceptance—** patients and families who understand and accept that death is approaching will typically ask or be thinking of the following questions and emotional reactions:

- How much time?
- What will happen?
- What do we do now?

B. **Non-Acceptance—** when patients or families are not ready to accept that death is coming, common questions include (see step 8-Managing Conflicts):

- How can you be sure?
- He was fine last week.
- We want a second opinion.
- There must be some mistake.
- Shifting focus by asking questions about a relatively minor aspect of care

**Common Emotional Responses—during this phase of the meeting, emotional reactions are common:**

- Sadness
- Grief, tears, crying, wailing
- Guilt
- Anger
- Regret

#### **8. Present Broad Care Options**

You will need to discuss prognosis to help patients/families decide among care options. A good entry to such a discussion is: "Has anyone talked to you about time?" Guidelines on providing prognosis include: a) always ask if such a discussion is desired before providing data, b) provide data in a range (a few weeks to a few months), c) stop and allow silence after providing data to gauge any emotional reaction.

**Options usually breakdown into two major domains**

- Continuing or expanding life-prolonging treatments with a goal of improved function, lengthened life, and/or improved quality, versus...
- Continuing comfort care, but discontinuation of life-prolonging treatments with expected death.

**When the patient can speak for themselves**

- Ask patient what treatment he/she is considering.
- Ask patient what type of support he/she would like from family members & health care team.
- Invite discussion from other family members about supporting the patient's decision.

### **When the patient cannot speak for themselves**

- Describe the goal of substituted decision making—to speak on behalf of the patient by making those choices we believe the patient would make if they could speak.
- Ask each family member what they believe the patient would choose if he/she were able to speak on their own behalf.
- Ask each family member what their own wishes are for the patient.
- At this point some families want time alone (10 or 15 minutes) to talk before making a decision.

### **Making a Recommendation**

When patients/families struggle to make a decision, or you believe there is one preferred medical decision based on the facts, and/or your knowledge of the patient's wishes, **make a clear recommendation**. Avoid statements such as: "what would you like us to do?" This type of statement only tends to worsen a family's sense of guilt about "pulling the plug."

### **9. Managing Conflict**

This is a point in the conference when conflicts between the family and the health care team, or conflicts between family members, typically surface. This is especially true when the questions listed above (non-acceptance) are verbalized. Common reasons for such conflicts include the following:

- **Grief/Time** -- family members have not had sufficient time to psychologically adjust to imagining their life without the dying person.
- **Information** -- incorrect, misleading, or conflicting information has been provided to the family by other health care providers.
- **Anger/Guilt** -- long lasting intra-family issues may disrupt or preclude logical decision making; in severe cases, the struggle you observe may be the result of long-standing serious family dysfunction—issues of past or current drug or alcohol dependence and/or physical, verbal or sexual abuse are common.
- **Trust** -- if a patient or family does not have trust in the medical team, it is impossible to work together to develop a treatment plan.
- **Culture** -- differences in culture, religion, socioeconomic status, etc. may all impede decision making. See chapter on cross-cultural issues for strategies.

### **Key points in managing conflict**

1. Active listening—strive to maintain a civil discourse; ensure that your body language is open, conveying concern and empathy, re-state or paraphrase what people are saying to make sure you and others understand.
2. Correct any factual mis-understanding.
3. Provide an empathic statement; "I can't imagine how hard this must be".
4. Keep the focus of the discussion on the patient's well-being.
5. Recognize that time may be necessary—schedule a follow-up meeting;
6. Establish a time-limited trial of continued life-sustaining treatments--establish clear goals and a time line (e.g. improved cognition, improved LFTs).
7. Recognize that other resources may help the family: psychologist, spiritual counselor, palliative care team, ethics consultation.
8. State directly that you (and health care team) will not abandon the patient and family, and will assure the patient remains as comfortable as possible.

### **10. Translate goals into a care plan**

When a decision has been made to limit further life-sustaining treatments, it is time to refocus the goals of care. Ask: "knowing that time is short, what is important, what do you want/need to do in the time you have left". Typical responses are home, comfort, being with family, living until a particular life event.

