Exploring medical students' perspectives on their training in serious illness communication and palliative care

December 2021

ABSTRACT

The Massachusetts Medical Schools' Collaborative conducted eight focus groups with medical students to understand their perspectives on their training in serious illness communication and palliative care. In this qualitative study with 50 fourth-year medical students, several key themes emerged. Students viewed serious illness communication as essential to high-quality medical practice and should be required and a formal part of medical school curriculum. It was important to students to have opportunities to learn and practice these skills both didactically during pre-clinical years as well as with patients during clinical rotations. Student recognized the expertise of palliative care specialists in this space, and identified the need to regularly debrief after difficult and emotional situations with patients. Project faculty and students shared a variety of recommendations for curricular change and faculty development to address the gaps identified in serious illness communication and palliative care training.

BACKGROUND

The Massachusetts Coalition for Serious Illness Care (the Coalition) convened the Massachusetts Medical Schools' Collaborative (the Collaborative) to ensure that all medical students receive foundational training in serious illness communication (SIC) as a graduation requirement and promote readiness for residency. The Collaborative includes expert faculty in palliative care and geriatrics, deans, administrative leaders, and students from Massachusetts' four medical schools: Boston University School of Medicine, Harvard Medical School, Tufts University School of Medicine, and the UMass Chan Medical School.

The Collaborative developed five shared competencies on SIC (see Appendix) and each school has mapped its curriculum to these competencies to understand the gaps in training. To better understand students' experiences and feedback on SIC education, the Coalition engaged Dr. Roberta Goldman, Alpert Medical School of Brown University, as an external facilitator to conduct focus groups with students at each school. This report is a summary of the data analysis presented in a full report written by Dr. Goldman that summarizes the findings from the student focus groups.

The Collaborative seeks to improve and expand student training in Massachusetts as well as disseminate its competencies and curricular mapping tool for adaptation by medical schools across

the country. The results from the curriculum mapping and focus groups will feed into planning faculty development among the schools, with opportunities to partner on curricular design and content.

METHODS

Design
A total of eight focus groups (two at each of the four schools) were conducted between January and May 2021 with fourth year medical students to understand:
- Students' perceptions about, interest in, comfort with, and self-assessed skills with serious illness conversations and palliative care;
- Students' assessments of their own learning experiences and curricular offerings around serious illness conversations and palliative care;
- Students' recommendations for improvements in the curriculum.

The focus group question guide was developed by Dr. Goldman along with project faculty. Core questions were open-ended and supplemented with follow-up probes. This study was approved separately by each school's Institutional Review Board.

Participants
Each school recruited students for its own focus groups by advertising the invitation to participate, aiming to involve around 8 students in each group. Once recruited, Dr. Goldman alone communicated with the students by email, and faculty were not told which students ultimately participated. Students received a $20 restaurant gift card for their participation.

A total of 50 fourth year medical students participated across the 8 focus groups. Group size ranged from 3 to 9, and the number of student participants per school ranged from 8 to 16. At the time of the focus groups, students were applying or had been accepted to various residency programs including internal medicine, primary care, psychiatry, pediatrics, anesthesiology, surgery, emergency medicine, family medicine, radiology, neurology, obstetrics/gynecology, ophthalmology, otolaryngology, and orthopedics.

Data Collection
The 1.5-hour focus groups were conducted virtually on Brown University's secure Zoom platform, moderated by Dr. Goldman. Groups were audio and video recorded, transcribed, and then de-identified for analysis

Data Analysis
Project faculty were given access only to the de-identified transcripts from their own school's focus groups. Each school's project faculty were invited to read and take notes about their two focus group transcripts and join a meeting with Dr. Goldman and Stephanie Chan (Associate Director of the Coalition) to discuss key findings and insights from only that school's transcripts. Dr. Goldman wrote a brief overview report for each individual school. Next, using a template style qualitative analysis approach (Crabtree & Miller, 1999), a defined code book was created by Dr. Goldman and Patricia Stebbins, based on the initial faculty discussions about focus group content, topics included in the focus group question guide, and test coding of two transcripts. After finalizing the code book,

Ms. Stebbins, in consultation with Dr. Goldman, conducted line-by-line coding of each transcript using the qualitative software, NVivo. Finally, Dr. Goldman and Ms. Stebbins used the immersion/crystallization qualitative data analysis approach (Borkan, 1999) to read and take notes about the code query reports generated in NVivo, for final identification of patterns and themes across transcripts and schools.

