

HOW DEATH ANXIETY AND EMPATHY ARE AFFECTED  
IN A CLASS OF MEDICAL STUDENTS WHO HAVE  
EXPERIENCED A PEER DEATH

CENTRE FOR NEWFOUNDLAND STUDIES

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FIONA TREND







HOW DEATH ANXIETY AND EMPATHY ARE AFFECTED IN A CLASS OF  
MEDICAL STUDENTS WHO HAVE EXPERIENCED A PEER DEATH

by

© Fiona Trend, B.Sc.

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## Abstract

Death is a certainty. We are socialized into our understanding of death by the culture, family, and society in which we live. We also live in a highly medicalized society. While it is possible for most of us to travel through life and, for the most part not think about death and dying, doctors do not always have that luxury. As a medical student one will unerringly be exposed to death as a part of their professionalization. In facing death, doctors face their own vulnerability. What they do with their emotions when they encounter death can influence the way they interact with patients. Showing empathy and compassion towards patients is essential for a good doctor-patient relationship. Research suggests, for example, that patient compliance is related to the physician's ability to communicate effectively with patients, and empathy is the key aspect of this communication (Jarski, 1987). In a class of medical students who have experienced a peer death, there is a unique opportunity to look at the effects of death on empathy and death anxiety. Differences between classes were statistically insignificant ( $p > .05$ ) for both empathy, measured with Hogan's Empathy Scale, and fear of death, measured with the Collett-Lester Fear of Death Scale. When divided into gender, females presented as slightly more empathetic than the men in the study ( $p > .10$ ). Gender also had a significant effect on overall death anxiety ( $p > .015$ ), and the "fear of death of self" ( $p > .000$ ) and "fear of dying of self" ( $p > .01$ ) domains of the scale with females presenting as more fearful. When divided by age, empathy scores were not statistically different between the groups. There was a significant difference in death anxiety for the overall scale ( $p > .01$ ) and "fear of dying of others" ( $p > .01$ ) with those 25 years of age and older presenting with less death anxiety.

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Med II, III and IV, 2002-2003- Thank you for your participation



Dedication

**In Memory of**

Gina Blundon

(1975–2001)

Soulmate, Sister, Daughter,  
Occupational Therapist, Medical  
Student, Friend



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## Chapter 1- Introduction

In the summer of 2001 I completed my internship in Counselling Psychology with the Department of Pastoral Care, Health Care Corporation of St. John's, General Hospital site. It was during this time that a first year medical student died suddenly of unexpected causes. I had an opportunity to join my site supervisor when he met with the first year medical students to provide them with an opportunity to talk about their experiences surrounding their classmate's death as well as decide what they would like to do in the future to commemorate her. The students were also split into discussion groups and given an opportunity to talk with each other about their experiences of the death. The funeral had taken place over the past weekend and the majority of the class had attended. They had already begun to consider how they would approach a memorial service within the medical school.

During this session they spoke about how they had first received the news. They had written a cardiology exam that morning and were asked to stay in the exam room when they finished. The Dean came in with several professors. It was at this point when the students said they knew something serious had occurred, or was going to occur. "The Dean doesn't just stop in to say 'hi'", said one student. An expulsion was the worst scenario that they could imagine to explain the Dean's presence that morning. No one expected news that a classmate had died.

The students made several statements that morning during the discussions; I began to think about them, leading to the development of this thesis. One student expressed that the hardest part of receiving the news was hearing the emergency room

doctor explain what happened and what the medical staff did to attempt to save Gina's life. After having just finished a cardiology exam, several students in the group I was facilitating expressed discomfort and uneasiness about hearing this information. I theorized that having been taught the material and studying to write the exam, they had objectified the process to such a great degree; now it was hard to hear someone they knew and loved becoming a part of that dehumanizing experience. I was curious to read the research literature and explore this theory farther. I also began to wonder if this experience would have an effect on how this class would relate to their patients in the future.

The memorial service followed at the end of the week; it was during this time that I realized that the student was someone that I knew from my childhood and then during our undergraduate years. I dedicate this work in her name.



I didn't know her very well but her death did affect me and I found myself thinking a lot more than I ever had before about taking people for granted, putting myself in other's shoes, understanding the importance of merely listening and how tremendous the impact is of a young person dying.

-Research Participant

### *Purpose of Study*

Death is a certainty. It is a part of life's cycle, as are birth, growth, decay, loss and gain, health and illness. Within Christian cultures, a common Bible passage reinforces this notion. Ecclesiastes 3:1-9 states, "For everything there is a season, and a time for every matter under heaven" (Revised Standard Version). Within popular culture, the Byrds used this passage in "Turn! Turn! Turn! (To everything there is a season)". Yet, despite our familiarity of death and its prominence ("only two things are certain, death and taxes"), we avoid thinking and talking about death.

Philosophers suggest that there are reasons why death is difficult for us to consider (Reeves, 2001). There is the inescapable fact that those we love and we ourselves will die. This brings us face to face with our mortality. We are not going to live forever. And we will die alone. No matter how many friends and family we have around us at the time of death, we will have a unique experience, shared by no one else. This creates in us an existential isolation. Our understanding of the meaning of life is a great unknown. We need meaning to exist, yet to understand the meaning of death is to understand the meaning of life and vice versa. These questions about the nature and meaning of life are forced upon us when we encounter death. When we encounter death, we fear our own death more than before, our own mortality becomes evident to us (Kübler-Ross, 1969). The glaring reality of one's own measurable finite existence is confirmed (Rousseau, 2001a).

We are socialized into our understanding of death by the culture, family and society in which we live. Morgan (1997) says that we "experience dying and grieving by

our exposure to it and in light of the predominate philosophies of our control over nature” (p. 7). We also live in a highly medicalized society. While it is possible for most of us to travel through life and, for the most part, not think about death and dying, doctors do not always have that luxury. Depending on their chosen field, issues of death and dying will affect them to varying degrees. However, as medical students, they will unerringly be exposed to death as a part of their professionalization to their chosen field of study as physicians.

Werner (1976) writes that the “encounter with morbidity and mortality heightens the student’s feelings of vulnerability” (p. 321). In facing death, the doctor faces his own vulnerability. Studies examining fear of death and anxiety have consistently shown these constructs to be positively related (Hoelter & Hoelter, 1978).

It is essential to increase the medical students’ awareness and understanding of their own reactions to illness and death (Werner, 1976). What they do with their emotions when they encounter death and their own feeling of death and mortality can influence the way they interact with patients. Showing empathy and compassion towards patients is essential for good doctor-patient relationships (Jarski, 1987). Research (Fine, 1977; Hornblow, 1977; Jarski, 1985, 1987) suggests that patient compliance is related to the physician’s ability to communicate effectively with patients. The most basic tenet in creating rapport is empathy (Fine, 1977). Kaye (1991) states that, “there is a clear relationship between professional attitudes to death and dying and the psychosocial experiences of dying patients” (p. 21).

However, this is juxtaposed with the need to acquire knowledge and technical skills, and large amounts of them, within a short period of time. Almost all medical instruction is focused on acquiring technical competence (Werner, 1976). There is also literature that demonstrates how medical schools are still falling short of providing and modelling empathy and caring (Lu, 1995). Lella (1997) has examined the history of medicine and shown how the culture of the hospital has lead to a bureaucratic treatment of disease rather than of the patient and the role medical school has played in this development. Dickinson and Pearson (cited in Kaye, 1991), studied 1093 physicians and discovered that those who had taken a course in death and dying reacted more positively to dealing with dying patients and their families on a interpersonal level.

### *Study Design*

In a medical class that has experienced a peer death, there is a unique opportunity to look at the effects of the death on empathy and death anxiety. It has been argued (Lester, 1967) that changes in attitudes towards death may be attributable to life experiences. This study attempts to discover if death anxiety and empathy are affected in a class of medical students who have experienced a peer death. Results may also yield information in response to the manner in which the Medical School at Memorial University responded to the tragedy, and the manner that the Medical School deals with death and dying. This study is important as the medical profession should take notice of evolving concepts in end of life management and factors that will affect the way their members carry it out, and their willingness to do so.

The target group for the study is the third year medical class (Med III). The class below (Med II) and above (Med IV) will be used as control groups. The research question – how does a peer death affect a class of medical students? – will be measured using two scales from the research literature, Hogan’s Empathy Scale and the Collett-Lester Fear of Death Scale. Change in the Med III’s empathy and fear of death, as measured by these two scales and compared to the control groups, will determine the outcome of the study. Additionally, a Biographical Questionnaire will be used to collect information such as age, gender and some qualitative questions about their previous experiences with death. Analysis of variance will be used to analysis the data. This is a quasi-experimental design because the research subjects are already grouped by the nature of the phenomenon and no random assignment of groups will occur.

## Chapter 2 - Review of Literature

In times of difficulty, darkness, and death, we have the opportunity to find strength. Some seem better able to use these experiences to grow into strength than others and many philosophers have reflected on this phenomenon to understand why it is that some people become stronger and wiser and more spiritually awakened during times of difficulty, while others allow themselves to be defeated.

Writings as early as the sixth-century B.C.E. show that this has been an issue of humanity since the creation of written records and probably before. Aeschylus, a Greek dramatist known as the “father of tragedy” makes the point in many of his plays that it is the horrible, agonizing life experiences that hurl his protagonists from their ordinary and limited lives into what can become a heroic one. Aristotle agreed, saying that we do not simply learn to comprehend the truth of life and the nature of reality, but we learn through suffering (Brehony, 2000).

Mystics and wise thinkers believe that suffering contains remarkable gifts and spiritual wisdom comes through this door of suffering. John of the Cross called the process “the dark night of the soul”. Sufi mystic Rumi in the 13<sup>th</sup> century stated, “spring seasons are hidden in the autumns”. The First Noble Truth of Buddhism states simply “life is suffering”. Zen Master D. T. Suzuki amplifies this by saying “The value of life lies in the fact of suffering, for where there is no suffering, no consciousness of karmic bondage, there will be no power of attaining spiritual experience and thereby reaching the field of non distinction”. The Bible concurs: “Consider it all joy, my brethren, when you encounter various trials, knowing that testing of your faith produces endurance” (James

1:2-3, Revised Standard Version). Jewish Theology of suffering through writings by Rabbi Eleazar Ben Jacob agree, “when sufferings come upon him man must utter thanks to God, for suffering draws man nearer unto the Holy One, blessed be He” (Brehony, 2000).

This theme does not just apply in the realm of the religious but resounds through the secular world as well. Helen Keller said, “Character cannot be developed in ease and quiet”. Henri Amiel, a late 19<sup>th</sup> century Swiss writer wrote, “Suffering was a curse from which man fled, now it becomes a purification of the soul, a sacred trial sent by eternal love... meant to sanctify and ennoble us”. British writer and Prime Minister Benjamin Disraeli said, “Seeing much, suffering much and studying much are the three pillars of learning”. And Martin Luther King, Jr. follows, “The ultimate measure of a man is not where he stands in times of comfort but where he stands in times of challenge and controversy” (Brehony, 2000).

