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초보의사의 사망선고 경험

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요약

본 연구는 초보 의사의 첫 사망선고 경험을 통해 의사의 죽음에 대한 경험 및 인식을 확인하고자 한 연구이다. 사망선고를 경험한 일개 대학 병원의 전공의 1, 2년차 11명을 대상으로 심층 면접을 실시하였으며, 근거이론에 의거하여 면접결과를 분석하였다. 분석 결과 크게 세 가지 범주가 도출되었다. 첫 번째 범주는 '죽음에 대한 경험'으로 죽음에 대한 '개인적인 경험'과 '전문가로서의 경험'으로 구분되었다. 두 번째 범주는 '죽음(사망선고)에 있어서 의사의 역할'로, 이 범주에는 '환자의 생사를 규정'하는 것과, '환자 가족에 대한 소극적 위로'가 포함되었다. 세 번째 범주는 '죽음 교육의 필요성'으로 연구 참여자 대부분은 사망선고와 죽음 관련 여러 쟁점에 대한 교육의 필요성에 동의하였다.

색인어

사망선고, 죽음, 죽음교육, 질적연구

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I. INTRODUCTION

Doctors are taught to save lives and to intervene in matters of life and death. To this end, current issues in medical practice and education are oriented primarily toward saving life and curing disease [1]. As a result, many doctors feel unprepared and vulnerable when they encounter end-of-life situations. The lack of education and training for doctors in end-of-life care leads to negative impression of death-related issues among doctors, hinders the quality of care, and eventually prevents patients from dying with dignity [2-4]. To improve the current situation, we need to develop and provide adequate education and training for doctors regarding end-of-life issues, but we first need to understand how doctors experience and perceive their patients' death and death-related issues.

However, investigating doctors' experience regarding death and death-related issues would involve some complications to overcome. First, studying such experience should be based on reports by the doctors but these reports may contain recollection bias and subjective interpretation. Second, as doctors encounter the death of their patients, they might get used to such phenomena, and their reports may lose vitality and necessary details. Third, the majority of experienced doctors might deemphasize death due to the predominance of current curative model in health care. Therefore, examining such experience of novice doctors would be the effective starting point to understand how doctors experience and understand death. Namely, the moment when doctors pronounce death for the first time would likely reflect their innate awareness and feelings toward death. Even though a number of research exist on the experience of doctors with the death of patients [5-9], no one has examined doctors' first experience in declaring death.

The purpose of our study is to analyze doctors' experience regarding death by examining their first death pronouncement and to deduce their perceptions and awareness toward death-related issues.

II. METHOD AND MATERIAL

We chose a qualitative study method for our research. The qualitative study method would be more suitable for our purpose because this study aims to understand socially and personally created phenomena that does not require prior understanding by utilizing inductive and interpretive methods. Traditional quantitative studies have not shown convincing results on the experience of death given the difficulty of examining an individual's experience using a numerical scale and a limited number of variables.

We recruited first-year and second-year residents. Most of the participants were residents from internal medicine or surgery, as these types of specialties are more likely to interact with dying patients and bereaved caregivers than are other specialty residents. The participating residents also had close contact with patient caregivers, which helped to increase the reliability of the study. We selected participants who were expected to be sensitive to their surroundings—predominantly females and those who have religions—in hopes that he or she would provide us with an extensive

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range of experience. Interns and medical students were excluded from the study, as they are more likely to be observers at death pronouncements and not to interact with caregivers.

Participants were informed of the purpose and methods of the study and participated in the study only if they voluntarily consented. They agreed to have their comments recorded, documented, and used only for the purpose of the study. This research was approved by the Research Ethics Committee of the anonymous university hospital in South Korea, where our participants were recruited.

The interview guide was extensively analyzed and revised several times until its questions were comprehensible and were shown to accurately reflect the desired information. A pilot interview indicated that doctors expressed different opinions and impressions as both individuals and as professionals. We saw this difference as significant and thereby modified the interview guide to reflect this finding. The final interview guide was a semi-structured tool to measure participants' impressions as both individuals and as professionals <Table 1>.

