



ORIGINAL RESEARCH PAPER

Students' Views about Doctor-Patient Communication, Chronic Diseases and Death

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Published: 21 April 2008

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Education for Health, Volume 21, Issue 1, 2008

Available from: <http://www.educationforhealth.net/>

ABSTRACT

Context: Students start their medical study with the opinion that saving lives and preventing deaths are the main goals of medicine. So, what will they do when faced with dying patients? How will they feel; how will they communicate? These are important, but often unspoken and neglected, issues.

Objectives: We assessed the attitudes and opinions of first-year medical students regarding doctor-patient communication, chronic diseases, death, and dying patients at Uludag University Medical School in Bursa/Turkey. Our secondary objective was to delineate the educational needs related to this field.

Methods: Cross-sectional survey of the first-year students in the class of 2004-2005. Students were evaluated using a questionnaire consisting of six questions and 18 Likert-type statements.

Results: Completed questionnaires were received from 253 of the 265 (95.5%) students. According to the students, the most fatal diseases were cancer and AIDS. Students strongly agreed with the importance of talking to patients, where female students agreed more than males with this statement ($p < 0.05$). Most students disagreed that patients should be informed that they are dying. Older students feared less for the death of patients. Female students would like to work in an environment where they can communicate with their patients and where they can be with them for a longer period.

Conclusions: The results of this survey indicate that the need of providing palliative care, enhancing communication skills with terminally ill patients, and integrating different teaching strategies are important aspects of the undergraduate medical curriculum.

Keywords: Medical students, communication, death, dying patients.



Introduction

“Ivan Ilych saw that he was dying, and he was in continual despair. In the depth of his heart he knew he was dying, but not only was he not accustomed to the thought, he simply did not and could not grasp it”. Tolstoy

Death is something that every living being will encounter. It must be regarded as a natural event, even though it is an unwanted situation that causes suffering to both the dying individual and family (Kolusayın & Koç, 1999). On the other hand, in some cases death can be a wanted situation to end suffering (Zylicz & Janssens, 1998). Patients with chronic diseases, who must live with life-long medical problems caused by the disease, have difficulty building sufficient relations with physicians due to insufficient time and literacy barriers (Royak-Schaler *et al.*, 2006). Social, psychological, and family problems begin to have a negative effect in the patient's life.

Most medical students state that the main reason to be a physician is to cure patients; medical education prepares physicians this way (Aull, 2005; Lloyd-Williams & Dogra, 2003). However, with the aging of society, deaths due to chronic diseases have outnumbered those due to acute diseases (Lloyd-Williams & Dogra, 2003; Lloyd-Williams *et al.*, 2004; Lloyd-Williams & Dogra, 2004). This situation has changed physicians' patient panels (Rakel & Storey, 1995), where over 90% of hospital beds are occupied with patients suffering from chronic disease or illness (Lloyd-Williams & Dogra, 2004). Recently, much attention has been directed toward death-related topics, including the role of the physician in caring for terminally ill patients and communicating with patients and their families about death and dying (Curtis & McGee, 2000). Physicians, whatever their specialty, frequently must break bad news to patients and their families (Buckman, 1984; Baile *et al.*, 2000), and students need to be trained for this (Fallowfield & Jenkins, 2004).

Uludag University, established in 1975, is located in Bursa, an industrial city with a strong historical and cultural heritage and a population of approximately 2,000,000. This public university is the only medical school in the Southern part of Marmara Region. Despite the persistence of traditional lecture-based teaching in the university, to achieve balance between theoretical and practical dimensions of education, individual departments have adopted several non-didactic approaches (i.e., audio-visual supporting tools, teamwork in practice and applications, and integrated courses). Within these medical education activities, the main goal is to save lives and cure patients. Unfortunately, the existing curriculum does not offer many possibilities for students to prepare them to take care of dying patients.

In this study, we aim to reveal the attitudes and opinions of first-year medical students, as representatives of the non-medically educated population, about doctor-patient communication (especially in relation to dying patients, chronic diseases, death and death related issues) in order to improve our medical curricula in this domain.

Methods

Study design was cross-sectional with a survey administered to all first-year students of the Uludag University School of Medicine's class of 2004-2005, who gave verbal consent to participate. The questionnaire was based on a literature search and was piloted using 30 students. Possible areas of confusion and misunderstanding were corrected after the pilot study. Questionnaires were distributed and collected within closed envelopes that students had filled out anonymously on their first school day.



The questionnaire consisted of two parts: 1) six questions, including demographic data and questions about their experiences in caring for someone with a serious disease and whether there currently was a family member who required care (a person who needed assistance or watchful supervision in their home). Students were also asked to name what they considered to be the deadliest disease and 2) students' evaluations of 18 statements about doctor-patient communication, chronic diseases and death, scored on a 10-point Likert scale (1 = strong disagreement and 10 = strong agreement).