This theme resounds through many myths in many cultures, some having painful rites of initiation into man or woman-hood, symbolically providing them with a new knowledge and understanding of the world from those who have not shared the experience. As medical students progress through medical school, they become initiated into a new profession. Through the trials and suffering of their learning, great wisdom and knowledge can be gained. Yet, there are many things that prevent students from acquiring the wisdom of their full compassionate, humanistic, spiritual and empathetic potential.

This chapter will examine some of those barriers that prevent students from acquiring their full potential during medical school, highlight why they are important to overcome, and outline Elisabeth Kübler-Ross's five stages of grief which can be used to understand the process through which patients pass as they die, so that the physician can better deal with death and dying.

### *Struggle to Develop Empathy during Medical Education*

As medical students enter and progress through medical school, they will progress into medical professionals. As they do so, they will face challenges that will prevent them from acquiring and developing their full potential as compassionate, empathetic physicians, able to connect with and help their patients to their full ability.

The first of these realities is that physicians in training often have to confront the reality of facing morality well before their same aged peers. The second includes several aspects of the process of professionalization. They are outlined in this section as: biological reductionism, fear of failure in a system that demands perfection and where less than perfection may mean death, lack of professional support and role modeling of empathy towards patients for medical students, the hidden curriculum of medical school that implies empathy and spirituality are unnecessary, the repression of emotional and spiritual values that is encouraged during medical training, encounters with responsibility to life and death by medical students, and the paucity of palliative care education within medical schools.



*The Reality of Mortality*

“I still feel anxious that it could happen to me”  
 “It was a sudden death and I never found out why. I had nightmares.”  
 -Research Participants

One reason that it is so hard to develop empathy during medical education is simply our humanity. Kübler-Ross (1969) says that as a human one has to guard oneself psychologically from the reality of one’s own death, since unconsciously we do not believe in our own mortality. With the number of deaths that are reported on news programming, those killed in wars and motor vehicle accidents and earthquakes, our unconscious belief is supported – always the other guy, not me.

Kübler-Ross (1969) writes that death is difficult for our psyches to conceive and therefore death is viewed as something bad and negative. It is important to remember this innate part of our psyches as it explains our reactions to death and our way of dealing with it. “Death is still a fearful, frightening happening, and the fear of death is a universal fear even if we think we have mastered it on many levels” (p. 5). It is this fear of death that leads to the difficulty of dealing with the dying.

However, it is clear that we cannot avoid death. It is something that is guaranteed to happen to each living creature on earth. We will all, at some point, become the patient, with all the uncertainty and fear and lack of control that comes with that. The further technology expands, the further we depart from natural death as we decide to use more technological interventions to delay death. Because of these interventions we also face more legal, ethical, moral and psychological dilemmas as we decide how to use the technology in reply to a natural death. While it may be human nature to avoid thinking

about death, these questions need to be faced and discussed. Each one of us needs to make a decision on where we feel life begins and ends and that can only be done by facing our own mortality. This is rarely done willingly. In becoming a physician, doctors are forced into situations involving life and death at a time when other peers may not need to contemplate these issues. Considering death may be the biggest crisis people have to face (Kübler-Ross, 1969). MacLeod (2001) states, “The care of people who are dying forms a significant part of almost all medical practitioners’ work” (p.1726).

Druss (1998) supports this notion. Speaking of medical students he writes, “they have never seen death before: grandparents for sure, parents perhaps, and even friends. But not up close, day after day, in such quantity and awfulness... Never before have they felt so ignorant, so helpless, and so vulnerable themselves”(p. 743). Werner (1976) agrees that the first and most overwhelming crisis that the medical student has to face is “the unceasing barrage of experiences with patients’ illness and death” (p. 322). It is inescapable not to make references to their own vulnerability and those close to them. Rousseau (2001a) agrees, saying, “a dying patient may move a physician’s awareness of mortality from the subliminal recesses of the mind into the glaring reality of one’s own measurable existence” (p. 284).

### *The Process of Professionalization*

As medical students enter their professional training there are a number of factors that have the potential to impair their ability to learn to care effectively for dying patients.

*Biological Reductionism.* Upon entering medical school, students are faced with a new world of knowing. Learning the new language of medical vocabulary is part of a

transformation that students experience. Their competency in medicine depends on their understanding and fluency in speaking, writing and reading in this language. Upon learning a new language, one has the ability to construct a whole new world and this new world allows the medical student to understand and explore the body and have it revealed to them in great detail (Good & Good, 1989). It sets them apart from others who do not have this language and knowledge and initiates them into a world of those who do.

However, students may also get swallowed up and lost in this “biological reductionism” (Good & Good, 1989). The abstraction of a human being, the dehumanizing of the body, and the objectivism created by the process must be counteracted. This leads to a struggle within the students in the way they relate to each other normally versus the way they are trained to look at patients. The students in the third year medical class in this study noted the objectivity of the emergency doctor as he explained what procedures had been followed on their classmate in the ER. Paired directly with the objectivity of the exam they had just written, the reality of treatment of a patient was suddenly put in sharp contrast to their subjective knowing of their classmate. As students come to see a body or a patient as an object of medical attention, how do they relate to that body?

The more advancements we make in science, the more we seem to fear and deny the reality of death (Kübler-Ross, 1969). We fight death more than ever before, and it has become in many instances a dehumanizing and mechanical process. Sometimes, there is even contention as to when death actually occurs. We become compartmentalized and sectioned and discussed with regards to treatment options and diagnosis. Perhaps, in our

fight for life, we can depersonalize our own mortality. It becomes a part of our defense.

Kübler-Ross (1969) writes

It is our concentration on equipment, on blood pressure, our desperate attempt to deny the impending death which is so frightening and discomforting to us that we displace all our knowledge into machines, since they are less close to us than the suffering face of another human being which would remind us once more of our lack of omnipotence, our own limits and failures, and last but not least, perhaps our own mortality? (p. 9)

Werner (1976) writes of this phenomenon, reflecting Stephens' philosophy of medical education. He quotes Engel, saying that there needs to be a "unified concept" (p. 325) of disease. This is to say, every person has not only a biological aspect, but also a social and emotional aspect and all three components must be dealt with together when planning effective treatment. Werner says failure to do so deprives physicians of one of their most effective tools in relieving pain; "the therapeutic relationship with the patient" (p. 325). Yet, students are often given inadequate training and support in relation to this model. It is of the utmost importance to put the person back together, to view her or him as a whole again, with a background, culture, family and sociology, as a part of a larger system both biologically and socially.

In 1994 the International Work Group on Death, Dying and Bereavement (International Work Group) published "Statements on Death, Dying and Bereavement". The purpose of the document was "to contribute to improvements in care and education in this field" (p. 1). The document contains 10 separate statements on death, dying or

bereavement; each presenting a set of assumptions that are based on commonly accepted facts. These facts are based on experience and associated principles or judgements as the proper response to these principles. In total, 190 assumptions and over 200 principles are included. The International Work Group says, “dying patients are living human beings ... these individuals are not just examples of malfunctioning biochemistry or defective organs. In fact, dying persons are individuals whose lives have not only physical dimensions, but also psychological, social and spiritual dimensions” (p. 5, emphasis original).

*Fear of Failure.* While biological reductionism, as described in the previous section, is occurring, another phenomenon, the view that death is a failure on the part of the physician, grows. As physicians learn more of the human body, there is a feeling that they should be able to control it. In what Lu (1995) calls “medical student mode” there is a fear of failure, knowing that to succeed was necessary while competing for the same few valued places, not only for entrance into medical school but then for placements and residencies. When students are distracted by the preoccupations of anxiety about failure and the necessity for success, it is hard to remain focused on the needs of the patients and remain compassionate to their emotional needs. The need for professional success can become more important to them than the needs of the patient. This is particularly a problem if the best interest of the patient is in opposition to what a standard prescription for the illness may be.

An assumption becomes built in during medical training that when confronted with an illness that perseveres despite the physician’s best abilities and understandings,

failure has resulted. It is easy to become caught up in the illness and the quest for a diagnosis while the patient is forgotten. Success is not perceived to be achieved with the comfort of the patient but rather the success of understanding a diagnosis, or an accurate presentation of a rare disease discovered (Lu, 1995).

*The Hidden Curriculum of Medical School.* A hidden curriculum is the covert learning that is unrecognized and occurs unconsciously by students and teachers. As in any culture, many practices are unstated and unexamined and even unacknowledged until recognized and challenged from the outside. The “why” and the “how” of teaching often go unexamined while focusing on the “what”. Those not understanding the “what” because of difficulties with the “why” and “how” often see themselves as failures rather than victims of an unaccommodating, unexamined system.

As faculty within the medical school and many other learning institutions are, by their presence there, successful, they have been well served by this prevailing culture. They understand it, share its beliefs and know and participate in the rules of the game (Adams, 1992). Understandably, it is difficult for them to see beyond their own environment and the culture of the school and profession.

In 1994, Hafferty and Franks published an article on the hidden curriculum as it applies to ethics in medical education. While the formal teaching of ethics occurs within the medical setting, they argue that

most of the critical determinants of physician identity operate not within the formal curriculum but in a more subtle, less officially recognized ‘hidden curriculum’. The overall process of medical education is presented as a form of

moral training of which formal instruction in ethics constitutes only one small piece (p. 861).

The same argument can be made for empathy. Although medical students are selected for admission based on academic ability as well as personal traits such as their compassion and empathy and ethical understandings, research shows that compassion and empathy suffer during this learning process (Branch, 1998).

A recent article in the *Journal of the American Medical Association* (Branch, 2001) discussed an informal, one-on-one study of more than 50 medical faculties throughout America. The authors wanted to determine the extent to which humanism is a part of medical education and to discover the barriers that prevent medical students from receiving adequate training in this area. The operational definition of humanism in this study, “the physician’s attitudes and actions that demonstrate interest in and respect for the patient, and that address the patient’s concerns and values”, can be seen to parallel the concept of empathy. The authors propose that modelling behaviour is a far more effective than formal coursework to teach humanism in medicine. They say that the climate of medical schools needs change to allow for this learning to take place.

The climate of elitism and hierarchy that contributes to an unquestionable trust given to, and taken by, doctors is still fostered within medical education. The White Coat Ceremony is an example of this. Since the 19<sup>th</sup> century, the white coat has signified entrance into the professional medical world. As such, the white coat is a symbol of status. Although students and faculty find meaning and inspiration in the ceremony, Wear (1998) finds a darker symbolism in the procedure. She proposes that there is a more

effective way to honour the education and humanism that the student dons as they accept the white coat. She questions if this ceremony is truly the best way to encourage compassionate care giving by providing the students with a symbol that will separate them further from their patients. She proposes instead “first Fridays”, in which the students visit community sites like rape crisis centres and drug treatment programs, places where they would learn to appreciate and comprehend the perspective of those suffering or disadvantaged. Finding ways to create an understanding between the physician and those they will be treating is more effective in to fostering humanism than a ceremony that presents a symbol of elitism.

