Viewpoint: **Cultural Competence and the African American Experience with Health Care: The Case for Specific Content in Cross-Cultural Education**

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Abstract

Achieving cultural competence in the care of a patient who is a member of an ethnic or racial minority is a multifaceted project involving specific cultural knowledge as well as more general skills and attitude adjustments to advance cross-cultural communication in the clinical encounter. Using the important example of the African American patient, the authors examine relevant historical and cultural information as it relates to providing culturally competent health care. The authors identify key influences, including the legacy of slavery, Jim Crow discrimination, the Tuskegee syphilis study, religion's interaction with health care, the use of home remedies, distrust, racial concordance and discordance, and health literacy. The authors propose that the awareness of specific information pertaining to ethnicity and race enhances cross-cultural communication and ways to improve the cultural competence of physicians and other health care providers by providing a historical and social context for illness in another culture. Cultural education, modular in nature, can be geared to the specific populations served by groups of physicians and provider organizations. Educational methods should include both information about relevant social group history as well as some experiential component to emotively communicate particular cultural needs. The authors describe particular techniques that help bridge the cross-cultural clinical communication gaps that are created by patients' mistrust, lack of cultural understanding, differing paradigms for illness, and health illiteracy.

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There has been much interest recently in preparing physicians to care for patients from a variety of cultural and ethnic backgrounds.[1–3] Despite this interest, recent studies suggest that this area of medical education is the still most lacking.[4,5] The population seeking primary care consists of people from varying racial and ethnic backgrounds, with approximately 40% belonging to racial and ethnic minorities; by 2015, this number will likely be over 50%.[6] New Jersey is the first state to mandate cultural competence as a medical licensure requirement, but others will soon follow this trend.[7] The Institute of Medicine has stated, on a national level, that cross-cultural training should have a significant role in improving quality of care for minorities and eliminating racial and ethnic disparities.[8]

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One approach to improving the cultural competence of physicians focuses on general attitudinal and organizational shifts and the application of general methods for communicating across different cultures.[9,10] Kleinman et al[9] pioneered this approach with the use of open-ended ethnographic-type questions in cross-cultural physician–patient encounters. Others have advocated an approach to cross-cultural education based on using specific background information about patients.[11]

Although both of these approaches have definite merit, we emphasize the importance of the specific cultural and historical factors that influence the nature and outcomes of the clinical encounter. We also assert that specific knowledge of these factors is necessary for the optimal cross-cultural clinical encounter. In this article we focus on the African American experience as a paradigmatic example of minority interaction with the American health care system. The fact that physicians themselves are increasingly coming from varied ethnic backgrounds adds emphasis to the need for greater cultural education, as both patients and providers are often ethnically distinct. Twenty-five percent of physicians practicing in the United States are international medical graduates (IMGs), and many of them come from a variety of countries.[12] In New York and New Jersey, IMGs comprise 40% of the physician workforce. Clinical communication between patients and physicians necessarily crosses many different cultural contexts, and effective communication in a cross-cultural clinical encounter hinges on a physician's ability to bridge cultural divides. IMGs who were raised in other countries will not generally be familiar with American history or cultural aspects, and therefore may have some difficulty communicating with American patients. This, if anything, raises the need for cross-cultural communication education, even as American medical graduates are surely in need of it as well.

As just one example of health care disparities between African Americans and Caucasians, recent studies indicate that differences persist between these two racial groups in terms of coronary refusion therapy and coronary angiography.[13,14] Caucasian patients were more likely than African American patients to undergo the potentially lifesaving procedures such as coronary

revascularization or reperfusion. Several factors can influence such treatment differences: physician bias, patient mistrust of physicians, reluctance to undergo invasive procedures or preventive testing, fundamentalist religious beliefs, and insurance coverage and other economic influences.

