Put Some Gloves On

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"Put some gloves on." My dad hands me a small pair- white cloth with orange rubber on the palms. They scratch a little, but I don't mind. I got to pick the flower seeds out at the store all by myself. Eyes wide, I watch my dad and follow along, poking my gloved finger into the soil and pouring the seeds inside. I pat, pat, pat dirt over the top. In my mind, I can already picture my garden. It is bursting with color and life. It will take water, and sunlight, and time. But for now, the soil beneath my gloves is enough. When I pull the gloves off, my hands are clean.

"Have you ever done CPR before?" I pull my gaze away from the active code, realizing the physician is talking to me. Eyes wide, I shake my head no. "Put some gloves on," he instructs. I fumble with the box and rush to snap the latex into place. I quickly push up the sleeves of my impeccably white coat. Watching his form, I follow along, placing one hand on top of the other and lacing my fingers. The team steps aside and I press, press, press down on the patient's chest. I know it will not be enough. The team has already determined that every measure was taken, and I am starkly aware that this is only for my practice, my benefit. I press, press, press. Someone else takes over.

I had never seen a patient die. Death stood just outside the door when I scribed a patient's aggressive cancer diagnosis a few years ago. It sulked in the corner when I shadowed in an Intensive Care Unit last summer. However, I never witnessed death in its full form until an experience in the Emergency Department (ED) during my first semester of medical school.

I spent my first fifteen minutes in the ED interviewing a different patient. I came out of their room excited to tell my facilitating physician about the information I discovered. It was my first interview in a hospital, and I did it all by myself. Before I could finish telling him about it, we were pulled into a trauma room to conduct an ongoing code. I would come to learn that the code had been going on for a long time, the patient's family was informed, and there was not

much left that could be done. After I practiced Cardiopulmonary Resuscitation (CPR), my facilitating physician instructed me to watch the monitor, stating that I wouldn't often get the opportunity to see a patient go from ventricular tachycardia to asystole. In other words, it wasn't every day that I would see an irregular heart rhythm transition to a flatline. In the meantime, he asked me about the interview and history I took before we were called into the code. I struggled to focus on the screen, the patient, the death in front of me, and accurately convey the interview that now seemed so distant.

After the code ended, I silently thanked the patient in my mind for all they had taught me. Shaken, I asked my facilitator how he coped with patient losses. He told me that he could sleep at night after all his years of experience, knowing they did everything in their power. But as a new medical student, I didn't have years of experience. I barely knew what "everything in their power" entailed. I certainly didn't know how to process the situation and the emotions that came with it.

In the days and weeks to follow, I found myself internally conflicted. As a student, I told myself it was a privilege to see these things so early in my medical training. I knew my peers would not have the same chances with their facilitators and clinical experiences. As a stranger to death, I could still see the aggressive indentations on the patient's chest, hear the monitor finding its final tone. I could not fathom describing these as *opportunities*. I began to question my abilities as a medical professional. Was I too sensitive? Unprepared? Naive? After all, Emergency Departments center around protecting and saving lives. They require highly efficient multidisciplinary teams to assess, treat, and discharge the patients that come through their doors. Inevitably, some patients will present at the end of their life. I knew that medical trainees can be thrust into these situations to practice life-saving techniques. I knew I would likely need to do

this in an even bigger and more invasive capacity later in my training. Despite this, I could not help but be bothered that I had done something for my education, not the patient's health.

This ethical dilemma extends beyond my two-hour experience in the ED and beyond simply performing CPR. Medical professionals have often questioned the ethics behind practicing life-saving techniques on dead or nearly dead patients. The ethical issues surrounding this practice involve considering the benefit of medical training for the future good of society against the reduction of harm to the patient, prioritizing patient autonomy and dignity, and maintaining public trust in the medical profession.

