Death and the Doctor: the museum as a tool for understanding the needs of the dying

Jim Harris, Ashley Moyse, Gina Hadley, Rachel Lane, Sally Frampton, Ariel Dempsey, Joshua Hordern, Kate Saunders & Gabriele C. De Luca

Over the past several years, the Teaching Curator of the Ashmolean Museum at the University of Oxford has been part of a multi-disciplinary team examining the question of how we train medical students to deal with those parts of their profession which are concerned primarily with the humanity of their patients. This article discusses one such intervention, asking fifth-year (of six) medical students to consider questions raised by their interactions with patients, their families and communities approaching, at, and after the end of life.

The preface to this article reflects broadly on a decade of medical collaboration at the Ashmolean; the article itself specifically on the processes of making and providing museum-based teaching on dealing with death, in a cross-disciplinary, non-medical context, asking not only what the Museum can do for medical education but why medical education might actually need the museum.

Preface, Dr Jim Harris

Medical Collaborations at the Ashmolean Museum 2012-2023: towards a Humanities-based curriculum for teaching Medical Professionalism

For over a decade, in collaboration with colleagues from Neuroscience, Psychiatry, General Practice, Experimental Psychology, History, English Literature and Theology, the Ashmolean Museum has developed teaching in which the Museum's collections and expertise in facilitating interdisciplinary dialogue have been brought to bear on questions of specific medical research, medical history, ethics, language and communication, the relationship of medicine to other fields of academic research and the continuing professional development of practitioners.

Since 2017-18 a principal focus of these collaborations has been to help define a place for the Museum (and the humanities more broadly) in the teaching of medical professionalism to students nearing the end of their training - what it means to be a doctor and how to be a better one. Bringing together doctors, museum professionals and Expert Patient Tutors (EPTs) in curriculum planning; this teaching has been delivered both online, using images from the Ashmolean's collections, and live, for example, by using the public galleries as spaces for the consideration of issues around death, dying, and end-of-life care.

The genesis of this work came shortly after the establishment of the Ashmolean University Engagement Programme, funded by the Andrew W Mellon Foundation, in 2012. In the last months of that year and early 2013, a number of medical colleagues came to the Ashmolean Museum to discuss with Teaching Curator Dr Jim Harris ways of putting the collections to work for their students. They talked, drank coffee and shared ideas, with the common aim of remaining open to whatever possibilities presented themselves. These meetings proved immensely fruitful.

In early interactions with students, the collections were offered up in a manner familiar from academic engagement programmes undertaken in other university museums, as source material for object-based learning sessions intended to improve skills of observation and the consideration of visual evidence, in order to improve diagnostic technique. However, it quickly became apparent that there was both an appetite and the potential to use the collections in other ways. For example, in light of a primarily observational class in early 2013, led by Dr Harris in collaboration with Dr Chrystalina Antoniades of Brasenose College and the Nuffield Department for Clinical Neurosciences (NDCN), one medical student, Jonathan Attwood, devised a museum-based experiment to measure the phenomenon of change-blindness in contrasting, simultaneous on-screen and live-viewing scenarios. The experiment and its results were later published (ATTWOOD et. al. 2018A; ATTWOOD et. al. 2018B). Having qualified in 2017, Dr Attwood is now pursuing a career in clinical neuroscience. His legacy at the Ashmolean has been to open a series of encounters between medical sciences and the collections that engage both with the needs of professional training and the curiosity of those in professional practice.

A meeting, also in early 2013, with Professor Robin Choudhury, Fellow in Biomedical Sciences at Balliol

College and Professor of Cardiovascular Medicine, led to an interdisciplinary seminar on the relationships between the heart as represented and understood in visual culture, from ancient Egypt to early modern Europe and Mughal India, and its actual physiology. This in turn gave birth to a public symposium featuring papers by art historians, conservators, surgeons, theologians and literary scholars, held in the Museum's principal sculpture gallery and attended by over 200 members of the public. Another symposium followed in 2014, convened by Dr Harris and Dr Antoniades, addressing questions concerning the brain. Again, theology was represented, alongside experimental psychology, psychiatry, neurology, art history and medieval literature; and again, the museum's principal sculpture gallery was full to capacity.

