



**ERIC HARDT'S REALIZATION THAT THERE WAS SOMETHING MISSING FROM THE WAY DOCTORS** are trained to talk about death didn't emerge from a single observation. It came, like so many of the deaths he's witnessed, from many troubling experiences that added up to what health-care professionals would call a systemic failure.

One particularly persuasive event happened like this: "My patient was an elderly woman with a long personal history as an advocate for elderly patients," says Hardt, a School of Medicine associate professor of medicine. "She had already survived five different cancers and now had an aggressive cancer that was causing her liver to fail. She had taken one last heroic shot with chemotherapy, but she was clearly doing poorly and seemed to have little time left. I sat next to the attending M.D. in charge of her case and mentioned some of her personal history and her large, devoted family. I suggested that she would probably die soon and that she might like to get home to say some good-byes and settle some affairs. The attending shuddered and said, within earshot of the rest of the team, 'I can't go there. We could try broadening her antibiotic coverage.'"

Hardt tells the story with a grim smile and a shake of his head. That attending physician is hardly an aberration. A study conducted last year at the Center for Palliative Care at Duke University Medical Center suggests that the doctor-patient communication problem is alive and unwell at hospitals everywhere. Duke researchers recorded 398 conversations between 51 oncologists and 271 cancer patients, then graded the doctors' efforts to empathize. Whenever the patients expressed fear, anger, or sadness, the researchers analyzed the doctors' response, describing it as a "continuer" if it allowed the patient to continue and a "terminator" if it didn't. The researchers found that even though fear, anger, or sadness came through from the patients in 37 percent of the discussions, the physicians responded with continuers only 22 percent of the time. Among the male doctors, 48 percent never used continuers; among the women, 20 percent never did.

Can medical schools teach future doctors to do better? Hardt is among the faculty at BU's School of Medicine who think they should try. Two years ago, with funding from the Aetna Foundation, he developed a curriculum called Culture, Spirituality, and End of Life Care, which is now part of the required fourth-year geriatrics clerkship. The course module, which focuses on understanding different cultural notions of death and dying, consists of lectures, readings, video viewings, and written work, including an essay by students on their idea of a good death. Other professors at MED are taking similar steps. Matthew Russell, an assistant professor of medicine, is putting a federal grant to work building new course work designed, in part, to facilitate discussion of end-of-life wishes.

**SCHOOL OF MEDICINE PROFESSORS ARE TEACHING STUDENTS TO TALK ABOUT THINGS NO PATIENT WANTS TO HEAR BY ART JAHNKE**

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# FINAL ANSWERS

And Miriam Hoffman, director of the family medicine clerkship at MED's department of family medicine, is walking students through session after session of "bad news" talks, where actors play the role of patients with grim diagnoses, and faculty and students critique the conversation. At bedside all over Boston Medical Center, professors serve as role models, inviting students to observe their sometimes painful discussions with patients and encouraging the doctors-to-be to think about the best tack to take.

### THE BAD NEWS ABOUT BAD NEWS

Why are doctors so bad at talking about bad news? Isidore Berenbaum, a MED assistant professor of psychiatry who advises doctors on the issue, points out that in a doctor's mind, death often equals failure, and failure is incompatible with hope. Physicians, says Berenbaum, are reluctant to extinguish hope, even in the most unpromising cases.

"Several years ago we admitted a young woman in her thirties," the psychiatrist recalls. "The attending physician was also in his thirties, and he had treated the woman for five years. The physician called me and said that when he told his patient there was nothing he could do to help her, he started to cry. He was extremely upset, because he felt that his crying gave the patient a negative message. He thought he had done something terrible. Later, I went to see the patient, and we talked about his reaction. Her interpretation was, 'He really cares about me.'"

"The greatest fear for doctors is that we will show emotion," says Berenbaum. "We think if we show sadness, the patient will think we are giving up and will become suicidal. More often, the patient will think, 'My doctor really cares. I'm not just a number.' That's the kind of thing we need to teach."

In his class, Hardt starts with the historical perspective. Sitting at the head of a narrow wooden table in a windowless conference room on the second floor of MED's Robinson Building, he tells his thirteen students that in 1847, the American Medical Association's code of ethics required doctors to steer clear of any discouraging words.

