

Practicing End-of-Life Conversations: Physician Communication Training Program in Palliative Care

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A Physician Communication Training Program (PCTP) utilizing scripts based on actual family conferences with patients, families, and the health care team was developed at one medical center in the Northeast. The program was designed, adapted, and directed by a palliative care social worker. The primary goal of the program is to help residents and attending physicians build better communication skills in establishing goals of care and in end-of-life planning. The scripts focus on improving physicians' basic skills in conducting family meetings, discussing advance directives, prognosis, brain death, and withdrawal of life support. Excerpts from the scripts utilized in the program are included. Feedback from participants has been positive, with all respondents indicating improvement in their capacity to take part in these challenging conversations.

KEYWORDS *communication skills, end-of-life conversations, family meetings, improvisation, palliative care, role-play*

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REVIEW OF THE LITERATURE

The many challenges to delivering high quality palliative and end-of-life care have attracted increasing attention in the academic and popular literature in recent years. This attention occurs in the context of significant medical advances and public health care issues that populate the national discourse (Brody, 2010; Gawande, 2010; Larson & Tobin, 2000). The topics of health care rationing, personal autonomy, and the limitations of modern medicine are all part of this discussion. Opinions written by physicians and ethicists grappling with the challenges faced by providers, families, and the health care system and explorations of innovative practices and model programs have been common (Back, Arnold, & Tulskey, 2009; Brody, 2010; Gawande, 2010; Kurtz, 2009; McNeil, 2010; Seelye, 2009; Truog & Miller, 2008). A 2010 article in the *New England Journal of Medicine* demonstrates increased life spans for patients with metastatic lung cancer who received early palliative care compared with counterparts not receiving palliative care. This study supports the central premise that early and comprehensive palliative care alleviates suffering and symptom burden and enhances quality of life for this cohort of patients (Temel et al., 2010). Palliative care is an important component of high quality health care delivery but is often underutilized or started too late to be maximally useful for patients and families struggling with terminal illnesses and end-of-life issues.

One important obstacle to palliative care's integration into the health care system is the dearth of training opportunities for physicians and medical students to learn the tenets and technical skills of palliative care—including pain management, communication with families, and how best to discuss sensitive issues such as Do Not Resuscitate orders and religious values (Browning, Meyer, Truog, & Solomon, 2007; Ford, Downey, Engelberg, Back, & Curtis, 2012; Seelye, 2009). Physicians and medical students consistently report that palliative care knowledge and skills are important to good clinical care but that training opportunities are lacking or absent from their medical education (Gawande, 2010; Larson & Tobin, 2000; Smith, O'Sullivan, Lo, & Chen, 2012). Having acknowledged this gap in knowledge and training, medical schools and residency programs have begun augmenting curricula with education about palliative care (Smith et al., 2012; Khot, Billings, Owens, & Longstreth, 2011; Arnold et al., 2010).

Several small pilot programs have experimented with offering educational modules about palliative care to residents, including monthly “death rounds” to help residents process their experiences with dying patients and lectures about palliative care including pharmacological pain management and applying effective communication skills to difficult conversations (Arnold et al., 2010; Back et al., 2009; Dickson, Engelberg, Back, Ford, & Curtis 2012; Khot et al., 2011; Kurtz, 2009; Smith et al., 2012; Weissman,

Ambuel, & Hallenbeck, 2004). These physician education approaches include small group meetings, formal lectures, seminars, and role-playing. A central aim of these training opportunities is to improve the physician's comfort and skill in navigating topics that many of them report being uncomfortable discussing—such as code status, religious and cultural values around death and dying, and futility regarding further aggressive medical management (Arnold et al., 2010; Ford et al., 2012; Von Gunten, 2001). Other studies utilize relational learning, qualitative analysis of the knowledge and skill sets of residents and medical students, define educational needs, and call for future action (Wear, 2002; Browning, 2010; Solomon, Browning, Dokken, Merriman, & Rushton, 2010). Group work literature also addresses teaching through using social work group methodology (Kurland & Salmon, 1992; Getzel, Kurland, & Salmon, 1987), including improvisations and role-plays. Education of physicians in the delivery of bad news has also utilized simulation (Jacques et al., 2011) and 2-hour and day-long training sessions (Maguire, 2012).

