**Station Name:** Mr. Roger Hubbard

**Issue:** Eliciting goals of care/code status

**Presenting Situation:** Mr. Hubbard is a 62-year-old gentleman with locally advanced pancreatic cancer diagnosed 2 months ago who presents to the emergency room with an acute abdomen due to perforation of a duodenal ulcer. The resident physician will meet with Mr. Hubbard to clarify the goals of care and elicit his code status.

**Activity:** Patient encounter

**Time Required:** 15 minutes
Instructions to Candidate

You are the resident on the general surgery team. Mr. Hubbard is a 62-year-old gentleman with locally advanced pancreatic cancer diagnosed 2 months ago who presents to the emergency room with an acute abdomen due to perforation of a duodenal ulcer. Mr. Hubbard was treated with chemotherapy and radiation initially, but he has not received anti-neoplastic therapy for at least 1 month. The ER physician told the patient that his pain is due to an ulcer, and he is now waiting alone (no local friends or family) to discuss the plan of care with the surgery team. He is awake, alert, and of clear mental status.

Your attending has informed you he thinks that it is reasonable to take Mr. Hubbard to surgery. He believes the patient is likely to survive surgery for this acute event. Your attending has discussed the risks and benefits of surgery with the patient given the diagnosis of cancer and prognosis of several months. You meet with Mr. Hubbard to clarify his code status.

Resident Tasks:

- Talk with the patient to clarify his code status
- No physical exam is required

Time required: 15 minutes

- You have 12 minutes with this patient
- 2 minutes to complete a brief self-assessment
- 1 minute to receive verbal feedback from the standardized patient
**Instructions to Standardized Patient**

You (Mr. Hubbard) are a 62-year-old gentleman with locally advanced pancreatic cancer diagnosed 2 months ago. You underwent chemotherapy and radiation immediately after diagnosis but haven’t had treatment in the last month. You are not married and have no children. You have several close friends that are like brothers and sisters to you but live at least an hour away from the hospital. You are living independently and not experiencing pain or nausea related to the tumor. You have been noticing increasing fatigue over the last several months.

This morning you began experiencing severe central, upper abdominal pain, right under the middle of your ribs. As the pain began to worsen, you worried that something was going on with the tumor and called 911. After a CT scan, the ER doctor told you the pain was coming from an ulcer and that she had called the surgery team to see you.

Your oncologist told you earlier that most people with pancreatic cancer live for months after diagnosis. You know your cancer is not curable but were hoping to have several more months to live and visit with friends out of town. Your current quality of life is good. Your mother died last year from metastatic lung cancer after suffering for months in the hospital and spending about a week on a ventilator. You are adamant that you don’t want to die like your mother. You are willing to undergo medical interventions that will help you feel better or live longer but not any that will result in your being in the ICU for weeks. Your feelings are so strong that you have shared them with all of your close friends and gave one of them your medical power of attorney. (You may decide what relationship you have with that friend.)

You have discussed the risks/benefits of surgery with the surgery attending. You intend to proceed with surgery. If your condition worsens before or after surgery, you would not want to be resuscitated with CPR or be on a ventilator.

- Be prepared to answer questions such as:
  - Could you tell me what the other doctors have told you is going on with your cancer? Abdominal pain?
  - Has anyone talked with you about how long you are likely to live? Do you want to know that kind of information?
  - Have you considered your wishes if you were to get sicker?
  - What do you want if your heart stops?
  - Who will make decisions for you if you are unable?

- If the resident asks, “What do you want if your heart stops?”, increase emotional expressiveness. Reply, “Well, I’d want you to restart it! Do everything you can to bring me back. I just don’t want to be hooked up to all those machines like my mother was.”
• If the resident asks your preferences on a laundry list of possible interventions—tube feeds, dialysis, antibiotics, blood products, mechanical ventilation, etc.—you feel ever more overwhelmed. Increase emotional expressiveness.

• If resident does not attend to emotion (does not make any “NURSE” statements), become more emotional. You are feeling overwhelmed by this sudden event and the difficulty of trying to make good decisions without friends to discuss the options with. You need to feel heard by the resident about how scary and overwhelming this situation is as well as how alone you feel. If the resident attempts to attend to emotion, start to decrease emotional expressiveness.