Notwithstanding the Ashmolean's appeal as a forum for interdisciplinary public engagement with research (PER), and the success of a series of whole-day activities organised with Dr Antoniades and a team of neuroscience researchers and neurosurgeons as part of Brain Awareness Week between 2013 and 2019, public events have formed only a part of the Museum's academic collaboration with Medical Sciences at Oxford. Also of significance have been interactions on a smaller scale with a more specialised focus, falling broadly into three categories: classes given for pre-clinical and clinical medical students in General Practice, Psychiatry and Neurology; continuing professional development for practising psychiatrists; and partnership in a humanities-based curriculum for teaching medical professionalism.

Class teaching in the Museum as an adjunct to the medical curriculum has involved sessions offered to second year students during their first experience working with general practitioners and to fifth-year students on psychiatric rotation, who are asked to consider both the historical image of the profession as seen through the eyes of the makers of early-modern satirical prints (and their audiences), and as projected by doctors themselves in official portraits and book illustrations. These sessions deploy the Ashmolean's extraordinary Hope Collection of portrait prints and other works on paper.

Under the heading *Looking, seeing and understanding: developing medical skills in a non-clinical environment*, fifth-year medical students in neurology undertake exercises intended to develop the linguistic skills required to communicate abstruse, complex information to non-specialists such as patients and their families. In seeking to describe complex, unfamiliar objects to an audience of their peers, they work together to agree a shared vocabulary and to acquire the critical listening skills to interpret what they hear. These classes have often been attended by Expert Patient Tutors (EPTs), whose experience of chronic and degenerative neurological disease informs the discussion, immeasurably enhancing the students' learning, and helping them to understand the dynamics of healthcare from the perspective of patients and their carers.

The collaboration with psychiatrists has taken the form of small seminars, attended by 8-12 doctors at consultant (attending) and specialist trainee (fellow and resident) levels. In these seminars, established in partnership with Dr Charlotte Allan, Dr Maria Grazia Turri, Dr Felipe da Silva, Dr Frederico Magalhes and Dr Kate Stein, the medical professionals choose themes pertinent to the experiences of their practice, for example *The Body*, *Community*, *Rage*, *Suicide*, *Play* and *Kindness*. As session convenor, the Teaching Curator chooses 10-12 works on paper from the museum's holdings of prints and drawings and for two hours we pursue an open conversation. Through the session, the Teaching Curator acts variously as art-historical interlocutor, interested observer and psychiatric naïf. The psychiatrists (and, as the sessions have continued, other medical professionals such as clinical psychologists) pursue questions springing from clinical experience, differences in approach or issues in professional development – or simply take the opportunity to step away from practice for a short while (ALLAN et. al. 2016; TURRI 2021).

Alongside these, it has been in the work of building a curriculum for teaching medical professionalism that one of the Museum's most rewarding and challenging partnerships in medical education has come about. The Ashmolean's involvement in this project stems from two other, long-term collaborations, with Professor Joshua Hordern, Professor of Christian Ethics in Oxford's Faculty of Theology and Religion, and with Dr Gina Hadley and Professor Gabriele de Luca of the NDCN, and Professor Kate Saunders of the Department of Psychiatry.

In the preparation of this curriculum, funded by the Wellcome Trust and the Nuffield Oxford Hospitals Fund, Professor Hordern's work on compassion in the ethics of healthcare and the training of doctors (in which Dr Harris has participated since 2013) has been brought into dialogue with the existing Ashmolean classes in Neurology and Psychiatry, and the expertise of medical humanities scholars including Dr Marie Allitt, Dr Ariel Dempsey, Dr Sally Frampton and Professor Ashley Moyse. This team has combined

to develop sessions using not only the resources of the museum but also historical locations in the University, photographic archives recording wartime medical care at Oxford and the evidence of medical journalism. Like the *Looking, Seeing and Understanding* classes (and other, non-museum-related aspects of neurological and psychiatric education at Oxford, these sessions have been informed by the input of EPTs, including Rachel Lane, one of the co-authors of this article. During the preparatory phases of the medical professionalism project a significant number of EPTs participated in a series of consultative events to garner their views on key aspects of the students' training.

