



COLLEGE OF
OSTEOPATHIC MEDICINE
at the Cherokee Nation

Appendix A

End-of-Life Simulation Facilitator's Guide CCF II 2021

Thank you for participating in the CCF II End-of-Life Simulation event as a facilitator. This event will take the full one hour and fifty minutes of lab for each CCF group on Nov. 4 and Nov. 11, 2021.

Learning Objectives

By the end of this simulation event the learner will be able to:

- Take an appropriate history of a patient presenting with an acute neurological syndrome
- Identify neurological symptoms in this history
- Identify appropriate physical exam skills to perform on a patient presenting with an acute neurological syndrome
- Identify abnormal physical exam findings in this physical exam
- Create an appropriate differential diagnosis based on the history and physical collected
- Discuss an appropriate assessment and plan
- Identify an appropriate time to have an advance directive discussion with a patient
- Have an appropriate advance directive discussion with the patient
- Identify the correct level of the patient's cerebrovascular accident based on history, physical, and diagnostic testing
- Formulate an appropriate plan based on the patient's advance directive

Facilitator Role

- Guidepost
 - Make sure the learners are hitting the learning targets and not going down too many rabbit holes.
 - Reinforce important concepts.
- Information Giver
 - You will be asked to read out the patient presentations and some parts of the physical exam.
 - Parts you are to read are in **blue**.
- Timekeeper



- Please make sure to watch the time as outlined and keep the learners on track. We ask that you wear a watch or have your phone available.
- Debriefers
 - Create a safe space for the learners to discuss their experience.

Synopsis and Timetable

The following is a timetable of **maximum times** at each stage. If you find your group moving faster than this, that is fine. The more time we can spend in debriefing the better. The entire event will take place in your assigned simulation suite.

	Time	Location	Facilitator Role
Prebrief – Safety Talk (simulation staff)	Group A 1-1:10 Group B 3-3:10	Simulation Center	Observe – will also serve as a break between Group A and B
Facilitator Role Prebrief and Patient Prebrief	1:10 – 1:20 3:10 – 3:20	Simulation Center	Facilitator
Stage One – Patient Outpatient Clinic	1:20 – 1:50 3:20 – 3:50	Simulation Center	Facilitator
Stage Two- Patient in ED	1:50 – 2:10 3:50 – 4:10	Simulation Center	Facilitator
Stage Three – Patient on comfort care	2:10 – 2:20 4:10 – 4:20	Simulation Center	Facilitator
Debrief	2:20 – 2:50 4:20 – 4:50	Simulation Center	Facilitator

This patient simulation will run in six stages:

1. **Prebrief – safety talk** is where the simulation staff will discuss the process of the simulation as well as orientation to the room.
2. **Facilitator Role and Patient Prebrief** will be where you as the facilitator will briefly go through the description of your role during the simulation and let the learners know they may opt-out at any time. On the large monitors, you will see a screenshot of the



patient's chart. Please review this with the learners and bring their attention to the Advance Directive notification.

3. **Stage One** is the patient presenting to the outpatient clinic with complaints of generalized fatigue, left upper and lower extremity moderate weakness, and central vertigo (sensation of the room spinning while they are still). This stage will take the longest amount of time and is the most important of the three. By the end of this stage, the learners should have an appropriate advance directive conversation with the patient. This should include the principles of medical ethics: Justice, Beneficence, and Autonomy.
4. **Stage Two** will have the patient present to the emergency room. At this stage, the patient will be somnolent and having difficulty breathing. The patient will eventually be admitted for comfort care after their child (played by voice actor) comes in and agrees to this plan of care.
5. **Stage Three** is the patient admitted to the medical floor until they are proclaimed deceased.
6. **Debrief** is where we will discuss with the learners the main learning objectives and give the learners the opportunity to voice their experience, questions, concerns, and thoughts.

Overall Goals

While all the learning objectives are important, our major goals are that the learners experience how to have the difficult discussion around advance directives and to experience a simulated patient death in a safe setting. Please keep these goals at the forefront when going through the prebrief, simulation scenario, and debrief. Do not become too bogged down in the medical details of the case or Advanced Cardiac Life Support procedures.

Expanded Stages

Prebrief – Safety Talk – 10 minutes

They will go through the safety talk as well as orientation to the room.

Facilitator Role and Patient Prebrief – 10 minutes

Facilitators should then move on to orienting the learners to their role and the patient scenario.



