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# Death, Dying, and Bereavement as it Relates to Physicians and Their Medical Education

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# Abstract

The intention of this paper is to evaluate the death and dying instruction received by students throughout medical school. The author originally hypothesized that more could be done in Tennessee's medical schools to improve this instruction. American medical schools are increasingly incorporating teachings on death and dying into their curriculums. However, the results of this paper show the author's original hypothesis to be correct. Although the intent of this paper is to improve medical school curriculums, chaplains were included in the research because of the valuable insight they provide as professionals working amidst death each day. The culmination of this paper is the formulation of curriculum suggestions on how death and dying should more effectively be taught. It is the author's opinion that the preparation given by medical schools would drastically improve with the implementation of these suggestions.

# Death, Dying, and Bereavement as it Relates to Physicians and Their Medical Education

Trina E. Dorrah

## Introduction

Death is a certainty. Regardless of how one lived life, or how many times one escapes misfortune, the final journey on earth ends with death. However, before it is one's time to die, a person is exposed to the dying process through the deaths of friends, family, and acquaintances. In the past, death was viewed as a natural part of life. In contrast to the familiar hospital setting, death usually occurred at home where one's friends and family could freely offer love and support during the final days. The dying process has now moved to the hospital where patients often find themselves approaching death in an intensive care unit. Patients are no longer able to die in familiar surroundings, and dying is no longer a family affair. Stella Mary O' Gorman (1998) explains this situation in the following manner: the "hospital takes over the care of the individual prior to death. The funeral director arranges for the preparation of the body…cremation is…a clean and accelerated way of avoiding the horrors of physical decay and the cost of an expensive gravestone. Grief is seen as a disease…to be worked out and gotten over" (pp. 1132-33). However, with the establishment of the hospice movement, dying patients and their families regained some of the autonomous control which had been reduced through the attitudes of modern medicine (O' Gorman, 1998).

American society is very much in denial of death. Technological advances enable people to survive situations and diseases that would have killed humans only a few years ago. Therefore, many people are no longer confronted with death on a consistent basis, and the miracles made possible by modern medicine often make one believe death can be cheated indefinitely (O' Gorman, 1998). Death and the dying process have unfortunately evolved into a taboo subject. Most people are extremely uncomfortable discussing the subject of death, and even fewer individuals have any idea how to deal with it once it arises. Physicians are one group of the population who deal with death and bereavement on a consistent basis. Even if a physician is not involved in a specialty such as oncology where one is faced with it on a consistent basis, physicians must encounter it either directly or indirectly.

I initially became interested in investigating the topic of death, dying, and bereavement when I took a class on this subject during my junior year of college. Although this class was not specific to death and dying issues from a pre-medical perspective, it sparked my initial curiosity about the subject. My interests in death became more focused around medical education when I shadowed a physician at a hospital in Bristol, Tennessee. As we visited each patient, I asked the physician how he learned to personally deal with death and relay the dying process to his patients. He answered that he was never formally educated about the subject, and instead had to learn through experience. Thus, I realized this topic was overlooked by his medical school. I became even more interested in this subject when a friend of mine was diagnosed with cancer. As her condition worsened, her physician told her not to bother with gaining a second opinion; nothing more could be done to help. Finally, a friend of mine described a situation which occurred while her father was also being treated for cancer. Upon entering the hospital room, the physician's first comment regarded her father's DNR (Do

Not Resuscitate) orders. Instead of providing comfort, this physician's insensitivity simply led to shock and anger.

Considering the inevitable link between death and the medical profession, I expected it to be one of the most discussed topics in American medical schools. At the very least, physicians should graduate from medical school with a high degree of preparation for dealing with this highly sensitive subject. Unfortunately, thorough instruction regarding this theme is not the standard. Since resources were limited, I chose to narrow the focus of my study to include Tennessee's four medical schools: Quillen College of Medicine at East Tennessee State University (Johnson City), Meharry Medical College (Nashville), The University of Tennessee College of Medicine (Memphis), and Vanderbilt University School of Medicine (Nashville). After contacting admissions personnel at each of the four schools, I discovered that Vanderbilt was the only medical school in Tennessee with a class specific to death, dying, and bereavement. The other three schools simply offer this instruction within the context of other classes. I therefore formulated the hypothesis that Tennessee's medical schools can improve the instruction given to medical students on the subject of death, dying, and bereavement. Through the course of this project, I hope to gain a better understanding of the death and dying process. I also hope to draw feasible conclusion that may be used by Tennessee's medical schools to improve the death and dying instruction given to their medical students. The following paper will highlight current literature on selected death and dying topics, the results of field research involving ten physicians and ten chaplains, and death and dying course suggestions for medical schools.

## Literature Review

One must first examine current issues and attitudes regarding death, dying, and bereavement before suggesting improvements in our current ideology. I therefore developed a list of focus areas to be addressed throughout this literature review. The first focal point addresses the five stages of dying as outlined by Elisabeth Kübler-Ross in her book, On Death and Dying (1969). These stages are denial, anger, bargaining, depression, and acceptance. Based on her work with thousands of dying patients, Kübler-Ross identified five general steps that the majority of persons dealing with death experience. However, it is important to note that not all patients experience each stage, and those who do may not experience them in any precise order. Likewise, stages may be revisited throughout the dying process.

The first stage of denial usually begins upon disclosure of the patient's illness and/or its seriousness. Those involved in the stage of denial are unable to accept their predicted fate, and they are unable to comprehend the possibility that their death may occur sooner than expected. Patients may respond with statements such as "No, not me, it cannot be true," or "You must be mistaken." Denial is a defense mechanism used to cushion the initial shock of disheartening news and allow one time to collect him/herself. Patients may respond with angry protests, uncharacteristic disinterest and cheerfulness are also possible responses. Although some dying patients never leave this stage, most are able to progress as they adjust to the reality of their diagnosis (1969).

Anger defines the second stage of dying, and it often emanates when one can no longer deny his/her impending death. During this stage, patients ask questions like, "Why me?" and "How could you let this happen?" Not only may patients become angry with their physicians, but they often show anger towards family, friends, and even God throughout this stage. Physicians must understand the stages of dying because patients experiencing anger are often labeled as "difficult and ungrateful." However, when physicians take the time to make patients feel respected and understood, they are more easily able to work through this stage (1969).

Throughout the stage of bargaining, patients attempt to prolong life by entering into agreements with others. These agreements follow a self-imposed deadline and include a reward for the patient in exchange for good behavior. The proposals may be directed towards the physician, God, or any other higher power the patient believes may deliver him/her from the illness. Patients often agree to faithfully take their medicine or become a better Christian in an attempt to delay death. Bargaining patients may promise to change their lifestyle if given the opportunity to live, or they may ask for the chance to complete an important task before death (1969).

If the disease progresses despite the patient's use of denial, anger, and bargaining, he/she moves to the stage of depression. At this point, the full impact of the impending death strikes. Patients begin to realize the tremendous affect their deaths will have on the lives of those close to them. Crying and extreme sorrow are commonly expressed. Those close to the patient must understand that depression is a normal part of the dying process. Do not admonish patients to adopt a more positive outlook on life or seek psychological intervention unless their depression is uncharacteristic of those experiencing this stage of grief (1969).

The final stage of death is acceptance. During this stage, the patient is neither depressed or angry about the impending death. Rather, one settles business affairs, repairs broken relationships, and offers final good-byes in preparation for death. By accepting one's impending fate, the patient is filled with peace. Although he/she may still wish for more time, acceptance ensures that the last moments of the patient's life are spent in the presence of friends and family. During this time, a patient's interests diminish, and nonverbal communication becomes more prevalent. Despite the fact that the patient has reached the stage of acceptance, a continuous shifting between stages for varying periods of time is not uncommon (1969).

The remaining portion of this literature review focuses on issues that arise throughout the progression of a patients disease, beginning with the moment the diagnosis is given by the physician. Caring physicians make it a priority to provide patients with the information needed to make knowledgeable health-care decisions. This process is known as truth-telling, and it requires physicians to present pertinent medical findings as clearly and accurately as possible. Patients have a right to be informed healthcare recipients. Without an accurate knowledge of their situation, patients may make misinformed decisions regarding their health. Thus, the patient's chosen plan of action is directly related to how much and how well he/she understands the situation (Glass, Hébert, Hoffmaster, & Singer, 1997).

In addition, the element of trust shared between the patient and physician is essential to his/her care. Without trust, the relationship between the physician and patient lacks respect. Without respect, a breakdown in communication occurs as the patient ceases to value the opinions and suggestions of the physician. Many lawsuits directed against physicians arise as a result of faulty communication skills. However, telling the truth from the beginning fosters an atmosphere of trust which may alleviate patient resentment at a later date as the disease progresses. Truth-telling also lessens the physician's burden because the responsibility for devising a treatment plan no longer lies with one individual. Despite this fact, not all cultures view truth-telling as a necessity. Because the patient is the physician's top priority, these families should be counseled about the importance of truth-telling in order for their loved one to receive the best possible care and make the most appropriate decisions throughout the course of the illness (Glass et al., 1997).

Despite the importance of truth-telling, the physician must use an appropriate technique in doing so. Hope is destroyed when devastating news is delivered in a brutal manner. Although the physician need not lie about the patient's condition, he/she should never completely eradicate the hope that an unforeseen miracle may occur. Even when a cure is no longer likely, the hope should remain that the patient and physician will together experience the dying process in the most dignified manner possible (Egnew, Farber, & Herman-Bertsch, 1999). The physician must remember that when patients cease to express hope, death is imminent (Kübler-Ross, 1969).

After the patient is truthfully informed of the illness, goals of care are formulated through a collaboration of the physician *and* patient. Goal-setting is important because goals of care help all involved parties identify a path to follow amidst uncertainty. In addition, they clearly define treatment choices, and they affirm that everyone is working together to provide the best possible care. Because a patient's needs change throughout the dying process, the physician and patient must continuously revise these goals (Latimer, 1998).

Dr. Elizabeth Latimer (1998) suggests that the care team consistently answer the following questions regarding treatment: What are the expectations of the illness (current problems, future developments)? What are the possible options for treatment and care? What is the recommended or most wise approach to treatment? She also suggests that the following questions regarding the patient be considered: Who is this unique person who has the illness? What are his or her values, choices, life circumstances, personal goals and plans for the time remaining? What is his or her perception of the illness and experience of it? What would he or she like to see happen? What is possible, given the nature of the illness? (pp. 1743-1744). Finally, physicians must ask themselves the following questions: Am I managing this patient's pain and other symptoms adequately? Have I addressed the relevant issues with respect to the use of life-sustaining treatment? Am I supporting this person and his or her family? (MacDonald & Singer, 1998, p. 162).

Throughout the course of care, the physician should adhere to the principles of beneficence, autonomy, nonmaleficence, and justice. Autonomy supports the practice of truth-telling and allowing the patient to make informed decisions about his/her care. Beneficence instructs the physician to relieve suffering and promote the highest quality of life possible under the circumstances. Nonmaleficence instructs that the physician do no harm (physical or psychological), and justice ensures that patients receive the care to which they are entitled (Latimer, 1998). Within the realm of these four principles lie the issues of pain and symptom control, life-sustaining treatment, and overall support for the dying patient (MacDonald & Singer, 1998).