Statistics

We analyzed the data using SPSS 11.0 software. Appropriateness of the normal distribution was evaluated by using Kolmogorov-Smirnov and Shapiro Wilk tests. Kruskal Wallis and Mann Whitney U tests were used for nonparametric comparisons between groups and interpreted according to significance level ($p < 0.05$). The level of significance in multiple comparisons is determined after Bonferoni correction (Shein-Chung & Jen-pe, 1998).

Results

Completed questionnaires were received from 253 of 265 (95.5%) registered students, 134 were male (53%) and 119 were female (47%). Age range was 16-23 years with a median of 19 years (18.9 ± 1.01). Students were mostly from the Western regions of Marmara, Middle Anatolia, and the Black Sea (20.2%, 19.4%, 18.2%, respectively). The remainder of students (42.2%) came from other regions or countries. The eastern part of Turkey is still underdeveloped in many aspects compared with the western part and socioeconomic status is higher in the western parts. Twenty-three students (9.1%) had a family member who needed care and had personal experience in caring for an ill person in their family. Family members who needed care were primarily parents (34.8%), grandparents (34.8%), and siblings (17.4%). The major diseases associated with need for care were cerebrovascular (17.4%), hypertension and heart (17.4%), diabetes (17.4%), pulmonary (13%), infectious diseases (8.7%), and cancer (4.3%). According to the students, the most fatal diseases were cancer and AIDS (47.4% and 34.8%, respectively).

As shown in Table 1, students strongly agreed with the importance of talking with patients and giving permission to die at home as the patient wants. Students preferred a medical specialty in which they could heal patients. They disagreed with the statements that cancer is not curable and that patients should be told that they were dying.

There were some statistically significant differences based on gender between students' responses, and females more likely agreed that while talking to patients is important, they were distressed when talking to dying patients. They wanted to choose a medical specialty after graduation that would allow follow-up on their patients for a long period and that patients should be told of a cancer diagnosis. Female students were less likely than male students to agree that they would avoid talking to dying patients, while male students were more likely to agree that physicians talking to children about death, was unnecessary.

When the relation between students' age and response to statements was evaluated, older students were significantly more likely than younger students to be less worried about the death of patients and to indicate that cancer was a non-curable disease. There were also statistically significant differences related to the presence of a person needing care in a student's family, where those caring for someone were more likely to agree that physicians should not worry when patients die, and caring for a dying patient may be a rewarding job for the physician.



Table 1. Students’ responses to statements about communication, chronic disease, and death

Statements (n=253)	Mean Likert Score ¹	sd
S1. Talking to patients is important	8.70	0.77
S2. I would prefer to chose a specialty in which patients can heal	6.35	2.66
S3. The patient should be allowed to die at home if he/she wants to	5.90	3.03
S4. I would prefer to work in a specialty where I can follow patients for long periods of time	5.77	2.56
S5. The cancer patient’s diagnosis should be reported	5.64	3.10
S6. Most patients I met in hospital are cured and heal completely	5.33	1.98
S7. I enjoy listening to patients reminisce	5.26	2.50
S8. Caring for a dying patient may be a rewarding job for a physician	4.80	2.82
S9. Most cancer patients have pain which cannot be relieved	4.33	2.36
S10. Doctors should not worry when patients die	4.28	2.61
S11. Talking to children about death is not necessary	4.26	3.30
S12. Talking to a relative of a dying patient is distressing	4.25	2.99
S13. I feel distress while communicating with dying patients	4.05	3.00
S14. Very little can be done by doctors for patients who are dying	3.73	2.73
S15. Not curing patients is a failure for doctors	3.35	2.21
S16. Patients should be told that they are dying	3.32	3.19
S17. I avoid talking with dying patients	2.90	2.70
S18. Cancer is a noncurable disease	2.32	2.46

Additionally, statistically significant differences were found between students who were personal caregivers for someone and those who were not. Care-giving students were more likely to indicate the importance of talking with patients and to state that caring for a dying patient may be a rewarding job for the physician and agree to letting patients die if they want to. In contrast, these students were less likely to be distressed when talking to a relative of a dying patient than non-caregiver students.

Finally, related to geographic regions of the country, students from the Mediterranean region were less likely to agree with the statement that most patients in hospital will be treated and healed than those from the Marmara region, Black Sea region, and other countries. And students from the Marmara region were less likely to agree that physicians talking to children about death is not necessary, compared with students from Middle Anatolia, Southeastern Anatolia, and other countries.