*Treatment goals drive our choice of diagnostic and therapeutic methods. When treatment goals change it is natural that diagnostic and therapeutic methods will also change—some will be discontinued and others started. The phrase “withdrawing treatment” can have a powerful emotional impact upon a patient and family because it may suggest abandonment. For this reason, the physician should not use this term, but should instead speak about changing the goal of treatment from cure to maintaining the patient’s comfort. In addition, the provision or discontinuation of certain treatments such as non-oral hydration and nutrition can have strong emotional meaning. Therefore, the physician should facilitate discussion of these decisions and explore their meaning with patients and families.*

Review the current medical tests, procedures, medications—decide which are helping to meet the patient’s goals, which are providing no benefit. Key items for discussion at this time include:

- Future hospitalizations or ICU admissions
- DNR status
- Use of artificial hydration/nutrition, blood products or antibiotics ● Home support, Hospice

Explore the meaning of changing treatment goals (and discontinuing some treatments) with the patient/family--some issues are inherently more difficult than others to consider (hydration and feeding withdrawal are typically the hardest decisions for families). Be aware of cultural beliefs and attitudes that will influence decision-making.

Develop a care plan that matches the patient/families goals, verbally summarize the care plan to ensure understanding and agreement. Caution against unexpected outcomes (e.g. if a dying patient does not die, as expected following discontinuation of treatment).

#### **11. Document and Discuss**

Discuss the meeting with health care providers who were unable to attend (e.g. the patient’s evening nurse). Provide concise written documentation of the meeting: Who was present; What was discussed; What was decided; What decisions were deferred; Plan of care; and, Next steps.

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## ESTABLISHING TREATMENT GOALS

### ROLE PLAYING EXERCISE

#### Faculty Guide

1. Review and discuss the **Establishing Treatment Goals, Withdrawing Treatments** teaching outline.
2. Ask students to form pairs and distribute the role-playing exercise.
3. Students should spend 5-7 minutes role-playing. The "patient" and "physician" should then independently complete an evaluation form and discuss their impressions of the interview. If there is time, have the students switch partners and change roles so everyone has the opportunity to role-play the "physician".
4. Debrief the experience with the entire group--good points, bad points, what worked well, what was less effective, what did they learn that they would apply in their work, etc.
5. You may choose to demonstrate your technique at this type of discussion using the case and choosing one student to play the role of the patient.

#### CASE BLUEPRINT

**Purpose of Case:** Discussing Treatment Goals

**Training Level:** Medical students, post-graduate trainee or faculty.

**Simulated patient name:** Mr./Mrs. Williams

**Diagnosis:** Metastatic Pancreas Cancer

**Setting:** Doctor's clinic office, primary care physician

**Reason for Visit** To go over test results and discuss treatment goals

**Time allotted:** 7 minutes

## INFORMATION FOR PHYSICIAN

**MEDICAL HISTORY:** Mr./Mrs. Williams is 59 y/o, diagnosed with pancreatic carcinoma 5 months ago after presenting with a locally advanced, unresectable, pancreatic mass and painless jaundice. The patient has been in your primary care clinic for more than 5 years. He/she underwent surgery to relieve the biliary obstruction and then received radiation and two months of chemotherapy. The chemotherapy was very hard on him/her, causing severe nausea and fatigue. The patient called you three days ago saying that over the past 3 weeks he/she has noticed a decline in energy, generalized fatigue and little appetite. He/she has no pain or nausea. You ordered an abdominal CT scan and asked him/her to come in today to go over the results.

The CT scan shows considerable tumor progression with multiple new liver metastases. You discuss the case with an oncologist who recommends no further chemotherapy since he/she tolerated the first treatments so poorly. The oncologist suggests that you refer the patient to a hospice program; he says the prognosis is 2-4 months.

### PAST HISTORY

Mild hypertension controlled with medication; one episode of renal colic 3 years ago.

### SOCIAL HISTORY

Patient is married with two daughters, ages 28 and 24, both live in the area. The patient is an elementary school special education teacher, on extended leave since the cancer surgery. The patient has never smoked and uses alcohol rarely.

### TASK

Enter the room and begin a discussion with Mr./Mrs. Williams, you have the following goals for this visit:

2. Review CT scan results and the oncologists recommendations
3. Elicit the patient's goals for the future

**Note:** Do not discuss the issue of DNR orders or hospice referral in this exercise.

## PATIENT PROFILE

### MEDICAL HISTORY

I am Mr./Mrs. Williams, 59y/o; I was diagnosed with pancreatic cancer 5 months ago after presenting with an unresectable pancreatic mass and jaundice. I underwent surgery to relieve the biliary obstruction and then received radiation and two months of chemotherapy. I became very ill from the chemotherapy and resolved never to do that again. Over the past 3 weeks I noticed a decline in energy, increasing fatigue and little appetite; I have no pain or nausea. I contacted my primary care physician who ordered an abdominal CT scan. I am coming to my primary care doctor today to get the CT scan results.