This case study reflects on the experience of developing and introducing to the curriculum a three-hour, museum-based seminar addressing questions of death, dying and end-of-life care.

Death and the Doctor: the museum as a tool for understanding the needs of the dying

Summary

Doctors and other health professionals dealing with end-of-life care are routinely faced with diverse responses to death, dying and its aftermath from patients, their families and communities. Responding appropriately to different and differently expressed needs requires physicians and their colleagues to speak with compassionate sensitivity and to think with intelligent agility. It also requires medical workers to express themselves in accessible, non-medical language. This paper discusses a teaching session on death and dying aimed at encouraging medical students to consider some of the questions they may encounter in dealing with the dying and to weigh their own potential responses to the patients and families they encounter *in extremis*. The session, held at the Ashmolean Museum, Oxford, deploys objects and images to enable medical trainees to interrogate aspects of end-of-life care and to invite reflection on the challenges presented by the pursuit of this inevitable part of professional practice in a diverse cultural environment.

Introduction

A museum is a good place to think about death and dying. It is also a good place to encounter it. Museums are filled with the belongings and material residue of long-dead people, their images, the contents of their graves, the art they created, bought and sold, and the memorials that were made to remember them.

Fig. 1: Unknown Artist, The Death of the Buddha, or Mahaparinirvana, grey schist, c.200 CE; Ashmolean Museum of Art and Archaeology, EAOS.10; Photograph: Jim Harris. © University of Oxford

However, despite the pervasive importance of death as a driver for cultural production (HALLAM & HOCKEY 2020) and as a theme in image and object-making, and despite a professed willingness to speak of it, there is little evidence that substantial discussion of end-of-life is a part of most people's experience, certainly in the context of Western cultures (SALLNOW et.al. 2022; Public Attitudes to Death and Dying in Wales 2022). Every doctor will encounter death in their training but for the medical student, this often happens first in the middle of a set of nights, when there is no time to stop, still less reflect (RHODES-KROPF et al. 2005). As educators, we have a duty not only to prepare our students for these encounters but, in doing so, to secure the best possible experiences for both patients and their families.

The UK General Medical Council's Outcomes for Graduates states: "Newly qualified doctors must demonstrate that they can make appropriate clinical judgements when considering or providing compassionate interventions or support for patients who are nearing or at the end of life." (Outcomes for Graduates, 2018). Yet the Royal College of Physicians 2018 report, *Advancing Medical Professionalism* (AMP) reminds its readers that such appropriate clinical judgement must attend also to the limits of medicine and the difficult conversations that must be pursued when confronting the actualities of dying and the "vulnerability inherent in such conversations" (TWEEDIE, HORDERN & DACRE 2018). Compassion in such conversations requires a 'two-way process of mutual understanding that involves openness to learning, change of mind and responsibility-taking by both doctors and patients', facilitating 'companionship

amid uncertainty, a sensitive approach to risk and intelligent reasoning and decision-making' (TWEEDIE, HORDERN & DACRE 2018).

As part of the Medical Professionalism course embedded within the Brain and Behaviour (Clinical Neurosciences and Psychiatry) rotation in year five (of six) of the University of Oxford BM degree, a session was devised with the intention of encouraging and enabling medical students to ask questions about their own experience of and encounters with death, and about the possible and likely encounters they might have with colleagues, patients, their families and with other members of the communities in which they live. The session is run jointly by Medical and Humanities faculties in collaboration with the Ashmolean Museum and includes perspectives from patients who participate in the medical education curriculum.

We asked students to follow a path around the Ashmolean Museum, in groups of 6-8, examining a number of objects and images at seven stopping points in the public galleries. During their journey, in which each group self-guided, we invited the students to consider, alone and in conversation with their peers, several aspects of death and dying, using the objects and images to stimulate reflection. At each point we offered prompts for discussion, for example:

- "Is it possible or necessary for the doctor to share the grief of the bereaved?",
- "How are privacy and comfort related in the approach to death?",
- "What impact might the perpetual awareness of death and its inevitability have on the health of the medical professional?"