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- The facilitators will start by reminding the learners that this simulation is an end-of-life scenario where a simulated patient will die of a cerebrovascular accident (CVA). If any learner feels that this will be too psychologically stressful for them, they may opt-out now or at any time during the simulation. There will also be counselors on hand after the activity if they need further decompression time.
- Advise the learners that you are there to help guide the experience and keep track of the pace of the event.
- There will be three stages: in clinic, in ER, and in hospital. The Facilitator will let the learners know when it is time to move on to the next stage.
- Please have them review the Electronic Health Record on the screen and direct them to the Advance Directive notification.

Please read to the learners based on site:

Outpatient Health Clinic

Tulsa – OSU Family Medicine Resident Clinic

Tahlequah – Cherokee Nation Family Medicine Resident Clinic

Name: Dave/Davina Ross

DOB: June 15, 1957 (64 y/o)

Gender: Mannequin Gender as well as voice actor/actress

- Patient presents to Outpatient Health Center Resident Clinic for a regular check-up and new complaints of fatigue, dizziness, and left upper extremity and left lower extremity weakness. Patient has been coming to the resident clinic for the past ten years, the learner has been their primary care provider (PCP) for the past eight months. Learner knows the patient and their history and has access to patient chart (see monitor).
- After reviewing the chart, the learners should identify elevated blood pressure, discontinuing of coumadin, and advance directive needing updating as the major concerns.

Stage One

- Next have one of the learners volunteer to gather history from the simulated patient. The simulator operator and/or faculty will voice the from the control room. We have included the script for your reference (see Appendix A). Please set a timer for 7 minutes for the learner to gather history.



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- Once the learner has completed their history taking, allow the rest of the group no more than 5 minutes more to gather any other history they would like.
- Next have a different learner volunteer to identify physical exam skills that they would perform on the patient (advise them to go from head-to-toe order). Allow them no more than 5 minutes to do so.
- After the learner is done, ask the rest of the group what other physical examinations they would perform. Allow them no more than 5 minutes. Then hand them print-out #1. Have a learner read the physical exam.
- Discuss pertinent positives and negatives – no more than 5 minutes
 - Positives
 - Negatives
- Decide on assessment/plan – no more than 5 minutes
 - Cerebrovascular accident – embolic stroke secondary to atrial fibrillation with discontinuation of anticoagulation should be the top differential. Right mid pontine would be the most likely level at the pontine arteries branching off the basilar artery.
 - They should want to send the patient to the emergency room for further evaluation of possible CVA.
- Have one learner volunteer to discuss this with the patient.
- The patient will decline to go to the emergency room due to fear of hospitals from previous bad experience. Patient will not be convinced to go. This should prompt learners to have Advance Directive conversation.
 - If the learners are struggling to get to that point, facilitator may intervene and suggest Advance Directive discussion.
 - Discuss autonomy, justice, and beneficence in this situation. What the patient wants must be known, accepted, and acted on.
 - Patient autonomy: The right of patients to make decisions about their medical care without their health care provider trying to influence the decision. Patient autonomy does allow for health care providers to educate the patient but does not allow the health care provider to make the decision for the patient. (MedicineNet)
 - Medical justice is the idea of fair and equitable distribution of health resources. In this case, making sure the patient has access to the Advance Directive.
 - Medical Beneficence: the idea of the provider acting in the benefit of the patient. The patient gets to decide the parameters of this.



- Patient will leave with Advance Directive paperwork discussed and filled out (print-out #2). Advise patient that the Advance Directive will be scanned into the chart. Learners should also give red flag warning signs and symptoms to warrant calling 911.
- The rest of the plan would be to continue the rest of the patient's medications but do NOT restart coumadin or any other anti-coagulants. With the patient not having a CT, can not rule out hemorrhagic stroke. Also give warning sign/symptoms for immediately calling 911 (worsening of condition, new symptoms such as vomiting, convulsions, increased weakness, etc.).

Please read to learners based on site

Stage Two

Tulsa – OSU Medical Center Emergency Room

Tahlequah – W.W. Hastings Hospital Emergency Room

- Learner is moonlighting in the Emergency Room one day later when patient presents for the second time. Patient comes via ambulance. Neighbor found patient down at his mailbox and called 911. Patient was somnolent when found by EMTs and would answer only name and date of birth. Couldn't move any of his limbs on demand. Placed IVs on the ambulance. Started convulsing as they were pulling into the ambulance bay.
- Patient now presents with convulsions and dyspnea. Patient will not answer questions.
- Have learners discuss immediate plan:
 - CT brain without contrast stat
 - CBC, CMP, troponin, ECG, PT, PTT/INR, Magnesium, Phosphorus, ABG are all reasonable labs at this time.
 - Lorazepam 8mg IV push and then Midazolam 0.4mg/kg/h drip (If learners acknowledge need for benzodiazepine, that is good enough. Facilitators can give the dosage and route with specifics). Convulsions will stop at this point but patient will remain unresponsive.
 - EEG referral
- Review results with learners (print-out #3) including CT and ECG on the monitor.
- Have learners review the Advance Directive, should show no heroic measures to be taken and comfort care only.
- Patient's only child will enter the room, agree to the Advance Directive and plan to admit to comfort care.
- Place patient inpatient for Comfort Care



