

Core Competencies in Palliative Care for Surgeons: Interpersonal and Communication Skills

Ciarán T. Bradley, MD, and Karen J. Brasel, MD, MPH

Surgeons are an important part of the multidisciplinary approach to the care of terminally ill and dying patients. Some surgical residencies have recognized the need to incorporate palliative care–related topics into graduate surgical education. One core competency of utmost importance to palliative care is the effective use of interpersonal and communication skills. Four areas of surgical practice are identified where these communication skills are important: during preoperative counseling, when presenting a

devastating diagnosis or poor prognosis, when discussing error, and when discussing death. Case examples and recommendations for the appropriate words and actions to use in these scenarios are offered. It is important for both surgeons in practice and those in training to achieve proficiency with these communication skills.

Keywords: communication skills; interpersonal skills; preoperative counseling; surgery; palliative care

Effective use of communication skills is a cornerstone of medical care. Responding to a shift in public expectation from passive recipient of medical care to active participant, the medical establishment has now embraced open disclosure as a bedrock principle of clinical practice.¹ Governing bodies, such as the National Cancer Institute, American Society of Clinical Oncology, and Accreditation Council for Graduate Medical Education, recognize the importance of communication skills for practicing physicians and residents alike.^{2,3}

Specific to palliative care, well-developed communication and interpersonal skills are of paramount importance. It is a specialty built on honesty and open disclosure. At the particularly vulnerable time of the end of life, patients and their families seek realistic hopes and earnest commitment from their caregivers and are ultimately harmed by ambiguous, evasive, or

dishonest interactions. Physician paternalism and misguided attempts to protect a patient from bad news with the thinking, “What he doesn’t know won’t harm him,” are now considered antiquated.⁴

The importance of good communication skills in surgical practice is equally undeniable. Patients have cited poor communication as a reason for not recommending a surgeon to their family or friends, and there is a long established perception that improved doctor-patient communication can help prevent malpractice litigation.^{5,6} Additionally, because surgical practice in almost every setting deals at some point with gravely ill and dying patients, surveyed surgeons have identified breaking bad news and bereavement counseling as areas worthy of instruction for surgical trainees.⁷

Consequently, surgeons have called for the inclusion of more information related to palliative care in surgical textbooks.⁸ Others have begun developing palliative care curricula designed specifically for surgeons, including modules on communication skills and standardized testing for surgical residents conducting family meetings in the surgical intensive care unit (ICU).^{9,10} But unfortunately, as Gross et al¹¹ acknowledged 7 years ago, it is still true

From the Department of Surgery, Medical College of Wisconsin, Milwaukee, Wisconsin.

Address correspondence to: Ciarán T. Bradley, MD, Department of Surgery, Medical College of Wisconsin, 9200 W Wisconsin Ave, Milwaukee, WI 53226; e-mail: cbradley@mcw.edu.

that, “. . . little is written on the practical decisions that surgeons make when discussing end-of-life issues with patients and their families.”

We identify 4 areas of surgical practice relating to end-of-life issues where effective communication skills are important:

1. The preoperative visit.
2. Discussing a poor prognosis.
3. Discussing an adverse outcome due to error.
4. Discussing death.

These scenarios are common to all types of surgical practice, and all will likely be encountered in some fashion over the course of a surgeon's career. Unless otherwise stated, we consider communication with a patient and his or her family to be synonymous skill sets. Likewise, the skills outlined below can be adapted to an interaction with the parents of a pediatric surgical patient.

Effective communication ability, similar to operative technique, is not an innate process. Bloom's taxonomy of learning establishes that education depends on achieving understanding at the cognitive, affective, and psychomotor levels.¹² This can be said of interpersonal skills as well, which rely on knowledge, appropriate emotional responses, and acquisition of a particular skill set for implementation. Through a review of the relevant literature, we provide guidelines and practical suggestions that can be tailored to specific scenarios when dealing with the end-of-life issues in surgical practice.

Preoperative Counseling

“What If Something Happens, and My Aneurysm Repair Isn't a Success?”

