END-OF-LIFE EDUCATION FOR MEDICAL STUDENTS:

GENERALISTS COMBAT THE “HIDDEN CURRICULUM” BY INTEGRATING STUDENT SELF-REFLECTION AND SKILL BUILDING OVER THE 4-YEAR CORE CURRICULUM

Society for General Internal Medicine 2008 Annual Meeting
Workshop Session, April 11, 2008 2:00-3:30 PM
Workshop Faculty

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Workshop Agenda

1. Introduction: Review of approaches to teaching end-of-life care to medical students and the “hidden curriculum.” – Dr. Ellman

2. Description of three innovative, integrated end-of-life educational programs
   
   - Generalist Physician Anatomy Faculty Program – Dr. Schwartz
   - Ward-based End-of-Life Care Program – Dr. Ellman
   - Culture, Spirituality and The End of Life – Dr. Hardt

3. Small group discussions – Drs. Ellman, Hardt, and Schwartz
   
   - Discussion of programs presented
   - Use of student self-reflection in end-of-life teaching
   - Integrating end-of-life care education: opportunities and challenges

4. Workshop evaluation
Breakout Group Discussions

I. Discussion of programs presented

II. Student self-reflection
   a. What student self-reflection activities have you used or encountered that have been successful?
   b. What challenges or stumbling blocks have you run into?
   c. What opportunities might exist to incorporate self-reflection exercises in end-of-life curriculum?

III. Integrating end-of-life teaching into medical student core curriculum
   a. How does end-of-life teaching take place at your institution?
   b. Are there examples of integration of this teaching into the core curriculum?
   c. What opportunities can you see to integrate end-of-life teaching into both the pre-clinical clinical core curriculum at your institution? Clinical core curriculum?
   d. What structural or logistical barriers are there?
   e. What sources of support or collaboration are there for integrating end-of-life teaching into the core curriculum?
REFERENCES

Charles E. Schwartz, MD
Internal Medicine/Psychiatry

Generalist Physician Anatomy Faculty Program (GPAFP)
Albert Einstein College of Medicine

Bibliography

Selected References: Hidden Curriculum


Selected References: Medical Student End-of-Life Care Education

Selected References: Medical Student End-of-Life Care Education, cont.


Selected Resources/References:
Culture, Spirituality and End-of-life Curriculum, Boston University School of Medicine

The Good Death – A World Perspective in the Twenty – First Century
http://www.deathreference.com/Gi-Ho/Good-Death-the.html

End of life: the Buddhist View
www.thelancet.com Vol 366 September 10, 2005
End-of-life: a Catholic view
www.thelancet.com Vol 366 September 24, 2005
End-of-life: the traditional Christian view
www.thelancet.com Vol 366 September 17, 2005
End-of-life: a Hindu view
www.thelancet.com Vol 366 August 20, 2005
End of life: the humanist view
www.thelancet.com Vol 366 October 1, 2005
End-of-life: the Islamic view
www.thelancet.com Vol 366 August 27, 2005
End-of-life: Jewish perspectives
www.thelancet.com Vol 366 September 3, 2005
Readings: Fast Facts
END-OF-LIFE EDUCATION FOR MEDICAL STUDENTS:

GENERALISTS COMBAT “HIDDEN CURRICULUM” INTEGRATING STUDENT SELF-REFLECTION AND SKILL BUILDING OVER 4-YEAR CORE CURRICULUM

SGIM Annual Meeting, 2008
Faculty

- Matthew Ellman, MD, Yale University
- Eric Hardt, MD, Boston University
- Charles Schwartz, MD, Albert Einstein
Workshop Objectives

- Appreciate the spectrum of EoL educ. and the effect of a “hidden curriculum”
- Learn about 3 new EoL educ. initiatives.
- See examples of student self-reflection activities, consider opportunities for implementation at your institution
- Discuss challenges in integrating EoL educ. into core curriculum
- Recognize the leading role a generalist can play to improve EoL education
Intro: EoL educ. approaches, “hidden curriculum”

3 programs: Schwartz, Ellman, Hardt

Small group discussions
  – Presented programs
  – Student self-reflection
  – Integrating EoL education

Evaluation
Approaches to Teach EoL Care

- Lectures: death and dying
- Case studies/problem solving conf.
- Reflective exercises/Role plays
- Standardized patient workshops
- Pre-clinical longitudinal experience
- Hospice visits
- Palliative care rotations
Limitations Existing Approaches

- Graduates not prepared for EoL care
- Courses elective
- Isolated, not longitudinal / reinforced
- Take place off site
- “Peripheral” curriculum / faculty
- Hidden curriculum
Hidden Curriculum

“Only a fraction of medical culture is to be found or can be conveyed within those curriculum-based hours formally allocated to medical students’ instruction. Most of what the initiates will internalize in terms of the values, attitudes, beliefs, and related behaviors deemed important within medicine takes place not within the formal curriculum but via a more latent one, a “hidden curriculum…”

–Hafferty FW, Franks, R, 2004
Hidden Curriculum

“...is what we *actually* do in our day-to-day work with patients and one another – not what we say *should* be done when we stand behind podiums in lecture halls”

- Inui TS, 2006.
Impact of Hidden Curr. on EoL Education.

- EoL care lesser value
- Marginalization patient-centered care (v. disease-centered)
- Marginalization palliative care (v. curative)
- Discourage certain feelings, reflection: hazard of being “too” involved
3 New Programs

- Generalist faculty in gross anatomy
  - Gross Anatomy (1st Year) - Dr. Schwartz

- Ward-Based EoL Care Program
  - Core Ward Clerkships (3rd Year) – Dr. Ellman

- Culture, Spirituality and The End of Life
  - Geriatrics Clerkship (4th Year) – Dr. Hardt

Key features

- Integration into Core Curriculum
- Student self-reflection
Generalist Physician Anatomy Faculty Program (GPAFP): Integrating Clinical Mentoring into First Year Anatomy and Dissection

Society of General Internal Medicine
Pittsburgh, PA
April 11, 2008

Charles E. Schwartz, Todd R. Olson, Alice Fornari, Elizabeth Lee-Rey, Sherry A. Downie

Albert Einstein College of Medicine, Bronx, NY
Montefiore Medical Center, Bronx, NY
Caution:

This presentation is rated R

Contains graphic photographs
We enter the lab as students........
and leave as incipient physicians.
CADAVER DISSECTION:
Educational Potential

In addition to learning normal anatomy, dissection provides a unique opportunity for students to:

- Experience the cadaver in a patient-centered context
- Begin to develop Professional Values
  - Permitted to violate taboos
  - Intimate access to bodies
  - Respect for living persons
  - Providing expert clinical assessment
Dissection has the potential to touch upon a wide range of important clinical issues beyond simply learning about the structure of the human body: The Cadaver was a person who lived, became ill, got medical care, and died.
Traditionally, dissection:
- Focuses only on normal anatomy

