

*The UCSF Department of Psychiatry and
Extended Programs in Medical Education present*

Care of Patients Facing Life-Threatening Illness

Friday, December 13, 1991 OR

Saturday, December 14, 1991





EXTENDED PROGRAMS IN MEDICAL EDUCATION

CARE OF PATIENTS FACING LIFE-THREATENING ILLNESS *Announcements*

Phone Message Number during the symposium: (415) 476-4251. Incoming calls will be received at the EPME office and carried to the meeting room. Messages will be posted at the course Registration Desk.

Coffee: Coffee will be available outside the meeting room during the scheduled mid-session break. Please check the syllabus program schedule for exact times.

Audiotaping: There is no objection to taperecording the symposium for your personal use only.

Smoking: UCSF is a non-smoking campus, and smoking is not permitted inside any of the campus buildings. Your cooperation in maintaining a smoke-free environment is appreciated.

Security: We urge caution with regard to your personal belongings and syllabus. We are unable to replace these in the event of loss. PLEASE DO NOT LEAVE ANY PERSONAL BELONGINGS UNATTENDED IN THE MEETING ROOM DURING SESSION BREAKS.

Parking: Public parking is available in the Millberry Union Garage on campus. The maximum rate for parking is \$14.00/day.

Accreditation: This course is approved for *4 hours of ACCME, AMA/CMA Category 1 credit*. Please report only those hours actually attended.

Certificates: Certificates of attendance for those participants who pre-registered for *CE credit*, may be picked up at the course registration desk at the conclusion of the program. Certificates will be mailed to participants who registered for credit at the course. Please allow 3-4 weeks for receipt of your certificate by mail.

Evaluation: Your cooperation in completing and turning in the course evaluation form will prove invaluable to future course planning. The form is printed on russet paper and located at the back of your syllabus book. It is perforated so that it can be easily detached from the book. Please complete the form and hand it in to the staff at the course Registration Desk.

Thank you!

About the Program....

Care of Patients Facing Life Threatening Illness is designed to enhance the knowledge and skills of physicians, nurses, mental health professionals, para-professionals, clergy, and students who care for seriously ill and dying people. The course will benefit those who work in oncology units, intensive care units, hospice programs, community and institutional AIDS and cancer programs, long-term care facilities, coronary care units, and medical offices.

Physicians and other health care providers are instrumental in shaping the patient's attitude toward illness and treatment. Recent advances in medical knowledge and technology have lengthened the average time between the onset of such illnesses as cancer or AIDS and the final outcome. While the quality of life of many patients is relatively high, others face the dim picture described by Aldous Huxley as "increasing pain, increasing anxiety, increasing morphine, increasing demandingness." In addition, patients who are not cured may experience "the ultimate disintegration of personality and a loss of the opportunity to die with dignity."

The specific purpose of this seminar is to provide an effective model for dealing with the issues involved in caring for patients facing life-threatening illness. The focus will be successfully managing the processes and events from diagnosis through remission (or death).

While considerable attention has been given to the psychosocial aspects of life-threatening illness, comparatively little attention has been devoted to the question: "How do we help the helper?" Many professionals and others may have great difficulty in maintaining their equanimity when they must care for and relate to seriously ill patients for many months or years. Severely demanding periods may leave health providers in a state of chronic stress overload, unprepared to cope with their own defensive reactions. This program will assist physicians and others who work in such challenging contexts to care for themselves as well as provide superior support to their patients.

The program is presented by the UCSF Department of Psychiatry, and Extended Programs in Medical Education.

Limited Enrollment....

This program will be presented on the UCSF Campus. Only 125 persons can be accommodated in the Auditorium. In order to maximize participation, the program will be offered on Friday afternoon, and repeated **for a different audience** on Saturday morning. Please register for the session of your choice on the enrollment application.

What You Will Learn....

- * The basic issues involved in supporting patients with life-threatening illness;
- * A sequence of events encountered by health care providers and patients from diagnosis through remission (or death);
- * How to apply to clinical practice an effective action plan for dealing with these patient care issues;
- * The origins of work stress and burnout and methods of reducing stress overload in working with patients facing life-threatening illness;
- * How to establish effective treatment partnerships with seriously ill patients;
- * How to build and motivate cohesive and committed interdisciplinary teams;
- * Ten steps in the art of delivering bad news;
- * The listening and communication skills of the most effective health care providers;
- * How department heads, team leaders, and project directors can identify, train, and reward superior care givers;
- * How to develop a mission statement of hope and effectiveness for individuals and units.

About the Speaker....

Charles A. Garfield, Ph.D., is founder and was long-term director of the SHANTI Project and is currently Associate Clinical Professor of Psychiatry at the University of California School of Medicine at San Francisco. His books include *Stress and Survival: The Emotional Realities of Life Threatening Illness*, and *Psychosocial Care of the Dying Patient*. Dr. Garfield is internationally known for his speaking and consulting in the field of the development of institutional and community based support systems for patients facing life threatening illness. He chaired the first three UCSF national conferences on *Care of the Dying Patient* (1976-1978).

About Credit for Health Professionals....

Extended Programs in Medical Education (EPME) of the University of California School of Medicine at San Francisco is accredited by the Accreditation Council on Continuing Medical Education (ACCME) to provide continuing education activities for physicians.

EPME certifies that this program meets the criteria for **4 credit hours in Category 1** of the Physicians Recognition Award of the American Medical Association and the Certificate Program of the California Medical Association.

Category 1 continuing education credit is also applicable for psychologists, social workers, California nurses, nurse practitioners, and physicians assistants.

FRIDAY, DECEMBER 13, 1991 OR SATURDAY, DECEMBER 14, 1991

Lecturer: Charles Garfield, Ph.D.

Topic: Care of Patients Facing Life-Threatening Illness

Objectives:

By the end of this lecture and readings you should:

- 1) Understand the basic psychosocial issues involved in supporting patients with life threatening illness.
- 2) Be able to establish effective treatment partnerships with seriously ill patients.
- 3) Understand the listening and communication skills required to work effectively with seriously ill and dying patients.
- 4) Understand the of job stress and methods of reducing stress overload in working with patients facing life threatening illness.

Media:

Video - Care of Patients Facing Life-Threatening Illness

Reading:

Garfield, C.: "ELEMENTS OF PSYCHOSOCIAL ONCOLOGY: DOCTOR - PATIENT RELATIONSHIPS IN LIFE THREATENING ILLNESS." **PSYCHO SOCIAL CARE OF THE DYING PATIENT**, Garfield, C. McGraw-Hill, 1978

Garfield, C.: "COPING WITH BURNOUT" in **STRESS AND SURVIVAL**, Garfield, C., Mosby Publishing Company, Missouri, 1979

Hogshead, H.: "THE ART OF DELIVERING BAD NEWS" in **JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION**, 1976

Lecture Outline:

- 1) Psycho Social issues basic to caring for patients with limited life span.
- 2) Video vignettes and large group case discussion.
- 3) The art of delivering bad news.
- 4) Developing action plan for effective psycho social care.
- 5) Coping effectively with heightened job stress and burnout in working with patients with a limited life span.