Interviews were administered from November 2009 to April 2010. Participants were interviewed in separate rooms in the annexe of the hospital in which they worked. The same interview guide was used for all participants. Supplementary questions were asked when additional information was needed. The interviews lasted 60 to 120 minutes, and all interviews were audiotaped in an MP3 format and were documented in Microsoft Word® (Microsoft, Redmond, WA, USA). All participants were identified using alphabetical symbols to protect their identity.

We established a coding scheme preliminarily

<Table 1> Content of Participant Interviews Used in the Study

Participant's personal information	Sex/age, family members, marital status, religion, specialty
Motivation for being a doctor	Purpose of entering medical school/being a doctor
	Reason why the participant decided to major in the current specialty
Previous impressions of death	Experience with the death of a significant other
	Participant's view on death before admission into medical school
On death pronouncement	Basic question: "Tell me about your first death pronouncement."
	Time, place, and patient's characteristics of first death pronouncement
	Participant's knowledge about death pronouncement at that time
	Support or advice of senior doctors for pronouncing death
	Feelings of family members at the time of death pronouncement
	Managing/assessing bereavement
Education of death pronouncement	Necessity of education
	Participant's expectations for contents of education

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based on the results of the pilot interviews and on the findings of existing literature. All interviews were recorded and dictated intact, and non-verbal expressions were separately documented. In the data analysis, we indicated the views of our researchers in parentheses to ensure objectivity and to avoid prejudice.

Collected data were analyzed using the grounded theory put forth by Corbin and Strauss [10]. As successive interviews were conducted, repetitive and common concepts among the participants were abstracted and reflected on, and modified plans for the interviews were constructed. The series of interviews was considered finished when the eleventh interview was completed, and all of the concepts abstracted were saturated. The validity of data analysis was verified by criterion-related evidence, as suggested by various authorities [11], and additionally by triangulation, a method suggested by Mathison, to exclude subjectivity and prejudice on the part of researchers [12].

III. RESULTS

A total of 11 participants were recruited, of which nine were females <Table 2>. Most of the participants had a religious affiliation (10 participants), and two stated that they had experienced the death of a significant other. The earliest death pronouncement made by a participant was reported as having occurred in March or April of the first year of residency.

The following three categories were identified from the experiences of participants: 1) participants' impressions when pronouncing death, 2) participants' views of their role in pronouncing death, and 3) participants' views on the need for education/training for doctors in pronouncing death. Figure 1 describes each category and subcategory, as well as the relationships among them. The first category was divided into personal and professional impressions.

1. Participants' impressions when pronouncing death

We analyzed the experiences of each of our participants at the time of pronouncing death. The overall impressions were subsequently divided into two subcategories of individual and professional. Most commonly on a personal level, participants experienced anxiety regarding their own impending death. Meanwhile, professional impressions originated largely from ignorance and lack of maturity as doctors. The following three notions were drawn: loss of authority, guilt, and fear of communicating with family members.

1) Personal impressions

Given their young age (in their 20s), most participants had been indifferent to death before their experiences with pronouncing death as novice doctors. When they pronounced the death of patients in their charge, however, the experience was extraordinary. The death of a patient with whom the participant had an empathetic relationship touched them deeply, resulting in their reconsideration of the nature of death and expressing a fear of death and mortality.

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<Table 2> Basic Characteristics of the Participants

Participants	A	B	C	D	E	F	G	H	I	J	K
Years in clinical practice at the time of the interview (y)	1	2	2	2	2	2	2	1	1	2	1
Sex	M	F	F	F	F	F	F	F	F	M	F
Religion	Christian	Christian	Catholic	Catholic	Christian	Christian	None	Catholic	Christian	Christian	Catholic
Participation level in activities associated with religious affiliation	Very active	Very active	Not active at all	Active	Very active	Active	N/A	Active	Average	Active	Average
Specialty	Family Medicine	Family Medicine	Internal Medicine	Internal Medicine	Family Medicine	Internal Medicine	OBGYN	OBGYN	OBGYN	Internal Medicine	Neurology
Time of patient's death	1st year of residency	1st year of residency	1st year of residency	1st year of residency	1st year of residency	1st year of residency	1st year of residency	1st year of residency	1st year of residency	1st year of residency	1st year of residency
Cause of patient's death	Sudden death	Myocarditis (infant)	Lung cancer	Terminal state of cancer*	Pancreatic cancer	ALL	Ovarian cancer	Ovarian cancer	Ovarian cancer	CBD cancer	Sepsis

M : male, F : female, N/A : not applicable, OBGYN : obstetrics and gynaecology, ALL : acute lymphocytic lymphoma, CBD : common bile duct.