Students develop:
- Narrow views
- Suppress their emotions
- Distance themselves from the cadaver as a once-living person

The “Hidden Curriculum” begins
How can we optimize the clinical education potential of human cadaver dissection?
Today, Specialist Physicians (surgeons, pathologists, radiologists) participate in anatomy courses at most medical schools by giving lectures and occasionally visiting the dissection lab.
Utilize Generalist Physicians (general internists and family practitioners on the faculty) to:

1. Introduce students to the cadaver and conduct a physical examination
Generalist Physicians as Anatomy Faculty

AECOM Innovation - GPAFP

During the Course, Generalist Physicians then:

2. Evaluate the first student report on Surface Anatomy/Physical Examination findings
3. Read and comment on 7 reports written by individuals during the course that describe their team’s findings
4. Evaluate Summative Reports each team writes synthesizing and integrating their findings
5. Attend Convocation of Thanks and Dinner with their dissection team
GPAFP: Goals

- Survival of Anatomy
- Generalists Incorporated into a Basic Science Course
Goal: to create a relationship that stimulates students to consider and explore quality-of-life, patient-care and end-of-life implications.

Generalist Physicians in the anatomy course promotes an inclusive patient-centered approach to learning anatomy that values anatomic variations and pathology, alongside normal anatomy. Individual variation and anatomic pathology are indicators of functioning during life, illnesses suffered, medical care received, and end of life care.

This relationship is largely conducted online using an internal developed software program named ARI.
Goal: to create a relationship that stimulates students to consider and explore quality-of-life, patient-care and end-of-life implications.

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Anatomy Report on the Intranet - ARI
What is it & How is it used?

ARI is an online database containing digital images and text files submitted by students.

Using ARI, students:
- submit a Surface Anatomy & Physical Examination Report
- describe (via text and photos) their Regional Dissection findings of variation and pathology
- generate hypotheses about the clinical significance/life impact of their findings
- dialog with anatomy faculty and Generalist Physicians
- write and submit a Summative Report
Using their notes, dissection teams enter their anatomical findings online via ARI (Grinspan et al., 2006)
GPAF and Patient-Centered Narrative

AND each team generates patient-centered hypotheses about:

• the causes or origins of the anatomic variations and pathology they finding

• how these findings might have affected the person’s:
  o daily quality of life
  o physical capacities
  o medical special needs and history
  o end-of-life circumstances

• their thoughts on the personal and cultural identity of the cadaver.
Lower Limb

Figure 1
Reason: Piriformis Syndrome
Description: On the right side the sciatic nerve split the piriformis muscle.

Figure 2
Reason: Normal Piriformis and Sciatic
Description: Left side piriformis and sciatic nerve are typical

Observations: From the surface exam:
The leg is turned so that the toes of the right foot have an anterior orientation and the toes of the left foot have toes were angled away from the center of the body. He had long toenails with thickening of the toenail on the left side. On the left 3rd toe there was an irregular round mass. One mole on the left anterior mid thigh with two strands of hair coming out, 5mm diameter. On the right upper thigh, slightly right of the leg's middle axis there is an oval mark that is purple/red with a scalloped edge. There were two cuts on the legs. One was on the left anterior leg midway between the ankle and knee, with a swelling and small bump on left long side, 4cm long by 1.5cm wide. The second was on the right anterior leg, 5 cm inferior to the knee and a heart shaped lesion.

From the dissection:
The left piriformis muscle was pierced by the left sciatic nerve. The right sciatic nerve was in the usual location.

Upon dissection: His left talus had an unusually bony ridge immediately distal/anterior to the ankle joint. Such that noticeably lower than the plain of the neck of the talus. The right foot (though not dissected) also had a similar ridge and mound upon surface palpation. The trochlea of the talus itself was fairly clean and smooth as were the articular surfaces. There was no sign of arthritis in the ankle joint nor in the knee (only left ankle and left knee completely dissected).

Hypotheses:
The orientation of the feet can be due to hip or leg fracture or displacement. He may have been born with a bunion. The thickening of the toenails and the irregular mass may be the result of untreated fungal infection. The mole could have been benign or the beginning of a melanoma. The purple/red mark with the white center looks like a bruise or a moldy or a cancerous lesion. The cuts on the leg can be the result of pre or post-mortem trauma.
As students submit their regional reports, GPAFs:
- logon
- read the reports
- provide feedback

Click To View Faculty Comments:

Good job labeling your thorax images. About the pleural adhesions, I think the procedure is pleurodesis. You may want to check that spell.
Good job at the table.
Dr. D.: sdownle on 2006-11-14 14:55:53

1. I wonder if the black spots reflect more than living in an urban environment -- if they could reflect a long hx of cigarette smoking, causi
2. The discussion about the limits of what you can say just by gross appearance is important in your future work in clinical medicine. Thou live pts -- by xray or imaging study), seems to so definitively tell us the diagnosis (e.g., cancer), we have to constantly remind ourselves that without a confirming "tissue diagnosis" -- examination of actually tissue under the microscope.
3. I wonder how long he had to live with his final/terminal illness -- and what symptoms he struggled with, e.g., severe shortness of breath restriction due to massive pleural effusion.

Excellent observations and hypotheses.
A Unilateral effusion from a unilateral lung tumor could indeed lead to a palliative ipsilateral pleurodesis being performed. chschwar@montefiore.org on 2006-11-29 22:15:02

22:48:13
At the conclusion of the course, the GPAFs read and evaluate the final summary report produced by their dissection team.

Meet their team at the Convocation of Thanks and Dinner 3 weeks after conclusion of anatomy course.
Focus group findings (n = 8):

- Role of generalist faculty must be clear to students.
- Avoid the “fluffy stuff.”
- Focus on clinical dimensions and possibilities of the clinical course ultimately leading to death.
- GPAF's help to apply anatomical learning.
- Did not perceive GPAF Program as enhancing professional development.
Face to face structured interviews with randomly selected GPAFs (n = 10):

• Program was a good idea.

• Program requires more active student engagement.

• Did not perceive GPAF Program as enhancing professional development.
“Due to my own difficulties in the anatomy lab I thought the idea for the venue to discuss psychosocial issues would be helpful and great.”

“Loved …web-based education and using technology to work with students at a distance”

“Great opportunity to connect to emotions and memories of anatomy. Goal was to make it more relevant and ease stress.”

“Like the idea of the patient as a person extending to anatomy-parallels clinical setting.”

“Connect with students in less time consuming way.”
• “Lab visit was great. The students were able to process their emotions and the PA (2nd year Peer Assistant) was very helpful. I was glad to be there to discuss the many aspects of the experience with them.”