The Physician Communication Training Program (PCTP) builds upon these existing programs by using an experiential approach that utilizes scripted role-plays of physician interactions with patients and families. The role-plays address key areas of communication in palliative care practice and are introduced in communication training sessions, held twice monthly for 30–45 minutes, led by the author.

THE EVOLUTION OF THE PHYSICIAN COMMUNICATION TRAINING PROGRAM

The PCTP grew out of the work of the Palliative Care Consulting Service and the Bioethics Committee at The Brooklyn Hospital Center. Utilizing group work methodology and theater skills, the palliative care social worker (PCSW), who also served on the Bioethics Committee, initially engaged other members of the committee and clinical staff—chaplain, ethicist, speech and swallow therapist, nurses, physicians—in informal learning sessions. Eventually theater skills including improvisation, reading, play-writing, directing, and acting were incorporated in these sessions. Although the PCSW in this program brought a theater background to the design of this program, the skills required to conduct such a program can be learned by any health care professional with an interest in education, role-play, and improvisation.

The program began with a professional actor, who was hired to interact with the resident physicians in role-plays focused on giving bad news and difficult ethical situations in end-of-life care. When funding for the actor ended, the PCSW engaged the residents in improvisational role-plays and over time documented these conversations, turning them into scripts. The residents found the scripts less intimidating than the improvisational

role-plays, as they did not feel the same degree of performance pressure. They could read the scripts and not risk criticism from their superiors as to the correctness of their responses. Rather, residents could reflect more on the conversations themselves, and engage in discussion about how the scripts played out, and how the conversations might be improved. The scripts are not intended to be exemplars or prescriptions for best practice. Rather, they are useful as teaching tools precisely because of the flawed communication and missed opportunities inherent in them.

Using scripted role-plays followed by engaged discussion was a novel and enjoyable way of learning for the residents. Residents were actively involved, found it a safe way to learn, and generally reported a reduction in stress when facing these conversations. The residents are young and from all over the world, at the beginning of their careers. Many of them have not had to deal with the death of loved ones in their own lives, yet they are suddenly thrust into situations where they are required to discuss quite serious and often intensely sad end-of-life issues with patients and families. It is understandable that their developmental, cultural, and emotional awareness has not yet “caught up” with the intense demands of the situation.

Physician champions of the program were identified. A geriatric attending physician began to incorporate the role-plays in her teaching. An attending from the medical intensive care unit showed interest and offered suggested improvements to the scripts being developed and resident feedback was incorporated. Finally, attending physicians and residents requested expanded emphasis on coping with families and patients in great distress. This has prompted the development of new scripts depicting highly emotional interactions among clinicians, patients, and family members.

When the program began, sessions with residents were entirely ad hoc; it seemed impossible to schedule regular sessions given the complex and changing schedules of the residents. More recently, the program has attained greater stability, because the Medical Director of Resident Education and the Chief Intensive Care Attending Physician has given explicit support to the training by scheduling each of the medical teams to meet once a month.

PROJECT GOALS

The primary goal of the program is to help physicians build better communication skills in establishing goals of care and in end-of-life planning as part of their palliative care education. Objectives of the program include helping physicians develop basic skills in conducting family conferences that focus on discussing advance directives, giving bad news, explaining brain death, and addressing withdrawal of life support as well as other ethical issues in palliative care.

The program focuses on skills such as making introductions, sitting at eye level, scanning the group assembled, and identifying the primary

decision maker(s) while respectfully including others in the conversation. Additional skills include asking patients and families what they understand at the beginning of the meeting; taking time to explain and let patients/families ask questions; being able to sit with silence as difficult information and complex emotions arise; taking time to listen and to clarify information; and clearly stating medical recommendations. Attention is also given to finding those moments in a discussion when it is valuable to encourage the patient and/or family members take the lead in the discussion, in this way allowing them to have as much control as possible.

The following are examples of scripts developed for the program. All of the examples portray challenging conversations that occur when patients are nearing the end of life, as these were identified by participants as the most difficult and anxiety-provoking conversations they encountered in daily practice.

