**APPENDIX**

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| **Questions** | **Further questions** |
| **In general** |  |
| To what extent do you find yourself represented in the described burdens and first ideas for the training course?  What is important for you? |  |
| **Burdens** |  |
| What is most burdensome when dealing with patients’ desires to die? | Could you describe relevant situations? |
| Who in the team is burdened the most by desires to die? | Does it need more courage and openness to address burden and stress?  Does the team deal with it appropriately? |
| What can relieve particularly affected team members? | (types/forms of meetings, rooms for retreat) |
| **Training needs** |  |
| In which aspects of your actions related to desires to die would you like to gain more competence or security? | What would you expect to learn? |
| Relationship building and professional boundaries were important results– how do you see the importance of that? |  |
| Should the training be multi-professional or occupational group-specific? |  |
| What are the most important aspects for this training in your opinion? |  |
| How should contents be taught? |  |
| How long should it be in hours or days? |  |
| What should never happen within the training? |  |

***Focus Group Interview Guide***

***Focus Groups‘ Quotes (Needs Assessment)***

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| Course aim |  |
| Self-confidence | Naturally, it should teach self-confidence (FG 1, 13; SPC).  If I am then suddenly caught out and can’t get out of it, it’s awkward. That’s why you sometimes just don’t talk about it in the first place (FG 4, 29; SPC). |
| Content |  |
| Concrete topics for communication | What are topics that I can work on with the patient? That would be good. It’s all a bit too focussed on emotions and relationships for me. What are actual topics that we could talk about? That makes it easier for me (FG 3, 63; SPC). |
| Differentiation of DHD | That it’s not called that you don’t want to live but rather that you currently feel like you don’t want to live anymore. And that’s a few hours later, it CAN be different. THAT’S why I ALSO think having knowledge about it is important (FG 5 861–864; GPC). |
| Law | For me, the legal framework should also be included. Information about what is even legally possible and what’s not (FG 1, 4; SPC). |
| Team | What is essential for the training program is to make clear that this sort of thing—if you come into contact with these kinds of talks—they have to be addressed in whichever way (FG 5, 53–56; GPC). |
| Psychosocial aspects | The psychosocial aspects should naturally be very clearly highlighted (FG 2, 7; SPC). |
| Recommendations / pocket card | It would certainly be helpful that you had in your head— what options do I have (FG 3, 21; SPC).  When I am there alone at night. These kinds of things come especially at night and then I need to have tools and to feel confident (FG 4, 32; SPC). |
| Time and attitude | And they are often late discussions. Yea, but I address them anyway, especially with the relatives, who are usually seen as a nuisance on the ward because they cost nerves, space, and time, and hinder the day-to-day running of the ward. And, in this way, the right attitude towards the topic isn’t there (FG 7, 189–194; GPC). |
| Dealing with emotions | Professional empathy, adequately expressing one’s own emotions—how do I feel when I try to help but the patient doesn’t want it—dealing with things professionally (emotions), expectations, my own emotions in dealing, dealing with ambivalence from patients (FG 3, 59; SPC). |
| Teaching methods |  |
| Self-experience, discussion | In this kind of training program, transferring knowledge or facts is of particular importance, legal things, but also things like self-experience and self-exploration (FG 1, 20; SPC). |
| Role-play | Also, role-play is helpful, if it/I mean if it is about thinking through the possibilities, that would be good and that you can maybe try out and put yourself into the patient’s shoes (FG 7, 637–641; GPC). |
| Self-reflection, dying, and death | At the beginning I even did mental hygiene, that I firstly thought to myself—how do I feel about death, about the topic of “death”?— so that I formed an opinion/I mean that you get ideas, yea, how do/would I MYSELF deal with my death (FG 7, 590-594; GPC). |
| Routine assessment of suicidality | Classification of suicidality: that you always repeat and make yourself aware of it and continually learn and check it (FG 3, 2; SPC). |
| Structure |  |
| Confident in setting | To virtually break the taboo on the ban on active euthanasia—for that it is necessary to pick a suitable setting for a training program with a lot of trust (FG 1, 36; SPC). |
| Multidisciplinary GPC and SPC course | I would be for training all occupational groups together so that you can gain an impression of how each occupational group thinks; I would advise and support that (FG 2, 30; SPC). |
| Length of the training program | It needs space to exchange views interprofessionally. Difficult to put that into a length of time. Hours won’t suffice—more like days. (I2, 35)  At least two dates in succession (FG 1, 52; SPC). |
| Experience exchange / Case reviews | I think that you learn from the wealth of others’ experiences. Even the fact that you learn how to deal with patients in different situations. Experience exchange is the best. (FG 3, 24; SPC) |

***Description of Modules (Final Course Concept)***

The course was designed as a two-day course (16 hours) for a maximum of 12 participants, comprising 6 modules.

Module 1: After an introduction of each participant and discussion of learning expectations, module 1 focused on experience exchange which facilitates mutual knowledge and generates a trusting atmosphere (Fillion et al., 2009; Morita et al., 2014). Participants discussed in small groups what they perceive as difficult or helpful in dealing with DD. Aspects were written down and discussed together.

Module 2: In order to reflect own attitudes, aims, and concerns and their possible influence on one’s own behavior HPs shared in module 2 their own opinions and emotions towards dealing with DD using case vignettes within their group.

Module 3: In module 3 the current research on DD was presented and discussed. Topics included were: Prevalence, types and classification, possible predictors, possible reasons for DD (e.g. physical, psychological, social or spiritual problems) and motivations, patients’ possible motives and intentions (Monforte-Royo et al., 2012; Hudson et al., 2006; Coyle & Sculco, 2004; Rodin et al., 2009). Furthermore, suicide assessment and the legal situation regarding physician assisted suicide, euthanasia and withdrawing life sustaining measures were discussed (Nauck et al., 2014).

Module 4: An impulse presentation summarized DD knowledge and focused on further key points on how to deal better with DD. Main aspects were how to react to a patient’s expression of a DD or how to initiate this dialogue with a patient. Also of importance is the reflection on the patient-HP-relationship including acceptance of the patient’s distress and their current state, encouraging the patient to express their emotions (Henoch et al., 2015), and listening actively and with honest interest (Strang et al., 2014; Hainsworth, 1996; Henoch et al., 2015). Ending the conversation should cover checking for mutual understanding and keeping communication channels open in order to maintain the relationship. Afterwards the conversation is to be documented (Hudson et al., 2006; Royal College of Nursing, 2011). A pocket card summarizing these recommendations on how to better deal with DD was handed out to serve as orientation.

Module 5: In module 5 the participants experienced and practiced DD communication within role plays with each other. The conduction and “rules” of role play were explained and participants were divided into small groups (Morita et al., 2014). Participants should have the chance to discuss and practice different communicative options and perspectives in a protected environment (Mansfield, 1991; Morita et al., 2014).

Module 6: Aim of module 6 was to sensitize for own boundaries and consists of collecting ideas on possibilities for relief when dealing with DD and reflecting one’s own practice. The module also explained how to involve team members in this issue for own resilience and shows possibilities for external support (Strang et al., 2014; Royal College of Nursing, 2011). It is recommended to deal consciously with own emotions, to express them in the conversation if adequate and to ensure realistic expectations (Galushko et al., 2015; Fillion et al., 2009). Suggestions on how to ask colleagues or superiors for help if necessary and to use opportunities of team reflections were also made.