

PALLIATIVE CARE FELLOWSHIP

FELLOW, FACULTY AND PROGRAM EVALUATION MATERIAL

PREPARED BY THE FROEDTERT/MEDICAL COLLEGE OF WISCONSIN, THE
CHILDREN'S HOSPITAL OF WISCONSIN AND ZABLOCKI VETERANS
ADMINISTRATION HOSPITAL PALLIATIVE CARE PROGRAMS, MILWAUKEE
WISCONSIN

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Material has been adapted from the following sources:

- American Board of Internal Medicine, portfolio for Internal Medicine Residency Program; www.abim.org
- Medical College of Wisconsin Internal Medicine Residency Program
- *Improving End-of-Life Care: A resource guide for physician education.* Weissman DE, Ambuel B and Hallenbeck, B. Medical College of Wisconsin, Milwaukee, Wisconsin, 3rd Edition 2000.
- Program Syllabus: *National Education End of Life Residency Education Project.*

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The following material is provided:

Global Evaluation Rating Form --- based on ACGME Core Competencies (faculty rates fellow for each rotation)

Communication Skills Global Rating Form --- overall assessment of communication skills (faculty rates fellow for each rotation)

360^o Core Competencies Rating Form --- overall assessment of fellow performance in each of the 6 core competencies, to be completed by all palliative care team members and other trainees working with the fellow; this can be done at whatever interval is deemed most appropriate, as there is no “standard”

Communication Skills Evaluation Exercises --- Role playing exercises and evaluation strategies for each of the major palliative care communication skills

Chart Audits --- three chart audit projects to assess fellow clinical practice behavior

Fellow Assessment by Patient/Family --- Survey form to gather information on fellow skills from patients or family members

Faculty Evaluation by Fellow --- Survey for fellow to complete following each rotation evaluating the faculty member (attending)

Fellows Annual Evaluation of Training Program --- Annual survey for fellow to complete evaluating all aspects of training program

Grid of Evaluation Measures versus Curriculum topics

PALLIATIVE CARE FELLOW: GLOBAL EVALUATION FORM

Fellow's Name:

Rotation Name:

Attending's Name:

Rotation Period:

Evaluation Date:

In evaluating the fellow's performance, use as your standard the level of knowledge, skills and attitudes expected from the clearly satisfactory fellow at this state of training. **For any component that needs attention or is rated a 4 or less, please provide specific comments and recommendations on the back of the form.** Be as specific as possible, including reports of critical incidents and/or outstanding performance. Global adjective or remarks, such as "good resident", do not provide meaningful feedback to the resident.

	Unsatisfactory	3	4	5	6	7	8	9	Superior
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1. Patient Care

Incomplete, inaccurate medical interviews, physical examinations, and review of other data; incompetent performance of essential procedures; fails to analyze clinical data and consider patient preferences when making medical decision.

1 2 3 4 5 6 7 8 9

Superb, accurate, comprehensive medical interview, physical examination, review of other data, and skill; always makes diagnostic and therapeutic decisions based on available evidence, sound judgment and preferences

Insufficient contact to judge

2. Medical Knowledge

Limited knowledge of basic and clinical sciences; minimal interest in learning; does not understand complex relations, mechanisms of disease.

1 2 3 4 5 6 7 8 9

Exceptional knowledge of basic and clinical sciences; highly resourceful development of knowledge; comprehensive understanding of complex relationships, mechanisms of disease.

Insufficient contact to judge

3. Practice-Based Learning Improvement

Fails to perform self-evaluation; lacks insight initiative; resists or ignores feedback; fails to use information technology to enhance patient care or self-improvement

1 2 3 4 5 6 7 8 9

Constantly evaluates own performance, incorporates feedback into improvement activities; effectively uses technology to manage information for patient care and self-improvement

Insufficient contact to judge

4. Interpersonal and Communication Skills

Does not establish even minimally effective therapeutic Relationships with patients and families;

1 2 3 4 5 6 7 8 9

Establishes a highly effective therapeutic relationship with patients and families: demonstrates excellent

Insufficient contact to judge

	Unsatisfactory		Satisfactory		Superior				
	1	2	3	4	5	6	7	8	9
5. Professionalism Lacks respect, compassion, integrity, honesty commitment disregards need for self-assessment, fails to acknowledge errors; does not consider needs of patients, families, colleagues; does not display									
<input type="checkbox"/> Insufficient contact to judge									
6. System-Based Learning Unable to access/mobilize outside resources; actively resist efforts to improve sys terms of care; does not use systematic approaches to reduce error and improve patient care									
<input type="checkbox"/> Insufficient contact to judge									

Resident's Overall Clinical Competence 1 2 3 4 5 6 7 8 9

Attending's Comments

Signatures: _____

Resident's _____ Attending's _____

PALLIATIVE CARE FELLOW: COMMUNICATION SKILLS GLOBAL EVALUATION FORM

Fellow name: _____

Rotation date: _____

Please evaluate the resident's ability to perform the following skills:	Needs basic instruction before further patient encounters			Perform only with faculty assistance			Competent to perform independently			Not Observed, No Opinion
				4	5	6	7	8	9	
1. Demonstrate basic communication skills (language choice, nonverbal behavior, interview structure, establishes setting).	1	2	3	4	5	6	7	8	9	0
2. Obtain informed consent.	1	2	3	4	5	6	7	8	9	0
3. Give bad news.	1	2	3	4	5	6	7	8	9	0
4. Run a family conference.	1	2	3	4	5	6	7	8	9	0
5. Discuss DNR orders with patient or family.	1	2	3	4	5	6	7	8	9	0
6. Counsel/educate patients RE: pain management, artificial nutrition/hydration or hospice care.	1	2	3	4	5	6	7	8	9	0
Please evaluate the resident's ability to perform the following skills:	Unsatisfactory			Satisfactory			Superior			Not observed, No Opinion
7. Demonstrate professionalism (appropriate and respectful) to:	1	2	3	4	5	6	7	8	9	0
Attendings										
Peers and residents	1	2	3	4	5	6	7	8	9	0
Students	1	2	3	4	5	6	7	8	9	0
Patients and Families	1	2	3	4	5	6	7	8	9	0
Nurses, social workers, chaplains.	1	2	3	4	5	6	7	8	9	0
8. Understand and respect the patient's perspective (awareness of cultural differences).	1	2	3	4	5	6	7	8	9	0
9. Demonstrate empathy through words and body lang.	1	2	3	4	5	6	7	8	9	0

*Grade this fellow's overall communication performance by making an "X" on the line below:

0 poor 25 fair 50 good 75 excellent 100

COMMENTS: _____

Fellow Signature _____ **Faculty Signature** _____ **Date** _____

This Evaluation was reviewed and discussed with the fellow.

