

Self-Assessment Questions with answers and explanations

Module 1

M1-1. Mr. Bennett is a 43-year-old man status post resection of a kidney for hypernephroma that extended through Gerota's fascia. He has a postoperative pain syndrome that suggests the formation of a neuroma with neuropathic pain. Although he is an airline pilot, he has been unable to work for the past year. He might be expected to be suffering in which sphere?

- a. emotional
- b. practical
- c. spiritual
- d. all of the above
- e. none of the above

Answer: d

This question is aimed at understanding the conceptual framework for suffering. He is likely to be suffering not just in the physical sphere (pain), but in emotional, social (practical), and spiritual spheres.

M1-2. Mr. Wright is seen in the office for follow-up of his Stage IIIA nonsmall-cell lung cancer and diabetes mellitus. During the interview, which comment most suggests psychological distress?

- a. "My leg hurts right here."
- b. "I'm so worried about my wife."
- c. "I don't know how I'll get to my appointment."
- d. "Why did I get this disease?"

Answer: b

This question is aimed at understanding the meaning of patients' questions in the context of assessing suffering. Worry falls in the psychological distress dimension. Although there is overlap, the other possible answers are focused on the physical (pain), practical (transportation), and spiritual (questions beginning with "Why").

M1-3. Mrs. DeGuilio is an 84-year-old woman with neuropathic pain affecting hands, feet, and knees after combination chemotherapy for Stage III ovarian cancer. Today she notes increased swelling and pain in her knees. An important question in pain assessment is:

- a. Have you noticed a fever?
- b. How does it affect your life?
- c. Have you lost weight?
- d. How are you feeling overall?

Answer: b

This question is concerned with pain assessment. The effect of pain on a patient's life is an important component. The other questions may be part of the overall assessment of the patient, but don't relate to the pain assessment.

M1-4. Mrs. Patton is a 54-year-old woman with advanced myelodysplastic syndrome and is bedbound with increasing fatigue. What question by Mrs. Patton most suggests spiritual suffering?

- a. "Why is this happening to me?"
- b. "How will I pay for my care?"
- c. "What is likely to happen next?"
- d. "Will I suffocate?"

Answer: a

Assessing spiritual suffering is important. Questions that begin with "Why" are often related to the spiritual dimension. They need to be recognized for what they are—simple answers or biologically based answers (e.g., your muscles are weak) will miss the mark. The other possible answers relate to social (financial and practical) and physical (prognosis and symptom management) issues.

Module 2

M2-1. Neuropathic pain is:

- a. usually treated with anti-inflammatory agents
- b. a result of disordered nerve function
- c. due to direct stimulation of intact nociceptors
- d. rarely responsive to opioid analgesics

Answers: b

This question concerns understanding pain pathophysiology. Neuropathic pain is a result of disordered nerve function. It does not result from inflammatory processes and does not relate to ongoing stimulation of intact nociceptors. Opioids are effective in managing neuropathic pain. However, relief is usually incomplete without the addition of adjuvant or coanalgesics.

M2-2. Mrs. Martinez is a 42-year-old woman who has breast cancer metastatic to bone and liver. Her pain has been well controlled on sustained-release morphine, 120 mg PO bid, for 3 months. Which of the following is most likely to occur as a result of this treatment?

- a. psychological dependence
- b. physical dependence
- c. pharmacologic tolerance

- d. respiratory depression

Answer: b

This question is aimed at understanding the pharmacology of opioids. Physical dependence (the appearance of a withdrawal syndrome if the drug is stopped suddenly) should be expected. Now that she is on a stable dose, it is unlikely she needs to be escalated unless her disease worsens. Progressive pharmacologic tolerance is unlikely. There is no evidence that opioids cause psychological dependence. Respiratory depression on a stable dose of morphine is unlikely.

M2-3. Mr. Martin has locally advanced transitional cell cancer of the bladder with chronic pelvic and abdominal pain. Which of the following is most important in determining the maximum dose of oral morphine during dose titration?

- a. pain relief
- b. respiratory depression
- c. risk of overstepping regulatory limits
- d. strength of pill

Answer: a

This question is aimed at understanding the pharmacology of opioids. There is no upper limit to pure agonist opioid analgesics. The dose is limited by side effects. Respiratory depression is exceedingly uncommon when doses are titrated to pain relief. There are no a priori limits to morphine dose escalation. Pill strength is not an issue—patients may need to take many pills to achieve the desired dose.

M2-4. Pharmacologic tolerance develops to all of the following side effects of opioid analgesics *except*:

- a. constipation
- b. nausea
- c. respiratory depression
- d. sedation

Answer: a

This question is aimed at understanding adverse effects of opioids. Constipation is nearly universal and does not get better with repeated dosing. Pharmacologic tolerance develops within days to weeks to the common adverse effects such as nausea and sedation, as well as to the uncommon effect of respiratory depression.