*Lack of Professional Support.* The difficulties of medical school and medical training are often compounded by a lack of support from faculty and staff. Stephens (Werner, 1976) considers “medical professionalization a crucible of emotionally wrenching experiences which most students undergo with little formal or informal support from faculty or peers” (p. 321).

*The Pulse* is a newspaper published regularly throughout the medicine academic year by the Medical Students’ Society, Faculty of Medicine, Memorial University of Newfoundland. As noted by Matt Lilly, Co-Editor in 2002, the role of the publication is something with which that the Society has wrestled. The publication includes articles that simply inform the medical students of current events within the School as well as those that challenge, through a socially responsible outlet, in an attempt to create an open forum for voices on the negative and positive aspects of medical school and medical training. By maintaining a high level of integrity and respect, the editors aim to bring



forward issues that have not been adequately dealt with behind closed doors, or expose issues for what they really are, “even if people become shocked or embarrassed in the process” so it can be “dealt with at some level.” (p. 2, May-June, 2002).

During 2002, two students wrote about experiences during their clinical clerkship that reflect the professionalization and hidden curriculum of the medical school. The MUN Faculty of Medicine Calendar 2002-2003 describes the clerkship years as a two-year portion of the curriculum in which “the student participates in the clinical care team and begins to assume the responsibilities which are associated with the care of patients” (p. 343). A student in his first year of clinical clerkship wrote, “Clerk abuse is semi-institutionalized in that it has become a rite of passage for many medical students” (2002a, p. 4). He cites as reasons for this abuse not being addressed is the “fear of treading on the toes of those higher up in the health care corporation hierarchy”. As well, he cites “the vicious cycle theory”, that those in power abuse because they themselves suffered through it- a rite of passage.

The second student, who chose to remain anonymous, was looking forward to clerkship as an opportunity to apply some of the last two years of classroom learning in an educationally relevant interaction with staff and patients. Unfortunately, what this student says they soon learned was that they were not there to learn, but to “provide cheap labour or stay out of the way” (2002b, p. 7). Branch (1998) also writes of reports of abuse of medical students. For someone looking for a mentor, role model, or resource, they found that judgements and criticism were more common than mentors and role models, and most of the learning was self-taught. Although literature states the teaching

methods that develop humanism in medical education include role modelling (Branch, 2001), many students find that learning aspects of humanity within the medical school context is difficult (Branch, 1998; Lu, 1995).

Positive interactions with patients can reinforce the altruism that brought them into medicine. A gap between the clinical teaching during the clerkship and what medical students already know and feel to be morally right can result in unethical practices. Even in the best of teaching practices, students will experience stress. This stress becomes aggravated when there is a discrepancy between the moral and ethical values they know and have learned, and what they observe in clinical practice. The result may be anger, disillusionment and cynicism. Any hypocrisy they observe teaches them that medical ethics are unimportant. Hence the vicious cycle continues. Similarly, Hundert and colleagues “concluded that many students suppress humanistic values simply in order to get on with their work” (Branch, 1998).

*Repression of Emotional and Spiritual Values.* It has traditionally been the practice to train caregivers not to become emotionally involved or display emotion (Corr, Morgan & Wass, 1994; Joyce, 2003). Students describe an informal recognition of being left alone to handle emotional experiences and stresses. They are left alone and can feel isolated. Some students feel that it is taboo to mention fears or emotions around death and dying. Dr Matthews, an associate professor of medicine at Georgetown University calls religion “the last taboo” in medicine (Gesensway, 1997). Students must “feel free to express their emotions without fear that they will be interpreted as evidence of weakness

of unsuitability for professional advancement” (Werner, 1976, p. 327). This juxtaposition between competence and caring is also described by Good & Good (1989).

Werner (1976) suggests, citing other studies, the people who are attracted to medicine are those who handle anxieties, such as fears of death and dying, intellectually. For these reasons, health care workers may be unprepared or have limited experience in dealing with spiritual matters and lack empathy in situations involving death and dying. The International Work Group recognizes that many health care workers are unprepared to discuss personal or spiritual matters. There is an assumption that spiritual work is the responsibility of the clergy; yet with the understanding that the body and spirit are two intertwined systems, benefits to both physician and patient increase when they are willing to discuss both issues together. More than 63% of Americans when asked indicated that they would like their doctor to discuss spirituality with them and 79% believe that faith can help recovery from illness, yet only 10% remember a physician ever talking to them about faith and physical health (Gesensway, 1997). In a review of 212 studies that looked at the connection between religious commitment and health care outcomes, about three-quarter, or 160 of the 212, demonstrated a positive benefit of religious commitment. With the importance that religion holds within the Newfoundland culture, these figures may be inflated within this culture.

There has been a paradigm shift within the field of medical education within the last 10 years. Spirituality in healing is becoming a more integrated part of mainstream medicine. More than half of the medical schools in the U.S are now offering education on spirituality. The Joint Commission on Accreditation of Healthcare Organizations has

established “Spiritual Assessment Standards”, and the American College of Physicians acknowledged the importance of spirituality by stating that before graduation, students should be able to demonstrate the ability to take a spiritual history and understand the spiritual dimension of a person’s life. Matthews states that if religious beliefs and practices aid or promote health and are such a strong ally in healing, it might even be unethical for physicians to ignore or oppose their patients’ religious beliefs and practices.

*The Encounter with Responsibility.* After medical students encounter mortality and vulnerability, they then often have another frightening experience when they realize their increased responsibility for life. A belief that medicine can almost always cure and that there is a right thing to do in every case exacerbates this fear (Werner, 1976). This fear of responsibility is seldom addressed in medical schools, highlighted within Memorial University’s school by *The Pulse* entries by two students in 2002 and cited earlier in this thesis. Students are not taught how to set reasonable expectations for themselves and must react to this stress. One way is to become responsible only for molecules and organs and reports, not for the person that is the patient. Students need to be taught the importance of self-care, as well as care for the patient, to be able to maintain a high level of professionalism and ability to learn.

*Paucity of Palliative Care Education.* Although Florence Nightingale demonstrated in 1855 that organized care and sensitivity to a patient’s needs for the severely ill has positive effects on a patient’s outcome, physicians may be reluctant to address end of life care and discuss issues of death and dying with their patients due to the lack of palliative care education and role models. (Rousseau, 2001a). Technology has

advanced so that now, a return to caring and a willingness to shift from “curing to comforting” (Mitchell, 2003) will improve end of life care for dying patients.

Without appropriate and adequate education and role models, it is unrealistic to expect physicians to be able to handle issues regarding end of life care. Dr. Robert Arnold (2002) writes that, “In my experience, it is only after doctors feel competent as ‘doctors’ that they have the leisure to ponder the importance of emotions and relationships in the care of patients”. In a study by MacLeod (2001), traditional, formal medical education did not prepare doctors for the task of “caring for someone at the end of life”. But studies have shown that general practitioners want more training in palliative and terminal care (Arnold, 2002). Although issues of death and dying are often addressed in medical school, the aspect of care and compassion as a distinct entity from ethics and physical therapy is often not addressed (MacLeod, 2001). Paucity in palliative care education among current or future health care providers is also noted by Mitchell (2003).

Arnold (2002) notes reasons it is difficult to develop palliative care education. Developing palliative care programming is a challenge when medicine views palliative care as the enemy. While doctors learn in a very mechanized manner, palliative care education runs the risk of becoming merely another set of facts needed to be assimilated by medical students, rather than learning to focus on a patient’s emotional, spiritual and existential needs and understanding how these domains relate to medicine. In a learning culture where students are used to absorbing information presented to them by an expert in the field, palliative care education is, by contrast, a field that needs to be learned

experientially. Although the amount of palliative care education available is increasing and the quality improving, the lack of training has resulted in generations of physicians who were not trained to care for dying patients. Now, the majority of palliative care educators are junior faculty, struggling to survive in a competitive academic world, a world that still values technology over the emotion.

*Why Issues of Death and Dying Need to be Addressed*

Because loss, grief, and bereavement are among the most fundamental of all human experiences, they also have much to teach us about the human condition and the benefits of interpersonal caring and concern (Corr, Morgan & Wass, 1994). To not do so is to deny both the patient and the doctor and staff of opportunities for discussion and growth. The patient can be given opportunities for potential resolution of spiritual, emotional and psychosocial issues that would not be made available with the veil of recovering being reinforced.

When death is imminent or one is experiencing great pain, it is one of the most revered obligations of the physician to alleviate the suffering (Rousseau, 2001). However, the desire to alleviate suffering and cure the sick leads to an inevitable rejection and failure as death will come to all of us. Physicians must be willing to accept death as an option.

There are several reasons why it is difficult for physicians to accept death as an option when treating a patient as have been mentioned in the preceding section. As hard as it is to face death as a human being and with the roadblocks that medical students face in embracing their feelings around death and dying, it is imperative to do so. If this is not

done it is often to the detriment of the patient. It is not only in the best interest of the patient physically, but also emotionally and psychologically.

Reasons for adequately and appropriately addressing death and dying with patients is important as it builds rapport in the doctor/patient relationship and enables the doctor to develop and project empathy, both of which aid in the patient's care and healing (Jarski, 1987). Furthermore, not only have studies shown that patients want to address spiritual issues surrounding death and dying with their doctors, but to do so actually significantly reduces the cost to our health care system (Harvey, 1997).

### *To Build Rapport*

Freud recommended that treatment of patients not begin until rapport had effectively been engaged with them (Ahlskog, 2001). Because of the assumption that death is equal to failure, aggressive therapies may be used to confront the illness. Such strategies may instill false hope and weaken the doctor-patient relationship, depleting patient rapport. Physical and psychological procedures may differ, but the premise remains the same. During professionalization and such rituals of medical school as the White Coat ceremony, doctors are separating themselves from and endowing themselves with a sense of knowledge and knowing. We should be cautioned against assuming one is deserving of trust or wisdom before getting to know them. To do so prematurely may be a good definition of psychosis (Ahlskog, 2001).

During a study of death and dying, Kübler-Ross (1969) asked patients how they had been told about their terminal illness. She learned that whether they were told explicitly or not, patients depended on the physician to present the news in an appropriate

manner. The most important aspect of this acceptable manner was an obvious sense of comfort with death from the physician. This develops with the physician's ability to face death and examine their own attitudes towards death so they can talk about such matters without anxiety.

