See One, Do One, Teach One, But Practice First

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ON THE FIRST DAY of my most recent ward-attending rotation, a third-year medical resident presented a case to me. As the presentation ended, it was clear that a metastatic cancer was the unifying diagnosis for his multiple problems including ascites, pain, fatigue, hypotension, and kidney failure. His cancer already had failed to respond to initial and secondary chemotherapies. The patient was dying and we were faced with helping him, and his family, accept that his death was rapidly approaching. It is an all too common situation, and yet how do we teach and train residents to thoughtfully and sympathetically communicate with clarity, kindness, and compassion about a patient's rapidly approaching death? I asked the resident what he wanted to do and he said we could consult hospice or the palliative care teams and even jokingly suggesting that we send the psychiatry intern rotating on the medical service to "do the job." Clearly there was some work for us to do too.

We discussed how to talk to a dying patient. We talked about our body language and how we sit or stand in the discussion. We talked about how to reach out and physically connect (or not) to a patient. We spoke about being aware that patients and family members might be uncomfortable or unready for this discussion and would direct our conversations away from death. We talked about how to redirect the conversation back to the matter at hand. We spoke about the need to communicate clearly and to use our words with great precision. We would not talk about the "disease process" but about "spreading kidney cancer." We spoke about using specific time points that everyone could understand. We agreed to say that this would be his last July 4th and we did not anticipate he would live until Thanksgiving. We spoke about clarifying the patient's wishes regarding resuscitation and life-prolonging interventions. And finally, we talked about sharing the "five tasks before you die."¹ These tasks reflect themes of closure and are summarized by considering what it would take for the patient to say: "I forgive you," "Forgive me," "Thank you," "I love you," and "Good-bye." It is important to voice these five tasks to patients and to help them prioritize and ultimately accomplish them. These are not simple tasks and this is not an easy conversation. It is a powerful experience to speak to patients about their death. It is so powerful that I have learned when I teach residents a structured approach to this difficult conversation (use precise language, provide an understandable timeframe, explain the five tasks) that I ask

residents to practice with me before they have the conversation with their patients.

Why practice? A structured discussion about death can be emotionally overwhelming. Certainly the intensity of the subject matter contributes to feeling overwhelmed, and fast approaching death is an emotional subject; however, that is not the main reason for practicing. Practicing provides us a chance to examine and manage our own emotions before we meet with patients. We need to process our personal experiences with death. It is our thoughts, focused on people we have known and who have died, that flood in on us with powerful and sometimes distressing feelings. That is understandable; yet when we speak to patients we need to focus on what they need and how they will cope with their death. That is why I ask the residents to practice before we meet with patients—so we can learn to manage our feelings. I can use the practice too.

During the practice session the residents often become tearful. At that point I stop the practice session, break character, and they begin to compose themselves. As they collect themselves, the residents often talk to me about their feelings, and they tell me how this conversation makes them think of a family member or a friend who has died. They know that what they are about to do is important, and they wonder if anyone took the time to help their loved one. They wonder if their relative's death was peaceful or burdened with unresolved conflict or unsettled struggles. They wonder if they could have done more to help their relative find a more peaceful death. Often they are embarrassed or worried that they were overwhelmed by their emotions. It is just the opposite. Their honesty reflects that they are gaining insight into themselves and is evidence of their development as caring physicians. I am honored that they share their thoughts and feelings with me. I know that sharing their insights will help them accomplish their professional duties. I am inspired too—I understand how hard this skill is to acquire, and I admire the bravery associated with developing this new competency.

After practicing, the resident arranged his thoughts (he even wrote down what he wanted to say), and we went to the patient's bedside. Our patient was in his room, surrounded by his family. I witnessed the conversation—it was difficult, poignant, and the resident was terrific. We emerged from the room feeling that we honored our patient and eased his suffering. The next day we went into the room and we were

introduced to one of the patient's surrogate sons. Our patient said, "I heard you yesterday and this is one of the people I love and I did not want to die without him knowing it. I called him and thanked him for everything he did and I told him what he meant to me, and he flew out to be with me. I want to thank you for helping me and reminding me what I need to do before I pass." The resident and I looked at each other, profoundly moved by what we'd heard and experienced with this man. That day the resident told me something that inspired me. He said, "I have had hundreds of 'code' discussions with patients and their families over the past three years, and I have written numerous 'do not resuscitate orders' too. But I never knew how to help someone find a peaceful death. I know how to do it now." I was bursting with pride for him and his new competency. I was reminded that when we practice this skill we examine and manage our feelings, and

that helps us deliver a structured conversation designed to help our patients plan. This is one way our trainees learn to provide clarity, kindness, and compassion when it is needed most; and that is worth practicing.

Reference

1. dying.about.com/od/thedyingprocess/a/5_tasks_dying.htm (last accessed May 20, 2016).

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