According to the Council on Scientific Affairs, most dying patients do not fear death, but rather the pain that usually accompanies this process. One study claimed that twenty-five percent of cancer patients received inadequate pain control at some point throughout their illness ("Good Care," 1996). In American society, no patient should ever die in pain considering the fact that anesthesia and even terminal sedation are permissible options. Even if a patient is incompetent, the relief of pain through increasing doses of medicine should remain a primary goal unless significant evidence exists to contradict this action (Alpers & Lo, 1999). Sedatives, anxiolytics, major tranquilizers, antidepressants, anticonvulsants, opioid analgesics, antinauseants, medications to control secretions, and steroids are all used to control pain (Latimer, 1998).

Because the most important goal of treatment is pain control, medication dosages may need to be increased as the disease progresses. In certain situations, it may be necessary to sedate the patient and wait for death due to the underlying disease. This act is known as terminal sedation. Terminal sedation is defined as the sedation of a patient with unmanageable suffering to the point of unconsciousness, the withholding of artificial nutrition and fluids, and the treatment of complications as they arise (Alpers & Lo, 1999). Three situations that may necessitate sedation are severe end-stage dyspnea, severe end-stage delirium, and intractable pain (Latimer, 1998). However, this method of treatment should only be utilized in situations where informed consent exists.

The principle of "double-effect" occurs when a physician increases the patient's medication with the purpose of managing pain and other symptoms as opposed to hastening death. For this principle to be valid, the physician's intentions must solely be directed towards alleviating the patient's pain. Although patients need not be overmedicated for their level of pain, the intentional failure to relieve suffering for fear of overmedication represents a moral failure on the part of the physician. Constant communication between the patient and physician about the evolution of the patient's pain is therefore a necessity (Latimer, 1998). When dealing with incompetent patients, the physician should not increase the dosage of pain medication as long as the patient appears comfortable. Signs of discomfort include restlessness or grimaces, withdrawal from touch and other stimuli, hypertension, tachycardia, tachypnea, and other symptoms that could reasonably be attributed to suffering (Alpers & Lo, 1999).

One option for patients facing pain management is the concept of palliative care. Palliative care refers to a philosophy of care where the patient and family are emotionally nurtured and encouraged to maximally participate in the dying process. Palliative care is focused on caring rather than curing. Although the disease may be incurable, palliative care recognizes that something can always be done to aid the patient ("Using Hospice Care," 1989). The physician should not solely consider palliative care to be an end-of-life option. The problems patients experience occur throughout the course of the illness. Therefore, early pain control is preferable (MacDonald & Singer, 1998).

The use or discontinuance of life-sustaining treatments is another important issue the dying patient must consider. The choice to either withhold or withdraw life-sustaining treatment is supported by the ethical principle of autonomy and the legal doctrine of informed consent (MacDonald & Singer, 1998). In making this decision, Dr. Edmund Pellegrino (2000) suggest four ethical questions to be asked by the patient and physician: Who decides? By what criteria? How are conflicts among decision makers resolved? How is conflict prevented? (p. 1065).

*Who decides?* Patients with the capacity to make decisions are awarded autonomous control over their care. This capacity depends upon the patient's ability to communicate and understand all pertinent information, the ability to make and persist in decisions, and the ability to make decisions in accordance with previously stated values and beliefs. If a patient is deemed incompetent, a valid proxy or power of attorney is appointed. The proxy must be competent enough to make decisions for the patient, be free of an obvious financial or emotional conflict of interest, and be knowledgeable about the patient's values and ethics (p. 1066).

When a patient is considered competent, his/her moral and legal authority often overrules the wishes of the physician, the surrogate, or the family. However, a physician is not obligated to follow the patient's wish if it violates the physician's beliefs or opinions regarding optimal care strategies. Likewise, the patient's authority, or the authority of the living will is not absolute under the following conditions: the patient's wishes could cause serious and probable harm to others, the physician must violate personal or professional integrity, the patient attempts to injure him/herself, or the requested treatment is clinically futile (p. 1066).

*By What Criteria?* When the procedure is considered futile and the burdens of treatment outweigh the benefits, one may consider withdrawing life-sustaining treatment. Dr. Pellegrino defines futility as "the relationship among effectiveness, benefit, and burden" (p. 1066). Effectiveness is the determination of the treatment's ability to alter the disease. Benefit refers to the patient's assessment of the treatment's validity, and burdens are defined by the cost, discomfort, and pain suffered as a result of treatment (p. 1066).

*How Are Conflicts Among Decision Makers Resolved?* and *How is Conflict Prevented?* Conflicts among decision makers are resolved through negotiation, ethics consultation, and pastoral/psychological counseling. In order to prevent conflict, a physician must anticipate dilemmas, hold frequent meetings between patients and families, set goals, and encourage the patient to prepare a living will (p. 1066).

The physician seeking to provide the best overall support for the dying patient is not only attentive to the patient's physical needs, but to the emotional, spiritual, and cultural needs as well (Latimer, 1998). The patient must be treated as a complete being as opposed to one who simply has physical needs. Therefore, the best possible care is obtained through a team approach by incorporating physicians, nurses, social workers, chaplains, pharmacists, nutritionists, occupational therapists, physiotherapists, and any other specialty able to bring unique skills to the patient's care (Latimer, 1998).

When considering the physical needs of a dying patient, pain control is the most important objective. In addition, the physician must recognize the physical symptoms of dying such as shortness of breath, delirium or dementia, fatigue, hiccoughs, mouth sores, skin breakdown, constipation, urinary retention, nausea, and itching ("Good Care," 1996).

Dying patients most often fear pain, loss of control, indignity, and being a burden on their family. Oftentimes, depression arises and the patient contemplates suicide. An attentive physician seeks to address the underlying issues causing this depression. When alternate methods fail, it may be treated with stimulants or antidepressants ("Good Care," 1996). Support must also be given to the primary caregiver since the quality of the patient's care partially depends on this person's emotional stability (Egnew et al., 1999). Throughout the dying process, families have a tendency to see the patient as an illness instead of a human being. This situation causes social death in that the patient is no longer included in familial decisions and events (O' Gorman, 1998). Thus, patients must also deal with the emotional issues that arise as family members unintentionally isolate them.

By 1999, more than sixty medical schools were teaching students how to take their patient's spiritual histories (Larson, 1999). This is significant, because in the words of Dr. Daniel Sulmasy (1999), "Illness is a spiritual event [which] grasps persons by the soul and by the body and disturbs them both" (p. 1003). In order to treat patients as complete beings, physicians must focus on how the disease affects both their physical *and* spiritual health. To be a spiritual healer, the physician must first cultivate his/her own spirituality. Patients often question the meaning of their illness and why they must suffer. They inquire about their value to others and wonder if their physician truly understands the spiritual turmoil they experience. A physician who has personally struggled with these questions is better able to help patients who struggle with the same concerns. In addition, he/she will avoid giving trite answers to a patient's spiritual questions when these same uncertainties are difficult for the physician to grasp as well (Sulmasy, 1999).

Spirituality and religion are not synonymous although the two terms are related. Sulmasy (1999) defines spirituality as "the characteristics and qualities of one's relationship with the transcendent" (p. 1002). Thus, every patient is a spiritual being because each one has a relationship with the transcendent either by accepting or rejecting it. Religion, on the other hand, is the certain set of beliefs about the transcendent held by an individual. Religion usually occurs within the context of a community sharing key beliefs, practices, and rituals. In order to treat patients as complete beings, their spiritual and/or religious needs must be considered by the physician throughout the dying process (Sulmasy, 1999).

The cultural needs of the dying patient are equally as important as the physical, emotional, and spiritual needs previously outlined. Physicians must not forget that each patient is a unique individual with different cultural value and ideas. The decisions a patient makes concerning care are often direct reflections of these values. In addition, each culture has its own rituals, mourning practices, and expressions of grief that are employed throughout the dying process (Kagawa-Singer, 1998). The physician who recognizes one's cultural needs is better able to assist the dying patient when specific rituals are requested.

As the patient's illness progresses, the physician may receive requests for physician-assisted suicide. However, physician-assisted suicide is currently illegal in every state excluding Oregon. Dr. Linda Emanuel therefore devised an eight-step approach which can be used by physicians to deal with these requests. The justification for these eight steps is two-fold: the right to be free from unwanted intervention and the physician's obligation to provide suffering patients with comfort care. The right to be free from unwanted intervention is based on a patient's right to bodily integrity and freedom from assault. This right substantiates the doctrine of informed consent, because a patient must receive complete information regarding the disease in order to decide what interventions are personally permissible. The right to be free from unwanted intervention also justifies a patient's decision to withhold or withdraw medical treatment, even if the treatment is life-sustaining. Relief of suffering, on the other hand, is an obligation documented in the Hippocratic oath (Emanuel, 1998).

Step one of Dr. Emanuel's approach calls for an evaluation of the patient for signs of depression and other psychiatric conditions. Depression is a major reason patient's ask for physician-assisted suicide, and the physician should first attempt to treat this condition. Next, the patient is evaluated for decision-making competence. If this competence is sub-par, the contributing symptoms should be treated. If needed, a health care proxy should be appointed. The third step calls for the formulation of treatment goals, while step four requires the physician to evaluate and treat the root cause of the patient's physical, mental, social, and spiritual suffering. The physician must next ensure that the principles of informed consent and truth-telling are being practiced. The patient should now know the full range of available palliative care services (1998).

At this point, the physician has completed steps one through five. If the patient still desires physician-assisted suicide, Dr. Emanuel instructs the physician to consult and involve professional colleagues to discuss various alternatives. The seventh step asks for an evaluation to ensure adherence to care goals. The physician should discontinue any unwanted life-support or life-sustaining treatments. Pain and suffering should continue to be maximally relieved. If the physician completes all of the above steps and the patient still requests assisted suicide, the physician must decline the request (except in the state of Oregon) and offer appropriate justification for the refusal (1998).

In June of 1997, the US Supreme Court ruled that competent, terminally ill patients have no general constitutional right to commit suicide or obtain assistance in committing suicide. In addition, the court concluded that a physician's intent can distinguish permissible acts of pain relief and comfort care from impermissible acts which hasten death (Alpers & Lo, 1999). The majority opinion accepted the previously mentioned principle of double effect by stating that "in some cases, painkilling drugs may hasten a patient's death, but the physician's purpose and intent is, or may be, only to ease his patient's pain" (Alpers & Lo, 1999). The majority opinion required that all states ensure that their laws do not interfere with access to adequate palliative care, especially when it is sought for the alleviation of pain and other physical symptoms of dying (Burt, 1997).

