Dying to Communicate: New Approaches to Teaching Medical Students the Art of Having Those Difficult Conversations

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Abstract
If a physician receives little or no training and guidance in managing end-of-life conversations in medical school, it may leave them anxious and unprepared emotionally later in practice when they need to discuss death and dying with their patients. The physician’s discomfort with the subject may result in having inadequate conversations with their patients. This often leaves the dying patient feeling confused, and even abandoned at a time they need their doctors the most. Incorporating death education throughout a student’s medical education, emphasizing relationship-centered communication skills, and providing early experiences with the terminally ill may change this disheartening phenomena.

Key words: death, dying, narrative medicine, communication, difficult conversations, end-of-life, palliative care, hospice

Student engagement, interactive learning, and interprofessional education is currently at the forefront of medical education. Finding new ways to introduce students to curriculum to stimulate interest and promote learning is of high priority. Medical education curriculum is already “overburdened with content, overwhelmed with mandates, notoriously resistant to change, and inundated with special interest domains that claim to be similarly neglected.”

Teaching medical students how to comfortably talk about death and dying does not necessarily require an abundance of instruction time, but rather compels educators to offer creative methods of delivery. This paper details a medical school’s humanities curriculum for first year students where emphasis on self-compassion, self-reflection, death education, and early exposure to patients with terminal illness may be significant in reducing death anxiety among medical students. Reducing death anxiety early in medical school may produce physicians who can comfortably communicate with their patients about end-of-life issues.

Death Education in Medical Schools

Death education in medical schools has steadily increased since the 1970s. Today, all U.S. medical schools offer their students some instruction on death and dying. The teaching methods for death and dying instruction are primarily lecture, small group discussion, role play, and clinical case discussions. Still missing in nearly half of medical schools is personal interaction with dying patients. Some schools, such as Yale and the University of Pittsburg, are implementing interactive programs and having positive results. Studies show that more direct contact through hospice or with hospital patients who are terminally ill would enhance medical students’ ability to relate to patients and their families.

Changing the Master Narrative of Death and Dying

Communication is said to be the art of medicine. Studies have shown that most patients who are terminally ill want to talk about dying. However, because of the discomfort surrounding the subject, most do not get the opportunity to talk about their dying experience with anybody including family, friends, and perhaps more disturbing, their doctors who had worked diligently to “save” their lives. Patients often feel “dumped” by their doctors, abandoned once they become terminally ill and elect comfort or hospice care. Patients feel the reason they were abandoned was that they did not get well. They felt they let their doctors down for not “beating” the disease or somehow insulted their physicians when they decided against additional treatments. Such miscommunications, mostly due to the sensitivity of the subject, polarizes people at a time when they should be brought together. Why is talking about death and dying so uncomfortable?

The master narrative of death and dying in the United States is pejorative: one of fear, anxiety, pain, and sorrow. Created from the medical model of dying that views death and dying as a failure, a relinquishing of power, and a defeat, the master narrative of death and dying validates the core belief of many people in western society and is especially enacted in conversations and interactions with healthcare workers. Indicative of the nature of the master
narrative is the emergence of the words, end-of-life and palliative care, to replace death, dying, and hospice as a “softer” way of communicating the subject matter. One way to change the master narrative of death and dying from pejorative to a more accepting narrative is to teach medical students to become more comfortable with conversations about death and dying. By the time they reach residency they will have the tools and skills necessary to handle those difficult conversations in a compassionate manner.

A New Curriculum

Communication is a core competency taught in all medical schools and healthcare settings. Not only is communication the art of medicine, it may also be the art of interpersonal relationships. Despite having an incurable illness, many patients who are terminally ill have a story to tell; somebody should be listening. The listener must do so with compassion and at the same time protect themselves from burnout and recognize personal bias and prejudices that might interfere in the therapeutic alliance.

To strengthen competency in communication and cultivate compassion, A.T. Still University, School of Medicine in Arizona (SOMA) introduced a medical humanities curriculum encompassing a relationship-centered, humanistic approach to care. To achieve a paradigm shift that embraces humanism, a curriculum must expand the content beyond end-of-life issues. Students not only learn interpersonal communication skills but how to engage in compassionate listening, principles of narrative medicine, experiential learning, self-reflection, and self-compassion. The school is creating a culture that embraces end-of-life care as earnestly as promoting health and wellness to all populations, people, and themselves.

