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ORIGINAL RESEARCH

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MEDICAL STUDENTS' EXPERIENCES WITH DYING PATIENTS: IDENTIFYING EDUCATIONAL NEEDS IN THE EASTERN CONTEXT

I Made Pramana Dharmatika[1*], Yoyo Suhoyo[2], Titi Savitri Prihatiningsih[2]
[1]Master in Medical and Health Professions Education, Faculty of Medicine, Public Health, and Nursing, Universitas Gadjah Mada, Yogyakarta – INDONESIA
[2]Medical Education and Bioethics Department, Universitas Gadjah Mada, Yogyakarta – INDONESIA

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ABSTRACT

Background: The death of a patient is an event that could trigger medical students' emotional reactions during clinical rotation. This study aimed to identify medical students' preparedness in dealing with patients' death and their educational needs through their lived experience.

Methods: This was a qualitative study with a descriptive phenomenological approach. Purposive sampling was used to select medical students with experience caring for dying patients during clinical rotation. Data were collected through semi-structured interviews. Colaizzi's method was used to analyze data.

Results: The experience of six medical students showed medical students' difficulties in discussing end-of-life with family members, giving emotional support to dying patients, and giving support to grieving family members. Hierarchies and hidden curriculums influenced the interaction between medical students and medical personnel during end-of-life care provision. The educational needs of medical students were teaching and learning about communication skills and attitudes in caring for dying patients, awareness of local culture in end-of-life care, opportunity in observing medical personnel communicate with dying patients and family members, and debriefing with healthcare team members after patients' death.

Conclusion: The findings of this study have provided insight into medical students' experiences in dealing with patients' death and their problems. Medical schools should prepare medical students in caring for dying patients through curriculum development.

Keywords: medical student, undergraduate, death and dying, end-of-life care, need assessment

PRACTICE POINTS

- Medical students can feel unprepared to deal with death and dying.
- Hierarchy influences the interaction between medical students and doctors during end-of-life care.
- Hidden curriculum can influence the emotional support and feedback given by medical personnel to medical students during the provision of end-of-life care..

*corresponding author, contact: imadepramanadharmatika@gmail.com

INTRODUCTION

The death of a patient could become one of the new challenges for medical students during their clinical rotations. Several studies had mentioned the emotional challenges that medical students have during their involvement with dying patients and ways of coping.[1-5] A systematic review also documented studies that reported low medical students' confidence to care for dying patients.[6]

Several reports mentioned learning activities for medical students in end-of-life care, such as roleplay and reflective essays.[7-8] Debriefing sessions were conducted between medical students and senior staff to discuss traumatic events and death amid the COVID-19 pandemic.[9] However, previous reports were mostly based on a Western context. It is unclear whether medical students in the Eastern context are having similar difficulties and educational needs toward end-of-life care. Several countries in Asia are classified as countries with high power distance index.[10-11] Power distance is a cultural dimension that explains the degree of society's social hierarchy, where the less powerful members within an organization accept unequal distribution of power.[11] A previous study in Indonesia found that fear of appearing incompetent and perception of inferiority could discourage residents to conduct discussions with senior doctors when caring for dying patients.[12] Hierarchy could influence the relationship and feedback process between senior staff and medical students.[13] So, it is important to know how medical students interact with dying patients and the role of power distance in the interaction between medical students and medical personnel during end-of-life care.

Indonesia ranked 53rd in the Quality of Death Index based on the survey of The Economist Intelligence Unit in 2015 and lack of education among healthcare members became one of the challenges in implementing palliative care.[14-15] Thus, we want to know how medical students in Indonesia experience death and dying during clinical rotations. The description of Indonesian medical students' experiences in dealing with patients' deaths can contribute to the body of knowledge for developing end-of-life care education that is suitable for the Eastern context. This study aimed to explore the experience of medical students with dying patients and their perceived preparedness for end-of-life care. The secondary aim of this study was to explore medical students' interaction with medical personnel and their educational needs toward end-of-life care education.

