



Into the darkness: medical student essays on first experiences of the dying patient

Hamish Wilson MBChB, MGP, FRNZCGP;^{1,3} Alexa Gilbert-Obrart C.Psychol, AFBPsS (UK), MAPS (Aust)²

¹Department of General Practice and Rural Health, Otago Medical School, Dunedin, New Zealand.

²Sydney, Australia; London, UK.

³Corresponding author. Email: Hamish.wilson@otago.ac.nz

As doctors, we often remember our first patient death; that particular moment when we realised that patients under our care can die. Those painful formative interactions with a dying patient are often etched in our memories.

While I knew cognitively that people didn't live forever, their deaths felt at odds with my prior expectations of being an effective healer. My first experience involved a male patient who presented with haemoptosis. When I clerked him into the ward, I discovered he had aortic incompetence. Although I had documented this as a still-unquantified anaesthetic risk, he was transferred to theatre for a bronchoscopy. I was standing at the patient's side during the procedure and found myself taking his pulse, intuitively worried something terrible was about to happen. He then arrested on the table and had major cerebral damage from which he never woke up. It took me years to understand just what had happened or why I was so upset about his death. (HW)

This issue of the Journal will publish two essays by Auckland University medical students, Rebecca Gandhi and Thomas Swinburn, about their first experiences of dying patients. These essays were submitted to the biannual writing competition of the Balint Society of Australia and New Zealand (BSANZ).¹ In 2021, there were 45 entries by students from a wide range of medical schools.

After initial sorting, the better essays were assessed in depth by a panel of international reviewers. Remarkably this year, 8 of the top 10 essays were about students' initial experiences and observations of patients who were dying. Many reviewers commented on this predominance. Student narratives

about the dying patient have already been described as 'painful and raw'² but what set these essays apart from other entries, and why had they engaged the reviewers so acutely?

There is now considerable research on the reactions and responses of medical students to the dying patient. Briefly, many students start their training with somewhat naïve expectations about the efficacy of medicine, beliefs that may be reinforced by cure-orientated pre-clinical curricula³ and if there is insufficient emphasis on or training in palliative care.⁴ Initially, students identify more with patients than with practicing doctors, and when they first enter the clinical phase of training, it can be profoundly shocking to get to know a patient who then dies.⁵

Just as illness can 'wreck' one's life story,⁶ such deeply disturbing experiences have been described as 'narrative wreckage' of a student's presupposed journey in training.² Scholars of narrative suggest that telling stories can help repair such damage^{7,8} through group discussion or reflective writing. As Shapiro suggests:

*'Storytelling serves as a method for healing students' initial sense of dislocation and purposelessness... through their stories, students begin the long process of reconciling their disillusionment with hope in and renewal of their vision of themselves as physicians.'*⁹

Medical training largely focuses on helping students develop their professional identities as 'technically skillful' and 'medically knowledgeable' practitioners. There is less pedagogical space devoted to helping them become 'caring and compassionate'.¹⁰ So unless there are superb role models who can

J PRIM HEALTH CARE
2021;13(4):293–301.
doi:10.1071/HC19568
Published 23 December 2021

demonstrate how to engage with a dying person,¹¹ it is challenging for students to learn how 'to be in the room' and to interact with those patients, especially if they or others around them have some degree of death anxiety.^{12,13}

The essays that follow are evidence of the initial apprehension and ambivalence of two medical students as they attempt to engage their own humanity in service of their patient.¹⁴ If attending doctors are perceived to be distant or uncaring,¹⁵ students can also experience 'moral distress'; their observations of clinical practice feel at odds with their own moral sense of what is right or what should be done.¹⁶

As we read these essays then, perhaps we are reminded of our own dissonance and discomfort when we first struggled with the contradictory tensions of clinical objectivity versus deeper engagement in relation to people who were suffering. Exposure to many thousands of patients over the years may fine-tune those tensions but arguably modern medical education also has a responsibility to nurture more deliberately the capacity of young doctors for empathy and compassion.¹⁷

Reflective practice in all its varied forms – discussion groups, audio-diaries, parallel charts, Balint groups, reflective writing¹⁸ – can contribute to self-awareness and emotional intelligence, as they focus on the interactions between student and doctor. These activities also focus less on medical details or content than on the process of clinical practice; how events unfolded and how the institutional context influences the outcomes.

Narrative reflective practice helps students to review and use their learning experiences thoughtfully,¹⁹ especially with respect to their own ideas about becoming a doctor. Reflecting on end-of-life care is particularly relevant, as those experiences can remind students of their own mortality and what sort of doctor they want to be. In New Zealand, medical students are encouraged to understand their patients' wellbeing through a *tea o Māori* lens that includes *Te Whare Tapa Wha* (physical, social, mental and spiritual domains).²⁰

As organisers and the reviewers of the essay competition, we noticed that the better essays had some

common features. All these students engaged well with a particular patient, often when others around them did not seem to have the courage to do so. Each student had made a real connection with their patient (*whakawhanaungatanga*), and in their writing, they wrote openly about their anxiety, self-doubt and *pōuri* or sadness about what was happening. This emotional openness may reflect a loss of personal boundaries in the dying patient, whose anxiety and suffering may then be received and experienced by the student.²¹

Interestingly, many students described how they used their own initiative and personal agency in service of the patient; spending extra time, listening and attending without a medical agenda, making space to hear the patients' *kōrero* or stories. All these actions contrasted with their usual feeling of being superfluous in ward settings. From those interactions, they made some useful insights about the nature of training, including significant shifts in their emerging perspectives about what it will be like to be a doctor. Lastly, we as readers were immediately engaged with each of these narratives.

