ORIGINAL ARTICLE

# Five-Year Experience: Reflective Writing in a Preclinical End-of-Life Care Curriculum

Marcy E Rosenbaum, PhD
Kristi J Ferguson, PhD
Ann Broderick MD, MS

## Abstract

**Introduction:** This paper examines the use of reflective writing in a preclinical end-of-life curriculum including comparison of the role and outcomes of out-of-class (OC) versus in-class (IC) writing.

**Methods:** Learners were required to complete one-page essays on their experiences and concerns about death and dying after attending a series of end-of-life care lectures. From 2002-2005, essays were completed OC and in 2006 and 2007 essays were completed during the first ten minutes of small group discussion sessions. Essays were collected and analyzed for salient themes.

**Results:** Between 2002-2007, reflection essays were gathered from 829 learners, including 522 OC essays and 307 IC essays. Essay analysis identified four major themes of student concerns related to caring for dying patients, as well as student reactions to specific curricular components and to the use of reflection. IC essays were shorter and less polished than OC essays but utilized a wider variety of formats including poems and bulleted lists. IC essays tended to react to lecture content immediately preceding the writing exercise whereas OC varied in curricular components upon which they focused. OC essays have the advantage of giving learners more time to choose subject matter, whereas IC essays provide a structured time in which to actively reflect. Both formats served as catalysts for small group discussions.

**Discussion:** Writing exercises can effectively provide an important opportunity and motivation for learners to reflect on past experiences and future expectations related to providing end-of-life care.

## Introduction

To compel learners to examine past experiences with death and address future concerns and expectations regarding caring for dying patients the University of Iowa Carver College of Medicine incorporated reflective writing into a primarily didactic preclinical curriculum. Details of the complete curriculum were published in the *Journal of Palliative Medicine* in 2005.[1] In the current paper, we present five years of experience using reflective writing exercises as part of the end-of-life curriculum for second-year medical students and physician assistant students. Discussion focuses on the role and outcomes of the reflective writing exercises to understand its value, with a specific focus on comparison of "out-of-class" (OC) versus "in-class" (IC) reflective writing to enhance educators' understanding of the most effective writing situation and tools.

Several reviews of the literature noted the importance of incorporating curricula on end-of-life care into medical education.[2,3] As part of this training, it has been argued that learners need to be aware of their own attitudes about death and caring for patients at end of life.[3] Reflection can be an especially useful tool as it compels learners to examine the context, the meaning, and the implications of their attitudes and experiences about death.[2,4]

## Methods

Since 1998, the University of Iowa, in Iowa City, has provided a required ten-hour didactic education module (reduced to 6.5 hours in 2004) for second-year medical learners and physician assistant learners on end-of-life care as part of their fourth semester Foundations of Clinical Practice course. During the didactic sessions, in this education module, learners are exposed to central concepts of palliative and end-of-life care, including: management of pain and nonpain symptoms, hospice and palliative



**Marcy E Rosenbaum, PhD,** (left) is an Associate Professor of Family Medicine at the University of Iowa Carver College of Medicine, Iowa City. E-mail: marcy-rosenbaum@uiowa.edu.
**Kristi J Ferguson, PhD,** (center) is an Associate Professor of General Internal Medicine at the University of Iowa Carver College of Medicine, Iowa City. E-mail: kristi-ferguson@uiowa.edu.
**Ann Broderick, MD, MS,** (right) is an Internist and specializes in Hospice and Palliative Care at the University of Iowa Hospitals and Clinics, Iowa City. E-mail: ann-broderick@uiowa.edu.

care approaches, bereavement and physician self-care. A variety of evocative materials are incorporated into the lecture sessions—videos of patients and parents dealing with end-of-life issues, poems, and stories conveying positive and negative experiences of health care providers caring for dying patients, a panel of learners who have been hospice volunteers, and an exercise in which learners are asked to visualize their own deaths. In addition, as an out-of-class assignment, learners complete a "Personal Death History" (PDH), which asks learners to inventory their first and most significant experiences with death, and their feelings during these experiences.[5] Learners also participate in small group sessions in which a physician facilitator reflects on his or her own experiences providing care to dying patients, and facilitates a discussion of student experience and concerns about their role in the care of the dying.