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Please read to learners based on site

Stage Three

Tulsa – OSU Medical Center Med/Surg floor

Tahlequah – W.W. Hastings Hospital Med/Surg floor

- Two days later and the learner is now on Internal Medicine service, rounding on patient.
- Nurse calls for the doctor, patient is now unresponsive.
- Please guide learners through the death exam as this will be their first experience with it.
- On exam: absent heart and lung sounds, no pupillary or corneal reflex. Hypoactive bowel sounds all 4 quadrants. Monitor shows pulseless electrical activity and then into asystole. Patient is declared dead.

Debrief

This is a set time for the learners to reflect on their simulated experience. It is important to focus on what they are feeling and processing, and not so much on the medical knowledge. Some general questions the facilitator may ask the learners:

- How did you prepare for the encounter?
- What were you most confident with during the encounter?
- What were you less confident with during the encounter?
- How did you feel about the team's overall performance during the encounter?
- How did you feel having the Advance Directive conversation?
- How did you feel when not performing heroic measures to save the patient's life?
- Had this patient wanted heroic measures, but the outcome was the same, how would that have changed the way you feel?

Please remind the learners that they have access to counselors if they need them. They may also direct any comments, concerns, or questions to their respective site course directors.

If you have time during the debrief after the learners have reflected, you may do some medical debriefing.



Appendix B

Section 1: Case Summary

Scenario Title:	CCF II End-of-Life Simulation: MidPontine CVA
Keywords:	End of life, death, cva, stroke
Brief Description of Case:	A patient will present in three different clinical settings with symptoms of CVA that will eventually lead to death.

Goals and Objectives	
Educational Goal:	Take history and perform physical consist with neurological presentation Practice an Advance Directive conversation with a simulated patient Practice work-up of a patient with an Advance Directive stating no heroic measures
Objectives: (Medical and CRM)	
EPAs Assessed:	

Learners, Setting and Personnel			
Target Learners:	<input checked="" type="checkbox"/> Junior Learners	<input checked="" type="checkbox"/> Senior Learners	<input type="checkbox"/> Staff
	<input type="checkbox"/> Physicians	<input type="checkbox"/> Nurses	<input type="checkbox"/> RTs
	<input checked="" type="checkbox"/> Inter-professional		
	<input checked="" type="checkbox"/> Other Learners: PA-1, OMS-IIs		
Location:	<input checked="" type="checkbox"/> Sim Lab	<input type="checkbox"/> In Situ	<input type="checkbox"/> Other:
Recommended Number of Facilitators:	Instructors: 4 on the Tulsa campus, and 2 on the CN campus		
	Confederates: 4 on Tulsa campus and 2 on the CN voicing manikins		
	Sim Techs: 4 on Tulsa campus and 2 on the CN campus		

Scenario Development	
Date of Development:	Oct. 5, 2021
Scenario Developer(s):	Janel Johnson, DO, MPH; Joshua Garde, RN
Affiliations/Institutions(s):	OSU-COM at the Cherokee Nation
Contact E-mail:	Janel.johnson@okstate.edu
Last Revision Date:	Oct. 18, 2021
Revised By:	Janel Johnson
Version Number:	1



Section 2A: Initial Patient Information

A. Patient Chart					
Patient Name: Dave/Davina Ross		Age: 64	Gender:	Weight: 95.7kg	
Presenting complaint: Fatigue, central dizziness, left upper and lower extremity hemiparesis					
Temp: 37 C	HR: 116	BP:158/70	RR: 18	O ₂ Sat:93%	FiO ₂ :
Cap glucose:			GCS: (E V M)		
<p>Triage note: Patient presents for routine appointment at Cherokee Nation Outpatient Health Center. They note above presenting complaints started about 2 days ago. Needs to walk along wall to keep steady at times.</p>					
Allergies: penicillin					
Past Medical History: Atrial fibrillation 5 years ago, rate-controlled Hypertension 12 years ago, controlled Hypercholesteremia 11 years ago, uncontrolled Tobacco dependence, 1 pack of cigarettes for the past 38 years			Current Medications: Metoprolol tartrate 25mg PO BID Lisinopril 20mg PO QD Lovastatin 40mg PO QD Warfarin 3mg PO QD (stopped taking about 3 weeks ago due to bruising)		