Module 3

Anxiety

M3-1. Mrs. Yokohama is a 98-year-old with progressive Grade II glioma. She is mostly nonverbal and has 24-hour help at home. Her caregiver complains that the patient is agitated and calls out at night, but is somnolent during the day. The caregiver thinks Mrs. Yokohama is anxious and wants you to give her something to “calm her down.” The best choice would be:

- a. trazodone
- b. amitriptyline
- c. diazepam
- d. diphenhydramine

Answer: a

This question is aimed at understanding the treatment of anxiety/agitation. There often seems to be day/night reversal. Of the medications listed, trazodone is best because it is a hypnotic with anxiolytic properties and it is well tolerated in the elderly and very ill. Amitriptyline, while sedating, will have undesirable anticholinergic side effects. Diazepam has a long half-life and is unlikely to be effective. Diphenhydramine, while initially sedating, will have undesirable anticholinergic side effects and is unlikely to have any sustained effect on anxiety and agitation. Neuroleptic medications might also be appropriate.

Constipation

M3-2. Which of the following is a stimulant laxative at conventional doses?

- a. psyllium
- b. docusate
- c. senna
- d. sorbitol

Answer: c

This question is aimed at understanding the treatment of constipation. Only senna is a stimulant laxative in this list. Psyllium is a bulk-forming laxative. Docusate at conventional doses is a stool softener. Sorbitol is an osmotic laxative.

Delirium

M3-3. Mrs. Mugia has malignant melanoma, metastatic to inguinal lymph nodes that were resected 2 years ago. There is no evidence of recurrence. She also has moderate Alzheimer’s-type dementia, and chronic obstructive pulmonary disease. She has chronic pain in her back, hips, and knees that is moderately well controlled with ibuprofen. She is hospitalized for an exacerbation of her chronic obstructive pulmonary disease. Her

overall level of consciousness has declined. On the third hospital day she begins moaning and crying out. Oncology is consulted to rule out brain metastases. Delirium is:

- a. unlikely
- b. rarely related to medications
- c. sometimes misinterpreted as pain
- d. usually inevitable

Answer: c

This question is aimed at diagnosing delirium. Delirium is very common in those hospitalized with advanced disease. Moaning and crying out, particularly in the setting of diminished level of consciousness, is a frequent sign of delirium. Particularly in the patient with a history of pain, it may be misinterpreted. Although common, delirium is not inevitable, and its treatment should be pursued. She may also need analgesics.

M3-4. Mrs. Mugia's agitation worsens, and the goal is to reverse the symptoms of delirium. She is initially best managed with:

- a. midazolam
- b. haloperidol
- c. diazepam
- d. amitriptyline

Answer: b

This question is aimed at understanding the treatment of delirium. Haloperidol, a relatively nonsedating neuroleptic, is the most appropriate when the goal is reversing the delirium. It can be given PO, IV, or SC; IM is possible but not necessary. The benzodiazepines midazolam and diazepam may sedate her, but won't reverse the delirium. Their use would be appropriate if the goal were to settle symptoms, but not reverse the delirium. Amitriptyline is an antidepressant.

Depression

M3-5. Mr. Arlinson is a 32-year-old man who has advanced AIDS and Kaposi's sarcoma. He has been nonadherent with HAART and has a multiple resistance strain of HIV. He has lost weight and reports a poor appetite. He sleeps poorly. He reports a lack of energy and spends most of his time at home. During a visit to his physician, he reports feeling hopeless and helpless. He is comfortable talking about the fact that he will die. A clinical suspicion of major depression is most supported by:

- a. changes in appetite and sleep patterns
- b. feelings of hopelessness and helplessness
- c. lack of energy
- d. comfort in talking about the prospect of death

Answer: b

This question is aimed at understanding the diagnosis of depression in patients with advanced illness. Psychological symptoms such as hopelessness and helplessness are the most sensitive and specific. Changes in appetite and sleep, and lack of energy are common to both depression and the advance stages of most illnesses. Talking about the prospect of dying is a healthy response to the situation; it is not *de facto* evidence of depression.

M3-6. To treat a diagnosis of major depression for Mr. Arlinson, with a goal of response within a few days, the best initial drug of choice would be:

- a. methylphenidate
- b. amitriptyline
- c. fluoxetine
- d. lorazepam

Answer: a

This question is aimed at understanding the pharmacologic treatment of depression. The psychostimulant methylphenidate acts within days without excessive or worrisome side effects. Amitriptyline is associated with unwanted side effects. Fluoxetine is likely to be effective, but will take several weeks to see an effect. Lorazepam is an anxiolytic sedative, not an antidepressant.

Diarrhea

M3-7. Which of the following antidiarrheal agents acts through opioid receptors?

- a. diphenoxylate
- b. atropine
- c. bismuth
- d. octreotide

Answer: a

This question is aimed at understanding how to symptomatically treat diarrhea, especially treatment-related diarrhea. Diphenoxylate is a synthetic opiate commonly available in combination with atropine, an anticholinergic. Octreotide is a synthetic analog of somatostatin.

Dyspnea

M3-8. When a patient is treated with morphine for breathlessness, the drug is titrated to:

- a. respiratory rate
- b. pulse oximetry
- c. patient's relief
- d. oxygen concentration

Answer: c

This question is aimed at understanding how to symptomatically treat breathlessness. Patient self-report is the gold standard. Neither respiratory rate, pulse oximetry, nor blood oxygen concentration will tell you whether breathlessness is relieved.

