

“I Will Never Let That Be OK Again”: Student Reflections on Competent Spiritual Care for Dying Patients

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Abstract

Purpose

To examine medical students' reflections on the spiritual care of a patient who has died so as to understand how students experienced this significant event and how they or their teams addressed patients' spiritual needs.

Method

In 2010–2011, the authors gave third-year students at Loyola University Chicago Stritch School of Medicine an essay assignment, prompting them to reflect on the experience of the death of one of their patients. The authors analyzed the content of the essays using an iterative, multistep process. Three

authors independently coded the essays for themes based on the competencies (developed by Puchalski and colleagues and reflected in the essay prompt) of communication, compassionate presence, patient care, and personal and professional development. The authors reached consensus through discussion.

Results

A salient theme in the students' writings was awareness of their personal and professional development. Students reported being aware that they were becoming desensitized to the human dimension of care, and particularly to dying patients and their families.

Students wished to learn to contain their emotions to better serve their patients, and they articulated a commitment to addressing patient and family needs. Students identified systemic fragmentation of patient care as a barrier to meeting patient needs and as a facilitator of provider desensitization.

Conclusions

Written student reflections are a rich source of data regarding the spiritual care of dying patients and their families. They provide insight into the personal and professional development of medical students and suggest that medical schools should support students' formation.

For several decades, medical education in the United States has sought to train physicians to focus on patient care issues beyond disease and procedures

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so as to meet the needs of the “whole patient.” This expanded focus includes recognizing the psychosocial impact of illness on the patient's life and, similarly, acknowledging and addressing patients' spiritual needs.

Although spirituality has a wide and complex array of definitions, in its simplest form, it is a meaning-making activity related to existence and the relationships that define worthwhile living for an individual. Spiritual needs can include community, religion, faith, God, family, hope, compassion, and prayer. The ability to integrate one's illness and impending death into meaning-making is possibly the ultimate spiritual need. Conversations pertaining to spiritual needs are increasingly expected of nurses; further, patients also desire such conversations with their physicians.¹ As a result, researchers from multiple schools, convened by the George Washington Institute on Spirituality and Health (GWish), recently outlined a set of six competencies for medical education curricula related to spirituality and medical care: communication, patient care, compassionate presence, personal and professional development,

knowledge, and health care systems (see Puchalski and colleagues² commentary in this issue of *Academic Medicine*).

Although spiritual needs can be minimal and form a distant backdrop to typical physician–patient encounters, issues related to a patient's spiritual needs are often more prominent when the patient is facing foreseeable death.³ During such times of potential existential crisis, supporting the patient and family in compassionate and caring ways is an important part of being a doctor and not merely a technician.⁴ In light of this growing awareness, we asked third-year medical students at the Loyola University Stritch School of Medicine (SSOM), a Jesuit (Catholic) medical school, to reflect in writing on the death of a patient that occurred during one of their clinical rotations. Through the students' own descriptions of these events, we sought to understand how students experienced this significant event and how they or their teams addressed patients' spiritual needs.

Several previous studies have examined students' experiences of caring for dying patients as well as the effects of

these experiences on their professional development. In two oft-cited studies by, respectively, Wear⁵ and Rhodes-Kropf and colleagues,⁶ students reported that the medical team typically focused on the biomedical aspects of the patient's care and death and did not explicitly discuss the emotional or spiritual dimensions of care. Researchers have been most interested in the process by which medical trainees form their professional identity during their medical education. Some medical schools have implemented reflective exercises related to the death of a patient with the express purpose of providing an opportunity for students to develop appropriate attitudes and affect.⁷ Although reflection does not necessarily translate to professional and personal formation, it has proved to be a viable means of counterbalancing negative influences within the hidden or informal curricula.⁸ Students are socialized not only by formal curricula but through interpersonal interactions (the informal curriculum) and the institutional structures that embody an implicit set of norms (the hidden curriculum).

The prompt we provided for SSOM students, asking them to reflect on spiritual needs at the end of a patient's life, is aimed—at least in part—at addressing the hidden curriculum which often fails to convey the importance of recognizing the patients' and others' needs outside of their medical needs. We hoped that by explicitly prompting students to consider how others cared for dying patients, they would more easily identify good role models.