Throughout the dying process, communication between the patient and physician is essential. According to Dr. Latimer (1998), valuable communication has four main components: "It must be timely and desired by the patient, it must be accurate, it must be provided in words that are understandable to the patient and the family, and it must be conveyed in a gentle, respectful and compassionate manner" (p. 1743). Communication must first be initiated with the patient. He/she should feel free to ask questions, and the physician must be attentive to the questions asked in order to effectively participate in the conversation (Egnew et al., 1999). Communication between the patient and physician should continue throughout the course of the illness, especially at times when the disease progresses or changes. Only after consent is given by the patient may the physician initiate communication about the patient's condition with the family. Non-verbal communication is equally as important throughout the dying process because it provides patients with emotional support and care (Latimer, 1998).

Once a patient dies, the physician must be prepared to deal with the remaining family's grief. Because America is a death-denying society, surviving family members often unprepared for the bereavement process. If the patient dies in the hospital, the family should be directed to a grieving room. A grieving room is a private place where the family can discuss concerns, questions, fears, and emotions which arise following death. This prevents them from leaving the hospital with unanswered questions and needs (Gaguski, 1999). In helping a family deal with grief, the physician may acknowledge his/her sorrow, and even grieve with the family to some extent. Sending a letter or card further expresses the physician's concern (Glass et al., 1997). One may also suggest bereavement counseling to the grieving family as long as suggestions are tactfully made (Levin, 1999).

Grief as a result of sudden death differs somewhat from the grief experienced with an expected death. Although the family dealing with the sudden death passes through the stages of dying previously outlined, there are distinct differences. Without advance preparation, the grief process may last longer than expected. Although families dealing with sudden death experience shock and denial, their expression of anger is often more intense. The stage of bargaining is either brief or entirely eliminated, while the period of depression is prolonged due to the unexpected nature of the loss. Inviting the family back to the hospital for a follow-up visit is suggested because it gives them an opportunity to resolve unanswered questions. For example, the family often asks about their loved one's last words and actions (Kübler-Ross, 1974).

Physicians dealing with sudden death often forget that they are the last people to be in the presence of the dying patient before death. In order to alleviate a family's grief, the physician might consider allowing the family to be with their loved one throughout the dying process, even if death occurs within the emergency room. Affording the family this privilege eases their fears that nothing was done to help their loved one in his/her final moments. In addition, because the dying might still be able to hear, families are comforted in knowing that their loved one heard them say "good-bye" or "I love you" one final time (Rosenczweig, 1998). After death occurs, the body should be cleaned and prepared for viewing so the family may see it and begin the grieving process (Kübler-Ross, 1974).

The caring physician understands that different types of death evoke a variety of emotions from survivors. For example, the grief felt by a family dealing with suicide is coupled to feelings of guilt, anger, and confusion. Survivors may ask questions like "What could I have done to prevent this?" and "Why would he/she do this to me? What did I do?" Accidental deaths in which some survive while others die also produce feelings of guilt for the survivors. On the other hand, the death of a child is especially painful because loved ones grieve for the child and the loss of his/her future. Even miscarriages, stillborn births, and deaths due to sudden infant death syndrome (SIDS) are difficult. In these cases, the physician should help the family acknowledge their loss by asking what the child's name was and by allowing the family to hold him/her one final time. The family should also be assured that the death was not their fault. Under no circumstances should the physician suggest that living children somehow compensate for the loss (Levin, 1999).

Depending on the physician's degree of involvement, the death of a patient causes a great deal of personal grief and stress for the physician (Kübler-Ross, 1974). This stress is initiated by feelings of doubt regarding one's ability to cope with the situation (Bonn, 2000). Because medical schools train their students to cure, treat, and prolong life, physicians often view the loss of a patient as a personal failure. Doubts arise as to whether or not more could have been done to save the patient's life. When death occurs, the physician experiences the stages of grief to some extent (Kübler-Ross, 1974). Grieving physicians, like survivors, need a support system when struggling with loss. Standard stress relievers such as eating a healthy diet, exercising, and having personal time are viable ways of dealing with grief. In addition, it may be helpful for the physician to engage in professional therapy and/or support groups with colleagues (Bonn, 2000).

Various personal problems may arise if a physician fails to effectively deal with grief. Stress correlates with an increased risk of mental strain, psychiatric disorders, coronary heart disease, hypertension, and hypercholesterolaemia. In addition, physicians dealing with unresolved grief are unable to meet their remaining patients' needs due to a loss of productivity and energy. Considering the aforementioned risks, it is imperative that physicians appropriately deal with their personal grief (Bonn, 2000).

As evident by this literature review, a variety of issues arise throughout the dying process for the patient, family, and physician. The most logical place to address these issues is in medical school. However, if American medical schools are indicative of Tennessee medical schools, much more can be done to improve physician training. The culmination of this paper will therefore outline my personal suggestions for the presentation of death and dying instruction throughout medical school.

## Methods

Initial research was conducted through a basic literature review on various subjects related to death and dying. Current opinions on these topics were investigated through the collection of data from various medical journals, nursing journals, and books. In order to provide accurate information, each journal article documented in this paper with the exception of one was published between 1996 and 2000. Books written by Dr. Elisabeth Kübler-Ross (1969 & 1974), her protégé David Kessler (1997), and Dr. Timothy Quill (1996) were read in order to gain a better understanding of the grief process and issues pertinent to dying patients.

In addition to the literature review, admissions personnel were contacted at each of Tennessee's four medical schools in order to estimate the prevalence of death and dying instruction included in their curriculum. Questions were asked about the type and duration of this instruction.

Next, a survey (see appendix) was designed by the researcher in order to assess the death and dying instruction received by physicians and chaplains in medical/seminary school and beyond. This survey was used to conduct the interviews of ten physicians and ten chaplains. All chaplain interviews and eight of ten physician interviews were personally conducted by the researcher. The remaining two surveys were sent to the physicians' offices, where they were personally completed by the physicians at their convenience. At the conclusion of each interview, the researcher recorded conclusions based on the responses of the interviewees to be used for the proposed strategies on death education.

Once the surveys were complete, results were compiled and analyzed. The researcher produced a series of charts and graphs based on this data using the Microsoft®

Excel computer program. The researcher concluded by devising a list of recommended suggestions for the teaching of death and dying instruction in medical school.

## Results

Ten of the physician's questions, and eleven of the chaplain's questions, provided quantitative data results. Graphs and charts illustrating this data are included in the appendix. For the purposes of all data analysis, medical school is compared to seminary training while residency training is compared to clinical pastoral education. Five of the ten participating physicians practice internal medicine. Of the remaining five physicians, two are family practitioners, one is a cardiologist, one is a nephrologist, and one is an oncologist/hematologist. All participating chaplains are certified in pastoral care. All chaplain interviews, and eight of the ten physician interviews, were personally conducted by the interviewer. The remaining two physicians were sent copies of the survey to be completed at their convenience and interpretation.

The results show the physicians and chaplains to be diversified in the types of death situations they encounter. Likewise, the majority of the interviewees deal with death on either a regular or frequent basis.

Seventy percent of chaplains and eighty percent of physicians reported to having some type of death and dying instruction while in medical/seminary school. However, only ten percent of chaplains (0% physicians) received instruction in a class specific to death and dying. The remainder received their instruction as a part of one or more courses. Although the majority of physicians and chaplains received some type of death education, interactive learning was only incorporated into the instruction of 20% of the physicians (0% chaplains). The overwhelming majority also reported that only 0% - 24% of their education dealt with the actual death and dying process

When asked whether they were taught strategies for sharing an impending death, 70% of chaplains and 80% of physicians were taught no strategies. Likewise, 70% of chaplains and 90% of physicians were never given suggestions on how to share an actual death with the surviving family members.

Sixty percent of physicians and chaplains reported that personal coping strategies were never discussed in their education. Likewise, when asked how prepared they felt for dealing with real-life death situations, neither group felt either well or excellently prepared. Instead, every physician and chaplain reported to feeling either adequately, fairly, or poorly prepared to deal with true death situations.

Finally, the interviewees were asked whether or not they believed death, dying, and bereavement should be a required course in medical school. The data shows that every physician and chaplain believed death should be a required course.

Chaplains were asked one additional question regarding their opinions on the performance of medical students and residents when discussing death with patients and/or families. Six of the ten chaplains were unable to answer the question due to the fact that they do not work in teaching hospitals with large populations of medical students and residents. Of the remaining chaplains, 30% rated their performance as fair while 10% of chaplains issued a rating of poor.

## Discussion

The primary aim of this paper is to improve medical education for medical students. However, chaplains were included in the study because as professionals regularly working amidst death, their insights are invaluable.

Because the sample size is so small, it is impossible to draw specific conclusions based on the data results. However, the data overwhelmingly illustrates the fact that both groups of interviewees would benefit from more comprehensive death education. Although some of the data results show physicians to be slightly better prepared for dealing with death than chaplains, one must remember that seminary school is intended to train a wide range of theological students. Every student completing seminary does not continue his/her education in the clinical pastoral education tract with the intent of becoming a hospital chaplain. Therefore, more specific education is offered following seminary for those students wishing to become certified in pastoral care.

All of the data results validate the original hypothesis that medical schools can improve the death and dying instruction given to their students. The most definitive proof for this conclusion is seen by the responses given when asked about the adequacy of their death and dying instruction for dealing with real-life death situations. None of the twenty interviewees felt either well or excellently prepared upon graduation from medical school or seminary.

This statistic is not as frightening in the case of chaplains, because those wishing to become hospital chaplains must complete a required year of clinical pastoral education (CPE). Because physicians do not have any training equitable to CPE, they must treat patients throughout residency without gaining additional death and dying training. The majority of this responsibility therefore falls on the physician's medical school.

Although all results were accurately reported by the researcher, one noteworthy flaw exists. First, my statistics were generated from a sample size consisting of ten physicians and ten chaplains. Because the sample size was so small, one error in reporting or documenting could drastically skew the results. It is the researcher's opinion that this situation occurred in regards to survey question three. This question asked how much of one's instruction dealt with the actual death and dying process (e.g. shortness of breath, fatigue). Each participant was personally interviewed by the researcher with the exception of two physicians. One of those two physicians checked 50% - 74% while the other checked 75% - 100%. It is highly unlikely that such a large percentage of a physician's death education focused on symptoms of the actual dying process. Because the sample size was so small, this potential inaccuracy greatly affected the results.

As previously mentioned, Vanderbilt is the only Tennessee medical school to offer a course specific to death and dying. The final section of this paper outlines my suggestions for the type of death and dying instruction that should be taught in every medical school.

## Curriculum Suggestions

If implemented within medical schools, the following course suggestions should help to demystify the dying process, quell personal anxiety about regularly dealing with death, and help students view the dying patient as a living individual who deserves the best possible care until death. The only limiting factor for the implementation of these suggestions is that they be presented to students before they begin regular clinical rotations. This enables the students to listen to and absorb all information without the bias that arises after one begins the actual practice of medicine (Dickinson, Gunn, & Mermann, 1991).

In my opinion, death and dying instruction should be presented in a lecture/problem-based format. The first day of class should begin by asking students to explore their personal experiences, perceptions, and anxieties regarding death and dying. Students cannot effectively help others until they have dealt with their own fears and misconceptions.