  Karina Berg, M.D.
  Dept. of Medicine
  Nov. 11, 2007

• “The shared experience I had meeting the anatomy students and their cadaver was one of the most amazing encounters I have had as a medical educator.”

  Bruce Soloway, M.D. Vice-Chair
  Dept. of Family & Social Medicine
  Oct. 21, 2007
This October I walked into the anatomy lab for the first time in many years…

the smell of formaldehyde brought back many memories… long nights in the lab with an atlas open, wondering… what nerve was… I looking at? how will I ever remember all the bones of the wrist?

I also remember the thrill.

For me, anatomy was the first step to becoming what I thought a true physician is. Someone who can tell you what it is that is actually hurting, someone who can tell you the names of all those bones, someone who knows where my pancreas is.

Anatomy class is a right of passage that all doctors go through….
… When we started (the)generalist program there was much debate:

Do we approach the bodies as we would a patient? How could we do this (with) no doctor-patient relationship? There would be no complaint to deal with…no problem to address… none of the give and take that we deal with…

But these were previously living people. They have given us all the gift of their bodies so we may learn. With this program, we try and put a context to their lives based on what we find….
… as a generalist faculty member in the anatomy class… I… help you connect what you are seeing in the lab with what you will see in your patients over the upcoming years…

… Last month I had a patient…. Ms. B… a 90 year old woman… frail and demented… admitted for fever and dehydration… bed bound… bed sore… devoted family takes excellent care of her at home…

Ms. B is a holocaust survivor…

She has donated her body to the med school…
... Will the students that learn from her in the upcoming years find her tattoo? 
Will they piece together these turbulent facts of her life other than her declining state towards the end? I don’t know. But I can hope that they will (devote) the same effort to understand life through the cadaver as I have been fortunate enough to see in the past two years...

Alfred Burger, M.D. 
Department of Medicine 
Anatomy Convocation of Thanks 
March. 24, 2008
“the Class of 2010 embarked on their days in the anatomy classrooms… careful to try and apply what we were learning in a humanized way, trying to understand what our donor’s life may have been like through our ARI reports. Our donors were not just teaching tools, but our patients and we, their final doctors. In the end, we learned compassion, understanding and that the most awesome man-made machine was man itself…”

Rachel Boyarsky, AECOM 2010
Anatomy Convocation of Thanks
April, 2007
In his introduction to anatomy, Dr. Olsen shared his vision of a more person-centered anatomy course. He said that we should view our cadavers as more than a collection of body parts, and still more than a complex integration of muscles, vessels, and organs woven on to a bony frame. Instead, he charged us to search for the person who once lived inside the body. He asked us to learn about their lives and circumstances from the clues they left behind in their remains. He told us their names, and asked us to consider their lives. My cadaver’s name is Ralph, and this is what I have learned…
One of the first things that I noticed was his clenched fists, a sign that his last moments, were moments of great pain. Unfortunately, this was not the first time he had suffered... with a feeding tube and a breathing tube... the atrophy of his muscles... Ralph was, most likely, bedridden and incapacitated... developed numerous bed sores... some... penetrated to the bone. We can only hope that he did not feel the pain these lesions caused...
…his troubles started well before… Ralph had a disastrous inguinal hernia… Great shame and discomfort must have accompanied this disfigurement. Ralph’s barreled-chest, blackened lungs… means that he was probably a smoker who suffered from COPD… scar tissue on the inferior portion of his left ventricle, almost certainly indicates a heart attack… Finally, he never felt the joy of fathering children because he only had one testicle and that testicle did not fully descend…
...But WAIT! Is this a fitting memorial for a man who lived for 86 years? Where is the person that Dr. Olsen asked us to find? ...the facets of his life that did not leave a physical remnant? Show me the memory of his First kiss. Point to the warmth he felt at the holidays... Identify the excitement... that reverberated throughout His body as he carried his bride... was he a loving man? ...an adventurer? Did he like basketball... Was he close to his parents?...married? ...religious? Did... he adopt? ...fight in wars? ...was he happy with his life?
...Dr. Olsen charged us to search for the people who once lived inside these bodies, and I am still searching. ...I am realizing that the gaps in my knowledge, the things that I cannot know about someone by just investigating their flesh are the things that truly frame their lives.

- As we continue our education and look forward to the world of medicine and healing, I hope that the lessons of anatomy will inform our daily interaction with patients. I hope that we will see passed the body and the disease, and see the person his life, hopes, and dreams.

David Stern, AECOM 2011
Anatomy Convocation of Thanks
March, 2008
Christine Montross: poet, teacher, medical student

“... Flat-calm summer evenings on the northern Michigan lake of my childhood, I’d tug on my swimsuit and wade out in the clear green water to float... I’d lie back in the water, arms and legs spread out like a snow angel... lie there and breathe, loving the way my body would rise and fall... wondering what domain my small breath had over water... I still think of that quiet, of that sense of something powerful and unseen in me...

... Now I am a student of medicine, a field with its own paradoxes. The first of these I encountered in my anatomy class, and it is still one of the most powerful: that you begin to learn to heal the living by dismantling the dead...
“…The dead body harbors the great mysteries of creation and humanity” the hidden beauty and intricacy of function, the insistence of individuality, the inevitability of decline, the incontestibility of death…

… The moment I raise a scalpel to a body is a rite of initiation. With my first cut, I have begun a personal transformation that differentiates me from my friends and family…

… It is about performing previously unthinkable actions in order to discover wondrous and previously unimaginable realms…

… It is about joining a history of anatomy that includes grave robbers and executioners, murderers and mutants, courageous blasphemies and bodies of saints…

… about dissecting a dead body in the hopes of one day making living bodies more whole…“

Christine Montross
Body of Work: Meditations On Mortality From The Human Anatomy Lab
Ward-Based EoL Care Program: Yale School of Medicine

Collaborators: Peggy Bia, MD, Julie Rosenbaum, MD.

Needs assessment
Program design and development
Challenges of implementation
Assessment of effectiveness
Survey 2004 Graduating Yale Med Students

- Over 20% of students feel inadequately prepared to provide EOL care.
- Students believe EoL care important
- 40% of students cared for 2 or fewer dying patients.
- Majority of deaths students encounter are post- resuscitation, not peaceful.
- Students want to learn with “real” patients in “real-life” clinical setting
Objectives of Program

- Increase awareness of EoL issues patients face in acute care setting.
- Understand elements of comprehensive EoL care assessment.
- Gain more comfort and ability to communicate with patients at EoL.
- Appreciate importance of reflection on experience of caring for patients at EoL.
Components of Exercise

1. Patient / family interview
2. Reflection and write-up
3. Facilitated group case discussion
Student Assignment

1. Identify suitable patient
2. Permission from attending and review record
3. Interview patient / family, MDs/nurses
4. Assess EoL domains and management plans.
5. Reflect on experience.
6. Prepare report, present at case conference.
EoL Areas Students Address

- Diagnosis and prognosis
- Evaluation of symptoms
- Management (and barriers)
- Sources / responses to suffering – physical, psychological, social, spiritual.
- End-of-life care planning
Self-reflection

- How does it feel to be with a seriously ill patient? To speak about EoL issues?
- What ways was this challenging for you?
- What was helpful to face challenges?
- What have you learned?
Implementation

- Support: Dean Educ, Director clinical skills
- Collaboration clerkship directors
- Core faculty recruitment
- Pilot: psychiatry (consult) and surgery

Improvements:
- Prep session “survival week”
- Faculty notification
- Student reminders
Participation

- 45 students pilot year
- 70-80 subsequent years
- Initially - patients mostly Psych consult
- Subsequent: more patients on other clerkships
6 Themes of Impact of Exercise

1. Recognition of complexity of patients reactions to dying
2. Communication issues
3. Value of the clinicians’ presence and listening
4. Interpersonal dynamics
5. Range of students personal reflections
6. Perception of assignment itself (positive and negative comments)
Reflections on Communication

- Realization of discomfort talking to patients at EoL
- Importance of clear, unified communication
- Barriers to effective EoL communication
- Relevance of timing and honesty in communication
“Spending time with Mr. G taught me a lot about illness, death, and the hassles of being sick. It was a joy to get to know him… I found that the comfort level varied widely amongst my attendings and residents. All in all, I think that this subject is addressed too seldomly in our medical education, and so this is a great project.”
“This assignment was truly a learning experience. I have never sat and talked openly about death with a sick patient or with anyone else for that matter. It has led me to think deeply about some of the decisions I am making in my life and where my priorities lie.”
Assessment of Effectiveness

- Annual graduating student survey
- Self-perceived preparedness in EoL care
- 5 domains of EoL care competency:
  1. Psychological, socio-cultural, spiritual issues
  2. Interviewing/communication skills
  3. Management common symptoms
  4. Ethical issues
  5. Self-knowledge, self-reflection.
## Survey Results

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<th>Category</th>
<th>N</th>
<th>(%)</th>
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<td>Medical student graduates</td>
<td>395</td>
<td>(100)</td>
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<tr>
<td>Female</td>
<td>200</td>
<td>(50.6)</td>
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<tr>
<td>MD/PhD recipients</td>
<td>41</td>
<td>(10.4)</td>
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<tr>
<td>Students completed EoL exercise</td>
<td>121</td>
<td>(30.6)</td>
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<tr>
<td>Students who completed EoL survey</td>
<td>258</td>
<td>(65.3)</td>
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<tr>
<td>Completed exercise</td>
<td>77</td>
<td>(29.8)</td>
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<tr>
<td>Did not complete exercise</td>
<td>181</td>
<td>(70.2)</td>
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<tr>
<td>Prepared</td>
<td>Participated</td>
<td>Did not participate</td>
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<tr>
<td>Prepared</td>
<td>39/77 (50.7%)</td>
<td>64/180 (35.6%)</td>
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<tr>
<td>Not enough prepared</td>
<td>38/77 (49.3%)</td>
<td>116/180 (64.4%)</td>
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(p=0.02)
## Effectiveness by EoL Domain

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<th>Domain</th>
<th>Participated</th>
<th>Did not participate</th>
<th>p-value</th>
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<tr>
<td>Management Common Symptoms</td>
<td>3.3 (0.7)</td>
<td>3.0 (2.6)</td>
<td>&lt;0.01</td>
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<td>Interviewing/Communication</td>
<td>3.7 (0.9)</td>
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<td>Ethical/ Legal</td>
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<td>Psychosocial</td>
<td>3.8 (0.8)</td>
<td>3.7 (0.9)</td>
<td>0.37</td>
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<td>Self-reflection</td>
<td>3.7 (0.9)</td>
<td>3.7 (0.9)</td>
<td>0.87</td>
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Summary of Ward-Based Program

- Integrating EoL care exercise into core clerkships: feasible, modest resources
- Improves self-reported level of preparedness (but not enough!)
- Recognize relevance/utility of improving comfort and skills in end-of-life care: Narrow gap formal and hidden curriculum
Culture, Spirituality and End of Life Care

A curriculum developed at Boston University School of Medicine funded by the Aetna Foundation 2006

SGIM Annual Meeting
April 11, 2008 Pittsburgh, PA

Eric J. Hardt Boston Medical Center
B USM IV Geriatrics Clerkship

• Required 4 week rotation for all 180
• Historical continuity with 125 year old BU “Home Medical Service”
• Clinical sites include: interdisciplinary precepted and independent home visits to a frail, diverse urban population as well as Geriatrics Clinic, nursing homes, ALFs, and ADH sites
• Detailed didactic schedule organized online via “Course Info” website
<table>
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<td>3</td>
<td>A. Burrows, MD PACE - Residents</td>
<td>S. Levine, MD HV - Residents</td>
<td>G. Rosenthal, MD BH - Residents</td>
<td>P. Kimbell, APRN HV - Residents</td>
<td>9 AM Geriatric Conference</td>
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<td>M. Hogan, APRN HV - Nicole</td>
<td>D. Oates, MD HV - Sohini, Kelly</td>
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<td>5</td>
<td>Orientation Day (students)</td>
<td>D. Oates, MD HV - Sohini, Kelly</td>
<td>M. Russell, MD HV - Marianne, Vicki</td>
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<td>6</td>
<td>Begine 8:30AM</td>
<td>L. Norton, MD Clinic - Ethan</td>
<td>L. Norton, MD HV - Sanjeev, David</td>
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<td>7</td>
<td>* Morning/Afternoon Lectures</td>
<td>L. Caruso, MD GH - Marianne, Vicki</td>
<td>L. Caruso, MD HV - Ethan, David</td>
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<td>8</td>
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<td>S. Chao, MD Clinic - Nicole</td>
<td>S. Chao, MD Clinic - Sanjeev, David</td>
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<td>S. Chao, MD Clinic - David</td>
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<td>9:71</td>
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<tr>
<td>11</td>
<td>LABOR DAY!</td>
<td>S. Levine, MD HV - Residents</td>
<td>G. Brandeis, MD BH - (Residents)</td>
<td>F. Kimbell, APRN HV - (Residents)</td>
<td>9 AM Geriatric Conference</td>
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<tr>
<td>12</td>
<td>A. Burrows, MD PACE - Residents</td>
<td>D. Oates, MD HV - Nicole, Sohini</td>
<td>M. Russell, MD HV - Marianne, Vicki</td>
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<td>L. Norton, MD Clinic - Kelly</td>
<td>L. Norton, MD HV - Sanjeev, Ethan</td>
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<td>L. Caruso, MD GH - Ethan, David</td>
<td>E. Hard, MD HV - Nicole</td>
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<td>G. Rosenthal, MD SCBH - Marianne, Vicki</td>
<td>D. Oates, MD HV - Kelly, Sohini</td>
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<td>H. Claude, APRN HV - Sanjeev</td>
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<td>* Afternoon Lecture</td>
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<td>19</td>
<td>A. Burrows, MD PACE - Residents</td>
<td>S. Levine, MD HV - Residents</td>
<td>G. Brandeis, MD BH - (Residents)</td>
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<td>D. Oates, MD HV - Nicole, Sohini</td>
<td>M. Russell, MD HV - Marianne, Vicki</td>
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<td>21</td>
<td>ADH - Sanjeev, Nicole, Kelly, Schri</td>
<td>G. Rosenthal, MD SCBH - Ethan</td>
<td>G. Rosenthal, MD SCBH - Vicki</td>
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<td>H. Auerbach, MD Clinic - Sanjeev, Sohini</td>
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<td>L. Caruso, MD GH - Nicole, Kelly</td>
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<td>L. Norton, MD HV - David, Ethan</td>
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<td>L. Norton, MD HV - David, Ethan</td>
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<td>* Afternoon Lecture</td>
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<td>27</td>
<td>A. Burrows, MD PACE - Residents</td>
<td>S. Levine, MD HV - Residents</td>
<td>G. Brandeis, MD BH - New Resident</td>
<td>D. Oates, MD HV - (Residents)</td>
<td>9 AM Geriatric Conference</td>
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<td>D. Oates, MD HV - Nicole, Kelly</td>
<td>M. Russell, MD HV - Marianne, Vicki</td>
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<td>L. Caruso, MD GH - Sanjeev, Sohini</td>
<td>G. Rosenthal, MD SCBH - David</td>
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<td>30</td>
<td>ADH - David, Ethan, Vicki, Marianne</td>
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<td>IVF - Vicki, David</td>
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<td>Final Exam and Wrap-up</td>
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<td>Primary Preceptors</td>
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**KEY**

- **Rogerson HOUSE (in P.):** *All Students*
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- **Rogerson HOUSE (in P.):** *All Students*
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<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
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<tbody>
<tr>
<td>ORIENTATION DAY</td>
<td>9:30A Introduction</td>
<td>Lisa Norton, MD</td>
<td>Erica Bernstein, MD, PhD</td>
<td>10:15-11:15A Falls</td>
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<tr>
<td>10-11A Geriatric Overview</td>
<td>Lisa Norton, MD</td>
<td>3:4-15P Intro: End of Life Care</td>
<td>Matt Russell, MD, MSc</td>
<td>11-12A Nursing Homes</td>
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<td>11A-12P Orientation</td>
<td>Patricia Kimball, MS, RN, C</td>
<td>3:4-15P Intro: End of Life Care</td>
<td>Dan Oates, MD</td>
<td>2P-3P The Biology of Aging</td>
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<td>12/3</td>
<td>9/4</td>
<td>9/5</td>
<td>3:30-4:30PM Health Literacy</td>
<td>Jim Kirkland, MD, PhD</td>
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<tr>
<td>Labor Day!</td>
<td>9/6</td>
<td>9/7</td>
<td>3:30-4:30PM Geriatric Screening</td>
<td>3P-4P Home Care</td>
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<tr>
<td>3-4P Community Resources</td>
<td>Patricia Kimball, MS, RN, C</td>
<td>3-4P Urinary Incontinence</td>
<td>Dan Oates, MD</td>
<td>S. Levine, MD HV</td>
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<tr>
<td>10-11A Elders Driving</td>
<td>3-4P Urinary Incontinence</td>
<td>3-4P End of Life Workshop A</td>
<td>Lisa Norton, MD</td>
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</tr>
<tr>
<td>1:15-2:15P Elder Abuse</td>
<td>Clare Wohlgemuth, APRN, BC</td>
<td>10-11A Elders Driving</td>
<td>Jane Greens, MD</td>
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<tr>
<td>3-4:15P Cross Cultural</td>
<td>Eric Hardt, MD</td>
<td>10-11A Elders Driving</td>
<td>Jane Greens, MD</td>
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<td>Geriatrics</td>
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<td>10-11A Elders Driving</td>
<td>Jane Greens, MD</td>
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<tr>
<td>3-4 End of Life Workshop B</td>
<td>George Rosenthal, MD</td>
<td>10-11A Elders Driving</td>
<td>Jane Greens, MD</td>
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Learning Objectives: Culture, Spirituality and The End of Life Module

Part of the Geriatrics Lecture series is a Culture, Spirituality and The End of Life module. This is a set of four sessions (see the folders in the Assignments section of Course Info) that will address palliative care, hospice, religion and culture at the end of life. One session will occur each week of the clerkship and will require a small amount of preparation before the session. Reading assignments, video clips, and brief writing assignments will be on Course Info. Please check at the beginning of each week for the assignments. These will not be graded but will count as participation and are designed to enhance group discussions.

- **Introduction to Palliative Care, Hospice and End of Life**
  Important reading and resources

- **The Good Death**
  Pre-reading assignments, to be completed prior to the lecture.

- **Cross Cultural Geriatrics**
  Important reading and resources

- **End of Life Curriculum Final Session**
  Descriptions of potential projects and important background information

- **Surveys**

- **Quizzes**
Learning Objectives  Session 1 Eric Hardt

Introduction to Palliative Care, Hospice and EOL

1. SWBAT describe and contrast key elements of palliative care and hospice care.

• 2. SWBAT list and organize the tasks appropriate to physicians related to end of life, including the time of death.

• 3. SWBAT compare different strategies for advanced care planning and its documents.

• 4. SWBAT construct a key symptom management plan.
Assignments

Current Location: Introduction to Palliative Care, Hospice and End of Life

- Presentation: Introduction to Palliative Care, Hospice and End of Life

- Required Readings: Fast Facts
  This folder contains three articles that are required reading for this course. The rest are optional. These fast fact articles are available at [http://www.eperc.mcw.edu/ff_index.htm](http://www.eperc.mcw.edu/ff_index.htm).

- Patient Video Clips
  This folder contains 2 video clips to be viewed prior to the lecture. Note: audio is poor due to noise in the patient's home. Find a quiet place to view these. We have some headphones in the student room.

- Comfort Care Sample Form
  Massachusetts Department of Public Health, Office of Emergency Medical Services Comfort Care/Do Not Resuscitate ("DNR") Order Verification sample form

- Death Certificate Sample
  U.S. Standard Certificate of Death

- MA Health Care Proxy
  Massachusetts Health Care Proxy Information, Instructions and Form

- MA Power of Attorney
  Massachusetts Durable Power of Attorney

- Inpatient Times Article: The Death Certificate Need Not Be Worse Than Death
Assignments

Current Location: Required Readings: Fast Facts

Back

Completing a Death Certificate
Completing a Death Certificate
Required reading for the first lecture.

Death Pronouncement
Death Pronouncement
Required reading for the first lecture.

Teaching the Family What to Expect When the Patient is Dying
Teaching the Family What to Expect When the Patient is Dying
Required Reading for the first lecture.

Optional Readings
Assignments

Current Location: Optional Readings

- Decision Making Capacity.pdf
 _decisionmakingcapacity.pdf

- Determining Prognosis in Advanced Cancer.pdf
  _determiningprognosisinadvancedcancer.pdf

- DNR Orders in the Hospital pt 1.pdf
  dnrordershospitalpt1.pdf

- DNR Orders in the Hospital pt 2.pdf
  dnrordershospitalpt2.pdf

- Dyspnea at End-of-Life.pdf
  dyspneaateol.pdf

- Grief and Bereavement pt 1.pdf
  griefandbereavementpt1.pdf

- Hospice Referral - Moving from Hospital to Home.pdf
  hospicereferralmovingfromhospitaltohome.pdf

- Medicare Hospice Benefits- Levels of Hospice Care.pdf
  medicarehospicebenefitslevelsofhospicecare.pdf
Current Location: Patient Video Clips

- Back

1. **Patient clip - Family**
   - One patient's perspective on family.

2. **Patient Clip - Funeral**
   - One patient's perspective on planning her funeral.

- Back
The Good Death

Please read "The Good Death – A World Perspective in the Twenty – First Century" and one or more of the reviews from the Lancet on views regarding end of life from various religious perspectives. You may choose to read about belief systems different from yours, or systems that you personally identify with.

After reading these articles, please reflect on what characteristics would describe a good death for you personally. These may describe the process, the event or the aftermath. Please LIST the three most important qualities that describe your personal preferences for death and then DISCUSS briefly your rationale for how you arrived at your final choices.

Due to be posted by Dr. Norton's lecture.

Week 1 assignments
Post your week 1 assignments here

Week 2 assignments
Post your week 2 assignments here

Week 3 Assignments
Post your week 3 assignments here

Week 4 Assignment
Learning Objectives Session 2
Lisa Norton-The Good Death

1. SWBAT contrast key features related to end of life from the student’s familial/personal/community perspective with key features related to end of life from the perspective of medical culture.

2. SWBAT compare a good death to a bad death from a personal point of view.
   • 3. SWBAT develop an approach to setting goals of care.
   • 4. SWBAT examine aspects of spirituality and religious/philosophical traditions related to end of life care.
Patient Video Clips
This folder contains 2 video clips to be viewed prior to the lecture. Note: audio is poor due to noise in the patient's home. Find a quiet place to view these. We have some headphones in the student room.

The Good Death – A World Perspective in the Twenty – First Century
Read the following prior to completing your assignment for "The Good Death" lecture:
http://www.deathreference.com/Gi-Ho/Good-Death-the.html

- End of life: the Buddhist view
  End of life: the Buddhist View
  www.thelancet.com Vol 366 September 10, 2005
  Do Not Reproduce

- End-of-life: a Catholic view
  End-of-life: a Catholic view
  www.thelancet.com Vol 366 September 24, 2005
  Do Not Reproduce

- End-of-life: the traditional Christian view
  End-of-life: the traditional Christian View
  www.thelancet.com Vol 366 September 17, 2005
  Do Not Reproduce

- End-of-life: a Hindu view
  End-of-life: a Hindu view
  www.thelancet.com Vol 366 August 20, 2005
  Do Not Reproduce

- End of life: the humanist view
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Welcome to geriatrics_ongoing

End-of-life: a Catholic view
End-of-life: a Catholic view
www.thelancet.com Vol 366 September 24, 2005
Do Not Reproduce

End-of-life: the traditional Christian view
End-of-life: the traditional Christian view
www.thelancet.com Vol 366 September 17, 2005
Do Not Reproduce

End-of-life: a Hindu view
End-of-life: a Hindu view
www.thelancet.com Vol 366 August 20, 2005
Do Not Reproduce

End of life: the humanist view
End of life: the humanist view
www.thelancet.com Vol 366 October 1, 2005
Do Not Reproduce

End-of-life: the Islamic view
End-of-life: the Islamic view
www.thelancet.com Vol 366 August 27, 2005
Do Not Reproduce

End-of-life: Jewish perspectives
End-of-life: Jewish perspectives
www.thelancet.com Vol 366 September 3, 2005
Do Not Reproduce

Fast Facts
Assignments

Current Location: Fast Facts

- Confronting Personal Mortality
  Confronting Personal Mortality

- Near Death Awareness
  Near Death Awareness

- Physicians and prayer requests
  Physicians and prayer requests

- Taking a Spiritual History
  Taking a Spiritual History [http://www.eperc.mcw.edu/fastFact/ff_019.htm](http://www.eperc.mcw.edu/fastFact/ff_019.htm)
Current Location: Patient Video Clips

- A Good Death
  One patient's perspective on a "good death".

- Religion
  One patient's perspective on a religion.
Current Forum: The Good Death
Date: 11-Sep-2006 20:52:19
Subject: good death

Time Course:
For me, I worry about who I would leave behind, whether I die early or late in life. A sudden death would not allow my family to say their goodbyes. Having time to do things that I had not done before, thank people I forgot to thank in life, and spend time with my family would be important to me.

In Islam, as part of my spiritual goals, there are certain things that one needs to complete before death if one has the means. This is specifically a pilgrimage to Mecca. This event gives one the opportunity to reflect on life, meditate and pray with others who share many of the same beliefs, and in many ways, ask for forgiveness for one’s errors made in life. I do think it would be important for me to complete this task before death. Consequently, it would be nice to know that death was upon me before I had the chance to complete the pilgrimage.

Suffering:
Like most people, I want to die in decent health so that I can do the things that I mentioned above. There has been much written about suicide and physician assisted suicide. However, for me, because of my beliefs against any form of suicide, I would endure all the suffering. Life is full of many trials and challenges that are given to us for a reason that we will never fully comprehend. End of life suffering is another challenge of one’s character, as terrible as it may be. Thus, it would be a blessing to die without any suffering.

In addition, I think the more that I suffer, the more of a burden I will be on others, including my family. I would not like to impart these difficulties on any one.

Family:
It would be nice for me to carry out my last days amongst family and friends. I would not want to be in a hospital or a nursing home. It would be important for me to be at home, with all my family members around.
Current Forum: The Good Death
Date: 02-Nov-2006 14:56:32
Author: [redacted]
Subject: A Good Death

To me, "the good death" would incorporate three main things:

1. A peaceful transition into the next life - in the Hindu tradition, "A good death should be prepared for throughout life, and entered into consciously and willingly (ichha mritu)." This is meaningful to me, as I would like to end my physical existence in this world after full spiritual and mental preparation. Should my life end abruptly, I would like to be spiritually ready. I believe that this can be accomplished only through constant meditation and self-reflection, in addition to the celebration of life and happiness.

2. The absence of pain and acute suffering - this is important to me both because of its personal implications and because of its effect on my family and friends. Regardless of the specific physiologic event that stops my heart from beating and my neurons from firing, I would like to die without agony and without a struggle. This would signify a smooth transition into the next existence (whatever this may be) and would allow my family and friends to suffer less for my passing. I would like my death to be remembered as a spiritual, positive event, and not as a type of "defeat."

3. The accompaniment of family and friends - I would like them to not mourn, but to celebrate life together and reminisce about the good times that we shared. I want them to share the moment with each other, to forge even stronger interpersonal bonds and to reflect on the value of life. I hope that my passing will bring my family even closer together and to revive any relationships that have become distant or disconnected.
Discussion Board
Forum: The Good Death

Current Forum: The Good Death
Date: 04-Oct-2006 08:57:26
Author
Subject: Jayz's 3 death wishes

3 personal preferences for death:

1. Pain-free / minimal
   This is an important quality for me, as I believe pain and suffering during death can significantly impact on my judgement and the level of interactions I wish to have with my loved ones who may be present. Nevertheless, I will accept reasonable medical interventions necessary, including intubation if indicated.

2. Control of my Environment
   Having gone through several migratory phases in my life, I value the concept of dying in a surrounding familiar to me. Not only will this minimize possible stress and confusion for the dying, I also hope this can reduce the burden of healthcare resources. :) A good home, on a comfortable chair, my favourite singer playing on my killer stereo is all I ask for right now. It is, however, not necessary to have all my loved ones present as travel can be an issue for them.

3. A short and efficient funeral
   Contrary to Traditional Chinese concept (you know, big funeral precessions, 49 days of vegetarian food etc), I believe in minimal burden to my loved ones that I leave behind. After all, it's better to celebrate while one is alive than to show your love when it's already over.
As the article discusses, there are a multitude of views on death and the process of dying. My opinion is just one of many, and is likely reflective of religious and family values that I was raised with. I would think, by and large, that most people overall have similar wishes for their deaths, differing mostly in the order of importance. Of course, there will always be differences...

1) In the days leading up to my death, I want to have the satisfaction that I lived my long life to the greatest extent possible and that I have no regrets and am happy with the manner in which I am about to leave the world: with a smile on my face, in a comfortable bed at home, and surrounded by a few close loved ones whose lives I had lasting effects on. Everyone wants to be remembered.
2) My death would be pain-free, without physical or spiritual struggle, and not prolonged. I do not want to have a period of partial incapacitation before my death; if I slip into a coma, I would prefer that it last no longer than a couple of days – a period of time which would give close family enough time to see me before my passing, but without prolonging the pain that a teetering life can bring.
3) I would have complete closure in dealing with my family and friends. I would not want there to be unspoken feelings or unsettled emotions between us. I want everyone in my family to understand how much I love them, and I'd also want to feel how much they love me. Hopefully, this will help my family through the grieving process and sitting shivah.

There are additional wishes that I would have in relation to my faith in Judaism, but they are not really mentioned above since I believe that my devotion and attention to religion will be present throughout my entire life, and my procurement of arrangements for a proper Jewish funeral can be achieved prior to my death.
A challenging topic for a young professional in the midst of a major career step... nonetheless.

1) The process: interestingly most of the articles seemed to focus on this aspect and how important it seems to people to avoid pain/suffering. I think it would tend to side with some of the major religions on this one. The body is a vehicle for the soul. Pain/suffering should be minimized but I doubt can be avoided. The cessation of function of the human body secondary to disease likely is not painless regardless of the amount morphine one is offered. Moreover, acceptance of the absence of a future is contradictory to the human experience and must provoke some suffering. So no specific requests for this one, just keep the pain manageable so the mind can function.

2) The event: again, considerable lip service paid to this aspect as well, surrounded by family, alone, etc. My request here would be one not for swiftness as a sudden death can cause considerable grief amongst loved ones, nor for prolongation as the human spirit can only tolerate so much pain/suffering before it becomes numb. My request would be for 1 week, 7 days of unrestricted time, not burdened by decision-making or obligation but by the pursuit of happiness with loved ones who were aware of what is to come. And not 5 minutes with a friend and 30 minutes with a family member but everyone together, eating, drinking, conversing and sharing human experiences. Then simply, after a glass or two of red wine, I would leave.

3) The aftermath: this step would be most important to me personally. That those left behind would cherish my memory, think of me truthfully, not only fondly and try to remember what I wished for them and pursue it wholeheartedly.

If the details are fuzzy, that is on purpose...
Assignments

Current Location: Cross Cultural Geriatrics

- **Patient Video Clips - Required**
  - This folder contains 2 video clips to be viewed prior to the lecture. Note: audio is poor due to noise in the patient's home. Find a quiet place to view these. We have some headphones in the student room.

- **Fast Facts - Required**
  - This folder contains three articles to be read prior to the lecture.
    - Cultural Differences at the End of Life Presentation
    - Cultural Competency at the End of Life bibliography
      - A list of additional articles is available: [http://www.eperc.mcw.edu/articles/art_cc.htm](http://www.eperc.mcw.edu/articles/art_cc.htm)
Learning Objectives Session 3

Eric Hardt    Cross Cultural Geriatrics

1. SWBAT recognize current and historical demographic trends in America.
2. SWBAT examine key cultural issues related to geriatrics and end of life care: e.g. breaking bad news, hospice utilization, pain and symptom management, etc.
3. SWBAT manage language barriers at EOL.
4. SWBAT develop a strategy to openly discuss issues of racism and race in end of life care.
Assignments

Current Location: Fast Facts - Required

- Cultural aspects of pain management
- Explanatory Model
- Use of Interpreters in Palliative Care

Back
Assignments

[Top] - [Cross Cultural Geriatrics] - [Patient Video Clips - Required]

Current Location: Patient Video Clips - Required

- Back

  - Reflections on History and Race
  - Patient's words on "a good doctor" and medical students

- Back
Reflections on History and Race

Patient discusses her personal history and responds to questions about racism's effects on her life.
Learning Objectives Session 4

George Rosenthal Final Session

• Presentations may include case discussion, cultural genograms, role plays, artistic expressions, etc.

• SWBAT demonstrate understanding of the objectives outlined in sessions 1, 2 and 3. Students will not be graded on these activities but will be encouraged to openly discuss patients encountered during the 4-week rotation, their own culture, medical culture, and to bring in creative elements. Students will be provided a suggested list of products to be prepared with in this 4th session. Though students are not graded on these products, they are expected to be prepared and participate, hopefully it will be fun.
Final Project Description

Assignment
The final week of the block you will be meeting as a class with Dr. George Rosenthal to present a small project.