Preventing Burnout And Improving Performance

Erma Bombeck once said that volunteers are like yachts. No matter where they are, they arouse your curiosity. Who are they? Where do they come from? Why are they here?

"They could stay moored where it's safe and still justify their being," Ms. Bombeck continues, "but they choose to cut through the rough waters, ride out storms and take chances."

"They have style. They're fiercely independent. If you have to ask how much they cost, you can't afford them."

Volunteers, like those of the Shanti Project, are the social conscience of the nation. The civil rights movement, the anti-war movement, the women's movement, environmental and conservation movements, neighborhood improvement organizing, and ethnic and religious organizations are all essentially volunteer efforts. They are the primary examples on this planet of human compassion, unselfishness, caring, patience, and just plain loving one another.

The use of volunteers as an important human resource has risen sharply. In 1980, the dollar contribution made in the U.S. by the volunteer sector will exceed the entire amount of the H.E.W. budget. Churches, hospitals, neighborhood associations, non-profit corporations, senior centers and many other organizations like the Shanti Project have discovered the considerable potential of volunteer efforts. In the non-profit sector, mental health, life-threatening and chronic illness, aging, grief, drug abuse, physical and emotional disability and many other areas, volunteers have made major contributions toward dealing with problems which cannot be dealt with by other institutions in the society. At the same time, people have been provided with opportunities for helping roles, roles which have become increasingly difficult to find in our society as more and more helping has been taken over by professionals. Volunteers are the grassroots answer to our hierarchical, professionalized society.

Shanti volunteers share with their professional colleagues an often intense and emotionally charged commitment to those who receive health care services. They also have a common enemy—burnout, the loss of caring for those in need.

For a great many health care professionals and volunteers, daily life constitutes an ongoing crisis of emotional survival. Every day thousands of physicians, nurses, and other health workers—who frequently are sensitive, empathetic individuals—go out in the hope of providing more than adequate care. Some of us can deliver it; some cannot. Some cope with the enormous occupational stresses of their work; others do not.

Health workers are prime targets for occupational stress because their everyday

work situations are associated with crisis, rapid decision making, and fast-paced schedules. A special burden is borne by those who work with patients facing life-threatening illness and their families, where high levels of physical and psychic pain are the norm and the hope of recovery is in doubt.

Increasing evidence suggests that stress does take its toll on health care workers. A recent major research study concluded that six of the ten most stressful professions are in the health care field. Health care workers, as a group, rank consistently high on every major index of stress—marital conflict, alcohol and drug abuse, mental illness, suicide, job turnover and dissatisfaction, etc.

Physicians, nurses, volunteers, and the entire health care system require certain levels of stress to function productively and creatively. But when stress levels reach chronic overload proportions, the results are increased health problems, impaired job performance, and "burnout," the loss of concern for people in need.

Preventing burnout and the loss of caring requires an understanding of the experience of the health care worker, patient and family member. Most importantly, developing antidotes to burnout requires us to understand the health care system itself and the way it is structured to meet and not meet the needs of all those in search of healthful care.

Constant or repeated emotional arousal is a very stressful experience for any human being and can often be disruptive or incapacitating. In order to perform our work efficiently and well, we may defend against powerful expressions of emotion through various forms of detachment.

- No social support system in the work arena and/or personal life
- Feeling trapped in the job situation
- Too many difficult and repetitive situations
- No opportunity for self-monitored "time out"
- Sense that the work is meaningless
- Lack of staff collaboration
- Unrealistic self-expectation and excessive individual responsibility
- Frequent interpersonal conflict between well-intentioned people

Fortunately, there are antidotes that both individuals and groups can employ to avoid burnout or reduce its impact.

Individual antidotes:

- 1) Develop effective personal support systems in the work environment and at home.
- 2) Learn to self-monitor the signs of burnout.
- 3) Develop exercise and relaxation outlets that counter chronic work stress.
- 4) Establish formal and/or informal mechanisms for getting feedback on positive accomplishments.
- 5) Understand the structure, function, and priorities of your work environment.
- 6) Develop concrete avenues for future personal and professional growth.

Group antidotes

- 1) Establish formal and informal mechanisms for group support.
- 2) Build in self-monitored opportunities for "time outs" from work.
- 3) Vary high-stress tasks and diffuse

They have a common enemy—burnout, the loss of caring for those in need.

Typical behavior changes

However, far too frequently, we are unable to cope adequately with the cumulative emotional stress, and burnout occurs. We lose all concern or emotional feeling for our patients and their families and come to treat them in detached and even dehumanizing ways. Burnout is often accompanied by a number of behavioral changes, including: reduced productivity and impaired performance; dislike of the work environment; heavy criticism of colleagues; use of primarily formal grievance procedures and institutional rules; increased opposition to change; expressed dislike for the recipients of service; chronic fatigue; insomnia, and bodily pains; and increased avoidance of interaction with colleagues, patients and their families.

Following are situations that contribute to the likelihood of burnout occurring:

- responsibility where feasible.
- 4) Develop group-supporting mechanisms for effective problem-solving.
- 5) Understand the priorities of the institution that favor and don't favor effective delivery of human services.
- 6) Allow for individual choice and flexibility in jobs.

I have seen the incidence of burnout reduced in many health care facilities. Cost-effectiveness and humane care of patients (and health workers) are surely not always mutually exclusive goals. However, we need to direct at least as much attention to caring for ourselves as our machinery and procedures. Surely this is an attainable goal worthy of our best efforts.

Charles Garfield

"THE ART OF DELIVERING BAD NEWS"

BY

HOWARD HOGSHEAD

Every physician derives satisfaction from delivering good news to a patient; and no physician that I know enjoys delivering bad news. Still, there are rare occasions when it becomes necessary for the physician to disclose a fatal or crippling diagnosis and prognosis to the patient. There is no greater test of the physician's skill and courage than this task of delivering medical bad news. Some physicians delay or avoid this unpleasant task for fear of provoking an emotional scene which they are ill prepared to handle, fear of producing a serious depression, or perhaps fear of losing the trust and confidence of the patient. All of these are valid possibilities which need to be considered.

There are as many ways of handling bad news conferences as there are physicians. There is probably no "right" way, and no "wrong" way to handle this. No thinking physician would use the same stock techniques with every patient. Patients are much too different and too sophisticated to be handled in such a fashion. The particular method of delivering bad news must be varied to meet the needs of the situation. The following are some general guidelines that I have found useful over the years. Most of these rules are not original with me, but I haven't found a single source that covers the subject.

1) KEEP IT SIMPLE. Perhaps as a result of apprehension or uneasiness, there is a tendency to go into too many details and technicalities.

2) Ask yourself, "What does this diagnosis mean to this patient?" Many patients are simply unable to comprehend the nature of the diagnosis, in which case methods must be found to gradually educate them.