RESULTS

Key Themes
In this qualitative study of 50 fourth-year medical students in Massachusetts, six key themes emerged about their experiences with SIC and palliative care:

1. Students view the skills of serious illness communication as essential to high-quality medical practice, regardless of specialty;
2. Students said training in serious illness communication and palliative care should be required and a formal part of the medical school curriculum;
3. Students prefer to learn by practicing with frameworks as they progress through preclinical and clinical years, especially in real-world situations;
4. Students describe palliative care as highly sought-out experts in best practices and teaching, but a scarce, often misunderstood resource in health care;
5. Students claimed it was mostly due to luck when they observed good role models and were included in family meetings;
6. Students strongly desire a regular practice of debriefing after difficult and emotional situations, and view physicians who engage them in debriefing and self-care as powerful role models.

Theme 1: Students view the skills of serious illness communication as essential to high-quality medical practice, regardless of specialty.

Focus group participants largely felt training in SIC is necessary for all students no matter what specialty they ultimately choose. They acknowledged some students will be more interested than others. They believe students should understand when to consult and collaborate with palliative care experts for very complex conversations.

> "Kind of like CPR, [navigating goals of care] is a skill that every doctor should have....as with most skills, it's probably perishable if you don't use it much."

> "There's something to be said for being honest with yourself, like 'Am I consulting palliative care because this is truly a complex situation that is beyond my expertise to handle, or is it just that I don't want to talk about death, it's scary and I'm uncomfortable?'"

> "Harm can come from that conversation going poorly, and so I think that's why people tend to lean on palliative care the way they do."

They expressed fear of leading these conversations poorly and concern that they will not be ready as interns.

> "One of my longitudinal patients who is 51, [with] severe crippling anxiety and end-stage COPD, had been admitted to the hospital. She came back to see me in primary care clinic and looked me in the eye and said, '[Student's name], did I almost just die?' And I had no idea what to do with that… I couldn't just defer to somebody else on the team because I was the team in that moment."

Theme 2: Students said training in serious illness communication and palliative care should be required and a formal part of the medical school curriculum.

Some students said a SIC curriculum in the preclinical years is essential for acquiring knowledge and skills to apply in future clinical rotations, where they might "pick up the stigma or biases or misperceptions [about SIC and palliative care]." Others felt they could not understand serious illness care until they cared for patients in the hospital or clinic. Overall, most students wanted tailored training throughout the preclinical and clinical years.

> "First year, one of the deans does a Being Mortal book club and I actually thought that was a really great way to start to introduce these topics early. I felt like the first time that I saw a patient die, I reflected back on that experience. I didn't understand it fully when I was in the Being Mortal book club, but I found that I would reference those conversations in my head when experiencing these things later, on the wards."

> "I was thinking about how useful some of the training we get in this area is…when they're teaching us phrases to use and having us role play and [in] a lecture…The stuff doesn't solidify until I actually get to do this in a real-life situation… I think it's something we should clinically be required to rotate through and have those experiences if we want to effectively train physicians to be better at this."

> "There are some acronyms that you go through before you give bad news, SPIKES, and then the 'I hope, but I worry' statement, which seems kind of ridiculous, but then I saw it used in practice and it was one of the most powerful tools. I feel like a lot of the palliative care doctors actually used it, which was amazing to see."

Nevertheless, students had vague recollections about where they learned about serious illness care during the preclinical years. The experiences they remembered were few and scattered, and varied across schools.

> "I don't necessarily think that we get enough of [serious illness conversation training] and the times that we do get it are if you're lucky enough to be on a clinical team where there's someone who's comfortable doing that and is happy to guide you in that process, which I feel fortunate that I've had a few times."