Students would then begin the lecture portion of the class. Professors may teach the following lecture topics in any order, but all lectures must be completed before students begin patient interaction. These topics were formulated by the researcher based upon the responses given by the physicians and chaplains to select survey questions. The suggested lecture topics are as follows:

- Physical (actual symptoms and appearance of death), emotional, spiritual, and cultural aspects of death and dying.
- Current literature available on death and dying. Include information found in books and journals.
- Death as it is viewed and dealt with by various religions.
- General techniques for being a better listener and communicator (verbal and nonverbal). Use audiovisuals to illustrate instances of good and bad communication/listening encounters between physicians and their patients.
- Fears and commonly-asked questions of the dying, and teach various ways for physicians to be emotionally supportive.
- Techniques that can be used to deliver bad news to patients.

- Pain management techniques and options such as hospice and palliative care measures.
- Quantity vs. quality of life debate, laws regarding physician-assisted suicide, advance directives, health care proxies, and living wills.
- Various coping strategies physicians can use to remain healthy and avoid burnout.
- A panel of doctors, nurses, chaplains, people dealing with grief, and dying patients may come and share their experiences with the medical students. Allow time for a question and answer session.
- Role-play death situations utilizing case studies in class and have the class critique student techniques (see appendix).

Throughout the lecture phase, students will also be given a reading assignment on death and dying to be completed before field work begins. My personal recommendation for this assignment is The Rights of the Dying (1997) by David Kessler (see appendix). The professor will lead a discussion following the completion of this reading where students will discuss their opinions/reactions on topics covered throughout the book.

After the lecture portion of the class is complete, students will begin gaining hands-on experience by volunteering in a hospice setting. They will involve themselves with as many patients as possible, and follow these patients to the completion of the dying process. Although students will always work with an attending physician, they should consistently practice the techniques and suggestions learned in the lecture portion of the class.

Regular verbatims will be held in which students present patient cases to a small group consisting of other medical students and a mentor. This environment enables students to constructively critique each other's techniques and offer suggestions for improvement. Bi-weekly group therapy sessions to be led by a trained counselor will be integrated into the class as well. These sessions are a time for students to discuss their feelings and difficulties regarding their encounters with death and dying. Students will also be required to keep a journal in which all experiences with death (including their first autopsy) and subsequent feelings are recorded.

Although all of Tennessee's medical schools offer some type of death and dying instruction, more can be done to prepare medical students. All physicians, regardless of their specialty, must face the reality of death throughout their career. Therefore, it is imperative that medical schools prepare future physicians to deal with difficult situations in a compassionate and effective manner. The research presented in this paper supports the original hypothesis that Tennessee's medical schools can improve the instruction given to medical students on the subject of death, dying, and bereavement. It is the opinion of the researcher that implementation of the aforementioned suggestions would alleviate this educational deficiency and pave the way for a generation of more empathic physicians. As we begin a new century, this goal ought to be the focus of every medical school.

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# References

Alpers, A., & Lo, B. (1999). The Supreme Court addresses physician-assisted suicide: Can its rulings improve palliative care? Archives of Family Medicine, 8, 200-205.

American Medical Association Council on Scientific Affairs. (1996). Good care of the dying patient. Journal of the American Medical Association, 275, 474-78.

Bonn, D., & Bonn, J. (2000). Work-related stress: Can it be a thing of the past? Lancet, 355, 124.

Burt, R. (1997). The Supreme Court speaks: Not assisted suicide but a constitutional right to palliative care. New England Journal of Medicine, 337, 1234-36.

Dickinson, G. E., Gunn, D. B., & Mermann, A. C. (1991). Learning to care for the dying: A survey of medical schools and a model course. Academic Medicine, 66, 35-38.

Egnew, T. R., Farber, S. J., & Herman-Bertsch, J. L. (1999). Issues in end-of-life care: Family practice faculty perceptions. The Journal of Family Practice, 49, 525-30.

Emanuel, L. (1998). Facing requests for physician-assisted suicide: Toward a practical and principled clinical skill set. Journal of the American Medical Association, 280, 643-647.

Gaguski, M. E. (1999). A private place: Consolation for grieving families. American Journal of Nursing, 99, 18-19.

Glass, K. C., Hébert, P. C., Hoffmaster, B. & Singer, P. A. (1997). Bioethics for clinicians: Truth telling. Canadian Medical Association Journal, 156, 225-228.

Kagawa-Singer, M. (1998). The cultural context of death rituals and mourning practices. Oncology Nursing Forum, 25, 1752-56.

Kessler, D. (1997). The rights of the dying: A companion for life's final moments. New York: HarperCollins Publishers.

Kübler-Ross, Elisabeth. (1969). On death and dying. Toronto: The Macmillan Company.

Kübler-Ross, Elisabeth. (1974). Questions and answers on death and dying. New York: Macmillan Publishing Company.

Kushner, K. P., Marchand, L. R., & Siewert, L. (1998). Death pronouncement survival tips for residents." American Family Physician, 58, 284-85.

Larson, S. (1999, November/December). Reviving the soul of medicine. Physician, pp. 18-22.

Latimer, E. J. (1998). Ethical care at the end of life. Canadian Medical Association Journal, 158, 1741-47.

Levin, B. (1999). Grief counseling. American Journal of Nursing, 98, 69-72.

MacDonald, N., & Singer, P. A. (1998). Bioethics for clinicians: Quality end-of-life care. Canadian Medical Association Journal, 159, 159-62.

MacKenzie, M. A. (1998). The interface of palliative care, oncology and family practice: A view from a family practitioner. Canadian Medical Association Journal, 158, 1705-07.

O'Gorman, S. M. (1998). Death and dying in contemporary society: An evaluation of current attitudes and the rituals associated with death and dying and their relevance to recent understandings of health and healing. Journal of Advanced Nursing, 27, 1127-1135.

Pellegrino, E. D. (2000). Decisions to withdraw life-sustaining treatment: A moral algorithm. Journal of the American Medical Association, 283, 1065-67.

Quill, T. E. (1996). A midwife through the dying process. Baltimore: The Johns Hopkins University Press.

Rosenczweig, C. (1998). Should relatives witness resuscitation? Ethical issues and practical considerations. Canadian Medical Association Journal, 158, 617-20.

Sulmasy, Daniel P. (1999). Is medicine a spiritual practice? Academic Medicine, 74, 1002-05.

Using Hospice Care When a Loved One is Terminally Ill. (1989). St. Meinrad: Abbey Press.

# Appendix

1. Survey

2. The Rights of the Dying

3. Case Studies

4. Graphs

This project focuses on the formal education given to medical students regarding the topic of death, dying, and bereavement. It is my hypothesis that Tennessee's Medical Schools can better prepare their students to deal with death in a clinical setting. In order to collect applicable data, the researcher devised the following surveys. These surveys were used to interview ten physicians and ten chaplains about the instruction they received throughout medical/seminary school on the subject of death, and their suggestions for the more effective teaching of death and dying instruction.

**A. Instruction received while in medical school**

1. Describe the instruction gained throughout medical school which taught you how to deal with death and dying. Was this instruction presented in the form of one course specific to death and dying, or a variety of courses which touched on the issue?

______ none received ______ one course ______ variety of courses

2. To what degree was interactive learning (e.g. role playing, videos) incorporated into your instruction?

______ never ______ minimally incorporated ______ every so often

______ regularly incorporated

3. How much of this instruction dealt with the actual death and dying process?

______ 0% - 24% ______ 25% - 49% ______ 50% - 74% ______ 75% - 100%

4. Were you taught how to share an impending death with the patient and/or their family while in medical school? ______ yes ______no If yes, what strategies were you taught?

5. Were you taught strategies for sharing an actual death with the family? ______yes ______ no If yes, what strategies were you taught?

6. To what degree did your education offer instruction on how to personally deal with the death of a patient?

______ never discussed ______ rarely discussed
______ discussed every so often ______regularly discussed

7. In retrospect, how well did the death and dying instruction offered by your medical school prepare you to deal with real-life death situations?

______ poorly prepared ______ fairly prepared ______ adequately prepared
______very well prepared ______excellently prepared

8. Throughout which year(s) of medical school was this material taught?

______ year

9. What would you have liked to learn in medical school about death-related concerns that you did not learn?

10. Do you feel Death, Dying, and Bereavement should be a required course in medical school, and why?

**B. Medical experience gained through <u>field exposure</u> (residency to the present)**

11. What type of death situations have you most frequently encountered beyond your medical school exposure?

______ Sudden loss of life ______ Death due to chronic illnesses
______ Death due to terminal illness ______ Death due to old age

12. Describe how you handled and explained the dying process to your first terminally ill patient who died.

13. Now that you are a practicing physician, what topics do you feel are important for a future physician to know about death and dying?

14. What experiences gained through field exposure best enable you to deal with patients and families regarding death situations?

**C. Continuing education**

15. What insights can you offer medical students to help them deal with their first dying patient?

16. How often do you deal with the death of your patients?

______ rarely ______ often ______ regularly

17. How do you consistently cope with death situations?

18. Is there anything else you would like to add?

Name_______________________________________________
Date________________________________________________
Type of physician_____________________________________
Years in practice since medical school__________________________

## A. Instruction received while in seminary school

1. Describe the instruction gained throughout seminary which taught you how to deal with death and dying. Was this instruction presented in the form of one course specific to death and dying, or a variety of courses which touched on the issue?

______ none received ______ one course ______ variety of courses

2. To what degree was interactive learning (e.g. role playing) incorporated into your instruction?

______ never ______ minimally incorporated (1-2x/course)

______ every so often (1-2x/month) ______ regularly incorporated (every week)

3. How much of this instruction dealt with the actual death and dying process?

______ 0% - 24% ______ 25% - 49% ______ 50% - 74% ______ 75% - 100%

4. Were you taught how to share an impending death with a patient and/or their family while in seminary? ______ yes ______no If yes, what strategies were you taught?

5. Were you taught strategies for sharing an actual death with the family while in seminary? ______yes ______ no If yes, what strategies were you taught?

6. To what degree did your education offer instruction on how to personally deal with the death of a patient?

______ never discussed ______ rarely discussed

______discussed every so often ______regularly discussed

7. In retrospect, how well did the death and dying instruction offered by your school prepare you to deal with real-life death situations?

______ poorly prepared ______ fairly prepared ______ adequately prepared

______very well prepared ______excellently prepared

8. Throughout what year of school was this material taught?

______ year

9. What would you have liked to learn in seminary school about death-related concerns that you did not learn?

**B. Experience gained through <u>field exposure</u> (clinical pastoral education to the present)**

10. What type of death situations have you most frequently encountered beyond seminary?

______ Sudden loss of life ______ Death due to chronic illnesses

______ Death due to terminal illness ______ Death due to old age

11. Describe how you would handle and explain the dying process to a terminally ill patient.

12. Describe how you would handle and explain the death of a loved one to their family.

13. What experiences gained through field exposure best enable you to deal with patients and families regarding death situations?

14. Based on your experiences, how would you rate the performance of medical students and residents when they discuss death with patients and/or families?