*The participant could not remember the specific type of cancer.

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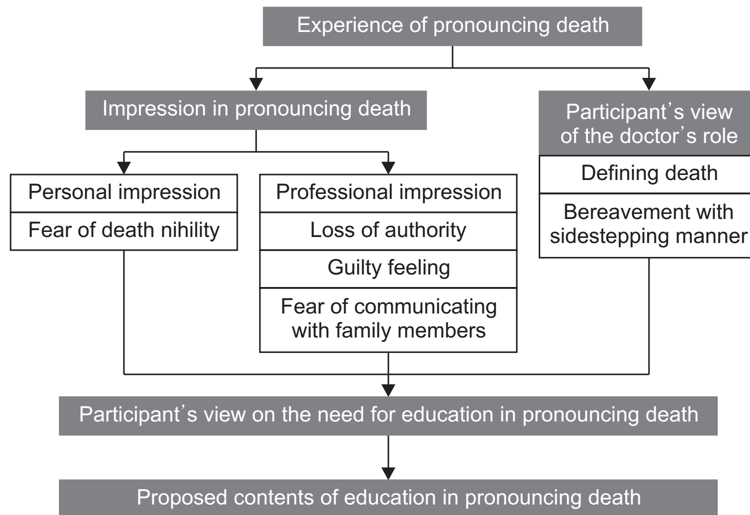
〈Figure 1〉 Categories and subcategories (including relationships among them) of study results.



a. Fear of death

Trained to save lives, doctors are distressed when a patient dies. Our participants, in particular, felt embarrassment and fear when they encountered their patients' death, and these encounters reminded them of the peculiar nature of death. A resident commented:

> I hadn't thought much about death before because I'm young, and it's a difficult subject. I have not had to deal personally with death, and when I learned about death during a philosophy lecture at college, it didn't affect me at all. But now when I care for terminally ill cancer patients, I think that my days are also limited. Death is inevitable, and I am fearful of it. (Participant B)

Seeing a patient die suddenly tends to cause fear of the other characteristics of death, particularly its unpredictability. As one participant reported, the sudden death of a patient who had otherwise been relatively healthy frustrated her immensely:

> One afternoon, many broadcasting staff and actors were making a film in the lobby of our hospital. It had been the day before my patient died. Eagerly looking forward to seeing some famous actors and catching a glimpse of the filming, she had put on makeup and dressed up. The next day, she was found dead. I was afraid and surprised at the unexpected death of someone who had been well just the day before. (Participant I)

b. Nihility

Death is the end of one's life as we know it; this truth applies to everyone, including doctors. Participants experienced the vanity of life when presented with this realization. One resident who

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firmly believed in the tenets of Christianity related her emotionally powerful experience:

> My patient also would have had various experiences in his life. But even though he is gone, his world will continue. It is so amazing that the world goes on after someone dies. Uncertainty or nihility of my being… (Participant E)

2) Professional impressions

Pronouncing death is a comprehensive process that includes the biological and social aspects of a patient's life. Due to their lack of ability to deal with these diverse aspects, the participant doctors experienced embarrassment. They also felt helpless regarding their lack of ability to save the patient's life. In addition, they found it challenging and uncomfortable to pronounce death surrounded by the patient's family, as the pronouncement of death can be an interactive process between a doctor and the family members of patients.

a. Loss of authority

Participants asserted their belief that a skilled doctor should make the pronouncement of death properly and effectively, and all the process should be well controlled by them. However, they worried about their own skills (or lack thereof) and were concerned that family members would notice this. More specifically, their perceived lack of skill in pronouncing death was connected with a feeling of loss of authority. One resident confessed:

> Death pronouncement is a unique event for family members, so I should conduct it accurately. For example, I should declare the exact time of death. But it would be so ridiculous if I announced the time of death using the time on my mobile phone. Such immaturity, doesn't it hurt them? (Participant I)

b. Guilt associated with a sense of failure

Doctors reported feelings of guilt at the time of a patient's death, even though no medical errors had been made. The death of a patient is seen as a loss in the war against disease, and the doctor is a defeated warrior. Curable or not, disease is a strong enemy that causes doctors to despair and feel guilty. One resident recounted:

> I thought that I should apologize to them… What if they don't appreciate how hard I tried to save the patient? What if they suspected that I caused the patient's death? I feel so weird after pronouncing death. (Participant G)

Caring for a dying patient is a demanding job. Doctors often stay up all night to care for their patients. In this regard, the death of a patient could mean relief from this duty. Participants were ashamed to regard the death of a patient as a reprieve from their duties. A resident commented:

> Writing 'discharge by death' on a discharge note, I thought that I could sleep well tonight as I would not be paged for her dyspnea. But on the other hand, I was ashamed for having such a nasty thought. (Participant G)

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c. Fear of communicating with family members

In unprecedented situations of family members receiving news of the death of their loved ones, our participants had difficulty coping with the grief of family members. Although the doctors empathized with family members, as a third party, the doctors were not as mournful as family members. The agony of a novice doctor lies in how to communicate with family members in such an incongruent situation. Participants retraced the experience of pronouncing death:

> I would be hesitant to pronounce death surrounded by a lot of family members. Somebody is crying in the corner; how can I pronounce death under such a circumstance? It is like drawing a hard-and-fast line. And if I try to console them by saying, “this must be difficult for you”, they may think my response is just a formality. (Participant B)

> I was under pressure when I entered the room. It was a grave moment for the family, but to me, it was merely a day’s task. Of course, I felt bad for them, but I was much less affected than they were. A day of great concern to them, it would have been cold-hearted and merciless for me to declare simply the hour and minute of the death. It was businesslike. But it would have been extreme for me to pray for the repose of the deceased or commend the patient’s soul, as I had not been very close with them and did not feel very sorry. (Participant E)

When patients die suddenly at a young age, family members may feel angry at the medical staff. Novice doctors have few skills in dealing with aggressive family members. Participants were anxious about how to calm family members and unsure of the language they should use to console them. Participants, especially female doctors, were concerned about physical harm to themselves by violent family members. One resident said:

> …Speaking with and controlling family members who are aggressive, that’s a tough task. I have no ability to calm them down and no previous similar encounters. There are large differences in coping skills among novice doctors. Some are good at it, and others make families even [more] angry. (Participant J)

2. Participants’ views of a doctor’s role in pronouncing death

Saving lives is the obligation of a doctor. Therefore, doctors are not adequately taught to deal with death. It is ambiguous for participants to say that a doctor’s responsibility ends at a patient’s death.

1) Defining death

Family members and other nonprofessionals can perceive the death of a patient, with or without a doctor’s formal verification. However, family members tend not to acknowledge the death or to bid farewell to a patient without a doctor’s pronouncement. That is, a death pronouncement is certification of a patient’s biological, legal, and social death, and the participants indicated that

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doctors should feel a heavy sense of responsibility in this regard. A resident stated:

> I'm not an arbiter who sets the boundary between life and death, but one word from me makes him alive or dead. A big responsibility… From a biological point of view, he was already gone. But the family would only accept his death and remember the time of death when I make the pronouncement. After I had declared the time of death, they called other family members. (Participant D)

2) Sidestepping the bereavement of family members or caregivers

Doctors cannot grieve like family members, as this type of grief is out of bounds for doctors in terms of their relationships with patients. Participants thought that they should less actively attempt to console family members—in other words, offer passive consolation—given that they did not share the same feelings as the family and therefore should avoid any emotional response. Doctors should maintain an "objective contemplation" of death, as described by the following male residents:

> I agree that doctors should console crying family members, but I could not say a word. It felt strange consoling them after I had just told them that he was dead. Leaving them as they grieve is the wisest choice. (Participant A)

> I tried to talk to family members as objectively as I could. I thought I could not stay objective when I shared feelings of family members. When they [family members] approached me emotionally, maybe I cannot be objective on the matter. I feared that. I think it is important to talk to them objectively, leaving my feelings behind. (Participant J)

3. Participants' views on the need for education in pronouncing death

Doctors place a taboo on reference to death because the mission of doctors is to save lives. One participant said, "Life after death is under the charge of the undertakers. Doctors should have nothing to do with it." This idea usually prevails among senior doctors training their subordinates to approach the pronouncement of death in a passive fashion. A participant remarked:

> No one wants to teach me how to pronounce death. An internist's role is to save lives. No one taught me about death. Doctors should only think about how to save lives, not how to handle dead or dying. (Participant C)

All participants requested a useful training program on pronouncing death taught by experienced doctors. They also desired training on communication with family members as well as guidelines and procedures for pronouncing death. One resident emphasized:

> During my first experience, not knowing how to pronounce death, the nurses told me how

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> to proceed the job. And this is all that I have learned about it (death pronouncement) until now. No other education has been offered. I think that experienced doctors should teach us about pronouncing death. I want to know how to conduct, handle and speak to family members. (Participant E)

IV. DISCUSSION

In this study, we found that the participants had compartmental positions—personal and professional impressions—when faced with the death of their patients. When novice doctors made their first death pronouncement, they acknowledged the frustrating and perplexing situation they had to cope with. Nevertheless, they deliberated upon how they should act appropriately and make the situation amicable, however embarrassing the circumstances might be. Recognizing such a specific role of doctors—making death pronouncements in an objective manner—led them to admit the need for death pronouncement education.

The participants acknowledged negative connotations of death because it is an uncertain, unpredictable, and inevitable process. As previous studies have noted, the fear of death mainly derives from its inexplicability and uncontrollability [13,14]. For doctors, the witnessing of dying people—especially people for whom they have cared and have empathy—produces fear, which can hinder further communication [15]. Because of this, fear of death can deprive doctors of the opportunity to provide the best possible care [16,17].

When healthcare providers experience the death of a patient, they are often unsure how to respond. This produces unique "professional" impressions of death. Ample research on doctors' experiences with end-of-life care and reflections on death offers a good opportunity to explore this issue. The work of Redinbaugh et al. [8] described doctors' emotional reactions to recent deaths of patients and explored the effects of the level of training on their reactions. In the study, novice doctors, including interns, demonstrated an emotional impact from the deaths of patients and reported the need for emotional support. The work of Kasman et al. [18] reported that medical trainees expressed painful emotions, including anxiety, guilt, sadness, anger, and shame. These difficult emotions were initiated by uncertainty, powerlessness, responsibility, liability, lack of respect, and differences in values. The work of Baverstock and Finlay [19] reported some of the emotions experienced by pediatric specialist registrars dealing with the recent deaths of patients, together with the coping mechanisms that the registrars used. In that research, the registrars reported various emotional reactions to the death of a child such as a feeling of shock and self-doubt. Another study on 25 pediatric physicians found that the reactions to patient deaths were similar to personal grief responses experienced with the death of a loved one [20]. However, as far as we know, no previous study has focused on residents' first experiences with the pronouncement of death to further probe the doctor's cognition of death.

These "professional impressions" are largely derived from the realization of incompetency, which is prevalent among novice trainees such as medical students during clerkships or in interns [7,21].

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This perceived incompetency is closely connected to feelings of guilt [18]. Although more experienced, most of the senior physicians in another study believed that they had “missed” something and feared they might be blamed for the death [22]. Another common finding is that, the greater is the emotional connection between patient and doctor, the greater is the sense of guilt the doctor experiences in the event of patient death [23].

We found that the residents in our study preferred sidestepping to being emotionally engaged when bereaved family members seemed to need consolation. Some studies have shown that doctors tend to balance the perceived need for objectivity with an emotional reaction to the patient’s death. Doctors who tend to remain “on the sidelines” during the pronouncement of death seem to attribute this behavior to medical educations that emphasize level-headedness [24]. Medical students are taught to hide their feelings and not to openly discuss emotional reactions. They are trained to refrain from being emotionally involved in crucial situations, such as cardiopulmonary resuscitation, because a detached decision-making process is regarded as essential for providing the best care for patients [25].

Moreover, the death of a patient is often regarded as representative of the failure of medicine [26,27]. Intellectualization of the patient’s death, in combination with a sense of failure, leads to “cognitive avoidance” of death-related issues and end-of-life care among doctors. The work of de Hennezel [28] observed modern technical medicine as a means of hiding behind the scenes and avoiding intimate encounters with patients. Also, medical students and junior doctors found that faculty tended to (seemingly purposefully) avoid talking about dying patients or after-death care [26,29].

This systematic shunning of death-related issues among doctors, which is presented as intellectual avoidance, primarily comes from a lack of end-of-life education, including how to pronounce death. The work of Field describes a common experience among general practitioners of not knowing exactly how far they should “intrude” into the affairs of bereaved relatives [30]. Novice doctors, as described in our study, tend to have difficulty in knowing what to say to the family members of a deceased patient [31]. In addition to technical incompetence, such ambiguities further contribute to avoidance of end-of-life care.

In some studies, medical students and residents have noticed a lack of preparedness to address end-of-life issues due to limited support and education [21,32-36]. Through better education about death, not only technical incompetence, but also negative attitudes toward death and caring for the dying can be minimized. Emphasis on death education and creation of a new module for training in death pronouncements would increase the confidence and competency of novice doctors in handling this precarious task. This would improve the ability of novice doctors to pronounce death precisely and ensure that they are secure enough to communicate effectively with bereaved family members [37,38].

This study has some limitations. Our interviews were conducted among participants late in the first year or at the beginning of the second year of

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residency. However, most of the participants had experienced their first death pronouncement at the beginning of their first year (e.g., in March or April). Although this time gap between an actual event and participants' memories and impressions of the event might limit the reliability of our study, it is difficult to interview doctors immediately following their first death pronouncement given the sensitivity of the situation.

Most of the participants in the study were females. Some would argue that bias in gender would weaken the result of the study. However, females tend to be more expressive, and are likely to share their inner feelings than men. Thus, they were more appropriate participants for this qualitative study, which required them to discuss their inner experiences.

Some may point out that the interviews we conducted for the research are from 2009 and 2010, which might be considered not recent enough. Until now, however, there have been no studies published regarding this subject, so we believe our results are significant. Moreover, our study is worth publicizing because the study aimed to figure out how doctors perceive death by employing a new method, which was to survey the death pronouncement experience from doctors, especially the novice.

In our study, we conducted a survey of medical residents. Considering that interactions between a medical team and patient families are a crucial part of patient care, everything that family members feel and perceive at a patient's bedside, as well as the demands of family members are worth further research. ◎

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Novice Doctors' Experience in Pronouncing Death

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Abstract

Doctors routinely deal with death, but their experience and impressions toward death are not well known. Examination into how doctors perceive death has been limited mainly due to complications in research methods. The purpose of this study is to assess doctors' experience regarding death qualitatively by examining their first death pronouncement and to deduce their perceptions and awareness toward death related issues. Eleven first-year and second-year residents from a university hospital in Korea participated in in-depth interviews. Their comments were recorded, documented, and analyzed using grounded theory. Three major categories were identified: participants' impressions when pronouncing death, participants' views of their role in pronouncing death, and participants' views on the need for education/training in pronouncing death. The first category was further divided into personal and professional impressions. The second category illustrated a doctor's role in pronouncing death (i.e., defining death and a doctor's role during bereavement). All participants expressed the need to be taught how to pronounce death and asked for further training in communicating with family members of the deceased. Participants shared negative feelings regarding their experiences in pronouncing death due to a lack of education in dealing with the death of a patient. It is essential for novice doctors to clearly understand their roles in pronouncing the death of a patient, a goal that may be achieved through education programs.

Keywords

death pronouncement, death, education of death, qualitative research

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