a patient's treatment course or impede communication about prognosis.

**Research Objectives.** To determine how and when physicians use empathy when interacting with their patients.

**Methods.** A cross-sectional survey of 76 physicians working in a large urban hospital was conducted in August of 2017. Physicians were asked a series of questions with Likert scale responses as well as asked to respond to open-ended questions.

**Results.** All physicians self-report that they always (42.1%) or usually (57.9%) use empathic statements when engaging with patients. 98.6% of physicians believe that their colleagues always (19.2%) or usually (79.5%) use empathic statements when communicating with patients. Almost half of physicians indicated that using the words "I understand" denotes an empathic statement. 68% of physicians report that they would not like to receive more training or assistance about how and when to use empathy in the health care setting.

**Conclusion.** Although almost all physicians report that they and their colleagues use empathic statements while engaging with patients, almost half of physicians surveyed identified that telling a patient "I understand" is an expression of empathy; however, using the words "I understand" is traditionally not considered to be an expression of empathy. Although almost half of all physicians could not correctly iterate words of empathy, the majority of physicians report that they are not interested in receiving more training about how and when to use empathy.

**Implications for Research, Policy, or Practice.** This study emphasizes the need for physician education on both the importance and application of empathy during clinical practice.

## *"No Really, Dr. Surgeon, I Am NOT Here to Kill Your Patient; Let's Collaborate!": The Development of Surgical Oncology Education Resources for Palliative Care Providers in the Perioperative Setting (S814)*

Allyson Cook, MD, Stanford University, Palo Alto, CA. Rebecca Aslakson, MD PhD FAAHPM FCCP, Stanford University School of Medicine, Stanford, CA.

*Objectives*

1. Describe the process used to develop surgeon and palliative care clinician approved learning materials focusing on diagnosis and surgical intervention to be used in the perioperative setting by palliative care clinicians in a multi-center study of perioperative palliative care.
2. Present the obstacles to consensus and how the materials were finalized, approved, and operationalized for use in a multi-center study by all stakeholders.

**Original Research Background.** Evidence supports significant cultural barriers to palliative care in surgical settings. Development of palliative care interventions targeting surgical patients and family members may benefit from close partnership between surgical and palliative care clinicians.

**Research Objectives.** To facilitate close engagement between surgical, oncologic, and palliative care clinicians to agree on key, and sometimes controversial, information concerning surgical oncologic diagnoses and operations for the use of palliative care clinicians providing palliative care in the perioperative setting for patients with upper GI cancers preparing for surgery.

**Methods.** Perioperative palliative care goals, barriers, and approaches were discussed among patient, family member, surgeon, oncologist, anesthesiologist, and palliative care clinician team members at a stakeholder summit. Based on these discussions, surgeon, palliative care physician and anesthesiologist team members developed one-page information sheets that were iteratively revised through a detailed feedback process involving front-line palliative care clinicians, oncologists, anesthesiologists, and surgeons.

**Results.** Sheets were developed for the seven diagnoses of pancreatic adenocarcinoma, pancreatic neuroendocrine tumors, hepatocellular carcinoma, gastric carcinoma, cholangiocarcinoma, and esophageal adenocarcinoma and the five surgeries of pancreatoduodenectomy, distal pancreatectomy, hepatectomy, gastrectomy, and esophagectomy. Sheet content involving prognostic information was controversial with regards to framing and content discussed, requiring multiple iterations. After five iterative drafts, the final content was approved by all stakeholders, including surgeons, and was operationalized for use in a multi-center randomized controlled trial of perioperative palliative care.

**Conclusion.** Close engagement between stakeholders can facilitate acceptance and utilization of palliative care, even in settings where significant cultural barriers exist and when content includes potentially contentious issues.

**Implications for Research, Policy, or Practice.** Barriers to palliative care can be addressed and overcome through close, open and iterative feedback between key stakeholders.