### SOCIAL HISTORY

**Family Relationships and Living Situation:** I am married and have two daughters, ages 28 and 24 who live in the area, they are both single.

**Occupation:** I am an elementary school special education teacher, on leave since the cancer was found. The work is very stressful but rewarding. **Hobbies and Recreation:** I sing in a community choir and like to grow vegetables.

**Religion:** I was raised Lutheran, but am not involved with a church. I do believe in God and an afterlife.

### MOOD, AFFECT, AND Demeanor

I appear anxious and sad. I know that the cancer has come back, but I still have hope of beating the cancer, especially since the doctor hasn't actually come out and actually said that I'm dying. I am scared about what is happening, as I don't know what the future will bring.

### TASK AND RESPONSES TO PHYSICIAN

The "doctor" will be telling you the results of the CT scan—you are alone today, no one came with you to the doctor's office. If the doctor does not tell you the CT scan results within the first 2 minutes, you become increasingly anxious. If 3 minutes go by without the doctor telling the results, say, "Just tell me---what did the test show?" (or something similar). As soon as possible after the doctor tells you that the cancer is growing, ask: "Does this mean I need to start chemotherapy again? — I really hate that."

If asked "what scares you most about this," "what are you most afraid of," or anything like these questions, explain your fear of the unknown, not of being dead, but your fear of dying; also, your sadness at not seeing your daughters married and with children.

If asked about your personal goals for the time remaining, say "I want to be kept comfortable and I don't want to be a burden on my family". "I'd like to be at home if possible".

**LEARNER EVALUATION TOOL  
OSCE: GOALS OF CARE**

**Content Checklist of skills: Make an "X" if the resident did this without prompting; "✓✓" if the resident did this only after prompting, and leave blank if this was not done.**

- \_\_\_\_\_ Greets the patient/family member and introduces self
- \_\_\_\_\_ Explains the purpose of the meeting
- \_\_\_\_\_ Asks the patient/family member to describe their understanding of the issue
- \_\_\_\_\_ Describes the current medical condition succinctly without jargon
- \_\_\_\_\_ Allows the patient/family member to digest the information, uses silence
- \_\_\_\_\_ Offers an opportunity for the family member to ask questions
- \_\_\_\_\_ Responds to questions using plain language, no jargon
- \_\_\_\_\_ Discusses prognosis
- \_\_\_\_\_ Describes treatment options
- \_\_\_\_\_ Makes a recommendation if appropriate
- \_\_\_\_\_ Allows patient/family to describe goals
- \_\_\_\_\_ Summarizes discussion

**Communication Skills - Please check ONE box per question using the following rankings: 3=Excellent, 2=Good, 1=Marginally Satisfactory, or 0=Unsatisfactory (either poorly done or not done at all)**

	<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>
Assures comfort and privacy				
Assumes a comfortable inter-personal communication distance				
Maintains an open posture				
Information provided is clear and unambiguous				
Allows family member time to reflect-does not rush discussion				
Reflects emotional meaning				
Resident displayed empathy through words, expression or touch that was appropriate to situation				

**Please provide your overall assessment:**

- \_\_\_ Competent to perform independently
- \_\_\_ Needs close supervision
- \_\_\_ Need basic instruction

**Do you believe the physician able to present bad news with compassion in a manner so as to do no harm? YES OR NO**

**If you feel additional training is needed, please indicate what problems need to be addressed (circle all that apply):**

- basic communication skills (eye contact, rate of speech, excessive use of jargon, personal space)
- professional attitude (sullen, not empathic, angry, giggles) other: please describe: \_\_\_\_\_
- Other:

# **THE DNR DISCUSSION**

## **LEARNING OBJECTIVES**

### **ATTITUDES**

- Self-reflect on personal attitudes and values surrounding DNR discussions.
- Considers DNR orders as one facet of advance directives, within the context of the patient's illness and other treatment goals, not as an isolated decision.