Theme 3: Students prefer to learn by practicing with frameworks as they progress through preclinical and clinical years, especially in real-world situations.

Taken together, students talked about learning "the words" in preclinical years and receiving guidance on how to use the words in clinical years.

> "I could have definitely used… structured curriculum around [serious illness communication) because I definitely saw these really skilled palliative care doctors using tools, and I could see them doing something, but I would have liked to learn more specifically what they're doing and why they're doing it."

Some students said they learned about delivering 'bad news' during their preclinical years, but most felt insufficiently prepared to translate this knowledge into effective communication with patients.

> "We sympathize. But we don't really learn how to help patients process their emotions or how to manage situations where things are tense, or people are very emotional."

In their clinical rotations, students learned about SIC mostly by observation, but expressed a strong desire to practice these skills. They voiced ambivalence about practice via simulation and role play.

> "I think you can glean a lot…about how to be successful and effective by watching other people give you either good or bad examples. It's very interesting, though, because there are very few other things that people do professionally or otherwise where we expect people to gain proficiency through observation alone."

> "I think even if it's not a real patient, that's the beauty of it - you're not harming someone the same way you would a real person. So, I really like the simulation."

> "It felt a little fake, to be honest, [when] we are dealing with a standardized patient…instead of trying to practice it ourselves…Sitting in a family meeting and seeing an actual palliative care conversation take place would have been a lot more powerful."

On the hospital floors, many students struggled to build their skills, and benefited from the times they received support and coaching from faculty.

> "When I was on the peds floor and I had a family meeting regarding my patient, my attending sat me down and went through everything with me, like had me practice what I was going to say, what my goals were. And that really helped me with my language. But I don't think that's a universal experience for everyone and that's very attending-dependent. And for some situations I've been in, I think an example is, I had to break difficult news as a second year to a patient, and I didn't have any really support from the faculty."

"It wasn't until I was a fourth year in the ICU that I actually interfaced with the palliative care team. I had one session where I got to sit down and learn with [a student on the palliative care team]… It has been helpful for almost every single patient conversation I've had to have since because you can apply the skills to so many different types of conversations."

Given her experiences of being left out of learning opportunities, one student vowed, "As an intern I'll think about those med students that want to be in on the family meeting and try to advocate for them so they can at least observe."

Theme 4: Students describe the palliative care team as highly sought-out experts in best practices and teaching, but a scarce, often misunderstood resource in health care.

One or two students in each focus group had taken the palliative care elective at their school. In all focus groups, there were students who had tried to enroll in a palliative care elective but were unable to get a slot. All students who took the elective gave extremely positive descriptions of their experiences, the role-modeling from faculty, their participation in family meetings, and other learning opportunities.

"At the end of my palliative care rotation I felt pretty prepared. The thing that helped the most was just being given a framework to have these conversations. I think we all have been trained in various ways to be empathetic and to acknowledge concerns and all those other smaller aspects. But before having this framework to really put it all together in terms of how you structure the conversation - you ask this part first and then you ask this other part and then you use that information or go to the next part… [Being] very deliberate about observing how practicing palliative care clinicians actually use that framework created the environment where I was coming to the conversation having all the necessary details, and I knew how to approach the conversation."

Students observed that the palliative care team appeared very well respected on some rotations, but not on others. They noted their attendings and residents waited to consult palliative until "the patient is going downhill," and often equated palliative care exclusively with end-of-life care.

Students said they needed to learn palliative care skills for their own medical practice, and to understand how to best partner with palliative care subspecialists.

Theme 5: Students claimed it was mostly due to luck when they observed good role models and were included in family meetings.

The theme of luck arose in many students' discussion about accessing opportunities to learn about serious illness and palliative care in the clinical setting. Students asserted that having luck determined whether they experienced good role models and whether they were able to participate in family discussions and patient case debriefings during their rotations.

> "Oh, I think [you] kind of get, like lucky. So you're usually around with the team and they'll kind of point at you and say 'Hey, you know, we're having a meeting for your patient. Will you join?'"