Nausea/Vomiting

M3-9. Which of the following antiemetics acts primarily at dopamine receptors?

- a. haloperidol
- b. ondansetron
- c. meclizine
- d. scopolamine

Answer: a

This question is aimed at understanding the pathophysiology of nausea and vomiting. Haloperidol is a potent dopamine antagonist. Ondansetron antagonizes serotonin. Meclizine is an antihistamine. Scopolamine is an anticholinergic.

Module 4

M4-1. Mr. Larson, a 48-year-old man with a history of stage I colon cancer 4 years ago returns to the office concerned that his cancer has returned. His daughter, age 11, died from acute lymphocytic leukemia 2 months ago. He comes to the office complaining of tightness in the chest, palpitations, lack of energy, a 4-pound weight loss, and difficulty sleeping. He seems “flat” and confirms that he feels emotionally “numb.” He is working and does report the ability to experience pleasure when playing golf or going out to dinner with his wife. The most likely diagnosis in this man is:

- a. coronary artery disease
- b. grief
- c. recurrent cancer
- d. major depression

Answer: b

Normal grief reactions include a range of physical, emotional, and cognitive behaviors. The bereaved may note feelings of hollowness in the stomach, tightness in the chest, heart palpitations, weakness, lack of energy, gastrointestinal disturbances, weight gain or loss, or skin reactions. Many say they feel emotional numbness, relief, sadness, fear, anger, guilt, loneliness, abandonment, despair, or ambivalence. They may be concerned about cognitive symptoms such as disbelief, confusion, inability to concentrate, and preoccupation with or dreams of the deceased. The other diagnoses, while possible, are less likely.

M4-2. The most useful thing the oncologist can do to support Mr. Larson is:

- a. educate him about normal grief
- b. not reschedule any visits so as not to remind him of cancer
- c. tell him his daughter is in a better place
- d. perform coronary angiography

Answer: a

Clinicians can provide education, communicating that painful feelings about a loss, such as sadness and anxiety, are understandable. It may be valuable to confirm that ambivalent feelings (e.g., sorrow and anger, anxiety and relief) in grief are common as most relationships have their difficult as well as their wonderful moments.

M4-3. Mr. Larson is seen again, 1 year later. He can talk about his daughter without intense feelings of loss. He reports his sleep is normal, and he has started volunteering for the leukemia society. This most likely represents:

- a. repressed grief
- b. resolving grief
- c. complicated grief
- d. disenfranchised grief

Answer: b

Worden and others have defined benchmarks from which to judge the resolution of the grief process. One indication is when the bereaved is able to talk about the deceased without intense, fresh feelings of loss. Another is when the survivor is able to invest energy in new relationships, roles, and responsibilities, without disabling guilt and feelings of disloyalty toward the deceased.

M4-4. Mr. Larson returns 18 months after his daughter's death for follow-up. He again thinks his cancer has returned. He reports feeling "low." He has stopped playing golf or going out. He stays home "sick" from work frequently. He expresses no enthusiasm for any of his work or family activities which previously gave him pleasure. The best approach would be to:

- a. refer to psychiatry for medication and therapy
- b. reassure that grief is episodic, sometimes for years
- c. plan restaging for cancer
- d. schedule return visit in 2 weeks to reassess

Answer: a

Interventions for clinical depression occurring during grief may include antidepressant or anxiolytic medication and psychotherapy. Supportive therapy and cognitive behavioral therapy are two psychotherapeutic approaches that are used to treat depression occurring with grief. The global nature of his complaints argues against grief. Cancer recurrence is unlikely.

Module 5

M5-1. The National Coalition for Cancer Survivorship (NCCS) defines a cancer survivor as “any person living with cancer at anytime.”

- a. true
- b. false

Answer: true

M5-2. Melinda Bennett had stage II breast cancer treated with lumpectomy, local radiation, and chemotherapy with adriamycin and paclitaxel. She is now 1 year out from completing treatment. Her emotional concerns at this time are likely to include:

- a. fear of recurrence and death
- b. desire to disconnect from her cancer treatment team
- c. feeling she is now “cured” of her cancer
- d. feeling her family has forgotten her cancer experience

Answer: a

Emotional concerns generally involve controlling fear, maintaining optimism, and focusing on the future and are specifically manifested in relating to the health care team and managing fear of recurrence and death.

M5-3. For Mrs. Bennett, the most likely source of professional support will be:

- a. a designated mental health professional
- b. a support group
- c. her oncologist and office staff
- d. her religious pastor

Answer: c

The oncologist, and his or her support team, will be the only professional support system for most patients.

M5-4. For Mrs. Bennett, her oncologist can explore her cancer experience by saying:

- a. “Have you noticed any swelling in your armpit?”
- b. “What impact has this illness had on your life?”
- c. “Have you had any pain?”
- d. “How are you feeling?”

Answer: c

The oncologist can prompt the patient in making meaning of the experience by asking questions, such as: “What impact has this illness had on your life? What impact has the illness had on the lives of your loved ones? How do you see this illness in relation to the rest of your life? Have you been able to gain any benefit from this difficult experience?”