As can be seen in Appendix A, some of these questions overlapped, enabling students to revisit some topics, for example the relationship between the medical practitioner and faith, either embodied in community leaders supporting patients and their families, or as a factor in patient and family responses to questions of care, or with respect to the role of practitioners' own faith or beliefs in the context of dying and death. Other questions were pertinent to one particular circumstance or set of circumstances, for example with regard to the self-care of the physician or the encounter with the deceased body. It was hoped that exploring the collections of the Ashmolean with these questions in mind would make possible compassionate, listening encounters between the students which would in turn attune them to the context- and person-specific encounters they would be likely to have in clinical practice.

Learning from the exercise

This reflective journey was emphatically not intended as an art historical exercise. Instead, as the students moved around the Ashmolean, they were encouraged to draw from the experience of long histories and diverse cultures, using the collections as tools for reflection on the end of life, and to interrogate the role of the doctor in the processes of dying and the aftermath of death (NICOL & POCOCK 2020).

Similarly, there was no intention to drive the students towards a correct or prescribed answer to any of the questions at issue, nor to constrain their looking only to the objects and images detailed in the guide. Rather, it was hoped that students might use the questions and prompts as stepping stones to a wider consideration of death beyond bodily decompensation and efficient causes (BISHOP 2011) and of the cultural output that our collective encounter with death has engendered (HALLAM & HOCKEY 2020); and to reflection on death as a universally shared but invariably uniquely-experienced social phenomenon (SALLNOW et al., 2022).

After completing the Ashmolean trail, the cohort was gathered for a plenary session. Each small group was invited to expand on the ideas pertinent to one of the staging posts on the trail, discussing their experience of the images and objects they had seen and sharing any further questions raised during their discussion in the galleries. These reflections were then opened to the whole cohort, ensuring that as many voices as possible were able to participate. A recurrent theme that emerged was that students valued the space to consider not only the facts of the end of life, but the effects of death and dying on their patients, their loved ones and themselves.

Feedback from participating students has demonstrated the need for space in the medical curriculum for precisely this kind of reflective, discursive work around death and dying, including making room for disagreement (see Appendix B). This space might also be expanded to include learning from patients themselves, which could help to narrow the 'gap between what doctors are trained to do and the realities

of modern practice' (TWEEDIE, HORDERN & DACRE 2018). This returns us to the precise place of this session in teaching a curriculum on medical professionalism.

AMP explores seven key aspects of modern medical practice and professional identity: healer, patient partner, team worker, manager and leader, learner and teacher, advocate, and innovator. It also emphasises three key values in medical vocation: integrity, respect and compassion. The Ashmolean session maps clearly onto questions of patient partnership and advocacy, and also of healing, while particularly emphasising the need for compassion in practice. The exercise itself is one of individual and group learning and peer-to-peer teaching.

AMP also acknowledges that the nature of the patient partnership might change, with a greater emphasis on end-of-life care when the body is shutting down but the patient is still cognisant. To explore this relationship more effectively, Expert Patient Tutors have been involved in shaping the Medical Professionalism curriculum and delivering teaching in response to the report. EPTs are trained to educate students about key elements of history and neurological examination signs specific to their disease, while providing constructive feedback about students' approaches, facilitated by clinician teachers.

As part of the development of the curriculum, EPTs with chronic neurological disease (multiple sclerosis, Parkinson's and peripheral neuropathy) were asked to reflect on the seven key aspects of professional identity identified in AMP in a series of online meetings convened by Dr Harris and using images from the Ashmolean as focal points for discussion. In the case of healing, for example, the EPTs were asked if there was conflict between healing and cure, responding that if there is 'no faith in a cure' then one had to 'focus on healing'. This reflects a key emphasis of AMP, which distinguishes cure from healing, with healing as the more encompassing vocation of doctors: 'Healing starts with the relationship between the doctor and the patient, and compassionate, listening doctors can heal simply through their presence.' (TWEEDIE, HORDERN & DACRE 2018). Honesty around whether cure or healing was on the horizon was important to EPTs, as were trust between patient and practitioner and the consideration of the patient's faith position.