> "In my clinical experiences, avoiding these conversations was something pretty easy to do if you weren't focusing on it…Due to serendipity, l [worked with] a couple of attendings who felt very passionately…and really pushed me to consider how can I have these conversations. Having that additional propulsion, I would say, and the encouragement to really tackle those conversations, I definitely came out feeling rather surprised I was able to have these conversations even if we were having a really heavy workday."

While some seemingly by chance had more experiences than others did, a few noted they made their own luck by actively advocating for themselves in order to have more opportunities to join family meetings. A small number of students had found themselves in a position to lead a serious illness discussion or family meeting, which was most successful when coached by attendings.

> "So on the wards I often had to advocate, like 'I really want to have this conversation with this patient. Can I give it a try?' And the resident says, 'Oh yeah, sure, if you want to.' But it wasn't valued in the same way as, like, 'Oh, I want to try and do this procedure, put in this line or take on this new admission.' So I think it's part of a value system and part of the medical hierarchy."

Theme 6: Students strongly desire a regular practice of debriefing after difficult and emotional situations, and view physicians who engage them in debriefing and self-care as powerful role models.

Students described numerous disturbing situations that they had to process alone.

> "As a third-year med student… I'm literally just standing there and [my patient] is dying alone. It just felt like a horrible experience, and…we just stood there for three hours rounding until she died, listening to her, and no one talked about it. We went back to the workroom and everybody just acted like it hadn't happened and I was like breaking on the inside."

> "One time we had a list with a lot of patients who were CMO. And then the next morning the list was really short and the residents were just like, 'Did they get discharged or did they die?' They were just like very casual and that was really jarring. I remember being nervous that I was going to become that jaded throughout residency."

"We sort of feel pressure to not let on that we've not been put in a similar situation before, that it's not a first time. And so, I think that perpetuates the cycle of us being put in situations for the first time… and then afterward, feeling like there's no space for us to react or to reflect on what we've just seen."

Students described mixed experiences with debriefing difficult and emotional situations, as well as what they learned through observation of experienced clinicians' strategies for processing their own emotions.

"I had a patient who was cared for in the ICU… who passed away. And I thought that I didn't have anyone to really debrief with and I had to sort of make my own opportunity to debrief with the attending. I had to ask specifically 'Hey, can we sit down and talk about this situation just because I, you know, I've never dealt with this?'… I feel like that should just be standard practice."

"We are frequently forgotten… it's hard for us to feel like we can demand any more of anybody else's time… I remember [a patient who] had gotten into a very bad car accident and died…And it was the first time I had been in a real code, and I think [the resident] could tell that I probably looked a little shell-shocked. And so, she, you know, took me aside and we went to get a coffee and she said, 'Are you okay?'… I just really appreciated that somebody cared enough to say that to me… I had seen people die before, but I never had my hands on their chest when they died, you know."

"I remember in [my first clinical rotation] one of our patients had died…We actually did have a debrief and… [talked about] how it feels to have these patients and the emotional toll it might take on us… But how do we learn how to feel the emotions we are feeling but also be ready for the next person?"

Some students commented on the palliative care team's ritual of making time to honor patients who have died with a few words and a moment of silence.

"I think that probably does more than we realize to help people process these things, even if they're not the most verbal person in terms of their feelings."

Student Reflections on Competencies
The Massachusetts Medical Schools' Collaborative previously defined five SIC competencies.

- Competency #1: Explores patient and family understanding of illness, concerns, values, and goals in order to develop goal-concordant treatment plans across settings of care.
- Competency #2: Demonstrates effective approaches to exploring and responding to strong emotions in patients and families facing serious illness.
- Competency #3: Applies a patient-centered framework to sharing difficult news, exploring pain and symptom burden, assessing prognostic awareness, discussing resuscitation preferences, and describing care at end of life.
- Competency #4: Demonstrates awareness of one's own emotions and attitudes, and coping strategies for managing stress and uncertainty when caring for seriously ill patients.

- Competency #5: Defines and explains the philosophy and role of palliative care, and differentiates hospice from palliative care.

When students were asked to choose which competency was most important, most students vacillated between Competency #3 and Competency #1. A majority selected Competency #3 as most important due to its concrete descriptions that "fill a void" in their education. One student described Competency #1 as "the end goal," and another called it "foundational."