Beginning in 2002, we asked learners to: *Write a one-page reaction essay addressing issues raised for you by this class in terms of your feelings about death and caring for the dying?* This assignment, given after the majority of in-class lectures, was due at the time of the small group sessions. The assignment's purpose was for learners to actively reflect on experiences, module content, and future concerns in preparation for small group discussion. In 2006-2007, we shifted the writing assignment from immediately before the sessions—either handed-in or completed online—to the first ten minutes of the group sessions, as a more immediate catalyst for discussion.

The essays were then collected after the group session. Responses were transcribed verbatim and entered into an Atlas.ti (Version 4.1, Scientific Development Software; Berlin, Germany, 1997) qualitative analysis software database. Each set of essays was read several times and a coding scheme was developed on the basis of predominant themes and topics discussed. Subsequently, transcripts were coded using the scheme, identifying both the quantity and quality of student essay content. Similarly, learners' open-ended comments on the small group evaluations were aggregated and coded for salient, recurring themes. For the purpose of the current paper, a subset of evaluation comments—related specifically to the reflective writing exercises—was also examined.

Student essays and comments were submitted as a standard part of the course curriculum. Because of this, the Institutional Review Board at the University of Iowa approved analysis of these materials as exempt.

## Results

Between 2002-2007, reflection essays were gathered from a total of 829 second-year medical students and physician assistant students (Student essays per year = 2002:164. 2003:189, 2004:169, 2005 not included, 2006:148, 2007:159).

### Overall Content of Essays

Across all years, the majority of learners chose the essay format to reflect on personal experiences with death. This recounting took many forms: 1) in-depth description of a significant death experience and the student's reaction to it; 2) a chronological inventory of a variety of experiences losing loved ones or friends, or being around patients at the end of life—mirroring information they would have provided in their PDH; or 3) an identification of students' lack of significant exposure to death and the implications of this for their practice as physicians.

The second most common use of the reflection essay was to describe concerns about future encounters with end-of-life issues. These essays focused on contemplation of the student's own death (and the fears and needs at that time) or the death of loved ones and/or patients at the end of life.

The third most common focus of the essays was to address or respond to issues raised in the course lectures, either by recounting their importance and/or reacting to concepts as affirming, new, or controversial.

Many of the essays combined all three of these elements recounting personal experiences, describing future concerns and tying it directly to lecture content.

### Major Themes in Student End-of-Life Concerns

Analysis of the content of the essays was condensed to four major themes, described below with representative student examples. (See sidebar: Themes and Concerns.)

#### Themes and Concerns

Emotional responses to caring for the dying
- Own emotional response
- Appropriate emotional sharing and connection
- Failing to portray, or even feel, enough emotion or empathy

Communicating support

Shifting emphasis from curing to caring

Feeling ill prepared

### Emotional Responses to Caring for the Dying

One of the most common student concerns was their own emotional response to involvement with dying patients and their families. These responses fell into three categories. The primary category was personal grief and discomfort about a patient's death. Their concern was both about "losing one's composure" or "crying" in front of patients, family members, even medical colleagues, and how to protect oneself from the pain of grief that could accompany a patient's death.

*I will be on the wards in a few months, and somebody might die. Somebody might cry while I interview her. I might cry. What will I do? How will I respond to these things? Will I give the wrong response? I have felt a significant amount of anxiety over these issues in the last year. Last week during the end-of-life care lectures, though, I felt a subtle wave of reassurance come over me.*

Learners expressed, as a second category of concern: their struggle to understand the amount of emotional sharing and connection appropriate in end-of-life situations—trying to keep a balance between being emotionally involved and supportive, while maintaining enough objectivity to accomplish the necessary clinical tasks in the context of end-of-life care.

**Their concern was both about "losing one's composure" or "crying" in front of patients, family members, even medical colleagues, and how to protect oneself from the pain of grief that could accompany a patient's death.**

*I've heard that you can go into the room of a patient, look her in the eye and tell her she is going to die, and then you can leave the room and go see your next patient and smile at them. How can this be done? How can you not leave part of yourself in that room, in every room, until there is nothing left? And if it is in fact feasible to be caring and compassionate and human while still performing as a physician, how long does it take to get there? How do you protect your soul while you are learning how to master this awful skill? These are not things we learn as part of the core physical. And I am scared they are things I will never learn. That I will try and try, until I get tired of practicing. Then I will numb myself to the pain of others because I cannot handle the learning curve of this job requirement.*

The third concern learners expressed was failing to portray, or even feel, enough emotion or empathy for patients and families at the end of life. Some attributed this to their self-perception of not being very emotional, while others anticipated that the demands of providing care may limit their ability or time to express support.