Method

For this project, we used the aforementioned list of competency domains developed by GWish. As explained by Puchalski and colleagues,² these competencies were developed through a process involving researchers from several medical schools who, first, conducted semistructured interviews with key informants and, then, articulated the specific domains and behaviors at a consensus conference.

Third-year medical students at SSOM usually submit a written analysis of a clinical case involving an ethical issue as part of their doctoring course, Patient-Centered Medicine. Approximately six

hours of this course focus on end-of-life care, particularly pain management and ethical decision making regarding treatment(s). Furthermore, all first-year SSOM students participate in a chaplain-mentor program that exposes them to the ideals of caring for the whole person, including his or her spiritual needs.

As part of a larger educational innovation during the 2010–2011 academic year, we randomized students such that one-third wrote the traditional ethics case paper and two-thirds submitted a reflection on the death of a patient. This prevented any self-selection bias and ensured that we had a large and representative group of students reflecting on the death of a patient. We gave the students the assignment approximately two months into their third year of medical school (October), and the final essay was due approximately five months later (March); thus, by the time they submitted their essays, almost all of the students would have participated in their five required clerkships (and the vast majority of these students would have completed these clerkships at the tertiary hospital associated with the academic health science center). The assignment's instructions explicitly prompted the students to reflect on four of the six GWish competencies (patient care, communication, compassionate presence, and personal/professional development):

Please tell us about your experience in caring for a patient who died. Your paper should focus on your personal experience of this patient and all the people involved in this process. We also hope that you will tell us about the ways in which you and the other members of the healthcare team took care of the patient and his or her family's spiritual needs.

Consider telling us about issues that were important from your perspective; this might include matters of communication, the ways in which particular care givers did or did not demonstrate compassionate presence, the extent to which the patient's and patient's family's spiritual needs were evident to, assessed, or addressed by the caregivers. Share any insights regarding the spiritual needs or resources of the members of the healthcare team, including yourself. Please close your paper with a discussion of how this experience has impacted how you care for yourself today and/or how this has influenced your care of patients, if at all.

We defined neither terms that may be less obvious (e.g., “compassionate presence”) nor those that relay more foundational concepts (e.g., “spiritual”) in order to keep the prompts as open-ended as possible.

This research was approved through expedited review by the institutional review board of the Loyola University Chicago Health Sciences Division. Students provided signed informed consent and, although the essay was a required assignment, they were given the option to not participate. We provided no incentives for participating in this study. We removed all patient and physician names and any other personally identifying information from all quotations included in this manuscript.

Coding of the student essays consisted of an iterative, multistep process using a content analysis approach.⁹ Content analysis is an approach widely accepted in health science research that aims to understand a phenomenon or experience; it does not make generalizations based on statistical inference.¹⁰ First, two medical school faculty, (i.e., a bioethicist [M.K.] and a physician [A.M.]), plus a medical school chaplain (M.M.), independently read and coded each of the student essays, looking for themes that emerged under each competency. They noted the initial impressions, topics, and themes the students raised under each competency, constantly comparing them with themes presented in previous essays and seeking potential explanations. Then we met to compare themes and salient quotes and to discuss and resolve discrepancies. We sought consensus, selecting those themes identified independently by at least two raters.

After we identified themes that emerged under each competency (patient care, communication, compassionate presence, and personal/professional development), we reorganized the qualitative data (quotes) relevant to each theme into code reports, which identify the text to which each particular code was applied. During the preliminary analysis, we reassembled data to promote coherent interpretation, to identify patterns, to test preliminary conclusions, and to place findings under the four areas of competency in addressing spiritual needs.¹¹

Results

Four themes emerged from the 68 students' responses to the prompt asking them to describe—in terms of the four competencies—the care of a patient who had died (a few students wrote about a patient who was in the process of dying). Several main themes emerged under each competency.

Communication

The major recurrent theme within the communication competency was conveying the prognosis of death. Students observed how their teams delivered and explained this prognosis. Conversely, they also wrote of teams that avoided it.