Module 6

M6-1. Mr. Larson is a 62-year-old building maintenance worker who is dying of advanced lymphoma. He has not had much pain during his illness. He has been unconscious most of the past 24 hours. The nurse calls to report that he has begun to moan. The family is very distressed. This is most likely to be:

- a. terminal delirium
- b. crescendo pain
- c. spiritual distress
- d. depression

Answer: a

This question is aimed at understanding how to manage the last hours of living. This condition is most likely terminal delirium. Pain does not suddenly appear in the last hours of life. Although spiritual distress and depression could be operative, it is too late to do anything about them. The goals are to settle the patient for as peaceful a death as possible that will not sear the family's memory.

M6-2. Ms. Montaldo is dying of uterine cancer. She has been essentially comatose for the past 12 hours. Her family is at her bedside stroking her hair. However, over the past hour they have noticed a "choking or gurgling" sound in her throat. The most likely medication to be helpful is:

- a. morphine
- b. scopolamine
- c. diphenhydramine
- d. lorazepam

Answer: b

This question is aimed at understanding how to manage symptoms at the end of life. Accumulation of bronchial secretions is common, and commonly misinterpreted by family and caregivers as "choking." A medication with a drying effect like scopolamine is most appropriate.

M6-3. Mr. Cianci is a 45-year-old former football player who is dying of advanced testicular cancer. He is in the hospital, mostly somnolent, but has periods of lucidity which his wife and children cherish. His urine output has declined over the past 48 hours. He has 4+ pitting edema to his thighs bilaterally. You should:

- a. increase IV fluids
- b. administer IV dopamine
- c. discontinue IV fluids
- d. administer morphine

Answer: c

This question is aimed at understanding how to manage symptoms at the end of life. He has edema that he cannot mobilize. Intravenous fluids will not help the urine output and will worsen the edema. Although morphine may help pain, it makes more sense to minimize the edema by not exacerbating it.

M6-4. Mr. Barnard has had good pain control with regular doses of morphine. He is now unconscious and near death and has begun to moan and be restless. You should administer:

- a. oxygen
- b. morphine
- c. scopolamine
- d. lorazepam

Answer: d

This question is aimed at understanding how to treat symptoms in the last hours of life. He most likely has terminal delirium; there is no reason to suppose an increase in pain. The goal is to settle the delirium. Therefore, lorazepam is the best choice. Morphine may, because of accumulating metabolites, actually make the situation worse.

Module 7

M7-1. Mr. Petty is a 58-year-old fast-food worker who had unresectable rectal cancer. The cancer initially disappeared from CT scans after combination chemotherapy and radiotherapy. He has always indicated he has faith in God and the doctor, and has never demonstrated much interest in the details of therapy. Yet, he has always made decisions by himself. At the present office visit, he complains of abdominal discomfort and poor appetite; physical examination shows a large nodular liver. After establishing an appropriate setting, you would next:

- a. tell him cancer has spread to the liver
- b. tell him he's in God's hands now
- c. determine what he understands
- d. determine who he relies on for support

Answer: c

This question is aimed at understanding the steps of information giving. It is best to ascertain the patient's understanding of his situation as well as how much information he wants to know before giving the new medical information. Euphemisms, even well intentioned, won't build a therapeutic relationship for the future. They may be interpreted as abandonment. Finding out his support system is important, but not the best answer to the question.

M7-2. Mrs. Twardowsky is a 62-year-old former cleaning woman with Rai Stage IV chronic lymphocytic leukemia, poorly controlled diabetes mellitus and consequent peripheral neuropathy, renal insufficiency, and coronary artery disease. She has advanced congestive heart failure that is not responding well to medical therapy. Her daughter asks you not to talk to her about the cancer because it “would take away all hope.” She wants you to give chemotherapy, but tell the patient it is “strong antibiotics.” Your best next response is to:

- a. ask the daughter more about what kind of hope she would like her mother to have
- b. agree and wait for a future opportune time
- c. disagree and tell the patient the truth
- d. tell the daughter you have to tell the patient the truth

Answer: a

This question is aimed at the physician’s response when the family says “don’t tell.” The best next step is to assess why the family member is making the request. Confronting the family by insisting you will tell or going around them will only create mistrust and likely endanger the therapeutic relationship. Not telling is also inappropriate without ascertaining that is the patient’s desire. After talking with the family member, the next aim may be to have a family meeting to ask the patient how she wants medical information handled.

M7-3. Mr. Oliver is a 53-year-old farmer with nonsmall-cell lung cancer metastatic to liver and bone. In talking about the future course of his illness, he begins to cry. His wife is also tearful. Besides having facial tissues available, the next best approach is to:

- a. continue with the discussion
- b. reassure him
- c. be silent
- d. tell them to stop crying

Answer: c

This question is aimed at the physician’s response to strong emotion. Silence usually is best at first. Telling them to stop crying directly or providing premature reassurance gives them the same message—that you are not acknowledging or interested in supporting them through their emotional response to the news. Continuing with the discussion in spite of tears can also give the same unfortunate message.