3) MEET ON "COOL GROUND" FIRST. It is very unpleasant to walk in to meet people whom you have never met before, knowing you have to give them a piece of really bad news. It is always easier to handle if you have some earlier relationship to the patient or his family, and have some notion of their background and possible reactions to the news.

4) DON'T DELIVER ALL THE NEWS AT ONCE. It is a good idea to try not to provide too much information at the first sitting. People have a marvelous way of letting you know how much they are able to handle. Like the newspaper that printed "all the news that's fit to print," I feel that the patient has the right to all the information that he is prepared to handle. This may mean that the full disclosure has to be spread out over two or three sessions.

5) WAIT FOR QUESTIONS. A long pause will allow the question that tells you where to go next.

6) DO NOT ARGUE WITH DENIAL. A characteristic response in many patients is outright denial of the reality of the situation. No matter how illogical the denial, it is serving a purpose, and there is nothing to gain by battering down the denial with logic. This usually leads to loss of rapport with the patient. In general, the patient will "hear" the message when he is ready to accept it. It is sufficient that he has been told at least once in some form that condition "x" has been discovered.

7) ASK QUESTIONS YOURSELF. Ask the patient to tell you what you have told him, or ask him what it means. Oftentimes you will be surprised at the answer. Or, ask the patient what the doctors at such-and-such a hospital have told him.

8) DO NOT DESTROY ALL HOPE. There are a hundred ways of handling this, and it requires real tact and experience to be able to acquire the necessary skill. "Most people with this kind of injury don't walk again" is a useful kind of treatment.

9) DO NOT SAY ANYTHING THAT IS NOT TRUE. This would be the most cruel blow of all.

Again, perhaps there is no right way, only varying degrees of wrong ways. The assistance of a minister, social worker, nurse or friend may be invaluable. Common sense and human compassion are the prerequisites for the physician who must artfully deliver the bad news.

* Reprinted from JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, October 1976.

"ELEMENTS OF PSYCHOSOCIAL ONCOLOGY: DOCTOR-PATIENT RELATIONSHIPS
IN TERMINAL ILLNESS"

IDENTIFYING THE PROBLEM

By

Charles A. Garfield

It does seem symptomatic that few words if any are directed to medical students about how to help a patient die. House staff members may be criticized for failing to carry out some relatively minor test or procedure, but seldom is there any evaluation of the care accorded to terminal patients' psyches during the last days. We all believe in treating the whole person and work hard at enhancing his physical and psychic comfort in small ways, which may have no influence on the final outcome of his illness, and yet it is not always noticed that a dying person very often seems to have less attention paid to him than to the patency of the multiplicity of tubes that are entering him from every direction and which will enable us to study his last, hopefully balanced, chemistries. Occasionally, it seems that more real effort is expended to get autopsy permission than to see to it that the patient does not die alone. It is as though, as doctors, we sometimes express our denial of death by focusing our attention upon the tubes, the chemistries, and the autopsy. (Bulger, 1963)

In identifying the basic problems associated with the care of the terminally ill, it is necessary to examine at least two points of view; the professionals' and the patients'. Kastenbaum and Aisenberg (1972) consider the following socialmedical issues to be the major ones: 1) the imposition of emotional isolation upon the dying person; 2) the routinization of treatment; 3) the condescension of professionals who treat the patient as though he were an irresponsible child, unable to cope with his situation like an adult; 4) among those responsible for the patient's well-being, the inadequate and unreliable patterns of communication ranging from the choice of what is communicated to the patient and how it is stated, to all the little ways significant information is withheld or misinterpreted; and 5) the failure of all persons engaged in caring for the patient to recognize and fulfill their share of the total responsibility.

The major issues identified by patients are 1) that the dying person will become quietly isolated because of a decrease in communication resulting from the unwillingness of those responsible for his care to maintain the openness and emotional support essential for him to live out his life with some hope and participation in meaningful relationships; 2) that the patient will be subjected to painful, uncomfortable, and demanding procedures that might prolong existence without prolonging a desirable quality of life, and that the disease will force that

patient to endure intense, chronic pain seemingly without end; and 3) that the terminally ill person will lose control of bodily, interpersonal, and cognitive functions, that will compel him or her to confront a terrifying and alien set of experiences, stripped of all decision-making powers.

The global problem encompassing both professional and patient identifications of the dilemma is epitomized by the question, "How do we know when we are treating a dying patient?" More specifically, "How do we decide when cure or prolonged life are still possibilities requiring aggressive treatment?" "When do we acknowledge that a patient is dying and that palliation and emotional support are the optimal strategies?" Having observed this dilemma many times, I am quite sure that a useful approach is to communicate the medical realities to the patient as skillfully, honestly, and clearly as possible and to allow the patient (with the help of his or her family or advocate) to decide upon the preferred treatment. To allow the patient to retain the basic right to choose comfort care and to accord him the opportunity to relate to his impending death in a meaningful way, health professionals must have the courage and willingness to acknowledge that the patient's wishes take priority over their own.

ELEMENTS OF PSYCHOSOCIAL ONCOLOGY

THE PHYSICIAN'S EXPERIENCE

What are the basic experiences of both physician and patient, the main participants, in the confrontation between life-threatening illness and medical expertise? It is clear that the physician and allied professionals are powerful figures for most patients facing life-threatening illness. We must, therefore, continually earn our positions of influence by earning respect and by showing we are worthy of this power. When the professional boxer commits violence against a person outside the ring, he is properly castigated, for his hands are registered lethal weapons; but at least he is conscious of his power. For the overworked and overburdened psychologist, nurse, or physician to commit emotional violence, even inadvertently, because he or she is unconscious of his or her personal power, is most unfortunate. The capriciousness of cancer is such that we can rarely outline a definitive time schedule or map out an accurate sequence of symptomatology for a given patient. Both physician and patient are often forced to confront considerable uncertainty. Prolonged and heightened ambiguity may result in the physicians' rejection of the largely untenable role as healer, psychological confidant, companion, and spiritual counselor. They may reluctantly, albeit correctly, conclude that they are unable to fulfill all the needs of the dying patient. Several medical colleagues have communicated observations similar to the following:

When there's nothing more I can do medically my tools are gone. There's nothing I can do for the patient and that's upsetting for me. I would rather fulfill my promises and expectations or at least be able to make some headway. When I think of other people who have time for relationships, time to relate to my patient, to sit and talk, I sometimes become jealous. I don't have that time and it's annoying to think that I may lose the affection of my patient. This is something physicians don't talk about very often.

A more distressing attitude is revealed in the following:

I've recently realized that for the past 25 years when a patient of mine has been terminally ill, I'd walk into the room talking constantly, approach the bed, and back out of the room talking. I do this because I have nothing to offer medically and I'm not willing to deal with the patient's emotional stress. That's not my training so it's probably better if I handle the situation that way. The psychologist or social worker or psychiatric nurse spends time with the patient and opens up a whole emotional can of worms and then who gets the brunt of it, I do, the physician. I don't have time to deal with these issues. It's better if physicians give brief general reassurance and don't dig too deeply.

