NYU SCHOOL OF MEDICINE
DEPARTMENT OF EMERGENCY MEDICINE
RESIDENCY PROGRAM

EMERGENCY MEDICINE PROFESSIONALISM AND
COMMUNICATION TRAINING
(EMPACT)

COURSE COORDINATORS:
Linda Regan, M.D.
Adina Kalet, M.D., M.P.H.
Sondra Zabar, M.D.

MASTER VERSION

Made possible by generous grants from the Picker Foundation
EMERGENCY MEDICINE PROFESSIONALISM AND COMMUNICATION TRAINING
CURRICULUM OVERVIEW

INTRODUCTION TO EMPACT (EMERGENCY MEDICINE PROFESSIONALISM AND COMMUNICATION TRAINING) .............................................................. 3

Course Calendar ........................................................................................................... 4

Course Curriculum ....................................................................................................... 5

EMPACT Course Overview ......................................................................................... 6

Session 1: Effective Communication In Emergency Medicine: Making Every Second Count .... 7
Session 2: Interdisciplinary Respect in the Emergency Room ........................................... 16
Session 3: Delivering Bad News in the Emergency Department ..................................... 23
Session 4: Dealing with Culturally Diverse Patients in the Emergency Department .... 31
Session 5: Medical Errors in the Emergency Department ........................................... 41

Appendices – The Toolbox .......................................................................................... 47

I. OSCE Overview ........................................................................................................ 48
II. How to Train Standardized Patients ...................................................................... 51
III. Information for Standardized Patient .................................................................... 52
III. OSCE Cases & Checklists .................................................................................... 53
III. Sample OSCE Report Card .................................................................................. 55
IV. Sample OSCE Rotation Schedule ......................................................................... 60
V. Pocket Cards .......................................................................................................... 61
July 18, 2007

Dear Members of the Emergency Medicine Housestaff:

The NYU Department of Emergency Medicine (EM) is strongly committed to developing the professionalism and communication skills of our EM residents. This handbook describes the curriculum that has been developed to aid in your understanding and performance in the following areas:

1. Effective Communication Skills in the Emergency Room  
2. Interdisciplinary Communication and Respect  
3. Delivering Bad News in the Emergency Department  
4. Dealing with Culturally Diverse Patients in the Emergency Department  
5. Medical Errors in the Emergency Department

The curriculum will be presented in five sessions throughout the year during [___________] lecture series. This handbook contains the goals and objectives for each topic, presentation handouts, and supplementary materials including information about the EMPACT OSCE evaluation and relevant EM literature. It is our hope that this handbook will serve as a point of departure to expand your thinking as you interact with patients, colleagues and your loved ones.

The Accrediting Council on Graduate Medical Education has mandated that we as EM physicians carry out our professional responsibilities adhering to ethical principles coupled with sensitivity to diverse patient populations. The curriculum in this handbook is aimed at the fulfilling these responsibilities and helping you to become thoughtful, concerned and effective physicians.

It is with this hope that we present this curriculum and anticipate your thoughtful participation in these six important sessions.

Sincerely,

Linda Regan, M.D.  
Curriculum Director

Jeffrey Manko, M.D.  
Residency Program Director

Adina Kalet, M.D., M.P.H.  
Curriculum Director

Sondra Zabar M.D.  
Curriculum Director
Course Calendar

Pre-Curriculum Evaluation OSCE
- PGY 1: DATE TBA
- PGY 2: DATE TBA
- PGY 3: DATE TBA
- Location: TBA

Seminars

Session 1: Making Every Session Count: Effective Communication Skills in the Emergency Room
- Lecturer:
- Date:
- Time:
- Location:

Session 2: Interdisciplinary Communication and Respect
- Lecturer:
- Date:
- Time:
- Location:

Session 3: Delivering Bad News in the Emergency Department
- Lecturer:
- Date:
- Time:
- Location:

Session 4: Dealing with Culturally Diverse Patients in the Emergency Department
- Lecturer:
- Date:
- Time:
- Location:

Session 5: Medical Errors in the Emergency Department
- Lecturer:
- Date:
- Time:
- Location:

Post-Curriculum Evaluation OSCE
- Rising PGY 1: DATE TBA
- Rising PGY 2: DATE TBA
- Rising PGY 3: DATE TBA
- Rising PGY 4: DATE TBA
- Location: TBA
Course Curriculum
## EMPACT Course Overview

<table>
<thead>
<tr>
<th>Session Title</th>
<th>Date</th>
<th>Picker Dimension</th>
<th>Communication Skills</th>
<th>Teaching Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Making Every Session Count: Effective</td>
<td>08/01/2007</td>
<td>Respect for patient's values, preferences, and expressed needs; Information, communication and education</td>
<td>Patient Education, Rapport Building</td>
<td>Videotape Reenactment and Debriefing, Mini Lecture</td>
</tr>
<tr>
<td>Communication Skills in the Emergency Room</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Interdisciplinary Communication and Respect</td>
<td>09/12/2007</td>
<td>Coordination and integration of care; Transition and continuity</td>
<td>Conflict Negotiation; Telephone Skills</td>
<td>Audiotape Trigger, Role Play</td>
</tr>
<tr>
<td>3. Delivering Bad News in the Emergency Department</td>
<td>10/03/2007</td>
<td>Emotional support and alleviation of fear and anxiety; Information, communication and education</td>
<td>Emotion Handling</td>
<td>Videotape Trigger from Medical TV Show, Role Play between Attending and SP</td>
</tr>
<tr>
<td>4. Dealing with Culturally Diverse Populations in</td>
<td>11/07/2007</td>
<td>Access; Respect for patient’s values, preferences, and expressed needs; Information, communication and education</td>
<td>Effective use of an interpreter, Elements of informed consent</td>
<td>Rolling Role Play between Residents and SP, Mini Lecture</td>
</tr>
<tr>
<td>the Emergency Department</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Discussing Medical Errors in the Emergency</td>
<td>12/05/2007</td>
<td>Respect for patient's values, preferences, and expressed needs; Emotional support and alleviation of fear and anxiety</td>
<td>Emotion Handling; Patient Education; Dealing with Challenging Patient</td>
<td>Videotape Trigger from Medical TV Show, Role Play with Small Groups</td>
</tr>
<tr>
<td>Department</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Session 1: Effective Communication In Emergency Medicine: Making Every Second Count

Sondra Zabar MD
Linda Reagan MD

Goal: To provide residents with tools to maximize the effectiveness of their communication with patients and their families.

By the end of this session, you should be able to:

Cognitive Objectives

- Appraise and interpret data from the EMPAT performance assessment of the professionalism skills of emergency medicine residents.
- Identify the major communication challenges of emergency medicine practice (e.g. explaining frightening bio-technical procedures, talking about risks and consequences, counseling acutely anxious individuals).
- Describe an evidence-based approach to efficient therapeutic relationship building.

Skill Objective

- Critique a videotaped interview of a Emergency Medicine resident talking with a patient who makes frequent trips to the ER for back pain.

Affective Objectives

- Support a patient centered communication model which requires the physician to elicit the patient’s story, accurately name and appropriately respond to patient’s emotions and ensure effective patient education.
- Commit to developing expertise through a process of “deliberative practice” in the realm of professionalism which requires honest assessment of communication skills.

CONCLUSION: Academic EDs present unique challenges to effective communication. In our study, the physician-patient encounter was brief and lacking in important health information. Provision of patient-centered care in academic EDs will require more provider education and significant system support.


Theoretical models for patient-physician communication in clinical practice are frequently described in the literature. Respecting patient autonomy is an ethical problem the physician faces in a medical emergency situation. No theoretical physician-patient model seems to be ideal for solving the communication problem in clinical practice. Theoretical models can at best give guidance to behavior and judgement in emergency situations. In this article the premises of autonomous treatment decisions are discussed. Based on a case-report we discuss different genuine efforts the physician can do to uncover treatment refusal and respect patient autonomy in an emergency situation. Autonomy requires competence and in emergency medicine time does not allow intimate exploration of patient competence and reasons for treatment refusal. We find that the physician must base her decision on a firm theoretical base combined with a practical and realistic view of the patient’s situation on a case to case basis.


The American Board of Medical Specialties described six core competencies considered essential elements of medical practice: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. In response, the Accreditation Council for Graduate Medical Education (ACGME) mandated that all residency programs assess trainees for the newly defined core competencies. Despite the mandate for including these six competencies in residency training, neither a specific curriculum nor a method to assess the outlined objectives has been developed by the ACGME. Instead, it is up to individual residency programs to document how they plan to incorporate and assess the core competencies in their programs. This article describes the potential use of direct observation to assess resident performance in the interpersonal skills core competency.
Session Outline

1. **Curriculum overview**

2. **Brainstorm**
   a. The most challenging emergency medicine communication tasks

3. **Group Discussion**
   a. How are we doing? Emergency room statistics
   b. Report cards from the OSCE

4. **Mini-lecture**
   a. Communication principles

5. **Videotape Review Using Checklist**
   a. Talking to family members about end-of-life decisions

6. **Practice**
   a. Emotion handling related to health proxy issues

7. **Take home points**
Effective Communication in Emergency Medicine Practice: Making Every Second Count

Lecture Slides

1. **Goals**
   - Introduce the EMPACT curriculum
   - Report on data from OSCE’s
   - Understand importance of relationship building skills and effect on patient care
   - Identify effective communication strategies
   - Analyze an example of common EM patient interaction

2. **Case Study**
   - Repeat ER Visit: Back Pain Patient
   - **RESIDENT INSTRUCTIONS**
     - Patient: Michelle King, 45 yo women who has had chronic back pain for 4 months
     - Ms. King seen in ER a week ago. At the time her neuro exam was normal; she shared an MRI report she recently obtained of her lower back revealing non-surgical inter-vertebral disc bulging.
     - She was given Vicodin and an appointment to see a neurologist 2 weeks from today.
     - She is presenting again today with same complaint.
     - You are the EM resident seeing this patient and need to address her concerns.

3. **Questions to the Group…**
   - What is your role?
   - What are your goals?
   - What are the professionalism issues?

4. **“Professionalism is demonstrated through a foundation of clinical competence, communication skill, and ethical and legal understanding, upon which is built the aspiration to and wise application of the principles of professionalism: excellence, humanism, accountability, and altruism.”**
   - Stern and Arnold, 2006

5. **“By three methods we may learn wisdom: first by reflection, which is noblest, second, by imitation which is easiest; third by experience which is bitterest.”**
   - Confucius
Slide 7

Developing Expertise
“Deliberative Practice”

Slide 8

Challenges Specific to EM Communication
- Lack of privacy
- Noise
- Frequent interruptions
- Long waiting times and short interactions
- Lack of prior established relationship
- Heightened patient anxiety
- Expectation of rapid turn around time

Slide 9

How are we doing?
General Info
In a 2003 study, 24 EM residents and 8 RNs were audiotaped in 93 encounters:
- Average length of H & P = 7.5 min (1-20)
- 52% did history while performing PE
- Greeted patient = 62%
- Introduced self = 65%
- Stated status as resident = 8%
- Average time to interrupt = 12 sec
- Facilitating 68%
- Of 48 interrupted patients, 82% not completed


Slide 10

How are we doing?
Data on Discharge
- N = 31 (45% RN, 45% MD, 10% both)
- Provider talked for average of 76 sec Range (7-202)
- Patient talked for average of 14 sec Range (0-75)
- Discharge Dx 55%
- Medications 90%
- Freq 44%
- Dose 26%
- Duration 11%
- None 14%
- Questions 16%
- Understood 0%

Slide 11

How are we doing?: Discussing High Risk Interventions
In a 2005 study, 30 PGY 3-5 residents completed an OSCE scenario involving high risk surgery (leaking AAA) with high risk patient (CHF, ESRD):
- Most did good job explaining the condition and the surgical vs non-surgical options
- Most did poor job addressing patient’s functional status, wishes, values and fears
- 20 % recommended speaking to family


Slide 12

How are we doing?: Giving Advice
- When asked for advice:
  - 36% gave advice (72% for intervention)
  - 6% stated it was not their job to give advice
  - 57% restated the medical risks
Slide 13

How are we doing?:
The Bellevue Experience
N=15, PGY 2 level

✓ Transfer of Care from ER to Surgery
✓ "Back Pain" Repeat Visit
✓ "Broken Wrist" X-Ray Recall
✓ "Bad News" Unexpected death
✓ Informed consent through interpreter

Slide 14

Aspects of Professionalism Measured

<table>
<thead>
<tr>
<th>Domain</th>
<th>Scoring</th>
<th>Reliability (Cronbach’s Alpha)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendation</td>
<td>Rating 1-4</td>
<td></td>
</tr>
<tr>
<td>Communication Relationship Development</td>
<td>% behaviorally grounded items rated &quot;well done&quot;</td>
<td>.61</td>
</tr>
<tr>
<td>Delivering Bad News</td>
<td>Rating 1-4</td>
<td></td>
</tr>
<tr>
<td>Managing Difficult Situations</td>
<td>Rating 1-4</td>
<td></td>
</tr>
</tbody>
</table>

Slide 15

Slide 16

Slide 17

Slide 18

Frequency of Witnessing Resident Colleagues’ Unprofessional Behavior (Past 6 Mos)
Among Senior EM Residents (n=12)

<table>
<thead>
<tr>
<th>Behavior</th>
<th>8%</th>
<th>8%</th>
<th>17%</th>
<th>8%</th>
<th>17%</th>
<th>33%</th>
<th>33%</th>
<th>17%</th>
<th>42%</th>
<th>33%</th>
<th>33%</th>
<th>17%</th>
<th>25%</th>
<th>25%</th>
<th>33%</th>
<th>42%</th>
<th>33%</th>
<th>33%</th>
<th>42%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inappropriately prescribing or acquiring controlled substances</td>
<td>Once</td>
<td>Several (2-3 Times)</td>
<td>4 or More Times</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engaging in sexual misconduct</td>
<td>Once</td>
<td>Several (2-3 Times)</td>
<td>4 or More Times</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being unable to fill responsibilities due to failure to care for self</td>
<td>Once</td>
<td>Several (2-3 Times)</td>
<td>4 or More Times</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falsifying medical records or misrepresenting a clinical situation</td>
<td>Once</td>
<td>Several (2-3 Times)</td>
<td>4 or More Times</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failing to provide transfer of responsibility</td>
<td>Once</td>
<td>Several (2-3 Times)</td>
<td>4 or More Times</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failing to respect patients’ rights</td>
<td>Once</td>
<td>Several (2-3 Times)</td>
<td>4 or More Times</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breaching confidentiality</td>
<td>Once</td>
<td>Several (2-3 Times)</td>
<td>4 or More Times</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participating in a conflict of interest</td>
<td>Once</td>
<td>Several (2-3 Times)</td>
<td>4 or More Times</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responding inappropriately to constructive criticism</td>
<td>Once</td>
<td>Several (2-3 Times)</td>
<td>4 or More Times</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failing to be available when on call</td>
<td>Once</td>
<td>Several (2-3 Times)</td>
<td>4 or More Times</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failing to show up on time</td>
<td>Once</td>
<td>Several (2-3 Times)</td>
<td>4 or More Times</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being abusive and critical during stress</td>
<td>Once</td>
<td>Several (2-3 Times)</td>
<td>4 or More Times</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Holding oneself to be more qualified than one is</td>
<td>Once</td>
<td>Several (2-3 Times)</td>
<td>4 or More Times</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbally abusing patients or colleagues</td>
<td>Once</td>
<td>Several (2-3 Times)</td>
<td>4 or More Times</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being disrespectful</td>
<td>Once</td>
<td>Several (2-3 Times)</td>
<td>4 or More Times</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
And then…….back to the videotape!

Three Functions of Clinical Communication
1. Data Gathering
2. Relationship Building
3. Patient Education/Information Giving

The evidence for relationship building skills:
Better Diagnosticians:
- Avoid interruptions
- Make eye contact
- Use facilitative body language
- Have positive attitudes toward patients
- Are willing to ask about psychological distress
- Make emphatic comments
- Giron, M. et. al. 1998

Delivering Bad News:
- Anxiety and Depressive is doubled if perceived as "inadequate"
  (Fallowfield, 1986)
- Unhurried, honest, balanced, and empathic delivery leads to better satisfaction
  (Cunningham 1984)

The evidence for relationship building skills:
Patient Satisfaction
- Closely linked to patient centered skills
- Patient complaints associated with poor relationship building
  "Never looked at me at the time"
  "Made me feel humiliated"
  "Used medical jargon that confused me"
- Frankel et. al.

The evidence for relationship building skills:
Physician Satisfaction
- Lawyers know:
  - Malpractice does not lead to suits
  - Perceived lack of compassion is primary motivation to sue
- Study Shows:
  - 71% of suits due to "problematic relationship issues"
Let's Go to the Video Tape!

What was the physician able to accomplish?