The question for a physician should not be "do I tell my patient of their terminal status", but rather "how do I tell my patient of their terminal status". This depends on the sensitivity of the physician to take cues from the patient that will show the speed and readiness with which the patient is prepared to receive the news. Kübler-Ross (1969) writes

If a doctor can speak freely with his patients... he will do the patient a great service. ... Such a patient will not fear isolation, deceit, rejection, but will continue to have confidence in the honesty of his physician and know that if there is anything that can be done, they will do it together (p. 29). If the news can be conveyed in such a manner the patient will continue to have confidence in the doctor and he will have time to work through the different reactions that will enable him to cope with this news and stressed life situation. All patients in this study stressed that it was "the sense of empathy that counted more than the immediate tragedy of the news" (p. 37).

#### *To Develop Empathy*

"...for the secret of the care of the patient is in caring for the patient."

Francis Peabody, *JAMA*, 1927 (cited in Rousseau, 2001 and MacLeod, 2001).



For Peabody, knowing the patient was part of the art of medicine, and empathy was a prerequisite for effective care for the person. Empathy is an abstract word; it is important to operationally define it as it is used in this study. This section will examine empathy from society's understanding and from the psychological descriptions to the definition that Hogan outlined as he developed his Empathy Scale.

The Oxford English Dictionary defines empathy as, "the power of projecting one's personality into (and so fully comprehending) the object on contemplation" (p. 184). To empathize, therefore, is "to treat something or someone with empathy" (p. 184). This term is often used in contrast to, or confused with, sympathy, defined in the Oxford English Dictionary as "a (real or supposed) affinity between certain things, by virtue of which they are similar or correspondingly affected by the same influence, affect or influence one another... or attract or tend towards each other". An additional definition states sympathy to be "the quality or state of being affected by the condition of another with a feeling similar or corresponding to that of the other; the fact or capacity of entering into sharing the feelings of another or others" (p. 460). Therefore, to sympathize is "to suffer with or like another; to be affected in consequence of the affection of someone or something else..." and sympathizing is "being similarly affected, or having an affinity, with something else" (p. 459).

The main difference between empathy and sympathy is considered to be an experiencing of a known emotion during sympathy and the intellectual understanding of that emotion during empathy. Hogan (1969) concurs, "The consensus of dictionaries is that empathy means the intellectual or imaginative apprehension of another's condition or

state of mind without actually experiencing that person's feelings" (p 308). His desire to develop an empathy scale is derived from the fact that although the general concept of empathy may be understood, a definition says nothing about the accuracy of performance.

Egan, in *The Skilled Helper* (1998), points out that there is much confusion in the psychological literature as to what empathy means. He defines it "as an intellectual process that involves understanding correctly another person's emotional state and point of view" (p. 73). Empathy can also refer to empathic emotions. This is when such phrases as "I feel for her" arise. This intellectual process becomes a communication skill if an understanding between the speaker and the listener is going to form. The skill of empathic listening focuses on developing an understanding of the speaker's world and empathic responding is the means in which the listener can communicate to the speaker that they understand them. Help must be based on correct and valid information from the client. Egan (1998) writes, "if people are to care for one another, some form of empathy is essential" (p. 74). In 1949, Cottrell and Dymond (cited in Hogan, 1969) similarly stated that empathy is the basic process of all social interactions.

There are many ways to listen inadequately. Therefore the message is missed by the listener. There is a natural tendency to listen in a biased manner. There are cultural, personal, familial and sociological filters that create a distorted listening and allow prejudice to enter our understanding of a speaker. Diagnosing, or labeling can also create a filtered understanding. To understand a situation as "a hernia", or a "borderline personality" is to remove many social and cultural and personal variables from a situation

that may serve as supports and aid in a solution. It is important not only to collect the facts of a situation but to also connect them back to a person. Identifying these obstacles to listening are important because help based on incorrect or invalid understanding of the speaker may lead you both astray (Egan, 1998).

Empathy is the basic tenet of many forms of therapeutic process and also a core aspect of interpersonal communication. Psychoanalysis is a system of psychology stemming from discoveries by Sigmund Freud. Many therapies have since grown and been adapted from psychoanalysis. Psychoanalysis works through three aspects of treatment: empathy, intuition and introspection, with empathy described as an “emotional knowing”, the experience of another’s feelings (Arlow, 1989, p. 49). Arlow (1989) suggests that there is a presupposition that a psychoanalyst can identify with a patient’s experience effectively as well as cognitively. He also states that the empathic process is central to the psychotherapeutic relationship and also a basic element in all human interaction. Arlow (1989) writes that two features characterize empathy: identification with the patient is only transient and, second, the therapist preserves separateness from the person being analyzed. It is therefore through intuition that the analyst understands the patient.

Hogan (1969) defines empathy as “the intellectual or imaginative apprehension of another’s condition or state of mind without actually experiencing that person’s feelings” (p. 307) and says that it is a part of personality development, particularly moral development. Empathy has also been explained as a phenomenon of taking the role of the generalized other. This includes a willingness or tendency to put oneself in another

person's place and to modify one's behaviour as a result. Thus, it is clearly an important aspect of moral growth.

Moral growth has been outlined by Kohlberg (cited in Myers, 1992) as he sought to identify the cognitive stages in which moral thinking matures. He grouped the stages into three levels: pre-conventional, conventional and post-conventional. The pre-conventional level develops in early childhood and is mainly concerned with protecting the self to avoid punishment or gain rewards. It reflects the child's interaction with a primary caregiver. The conventional level develops in late childhood and early adolescence. It reflects the person's learning of the world in which she or he will have to live and is concerned with knowing and responding to the laws and social rule of their society. The post conventional level may develop from adolescence on and reflects the development of a morality of abstract principles. While they affirm agreed upon principles with the general population, it is here that people may challenge the status quo and develop personal ethical principles. It is noted, however, that we are just as likely to act because of what we think, as we are to think because of our actions. Moral ideas grow stronger when they are acted upon. To develop deeper morals, one must act upon them and test them. Acting in the face of adversity is often a test of our convictions to our morals. As mentioned earlier, medical students often face moral dilemmas and the resolution of them can greatly affect their ethical development.

In 1932, Piaget developed four stages of cognitive development and believed that moral judgment was built upon cognitive development (cited in Myers, 1992). Indeed, as we begin at the bottom rung of Kohlberg's moral ladder and ascend to varying heights,

the post-conventional level appears mostly in the educated middle class of countries that value individualism, such as North America and Europe. This can speak to the bias of the development of the instrument, but also highlights the importance of moral development among the most educated in our society. It is also important to note that Kohlberg's moral concepts are based upon research done primarily with male subjects. Because of Kohlberg's research, and the trend in feminist literature to recognize gender difference in research, my study contains a biographical questionnaire that asks for gender identification so as to examine any gender differences in empathy.

As empathy plays a central role in many aspects of psychology, a valid and easily administered measure would be useful. Other measures are conducted by a third party have cumbersome methods, questioned validity or methodological errors (Hogan, 1969). And although we may have a cognitive understanding of empathy, the definition in itself does not imply its accuracy or any resulting construct. Hogan's scale is used in this study as it is self-administered and gives not only an indication of empathy, but also implies the magnitude of the sense of empathy experienced.

In conclusion, the American Association of Medical Colleges (AAMC) reported that students need special assistance developing empathy with their patients because it is such an important skill in clinical practice. Lu (1995) agrees saying that "compassion needs to be taught, nurtured, and cultivated as a part of the curriculum" (p. 457). Rousseau concurred in 2001 stating, "The development of a venerable physician-patient relationship founded upon trust, communication, and truthfulness will do much to

assuage the fear that accompanies death and provide the basis for a clinical environment structured on caring and empathy” (p. 224).

### *To Help the Patient*

Effective delivery of health care does not only depend upon the technical knowledge of the physician, but also on their ability to understand the psychological and emotional needs of their patients and respond accordingly (Jarski, 1985). As demonstrated in the preceding two sections, if physicians make an attempt to build rapport and show empathy for their patients, the patients will be more at ease and comfortable with their care giver. These skills have also been related to the educational background of a clinician. As such, in order to best help a patient, a physician must be capable in demonstrating affective skills such as empathy. Empathic skills in allied health professionals are associated with both patient satisfaction with health care services and compliance to therapeutic regimes (Fine, 1977; Jarski, 1987). Similarly, when low levels of empathy are communicated, actual deterioration of the patient’s condition may occur. This demonstrates that for a physician to be effective, they must not only be technically competent, but also emotionally and psychologically responsible to the patient. In fact, if they are not, their technical skills become less effective.

Creating this rapport with the patient can also relieve the clinician’s fear of responsibility as the sole provider of the solution and cure when one may not be available. If there is dialogue between patient and physician, an understanding of care can be communicated and understood between the two.

*To Reduce the Cost to Our Health Care System*

If issues surrounding death and dying are recognized and properly managed or referred, cost of health care will be lowered (Harvey, 1997). Psychological and emotional problems can be exacerbated or triggered upon receiving news of imminent death. It is a case where a little prevention can go a long way.

Attitudes and approaches to death are not only personal in nature, but also societal. As a society we value technological over humanitarian work. This is reflected in the respective higher salaries of a surgeon, laboratory technologist or computer programmer in comparison with a pastoral care worker, social worker or childcare provider, whose pay is often lower and deemed disposable in times of financial crisis. When work can be quantified, more value is placed on it.

Human sophistication is marked by its tolerance for ambiguity whereas technology removes ambiguity. It is proposed that the more sophisticated one becomes, the more ambiguity will be tolerated. Pastoral or psychological care in a technological culture can be viewed as ambiguous, and therefore, expendable (Trend, 2001). This is reflected within a medical school culture where the number of lectures provided in technical learning far outweighs those on relationships between the doctor and patient, where the emphasis on class standing is far more important than students' perceptiveness, sensitivity and tact. As the International Work Group on Death, Dying and Bereavement note, "spiritual concerns often have a low priority in health care systems" (p. 35).

The International Work Group note in Assumption 19 that, "Patients and families facing death frequently experience a search for the meaning of their lives, making the

provision of spiritual support essential” (p. 19). For caregivers to be aware of this and recognize the need in their patients, emotional and psychological angst may be avoided, as well as unnecessary financial costs. Dying is more than a biological experience. It is also a spiritual event that affects not only the person dying, but also those around her or him. Often, the spiritual dimension is neglected for a misinterpretation of a more important biological aspect.

In a study tracking 700 cardiac patients in Brockton, Mass. over 30 months, the researcher found that those who received daily visits from a chaplain left the hospital an average of three days earlier than those not receiving a visit. Dr. Elizabeth McSherry, the author of the study, estimated the saving at \$4000 USD per patient. The cost to pastoral care per patient was \$100 USD. Similarly, a double blind study done by Dr. Randolph Byrd confirmed that patients randomly divided into two groups and prayed for by people unknown to them had less congestive heart failure, fewer cardiopulmonary arrests and less pneumonia. As much as a physicians’ work is needed and valued, if it is done at the expense of emotional and psychological care of a patient, the medical system will suffer. Kathy Slattery, a clinical nurse educator with intensive care and emergency staff at Ottawa Civic hospital, sees patients respond to pastoral care and says, “Pastoral care saves lives” (cited in Harvey, 1997).

