Dyspnea: Assessment and Management

Medical Resident/Oncology Fellow Competency Assessment Tool
Palliative Care Domain: Pain and Symptom Management

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Introduction for the Learner (Resident/Fellow)

Prior to your evaluation of competency:

- Complete the web-based palliative care training program “Medical Resident Training in End-of-Life and Palliative Care” before you undergo this competency assessment. The training program is available on the UMMS Intranet, click on Physicians. The course is listed under “Helpful Links.” It is also available via the internet at http://134.192.120.12/canRes/htdocs/login.asp
  - Review Unit II, Module 5 (Dyspnea) of the training program.
  - Review Part 1 (Learning Objectives), Part 2 (Teaching Outline) and Part 3 (Evaluation Checklist) THOROUGHLY so that you are aware of what is required of you.
- When you think you are suitably prepared for testing your competency in this area, ask the attending physician on your inpatient clinical rotation to evaluate the selected competency when the appropriate clinical situation arises.
- Ascertain that the attending/faculty member is certified to conduct the Palliative Care Competency Evaluation.

Field evaluation of competency:

- During the course of a clinical rotation, it is anticipated that you will have opportunities to demonstrate your competency in DYSPNEA ASSESSMENT AND MANAGEMENT with regard to palliative and end-of-life care during morning work rounds with your attending, and also throughout the day or during times of night call or cross-coverage.
- Identify a faculty member to evaluate your competency – current service attending recommended, if s/he is certified to conduct evaluation. ASK FACULTY MEMBER TO REVIEW THIS COMPETENCY ASSESSMENT TOOL PRIOR TO YOUR PERFORMING THIS TASK SO THAT THEIR MEMORY WILL BE REFRESHED AS TO THE DESIRED CHARACTERISTICS OF PERFORMANCE THEY WILL BE EVALUATING during the course of the rotation.
- At the end of the rotation, the Clinical Faculty Evaluator completes the Evaluation Checklist (Part 3) of this document, and shares it with you.
- You will also complete the self-evaluation portion of the checklist as a measure of competency in practice based learning.
- Evaluation Checklist must be signed by faculty and Resident.
- Return Evaluation Checklist to Dr. Susan Wolfsthal, Internal Medicine Residency Director or Dr. Heather Mannuel, Hematology/Oncology Fellowship Director.

Introduction for the Clinical Faculty Evaluator

How to perform this competency assessment:

A Medical Resident or Oncology Fellow has requested that you assess their competency in a selected palliative care domain during the time you are the attending physician on this service. To assist you with this evaluation, please do the following.

Preparing for field evaluation of competency:

- Review this Competency Assessment Tool thoroughly including the Learning Objectives (Part 1), Teaching Outline (Part 2) and Evaluation Checklist (Part 3) prior to pre-discussion counseling with Resident (required).
- Review Unit II Module 5 (Dyspnea) of the Web-based palliative care training program, “Medical Resident Training in End-of-Life and Palliative Care”. The training program is available on the UMMS Intranet, click on Physicians. The course is listed under “Helpful Links”. It is also available via the internet at http://134.192.120.12/canRes/htdocs/login.asp (optional).

Format of competency evaluation:

During the clinical rotation

- Based on the Learning Objectives (Part 1), Teaching Outline (Part 2), and Evaluation Checklist (Part 3) of this document and the content in Unit II, Module 5 of the palliative care training website, assess whether the Resident or Fellow meets the Learning Objectives during the course of this clinical rotation.

End-of-rotation feedback

- Review strengths and weaknesses of competency evaluation with Resident/Fellow.
- Provide constructive feedback to improve Residents/Fellows’ performance and patient outcomes.

Complete Evaluation Checklist (Part 3 of this document)

- Share with learner; allow learner to make his/her own self-assessment of performance.
- Faculty and Resident/Fellow must sign this Evaluation Checklist (Part 3).
- Learner is responsible for returning Evaluation Checklist to Dr. Wolfsthal (Residents) or Dr. Mannuel (Fellows).
Part 1: Learning Objectives

Note to learner and Clinical Faculty Evaluator: The Learning Objectives are listed in terms of fulfilling the six ACGME core competencies, listed below; these are reflected in Evaluation Checklist in Part 3 of this document.