_______poor _______fair ______ adequate

_______good _______excellent ______ N/A

15. Do you feel Death, Dying, and Bereavement should be a required course in medical school, and why?

16. If you were to teach a course in medical school on death and dying, what topics do you feel are important for a future physician to know about death and dying?

## C. Continuing education

17. What insights can you offer medical students to help them deal with their first dying patient?

18. How often do you deal with the death of a patients?

______ rarely ______ often ______ regularly (weekly)

19. How do you consistently cope with death situations?

20. What do you view as the best approach for dealing with a patient's faith and spirituality issues?

21. Is there anything else you would like to add?

Name________________________________________________
Date________________________________________________
Job Title_____________________________________________
Years in practice since seminary ___________________________

- The following seventeen rights are explained and illustrated throughout David Kessler's book, The Rights of the Dying. The researcher suggests that medical students read this book throughout the lecture portion of the class. In addition, students may participate in book discussions where they discuss their feelings and opinions of what has been read.

### The Rights of the Dying

1. The right to be treated as a living human being.
2. The right to maintain a sense of hopefulness, however changing its focus may be.
3. The right to be cared for by those who can maintain a sense of hopefulness, however changing this may be.
4. The right to express feelings and emotions about death in one's own way.
5. The right to participate in all decisions concerning one's care.
6. The right to be cared for by compassionate, sensitive, knowledgeable people who will attempt to understand one's needs.
7. The right to expect continuing medical care, even though the goals may change from "cure" to "comfort" goals.
8. The right to have all questions answered honestly and fully.
9. The right to seek spirituality.
10. The right to be free of physical pain.
11. The right to express feelings and emotions about pain in one's own way.
12. The right of children to participate in death.
13. The right to understand the process of death.
14. The right to die.
15. The right to die in peace and dignity.
16. The right not to die alone.
17. The right to expect that the sanctity of the body will be respected after death.

Kessler, D. (1997). The rights of the dying: A companion for life's final moments. New York: HarperCollins Publishers.

## Case Study I

Mrs. Adams, 56, is admitted to the hospital in order to investigate a rapid amount of weight loss and continual headaches. As her physician, she explains to you her fear of dying, and her fear of enduring intense pain. After conducting the appropriate tests, you find a brain tumor and realize that surgery is not an option.

Mrs. Adams' family includes her husband, Tom, and their three children ranging in ages from 21 to 26 years. Because Mrs. Adams is the primary breadwinner for the family, you know her death will add an additional burden to the pain her family is already experiencing. After discussing her tumor with a colleague, you decide that she has approximately 2-4 months left to live.

One additional complication results from the fact that Mr. Adams asked you not to inform his wife of her test results if the news was not favorable.

A. Discuss communication strategies you should use to help Mr. Adams understand why his wife must be fully informed of her test results.

B. Discuss the strategies you can use to tell Mrs. Adams of her results and likely death within 2-4 months.

C. What types of emotional support and resources should you offer Mrs. Adams' family?

D. How can you best alleviate Mrs. Adams' fears surrounding death and dying in pain?

Created by Trina E. Dorrah

## Case Study II

Mr. Burks was recently diagnosed with AIDS. Although he consulted a variety of different physicians, the diagnosis remains the same. You are his seventh physician, and you notice that he is still very much in denial regarding his prognosis. Given the advanced nature of his disease, you realize he probably has less than a year to live.

During your first visit with Mr. Burks, he tells you that he has not prepared a living will, and he refuses to talk about his feelings on issues such as life-sustaining treatment, palliative care, or pain control. He simply states that if the need arises, he will explore the option of physician-assisted suicide. Considering the fact that physician-assisted suicide is illegal in your state, you fear Mr. Burks' refusal to plan ahead will force someone else to make his decisions when he is no longer capable. However, this person's decisions may contradict the unexpressed wishes of Mr. Burks.

A. As Mr. Burks' physician, how can you help him move beyond his denial?

B. How can you help him understand the importance of planning ahead and formulating care goals?

C. What types of issues are important for you and Mr. Burks to consider as the two of you formulate care goals?

D. How can you continue to help Mr. Burks while simultaneously refusing his request for physician-assisted suicide?

Created by Trina E. Dorrah

## Case Study III

Stephanie, 7, suffers from acute lymphocytic leukemia. Her suffering has greatly affected you, considering her youthful age and the fact that she has been a patient of yours since her birth. Since the progression of her disease, she has bravely endured chemotherapy and a bone marrow transplant. However, none of these treatments have proven successful. As her oncologist, you recognize the fact that Stephanie's death is most likely imminent.

Her family approaches you and explains the fact that a special ceremony must be performed at the time of her death in accordance with their culture and religion. Because the hospital chaplain is of a different culture and religion than Stephanie, he is unable to perform the ceremony. However, as Stephanie's physician, you want to do everything possible to accommodate the family's wishes.

A. If Stephanie dies, how can you ensure that her religious wishes are met despite the fact that the hospital chaplain cannot perform the ceremony?

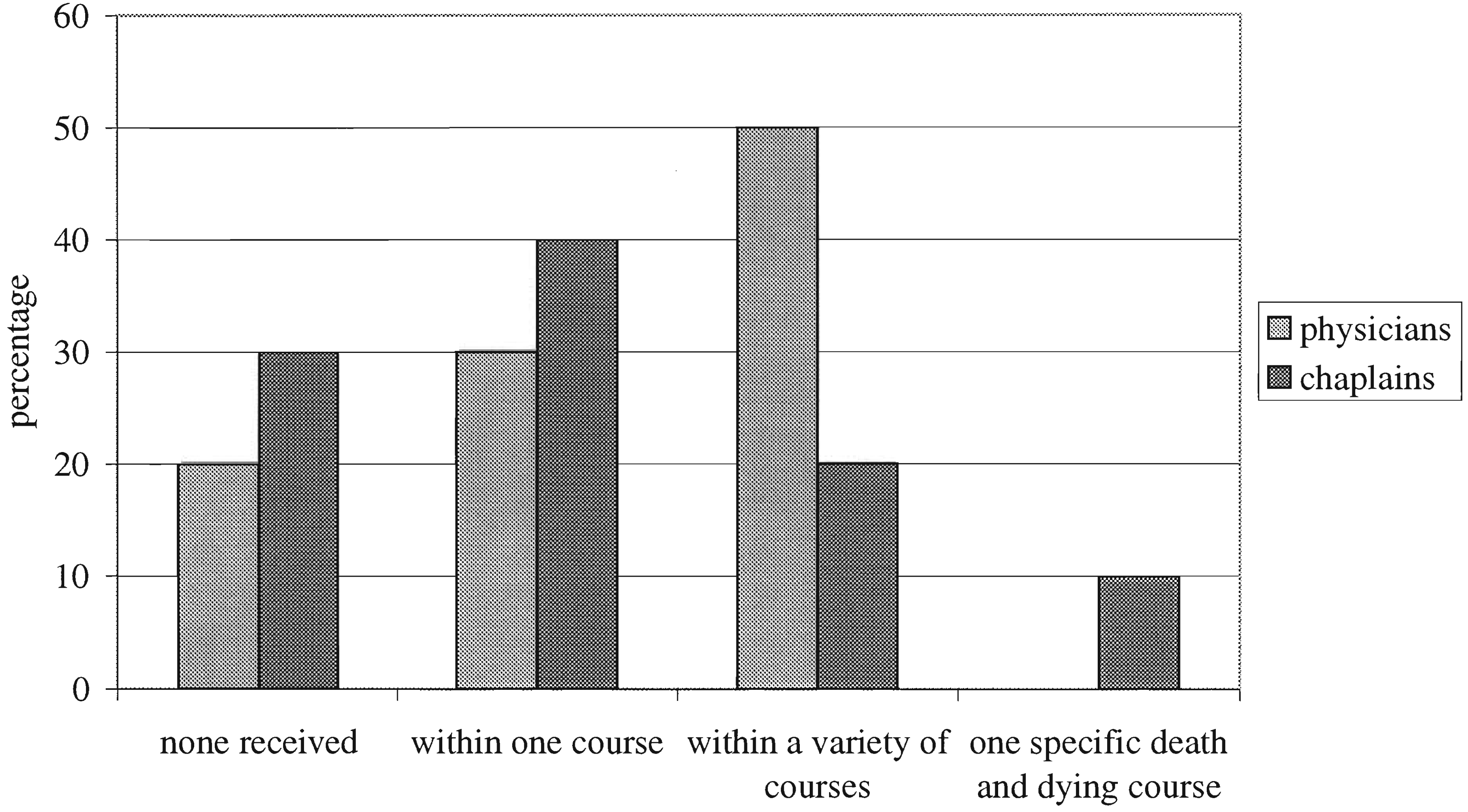
B. What cultural issues must you understand in order to effectively help Stephanie and her family throughout the remainder of the dying process?

C. What are some personal coping strategies you could use in order to effectively deal with the pain you feel surrounding Stephanie's condition?

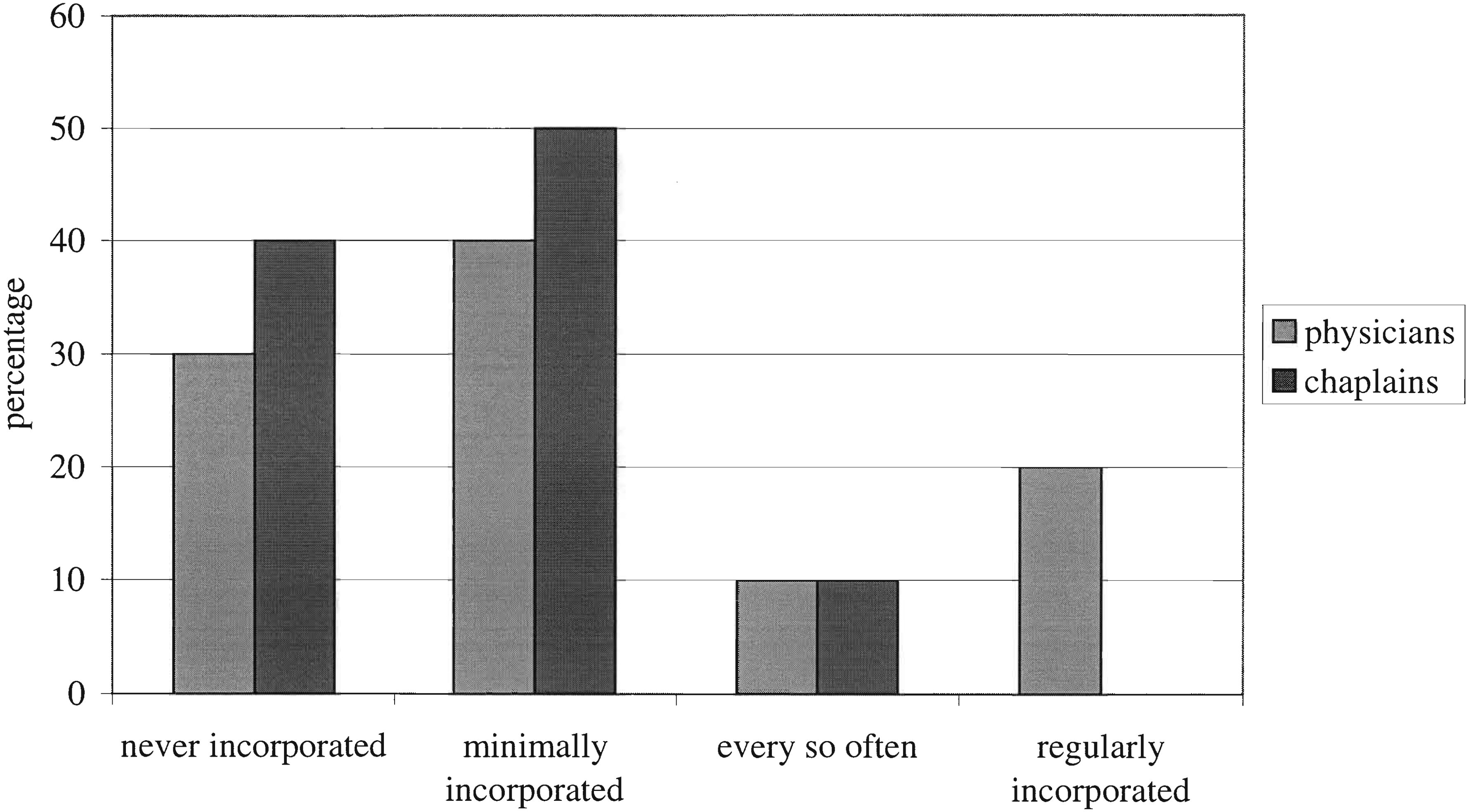
D. How can you help Stephanie's family accept her death if or when it occurs?