The role of mistrust is one important aspect in the African American experience of medical care. African American history in the United States includes a protracted period of slavery, post-Emancipation "Jim Crow" discrimination and persecution in the South, and an extended period of socioeconomic disadvantages during ghettoization in northern cities.[15] Health care during these periods was often unavailable to African Americans, or the quality and quantity of the care was deficient. Specific medically related discrimination included hospital ward segregation, which at one time was common,[16] and the well-known U.S. Public Health Service–sponsored Tuskegee syphilis study in which informed consent was not used and indicated treatment was withheld without the patients' knowledge.[17] This event was revealed through an investigative report by the *Atlanta Constitution Journal* and was followed decades later with a presidential apology.[18] Today, the study is widely known in the African American community. The cumulative effect of many negative clinical and clinical research experiences, of which Tuskegee is only the best known, continues to foster distrust of health care providers and the health care system within the African American community.[19,20] Many African Americans today, regardless of socioeconomic status, still carry lingering mistrust as the result of this legacy of mistreatment and lack of informed consent.

The historical and cultural legacy of discrimination against African Americans influences their socioeconomic status and affects their health care interactions and clinical outcomes. African Americans receive disparate care for a number of conditions, including cardiac care,[21,22] and most caregivers are oblivious to such disparate care differences.[23] In addition to the discrimination that is prominent in African American history, certain aspects of the African American cultural historical experience are unique to this particular group. Understanding these cultural aspects is necessary in achieving the optimal cross-cultural clinical encounter between an African American patient and a physician from a different racial or ethnic background.

Religion and African Americans

Many African Americans have either a religious orientation or a viewpoint grounded in African American social and cultural history, which may emphasize a holistic approach to health and health care.[24] Religion is a source of enormous emotional support for African Americans, and religious observance or religiosity can, in many regards, correlate with improved health outcomes.[25]

Religious and medical perspectives are, of course, different and could come into conflict, though in general they need not be contradictory. Furthermore, religious belief and practices may vary widely among individuals, even within the same religion or specific denomination. Although most, if not all, religious denominations have memberships that span the racial spectrum, the African American religious experience brings a particular intensity borne of the powerful role that Christian churches played in the African American communities during and after slavery, as well as in the civil rights movement.[26] The church became the source of salvation for both body and soul when often there was no other institution available.[27]

Within the African American community, several distinctive groups of churches can be identified,[28,29] including mainstream Baptist or Methodist churches, messianic or nationalistic churches, conversionist (e.g., Pentecostal) churches, and "spiritual" churches that emphasize magical contact with the spirit world to improve physical as well as spiritual states.[29] As a prominent component of African American history and culture, religion has a strong role in establishing African Americans' health care attitudes and practices. The spiritual churches also relate to African American faith healers who provide consultations in individual as well as group settings as an alternative to mainstream health care.[30] The mainstream churches are less likely to encourage a fundamentalist religious belief. For African American women, faith-based institutions provide a social context whereby a new awareness of health promotion can be possible.[31,32]

In addition to Christianity, Islam has had an impact on African American history and culture. It is estimated that 10% to 20% of the slaves brought over from Africa were Muslims, and Islam has had a growing presence in the African American community since the 1960s.[33] Individuals who embrace the Islamic faith are likely to define a good physician as one who addresses issues of faith and spirituality as well as biological needs. It is reasonable to expect that African American Islamic patients expect some of these broader issues of faith and belief—not merely biological issues—to be addressed in the clinical encounter.[34] If these issues are not addressed or acknowledged by the clinician, the result can be the patient's mistrust of the physician and noncompliance in the medical regimen. In our opinion, this is likely to be true for patients of other religions as well.

A scientific medical approach does not preclude a religious perspective, but it does qualify the domain of religion to some extent with regard to some health care matters. Many health care providers as well as many hospitals have an overtly religious perspective or mission, yet they deliver evidence-based medical care. In general, it should not be difficult for physicians and other care providers to show courtesy to patients' religious beliefs without compromising evidence-based health care. In rare circumstances of extreme belief, there may be direct conflict between evidence-based medicine (EBM) and religious belief, and this should be approached with tact as well as community resources.