*I have always been a little concerned with my lack feeling towards death and have felt that maybe I'm not sympathetic enough, heartless, or just don't have the emotional capacity to handle death appropriately. I have grown to understand that everyone deals with death differently and it is fine that I am not visibly moved by death. I have grown a lot emotionally and spiritually since the last time I was close to a person who died and I am very curious about how I will react to the next death.*

### Communicating Support

Many of the essays contained learners' worries about their ability to provide effective and supportive interactions with patients and families.

*I think one of the more difficult challenges I will face in dealing with end-of-life issues as a physician will be knowing how best to provide my support for the family and to find the best way to help them through their grief. It will be hard for me to tell the family that their loved one is gone, partly because I'll be frustrated with the limitations of medicine and I don't like the idea of someone dying under my care: almost as if their death is my failure as a physician. It will take me some time to work through this frustration and realize that not everybody is going to live and I must do all that I can to help them, but it's not necessarily a shortcoming if they do die.*

The majority of these statements include concerns about being able to "say the right thing" both to patients and to families. As major concerns, essays addressed not only grief at the loss of a loved one, but also delivering bad news.

### Shifting Emphasis from Curing to Caring

The third major theme in learners' essays was when curative therapy is no longer a viable option, examining the clinician's role in providing both physical and emotional support to patients. Thus far through medical school many learners noted that they had thought little about dealing with dying patients, since the curricular emphasis had been on diagnosis and treatment.

*I am worried about caring for dying patients. I haven't worked out my own feelings about death and am unsure how to deal with dying patients. Most of my experiences with death have been with quick deaths. If I were more confident about my own beliefs about death and dying, I think I would be more confident with those patients. I am also worried about seeing death as a failure to help/cure the patient. Whenever I thought of medicine, I always pictured treating and healing patients. End-of-life scenarios were not part of my visualized medical career. I now know that is not the reality, but I am still concerned about how I will deal with death and dying.*

Learners come to recognize the need to shift from curative to palliative care, many acknowledging the personal discomfort of grappling with it.

### Feeling Ill Prepared

Many of the learners expressed, as the fourth theme, feeling unprepared to deal with end-of-life issues, not only in relation to patients, but also in regard to the eventual loss of loved ones and—even facing their own deaths. For many, the PDH was a catalyst and premise for their conclusion that they have had little preparation.

*I have concerns about dealing with patients as they die. I have had very little personal experience with death and I am unsure how to comfort someone or his or her family as that patient dies. I also wonder how my first patient death will affect me. I've never been present for someone's death and I don't know how it may change my feelings on mortality and treating patients. It's difficult to know any strong feelings that I have with death because I have never been close to anyone who has died.*

Many of these four themes were expressed as interrelated. For example, learners who had little experience also expressed concern about balancing their own emotional responses, about providing appropriate support to patients and their families, and being able to properly shift their emphasis from caring to curing.

### Responses to the Curriculum

In addition to identifying areas of student experience and concerns, reflection essays provided an opportunity for learners to directly react to the end-of-life curriculum, positively or negatively, which some chose to do.

*To have the end-of-life module built into the first two years of medical school is a privilege. Many of my friends at other medical schools don't have this opportunity to openly discuss and acknowledge the difficult challenges health care professionals and their patients face when confronted with end-of-life issues. I think that it's assumed if you embark on the career of doctoring, that you somehow integrally know how to handle difficult situations, how to protect yourself and your patients and patients' families from the rawness of death. I think that's an enormous leap from what's actually true. I personally have never dealt with the death of a loved one or anyone close.*

### The Value of Reflection

In some essays, the value of, and opportunity for, reflection on end-of-life issues was directly addressed—most commented on the opportunity for reflection on issues, while a small number commented directly about the value of the reflection essays.