Section 2B: Extra Patient Information

A. Further History



Onset: two days ago, of all symptoms
Provocative: Standing up too quickly exacerbates but the dizziness and weakness are always there
Palliative: Walking with support (wall, support of some kind), none for fatigue or weakness
Quality: weakness, feels like they are spinning, not room
Radiation: generalized fatigue
Severity: 9/10 for fatigue, weakness 6/10, really struggling to move left upper and lower extremity, 7/10 dizziness, pretty constant
Timing: All symptoms pronounced two days ago, left upper and lower extremity weakness and dizziness have progressively worsened over the past two days
Associated symptoms: Minimal nausea, headache, and taking deep breaths. Denies chest pain, edema, or any other symptoms.
 ROS: Denies fever, chest pain, shortness of breath, bowel or bladder complaints, notes that turning head one way or the other does not affect the dizziness.

B. Physical Exam

List any pertinent positive and negative findings

Cardio: irregularly, irregular rhythm	Neuro: +Romberg's, 2/5 LUE and LLE strength, 2/4 LUE and LLE reflexes. Otherwise WNL.
Resp: RR 12, mildly labored, CTA bilaterally	Head & Neck: HEENT WNL
Abdo: normoactive BS x 4 quadrants, NTTTP	Skin: WNL

Section 3: Technical Requirements/Room Vision

A. Patient

- Mannequin (*specify type and whether infant/child/adult*)
- Standardized Patient
- Task Trainer
- Hybrid

B. Special Equipment Required

None.

C. Required Medications

None.

D. Moulage

E. Monitors at Case Onset

- Patient on monitor with vitals displayed
- Patient not yet on monitor



F. Patient Reactions and Exam

Learners will pull up the patient's "chart" before speaking with the patient. Screenshot in Appendix A.

Stage One (in office): No reactions from mannequin. Cardiac: irregularly, irregular rhythm. Otherwise WNL. Voice over will answer all questions and handouts will cover physical exam. Eventually, learners will direct the patient to go to Emergency Room (ER) via ambulance. The patient will adamantly deny going to the hospital or the ER. Then the learners should have the advance directive talk with the patient. Patient will want Do Not Intubate, Do Not Resuscitate, and No Heroic Measures on their advance directive. Patient will go home against medical advice.

Stage Two (In ER): Patient comes in via ambulance two days after clinic visit. Patient's neighbor called the ambulance after patient was found down by the mailbox. Neighbor did not come in to give history. Patient with tonic-clonic convulsions. Cardiac: irregularly, irregular rhythm, tachycardic. Eyes mostly closed. No other physical signs. Will only briefly answer name and date of birth. Somnolent. Learners will perform appropriate workup (see Appendix A) and find a right midpontine CVA on CT and admit patient for comfort care per advance directive.

Stage Three (On comfort care): Patient is day two in hospital on comfort care. Nurse will call for physician to room. Patient will be in active death. No blinking, Cardiac: irregularly, irregular rhythm leading to no sounds. Lungs: agonal breathing leading to cessation of breathing. Abdominal: hypoactive bowel sounds x 4 quadrants. Monitor will show pulseless electrical activity and then asystole as well as all vital signs trending to death.

Section 5: Scenario Progression



Scenario States, Modifiers and Triggers				
Patient State/Vitals	Patient Status	Learner Actions, Modifiers & Triggers to Move to Next State		Facilitator Notes
1. Baseline State/Office Rhythm: Atrial fibrillation HR: 116 BP 158/70 RR: 18 O ₂ SAT: 93% T: 37.2 C GCS:	Fatigue, central dizziness, left upper and lower extremity hemiparesis Awake and Alert	<u>Expected Learner Actions</u> <input type="checkbox"/> Take history <input type="checkbox"/> Perform physical exam: cardiac (including radial pulses) and lung <input type="checkbox"/> Develop differential diagnoses <input type="checkbox"/> Recommend patient go to ED <input type="checkbox"/> Have Advance Directive discussion	<u>Modifiers</u> None <u>Triggers</u> None	Learners will be able to perform cardiac and lung exam. The rest of the exam will be found in the facilitators guide.
2. Emergency Department Rhythm: Atrial fibrillation w/RVR HR: 136 BP: 150/74 RR: 8 O ₂ Sat: 92% T: 38.2 C ETCO ₂ : 58	Convulsions	<u>Expected Learner Actions</u> <input type="checkbox"/> Recognize and oblige advance directive <input type="checkbox"/> Administer Lorazepam IV push and then Midazolam drip <input type="checkbox"/> CT head <input type="checkbox"/> CBC, CMP, ABG, Mag, Phos, Troponin, Coags <input type="checkbox"/> Admit patient to comfort care	<u>Modifiers</u> -Midazolam drip controls status epilepticus <u>Triggers</u>	
3. Hospital Comfort Care Rhythm: Atrial fibrillation (PEA) BP: Undetectable RR: 0 O ₂ Sat: 80%	Non-convulsive, agonal breathing, Non-responsive	<u>Expected Learner Actions</u> <input type="checkbox"/> Recognize PEA <input type="checkbox"/> Oblige advance directive <input type="checkbox"/> Learners can recognize sudden drop in EtCO ₂ to cue them to loss of cardiac function <input type="checkbox"/>	<u>Modifiers</u> After learners recognize PEA move into state 4 <u>Triggers</u>	Facilitator's guide will have transition of overhead page for doctor to the room.
T: 36.8 C EtCO ₂ : 12		<input type="checkbox"/>		
4. Hospital Comfort Care/Death Asystole	Deceased, no cardiac or pulm sounds. Hypoactive bowel sounds	<u>Expected Learner Actions</u> <input type="checkbox"/> Pronounce patient	<u>Modifiers</u> None <u>Triggers</u> None	