Many African Americans have a deep sense of spirituality, and this spiritualism is intertwined with other aspects of their lives, including health.[29,30] Traditional African American folk beliefs concerning health and illness focus on herbal remedies and magical aspects of illnesses that invoke spiritual components, including hexes, roots, and divine displeasure of people or their offspring.[35] The humoral theory of illness that dates back to antiquity and was codified by Galen found its way to the Americas and persists in Hispanic folk medicine

culture.[36] It also entered the African American health practices of the antebellum South.[37] In this spiritual–magical schema, the allopathic physician may have been viewed as inferior to an evangelist or spiritualist "gifted in the healing arts."[37,38] These beliefs and practices were strongest in the South but made their way to northern cities, including Philadelphia.[39,40] This phenomenon is analogous with the burgeoning complementary medicine movement in the general population in recent decades.[41,42] The urge to have a theurgical or magicoreligious cure to illness perennially supersedes the emotionally colder approach that scientific medical practice tends to entail.

However, a fundamentalist religious belief that God will cure illness without medical treatment is associated with a greater than fourfold increased likelihood of presentation with late stage of breast cancer among breast cancer patients.[43,44] Similarly, the belief that "roots or spells" will cause or cure cancer has a fivefold increase in the likelihood of a patient presenting with an advanced stage of cancer.[43] This study found that African American patients are more likely to have such a perspective. Another study showed that African American women who believed in God as a controlling agent over health were less likely to obtain mammography and clinical breast examination.[44] These particular aspects of religiosity can complicate health care by delaying appropriate interventions and may contribute to presentation at a late stage of disease.

African American women were also more likely than Caucasian women to consider breast self-examination an effective form of early detection of breast cancer; however, self-examination is insufficient in this role because mammography and physician examination are required for appropriate screening.[45] Such an information gap must be closed if clinical outcomes are to improve.

Religious beliefs and practices can affect patients' attitudes toward health care in a number of ways. On one hand, patients' spiritual and religious participation tends to correlate with better blood pressure control in some studies of African Americans.[46] Conversely, patients with folk beliefs that "high-pertension" (as some of those surveyed referred to the condition) is causally related to stress and a negative emotional state were less likely to comply with a regimen of antihypertensives among African American outpatients in New Orleans.[47] The president of the National Medical Association when this article was written, Sandra Lynn Gadson, MD, a nephrologist, related that in one case she needed a court order to dialyze a patient with kidney failure, who was being confined by an alternative "minister" practicing faith healing.[48] Dr. Gadson, herself an African American, noted that her own spirituality was a powerful influence in her own life, yet it was compatible with biomedical practice. Clearly, religious beliefs can vary greatly, and some improve health practices whereas others may delay important medical interventions.

At times, belief in God may be accompanied by a reduction in medication compliance. For example, Polzer and Miles[49] found that strong spirituality in African American diabetic patients was correlated with self-management of the disease and greater noncompliance with a diabetic regimen. Religious beliefs may at different times exert differing effects, positive or negative, on the delivery of effective health care. The challenge in realizing improved health outcomes among African Americans is to maximize the positive influence of faith while minimizing the negative influence.

Delay in diagnosis of breast cancer is an example of correlation between religiosity and an increased probability of late diagnosis. A "true believer" who is awaiting divine intervention may have a worse outcome than a patient who seeks allopathic medical attention at the first signs of disease. Clinicians must be attuned to this possibility and recommend an approach that permits faith to support the patient without impeding evidence-based evaluation and treatment. Physicians can explain to their patients who adhere to African American religious and cultural traditions that faith can be compatible with timely medical interventions. Physicians can refer to the many examples wherein faith and medical approaches are pursued concurrently, such as by the many faith-based medical institutions, as well as by medical practitioners like Dr. Gadson, the president of the National Medical Association, and many other clinicians who embrace religious faith while practicing EBM. Physicians who express respect for patients' religious beliefs while providing the latest in EBM are likely to be most positively received in cross-cultural clinical encounters. In one author's (ARE) practice, a rare, previously invariably fatal infection (cryptococcemia) was effectively treated when the patient's faith group was permitted to pray at the bedside and the latest medical management was applied.[50] This act of respect and acknowledgement of the religious and cultural beliefs of the patient facilitated the cooperation that was necessary for the application of the complicated and difficult medical technology that the patient required. One cannot state that the praying at the bedside altered the clinical outcome, but it did improve mutual respect and communication between the physician and the patient, and it may have improved the patient's frame of mind. Physicians can also demonstrate respect of their patients' cultural and religious needs by permitting them to discuss treatment options with their clergy and family before making decisions about treatment.