M7-4. You are completing a family meeting for a patient with moderately advanced Alzheimer’s-type dementia and newly diagnosed unresectable pancreas cancer in which you have been describing the nature and likely course of the disease. The patient is unable to participate. In concluding the meeting, it is most important to:

- a. summarize the plan of care
- b. reassure the family that all will be well

- c. tell them to be strong
- d. summarize their decisions about code status

Answer: a

This question is aimed at understanding how to finish the interview. It is best to conclude with a summary of the plan for the next steps. Reassurance that “all will be well” may not, in fact, be true. Avoid unintentional messages to not complain. Although a decision about code status may be part of the plan, it should generally not be a single focus of care and should only be summarized in the context of the total plan of care, including what will be done.

Module 8

M8-1. Mr. Gonzales is a 47-year-old man with colon cancer metastatic to liver. The most powerful predictor of life expectancy in this man is:

- a. performance status
- b. stage
- c. grade
- d. CEA level

Answer: a

Performance status is a measure to quantify the functional status of cancer patients, and with the Karnofsky performance scale (KPS), to measure medical care requirements. KPS, a reliable, valid, simple, and reproducible measure of patient function, is an independent predictor of survival. The predictability of KPS for survival is, however, valid only for patients with scores less than 50. Data from the 1,592 patients in the National Hospice Study identified KPS as the most important clinical factor estimating prognosis. KPS differentiated the survival time of three distinct patients groups: $KPS \geq 50$ (86.1 days), $KPS=30-40$ (49.8 days), and $KPS=10-20$ (16.8 days).

Loprinzi et al. have also demonstrated the ability of KPS to define three advanced cancer patient populations with statistically distinct survival curves by univariate and multivariate analyses. The strength of the association between performance status and survival appears to be time dependent; KPS is of greater prognostic value when the anticipated survival is less than 3 months.

M8-2. For Mr. Gonzales, the severity and number of symptoms would have the following influence on his prognosis:

- a. improve it
- b. leave it unchanged
- c. worsen it

Answer: c

Integrating the impact of various physical symptoms with performance status improves its predictive capability. A systematic review of prognostic factors in advanced cancer from 24 studies examined more than 100 variables and identified cognitive factors, weight loss, dysphagia, xerostomia, anorexia, and dyspnea as independent survival factors for patients with advanced cancer.

M8-3. Of the following common cancers treated with standard therapy, which is associated with a median survival of 9-14 months?

- a. metastatic breast cancer
- b. advanced liver cancer
- c. advanced pancreas cancer
- d. extensive small-cell lung cancer

Answer: d

M8-4. As a general rule, when predicting prognosis for an individual patient, oncologists are usually:

- a. overoptimistic
- b. accurate
- c. overpessimistic

Answer: a

In 7 out of 8 studies, physicians overestimated survival in patients with advanced disease.

Module 9

M9-1. Mr. Lee is a 58-year-old grocer who was recently diagnosed with stage IV nonsmall-cell lung cancer that is inoperable. He is in the office today. He would like to live as long as possible. At this visit, it would be best to:

- a. avoid discussing dying
- b. identify the additional priorities
- c. support the hope of living a long time
- d. introduce the concept of hospice

Answer: b

This question is aimed at understanding how to set appropriate goals. There are many possible goals of therapy—Mr. Lee has identified only one. It would be best to identify additional goals and priorities. Avoiding any discussion of dying or supporting unrealistic hope is unlikely to lead to appropriate decision making. Although discussing the role of hospice care is appropriate, it is unlikely to be the next best thing to discuss.

M9-2. Mrs. Gupta is a 74-year-old matriarch of a large and devoted family. She has advanced diabetes mellitus and severe renal insufficiency. She has been mostly

homebound, where she lives with her daughter and her family. Osteosarcoma of her right foot has developed. After discussing the reasons for amputation and the risks and benefits of amputation, the most important factor is the:

- a. patient's viewpoint
- b. chances for renal failure
- c. likelihood of successful operation
- d. family's viewpoint

Answer: a

This question is aimed at understanding how priorities are set when determining goals of care. Although it is possible to pursue a goal of prolonged life with an operation that many would consider appropriate, it is the competent patient's viewpoint that is most important. Although the family may play an important role, it is the patient's viewpoint that is most important.

M9-3. Mr. McCullough is an 89-year-old accountant who has been in a nursing home for 2 years with a diagnosis of dementia. He lacks decision-making capacity. He was recently hospitalized for pneumonia thought to be secondary to aspiration. An enlarged supraclavicular lymph node biopsy showed adenocarcinoma, poorly differentiated. In considering the placement of a gastrostomy tube, the physician is best guided by:

- a. the Power of Attorney for Health Affairs
- b. the hospital ethics committee
- c. the closest family member even though the patient has given power of attorney to a nonfamily member
- d. the Living Will

Answer: a

This question is aimed at understanding how to set goals when the patient lacks decision-making capacity. The Power of Attorney for Health Affairs makes the surrogate decision maker the legally recognized individual with authority to provide guidelines to the physician. The Living Will is unlikely to be operative as his situation is not imminently terminal. The family member's guidance has no legal standing in the presence of a legitimate power of attorney for health affairs. There is no need to involve the hospital ethics committee.