Minimizing Burnout: Developing Compassion for Self and Others

To have compassion for others, one must have compassion for self. On the first day of school, all first-year students at SOMA are exposed to different ways of minimizing burnout with an introduction to concepts such as mindfulness and self-care. They are encouraged to participate in activities that foster personal and spiritual growth including meditation, guided imagery, prayer, breath management, yoga, exercise, creative arts, music, tai chi, and other exercises that meet their personal needs. Mental health facilities and counseling resources are available as needed. Promoting self-care early and continuously in medical education may prevent the growing epidemic of physician burnout and self-harm prevalent lately in medicine. Part of self-care includes self-reflection. Throughout medical school students are schooled in the practice of Narrative Medicine.

Narrative Medicine

Narrative Medicine is “the ability to recognize, absorb, interpret, and act on the stories and plights of others.” Artistic and creative projects are assigned to use the visual arts to allow for self-expression and the use of color and/or video, music, prose, or poetry to express students’ feelings associated with patient or medical school experiences. Throughout their medical education students are encouraged to “hear the story” behind the clinical details. Realizing humans are storied by nature, and a patient is more than a SOAP note (subjective, objective, assessment, and plan) and detailed medical history, students are taught to validate the experience of the patient. Narrative medicine goes beyond the patient, encouraging creativity and self-reflection in the physician as well. Once students understand the importance and practice of self-care they begin learning the significance of forming a therapeutic alliance with their patients.

The Therapeutic Alliance

Students begin learning how to form therapeutic alliances with all patient populations through intense exercises in listening, communication, and touch. For example, students are exposed to tactile learning and listening with their hands and understanding the relationship between touch and the brain. Communicating through listening and touch may be one of the most important tools the student can learn in their first year of medical school. Students are usually comfortable talking but need to learn the skills to actively listen. Rigorous listening exercises are facilitated to promote active listening skills. Students are also taught to become comfortable with silence.

One such exercise has students sit facing one another, both have their eyes closed. For one minute, one student talks about what challenges they experienced the day before; what they did not like. The other student listens without
As the patient becomes the talker, the other person becomes the listener. After the student begins to talk, the listener remains silent for two minutes, then they switch roles. After the exercise, students begin to hone their communication and listening expertise in the clinical skills lab.

The clinical skills lab is designed for students to see standardized patients and learn to form a therapeutic alliance with patients. Standardized patients are lay people who follow a written script that portrays a specific clinical scenario. First, students are taught how to take a full medical history and practice their listening skills while they document a patient’s medical and social history. They are taught the nuances of the relationship model of care featuring communication skills of rapport building, empathetic responses, feedforward, agenda setting, and getting the patient’s story. SOMA students are taught to assess a patient’s social determinants of health risk factors. Social determinants of health can be described as the physical environment in which a person develops, is educated, is physically and mentally nourished, works, and is represented politically. They learn to address those challenges in a multi-disciplinary approach to care. The student begins to understand the importance of interprofessional collaboration and learns to work with other healthcare professionals to provide comprehensive services to meet their patient’s healthcare demands. Later, as the student progresses in their medical skills education they will perform a full history and physical or a focused exam. Students will participate in over 20 clinical skill labs during their first year of medical school. As their clinical, communication, and humanistic skills develop students participate in experiential learning exercises designed to engage them in critical self-reflection.

Recognizing Personal Biases and Prejudices

Students begin participating in experiential learning exercises early in the school year. These interactive exercises expose students to potentially uncomfortable situations and are the precursor for the introduction of death education. Experiential learning engages students in critical thinking, problem solving, and decision making in contexts that are personally relevant to them. After participating in the exercises, students reflect upon the experience. They are encouraged to apply their thoughts and feelings to their personal and professional identities. Participation in these types of experiences, the emphasis on self-care, semi-monthly practice with standardized patients, and training on forming therapeutic alliances culminates in the next step: death education and the hospice project.

Death Education

Students are formally introduced to death and dying in the most traditional way: by lecture. Theoretical constructs such as Kubler-Ross, Worden, and Glaser and Strauss are briefly explained. After the lecture, a patient with a terminal illness is invited to tell their story to students. As a result of valuable collaborations between community hospice organizations and palliative care doctors, finding a patient to speak is usually not a difficult task. Patients have positively responded to the request. Students are likewise eager to engage and find this addition to the lecture to be most valuable. Later in the week students take part in “Six months to live.”