Although the quality of the growing body of research on the psychosocial aspects of dying has improved markedly in recent years, relatively few studies have focused on the physician's reaction to the dying patient. Working for extended periods with dying patients is an emotionally charged experience, and physicians frequently sustain great stress when they must relate intimately to patients and families facing a protracted life-threatening illness. The psychological defenses and coping strategies elicited by this

DOCTOR-PATIENT RELATIONSHIPS: EMOTIONAL IMPACT

stressful contact are legion. Physicians and allied professionals may view close relationships with patients as perplexing dilemmas to be avoided at all costs. Many regard the patient's basic emotional needs as relatively insignificant compared to the primary task of biomedical treatment. Other professionals consider long discussions about feelings and emotional stress a waste of invaluable time.

When Freud observed that "the ego cannot comprehend its own dissolution," he shared with a leukemic man named Ted Rosenthal (1971) an appreciation for that emotionally incomprehensible question: "How could I not be among you?" (Garfield, 1977). Physicians who acknowledge the preeminence of the ultimate contest between the possibilities of "ceasing to be" and survival become involved in supramedical issues that affect physician and patient alike. Physicians and others may view this as a dangerous commitment and seek to protect their own personal and professional integrity by indicating an unwillingness to entertain any questions that elicit feelings of vulnerability. As Artiss and Levine (1973) have noted, a physician's manner of coping with the anxiety aroused by a patient's imminent death becomes the crucial element in considering the relationship between patient and physician. However, physicians rarely discuss their feelings about specific patients except in the company of other physicians and then only seldom. It is a major drawback in medical practice that no professional context exists in which physicians can share their feelings about their patients, the demands of professional work, and especially the death of a patient with whom one has worked for months or years. There are virtually no available emotional support systems for physicians. Because a majority of practitioners manage to continue despite the severe emotional stress inherent in those medical specialties requiring frequent life-and-death decisions, the medical profession participates in society's perpetuation of the "superhuman doctor" myth that has unnecessarily limited and isolated physicians.

At some point in a patient's terminal illness the physician must confront the eventuality that all efforts to prevent death will likely fail (Artiss and Levine, 1973). When this point is reached, various aspects of the doctor-patient relationship become evident. If the concerned parties do not understand and adequately deal with all facets of this interaction, the physician's effectiveness may be severely hampered. Just as it is essential to understand the emotional realities of dying from the patient's perspective, it is equally important to comprehend its emotional impact on the physician and other health personnel. Anger, denial, and depression/resignation are the three most frequent physician reactions to the probable death of a patient. These are precisely the three most common reactions of patients themselves. Physicians and patients alike experience basic human reactions to loss. The prospect of losing one's own life or the loss of a patient, the end of a relationship with a dying person or the sad conclusion to a battle with an illness all may generate similar psychological repercussions.

Anger

Physicians may employ anger as a defense against anxiety, particularly if such anger proves effective in establishing its possessor as the adversary of a shared "enemy" (Artiss and Levine, 1973). This phenomenon, known as displacement, allows the

ELEMENTS OF PSYCHOSOCIAL ONCOLOGY

physician to trace the patient's death to external circumstances, overwhelming disease process, patient and family tardiness in seeking help, bureaucratic complications, etc. Given the superhuman qualities imputed to physicians and the high degree of physician-acceptance of these cultural projections, it may become necessary for physicians to explain death in a way that allows them to escape relating to it as a personal failure. For oncologists, for example, to relate to each death as a personal failure would result in an enormous blow to their self-esteem. Therefore, they may direct the anger mobilized after a patient's death toward a human, situational, or disease-related adversary that serves to "explain away the failure." The problem lies in equating death with the failure of the physician. This equation is most often erroneous and unfair to both physician and patient.

Denial

Physicians may deny that a patient's death appears imminent, claiming "heavy patient load or home and social obligations" to explain their reluctance to accept and confront the reality of impending death (Artiss and Levine, 1973). Physician denial sometimes reaches extreme proportions as in the case of one oncologist who told me that he had never had a patient who died. Surprised at the claim, I discussed it with him further and found that he took one of two precautions when a patient seemed near death; he either transferred the patient to another facility in order to avoid being the physician of record at the time of death, or he transferred the case to a younger colleague for similar reasons. Therefore, he was able to somewhat pathetically make the claim that he had never had a patient who died. A more common form of denial is the disavowal of a close relationship between physician and patient. No physician would deny the existence of the conventional, professional-client, doctor-patient relationship. However, when treatment toward maintenance, remission, or cure is no longer possible and emotional/physical comfort as well as the reduction of pain become the major issues, some physicians may deny that they have a responsibility to continue this relationship. This circumscribed definition of the doctor-patient relationship, as limited to the resolution of biomedical problems, is another way of avoiding or denying the emotional aspects of terminal illness.

Depression/Resignation

One of the most poorly understood physician reactions to prolonged contact with terminal patients is depression. Whereas denial and anger allow the physician to continue functioning, albeit sometimes at a fever pitch or in a somewhat disorganized fashion, depression can debilitate the physician and severely impair his or her efficiency. I have known physicians who, for years, via a sheer act of will, fought off incipient depression only to succumb finally to the cumulative emotional impact of patient deaths. Depression and its real or imagined emotional engulfment are extremely threatening to physicians whose heavy work schedule and personal expectations do not allow them the "luxury" of more modulated and frequent emotional expression. In the past several years, I have seen an increasing number of physicians in psychotherapy with presenting complaints related to a variety of emotional disorders. The majority have been highly

DOCTOR-PATIENT RELATIONSHIPS: EMOTIONAL IMPACT

productive in their careers but had not adequately attended to the emotional impact of their work. Most frequently, they suffered from one of a variety of psychosomatic disorders or depressions that had culminated in the impairment of work efficiency and severe emotional stress. For an individual, no matter how emotionally adaptive, to select as demanding a profession as clinical oncology without recognizing its emotional impact can only be detrimental to both physician and patient.

Wheelis offers a vivid and literate picture of the professional man's final but necessary disillusionment. He writes of what happens when a man travels a long road to salvation and, until he is too far along to go back, doesn't realize that he is headed for the abyss. Nor could anyone have told him earlier. His hope then lies in finding that it would have been the same no matter which route he had chosen, and that he can help himself and others along the way. A mature resolution, but a poor one when compared with early dreams of ultimate conquest. For the man who cannot mature in his profession, every subsequent day of his life challenges his magic and with it, his identity. He has staked his life, like Faust, on learning the secret and he cannot turn back admitting failure. He knows well enough that he cannot win—that he will die, as will all his patients. He knows this not with equanimity but with the cynicism of the frustrated idealist. He less than other men is suited to face the dying; they are a personal affront, a symbol of his human helplessness, and an end to his life. He whose marriage is shaken because he cannot bear his wife's small complaints, whose children cry in their nights of illness for a father who has to be at an induced delivery—this man must often help a stranger die, and what can he do? He can be tough about it, maybe breezy, or maudlin—or maybe he can get an intern or nurse to drink the dregs of his heady wine while he is called to more positive and hopeful cases (Kasper, 1959).