So perhaps then, our resonance with these stories has something to do with recognising the student in all their courage and bravery. We resonate with the enormity of their struggle to engage and connect compassionately with the dying patient within a culture of medicine that defaults to clinical detachment and sees death as failure.²²

No wonder then, that the top 10 essays were largely about end of life care, which acutely exposes some of the major conflicts for students in their learning to become a doctor. Many students also commented on the personal benefits of writing their essays. Perhaps through crafting their stories, they gained some understanding of just what happened between them and their patient, and how they were currently negotiating their personal and professional identities.

References

1. The BSANZ Medical Student Reflective Essay Competition. Balint Society of Australia and New Zealand. [cited 2021 November 23]. Available from: <https://balintaustralianewzealand.org/writing-prize/>.
2. Monrouxe L, Sweeney K. Between two worlds: Medical students narrating identity tensions. In: Figley C, Huggard P, Rees C (Eds). *First do no self harm: understanding and*

- promoting physician stress resilience. New York: Oxford; 2013. p. 44–66.
3. Fox E. Predominance of the curative model of medical care: a residual problem. *JAMA*. 1997;278(9):761–3. doi:10.1001/jama.1997.03550090085038
 4. Pieters J, Dolmans DH, van den Beuken-van Everdingen M, et al. A national, Palliative care competency framework for undergraduate medical curricula. *Int J Environ Res Public Health*. 2020;17(7):2396. doi:10.3390/ijerph17072396
 5. Wilson H, Warmington S, Johansen ML. Experience-based learning: junior medical students' reflections on end-of-life care. *Med Educ*. 2019;53:687–97. doi:10.1111/medu.13907
 6. Frank AW. *The wounded storyteller: body, illness, and ethics*. Chicago, IL: University of Chicago Press; 2013.
 7. Wortham SE. Interactional positioning and narrative self-construction. *Narrative Inq*. 2000;10(1):157–84. doi:10.1075/ni.10.1.11wor
 8. Pennebaker JW. Telling stories: the health benefits of narrative. *Lit Med*. 2000;19(1):3–18. doi:10.1353/lm.2000.0011
 9. Shapiro J. Stories medical students tell. *Story Tell Self Soc*. 2005;1(2):48–61.
 10. Clandinin DJ, Cave MT. Creating pedagogical spaces for developing doctor professional identity. *Med Educ*. 2008;42(8):765–70. doi:10.1111/j.1365-2923.2008.03098.x
 11. Mannix K. *With the end in mind: dying, death, and wisdom in an age of denial*. London: William Collins; 2017.
 12. Dickinson GE, Lancaster CJ, Winfield IC, et al. Detached concern and death anxiety of first-year medical students: before and after the gross anatomy course. *Clin Anat*. 1997;10:201–7. doi:10.1002/(SICI)1098-2353(1997)10:3<201::AID-CA5>3.0.CO;2-W
 13. Draper EJ, Hillen MA, Moors M, et al. Relationship between physicians' death anxiety and medical communication and decision-making: a systematic review. *Patient Educ Couns*. 2019;102(2):266–74. doi:10.1016/j.pec.2018.09.019
 14. Smith-Han K, Martyn H, Barrett A, Nicholson H. "That's not what you expect to do as a doctor, you know, you don't expect your patients to die." Death as a learning experience for undergraduate medical students. *BMC Med Educ*. 2016;16(1):108. doi:10.1186/s12909-016-0631-3
 15. Rhodes-Kropf J, Carmody SS, Seltzer D, et al. "This is just too awful; I just can't believe I experienced that...": medical students' reactions to their "most memorable" patient death. *Acad Med*. 2005;80(7):634–40. doi:10.1097/00001888-200507000-00005
 16. Dzung E, Wachter RM. Ethics in conflict: moral distress as a root cause of burnout. *J Gen Intern Med*. 2020;35(2):409–11. doi:10.1007/s11606-019-05505-6
 17. Barr J, Bull R, Rooney K. Developing a patient focussed professional identity: an exploratory investigation of medical students' encounters with patient partnership in learning. *Adv Health Sci Educ Theory Pract*. 2015;20(2):325–38. doi:10.1007/s10459-014-9530-8
 18. Sandars J. The use of reflection in medical education: AMEE Guide No. 44. *Med Teach*. 2009;31(8):685–95. doi:10.1080/01421590903050374
 19. DasGupta S, Charon R. Personal illness narratives: using reflective writing to teach empathy. *Acad Med*. 2004;79(4):351–6. doi:10.1097/00001888-200404000-00013
 20. Wilson D, Moloney E, Parr JM, et al. Creating an Indigenous Māori-centred model of relational health: a literature review of Māori models of health. *J Clin Nurs*. 2021;30(23–24):3539–55. doi:10.1111/jocn.15859
 21. Bapat AC, Bojarski EF. Transference and countertransference in palliative care. *J Palliat Med*. 2019;22(4):452–3. doi:10.1089/jpm.2019.0042
 22. Kind T, Everett VR, Ottolini M. Learning to connect: students' reflections on doctor–patient interactions. *Patient Educ Couns*. 2009;75(2):149–54. doi:10.1016/j.pec.2008.09.011