“Six months to live” is an experiential exercise on dying where students are taken through a thirty-minute personal dying experience. The students are asked to imagine themselves at their present age and time and put themselves in a story. The story begins in the present with the student not feeling well, seeking medical advice, being tested for a diagnosis, getting a terminal diagnosis and prognosis, telling family and friends that they are dying, physically and mentally deteriorating, isolating, saying goodbye and, finally dying. After the exercise, students discuss their feelings associated with the different moments during the dying process so that they may fully digest and process their associated feelings and beliefs. This is a powerful and unforgettable exercise that many students find helpful in understanding what terminally ill patients experience during their dying process.

Other components of the death education curriculum for first year students include movies and other media type portrayals of death and dying where rich discussion follows. The 1991 movie, *The Doctor* is still relevant and generates a good discussion as does *Wit*, *Whose Life is it Anyways*, and *My Sister’s Keeper*. Legal aspects such as advanced directives, power of attorney, death certificates, and Death with Dignity laws are reviewed using case
studies and small group discussions. The Medicare Hospice benefit is fully explained and hospice, palliative care, and aggressive treatment are carefully detailed to give students a broad understanding of the complexities of the levels of care in medicine. The students are then introduced to the Hospice Project.

The Hospice Project

The Hospice project, in affiliation with Banner Health, was implemented as a pilot program to give students a voluntary opportunity to engage with terminally ill patients and develop increased comfort with end-of-life issues. Students may participate in the hospice project as early as the third month of medical school, after they receive end-of-life instruction and participate in the experiential exercise on dying. Students accompany an interprofessional hospice team member (i.e., a physician, nurse, social worker, or chaplain) on a home visit to observe the professional in the field and interact with a patient who is dying. On average, students conduct up to five visits with various team members and interact with as many as eight patients during the school year. As measured by the Templer Death Anxiety Scale \textsuperscript{18} and the Kneff Self-Compassion Scale, \textsuperscript{19} students demonstrated lower death anxiety and more self-compassion following participation in the hospice project. More convincing of the project’s success are the narrative notes which document the students’ experience and provide rich qualitative data such as the following:

As I was sitting with her and watching her labored breathing, I noticed her arm twitching. I then turned to look toward her face and saw what looked like spasms of her axillary artery just beneath her collarbone. I knew that it wasn’t purposeful movements, but a part of me wanted to believe that at that moment, she knew that someone was there—that she was not alone. I truly hope that she was comforted and not offended that a 26-year old, Asian male was holding her hand when she took her last breath.

The Second Year and Beyond

At the beginning of the second year of medical school, SOMA students leave the main campus, separated into approximately ten groups, and sent to ten different Community Health Centers (CHCs) across the country where they continue with didactic education. Supervised by preceptors, students begin seeing patients for an early introduction into the clinical aspects of medicine. The Medical Humanities curriculum continues under the tutelage of the Regional Director of Medical Education. The narrative medicine model continues to be emphasized, with two projects due each semester that describe the student’s feelings about a clinical encounter they have had with a patient.

Further steps are being taken to formally organize programs at each site to allow second year students to continue their participation in the hospice project. However, students are already seeking opportunities on their own to volunteer with local hospice organizations. Finally, students will be encouraged to take a hospice or palliative care clerkship or clinical rotation during their third or final year of medical school.

Summary

First year medical students participate in an end-of-life component within the humanities curriculum emphasizing self-care, self-reflection, experiential learning, and building a therapeutic alliance with patients. Students are taught to use Narrative Medicine as a tool for self-reflection and a model for the importance of eliciting the patient’s story. Enhancing communication skills while building rapport and showing compassion is practiced while participating in over twenty clinical skills labs with standardized patients throughout the school year. The integration of death education and exposure to terminally ill patients is introduced early in the curriculum to broaden students’ knowledge of and comfort with end-of-life issues. Early and frequent exposure to hospice care and work with terminally ill patients lessens students’ death anxiety. In combination, it is suggested this paradigm shift so early in a medical student’s education will increase their efficacy as communicators as practicing physicians when discussing end-of-life issues with their patients.

References


16. Whose life is it anyway; 1981.

17. My sister’s keeper; 2009.