THE PATIENT'S EXPERIENCE

The subjective experience of cancer is nearly unfathomable from the perspective of the observer. Whereas disease-related cellular and systemic metamorphoses have many identifiable and predictable characteristics, the phenomenology of the patient is in some ways harder to analyze. To help identify and meet the psychosocial needs of cancer patients, my optimal consultants are the patients themselves. It is only by communicating with these valuable sources of information that the possibilities for effective psychosocial support can emerge. It takes courage; but the courage necessary for us to minimize the differences between "Us" and "Them" is one prerequisite to really understanding the emotional impact on the patient of the words "and I, too, shall die."

The threat of ceasing to be, personality disintegration, or ego annihilation (i.e., the death of one's identity) has been identified as the core component of our fear of death (Choron, 1964). Despite the considerable magnitude of this fear for most of us, Annas (1974) cites seven studies from journals such as *Cancer*, *JAMA*, etc., that note that approximately 90 percent of all patients interviewed preferred to know their diagnosis, even if terminal, whereas 60 percent to 90 percent of their physicians

ELEMENTS OF PSYCHOSOCIAL ONCOLOGY

opposed telling them. In my own research, over 85 percent of those terminal patients I have counseled strongly suspected they were dying before being formally told by house staff. It is very difficult to deny indefinitely as monumental a psychobiological phenomenon as a widely metastasized cancer. At times, we all use denial as a psychological defense to preserve our psychic integrity in the face of potentially traumatizing realities. What is not often recognized is that this process is both interpersonal (and selective) and most often time-bound (we all process information of a potentially traumatizing nature at differential rates). It is important to honor a patient's denial for as long as it is psychologically adaptive; that is, for as long as the individual chooses to admit into consciousness only those relatively nontraumatizing aspects of the illness—those with which he or she can cope more or less successfully. Through being emotionally accessible to the patient in the context of a caring, trusting relationship, a physician may provide the optimal occasion for a patient to choose to acknowledge the more traumatizing aspects of his illness—the possibility of death and his fear of dying.

Why then has so much been written about patient denial? I have consistently encountered as much denial by staff members as by patients. As health providers we experience ourselves as trained healers and view the death of a patient as an unacceptable conclusion to the health care process. As professionally skilled adversaries of illness and death, we may be less able to respond effectively to the dying patient. Our anxiety and sense of impotence may force us to keep our distance from a patient whose death appears inevitable, leaving the patient psychologically abandoned and emotionally and physically isolated. The vital question is not whether or not we have a "denier," but denial when and with whom and under what circumstances? I hope that we all subscribe to the notion that the dying patient has a right to know, but that this right is clearly contingent upon his or her right not to know. It is imperative that we honor a patient's denial until he chooses to admit into consciousness, frequently in symbolic form, a growing awareness of the life-threatening nature of his illness.

A 55-year-old truck driver with seriously advanced lymphosarcoma discussed his feelings about driving a large truck across country late at night. He spoke intensely of the dark, the shortage of gas, and how lonely and frightened he felt when it seemed as if it might not be possible to reach the next gas stop. He spoke of the loneliness of the open road, the trucker's lack of human contact and relationships, and his fear of the uncertainty of the situation. I honored his chosen metaphor and we spoke "truck language" for approximately one-half hour, after which time he made intense eye contact and said "I hope you realize that I'm not talking about trucks and the highway." I indicated that I understood what he was referring to and thanked him for sharing so intimate a set of feelings.

A 16-year-old girl dying of choriocarcinoma shared the following:

"I used to be a tremendous softball player. I could bat .900—I'd get nine hits each ten at-bats. Then my batting average began to fall. I started batting .500, then .400, and finally I couldn't hit the ball out of the infield and I had to bunt." I shared the observation that sometimes even the strongest hitter had to bunt. She smiled and said

DOCTOR-PATIENT RELATIONSHIPS: EMOTIONAL IMPACT

"I realize now that I don't have to hit a home run each time. I just have to get on base and it doesn't matter how. The one thing I have to watch out for," she cautioned, "is hitting the ball to third base. If you hit it to third you're dead, third base is the coffin corner." This interchange opened up an extended discussion of the patient's fear of death, her feelings of isolation from her parents and the medical staff, and her sadness about being treated as a child when in reality she considered herself an adult.

A rule of thumb fundamental to the evolution of effective doctor-patient communications is that the physician answer all questions honestly, giving as much information as is asked for by the patient. For many people in extraordinarily high-stress situations, ambiguity produces far more emotional distress than even the most negative reality. I occasionally hear physician colleagues state that "the patient knows anyway." If this is true, then any reluctance to communicate honestly and openly merely compels the patient, his or her family, and the staff to collude in a lie that may severely increase the patient's anxiety. Situations similar to that faced by Tolstoy's Ivan Ilych are not rare.

What tormented Ivan Ilych most was the deception, the lie, which for some reason they all accepted. That he was not dying but simply ill, and that he only need keep quiet and undergo a treatment and then something very good would result. He, however, knew that, do what they would, nothing would come of it only still more agonizing suffering and death. This deception tortured him—their not wishing to admit what they all knew and what he knew . . . Those lies enacted over him on the eve of his death and destined to degrade this awful, solemn act to the level of their visiting, their curtains, their sturgeon for dinner—were terrible agony for Ivan Ilych.

Ambiguous or dishonest communication imposes needless emotional pain on patients and families facing life-threatening illness. The deleterious impact of the deliberate choice to withhold information without first accurately assessing the awareness of the patient is illustrated by the tragic case of an elderly couple from the Midwest. While the husband was dying of lung cancer, the physician and family firmly stood by their decision not to inform him that his illness was terminal. The wife, whom her husband described as his "bride of 50 years," tried valiantly not to leak the information to him. Given the fact that the latest research in nonverbal communication indicates that between 70 percent and 90 percent of what we communicate to one another is transmitted through nonverbal channels, how long could the wife maintain this facade without nonverbally leaking signs of her obvious distress? In minutes the tension resulting from her emotional stress was clearly perceived by her terminally ill husband who only hours before had confided to me that he had known he was dying for several weeks. He had long since noticed his wife's distress but had chosen not to tell her what he knew in an attempt to spare her the emotional pain of confronting his death. The inaccurate assessment of the patient's awareness of his prognosis resulted in a restricted system of communication that inflicted great stress on both husband and wife. Since both defined their relationship of 50 years as a "marriage made in heaven"

ELEMENTS OF PSYCHOSOCIAL ONCOLOGY

what value existed in reducing their last set of interactions to a lie? The unfortunate and deceitful conclusion that such dishonesty prevents (rather than causes) pain results from a desire for mutual protection frequently observed among patients, families, and staff. A professional or volunteer who has been trained in communication skills, has more time, and is able to understand personal metaphor and symbolic communication is in a better position to assess the level of all concerned. Without such assistance, a conspiracy of silence (in which everyone knows and yet no one is willing to share the fact that he knows) can overwhelm and alienate the patient, his family, and the physician.