Some students reported that the care team treated various immediate health problems but never specifically discussed the fact that the patient was dying, either among themselves or with the patient and family. To illustrate, one student wrote:

Not once did my team mention or consider that Ms. W was in the process of dying. I did not hear any talk about end-of-life care, so I didn't think it was necessary to talk about this with the family. I spent a lot of time with them [the family] answering questions.... She [patient's sister] was very suspicious and felt like she was not getting the whole story. I don't think she did get the whole story either.

Several students noted that their team indicated that discussing death with the patient was the responsibility of another team. Students did not always feel empowered to broach the topic of death if the team leaders had not—and sometimes this disempowerment was explicit:

I was concerned that he [the patient] didn't really understand what was going on and asked my senior resident if one of us should have another talk with him to see what exactly his understanding was. "Don't do that," my senior resident said. "The other team is taking care of that."

However, students' essays more frequently revealed that faculty and resident physicians are doing good work in telling patients and family members about a foreseeable death. Students often noted clarity of expression and the absence of jargon in the messages of those who "broke bad news" to patients. These students highlighted a physician's

ability to be compassionate while not compromising the nature of the bad news by giving false hope of recovery.

I witnessed how Dr. B adapted his communication to each family member, making sure to focus on each [adult] child's specific questions and concerns and offer supportive reassurance while still conveying the likely outcome of Mr. S's situation.

Students reported that no matter how well a physician communicated a prognosis, families and individual family members absorbed and digested information in their own manner and at their own pace. One student recounted:

A minister was sent up to speak with the family ... the patient's wife began crying as soon as the minister had introduced himself.... We had previously informed them that the prognosis was dismal, however, it was as though that message was not clear until they were speaking to the minister.

Compassionate presence

We asked students to describe caregivers who were—or who failed to be—a "compassionate presence." As mentioned, we did not define this term in order to keep the prompt as open-ended as possible, which likely enabled the students to respond to what they saw as its plain meaning.

Students indicated that to be a compassionate presence is to take the time to actually be present to a patient and family. One student stated that as a medical student she had the "gift of time" to give to her patients:

After talking with the family member, I made a promise to spend more time with Ms. W and to understand all the details of her care, so I could be the one to communicate with the family. As a third-year medical student, there is only so much we can offer the team. Time is definitely one of those things.

Students noted that this presence includes personal contact beyond routine medical interaction, such as sharing interests, conveying affection, or continuing to show interest in the patient after treatment has ended. Such interactions can be more important than explicit spiritual counseling.

[O]ne aspect of our team's care that has remained with me, even months later, was the attending's intentional actions

to make a relational connection with the patient.... I was surprised by the softening of my attending's approach in this post-op period. While he did discuss prognosis and treatments from a medical perspective, he intentionally sought to connect with Mr. K. He spent time talking about their shared Civil War interests and discussing recent books they both enjoyed. I found out, after talking with Mr. K., that a combination of the intellectual approach and the personal connection with the surgeon were enough for [him] and his family to be "forever grateful." Before this realization, I wrestled with my perceived need to be able to offer deep, spiritual, and insightful words to this man.... However, Mr. K. both told and showed me that I didn't need "all the answers" ... I just needed to take the time to care.

From the students' perspective, compassionate presence is not a single technique but a way of comporting oneself to signal warmth and care for the patient.

Patient care

Five themes related to patient care emerged from the students' reflections: referring patients to pastoral care, participating in shared prayer when invited, addressing feelings of guilt and recrimination, reaching across the fragmentation of the health care system, and tailoring treatment plans to meet the patient's goals.

First, students noted the importance of involving pastoral services in the care of dying patients, whether through a formal referral or through less formal means.

It's important that even if the physician does not talk directly with the patient about [the patient's] spirituality, that the act of offering for them to talk to a chaplain is a means of communicating that they care about this aspect of the patient's emotional and spiritual well-being and [that they are] not solely focused on the physical aspects of [the patient's] health.

Second, students reported that some patients or their family members invited them to join in prayers. Praying with patients and families sometimes involved chaplains, and one student mentioned the involvement of an attending faculty member. The students uniformly reported that their experiences praying with patients and families were positive. One student's experience is illustrative:

On a couple of different occasions the family asked me if I would join them in a quick word of prayer when I came to check in on the patient. Through these moments I completely forgot that I was in the medical profession, and I became connected and a part of this family and the grieving and emotional process.