What to DO when you don't know what to SAY...
• Be quiet, listen, don't change the subject
• Remain patient/family member centered
• Explore patient's concerns further
• Be empathetic

Making Every Second Count....
• Encourage and facilitate the interview
  – Make eye contact (put down your pen)
  – Offer encouragement
  – Give explanations
  – Notice verbal emotional expression
  – Ask when you are not sure
  – Trust the non-verbal cues

“Care more for the individual patient than for the special features of the disease....
Put yourself in his place .... The kindly word, the cheerful greeting, the sympathetic look
-- these the patient understands.”
Sir William Osler
<table>
<thead>
<tr>
<th>Checklist</th>
<th>Not Done</th>
<th>Minimally Done</th>
<th>Well Done</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Relationship Development</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communicated concern or intention to help</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-verbal behavior enriched communication (e.g., eye contact, posture)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acknowledged emotions/feelings appropriately</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was accepting/non-judgmental</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Used understandable words and/or explained jargon</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td><strong>Delivering Bad News</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepared patient to receive the news:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Entered room prepared to deliver news, Ensured sufficient time and privacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identified immediate support system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Husband, Mother’s friend in NYC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessed patients readiness to receive news:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Gives warning shot (e.g., “I have some bad news for you…”)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delivered medical status appropriately</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Avoids euphemisms, Delivers information in small doses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gave you opportunity to emotionally respond:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Remains sensitive to your venting of shock/anger/disbelief/accusations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Attends to emotions before moving on</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Directly asked “What are you thinking/feeling?”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Managing a Difficult Situation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessed patient’s expectations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintained professionalism by controlling negative emotions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Respect for Patient Values</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge of the law: Proxy/Living will, Medical Futility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ascertained patient’s health beliefs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Addressed barriers to accepting mother’s wishes:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Faith, Guilt, Absence of a “goodbye”, Grief, Support/timing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upheld mother’s wishes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Creation of Follow-up Plan</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Personally mitigated feelings of aloneness or isolation (“We will…”, “I’m available”)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provided appropriate “next steps”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Social work, Bereavement counselor, Funeral home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asked about pastoral services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determines desire/offers to alert pastoral services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arranged for follow-up</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Session 2: Interdisciplinary Respect in the Emergency Room

Sondra Zabar MD
Linda Reagan MD

Goal: To teach residents to effectively work with the professionals around them to optimize patient care.

By the end of this session, you should be able to:

**Cognitive Objectives**

- Name important stages of conflict management
- Explain the role of interdisciplinary respect in the quality of patient care.

**Skill Objective**

- Demonstrate effective interdisciplinary communication skills

**Affective Objectives**

- Identify your own personality traits which may add to or detract from these interactions.
Relevant Literature (annotated in order of priority)


In this classic text, Fisher and Ury describe their four principles for effective negotiation. They also describe three common obstacles to negotiation and discuss ways to overcome them.


The future of the health system is dependent on health professionals re-tooling the way we practice together. No longer can a multi-disciplinary model support the complex health needs of many clients nor can any one-health profession have all the knowledge needed to provide total patient-centered care. However, our current education and health systems are structured around a multi-disciplinary model of practice with physicians or nurse practitioners as decision-makers and rarely are clients included in care planning. True interdisciplinary practice is defined as a partnership between a team of health professionals and a client in a participatory, collaborative and coordinated approach to shared decision-making around health issues, required a revamping of how future health professionals are educated and how they system can accommodate shared decision-making. A client-centered collaborative professional practice model is proposed in this paper as a means for fostering and facilitating the culture for this change.


Problem-based Learning (PBL) has become a popular method of instruction among educators in the health professions. Central to the effectiveness of PBL is the ability of students to work together to solve problems. When these abilities are lacking, PBL outcomes can be compromised. Since these skills have not been emphasized in public school or higher education, students are often forced to muddle through group processes in the effort to learn. The purpose of this paper is to discuss the interpersonal skills necessary to enhance PBL, and suggest how these skills can be improved and incorporated into the curriculum.


Communication issues arise in emergency physician relationships with patients, nursing, and physician colleagues. It is important to acknowledge various perspectives in order to promote positive relationships and to avoid the social, medical, and legal hazards associated with miscommunication. This article outlines fundamental processes involved in these three important relationship groups.
Emergency Medicine Professionalism and Communication Training
“EMPACT”

Interdisciplinary Respect and Communication
Linda Regan, MD
Sandy Zabar, MD

Goals
• To teach residents to effectively work with the professionals around them to optimize patient care.

Objectives
• To demonstrate effective interdisciplinary communication skills
• To name important stages of conflict management
• To explain the role of interdisciplinary respect in the quality of patient care.
• Identify your own personality traits which may add to or detract from these interactions.

Interdisciplinary Communication
The Good and The Bad

Listen to the following tape...

Common Sources of Conflict
• Between Disciplines:
  – Ignorance
  – Poor communication
  – Distrust
  – Lack of confidence
Whenever two good people argue over principles, they are both right.

Marie Ebner von Eschenbach

- Seeking to understand one another
- To clarify meaning
- To understand the other viewpoint
  - Brainstorming
  - Clarification
- Not to make a decision

Enter into a Discussion
- To make a decision
- To reach closure
- Discussion is NOT a debate
- Discussion is NOT about winning
- Focuses on issues, not people

Conflict
- Healthy
- Common
- Necessary
- However...

How are we doing?: Communication Skills Telephone Transfer Case
- Good news:
  - most received full credit for information-gathering communication items
  - provider education communication items
  (on average, >67%)
  - provider education communication items
  (on average, >64%)
Slide 13

How are we doing?:
Communication Skills
Telephone Transfer Case

* Bad news:
  - relationship development

Slide 14

![Bar chart showing communication-related developmental metrics](chart.png)

Slide 15

How are we doing?:
Skills Specific to Transfer Case

* Good news:
  - most received full credit for
    - ability to manage a difficult situation (64%)
  - hospital guidelines regarding admission (85%)
  - acknowledged role in this patient’s care (82%)

Slide 16

How are we doing?:
Skills Specific to Transfer Case

* Bad news:
  - Phone skills=Identified self/role, whom speaking to
  - Accountability
  - Interdisciplinary respect

Slide 17

![Bar chart showing skills metrics](chart.png)

Slide 18

**Telephone Communication**

* Why is it so hard?
  - Limited education
  - Limited feedback
  - Loses body language
  - Background noise
  - Timing
Slide 19

Telephone Skills
- Identify your name and role
- Clarify who you are talking to
- Clarify information and your understanding
- Listen for tone of conversation
- Clearly acknowledge emotions
- Summarize next steps

Slide 20

Telephone Skills: Communication of concern and understanding
- Use Reflective Statements
- Express Partnership
- Communicate Respect

Slide 21

Getting to YES! Negotiating Agreement Without Giving In
- Separating people and issues
  - Understand each other
  - Control emotion
  - Communication needs LISTENING!

Slide 22

Getting to YES! Negotiating Agreement Without Giving In
- Focus on INTERESTS rather than POSITIONS
  - Ask
  - Discuss

Slide 23

Getting to YES! Negotiating Agreement Without Giving In
- Generate Options Before Agreeing
  - Obstacles
  - Solutions

Slide 24

Getting to YES! Negotiating Agreement Without Giving In
- Use Objective Criteria
  - Hospital policies
  - Evidence from the literature

Slide 25

The Stubborn Other!
- Be contagious!
- Get a mediator

Slide 26

Role Play

Slide 27

Managing Yourself
- Personal
  - Be aware of own triggers
  - Frustration
  - Anger
  - Fear
  - Sadness
- Positive and negative personality traits

Gray-Eurom. 2006. EM & CC

Slide 28

Discrepant Attitudes
- Between nurses and doctors
- Nurses reported high level: 33% of the time
- Doctors reported high level: 73% of the time


Slide 29

Take Home Points
- Understand differences
- Focus on the BIG PICTURE
- Identify a COMMON goal or purpose
- Be non-threatening
- Control your emotion
Session 3: Delivering Bad News in the Emergency Department

Sondra Zabar MD
Linda Reagan MD

Goal: To improve residents’ effectiveness in their delivery of bad news and provide residents with facts about post-death procedures.

By the end of this session, you should be able to:

Cognitive Objectives

- Know the basic skills of delivering bad news

Skill Objective

- Demonstrate the ability to deliver bad news
- Demonstrate recognition and appropriate responses to patients’ emotional reactions to bad news

Affective Objectives

- Acknowledge patients’ strong emotional reactions as appropriate and healthy responses
- Understand that delivering bad news is difficult for both the patient and doctor and may influences the doctor patient relationship.
Relevant Literature (annotated in order of priority)


Regardless of severity, parents want to be informed of error. Educational interventions to improve error disclosure should emphasize the uniformity of parental preferences for disclosure, reporting, and the decreased likelihood of legal action when errors are disclosed than if discovered through other means.


Death from trauma frequently comes without forewarning. Relating the news of death to the family is often the responsibility of trauma surgeons. The purpose of this study was to investigate the key characteristics and methods of delivering bad news from the perspective of surviving family members. The most important features of delivering bad news were judged to be attitude of the news-giver, clarity of the message, privacy, and knowledge/ability to answer questions. Sympathy, time for questions, and location of the conversation were ranked of intermediate importance. The attitude of the news-giver, combined with clarity of the message and the time, privacy, and knowledge to answer questions are the most important aspects of giving bad news.


Notification of family when sudden death has occurred is often a highly stressful experience for hospital Emergency Department physicians and nursing personnel. This article will offer some guidelines to health care professionals in helping a deceased patient's family cope with the initial grief and loss that accompanies the unexpected death of a loved one. At the same time, an understanding of the wide range of emotional responses of bereaved survivors may case some of the anxiety Emergency Department staff members associate with "breaking the bad news."


The provision of a positive HIV antibody test result and the direction and support given to the test recipient are critical components of care and prevention. There has been little research that describes what happens in such interactions between recipient and provider. The impact on the test provider of delivering the HIV test result is an important issue to consider. The discomfort experienced by some health providers in giving a positive test result may have adverse effects on the client interaction or may carry over into subsequent client interactions. Utilizing a thematic analysis on interview data from 24 HIV test providers, we describe the impact of delivering a positive test result on HIV test providers, identify the factors that influence this impact, and describe strategies used to manage the impact. As with other health care professionals communicating "bad news," HIV test providers experience a variety of impacts. While a small number of providers indicated little or no impact of delivering the HIV positive test result because the diagnosis is "not the end of the world," most indicated it was difficult as it was anticipated that the test recipient would (or did) find the news distressing. Several coping strategies were identified.
Slide 1

Emergency Medicine Professionalism and Communication Training “EMPACT”

Delivering Bad News in the Emergency Department

Linda Regan, MD
Sondra Zabar, MD

Slide 2

Goals

• To improve resident’s effectiveness in their delivery of bad news
• To provide residents with facts about post-death procedures.

Slide 3

Objectives

• Know the basic skills of delivering bad news: Prepare, Assess Readiness, Check in, and Make a follow-up plan
• Demonstrate the ability to deliver bad news
• Demonstrate recognizing and responding to patients emotional reactions to bad news
• Recognize that a patient’s strong emotional reaction is an appropriate and healthy response
• Understand that delivering bad news is difficult for both the patient and doctor and may influence the doctor-patient relationship.

Slide 4

Delivering Bad News

• Death
• Diagnosis
• Impairment of vital function (personal or professional)

So here is how it is done…..

Slide 5

Why is this so hard?

• Lack of confidence in skill
• Lack of knowledge
  – To navigate the system
  – Medical knowledge
• Time constraints/Privacy/Personal Discomfort
• Education
  – Role modeling
  – Lecture

Slide 6
Delivering Bad News

- Mr. Cooper is a 28 year old bartender who comes to ER to be evaluated for a sore throat and fever
- Agrees to get HIV screening
- Awaiting results of rapid HIV test

Communication Skills: Bad News

- 67% did not provide clear explanations/information
- 75% did not fully collaborate in identifying next steps

Giving Bad News

Preparation
Delivery
Evaluation of Response
Managing a Difficult Situation
Follow Up

- 44% did not fully identify immediate source of social support
- Only 33% used direct terms “death” or “died”
- 71% did not directly ask: “What are you feeling?”
- 87% did not become defensive/assign blame
- 75% controlled emotions fully
Giving Bad News

Preparation
Delivery
Evaluation of Response
Managing a Difficult Situation
Follow Up

39% did not offer specific next steps
62% did ask if would like pastoral services and offered to contact
50% did not ask about an autopsy
33% did not arrange for follow-up

SP Comments
• “Called Richard by name – showed respect.”
• “Kept calling Richard ‘the body’ even after complained.”
• “Didn’t always wait for my answer.”
• “Talked a lot instead of letting me talk.”
• “Talked a lot, rather than listened.”
• “Touched me sympathetically.”
• “Touched me physically in sympathy – very kind, helpful.”

Death Notification: GRIEV_ING
• Gather
• Resources
• Identify
• Educate
• Verify
• Space
• Inquire
• Nuts & Bolts
• Give

Gather family members
Inquire if there is anyone else who should be present

Resources
• Call for support for YOU and the FAMILY
• Chaplain/minister/rabbi
• Social work
• Friends or family

Identify
• Yourself
• Family/relatives/friends
• Their state of knowledge
• The deceased BY NAME
Slide 19

Educate

• Surrounding events leading up to.
• Current state

Slide 20

Verify

• That they understand they have died
• Use concrete words
  • “dead”
  • “died”

Slide 21

Space

• Give personal space and time to absorb the information

Slide 22

Inquire

• For any questions
• Be sure to answer ALL of them

Slide 23

Nuts & Bolts

• Organ Donation (call the network)
• Post-mortem/autopsy (defer until ME)
• Personal effects (defer until ME)
• Victim Services (SW)
• Viewing the body (preparation)
• Paperwork
  – Preliminary information sheet
  – Medical examiner notification *
  – Death certificate

Slide 24

Give

• Your card
• Your number
• Some way for them to access you for information later.
Take Home Points

• Giving bad news is NEVER easy
• Following an outline will help you feel more at ease
• Debriefing can help YOU cope
• Remember, you never have to do it alone!
EMPACT Session 3 – Breaking Bad News
Rolling Role Play (HIV+)

<table>
<thead>
<tr>
<th>Patient:</th>
<th>27 yo (non AA or latino) male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Complaint:</td>
<td>sore throat and fever</td>
</tr>
<tr>
<td>Occupation:</td>
<td>Bartender</td>
</tr>
<tr>
<td>Sexual History:</td>
<td>active heterosexual</td>
</tr>
<tr>
<td></td>
<td>mostly uses condoms, although not always</td>
</tr>
<tr>
<td></td>
<td>knows people who are HIV +</td>
</tr>
<tr>
<td>Scenario:</td>
<td>Was offered HIV screen by HIV counselor</td>
</tr>
<tr>
<td></td>
<td>Told by counselor that HIV test is positive and</td>
</tr>
<tr>
<td></td>
<td>you are asked to go and tell the patient</td>
</tr>
<tr>
<td></td>
<td>Will be told about an HIV+ result. In shock when</td>
</tr>
<tr>
<td></td>
<td>you hear diagnosis</td>
</tr>
<tr>
<td></td>
<td>If acknowledgements from doctor are good, patient</td>
</tr>
<tr>
<td></td>
<td>acknowledges unsafe behavior</td>
</tr>
</tbody>
</table>

For the Doctor:

1. Prepare
   a. Know the information
2. assess readiness
   a. Give warning shot, patient is ready to hear what you have to say
3. Give information
   a. Ask tell ask
4. Check patient’s response
   a. Understand patient’s level of acceptance
5. Follow up
   a. Virology clinic
   b. HIV counselor resources
Session 4: Dealing with Culturally Diverse Patients in the Emergency Department

Sondra Zabar MD
Linda Regan MD

Goal: To understand appropriate use of interpreters in the ED and improve residents’ interactions with culturally diverse patients in the ED.

By the end of this session, you should be able to:

Cognitive Objectives

- Know the different types of interpreters
- Know the basic skills for using an interpreter

Skill Objective

- Demonstrate the ability to use an interpreter
- Recognize the difference between physician and patient perceived need for using an interpreter

Affective Objectives

- Develop self awareness about one’s owns cultural influences and biases.
Relevant Literature (annotated in order of priority)


CONCLUSIONS: Informed decision making among this group of primary care physicians and surgeons was often incomplete. This deficit was present even when criteria for informed decision making were tailored to expect less extensive discussion for decisions of lower complexity. These findings signal the need for efforts to encourage informed decision making in clinical practice.


Interpreters are often not used despite a perceived need by patients, and the interpreters who are used usually lack formal training in this skill. Language concordance and interpreter use greatly affected patients' perceived understanding of their disease, but a high proportion of patients in all groups had poor knowledge of their diagnosis and recommended treatment.


Hospital-trained interpreters are a valuable and needed resource to facilitate communication with limited English-proficient patients and families. Other interpretation services are useful but have limitations.


Due to the distinctive features of the hospital emergency department and its patients, emergency physicians confront special challenges in respecting patient rights to informed consent to treatment. After a brief review of the doctrine of informed consent and of its significance in the emergency department, this article will examine three specific challenges for informed consent and refusal of treatment in emergency medicine: (1) assessing patient decision-making capacity, (2) performing procedures on the newly dead, and (3) making treatment decisions for patients in legal custody.


Resident physicians' self-reported preparedness to deliver cross-cultural care lags well behind preparedness in other clinical and technical areas. Although cross-cultural care was perceived to be important, there was little clinical time allotted during residency to address cultural issues, and there was little training, formal evaluation, or role modeling. These mixed educational messages indicate the need for significant improvement in cross-cultural education to help eliminate racial and ethnic disparities in health care.
Dealing with Culturally Diverse Populations in the Emergency Department

Linda Regan, MD
Sondra Zabar, MD

Goals
- To improve residents interactions with culturally diverse patients in the ED.
- To understand appropriate use of interpreters in the ED.

Objectives
- Know the different types of interpreters
- Know the basic skills for using an interpreter
- Demonstrate the ability to use an interpreter
- Recognize the difference between physician and patient perceived need for using an interpreter
- Develop self awareness about one’s own cultural influences and biases.