### **KNOWLEDGE**

- Explains the ethical and legal principles guiding treatment withdrawal / DNR discussion.
- Describes risks / benefits of CPR in different patient populations: health young adults, patients with metastatic cancer, renal failure or multi-organ failure.
- Describes situations when it is appropriate to discuss treatment withdrawal and DNR orders.
- Describes the appropriate physical setting for DNR discussions.
- Describes the important first steps when discussing treatment withdrawal or DNR orders.
- Describes who should be present at discussions of DNR orders.
- Describes how to close a discussion of treatment withdrawal or DNR orders.
- Describes the steps to take when there is no consensus between physicians and patient/family.

### **SKILLS**

- Demonstrates communication skills necessary to discuss DNR orders.
- Demonstrates skills necessary to describe the current medical care situation using appropriate language.
- Demonstrates ability to work with allied health professionals in planning a discussion of DNR orders.
- Demonstrates how to document the outcome of a DNR discussion in the medical record.

## THE DNR DISCUSSION

### PRE / POST TEST

1. What is the physicians legal responsibility concerning DNR discussions?
2. List two statements to avoid during a DNR discussion a)  
b)  
c)
3. List three options for managing conflicts about DNR orders between doctors and patients.  
a)  
b)  
c)

#### **Answers**

1. In most states there are no legal guidelines, only hospital policies concerning the role of physicians in inquiring about a patient's CPR/DNR wishes. 2. Do you want us to do everything?; What should we do if your heart stops? 3. allow time, seek out underlying reasons for the conflict, seek palliative care consultation.

## THE DNR DISCUSSION

DNR discussions should be conducted within the context of a larger discussion reviewing overall patient condition, prognosis and goals (see: *Establishing Treatment Goals* ).

### **DISCUSSING DNR ORDERS**

#### **Who needs a DNR order discussion? (in order of priority)**

- inpatients with an advanced life-threatening illness (e.g. metastatic cancer, sepsis, acute stroke);
- inpatients with other "serious" chronic illnesses;
- outpatients as part of routine advanced directive discussion;
- for inpatients with non-life threatening diseases (births, simple infections, etc.)--CPR is assumed in the unlikely event of a medical catastrophe requiring resuscitation.

#### **Who should participate in a DNR order discussion?**

- the decisional patient together with physician-of-record;
- others may participate and be of assistance: family, friends, social worker, nurse, chaplain.

#### **Cardiopulmonary Resuscitation: benefit vs. burden**

- primary indication for resuscitation is cardiopulmonary arrest due to an acute event (e.g. MI, PE).
- overall, 15% of in-hospital CPR attempts lead to hospital discharge. Predictors of poor outcome include metastatic cancer, sepsis, multi-organ failure, CPR event > 30 minutes.
- burdens of CPR include: permanent vegetative state (10%), chest wall trauma (25-50%), cost, prolonging the dying process from an expected death from a chronic disease.

### **CONDUCTING THE DNR DISCUSSION**

#### **1. Physical setting**

- quiet, comfortable room, turn off beeper, check personal appearance;
- make sure you understand prognosis and treatment options;
- ask the patient or legal decision maker who they would like have participate;
- have participants, including yourself, sitting down;
- decide if you want others present (e.g. nurse, chaplain, social worker) and obtain patient's permission.

#### **2. First steps**

- ask if the patient has ever completed an advance directive;
- determine if the patient is decisional;
- before initiating a discussion with the patient/family/surrogate clarify in your own mind whether or not you think CPR is an appropriate medical intervention, at this time, for this patient, given the current medical condition;
- determine what the patient knows--"what is your understanding of your present condition" or "what have the doctors told you about your condition".

#### **3. Discuss DNR in the context of overall Goals of Care** (see Chapter: Establishing Treatment Goals)

- review with the patient their current medical condition and expected prognosis;
- review with the patient your overall treatment plan;
- discuss the relative benefits/burdens of CPR within the context of the patients' current condition and personal goals. As part of this discussion provide you professional, evidence-based opinion;
  - i. if you feel that CPR is not medically indicated, this should be expressed to the patient as one aspect of the overall treatment plan, stressing the positive things that will be



done: e.g. *"Your cancer is growing despite the latest chemotherapy; I am recommending no further chemotherapy but I will provide you with maximal treatments for your pain or any other symptoms you may experience. I do not recommend the use of breathing machines or other artificial means to prolong your life; I do recommend a variety of interventions to help you remain comfortable and be as active as possible";*

- ii. if you believe that CPR is medically indicated, you may express this opinion to the patient.
  - iii. If you are uncertain about the benefits of CPR, you should tell the patient that CPR may or may not benefit them and describe the range of benefits/burdens.
- reinforce that DNR does not mean *do not treat*, it only applies to cardiopulmonary resuscitation.