Simulation Scenario Template

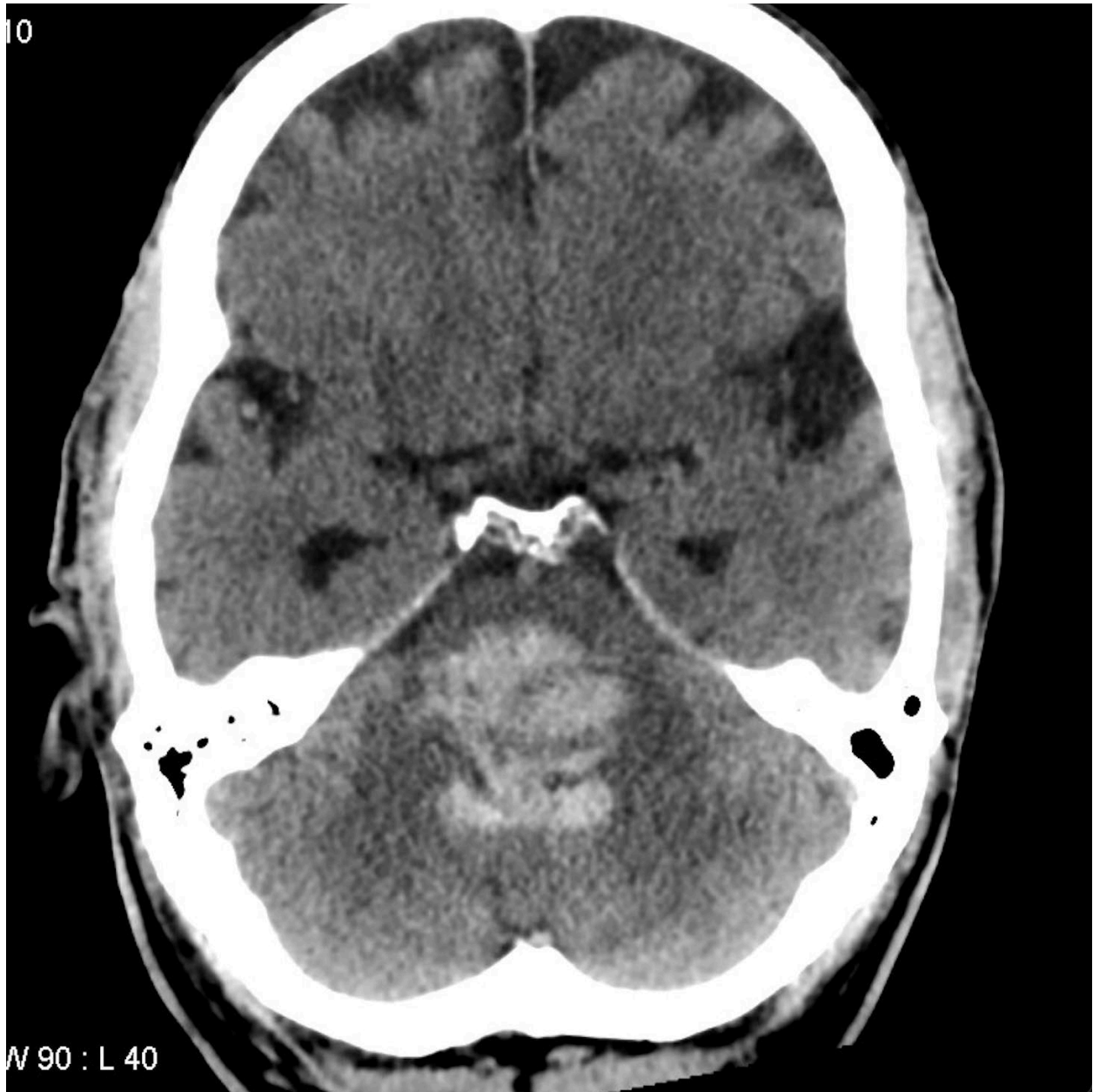
Appendix A: Laboratory Results – In Emergency Room