Why is this so hard?
- Using an interpreter is...
  - Time consuming
  - Impersonal
  - Hard
  - Not recognized as an needed
  - Sometimes... not an option ?

Types of Interpreters
- Professional
- Ad Hoc
  - Family
  - Friends
  - Children
  - Staff
- Telephone
Common Interpreting Errors
- Omission
- Addition
- Condensation
- Substitution

What do we know?
- Data collected at UCLA-Harbor
- Of 513 Spanish speaking patients
  - 8% rated English ability good to very good
  - 22% wanted an interpreter and did not receive
  - 52% had no interpreter and felt not needed

Do we over-rate our Spanish proficiency?
- For providers with patient-rated Spanish less than good
  - More than 25% preferred an interpreter even if they rated their own English as good
  - 87% preferred an interpreter if they rated their English as poor

Who are we using?
- 22% MD
- 28% RN or LPN
- 12% professional
- 12% family or friends (1/3 < 18 years old)
- 11% hospital clerks
- 16% other staff

What is the significance?
- No difference
  - Discharge medications
  - Follow up plan
- Significantly lower perceived understanding
  - Discharge diagnosis
  - Treatment plan

Patient Satisfaction
- Study looked at satisfaction of 180 parents to Peds ED
  - Hospital trained had highest satisfaction
  - Phone interpreters had the lowest satisfaction
Slide 13

So let's try it

- 50 y.o. Bengali speaking women came to the ER after she panicked when she received a phone call recalling her to clinic for positive fecal occult blood.
- A bilingual staff member has volunteered to interpret.

Slide 14

Common Medical Education mistakes (or a slide or 2 from colleen)

- Using jargon – “Your screening test is positive”
- Talking louder
- Using complex descriptions
- Focusing on normal results

Slide 15

How can we do this well?
Maximizing an interpreter's effectiveness

- Attend to the patient not the interpreter – First person, position, eye contact
- Explicitly correct the interpreter – Word for word,
- Prepare a clear and succinct description of common tests and procedures – Deliver info in small chunks – Check understanding

Slide 16

Take Home Points

- Use and interpreter
- Feel empowered to maximize their effectiveness
- Deliver information in small chunks
- Check in on patient's understanding and personal belief system
- Track own reactions
### RESIDENT INSTRUCTIONS

<table>
<thead>
<tr>
<th>Patient Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name:</td>
</tr>
<tr>
<td>Age:</td>
</tr>
<tr>
<td>Marital Status:</td>
</tr>
<tr>
<td>Children:</td>
</tr>
<tr>
<td>Occupation:</td>
</tr>
</tbody>
</table>

**The Scenario**

This is a follow up for a patient you saw two weeks ago for an upper respiratory infection. You took the opportunity to start some age-appropriate health care maintenance. Her mammogram and GYN appointments are pending and she is here to review her lab results.

She only speaks Bengali. You are relieved that today she is here with her brother to translate instead of her 15 year old daughter.

**Lab Results:**
- CBC, LFTs, BUN/Cr and TSH: all normal
- Stool guaiac cards: 2 out of 3 positive

**Your Tasks**

- Review the patient’s lab results and make an appropriate plan
- Facilitate her brother to interpret effectively
Your name is Abdur Rashid. You are 48 years old and came with your sister to help interpret for her.

You came to clinic because your sister needed your assistance. She speaks very little English and is too shy to use the little she knows in public. She grew up in Bangladesh and only came to the US 10 years ago. She lives in a pretty isolated community where she speaks Bengali most of the time and has her husband and her children help her navigate the English world around her.

You came to the US when you were 20 to study and did not go back to Bangladesh. You are fluent in both English and Bengali and are proud you can be of help. Every one in your family is healthy but your sister has always had “delicate” health. She frequently needs to lie down in the afternoon in a dark room. She was sick as a child with TB, and your family treats her as sickly even though she recovered. She seems to get easily overwhelmed. Her husband provides well for his family but is very traditional and does not help at all at home. He expects a lot from his two sons and spoils his daughter.

You are in good health. You have an electronic store, enjoy going to the gym and going out with your friends. You do not really have a primary care doctor.

Your wife has 3 other siblings, 2 younger and one older. One died a few years ago from cancer in Bangladesh but you do not know of what kind. Your mom is 80 and is still alive and lives in Bangladesh with one of your other siblings and you have a brother who lives in California whom you are not very close too. Your father died of some kind of infection about 4 years ago at the age of 80.

You are a little anxious to hear about the results since your sister has this delicate disposition. You wonder if there is really some thing wrong with her or she was “born sad” as your mother says. You think the doctor is nice and you want to be helpful. Your sister is very shy in public and you know you are going to have to do most of the explaining.
Now you find yourself:
Sitting next to your sister discussing what time your niece needs to be picked up from school. When the doctor walks in you smile and introduce yourself first and your sister who just nods her head and smiles. You state you are here to translate for her since she speaks almost no English.

If the doctor thanks you for coming you tell him it is no problem - that is what family is for.
If the doctor expresses concern about your translating, tell him not to worry because you speak English very well.

For the first few questions have an extended back and forth exchange with your sister before answering the doctor with either a yes, no or few word answer. For example, if the doctor asks how she is feeling, talk with her for a minute before answering “She feels fine.”

Make eye contact with your sister when you are talking and then turn or move closer to the doctor to give them the answers. You should give the impression you are separating yourself from your sister when you interact with the doctor.

If doctor makes too much eye contact with you, keep talking to him.

If the doctor asks you to please just translate word for word explain that your sister is very shy and you are just coaxing her to answer and reminding her how important this is.

When the doctor asks if she has noticed any blood in her stool or if she has felt weak tell the doctor that your sister has a delicate disposition.

When the doctor explains why they ordered the stool tests instead of answering whatever question is directed at the patient ask if you too should have the test. You heard it was important.

If the doctor mentions anything about the positive blood test tell him that you don’t want to tell your sister because it will worry her. Your brother died of cancer a few years ago.

If asked if she understands why she got the test she states no. She has no symptoms and has never heard of a sigmoidoscopy or colonoscopy. Once explained you make some comment “that sounds pretty uncomfortable.”

If the doctor gives you very specific instructions about how he wants you to interpret and reminds you a few times, ie “it is important that you translate only what I say or she is saying” then calm down and stop editorializing.

If the doctor is trying to engage the patient and make eye contact with her then she reluctantly agrees to have a sigmoidoscopy or colonoscopy. She has Medicaid.
### Personality
You are a chatty person. You enjoy talking and can be a little dramatic at times. You are the man of the household and feel you have to take care of your sister since she has come to the US. You do not see it as a burden but you really do not have any one to talk to about her “delicate” disposition. Your mother just thinks, “she was born sad”.

### Current Life Situation
You live with your wife and your 17 year old son. Your daughter is at Stony Brook and you are very proud of her. You own an electronics store and you work as the manager.

### Past Medical/Surgical/Psychiatric History
You have no medical problems or psychiatric problems. You have not seen a doctor in a long time since you have had no problems. You don’t have any allergies to medicines.

### Family Medical History
Your mother is alive and lives in Bangladesh. You think she has diabetes and hypertension. Your father died 4 years ago from some kind of infection and your oldest brother died of some kind of cancer. Your two other siblings are in good health as far as you know.

Your sister has a delicate disposition and sometimes takes to her bed for a few days. She has no past medical or surgical history and has never been hospitalized. She takes no medications.

As far as you know she has not actually seen a doctor recently and the only reason she did the test was she had come for her sore throat and your daughter took her down the lab to follow the doctor’s instructions.

### Psychosocial History
You feel it is your duty to help your sister but you are a pretty chatty person and can go off on some tangents.

### Life-Style History

<table>
<thead>
<tr>
<th>Smoking</th>
<th>No one in your family smokes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol/Drugs</td>
<td>Your sister does not drink at all. You do occasionally when you go out to dinner.</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Your sister eats a traditional Bengali diet. Yours is more western.</td>
</tr>
<tr>
<td>Exercise</td>
<td>Your sister does not exercise.</td>
</tr>
<tr>
<td><strong>Interview Challenge</strong></td>
<td><strong>For Resident</strong></td>
</tr>
<tr>
<td>------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td><strong>Timing</strong></td>
<td><strong>Discuss with the patient her test results using a family member as a translator.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Exhibit non verbal communication with the patient</strong></td>
</tr>
<tr>
<td></td>
<td><strong>State clearly what your expectations are from the interpreter</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Make clear statements to redirect translator</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Advise patient to get a diagnostic test</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Beginning</strong></th>
<th>You are sitting chatting with your sister as the doctor comes in. You first introduce yourself and then your wife. If doctor asks you to ask wife how she is, you speak for a bit and then tell him she is fine.</th>
</tr>
</thead>
</table>
| **Middle**    | You continue to respond directly to the doctor and editorialize your sister’s responses until he does the following:  
|               | Explains why it is important that you translate properly  
|               | Gives you very specific instructions about what to do and reminds you a few times |
| **End**       | If the doctor had built a rapport and explained their concerns, attempted a number of time to focus on the patient not the interpreter then accept the recommendation of further testing for colon cancer. |
Goal: To improve resident’s effectiveness in their disclosure of medical errors.

By the end of this session, you should be able to:

**Cognitive Objectives**
- Know the basic skills of disclosing medical errors
- Understand barriers to disclosure of errors in the ED

**Skill Objective**
- Demonstrate the ability to disclose a medical error
- Demonstrate recognizing and responding to patients emotional reactions

**Affective Objectives**
- Recognize that a patients strong emotional reaction is an appropriate and healthy response.
Relevant Literature (annotated in order of priority)


Attention has recently been focused on medical errors as a cause of morbidity and mortality in clinical practice. Although much has been written regarding the cognitive aspects of decisionmaking and the importance of systems management as an approach to medical error reduction, little consideration has been given to the emotional impact of errors on the practitioner. Evidence exists that errors are common in clinical practice and that physicians often deal with them in dysfunctional ways. However, there is no general acknowledgment within the profession of the inevitability of medical errors or of the need for practitioners to be trained in their management. This article focuses on the affective aspects of physician errors and presents a strategy for coping with them.


Error in medicine is a subject of continuing interest among physicians, patients, policymakers, and the general public. This article examines the issue of disclosure of medical errors in the context of emergency medicine. It reviews the concept of medical error; proposes the professional duty of truthfulness as a justification for error disclosure; examines barriers to error disclosure posed by health care systems, patients, physicians, and the law; suggests system changes to address the issue of medical error; offers practical guidelines to promote the practice of error disclosure; and discusses the issue of disclosure of errors made by another physician.
**Emergency Medicine Professionalism and Communication Training**

"EMPaCT"

Medical Errors in the Emergency Department
Linda Regan, MD
Sondra Zabar, MD

---

**Slide 2**

**Goals**

- To improve resident’s effectiveness in their disclosure of medical errors.

---

**Slide 3**

**Objectives**

- Know the basic skills of disclosing medical errors
- Understand barriers to disclosure of errors in the ED.
- Demonstrate the ability to disclose a medical error
- Demonstrate recognizing and responding to patients emotional reactions
- Recognize that a patient’s strong emotional reaction is an appropriate and healthy response

---

**Slide 4**

**“Scrubs”**

---

**Slide 5**

Let's Define What We are Talking About!

- **Medical Error**
  "An act not completed as intended, or the wrong plan of action to achieve a specific aim."

- **Adverse Event**
  "An injury to a patient resulting from medical care."

---

**Slide 6**

**Statistics**

- Potentially up to 100,000 deaths/year from medical errors
- Approximately 18% of cases in the ED have a medical error.
- Only 2% have a serious adverse event.
Why is this so hard?
• Lack of knowledge
  – What to disclose
  – Facts surrounding error
• Fear
  – Lawsuits, professional repercussions
  – Patient's response
• Emotion
  – Self
  – Patient
• Education
  – Role modeling
  – Lecture

Why is it even harder in the ED?
• Lack of privacy
• Lack of established relationships
• Vulnerable patients
• High risk environment

What to say?
• Similar to delivery of bad news
• Describe what you know happened
• Assure investigation/preventative techniques etc
• Apologize
  – Don’t blame
  – Group responsibility “We are sorry this happened to you”

How to Disclose a Medical Error: The Five W’s
• Who?
  – Senior most physician with relationship
• What?
  – Information you are certain of at the time of the discussion
• Where?
  – Somewhere private (do your best!)
• Why?
  – You have an ethical obligation to disclose
• When?
  – As soon as you can, but PATIENT CARE FIRST!

Skills Practice
• Please split up into three groups
• Pick one person to play the patient and one to play the physician
• The rest of the group will observe with checklists
• Discuss the challenges and strategies to disclose a medical error to a patient
• Be prepared to report back to the large group
Skills Practice

• Group 1: You ordered an x-ray on the wrong foot and now they need to go back for a second.

• Group 2: You placed a central line and the patient has developed a pneumothorax.

• Group 3: You neglected to order an x-ray on a patient with an open wound and sutured it. Your attending sent the patient for a film and noted a superficial metallic FB.

Take Home Points

• Disclosing a medical error is not easy for YOU or the PATIENT.

• State if you don’t have all the facts.

• Reassure the patient that this will be taken seriously

• Don’t be afraid to apologize.
Medical Errors in the Emergency Department
Role Play

⇒ Pick one resident to play the physician and one to play the patient.
⇒ The rest of the group will be observers and use the checklist.
⇒ Please have one-person report back:
  • What were the challenges?
  • What strategies help to overcome the challenges?

Group 1

A patient came in with trauma to their foot. You ordered an x-ray on the wrong foot and now they need to go back for a second.

Please disclose the error to the patient

Group 2:

You placed a central line in a patient who limited options for access. The patient has developed a pneumothorax.

Please disclose the error to the patient

Group 3:

You just finished suturing a patient wound. You neglected to order an x-ray on a patient with an open wound before you sutured it. Your attending sent the patient for a film and noted a superficial metallic foreign body.
Appendices – The Toolbox

I. OSCE Overview
II. How to Train Standardized Patients (SPs)
III. SP Instructions
IV. OSCE Cases & Checklist
V. Sample OSCE Report Card
VI. Sample OSCE Rotation Schedule
VII. Pocket Cards
I. OSCE Overview

The EMPACT OSCE included 5 cases focusing on various skills:
1. Transferring patient care responsibilities
2. Admitting a medical mistake
3. Dealing with Repeat Visitors
4. Working with an interpreter
5. Delivering bad news

For each case, residents spent ~10-15 minutes completing the clinical task. The total time to complete the experience was 2 hours.

We created checklists with highly reliable measures to assess residents’ performance. Standardized Patients (SP) with 2 hours of training in using the rating forms completed these checklists. Many of our SPs are experienced in rating clinical competence in other venues.

The following graphs demonstrate how the entire cohort of 15 EM residents performed on the 3 competencies (Communication Skill, Professionalism as demonstrated in case-specific knowledge, and Patient Satisfaction) when comparing their Pre and Post-Curriculum OSCEs across cases as well as how they performed within each case.

Impact of EMPACT:
Pre-Curriculum vs. Post-Curriculum OSCE Communication Scores (n=15)
Impact of EMPACT:
Pre-Curriculum vs. Post-Curriculum OSCE Case Specific Scores (n=15)

<table>
<thead>
<tr>
<th>Situation</th>
<th>Pre (%)</th>
<th>Post (%)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bad News</td>
<td>54%</td>
<td>67%</td>
<td>p&lt;.10</td>
</tr>
<tr>
<td>Interpreter</td>
<td>54%</td>
<td>53%</td>
<td></td>
</tr>
<tr>
<td>Broken Wrist (Medical Error)</td>
<td>44%</td>
<td>53%</td>
<td></td>
</tr>
<tr>
<td>Repeat Visitor</td>
<td>39%</td>
<td>73%</td>
<td>p&lt;.001</td>
</tr>
<tr>
<td>Transfer</td>
<td>54%</td>
<td>59%</td>
<td></td>
</tr>
</tbody>
</table>
Impact of EMPACT:
Pre-Curriculum vs. Post-Curriculum Recommendation Ratings (n=15)

Recommendation - Interpersonal Skills

- Recommendation: 2.84
- Recommendation with Reservations: 3.09

Recommendation - Applic of Expertise

- Recommendation: 2.90
- Recommendation with Reservations: 3.19

*P < .10*
*P < .01*
II. How to Train Standardized Patients

III. Information for Standardized Patient

<table>
<thead>
<tr>
<th>COURSE/PROGRAM:</th>
<th>CONTACT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>OSCE:</td>
<td>PHONE:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SCENARIO:</th>
<th>REHEARSAL DATE:</th>
<th>REHEARSAL TIME:</th>
<th>REHEARSAL LOCATION:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>EXAM DATE:</th>
<th>EXAM LOCATION:</th>
<th>CALL TIME:</th>
<th>START TIME:</th>
</tr>
</thead>
</table>

**USE OF STANDARDIZED PATIENTS IN MEDICAL EDUCATION**

Standardized patients (SPs) play a crucial role in medical education. At NYU School of Medicine, we routinely rely on SPs in our Objective Structured Clinical exams (OSCEs) to play specific patient roles in a uniform and consistent manner. OSCEs provide medical students, residents, and medical faculty the opportunity to hone their communication skills, history gathering techniques, and, at times, their physical exam skills.