A third, far less tranquil theme that students raised involved addressing the expressed emotional needs of patients' family members. Several students who related experiences of the death of a child described how parents often seemed concerned that they had in some way caused their child's illness or did not seek treatment soon enough. Students noted that attending physicians and chaplains were quick to address potential self-recriminations and guilt and to provide reassurance.

I was reminded that physicians should put themselves at the same level as patients/loved ones, just as the intensivist did when he hugged the mother. His touch, simple enough to give, seemed to help her absorb and deal with the devastating news. Also, he was very [cognizant] to reassure the parents that they were not at fault for their child's illness.

A fourth theme related to health care that emerged was system fragmentation. Students reported that system-wide fragmentation of the health care system was a barrier to effective patient care. They described how patients move from one service to another and are cared for by entirely different people. Students discussed the importance of reaching across this fragmentation. One student described following a patient once that patient had been sent from the student's medicine service to a rehabilitation floor:

Despite this move and that we were no longer responsible for her, my attending encouraged me to check in on her regularly ... it also became evident that he was reading her chart regularly to ensure she was well cared for. Checking in on Ms. C every few days did indeed seem to be of benefit to her as well.... The knowledge that she was to go home and that people cared about her goals and her progression toward them seemed to truly lift her spirits.

Students observed that even if a patient remains on the same unit, personnel rotate off service. As a result, caregivers can avoid difficult discussions about spiritual needs—and they can foster their own denial of a patient's death. A student noted:

When I left the [unit], Ms. W. was still alive. I hoped that she would make it. In my head, I pretended that is what would happen because I knew that once I started my next rotation, it was likely that I would never see Ms. W. again. I was more or less "able to wash my hands of the situation." I think that as residents and students, we have the ability to do this because of our ever changing schedule.... I know that it is necessary to be able to move on, but there is still something so superficial about this that makes me sick.

Lastly, a couple of students astutely observed that consultant medical services often took a cookie-cutter approach to patients and would not tailor treatment to patients who no longer wished to try to extend their lives. One student discussed a dying patient who had poor cardiac output: The attending called a cardiac consult team because he believed that the patient's inability to clear fluid from her lungs and legs added to her discomfort. The cardiac team recommended a regimen of several intravenous (IV) medications. The attending asked for a modified regimen because the IVs would keep the patient hospitalized and she strongly desired to go home. But the cardiac team responded that they "would take no responsibility" for this patient's care unless their recommendations were followed. Other consulting teams were noted to be similarly inflexible.

Personal and professional development

As noted, we prompted students to tell us about (1) their own spiritual needs or resources and those of the health care team in coping with a patient's death, (2) their own self-care, and (3) the potential impact of experiencing a patient's death on their future patient care. We hoped these prompts would provide a snapshot of who the students are presently, how they maintain themselves through these intense experiences, and what kinds of physicians they see themselves becoming.

The spiritual needs or resources of the student and health care team.

Three themes emerged. First, students often reported feeling surprised by the death of the patient. Like students in previous research,¹² SSOM students characterized the suddenness of death or a patient's rapid decline toward death as surprising, shocking, or stunning. Students described experiences such as entering the patient's room and finding it empty and scrubbed of any trace of the patient. According to

students, such an experience was only sometimes followed by an attending or resident leading the team in some kind of debriefing.

Second, although some students wrote that their teams had some way of acknowledging death, others reported having no avenue for finding closure. Students related that their basic human tendency to connect with patients and family members was thwarted by the clinical routine, which usually fails to explicitly acknowledge death; these students relayed that when a patient died, the team simply moved on to the next case, leaving the student with unresolved feelings. One student wrote:

I didn't even get a chance to say goodbye to the family. Before I even realized what had happened, the family was gone, the patient removed from the list, and my next patient was waiting for me to take care of them. The team didn't make any comments about her death that morning, and everything seemed to continue and move on as if nothing had happened.... I initially did not know what I wish had happened [with the team], but the way the situation ended lacked any closure for me.