<p><u>CBC</u> WBC - 12.4 Hgb - 11.5 Hct - 38% Plt - 120,000</p> <p><u>Lytes</u> Na - 130 K - 3.2 Cl - 90 HCO₃ - 25 cAG - 17.5 Urea - 7.5 Cr - 1.8 Glucose 210</p> <p><u>Extended Lytes</u> Ca - 7.8 Mg - 1.2 PO₄ - 2.0 Albumin - 3.0 TSH - 7.0</p>	<p><u>Cardiac/Coags</u> Trop - 0.8 D-dimer - 0.9 INR - 1.0 aPTT - 32 seconds</p> <p><u>Biliary</u> AST - 200 ALT - 320 GGT ALP Bili - 2.1 Lipase</p> <p><u>Tox</u> EtOH ASA Tylenol Dig level Osmols</p> <p><u>Other</u> B-HCG</p>
<p><u>ABG</u> pH - 7.24 paCO₂ - 47 pO₂ - 65 HCO₃ - 18 Lactate</p>	

Patient has a metabolic and respiratory acidosis resulting from End Organ Damage and decreased respiration. Patient is also having a cardiac event.



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Case courtesy of Assoc Prof Frank Gaillard, Radiopaedia.org, rID: 11062



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Patient likely started with an embolic CVA but without treatment has become hemorrhagic and is now deteriorating quickly.



Appendix C

End-of-Life Simulation Voice Script
Fall 2021
Dave/Davina Ross

Thank you for agreeing to be a part of this simulation. In this simulation event, you will be portraying a patient who presents with a neurological syndrome but refuses to go to the hospital for further evaluation. You will have a short tenure, only voicing during stage one of the event and then in the second stage presenting as the patient’s only child. However, your part is crucial to the learners success.

Timetable

Again, you will only voice the patient during stage one but we wanted you to have an overview of the entire simulation event.

	Time	Location	Actor Role
Prebrief – Safety Talk (simulation staff)	Group A 1-1:10 Group B 3-3:10	Simulation Center	Observe – will also serve as a break between Group A and B
Facilitator Role Prebrief and Patient Prebrief	1:10 – 1:20 3:10 – 3:20	Simulation Center	Observe
Stage One – Patient Outpatient Clinic	1:20 – 1:50 3:20 – 3:50	Simulation Center	Patient Voice
Stage Two- Patient in ED	1:50 – 2:10 3:50 – 4:10	Simulation Center	Patient Child
Stage Three – Patient on comfort care	2:10 – 2:20 4:10 – 4:20	Simulation Center	Observe
Debrief	2:20 – 2:50 4:20 – 4:50	Simulation Center	Observe



Progression of Stage One

The sim staff will give the safety and psychological talks in the first ten minutes of the event. Next the facilitator will introduce themselves and their role. They will then read the introduction to the case:

Name: Dave/Davina Ross

DOB: June 15, 1957 (64 y/o)

Gender: Mannequin Gender as well as voice actor/actress

- Patient presents to Outpatient Health Center Resident Clinic for a regular check-up and new complaints of fatigue, dizziness, and left upper extremity and left lower extremity weakness. Patient has been coming to the resident clinic for the past ten years, the learner has been their primary care provider (PCP) for the past eight months. Learner knows the patient and their history and has access to patient chart (see monitor).

When this is done, the facilitator will instruct the learners to start their history taking.

Onset: two days ago, of all symptoms

Provocative: Standing up too quickly exacerbates but the dizziness and weakness are always there

Palliative: Walking with support (wall, support of some kind), none for fatigue or weakness

Quality: weakness, feels like you are spinning, not room

Radiation: generalized fatigue

Severity: 9/10 for fatigue, weakness 6/10, really struggling to move left upper and lower extremity, 7/10 dizziness, pretty constant

Timing: All symptoms pronounced two days ago, left upper and lower extremity weakness and dizziness have progressively worsened over the past two days

Associated symptoms: Minimal nausea, headache, and needing to take deep breaths. Denies chest pain, edema, or any other symptoms.

ROS: Denies fever, chest pain, shortness of breath, bowel or bladder complaints, notes that turning head one way or the other does not affect the dizziness. Does have “fluttering in chest” occasionally.