ETHICAL CONSIDERATIONS AT END OF LIFE

“Ethical Considerations at End of Life” was the first script developed. This script documented the discussion by the medical team and hospital ethicist that followed a conversation with a patient’s adult son. In the training session, the script is read by the medical staff (residents, medical students, and attending physicians as well as members of the hospital ethics committee) with discussion throughout the reading and again at the completion of the reading. The purpose is to highlight the complexities of communicating with family members when a patient is nearing death and to strengthen the physicians’ understanding of the inherent ethical concerns in these conversations.

This training session includes the stopping and starting of the action by the PCSW, with discussion focused on analyzing the action of the scripted scene. Everyone present has the opportunity to play the part of the family member, resident, or attending physician. The conversation with the son had focused on the need for his mother to be discharged to home hospice, and the importance of having a Do Not Resuscitate (DNR)–Do Not Intubate (DNI) in place. The son wanted his mother home but did not recognize that she was dying. The son wanted “everything done.”

(Excerpts from the scripted conversation)

Resident: We explained to the son that she is terminal but he wants everything done and he wants to take her home.

Ethicist: Is the patient able to make her own decision?

Resident: No, she has dementia.

PCSW: Did you talk about a DNR?

Resident: Yes, but he wants everything.

Ethicist: Do you think she can go home?

Attending Physician: The only way she could go home would be on a Hospice Program. It would be irresponsible to go along with his wishes.

Chaplain: Have you asked him why he feels that way? (MD shakes head no.) Sometimes there are other things going on. He may not understand the gravity of her condition or he may feel guilty for some neglect or some imagined neglect on his part in the past.

Attending Physician: I explained everything to him in detail. I said we didn't want to have to code her; that palliative care would be the best treatment and I just don't think he gets it. He is in such denial and I don't know how to break through. Since her pressure is dropping we will need to code her.

PCSW: Does he know she probably won't come off the vent due to her dementia once she is put on it?

Resident: No, I didn't say that.

PCSW: Frequently "doing everything" for a family member is pretty much tied into emotions. He could be thinking, "Since she did everything for me, I won't give up on her." Maybe we need to ask the son to say more about that.

Rabbi: I believe that people never really know what someone would want in that last minute of life. How can anyone really make the choice?

PCSW: Yes. Religion, culture, and spirituality play a big part in choices.

Chaplain: Most religions see life as sacred and that it needs to be preserved, but if there is an excessive burden on the patient and the family then prolonging life may not be the answer.

Ethicist: The burden or benefit to the patient and family is at the crux of the ethical dilemma.

Following the role-play/reading, participants discussed the salience of the script and expand on the issues raised by the scripted conversation. They discuss the meaning of "denial" in family members, with a realization that the word is often used by clinicians when they are not sure how to understand the complex personal stories that family members bring to these situations. They realize that, while time is a realistic concern in hospital settings, it can easily create problems when clinicians try to rush these conversations. In the process of re-enacting the script together, they appreciate the value of an interdisciplinary approach to palliative care, specifically the importance of becoming aware of emotional and spiritual needs of patients and families at these times.

DO NOT RESUSCITATE–DO NOT INTUBATE ORDERS

Three DNR–DNI scenes were developed in response to requests from residents. One first-year resident confided that talking to families about DNR–DNIs (Kind, 2012) was the most difficult for her, and requested that more scenes be developed to address these challenging conversations.

In the following DNR scene, the surgical resident is approaching the patient's elderly cousin in the hope of attaining a DNR. This script is adapted using words to convey how confusing conversations with clinicians can be for lay people when they are filled with medical jargon.

(Excerpt)

Surgical Resident: He developed a fistula and we took him back to surgery and capsias with aaotictytron was installed but he doesn't seem to be responding and a venal dyverticulama developed and further surgical intervention was needed. But last night a capsias occurred. When this happens sometimes a toolemyotic intervention or a clotic valve is needed. In your cousin's case it was both and further drainage was needed so we took him back to surgery a fifth time and then another capsias occurred . . .

Family Member: A capsias?

