

Personal practice

Educating medical students about death and dying

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Doctors in every branch of medicine must from time to time deal with patients who are dying or who have life threatening illnesses. Many young doctors avoid facing their own feelings about death, finding them stressful.¹ When patients die we are perhaps reminded of the certainty of our own deaths.

In 1915 Freud² wrote: 'Our own death is indeed unimaginable . . . at bottom no-one believes in his own death, or to put the same thing in another way, in the unconscious everyone of us is convinced of his own immortality'. An inability to acknowledge death in a personal sense may account in part for our difficulty in approaching the subject³ and everybody has some degree of anxiety about death.⁴ This comes in part from the irreversibility of death, and in part from the impossibility of that experience being conveyed to others.⁵

We live in a society that rejects death, and doctors may have a greater need than others to do so.⁶ Some authors suggest that doctors may compensate for their unconscious personal fear of illness and death by using distancing tactics⁷ and other mechanisms in attempts to protect themselves through a process of mastery by becoming doctors.⁸

In medical training it is necessary for medical students to develop technical skills necessary to deal efficiently with illness. During this period, however, and without appropriate training and acknowledgment of the feelings elicited by medical work, it is likely that responses harmful to both doctor and patients will develop. Werner and Korsch⁹ describe this process and show how spending time with a supportive group can help medical students become aware of the ways in which their own reactions can interfere with the effective treatment of patients.

It has been shown, however, that first year medical students did not differ from non-medical students in their attitudes towards death before they had direct clinical experience with dying patients.¹⁰ Later on in their clinical studies medical students became more preoccupied with thoughts about their own deaths and the possible physical pain of dying, as well as about the breaking up of relationships as a

result of someone else's death.¹¹ Death and some of the processes of dying may contradict the doctor's concept of his professional purpose,³ and the death of a patient may be viewed as professional failure and generate guilt.¹²

Though in the past doctors tended to avoid breaking bad news to patients and their families, nowadays it is generally accepted that truthful information should be shared with them.^{13–16} When children are concerned doctors are particularly ill prepared. For example Stein *et al* found that families in which there was a child with a life threatening illness remembered vividly the manner in which the diagnosis was imparted, and only about half the parents interviewed were satisfied with the way they had been told (Stein A, Woolley H, Forrest G, Baum JD. Imparting the diagnosis of life threatening illness. Paper presented at British Paediatric Association, York 1988).

Although doctors cannot prepare themselves for all possible circumstances that might arise regarding death and dying, some sort of preparation is necessary before a consultation with the family of a dying patient. A review of the cumulative Index Medicus heading 'Death' from 1960 to 1971 showed not one article about the teaching of medical students about death and dying.⁶ Barton was one of the first authors to report his experience of working with groups of students on this issue.³ He met groups of six to 10 students for one to two hours, and tried to focus their attention on death and dying and to examine and rationalise their personal feelings and attitudes towards the psychological and sociocultural issues that are an integral part of the care of patients with life threatening illnesses. In 1973, Liston reported that since the late 1960s about half the medical schools in the United States had included some formal teaching on death and dying in the curriculum,¹⁷ and by 1980, 104 out of 114 (92%) medical schools in the United States had courses about death and dying.¹⁸ In England in 1983 only four of 62 medical schools reported the absence of a programme for medical students on death and

dying,¹⁹ but often these were only an hour in a five year course.

A consensus had therefore been reached that medical students required education about the way to approach the dying patient and his family, and instruction on coping with these difficult issues. There is, however, no general agreement about the timing or the form of this education. Here we report on two different courses run by the authors for medical students in their clinical years—one in their child psychiatry, and the other in their medical attachment.

The child and death

At the Royal Free Hospital medical students have one seminar in their preclinical psychology course on the psychology of grief, which includes the processes of normal grief and pathological grief reactions. One of us (DB) introduced (in 1985) a seminar on death and dying in the child psychiatry teaching which takes place during the paediatric attachment. This arose because of a special interest she had in the effect of loss by death on children and families.^{20 21} The hospital chaplain gives six hours teaching on the ethical aspects of death and dying to clinical students on their obstetric and gynaecology, and general practice attachments.²²

The one and a half hour seminar in paediatrics and child psychiatry can therefore concentrate on children, giving the students an experience of breaking bad news to parents and child by playing the parts. It also covers the developmental aspects of grief and mourning in children and adolescents²³⁻²⁵ and touches on the effects on a child when a parent dies.²⁶

The students are given the hospital's guidance booklet for staff on the *Care of the dying patient*.²⁷ Using techniques adapted from the teaching of family therapy, the tutor gives most of the 12 students in the seminar group the opportunity to experience the difficulties and frustrations of the doctor, or the pain and anger of the parents, by playing the parts.

Although students are initially resistant to exposing themselves to their peers in simulated doctor parts, if each one has only a short turn and is replaced by another, the various ways of approaching the task can be explored and discussed. The agony for each student is short but it enables each one to have an experience that seems to be important, and it reduces defensiveness. The evaluation from the students is positive.

Dying patients and their families

While she was a senior registrar at the Whittington

Hospital, JN, together with a psychiatric registrar and social worker, organised seminars for first year clinical medical students from University College Hospital on how to talk with dying patients and their families. Their only formal teaching on this subject is two talks of one hour each during the introductory course and before their preclinical attachments.