Expectations:
- Students will be expected to demonstrate understanding of the objectives outlined in sessions 1, 2 and 3. (See “Learning Objectives” in the Assignments section of CourseInfo.)
- **Students are expected to turn-in a product at the end of the session.**
- Students are encouraged to openly discuss patients and families, their own culture, medical culture, and to bring in creative elements.
- Though students are not graded on these products, they are expected to be prepared and participate. Hopefully it will be fun!

Suggested time frame:
- Students are expected to spend 1 to 2 hours in preparation for their presentation.
- Each student is allotted approximately 10 minutes for his or her presentation. Students who choose to work in teams will be expected to present 10 minutes per student. For example, a two-student team will have 15 minutes to present and lead discussion, a three-student team will have approximately 20 minutes. Group presentation time requirements are approximate.

Suggestions for Final projects:
- First and foremost- Be Creative!
- Feel free to draw from literature, poetry, movies, fine art and other media.
- Role-plays are an excellent way to work as a team and can elicit very interesting discussion amongst your classmates. These can be used to display best-case and worst-case scenarios; and to open a discussion about the challenges presented in your scene.
- You can present a case discussion from this clerkship, other settings, or your own life experience.
- The Cultural Gerogram (similar to what you did in ICM 2) can be used to explore your own family history, or
The vision of how I die goes like this. Laying in MY home in MY bed with MY family around me. All involved are accepting of the reality with minimal tears shed if possible. I say this because that, to me, is the all telling moment I have lived a good life to deserve a good death. Dying is not an event to grieve for too long. It should be seen as closure to a slot of time that had existed next to someone else’s slot of time, hopefully in a harmonious manner. A new life will soon begin again at the closure of mine...that is how my harmonious time hopefully ends. Reincarnation...that’s the closure of my time...and that would be another discussion altogether.

Dying in harmony...spiritually, emotionally, and physically. I ask these 3 simple things. It may sound vague or abstract, but when I think about it, they make some real sense.

Spiritual harmony- this tells me I have found inner peace, accepting of both my sins and my virtues. This is a state of being I would love to reach.

Emotional harmony- this tells me I have left those I love with a part of me that they will not grieve ever but cherish as my legacy. I hope I will have made them better for having known me. This tells me that I died loving them and with them loving me.

Physical harmony- this tells me that I have left this world in a respectable condition so to not offend others and taint the first two requests. I want to have a physical presence that exudes pride and respect for myself and for others.
My thoughts on how it may end...

1) Family: The most important thing to me and my Italian culture. Most of my parents generation and back were both born, and died, at home surrounded by their family. I want my loved ones near so I can tell them how much they all meant and how family and friends are what comprise the "stuff" of life.

2) Home: I do not want to die in a hospital-- under any circumstances. It's very important to me to be in familiar, happy surroundings.

3) Mental state: Hopefully I will still be "with it" when the time comes. I want to be able to smile and talk with my grand (great grand maybe?) kids and sneak them a couple bucks I kept hidden away. In addition, I hope to be able to bear any pain while remaining positive with a great sense of humor. I'm inspired by my grandfather who'll be 90 years old at the end of this month. He's doing ok health wise- but you'd never know if he wasn't. In all these years I don't think I've ever heard him complain once. He accepts it all with a sense of humor and strength that I hope I've inherited.
Erik J. Hart

Discussion Board

Forum: The Good Death

Current Forum: The Good Death

Date: 04-Mar-2008 16:03:49

Author: [Redacted]

Subject: A Good Death

Read 4 times

1) Being Catholic and having received many of the Sacraments since being born beginning with Baptism, I would like to have my life come to an end in similar fashion with receiving the last sacrament, anointing of the sick.

2) I would also like to make sure that my financial issues have been completely dealt with. I have family friends who have had elders pass away without having their financial situations squared away, ultimately resulting in legal and financial problems for those families. I want to have everything paid off and make sure that everything is set so that there are no questions with what should be done once I pass away.

3) I would also like to have someone, an "expert" in the field of death and the dying process who I can talk to and might help alleviate any concerns or fears that I may have throughout this process. I know many elderly people who are afraid of aging and dying who have no one to talk to because of access issues, feelings of embarrassment or guilt, etc, and wish they could express their feelings to someone. I want to have as little anxiety about dying as possible and for me having someone to talk to will definitely help.

Bonus: Finally, I want to be mentally and emotionally with it when I pass away, comfortable in my home and the chance to say my last good byes to those closest to me.

[Reply]
I am a Christian, and to me a good death is one that reflects that I have lived a good life prior to that death. My family and I believe that life on earth is a test of the human spirit, and to have a good death, one should have made an effort to follow the moral code proposed in the bible. i.e. good will toward others etc.

The three things that are most important to me for a good death are:

1. To feel as if I lived a good life and contributed to society, helped others, and was as selfless as possible.
2. To be surrounded by friends and family and to have all of my financial and economic matters settled for their sake.
3. To feel calm, peaceful and ready to pass on.

Attached are a few pictures that I associate with a good death. I took them in a small eskimo village in alaska, and I feel that these pictures indicate that these people are very cared about by their families, and that they are at peace with God and the world.
Feedback and Evaluation

- better articles for Catholicism and Christianity
- Was not totally comfortable with the conversation, felt like it was inappropriate to discuss personal religious views in med school
- best part of the rotation
- I loved this and think it was the best lecture which really showed the great diversity of our class
- Learned the most from this session. Really impressed with my groups’ presentations. I enjoyed this session a lot.
- something different and creative in medical school, good idea
- keep this project
References/Resources

• The Good Death – A World Perspective in the Twenty – First Century
  http://www.deathreference.com/Gi-Ho/Good-Death-the.html

• End of life: the Buddhist View
  www.thelancet.com Vol 366 September 10, 2005

• End-of-life: a Catholic view
  www.thelancet.com Vol 366 September 24, 2005

• End-of-life: the traditional Christian view
  www.thelancet.com Vol 366 September 17, 2005
References/Resources

- **End-of-life: a Hindu view**
  www.thelancet.com Vol 366 August 20, 2005
- **End of life: the humanist view**
  www.thelancet.com Vol 366 October 1, 2005
- **End-of-life: the Islamic view**
  www.thelancet.com Vol 366 August 27, 2005
- **End-of-life: Jewish perspectives**
  www.thelancet.com Vol 366 September 3, 2005
References/Resources

- **Readings: Fast Facts**
  This folder contains some articles that are required reading for this course. Others are optional. These fast fact articles are available at [http://www.eperc.mcw.edu/ff_index.htm](http://www.eperc.mcw.edu/ff_index.htm).