The resident is extremely sincere in her approach and details every surgical intervention to the patient's cousin, not appreciating her inability to understand the patient's condition in the terms being used. In the midst of his bewilderment, the family member simply defers to the doctor's judgment. When asked at the close of the scene whether he wants "everything done," the overwhelmed cousin says, "yes, do what you can."

In the discussion that follows the reading of the script, we talk about the risk of physicians choosing to hide behind their expertise, failing to recognize that to a family member their words can be experienced as making no sense. On one occasion, a medical student reading the part of the patient's cousin made this point clear to the individual playing the resident: "I don't know what you are saying!" It is suggested that the resident could say instead that we have taken the patient to surgery five times to stop the bleeding and to repair each problem, but that each time, serious complications have occurred that prevent the surgery from working. The patient is suffering multiorgan failure and the physician is unable to intervene in ways to improve the patient's condition. The prospect of addressing a DNR with the family, since there seems to be nothing curative that can be done for the patient, is discussed.

The use of the question, "Do you want us to do everything?" comes up repeatedly in follow-up discussions for many of the scripts. One attending advises never to use this phrase, as the opposite of doing everything is doing nothing, and who would agree to that for a loved one? This teaching point is at the heart of palliative care, and is one that can be made repeatedly. It is elucidating for physicians-in-training to be reminded that there is appropriate care to be provided at every juncture in a person's illness.

The central value to be conveyed is that clinicians need to help the patient and family define what quality of life means to them, and then support them in maintaining that quality for as long as is feasible. Clinicians learn in this discussion that their presence and counsel can be a tremendous asset for patients and families at these times. They learn that they are capable of helping patients and families appreciate, in concrete and understandable terms, the benefits and burdens of resuscitation and other life-sustaining measures. Physicians often discuss their reticence to make direct recommendations to patients and families in these situations; they receive feedback about how and when being direct on the part of the physician can be experienced as an important supportive act by family members.

WITHDRAWAL OF LIFE-SUSTAINING TECHNOLOGY

The “Withdrawal of Life-Sustaining Technology” script was based on an actual family meeting with a patient’s two adult daughters and adult son. The attending physician wanted to discuss a DNR order and possible withdrawal from the ventilator, as the patient was in a persistent vegetative state. The siblings were in conflict as to what they thought the patient would want. Emotional and spiritual beliefs as well as complex family dynamics were evident. The use of this script can teach the essentials of conducting a family meeting—such as making introductions, asking for input and addressing feelings of family members, appreciating the emotional toll the meeting can take on the physician and other members of the health care team, and being as clear as possible in discussing expectations and prognosis.

(Excerpt)

PCSW: Did she ever say anything about being on a machine at the end of her life, about not wanting to go through the end her life being hooked up to a machine?

Daughter #1: She told me to let her go.

Daughter #2: What are you saying?

Attending Physician: You can choose to have her taken off the machine if you believe that is what she would want based on what she has told you and the kind of person she is. You need to think of the quality of life you feel she would want.

Daughter #2: No.

(Silence)

PCSW: Myra, what did she say to you?

Daughter #1: When her brother died, he was on a machine too.... Nana said she didn’t want to be that way...to let her go.

PCSW: That’s good to know.

Son: If you took her off the machine, how long would she live?

Attending Physician: No one knows, but I don't think it will be long. It could be hours, and it could be days. No one knows for sure.

Daughter #2: But God may let her live. Miracles can happen. God can let her live.

Chaplain: There is a balance. On one hand you have hope, on the other, reality. We carry them both. If you take her off the ventilator, if you decide to not let her be on a machine, she will pass in God's time.

Daughter #1: I want to know what Nurse B thinks. What would you do?

Nurse: If she were my mother, I would at least get a DNR. If her heart stops, none of us would like to code her. We have to pound on her chest. She is very frail. She most likely would not survive but her body would be put through further abuse and it wouldn't help.