As an SP, you will interact in character with medical students, residents, or physicians who have been assigned to interview you, often delivering structured feedback—depending on the exam structure—to OSCE participants regarding aspects of their performance. Medical schools have found that through this experience SPs can provide trainees and faculty with more effective feedback on their clinical skills, a competency not easily captured by traditional written exams. Your participation enables NYU SOM to generate invaluable feedback to our students, evaluate the effectiveness of curriculum and ultimately improve patient care. **As an SP, you contribute to the future of healthcare: training future doctors to be better listeners, caretakers, and providers.**

**Professional Standards:** SP’s are subject to standards of professional behavior including but not limited to a. what transpires in your role as SP is confidential b. no personal relationship(s) are to expected or pursued in any manner as a result of your role c. no private or personal recordings may be made without permission d. dress will be role appropriate e. respect and politeness will characterize your conduct in working with the faculty and learners.

**REHEARSING YOUR PART: SP TRAINING**

To prepare for your role as an SP, you will attend at least one rehearsal, or case-specific training. Prior to rehearsal and training, please review your character description. You will be expected to be familiar with this information at the time of the rehearsal. A doctor and OSCE coordinator will be on hand to discuss character history and medical specifics and to answer any questions you may have about the character, the exam, etc. At the rehearsal, you may also be trained in feedback protocol as well as the use of specific exam checklists tailored to your character.

**OSCE SESSION**

During the OSCE, you will be interviewed by a series of students, residents or faculty. Generally, you will be interviewed by one individual; however, occasionally you will be interviewed by participants in pairs or in groups. Each participant will have the opportunity to interact with you for a pre-established time period ranging from 10-25 minutes. In many OSCEs, you will be asked to give feedback after the interview, using a structured checklist and specified feedback protocol. In some OSCEs, a faculty member will sit with you in the room to observe and give feedback to the students.

**SP PAYMENT**

In the Section of Primary Care, SPs are paid at the rate of $25/hour. Invoices will be prepared for your signature to reflect the date(s) and hours worked. Checks are processed and mailed to you within 3-4 weeks of your last OSCE session date.

**CANCELLATION**

Your participation is necessary for the success of the OSCE. It is important that you are prompt for your training and OSCE sessions, since lateness and last minute cancellations significantly disrupt the OSCE. If you are unable to make a session, please alert our office at least 72 hours in advance. In the unlikely event that NYU SOM cancels the exam, we will provide you with payment for any time less than 72 hours advance notice.

If you find that you are unable to honor your commitment to participate, you must contact both Ari Kreith [medtheater@yahoo.com] and the program contact [via phone as found in the shaded area above]. As in any professional setting, failure to notify us of a cancellation in a timely fashion negatively impacts your future participation as an SP.
III. OSCE Cases & Checklists

1. Medical Mistake/ Broken Wrist
2. Repeat Visitor/ Back Pain
3. Interpreter/ Informed Consent
4. Transfer to Surgery
5. Unexpected Death/ Breaking Bad News
## STATION OVERVIEW

### OBJECTIVES

To test the resident’s ability to:

1. Admit an error has been made
2. Be empathic
3. Address patient concerns surrounding an error

### LOGISTICS

<table>
<thead>
<tr>
<th>Personnel:</th>
<th>Standardized patient, male, 32 y.o., dressed in regular clothing, sitting in chair.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Station Materials:</td>
<td>• Resident instructions</td>
</tr>
<tr>
<td></td>
<td>• SP Instructions</td>
</tr>
<tr>
<td></td>
<td>• SP evaluation forms</td>
</tr>
<tr>
<td></td>
<td>• Faculty evaluation forms</td>
</tr>
<tr>
<td>Room Arrangement:</td>
<td>• Station signs</td>
</tr>
<tr>
<td></td>
<td>• Chair (2)</td>
</tr>
<tr>
<td></td>
<td>• Exam table</td>
</tr>
</tbody>
</table>
**RESIDENT INSTRUCTIONS**

<table>
<thead>
<tr>
<th>PATIENT INFORMATION</th>
<th>Name: John McCoy</th>
<th>Age: 32</th>
</tr>
</thead>
</table>

**REASON FOR ENCOUNTER**

- John McCoy came to the ER 2 days ago complaining of right wrist pain after falling while rollerblading near Washington Square Park.
- At that time, his hand x-ray was **MISREAD** by a resident as normal and he was sent home with an Ace bandage and some ibuprofen.
- The Radiology Attending re-read the x-ray and found a non-displaced, non-intra-articular right distal radius fracture.
- He presents today to the ER after having been called back.

**YOUR ROLE**

ER Resident

**YOUR TASKS**

1. See the patient, explain what has occurred, and develop a plan.
STANDARDIZED PATIENT INSTRUCTIONS

THE SCENARIO

Your name is John McCoy and you are 32 years old. 2 days ago you were rollerblading in Washington Square Park prior to when your shift started for work at a restaurant (you work as a waiter at the Union Square Cafe). You fell and hit your outstretched right hand on the pavement. Your right wrist hurt a lot and you were afraid that it might have been broken. This was particularly concerning as you work as a jazz pianist occasionally. You went to the Emergency Room and after waiting for 4 hours, finally saw a doctor. They took some x-rays and told you it was just a sprain. You got some pain drugs (ibuprofen) and a bandage to wrap your wrist. You were told to rest your wrist, use ice, and keep it wrapped and raised as much as possible. Because of the wait at the ER, you had to have someone cover for you at work.

Because you don’t get sick pay, you decided to work yesterday even though you were in pain. This morning, you got a call from a nurse instructing you to return to the ER as the doctors had some information about your wrist. You again got someone to cover for you (although you still won’t get paid) in order to go back to the ER today. Today, the pain in your right wrist is about 5/10 (10 being the worst pain in your life) and it only gets worse when you bend it back or press on it. The swelling has gone down from 2 days ago and it seems like it is slowly getting better, despite having used it yesterday at work.

Objective:
- To understand what has occurred and know when you can return to work

Obstacles:
- You are upset about missing work as you are having a tough time making ends meet.
<table>
<thead>
<tr>
<th>EMPACT OSCE – Broken Wrist Station ___</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tactics:</strong></td>
</tr>
<tr>
<td>You are initially somewhat agitated as you are missing work again.</td>
</tr>
<tr>
<td>When you hear the news of the mistake you become further agitated.</td>
</tr>
<tr>
<td>If the resident is empathic, apologizes, and is helpful, you calm down a little.</td>
</tr>
<tr>
<td>If, however, the resident is at all defensive, argumentative or unhelpful, then your agitation continues to increase.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SINCE YOU LEFT THE ER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Since you left the ER 2 days ago, you have been trying to do what the doctor told you to do: rest it, use ice, compress it with the bandage and keep it elevated. You did, however, go to work yesterday after taking a few ibuprofen (Advil) tablets and a strong gin and tonic in order to minimize the pain. You got thru your shift without too much trouble and were able to compensate using your left hand more often than usual. Today, you still have some pain, but the ibuprofen is helping.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PERSONALITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>You tend to be a little dramatic. When you are happy, you border on gushy and when you are upset, you can get angry. This is partly due to the fact that your financial situation is slightly unstable and it can put you on edge at times.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CURRENT LIFE SITUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>You live with a roommate in the East Village. You have no children. You work as a waiter at the Union Square Cafe and play jazz piano intermittently with various local groups. You are still hoping to make it as a pianist, but it hasn’t worked out that well so far.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PAST MEDICAL AND SURGICAL HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>None. You are otherwise very healthy and active.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FAMILY HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your mother and father are both living in Ohio. They are healthy as far as you know. You have one brother who is healthy and married living in Ohio as well.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SOCIAL HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>You smoke ½ pack a day for the past 10 years. You drink alcohol at least 3 times per week, usually having 2-3 drinks each time. You do not use recreational drugs.</td>
</tr>
</tbody>
</table>
EMPACT OSCE – Broken Wrist

You are sexually active with a girlfriend you have had for the past 6 months. You use condoms for protection. You are eating and sleeping well and staying active by rollerblading and going to the gym occasionally.

MEDICATIONS

Ibuprofen (Advil) – 2 tablets every 4 hours for pain

ALLERGIES

None

THE ENCOUNTER

When the Resident knocks and enters the room, you are sitting in a chair in the exam room talking with a colleague trying to get someone to cover for you as you are missing work. You are upset interrupting the person on the other end of the phone line and end the conversation about 20-25 seconds after the resident enters the room. When you hang up, you are still upset having had to miss work for the second time this week. You show this by making eye contact with the resident, occasionally breathing deeply and audibly, and have aggravated tone to your voice.

You are testy and confrontational the entire interview and occasionally interrupt the resident to voice your frustration.

If asked in an open-ended way why you are here, state: “You guys called me. I was here a couple days ago about my wrist, so I assume it’s about that.”

With respect to your wrist-

Any pain? – “A little, but the Advil helps.”
How bad is the pain? – “About 5 out of 10”
Any pain with movement? – “Only when I bend it back”
Any swelling? – “It’s gotten a lot better.”
Any tingling or loss of sensation? – “No”
Any redness? – “No”
Any tenderness? – “It hurts a little when I push on it.”

In general currently:

How have you been? – “Fine, I guess. My wrist hurt a bit during work yesterday, but I got through it. But I’ve missed two days because of this stupid thing.”
If/when you are told a mistake was made (i.e. someone read the x-ray of your wrist incorrectly and you actually have a bone fracture) regardless of where it occurs in the interview, take a moment to let it set in and then at first become upset. Raise your voice, but do not shout, look the Resident straight in the eye, and impatiently tap your finger on the desk or table to underline your frustration. State:

“So my wrist is broken?”

“This is so annoying.”

“I mean, what’s going on here? I had to miss two days of work because of this.”

If then the Resident acknowledges the mistake, states that he/she is sorry that it happened/empathizes, you still remain angry and state in a slightly aggressive tone:

“Oh man. I knew it. I knew it was something bad. This always happens to me. Well, will there be any long-term damage?”

When you realize the long term damage will be nil or minimal, you are only a little relieved. State in a somewhat frustrated way:

“Why did this happen? What if this was something really serious? I mean, my God, does this happen all the time?”

Whatever the resident’s response is state: “Well, don’t you think this is a bad system here?”

If the Resident remains apologetic and non-confrontational, you calm down a little and ask:

“Well, when can I go back to work?”

If the Resident acknowledges that a mistake was made, but then becomes defensive, does not empathize or say he/she is sorry, or makes up a bizarre story -> get more upset:

“I mean, me missing work today would have been totally unnecessary right? If you guys actually did your job, I wouldn’t have had to come down here.”

“I knew I shouldn’t have come to his ER.”

If the resident asks if they can write you a note, state sarcastically: “A note? What I am I going to do with a note?”
Whenever the Resident changes course and becomes more apologetic/empathic, react accordingly. Adequately challenge the resident. You are upset for a multitude of reasons: losing work pay, being in pain, losing faith in your health care provider, and not being able to play piano. If you feel the resident is making a genuine effort to address your concerns, is empathic and non-confrontational, become less angry, but maintain a baseline of annoyance and frustration. If the resident ever becomes dismissive/confrontational or you don’t feel supported, become more upset.

Towards the end of the interview, **regardless of the Resident’s reactions**, become calm. Your motivation for doing this is as follows: If the Resident has admitted the mistake and acted appropriately, you are satisfied. If the Resident has done poorly by not admitting the mistake or making fabrications you become withdrawn contemplating a lawsuit: **(Please note: Do not mention lawsuit, litigation, suing, or anything relating to malpractice unless the Resident brings it up)** - this is purely an internal cue for you to help you act out the character). If the latter is the case – partially cross your arms, rest your head on one hand, and avoid eye contact.

Once you have calmed down a little, state: “Well, I came all the way down here. Now what?”

**CHALLENGES FOR THE RESIDENT**

- Admit that an error was made
- Regain patient trust

**CUES FOR THE RESIDENT**

| Non-verbal 1 | At the beginning of the interview, eye contact with occasional audible breathing. |
| Verbal 2: | State: **Why exactly was I called back?** - Resident to verbally acknowledge your concern and explain reason |
| Verbal-Non-Verbal 3: | Express **anger** (state that you are upset, raise your voice, look at the Resident in angry and accusatory fashion, underline your verbal comment with tapping your fingers on the table) - Resident to verbally acknowledge your anger/being upset and label it as understandable |
EMPACT OSCE – Broken Wrist  Station ___

Verbal-Non-Verbal 4:

- **Calm down** in last part of encounter; if Resident acted **appropriately**: calm down (e.g., appear more relaxed in your posture and voice); if Resident acted **inappropriately**: withdraw (e.g., cross arms, speak in short sentences, etc). State: “Well, I’m here. What do we do now?”

**TIMING**

Initially: You are already a little upset.

**Ongoing**: If the Resident is empathic/truthful/straightforward, become more and more calm. If the Resident is defensive/evasive/making up bizarre stories, become more and more upset.

**2 minute warning**: Begin to calm down because the Resident is acting appropriately or withdraw because the Resident is acting inappropriately. State: “What do we do now?”
### Broken Wrist

Evaluator’s Name: ____________________

<table>
<thead>
<tr>
<th>COMMUNICATION</th>
<th>Not Done</th>
<th>Partially Done</th>
<th>Well Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Gathering</td>
<td>Impeded story by asking leading/judgmental questions AND more than one question at a time</td>
<td>Used leading/judgmental questions OR asked more than one question at a time</td>
<td>Asked questions one at a time without leading patient in their responses</td>
</tr>
<tr>
<td>Clarified information by repeating to make sure he/she understood you on an ongoing basis</td>
<td>Did not clarify (did not repeat back to you the information you provided)</td>
<td>Repeated information you provided but did not give you a chance to indicate if accurate</td>
<td>Repeated information and directly invited you to indicate whether accurate</td>
</tr>
<tr>
<td>Allowed you to talk without interrupting</td>
<td>Interrupted</td>
<td>Did not interrupt directly BUT cut responses short by not giving enough time</td>
<td>Did not interrupt AND allowed time to express thoughts fully</td>
</tr>
</tbody>
</table>

### Relationship Development

<table>
<thead>
<tr>
<th>Communicated concern or intention to help</th>
<th>Did not communicate intention to help/concern via words or actions</th>
<th>Words OR actions conveyed intention to help/concern</th>
<th>Actions AND words conveyed intention to help/concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-verbal behavior enriched communication (e.g., eye contact, posture)</td>
<td>Non-verbal behavior was negative OR interfered with communication</td>
<td>Non-verbal behavior demonstrated attentiveness</td>
<td>Non-verbal behavior facilitated effective communication</td>
</tr>
<tr>
<td>Acknowledged emotions/feelings appropriately</td>
<td>DID NOT acknowledge emotions/feelings</td>
<td>Acknowledged emotions/feelings</td>
<td>Acknowledged &amp; responded to emotions/feelings in ways that made you feel better</td>
</tr>
<tr>
<td>Was accepting/non-judgmental</td>
<td>Made judgmental comments OR facial expressions</td>
<td>Did not express judgment but did not demonstrate respect</td>
<td>Made comments and expressions that demonstrated respect</td>
</tr>
<tr>
<td>Used words you understood and/or explained jargon</td>
<td>Consistently used jargon WITHOUT further explanation</td>
<td>Sometimes used jargon AND did not explain it</td>
<td>Explained jargon when used, OR avoided jargon completely</td>
</tr>
</tbody>
</table>

### Education and Counseling

<table>
<thead>
<tr>
<th>Asked questions to see what you understood</th>
<th>Did not check for understanding</th>
<th>Asked if patient had any questions BUT did not check for understanding</th>
<th>Assessed understanding by checking in throughout the encounter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provided clear explanations/information</td>
<td>Gave confusing OR no explanations which made it impossible to understand information</td>
<td>Information was somewhat clear BUT still led to some difficulty in understanding</td>
<td>Provided small bits of information at a time AND summarized to ensure understanding</td>
</tr>
<tr>
<td>Collaborated with you in identifying possible next steps/plan</td>
<td>Told patient next steps</td>
<td>Told patient next steps THEN asked patient's views</td>
<td>Told patient options, THEN mutually developed a plan of action</td>
</tr>
</tbody>
</table>

### ADDRESSING MEDICAL ERROR

| Accountability | |
|----------------|-----------------|-----------------|-----------------|
| Disclosed error | Did not directly disclose the error (there was a “problem”) NOR was the explanation upfront | Did not directly disclose the error (there was a “problem”) OR directly disclosed late in the interview | Directly disclosed the error upfront |
| Personally apologized for the error (“I am sorry that this happened”) | Did not apologize for error NOR for the inconvenience it caused you | Apologized for the error OR for the inconvenience it caused you | Apologized for the error AND for the inconvenience it caused you |
| Shared the cause of the error (i.e., Explained issues with system) | Did not acknowledge issues with system | Acknowledged issue with system BUT was dismissive/condescending | Acknowledged issue with system AND was genuine in addressing it |
### Empact 2007: Medical Error – Broken Wrist

#### Accountability (continued)

<table>
<thead>
<tr>
<th>Accountability (continued)</th>
<th>Not Done</th>
<th>Partially Done</th>
<th>Well Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Took responsibility for situation</td>
<td>Took no personal responsibility for your present situation (e.g., assigns your problem to other person/department)</td>
<td>Took a general responsibility as part of the department for your present situation</td>
<td>Took a personal responsibility for your situation (“I will…”)</td>
</tr>
<tr>
<td>Identified future preventative strategies to prevent situation from happening again</td>
<td>Did not address how situation would be prevented in future</td>
<td>Made general suggestion for improvement (e.g., “We’ll look into it,” “I’ll make a note of it to my Attending”)</td>
<td>Offered specific strategies for potential improvement of system</td>
</tr>
</tbody>
</table>

#### Managing a Difficult Situation

<table>
<thead>
<tr>
<th>Managed a difficult situation</th>
<th>Not Done</th>
<th>Partially Done</th>
<th>Well Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoided assigning blame</td>
<td>Became defensive/argumentative AND assigned blame to a person/department</td>
<td>Became defensive/argumentative OR assigned blame to a person/department</td>
<td>Remained calm AND did not mention blame someone else</td>
</tr>
<tr>
<td>Maintained professionalism by controlling emotions</td>
<td>Unable to control emotions, became dismissive and condescending</td>
<td>Attempted to control emotions (e.g., was somewhat dismissive or condescending)</td>
<td>Maintained a high level of professionalism in handling your specific situation, did not show anger or frustration</td>
</tr>
</tbody>
</table>

#### Delivering Bad News

<table>
<thead>
<tr>
<th>Delivered bad news</th>
<th>Not Done</th>
<th>Partially Done</th>
<th>Well Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepared you to receive the news:</td>
<td>Entered room in a manner unfitting the news AND physically situated him/herself far from you</td>
<td>Entered room in a manner unfitting the news OR physically situated him/herself far from you</td>
<td>Entered room in a manner befitting the news AND physically situated him/herself close to you</td>
</tr>
<tr>
<td>• Entered room prepared to deliver news</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Ensured sufficient time and privacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessed your readiness to receive news:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Gave warning shot (e.g., “I have some good and bad news for you…”)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Remained sensitive to your venting of shock/anger/disbelief/accusations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Attended to emotions before moving on</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did directly ask what you are feeling: “What are you thinking/feeling?”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Provided appropriate next steps</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Orthopedics for immediate care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What to expect long-term</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not ask specifically “What are you thinking/feeling?”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acknowledged your feelings (e.g., “I see that you are upset…”) BUT did not specifically ask you to name your emotions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allowed you to emotionally respond (e.g., “I’ll be calling Ortho) OR promised to “ask the attending” for next steps</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Offered only general next steps (e.g., “I’ll be calling Ortho) OR promised to “ask the attending” for next steps</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Would you recommend this doctor to a friend for his/her interpersonal skills?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Recommend</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommend with Reservation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommend</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highly Recommend</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Would you recommend this doctor to a friend for his/her medical competence?