Created by Trina E. Dorrah

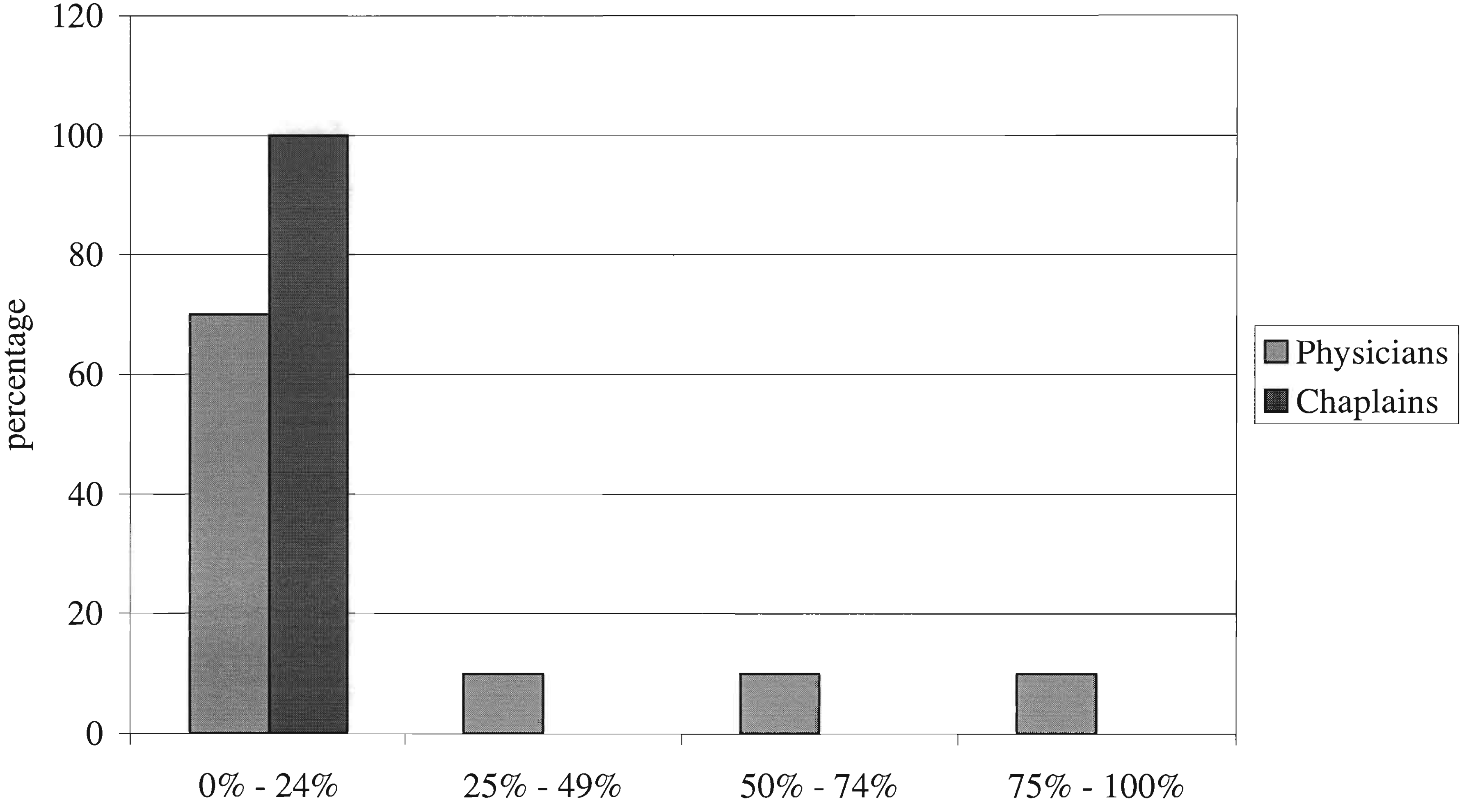
### The Amount of Death and Dying Instruction Received by Physicians and Chaplains While in Medical/Seminary School



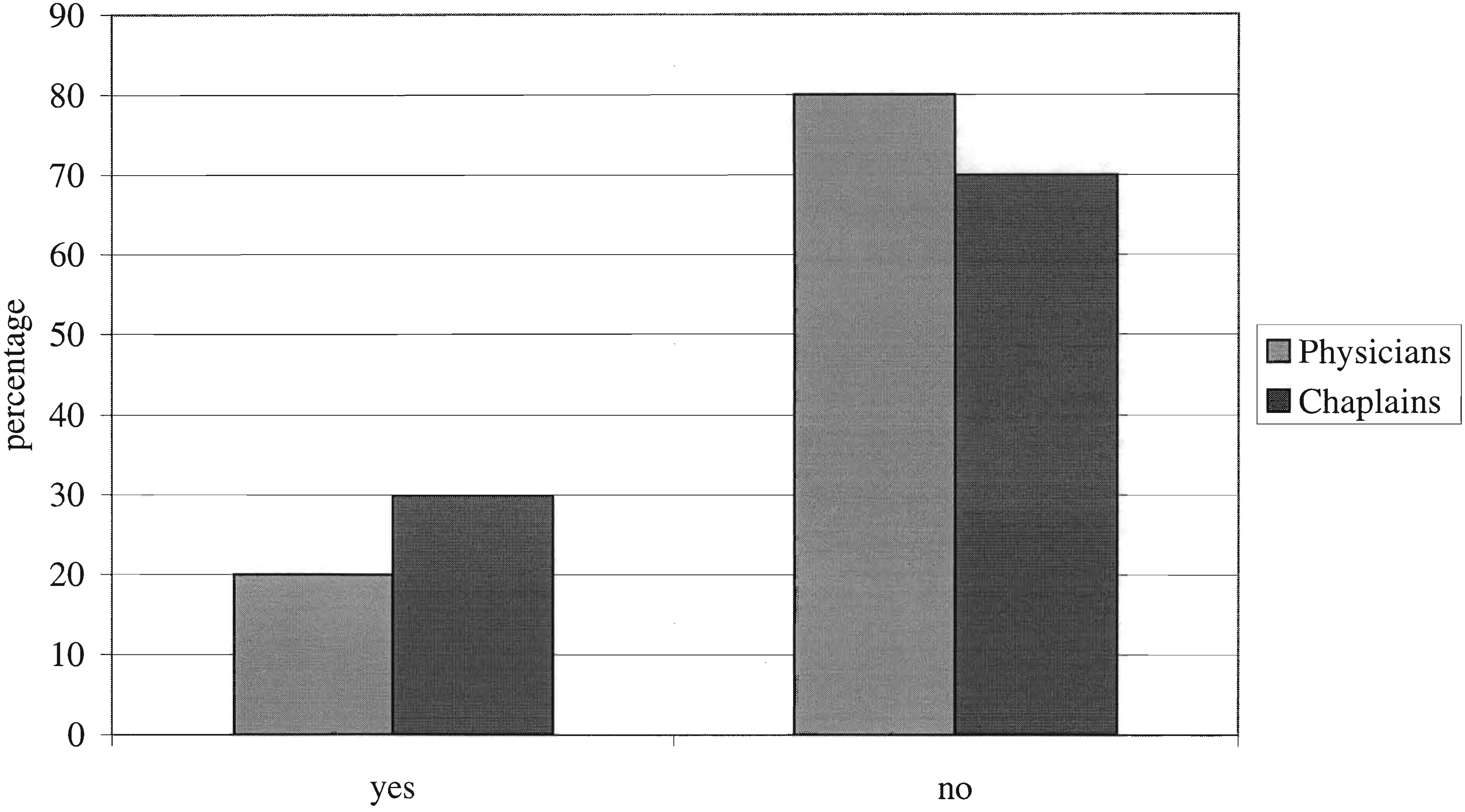
## The Amount of Interactive Learning Incorporated into Death and Dying Instruction While in Medical/Seminary School