This script leads to a rich discussion of the complexities of family meetings, responding to the varying beliefs and feelings of different family members, appropriate ways to discuss spiritual issues, and how to communicate one's clinical opinion as a member of the health care team in ways that family members can hear. For example, team members in this conversation may feel challenged to find the best words to convey what they feel is the futility of coding the patient when her heart stops. Exploration of the use of different words and their potential impact on patients and families is possible in this scenario. In the discussion of this script, the use of the words "pounding on her chest" and "further abuse" by the bedside nurse is explored both in its potential harshness, but also in its potential to communicate to the family the nurse's wish to not see a frail elderly patient suffer needlessly. As described earlier, the purpose of these scripts is not to teach some form of idealized communication, but rather to examine actual words, with all their imperfections, that are communicated in the context of real conversations with patients and families.

FEEDING TUBES

Feeding tube discussions are often very controversial. Important points to make regarding the use of feeding tubes at the end of life are detailed in this script. Recently this scene has been used to introduce the MOLST Form (Medical Orders for Life Sustaining Treatment) in discussion with families

regarding end-of-life issues. Prior to the reading of the script, the MOLST (New York State Department of Health, 2010) is introduced as a tool to educate families on end-of-life issues and the trajectory of survival with advance terminal illnesses such as stage IV cancers and end stage dementia. In some states a MOLST is called POLST (Physician Orders for Life Sustaining Treatment).

(Excerpt)

Son: But if she doesn't get a feeding tube, won't she starve?

Attending Physician: At this point she is not craving food. In patients at the end of their lives, their bodies are slowing down, shutting down. They are not eating but they are not hungry as they are producing a chemical called ketones and they don't feel hunger. It sort of produces a natural high, a state of euphoria. Feeding tubes also have complications, create infections, and studies show they don't really prolong life. Palliative care is the recommended treatment at this time. Your mother will be kept comfortable and not receive aggressive treatment.

Son: I don't know. I have to talk to my sister.

Resident: Of course. If you need us to discuss with your sister, we can have another meeting.

Son: I can't think about this.

Attending Physician: We also recommend that you and your sister think about putting a Do Not Resuscitate order in place, a DNR. Some states call this an AND, allow natural death. This means that if her heart stops she will die peacefully with as much dignity as possible. We will not use aggressive means to bring her back and put her on a ventilator. She is so frail; she may not survive the code. But if she does, there will be further brain damage due to the time it takes for oxygen to get to the brain . . . she will be in pain and need to be sedated. Chances are she will never get off the vent.

Son: I just want to get her home, take her out back. She always liked to sit there and watch me in the yard.

PCSW: Hopefully we can do that. Hospice can be at home if that is preferred.

Son: Hospice?

PCSW: Hospice is comfort care at home. They will help you get the wheelchair so she can go outside if she is able. At this point she will need 24 hour care. She can't be alone.

Son: It's been that way the past 5 years. I work at home.

PCSW: Hospice can provide the additional care of a home

health aide. This may help. Also a nurse, social worker, and doctor make home visits. It's not just for your mother, but to help you and your sister cope with the end of life.

Son: Stop it. We want to keep her alive. How can you talk to me like that? *She has pneumonia—that's it!* You have to make her better. I can't hear this anymore. You have no right to talk to me like this!

This script raises numerous issues about the timing, pacing, and quality of communication with families facing end-of-life issues. Discussion tends to focus on how and why it may be difficult for the son in the context of this conversation to understand the disease progression of advanced dementia and to absorb the information presented. Many feel the physician went too far, providing too much information and too many recommendations without appreciating the son's emotional state. The son becomes angry and defensive and screams at the doctors present. This gives the physicians the opportunity to learn how to sit with the intense emotions of family members, on the one hand, and on the other hand, to appreciate how their own actions and sense of urgency can play a role in eliciting such emotions.

Discussion focuses on the importance of acknowledging the son's emotions and the need to listen carefully and to tolerate one's own emotional discomfort. Residents engaged in the role-play have the opportunity to practice conveying empathy and better pacing in order to help the son come to terms with his mother's condition. It is also pointed out that if earlier in the disease progression, either at the point of diagnosis or earlier in the process of dementia, the physician had initiated conversation around the MOLST to educate this family, perhaps the son might have been able to take in the information and the shock would not be so great when his mother was nearing the end of life.