<table>
<thead>
<tr>
<th>Not Recommend</th>
<th>Recommend with Reservation</th>
<th>Recommend</th>
<th>Highly Recommend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non -exemplary Physician: superficial, artificial demeanor applied knowledge base inadequate to my situation</td>
<td>Unexceptional Physician: awkward, knowledge base only somewhat apparent in application to my situation</td>
<td>Recommend Satisfactory Physician: appropriate knowledge base applied adequately to my specific situation</td>
<td>Model Physician: sophisticated, wise, thoughtful, applied profound knowledge base specifically to my situation</td>
</tr>
</tbody>
</table>

COMMENTS:
| OBJECTIVES | This station is designed to test the resident’s ability to:  
|           | • Effectively and respectfully work with a patient who is inappropriately using the ER as his/her primary source for health care. |
| LOGISTICS | Personnel: SP, male, 45 y.o., dressed in normal clothes, sitting in a chair. |
|           | Station Materials:  
|           | • Resident instructions  
|           | • SP Instructions  
|           | • SP evaluation forms  
|           | • Faculty evaluation forms  
|           | • MRI report  
|           | Room Arrangement:  
|           | • Station signs  
|           | • Chair (2) |
Name: Michael King
Age: 45 years old

• Michael King is a 45 y/o man who has had chronic low back pain for 4 months.

• He was seen in the ER a week ago. At that time his neuro exam was normal and he shared a report from an MRI he recently received of his lower back revealing non-surgical inter-vertebral disc bulging.

• He was given Vicodin and an appointment to see a neurologist 2 weeks from today.

• He is presenting again today with the same lower back complaint.

YOUR ROLE
ER Resident

YOUR TASKS
1) Address the patient’s concerns

Do not perform a physical exam – assume it is normal
STANDARDIZED PATIENT INSTRUCTIONS

THE SCENARIO

Your name is Michael King and you are 45 years old. You have been having chronic lower back pain for the last 4 months. The pain is mostly in your lower back and sometimes shoots down the back of your right upper leg. The pain is sharp and at times can be a 9/10 in severity (10 being the worst pain of your life). Right now it is around 6/10. You take Vicodin, a pain medication, to help you about 3-4 times a day. It gives you relief when you take it, but it does not get rid of the pain completely. You initially saw your primary care physician about 2 months ago and she sent you for an MRI (a computerized image) of your back which you subsequently got. Because of the pain, you were unable to work at your job as an electrician and could not pay for your health insurance. Frustrated after fighting over the phone with the insurance company and not having any more pain medication, you went to the ER about a week ago to see what could be done for your back. They looked at the MRI report, did a brief physical exam and sent you home having prescribed you some more Vicodin and an appointment to see a neurologist that is scheduled for 2 weeks from today. They didn’t explain exactly what was wrong with your back, but you were glad to have been given some medication that gave you some relief.

The pain, however, has not changed significantly. Frustrated again, you have returned to the ER hoping to get an earlier appointment to see the pain specialist as the appointment you currently have is not until next week.

CHARACTER DESCRIPTION

Objective: To have your complaint taken seriously and to understand what is wrong with your back

Obstacles:
- You feel the need to vent about how frustrating the system is.
- You are in pain and it affects your mood at times making you sad and frustrated, particularly if people are giving you a hard time.
- You are also frustrated due to your inability to work and your loss of health insurance.
### Tactics:
If asked what you want, you state that you want to see the pain specialist sooner, like today or tomorrow. You give the MRI report to the physician by the middle of the interview and ask “Should I be worried?” You become more engaged if the physician is making an effort to be helpful and empathic. Conversely, you become more withdrawn and frustrated if the physician is dismissive or judgmental.

### YOUR CURRENT LIFE SITUATION AND PAST HISTORY
Until recently, you worked as an electrician in Manhattan. You are married with no children. Your wife is a dental assistant and you have been married for 20 years living near the East River on the upper east side. You are generally active taking walks with your wife often and playing softball when the weather permits. Now, with your back pain, you rarely play softball, but are still able to walk briskly without too much pain.

Other than your back pain, you are healthy. You have never had surgery and have never been hospitalized. You saw your primary care physician fairly regularly (every 6 to 12 months) when you were insured.

### SOCIAL HISTORY
You drink alcohol occasionally (3-4 beers per week). Alcohol gives you some back pain relief. You do not smoke and never have. You do not use recreational drugs. You are sleeping and eating well and are able to enjoy things like going to the movies and restaurants with your wife.

### FAMILY HISTORY
Both of your parents live on Long Island. Your father has high blood pressure, but is otherwise healthy. Your mother has osteoarthritis and is overweight. Your only brother lives in Chicago and is healthy.

### MEDICATIONS
Vicodin, 1 tablet every 4-6 hours
Multivitamin

### ALLERGIES
None
When the resident enters the room, you are sitting in a chair slightly hunched over. Your back hurts and at times it is painful to move. You don’t directly face the resident. In general, your frustration is manifested in self pity and sadness. You punctuate your performance with moments of intense frustration and at times anger regardless of how nice the resident may be.

You are somewhat poorly engaged with the resident. You occasionally answer straightforward questions by repeating the question in a frustrated fashion and give a somewhat ambiguous answer. For example, if the physician asks “What makes the pain better?”, state: “What makes it better? Well, I don’t know. I mean, it just hurts you know?”

If asked in an open ended way about why you are here, state: **“Well, I’m here because my back hurts. It’s been hurting for awhile and I need some help.”** Do not offer more spontaneously.

If asked to go further in an open-ended fashion (ie: “Tell me more” or “Can you share with me what has been going on?”), state with a frustrated almost sad tone: **“Well, this has been going on for a few months now and it just isn’t getting better. My regular doctor won’t see me anymore...I can’t really work, you know? I was here last week, but I didn’t get a straight answer about what’s going on and I’m not any better. I really need someone who can help me.”**

If asked specifically what you want, state: **“I would like an earlier appointment to see this pain specialist, like today or tomorrow.”**

If the resident is dismissive to this request or becomes frustrated without giving an explanation, you become less engaged by turning slightly away from the resident and becoming more frustrated in your answers to questions.

If the resident is respectful and non-condescending in explaining why you can’t get an earlier appointment, turn towards the resident and become less frustrated.

If asked if you want more pain drugs, state: **“Do you think that will help?”**
Whatever the resident’s response, state: “**You know, I don’t really want to take any more drugs.**”

If not already discussed in the interview by the middle, give the MRI report to the resident and state: “**I got this MRI a few weeks ago. Should I be worried?**”

If the resident begins to explain to you what is wrong with your back or explain the MRI report in a way that you understand, you turn towards the resident and become less frustrated.

If the resident uses a word you don’t understand, ask “What does that mean?”

Towards the end of the interview, **be sure to vent**. Regardless of how the interview has gone, state in annoyed almost angry tone: “**Well, what am I supposed to do now? I came here to get help and I’m not really getting any. These meds don’t really work and I’m going to have wait for a month to see a specialist? How do you expect me to go on?**”

Adequately challenge the resident. If he/she is making an obvious effort to be helpful and understanding, you become less frustrated and more engaged with him/her. If the resident is dismissive, judgmental, or not empathic, you become less engaged and more frustrated, sad and annoyed.

You remain frustrated and angry unless the resident performs the all of the following:

1. asks about impact of pain on functioning
2. apologizes for the system
3. assess resources (ie lack of insurance/employment) and offers social services to help
4. addresses the need for you to find a primary care physician
5. offers to call/help you get an earlier neurology appointment

**SYMPTOM HISTORY**

You’ve been asked these same questions 4 or 5 times in the last few months, so you get annoyed a little when asked and answering them. Remember to occasionally answer a few questions by repeating the question in a frustrated way and then answer it **ambiguously** (i.e. “What does it feel like? Well, I don’t know. I
mean, I guess it kind of sharp, or stings maybe. It just hurts you know?”

Where is the pain: “Just to the right of center on the lower part of my back.”
What does the pain feel like: “It is sharp, sometimes electric.”
Does the pain radiate? “Down my right leg sometimes”
How far down your leg? “Just above the knee”
How bad is the pain on a scale from 1-10? “About a six”
How often do you get the pain? “On and off”
Is it getting worse? “I guess not, but it still hurts.”
Anything make it worse? “Sitting for a long time or bending too far.
Like reaching down to tie my laces.”
Anything make it better? “Not much.”
What about the Vicodin? “Sure. When I take it. I mean, it helps a little.”

Any pain anywhere else or in any joints? “No”
Any recent trauma? “No”
Any fevers? “No”
Any weight loss? “No”
Any cough? “No”
Any night sweats? “No”
Any rash? “No”
Any loss of bladder control? “No”
Any loss of sensation? “No”
Any weakness in the legs? “No”
Any abdominal pain? “No”
Any pain with eating? “No”
Any trouble breathing? “No”
Any chest pain? “No”
Any constipation? “No”

Do you feel depressed? “No, just frustrated.”
How is your concentration? “Fine”
Do you feel guilty? “No”
### CHALLENGES FOR THE RESIDENT

- Educate a frustrated patient on how to best manage their disease
- Educate a frustrated patient about how to use the ER appropriately
- Encourage use of social services and emphasize finding a primary care physician.
- Remaining respectful and helpful when working with a frustrated patient

### CUES FOR THE RESIDENT

<table>
<thead>
<tr>
<th>Non-Verbal 1</th>
<th>Turned away from resident if dismissive or not empathic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Verbal 2</td>
<td>Turn toward resident if making an obvious effort to be helpful and understanding</td>
</tr>
<tr>
<td>Verbal 3</td>
<td>In regards to the MRI report: “Should I be worried?”</td>
</tr>
<tr>
<td>Verbal 4</td>
<td>(venting): “Well, what am I supposed to do now? I came here to get help and I’m not really getting any. These meds don’t really work and I’m going to have wait for a month to see a specialist? How do you expect me to go on?”</td>
</tr>
</tbody>
</table>

### TIMING

**Initially:** In pain, slightly withdrawn and frustrated with a sad tone.

**Ongoing:** Become more withdrawn or sad if the resident is dismissive or not understanding/helpful. Conversely, become more engaged if the resident is understanding and helpful.

Provide the MRI report if not discussed by middle of interview.

**2 minute warning:** Remain dissatisfied with the plan and be sure to vent.
**Repeat Visitor**

Evaluator’s Name: __________________________

### COMMUNICATION

<table>
<thead>
<tr>
<th>Information Gathering</th>
<th>Not Done</th>
<th>Partially Done</th>
<th>Well Done</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Used open-ended questions</strong></td>
<td>Replied heavily on single response questions</td>
<td>Used some open-ended questions but stopped prematurely</td>
<td>Used open-ended questions as appropriate to fully gain your perspective</td>
</tr>
<tr>
<td><strong>Managed the narrative flow of your story</strong></td>
<td>Was not able to elicit story because questions not organized logically</td>
<td>Elicited main elements of story, but illogical order of questions disrupted flow</td>
<td>Elicited full story by asking questions that facilitated natural flow of story</td>
</tr>
<tr>
<td><strong>Elicited your responses using appropriate questions:</strong></td>
<td>Impeded story by asking leading/judgmental questions AND more than one question at a time</td>
<td>Used leading/judgmental questions OR asked more than one question at a time</td>
<td>Asked questions one at a time without leading patient in their responses</td>
</tr>
<tr>
<td>- No leading questions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Only one question at a time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Clarified information by repeating to make sure he/she understood you on an ongoing basis</strong></td>
<td>Did not clarify (did not repeat back to you the information you provided)</td>
<td>Repeated information you provided BUT did not give you a chance to indicate if accurate</td>
<td>Repeated information AND directly invited you to indicate whether accurate</td>
</tr>
<tr>
<td><strong>Allowed you to talk without interrupting</strong></td>
<td>Interrupted</td>
<td>Did not interrupt directly BUT cut responses short by not giving enough time</td>
<td>Did not interrupt AND allowed time to express thoughts fully</td>
</tr>
</tbody>
</table>

### Relationship Development

| Communicated concern or intention to help | Did not communicate intention to help/concern via words or actions | Words OR actions conveyed intention to help/concern | Actions AND words conveyed intention to help/concern |
| Non-verbal behavior enriched communication (e.g., eye contact, posture) | Non-verbal behavior was negative OR interfered with communication | Non-verbal behavior demonstrated attentiveness | Non-verbal behavior facilitated effective communication |
| Acknowledged emotions/feelings appropriately | Did not acknowledge emotions/feelings | Acknowledged emotions/feelings | Acknowledged AND responded to emotions/feelings in ways that made you feel better |
| Was accepting/non-judgmental | Made judgmental comments OR facial expressions | Did not express judgment BUT did not demonstrate respect | Made comments AND expressions that demonstrated respect |
| Used words you understood and/or explained jargon | Consistently used jargon without further explanation | Sometimes used jargon AND did not explain it | Explained jargon when used OR avoided jargon completely |

### Education and Counseling

| Asked questions to see what you understood | Did not check for understanding | Asked if patient had any questions BUT did not check for understanding | Assessed understanding by checking in throughout the encounter |
| Provided clear explanations/information | Gave confusing OR no explanations which made it impossible to understand information | Information was somewhat clear BUT still led to some difficulty in understanding | Provided small bits of information at a time AND summarized to ensure understanding |
| Collaborated with you in identifying possible next steps/plan | Told you next steps | Told you next steps THEN asked your views | Elicited your views on next steps, shared own ideas, THEN mutually developed a plan of action |

### MANAGING DIFFICULT SITUATIONS

| Managing a Difficult Situation | | | |
| Assessed patient expectations | Did not ask about your expectations for the visit | Asked about your expectations BUT did not acknowledge/validate your wants | Asked about your expectations AND acknowledged/validated your wants |
| Avoided assigning blame | Became defensive/argumentative AND assigned blame to a person/department | Became defensive/argumentative OR assigned blame to a person/department | Remained calm AND did not mention blame |
| Maintained professionalism by controlling emotions | Unable to control emotions, becoming dismissive and condescending him/herself | Attempted to control emotions (e.g. was somewhat dismissive or condescending) | Maintained a high level of professionalism in handling your specific situation, did not show anger and frustration |

**EMPACT 2007: Repeat Visitor**
<table>
<thead>
<tr>
<th>Accountability</th>
<th>Not Done</th>
<th>Partially Done</th>
<th>Well Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledged issues with system</td>
<td>Did not acknowledge issues with system</td>
<td>Acknowledged issue with system</td>
<td>Acknowledged issue with system AND attempted to explain how system works</td>
</tr>
<tr>
<td>Took responsibility for situation</td>
<td>Took no personal responsibility for your present situation (e.g., assigns your problem to other person/department)</td>
<td>Took general responsibility as part of the department for your present situation</td>
<td>Took personal responsibility for your situation (&quot;I will...&quot;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Delivering Bad News</th>
</tr>
</thead>
</table>
| **Gave you opportunity to emotionally respond:**  
  - Remains sensitive to your venting of shock/anger/disbelief/accusations  
  - Attends to emotions before moving on                                          |
| Responded inappropriately to your emotional response (no opportunity to vent, cuts you off, becomes defensive)                                                                                                      | Allowed you to emotionally respond (vent) BUT did not address/acknowledge response before moving on | Allowed you to express your feelings fully, giving you the feeling you were being listened to before moving on |
| Did not ask specifically "What are you thinking/feeling?"                                                                                                                                                    | Acknowledged your feelings (e.g., "I see that you are upset...") BUT did not specifically ask you to name your emotions | Specifically asked you "What are you thinking/feeling?"                                           |
| Did not make plans to contact you again                                                                                                                                             | Offered in general to be available should you need him/her                                                                                   | Made him/herself available for follow-up by providing you with his/her personal contact information |

<table>
<thead>
<tr>
<th>Patient Education</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessed resources</strong></td>
</tr>
<tr>
<td>Did not assess resources (insurance, employment) AND did not offer social services (social work, etc.)</td>
</tr>
<tr>
<td><strong>Identified need for a primary care physician</strong></td>
</tr>
<tr>
<td>Did not identify need for finding a primary care physician</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Would you recommend this doctor to a friend for his/her interpersonal skills?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Not Recommend</strong> Non -exemplary Physician: superficial, artificial demeanor applied knowledge base inadequate to my situation</td>
</tr>
</tbody>
</table>

**COMMENTS:**
STATION OVERVIEW

OBJECTIVES
This station is designed to test resident’s ability to:

- Appropriately use an interpreter
- Obtain informed consent
- Develop a plan

LOGISTICS
Personnel: SP, female, 50 y.o., wearing a gown, sitting in chair. Interpreter, male, sitting next to SP

Station Materials: 
- Resident instructions
- Informed consent sheet
- SP Instructions
- SP evaluation forms
- Faculty evaluation forms

Room Arrangement: 
- Station signs
- Examination table
- Chair (3)
**PATIENT INFORMATION**

Name: Kamrun Naher  
Age: 50 y.o.