M9-4. Mrs. LeBlanc is a 63-year-old housewife with squamous cell cancer of the right breast that has metastasized to her right axilla. It causes her intense pain with movement. She has declined an operation that might relieve her pain. No further radiation or chemotherapy is thought to be helpful. Hospice referral has been advised. Her husband insists that she not give up hope. An appropriate response is to:

- a. tell him there is no hope for cure
- b. tell him there is always room for a miracle
- c. ask him what he is hoping for

- d. ask him to delay talking with hospice

Answer: c

This question is aimed at understanding how to negotiate goals with a family member. Physicians should approach families with the same approach as for patients. Probe with an open-ended question that permits him to describe what he is hoping for and his understanding and expectations for the future. Telling him bluntly that there is no hope for cure or fostering unrealistic hope is unlikely to be therapeutic. Putting off plans to help cope with reality will only promote crisis-oriented interventions.

Module 10

M10-1. Mrs. Kuzel is a 43-year-old nurse who has recurrent acute myelogenous leukemia after transplant. The most likely reason why she would not participate in a clinical trial is:

- a. too many clinical trials
- b. eligibility criteria too vague
- c. the oncologist won't offer the trial
- d. the trial will be too expensive

Answer: c

This question gets at why clinical trial participation is low. Surveys suggest there are many reasons for this low participation rate: too few trials, restrictive eligibility criteria on the trials that are offered, physicians not offering eligible patients trials, and patients refusing enrollment in trials. Physicians not offering the trials is the most often cited reason.

M10-2. Ms. Shega is a 21-year-old woman with a diagnosis of BRCA-1 positive breast cancer that is refractory to standard therapy. She is eligible for a Phase I clinical trial. Her view of why she would participate is most likely to be:

- a. hoping she will have no side effects
- b. knowing that she is likely to benefit personally from experimental therapy
- c. hoping to benefit, but knowing that is unlikely
- d. ensuring that her mini-mental status shows she has capacity

Answer: c

This question gets at the reasons patients say they participate in clinical research. Patients recognize that there is a chance, even a high chance, that they will not benefit, while simultaneously hoping they will benefit—hoping they will be among the few who will have tumor shrinkage or even cure.

M10-3. If Mrs. Shega's oncologist were to offer clinical trials to all of her patients, she should expect that:

- a. a majority of patients would enroll

- b. only a few patients would enroll
- c. she will need to provide financial incentives for enrollment
- d. she will need to tell them they are likely to benefit

Answer: b

This question gets at what oncologists should expect when offering clinical trials. Oncologists should expect that only a few patients will opt for such trials; participating in such trials will probably appeal only to the “fighters” or “risk takers.” Oncologists should make a special effort to delineate to such patients the full range of trials that are available and the kinds of risks they may confront.

M10-4. If Mrs. Shega enrolls in the clinical trial, she will need to understand that palliative care:

- a. will have to wait until the trial is over
- b. can be offered concurrently with the clinical trial
- c. will only be offered if covered by her insurance plan
- d. can only be provided once she elects hospice care

Answer: b

Enrolling in early-phase trials is not mutually exclusive with treating pain, nausea, or any other appropriate palliative care. Too often, both oncologists and patients seem to think that palliative care is an *alternative* to chemotherapy or enrollment in clinical research trials. This is not and should not be an either/or choice. It is not palliative care *or* anti-cancer treatment. Both can and should be provided simultaneously.

Module 11

M11-1. Mrs. Montanez is a 64-year-old woman with hypertension, diabetes, and renal failure who had a feeding tube placed during treatment for head and neck cancer. She has been increasingly debilitated due to advancing disease and leaves the house only to come to oncology appointments. She has been admitted to the hospital. Although she is awake, she does not have the capacity to make decisions. In discussing the continuation of the use of the feeding tube with her family, the physician should begin by:

- a. telling the patient and family about the current condition
- b. telling the patient and family the benefits and burdens of tube feeding
- c. asking what they understand about her current condition
- d. asking what they understand about tube feeding

Answer: c

This question is aimed at understanding how to discuss treatment decisions of withdrawing or withholding therapy. Begin with asking the patient/family what they understand about her condition before telling any new information. Although asking

about the feeding tube is important, it is a more focused question that should come after a more general open-ended question.

M11-2. Mr. Maltoni is an 84-year-old man with hormone refractory metastatic prostate cancer, weight loss of 13% of his usual body weight over the past 4 months, and increasing fatigue. He is currently an ECOG 3 in performance status. In considering the placement of a percutaneous gastrostomy feeding tube in this man for supplemental nutrition, his oncologist should be guided by:

- a. the evidence that enteral nutrition does not improve energy, weight, or prognosis
- b. the low operative complication rate of percutaneous gastrostomy tube placement
- c. the low complication rate from the use of percutaneous gastrostomy feeding tubes
- d. the family's insistence that the tube be placed to keep him from starving to death

Answer: a

In contrast with conventional wisdom, there is no evidence that enteral nutrition improves energy level or survival in patients with progressive cancer.