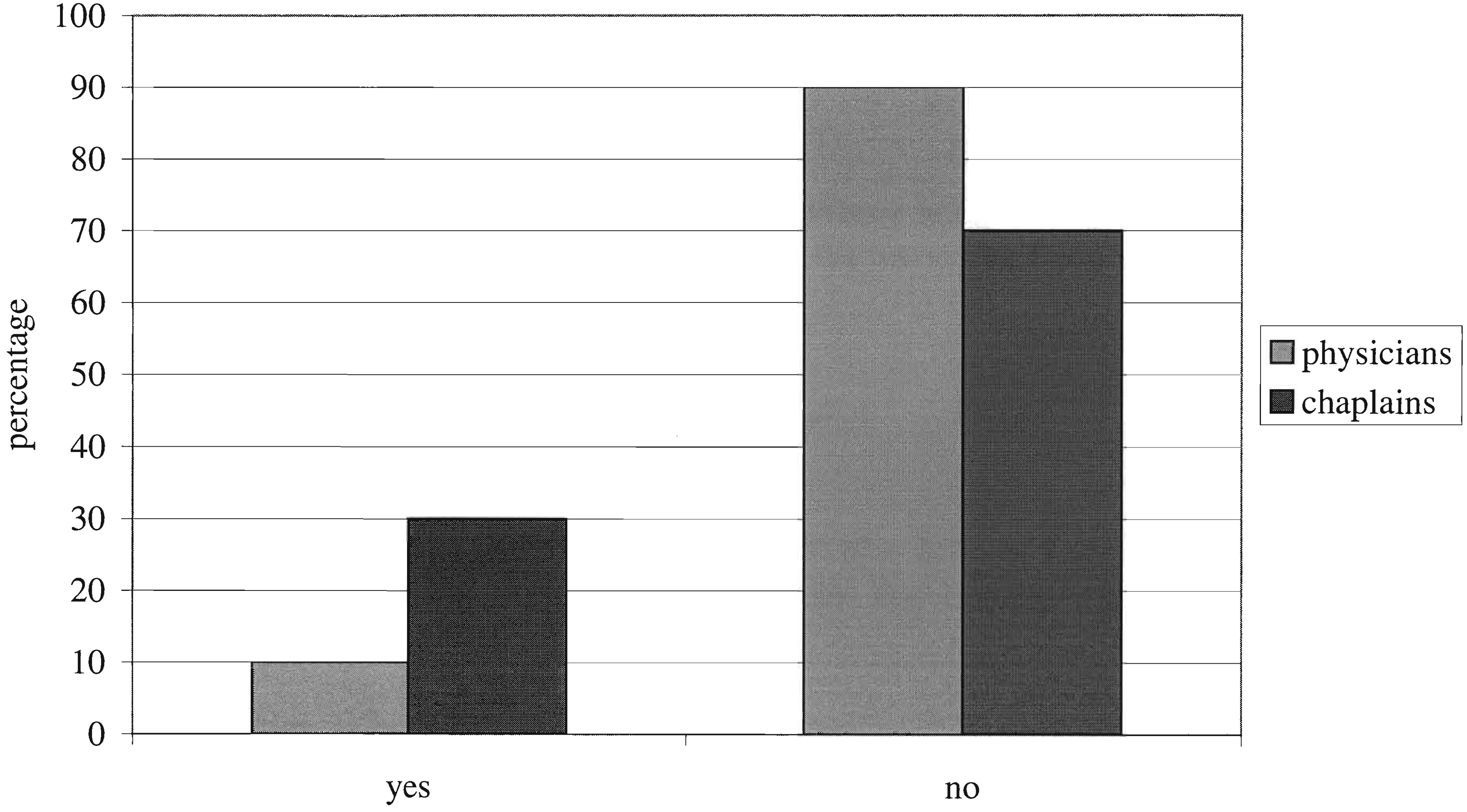
## The Amount of Instruction Received in School Dealing with the Actual Death and Dying Process



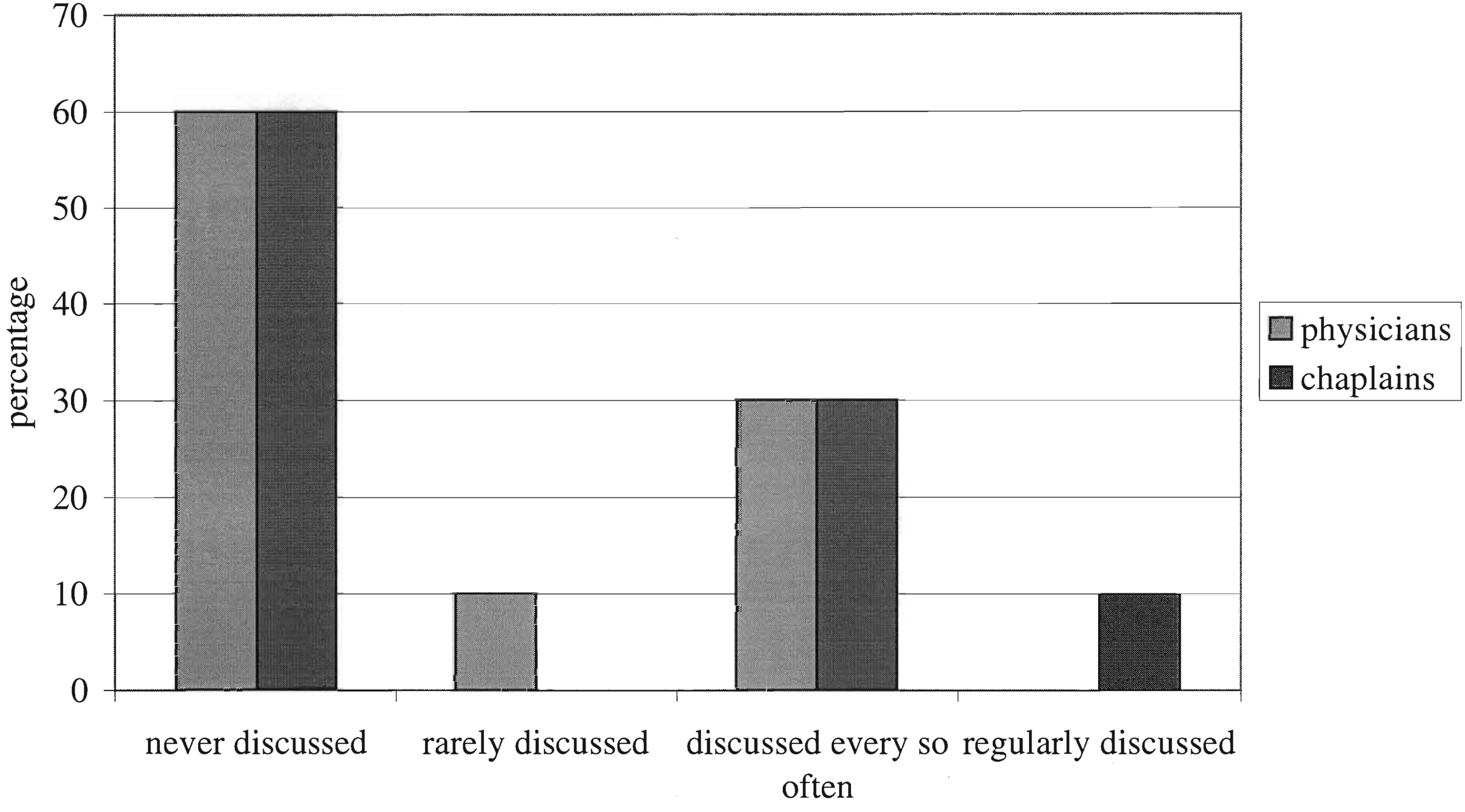
# The Percentage of Physicians and Chaplains Whose Schools Taught Strategies for Sharing an Impending Death with the Patient/Family



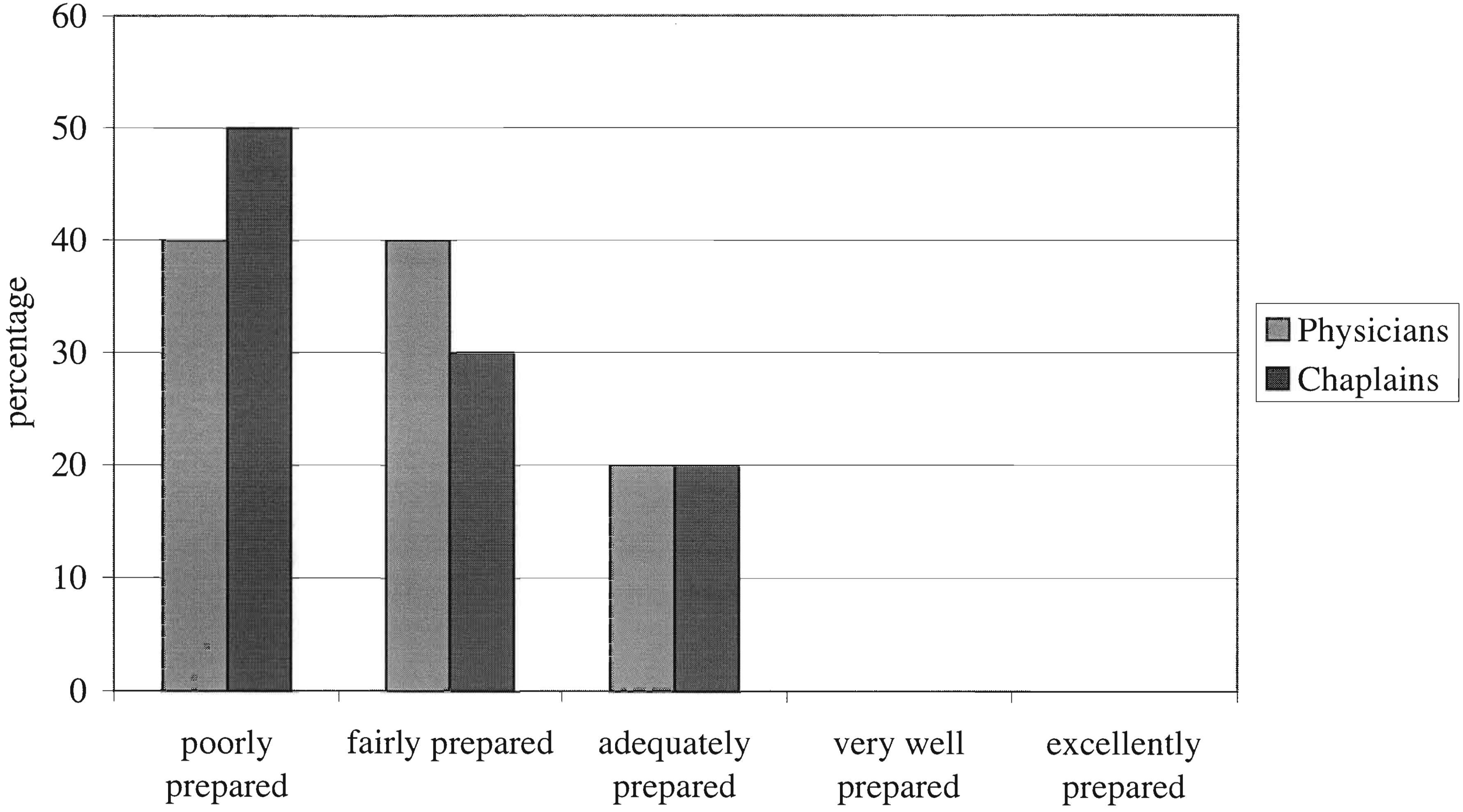
**The Percentage of Physicians and Chaplains Whose Schools Taught Strategies for Sharing an Actual Death with the Surviving Family**