#### 4. Statements to avoid during the DNR discussion:

- What would you like us to do if your heart stops?
- Do you want us to do everything?
- Do you want us to start your heart if it stops?
- If we do CPR we will break your ribs and you will need to be on a breathing machine--you don't want us to do that--do you?

#### 5. Documentation

- review DNR discussion with involved staff--nurse, social worker, etc.;
- write a DNR order in medical record;
- write a progress note--include participants at discussion, indications for DNR order, role of consultants, and the decision-making capacity of the patient or the authority for use of a surrogate (see discussion of surrogate decision making).

#### 6. Managing patient-family-physician DNR order conflicts

- review overall patient prognosis and treatment goals with patient/family;
- clarify patient/family misconceptions that may exist regarding the nature and purpose of CPR;
- use time as an ally—allow patient and family to consider options;
- ask other patient advocates--family, friends, clergy, nurses, social workers--to become involved;
- be aware of reasons for a seemingly irrational DNR request: unrealistic goals, guilt, confusion concerning the therapeutic plan, mistrust of the physician, family differences, ethnic or socio-cultural differences, language barriers; ● consider palliative care or ethics consultation.

#### 7. Continued conflict – physician options

- a) decide if you believe that CPR represents a futile medical treatment--that is, CPR cannot be expected to either restore cardiopulmonary function or to achieve the expressed goals of the patient;
- b) if you believe that the patient/family is requesting a futile treatment and you have tried all the options suggested above you still have options:
  - a physician is not legally or ethically obligated to participate in a futile medical treatment;
  - in some facilities, a physician may enter a DNR order in the chart (may require one or two other physicians to review case and concur depending on local policy)-- you must instruct the patient/decision maker of your decision and rationale, and in some cases, hospital administration;
  - you may transfer care to another physician chosen by the patient/family.

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**THE DNR DISCUSSION**  
**ROLE PLAYING EXERCISE**

**Faculty Guide**

1. Review and discuss the **DNR Discussion** teaching outline.
2. Ask students to form pairs and distribute the role-playing exercise.
3. Students should spend 5-7 minutes role-playing. The "patient" and "physician" should then independently complete an evaluation form and discuss their impressions of the interview. If there is time, have the students switch partners and change roles so everyone has the opportunity to role-play the "physician".
4. Debrief the experience with the entire group--good points, bad points, what worked well, what was less effective, what did they learn that they would apply in their work, etc.
5. You may choose to demonstrate your technique at this type of discussion using the case and choosing one student to play the role of the patient.

**CASE BLUEPRINT**

**Purpose of Case:** Discussing DNR orders

**Training Level:** Medical students, post-graduate trainee, or faculty

**Simulated patient name:** Mr./Mrs. Williams (same patient as in Treatment Goal Role Play)

**Diagnosis:** Metastatic Pancreas Cancer

**Setting:** Hospital room

**Reason for Visit:** Discuss goals and DNR orders

**Time allotted:** 7 minutes

## INFORMATION FOR PHYSICIAN

**MEDICAL HISTORY:** Mr./Mrs. Williams is 50 y/o, diagnosed with pancreatic carcinoma 5 months ago after presenting with a locally advanced, unresectable, pancreatic mass and painless jaundice. He/she underwent surgery to relieve the biliary obstruction and then received radiation and two months of chemotherapy. The chemotherapy was very hard on him/her, causing severe nausea and fatigue. He/she called you one week ago saying that over the past 3 weeks there was a decline in energy, generalized fatigue and little appetite. He/she has no pain or nausea. You ordered an abdominal CT scan which showed new liver metastases. You met the patient last week to review treatment options; the patient elected not pursue any further chemotherapy, that his/her goal was to remain at home and be as comfortable as possible. However, yesterday he/she called and said the pain was much worse and he/she was vomiting and unable to keep food down. The patient was admitted yesterday for pain and nausea management. Overnight he/she did much better and today is taking clear liquids with much less pain.

### PAST HISTORY

Mild hypertension controlled with medication; one episode of renal colic 3 years ago.

### SOCIAL HISTORY

Patient is married with two daughters, ages 28 and 24, both live in the area. The patient is an elementary school special education teacher, on extended leave since the cancer surgery. The patient has never smoked and uses alcohol rarely.