### *Kübler-Ross’s Five Stages of Loss*

Kübler-Ross (1969) introduced five stages of loss that have become known universally. Although these stages can be seen during many types of loss, such as divorce or bankruptcy, her studies originated in death and dying. Each of these stages can be



eased or facilitated by a physician who shows care and empathy and compassion throughout patient care. Conversely, understanding these stages can aid a physician's understanding of a patient's experience.

The first stage is 'denial and isolation'. When a person is first told of a terminal illness, or a loved one is told of a death, the initial reaction is often, "Oh no, it can't be true, not me", or "They can't really be gone". This is followed by searching for confirmation of the denial in such actions as needing reassurance that pathology labs are mixed up, or that the patient can actually be resuscitated. Denial following the presentation of a diagnosis is typical of a patient who is informed prematurely or abruptly by someone who does not know the patient well or does it quickly to get it over with. To postpone discussion with a patient about their situation serves to support defensiveness towards death and often does not facilitate a positive relationship between the patient and doctor. Furthermore, patients can be selective in discussion with medical staff, tending towards those who are also uncomfortable facing their death and thus their denial being reinforced by the staff. To avoid discussions of death and dying with patients is to deny them, and us, the opportunity to learn more about our reactions to such stresses.

When denial can no longer be maintained it is replaced by anger, envy and resentment. This anger is often displaced and projected outwards onto those around them. The anger is often taken personally. Yet when the source of the anger is considered, it can be seen in a different light. When empathy is used, the patient then feels respected and understood and valuable. When they are included in care decisions they are made to feel like they are still alive and being heard and the anger is no longer needed. To understand

that, in similar circumstances, if one's life had been drawn to a premature end, we too would feel robbed of those things we had left to do in life, we too would be angry.

If denial and anger have not worked to change the situation the patient faces, they enter into bargaining. This third stage is often reflective of an unconscious or conscious guilt from the patient. If the patient feels they have not spent enough time with their family and children, the bargaining would include a promise to do so if their life would be extended. Similarly, bargains often include promises to live better lives, in service to God or the church. Listening to these bargains, which are rarely forthcoming unless within a close and trusting relationship, can help to assuage the patient of their guilt.

These three stages require energy. When the energy has been depleted, the patient enters a depression. The fourth stage of depression can be either reactive, when a patient is reacting to past losses, or a patient can be reacting to future losses. Our own needs create a viewpoint that can again prevent us from helping that patient. Instead of being with the person in their pain, and as it is much more pleasant to be around people who are happy and upbeat, people in a depression are often encouraged to "cheer up", or "look on the bright side". However, the person facing death is going to lose everything and everyone they love, and depression is a way to experience those feelings and work towards acceptance. Although the desire may be to do something for this patient, in actuality the best way to help someone in this grief is simply to be with them and listen if they want to share their feelings.

When enough time has passed for the patient to work through the previous four stages of loss, finally, 'acceptance' of the loss can be realized. To family, friends, or staff

still fighting for the patient's life, this stage can look like giving up. There often comes a point when death becomes a relief and a patient may feel the need to detach from their surroundings, which can feel like rejection to those around who do not understand this needs to be done to aid in the process of death. When this stage has been reached and there is nothing more to do for the patient medically, there is a danger of the patient feeling forgotten. Kübler-Ross suggests that, "it is not in human nature to accept the finality of death without leaving a door open for some hope" (p. 117). Giving up on a patient because there is nothing more medically that can be done may leave the patient feeling deserted. The patient may feel left out of making important decisions about their care. With only a little time each day, physicians can show that they still care about the patient and that they are still worthy of care. Responding tactfully to these subtle needs allows the patient to die with dignity.

Kübler-Ross says, "It might be more helpful if more people would just talk about death and dying as an intrinsic part of life just as they do not hesitate to mention when someone is expecting a baby" (p. 141). If this were done more often discussing end of life care and issues with those who are dying would not be so difficult. She writes of patients who were uncommunicative and not eating until her staff began to talk to the patient about the terminal state of their illness, demonstrating that more harm than good is done by avoiding the issue. Learning to be in tune with patient's needs, when the patients need to talk about their illnesses, and when they need to talk about lighter things is important to the patient. In fact, talking is not even necessary. Kübler-Ross writes, "Those who have the strength and the love to sit with a dying patient in the silence that goes beyond

words will know that this moment is neither frightening nor painful, but a peaceful cessation of the functioning of the body” (p. 276).

Remembering that dying patients are still alive and have things that they want to do with the remainder of their lives, means those who wish to provide care must listen to the needs and wishes and address their priorities. People facing death have much to teach us about our shared mortality and human dignity if we are willing to experience it with them.

This chapter has outlined reasons why it is important for medical students to communicate empathically with their patients, the barriers that prevent it from developing during medical training, and Kübler-Ross’s theory on how to better understand what a dying person may experience as they go through the process of dying. In the next chapter I will outline the methodology used in this study to investigate if there is a change in empathy and death anxiety in medical students who have experienced a peer death.

## Chapter 3 – Methodology

### *Subjects*

Subjects included the entire population of the second, third and fourth year classes of the Medical School of Memorial University of Newfoundland in 2002-2003. These populations are 63, 58 and 60, respectively. The samples for each class were  $n=40$  for Med II;  $n=46$  for Med III; and  $n=36$  for Med IV. This is a response rate of 63.49%, 79.31%, and 60.00%, respectively. Due to the voluntary nature of the study, the sample occurred by lack of a 100% response rate. The Med III class was the class that had experienced the peer death and a higher interest in the study may account for the higher rate of participation in this class.

The Biographical Questionnaire collected information on age and gender. The distribution of ages of each class is displayed in Figure 1. The average age in Med II is 24.67; in Med III, 25.15; and in Med IV is 27.15. More females than males participated in Med II and Med IV. There were more male participants in Med III. Overall, there were 68 female participants and 53 male participants.

At the time of the peer death, this medical class was in its first year of studies. At the time of the study, the students were entering their third year of medical studies and beginning two years of clerkship. Comparison groups used were the class below, Med II's, and the class above, Med IV's. The study instruments were administered to the experimental and comparison groups. The class below was within four months of their program at the time of administration of the instruments in relation to where the target group was at the time of the peer death. This class had not begun medical school at the

time of the peer death referred to in this study. The group above was within four months of the place in the program that the target group would be at the time of the administration of instruments. This group was involved in medical school at the time of the peer death. There is no experimental manipulation in this study so subjects only completed the questionnaires once.

### *Procedure*

The following instruments were distributed in a group setting: Informed consent forms, The Collett-Lester Fear of Death Scale, the Hogan Empathy Scale, and a brief Biographical Questionnaire. The questionnaires were administered immediately following class lecture time and a lunch was provided. Understanding the time demands on medical students, this was deemed the most reasonable attempt at the return of the highest number of completed responses. The nature of informed consent for participation in the study and the freedom to end participation at any time without penalty was explained. Appropriate instruction for completing the forms was provided. I remained available throughout the administration of the questionnaires for any questions. Average times for completion of the questionnaires ranged between 20 and 40 minutes in each group. No difference in completion times was noted between groups.

I visited each class of the medical school at the end of a prescribed lecture period. Students had been previously informed of the visit by a group email distributed through the Student Affairs office and posters had been placed outside the lecture rooms several days before the questionnaires were to be administered. Remaining questionnaires were then placed in the in Student Affairs office and another email distributed to inform any

students who had not been available after the class period of the opportunity to complete one. An exception to this was the fourth year class whose lecture had been rescheduled on the day scheduled to administer the questionnaires. A class member informed me of the change and, in addition to visiting the class during a scheduled period at a later date, I also met the students in a lounge area of the school where many of them completed the survey between classes that day.

Approval for the research was provided by the Interdisciplinary Committee on Ethics in Human Research (ICEHR), the Office of Research, Memorial University of Newfoundland and by the Dean of Medicine at the Memorial University of Newfoundland's Medical School.

#### *Instruments Used*

To assess fear of death the Collett-Lester Fear of Death Scale has been selected. To assess Empathy, Hogan's Empathy scale has been selected. The Biographical Questionnaire will allow comparisons results by gender, age and religious orientation. The following is a discussion on each of these instruments.

#### *Hogan's Empathy Scale*

Hogan's empathy scale is a self-administered written test containing 39 true and false statements. The respondent must indicate agreement or disagreement for each item. This scale has been validated on a variety of populations including medical personnel. The scale takes eight to 10 minutes to complete. The items in Hogan's Empathy Scale are selected from the California Psychological Inventory (CPI), the Minnesota Multiphasic

Personality Inventory (MMPI) and the University of California's Institute of Personality Assessment and Research (IPAR)

This scale was selected for this study because it is self-administered. Several other empathy scales have been validated with the same population, such as Hornlow's general empathy rating, Barrett-Lennard's relationship inventory and Carkhuff's empathy understanding scale. Because these scales require a subject to be evaluated by an observer in a simulated clinical encounter, they did not suit the time lines and resources of this research. Therefore, it is important to note that empathy in this study relates to the students' self-perceptions of their own empathic skills, not an observer's rating (Jarski, 1985).

To develop this scale, Hogan provided faculty, graduate and advanced psychology students at the University of California, Berkley with a definition of empathy – the intellectual or imaginative apprehension of another's condition or state of mind – and asked them to select their conceptions of a highly empathetic man from the full California Q sort. These descriptions had an estimated reliability of .94 correlation and this composite description served as the empathy criterion for further developing the scale. The content of the items all reflected insight, perceptiveness and social acuity, all in accordance with an *a priori* understanding of empathy. The empathy ratings were also correlated with the California Psychological Inventory (CPI), the Minnesota Multiphasic Personality Inventory (MMPI) and the Chapin Social Insight Test. In general, the correlations were positive with the CPI and Chapin test, emphasizing positive social functioning, and negatively to the MMPI, which is oriented negatively to social



functioning. This suggests that empathy rating define a dimension that includes, “social competence, intellectual promise and feelings of self worth” (Hogan, p.309). Hogan’s scale was developed by a standard item analysis of high versus low rated responses. Thirty-one items are from the CPI, 25 from the MMPI and eight from the University of California’s Institute of Personality Assessment and Research (IPAR). Although Hogan’s original scale contained 64 items, this 39-item form will place less demands on the student’s time and the correlation between the two instruments has been reported at 0.9 (Hogan, 1969).

The scale validity is suggested by the correlations reported by Hogan during the development of the scale at .39 between the scale and empathy ratings of medical school applicants. During its development, correlations were reported at .62 between the scale other empathy ratings.