**REASON FOR VISIT**

Bengali speaking woman with history of Type II Diabetes controlled on Glucophage presenting with right lower quadrant pain for 1 day. She has associated fever and chills, poor appetite with nausea and vomiting.

**VITALS**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>T:  99.5</td>
<td>BP: 115/75</td>
</tr>
<tr>
<td>HR:  75</td>
<td>RR:  10</td>
</tr>
<tr>
<td>O2sat: 100% room air</td>
<td></td>
</tr>
</tbody>
</table>

**LABS**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CBC</td>
<td>WBC: 18, otherwise normal</td>
</tr>
<tr>
<td>Electrolytes</td>
<td>BUN 18  Cr 1.3, otherwise normal</td>
</tr>
<tr>
<td>Other labs</td>
<td>Normal</td>
</tr>
</tbody>
</table>

**YOUR ROLE**

Resident

**YOUR TASKS**

1) Obtain informed consent from the patient for a CT with IV contrast to evaluate for a diagnosis.  
2) Effectively and appropriately use an ad hoc interpreter

*DO NOT PERFORM A PHYSICAL EXAM*
STANDARDIZED PATIENT INSTRUCTIONS

THE SCENARIO
You work as a registration clerk in the ER. Today, things have been slow and one of the nurses has asked you to translate for a Bengali speaking patient who is here today. You have done this a few times before and you enjoy it. Your job is relatively boring and you feel important when you get asked to translate. Also, you like chatting with Bengali speaking patients because you often feel lonely at your job.

You live with four Bengali men in Jackson Heights, all of whom are married, including you. The rest of your families still live in Bangladesh. You miss them a lot but are hopeful that you will be able to move them out here soon.

You have already been speaking with the patient, Momena Khatu, for about 10 minutes before the doctor enters the room. She seems very shy, but pleasant. You learn her family is from a village near where your family is from and that she lives in Queens. You learn that she may need a CT scan. Your aunt had one for her head last year. Mrs. Khatu didn’t seem to know all that much about it so you are eager to educate her and share some of the thoughts you had on your aunt’s situation.

TARGET OBJECTIVE: To effectively translate for the patient and the doctor

TARGET OBSTACLES:
- You are chatty and can’t help yourself sometimes to go off on tangents
- You editorialize sometimes because you feel you are helping

TARGET TACTICS:
After the first question posed by the doctor, have an extended back and forth with the patient and then give a one word or very brief answer. Occasionally, interrupt the patient in Bengali and have a brief back and forth. If there is a pause in the interview, start a casual conversation with the patient.
Kamrun Naher is a 50 year old Bengali woman who has been living with her husband and her 3 children (2 sons and a daughter) in the US for 10 years. She lives in a fairly isolated community where she almost exclusively speaks Bengali. She does not work outside of the home. Her knowledge of medicine is limited. She had a grandmother who had kidney failure.

With respect to her possible appendicitis, she understands that it is serious and that she could die if it is not treated. She also understands that contrast has risks (could cause kidney failure, but thinks that the likelihood of that happening is high). She remembers her grandmother who had kidney failure and is does not want to end up like her.

If the resident adequately explains (by using the interpreter correctly) the risks (i.e. shares that the risk is low, preventable and reversible) and is not dismissive and does not minimize of the patient’s concerns, then she decides to have the CT with contrast. If the resident does not completely explain the nature of the risks and address the patient’s concerns, then she refuses the CT with contrast.
## SYMPTOM HISTORY

With respect to her abdomen:

- Where is the pain? – lower right side
- What does it feel like? – it is an achy pain, that is sharp at times
- Is it constant? – yes
- How severe? – 7 of 10 (where 10 is the worst)
- Does the pain radiate anywhere? - No
- Does it hurt when you touch it? - Yes

In general:

- Fever? – Feel feverish, but never measured it
- Nausea? – Yes
- Vomiting? – No
- Diarrhea? – No
- Blood in stool? - No
- Able to eat? - No
- Back pain? – No
- Pain with urination? – No
- Vaginal pain or irritation? – No
- Any recent travel? - No

## PAST MEDICAL HISTORY

Until one day ago she had felt fine. She sees a doctor intermittently for her diabetes and high blood pressure.

## FAMILY HISTORY

The patient has 3 other siblings, 2 younger and one older. One died a few years ago from cancer in Bangladesh but she does not know of what kind. Her mom is 80 and is still alive and lives in Bangladesh with one of her siblings and she has a brother who lives in California with whom she is not very close to. Her father died of some kind of infection about 4 years ago at the age of 80.

## MEDICATIONS

Glucophage for diabetes
Lasix for high blood pressure

None
<table>
<thead>
<tr>
<th><strong>SUBSTANCE USE</strong></th>
<th><strong>THE MEDICAL ENCOUNTER</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol: None</td>
<td>When the resident enters the room, you are sitting next to the patient discussing her family and where she is from. You are happy to be interacting with her enjoying speaking with someone from a similar background. When the resident enters, smile and introduce yourself first as a clerk in the ER who speaks Bengali. Then introduce the patient who just nods her head and smiles. You state you are here to translate for her since she speaks almost no English.</td>
</tr>
<tr>
<td>Smoking: None, nor anyone at home</td>
<td>If the resident thanks you for helping, you tell him it is not a problem. State: “Things aren’t too busy right now.”</td>
</tr>
<tr>
<td>Illicit drugs: None</td>
<td>If the resident expresses concern about your translating, state: “Don’t worry, I speak English and Bengali very well.”</td>
</tr>
</tbody>
</table>

For the first few questions, have an extended back and forth exchange with the patient before answering the doctor with either a yes, no or few word answer. For example, if the resident asks how she is feeling, talk with her for a minute before answering “She feels fine.”

Make minimal eye contact with the patient when you are talking as you are strangers, but still face her. Then turn or move closer to the resident to give them the answers. You should give the impression you are separating yourself from the patient when you interact with the resident.

If the resident makes too much eye contact with you, keep talking to him/her.

If the resident asks you *once* to please just translate word for word, explain that the patient seems very shy and you are just coaxing her to answer. You agree verbally to translate as asked by the resident; but, you continue to translate as before having a back and forth with the patient before answering the question. If the resident asks you a *second time* to translate word for word, you now do exactly what the resident asks of you.
Should the resident never give you instructions on how they want you to translate (or only stops the interview once in a while to clarify with you what the patient said but never specifically tells you how they want you to translate) you conduct the entire interview in the original manner, continuing a back and forth conversation with the patient and summarizing what she says for the resident.

If the resident begins the interview by telling you how they want you to translate, you still have a back and forth with the patient before answering/responding. However, the resident only needs to correct your behavior once for you to follow the resident’s instructions.

When the resident is first explaining the risks of contrast, regardless of what he/she says, state: “You know, my aunt had one of those once. She got a very warm feeling when it happened. Is that normal?”

Once the patient understands what the CT is, she explains that she wants to consult with her husband before agreeing to get the CT. He is, however, about an hour away. If the resident explains that the test is urgent, she agrees to get the CT anyway.

When it comes to making a final decision about treatment, if the resident has built rapport, focused on the patient, given appropriate instructions and redirections to the interpreter, and addresses her concerns respectfully, then the patient chooses to get the CT with contrast. If the resident has not, she still agrees, but becomes more withdrawn from the encounter.

**CHALLENGES FOR THE RESIDENT**

- Discuss with the patient the risks and benefits of having a CT with contrast using an ad hoc translator.
- Exhibit non-verbal communication with the patient
- State clearly what your expectations are from the interpreter
- Make clear statements to redirect interpreter
- Elicit the patient’s preferences.

**CUES FOR THE RESIDENT**

- **Non-verbal:** Continue to make eye contact with the resident if the resident makes too much eye contact with you.
- **Verbal/Non-verbal:** Shake the resident’s hand first and then introduce the patient


**COMMUNICATION**

<table>
<thead>
<tr>
<th>Information Gathering</th>
<th>Not Done</th>
<th>Partially Done</th>
<th>Well Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Used open-ended questions</td>
<td>Replied heavily on single response questions</td>
<td>Used some open-ended questions but stopped prematurely</td>
<td>Used open-ended questions as appropriate to fully gain your perspective</td>
</tr>
<tr>
<td>Managed the narrative flow of your story</td>
<td>Not able to elicit story because questions not organized logically</td>
<td>Elicited main elements of story, but illogical order of questions disrupted flow</td>
<td>Elicited full story by asking questions that facilitated natural flow of story</td>
</tr>
<tr>
<td>Elicited your responses using appropriate questions:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- No leading questions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Only one question at a time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarified information by repeating to make sure he/she understood you on an ongoing basis</td>
<td>Did not clarify (did not repeat back to you the information you provided)</td>
<td>Repeated information you provided BUT did not give you a chance to indicate if accurate</td>
<td>Repeated information AND directly invited you to indicate whether accurate</td>
</tr>
<tr>
<td>Allowed you to talk without interrupting</td>
<td>Interrupted</td>
<td>Did not interrupt directly BUT cut responses short by not giving enough time</td>
<td>Did not interrupt AND allowed time to express thoughts fully</td>
</tr>
</tbody>
</table>

| Relationship Development | | | |
| Communicated concern | Did not communicate intention to help/concern via words or actions | Words OR actions conveyed intention to help/concern | Actions AND words conveyed intention to help/concern |
| Non-verbal behavior | Non-verbal behavior was negative OR interfered with communication | Non-verbal behavior demonstrated attentiveness | Non-verbal behavior facilitated effective communication |
| Acknowledged emotions/feelings appropriately | Did not acknowledge emotions/feelings | Acknowledged emotions/feelings | Acknowledged AND responded to emotions/feelings in ways that made you feel better |
| Was accepting/non-judgmental | Made judgmental comments OR facial expressions | Did not express judgment BUT did not demonstrate respect | Made comments AND expressions that demonstrated respect |
| Used words you understood and/or explained jargon | Consistently used jargon without further explanation | Sometimes used jargon AND did not explain it | Explained jargon when used OR avoided jargon completely |

| Education and Counseling | | | |
| Asked questions to see what you understood | Did not check for understanding | Asked if patient had any questions BUT did not check for understanding | Assessed understanding by checking in throughout the encounter |
| Provided clear explanations/information | Gave confusing or no explanations which made it impossible to understand information | Information was somewhat clear BUT still led to some difficulty in understanding | Provided small bits of information at a time and summarized to ensure understanding |
| Collaborated with you in identifying possible next steps/plan | Told you next steps | Told you next steps then asked your views | Elicited your views on next steps, shared own ideas, then mutually developed a plan of action |

| WORKING WITH AN INTERPRETER | | | |
| Overcoming Language Barriers | | | |
| Made clear statements about translating process (e.g. word for word) | Did not direct the interpreter on how to proceed | Directed interpreter how to proceed once or made confusing statement about translation process | Clearly directed interpreter how to proceed more than once AND adjusted seating |
| Maintained eye contact with the patient | Did not make eye contact with patient | Made some eye contact with patient but spent majority of time looking at interpreter | Maintained eye contact with patient |
| Maintained respectful attitude towards interpreter | Demonstrated annoyance or disrespect towards interpreter | Attempted awkwardly to maintain respectful attitude towards interpreter | Maintained respectful attitude towards interpreter at all times |
**Shared Decision Making/Informed Consent**

<table>
<thead>
<tr>
<th>Item</th>
<th>Not Done</th>
<th>Partially Done</th>
<th>Well Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discussed patient’s role in the decision</td>
<td>Assumed the role patient would like to take (active OR passive)</td>
<td>Only asked about patient’s preference OR only stated own preference</td>
<td>Stated own preference (e.g., “I’d like us to make this decision together”) BUT also inquired about and respected patient’s wishes</td>
</tr>
<tr>
<td>Discussed the clinical issue clearly and advises CT scan with contrast</td>
<td>Did not clearly describe CT scan or advise patient to have test</td>
<td>Advised patient but had unclear, too much in-depth or complicated description of test or indications</td>
<td>Clearly advised CT scan AND had a short, clear description of procedure and indications</td>
</tr>
<tr>
<td>Described benefits:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Makes diagnosis fast</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Less chance of rupture and infection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Option of less invasive surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Described risks:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Allergies: flush, itch, rash, shortness of breath or death</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Kidney damage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussed alternatives to CT scan</td>
<td>Did not discuss alternatives</td>
<td>Mentioned alternatives without adequate discussion</td>
<td>Discussed alternatives in clear and understandable manner</td>
</tr>
<tr>
<td>Assessed patient’s understanding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not assess your understanding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agreed on an action plan and completed arrangements</td>
<td>Did not state next steps</td>
<td>Stated what you need to do next without checking if you agree to the plan</td>
<td>Summarized and checked on agreed upon plan</td>
</tr>
<tr>
<td><strong>Would you recommend this doctor to a friend for his/her interpersonal skills?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Recommend</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommend with Reservation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommend</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highly Recommend</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Would you recommend this doctor to a friend for his/her medical competence?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Recommend</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommend with Reservation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommend</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highly Recommend</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**COMMENTS:**
Verbal 1: Have an extended back and forth with the patient during the first few questions

Verbal 2: When the resident is explaining what a CT is/the risks or benefits, you ask if feeling a warm sensation while having a CT is normal.

**Initially:** You are sitting chatting with the patient as the doctor comes in. You first introduce yourself and then the patient. If the resident asks you to ask the patient how she is, you speak for a bit and then tell him/her she is fine.

**Ongoing:** You continue to respond directly to the resident and editorialize the patient’s responses until the resident does the following:

- Explains why it is important that you translate properly
- Gives you very specific instructions about what to do and reminds you a few times

**2-minute warning:** If the resident has built rapport and explained his/her concerns and attempted a number of time to focus on the patient not the interpreter, then the patient will decide to get the CT with contrast. If not, then the patient refuses.
<table>
<thead>
<tr>
<th><strong>OBJECTIVES</strong></th>
<th>This station is designed to test resident’s ability to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Transfer patient care responsibility effectively,</td>
</tr>
<tr>
<td></td>
<td>professionally, and accurately.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>LOGISTICS</strong></th>
<th>Personnel: Standardized resident, phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Station Materials:</td>
</tr>
<tr>
<td></td>
<td>• Resident instructions</td>
</tr>
<tr>
<td></td>
<td>• SR Instructions</td>
</tr>
<tr>
<td></td>
<td>• SR evaluation forms</td>
</tr>
<tr>
<td></td>
<td>• Faculty evaluation forms</td>
</tr>
<tr>
<td></td>
<td>Room Arrangement:</td>
</tr>
<tr>
<td></td>
<td>• Station signs</td>
</tr>
<tr>
<td></td>
<td>• Chair (2)</td>
</tr>
</tbody>
</table>
EMPACT OSCE - Transfer Station ___

RESIDENT INSTRUCTIONS

REASON FOR ENCOUNTER

- You arrived in the Bellevue ER an hour ago for your shift and got sign out.
- The Resident who signed out to you had been waiting for the General Surgery Service to return a page in order to admit an ER patient to their service due to an open ulcer on her right medial malleolus.
- Your fellow resident had to leave, and you have agreed to take responsibility for the patient and present the patient to the Surgery Service.
- The patient’s chart is provided for you in the room as are the ER guidelines for admitting this patient.

YOUR TASKS

1) Review the patient’s chart
2) Call the operator at: ___ and ask to have Surgery paged to the phone in the room (___)
3) Present the patient as she is to be admitted to the Surgery Service due to an open diabetic ulcer on her right ankle.
You are Joanna Lee, a 30 year old 3rd year Surgery Resident (a doctor in training who has worked at Bellevue Hospital as a surgeon for 3 years). You are running the General Surgery Service (a group of health professionals that take care of patients with medical problems that may require surgery), a busy service at Bellevue with many patients. An hour ago you received a page from the Emergency Room. They typically page you in order to either admit patients to your service or ask for your advice (i.e. a consult) about how to manage a patient.

When the ER paged you, you were operating with your Chief (your boss) and could not get away to return the page. You have just finished and your Chief is going to a room in the hospital to rest having been up for 24 hours. You are loath to disturb him. You have been working as a surgeon for awhile now and you feel like you should be more proactive and independent in making decisions about patients.