PALLIATIVE CARE FELLOWSHIP
COMMUNICATION SKILL EVALUATION EXERCISES ^{1,2}

TABLE OF CONTENTS

Instructions	2
Pain assessment	3
Discussing bad news	7
Establishing end of life goals	11
Discussing DNR orders	16
The Hospice referral discussion	21
Pediatric advance care planning (1)	25
Pediatric advance care planning (2) (difficult)	30

¹ Material adapted from: Improving End-of-Life Care: A resource guide for physician education. Weissman DE, Ambuel B and Hallenbeck, B. Medical College of Wisconsin, Milwaukee, Wisconsin, 3rd Edition 2000.

² Final material prepared by David E. Weissman, MD and Bruce Himmelstein, MD; Palliative Care Fellowship Directors, Medical College of Wisconsin.

USING THE COMMUNICATION SKILL EXERCISES

Role playing exercises have been designed to a) practice critical end-of-life skills, b) reinforce knowledge and as c) serve as learner evaluation tools. The exercises are best done with 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”. When used as a method of learner evaluation, it best to provide the learner with immediate feedback on their performance.

The teacher can reduce the inevitable anxiety that accompanies experiential activities such a role-playing by encouraging participants to view the role-play as a time 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.

Each role-play exercise has three components:

- Information for the patient (Patient Profile)
- Information for the physician
- An evaluation form (checklist of observed skills)

Procedure

1. Decide ahead of time who will play the role of the patient/family member (simulated patient). This can include one of several options:
 - A faculty member
 - Another member of the palliative care team (e.g. nurse, chaplain)
 - A pain “simulated patient” (check with your medical school or other residency programs—they may have a list of people who serve as simulated patients for other communication skills education programs)
2. Brief the simulated patient and have them practice the role with you; answer any questions, ensure that the simulated patient is “acting” in a manner you desire for the exercise.
3. Brief the palliative care fellow on the purpose of the exercise (e.g. education and evaluation); provide the “Information for Physician” ahead of time for the fellow to review.
4. Begin the exercise with a third person (e.g. the program director or other faculty) keeping track of time and completing the checklist. Each exercise is designed to be completed in 7-10 minutes or less.
5. Debrief the exercise; ask the fellow and the simulated patient for their impressions: what went well, poorly, what could be improved. Complete the checklist and go over results with the fellow. If necessary, develop a plan with the fellow for additional training and practice. Keep the results of the exercise in the fellow’s evaluation file.

PAIN ASSESSMENT

PATIENT PROFILE

MEDICAL HISTORY

You are Mr. Smith, a 35 y/o admitted to the hospital because of severe back pain. You describe the pain as a constant dull aching pain over the mid to lower spine. You occasionally have shooting pain down your left leg. You hurt more if you stand. You have had the pain for 3-4 weeks but it became more severe in the last week. It is now a "10" on a 0-10 point scale. You have not been able to get out of bed the past two days except to go the bathroom. Your left leg feels a little weak, but you have not fallen.

You have been taking Percocet, 2 tabs, off and on when the pain "gets really bad" - about 4-5 times a day for the last 2 days. The Percocet takes your pain partially away (to a 7/10) for about an hour - it takes an hour for you to notice that it has started working at all. You hate taking pills so you are hoping that the physicians can do something to take the pain away. A heating pad has been helpful when the pain gets severe.

You had a localized melanoma removed from your thigh one year ago—you were told "we got it all". You have been working full time since then but have missed the last week of work because of the pain. The pain wakes you at night when you try to turn over in bed. You haven't had much appetite - you think that's because of the pain pills. You live with your spouse. This is a very scary experience for you. You are beginning to wonder if it is "all in your head", or if it could be related to the melanoma.

You are in the hospital to find out what's going on and to get help with your pain. You would like to have your pain controlled enough so that you can sleep and go back to work. Your pain relief goal is improved mobility.

SOCIAL/FAMILY HISTORY

You are married and have 2 children, age 4 and 8. You work as a real estate agent. Your parents are alive and well, you have no siblings; you do not smoke or drink alcohol.

SETTING

You are in a hospital room sitting in a chair next to your bed. You should appear mildly anxious and uncomfortable, rubbing your back and leg frequently.

TASK

Your partner, in the role of a physician, will perform a verbal pain assessment.

INFORMATION FOR PHYSICIAN

MEDICAL HISTORY

You are a physician caring for a 35 y/o, Mr/Mrs. Smith, admitted to the hospital with increasingly debilitating back pain of unclear etiology. You prescribed Percocet when he first called your office about the pain last week. Today he called saying his Left leg was weak--you arranged for a direct admission to the hospital.

The patient has a history of localized melanoma one year ago, no evidence of local-regional or distant metastases.

SETTING

You are seeing the patient in the inpatient hospital room. The patient will be seated in a chair.

TASK

Complete a verbal pain assessment.

EVALUATION FORM

PAIN ASSESSMENT

Check off the items completed during the pain assessment interview.