To address these issues in a museum context enables the subjective nature of a response to an image to underline the necessarily subjective response of the physician to the individual challenges posed by each patient they encounter. In the absence of the possibility for a single approach to end-of-life care, it is not the physician's courage that will enable difficult conversations to be pursued successfully but their ability to understand the specific needs of the individuals and communities in any given case. The capacity of the Museum to present a range of cultural possibilities in a single afternoon makes it a unique resource to explore the demands made by the serial, daily reorientations expected of medical professionals.

Conclusion

It is important to distinguish this work from the many studies made of the utility of art objects in improving the observational skills of medical professionals (MUKUNDA et al. 2019; IKE & HOWELL 2022). We make no claim to fundamental novelty, merely of difference in intention. In this instance, the artwork serves not as a neutral tool, whose precise content is unimportant, but as a value-laden artefact whose content and context are useful in understanding both patient and self as equally complex and value-laden individuals working in relationship. This does not mean that the session is intended to 'humanise' the doctor-in-training, or to inculcate compassion through the encounter with the art object. However, we believe it has the effect of foregrounding compassion as part of a contextually-appropriate response to death.

It is our hypothesis that this work will help train and empower doctors who are more capable of engaging compassionately in the unique circumstances surrounding the end of their patients' lives. Interest has been shown amongst General Practitioners both in their own training and in their part in the education of medical students. However, we propose that this concept could and should be adapted more widely. There is not only interdisciplinary but also intradisciplinary relevance, with a planned extension of the project to allied health professionals including, but not limited to, nurses, clinical psychologists, physiotherapists and occupational therapists. Towns and cities with institutions for training future healthcare professionals have museums, galleries and other cultural spaces that can provide novel settings, separate from the confines of a clinical environment. This is not a practice constrained by the contents of any one museum but one capable of reinvention in light of whatever collections are accessible. What is offered here,

therefore, is not a particular set of images and objects around this work must be built, but an adaptable idea for using images and objects. Death is one of the only certainties in medicine, and as such must be approached without squeamishness or coyness but equally in a manner which is not only medically but also personally and culturally appropriate. Museums are precisely the kind of capacious, heart-expanding space into which to invite medical students and professionals on a path to understanding what that might entail.

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Contacts

Dr Jim Harris, Teaching Curator, Ashmolean Museum, University of Oxford
Address: Ashmolean Museum of Art and Archaeology, Beaumont Street, Oxford OX1 2PH
E-mail: jim.harris@ashmus.ox.ac.uk https://www.ashmolean.org/people/jim-harris

Professor Ashley Moyse, Assistant Professor of Medical Ethics, Columbia Center for Clinical Medical Ethics, Columbia University, Vagelos College of Physicians & Surgeons
Address: Columbia Center for Clinical Medical Ethics, 622 W 168th St, PH 8E-105
New York, NY 10032 E-mail: ajm2348@cumc.columbia.edu

Dr Gina Hadley, John Henry Felix Fellow and Associate Tutor in Medicine, Harris Manchester College, Honorary Clinical Lecturer in Neurology, NDCN, University of Oxford
Address: Harris Manchester College, Mansfield Road, Oxford OX1 3TD
E-mail: gina.hadley@hmc.ox.ac.uk https://www.hmc.ox.ac.uk/people/dr-gina-hadley

Rachel Lane, Expert Patient Tutor
Address: c/o Dr Gina Hadley, Harris Manchester College, Mansfield Road, Oxford OX1 3TD

Dr Sally Frampton, Humanities and Healthcare Fellow, Faculty of Theology and Religion, University of Oxford. Address: Faculty of Theology and Religion, Gibson Building, Radcliffe Observatory Quarter, Woodstock Road, Oxford OX2 6GG
E-mail: sally.frampton@humanities.ox.ac.uk https://www.theology.ox.ac.uk/people/dr-sally-frampton-0

Dr Ariel Dempsey MD, DPhil candidate in Science & Religion, University of Oxford
Address: Wycliffe Hall, 54 Banbury Road, Oxford, OX2 6PW
E-mail: ariel.dempsey@theology.ox.ac.uk