METHODS

This was a qualitative study with a descriptive phenomenological approach, which aimed to describe the meaning of an experience from the perspective of the people who experienced the phenomena of the study.[16] We also used the targeted need assessment of the six-steps approach to curriculum development to support this qualitative study. Targeted need assessment aims to identify the needs of a specific group of learners.[17] In our study, we aimed to explore the difficulties experienced by medical students when caring for dying patients, their perceived deficiencies, and their learning needs.

The study was conducted on November 2021 until May 2022, located at a public medical school in Indonesia. The undergraduate medical students undergo the preclinical phase for seven semesters, situated at the campus building. The clinical phase lasted for four semesters at an affiliated public hospital. There were some restrictions implemented by the institution during the COVID-19 pandemic, such as a reduction in students' hospital shift duration. Students are mainly observers and do not involve in clinical decision-making. However, students can participate in some clinical activities, under the supervision of medical personnel in the hospital.

The first author (DHA) distributed the study information to medical students through social media. He then invited the students to report the number of dying patients encountered during clinical rotation, circumstances of death, and location of death through Google Forms. 25 students reported back to DHA. Six students never encountered dying patients. Four students opted not to be involved in the study due to their busy schedules. He selected students one-by-one, based on the variability of the patient's cause of death until data saturation. The interviews of the first three students resulted

in four main themes. The interview with the fourth student resulted in six main themes. There was no new theme created from the interview of the fifth and the sixth student.

The interview guide consists of several questions, such as "How was your experience caring for dying patients?"; "How was your interaction with the medical personnel?"; "How did you feel?"; "What did you learn from the experience?"; "What was the difficulty that you had when you observe or take care of the dying patient?" "What do you need regarding this experience?". The interview guide was pilot tested on two non-respondents before collecting data. Semi-structured interviews were conducted once or twice between DHA and each of the students, which were audio recorded using a voice recorder. Interviews were conducted either at the campus building or through videoconferencing service. There was no presence of non-participants during interviews. Transcript interviews were transcribed verbatim and sent back to the students before data analysis began.

DHA was a recent graduate medical doctor who had some encounters with dying patients during his undergraduate study. He created a reflexivity diary during the data collection process and data analysis to write down assumptions and biases. He didn't work in the medical school that was chosen as the study location.

Data analysis was conducted with Colaizzi's method.[18-19] Data were analyzed by DHA, who read the interview transcript several times and listened to the audio recording. He independently highlighted significant statements, which are statements that related to the study aims. He created formulated meanings based on significant statements. There were 240 formulated meanings derived from the data analysis process. Formulated meanings were grouped into cluster themes. There were 20 cluster themes developed in this study, which were then grouped into six main themes. A short description of the study result was sent back to the students. The students gave positive feedback on the short description. There were several discussions between the first author, the second author, and the third author during theme construction.

Ethical approval was granted for this study from the Medical and Health Research Ethics Committee (MHREC) at Universitas Gadjah Mada (Ref. No. : KE/FK/1242/EC/2021). Informed consent was obtained from the study participants.

RESULTS AND DISCUSSIONS

There were three female and three male students. One student was a Buddhist, two students were Hindus, and three students were Christians. The students came from two different batches, with an age range of 22-24 years. Nine interviews were conducted, varying in length from 30 to 75 minutes. All six students had experienced the patients' death. They mentioned the circumstances related to the patient's death such as cervical cancer, breast cancer, brain tumor, alcohol intoxication, and traffic accident. The patients' death happened in intensive care units, wards, or emergency rooms. Six themes were developed and explained as follows.

Theme 1 – Medical students' journey with patients' death: Students were able to identify several symptoms in dying patients such as unconsciousness, change in breathing pattern, and restlessness. However, the study found students that felt surprised by the patients' death and students who thought that the dying patient would get better. These findings indicated that the process of recognizing dying was a challenge for medical students. A similar finding was also mentioned by another study in the UK, which mentioned junior doctors' challenges in recognizing dying.[20]

> *"She was already unconscious but I never thought that she would die that fast. I probably met her two or three times. I saw the patient in two or three shifts. But I never expected to see her death in three shifts." (student no. 1)*
>
> *"She looked like she was getting better. I thought "oh okay then... she will get through this," but she eventually got worse and worse." (student no. 2)*

Students had opportunities to interact with family members of the dying. Students considered end-of-life as a sensitive phase. There was a student who diverted the conversation and gave hope to the worried family members of the dying. Another

student felt not brave to explore the concern and feelings of the family member who looked sad during the last days of the patient's life.

