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Leonard Kuan-Pei Wang
John Sealy School of Medicine, University of Texas Medical Branch, Galveston, TX

Jenna Dale Reisler
John Sealy School of Medicine, University of Texas Medical Branch, Galveston, TX, jdreisle@utmb.edu

Meghan Mukthi Mallya
John Sealy School of Medicine, University of Texas Medical Branch, Galveston, TX

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EDITORIAL

No One Dies Alone: Addressing a Gap in Medical Education

Leonard K-P. Wang[1], Jenna D. Reisler*[,1], Meghan M. Mallya

John Sealy School of Medicine, University of Texas Medical Branch, Galveston, TX, USA

Abstract

Medical school curriculum typically consists of didactical experiences with minimal patient interaction for junior students followed by clinical experiences with supplementary didactics for senior students. Due to the focus on understanding basic medical concepts and disease pathophysiology during the first few years of medical school, students have limited exposure to real-life clinical situations that involve complex, difficult concepts such as death and dying. This leaves students ill-prepared to contribute meaningfully to patients' end-of-life (EOL) care that they will inevitably encounter during their clerkship years. We believe that students would benefit from increased exposure to these difficult situations through structured educational environments, such as the No One Dies Alone Program. In this way, students can become more familiar with the difficult concepts of death and dying, learn how to make meaningful contributions in their patients' EOL care, and ultimately provide patients with the "good death" they deserve.

Keywords: Medical education, Death, Empathy

Curriculum structure across various medical schools typically consists of didactics, which is a combination of lectures, laboratory sessions, and problem- or team-based learning, along with clinical experiences that involve both simulation and real patient interactions. At our institution, the first two years of medical school consist mainly of didactic courses that focus on organ systems and the pathophysiology of disease. The curricula for these first two years are supplemented by occasional lectures on ethics and by a handful of standardized and real patient interactions. There are minimal curricular experiences that focus on having difficult conversations with patients and even less that focus on comforting dying patients.

The curricula for the third and fourth years of medical school at our institution consists of clerkships, or clinical rotations, in which students rotate through core specialties. Inevitably, many students are exposed to dying patients during their clerkships, with some participating in end-of-life (EOL) discussions with the patient and family. These conversations and interactions can be distressing and overwhelming for anyone involved—not only to the patient and their family, but also to the inexperienced students who do not have the familiarity with these topics necessary to allow them to contribute meaningfully. Ho et al. performed a systematic scoping review to understand the impact that death and dying had on medical students, and although many students learned the value of palliative care and empathy, many students found these experiences to be emotionally challenging and discouraging. Additionally, many students reported feelings of awkwardness and disconnection from not knowing how to act or what their role is in EOL care.[1] These feelings represent an educational gap in medical education that we believe can be addressed with structured EOL programs. Many students recognized a lack of institutional support when they cared for dying patients. As a result, many students suppress their emotions and become desensitized to their patients' humanity.[1] We believe that students would benefit from more organized extracurricular and/or curricular activities during their preclinical years that expose them

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* Corresponding author at: 301 University Blvd, Galveston, TX, 77555-0526, USA.
E-mail address: lkwang@utmb.edu (L. K-P. Wang), jdreisle@utmb.edu (J.D. Reisler), memallya@utmb.edu (M.M. Mallya).
[1] LKPW and JDR contributed equally to this manuscript.

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to the concepts of death and dying. By gaining exposure to these difficult situations early on in a structured educational environment, students can better understand how to comfort dying patients through companionship and compassion and how to build the tools necessary to be a more empathetic, effective provider.

One such environment is the No One Dies Alone (NODA) program. The first NODA program was started in November 2001 at a community hospital in Eugene, Oregon.[2] Since its inception, NODA has rapidly grown to reach over 400 hospitals and hospices across the U.S. and around the world. Launched at our institution in 2017, NODA firmly believes that every human life is valuable, and no one should have to experience the process of dying alone. NODA facilitates student and community volunteers to provide companionship to patients at our institution's hospitals who are in their last 48 h of life but do not have family or friends at their bedside.

Each NODA vigil follows a protocol. Nursing staff at community hospitals in the Galveston, League City, and Clear Lake campuses will page Vigil Coordinators, comprised of a team of volunteer medical students of all years, when a patient may potentially require a vigil. A vigil is activated when a patient meets all of the following criteria: 1) actively dying and in the last 48–72 h of life, 2) receiving comfort care only and a do-not-resuscitate order is present, 3) no family or friends that are available, 4) desires the presence of a compassionate companion at the bedside as they pass away. Once a vigil is activated, volunteers are notified and sign up for hourly shifts to provide a compassionate presence to the patient. Prior to attending a vigil, volunteers receive training at NODA orientations held throughout the year. Orientations cover our chapter's history, vigil protocols, and discussions on EOL care. Volunteers are briefed on the expected changes in dying patients and different methods to comfort them. NODA leaders also explore the role of a healing presence through interactive facilitated discussions with volunteers. Finally, a current NODA volunteer will share his or her experience as a compassionate companion at the vigil. We find that sharing these anecdotal experiences during our orientations offers volunteers a supportive introduction to EOL care.

To date, our NODA chapter has held 43 vigils since its inception. Collectively, medical students and community members volunteered over 360 h holding vigil with patients. While no formal results have been measured yet, anecdotal experiences have shown us that the volunteers at our NODA chapter have found their vigil experiences meaningful. One student recounted how one humbling vigil taught her the importance of intentional connection and inspired her to remain benevolent when practicing medicine, especially with patients near the end of life.[3] A single center study of a NODA chapter at a different institution supports our anecdotal findings. The researchers found that medical students who were NODA volunteers obtained higher scores on a validated measure of empathic orientation toward patient care compared to medical students not involved with NODA.[4] Their findings suggest that NODA volunteers exhibit more potential to become empathic physicians. However, we also recognize the limitations in analyzing prosocial volunteer programs like NODA. There is a self-selecting bias because the type of medical students interested in this EOL work are the ones who choose to volunteer with NODA.

Participation in programs like NODA could help student providers better understand dying patients' experiences, increase comfort with emotionally challenging situations, and ultimately improve how they care for other terminally ill patients.[5] We believe that in addition to early training for and exposure to caring for dying patients, an institutional support system based on debriefing and reflection may further assist students in coping with these difficult experiences and promote emotional expression and empathy. To our knowledge, real-time debriefing sessions and supportive discussions have not been integrated into medical school curricula. As medical students, although we recognize the benefits of participating in programs like NODA, we advocate for educational curricula focused on death and dying that includes direct and structured experiences with dying patients along with supportive debriefs. In this way, we hope students will feel supported when participating in these inevitable and difficult experiences while cultivating a sense of empathy in caring for individuals at the end of their lives.

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Prior presentations

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