- Pain quality
- Pain location
- Pain temporal pattern/duration
- Exacerbating/relieving activities
- Analgesic history
- Other strategies that help
- Impact on sleep/rest
- Emotional state
- Support systems
- Pt. asked to name goal of pain relief ¹
- Pt. asked what they believe pain is from
- Summary-restatement of pain history by doctor, to confirm facts with patient

Overall Impression—was the physician able to perform an adequate verbal pain assessment?

YES or NO, needs more training

¹ Either numerical goal (0-10 scale) or functional goal (improved sleep).

GIVING BAD NEWS

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 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?

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.

LEARNER EVALUATION TOOL

DELIVERING BAD NEWS

Check all skills satisfactorily completed.

- Greeting--Greet the patient
- Introductions-- Makes appropriate introductions
- Comfort-- Assures comfort and privacy
- Assumes a comfortable inter-personal communication distance
- Eye contact-- Makes appropriate eye contact
- Open posture-- Maintains an open posture
- Uses language that is clear and understandable; no jargon
- Attends-- Allows patient to respond fully to questions.
- Attends-- Shows attention by nodding head and with verbal cues ("yes", "hmm", "I see").
- Reflects cognitive meaning—thoughts & ideas
- Reflects emotional meaning
- Paraphrases and summarizes patient's concerns
- Gives client/patient opportunities to ask questions
- Answers questions in a straightforward manner
- Asks client/patient to explain their understanding of the disease
- Gives advanced warning of bad news
- Uses meta-communication skills (e.g. establishes an agenda, solicits feedback from patient about agenda, establishes a game plan for future visits, etc.)
- Uses touch appropriately
- Summary and Plan (doctor discusses future plans and follow-up)

Overall Impression—was the physician able to present bad news with compassion in a manner so as to do no harm?

YES OR NO, Needs more training

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, personal space)
- professional attitude (sullen, not empathic, angry, giggles) other: please describe: _____

Other comments:

ESTABLISHING END OF LIFE GOALS

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".

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:

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

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

LEARNER EVALUATION TOOL

ESTABLISHING END OF LIFE GOALS

Check all skills satisfactorily completed.

Basic Interviewing Skills

- Introduction—doctor introduced him/herself
- Comfort—doctor put patient at comfort, ensured privacy
- Doctor assumed a comfortable interpersonal communication distance
- Doctor made appropriate eye contact
- Doctor's posture was open (was leaning forward, didn't cross arms over chest, etc)
- Used language that was clear and understandable; no medical jargon
- Doctor was attentive to comments--nodding head, used verbal cues ("yes", "hmm", "I see")
- Doctor gave me opportunity to ask questions
- Doctor answered questions in a straightforward manner
- Doctor suggested a follow-up plan
- Appeared empathic (indicated by body posture, tone of voice, facial expressions and choice of words, that they care about the patient and have some sense of understanding of the impact of the bad news)

Goal Setting Skills

- Patient was asked to explain understanding of the disease
- Doctor clearly articulated the current status of the cancer
- Doctor asked patient to articulate personal goals
- Summary

Overall Impression—was the physician able to present bad news with compassion in a manner so as to do no harm?

YES OR NO, Needs more training

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, personal space)
- professional attitude (sullen, not empathic, angry, giggles) other: please describe: _____

Other comments:

CRITERIA

Basic Skills

(see rating sheet)

Goal setting

Asked to explain understanding of disease--the physician should first ask the patient what they already know about their illness;

Articulated current status--the physician should present the new information clearly and succinctly; review the overall clinical picture and clearly state that recommendation of the oncologist that no further anti-cancer treatment is recommended.

Personal goals--the physician should reflect the new information back to patient and ask them to articulate their goals for the time they have left.

Summary --- The physician should then summarize the patient's goals as confirmation of mutual understanding and areas of agreement.

THE DNR DISCUSSION

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.

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 to 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.

LEARNER EVALUATION TOOL

THE DNR DISCUSSION

Check all skills satisfactorily completed.

Basic Interviewing Skills

- Introduction—doctor introduced him/herself
- Comfort—doctor put patient at comfort, ensured privacy
- Doctor assumed a comfortable interpersonal communication distance
- Doctor made appropriate eye contact
- Doctor's posture was open (was leaning forward, didn't cross arms over chest, etc)
- Used language that was clear and understandable; no medical jargon
- Doctor was attentive to comments--nodding head, used verbal cues ("yes", "hmm", "I see")
- Doctor gave me opportunity to ask questions
- Doctor answered questions in a straightforward manner
- Doctor suggested a follow-up plan
- Appeared empathic (indicated by body posture, tone of voice, facial expressions and choice of words, that they care about the patient and have some sense of understanding of the impact of the bad news)

Goal Setting / DNR Skills

- Doctor asked patient to articulate personal goals
- Doctor discussed the use of CPR within the context of the disease, and prognosis
- Doctor made a clear recommendation regarding CPR/no-CPR
- Summary

Overall Impression—was the physician able to present bad news with compassion in a manner so as to do no harm?

YES OR NO, Needs more training

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, personal space)
- professional attitude (sullen, not empathic, angry, giggles) other: please describe: _____

Other comments:

CRITERIA

Basic Skills

(see rating sheet)

Goal setting/DNR skills

Personal goals—the physician should reflect the new information back to patient and ask them to articulate their goals for the time they have left.

Discussed CPR / Recommendation—the physician should discuss the role of CPR in relation to terminal illness and make a recommendation to the patient, but allow an opportunity for the patient to reflect on their goals and ask questions or challenge the recommendation about CPR.

Summary --- The physician should summarize the discussion; confirm mutual understanding and areas of agreement.

THE HOSPICE REFERRAL DISCUSSION

PATIENT PROFILE

MEDICAL HISTORY

I am Mr./Mrs. Adams, a 68 y/o patient in the hospital for the past four days—admitted with end-stage pulmonary fibrosis. This is my fourth hospital admission in the past three months, all for dyspnea. With high-dose steroid treatment and respiratory treatments I get a little better, but only for a short time. My functional ability is bed to chair with assistance; with a twenty pound weight loss in the past four months. I have previously expressed a wish to my doctor for No Code status and no ICU admissions.