Past Medical History:

Atrial fibrillation 5 years ago, rate-controlled

Hypertension 12 years ago, controlled

Hypercholesteremia 11 years ago, uncontrolled

Tobacco dependence, 1 pack of cigarettes a day for the past 38 years



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Current Medications:

Metoprolol tartrate 25mg PO BID

Lisinopril 20mg PO QD

Lovastatin 40mg PO QD

Coumadin 3mg PO QD (stopped taking about 3 weeks ago due to bruising)

Allergies

Penicillin (rash and itching)

Family History:

Mother died at age of 80 from CVA. Patient saw her on a ventilator and other measures for two weeks before she passed and this left a hurtful impression. Father died at age 67 from myocardial infarction in his recliner. No siblings. One child in good health.

PShx

Open Appendectomy at age 13

Laparoscopic Cholecystectomy (gallbladder removal) at age 42

Social History

Divorced for the past 20 years. One child who lives over an hour away, in good health. Lives with dog, but no humans. Sees neighbor every day at the mailbox. Retired from the paper mill about five years ago. Smokes a pack of cigarettes a day for the past 38 years. Drinks a beer/glass of wine a night. Denies illicit drug or medical marijuana use. Eats a lot of frozen meals and canned soups, doesn't have much of an appetite.

Compliance history: Stopped taking coumadin because was tired of coming to the clinic (didn't retire to have to be somewhere all the time). The bruising and bleeding was annoying while doing activities (gardening, checking on cattle, etc).

After the history taking the learners will start their physical exam. During this time, they may ask your consent for certain exams. Go ahead and give it to them.

Once done with physical exam, the learners will try to send you to the Emergency Room for further evaluation. You are going to decline to go. You don't like hospitals, needles, don't have anyone to watch the dog, etc. The learners should then proceed with the Advance Directive conversation. You will want to have a DNI, DNR, and no heroic measures. You don't want to die with all those tubes or broken bones. Once this conversation is over, the voice acting is done.

Progression of Stage Two



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You will transition to playing the patient's only child. You will enter the simulation room once the learners have gotten to the point of reviewing the Advance Directive. You will announce yourself to the room as the patient's child and that you just got in. Let the learners explain to you what is happening and that the patient has an Advance Directive advising DNR/DNI and no heroic measures. You agree with this plan ("We talked about it on the phone, and this is what they wanted." Something to that effect). You may be tearful but not overly dramatic. Agree with plan of care for admission to comfort care. You may leave the room at this point so that the learners can move onto stage three. This is the last of your responsibilities.



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Appendix D

OSU COM OMS-II and PA-S1 End-of-Life Post-Simulation Questionnaire - 2021

Informed Consent

This online survey is completely voluntary. The purpose of this study is to evaluate the utility of the End-of-Life simulation from the perspectives of the medical students. It will not affect your grade in any way, whether you participate or not, and whatever your answers. Your primary responses will be anonymized and only viewed by the principal investigators: Dr. Janel Johnson, Dr. Stacy Chronister, and Dr. Nicole Farrar. They will not access the responses until after the Clinical Care Foundation II grades have been sent to the registrar. **You may opt out at any time during the survey.** The principal investigators may use anonymized quotes from the survey in publications.

- I consent to the above terms and wish to proceed with the survey.
- I do not consent to the above terms and do not wish to proceed with the survey.

All questions in this survey will have an opt out option that ends the survey:

- I do not wish to continue the survey.

Demographics

1. Are you an OSU-COM osteopathic medical student or a physician assistant student?

- Osteopathic Medical Student
- Physician Assistant student
 - Skip question 2 and 4
- Neither
 - Exit survey

2. Are you on the Tulsa (CHS) campus or the Cherokee Nation (Tahlequah) campus?

- Tulsa (CHS)
- Cherokee Nation (Tahlequah)

3. What is your gender identity?

- Female



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- Male
- Transman
- Transwoman
- Non-binary
- Two-spirit
- Prefer not to say
- Other
 - Text box

4. What is your current **TOP** medical specialty interest for residency?

- Family Medicine
- Internal Medicine
- General Surgery
- Obstetrics and Gynecology
- Pediatrics
- Prefer not to say
- Other
 - Text Box

5. What is your age range?

- 18-24 years old
- 25-29 years old
- 30-35 years old
- 36-40 years old
- 41-45 years old
- 46 years and older
- Prefer not to answer

Evaluation Questions

1. I found the End-of-Life Simulation worth participating in.

- Yes
- No
- Prefer not to answer

2. Please reflect on your answer above. Why did you make that selection?



- Text Box
- Prefer not to answer

3. When thinking about your upcoming clinical rotations, do you think this simulation will help you navigate a terminal patient?

