

**STANDARDIZED PATIENT CASE FOR ROLE PLAYING
EXERCISE/OSCE STATION**

**PURPOSE: ASSESSMENT OF COMMUNICATION SKILL
“DISCUSSING TREATMENT GOALS AND PROGNOSIS”**

**DEVELOPED BY THE RESIDENT COMMUNICATION COMMITTEE,
DEPARTMENT OF INTERNAL MEDICINE,
MEDICAL COLLEGE OF WISCONSIN**

AUTHORS:

Ruric Anderson, MD¹
Laura Cantwell, MD¹
Charlotte Heidenreich, MD¹
Michele Masluk, PhD²
Ralph Shapira, MD³
Ben Tobin, MD¹
Basil Varkey, MD³
Rebecca Wang-Cheng, MD¹
David E. Weissman, MD¹

- 1) Department of General Internal Medicine
- 2) Office of Educational Services
- 3) Division of Pulmonary/Critical Care Medicine
- 4) Division of Hematology/Oncology Palliative Care Program

Acknowledgement: Dr. James Tulsy provided assistance in case design structure.

PATIENT CASE BLUEPRINT

Introduction

This case is designed as learner assessment tool, at any physician educational level (medical student, post-graduate or faculty or continuing education), in the skill of Discussing Goals and Prognosis. This is a high-order communication skill, students should already have mastered basic communication skills (general verbal and non-verbal skills) and the skill of Giving Bad News. Use of this assessment tool can be done prior to and/or following a didactic training session where the skill of discussing prognosis and goal setting is reviewed and practiced. Training of the standardized patient and the observer/evaluator for this scenario is essential to ensure uniformity of the evaluation exercise.

Purpose of Case: Discussing Treatment Goals and Prognosis

Training Level: Appropriate for medical students, any post-graduate trainee, or faculty.

Standardized patient name: Mr./Mrs. Williams

Age range for standardized patient: 50-65.

Diagnosis: Metastatic Pancreas Cancer

Setting: Private doctors' office, primary care physician. There is a desk with a chair and a chair for the patient. On the desk is a notepad and a pen.

Reason for Visit: To go over test results; discuss goals.

Time allotted: 10 minutes.

References:

- Council Report – Decisions near the end of life. JAMA 1992;267:2229-2233.
- Fox, E. Predominance of the curative model of medical care. JAMA 1997; 278:761-763.
- Junkerman, C and Schiedermayer, D. Practical ethics for students, interns and residents. University Publishing Group, Maryland, 1994.
- Quill, TE and Brody, H. Physician recommendations and the patient autonomy: Finding a balance between physician power and patient choice. Annals of Internal Medicine 1996;15:763-769.

INFORMATION OF PHYSICIAN

MEDICAL HISTORY: Mr./Mrs. Williams is 54 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 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 CAT scan and asked him/her to come in today to go over the results.

The CAT scan shows considerable tumor progression with multiple new liver metastases. You discuss the cases 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 weeks to a few months.

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

1. Review CT scan results and the oncologist's recommendations
2. Ask the patient if they wish to discuss prognosis
3. Elicit the patient's goals for the future

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

PATIENT PROFILE

MEDICAL HISTORY: I am Mr./Mrs. Williams; I was diagnosed with pancreatic cancer 5 months ago after presenting with a locally advanced, unresectable, pancreatic mass and painless 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 have no pain or nausea. I contacted my primary care physician who ordered an abdominal CAT scan. I am coming to see the doctor today to get the CT scan results; I did not bring anyone with me to the doctors appointment.

SOCIAL HISTORY

Family Relationships and Living Situation: I am divorced and have two daughters, ages 22 and 24 who live in the area, they are both single.

Occupation: I am an elementary school principal. The work is very stressful but rewarding. I took a leave of absence two weeks ago.

Hobbies and Recreation: I sing in a community choir and play a summer volleyball league.

Religion: I was raised Lutheran, but I am not involved with a church. I do believe in God religious. I am not sure if I believe in God.

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

RESPONSES TO PHYSICIAN: If the doctor does not tell you the CAT scan results within the first few minutes, you become increasingly anxious. If 3 minutes go by without the doctor telling you the results, say, "Doctor, please 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 the doctor tells you that chemotherapy is no longer recommended, say, "Well, I'm glad about that—I hated feeling so sick, but, ...I guess this means I'm not going to get better".

At this point say, "So, what happens now? How much time do I have?" If told you have a short time, only weeks to months, say, "that's about what I thought". If the doctor says there is no way to know for sure, or something equally vague, try to push for more information.

If asked “what scares you most about this,” “what are you most afraid of,” or similar questions, explain your fear of the unknown, 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, I don’t want to be burden only family” I’d like to be at home if possible.

IMMEDIATE PLANS AFTER THE VISIT: You plan on calling your daughters, asking them to come over to the house so that you can discuss what you’ve been told today—you know it will be hard, but you need to have this talk.

LEARNER EVALUATION TOOL
(To be completed by the observer and/or simulated patient)

Name: _____

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

- _____ Sat down
- _____ Assumed a comfortable interpersonal distance
- _____ Was easily understood / Avoided the use of medical jargon
- _____ Asked what the patient already knew
- _____ Gave a “warning shot”
- _____ Listened attentively – followed patient needs
- _____ Physician clarifies patient understanding
- _____ Invited questions
- _____ Doctor clearly articulated the current status of the cancer
- _____ Doctor answered questions about prognosis truthfully
- _____ Doctor asked patient to articulate personal goals
- _____ Suggested a follow-up plan
- _____ Appeared empathic

Overall Impression: Do you feel comfortable that this trainee can discuss goals and prognosis in a sensitive 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):

- a) Verbal communication skills (use or jargon, tone, speed)
- b) Non-verbal communication skills (body language, posture)
- c) Professional attitude (sullen, not empathic, angry, giggles)
- d) Other: please describe _____

CRITERIA

Sat down – the physician should move the chair near patient and sit down.

Assumed a comfortable interpersonal distance – physician should sit at approximately arm's length from the patient.

Was easily understood/Avoided the use of medical jargon– the physician should use a tone of voice that is clearly understood with no or minimal use of technical terms.

Asked what the patient already knew – the physician should first ask the patient what they already know about their illness.

Gave a “warning shot” – the physician should preface giving the bad news by some warning statement, word or inflection/tone of voice—e.g. “I’m afraid I have some bad news” or “unfortunately, (pause) the test results...”).

Listened attentively – Provide information at the desired level – physician should pay attention to patient’s reaction, allow time for silence, not rush into treatment options when spouse indicates they are not ready for that information.

Physician clarifies patient understanding – the physician asks questions to ensure that the patient has heard/understood the bad news.

Invited questions – the physician should give the patient an opportunity to ask questions.

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

Prognosis – the physician should answer the patient’s question about prognosis in a straightforward and sensitive manner, (e.g., used a range: weeks to months; does not say: “No one can tell for sure, or Only G-d can tell how long someone has to live”)

Personal goals – the physician should ask the patient to articulate their goals for the time they have left.

Suggested a follow-up plan – physician should initiate discussion concerning a follow-up visit or future treatment plan discussion.

Appeared empathic – physician should be 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.