### TASK

Enter the "hospital" room and begin a discussion with Mr./Mrs. Williams, you have the following two goals for this visit:

1. Re-affirm the patient's goals for future care
2. Discuss CPR/DNR orders

**Note:** Do not discuss the issue of hospice referral in this exercise.

## PATIENT PROFILE

### MEDICAL HISTORY

I am Mr./Mrs. Williams; I was diagnosed with pancreatic cancer 5 months ago after presenting with an unresectable pancreatic mass and jaundice. I underwent surgery to relieve the biliary obstruction and then received radiation and two months of chemotherapy. I became very ill from the chemotherapy and resolved never to do that again. Over the past 3 weeks I noticed a decline in energy, generalized fatigue and little appetite. I contacted my primary care physician who ordered an abdominal CAT scan.

Last week I came to his/her office and was told that the cancer was progressing, that further chemotherapy would be of little benefit. The doctor asked me about my goals for the time I had left. I indicated a desire to be kept comfortable and to be at home.

Two days ago, I began having increasing abdominal pain, nausea and vomiting; yesterday my doctor admitted me to the hospital for pain and nausea control. He/she started some new medication and I feel much better today, I am hoping to go home by tomorrow. I ate breakfast today; the pain is much better.

### SOCIAL HISTORY

**Family Relationships and Living Situation:** I am married and have two daughters, ages 28 and 24 who live in the area, they are both single.

**Occupation:** I am an elementary school special education teacher, on leave since the cancer was found. The work is very stressful but rewarding.

**Hobbies and Recreation:** I sing in a community choir and like to grow vegetables.

**Religion:** I was raised Lutheran, but am not involved with a church. I do believe in God and an afterlife.

### MOOD, AFFECT, AND DEMEANOR

I appear in my normal mood, fairly cheerful since I feel much better today. However, this recent pain and nausea was scary, I don't know what the future will bring.

### TASK AND RESPONSES TO PHYSICIAN

Your primary care doctor will be coming to visit you. He/she will ask you to re-affirm your goals for the time remaining, say "I want to be kept comfortable and I don't want to be a burden on my family". "I'd like to be at home if possible".

If the doctor asks you about CPR/DNR, be sure to ask him/her to explain any terms you don't think an average patient would understand. After you feel you understand the question, ask the doctor:

- If I get better in the coming days, can you change the order?
- Will you still be my doctor even if I decide I want to go on "life support?"

The doctor may make a recommendation about CPR; tell the doctor that you do not want to be resuscitated.

## DNR DISCUSSION LEARNER ASSESSMENT FORM

**Make an "X" if the resident did this without prompting; "✓✓" if the resident did this only after prompting, and leave blank if this was not done.**

- \_\_\_\_\_ Greets the patient member and introduces self
- \_\_\_\_\_ Explains the purpose of the meeting
- \_\_\_\_\_ Asks the patient member to describe their understanding of the illness
- \_\_\_\_\_ Describes the current medical condition succinctly without jargon
- \_\_\_\_\_ Allows the patient to digest the information, uses silence
- \_\_\_\_\_ Offers an opportunity for the patient member to ask questions
- \_\_\_\_\_ Responds to questions using plain language, no jargon
- \_\_\_\_\_ Discusses prognosis and treatment options
- \_\_\_\_\_ Asks patient to describe goals
- \_\_\_\_\_ Discusses CPR within the context of the disease, and prognosis and patient-defined goals
- \_\_\_\_\_ A clear recommendation regarding CPR/no-CPR is made
- \_\_\_\_\_ Summarizes discussion

**Communication Skills - Please check ONE box per question using the following rankings: 3=Excellent, 2=Good, 1=Marginally Satisfactory, or 0=Unsatisfactory (either poorly done or not done at all)**

	3	2	1	0
Assures comfort and privacy				
Assumes a comfortable inter-personal communication distance				
Maintains an open posture				
Reflects emotional meaning				
Displays empathy through words, expression or touch that was appropriate to situation				

**Please provide your overall assessment:**

- \_\_\_ Competent to perform independently
- \_\_\_ Needs close supervision
- \_\_\_ Need basic instruction

**Do you believe the physician able to discuss DNR with compassion in a manner so as to do no harm? YES OR NO**

**If you feel additional training is needed, please indicate what problems need to be addressed (circle all that apply):**

- basic communication skills (eye contact, rate of speech, excessive use of jargon, personal space)
- professional attitude (sullen, not empathic, angry, giggles) other:  
please describe:
- other: