

fects on both the parent and the child. Indeed, physicians' greatest effect on the health of children may, at times, be the result not of what they do for children, but of what they do for parents.

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DOI: 10.1056/NEJMp1611499

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Learning to Drive — Early Exposure to End-of-Life Conversations in Medical Training

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As I drove to Carol's home, I couldn't help but notice that even her location seemed terminal: it was the last exit off the freeway, at the end of a winding village road, in the bulb of a quiet cul-de-sac. This was the first of three home visits I would make to Carol, part of an assignment for my primary care clerkship in medical school. There was a task for each hour-long visit with my chronically ill patient: an in-depth medical and psychosocial history; a geriatric screen, functional assessment, and quality-of-life review; and a values history to inquire about advance care planning.

Carol lived alone in a split-level house, a fact that might not have meant much on its own. But when you considered her history of spinal fractures (due to osteoporosis) and her recurrent urinary tract infections (caused by long-term immunosuppression), the split-level design meant that when her urinary problems were at their worst, Carol had to negotiate a set of stairs several times

a night with a bad back to get from her upstairs bedroom to the bathroom. Not only did that put her at great risk for falls (she'd already had one hip replaced), but anxiety about these nightly trips robbed her of sleep.

Just by walking around Carol's home, I gained insight into her health, despite my limited clinical knowledge. As I left on the first day, I wondered how much more I would have learned from Carol had I stopped worrying about asking the "right" questions about her history. So on my next visit, I left my white coat in the car and let Carol take the lead. She showed me photos of her grandchildren, and we discovered our shared love of Chopin. But when I asked about her plans for the future, to my surprise, Carol said she knew she'd long outlived her prognosis. "I do my own studying online, too, you know," she said. I looked around the room crowded with books and photographs and the piano she could no longer play, and I wondered what it must be like to

sit in the stillness, making peace with the end that awaits us all.

I then asked Carol about death. A year earlier, I'd been too nervous to ask a standardized patient about his chief symptom, but here I was asking Carol how she envisioned the end of her life. Which is not to say that I knew what I was doing — I even struggled to read the suggested prompts off my worksheet. But by sharing her story so candidly with me, Carol seemed to have given me permission.

She revealed that she had her death all planned out, right down to the spot where her daughters would spread her ashes. "Mind you, I haven't told them all this yet," she confided. "I don't think they'd want to hear it." I asked her how much she'd be willing to go through in order to gain more time. She told me how difficult her last taper of prednisone had been. "If I had to go through something like that again just to stay alive, I don't think I would," she said. "No, in fact, I wouldn't."

Every now and then as I lis-

tened to her, I would picture myself in that chair, my own piano-playing days behind me. Would I be able to make the kinds of decisions she had made about dying? Carol taught me that regardless of what I would choose, I deserved the chance to make those decisions for myself.

I had come to her home insecure about my inexperience, believing that I would have to guide her through a difficult conversation, though I barely understood the medical options available. As

trained to handle this responsibility, as would be expected for any other billable service.

Many medical schools and residency programs now teach communication skills through role playing and objective structured clinical examinations (OSCEs), providing direct observation and feedback to trainees. During my own OSCEs, I remember earning points for every “correct” action I took, so before each encounter I rehearsed what I would say, strategizing about how to elicit

me that this skill should be emphasized earlier in medical education, before students begin feeling that they’re expected to have all the answers. The process of becoming a physician generally contributes to an identity based on expertise and competence, reinforced over years of training and specialization. Yet counseling patients near the end of life requires the humility to reject this perception and to be attentive and honest, despite our fallibility in prognostication, our fear of taking away hope, and our own insecurities about death. How can we cultivate this vulnerability appropriately in future physicians so that they can support their patients through difficult choices?

Most educational models acknowledge an attitudinal, non-technical component to teaching and learning. For instance, Bloom’s taxonomy of learning domains includes an affective (“feel”) domain, alongside the cognitive (“think”) and psychomotor (“do”) domains of education.¹ Home-visit experiences early in medical school can offer an ideal setting for such learning. When students are forced to leave the protection and familiarity of their clinical environments, they may be more likely to hear and consider the human stories that can’t be captured in progress notes and to recognize the ways in which those stories affect medical decision making. With faculty mentorship and guided self-reflection, these lessons can form the foundation for communication training in residency and beyond, when trainees have greater responsibilities.

My home visits with Carol taught me how quality of life can

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it turned out, my inexperience — and the options themselves — didn’t seem to matter that much. Instead, my job was to quell my own existential discomfort and find out what was important to Carol, to sit in the passenger seat and let her steer through this difficult terrain. As she explained her wishes, I learned that although we may not have control over the hand we’re dealt, we can determine how the cards ultimately fall, if we’re given the opportunity.

Much has been written about how advance care planning discussions are mishandled, or never initiated. Various groups are working to address this need, including the Centers for Medicare and Medicaid Services, which has begun reimbursing physicians for voluntary discussions about end-of-life planning. But such a measure requires that physicians be

as much information as possible in the time allotted. Looking back, I realize my OSCEs offered me a way to practice being the “expert” by taking charge of each encounter.

But talking to Carol was different. Because I was only a second-year medical student, Carol didn’t expect me to be an expert. In fact, there was only one expert when it came to Carol’s goals and values: Carol herself. My role was to listen to her for guidance and connect her to further resources for advance care planning, so that she could act on her wishes. In this regard, my inexperience turned out to be a strength. Instead of worrying about the right words and how to say them, I learned how to listen.

Reflective, patient-centered listening is essential to effective end-of-life communication, and my experience with Carol convinced

mean much more than quantity, how a personal connection can help you ask the tough questions, and how actively listening despite your own discomfort can empower your patient to articulate her wishes. It wasn't easy to manage my own feelings about mortality, but between visits I debriefed with my preceptor, who reassured me that these feelings were to be expected. Armed with his advice, I could return each time with renewed confidence

that I already had what it took to support Carol through this process: an open ear.

It's been 3 years since my last visit to Carol, but we still keep in touch by phone. As she continues to defy the odds, I sometimes feel guilty about the assumptions I made when I first arrived at her cul-de-sac. So often physicians' biases can prevent us from truly listening to what patients have to say, but I'm glad I had a chance to understand Carol's perspective

and see how I was misguided. After all, from her vantage point, that cul-de-sac wasn't a dead end at all — it was just the beginning of the road. Who knows where it will take her from here?

Disclosure forms provided by the author are available at NEJM.org.

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DOI: [10.1056/NEJMp1609234](https://doi.org/10.1056/NEJMp1609234)

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