> *"…we made some conversations with the family members. And we also cheered them up and gave hope "the patient will get better, just pray for her." (student no. 3)*

> *"…We are just medical students… I mean we don't know what we can give. So, we can disturb them if we ask too much." (student no. 2)*

These findings indicated the discomfort of medical students in conducting end-of-life conversations with family members of the dying. A similar finding was also found in a study in the United Arab Emirates, where 45% of medical students surveyed were not comfortable informing a terminal diagnosis to patients and families.[21]

Students also had opportunities to interact with healthcare team members in the hospital. One student mentioned his experience having a discussion with a resident after resuscitation and a patient's death.

> *"…it made me think… "was my action correct?" I was also afraid that I made a mistake… I was afraid that they were mad at me. But the resident's respond was okay so… after communicating with the resident I feel a bit guilty." (student no. 4)*

The discussion between a medical student and a resident after the death of a patient depended on how busy the resident was and whether students actively seek for explanations from the resident. The discussions were mainly clinical and not discussing emotion or feeling.

> *"…maybe because people are more curious about the cause of death compared to… the death itself, so we never discuss it. And then… about… what we feel… never. Maybe it's not something that ever crosses our mind, people are busy seeking knowledge." (student no. 5)*

Our findings found that students were hesitant in discussing emotional reactions with doctors before and after the death of a patient. This phenomenon could be explained by the hierarchical structure that discouraged lower members of the hierarchy to express their feelings.[22]

> *"Because of seniority, and also not comfortable. I also didn't know what to ask. Because they already get used to that, but that's new for us so… not comfortable to ask." (student no. 3)*

> *"That's… not a question that... should be asked to other people like... maybe if I asked the doctor, they would probably be mad. I mean... the question wasn't... a good question. That's an emotional question. A personal question. I don't dare to talk about that to other people. That's only… concern on my feeling." (student no. 1)*

It was known that debriefing between medical students and doctors after the death of a patient is needed for the formation of a professional identity.[23] Faculty development for doctors is needed to promote debriefing sessions that are suitable for the local context and still be able to promote reflection and emotional support.

Theme 2 – Lessons learned from dying patients: Medical students learned several lessons from their encounters with dying patients. Students learned about end-of-life care and death as a reality in healthcare.

> *"…I also think that… doctor is not a superior profession… that could always save the patients. I think… maybe if we could make the patients prepared and have some comfort in dealing with their death… I think it is also important as a doctor." (student no. 2)*

There were hidden curriculums identified in this study. Students received messages that encouraged them to be less sensitive to patients' death, which were different from the messages received by the student in the Western context,[3] as seen in Figure 1. Culture can affect the interaction during debriefing and feedback.[24] The power distance and other cultural factors such as beliefs and values could play a role in these contrast findings.

> *"…from what I see I think they [the residents] are already getting used to patients' deaths because they see those things very often. And the hospital receives a lot of patients in bad condition. A resident also said to me like "You are new to this, don't you? Well, I see this every day and already get used to this thing." (student no. 6)*

Example of Eastern context	Example of Western context
"A resident also said to me like "You are new to this, don't you? Well, I see this every day and already get used to this thing."	*. . . they expressed their own feelings about it too . . . it's not like them saying, "Well, you've got to deal with this because you're new" . . . "It's still kind of hard for all of us."*
(Result from this study)	(Ratanawongsa et al., 2005)

Figure 1. Comparison of Quotes Showing Different Values Conveyed by Residents to Medical Students

> *"…some said that… the more a doctor exposed to death, they would get used to it. I'm afraid that… I could lose my empathy or sympathy to the patients." (student no. 2)*

Hidden curriculums of being less sensitive toward death and dying also extended to the perception of a student who felt that the supports given by medical personnel for dying patients were just formalities. Death also can be seen as a failure by students.

> *"…well, our job is to speak it through, but in our hearts, we don't feel sorry. Because it's so common to happen in hospitals. As medical personnel, we also only repeat what we already say before like a broken record." (student no. 3)*

> *"…I think if the patient dies… well it's the end. "What else can be discussed?" I feel that way from the way the doctor makes us [medical students] scared like "if you do like that then the patient will die," well it's the end for us if the patient dies." (student no. 5)*

Theme 3 – Emotional Challenge: Some students felt sad after patients' death. The emotional reactions that arose were similar to findings from previous studies.2,4 A sense of helplessness and guilt was also found in the student that saw grieving family members.

> *"… I felt guilty because… I was not able to save him. Maybe the family was hoping for him to stay alive or stay stable and not die. I felt that kind of guilt." (student no. 4)*

> *"… with their condition in bereavement… it's hard to give them support. I mean when the death happened recently. I don't know what we could do. We as doctors are limited like… we can't fall into sympathy, only empathy..." (student no 2)*

Theme 4 – Coping with death: Students were able to cope with patients' death by sharing their stories with family and friends. Students were also able to accept patients' death because they see death as a part of human life. Coping mechanisms in this study were similar to previous studies.[4-5] The stress that students have after patients' death depended on the connection built between them.

> *"…the interaction with the patient was not intense. I only checked her vitals because the patient was not able to have any kind of interaction. So maybe the sadness was not that deep." (student no. 1)*

Theme 5 – Medical students' preparedness to face dying patients: There were some aspects that the students felt not prepared to do. A student expressed her difficulty to give emotional support to a dying patient who was crying due to the realization of the prognosis and would leave her children behind.

> *"Um... I am not ready at all. Honestly, I didn't know what to say to a patient with… stage four cervical cancer… and she was crying a lot during anamnesis. I was really confused and only able to say "cheer up ma'am, eat enough, get enough rest." I was so confused about what should I say to her." (student no. 5)*

Some students felt not ready to deal with the emotional reactions of dying patients or family members during breaking bad news.

"…maybe the patient will not receive it easily. I don't know… maybe I should console them… or maybe I should do something with the family member. So, I am not brave enough to judge myself ready to do it." (student no. 2)

"But for the breaking bad news, I still feel confused. Maybe I need more training because there are some patients… or their family members that can't accept easily." (student no. 3)

A student described his difficulty in giving support to grieving family members after unsuccessful resuscitation.

"…I didn't know how to deal with the family… what should I say to them… how should I act. Should I help them… console them when they were crying or wait until they stop crying and then talk with them." (student no. 4)

Theme 6 – Medical students' views on end-of-life care education: Students mentioned their experience having education related to palliative care, breaking bad news, and empathy during preclinical years. However, a student felt that education is lacking in the cultural aspect of death and dying.

"…the theories were okay, but for the clinical practice is a different story. Because every family can't be generalized with the preclinical theory. There are some ways to enter like… ways to give support, local custom, or culture. That's why you have to learn each culture for the clinical rotation. Because different cultures will have different ways to tell." (student no. 3)

Another student explained that the preclinical study wasn't preparing her to deal with death and dying.

"…they taught us pathophysiology, clinical manifestation, and treatment. But they taught us less about prognosis, and also the communication… especially to the patient with terminal illness… is very lacking. So, the medical student would surely feel shocked when seeing a patient die in front of their eyes during clinical rotation." (student no. 5)

Medical students learned about end-of-life care during clinical rotation by observing interactions between medical personnel, dying patients, and family members. A student mentioned the lack of discussion related to dying patient encounters.

"Clinical rotation never mentioned that. Mostly, it's about why the patient gets worse and what medicines to give. However, we never discuss… how to deal with dying patients. It's an art that we learn on our own." (student no. 2)

Students already received education in palliative care, breaking bad news, and empathy during preclinical years. However, this study found students who felt not prepared in giving emotional support to dying patients, manage emotional reactions in family members in breaking bad news, and give emotional support to grieving family members. These findings indicate that the existing curriculum should be improved, which ideally addresses the practical aspect and emotional aspects of managing the death of a patient.[1]

Students felt important to learn end-of-life care as a way to learn the emotion of the dying patient and give the best possible care. They also mentioned several educational needs. A student expressed her opinion about learning attitude and mindset in end-of-life care.

"…how we as a doctor should put ourselves. Because I think someday if we directly take care of the patient and the patient dies… we probably can feel guilty. So, I think it's important to teach the mindset… and what are tasks that we need to do, and how we should think if the patient that we take care of becomes die." (student no. 5)

Several students stressed the importance to have more chances in observing end-of-life discussions between medical personnel, dying patients, and family members.

"Um… I want to know about the things that are being discussed. I want to know the things that need to be discussed and how the language, maybe the residents understand it better." (student no. 1)

"When we are at the hospital, I think the students should receive an explanation. They [medical personnel] should teach us about the thing that we should educate the family member of the dying. What we should say to them." (student no. 5)

A student expressed her opinion about the importance of healthcare team members' explanations for students after patients' death.

> *"Maybe there should be briefings, or maybe after the event, at least there's medical personnel nearby who knows the situation and give an explanation to students, and what should they do to not feel surprised, or bumbled. Because some of my friends could think about it for several days." (student no. 3)*

Students expressed interest in learning activities for end-of-life care education, such as group discussion, roleplay, and bedside teaching. Students felt that the transition phase from preclinical to clinical years can be used to learn end-of-life care.

> *"Usually there is a break between the preclinical and clinical phases, so it can be included there with the basic life support education. Basic life support can be related to breaking bad news if the resus is not working." (student no. 3)*

> *"Turns out it is quite important in the hospital where we can directly meet the dying patient, so maybe the education should be included in clinical orientation phase so it will be more remembered." (student no. 1)*

A student mentioned the need to develop cultural competency in end-of-life care.

> *"Maybe the culture and the things that are considered taboo. Because different regions can have different taboos. Like palliative care, some regions don't allow us to… say it or do it because it can happen. Whereas in other regions are the opposite." (student no. 3)*

The educational need of being culturally competent in end-of-life care implied the diversity of culture and norms in Indonesia that could play a role in end-of-life care. Spirituality could play a role during the provision of palliative care.[25] The implementation of palliative care in Indonesia can be influenced by culture, religion, and beliefs.[26] Thus, medical schools need to provide learning activities that could develop medical students' cultural competency in end-of-life care. This study didn't explore the medical students' experiences regarding the sociocultural aspect of death and dying in-depth, and those can be studied further in the future.

The study comprised a small number of students, which may be seen as a limitation. However, our focus was to obtain a richness of data from the participants. The position of the first author as a recent graduate doctor can be seen as a peer and could promote open discourse with study participants during data collection. Data was collected from one medical school in Indonesia. Thus, considerations should be made in assessing the transferability of the study result to other medical schools in Indonesia.

CONCLUSION

Medical students experience an emotional challenge when caring for dying patients. Students can find it difficult to conduct end-of-life conversations with family members of the dying, give emotional support to dying patients, and give support to grieving family members. Medical schools should pay attention to the educational needs of the students, such as communication skills and attitude in end-of-life care, awareness of the cultural aspect of end-of-life care, and debriefing sessions. The hidden curriculum surrounding death and dying should be noticed by stakeholders.

RECOMMENDATION

There are many learning activities that we can use for end-of-life care education and can be prioritized with the educational needs of medical students. When it comes to developing educational activities related to death and dying, every stakeholder should reflect on their views related to end-of-life care: "Is it something important to be studied?" "Is it acceptable for medical personnel to show their emotion or even cry when a patient dies?" "Is it necessary for medical personnel to debrief after a patient dies?" Discussing the hidden curriculum in your institution would be relevant when developing palliative care and end-of-life care education.

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COMPETING INTEREST

The authors declare that they have no conflict of interest related to the study and manuscript.

AUTHORS' CONTRIBUTION

I Made Pramana Dharmatika – initiating research idea, literature review, data collection, data analysis, and manuscript writing

Yoyo Suhoyo – research conceptualization, data analysis, and manuscript writing

Titi Savitri Prihatiningsih – conceptualizing study method, data analysis, and manuscript writing

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