In 1985, Jarski reported that Hogan’s empathy scale did not agree with three other instruments used to measure empathy. These three other measures were behaviourally based and empathy was rated by a third party. This may be an indication that students do not perceive themselves the same way others perceive them. In 1987, Jarski showed that medical students rated themselves significantly lower ( $p < 0.001$ ) than observers, while physician assistant students did not. Jarski (1985) also drew attention to a lack of face validity that may exist in Hogan’s Empathy Scale when used with medical students. In 1977, Hornblow reported that Hogan’s Empathy Scale can be supported as “a measure of interpersonal effectiveness, but has not established it as a valid measure of empathy in a clinical setting” (p. 7). He suggests, “that relating to others empathetically involves

distinct phases, and that different scales tap the process at different points” (p. 7). Despite any difficulties with the scale, it continues to be used in medical and nursing research (Evans, 1998).

Reliability is shown in a sample of 50 college undergraduates the test-retest correlation after a 2-month period was .84. (Hogan, 1969). Hogan also states that “ A more fundamental indication of the scale’s utility, however, is that it predicts rated empathy better than all existing measures with which comparisons have been made.” (p. 312).

#### *Collett-Lester Fear of Death Scale*

The Collett-Lester Fear of Death Scale was published in 1975 by Dr. David Lester at the Department of Psychology, Stockton State College through the ETS Test Collection (Lester, 1975). It was designed after researchers realized the need for standardized measures of the fear of death. It is an instrument designed to measure four dimensions of the general fear of death: death of oneself, death of others, dying of oneself, and dying of others, and an attempt to distinguish between the fear of death and the fear of the process of dying as well as distinguish between these fears based on whether they are for oneself or for someone else (Lester, 1969). This makes it a good measure for members of the medical community who may have to deal with issues of death and dying more often than the general population. The scale can be administered to adults individually or in groups. The scale is comprised of 36 questions answered on a 6 point Likert scale with the higher score indicative of endorsement of the fear indicating

items. This scale has been validated by low correlation between the four subscales indicating potential usefulness of differentiating between these four fears.

At the time of publication there were no adequate norms for the scales. Several studies have been published and report mean scores on each of the scales for a variety of subject populations. Therefore, the final score for any subject for each scale has no meaning in itself, only in relation to the scores of other test subjects. It cannot be said that score X means a subject has a fear of death and a score of Y means there is no fear, only that subject A has a higher or lower score than subject B (Lester 1975). The scale was developed using a -3 to +3 Likert scale. It is meaningful to suggest that a score of zero implies no fear of death, and as the score increases there is more fear. Positive numbers describe an increase in fear and, as the numbers decrease, the fear is decreasing. It makes sense to arrive at a score of zero for “complete lack of fear”. To avoid the need to explain “negative fear”, the numbers in this instrument was re-scaled after administration. To describe the “fear” related to a negative score suggests that there is a feeling opposite to fear occurring. The new scale used was 0-5. Three was added to previous scores of -3, -2 and -1 and two was added to previous scores of +1, +2 and +3. Results provided for both the original and re-scaled versions are included as Appendix A in this report. Validity in re-scaling the Collett-Lester Fear of Death Scale is provided in the high correlation between the two arrays for the total values,  $r(119) = .993$ .

Studies (Hoelter, 1978) examining fear of death and anxiety have consistently shown these two constructs to be positively related. However, researchers recognize that fear of death and the anxiety accompanying it is probably a multidimensional rather than

uni-dimensional phenomenon. In 1978 Hoelter and Hoelter examined eight types of fear of death and two types on anxiety: fear of the dying process, fear of premature death, fear for significant others, phobic fear of death, fear of being destroyed, fear for body after death, fear of the unknown, fear of the dead. With the exception of fear of being destroyed, all of the fear subscales had positive correlations with each other.

As research attitudes on death and dying continues with medical personnel and these professionals are encouraged to come to terms with their own feelings on death and dying in order to more effectively care for their patients, valid and reliable methods of measuring fear of death and dying is needed. Collett and Lester (1969) confirmed good test-retest reliability for the Collett-Lester Fear of Death Scale and low inter-correlations between the Collett-Lester subscales, indicating the scale has usefulness for differentiating among these four specific fears of death.

The Collett-Lester Fear of Death Scale groups items into four domains. Using the data from this study, a factor analysis with varimax rotation, extracting eigenvalues over 1, the rotated component matrix failed to converge on 25 iterations (convergence = .002). When the rotation was forced to 4 factors, to investigate the similarities to the original scale, 34% of the variance of the scale was accounted for by the factor analysis. Absolute values less than .20 were suppressed. The low ratio of subjects to number of items, it is perhaps due to the fact that the structure is unstable and no factors were spontaneously extracted, and that there was a low amount of variance accounted for when forced to 4 factors.

### *Biographical Questionnaire*

Questions included in the biographical questionnaire were composed to provide information on age, gender, religion of origin, and religion currently, as well as to make an attempt at identifying the difference between previous exposure to death and discussions on death, both within the family of origin and the medical school. Some guidance in the structure of the questionnaire was found in a questionnaire designed by Edwin Shneidman of the Center for Advanced Study in the Behavioural Sciences, in consultation with Edwin Parker and G. Ray Funkhouser of Stanford University. It is a modification of a questionnaire developed at Harvard with the help of four graduate assistants: Chris Dowell, Ross Godlstein, Dan Goleman and Bruce Smith (Shneidman, 1971). The questionnaire is shown in Appendix B.

The questionnaire also allowed for the collecting of qualitative data regarding the response of the medical school during the crisis of Gina's death as well as data on gender to allow an examination of the effect gender may have on empathy and death anxiety. This data can then be used to qualify quantitative data regarding empathy, death anxiety and perhaps, infer that the way the medical school responded to Gina's death influenced changes within the students.

### *Predictive Hypotheses*

Having had the opportunity to process their death experience within the medical school community and as a group, it is predicted that death anxiety will be lower in the Med III class, as compared to the Med II and Med IV classes. It is expected that empathy scores will be higher in the Med III class as compared to the Med II and Med IV classes.

Confirmation of this hypothesis can indicate that handling death in a positive manner within the medical community lowers death anxiety. A contrary finding may suggest that the medical school is not handling issues of death and dying adequately with medical students.

Results will be discussed in relation to the current literature on death anxiety and empathy in medical students as well as in relation to the current programming around death and dying at Memorial University's Medical School.

### *Ethical Considerations*

As there is no experimental manipulation of groups, it is reasonably predicted that there is no foreseeable risk to the participants. However, due to the nature of the material, recall of the event may be upsetting to some participants. Thus participation was voluntary, a fact stressed along with the right to refuse to participate at any point during the administration of the questionnaires and to discontinue involvement in the project without negative consequences or prejudice. Participants were given my name and the contact number for my supervisor at the Pastoral Care Department. Contact numbers for the University Counselling Centre and Student Affairs for the Medical School were also provided.

### *Limitations*

This study was conducted in only one university, and therefore, the results may be generalized only to similar populations. Newfoundland and Labrador has a Christian culture that has dictated cultural and societal norms for many centuries. For this reason, information on the religious background of participants will be collected.

This study also solicited volunteers for its collection of data. Although a high percentage of the classes agreed to participate, the effect from the data from those choosing not to participate is unknown.

There is such a wide variance of factors that effect emotional responses in people. This study attempts to collect data only from a select few of them. For example, it does not attempt to determine which deaths are imminent or new, and which are historical. Nor does it attempt to measure the intensity of the death experience, a subjective measure, known only to the person.

This study arose after a class member died of sudden but natural causes. Caution should be made in generalizing these results to a class who has experienced a class member's death from suicide or homicide, or one whose death was expected or anticipated.

## Chapter 4 – Results

*Hogan's Empathy Scale and Collett-Lester Fear of Death Scale**Differences in Empathy and Fear of Death Between Medical Classes*

The average empathy scores arrived at using the Hogan's Empathy Scale for Med II, III and IV are 26.30, 26.03 and 25.36, respectively. The difference between the classes was statistically insignificant by ANOVA,  $F(2,119) = .74, p > .05$ .

Table 4.1

*Analysis of Variance for Empathy between Medical Classes*

Source	SS	df	F	p
Between Groups	23.66	2	.74	.48
Within Groups	1893.14	119		
Total	1916.80	121		

The average scores for Med II, III and IV as calculated by the Collett-Lester FDS are 87.50, 85.70 and 83.36 respectively. Values for the four domains of the Collett-Lester Fear of Death Scale are provided in Table 1. The differences between the classes were statistically insignificant by ANOVA,  $F(2,119) = .58, p > .05$ , for the total score as well as each of the domains; “fear of death of self”,  $F(2,119) = 1.0, p > .05$ , “fear of death of others”,  $F(2,119) = .24, p > .05$ , “fear of dying of self”  $F(2,119) = .43, p > .05$ , and “fear of dying of others”,  $F(2,119) = .39, p > .05$ .



Table 4.2

*Analysis of Variance for Fear of Death between Medical Classes*

Group	Source	SS	df	F	p
Total	Between Groups	325.257	2	.58	.56
	Within Groups	33520.05	119		
	Total	33845.32	121		
Death of Self	Between Groups	116.80	2	1.00	.37
	Within Groups	6959.86	119		
	Total	7076.66	121		
Death of Others	Between Groups	13.87	2	.24	.80
	Within Groups	3493.74	119		
	Total	3507.61	121		
Dying of Self	Between Groups	14.51	2	.43	.65
	Within Groups	2004.49	119		
	Total	2019.00	121		
Dying of Others	Between Groups	27.17	2	.39	.68
	Within Groups	4114.40	119		
	Total	4141.57	121		

There was no correlation between Hogan's Empathy Scale and The Collett-Lester Fear of Death Scale,  $r = -.07$ ,  $n=119$ ,  $p > .05$ , one tail.

*Differences in Empathy and Fear of Death Between Genders*

Biographical data was collected to analyze the effects of aspects such as gender, age, religion and past experience with death on empathy and death anxiety.

When data from all three groups was combined, gender had a minimal effect on empathy, with females presenting as slightly more empathetic,  $F(1,120) = 3.12, p < .10$

Table 4.3

*Analysis of Variance for Empathy between Genders*

Source	SS	df	F	p
Between Groups	48.52	2	3.12	.08
Within Groups	1868.28	120		
Total	1916.80	121		

Gender had a significant effect on overall death anxiety,  $F(1,120) = 6.10, p < .015$ , “fear of death of self”  $F(1,120) = 13.10, p < .000$ , and “fear of dying of self”,  $F(1,120) = 6.89, p < .01$  with females presenting as more fearful of death. There was no significant difference between genders for “fear of death of others”,  $F(1,120) = 2.89, p > .05$ , or “fear of dying of others”,  $F(1,120) = .909, p > .05$ .