LEGEND to ACGME core competencies: http://www.acgme.org/Outcome

<table>
<thead>
<tr>
<th>OBJECTIVES –</th>
<th>ACGME Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>A competent Medical Resident or Oncology Fellow will be able to:</td>
<td>PC</td>
</tr>
<tr>
<td>Recognize that treating terminal dyspnea with appropriate doses of opioids and other medications is ethically appropriate if the intent is to relieve suffering.</td>
<td>X</td>
</tr>
<tr>
<td>Differentiate dyspnea of known etiology and terminal dyspnea.</td>
<td></td>
</tr>
<tr>
<td>Discuss at least 4 non-pharmacological treatments for dyspnea.</td>
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</tr>
<tr>
<td>Relate the role of opioids and benzodiazepines in managing terminal dyspnea.</td>
<td></td>
</tr>
<tr>
<td>Compare medical facts and ethical arguments concerning opioid-induced respiratory depression, physician-assisted suicide and euthanasia in relation to treating terminal dyspnea with opioids.</td>
<td></td>
</tr>
<tr>
<td>Appropriately discuss the treatment of terminal dyspnea with patients and families.</td>
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</tr>
<tr>
<td>Develop an initial treatment plan for at least 3 patients with dyspnea.</td>
<td>X</td>
</tr>
<tr>
<td>Choose and titrate an initial opioid and/or benzodiazepine dose.</td>
<td></td>
</tr>
<tr>
<td>Choose and implement non-pharmacological treatment of dyspnea.</td>
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</tbody>
</table>

LEGEND:
PC – Patient Care  
MK – Medical Knowledge  
PBL&I – Practice-Based Learning and Improvement  
IPCS – Interpersonal and Communication Skills  
P – Professionalism  
SBP – Systems-Based Practice

Part 2: Teaching Outline for Learner and Clinical Faculty
Evaluator Definition

Dyspnea is a subjective sensation of difficulty in breathing; an abnormally uncomfortable awareness of breathing.

Differential Diagnosis

1. Obstructive airway process
   - tracheal obstruction--intrinsic/extrinsic
   - asthma / COPD
   - aspiration
2. Parenchymal / pleural disease
   - diffuse primary or metastatic cancer
   - lymphangitic metastases
   - pneumonia
   - pleural effusion--malignant/other
   - pulmonary drug reaction
   - radiation pneumonitis
3. Vascular disease
   - pulmonary embolus
   - superior vena cava obstruction
   - pulmonary vascular tumor emboli
4. Cardiac disease
   - congestive heart failure
   - pericardial effusion--malignant/other
   - arrhythmia
5. Chest wall/respiratory muscles
   - primary neurological disease (e.g. ALS)
   - malnutrition
6. Other
   - anxiety
   - anemia

Treatment

Non-Drug Therapy

1. Oxygen
   - Nasal cannula better tolerated than mask, especially in the terminal setting
   - Oxygen is not always helpful. A therapeutic trial, based on symptom relief, not pulse oximetry, is indicated to determine usefulness.
2. Positioning
   - Sitting up
   - Leaning forward
3. Increase air movement
   - Open window
   - Bedside fan
4. Behavioral treatments

Drug Therapy

1. Opioids
   - Dose depends on current/prior use.
   - Morphine sulfate is drug of choice
   - All opioids are effective
   - Can be administered by any route
     - Oral
     - Subcutaneous
     - IV
     - Nebulized (2.5 - 25 mg in 2 ml. saline nebulized q4h - contraindicated in pts with asthma)
   - For opioid naïve patients with severe dyspnea
     - Start with MS 2-5 mg IV or Subcutaneous every 5 minutes until symptoms improve.
2. Anxiolytics
   - Valium
   - Ativan
   - Versed - oral, IV, Subcutaneous or rectally.
   - For severe (terminal) dyspnea, give Valium 2-5 mg or Ativan 1 mg IV every 5-10 minutes until symptoms improve.
3. Cough suppressant
   - Use when cough exacerbates dyspnea
   - Oral cough medicine and/or inhaled lidocaine
4. Steroids
   - IV dexamethasone or oral prednisone for SVC syndrome or diffuse parenchymal metastases.
5. Sedatives
   - Major tranquilizers (thorazine) or barbiturates (pento-barbital, Phenobarbital [rarely]) may be needed to control terminal dyspnea/anxiety not manageable with opioids and benzodiazepines.

Specific Treatments

Treat underlying cause when appropriate (e.g. anticoagulation for PE, diuretics for CHF).

Ethical Consideration – Terminal Dyspnea

The fear of using drug therapy (drugs with the potential for respiratory depression) to ease the distress of terminal dyspnea often leads to inadequate symptom control. Health professionals and the public often mistakenly equate use of drugs to ease terminal dyspnea with euthanasia or assisted suicide. Ethically,
the use of these drugs is appropriate and essential, as long as
the intent is to relieve distress, rather than shorten life. NOTE:
There is no justification for withholding symptomatic treatment
to a dying patient out of fear of potential respiratory depression.
Understanding the patient’s wishes for end-of-life symptom
treatment, and good communication with both family and other
caregivers (e.g., nursing staff) regarding why drugs to relieve
distressing dyspnea in a terminal patient are administered, is es-

essential to avoid misunderstanding.

References

Del Fabbro E, Dalal S, Bruera E. Symptom control in palliative
care -- part III: dyspnea and delirium. J Palliat Med. 2006;9:422-
436.