Some students chose Competency #4 because managing one's own emotions is often "unacknowledged in the formal curriculum." Only a few students chose Competency #2, and one student asserted that Competencies #2 and #4 are difficult to assess in students.

> "On an airplane they always say you put your own oxygen mask on first before helping someone else…[It's] important because you have to be able to cope with it so you can give effective care."

> "Both Competency 2 and 4 require demonstrating things… so, you kind of have to not only be able to do it…you have to show that you're doing it."

RECOMMENDATIONS

Student Recommendations

Students shared a variety of ideas and recommendations to improve their training in SIC and palliative care. While some were examples of existing elective opportunities that some students participated in, others were new suggestions developed during of the focus group sessions.

Especially in the pre-clinical years, students want to be introduced to the frameworks, language, and behavioral skills of SIC, and practice them in simulation at the start of the clinical years and again before graduation. They also called for stronger illustrations of how advanced communication skills are transferrable to many aspects of clinical practice and useful to all physicians regardless of specialty. Engaging with the topic of serious illness and death early in training, for example reading *Being Mortal* by Atul Gawande, early in training was seen as a valuable component of pre-clinical training.

In the clinical years, students identified attending physicians and residents as key teachers of SIC skills. Students recommended training attendings and residents in high-quality SIC (including delivering difficult news, navigating goals of care discussions, and discussing code status), as well as in the nuts and bolts of palliative care and how to partner with them to improve patient and family care. Understanding how advanced communication skills integrates within each clinical rotation and specialty would be useful to students.

The students expressed strong desire to be included in clinical experiences where they could practice SIC. This could involve allowing students to observe and learn from residents practicing serious illness conversations in simulated settings first. After some practice, students wanted to be recognized and included in family meetings, either in an observational role or coached for active participation. Additionally, students strongly valued the practice of routine debriefing, especially

after challenging and emotional situations, and sharing strategies for coping with loss and fostering resiliency.

Lastly, students asked to expand the number of slots available for students to participate in both the palliative care elective clinical rotation and other SIC-related educational activities that often have limited enrollment.

Faculty Recommendations
Project faculty were invited to read and discuss key findings and insights from their own school's focus group transcripts. Faculty shared a variety of ideas and recommendations, some of which may be school-specific while others could be applicable to the Collaborative at-large.

Faculty felt that all students should have the opportunity to observe and debrief serious illness conversations led by palliative care specialists (whether in a workshop, simulation session, or at the bedside). A longer-term goal is to ensure students observe well-trained, multi-disciplinary faculty (not just palliative care subspecialists) with proficiency in SIC in both inpatient and outpatient settings.

Adequate exposure to patients living with serious illness, palliative care, and hospice are key. Course directors and faculty could identify opportunities within required clerkships to integrate palliative care topics and bedside communication skills practice. When available, students should have more exposure to outpatient and community-based palliative care to understand the continuum of serious illness care and conversations. Faculty should cultivate awareness of how they role model and debrief serious illness conversations, engage palliative care teams and care for dying patients, as these behaviors impact students' professional identity formation.

Faculty affirmed the expectation that debriefing should be a routine and best practice in clinical medicine and called for faculty development that includes effective debriefing. Many students witness death and dying for the first time on their inpatient rotations. Faculty should be equipped with education about the dying process and high-quality end-of-life care and provide support for students to process their experience. Students should be encouraged by faculty to play meaningful and practical roles on clinical teams, such as spending time with patients to hear their personal stories and organizing family meetings.

REFERENCES

Crabtree B, Miller W. (1999) Using Codes and Code Manuals: A Template Organizing Style of Interpretation. B. Crabtree & W. Miller (Eds.), Doing Qualitative Research (2nd ed., pp. 163-177). Sage Publications.

Borkan J. (1999). Immersion/Crystallization. In B. Crabtree & W. Miller (Eds.), Doing Qualitative Research (2nd ed., pp. 179-194): Sage Publications.

ACKNOWLEDGEMENTS