M11-3. If Mr. Maltoni's family asks about parenteral nutrition, the oncologist should best be guided by:

- a. the results of a time-limited trial of a week of total parenteral nutrition
- b. the data of no general benefit for parenteral nutrition
- c. the desire to avoid conflict with the family
- d. the practice of other oncologists in the area

Answer: a

The weight of scientific evidence has shown no general benefit for parenteral nutrition in patients with cancer.

M11-4. Suggestions the oncologist might have for the Maltoni family include:

- a. urging the patient to eat
- b. planning social interactions that don't center on meals
- c. hiring staff to provide direct care
- d. avoid talking about the past when he was healthy

Answer: b

Urging the patient to eat will only increase conflict. Focusing on eating only for pleasure and planning social interactions that don't center on meals like reading or watching movies together are more likely to substitute for the social needs of the family. Teaching them to provide care and speak openly about the past is also helpful.

Module 12

M12-1. Mrs. Magilicuddy is a 93-year-old seamstress with hemiparesis due to the original resection of a Grade III glioma (astrocytoma) and hypertension. She came to the emergency department, was intubated, and was admitted to the intensive care unit after a decrease in consciousness. The cause is likely worsened tumor vs. hemorrhage. Three weeks have passed. Her family, who has cared for her at home, is continuously at her bedside and expects her to wake up as she has done in the past. In addressing possible withdrawal of ventilation, indicate that continued ventilation:

- a. is futile
- b. is standard treatment
- c. is a treatment option
- d. requires an ethics consult

Answer: c

This question is aimed at understanding how to set goals when there is disagreement. Identifying all of the options for the patient's care, rather than stressing what won't be done or calling in the "ethics police," is a better first option. Continued ventilation in the face of poor prognosis is not standard.

M12-2. In a meeting with Mrs. Magilicuddy's family, it is best to begin by:

- a. asking about their understanding
- b. telling the medical condition
- c. telling them care is futile
- d. asking them to discontinue therapy

Answer: a

This question is aimed at understanding how to discuss treatments when there is conflict. Begin by asking about their understanding of diagnosis and prognosis. Starting an interview with open-ended questions where the family does most of the talking is a far more effective strategy than telling them information they may not be in a position to understand or accept. If there is hostility or disagreement, it is best to have it "on the table."

M12-3. Mrs. Magilicuddy's family related that the last time she was intubated, a physician told them they should disconnect the ventilator because she was unlikely to recover. The physician conducting the meeting might next want to explore:

- a. trust of the medical system
- b. belief in science
- c. family relationships
- d. belief in miracles

Answer: a

This question is aimed at understanding how to discuss treatment when there is disagreement. Even though it may feel “dangerous,” it is best to explore areas where there is distrust, rather than to gloss over it. Focusing the interview in areas of biomedical science, other family, or religion does not address issues of mistrust.

M12-4. In approaching conflict over medical futility, which should be the last action among the following?

- a. consult chaplaincy
- b. consult ethics committee
- c. transfer care to another physician
- d. transfer care to another facility

Answer: d

This question is aimed at understanding a fair-process approach to settling conflict. Involving other disciplines, consulting other colleagues, including the ethics committee, or transferring care to another physician should precede transfer to another facility.

Module 13

M13-1. Mrs. Lanzini is a 68-year-old widow with four living adult children who has advanced breast cancer. During an office visit, after a full discussion, she indicates that she would like her priest to make medical decisions for her in accordance with Catholic doctrine in the event she cannot make decisions for herself. The best advice you should give her is to:

- a. write a letter to the doctor indicating her wishes
- b. complete a Statutory Living Will
- c. complete a Statutory Power of Attorney for Health Affairs
- d. choose one of her children to make decision for her

Answer: c

The question is aimed at determining knowledge. The only legally recognized way that the patient can authorize someone to make medical decisions for her, other than her legal next of kin, is through the Statutory Power of Attorney for Health Affairs. A letter to the doctor would support this choice and help the physician determine whether the power of attorney were acting in her best interests. In most states, a Living Will is only operative if it is determined that the patient has a terminal illness and is unable to make decisions. She has the ability to choose anyone she wants as an agent; there is no need to choose her child.

M13-2. Mr. Robinson is a 34-year-old pipe fitter who has been admitted with hepatoma and liver failure secondary to hepatitis and alcohol use. He lacks capacity to make

decisions for himself. He has not indicated any prior wishes or completed any advance directive form. The physician is best guided by:

- a. duty to prolong life at all cost
- b. medical judgment about what is best
- c. state law governing substituted judgment
- d. the family's wishes even though the physician suspects selfish motives

Answer: c

This question is aimed at the issue of substituted judgment in the absence of written advance directives. Laws governing who makes decisions for the patient in the absence of clear evidence about what the patient wanted vary from state to state. Many, but not all, recognize "next of kin" in the absence of written directives. Although medical judgment is important, it is advisory to the person who has the authority to speak for the patient. This is determined by state law. The family is not always the best decision maker.

M13-3. Ms. Monadnock is a 93-year-old former waitress with recurrent colon cancer with metastases to liver, osteoarthritis, hypertension, and a prolapsed mitral valve. She completed a Living Will and named her niece as her Power of Attorney for Health Affairs some years ago. She was hospitalized for pneumonia 3 months ago. In accordance with her wishes, she was intubated for 5 days and had an extended period of recovery. She is again living alone in her own home. On what occasion(s) should her plans be revisited?