Professor Joshua Hordern, Professor of Christian Ethics, Fellow of Harris Manchester College, University of Oxford. Address: Harris Manchester College, Mansfield Road, Oxford OX1 3TD
E-mail: joshua.hordern@theology.ox.ac.uk https://www.hmc.ox.ac.uk/people/dr-joshua-hordern

Professor Kate Saunders, Associate Professor, Director of Medical Studies, Department of Psychiatry, University of Oxford. Address: Department of Psychiatry, Warneford Hospital, Oxford, OX3 7JX. E-mail: kate.saunders@psych.ox.ac.uk https://www.torch.ox.ac.uk/people/kate-saunders

Professor Gabriele C. De Luca, Professor of Clinical Neurology and Experimental Neuropathology, NDCN, University of Oxford. Address: Nuffield Department of Clinical Neurosciences. Level 6, West Wing, John Radcliffe Hospital, Oxford OX3 9DU E-mail: gabriele.deluca@ndcn.ox.ac.uk
https://www.ndcn.ox.ac.uk/team/gabriele-de-luca

Appendix A: The structure of the Ashmolean Death and Dying trail

The trail involves a journey to seven locations in the Museum over the course of approximately 90 minutes, and a conversation between the students at each staging post, informed by encounters with particular objects and images and aided by questions posed in the guide supplied to each participant.

These are the seven staging posts, the prompts given and the questions the students are asked to consider. Where possible, links are given to the objects and images in the Ashmolean's Online Collections.

1. **Encountering death**

The dead Christ is one of the most important iconographies of death in the Western European tradition. However, this dead body is not always seen in the same way. The bloodied, wounded body is both familiar and unfamiliar. We see broken and traumatised bodies often in popular culture, but seldom in reality.

Anthony Van Dyck, *The Deposition*, oil on canvas, c.1619
https://www.ashmolean.org/collections-online#/item/ash-object-372686

- How does the prevalence of death in popular culture affect how we think about it?
- Are we inured to the reality of physical trauma by the frequency of its depiction for entertainment?

In reality, a more familiar death is seen in the body cleaned and prepared for burial, or perhaps in the hospitalised body not traumatised by injury but wasted by disease.

These bodies will need to be dealt with in different ways depending on the needs of the bereaved. Although death itself is not culturally determined, responses to it, beliefs around it and the treatment of the physical remains it leaves behind invariably are.

Pietro Testa, *The Dead Christ Mourned by Angels*, oil on canvas, mid-1640s
https://www.ashmolean.org/collections-online#/item/ash-object-373598

- What, if any, might the role of the doctor be in those culturally determined parts of the processes of death and dying?
- What help might a doctor need to seek when no healing is possible?
- Whose voices will need to be heard?
- What strategies do people employ to avoid the realities of death?
- What might be the role of the doctor in both mitigating and helping to recognise the approach and event of death?

It is commonplace for memorials of the 18th, 19th and 20th centuries to describe death as sleep, and this idealised body of Christ is laid out as if sleeping.

Unknown Artist, after Jacopo Sansovino, *The Dead Christ*, polychromed terracotta, c.1610
https://www.ashmolean.org/collections-online#/item/ash-object-746284

- What strategies do people employ to avoid the realities of death?
- What might be the role of the doctor in both mitigating and helping to recognise the approach and event of death?

2. **Death and the everyday**

Still-life painting is often full of reminders of death in the everyday objects of life.

Philips Angel, *Still Life of Game with Four Plovers*, oil on panel, c.1650
https://www.ashmolean.org/collections-online#/item/ash-object-372299

- What impact might the perpetual awareness of death and its inevitability have on the health of the medical professional?
- How do doctors care for themselves and each other in dealing with death?
- How can a doctor deal with precariousness in their interactions with patients and their families, and in their own life?

Clara Peeters, *Still Life of Fruit and Flowers*, oil on copper, 1612-13
https://www.ashmolean.org/collections-online#/item/ash-object-373327

- What other concerns, for example financial, might preoccupy the families of the dying during and after terminal illness and death?
- Is it ever the role of the doctor to address and help with those concerns?

3. **The death of a child**

The text on this gravestone ends with a prayer for the consolation of the deceased's parents, which often forms part of the inscriptions on the tombs of young children in the Islamic world. The aftermath of death may involve wider conversations in partnership, for example, with faith-leaders.