Home or Natural Remedies

Home or natural remedies are commonly known and are used by African Americans, particularly among the elderly. Turning to an herbalist for remedies is a part of the African American cultural history dating back to the time of slavery, and in Africa before slavery.[51] Indeed, it is difficult to separate African herbal medicinal usage from African religions, including those of Igbo, Yoruba, and other traditions.[52] African Americans were often deprived of standard medical treatments during slavery and for some time thereafter. As a result, a common practice in the past among African Americans was to try the home herbal remedies before accessing medical institutions that were often inhospitable or, in many instances, unavailable. For example, an ailing person may have tried Epsom salt ingestion and apple vinegar for a cathartic effect to "cleanse" the body of illness. Root or faith healing is a tradition dating back to African origins that was nurtured during slavery and has endured

to current times. It is not uncommon that an African American today has tried a home remedy before seeking medical treatment. Traditionally, the family matriarch was the source of knowledge of roots and home remedies, and this knowledge was considered part of domestic expertise and was passed down from the matriarch to her daughters.[53] One study reveals that elderly African Americans with osteoarthritis are more likely than elderly Caucasian patients to perceive that traditional remedies are efficacious and are less likely to seek joint-replacement therapy.[54]

One author (GE) was the proprietor of a health food and herbal store located near the hospital of the University of Pennsylvania during the 1990s. It was his personal experience that African American patients routinely went to the store directly from a physician's office or clinic to seek an herbal remedy alternative to the physician's prescribed treatment. Often, the patients would not inform the physician that they were taking the herbal remedy instead of or in addition to the prescribed medication. A clinical study in North Carolina found that African Americans and American Indians were 81% and 76%, respectively, more likely to use food home remedies than Caucasian study participants.[55]

Health care providers, physicians, and others need to understand the role of home remedies in the social history of African Americans and how that role influences the current context of a clinical counter today. If the providers show some understanding and respect for these traditions, even without endorsing them, it can help in caring for African Americans by gaining their respect and trust. Minority groups' skepticism about evidence-based medicine can be bridged by creating trusting relationships grounded in physicians' understanding of particular aspects of the minority culture.

Distrust and Race

We note that distrust of institutions and authority figures is rooted in the African American history of racial discrimination, including slavery, post-Emancipation persecution, and persistent racial discrimination.[56] Boulware et al[57] have demonstrated that African Americans were less likely to trust their physicians and hospitals than Caucasians were. The Tuskegee syphilis study is frequently cited for this distrust and undoubtedly contributes to it, as do more recent instances of racial bias in health care.[19,20] Distrust itself contributes to racial disparity in health outcomes. Trust in a physician has been shown to increase the likelihood of compliance with a medical regimen, despite cost pressures and other influences.[58,59] Patients with lower levels of trust were less likely to comply with a medical regimen for diabetes.[60] Furthermore, the quality of patient–physician communication may be lower when Caucasian physicians treat African American patients. According to Johnson et al,[61] physicians were more verbally dominant and less engaged in patient-centered communications when dealing with African Americans. In another study, African Americans were less trusting of Caucasians regarding medical research participation.[62] This distrust of medical intervention, illustrated by African Americans' unease with cross-cultural physician–patient communication and medical research participation, also applies to invasive but effective clinical practices. African American veterans were significantly less likely to accept a recommendation for carotid endarterectomy in VA system hospitals.[63] In this study, African American patients were more likely to express a high aversion to such an intervention and fewer African American patients received the intervention, though all patients had a carotid stenosis of at least 50%.