Table 4.4

*Analysis of Variance for Fear of Death between Genders*

Group	Source	SS	df	F	p
Total	Between Groups	1627.29	2	6.06	.02
	Within Groups	32218.03	120		
	Total	33845.32	121		
Death of Self	Between Groups	695.08	2	13.10	.00
	Within Groups	6381.59	120		
	Total	7076.66	121		
Death of Others	Between Groups	82.52	2	2.89	.10
	Within Groups	3425.09	120		
	Total	3507.61	121		
Dying of Self	Between Groups	109.63	2	6.89	.01
	Within Groups	1909.36	120		
	Total	2019.00	121		
Dying of Others	Between Groups	31.12	2	.91	.34
	Within Groups	4110.45	120		
	Total	4141.57	121		

*Differences in Empathy and Fear of Death between Age Groups*

When data from all three groups was combined, students aged 24 years of age and younger constitute 41.3% of the participants. Students 25 years of age and older constitute 64.5% of the group. Empathy was not significantly different between these two groups,  $F(1,119) = .13, p > .05$ . The distribution of ages within the classes is shown in Figure 1.

Table 4.5

*Analysis of Variance for Empathy between Age Groups*

Source	SS	df	F	p
Between Groups	1.12	1	.13	.72
Within Groups	1910.47	119		
Total	1912.60	120		

There was a significant difference in death anxiety between the two groups for the overall scale,  $F(1,119) = 9.51, p < .01$  as well as for “fear of dying of others”,  $F(1,119) = 9.51, p < .01$ , with students aged 25 and older presenting with less death anxiety. “Fear of death of self”,  $F(1,119) = 4.76, p < .05$  and “fear of death of others”,  $F(1,119) = 4.70, p < .05$  were also significant but to a lesser degree. “Fear of dying of self” was not significantly different,  $F(1,119) = 2.58, p > .05$

Table 4.6

*Analysis of Variance for Fear of Death between Age Groups*

Group	Source	SS	df	F	p
Total	Between Groups	2478.98	1	9.51	.00
	Within Groups	31024.92	119		
	Total	33503.90	120		
Death of Self	Between Groups	271.49	1	4.80	.03
	Within Groups	6793.67	119		
	Total	7065.16	120		
Death of Others	Between Groups	132.98	1	4.7	.03
	Within Groups	3363.89	119		
	Total	3496.88	120		
Dying of Self	Between Groups	41.50	1	2.58	.11
	Within Groups	1913.10	119		
	Total	1954.60	120		
Dying of Others	Between Groups	235.28	1	7.19	.01
	Within Groups	3892.00	119		
	Total	4127.24	120		

### *Differences in Empathy and Fear of Death Between Identified Religious Groups*

Religious orientation, either from family of origin or what the student considered to be their current religious affiliation, did not have an effect on either empathy or death anxiety. Neither does the amount of effect the participant believes religion or spirituality has on their understanding of death and dying, or how death was discussed in their family.

### *Biographical Questionnaire*

82.5% of second year students, 100% of third year students and 97.2% of the fourth years identified having experienced a death within medical school. 10% of the second years, 97.8% of the third years and 41.7% of the fourth year students identified Gina's death as at least one of those experiences. Other experiences included patients (5%, 6.5% and 52.8%, respectively), as well as the death of family members, the murder of a past medical school alumni, concern for suicide rates within the profession and the use of cadavers during medical training.

The most frequently occurring response to the question of how the medical school handles death as a topic was "Openly". The second year students had no response as often as they responded "Openly" (32.5%), followed by not recalling any discussion (17.5%), "With Discomfort" (10%) and "Other" (7.5%).

The third year students responded predominantly that the medical school responded well to Gina's death and deals with death openly (91.3%). Students reported in positive feedback that their expectations were met and exceed with regards to the support received by the medical school. They wrote that everything was done to ensure comfort

and support and all the support that was available was offered, that the administration and Dean of Medicine was supportive and should be commended, and that some of the class became closer after Gina's death. Most members said that support came from other classmates and friends (Figure 2) followed by faculty, family, friends, significant others, staff and counsellors. 73.9% of this class responded that there was not any more that could have been done at this time to support them.

Several students were upset about the way they were told about the details of Gina's death and the steps attempted to resuscitate her; they also felt that there was not enough information provided in the days following when the investigation as to the cause of death was ongoing. Some class members felt that not enough was done, that the supports disappeared after the first few weeks and more follow up and group discussion and debriefing were needed. The time off from classes was appreciated; however, students were uncomfortable going back into the classroom without Gina and felt this magnified the loss, wishing another room could have been provided for the short term. Students wrote about their anxiety that if something like this happened to Gina then it could happen to them, and of having nightmares after her death. Students wrote that there was support coming from faculty but also wanted to see more faculty involved and informed about what had happened. There was pressure from faculty who were unaware of what happened to continue with learning when class members were not yet ready to do so. Class members found discussions with others helpful. 4.3% of the class said that death is handled with "Discomfort", or only "When Necessary".

Fourth year students predominantly responded that the topic of death is handled “Openly” within medical school (69.4%). That death is discussed “When Necessary” (13.9%) and with “Discomfort” were the next frequent responses. 5.6% responded they don’t recall any discussion around the topic of death and dying. Feedback included comments that more open discussion about dealing with death and dying and ethics is needed, more awareness during rotations about death and dying and providing debriefing opportunities, and having to attend autopsies on patients that they had cared for being distressing. There was a comment from both the Third and Fourth year class that death is dealt with too openly, and had any more support been offered, it would have been intrusive.



## Chapter 5 – Discussion

### *Hogan's Empathy Scale*

Although the Empathy Scale scores decrease as a student progresses through medical school, these numbers are not significant enough to say that this phenomenon did not occur by chance alone. These results are in opposition to others (Good & Good, 1989) who say that medical school not only fails to promote positive qualities in students, it often suppresses them. “Medical educators aim to provide a learning environment which fosters positive attitudes both in students and in their views about patients care” (Webb, 1977). Unfortunately, learning compassion as a medical student is often difficult. “Almost all medical instruction is focused on acquiring knowledge and technical skills” (Werner, 1976).

However, Evans showed that there may in fact be two types of empathy. The first type of empathy, labeled “basic”; this included the type of empathy that is natural to a person, that is raw, and that the professional has a feeling for. The second type of empathy, “trained”, included a role-taking, professional form. Their study in 1998 showed that trained empathy was not sustained.

If, as research shows us, empathy deteriorates as students progress through medical school, what can be done about it? Several authors point for a need to modify curriculum (DeMarco, 1999; Hafferty, 1994; Lu, 1994). They suggest time for self-reflection, meditation, time for students to develop their thoughts on their new perspective of life and death, and time to engage their own faith traditions (DeMarco, 1999). Branch (1998) cites Konner and suggests that another issue of medical school

preventing students is the time required in medical school for subjects. Time is not available to do the necessary self-reflecting and moral grappling needed to become the type of physician's able to provide the care we expect when faced with death and dying. DeMarco (1999) agrees that, "a progressive awareness of self that permits an individual to integrate the experience of service" is needed (p. 73).

Students need to be in a place where compassion is expected and nurtured, where there are teachers and mentors for them to identify with and to show them how to respond to suffering, a place where compassion is the central goal of medicine. Lu quotes Sir Robert Hutchison,

From ability to let well alone; from too much zeal for the new, and contempt for what is old; from putting knowledge before wisdom, science before art, and cleverness before common sense, from treating patients as cases, and from making the cure of the disease more grievous than the endurance of the same, Good Lord, deliver us. (p. 458)

To teach clinical skills for a semester or two during the first two years of medical school and not continue consciously integrating and supporting these skills as medical training moves from the theoretical to the practical is to do a disservice to the student, patient, and the importance of the skills.

The fact that Memorial medical students showed no significant change in empathy over years two, three, and four, may demonstrate this school's ability to provide what is necessary for students to make these changes within their medical training.

However, as two students wrote in *The Pulse*, it is not necessarily the reality for every student.

I had the opportunity to speak with a third year medical student from another medical school. In casual conversation we discussed our respective theses. Her class had also suffered a peer death, but through suicide. The response from the medical school she attended, from her perspective, was quite different from the one described in the introduction of this paper. She said that the administration provided no help to the students and in fact, did not even acknowledge the death as a suicide or address any students' concerns that the administration had a role in the events leading to the suicide. This left the students with no support within the school and on their own to seek out help, or develop it within themselves. This is in stark contrast to the way Memorial University Medical School addressed a concurrent situation.

The International Work Group on Death, Dying and Bereavement cite a need to be proactive rather than reactive when it comes to addressing care giving problems and making informed decisions. That this can be done through continued education and ongoing collaborative support from colleagues in order to address care giving problems and to make informed decisions.

When divided into gender, females presented as slightly more empathetic than the men in the study. This is not a surprising finding given gender research to date. As studies continue to recognize that men and women are socialized differently, are biologically different, and have had different evolutionary needs, it has been recognized that relationships are of greater evolutionary value to women, therefore female genetics

compliment this, and females are socialized to be kind and soft spoken and not emote with anger (Heim & Murphy, 2003).

*Collett-Lester Fear of Death Scale*

The International Work Group on Death, Dying and Bereavement also support ongoing spiritual education and growth as a part of health care curriculum and a staff support program so the spiritual dimension of the clinical setting can grow. They cite the problem for the current lack of spiritual care is that it assumed to be only within the realm of the role of pastoral care workers, as well as a lack of research about spiritual care. With this base research knowledge, this aspect of medical education can become enriched. Furthermore, humanism, empathy and compassion can be more readily accepted within the clinical domain, saving money within our system. “Research designed to investigate people’s attitudes towards death and dying has never been able to describe successfully what factors contribute to the personal meaning of death for any one individual” (Robinson, 1983, p. 213)

Robinson (1983) found a significant relationship between actualization and orientation toward death, with higher levels of actualization being associated with reduced death anxiety and fear of death (p. 266). Perhaps this is an explanation for the group of students aged 25 and older had a reduced death anxiety over all and on three of the four subscales. More experience in life has permitted them to reflect and become more self actualized.

There is disagreement as to whether students develop anxiety as they come into contact with dying patients, or whether it will decrease. Some reports demonstrate

students anxiety increasing (Kaye, 1985, Black 1989) while others found that there was no difference from students with no experience with dying patients (Howells, 1986). As there was no increase or decrease between the fourth year students and the second and third who had yet to work with patients, this study supports Howells' (1986) findings.

However, there were significant gender differences for the overall Fear of Death Scale, as well as for the domains of "fear of death of self", "fear of death of dying of self", "fear of death of others". Perhaps socialization of females permits them to express these feelings, whereas males are taught to repress the expression of feelings such as sympathy, sadness, and fear in which they would be perceived as weak.