Unknown Carver, *Gravestone of a Muslim girl*, marble, 431 AH/1040 CE
https://www.ashmolean.org/collections-online#/item/ash-object-388333

- What kinds of continuing care are required after death?
- How does a doctor manage the difficult conversations about death in talking to parents?
- How does the doctor remain involved in the processes of grief, or is there a moment for that responsibility to be handed over?
- What is the doctor's role in the space between the facts of death and the faith of those experiencing it?
- Is it ethical for a doctor to speak of faith and belief in the course of their interactions with patients?

4. **Seeing and not seeing**

The language used around terminal disease and end-of-life narratives often employs metaphors of battle - war and warriors, bravery and courage - with the disease playing the part of an implacable enemy or a wily monster to be fought and defeated.

This language can represent a very visible and open approach to death, placing the dying person in a publicly combative relationship with their disease or even with reality.

Unknown painter, *Amir Hamza defeats Umar-i Madi Karab*, ink and watercolour on cotton and paper, c.1561-65
https://www.ashmolean.org/collections-online#/item/ash-object-356000

- Does it make a difference to the doctor to be cast in the role of a warrior in a battle?
- Is this language problematic or a useful set of metaphors to encourage and support the dying and the bereaved?

These Jali screens were intended to shield interiors from the sun and to create cool, private spaces (fig.2)

- How are privacy and comfort related in the approach to death?
- When is separation from the dying person a necessary mechanism medically, but a source of difficulty for the dying person and their family or friends?
- Has the shared experience of the pandemic modified your view of this?

5. **Suffering before and after death**

Fig 2: Unknown Carvers, Jali Screens, sandstone, 19th century; Ashmolean Museum of Art and Archaeology, EAX.7346, EAX.7347, EAX.7348; Photograph: Jim Harris © University of Oxford

In Buddhist tradition, Bodhisattvas are enlightened beings who devote their lives to freeing others from suffering. Bodhisattvas are not worshipped, but inspire others to reach enlightenment.

Unknown Artists, *Figure of the Bodhisattva, Jizō*, polychromed wood, 16th century
https://www.ashmolean.org/collections-online#/item/ash-object-364677

- What are some of the expectations of the doctor around death and the preparation for death?
- Are you part of the process of release from suffering or part of the suffering itself?
- Is it possible for the doctor to fulfil the role of Healer at the moment when no healing is possible, or is that the job of others?

The last words of the Buddha to his disciples before attaining final nirvana were, 'All composite things must pass away. Be therefore mindful and vigilant!'
In this image, though, the Buddha's followers are nonetheless depicted physically expressing their grief.

Unknown Artist, *The Death of the Buddha*, or *Mahaparinirvana*, grey schist, c.200 CE
https://www.ashmolean.org/collections-online#/item/ash-object-354746

- Is it possible or necessary for the doctor to share the grief of the bereaved?
- Or the opposite?
- How does the doctor's role change in light of the responses of the bereaved, whether stoic or emotional?

6. **The needs of the dead**

The question of what the dead need has preoccupied humans since prehistoric times and the Ashmolean is full of the contents of graves. Grave goods also, inevitably, reflect the needs of the living for reassurance concerning the well-being of loved ones, the maintenance of memory, and the specific requirements of a particular culture.

Unknown Sculptor, *Figure of a horse*, earthenware, 701-750 CE
https://www.ashmolean.org/collections-online#/item/ash-object-358445

- How is the doctor involved with the needs of the dead?
- How do we manage these needs in conversations about end-of-life care?
- What conversations are necessary in preparing for death?
- How does the doctor play a role in maintaining the mental health of the families and friends of a dying person?
- How do we ensure our approach is culturally sensitive and appropriate?

This is one of the oldest pieces of sculpture ever discovered: a skull modified with clay, cowrie shells and pigment. We have no idea what precise function it served or why it was made but it appears to be an effort to give life back to the dead person.
Although death itself is familiar, its aftermath is unknowable and the continuation of existence is taken from the deceased and placed into the hands of the surviving friends and families.