Within the African American community, a patient's distrust of institutions and physicians may act synergistically with fundamentalist religious beliefs to cause him or her to delay seeking medical treatments in favor of trying faith healing or herbal remedies first. Clearly, there exists an opportunity for African American religious and community leaders to affirm to their community members the value of evidence-based medical care and its concordance with religious beliefs. Although there may be some religious beliefs that are incompatible with evidenced-based medical practice, most are not. We suggest in this regard the perspective that "God helps those who help themselves to preventive care and timely medical intervention," though we recognize that all religious leaders may not agree with this proposition.

Distrust of physicians occurs among Caucasians and African Americans as well as other ethnic groups. Surveys reveal a somewhat higher rate of distrust of physicians among African Americans.[64] Physicians can mediate racial differences by showing emotional support for their patients and involving other health care providers (nurses, social workers, therapists, dietitians) of various ethnicities in the patient's care. Respectful, emotionally supportive dialogue can help overcome racial barriers.

Racial Concordance

African American patients rated their encounters with physicians more rewarding and participatory when the physician was also African American. However, only 22% of respondents expressed a preference for an African American physician, but those who did were more likely to express satisfaction with a racially concordant physician.[65] The Commonwealth Fund's Health Care Quality Survey found that African Americans were more likely to rate their physicians as excellent if the physician was also African American.[66] Racially discordant clinical dyads were found to be less likely to engage in a participatory communication process.[61] It is unlikely in the foreseeable future that most minority patients will be treated by racially concordant physicians, given the differing patient and physician demographics. African American physicians account for less than 4% of the medical profession, whereas African Americans account for approximately 13% of the population,[67] so the majority of African Americans will see non-African American physicians. The ability to cross cultural and ethnic divides is an essential component of the 21st-century physicians' "toolkit." Moreover, today physicians themselves come from diverse ethnic backgrounds, making cross-cultural clinical dialogue inevitable, and all physicians should work to improve their cultural competence.

Bridging the Gulf

Cultural competence in the clinical setting indicates that the physician is sensitive to the individual patient's needs and establishes rapport across ethnic differences. Establishing interpersonal rapport with a patient by identifying and relating to his or her personal humanity

has been described in the context of narrative ethics.[68,69] Physicians needs to comprehend the "patient's story," not merely detect the disease and treat it. Such a more narrative approach can also help bridge cultural differences and improve clinical communications in general.

Demonstrating humility and mutual concern can also be effective in this regard, although the former is not a common physician characteristic. Bridging the cultural gap requires the non–African American physician to reach out to the African American patient to establish an individual rapport that transcends historical distrust of medical institutions. The physician can establish such a rapport by making an effort to observe, learn, and practice the techniques of cross-cultural communication. For example, although it may be necessary, referring to insurance coverage does not build trust between the physician and the patient. When possible, it is preferable for the physician to leave this aspect of interaction to his or her support staff to avoid the appearance that self-interest is guiding the physician–patient interactions. A patient's perception of a physician's self-interest can also be one of the causes for mistrust.

List 1 summarizes techniques we suggest in this article for bridging the gulf in cross-cultural clinical communication.

Health Illiteracy

The prohibition against educating African American slaves has seriously impacted on the long-term literacy of certain components of the African American population.[24] Health illiteracy is a common hindrance to optimal health care and is more frequent in lower socioeconomic groups.[70] Among ethnically and racial diverse patients, 43% report difficulty understanding information in the clinical encounter. Among patient with chronic illness, three quarters have limited literacy. Low literacy in diabetic patients was associated with worse glycemic control and increased rates of retinopathy and blindness.

One of the authors (ARE) was part of an Agency for Healthcare Research and Quality–sponsored research collaboration that developed and evaluated a multimedia computer program for diabetes education in low-literacy minority populations.[71] This program was developed with the concept that racial and ethnic concordance enhance communication of information. The study demonstrated that the program increased perceived awareness of susceptibility to diabetic complications, especially among those with low literacy. Other studies reveal that health illiteracy increases medical costs and reduced efficiency of services.[72] Thus, improving health literacy can conceivably improve outcomes and reduce costs if it is culturally sensitive.

Certified health educators are infrequently African American (10%) and only a minority (34%) of health educators are community based.[73] Hence, there are relatively few African American health educators to provide racially concordant health education. Health educators can educate patients about self-care, communicate with health care providers, and advocate for patients with reduced health literacy.[74] Federal funding of community-based ethnically similar health educators may be efficacious and cost-effective if it is shown to improve compliance and avoid late-stage disease.