SOCIAL HISTORY

I live at home with my spouse of 41 years who is in good health; I live in a two-story home. I have two grown children, both married with children, who live in the metropolitan region. I am a non-observant Catholic, not connected with a church. I am a retired accountant, my spouse works part-time at a hardware store.

SETTING

I am in a chair, next to the hospital bed, my spouse is with me when the doctor comes in the room.

TASK

Your doctor will be coming to discuss a referral for home hospice care.

Some questions you may pose to the doctor:

- Does this mean you will no longer care for me?
- Does this mean I can not come back to the hospital?
- What happens if my breathing gets bad at night—do I just call 911?
- I'm not sure I want someone coming into my home.

As the physician talks to you about hospice care, think about these questions:

1. what emotional reactions are elicited by the term *hospice*?
2. what are your concerns / fears about home hospice care?

INFORMATION FOR PHYSICIAN

MEDICAL HISTORY

Mr./Mrs. Adams is a 68 y/o patient on your inpatient service for the past four days—admitted with end-stage pulmonary fibrosis. You have cared for him/her for the past seven years. This is his fourth hospital admission in the past three months, all for dyspnea. He/she has severe hypoxemia and mild hypercarbia. With high-dose steroid treatment and respiratory treatments there is some short-term improvement in the dyspnea. His/her functional ability has declined over the past six months dramatically—currently it is bed to chair with assistance; there has been a twenty pound weight loss in the past four months. The patient has previously expressed a wish for No Code status and no ICU admissions.

SOCIAL HISTORY

The patient lives at home with his spouse of 41 years who is in good health. When you last spoke with the spouse he/she was very anxious, asking about newer experimental treatments. They live in a two-story home. They have two grown children, both married with children, who live in the metropolitan region. They are non-observant Catholics, not connected with a church. The patient is a retired accountant, the spouse works part-time in a hardware store.

SETTING

The patient will be sitting in a chair in the hospital room, the spouse is with him/her.

TASK

You will role-play the physician who enters the patient room to discuss home hospice care. Your task is to bring up the subject of hospice care, tell the patient/spouse that you think it is time to begin home hospice services and answer any questions they have.

EVALUATION FORM

THE HOSPICE REFERRAL DISCUSSION

Check all skills satisfactorily completed.

- Greeting--Greet the patient
- Comfort-- Assures comfort and privacy
- Assumes a comfortable inter-personal communication distance
- Eye contact-- Makes appropriate eye contact
- Open posture-- Maintains an open posture
- Uses language that is clear and understandable; no jargon
- Attends-- Allows patient to respond fully to questions.
- Attends-- Shows attention by nodding head and with verbal cues ("yes", "hmm", "I see").
- Reflects cognitive meaning—thoughts & ideas
- Reflects emotional meaning
- Paraphrases and summarizes patient's concerns
- Gives client/patient opportunities to ask questions
- Answers questions in a straightforward manner
- Asks client/patient to explain their understanding of the disease
- Uses meta-communication skills (e.g. establishes an agenda, solicits feedback from patient about agenda, establishes a game plan for future visits, etc.)
- Uses touch appropriately
- Discussed the role of hospice care within the context of the particular case and prognosis
- Indicated a clear recommendation about hospice care
- Recommended hospice care in a manner that respected patient autonomy
- Summary and future plans

Overall Impression—was the physician able to discuss hospice care in a compassionate manner so as to do no harm?

YES or NO, Needs more training

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, personal space)
- professional attitude (sullen, not empathic, angry, giggles) other: please describe: _____

Other comments:

ADVANCE CARE PLANNING PEDIATRICS (1)

ADVANCE CARE PLANNING PEDIATRICS (1)

ROLE PLAY EXERCISE I

TEACHING GUIDE

1. Review teaching materials
2. Briefly explain the process of the role play. Ask students to group in 2's and distribute the role playing exercise. Another option would be to have a faculty facilitator play patient role and allow a student to play the physician role.
3. Students should spend 10 minutes role playing
4. Students should each complete an evaluation form and discuss their impressions with each other.
5. Students should have an opportunity to debrief as a group with the faculty. Questions to guide discussion may include:
 - "what are some of the barriers to determining who the decision makers are?"
 - "what factors contribute to understanding of illness and goals of care?"
 - "What happens when you ask about concurrent care concerns before addressing other steps?"
 - "what worked?"
 - "what did not work?"It may be helpful to note important concepts on a blackboard, overhead or flip chart.
6. You may chose to repeat the role play using yourself as the physician as a way of demonstrating new techniques.
7. Thank your learners

CASE BLUEPRINT

Purpose of case: Discussing advance care planning
Training level: Medical student, post-graduate trainee or faculty
Simulated patient name: John Peters
Diagnosis: Relapsed acute myelogenous leukemia after second bone marrow transplant
Setting: Hospital Room
Setup: 2 chairs, in front of a group of observers if desired
Reason for visit: Find out what John wants to do in the future, "next steps"
Time allotted:

Setup	5 minutes
Role Play	10 minutes
Debrief	35 minutes
Total	50 minutes

Materials needed: Role Play parts
Blackboard, flip chart or overhead

PATIENT PROFILE, JOHN PETERS

MEDICAL HISTORY

I am John Peters. I am 14 years old and I have relapsed acute myelogenous leukemia. I've had 2 bone marrow transplants. After the first one from my older brother Jim, I did well for 18 months. I had few complications and got back to school quickly. After the second one 3 months ago from an unrelated donor, I had severe acute and now moderate chronic graft-versus-host disease. I need to take a lot of medicines and I have a lot of pain in my joints and bones. My skin itches a lot, and I have diarrhea. I feel lousy all of the time. My doctor told me that my leukemia is back and that without treatment I have only a few weeks to live. I know and accept that I am going to die.

SOCIAL HISTORY

I live with my parents, but they have let me make decisions on my own throughout the treatment. I have a girlfriend for the past year – we are very close to each other and hope to get married some day. I enjoy school, hanging out with my friends, going to the movies, and staying up late every night. I want to live because I am having so much fun despite feeling bad. I pray a lot, and I pray to get better, but God has told me that it's my time to "go home."

MOOD, AFFECT, DEMEANOR

I speak in a very quiet, reserved voice. I make poor eye contact, preferring to look at my feet. I am sad but not angry.

TASKS AND RESPONSES TO PHYSICIAN

Your physician will be visiting you. He/she will want to talk about next steps with you. You will ask him:

- "how long do I have?"
- "what will it be like?"
- "can I be at home?"
- "what's it like on the other side?"

You tell the doctor you don't want to be put on machines to be kept alive. You have heard about hospice and think it would help. You want to go home as quickly as possible. You need help because you are so sad. You do not want the experimental therapy the doctor is offering you.

INFORMATION FOR PHYSICIAN

Medical history

John Peters is a 14 years old with relapsed acute myelogenous leukemia following 2 bone marrow transplants. After the second unrelated donor transplant John did poorly with both severe acute and now moderate chronic graft-versus-host disease. He has bone and joint pain and feels poorly all of the time. You have told John that without treatment he has only a few weeks to live.

Past history

Bone marrow transplant one was from older brother Jim; John sailed thru and remained in remission 18 months. History of second transplant as above.

Social history

Parents have let John make his own decisions. He has been in school until recently.

Task

Enter the hospital room and begin conversation with John. You will have 10 minutes to work with John to figure out what to do next. You will offer an experimental chemotherapy agent that may keep the leukemia under control for a few extra weeks.

LEARNER EVALUATION TOOL

ADVANCE CARE PLANNING ROLE PLAY I

Checklist of role play skills: Use a 1-3 scale (1=not at all, 2= somewhat, 3=excellent)

Basic skills

- Doctor introduced him/herself
- Doctor sat down and used a comfortable distance from patient
- Good eye contact
- Accepting posture (leaning forward, feet on ground, arms uncrossed)
- Used clear language
- Responded attentively with body language, reflective comments (e.g. "I see")
- Provided opportunity to ask questions
- Answered questions respectfully
- Made a follow-up plan
- Expressed empathy (body posture, tone of voice, choice of words and language)

Advance Care Planning

- Identified major decision makers (should reflect legal need to involve parents)
- Asked about understanding of illness
- Asked about goals of care
- Discussed concurrent care concerns (e.g. chemotherapy, going home)
- Attentive to psychological and spiritual issues raised such as faith in God, sadness

Overall Impression: Was the physician able to discuss advance care planning effectively and respectfully?

YES NO

Comments/areas for improvement:

ADVANCE CARE PLANNING PEDIATRICS (2)

ADVANCE CARE PLANNING PEDIATRICS (2)

ROLE PLAY EXERCISE II (DIFFICULT)

TEACHING GUIDE

1. Review teaching materials
2. Briefly explain the process of the role play. Ask students to group in 3's and distribute the role playing exercise. Another option would be to have two faculty co-facilitators play patient roles and allow a student to play the physician role.
3. Students should spend 10 minutes role playing
4. Students should each complete an evaluation form and discuss their impressions with each other.
5. Students should have an opportunity to debrief as a group with the faculty. Questions to guide discussion may include:
 - "what are some of the barriers to determining who the decision makers are?"
 - "what factors contribute to understanding of illness and goals of care?"
 - "What happens when you ask about concurrent care concerns before addressing other steps?"
 - "what worked?"
 - "what did not work?"It may be helpful to note important concepts on a blackboard, overhead or flip chart.
6. You may chose to repeat the role play using yourself as the physician as a way of demonstrating new techniques.
7. Thank your learners

CASE BLUEPRINT

Purpose of case: Discussing advance care planning
Training level: Medical student, post-graduate trainee or faculty
Simulated patient name: Mr. and Mrs. Jones
Diagnosis: GTP cyclohydrolase deficiency
Setting: Hospital Room
Setup: 3 chairs, 2 chairs paired together, 1 opposite paired chairs, in front of a group of observers if desired
Reason for visit: Request by attending to "get the DNR"
Time allotted:

Setup	5 minutes
Role Play	10 minutes
Debrief	35 minutes
Total	50 minutes

Materials needed: Role Play parts
Blackboard, flip chart or overhead

PROJECT #3

Continuity—Palliative Care Approach

- 1. Select 5-10 inpatient or outpatient charts, criteria for chart selection:**
 - Patient with a prognosis of less than 6 months (any diagnosis).
 - Patient has ≥ 2 clinic visits or inpatient visits with fellow

- 2. Review fellows clinic/progress notes for documentation that the following domains are discussed and documented (note: not all domains need to be documented at each patient encounter):**
 - Pain and symptom management
 - Psychosocial assessment
 - Family dynamics and coping
 - Spiritual assessment
 - Advance Care Planning

- 3. Discuss deficiencies with fellow.**

- 4. Ask fellow to use data to develop an Action Plan for personal improvement.**

PATIENT PROFILE, MRS. JEANNIE JONES

MEDICAL HISTORY

I am Mrs. Jeannie Jones, mother of 2 year old Jane thought to have cerebral palsy and seizures, recently diagnosed with GTP cyclohydrolase deficiency, a progressive, rare and fatal metabolic defect. Jane has a gastrostomy tube, a tracheotomy due to airway obstruction, frequent seizures, and has lost most developmental milestones. During the current hospital stay Jane has demonstrated central hypoventilation. The pulmonary consultant has recommended nighttime mechanical ventilation.

SOCIAL HISTORY

I stay at home and care for Jane. I feel that it is Jane's time to go. She has suffered so much, I can't bear to see her on the ventilator. I want to take her home. I have experience with two grandparents who died peacefully at home with hospice, I want the same for Jane. I have no religious or faith concerns about a child dying, although I am very sad. I think my husband does not spend enough time in the hospital when Jane is sick to know how much she is suffering. He drinks too much.

MOOD, AFFECT, Demeanor

During the interview I sit quietly, cry occasionally, yet respond with venom to my husband's beliefs that Jane will get better. As for the doctor, I will take any opportunity to distract the "doctor" from his task at hand by focusing on my conflict with my husband.

TASKS AND RESPONSES TO PHYSICIAN

Your resident physician will be visiting you. He/she will want to talk about a DNR order. Given the opportunity you will concur with the doctor that you want a DNR order for Jane because she has "suffered too much."

INFORMATION FOR PHYSICIAN

Medical history

Mr. and Mrs. Jones are the parents of Jane, a 2 year old thought to have cerebral palsy and seizures, recently diagnosed with GTP cyclohydrolase deficiency, a progressive, rare and fatal metabolic defect. Jane has a gastrostomy tube, a tracheotomy due to airway obstruction, frequent seizures, and has lost most developmental milestones. During the current hospital stay for “breathing trouble” Jane has demonstrated central hypoventilation. The pulmonary consultant has recommended nighttime mechanical ventilation. The team under the direction of your attending feels that ventilation will only prolong suffering as Jane has a fatal illness, and that we should “let her go.”

Past history

Frequent hospitalizations for pneumonia and respiratory failure. Trach placed 6 months ago.

Social history

Parents have been married for one year. Jane is an only child.

Task

Enter the hospital room and begin conversation with Mr. and Mrs. Jones. Your goal is to “get a DNR” at the request of your attending physician. You will have 10 minutes to work towards “getting the DNR” from the family.

LEARNER EVALUATION TOOL

ADVANCE CARE PLANNING ROLE PLAY II

Checklist of role play skills: Use a 1-3 scale (1=not at all, 2= somewhat, 3=excellent)

Basic skills

- Doctor introduced him/herself
- Doctor sat down and used a comfortable distance from family
- Good eye contact
- Accepting posture (leaning forward, feet on ground, arms uncrossed)
- Used clear language
- Responded attentively with body language, reflective comments (e.g. "I see")
- Provided opportunity to ask questions
- Answered questions respectfully
- Made a follow-up plan
- Expressed empathy (body posture, tone of voice, choice of words and language)

Advance Care Planning

- Identified major decision makers
- Asked about understanding of illness
- Asked about goals of care
- Recognized family conflict as barrier to DNR discussion, did not pursue
- Recommended additional supports prior to decision making (e.g. social work, psychology, chaplain services) to help with family conflict

Overall Impression: Was the physician able to discuss advance care planning effectively and respectfully?

YES NO

Comments/areas for improvement:

PALLIATIVE CARE FELLOWSHIP FELLOW EVALUATION TOOLKIT

CHART AUDIT PROJECTS

The following projects have been designed to provide quantitative data for the following purposes:

- Assist in improving fellow end of life care practices
- Provide data to fulfill ACGME Core Competencies in *Patient Care, Practice-Based Learning and Communication/Interpersonal skills*.

1. **Pain assessment documentation**
2. **Pain Management – Drug therapy**
3. **Continuity – Palliative Care Approach**

PROJECT #1

PAIN ASSESSMENT DOCUMENTATION

Purpose: Review pain assessment and documentation practices

Protocol:

1. Select 5-10 inpatient or outpatient charts; criteria for patient-chart selection:

- Pain was a major problem at the time of admission/consultation;
- Any primary pain diagnosis is appropriate: acute, chronic non-malignant or malignant
- Patient was cognitively intact—can give reliable pain history;

2. Review Fellow notes for following items on the initial admission/consult or outpatient clinic note:

	YES	NO
Pain location	___	___
Pain duration	___	___
Pain intensity (using a quantitative scale)	___	___
Pain quality (descriptors: e.g. sharp, dull)	___	___
Patient's goal for pain relief is defined (numeric or functional)	___	___
Effect of pain on ADL's (sleep, movement, mood)	___	___
Analgesic history (current and past meds, effect and toxicity)	___	___
Pain is listed in <i>Problem List</i> as distinct entity	___	___
A plan for pain management is outlined	___	___

Scoring: 1 point for each item marked YES:

- 8-9 Excellent
- 6-7 Good
- 4-5 Fair
- 1-3 Poor

3. Review results with the fellow; discuss areas of strength and weakness and provide resources for additional education.

4. Ask fellow to use data to develop an Action Plan for personal improvement.

PROJECT #2

PAIN MANAGEMENT – DRUG THERAPY

Purpose: review prescribing patterns of analgesic medication

Protocol:

- 1. Select 5-10 inpatient or outpatient charts, criteria for chart selection:**
 - Pain was a major problem at the time of admission/consultation or clinic visit;
 - Any primary pain diagnosis is appropriate, acute, chronic non-malignant or malignant
- 2. Write down all analgesic orders from the order sheets for the first 72 hours after admission/consultation or past three clinic visits. The following guidelines should be used as standards, against which the orders should be judged as being “appropriate” or “inappropriate”:**

Inappropriate orders:

- More than one combination analgesic (Tyl. #3 and Percocet), is ordered at the same time;
- Only “prn” medications are ordered for a continuous pain syndrome;
- The duration of administration is greater than 4 hours for the following drugs:
 - any codeine, oxycodone or hydrocodone combination product;
- Any intramuscular opioid injections;
- More than one long-acting opioid (MS Contin and Fentanyl patch) is ordered at the same time;
- MS Contin, OxyContin or Oramorph SR are ordered more frequently than q8h;
- A long-acting opioid is ordered without a short-acting opioid for breakthrough pain;
- Meperidine ordered for any pain, except for an acute procedure (e.g. bone marrow bx);

Scoring: 1 point for each inappropriate item; for each chart, a score of 1 or greater is considered poor prescribing practice.

- 3. Review results with the resident; discuss areas of strength and weakness and provide resources for additional education.**
- 4. Ask fellow to use data to develop an Action Plan for personal improvement.**

PROJECT #3

Continuity—Palliative Care Approach

- 1. Select 5-10 inpatient or outpatient charts, criteria for chart selection:**
 - Patient with a prognosis of less than 6 months (any diagnosis).
 - Patient has ≥ 2 clinic visits or inpatient visits with fellow

- 2. Review fellows clinic/progress notes for documentation that the following domains are discussed and documented (note: not all domains need to be documented at each patient encounter):**
 - Pain and symptom management
 - Psychosocial assessment
 - Family dynamics and coping
 - Spiritual assessment
 - Advance Care Planning

- 3. Discuss deficiencies with fellow.**

- 4. Ask fellow to use data to develop an Action Plan for personal improvement.**

FELLOW ASSESSMENT BY PATIENT OR FAMILY

As part of the training program for new doctors, you have been selected to answer the following questions to provide information that will be used to help physicians improve their practice. This is a voluntary activity and you may decline to participate. Your answers will be confidential. If you have any questions about this survey, please contact _____.

How is your doctor (Dr. _____) at:	RATING SCALE			
	Poor	Fair	Good	Excellent
Treating you like you are on the same level; being friendly and courteous; does not talk down to you	1	2	3	4
Listening to you, letting you tell your story about your illness	1	2	3	4
Explaining what you need to know about your problems; how and why they occur and what to expect	1	2	3	4
Controlling your pain	1	2	3	4
Controlling other symptoms you have	1	2	3	4
Encouraging you to ask questions and to voice your opinions and concerns.	1	2	3	4
Discussing options and asking your opinion.	1	2	3	4
Using words that you understand; explaining technical information in plain language.	1	2	3	4
Would you recommend this doctor to other patients?	YES	or	NO	

Please write any other comments you have (use back if needed):

11. Please check one of the following:

_____ I am a patient of this doctor or

_____ I am a family member of a patient cared for by this doctor

THANK YOU

FELLOW ASSESSMENT BY PARENT (PEDIATRICS)

As part of the training program for new doctors, you have been selected to answer the following questions to provide information that will be used to help physicians improve their practice. This is a voluntary activity and you may decline to participate. Your answers will be confidential. If you have any questions about this survey, please contact _____.

How is your doctor (Dr. _____) at:	RATING SCALE			
	Poor	Fair	Good	Excellent
Treating you like you/your child are on the same level; being friendly and courteous; does not talk down to you	1	2	3	4
Listening to you/your child, letting you tell your story about your illness	1	2	3	4
Explaining what you/your child need to know about your problems; how and why they occur and what to expect	1	2	3	4
Controlling your/your child's pain	1	2	3	4
Controlling other symptoms you/your child has	1	2	3	4
Encouraging you/your child to ask questions and to voice your opinions and concerns.	1	2	3	4
Discussing options and asking you/your child's opinion.	1	2	3	4
Using words that you/your child understand; explaining technical information in plain language.	1	2	3	4
Would you recommend this doctor to other patients?	YES	or	NO	
Please write any other comments you have (use back if needed):				

11. Please check one of the following:

_____ I am a patient of this doctor or

_____ I am a family member of a patient cared for by this doctor

THANK YOU

EVALUATION OF ATTENDING PHYSICIAN

Attending Physician: _____ Service/Rotation _____

Month/Year: _____

For each of the following criteria, please rate (√) the attending physician whose rotation you have just completed.

<u>Availability:</u>	Not Observed	Marginal	Satisfactory	Very Good	Excellent
• Was usually prompt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Adhered to rounds and consult schedules	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Kept interruptions to a minimum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Spent enough time on rounds; was unhurried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

<u>Teaching:</u>	Not Observed	Marginal	Satisfactory	Very Good	Excellent
• Kept discussions focused on case or topic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Asked questions in non-threatening way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Used bedside teaching to demonstrate history-taking and physical skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Emphasized problem-solving, (thought processes leading to decisions)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Integrated social/ethical aspects of medicine (cost containment, pain control, patient management, humanism)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Stimulated team members to read, research, and review pertinent topics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Accommodated teaching to actively incorporate all members of team	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Provided special help as needed to team members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

<u>Professionalism and Humanistic</u>	Not Observed	Marginal	Satisfactory	Very Good	Excellent
<u>Patient Care:</u>					
• Placed the patient's interests first	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Displayed sensitive, caring, respectful attitude toward patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Established rapport with team members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Showed respect for physicians in other specialties/subspecialties and health care professionals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Served as a role model	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Was enthusiastic and stimulating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Demonstrated gender sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Recognized own limitations; was appropriately self-critical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

Fund of Knowledge/Continuing **Not Observed** **Marginal** **Satisfactory** **Very Good** **Excellent**

Scholarship:

- | | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| • Demonstrated broad knowledge of medicine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Was up-to-date | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Identified important elements in case analysis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Used relevant medical/scientific literature in supporting clinical advice | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Discussed pertinent aspects of population and evidence-based medicine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments: _____

Organization: **Not Observed** **Marginal** **Satisfactory** **Very Good** **Excellent**

- | | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| • Reviewed expectations at beginning of rotation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Provided useful feedback including constructive criticism | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Balanced service responsibilities and teaching functions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments: _____

Recommendations:

- | | | |
|--|--------------------------|--------------------------|
| | <u>Yes</u> | <u>No</u> |
| • Would you recommend that this faculty member continue to serve as an attending physician for the training program? | <input type="checkbox"/> | <input type="checkbox"/> |
| • To further enhance professional development, would you recommend that this faculty member receive formal training in teaching and faculty education? | <input type="checkbox"/> | <input type="checkbox"/> |