Third, students struggled to avoid becoming desensitized to the human reality that their patients were experiencing while also learning to control their emotions. Students noted feeling great empathy for patients and families. While wanting to remain sensitive, they also understood that they must develop control over their emotions lest these feelings distract from patient care. One medical student related an incident in which he cried when a baby unexpectedly died during delivery:

I just couldn't hold my emotions anymore and began balling.... I have never felt so helpless in holding my emotions. The hospitalist [who] was in charge of us immediately grabbed me and took me to a quiet room so I could sit down. I was so thankful for him to listen to me cry uncontrollably and attempting to get a handle on just what happened. He told me to let it out that it was OK. I will never forget that day.

Although students sometimes spoke of poignant experiences in which their emotions overflowed, many were aware that increasingly they were ceasing to react emotionally to situations as they typically would have prior to their clinical

experiences. In other words, students noticed their growing tendencies toward desensitization. Concern about becoming too callous prompted self-reflection and sometimes revulsion. One student related the story of watching a young gunshot victim die in the ER. After the trauma surgeon pronounced the patient dead, a nurse escorted the student to look at the body and engage this opportunity for a “human anatomy class.” The student was ambivalent:

I kept seeing the scene over and over again in my mind and I struggled to define my feelings toward the situation ... the medical student side of me ... kept thinking, “I’m so glad I got to see that,” or “That was awesome to see everything I’m learning come together so quickly.” But, then the other half of my mind kept thinking, “That was a real human being [who] died in there.... It was not awesome, it was horrible.”

Some students clearly articulated their ambivalence toward the socialization process they were undergoing. They were concerned to complete it successfully so they could be good physicians but feared leaving too much of their better selves behind. One aspiring surgeon wrote:

In the end, I realized a transformation has happened over the course of my third year. I’ve tiptoed the line between attachment and detachment, either becoming too emotionally involved in a case or too distant.

Student self-care. Students noted that reflection can be helpful for improving their care of patients and enhancing their own sense of meaning.

I have always been more thoughtful and have worked on processing things in my own life. However, since starting medical school, I have realized that my times of reflection have significantly decreased. I have been processing my academic performance, but have spent much less energy focusing on the deeper meanings of my patient encounters. Mr. K reminded me of this deficit. Even as students, we are part of our patient’s stories, and they are/ should be a part of ours.

Some students noted prayer as a self-care technique. The student who was torn between fascination with the physiology of death and horror at a tragic, violent death reached reconciliation through prayer.

At the end of the night, I had not found any sort of peace with the events I

witnessed that day. I was still torn between siding with the medical student in me, or the emotions of a human being. Finally, I realized that I did not have to pick sides. I could be, and should be, both.... So, at the end of the night, I simply ended my internal argument by praying. I prayed for Mr. P and his loved ones.... I prayed for medical staff who care for these patients on a daily basis. And lastly, I prayed that throughout my career, no matter how many patients I see or deaths I encounter, I hope that I continue to face these questions and emotions so that I can help my own patients to die with the great deal of dignity and respect which we all deserve.

Impact on the student’s future caring for patients. Students often expressed a kind of pledge to take certain steps in the future. One student, remarking on how her team did not address the spiritual and palliative needs of the patient or family, asserted, “I will never let that be OK again.” Many students expressed similar pledges related to breaking bad news effectively, providing information directly and compassionately, and tailoring care plans to meet the needs of dying patients.

Students made commitments to remain aware of and sensitive to the needs of patients and families. These commitments seemed to be a response to their frustration at the silence that often surrounded a patient’s impending death and the lack of acknowledgment that followed it. Students emphasized spending time with patients, and vowed to take the time to listen to and meet the needs of each dying patient and his or her family. To illustrate, one student wrote, “All I can do is take this experience and move forward by being there for others when the time comes.” Another student indicated that he has concretely taken steps to implement this commitment:

[I]n a few situations since the time described above, I have turned to the family and asked them if they would like me to be present throughout the whole situation and if it would offer them any comfort if they had my number and knew I would be there when the time came for the death of their loved ones. I have also turned to my residents and asked them to please let me know/call me when this time arises.

Another pledge was a commitment to make pastoral care referrals. One student promised, “If I am not available to be present with those grieving, I will make

sure that other qualified people are so these people are not alone.”