#### *Death and Dying Curriculum in Medical School*

In a study by Dr. Rick Singleton, Director of Pastoral Care, Health Care Corporation of St. John's (1999), people who had experienced a loss of parent, spouse, child, sibling or friend anywhere from two weeks to four and half years after the death, were asked what services they felt would be worthwhile follow-ups to offer people after the death of a loved one. From the collection of this information, Singleton concluded the services that are the most important are information about grief and bereavement, information about grief counselling, information about support groups and an opportunity to connect with the hospital and representatives of significant care providers. He also highlighted that the "needs of staff must not be forgotten in the development of a bereavement program" (p. 4).

Responses were similar to responses given by the medical students in this survey, including, information about grief and bereavement. It appears from the information

provided by the students, the death of a peer was handled well by the medical school and its staff, providing the students with the resources they needed to deal with the sudden death of their classmate.

One suggestion to the blending to the juxtaposed objective competence and subjective caring, both needed in medical teaching is a suggesting of more science, not less. But a new science, “one that incorporates the clinical social sciences and thus refigures the discourse of medicine rather than simply reproduce the dual discourse” (Good & Good, 1989). Webb (1977) also suggests that “a good time for gaining positive attitudinal change in professional education is during the students’ first or second year” when the student is ready for “assimilation of new information and approaches”.

#### *The Importance of Program on Death and Dying in Medical Schools*

It is essential to enable the future physician to be able to support a dying patient by providing them with opportunities to increase their awareness and understanding of their own reactions to death and dying and illness.

A student must reach the delicate balance between over identifying with the patients and dehumanizing them. A student’s first response is often to over identify (Werner, 1976). When medical students over identify and their feelings of vulnerability emerge, a common defense is to dehumanize. Literature (Hornblow, 1977; Lu, 1995) points to the need to for the physician to develop empathy, a detached concern, rather than a sympathy in which the physician enters the patients suffering. In this way, physicians maintain their identity yet can utilize their human understanding to care for

their patient. Empathy is one of the most important, yet difficult processes to master within the medical profession. Ineffective medical care may be the result (Werner, 1976).

There is literature that encourages and point towards the importance of death education and a curriculum that promotes caring, empathic and compassionate interaction in medical students. There is also literature that demonstrates how medical schools are still falling short of providing and modelling empathy and caring. “Central to medical education is the charge to educate competent physicians while maintaining and enhancing the qualities of caring” (Good & Good, 1989). The process of accomplishing this is the challenge of medical schools. “Medical educators aim to provide a learning environment which fosters positive attitudes both in students and in their views about patients care” (Webb, 1977). Unfortunately, learning compassion as a medical student is often difficult. “Almost all medical instruction is focused on acquiring knowledge and technical skills” (Werner, 1976).

Contrary to the goal of creating a positive learning environment for medical students are studies that show, “that medical students increase in cynicism and either decrease or show no sign of change in humanitarian attitudes by the final year of medical education” (Hornblow, 1977; Webb & Lynn 1977). It has even been proposed that medical education “not only fails to produce physicians who embody the qualities we most value in medical care, but often suppresses positive qualities possessed by those entering medical school” (Good & Good, 1989).

Despite struggles throughout medical school such as lack of empathetic role modeling, biological reductionism, paucity of palliative care education, repression of

emotional and spiritual values and fear of failure, as outlined in Chapter 2, there was no difference between empathy and death anxiety in the medical class that had experienced a peer death as compared to the class above and below. It may be inferred from this study that Memorial University of Newfoundland Medical School is doing a good job both in dealing with acute tragedies of death and the overall education of death and dying within the curriculum. Because empathy and death anxiety can be argued to be multi-dimensional phenomenon, the results could also be a result of the lack of uni-dimensional scales. The strength of positive feedback from the students with regards to the way the medical school responded to the death, lead me believe that regardless of the compounding factors inherent in either of the scales, Memorial University Medical School handled the situation well.



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## Figures

Figure 1

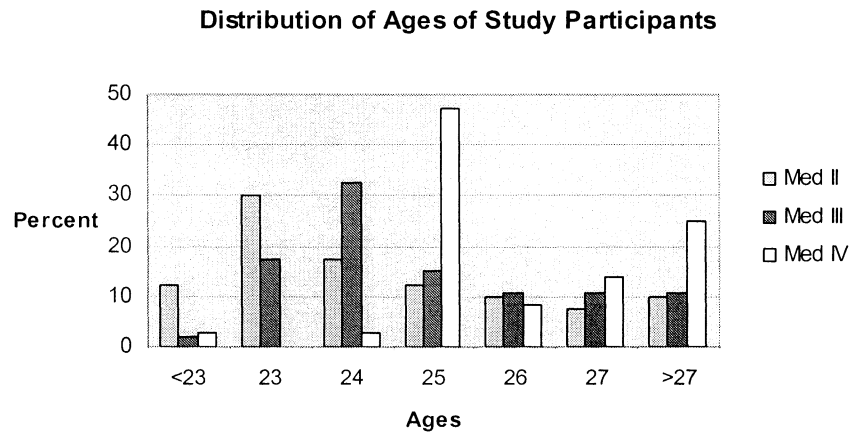
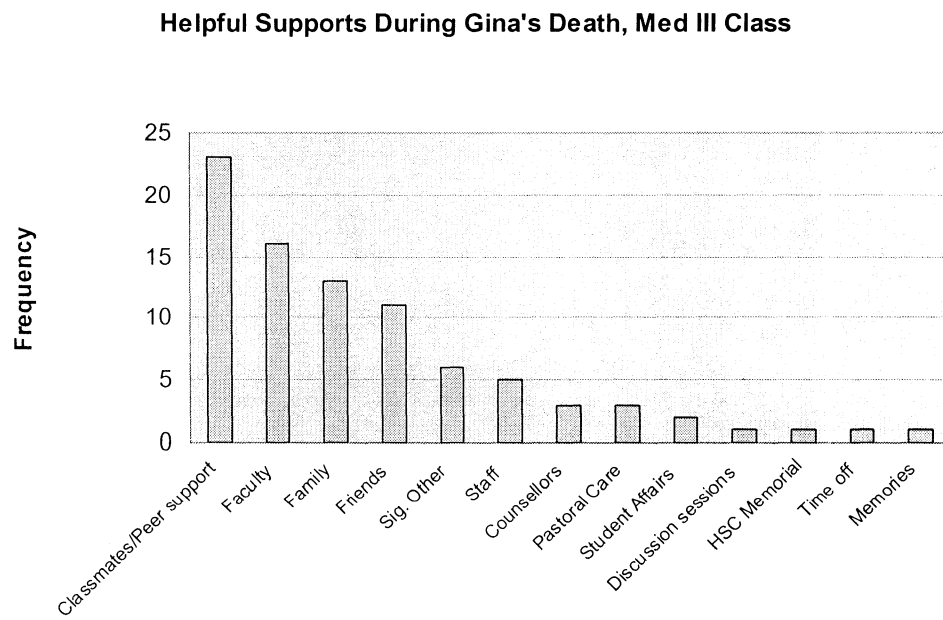


Figure 2



## Appendix A

Table A.1 Values for Collett Lester Fear of Death Scale for Med II, III and IV, Rescaled

		Fear of Death		Fear of Dying		Total
		of Self	of Others	of Self	Of Others	
Class 2	Ave.	26.23	28.00	17.40	15.88	87.50
	StD	8.76	5.93	4.86	6.56	26.11
	CI	2.714698	1.83769	1.5061	2.032925	8.090036
Class 3	Ave.	26.28	27.30	17.04	15.07	85.70
	StD	7.38	4.61	3.86	5.89	16.11
	CI	2.132676	1.3322	1.115465	1.702095	4.655476
Class 4	Ave.	24.11	28.00	16.53	14.72	83.36
	StD	6.58	5.78	3.43	5.00	12.83
	CI	2.149424	1.888096	1.120444	1.633301	4.19105

Table A.2 Values for Collett Lester Fear of Death Scale for Med II, III and IV, Original Scale

		Fear of Death		Fear of Dying		Total
		Of Self	Of Others	Of Self	Of Others	
Class 2	Ave.	4.65	3.60	3.05	-14.30	3
	StD.	10.87	7.49	6.01	8.13	25.36
	CI	3.368581	2.321129	1.862481	2.519463	7.858989
Class 3	Ave	5.00	2.61	2.87	-14.98	-4.50
	StD	9.48	5.64	4.82	7.24	19.79
	CI	2.739535	1.62985	1.392886	2.092219	5.718924
Class 4	Ave.	1.92	3.58	2.28	-15.69	-7.92
	StD	8.55	7.38	4.33	6.05	16.39
	CI	2.792945	2.410752	1.414439	1.976294	5.35396

## Appendix B

## How death anxiety and empathy are affected in a class of medical students who have experienced a peer death

### Biographical Questionnaire

*(Please use the back of this form if more room is needed to write)*

Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Affiliated religion/spiritual perspective of family of origin: \_\_\_\_\_

Current affiliated religion/spiritual perspective: \_\_\_\_\_

How much do you believe your religion or spirituality affects your understanding and perspective of death and dying?

\_\_\_\_\_ A lot    \_\_\_\_\_ Some    \_\_\_\_\_ A little    \_\_\_\_\_ None

Comments: \_\_\_\_\_

When you were a child, how was death talked about in your family?

- ☐ Openly
- ☐ With some discomfort
- ☐ Only when necessary
- ☐ As though it were a taboo subject
- ☐ I don't recall and discussion
- ☐ Other \_\_\_\_\_

Please indicate who died in any personal involvement with death. Please indicate a number is there is more than one death per category and specify the relationship to you.

- ☐ Grandparent or great grandparent \_\_\_\_\_
- ☐ Parent \_\_\_\_\_
- ☐ Brother or sister \_\_\_\_\_
- ☐ Other family member \_\_\_\_\_
- ☐ Friend or acquaintance \_\_\_\_\_
- ☐ Spouse/Boyfriend/Girlfriend/Fiancé(e) \_\_\_\_\_
- ☐ Stranger \_\_\_\_\_
- ☐ Public figure \_\_\_\_\_
- ☐ Animal \_\_\_\_\_

☐ I have not yet had any personal involvement with death

Was there more that could have been done to support you during that time?

Yes \_\_\_\_\_ No \_\_\_\_\_

If so, what? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you experienced any deaths within the context of medical school?

Yes \_\_\_\_\_ No \_\_\_\_\_

*(these may or may not be mutually exclusive from those already listed)*

Please list and describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How is death, as a topic, handled within the medical context?

- ☐ Openly
- ☐ With some discomfort
- ☐ Only when necessary
- ☐ As though it were a taboo subject
- ☐ I don't recall and discussion
- ☐ Other \_\_\_\_\_  
 \_\_\_\_\_

What support was provided for you at this time? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Was there more that could have been done to support you during that time?

Yes \_\_\_\_\_ No \_\_\_\_\_

If so, what? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

***Thank you very much for participating in this study.***