Anger

One of the most perplexing responses for hospital staff to cope with is patient anger. The patient may be furious at what he perceives as a capricious universe unjustly inflicting cruelty in the form of his cancer. The emotional stress may cause the patient to search incessantly for some psychological and/or spiritual explanation for the cruel fate that has befallen him. In counseling cancer patients, it is important to realize that no definitive research has indicated a clear etiological equation specifying the relation between causes and effect (malignancy); hence, to the lay public (as well as many health professionals) the selection of those who get cancer often appears random and chaotic. The possibility of a random and meaningless universe, or worse, a tyrannical and capricious god, operating without plan or with malevolent intent can be powerfully unsettling. Some people attempt to explain cancer as a form of severe retribution; such an "explanation" may evoke considerable fear and guilt in many cancer patients. It is not rare for terminally ill patients to direct their anger against the infuriating whimsy of their illness. The services instituted by many hospitals simply do not meet the psychosocial needs of patients, families, and staff under considerable emotional stress. Overburdened medical and nursing personnel and anxious family members may be too preoccupied with their own needs and demands to provide adequate support to the patient. At minimum, it is important for us to recognize the difference between anger directed against a seemingly random and whimsical "death-sentence" and anger directed against (1) a physician who may have been slow at making a diagnosis or who had inaccurately diagnosed the illness until it was too late to treat effectively; (2) nursing staff who seem too busy to attend to the emotional needs of the patient; and (3) family members who choose to withdraw in fear rather than engage in meaningful dialogue with the patient.

Anger is frequently a defense against terror and severe loss of control. An effective approach is to help the patient understand his response by actively listening as he vents his anger and then distinguishing with him the issues that are realistically subject to variation from those that are not. Anger can be a psychologically adaptive and important reaction to severe emotional stress. It is vital that we not assume that anger is an immature response directed at an inappropriate target. We have much to learn about the emotional realities of people facing life-threatening illness and must always guard against stereotyping their responses and rendering them invalid.

DOCTOR-PATIENT RELATIONSHIPS: EMOTIONAL IMPACT

Depression

Another frequently observed patient response to life-threatening illness is depression, both reactive and preparatory. When a patient experiences the tremendous loss of self-esteem that often results from prolonged and painful hospitalization and treatment, emotional abandonment by family and friends, the real or imagined insensitivity of hospital personnel, and the depletion of finances due to expensive medical care, he may understandably become severely depressed. Those who take the time to listen will frequently find that this depression is traceable to concrete life circumstances. Furthermore, some of these circumstances may be subject to modification, and all available supports should be mobilized to this end. Facilitating communication with family members, helping to minimize financial burdens, diminishing the impact of severe body-image changes, and sensitizing staff to the emotional needs of patients are areas that can be explored in an effort to alleviate depression of a reactive nature.

Preparatory depression is primarily an anticipatory reaction to the threatened "loss of oneself," that is, a grief reaction to the impending cessation of embodiment. The patient is threatened "not only" with the loss of life, but also with the loss of self-esteem, physical potency, and personal relationships. Typical reactions include frightening dreams, irritability, extreme sadness, anorexia, and apathy. Intense and prolonged suffering can exacerbate preparatory depression to the point where it incorporates elements of suicidal preoccupation. It is not helpful to interrupt this preparatory response with false promises of cure or positive response to treatment. This is a classic mourning period that offers a true test of the professional's (or family members') ability to provide continuous emotional support to the patient. One can be extremely supportive by sitting with the patient, often in silence, in an attempt to convey a willingness to share this emotionally demanding period. The health professional or volunteer can help a patient cope successfully with reactive depression by assisting in the development of a sense of closure (i.e., a sense of completing life's "unfinished business"—personal, interpersonal, spiritual, and financial). To offer on-going support during the preparatory period we must become attuned to the emotional realities of each dying patient and the personal significance of his imminent death.

Acceptance

Recent research has focused on the fact that some terminal patients seem able to accept their impending death. I have found that 5 to 10 percent of those cancer patients who die in the hospital maintain a predominately consistent death-accepting attitude. However, 15 to 20 percent of those terminal patients who choose to die at home achieve a similar level of acceptance. In caring and supportive families capable of substantially meeting the needs of the terminally ill member, the acceptance of death may resemble not so much the resignation of a beleaguered soldier accepting defeat, but rather an emotionally and cognitively integrated sense of "alrightness" about the termination of one's life. The degree of this acceptance often fluctuates depending on shifts in mood due to pain, drug side effects, and assorted emotional conflicts. In some instances, a major difference between the hospital and home context may be the

ELEMENTS OF PSYCHOSOCIAL ONCOLOGY

willingness to honor the patient's chosen attitude toward death. The influence of a powerful antideath institutional belief (the basic attitude toward life-threatening illness of medical and nursing staff) frequently precludes a patient's acceptance of death. Understanding the impact of a death-accepting or death-denying environment on the dying person is crucial. It is unreasonable to expect a terminal patient to accept death when he or she is embedded in a hospital social system that views disease as an evil adversary and death as unacceptable. It may be extremely difficult for a dying patient who is dependent upon a fiercely death-denying family or hospital staff to ever accept his own death. It is a rare individual (usually someone with a profound spiritual or philosophic commitment) who can counteract the pervasive death-denying institutional bias militating against death-acceptance. The heroic measures sometimes used to prolong the lives of patients who have peacefully and clearly indicated their preference for letting nature take its course bears witness to the institutional abhorrence of death under any conditions. Many patients are not physically capable of sufficient impact on the decision-making process to suspend these aggressive measures. The point is certainly not that death-acceptance is always the preferable response, but rather that patient input and the right of self-determination are fundamental. As health professionals, we must avoid those absurdly macabre scenarios wherein medical heroics are directed at the prolongation of the life of a patient who has clearly and nonhysterically expressed an aversion to such measures.

For many people, particularly the elderly, the completion of unfinished business—economic and work-related, psychological and related to self-esteem, interpersonal, religious—may enhance a sense of the appropriateness of their own death. The ability to derive a sense of purpose and meaning from life and perhaps death, to have, in Weisman's (1972a) terms, "an appropriate rather than an appropriated death," appears integral to any self-accepting experience of terminality. This is not to suggest that the acceptance of death is the equivalent of an emotionally or physically painless death, but rather that such acceptance may enhance a person's opportunity of relating to death in a more meaningful fashion. Few people realize that personal change and maturation often appear more possible on one's deathbed than perhaps at any other time in the life cycle. The fluidity of ego boundaries and the suspension of stereotypic modes of social interaction, of "the games people play," may allow for such maturation. The culturally dominant notion that death, the Grim Reaper, is nothing but tragic prevents us from realizing that even in the midst of painful chaos and parting, the possibility of positive change exists. However, such change can occur only with the patient's willing support and can often be facilitated by a person trained to develop these subtle but important possibilities.