In chronic medical disease, patients may undergo a slow decline during which their physician may have the opportunity to introduce palliative care planning after a relationship is established over several visits. In contrast, the surgeon's involvement in end-of-life care is often more abrupt. There is a watershed moment (the elective operation) before which a patient is likely in a steady state of relative health, but after which, owing to unforeseen complications or the cumulative effect of comorbidities, the transition toward end-of-life care can accelerate. It is precisely because of this potential for abrupt postoperative change that preoperative counseling is

the most appropriate time for exploring patient preferences, goals, and expectations about end-of-life care. There may not be an opportunity for a similar discussion later, when a life-threatening complication has occurred and death may be imminent.¹³

Since the implementation of the Patient Self-Determination Act in 1990, the use of advance directives has become more prevalent.¹⁴ In the Act, the federal government mandates that all health care institutions receiving Medicare or Medicaid reimbursement inquire whether their patients have an advance directive and inform the patient about their rights to refuse treatment. Some assert that the presence of advance directives does not have any significant effect on a patient's disease course, the decision making of their caregivers, or resource utilization.¹⁵ Others have shown a greater proportion of patients with advance directives dying outside the hospital.¹³

From this debate, a call has emerged for an emphasis to be placed on the nature in which the patient is counseled, and the specific communication skills used rather than the end result of an advance directive.¹⁶ This redirects the conversation from a simple preoperative checklist of relevant documents to a broader understanding of the patient's goals of care and their knowledge of their own disease severity and trajectory.¹⁷

In surgical practice, there may be a misconception that discussing end-of-life issues might make the patient apprehensive about proceeding with an operation. Consequently, preoperative counseling is often reduced to a cursory review of the major risks and benefits, fulfilling only the basic requirements to obtain informed consent. In an observational study of trainee physicians faced with counseling a hypothetical patient with a surgical emergency (leaking abdominal aortic aneurysm) who had significant comorbidities (end-stage cardiac, respiratory, and renal disease), the trainees scored highly on the technical or medical aspects of the case but discussed the patient's functional status, values, wishes, and fears much less consistently.¹⁸

In fact, patients crave a more frank discussion of all possible outcomes. In a randomized controlled trial of patients undergoing cardiac surgery, Song et al¹⁹ demonstrated that the majority of patient-surrogate pairs who engaged in advance care planning were interested in having such a discussion and wanted to, “Prepare for the worst while hoping for a cure.” Patient-centered advance care planning, as described by Briggs et al,²⁰ involves an all-encompassing

approach and a lengthy discussion of the patient's expectations with a designated surrogate present.

Several steps are integral to the patient-centered approach:

1. Help the patient select a surrogate decision maker.
2. Clarify the patient's values and preferences with the surrogate present:
 - “What activities are important for you to give your life meaning?”
 - “What have you discussed with your family about what you might choose for your future medical care, including at the end of life?”
 - “Do you think that the discussion has been specific enough?”¹⁸
3. Define with the patient and their surrogate what decision-making authority the surrogate will have.²¹
4. Provide information about the benefits and burdens of medical treatments, (in this case, the operation and the possible adverse outcomes that could lead to palliation: long-term ventilator dependence, sepsis with pressor demand, acute renal failure with dialysis dependence, etc).²⁰

Describing specific outcomes likely to result from a particular treatment is an important part of end-of-life communication. In a cohort of patients older than 60 years, who had limited life expectancy due to cancer, congestive heart failure, or chronic obstructive pulmonary disease, more patients chose a treatment when quoted a 50% chance of death than a treatment with a 50% chance of severe cognitive or functional impairment. This demonstrates that patients' decisions are based at least partially on perceived outcomes, particularly with respect to functional and cognitive ability.²²

In the patient-centered model, a 1-hour interview was conducted with an experienced facilitator. They observed better concordance in the end-of-life preferences between patient and surrogate in those interviewed compared with those offered standard counseling.²⁰ Although this model is lengthy and time consuming, it can serve as a template for framing a discussion of advance care planning in the clinic. Even a shorter discussion of 5 to 10 minutes addressing advance care planning conducted by anesthesiologists in a preoperative clearance clinic has been shown to enhance patient-surrogate communication about end-of-life preferences.²³

Special consideration needs to be given to race and ethnicity in the context of end-of-life discussions, as

there are certain ethnic and racial groups that are less likely to discuss end-of-life issues with clinicians.¹³ It is unclear whether this is a result of the cultural preferences of the patients or the perceptions of the clinicians who may be hesitant to discuss end-of-life issues with these groups. Regardless, the opportunity for advance care planning with these populations should not be missed.