Overall Comments: _____

FELLOWS ANNUAL EVALUATION OF PALLIATIVE MEDICINE TRAINING PROGRAM 1

Please evaluate your training program, based on your experiences during this past year.
Your feedback is very important to the continuous quality improvement of the fellowship program

Rating Scale: N/A	Poor	Fair	Good Not applicable	Very Good (1) (2)	Very Good (3)	Excellent (4) (5)
I. TRAINING ENVIRONMENT:						
1. Diversity of patients seen	N/A	1	2	3	4	5
2. Learning value of consultation	N/A	1	2	3	4	5
3. Adequacy of attending supervision	N/A	1	2	3	4	5
4. Quality of attending supervision	N/A	1	2	3	4	5
5. Quality and timeliness of feedback from attending	N/A	1	2	3	4	5
6. Opportunity to preform required skills	N/A	1	2	3	4	5
7. Opportunity to perform research	N/A	1	2	3	4	5
8. Quality of research	N/A	1	2	3	4	5
9. Interdisciplinary support	N/A	1	2	3	4	5
a. nursing	N/A	1	2	3	4	5
b. social work	N/A	1	2	3	4	5
c. dietary	N/A	1	2	3	4	5
d. pharmacy	N/A	1	2	3	4	5
e. chaplaincy	N/A	1	2	3	4	5
10. Ancillary Services	N/A	1	2	3	4	5
a. laboratory data retrieval	N/A	1	2	3	4	5
b. radiology data film retrieval	N/A	1	2	3	4	5
c. procedure report retrieval	N/A	1	2	3	4	5
d. intravenous and phlebotomy services	N/A	1	2	3	4	5
e. messenger/transport services	N/A	1	2	3	4	5
f. secretarial/clerical services	N/A	1	2	3	4	5
11. Appropriateness of workload	N/A	1	2	3	4	5
12. Overall quality of rotations	N/A	1	2	3	4	5
Rating Scale: N/A						
14. Program Director provide comprehensive evaluation of resident's competence in:						
a. patient care	N/A	1	2	3	4	5
b. medical knowledge	N/A	1	2	3	4	5
c. practiced-based learning	N/A	1	2	3	4	5
d. interpersonal & communication skill	N/A	1	2	3	4	5
e. professionalism	N/A	1	2	3	4	5
f. system-based practice	N/A	1	2	3	4	5
15. Identify the core strengths and weaknesses of the program:						
Core strengths:						
Areas needing improvement:						
II. CORE EDUCATIONAL DOMAINS:						
1. Pain management	N/A	1	2	3	4	5
2. Non-pain symptom management	N/A	1	2	3	4	5
3. Communication skills	N/A	1	2	3	4	5
4. Psychosocial and spiritual care	N/A	1	2	3	4	5
5. Death/Dying/Bereavement	N/A	1	2	3	4	5
6. Self care	N/A	1	2	3	4	5
7. Quality improvement	N/A	1	2	3	4	5
8. Ethics	N/A	1	2	3	4	5
9. Education skills	N/A	1	2	3	4	5
10. Research skills	N/A	1	2	3	4	5
III. TEACHING FACULTY						
1. Availability	N/A	1	2	3	4	5
2. Commitment to teaching	N/A	1	2	3	4	5
3. Quality	N/A	1	2	3	4	5
4. Promote scientific/discovery literacy	N/A	1	2	3	4	5

FELLOWS ANNUAL EVALUATION OF PALLIATIVE MEDICINE TRAINING PROGRAM

Rating Scale:	N/A	Poor	Fair	Good Not applicable	Very Good (1) 2)	Good (3)	Very Good (4)	Excellent (5)
IV. TEACHING CONFERENCES:								
1. Weekly core education series	N/A	1	2	3	4	5		
2. Palliative Care seminar series	N/A	1	2	3	4	5		
3. Journal club	N/A	1	2	3	4	5		
4. Research meeting	N/A	1	2	3	4	5		
5. Attending round teaching	N/A	1	2	3	4	5		
6. Other:								
General Comments								
1. My colleagues behave in an appropriate manner.	N/A	1	2	3	4	5		
2. My colleagues are reliable.	N/A	1	2	3	4	5		
3. My attending physicians behave in an appropriate manner.	N/A	1	2	3	4	5		
4. My attending physicians are reliable.	N/A	1	2	3	4	5		
5. The training program promotes self-assessment	N/A	1	2	3	4	5		
6. The training program promotes life-long learning	N/A	1	2	3	4	5		
7. The training program recognizes excellence in continuous quality improvement	N/A	1	2	3	4	5		

Comments: _____

PALLIATIVE CARE FELLOWSHIP: ASSESSMENT METHODS

Sample Grid

	360 Eval	Skills Assmnt	Global Rating	Portfolio	Test	Chart Audit	Patient Log	Pt-Fam Survey
Pain assessment	x	x				x		x
Pain: Drug Rx	x	x			x	x		
Pain: Non-Drug	x				x			
Other Symptoms	x				x	x		
Communication skills	x	x	x				x	x
Adv care Planning	x		x		x		x	
NeuroPsych Mor	x				x			
PsySoc/Spir Supp	x		x					x
Bereavement	x							
Death/Dying					x			
Self Care		x						
QI				x				
Ethi/Law	x				x			
Med Co-Morbidities					x			
Hosp/ Pall Approach	x		x					
Professionalism			x			x		x
Teaching		x		x				
Research				x				
Inf Team Work	x		x					x
FREQUENCY OF ASSESSMENT								
1. 360 Degree Eval: Completed by all team members for each new learning experience/rotation								
2. Skills Assessment: once or twice								
3. Global Rating Scale: completed by attending MD w/IDT for each learning experience/rotation								
4. Portfolio and Patient Log: Ongoing, kept by fellow								
5. Test--Multiple Choice Exam (e.g. UNIPACS, EPERC) every 6 months								
6. Chart Audit: once, at 6 months of first year								
7. Patient-Family Assessment: Three times per year								