You are paged again by the ER and promptly return their call.

Objective: To feel confident in your decision to admit or not admit the ER patient with an ulcer on her ankle.
Obstacles:

- You haven’t managed a diabetic patient in awhile, even though you know you should be able to. You would prefer that a diabetic patient be admitted to a General Medicine Service as they typically have more experience in managing high blood glucose.
- You are suspicious of the ER resident’s diagnosis of urinary tract infection. You are worried that the blood in the patient’s urine may be more serious than a simple urinary tract infection and should be further worked-up (evaluated) by a specialist (i.e. Urology, surgical experts in bladder and kidney problems)
- You are loath to wake up your Chief (your boss).

Tactics:

You are initially resistant to admitting a patient with uncontrolled diabetes. You feel that this patient could be better served by a Medicine Service.

You are further resistant to admitting a patient with blood in her urine without having first been seen (evaluated) by Urology.

If the ER resident adequately addresses your concerns about the patient’s uncontrolled diabetes and the blood in her urine, you will agree to admit the patient.

If the ER resident inadequately addresses your concerns, you share with the ER resident that you will talk with your Chief and get back to him/her.

You have been married for 3 years, but are currently separated from your husband. You have been very dedicated to your work and it has put a strain on your marriage. Your husband has become less and less supportive as you have worked more and more (80 hour weeks, sometimes more). He views it as you choosing your work over him. You view his attitude as selfish as your work is important, but often draining requiring you to have someone in your life who is supportive. In addition, work has become more and more stressful as your responsibilities have been increasing. As a result, when patients die (which is not uncommon) you have been feeling more and more guilty. Most of your colleagues at work are in
similar situations. You are reticent to talk about it with them, finding it easier to immerse yourself even deeper into your work. You do, however, find great satisfaction in caring for patients and solving their problems which keeps you going day after day.

Overview: You are about to return a page to the Emergency Department about a patient who has blood in her urine (the ER Resident thinks the blood is due to a urinary tract infection, but you are suspicious it could be something else), an ulcer on her ankle as well as under-controlled diabetes. The ulcer is a surgical problem, but will in all likelihood NOT require surgery. The diabetes is a problem that typically is treated by an Internal Medicine Service. You are, however, most concerned about the blood in the patient’s urine. You want a specialist from Urology to see the patient before you admit the patient to the General Surgery Service because you don’t feel comfortable treating someone with blood in their urine as it is not a problem that you treat very frequently.

You feel like this has happened before: the ER is trying to admit a patient to your service that you feel the patient should go to a different service or at least be seen by a specialist prior to being put on your busy service because you honestly feel that their medical problems would be better addressed by a different type of doctor.

The ER resident may state that “the guidelines” indicate that this patient should go the Surgery Service. Although institutionally appropriate, the use of the guidelines annoys you a little. You feel that patients should be treated as individuals, not algorithms. So when the guidelines come up, you accept them, but are a bit condescending (as though the ER resident is acting like a goody-two shoes).

When the resident answers the phone, state in an almost annoyed tone,“Surgery, I was paged.”

When the ER Resident says they have a patient for you state skeptically: “Alright. Go ahead.”

Then allow the resident to present the patient and let him/her finish
before responding. The presentation will most likely go something like this:

“This is Meredith Jones, a 55 year old woman with diabetes presenting with increased pain, redness and drainage from a chronic venous stasis ulcer on her right medial malleolus for the last 2-3 days. She’s never had it debrided and she’s on Tylenol for pain and glucophage for her diabetes. She also has dysuria with increased frequency and intermittent hematuria for a day. She has a history of UTI six months ago.

“On exam, she has a draining ulcer on her right medial malleolus without streaking. She has suprapubic tenderness and no CVT.

“Labs were significant for a WBC of 10.6, a glucose of 290 and a dirty urine. She got 3 grams of Unasyn and some Norco for pain. Do you want to come down to see her?”

Please reference the flowsheet to guide your response to the presentation.

If the Resident only mentions the diabetes (ie never brings up the UTI or a urinalysis) state: “Well, what’s the patient’s urine look like?” and proceed down the UTI flowsheet.

After going through the flowsheet, if the Resident is not being helpful and/or becomes confrontational and the conversation needs to end, state: “Don’t admit her until I get down there.”

If the resident remains confrontational, state: “Look, I’m just gunna have to talk with my Chief, okay?”

- Maintain a calm and professional attitude in a time of conflict with another service

Initially: Annoyed tone, curt, asking for clarification.
Ongoing: Resistant to admitting the diabetic patient and suspicious of the UTI diagnosis, somewhat confrontational.

2-minute warning: If the Resident has been accommodating maintaining a calm tone and explaining the situation without making it personal, then acquiesce and accept the patient. If the Resident is confrontational and not addressing your concerns, then you say that you will have to talk with your attending before accepting the patient.
## Transfer

Evaluator’s Name: ____________________

### COMMUNICATION

<table>
<thead>
<tr>
<th>Information Gathering</th>
<th>Not Done</th>
<th>Partially Done</th>
<th>Well Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elicited your responses using <strong>appropriate questions</strong>:</td>
<td>Impeded story by asking leading/judgmental questions AND more than one question at a time</td>
<td>Used leading/judgmental questions OR asked more than one question at a time</td>
<td>Asked questions one at a time without leading patient in their responses</td>
</tr>
<tr>
<td>- No leading questions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Only one question at a time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarified information by repeating to make sure he/she understood you on an ongoing basis</td>
<td>Did not clarify (did not repeat back to you the information you provided)</td>
<td>Repeated information you provided BUT did not give you a chance to indicate if accurate</td>
<td>Repeated information AND directly invited you to indicate whether accurate</td>
</tr>
<tr>
<td>Allowed you to talk <strong>without interrupting</strong></td>
<td>Interrupted</td>
<td>Did not interrupt directly BUT cut responses short by not giving enough time</td>
<td>Did not interrupt AND allowed time to express thoughts fully</td>
</tr>
</tbody>
</table>

### Relationship Development

| Communicated concern or intention to help | Did not communicate intention to help/concern via words or actions | Words OR actions conveyed intention to help/concern | Actions AND words conveyed intention to help/concern |
| Acknowledged emotions/feelings appropriately | Did not acknowledge emotions/feelings | Acknowledged emotions/feelings | Acknowledged AND responded to emotions/feelings in ways that made you feel better |
| Was **accepting/non-judgmental** | Made judgmental comments | Did not express judgment BUT did not demonstrate respect | Made comments that demonstrated respect |

### Education and Counseling

| Asked questions to see what you understood | Did not check for understanding | Asked if you had any questions BUT did not check for understanding | Assessed understanding by checking in throughout the encounter |
| Provided **clear explanations/information** | Gave confusing OR no explanations which made it impossible to understand information | Information was somewhat clear BUT still led to some difficulty in understanding | Provided small bits of information at a time AND summarized to ensure understanding |
| Collaborated with you in identifying possible next steps/plan | Told you next steps/plan | Told you next steps then asked your views | Elicited your views on next steps, shared own ideas, then mutually developed a plan of action |

### PHONE CALL WITH COLLEAGUE

<table>
<thead>
<tr>
<th><strong>Phone Skills</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ID self/role ID patient</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Accountability</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Focused on the needs of patient</strong></td>
</tr>
</tbody>
</table>

| **Shared responsibility for the situation** | Took no personal responsibility for present situation (e.g., assigned problem to your department) | Offered you advice for how to proceed (“You can call Med Consult”) | Took personal responsibility for situation (I am happy to contact Med Consult for you) |
### Interdisciplinary Respect

<table>
<thead>
<tr>
<th>Demonstrated respect</th>
<th>Made inflammatory or insulting comments AND raised his/her voice</th>
<th>Was neutral</th>
<th>Remained calm, connected and respectful toward you</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledged his/her own role in this patient's care (e.g., need to address surgical residents clinical concerns)</td>
<td>Engaged in evasive discussion to avoid having to discuss level of sugar or blood in urine, stressing that &quot;this is a surgery case&quot;</td>
<td>Acknowledged surgical residents issues with the sugar and urine BUT expressed annoyance and reluctance to address surgical residents concerns</td>
<td>Acknowledged role in patient's care AND offered solutions to clinical concerns</td>
</tr>
<tr>
<td>Understood hospital guidelines regarding the appropriateness of the admission</td>
<td>Did not mention guidelines</td>
<td>Mentioned guidelines BUT did not explain them</td>
<td>Either stated correctly OR asked for clarification of guidelines AND embraced them</td>
</tr>
</tbody>
</table>

### Managing a Difficult Situation

<table>
<thead>
<tr>
<th>Avoided assigning blame</th>
<th>Became defensive/argumentative AND assigned blame to a person/department</th>
<th>Became defensive/argumentative OR assigned blame to a person/department</th>
<th>Remained calm AND did not mention blame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintained professionalism by controlling emotions</td>
<td>Was unable to control emotions, becoming dismissive and condescending him/herself</td>
<td>Attempted to control emotions (e.g. Was somewhat dismissive or condescending)</td>
<td>Maintained a high level of professionalism in handling your specific situation, did not show anger or frustration</td>
</tr>
</tbody>
</table>

### Would you recommend this doctor to a friend for his/her interpersonal skills?

<table>
<thead>
<tr>
<th>Not Recommend</th>
<th>Recommend with Reservation</th>
<th>Recommend</th>
<th>Highly Recommend</th>
</tr>
</thead>
</table>

### Would you recommend this doctor to a friend for his/her medical competence?

<table>
<thead>
<tr>
<th>Not Recommend</th>
<th>Recommend with Reservation</th>
<th>Recommend</th>
<th>Highly Recommend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-exemplary Physician: superficial, artificial demeanor applied knowledge base inadequate to my situation</td>
<td>Unexceptional Physician: awkward, knowledge base only somewhat apparent in application to my situation</td>
<td>Satisfactory Physician: appropriate knowledge base applied adequately to my specific situation</td>
<td>Model Physician: sophisticated, wise, thoughtful, applied profound knowledge base specifically to my situation</td>
</tr>
</tbody>
</table>

**COMMENTS:**
STATION OVERVIEW

OBJECTIVES
This station is designed to test student’s ability to:

- Break bad news in an appropriate fashion
- Respectfully handle the emotions of family members and addressing their concerns.

LOGISTICS
Personnel: SP, female, 55 y.o., dressed in normal clothes, sitting in a chair.

Station Materials:
- Resident instructions
- SP Instructions
- SP evaluation forms
- Faculty evaluation forms

Room Arrangement:
- Station signs
- Chair (2)
EMPACT OSCE – Unexpected Death

RESIDENT INSTRUCTIONS

FAMILY MEMBER INFORMATION
Name: Meredith Kendall
Age: 55 years old

REASON FOR ENCOUNTER
• Richard Kendall (husband to Meredith Kendall) is a 58 year old man who was brought to the ER in ventricular fibrillation secondary to an anterior wall myocardial infarction.

• You were the resident in the CRU and after performing a textbook resuscitation (including administering intravenous fluid, epinephrine, vasopressin, amiodarone, chest compressions and defibrillation), the patient \textbf{DIED}.

• The attending has another patient in critical distress and has asked you to go speak with the deceased’s wife of 30 years, Meredith Kendall, and inform her of her husband’s death.

• The body is still in the ER and intubated.

YOUR ROLE
Resident

YOUR TASKS
1) Inform the deceased’s wife of her husband’s death
2) Address her concerns

STANDARDIZED PATIENT INSTRUCTIONS

THE SCENARIO
You are Meredith Kendall and you are 55 years old. Your husband, Richard Kendall (58 years old), was brought to the Emergency Room for chest pain this morning. He went to work feeling fine this
morning, but his secretary called you letting you know that the paramedics had been called as Richard was having chest pain that wouldn’t go away. She told you to go to the Bellevue emergency room as that is where they were taking your husband. Richard has had a few episodes of chest pain in the past, usually when going on walks with you. The pain typically went away after taking a break, so he didn’t think that much of it. You had been nagging him to see a doctor about it and he said he would schedule an appointment, but never need saying he was just too busy at work.

Your husband had generally been healthy, eating a normal diet and walking a few times a week with you. His work as a banker has been stressful and he has been thinking about retirement. You hope he does retire soon because he works too hard and should take it easy.

Now, you find yourself in the waiting room of the ER 40 minutes after your husband came in. You are anxious trying not to think about what might be happening, when a young doctor enters the room to tell you that your husband has died.

**Objective:** To see the body of your husband

**Obstacles:**
- You are emotionally overcome by the news
- You want to know what happened and if everything that could have been done was.
- You are not sure what the next steps are

**Tactics:**

You initially are shocked and bewildered speaking with a stutter, breathing faster, and with a harsh tone. You then become angry outwardly wanting to speak with the surgeon you previously spoke with. This all happens in less than two mintues.

Then you turn your anger inwardly and toward your husband for not doing more (even though in actuality there is nothing you or he could have done).

You eventually become calm (due to the resident’s support or, if minimal support is given, a quiet acceptance of the reality) and ask “what do I do now?” and then ask to see your husband.
Revised 7/10/2008

EMPACT OSCE – Unexpected Death

<table>
<thead>
<tr>
<th>YOUR CURRENT LIFE SITUATION AND PAST HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>You have been married for thirty years to your husband Richard. You live in Murray Hill near his work as a banker at Chase Manhattan (<a href="http://www.jpmorganchase.com">www.jpmorganchase.com</a>) on Park Avenue at 27th St. You used to work part time at a local school, but have subsequently retired volunteering at various charities in the area. You met your husband through mutual friends after college. You had an instant connection and got married soon afterward. You decided not to have children allowing the two of you to have a lot of free time together and to pursue personal and professional interests (you, your charity work and recreational painting, and him, mostly his business and the occasional golf game). You see each other weeknights (he works some late nights occasionally) and weekends, going for walks along the East River, often going to restaurants and occasional day trips. He is most certainly your best friend and your relationship has improved as the years have gone by.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SOCIAL SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>You have a good friend, Marie, who lives two blocks from you. You have been friends for years and she was very helpful and supportive when your mother passed away 10 years ago. She, like you, does not work full time and you often spend time together.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SPIRITUAL HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>You are a lapse Catholic. You haven’t gone to church for years and neither has Richard although you had a Catholic wedding. You have been meaning to go back, but just haven’t done it.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FAMILY HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your father passed away 15 years ago due to a stroke. Your mother passed away 10 years ago due to colon cancer. You have an older sister in Boston who is healthy.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>THE ENCOUNTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Before the resident enters the room, you are sitting. When the resident enters, stand up and say with a hopeful tone: “Is he okay? Can I see him?”</td>
</tr>
<tr>
<td>▪ Initial: When you hear the news of his death, you are shocked. Your initial response is something like “Oh my god. Oh my god. This can’t be happening. How is this happening? He passed?” Your agitation is reflected in an increased speech rate and a harsher tone with a stuttering quality as well as an increased breathing rate.</td>
</tr>
<tr>
<td>▪ Next: You don’t understand. You state: “I thought it was going to be okay. Did something go wrong?”</td>
</tr>
<tr>
<td>▪ Next: Who is the person talking with you. “Who are you?”</td>
</tr>
</tbody>
</table>
Isn’t there someone…older?”

- Next: Anger. State: “I knew they shouldn’t have brought him to this hospital. Why did you kill my husband?”
- Eventually (the above occurs in under 2 minutes) it starts to sink in that he has died. Your anger turns inward and toward your husband. State: “He was so healthy. I told him he should have retired earlier. He was so stubborn. I should have done more.”

Your primary concerns are:
1. Was there anything anyone could have done/known to prevent this? (finding out that this was completely unexpected and unpredictable makes you feel better)
2. You have a need to “justify” yourself a little:
   - I did everything I could. I told him to go to the doctor.
   - I made him eat well at home, but he ate whatever he wanted at work
   - I should have made him retire early. I told him to, but he just wouldn’t listen

You feel the need to talk about the above – to be heard. If the resident gives you the chance to say these things and responds in an affirming/supportive way, you are comforted and start to accept that even though this is a great loss, there’s nothing that you (or anyone else) should have done differently. As this happens, you start to calm down and your speech rate and tone become more relaxed.

If the resident does not give you a chance to say what you feel you need to say, you stay agitated and your speech quality continues to reflect that.

If the resident asks about family, state: “I have a sister.”
Do not offer more spontaneously. The resident needs to ask where she lives/if she is nearby to find out she is in Boston.

If the resident asks about friends in the area, state: “Yes, Marie.” Do not offer more spontaneously. The resident needs to ask where she lives/if she is nearby to find out that she lives a few blocks away from you.

Towards the end of the encounter, ask “Where is he.? Can I see him?”

If the resident asks for an autopsy, or suggests it, and doesn’t explain or suggest why it could be useful, you ask: “Why?”
If the resident explains why it might be helpful, state in a thoughtful and neutral way: “Let me think about it.”

As the last portion of the interview, ask: “What happens now?”

If the resident asks something like, “Would you like to call a funeral home?”, state “I don’t know any.”

If the resident offers to do something for you (i.e. call pastoral services and/or a funeral home) accept the resident’s offer.

**CHALLENGES FOR THE RESIDENT**

- Deliver bad news appropriately (warning shot, no euphemisms)
- Provide support and allow room for family member venting/being heard
- Assess social support and offer professional social services
- Provide resources surrounding handling the remains (clergyman, funeral home)

**CUES FOR THE RESIDENT**

Verbal/Non-verbal 1: Shock and bewilderment reflected in increased speech rate/harsh tone and increased breathing rate

Verbal 1: Did something go wrong?