Finally, it is important to remember that advance care planning does not always occur in the outpatient setting. The preoperative visit can take place at the bedside, in the emergency room, or in the ICU. When surgeons are consulted to intervene in difficult situations, there still can be a place for meaningful discourse about end-of-life planning. In the emergency setting, whether the diagnosis is a ruptured abdominal aortic aneurysm or a septic patient with free intraperitoneal air, there is time to inquire about the patient's wishes. Identify whether there is an appropriate surrogate or whether previous advance care planning and end-of-life discussions have occurred, and inform the patient and surrogate of the likely outcomes. In a compressed time frame, the answers to all these questions might not be available, but they should be asked. Ensuring a collaborative approach among surgeon, patient, and family at the outset will make difficult decisions easier to handle when they arise later.

Presenting a Devastating Diagnosis or Poor Prognosis

“Do You Think She'll Ever Get Off the Ventilator?”

Although there are some specialties where breaking bad news is considered a common occurrence, no specialty, particularly surgery, should be considered immune from this responsibility.²⁴ Further adding to the challenge is the variety of locations and situations where a surgeon might be called upon to give bad news: the clinic, ICU, operating room waiting area, or patient's bedside. There are several reasons why delivering bad news appropriately is a useful tool. Primarily, patients expect it from their doctors, and the public now considers it an essential skill for any physician.²⁵ In addition, delivering bad news poorly, with little regard for the patient's concerns, can place the patient at high risk of developing depression, anxiety, and even suicidal ideation.^{26,27} From the physician's point of view, doctors who are

comfortable delivering bad news may suffer from less stress and burnout.^{28,29} Finally, physicians who have difficulty delivering bad news are more likely to recommend therapies with limited foreseeable benefit, such as third-line or fourth-line chemotherapy regimens.³⁰

The most commonly cited protocol for breaking bad news is Buckman's 6-point SPIKES method.^{25,31} Although often applied to literature in medical subspecialties, his general principles are useful to surgeons as well.

1. The SET-UP: Choose an appropriate setting that is private and sufficiently quiet. Limit distractions by turning off a pager or having a colleague carry it. Set aside enough time, or warn the patient and his or her family if there will be time constraints. Sit at the same level as the patient, so that eye contact is natural.
2. Assess the patient or his or her family's PERCEPTIONS: Find out how much they know about what is happening. Use open-ended questions such as, "What do you understand about the situation thus far," or "Summarize what has been happening in your opinion."

When specifically applied to the end-of-life discussion in the ICU, Barton et al³² refer to this stage of the conversation as phase II: the description of status. By asking questions like, "How do you think she is doing?" physicians can allow her family to come to their own conclusions about grave prognosis. Sometimes, families will then move to the decision-making stages of the conversation independently.

3. Obtain the patient's INVITATION: Find out how much the patient or his or her family wants to know about the details of the condition at hand. This sets the basic rules for any further discussion. If the patient declines an offer to discuss matters in detail, then remind him that he can always change his mind later. Likewise, take this opportunity to establish a surrogate: "Is there someone else to whom you would like me to give the details?"

Ensuring that this step is complete also helps avoid the ethical dilemma that ensues when a family asks that their loved one not be burdened with bad news: "She's not the type to take bad news lightly. Let's not crush her spirits." This clearly violates the ethical principles of patient autonomy and the right to their health information.³³ After establishing how

much the patient herself wishes to know, the physician can then try to honor both the patient's and family's preferences.

4. Impart KNOWLEDGE: This is the part of the dialogue where the physician relates the facts at hand. Avoid medical jargon such as "intubated" or "metastasized." Assume that the patient or his or her family knows very little at the start, and then tailor the conversation to their reactions: "Let me start at the beginning, but tell me if I am covering what you have already heard." Give a warning shot: "Unfortunately, I have some bad news." Don't be a defeatist. There is never a situation in surgery where, "There is nothing we can do." Therapy can always be offered in the form of palliative measures.
5. Respond to the patient's or his or her family's EMOTIONS: Patients will have a variety of emotional responses to bad news. Whether they respond with anger, disbelief, sadness, or denial, it is important to acknowledge their emotions. An empathetic response involves understanding the patient's feelings and communicating that understanding back to the patient. Allow the patient time for their emotions. Remain silent. Coulehan et al³⁴ recommend, "Don't just do something, stand there!" Then, after this brief pause, connect their emotion back to the cause: "I know this is not what you were hoping for, as we had hoped to remove all the cancer. I wish I had better news." In this instance, the use of an "I wish . . ." statement allows the clinician to express their simultaneous dissatisfaction with the outcome. This is the essence of empathy.³⁵

Although it may be appropriate sometimes to share the emotional response of the patient, as will be described later, one does not need to be sympathetic (experience the same emotion as another) to be empathetic. In fact, empathy can enable the physician to understand and acknowledge a patient's emotions without an obligation to feel the same way.