The Doctrine of Double Effect. Stanford Encyclopedia of
Philosophy. Available at http://plato.stanford.edu/entries/double-
effect/

Hanks G, Cherney NI, Chrstakis NA, Fallon M, Kaasa S,
Portenoy RK, eds. Oxford Textbook of Palliative Medicine, 4th

See book index for dyspnea related to specific disease entities
and end-of-life

Assessment and management in cancer patients – 1107-1117.
Palliative sedation – pg. 1137
COPD – pg. 1186-89

Fohr SA. The double effect of pain medication: separating myth

Goldworth A. Deception and the principle of double effect. Cam-

Kockler K. The principle of double effect and proportionate

Luce J, Luce JA. Management of dyspnea in patients with far-
advanced lung disease: “Once I lose it, it’s kind of hard to catch

Qaseem A, Snow V, Shekelle P, Casey DE, Cross JT, Owens DK.
Evidence-based interventions to improve the palliative care of
pain, dyspnea and depression at the end-of-life: a clinical prac-
tice guideline from the American College of Physicians. Annals
of Internal Medicine. 2008;148:141-146

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Vyjeyanthi SP, Skultety K and Sheikh J. Panic, anxiety and
### Dyspnea: Assessment and Management

**Part 3: Evaluation Checklist**

**Date:**

- **Learner name:** ____________________________
- **Evaluator/Attending:** ______________________

**Objectives**

<table>
<thead>
<tr>
<th>Patient Care</th>
<th>Medical Knowledge</th>
<th>Interpersonal and Communication Skills</th>
<th>Practice-Based Learning and Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 3 2 1 n/o</td>
<td>4 3 2 1 n/o</td>
<td>4 3 2 1 n/o</td>
<td>4 3 2 1 n/o</td>
</tr>
<tr>
<td>Developed an initial treatment plan for patient with dyspnea.</td>
<td>Recognized that dyspnea is a common end-of-life symptom that has a significant negative impact on quality of life.</td>
<td>Appropriately discussed the treatment of terminal dyspnea with patients and families.</td>
<td>Compared medical facts and ethical arguments concerning opioid induced respiratory depression, physician assisted suicide and euthanasia in relation to treating terminal dyspnea with opioids.</td>
</tr>
</tbody>
</table>

**Overall Performance:**

<table>
<thead>
<tr>
<th>Cannot Evaluate</th>
<th>1 to 3 Unsatisfactory</th>
<th>4 to 6 Satisfactory</th>
<th>7 to 9 Superior</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2 3 4</td>
<td>5 6 7 8 9</td>
</tr>
</tbody>
</table>

**For competency/skills**

4 = Competent to perform independently  
3 = Competent to perform with minimal supervision  
2 = Competent to perform with close supervision / coaching  
1 = Needs further basic instruction  
n/o = not observed

**For knowledge and attitudes (e.g. Medical Knowledge)**

4 = Superior  
3 = Satisfactory  
2 = Below average  
1 = Insufficient – needs further learning  
n/o = not observed

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**Rotation Site:**  
- [ ] Inpatient Cancer Center  
- [ ] Inpatient GIM  
- [ ] Oncology Clinic  
- [ ] Continuity GIM clinic  
- [ ] Other

**Resident PGY Level:**  
- [ ] 1  
- [ ] 2  
- [ ] 3  
- [ ] 4  
- [ ] 5

**Fellowship Year:**  
- [ ] 1  
- [ ] 2  
- [ ] 3  
- [ ] 4  
- [ ] 5

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**Related the role of opioids and benzodiazepines in managing terminal dyspnea.**

**Discussed at least 4 non pharmacological treatments for dyspnea.**

**Appropriately discussed the treatment of terminal dyspnea with patients and families.**
## Part 3: Evaluation Checklist

### Systems Based Practice

<table>
<thead>
<tr>
<th>Overall Performance:</th>
<th>Cannot Evaluate</th>
<th>1 to 3 Unsatisfactory</th>
<th>4 to 6 Satisfactory</th>
<th>7 to 9 Superior</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>1</td>
<td>2</td>
<td>3</td>
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</table>

### Professionalism

<table>
<thead>
<tr>
<th>Overall Performance:</th>
<th>Cannot Evaluate</th>
<th>1 to 3 Unsatisfactory</th>
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<td>0</td>
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<td>3</td>
</tr>
</tbody>
</table>

### Resident/Fellow strengths:

### Resident/Fellow areas for improvement:

### Overall impression: Did the Resident/Fellow demonstrate competency in a manner so as to do no harm?

<table>
<thead>
<tr>
<th>Overall Performance:</th>
<th>Cannot Evaluate</th>
<th>1 to 3 Unsatisfactory</th>
<th>4 to 6 Satisfactory</th>
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<td>3</td>
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</table>

### Resident/Fellow self-evaluation of performance: May comment on any of the above checklist items or other reflections on performance; perceived strengths, and need for improvement and learning.

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Clinical Faculty Evaluator/Attending

Resident/Fellow

Clinical Faculty Evaluator/Attending – PRINTED NAME/DATE

Resident/Fellow – PRINTED NAME/DATE