In general, students pledged to avoid the mistakes or shortcomings they had seen modeled. Students committed to improving their skills in end-of-life care: delivering bad news, making hospice referrals, and connecting with patients. They also committed to ongoing reflection, which some viewed as a way to improve their skills. For others, reflection serves as a tool to help them remain sensitive to the dignity of each patient and not allow clinical stressors to desensitize them. One student’s comments illustrate the value students place on ongoing reflection:

Looking back on this experience many months later, I see how much that first experience with patient death has shaped my third year. Unfortunately but predictably, I’ve had other patients this year who have passed away. Even in the moments when I’ve been really tired and just overwhelmed, I remember Mr. A—that to someone—this is the loss of someone immensely important.

Discussion

The various themes that developed under the competencies of communication, patient care, compassionate presence, and professional development provide insight into what knowledge, skills, and attitudes students found most relevant in meeting the spiritual needs of patients. In addition, by providing an opportunity to reflect on a salient patient encounter and develop a narrative that includes the self-perceived impact on their future care, we also gained insight into the students’ experience of the socialization process of becoming a physician.

For the medical students, competent care that addresses the spiritual needs of patients and families is fairly straightforward: It involves clearly communicating that death is imminent, personally connecting with the patient and family, being open to requests (e.g., participating in a moment of prayer), and respecting the wishes of dying patients (e.g., a medical protocol that allows a patient to go home). Being available to patients and families and showing small kindnesses is a hallmark of the competent physician. Competent physicians also understand the roles of other experts and call chaplains to address patients’ deeper

spiritual issues. Interestingly, although in the first-year doctoring course (Patient-Centered Medicine 1) we teach students to take a spiritual history,¹³ no student mentioned doing so.

The clinical learning environment clearly exerts both a positive and negative influence on students. Students described many positive role models who demonstrated communication and interpersonal skills worth emulating. Many educators demonstrated sensitivity to patients' (and students') emotional needs. Others seemed to give into the temptation that has historically been described as treating the disease rather than the patient.⁶ Similarly, students noted that consulting teams sometimes deliver a one-size-fits-all regimen that fails to take into account the dying patient's particular goals. Students indicated that the fragmentation of the U.S. care system aids and abets these negative tendencies. Patients are moved along the continuum of care quickly, and patient care is delivered by ever-changing faces. Students understood compassionate presence to include not only literally being present but also reaching across the fragmented system to preserve continuity of care and a personal connection.

In this clinical environment, students were very concerned about their potential desensitization. They described the aftermath of a patient's death as rarely involving any specific acknowledgment, processing, or closure. Although they were frustrated by this seeming denial of a profound event, they also understood that denial could easily become commonplace for them. Students understood that they must temper their emotions in order to be patient-focused but not become so desensitized that the patient's emotional and spiritual needs recede from view. Similar to the finding of Kelly and Niskaer,¹⁴ our students evinced a tension between appropriate detachment and emotional connection with the death of the patient. As a result, students are eager to engage in reflection and to make commitments towards becoming the physicians they wish to be.

Our findings have two important implications for clinicians and educators.

First, we believe that teaching institutions should seek to standardize team protocols to formally recognize and process patient deaths. Something akin to a spiritual "time out" procedure after a patient dies might be an efficient yet effective way to acknowledge death.

Second, educators must find a way to support students in their wish to remain connected to and be present for dying patients and their families. Most immediately, students need support in developing habits of action conducive to their stated goals. For instance, if a student wishes to keep in mind the uniqueness and importance of each dying patient, he or she might pledge to write a brief reflection after breaking bad news to the family or after the patient dies. We must also find ways to reinforce constructive behaviors. To some extent, these behaviors must be self-reinforcing so that they can thrive amidst a system that offers no extrinsic rewards. Encouraging students to follow dying patients who have rotated off their service, allowing students to offer their pager number and physical presence to dying patients, and other like behaviors should be recognized as "best practices" among faculty. Medical student reflection exercises may lead to additional recommendations for behaviors that should be reinforced as part of the GWish competencies.¹⁵

Conclusions

Written student reflections are a rich source of data regarding the spiritual care of dying patients and their families. In our opinion, these reflections provide some insight into the ways that the spiritual needs of dying patients and their families are addressed within the hospital environment. Additionally, the reflections provide insight into the personal and professional development of medical students as they make the transition from layperson to professional. Medical schools must be attentive to these student needs and develop ways to support students in their formation.

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