Cultural Competence of Health Care Providers and Cross-Cultural Education

Betancourt[75] delineated a useful framework of cross-cultural medical education that noted three approaches to or components of such education: promoting awareness of attitudes, including self-reflection; knowledge of cultural issues; and developing the ethnographic skills in a clinical setting to understand the cultural context of illness for a given patient.

Lavizzo-Mourey and Mackenzie[76] have recommended including cultural sensitivity and knowledge of differences

List 1

Cultural Competence and the Care of the African American Patient: Practical Suggestions and Applications

Ethnic social history	Racial con/ discordance	Home remedies	Health illiteracy	Religion
• Learning about African American history (slavery, reconstruction, Tuskegee study instance of human experimentation without consent, discrimination in 20th century in hospital settings, current racial disparities in health services)	• Greet respectfully through body language, choice of language, and personal greeting	• Be aware that home remedies may be used in addition to prescribed treatments or prior to seeking medical treatment	• Communicate in simple, direct language; write down and diagram if possible	• Delineate the boundaries between evidence-based medical treatment and fundamentalist beliefs and explain outcome differences as appropriate
• An experiential component through theatrical performances and/or simulation workshops is recommended	• Avoid inappropriate familiarity but encourage friendly discourse and be cognizant of and acknowledge the patient's emotions in clinical encounters	• Avoid disparaging comments regarding alternative medication; calmly inform patient that some home remedies may be harmful and provide specific risks when known	• Use others (nurses, health educators, etc.) to better communicate in the vernacular that is familiar to a patient of a particular ethnicity	• Show respect for religious beliefs, permitting observation of religious practice, even in the hospital as the setting permits
				• Encourage patients to engage clergy in a supportive role

among subpopulations in medication response as a part of medical quality. We hold that cultural competence encompasses a variety of different competencies, some knowledge based and others more rooted in communication styles based on cultural awareness.

Some, out of concern that it might lead to stereotyping, have discouraged the knowledge approach to cultural competence training.[77] Others have argued that cultural humility is superior to cultural competence because the latter suggests the "detached mastery of a . . . finite body of knowledge."[78]

We contend that ignorance is not bliss and that cultural and even historical knowledge is needed to inform physicians' sensitivity and permit an ethnographic approach to cross-cultural communication. More specifically, physicians, nurses, and other health care providers need to be better informed regarding the history, sociology, and cultural–religious aspects of minority patients, including African Americans. Cultural competence requires learning specific information, including the role of religion in health-related decision making and effects of historical racism that may render an African American patient reluctant to seek needed medical care. Self-reflection regarding personal, institutional, internalized, and subtle forms of bias is an important part of cultural competence in general. Cultural competence training requires both general attitudinal approaches as well as specific advice based on cultural aspects of minority life.

Such cultural competence education should be modular and tailored for the ethnic and racial minorities that are present in the community served by specific health care providers. Individualized cultural information and awareness can be taught in the settings of graduate and undergraduate medical education, as well as continuing medical education (CME) as states are beginning to add CME to the regulatory mandate. Computer-based cultural competency education can be useful and can include video streaming, but should be in addition to live interactive workshops.

An experiential component of cultural competence education is important inasmuch as didactic material is inadequate in communicating the emotive content of some historical and cultural information, events, attitudes, and values. Works of cultural and historical context from the world of performing arts, such as Joan Myers Brown's Philadanco dance company performing Tally Beaty's "Southern Landscape," which depicts the brutal repercussions of Reconstruction events involving African Americans [79] are capable of communicating viscerally across differing cultures. Such cultural works, if recorded and replayed for physicians-in-training, could help provide an experiential component of cultural histories of African American populations and provide such trainees with greater cultural awareness.