6. SUMMARIZE and develop a STRATEGY: Although in some cases, physicians are legally required to present their patient with all the treatment options, this does not prevent us from making recommendations.³⁶ In the case of a critically ill patient at the end of life, the decision to withdraw care is often burdensome for a family. They will be reassured by the objective opinion of their physician.^{16,37} Consider this equivalent to the patient with gallstones and abdominal pain.

At the end of a visit, you make a recommendation as to whether cholecystectomy is appropriate. After discussion about a grave prognosis, a recommendation about further care and next steps is appropriate.

This is an important opportunity to develop a contract with the patient and his or her family thus preventing them from feeling abandoned. Use this time to formulate a plan and time line for follow-up visits. Make sure the patient and his or her family know how to contact their physician. Even in a situation where there is little curative therapy to offer, no cure does not mean no care. If palliative measures are to be used, reaffirm that the patient will still receive aggressive, timely, and appropriate treatment for their symptoms as best as possible.³⁸

At the end of life, this stage corresponds to Barton's phase III, holistic decision making and phase IV, an explanation of the logistics of dying. In phase III, we call upon the family to use substituted judgment on the best course of action: "What would she want." The goal of this stage is to achieve alignment among the family and then between the family and the medical team. This may not be possible in 1 sitting, but even if consensus is not established, the medical team can still advance the discussion to phase IV using hypothetical statements: "If we were to decide to withdraw care, this is what the process would entail . . ."

Some mention of the role of spirituality in the bad news discussion is warranted. Although traditional thinking advocates that physicians should avoid discussions of religious beliefs with their patients, there may be a role for exploring questions of faith in a flexible and nonjudgmental fashion to better understand the patients' end-of-life choices.³⁹ Indeed, many patients want their physicians to explore their religious beliefs in the setting of grave illness.⁴⁰ Often, their spiritual lives are revitalized when nearing the end of life. Particularly in situations when the medical team and family are in disagreement over continuing extraordinary therapeutic measures, the simple question, "How do you feel your faith plays a role in your feelings about your loved one?" may engender mutual appreciation and understanding. This might place the family at more ease to talk frankly about prognosis.

It should be noted that although physicians ought to respect their patients' religious beliefs without bias, they are at no obligation to discuss

their own faith with the family. Also, the purpose of mentioning religion in this setting is not to attempt to answer theological questions that may be beyond the scope of the physician's expertise but rather to gain understanding of the many different factors that drive patients' decision making at the end of life.⁴¹ A hospital chaplain or the family's own minister can take over the conversation as it ventures into specific questions about faith and coping.

Discussing Error

"Do You Mean That My Wife Died Because an Instrument Went Through an Important Artery, and She Lost Too Much Blood?"

One of the hardest communication tasks confronting a surgeon is to discuss an adverse outcome resulting from medical error. This is made especially difficult when that error has led to a catastrophic outcome and conversion to palliative care. Medical errors leading to an adverse event in patient outcome are not uncommon. The Institute of Medicine declared in 1999 that up to 98 000 patients die in the United States every year as a result of a medical error.⁴² Although not all errors are fatal, they have been estimated to occur in up to 46% of surgical patients.⁴³ Considering the variety of errors (delay in diagnosis, improper diagnosis and treatment, technical mistakes, medication administration errors) and their reported frequency, it is likely that surgeons will be called upon at some point in their careers to discuss with a patient or his or her family a poor outcome as a result of error.

The proper manner to discuss catastrophic error with patients and their families is a matter of much controversy among the medical, legal, and risk-management communities. Both the bioethics literature and published guidelines from professional bodies have started to advocate a policy of open disclosure.^{1,44,45} This movement is in part due to calls from the public who have repeatedly favored full disclosure.^{46,47} More importantly, the concept of openly discussing errors with patients and their families speaks directly to the bioethical principles of justice and autonomy, as well as of honesty, which are pillars of sound palliative care.⁴

Nevertheless, there seems to be a lag in clinical practice, where reticence to discuss errors with patients persists. In a survey of physicians and

patients who had experienced a medical error, only one-third of the respondents reported that the health care professionals involved disclosed the error.⁴⁸ Likewise, 30 academic surgeons counseling standardized actor-patients who experienced 1 of the 3 surgically related errors (wrong site lumpectomy, retained sponge, hyperkalemia-induced arrhythmia) were inconsistent in explicitly stating that the adverse event was in fact the result of an error (only 57% used the words “error” or “mistake”) and scored poorly in expressing any empathy. Predictably, they scored well explaining the medical facts surrounding the error.