Training procedures include medical interventions performed on a patient after a leading physician has determined the patient to be beyond resuscitation. After this point, procedures become beneficial for education and no longer contribute to patient care. What someone determines to be a procedure may differ. The most ethically concerning, however, are invasive procedures, including but not limited to tracheal intubation, placement of central venous catheters, lumbar puncture, thoracentesis, and temporary transvenous pacemaker insertion (Berger et al. 2). These procedures pose the highest risk of harm to the patient and their body.

Procedures may be practiced on patients who are considered "nearly dead" and still undergoing resuscitation. Procedures performed on nearly dead patients often occur during CPR. There are many essential, life-saving techniques a physician may need to perform during CPR, and doing this during active CPR makes for the most realistic practice. There may also be less opportunity for onlookers to discern practice from treatment. (Berger et al. 2). Training procedures can also be performed on “recently” dead patients. These typically occur between calling "time of death" and notification of necessary parties. Most commonly, this happens in the emergency department following a cardiac death (Rajagopal and Champney 2).

Training procedures can be a standard in medical education, particularly in emergency care settings. In the United States, almost two-thirds of emergency training programs employ practicing procedures for training (Rajagopal and Champney 2). This exhibits the prevalence of training procedures in modern medical education. A survey of internal medicine residents performed in three different training programs found that one-third believed practicing procedures on dying patients may be appropriate, and 16% had done so (Burns et al. 1). This further emphasizes that medical trainees practice procedures while revealing conflicting beliefs in this practice.

There is a utilitarian argument that medical trainees must practice procedures on nearly dead and recently dead patients. It is rooted in the idea that medical students must learn in such a way for the good of the most people. After all, to become competent physicians who care for our future patients, we need to be proficient in numerous technical life-saving procedures. There may not be simulations that accurately emulate what it is like to perform these techniques in a high-stakes environment. There may not be ample time to ask for permission after a patient has died. However, even a physician arguing for this acknowledges that "the worst possible, but common, alternative to postmortem procedures is to practice and teach procedures on the living or the not yet dead" (Iserson 2). He also affirms that physicians should never prolong resuscitation for the sake of education. These qualifying statements alone highlight ethical concerns about practicing procedures for the sake of education. While we must become competent physicians for our future patients, we also have a duty to the patient in front of us.

Physicians, medical students, healthcare workers, and the public at large have heard the adage "do no harm". This saying, often attributed to the ancient physician Hippocrates, encompasses essential principles of medical ethics: do good for the patient, or beneficence, and

do not harm the patient, or nonmaleficence. Medical students and physicians swear diligence to these principles as they undertake their profession, knowing the power, responsibility, and trust they will hold in a patient-provider relationship. In modern medical schools, a version of the Hippocratic Oath is commonly used at the start of medical education, upon graduation, or both.

The American Medical Association adopted the Hippocratic Oath in its Principles of Medical Ethics. The first principle states, "A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights." While they do include the "responsibility to participate in activities contributing to the improvement of the community for the betterment of public health", they also declare that "a physician shall, while caring for a patient, regard responsibility to the patient as paramount" (Hajar 4). These principles further the idea that while physician education is essential to the job, a duty to the patient remains of utmost importance. Based on the Hippocratic Oath, the revised 2017 World Medical Association Declaration of Geneva offers another physician pledge. This reads, "The health and wellbeing of my patient will be my first consideration. I will respect the autonomy and dignity of my patient." It references a responsibility to education in the testament: "I will share my medical knowledge for the benefit of the patient and the advancement of healthcare." This is another example in which both the ideas of "do no harm" and sustaining medical education co-exist as responsibilities of a physician. Still, the commitment to the patient remains paramount.

Medical practice in the United States emphasizes this responsibility to the patient in granting autonomy, dignity, and respect. In any general medical setting, patient consent is needed for a procedure and "informed consent" is obtained. In this process, procedures are outlined to the patient with detailed information regarding the risks and benefits. While a physician can inform and recommend, the ability to decide is granted to the patient. Necessary to this process is

the idea that the patient has the proper reasoning and information to decide on their care (Hajar 1). In other words, they have autonomy over their person and treatment. If a patient is unable to make a decision for themself, consent can be given by their family or legal guardian. Respect and dignity are given throughout care in deference to the patient's or family's decision.

Some argue that those who enter the ED have a shared responsibility in society to teach those who can further help society (Iserson 2). Additionally, if this emergency care setting is a teaching hospital, there can be implied consent to educating medical trainees. Otherwise stated, simply becoming a patient grants trainees consent to practice medical procedures. However, there are many assumptions about the patient's ability to make that decision within this perspective. Patients may not be aware of these implications, may need to go to a clinic setting dictated by their insurance, or may not even be conscious (Berger et al. 3). These assumptions do not fulfill a patient's decision-making capacity and, therefore, do not allow for patient autonomy.

These principles can be extended beyond when "time of death" is called. One can show respect and give capacity for decision-making by asking permission from a patient's family or guardian to perform an educational procedure. Studies have shown that the majority, if asked, would grant permission for training on newly dead relatives (Berger et al. 3). Furthermore, informed consent is obtained prior to other posthumous processes in which the patient does not benefit. These include organ donation and anatomical donation (Rajagopal and Champney 6). These illustrate the capacity for permission in ethically concerning medical practices. Respect can be shown in numerous other ways, such as following the cultural beliefs and practices of the patient and their family, particularly those surrounding death and a body. These practices emphasize that there is the capacity for autonomy and respect in using nearly dead or recently dead patients in medical training. While these may be difficult conversations to conduct, and

various obstacles may present themselves, there is a precedent that they can occur *and* facilitate medical education.

The principles of beneficence and nonmaleficence, as well as the informed consent process for typical and posthumous procedures, raise another critical consideration: societal trust in the medical profession. Inherent in a provider-patient relationship is trust on behalf of the patient that the provider will do what is in their best interest. Medical mistrust can be created and infiltrate society at large when this relationship is betrayed. Medical mistrust is rooted in historical mistreatment and lack of transparency in medical experimentation and treatment, particularly among marginalized groups. This pattern can be translated to the practicing of medical procedures on recently dead or nearly dead patients without patient or familial permission. One physician argues that "should family members learn of a gratuitous procedure, trust in their community health facility and physicians may be damaged. Furthermore, public awareness of this practice might damage trust in the health care system and compromise physicians' claims of professional integrity" (Berger et al. 3). There are significant implications for how medical training procedures can impact public perception of physicians, healthcare, and science.

Physicians Jefferey Bruns, Frank Readon, and Robert Truog proposed a policy to manage these concerns. They recognized that there is a benefit in practicing resuscitation techniques on newly dead patients, as these can't always be simulated or would pose more significant harm to living patients. However, they recommended that institutions follow guidelines in this practice. These include determining which trainees would gain essential knowledge and allowing only them to be involved in such procedures. Additionally, only non-mutilating procedures that respect the patient's body should be performed. They add that teaching should be the

"culmination of a structured learning sequence, rather than an opportunistic and sporadic event" (Berger et al. 3). Finally, they emphasize that permission should be obtained prior, given the precedent set in other posthumous practices, and that permission should be facilitated similarly to an informed consent process (Berger et al. 3). This proposal enables a balance between duty to the patient and society as a medical student, trainee, or physician. Knowledge of such a policy may have helped quell some of the conflicts I felt between my role as a student seeking knowledge and my role as a future provider seeking care.

On top of this internal turmoil, I was also coping with my first patient loss. Along with entailing ethical dilemmas, patient deaths in the ED can be chaotic, sudden, and traumatic. The emotional toll of these patient losses weighs on patient families and the entire healthcare team. A United Kingdom study interviewed nurses and families who experienced the death of a patient or relative in the emergency room. Families expressed that the experience was shocking and distressing, especially given the emergency department environment. An overarching theme among nurses was a lack of control and a desire to do more in their end-of-life care. Moreover, they highlighted the impact that patient death can have on healthcare workers, one stating, "'We don't get time to grieve and that's important because we do grieve.'" Another said, "'I think we need to remember that end of life care involves not only the patient and the family, but also the staff who are involved'" (McCallum et al. 5). These underscore the emotional impact of a patient loss that extends beyond the patient and their family to each individual involved in their care.

This emotional impact is something that Jonathan Bartels also noticed in his time working as a trauma and emergency department nurse. He has since dedicated his career to palliative and hospice care, mentorship of other healthcare professionals, and advocacy for compassion in healthcare. In 2009, he created the medical "Pause", a practice to stop and honor

patients after they die to respect them and care for ourselves as healthcare workers. The Pause is a practice of shared silence amongst a healthcare team following a patient's death. It can be requested by any team member, shared with a patient's family if they are present, and performed for a donor before organ recovery. It is recommended to be performed for 45 seconds to one minute. A suggested script is as follows: "*Let us take a moment to pause and honor (patient's name). They were someone who loved and was loved; was someone's family member and friend. In our own way, let us take a moment in silence to honor (patient's name). Let us also honor and recognize the care provided by our team*". After the Pause, an expression of gratitude is recommended: "*Thank you everyone*" (Bartels).

Scrolling through the website created by Jonathan Bartels to share his method, many healthcare workers have commented about how they utilize it in their practice. One commenter wrote: "I have recently introduced the Pause into my emergency medicine practice. It has created a brief but powerful space after the intense efforts of resuscitation. A moment to breathe, reflect, and regroup. It gives recognition to the power of the moment when another's life has ended. It has been universally well received thus far. Thank you for introducing this concept, and helping bring a moment of healing for my colleagues and myself" (Bartels). This and other comments recount the benefit of the Pause in an emergency setting and demonstrate its usefulness in healthcare.

Moreover, studies have performed analyses showing that the Pause can help emergency providers feel more grounded after death before treating the next patient (Cunningham and Ducar). That is, it allows team members to recollect themselves before moving on to the next patient that needs their undivided attention. Studies have also shown that it reduces caregiver stress, moral distress, and symptoms of burnout (Hendrick and Fuller). This allows physicians to

treat the patient in front of them and maintain their own mental health and wellbeing to provide for future patients.

In reading about the Pause, I realized that one of the most challenging parts of my experience was splitting my attention between the patient in front of me and a previous interview I conducted outside the door. My mental reflection and gratitude to the patient helped to reconcile this in that moment. Implementing the Pause more formally could enable the entire healthcare team to process their emotions, reflect on their actions, and maintain their humanity after witnessing death. The medical Pause facilitates principles essential to medicine. It shows honor and respect to the patient in acknowledging their life and family. It allows for better care and decreases harm to other patients through regrouping as a team. It can improve education and burnout to further a physician's role and good in society. Finally, it can build trust between a healthcare team, a family, and the public by connecting them as human beings experiencing the loss of a life. Bringing a moment of compassion to an emergency department setting can fulfill the oath we pledge ourselves to as current and future physicians.

When I first fell in love with medicine, it was with planting flower gardens. I longed to learn the science and skills that would allow me to bring life and color to other people. During my first patient code, I was reminded that the responsibility of a physician and enduring the path to become one necessitates more than this. In medical education and healthcare, there's an urgency to put some gloves on and learn. Put some gloves on and take opportunities as they come. Put some gloves on and help the next patient. Often, this work can carry moral conflict and emotional salience that weigh on us as human beings. We must strive to balance our pursuit of knowledge and work with a deep respect for the patient before us. We can be considerate of the potential harm, respect, and portrayal of trust to the patient. We can ask permission to have

the privilege of our education. We can connect with patients, families, and colleagues through shared empathy and humanity. While we put our gloves on and do our jobs, we must remember that so much can be found in a brief reflection, moment, *pause* before the gloves come off.

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