*The most important aspect of this lecture series for me was the emphasis on reflection on personal experiences. I find this to be especially important because it would be very difficult to be an effective part of a health care team serving a dying patient and his or her family if you tried to remain entirely objective. To serve your role as a healer you must use personal experience to provide the best possible care.*

*This probably wasn't the purpose of this assignment but you have no idea how much this has helped me to put down on paper at least a little bit that I went through that has been bottled up. I think these classes are essential to our training. I've found that medical school and our hectic world make it easy to slip into a routine that makes self-reflection next to impossible. I appreciate the chance to take a moment to recalibrate myself and realize that I haven't strayed too far from the person that I was before I got here.*

### Out-of-Class versus In-Class Reflective Writing

We discovered differences in the overall content of essays between the subset of OC essays compared to IC essays. Although the number of learners discussing personal experiences and future interactions was essentially the same in both formats, more of the IC essays directly responded to lecture content. This appears to be an artifact of the little time to contemplate. Overall, most IC essays were shorter and less polished than OC essays. The OC essays recounting a personal experience had a polished story format—rather than a rough recounting of incidents—and more were written in third person. Conversely, alternative formats to a prose essay were more prominent in the IC writing including bulleted lists of concerns and/or questions, poems, cartoons and even concept maps. The latter two more creative formats were constrained during the required OC online submission process.

Small group evaluation comments revealed that some found the IC writing exercise helpful and even fun; others found it less useful and felt that it limited time for important group interaction. Several learners questioned the utility of the IC and/or the PDH when they were not incorporated into the discussion by individual facilitators. Learners especially appreciated hearing other learners' experiences and concerns. One of the purposes of the reflective writing exercise was to prepare learners for identification and discussion of issues in the small group sessions.

## Discussion

### Reflective Writing

Without formal inclusion of reflective writing in our end-of-life curriculum, it is not clear how many learners would have spent much time reflecting on their experiences and concerns related to death and dying. The reflective writing process caused them to personalize both the experiences and the information provided in lectures. Especially telling, regarding the value of reflection, is that more than half of the essays began with a reference to having thought little about caring for dying patients—as a major aspect of their role as health care professionals—prior to the end-of-life module. They attributed this to either consciously avoiding the topic, or their emphasis on treatment and curing as best actualizing their motivation to pursue a medical career.

Use of reflective writing served several purposes in our end-of-life curriculum. First and foremost, it provided an opportunity for learners to more seriously think about both past experiences and issues being presented in lectures. We believe that the reflective writing process assists learners to internalize new information about caring for dying patients, similarly to, personalize what otherwise might be abstract concepts. Second, the reflective writing exercises provided learners an opportunity to consider their experiences and concerns prior to participating in small group discussions, where they verbalized these issues. Third, reflective writing provides insight for course instructors regarding student concerns, needs and expectations to guide curriculum revisions. These essays also provide evaluation of the impact of end-of-life curriculum on learners' attitudes, knowledge and expectations.

**It will be hard for me to tell the family that their loved one is gone, … I'll be frustrated with the limitations of medicine and I don't like the idea of someone dying under my care …**

### Timing of Reflective Writing

There are advantages and disadvantages to using either format for reflective writing—OC or IC. OC reflective writing allows learners time to reflect and then better choose what to write about, which results in more elaborate and polished examination of their concerns and, in some instances, they become more creative in prose and storytelling. Specifically in relation to end-of-life issues, writing alone permits more introspection and more comfortable emotional expression. Disadvantages include less spontaneity in reaction to issues that are most salient for the student and perception of burdensome homework assignment robbing time from something else.

In addition, because the OC reflection assignment could be completed any time prior to small group sessions, learners are less likely to base small group discussions on what they had written. Advantages of writing in-class include reacting to what comes immediately to mind and allows room for alternative and freeform expressions such as cartoons, concept maps, and bulleted lists. Because it is time limited, the activity is not perceived as additional homework. Finally, in the context of small group discussions, learners easily access experiences and concerns they just wrote about. Disadvantages to IC writing include shorter responses with less thought and polish, and potential inhibition in learners' exploration and expression of emotions about their reflections.