The perception is that this reluctance is a result of doctors’ fear of litigation.^{44,49} However, there is strong evidence to suggest the converse that complete disclosure does not increase the likelihood of patients seeking legal advice.⁵⁰ Rather, patients are more likely to either report or sue their physician if that person failed to acknowledge the mistake.⁴⁶ Institutions that have adopted open disclosure policies have also seen a drop in claims, annual litigation costs, and average payout per case.^{51,52}

There is a paucity of empiric data outlining the exact components of an open-disclosure discussion.⁵³ Breaking down the specific steps, Hebert et al⁴⁴ recommend taking the lead in disclosure. Do not wait for patients to ask. Being forthright and prompt will allay the inevitable suspicion that often results when families are left to draw their own conclusions. Straumanis⁵⁴ reminds us to know the facts of the case, even if this entails contacting a referring physician to find the significant events in care that occurred before transfer. This will help avoid the temptation to speculate where there may be gaps in the story.

Do not send subordinates or trainees to discuss an error. The attending surgeon should lead the discussion. In a time when medical care is increasingly spread among members of a team (residents, nurses, physician extenders, consultants, etc), we all are often called to bear some element of accountability in errors. Indeed, a single responsible person can be identified when errors occur only approximately 40% of the time.⁴³ Nevertheless, diffusion of accountability does not reduce the responsibility of the team leader who “. . . still bears the burden of the patient’s trust.”⁵⁵ Trainees should still be invited to attend the meeting, as this is a good learning opportunity.

Additionally, make sure that all members of the team who might have exposure to the patient or his or her family understand what is being communicated. This is no time for the family to hear conflicting

accounts, thus creating confusion among the family and division within the medical team.

Finally, the issue of apology is a contentious one. It is suggested that saying sorry implies guilt and may damage a doctor’s or hospital’s reputation if litigation ensues.⁵⁶ However, questionnaires and focus groups repeatedly identify patients’ desire for a sincere apology after an error. Perhaps what is more important than the apology itself is the conveying of empathy. Patients seek reassurance that the error is regretted and that steps will be taken to avoid the error in the future.^{47,50} Patients are not reassured by melodrama or excessive self-flagellation: “We screwed up . . .,” “I feel so guilty . . .”⁵³ To that end, a simple “I am sorry that this happened,” should suffice.

To summarize, the steps of open disclosure are:

1. Disclose the error to the patient or his or her family. Be clear, concise, and timely.
2. Take the lead as the attending surgeon. Ensure alignment among the entire team.
3. Apologize.
4. Reassure that it will not happen again and that safeguards are being implemented.

Death

“I Have Some Bad News.”

It is clear from surviving family member interviews that the manner in which families are notified of their loved one’s death often leaves a lifelong impression. This is true regardless of whether the patient and his or her family have a long-term relationship with the physician or whether they have known the physician for only minutes to hours. Families repeatedly look for a caring attitude in the newsgiver and crave an ample amount of time for questions and synthesis of the news. Consequently, the seniority or professional attire of the caregiver is considered less important than spending time with the family in an unhurried fashion.^{57,58}

Some of the same communication skills already mentioned apply to this scenario. To reiterate, find the appropriate quiet setting, away from the commotion of regular hospital activities. Use a forecasting statement: “I’m sorry, but I have some bad news.” Avoid euphemisms for death or dying. It is better to be clear and concise than create confusion in such a difficult time.³⁸ Do not leave too hastily. Ensure that the family has time to ask questions. It is the time spent allowing the questions to be asked,

many of which do not have answers, that is more important than the questions themselves. Provide the family with a way to contact someone at a later date should questions arise. Many will want 1 last question answered several days or weeks after their family member's death. This does not mean that they have suspicions or questions about the care delivered.⁵⁸

Surgeons are known for their cool detachment in moments of stress. In this situation, a family might misconstrue such attempts at maintaining a professional air as cold, unsympathetic, or evasive.⁴ Families may express grief and emotion in ways that are foreign or uncomfortable, particularly if they are from different cultures. Behavior ranges from stoic silence to vocal and physical keening. Be prepared to respond to emotion, and be comfortable with silence. Be open to showing empathy and sometimes sympathy as well—a natural display of one's own emotions.⁵⁸ No patient or his or her family ever complained of their doctor showing too much concern.