Unknown Maker, *Modified Human Skull*, plaster, shells, human bone, c.7000 BCE
https://www.ashmolean.org/jericho-skull

- Do we, those we treat, and their families fear the anonymity of death?
- Does the doctor have a part to play in maintaining the memory of the deceased?

7. **Celebrating Life**

Ideas about the afterlife vary from culture to culture but many people share a powerful belief in life after death irrespective of religious faith.

Jacopo Robusti, known as Tintoretto, *The Resurrection*, oil on canvas, 1550-1570
https://www.ashmolean.org/collections-online#/item/ash-object-373608

- How might a doctor's own belief system enable them to empathise with patients and their families facing death?
- Is it ethical for a doctor to speak of faith and belief in the course of their interactions with patients?

The potential for involvement in birth as well as death offers the general practitioner unique access to some of the most emotionally significant moments in the lives of individuals, families and communities.

Unknown Flemish Painter, *The Adoration of the Shepherds,* oil on panel, c.1560-70
https://www.ashmolean.org/collections-online#/item/ash-object-372824

- How might the celebration of life impact on the sensitivity of a doctor's approach to death?
- Appendix B: Some feedback from medical students on the Ashmolean Death and Dying session
- "I really enjoyed space for open discussion; [we] rarely get the chance in med school. Created a space where people felt comfortable."
- "Coming here is really good - getting away from hospital. The conversations we had reflecting on prompts were really interesting - perhaps trail felt a bit rushed?"
- "Why have we not had a space to ask these questions earlier in our training?"
- "Prompted discussions we would not otherwise have. More time! The role of the doctor in the aftermath of death was something I had not really considered previously."
- [It was a] really useful way of approaching the topic and much better than a lecture. Really made me think about the extent to which we shield ourselves from the reality of death and how alone that leaves the dying."
- "We say we are comfortable with death in our profession but Western Society is afraid of it"
- "The framing of disease a battle/war makes me think about the outcomes of a situation – there must be a winner or loser. However, medicine isn't so binary and often it's making the best of a bad situation. Death doesn't have to be a loss; it can be the last tied up chapter in a lovely book or a means to escape suffering. It is absolute, but doesn't have to be a loss, it's natural. I think [the session] will affect the way I use language in medicine moving away from the idea of a battle."
- "A lot of our answers to the questions came back to having an individual approach to each patient/ family and being guided by what they want/need from the doctor and the rest of the team. "
- "The role of a doctor in the death of a patient can be a very difficult topic, especially as the doctor feels separate to the patient and their family perhaps emotionally, but intimately involved in one of their most important and vulnerable moments. Thinking about how a doctor can utilise their role to help patients and families make the most of this time, by providing support is something I hope to take into my future practice."
- "[The session] made me think about what it means to grieve – to lose something, and how this can apply to miscarriage etc as well as a 'normal' death."
- "I liked that we were left to discuss by ourselves rather than having a staff member facilitating as it allowed for more organic discussion. This session made me think a lot about what we consider

to be a 'life well lived' and how this is often related to age."

- Not all participants have found this to be a wholly positive exercise.
- "Today I reflected on the fact that whilst it may be therapeutic to reflect with peers [on] difficult experiences, this is not always beneficial. We should not feel expected to share intimate memories of death with peers who are unable to empathise with us. I think it is important to reflect in settings that feel safe, but not to feel that this is a requirement in all situations."
- Some students reflected on the limitations of the role of the medical professional, and the importance of other members of the wider team responsible for patient care.
- "Faith, like other aspects of identity, can be a quintessential part of what it means to be human. It is important for anything involving death and dying to be steeply patient driven. Personal faith can play a role in the end-of-life care of a patient, but we should be careful to let patients guide us in exactly how that looks. Asking someone if they'd like to be (linked) into religious services feels like a good way to do this and from then on Chaplains who are very specialised and good at what they do can take the lead, though we may at some point find ourselves in shared faith scenarios where that personal aspect of our identity can be quite powerful."
- "As someone who has worked in chaplaincy and has seen how beneficial chaplains are: uniquely trained to be faith questioners in healthcare. I don't see a role for the doctor and their personal faith in this process as we each have different roles which we are experts in."

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