Experiential workshops using actors can have a strong emotional as well as cognitive impact on physicians-in-training. For example, one author (GE) participated in a workshop demonstrating ethnic issues in medical ethics consultation.[80] In such workshops, individuals simulate clinical ethics consultation and elicit interaction that includes cross-cultural dialogue. Seminar participants receive observer feedback on their interaction. This type of experiential education could become a standard part of undergraduate and graduate medical education.

Accepting the Challenge

The challenge of achieving culturally competent medical care in a multicultural society requires several different skill sets. Specific knowledge of minority communities' culture and history is crucial to the cross-cultural clinical encounter. The authors have pointed out some of the key features of that knowledge with regard to the literature on African Americans' interaction with health care. Belief systems, especially religious ones, have a unique and complex relationship to health care. This needs to be taken into consideration for all patients, but especially for minorities. Health literacy is a crucial aspect of being an informed consumer of health care, and providers also need to be aware that there are barriers to this. We recommend that cultural and historical information for different ethnic minority groups be compiled and that physicians and physicians-in-training have both experiential and informational training on the appropriate cultures and ethnic groups that characterize their patients. These methods need to be further evaluated by methodologically vigorous studies. It is reasonable to expect that efforts in this regard will, at least in part, reduce disparities in health outcomes.[81]

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Teaching and Learning Moments

Death, Quietly?

"Do you think about dying?"

Perched beside his hospital bed, she placed her hand firmly on his wilted shoulder, a gesture that caused the young man to peer up at her with his wide, fragile eyes. She had said that word—*the* word; it was for just that reason that she'd been invited into the room.

"Yes, I think I'm scared to die."

She continued to sit beside him, feeling increasingly awkward in the confines of the small room, although she knew that the best thing she could do was to silence her own discomfort and pay several moments of quiet respect to the young man's humble response. They sat looking at each other, each knowing the weight of those words, and then she pushed a little further.

"What are you hoping for?"

He cast his eyes downward, the fright sweeping across his face, tears welling in his eyes. Her hand squeezed his shoulder and they sat together, he crying, she trying not to. Nevertheless, it was apparent in his repeated attempts to catch his breath and answer her question that he wanted to talk about it. Before he could, the voice of his father broke the silence.

"Doc, you need to stop—now," he interjected, filling the small room with the kind of uncomfortable tension that everyone had tried to avoid.

In my three years of medical school, this was the first time I had ever been included in a discussion about death, and I now understood the reasons why medical students are routinely left out of sensitive family meetings (too private, too emotional, too intense). Instead, we are assigned to follow healthier patients. We receive little training in breaking bad news, and, even when we do witness death, there is rarely the opportunity to discuss it. The topic of death often sits quietly at the periphery of the medical school curricula.

The following day, the physician, who had permitted me to witness the tense meeting with the young patient and his family, pulled me aside. She explained that she'd gone back the previous night to visit with the young man and his family once they had time to calm down. She admitted how awkward she'd felt as she reentered his room, but also how surprised she was when his family ultimately thanked her.

"You could see it—with everything out on the table, there was this 'Ah, what a relief, now we can talk about the important things' kind of feeling."

Interestingly, as uncomfortable as I had felt in the moments after the outburst by the patient's father, once the physician and I debriefed about the experience, I slowly felt that raw feeling in my stomach beginning to recede. By introducing me head-on to the emotionally charged world of death, my teacher had paradoxically quieted some of my fears.

For all the charged emotion that had initially coursed through the cramped hospital room (perhaps *because* of all of the emotion), in the end, the young man, his family, and his physician had *not* allowed the words of death to stand silently at the periphery, to go unspoken. Having then said the important things, having talked about his hopes and his priorities, death finally arrived.

In the wake of this patient encounter, I remain grateful to my teacher for allowing me to gain knowledge through this highly personal and sensitive experience. However, it was a rare opportunity. I desperately believe that we must try to take more time to include medical students in the dealings of death.

When the time comes for me to finally speak with my first dying patient, even with this experience in mind, I may falter. Perhaps that is the nature of a process that is so final—there is no room for rehearsal. But at least by allowing medical students to hear the words and see the emotions, it will mean that as future doctors we will have the confidence and compassion to address the issues surrounding a patient's impending death.

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All identifying names and events have been changed or removed.

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