Finally, part of caring for a patient at the time of their death involves repersonalizing them back to a unique identity from that of just another patient. In the hospital setting, particularly in the ICU, this process can be very difficult. Families can be disoriented by the noise and machinery in a busy ICU. We often treat patients with relative anonymity, referring to them as a bed number or underlying diagnosis. It is often helpful to ask the family members to share stories about their loved one, particularly when the patient is not one with whom we have a long-term relationship. Additional measures that respect the patient's individuality include accommodating family visits beyond normal hours, arranging for transfers to a quieter room or hospice floor, food for the family to share in the patient's room, use of handmade blankets or quilts rather than sterile hospital linen, allowing favorite pets to visit, and facilitating any spiritual rituals that the family might want. Although a hospital chaplain can help in emergencies, if time permits, the family should be encouraged to invite their own spiritual leader to the bedside. Depending on one's comfort, a physician may even choose to participate in such a ritual, for as one author states, it can help “. . .comprehend the social and personal meanings of dying to families.”⁵⁹ Much of the above points may be a part of a formal bereavement program. These programs also provide cards and further support in the days, weeks, and anniversaries after a patient's death.

Conclusion

Surgeons will encounter end-of-life issues many times. During these interactions, patients and their families want guidance and honest information. Sound communication skills are integral to the successful navigation of these encounters, and can be taught with reference to the 3 domains of adult learning. The cognitive domain includes the knowledge required to understand the importance of palliative care in surgery. The affective addresses developing comfort in situations with heightened emotion, and the psychomotor domain includes the words and actions required for communicating with patients and their families. These skills improve patient and family satisfaction, strengthen the doctor-patient relationship, and can reduce the stress experienced by physicians when dealing with end-of-life care.^{5,27,29} Surgeons should feel comfortable and facile discussing end-of-life issues with their patients, regardless of whether they routinely utilize palliative care specialists. To develop this comfort, surgical trainees should have the necessary education in discussing palliative care topics with patients. These guidelines serve as a framework to integrate end-of-life communication skills into surgical training and practice, to better serve our patients.

References

1. Gallagher TH, Studdert D, Levinson W. Disclosing harmful medical errors to patients. *N Engl J Med*. 2007;356:2713-2719.
2. Back AL, Arnold RM, Tulsy JA, Baile WF, Fryer-Edwards KA. Teaching communication skills to medical oncology fellows. *J Clin Oncol*. 2003;21:2433-2436.
3. Larkin GL, McKay MP, Angelos P. Six core competencies and seven deadly sins: a virtues-based approach to the new guidelines for graduate medical education. *Surgery*. 2005;138:490-497.
4. Fallowfield L. Communication and palliative medicine. In: Doyle D, Hanks G, Cherny N, Calman KO, eds. *Oxford Textbook of Palliative Medicine*. Oxford, UK: Oxford University Press; 2004:101-107.
5. McLafferty RB, Williams RG, Lambert AD, Dunington GL. Surgeon communication behaviors that lead patients to not recommend the surgeon to family members or friends: analysis and impact. *Surgery*. 2006;140:616-624.
6. Shapiro RS, Simpson DE, Lawrence SL, Talsky AM, Sobocinski KA, Schiedermayer DL. A survey of sued and