- a. at the next suitable office visit
- b. when the patient is enrolled in hospice care
- c. neither
- d. both

Answer: d

This question is aimed at understanding how advance care planning should be woven throughout a care plan. Appropriate times to review advance directives are both when things are going well (particularly after a major health care event) and with new developments. They shouldn't be accomplished once and never reviewed again.

M13-4. Mr. Arteresian is an 84-year-old retired judge recently discharged from the hospital for evaluation of rectal bleeding. A malignant polyp was removed. A definitive resection is planned. He completed a Living Will and named his son as his Power of Attorney for property and health affairs. In the office, he says he would also like to make plans about his funeral and wants to arrange for his body to go to the medical school. Your best response is to:

- a. tell him to talk to his son
- b. note this in the medical record
- c. both of the above
- d. neither of the above

Answer: c

This question is aimed at the larger sphere of advance planning that is appropriate for patients with advanced disease. The patient's son, as Power of Attorney for property, will be responsible for his father's affairs after death, including disposition of his body. It is useful to put all this information in the medical record, both to help ensure that the son acts in accordance with the patient's wishes and to ensure continuity and communication.

Module 14

M14-1. Dr. Arlington is a 74-year-old obstetrician/gynecologist with chronic myelogenous leukemia that recurred after treatment with imatinib and interferon. His counts are controlled with cyclophosphamide. After an office visit, he asks you to help him commit suicide. You should respond next by saying:

- a. "Tell me more about what you have in mind."
- b. "I would never do that."
- c. "Are you having trouble sleeping?"
- d. "Where do you have pain?"

Answer: a

This question is aimed at understanding how to therapeutically respond to requests for physician-assisted suicide. The first step is to clarify precisely what the patient is asking for. This leads to the development of better understanding as well as the foundation of a therapeutic relationship. First, telling the patient that you won't do it, or moving too quickly into physical and psychological assessment, will likely miss important information.

M14-2. A 43-year-old woman with AIDS has non-Hodgkins lymphoma as well as aortic, mitral, and tricuspid insufficiency secondary to multiple episodes of endocarditis. She has severe peripheral and pulmonary edema that is poorly controlled with diuretics. She has no appetite or thirst. She is seeking to regain some control as she faces death. What options might she have?

- a. refusing ICU admission and mechanical ventilation
- b. stopping diuretics and starting comfort-only care
- c. stopping eating and drinking
- d. all of the above
- e. none of the above

Answer: d

This question is aimed at what is legal and ethical near the end of life. Patients have the right to refuse any treatment, including food and water.

M14-3. A long-time patient of yours has primary central nervous system lymphoma. Although in clinical remission, he has had several strokes, probably related to whole-

brain radiotherapy some years ago, that have left him debilitated and dependent on nurse's aides for feeding and toileting. He has asked you to help him commit suicide. This request should be:

- a. held privately between the two of you
- b. immediately referred to the hospital ethics committee
- c. also discussed with other health care colleagues
- d. declined without discussing the subject

Answer: c

This question is aimed at understanding how to handle requests for physician-assisted suicide. Discussing requests with others helps to share the emotional burden, as well as bringing additional expertise and perspective. Keeping the discussion completely private runs the risk of transference and counter-transference reactions. Yet, there is no need to formally consult an ethics committee. Declining to discuss it at all is likely to miss the unmet need that underlies the request.

Module 15

M15-1. Burnout is a psychological syndrome in response to chronic interpersonal stressors on the job. Which of the following is NOT a key feature of this syndrome:

- a. overwhelming exhaustion
- b. feelings of cynicism or depersonalization
- c. sense of ineffectiveness and lack of accomplishment
- d. pervasive helplessness and hopelessness

Answer: d

Pines suggests that “the root cause of burnout lies in people’s need to believe that their life is meaningful, and that the things they do—and consequently they themselves—are important and significant. Most of the physicians who are treated for burnout do not come in saying they are burned out. Most commonly, they say, ““There’s something wrong with me. I don’t care anymore. Terrible things happen in front of me, and I feel nothing.””

M15-2. The prevalence of burnout among practicing oncologists has been reported to be:

- a. 5%
- b. 10%
- c. 25%
- d. 50%

Answer: d

In a large study of stress in oncologists, 56% of oncologist subscribers to the *Journal of Clinical Oncology* reported experiencing burnout in their professional lives.

M15-3. In evaluating risk factors, young age (<50 years) is associated with:

- a. less burnout than older oncologists
- b. about the same as older oncologists
- c. more burnout than older oncologists

Answer: c

Those under 30 or 40 years of age have more burnout than those over 30 or 40. Age is confounded with work experience, so burnout appears to be more of a risk earlier in one's career.

M15-4. In evaluating risk factors, female gender is associated with:

- a. less burnout than male oncologists
- b. about the same as male oncologists
- c. more burnout than male oncologists

Answer: c

In the Physician Work Life Study, women were 1.6 times more likely to report experiencing burnout than were men.