• *If the resident attends to the patient’s emotion*, this case should end with resident and patient agreeing that the patient will proceed with surgery, but if complications arise, his code status will be do not resuscitate/do not intubate (DNR/DNI), no escalation of care. Resident and patient should discuss:
  - Patient's prognosis from cancer: weeks to months
  - Patient's medical power of attorney
  - Patient's values: Continue to be able to live independently to visit with friends and maintain current quality of life. If he is not able to be independent, discontinue aggressive medical interventions.
  - Goal of surgery: prolong life at current level of functional status
  - Code status: DNR/DNI

*Prompts are used to standardize the scenario and give all candidates an opportunity to discuss relevant issues if they are attending to emotion. You do not need to use all or even any prompts if the candidate is reaching the issues independently.*

Prompt 1: What will happen if I get a lot sicker after surgery?
Prompt 2: I don't want to die like my mother.
## Checklist Items

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<thead>
<tr>
<th>Skill</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>1. Demonstrated nonverbal empathy</td>
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<td>a. Sat down</td>
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<td>b. Made eye contact</td>
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<td>2. Demonstrated verbal empathy*</td>
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<tr>
<td>a. Named emotion</td>
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<td>b. Stated understanding of an emotion</td>
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<td>c. Stated respect for patient’s decision-makers</td>
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<td>d. Offered support</td>
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<td>3. Asked what the family already knew/assessed understanding</td>
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<td>4. Used open-ended questions</td>
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<td>5. Fired a “warning shot,” such as “I’m afraid I have some bad news”</td>
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<td>6. Stated prognosis</td>
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<tr>
<td>7. Attempted to elicit patient/family's treatment goals and expectations</td>
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<td>8. Discussed treatment options</td>
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<td>9. Used appropriate level of directiveness/made a recommendation</td>
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<td>10. Was easily understood</td>
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<td>11. Avoided medical jargon</td>
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<td>12. Listened attentively/followed family’s needs</td>
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<td>13. Invited questions</td>
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<td>14. Suggested a plan</td>
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<tr>
<td>15. Concluded with a review of what had been decided and a plan for follow-up</td>
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### Negative Behaviors

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<tr>
<td>1. Interrupted</td>
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<td>2. Asked surrogates what <em>they</em> would want or want to do</td>
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<td>3. Made recommendation/suggestion before eliciting patient’s preferences</td>
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*See the following pages for examples of NURSE statements.
NURSE Statements

These examples are not exhaustive

**Name an emotion**

- Refers to an attempt by the physician to name an emotion that the patient seems to be experiencing but has not **explicitly articulated**.
- The attempt is still valid even if the patient claims the named emotion is not how they're feeling.
- **NOTE:** When a physician simply repeats an emotion a patient suggests, this does not count as naming an emotion. (PT: “I’m scared.” MD: “You sound scared.”)
- Acceptable examples:
  - “Sounds like you’re feeling scared.”
  - “You seem overwhelmed.”
  - “You’ve been worried about that, huh?”
  - MD: “You seem shocked.” PT: “No, I’m actually just worried about my kids.”
- Unacceptable example: “I know this is a shock, and it’s tragic when complications come up after surgery.”

**Understand an emotion**

- Refers to an attempt by the physician to verbally show the patient that the physician comprehends and/or appreciates the patient’s emotion.
- Acceptable examples:
  - “I understand I gave you some bad news.”
  - “I see this is upsetting.”
  - “I cannot imagine what it is like to (X).”

**Respect/praise the patient/family**

- Refers to a statement made by the physician communicating to the patient that he/she admires, commends, or has a high regard for how the patient/family has and/or is handling the situation.
Acceptable examples:
  o "I’m really impressed with the strength you’ve shown throughout this illness."
  o "You’ve done an amazing job coping despite everything this cancer’s thrown at you."
  o "You’ve done a great job taking care of yourself during this illness—I know how much you’ve worked on your diet and other things to stay healthy."
  o “You have done a tremendous job handling everything that has been put before you. I think you should be very proud of what you have accomplished.”

Support/non-abandonment statement

- Refers to a statement made by the physician communicating to the patient that he/she will be available to the patient, or support them, throughout the entire disease process.

Acceptable examples:
  o “You are not in this alone. I am there for you.”
  o “I will be here for you throughout this process.”
  o “I’m always going to be your doctor.”
  o “We’ll do all we can to help you.”
  o “I will be here along the way.”

Unacceptable example: “If you have any questions before your next visit, please feel free to call me.”