Discussion

“While you are not able to serve men, how can you serve spirits [of the dead]?...While you do not know life, how can you know about death?” Confucius (Chinese philosopher & reformer, 551 BC - 479 BC)

Recently, due to aging and associated chronic diseases, physicians see more patients with diseases at terminal stages as well as more patients with incurable and life-limiting diseases. Physicians aiming to save the lives of patients not only feel discomfort with seeing dying patients and those facing death (Cleeland *et al.*, 1986; Von Roenn *et al.*, 1993), but also feel unprepared to provide good care for the dying (Sullivan *et al.*, 2003; Wear, 2002; Weissman *et al.*, 1998). This occurs because of insufficient knowledge and skills regarding death. Therefore, many medical schools have added courses to their medical curricula focusing on caring at the end-of-life and dying patients (Field, 1984; Field & Wee, 2002; MacDonald *et al.*, 1993; Billings & Block, 1997; Hill, 1995; Dickinson, 2002).



In our study, prospective physicians strongly believed that talking to patients is important, and if a patient wants to die at home, he/she should be allowed to do this. Many studies have shown that the favored place of death is the home, rather than the hospital (Higginson & Sen-Gupta, 2000; Gott *et al.*, 2004; Brazil *et al.*, 2005). The vast majority of our students disagreed that patients should be told they are dying, a finding contrary to the result of a study from the United Kingdom (Lloyd-Williams & Dogra, 2003). This difference may be due to culture, life situations and religion. Students preferred to train in a medical specialty in which patients could be healed. These results are compatible with two studies by Lloyd-Williams *et al.* (2003; 2004). However, in our study, students responded less favorably to the statements “I enjoy listening to patients’ reminisce,” “talking to a relative of a dying patient is distressing,” and “caring for a dying patient may be rewarding for physicians” than they did in the Lloyd-Williams research (Lloyd-Williams *et al.*, 2004; Lloyd-Williams & Dogra, 2003). Such differences in findings may be due to cultural differences between the two student populations or to their differing life experiences.

More female than male students agreed with the importance of talking to patients, and female students wanted to follow up with their patients for a longer period of time than male students. More female students indicated that a cancer diagnosis should be revealed to a patient. Lloyd-Williams *et al.* (2003; 2004) reported similarly that female students communicated more often with patients than male students. Another study showed that female students preferred general medicine, palliative care, and psychiatry branches than males, and these disciplines support the value and importance of communication (Field & Lennox, 1996).

Older students more often indicated that physicians should not worry if their patients were going to die. This may be explained by the acceptance of death and viewing it as a normal event. Students who began the study of medicine at older ages showed positive approaches for chronic diseases and caring of dying patients. This may be due to their different life experiences (Buss *et al.*, 1998; Reuben *et al.*, 1995). Further, students with care-giving experiences placed more importance on talking to patients and found talking to a relative of a dying patient less distressing.

These types of findings underscore the importance of adding issues of communication with terminal and chronic diseases into medical training. Many medical schools in England have trained their students in the care of terminal patients (Field & Wee, 2002). This training includes hospice rotations to increase the communication skills of students with chronic and terminal stage patients, and the students reacted very positively (Stedeford & Twycross, 1989; Knight *et al.*, 1992).

We expected to find differences among students from different parts of our country concerning their approaches to death and dying as there are great developmental differences between the eastern and western parts of Turkey. People living in the eastern parts are more fatalistic and death is accepted as a gift from God where death is seen as a positive life matter. The eastern region has a wide family structure and tight family relations in which many generations are living together. On the contrary, the western region has mostly core families and also higher socio-economic status (Census of Population, 2000). However, we found few statistically significant differences among students from the different regions. This may be a variable to further explore in future studies.

Past research has shown that physicians find themselves inadequate in their approach to dying patients (Sack *et al.*, 1984; Plumb & Segraves, 1992; Martini & Grenholm, 1993). Offering undergraduate and graduate training about death and dying care, breaking bad news and communication with dying patients and their families can prove useful (Billings & Block, 1997; Field & Wee, 2002; Hill, 1995; Mavis, 2001; Wood *et al.*, 2002). Training students about death and dying, approaches to patients who are close to death, communication with chronic and terminally-diseased patients at the beginning of their medical education, and continuing this throughout the curriculum, will be useful to both students and their future patients. Gaining insight into student opinions and attitudes about death-related issues at an early stage in their training can inform the curricula in this subject area. For our medical



faculty, a formal approach to dying patients has recently been accepted as a necessary skill. Some basic short courses have been introduced into the curriculum, however, these need to be expanded and improved.

Since we included only first-year students in this study, our results are not representative of all medical students. Moreover, the data were collected from one medical school in one part of the country. Next steps include following students in their later medical school years to better understand the effects of medical education on opinions and attitudes in this important area.

Conclusion

Prospective physicians will feel better about and act more appropriately with dying patients if they have received training throughout their medical education. Communication skills with non-curable patients and their families are not easy to gain. Therefore, training programs regarding this issue should begin at early stages of education. This will ease the way to death and help the physician to better attend to the needs of dying patients and their families.

Acknowledgment

We would like to thank Scribendi Language Services for their grammatical review and editorial assistance.

Ethical consent

Ethical consent for this study was not required at our institution at the time of the study.

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