As noted previously, the two main areas of serious concern to terminal patients are (1) extreme pain and (2) emotional and physical isolation and the threat of abandonment. The most cogent analysis of patient isolation and abandonment I have read is that of Erikson and Hyerstay (1974), who describe the psychosocial gestalt of a hospital death with considerable accuracy. The need for developing better palliation strategies has been discussed by LeShan (1964) and Marks and Sachar (1973). With the help of our colleagues at the hospices in Great Britain, we are beginning to learn that patients in the United States may, at times, endure much needless pain because of

DOCTOR-PATIENT RELATIONSHIPS: EMOTIONAL IMPACT

undereffective palliation strategies. Hospice physicians and patients claim that (1) effective pain management strategies exist for almost all patients facing life-threatening illness, (2) patients can remain lucid *and* pain-free throughout most of the dying process, and (3) addiction and habituation result from the ineffective administration of palliative drugs. There is no possible excuse for not thoroughly investigating these claims. My own clinical experience and observation has substantially borne out their validity (which does not derive from the fact that British pain-killers contain heroin as the active pharmacological ingredient since morphine is often the agent of preference). In studying the psychopharmacological aspects of pain, it is important to remember that making judgments about another person's pain is an extremely hazardous proposition. Physicians must use their patient's feedback as the most significant criterion. In evaluating the effectiveness of pain-management strategies, to say, as one professional did in reaction to a patient in extreme pain, "He's not in as much pain as he says he is," is most unfortunate. In general, physicians need to acknowledge as primary data the subjective reports of their patients and prescribe palliative strategies based on this acknowledgment.

Individualized Approaches to Psychosocial Care

I have found the following outline useful in determining and meeting the psychosocial needs of terminal patients.

- 1 With the assistance of the patient, define the major areas of emotional distress.
- 2 Respond to the patient's requests for information with an honest, complete, and accurate presentation of the major aspects of illness and treatment.
- 3 Inform the patient's family of the status of his health so that family members can assume their rightful status as members of the treatment team.
- 4 Make it possible for the patient to be aware of staff expectations concerning treatment, patient-staff relationships, etc., and conversely be aware of patient expectations.
- 5 Always compare your perceptions of the patient and his situation with those of your colleagues. It is hazardous to make unilateral judgments about another person's emotional reality.
- 6 Remember that psychosocial evaluation, like medical appraisal, is a continuous process. Two innovations that have proven successful in maintaining ongoing evaluation are (a) the institution of interdisciplinary psychosocial rounds the specific purpose of which is to evaluate staff success in meeting the emotional needs of all patients (the option of inviting patients to talk to staff about how to best care for them has been a successful aspect of these rounds), and (b) the use of a psychosocial log in which all health providers may record their feelings and thoughts on various aspects of working with seriously ill patients. This log can serve as a catalyst for discussion during psychosocial rounds.

Several premises are basic to the effective psychosocial care of patients and families facing life-threatening illness. First, it is important for those who work with the dying

ELEMENTS OF PSYCHOSOCIAL ONCOLOGY

to monitor their own feelings. As Weisman (1972b) has pointed out, "We are not immune to denial, dissimulation, antipathy, and fears of personal annihilation." We must not be ashamed to recognize that caring for the dying is itself an "exposure to endangerment" that often necessitates enlisting the aid of key individuals and a variety of modes of support. Second, as Dobihal (1974) has noted, the dying patient and his or her family constitute the optimal unit of health care. It is extremely important for patients to live out and conclude family relationships in as emotionally satisfying a way as possible. It can be very distressing for critically ill persons and their families to be separated by the treatment milieu and forced to limit or terminate their relationships. Dobihal offers the following suggestions to health professionals:

- 1 Train family members to participate in treatment.
- 2 Encourage them to do such things as continue to cook special meals for the patient.
- 3 Allow unlimited visiting so that the total family, including children, can spend time with the patient.
- 4 Provide special hospital space for patient-family meetings, as well as space for family members to live when the patient's death is imminent.
- 5 Provide special social and educational programs for the family and patient, and continue these programs, adding home visits for the family, after the patient has died. Research in preventive health indicates that the bereaved are much more susceptible to mental and physical trauma (including early death) than people not suffering from the loss of a close friend or relation.

Third, as Schmale (1974) has observed, the capacity of the physician to accept and relate to the patient's awareness of dying is important. It is not easy to listen and respond to patients' statements about their readiness to die, but the opportunity to relate to patients approaching the end of their lives (when they often relinquish former attitudes, behavioral patterns, and defensive strategies to become totally immersed in the present) may provide a unique learning experience for the health professional.

Fourth, staff members should make every attempt to relate to the patient as a colleague. This case of a woman labelled "difficult patient" for many months and who was the subject of endless discussions in rounds and case conferences offers a graphic example of the success of this orientation. Staff members were unable to develop an approach adequate to the situation. The woman appeared belligerent, demanding, and unresponsive to staff efforts. It was only when I suggested that she be allowed to attend management rounds as a colleague and speak to staff about how to best care for her that the situation changed. When presented with this alternative, she responded "Now, that's the first sensible thing I've heard since I got here." Following her carefully outlined lecture, staff adopted many of her suggestions, negotiated others, and the situation changed substantially for the better.

Fifth, it is most useful for a patient-advocate or companion to be available for each patient, that is, someone who is able to listen and follow through on specific patient requests. Given the powerful conditioning inherent in our training as health professionals, we may unconsciously adopt an ironclad distinction between professional

DOCTOR-PATIENT RELATIONSHIPS: EMOTIONAL IMPACT

and patient and further equate professional with *correct* and patient with *incorrect*. It is urgent for us to realize that as professionals we may require attitudinal reorientation as much as our patients. Having a patient-advocate or representative available to the patient in an unconditionally supportive manner may allow for more effective coping in the face of life-threatening illness.

Finally, we should recognize that the disease process and medical treatment may affect the patient's mental faculties, causing fluctuation between slightly altered levels of cognitive and perceptual functioning and states of consciousness distinctly discontinuous with the waking state (Pelletier and Garfield, 1976). In light of these alterations in psychological functioning, it is important to avoid pressuring the patient toward some staff ideal of how to successfully cope with his impending death. Each patient's "deathstyle" is as unique as his lifestyle, and it takes time and a willingness to understand the attitudes and behavior of a given patient before successful psychosocial support is possible.

CONCLUSION

Worchester (1935), in a fine book entitled *The Care of the Aged, the Dying and the Dead*, offers the following guidelines for care of the dying patient:

- 1 Disturb him not, let him pass peaceably. Even while only watchful waiting is needed, the physician must not underrate the help that his mere presence may afford in steadying and comforting both the dying patient and the family. They also serve who only stand and wait.