We offered this because the one and a half hours allocated to the teaching of interviewing skills was not adequate to cover this topic, and because the students expressed concern at the lack of teaching about death and dying: their theoretical knowledge helped little when talking to 'real' patients, and they felt overwhelmed by their own feelings when trying to talk about dying with patients and their families. Our aim then was to help medical students develop skills for dealing with dying patients and their families.

After discussion between the Dean of the medical school and the consultant child psychiatrists, a group of 20 third year students was offered an optional extra three hour teaching session led by two teachers. Preparatory meetings usually resulted in personal and professional bereavements being discussed; it was thought that this was likely to happen with the students too, and extra time was allowed for this. Little theory was offered but a leaflet, reading list, and two articles were given out at the end.^{10 28}

In the introduction, normal grieving was described and students asked to describe their own experiences since being on the ward. They talked readily about the discomfort and anxiety they felt, and drew up a list of distancing tactics,⁷ together with their thoughts about why they might be used. They were asked how they would like to talk to patients and their families. What factors would they want to take into account and what would they not want to do?

In the first section, the students played the part of a doctor telling a patient about her terminal illness. They were told 'she has six months to live' as, without that, discussion of the patient's imminent death could easily be avoided. The encounter was recorded on video tape and reviewed together after 10 minutes. Distancing tactics immediately became apparent and were discussed in the review. The students were often shocked by their emotional responses and were also able to get some idea of a patient's reaction to what they had said. Reviews of each session were necessary to avoid any student being left in the uncomfortable part of a dying patient.

The next section began with a talk on family reactions to loss and the mechanisms used to avoid facing the death—ones that doctors may easily and

unwittingly use themselves.²⁹ A short 'play' in which everyone took part was performed, in which a family was visited in turn by a general practitioner, a vicar, a neighbour, and a relative after a sudden recent bereavement. The students were able to see how families rearrange themselves and roles change quickly to fill the gap left by the dead person.³⁰ Older children take on the part of a parent if an adult dies, and younger children are often ignored. Students found this approach powerful, and it often led to discussion of personal losses and unresolved grief. In the reviews of the sessions their own responses and personal experiences were shared, and the application of such sessions to their clinical work was discussed.

Responses by students

Attendance at the seminars was voluntary; the group was therefore self selected and the number variable. Almost 100 students attended over two years, the ratio of women to men being 5:1. Those who attended and filled in evaluation forms found it helpful and requested more. Typical responses were: 'Though terrifying, the role-play helped me to see a bit of what it felt like to be a patient.' 'I never realised how little a patient could take in of what I was saying.' 'It will make it easier to talk to patients about what they are feeling.'

Such experiences are not yet recognised as being necessary in the training of medical students and the courses stopped when JN moved to another post. If formally integrated into the teaching, it would be possible to measure its effects accurately, and find out whether those medical students with more training in this area experience less stress when they become junior doctors.¹

The value of a single teaching session is bound to be limited and it was frustrating for the teachers not to be able to see the students again. A regular series of meetings might have been more helpful so that individual patients could be discussed in detail and an attempt made to integrate the social, psychological, and medical aspects of death and dying.

Discussion

In the early 1970s most of the courses on death and dying were given in the preclinical years,¹² and the preferred time to approach the subject was during courses in anatomy and pathology,³ thus preparing students for the clinical years when they would meet patients with terminal illnesses. Linn *et al* suggested that because there was no difference in students' attitudes towards death and dying in preclinical and clinical years it would be more appropriate for these

special subjects to be taught during the clinical years when the students actually experienced circumstances of death and dying.⁴ As with the teaching of physical examination (which is done in small groups with self examination before the actual examination of patients) Liston recommended that students should not first learn about death and dying during bedside teaching.⁶ Both formal lectures given by experts from different disciplines and small group discussions are needed for a comprehensive approach.³¹

From our experience in working with students on this subject we would like to recommend that each course should have the following objectives:

- To identify the dying patient's needs and wishes
- To understand the family's needs
- To recognise the phases of normal grief and mourning
- To be aware of cultural and religious aspects with regard to death and the roles of other people, such as chaplains, in caring for the person and the family
- To clear away the barriers that have been erected around the subject
- To make the student appreciate his or her own death, thus contributing to his or her emotional development
- To appreciate the need to relieve the physical and emotional distress of the dying patient^{32 33}
- To consider ethical issues such as euthanasia, abortion, organ transplantation, and so on.

Different educational methods could be used in these courses, including formal lectures, discussions, interviews with patients, video tape illustrations of particular events, actors simulating patients and family members, students playing different parts,³⁴ and students being assigned to a dying patient and his family until the death and for some time during the period of bereavement.³⁵

We suggest that the best time to offer such a course is in the clinical years when students have had some experience of clinical work. We recommend that no course be less than six hours and that teachers may come from any discipline but share an ability to communicate the skills of a clinician in reaching out to families in distress.

Conclusion

There is no one way leading to death, and there is no one way of teaching students how to approach the issues of death and dying. The removal of the taboos about death, however, and the development of a structured comprehensive educational programme for medical students on terminal care, death, and

dying in different stages of their studies, will improve the future physicians' skills in handling delicate and sensitive moments in their patients' lives.

There is still a danger that our medical training is teaching us that our tools are more important than we are.³⁶ By encouraging the acquisition of technical skills and factual knowledge but undervaluing our human reactions to the people we meet, medicine can become a dehumanising process³⁷ rather than one in which our human qualities can be used in conjunction with our technical knowledge to offer patients and their families a complete rather than a compartmentalised treatment.

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