- nonsued physicians and suing patients. *Ann Intern Med.* 1989;149:2190-2196.
7. Sise MJ, Sise CB, Sack DI, Goerhing M. Surgeons' attitudes about communicating with patients and their families. *Curr Surg.* 2006;63:213-218.
 8. Easson AM, Crosby JA, Librach SL. Discussion of death and dying in surgical textbooks. *Am J Surg.* 2001;182:34-39.
 9. Klaristenfeld DD, Harrington DT, Miner TJ. Teaching palliative care and end-of-life issues: a core curriculum for surgical residents. *Ann Surg Oncol.* 2007;14:1801-1806.
 10. Chipman JG, Beilman GJ, Schmitz CC, Seatter SC. Development and pilot testing of an OSCE for difficult conversations in surgical intensive care. *J Surg Educ.* 2007;64:79-87.
 11. Gross SC, Cairns BA, Baker CC. Addressing end-of-life issues in the surgical intensive care unit-practical and ethical guidelines for residents and surgeons. *Contemp Surg.* 2000;56:612-619.
 12. Bloom BS. Taxonomy of Educational Objectives, Handbook I: The Cognitive Domain. New York, NY: David McKay Co Inc; 1956.
 13. Curtis RJ, Patrick DL, Caldwell E, Greenlee H, Collier A. The quality of patient-doctor communication about end-of-life care: a study of patients with advanced AIDS and their primary care clinicians. *AIDS.* 1999;13:1123-1131.
 14. Teno JM, Gruneir A, Schwartz A, Nanda A, Wetle T. Association between advance directives and quality of end-of-life care: a national study. *J Am Geriatr Soc.* 2007;55:189-194.
 15. Schneiderman LJ, Kronick R, Kaplan RM, Anderson JP, Langer RD. Effects of offering advance directives on medical treatments and costs. *Ann Intern Med.* 1992;117:599-606.
 16. Tulsky JA, Fischer GS, Rose MR, Arnold RM. Opening the black box: how do physicians communicate about advance directives? *Ann Intern Med.* 1998;129:441-449.
 17. Teno JM. Do-not-resuscitate orders and hospitalization of nursing home residents: trumping, neglect, or shared decision-making at the eleventh hour. *J Am Geriatr Soc.* 2004;52:159-160.
 18. Corke CJ, Stow PJ, Green DT, Agar JW, Henry MJ. How doctors discuss major interventions with high risk patients: an observational study. *BMJ.* 2005;330:182-186.
 19. Song MK, Kirchhoff KT, Douglas J, Ward S, Hammes B. A randomized, controlled trial to improve advance care planning among patients undergoing cardiac surgery. *Med Care.* 2005;43:1049-1053.
 20. Briggs LA, Kirchhoff KT, Hammes BT, Song MK, Colvin ER. Patient-centered advance care planning in special patient populations: a pilot study. *J Prof Nurs.* 2004;20:47-58.
 21. Hammes BJ. What does it take to help adults successfully plan for future medical decisions? *J Palliat Med.* 2001;4:453-456.
 22. Freid TR, Bradley EH, Towle VR, Allore H. Understanding the treatment preferences of seriously ill patients. *N Engl J Med.* 2002;346:1061-1066.
 23. Grimaldo DA, Wiener-Kronish JP, Jurson T, Shaughnessy TE, Curtis JR, Liu LL. A randomized, controlled trial of advance care planning discussions during preoperative evaluations. *Anesthesiology.* 2001;95:43-50.
 24. Fallowfield L, Lipkin M, Hall A. Teaching senior oncologists communication skills: results from phase I of a comprehensive longitudinal program in the united kingdom. *J Clin Oncol.* 1998;16:1961-1968.
 25. Buckman R. *How to Break Bad News.* Baltimore, MD: The Johns Hopkins University Press; 1992.
 26. Maguire P. Breaking Bad News. *Eur J Surg Oncol.* 1998;24:18-191.
 27. Quill TE. Delivering bad news. In: Quill TE, ed. *Caring for Patients at the End of Life: Facing an Uncertain Future Together.* Oxford, UK: Oxford University Press; 2001:78-99.
 28. Ptacek JT, Ptacek JJ, Ellison NM. "I'm sorry to tell you . . ." Physicians' reports of breaking bad news. *J Behav Med.* 2001;24:205-217.
 29. Ramirez AJ, Graham J, Richards MA, et al. Burnout and psychiatric disorders among cancer clinicians. *Br J Cancer.* 1995;71:1132-1133.
 30. Back AL, Arnold RM, Baile WF, Tulsky JA, Fryer-Edwards K. Approaching difficult communication tasks in oncology. *CA Cancer J Clin.* 2005;55:164-177.
 31. Baile WF, Buckman R, Lenzi R, Glober G, Beale E, Kuelka AP. SPIKES-a six-step protocol for delivering bad news: application to the patient with cancer. *Oncologist.* 2000;5:302-311.
 32. Barton E, Aldridge M, Trimble T, Vidovic J. Structure and variation in end-of-life discussions in the surgical intensive care unit. *Comm Med.* 2005;2:3-20.
 33. Goldberg RJ. Disclosure of information to adult cancer patients: issues and update. *J Clin Oncol.* 1984;2: 948-955.
 34. Coulehan JL, Platt FW, Egener B, et al. "Let me see if I have this right . . .": words that help build empathy. *Ann Intern Med.* 2001;135:221-227.
 35. Quill TE, Arnole RM, Platt R. "I wish things were different": expressing wishes in response to loss, futility, and unrealistic hopes. *Ann Intern Med.* 2001;135:551-555.
 36. Nattinger AB, Hoffmann RG, Shapiro R, Gottlieb MS, Goodwin JS. The effect of legislative requirements on the use of breast-conserving surgery. *N Engl J Med.* 1996;335:1035-1040.
 37. Quill TE, Brody H. Physician recommendations and patient autonomy: finding a balance between physician power and patient choice. *Ann Intern Med.* 1996;25: 763-769.
 38. Curtis JR, Patrick DL. How to discuss dying and death in the ICU. In: Curtis JR, Rubenfeld GD, eds. *Managing Death in the Intensive Care Unit.* Oxford, UK: Oxford University Press; 2001:85-102.