Verbal 2: Who are you/?I knew we should have gone to a different hospital.

Verbal 3: Justify: “I told him to go see the doctor”, etc

**INITIALLY:** Shock and bewilderment. Stuttering speech, harsh tone, increased breathing rate. Then outward anger, then inward anger.

**ONGOING:** You have the need to be heard. If you are supported, feel listened to, etc, you begin to calm down. If not, you maintain a frustrated, angry tone.

**2-MINUTE WARNING:** Begin to calm down and ask to see your husband’s body.
## Unexpected Death - Breaking Bad News

**Evaluator’s Name:** ____________________

### COMMUNICATION

<table>
<thead>
<tr>
<th>Information Gathering</th>
<th>Not Done</th>
<th>Partially Done</th>
<th>Well Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elicited your responses using <strong>appropriate questions:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- No leading questions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Only one question at a time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarified information by repeating to make sure he/she understood you on an ongoing basis</td>
<td>Did not clarify or repeat back to you the information you provided</td>
<td>Repeated information you provided BUT did not give you a chance to indicate if accurate</td>
<td>Repeated information AND directly invited you to indicate whether accurate</td>
</tr>
<tr>
<td>Allowed you to talk <strong>without interrupting</strong></td>
<td>Interrupted</td>
<td>Did not interrupt directly BUT cut responses short by not giving enough time</td>
<td>Did not interrupt AND allowed time to express thoughts fully</td>
</tr>
</tbody>
</table>

### Relationship Development

<table>
<thead>
<tr>
<th>Communicated concern or intention to help</th>
<th>Did not communicate intention to help/concern via words or actions</th>
<th>Words OR actions conveyed intention to help/concern</th>
<th>Actions AND words conveyed intention to help/concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-verbal behavior enriched communication (e.g., eye contact, posture)</td>
<td>Non-verbal behavior was negative OR interfered with communication</td>
<td>Non-verbal behavior demonstrated attentiveness</td>
<td>Non-verbal behavior facilitated effective communication</td>
</tr>
<tr>
<td>Acknowledged emotions/feelings appropriately</td>
<td>Did not acknowledge emotions/feelings</td>
<td>Acknowledged emotions/feelings</td>
<td>Acknowledged AND responding to emotions/feelings in ways that made you feel better</td>
</tr>
<tr>
<td>Was accepting/non-judgmental</td>
<td>Made judgmental comments OR facial expressions</td>
<td>Did not express judgment BUT did not demonstrate respect</td>
<td>Made comments AND expressions that demonstrated respect</td>
</tr>
<tr>
<td>Used words you understood and/or explained jargon</td>
<td>Consistently used jargon without further explanation</td>
<td>Sometimes used jargon AND did not explain it</td>
<td>Explained jargon when used OR avoided jargon completely</td>
</tr>
</tbody>
</table>

### Education and Counseling

<table>
<thead>
<tr>
<th>Asked questions to see what you understood</th>
<th>Did not check for understanding</th>
<th>Asked if patient had any questions BUT did not check for understanding</th>
<th>Assessed understanding by checking in throughout the encounter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provided clear explanations/information</td>
<td>Gave confusing OR no explanations which made it impossible to understand information</td>
<td>Information was somewhat clear BUT still led to some difficulty in understanding</td>
<td>Provided small bits of information at a time AND summarized to ensure understanding</td>
</tr>
<tr>
<td>Collaborated with you in identifying possible next steps/plan</td>
<td>Told you next steps/plan</td>
<td>Told you next steps THEN asked your views</td>
<td>Elicited your views on next steps, shared own ideas, THEN mutually developed a plan of action</td>
</tr>
</tbody>
</table>

### DELIVERING BAD NEWS

<table>
<thead>
<tr>
<th>Preparation</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prepared you to receive the news:</strong></td>
<td>Entered room in a manner unfitting to news AND physically situated him/herself far from you</td>
<td>Entered room in a manner unfitting to news OR physically situated him/herself far from you</td>
<td>Entered room in a manner befitting to news AND physically situated him/herself close to you</td>
</tr>
<tr>
<td>- Entered room prepared for delivering news</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Ensured sufficient time and privacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identified immediate <strong>support system</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Sister in Boston</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Friend in NYC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not identify immediate source of social support (i.e. identifies sister but not friend)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Assessment of Readiness</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessed your readiness to receive news:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Gives warning shot (e.g., “I have some bad news...”)</td>
<td>No warning shot</td>
<td>Attempted to deliver warning shot, BUT inappropriate (does not pause for your assent OR warning shot too long)</td>
<td>Gave you a well-timed warning shot</td>
</tr>
<tr>
<td></td>
<td>Not Done</td>
<td>Partially Done</td>
<td>Well Done</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------------------------</td>
<td>-----------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td><strong>Delivery of Information</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delivered death notification appropriately:</td>
<td>Only uses euphemisms AND delivered too much information at once</td>
<td>Did not use “Death” or “Died” OR delivered too much information at once</td>
<td>Used “Death” or “Died” AND delivered information in small quantities</td>
</tr>
<tr>
<td>• Avoided euphemisms (uses the word “died”)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Delivered information in small doses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gave you opportunity to emotionally respond:</td>
<td>Responded inappropriately to your emotional reaction (no opportunity to vent, cut you off, become defensive)</td>
<td>Allowed you to emotionally respond (vent) BUT did not address/acknowledge response before moving on</td>
<td>Allowed you to express your feelings fully, gave you the feeling that you were being listened to before moving on</td>
</tr>
<tr>
<td>• Remained sensitive to your venting of shock/anger/disbelief/accusations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Attended to emotions before moving on</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Directly asked what you are feeling: “What are you thinking/feeling?”</td>
<td>Did not ask specifically “What are you thinking/feeling?”</td>
<td>Acknowledged your feelings (e.g., “I see that you are upset…” BUT did not specifically ask you to name your emotions</td>
<td>Specifically asked you “What are you thinking/feeling?”</td>
</tr>
<tr>
<td><strong>Managing a Difficult Situation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoided assigning blame</td>
<td>Became defensive/argumenative AND assigned blame</td>
<td>Became defensive/argumenative OR assigned blame</td>
<td>Became defensive/argumenative AND did not assign blame</td>
</tr>
<tr>
<td>Maintained professionalism by controlling emotions</td>
<td>Was unable to control emotions, becoming angry and frustrated him/herself</td>
<td>Attempted to control emotions (e.g. Was somewhat angry or frustrated)</td>
<td>Maintained a high level of professionalism in handling your specific situation, did not show anger or frustration</td>
</tr>
<tr>
<td><strong>Creation of Follow-up Plan</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personally mitigated feelings of aloneness or isolation</td>
<td>Did not attempt to personally make you feel less isolated/alone</td>
<td>Suggested alternative sources of support BUT did not offer him/herself personally</td>
<td>Included him/herself personally in your support system</td>
</tr>
<tr>
<td>• “We will…” or “I’m available”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provided appropriate “next steps”</td>
<td>Did not offer or suggest any services</td>
<td>Offered only general next steps OR promised to “Ask the attending”</td>
<td>Offered specific next steps (e.g. offered to put you in touch with a funeral home)</td>
</tr>
<tr>
<td>• Social work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Bereavement counselor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Funeral home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asked about pastoral services</td>
<td>Did not mention pastoral services</td>
<td>Attempted to determine your need BUT did not offer to contact anyone for you OR offered to notify pastoral services without first determining your need</td>
<td>First determined if you would like pastoral services; THEN offered to notify them for you</td>
</tr>
<tr>
<td>1. Determines desire for pastoral services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Offers to alert pastoral services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Offered directives for seeing the body, including</td>
<td>Could not explain why or why not you could see the body (e.g. “I wouldn’t advise it.” OR “Sure, you can see him.”)</td>
<td>Offered directives for seeing the body; addressing the physical state of the body OR explained logistics for seeing the body</td>
<td>Fully explained the process of seeing the body addressing BOTH the state of the body AND logistics</td>
</tr>
<tr>
<td>• The state of the body</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Logistics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asked if you want an autopsy performed</td>
<td>Did not ask about an autopsy</td>
<td>Asked about an autopsy but did not explain how it could be helpful</td>
<td>Asked about an autopsy AND explained how it could be helpful</td>
</tr>
<tr>
<td>Arranged for follow-up</td>
<td>Does not make plans to contact you again</td>
<td>Offered in general to be available should you need him/her</td>
<td>Made him/herself available for follow-up by providing you with his/her personal contact information</td>
</tr>
</tbody>
</table>

**Would you recommend this doctor to a friend for his/her interpersonal skills?**

<table>
<thead>
<tr>
<th>Not Recommend</th>
<th>Recommend with Reservation</th>
<th>Recommend</th>
<th>Highly Recommend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-exemplary Physician: superficial, artificial demeanor applied knowledge base inadequate to my situation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Would you recommend this doctor to a friend for his/her medical competence?**

<table>
<thead>
<tr>
<th>Not Recommend</th>
<th>Recommend with Reservation</th>
<th>Recommend</th>
<th>Highly Recommend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unexceptional Physician: awkward, knowledge base only somewhat apparent in application to my situation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfactory Physician: appropriate knowledge base applied adequately to my specific situation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model Physician: sophisticated, wise, thoughtful, applied profound knowledge base specifically to my situation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

COMMENTS:

EMPACT 2007: Breaking Bad News – Unexpected Death
III. Sample OSCE Report Card

EMERGENCY MEDICINE PROFESSIONALISM AND COMMUNICATION TRAINING (EMPACT)

SAMPLE OSCE Report of Results – July 2007

Communication Scores for Rachel Alt

OVERALL COMMUNICATION SCORE: 28%
Communication - Information Gathering: 53%
Communication - Relationship Development: 17%
Communication - Patient Education: 8%

Class Mean:
Communication - Information Gathering: 52%
Communication - Relationship Development: 61%
Communication - Patient Education: 33%

Error Bars: +/- 1 Std Dev
Overall Recommendation Rating for Rachel Alt

- Overall Recommendation Rating: 2.25
- Recommendation for Each Case:
  - Unexpected Death: 3.35
  - Informed Consent: Recommend
  - Repeat Visit: Recommend
  - Transfer of Care: Recommend

Error Bars: +/- 1 Std Dev

*Unreliable Case - Interpret with Caution
Overall Rating of Application of Expertise for Rachel Alt

2.25

2.90

Error Bars: +/- 1 Std Dev

Ratings for Each Case

Your Scores □ Class Mean

OVERALL RATING APPLICATION OF EXPERTISE

Exceptional Application of Expertise
Sufficient Application of Expertise
Slight Application of Expertise
Insufficient Application of Expertise

*Unreliable Case - Interpret with Caution
Case-Specific Skills for Rachel Alt

- Unexpected Death: 50%
- Informed Consent: 40%
- Repeat Visit: 40%
- Transfer of Care: 20%
- X-Ray Recall: 17%

Error Bars: +/- 1 Std

*Unreliable Case - Interpret w/ Caution
Skills Across Cases for Rachel Alt

- Delivering Bad News: 27% (Your Score), 47.1% (Class Mean)
- Managing Difficult Situations: 40% (Your Score), 66.5% (Class Mean)
- Accountability: 13% (Your Score), 27.5% (Class Mean)
- Handling Emotion: 25% (Your Score), 46.3% (Class Mean)

Error Bars: +/- 1 Std Dev

Your Scores □ Class Mean
IV. Sample OSCE Rotation Schedule

OSCE SCHEDULE

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>LOCATION</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Resident Number</th>
<th>Rotation 1</th>
<th>Rotation 2</th>
<th>Rotation 3</th>
<th>Rotation 4</th>
<th>Rotation 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>001-08</td>
<td>Station 1</td>
<td>Station 2</td>
<td>Station 3</td>
<td>Station 4</td>
<td>Station 5</td>
</tr>
<tr>
<td>002-08</td>
<td>Station 5</td>
<td>Station 1</td>
<td>Station 2</td>
<td>Station 3</td>
<td>Station 4</td>
</tr>
<tr>
<td>003-08</td>
<td>Station 4</td>
<td>Station 5</td>
<td>Station 1</td>
<td>Station 2</td>
<td>Station 3</td>
</tr>
<tr>
<td>004-08</td>
<td>Station 3</td>
<td>Station 4</td>
<td>Station 5</td>
<td>Station 1</td>
<td>Station 2</td>
</tr>
<tr>
<td>005-08</td>
<td>Station 2</td>
<td>Station 3</td>
<td>Station 4</td>
<td>Station 5</td>
<td>Station 1</td>
</tr>
</tbody>
</table>

CASE TIMING

<table>
<thead>
<tr>
<th></th>
<th>00:00-08:00</th>
<th>08:00-10:00</th>
<th>10:00-15:00</th>
<th>15:00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start Case</td>
<td></td>
<td>08:00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“2-Minute” Warning</td>
<td></td>
<td>Continue Case</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Time’s Up”</td>
<td></td>
<td></td>
<td>Break SPs</td>
<td>Start New Case</td>
</tr>
<tr>
<td>Complete Checklist</td>
<td></td>
<td></td>
<td>Complete Checklist</td>
<td></td>
</tr>
</tbody>
</table>
Emergency Medicine Professionalism and Communication Training

Working with Medical Interpreters

**The Need:**
- Language barriers pose obstacles to obtaining effective health care for many people in the United States.
- Use of qualified medical interpreters is a critical part of the solution.
- Untrained interpreters are likely to commit the following errors in interpretation:
  - **Omission** – message completely or partially deleted by interpreter
  - **Addition** – includes information not expressed by the patient
  - **Condensation** – response is simplified and paraphrased
  - **Substitution** – replacement of one concept with another.

**Trained Language Interpreters:**
- Have formal training in role of the medical interpreter
- Are guided by standards of confidentiality, accuracy, completeness
- Are familiar with medical terminology
- Are culturally competent
- Communicate verbally and non-verbally in a non-intrusive manner

**Key Principles When Using an Interpreter:**

**A. Setting the Stage**
- Ask for the patient’s permission to use an interpreter
- Meet with the interpreter to talk about the goals for the interview, give instructions and guidance, and to make sure the interpreter is comfortable with the questions and topics to be discussed
- Remind the interpreter that everything you and the patients says and all information are confidential
- Request that the interpreter does alter the patients words as he/she states them
- Position the interpreter so that she he is sitting beside the patient or the health care provider

**B. Managing the Communication Flow**
- Maintain eye contact with the patient
- Address the patient, not the interpreter, using “I” or “You”
- Keep sentences brief and avoid medical jargon
- Pause occasionally to determine if the patient has questions
- When giving critical information, ask for a back translation

**CULTURAL BELIEFS AND IMPACT ON HEALTH CARE AND OUTCOMES**
- To avoid stereotyping, it is important to elicit the cultural content from the patient, through the interpreter and not from the interpreter.
- Cultural beliefs affect the presentation, course, outcomes of illness, and perceptions of wellness and treatment.
- Arthur Kleinman, MD, proposes the Explanatory Model as a culturally sensitive approach to asking about health problems:
  - **Asking inquiry questions about a health problem:**
    - What do you call your problem?
    - What do you think caused your problem?
    - Why do you think it started when it did?
    - What does your sickness do to you? How does it work?
    - How severe is it? How long do you think you will have it?
  - **Culturally sensitive approach to asking about a health problem:**
    - What do you fear most about your illness?
    - What are the chief problems your sickness has caused you?
    - Anyone else with the same problem?
    - What have you do so far to treat your illness? What treatments do you think you should receive? Who else can help you?

For consultations regarding use of interpreters, contact:
Dr. Sondra Zabar (szabar@breitezabar.com) or
The Center for Immigrant Health, cihinfo@med.nyu.edu
MANAGING DIFFICULT PATIENT SITUATIONS

• **Delivering** bad news is difficult.
  • We fear being blamed
  • We fear strong emotional reactions—ours and the patient’s
  • Some lack practice or training in giving news
  • We may have to confront our own fear of death or illness
  • What is “bad news” for the patient may not be for us
  • “Relevant” facts may differ based on the patient’s understanding and belief of illness

• **Hearing** bad news is difficult.
  • Having a strong emotional reaction doesn’t mean that you did not deliver the news sensitively
  • A strong emotional response may be appropriate

**SKILLS FOR DELIVERING BAD NEWS**

1. **Prepare**
   • Attend to your own emotions.
   • Deliver news face-to-face whenever possible.
   • Have all the necessary information at hand.
   • Ensure sufficient time and privacy.
   • Explore with patient possible outcomes prior to testing.
   • Have the patient have a significant other present.
   • Tape the session and give the tape to the patient.

2. **Assess Readiness**
   • Assess patient’s readiness to receive bad news.
     “Would you like to talk about your biopsy results now?”
   • Prepare patient by forecasting news.
     “I have some difficult news for you”.

3. **Check the patient’s response**
   • Remember, what we find most concerning may not be what’s most distressing to the patient.
     “What are you thinking/feeling?” “What are your concerns?”
   • Give time and opportunity to respond. Expect strong emotional responses and attend to them before proceeding with information giving. Watch for shock and shut down.
     “We have some decisions to make about how to proceed. Are you able to discuss this now?”
   • Address basic information needs. Don’t try to give too much information at once. Give more details after patient gets out of shock.
   • Goal is to achieve a shared understanding of the problem.
     “Can you tell me what you understand about your problem?”

4. **Follow-up plan**
   • Minimize feelings of aloneness and isolation.
     “We will…” “I’m available…” “Is there anyone else you’d like me to speak to?”
     “Would you like me to call the chaplain, social worker, …etc?”
   • Schedule timely follow-up visit and be sure patient knows how to contact you in between.