Regardless of the format used—IC or OC—promoting future use of reflective writing among medical learners is best facilitated if the purpose of these types of reflection exercises is made explicit. As noted, learners who felt their reflections were not explicitly or implicitly incorporated into the small group sessions perceived them as less valuable. When reflective writing exercises occur in class, small group facilitators have no opportunity to read these reflections. Learners are informed that their writing will not be read by their facilitators, but that the course directors remove all identifying information and read all of them to guide future curricular activities. We considered having learners write reflection essays before group so that facilitators could read them prior to discussion, however, this could inhibit what learners choose to write about.

As the essays demonstrated, requiring reflective writing resulted in acknowledgement and sometimes discovery by learners of the conflicting and poignant emotions that can arise in contemplating caring for patients and families who are suffering in the context of illness and death. Learners' consistent references to having not considered these issues during their medical training points to the purpose that reflective writing can serve: compelling and empowering learners to consider the complexities of their transition to their roles as medical professionals who will and do confront emotionally challenging issues in patient care. Our findings also point to the importance of not only requiring reflective writing but also creating time for these reflections to occur. Whereas IC writings revealed similar issues of concern to learners, OC writings often had more depth and breadth in learners' descriptions of issues they considered both challenging and salient. On the basis of our experiences with one simple and time-limited reflective writing

activity, we encourage more consistent incorporation of time and purpose for reflective writing throughout the medical school curriculum. Beyond the focus of end-of-life care, encouraging reflection throughout training can lead to a more considered practice in interactions with patients, colleagues, and balancing of personal and professional lives.

The potential importance of incorporating opportunities for student reflection on their reactions to difficult patient care and particularly end-of-life care issues cannot be understated. Studies by Wear[6] and Rhodes-Kropf[7] with third- and fourth-year medical students revealed that learners experience complex and longstanding emotional reactions to patient deaths and often receive no support or role modeling from clinical faculty and residents in processing these strong reactions. As Wear argues, end-of-life care can provide a significant curricular opportunity for faculty to examine and role model self-reflection as a coping tool for medical professionals and has a particularly important role in the clinical curriculum where learners are experiencing these patient care encounters.

In summary, regardless of whether it is conducted in or out of class, reflective writing provides instructors information about student experiences and concerns, reactions to the curriculum, and insight into the reflection process itself. More importantly, reflective writing early in medical school experiences has the potential to motivate learners to be more reflective practitioners throughout their medical training. Finally, reflective writing and promotion and modeling of self-reflection should be considered as important elements to be incorporated into physician training not only in preclinical curriculum but throughout medical school and residency training. ❖

**Editor's note**

*The University of Iowa Writers' Workshop was the first creative writing degree program in the United States and is the model for contemporary writing programs. It has produced Pulitzer Prize and National Book Award-winning authors.*

**References**

1. Rosenbaum ME, Lobas J, Ferguson KJ. Using reflection activities to enhance teaching about end-of-life care. J Palliat Med 2005 Dec;8(6):1186-95.
2. Barnard D, Quill D, Hafferty FW, et al. Preparing the ground: contributions of the preclinical years to medical education for care near the end of life. Working Group on the Pre-clinical Years of the National Consensus Conference on Medical Education for Care Near the End of Life. Acad Med 1999 May;74(5):499-505.
3. Block SD: Medical education in end-of-life care: the status of reform. J Palliative Med 2002 Apr; 5(2):243-8.
4. Hill TP. Treating the dying patient: The challenge for medical education. Arch Intern Med 1995 Jun 26;155(12):1265-9.
5. Tait DC, Depta JL. Play therapy group for bereaved children. In: Webb NB (editor). Helping bereaved children: a handbook for practitioners. New York: Guilford; 1993. p 169-88.
6. Wear D. "Face-to-face with It": medical learners' narratives about their end-of-life education. Acad Med 2002 Apr;77(4):271-7.
7. Rhodes-Kropf J, Carmody SS, Seltzer D, et al. "This is just too awful; I just can't believe I experienced that …": medical learners' reactions to their "most memorable" patient death. Acad Med 2005 Jul;80(7):634-40.

## Fear of Death

Most doctors are frightened of death and the dying.
People need an incredible amount of support when they die.
And the doctor who is frightened can't give it to them.

— The Anatomy Lesson, *Philip Roth, b 1933, American novelist*