DISCUSSION

The Physician Care Training Program offers residents and attending physicians the opportunity to appreciate the imperfect process of communicating with patients and families, while also identifying ways to improve their skills. The scripts document actual meetings between physicians and the patients/families, with all their inherent flaws. The participants are engaged in an experiential process as they portray the roles of patients, family members, resident, social workers, and attending physicians. The process encourages learners to identify with peers in their own discipline, with clinicians from other disciplines, and with patients and family members. This is an enormous asset in a medical culture that continues to educate

physicians and other clinicians within the confines of professional silos. In the highly technical world of medicine, becoming involved in training that addresses difficult issues and complex emotions in palliative care and end-of-life conversations can be enlightening for young residents and medical students. It is a unique and effective approach, as participants are not directly asked to experience their emotions but rather to identify and reflect on those emotions by reading the words of others. A safe learning environment is created in which participants can reflect on what they see and incorporate new learning without being directly under the microscope themselves.

In pretests and posttests, all participants have described an increase in understanding how to run family meetings and how to give bad news. Variations occurred in presession knowledge relative to training. Generally a first-year medical student had less understanding than a second-year resident. Attending physicians as well have learned from this process. For example, after attending a resident training session on how to conduct a family conference, in subsequent family meetings, an attending physician no longer stood above the family but sat and gave time for group introductions.

In feedback solicited from residents regarding the value of the scripts in talking with families and patients on DNR issues, only one third-year resident stated he didn't find it that helpful. It is important to note that the majority of physician trainees involved in the program come from countries where English was not their primary language. This means that they are striving to not only take in communication skills in general, but also to learn to convey complex information to patients and families in a language they are still in the process of mastering. These learners bring a wide range of cultural assumptions and beliefs, and they are learning to practice in a community that is itself highly diverse ethnically, socially, and economically.

Perhaps the most difficult challenge in implementing this training program is that of engaging physicians in a process of experiential education that is not their accustomed mode of learning. Although the training sessions are generally well received, it is critical to gain the support of attending physicians and others in leadership roles to function as champions for the program. Because physician leaders understand that learning to engage well in these kinds of challenging conversations is an important part of resident training. Forging alliances with these leaders becomes an important way to "authorize" the sessions. Finding the time for training sessions is also a challenge. In the busiest settings within the hospital, the sessions are kept to 15–20 minutes in duration and are incorporated with clinical discussions about the content and outcomes of recent family meetings. Training sessions take place in proximity to the nurses' station, allowing the engagement of nurses, residents, fellows, and attending physicians. There is also a more formal opportunity to learn about these issues at noontime medical rounds that all residents are required to attend. In these sessions, a combination of didactic (power point and lecture) presentations and brief role-plays utilizing the scripts is utilized.

The completed scripts are now incorporated in the Palliative Care Consulting Service weekly team meetings led by the PCSW that involve the residents, the social work intern, hospice nurse, chaplain, various interest attending physicians from Hematology and Oncology, and the Palliative Care Medical Director. In this forum, it is interesting to see how more seasoned physicians struggle with many of the same communication challenges as their younger counterparts when engaging in difficult conversations involving DNR–DNI, feeding tubes and the range of challenging ethical issues in palliative care.

The completed scripts are also being utilized in other settings of physician training. The training has been incorporated and recognized by the Medical Directors as essential to physician education with monthly groups for the Medical Intensive Care Residents and the varied Internal Medicine Teams. New scripts will be developed to address communication challenges when using the MOLST (Medical Orders for Life Sustaining Treatment) form with patients and families, as well as to address the complex emotions that arise for clinicians as well as patients and families in palliative care and end of life conversations.

CONCLUSION

Residents felt safer and more willing to participate when asked to read scripts of conversations rather than to improvise or role-play conversations in an educational program. The reading of a script enables enough distance for learners to see the strengths and weaknesses in the conversations they enact, and to absorb insights and new ways of communicating in a nonthreatening manner.

The process of creating a teaching program for physicians in training that utilizes theater group work skills within the rather rigid and highly organized structure of a busy community hospital is a challenging one. However, the Physician Communication Training Program has become an established entity in this environment, providing a fruitful forum in which to build better communication skills and to reflect on the complex demands of palliative care and end-of-life conversations.

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