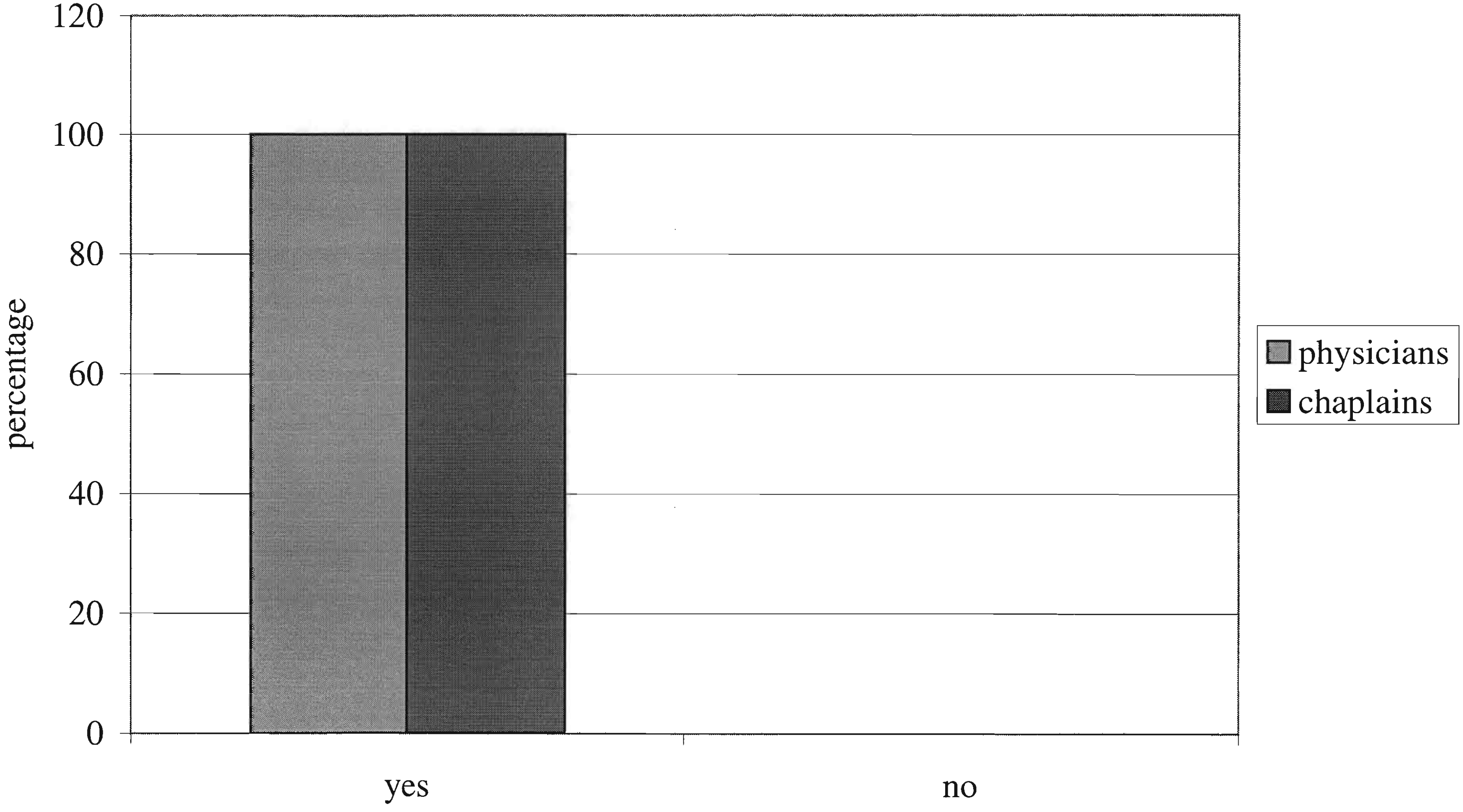
**The Frequency of Instruction Received by Physicians and Chaplains on How to Personally Deal with the Death of a Patient**



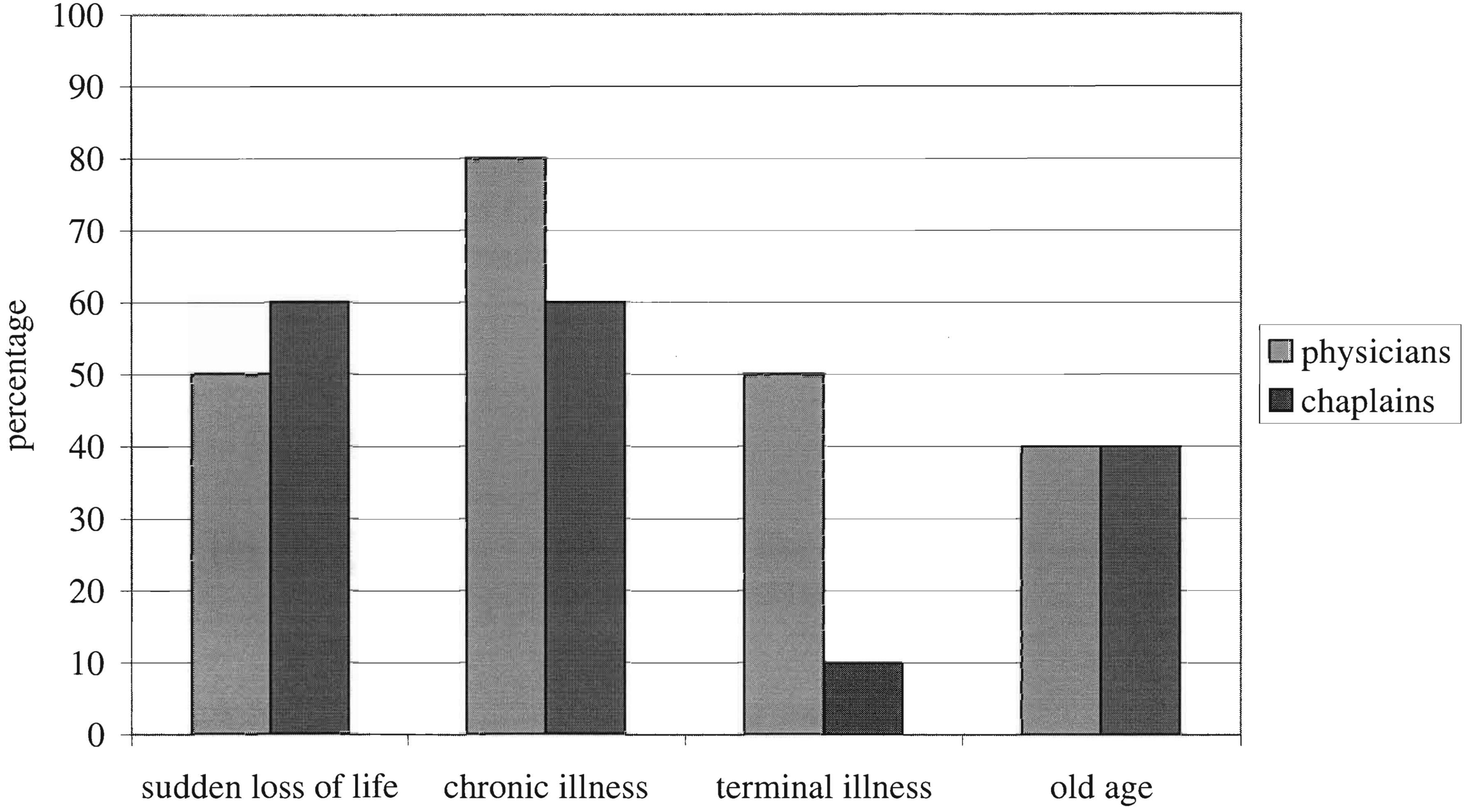
## How Prepared Physicians and Chaplains Felt when First Encountering Death Situations Following Medical/Seminary School



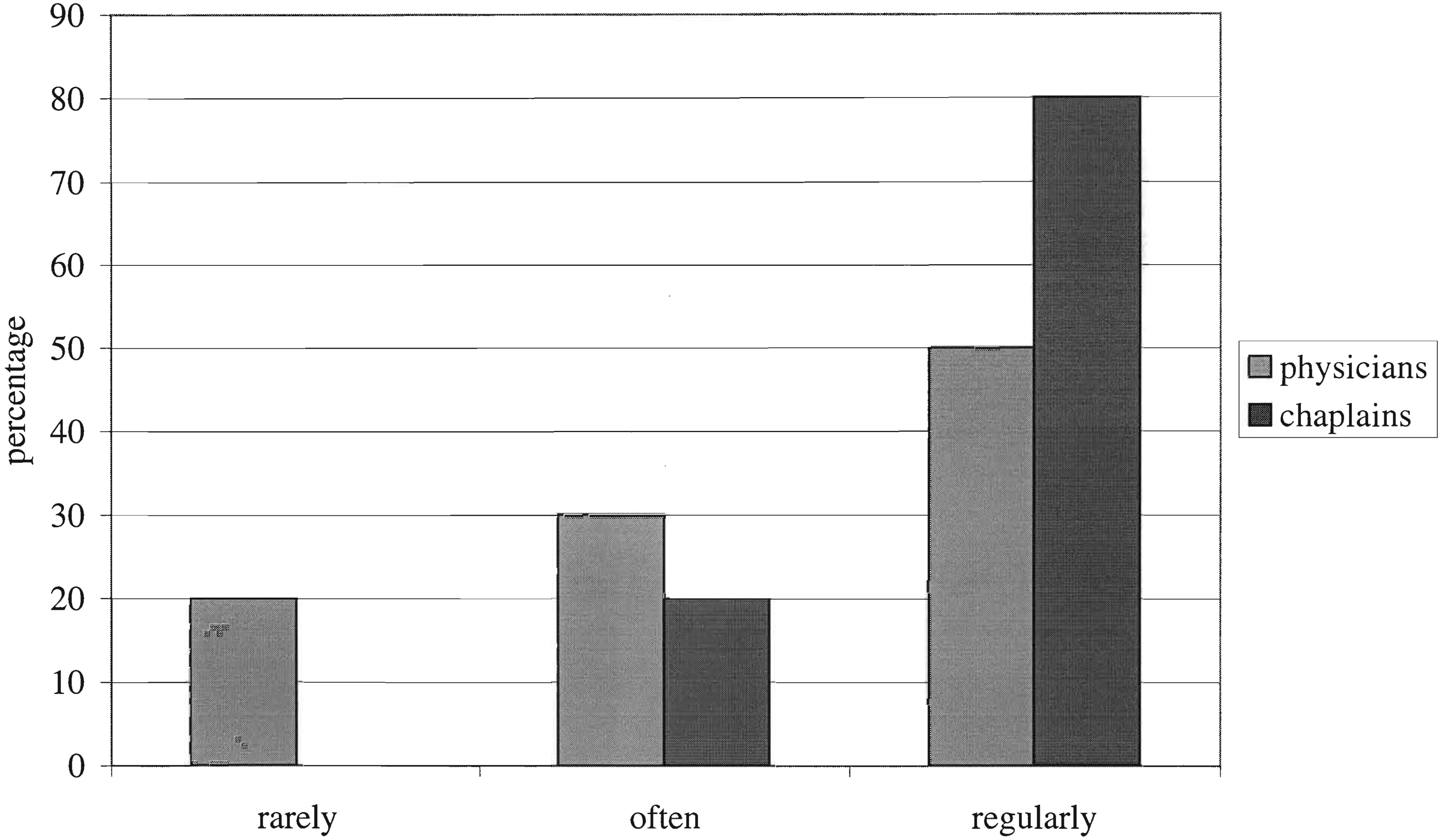
**Percentage of Physicians and Chaplains Believing Death, Dying, and Bereavement Should be a Required Course in Medical School**



## The Most Frequent Causes of Death Encountered by Physicians and Chaplains in their Current Practices



## How Frequently Physicians and Chaplains Deal with their Patients' Deaths



## How Chaplains Rate the Performance of Medical Students and Residents as they Discuss Death with Patients/Families