- 2 In the practice of our art it often matters little what medicine is given, but it matters much that we give ourselves with our pills. Until the doctor had had the sad experience of standing by to the very last those nearest and dearest to him, he can only imagine the heartache of his dying patient's family and their sore need of sympathy; nor until he himself has been nye onto death can he more than imagine the comfort that even the firm clasp of a friendly hand can give to one in such extremity.

Shortly after the First National Training Conference for Physicians on Psychosocial Care of the Dying Patient, I heard Walter Alvarez, one of the elder statesmen of America's medical community, comment that in 70 years of medical practice he had never seen a patient die. I was struck powerfully by the contrast between Dr. Alvarez's experience and my own. As mentioned earlier, in the past 3 years I have provided emotional support to 156 cancer patients who finally succumbed to their illnesses. On a number of occasions I have been present at the moment of death. I have experienced 156 times a few of the emotional realities of life-threatening illness but not nearly so intensely as those who have died. Their deaths and my enforced separation from them have been painful to varying degrees, but not nearly so painful as the loss experienced by their families and friends. I have wondered often what it will be like for me when I am compelled to face the deaths of those I love most and my own. The power

ELEMENTS OF PSYCHOSOCIAL ONCOLOGY

of these reflections in reformulating the values that govern my life has been considerable. To say the least, we have much in common with many of our patients. Perhaps the best expression of this commonality in human experience was offered by a 38-year-old man dying of intestinal cancer.

Several days before he died Roger asked me to read to him. As I proceeded slowly through the lines while he drifted in and out of waking-state consciousness, I wondered whether he even heard me at all. Suddenly, as though he had been stung by a needle, his eyes shot open and he looked at me and said, "Please read that line again." I read the entire paragraph again and he repeated his request. "The line near the end," he said, "please read the line near the end." I read the line three or four times and each time Roger nodded his head. Finally, with tears gently streaming down his face he said, "Please tell my doctor and the nurses that's why I'm so afraid." The line that Roger asked me to read was "The eternal silence of these infinite spaces frightens me."

As I reflect on Roger's words while writing during the hours before dawn, a time when my humility is apparently at its peak, I must confess with a sharp jolt of *ego-chill* (Erik Erikson's term) that "the eternal silence of these infinite spaces frightens me" also.

BIBLIOGRAPHY

- Annas, G.: "Rights of the Terminally Ill Patient," *Journal of Nursing Administration*, 4:40-43, 1974.
- Artiss, K. and A. Levine: "Doctor-Patient Relations in Severe Illness," *New England Journal of Medicine*, 288:1210-1214, 1973.
- Bulger, R.: "Doctors and Dying," *Archives of Internal Medicine*, 70(3):327-332, 1963.
- Choron, J.: *Death and Modern Man*, Collier, New York, 1964.
- Dobihal, E.: "Talk or Terminal Care," *Connecticut Medicine*, 38:364-367, 1974.
- Erikson, R. and B. Hyerstay: "The Dying Patient and the Double Bind Hypothesis," *Omega*, 5(4):287-298, 1974.
- Garfield, C.: "The Impact of Death on the Healthcare Professional," in H. Feifel (ed.), *New Meanings of Death*, McGraw-Hill, New York, 1977.
- Kasper, A.: "The Doctor and Death," in H. Feifel (ed.), *The Meaning of Death*, McGraw-Hill, New York, 1959.
- Kastenbaum, R. and R. Aisenberg: *Psychology of Death*, Springer, New York, 1972.
- LeShan, L.: "The World of the Patient in Severe Pain of Long Duration," *Journal of Chronic Diseases*, 17:119-126, 1964.
- Marks, R. and E. Sachar: "Undertreatment of Medical Inpatients with Narcotic Analgesics," *Annals of Internal Medicine*, 78(2):173-181, 1973.
- Pelletier, K. and C. Garfield: *Consciousness: East and West*, Harper and Row, New York, 1976.
- Rosenthal, T.: *How Could I Not Be Among You?*, Braziller, New York, 1971.
- Schmale, A.: "Principles of Psychosocial Oncology," in P. Rubin (ed.), *Clinical Oncology for Medical Students and Physicians*, American Cancer Society, Rochester, 1974.
- Weisman, A.: *On Dying and Denying*, Behavioral Publications, New York, 1972a.

NOTES

NOTES

NOTES



EXTENDED PROGRAMS IN MEDICAL EDUCATION

EVALUATION QUESTIONNAIRE

Your thoughtful appraisal is essential for improving future continuing medical education activities. After the program, please complete this confidential questionnaire and give it to the UCSF personnel at the Program Registration Desk.

CARE OF PATIENTS
FACING LIFE-THREATENING ILLNESS

M14120/21

DEC. 13 or
DEC. 14, 1991

Program Title

EPME Number

Dates

1. Did you make your decision to attend this course based on (Circle all that apply)

a: Previous Attendance
d: Journal Announcement

b: Recommendation
e: Other: _____

c: Brochure Information

2. Degree

a: M.D.
d: CSW/MSW/MFCC

b: RN/PA/NP/LVN
e: M.Div/DD

c: Respiratory Therapist
f: Other: _____

3. If a health care worker, what is your specialty?

a: Oncology
d: AIDS Care
g: Hospice Care

b: Intensive Care
e: Burn Therapy
h: Geriatrics

c: Coronary Care
f: Extended Care
i: Other: _____

4. Year first entered practice? _____

5. Which topics did you find most valuable? (Circle All That Apply)

a: Basic Issues
d: Stress and Burnout
g: Communication Skills

b: Sequence of Events
e: Patient Tmt. Partnerships
h: Personnel Issues

c: Action Plan
f: Interdisciplinary Teams
i: Mission Statement

6. Which topics did you find least valuable? (Circle All That Apply)

a: Basic Issues
d: Stress and Burnout
g: Communication Skills

b: Sequence of Events
e: Patient Tmt. Partnerships
h: Personnel Issues

c: Action Plan
f: Interdisciplinary Teams
i: Mission Statement

EVALUATION QUESTIONNAIRE

Page 2

7. Please rate the following aspects of the program. (Circle Your Responses)

	EXCELLENT	SATISFACTORY	POOR
a. Overall quality of program	2	1	0
b. Selection of topics	2	1	0
c. Program organization	2	1	0
d. Opportunity for questions/discussion	2	1	0
e. Relevance to practice	2	1	0
f. Audiovisuals			
- Quality of slides	2	1	0
- Performance of projectionist	2	1	0
g. Syllabus			
- Educational content	2	1	0
- Relevance to practice	2	1	0
- Appearance, format	2	1	0

8. Please rate the speaker (Circle Your Responses):

SPEAKER	EXCELLENT	SATISFACTORY	POOR
Charles A. Garfield			
Organization	2	1	0
Knowledge of Subject	2	1	0
Communication Skills	2	1	0

Comments _____

9. Would you recommend this program for a fellow colleague?

Yes_____ No_____ Why or Why not?

10. Please list one or two major topics which you would like to see addressed at future programs.

11. SUGGESTIONS for improving the quality of this program, or additional comments: