

On Losing Our First Patient

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As first-year medical students beginning our initial anatomy dissection, the smell of formaldehyde and sight of chemically fixed tissues evoked in us a palpable level of uncertainty. The donor's head, shoulders, and chest were slowly exposed as we nervously peeled back the drape. An unmistakable swastika tattoo became visible and our anatomy team fell silent. The resulting chain of events served as a formative tool in our medical education. With this background in mind, in this article we hope to explore medical student and faculty reactions to the ethical dilemma of dissecting a donor with a tattoo associated with a hateful ideology. Finally, we discuss how medical students can be better prepared to handle such difficult encounters in future patient scenarios.

One member of the anatomy team recalls her response: The location of the tattoo on the upper forearm was immediately striking. The skin of the forearm is usually devoid of covering and thus visible to both family members and everyday strangers. Presumably, the swastika tattoo was meant to be an outward display of this individual's beliefs to be seen in public locations. I thought back to the memorial service that Michigan holds for medical students, during which faculty speakers framed my anatomical donor as the first patient I would care for in my career as a physician and emphasized how privileged I should feel for their donation. I had entered the laboratory aiming to appreciate the gift of this body to my education. However, upon uncovering the unexpected tattoo, I struggled to feel appreciative as I recognized the ideology my first patient potentially supported.

Another member of the anatomy team recalls his response: I felt inclined to simply remove the tattoo-bearing skin as quickly as possible. The first dissection involved exposing musculature of the upper chest, back, and extremities, making the removal of the tattoo a regular continuation of the laboratory protocol. However, I quickly realized that removing the symbol was a superficial solution. Our group was unsure about how to proceed, so we decided to delay our dissection until a conversation with faculty was possible. We notified an instructor and excused ourselves from the anatomy laboratory.

The next day our anatomy team received an email from University of Michigan anatomy faculty, stating, "We were absolutely unaware, and we apologize first for you having to see [the swastika] and second for putting you in the position to see [the swastika] . . . We want you to know that this donor has been moved from your table, and you will be assigned another donor for the M1 year." Based on follow-up conversations with faculty, we learned that the University

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of Michigan Anatomical Donations Program had never faced a situation of this nature. With that said, a protocol for screening anatomical donors for culturally provocative tattoos has been instituted to avoid such situations in the future.

Keeping both our own and our faculty's responses in mind, should our anatomical donor have been replaced on the basis of a swastika tattoo? While great care is taken to ensure each anatomical donor maintains autonomy throughout the decision to gift their body, we initially felt uncomfortable with the paradoxical situation in which we would dissect a donor with presumed anti-Semitic views. At the same time, we viewed our anatomical donor as our first patient and felt morally inclined to care for them in a respectful manner regardless of a potentially extremist viewpoint. During our future careers, we will undoubtedly encounter patients from a variety of demographic and cultural backgrounds, and we will be expected to form trusting patient–doctor relationships. In a 1999 *JAMA* article, Kamau describes how the first neo-Nazi he encountered in his life he had to care for.¹ He recounts the difficulty and the mutual distrust they shared, and while one will never be fully prepared to handle these interactions, he states that previous exposures to comparably challenging situations would have been helpful. In a 2016 *Academic Medicine* article, Whitgob et al argue that terminating a patient encounter when it is uncomfortable should not be the first response because a potential learning opportunity is missed, and they propose a strategy for dealing with such encounters.² Considering Kamau's historical reflection and Whitgob et al's proposed response, replacing our donor may have been quixotic.

Replacement of the donor was not congruent with what will happen in our future careers—we will not be able to simply replace patients whose values, ideologies, or beliefs do not align with our own. In the same way that we are taught to notice the anatomical variation between donors, we should be encouraged to notice ideological variations. Moreover, we are thankful that this experience forced us to reflect and to be uncomfortable. We had to consider and be challenged by the notion that the way an individual chooses to live their life does not make them any more or less worthy of receiving care. Why should this individual's beliefs preclude them from being an anatomical donor? If the answer is that it would make students uncomfortable, how will students be able to navigate similar situations involving *living* patients in the future? Medical students already practice physical exams and the delivery of difficult news to patients. Why not practice interacting with and responding to those who hold worldviews different from their own?

While we appreciate our anatomy faculty's swift response to the detection of the swastika tattoo, we feel that maneuvering this unique scenario head-on without replacement of the donor may have expanded our capacity to handle similar situations in future living patients with tact and professionalism while providing a safe and inclusive environment. The reflections from and early exposure to this situation did just that. Our concluding sentiment is as follows: A human body is a human body, and we remain indebted to our original donor for gifting their physical form to our medical education. Whitgob et al developed a strategy for those in medicine to better deal with such uncomfortable situations: (1) first assess a patient's illness acuity, (2) cultivate a therapeutic alliance, (3) depersonalize the event, and (4) ensure a safe learning environment for trainees.² This same framework can be applied to make improvements in the medical school curriculum.

What can be done to better prepare students for the uncomfortable interactions inherent to medicine? We feel that more opportunities in our curriculum to practice responding to ideological variation would help tremendously. While we do not agree with racist ideology and do not tolerate it, we do need to know how to respond to it. As trainees, we should be prepared to address discriminatory patient encounters because prevention is impossible.² During pre-clinical training, this may include unexpected, simulated scenarios with actors or standardized

patients that express unpopular viewpoints or beliefs. Additionally, case-based discussions have been endorsed as an additional way to practice working through these scenarios.² During clinical training, open reflection and debriefs after organic encounters, while maintaining a safe learning environment, will enhance students' ability to traverse racial or cultural confrontations more effectively in the future. Most important, we believe faculty should be trained in dealing with ideological variation and actively support students in their development of patient–doctor relationships no matter the situation, from the first day of anatomy laboratory to the last day of medical school and beyond.

References

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