Real change in that attitude did not come until the second half of the twentieth century. As late as 1961, Hardt says, researchers found that 90 percent of U.S. physicians preferred not to tell patients they could do nothing more for them. By 1979, a dramatic shift had occurred: 98 percent of doctors were saying they favored giving patients the grim facts. And in 1990, the Patient Self-Determination Act required all health-care institutions that receive Medicare or Medicaid to give patients sufficient information to make an informed decision about what medical care to accept or decline. The same bill guaranteed patients the right to make an advance directive,



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telling physicians what kind of care to offer, or not to offer, should they become unable to make their own decisions.

Hardt urges students to take advantage of opportunities to witness death and to pay attention to everything that happens. "I want you to be there when the family comes in," he tells his class. "I want you to greet the family. These are things you need to know how to do."

Mainly, he says, the next generation of doctors needs a better understanding of end-of-life issues. He has seen more than one study showing that when doctors are asked how much time a patient has left, they overestimate survival time by a factor of between three and ten.

### A DELICATE OPERATION

Many professors at the School of Medicine agree that when it comes to bad news, most doctors' communication skills need improvement, but they are careful not to judge too harshly. Most of them know from experience that delivering a poor prognosis is one of the more delicate operations that doctors per-

form. Unlike many surgical procedures, successful end-of-life conversations don't come with a set of rules. Rather, the best talks rely on the right combination of time, place, and a patient's readiness to hear what is being said. The catch-22, says Hoffman, is that what doctors say is predicated on their estimation of what patients are ready to hear.

"In the best situations, sitting with a patient will help you guess how they would want the news to be presented," says Hoffman, whose family medicine clerkship runs students through simulated "bad news" talks. In one simulation, students are told that their patient is a fifty-five-year-old woman whose mammogram shows some highly suspicious spots. "The students talk with a faculty member about what they should say to the patient," Hoffman says. "If a test reveals a probability that the patient has cancer, should the doctor use the word 'cancer'? Generally, we avoid euphemisms, but there is no book that will tell you what to say."

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The workshop's goal is to train students to avoid some of the unhelpful behavior Hoffman sees too often. "In situations where doctors are uncomfortable," she says, "we tend to do two things: we talk a lot, and we use a lot of jargon." Doctors should try to gauge the patient's ability to understand. "When presented with bad news," she says, "some patients will just shut down and will not even hear what the doctor is saying."

In their fourth year of training, medical students take the instincts honed in simulated settings into the real world, accompanying attending physicians when they talk with patients. "There are some very good role models here," says Megan Adamson (MED'08), who plans to practice family medicine. "Just being there when they talk about bad news is very valuable. Much of it is watching how they gauge how the patient is feeling and how they react to the patient's reactions. It's the kind of thing that's hard to put in a lecture."

Romina Ilic (MED'08) says that talking with attending physicians has helped her navigate difficult situations. "They'll tell us about their experiences and how they figured out how to do it," says Ilic. "We'll talk about what I think we should do. They say that ultimately we have to find our own way, and it's always scary."

Matthew Russell, the MED faculty member developing the end-of-life curricula, says he has found a fairly reliable path to helpful conversation. A good talk, he says, starts with a routine discussion of advance directives, those instructions about what medical care a patient would want if he became too ill to make decisions. With many elderly patients, he says, what begins as a practical talk will evolve into an expansive conversation about life, its meaning, and spirituality. Last fall, Russell received an Academic Career Award, given by the federal Health Resources and Services Administration to young faculty. The money, \$236,000 over three years, allows him to translate some of his long-held convictions into first-of-its-kind course work. Russell says his new curricula will focus on three important end-of-life issues: disease trajectories, discussions of end-of-life expectations, and the creation of a standardized test (known as an observed structured clinical encounter) of a student's communication skills. His goal is to pull down the barrier that keeps doctors taking blood pressure when they should be focused on treating the patient's mind.

"Really," says Russell, "the name of the game is, where do you want to go from here? You want to get to a point where the patient can say, 'I'm ready to go home.'" ■



**READ ESSAYS BY MED STUDENTS  
ON THEIR IDEA OF A GOOD DEATH  
AND LISTEN TO DOCTORS TALKING  
ABOUT GIVING BAD NEWS AT  
[WWW.BU.EDU/BOSTONIA](http://WWW.BU.EDU/BOSTONIA).**