39. Cohen CB, Wheeler SE, Scott DA, Anglican Working Group in Bioethics. Walking a fine line. Physician inquiries into patients' religious and spiritual beliefs. *Hastings Cent Rep.* 2001;31:29-39.
40. Ehman JA, Ott BB, Short TH, Ciampa RC, Hansen-Flaschen J. Do patients want physicians to inquire about their spiritual or religious beliefs if they become gravely ill? *Arch Intern Med.* 1999;159:1803-1806.
41. Lo B, Ruston D, Kates LW, et al. Discussing religious and spiritual issues at the end of life. A practical guide for physicians. *JAMA.* 2002;287:749-754.
42. Kohn LT, Corrigan JM, Donaldson MS, eds. *To Err Is Human: Building a Safer Health System.* Washington, DC: National Academy Press; 2000.
43. Krizek TJ. Surgical error, ethical issues of adverse events. *Arch Surg.* 2000;135:1359-1366.
44. Hebert PC, Levin AV, Robertson G. Bioethics for clinicians: 23. disclosure of medical error. *CMAJ.* 2001;164:509-513.
45. Snyder L, Leffler C. Ethics manual, ethics and human rights committee, american college of physicians. *Ann Intern Med.* 2005;142:560-582.
46. Witman AB, Park DM, Hardin SB. How do patients want physicians to handle mistakes? A survey of internal medicine patients in an academic setting. *Arch Intern Med.* 1996;156:2565-2569.
47. Gallagher TH, Waterman AD, Ebers AG, Fraser VJ, Levinson W. Patients' and physicians' attitudes regarding the disclosure of medical errors. *JAMA.* 2003;289:1001-1007.
48. Blendon RJ, DesRoches CM, Brodie M, et al. Views of practicing physicians and the public on medical errors. *N Engl J Med.* 2002;347:193-1940.
49. Kaldjian LC, Jones EW, Rosenthal GE. Facilitating and impeding factors for physicians' error disclosure: a structured literature review. *Jt Comm J Qual Patient Saf.* 2006;32:188-198.
50. Mazor KM, Simon SR, Yood RA, et al. Health plan members' views about disclosure of medical errors. *Ann Intern Med.* 2004;140:409-418.
51. Kraman SS, Hamm G. Risk management: extreme honesty may be the best policy. *Ann Intern Med.* 1999;131:963-967.
52. Clinton HR, Obama B. Making patient safety the centerpiece of medical liability reform. *N Engl J Med.* 2006;354:2205-2208.
53. Fein SB, Lee HH, Spiritus EM, et al. The many faces of error disclosure: a common set of elements and a definition. *J Gen Intern Med.* 2007;22:755-761.
54. Straumanis JP. Disclosure of medical error: is it worth the risk? *Pediatr Crit Care Med.* 2007;8:S38-S43.
55. Morrman DW. Communication, teams, and medical mistakes. *Ann Surg.* 2007;245:173-175.
56. Butcher L. Lawyers say "sorry" may sink you in court. *Physician Exec.* 2006;32:20-24.
57. Jurkovich GJ, Pierce B, Pananen L, Rivara FP. Giving bad news: the family perspective. *J Trauma.* 2000;48:865-873.
58. Finlay I, Dallimore D. Your child is dead. *BMJ.* 1991;302:1524-1525.
59. Miles SH. The role of physicians in sacred end-of-life rituals in the ICU. In: Curtis JR, Rubenfeld GD, eds. *Managing Death in the Intensive Care Unit.* Oxford, UK: Oxford University Press; 2001: 207-211.