- Yes
- No
- Prefer not to answer

4. Please reflect on your answer above. Why did you make that selection?

- Text box
- Prefer not to answer

Revised Thanatophobia Scale

Merrill J, Lorimor R, Thornby J, Woods A. Caring for terminally ill persons: comparative analysis of attitudes (thanatophobia) of practicing physicians, student nurses, and medical students. Psychological reports. 1998; 83(1): 123-128.

Questions	1. Strongly Disagree	2	3	4	5	6	7. Strongly Agree
5. The dying simulation patient made me feel uneasy.							
6. Managing the dying simulation patient traumatized me.							
7. It made me uncomfortable when the dying simulation							



patient wanted to say goodbye to me.							
8. I don't look forward to being the personal healthcare provider to a dying patient.							
9. When the simulation patient began discussing death, I became uncomfortable.							

10. Are there any final thoughts you wish to convey about the simulation?

- Text Box

Thank you for completing the survey and helping improve medical education.



Appendix E

OSU COM OMS-II and PA-S1 End-of-Life Post-Simulation Questionnaire - 2023

Informed Consent

This online survey is completely voluntary. The purpose of this study is to evaluate the utility of the End-of-Life simulation from the perspectives of the medical students. It will not affect your grade in any way, whether you participate or not, and whatever your answers. Your primary responses will be anonymized and only viewed by the principal investigators: Dr. Janel Johnson, Dr. Nicole Farrar, and Courtney Abernathy, PA-C. **You may opt out at any time during the survey.** The principal investigators may use anonymized quotes from the survey in publications.

- I consent to the above terms and wish to proceed with the survey.
- I do not consent to the above terms and do not wish to proceed with the survey.

All questions in this survey will have an opt out option that ends the survey:

- I do not wish to continue the survey.

Demographics

1. Are you an OSU-COM osteopathic medical student or a physician assistant student?

- Osteopathic Medical Student (OMS)
- Physician Assistant student (PA)
 - Skip question 2 and 4
- Neither
 - Exit survey

2. Were you on the Tulsa (CHS) campus or the Cherokee Nation (Tahlequah) campus for your first two years?

- Tulsa (CHS)
- Cherokee Nation (Tahlequah)

3. What year in your medical education are you in?

- OMS-III



- OMS-IV
- PA-2
- None of the above
 - Exit the survey

3. What is your gender identity?

- Female
- Male
- Transman
- Transwoman
- Non-binary
- Two-spirit
- Prefer not to say
- Other
 - Text box

4. What is your current **TOP** medical specialty interest for residency?

- Family Medicine
- Internal Medicine
- General Surgery
- Obstetrics and Gynecology
- Pediatrics
- Prefer not to say
- Other
 - Text Box

5. What is your age range?

- 18-24 years old
- 25-29 years old
- 30-35 years old
- 36-40 years old
- 41-45 years old
- 46 years and older
- Prefer not to answer

Evaluation Questions



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1. Looking back at the End-of-Life simulation experience, I have found that it was worth participating in.

- Yes
- No
- Prefer not to answer

2. Please reflect on your answer above. Why did you make that selection?

- Text Box
- Prefer not to answer

3. While thinking about your clinical rotations, do you think this simulation has helped you navigate a terminal patient?

- Yes
- No
- I have not had a terminal patient.
 - Skip question 4 go to question 5
- Prefer not to answer

4. Please reflect on your answer above. Why did you make that selection?

- Text box
- Prefer not to answer

5. (Only for those who answered I have not had a terminal patient in question 3). While thinking about your clinical rotations, do you think the End-of-Life simulation will help you navigate a terminal patient?

- Yes
- No
- Prefer not to answer
 - Skip question 6

6. Please reflect on your answer above. Why did you make that selection?

- Text box
- Prefer not to answer



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Thanatophobia Scale

Merrill J, Lorimor R, Thornby J, Woods A. Caring for terminally ill persons: comparative analysis of attitudes (thanatophobia) of practicing physicians, student nurses, and medical students. *Psychological reports*. 1998; 83(1): 123-128.



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	1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree
1. Dying patients make me feel uneasy							
2. I feel pretty helpless when I have terminal patients on my ward.							
3. It is frustrating to have to continue talking with relatives of patients who are not going to get well.							
4. Managing dying patients traumatizes me.							
5. It makes me uncomfortable when a dying patient wants to say goodbye to me.							



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6. I don't look forward to being the personal healthcare provider of a dying patient.							
7. When patients begin to discuss death, I feel uncomfortable.							

7. Are there any final thoughts you wish to convey about the simulation?

- Text Box

Thank you for completing the survey and helping improve medical education.