Surgery Hurts: Characterizing the Experience of Pain in Surgical Patients as Witnessed by Medical Students

Tiffany J. Zens, MD, [*] *Kimberly E. Kopecky, MD,* [†,‡] *Margaret L. Schwarze, MD, MPP,* [*,§] *and Pasithorn A. Suwanabol, MD, MS* [‖]

[*]Department of Surgery, University of Wisconsin, Madison, Wisconsin; [†]Department of Surgery, Stanford University, Stanford, California; [‡]Department of Medicine, University of Wisconsin-Madison, Madison, Wisconsin; [§]Department of Medical History and Bioethics, University of Wisconsin, Madison, Wisconsin; and [‖]Department of Surgery, University of Michigan, Ann Arbor, Michigan

BACKGROUND: The patient experience around surgical care is poorly characterized. Medical students have a unique position on the surgical team, which allows them to observe patient experiences that may otherwise be overlooked. The objective of this study was to characterize surgical patients' experience with pain as witnessed by medical students.

STUDY DESIGN: At the end of an 8-week surgical clerkship, we asked all third-year medical students to write a reflective essay describing one surgical patient in pain. We collected 341 essays over a 4-year period and used qualitative content analysis to explore the students' reports of pain experienced by surgical patients.

RESULTS: When asked to tell a story about a surgical patient in pain, medical students report vivid descriptions of physical agony, emotional distress, and patient regret. For example, "Throughout the procedure our patient cried out and writhed in agony from the searing pain in his chest," and "The patient was practically shedding tears, complaining of pain, as [we] changed her dressing." The students' accounts reveal wide-ranging physical and emotional suffering among surgical patients, including alterations in self-image and feelings of vulnerability. Pain and suffering were intensified when patients felt they had lost control, in settings of uncertain prognosis and with unexpected outcomes.

CONCLUSIONS: Students' descriptions of the surgical patient's experience are disturbingly graphic. They expose suffering ranging from generalized discomfort to anguish and excruciating pain. These data suggest that surgical patients have substantial unmet needs with respect to symptom management and emotional support that, if better addressed, could improve the patient experience. (J Surg Ed 76:1506–1515. Published by Elsevier Inc. on behalf of Association of Program Directors in Surgery.)

KEY WORDS: pain, surgery, medical student, surgical quality, palliative care

COMPETENCIES: Patient Care, Professionalism, Interpersonal and Communication Skills

INTRODUCTION

Surgery hurts. Pain is a near universal experience for patients who receive surgical care. Although surgeons routinely provide opioid and nonopioid pain medications, few surgeons have expertise in symptom management despite routinely engaging patients in burdensome therapy. This may be in part due to the nature of surgical training, general lack of attention in health care to the suffering of patients, or simply because surgeons see patients in pain so frequently that they fail to recognize its consequences.

Physicians, and surgeons specifically, are often cited for lacking empathy.[1-4] This criticism may be related to their

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Correspondence: Inquiries to Pasithorn A. Suwanabol, MD, MS, Department of Surgery, University of Michigan, 2124 Taubman Center, 1500 E. Medical Center Drive, Ann Arbor, MI 48109; e-mail: pasuwan@med.umich.edu

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inattention to human suffering. To rectify this problem, the Gold Humanism Foundation has commissioned focused learning experiences in medical schools to create clinically excellent and compassionate clinicians.[5,6] In response, we developed an educational session for third-year medical students to critically examine the experience of patients during their surgical clerkship. We asked students to write a reflective essay about observing one surgical patient in pain. Interestingly, when asked to describe patients in pain, many students wrote about the complex nature of the pain experience including regret and sadness as modifiers of the experience of physical pain. This study therefore exposes frequently overlooked hardships experienced by patients with surgical illness and supports the previously described concept of total pain, a concept which acknowledges how the emotional, social, and spiritual experiences of illness equally contribute to a patient's experience of distress and suffering.[7]

Medical students are uniquely able to provide on-the-ground insight about the patient experience as they are intimately integrated into care processes and spend sustained time with patients. Because they are not fully indoctrinated to the customs and norms of clinical practice, their transitional role allows them to function as an active observer who understands the clinical team's values and dynamics with fewer inbred assumptions.[5,8-10] As such, students can both identify unrecognized patient needs and act as patient advocates.[11,12] Although we created this learning experience to enrich student performance, their observations provide novel insight into the hazards of surgical treatment and present an opportunity to learn more about adverse patient experiences. Furthermore, reports from medical student may allow for a more nuanced and independent assessment than reports from patients or clinicians. Patients beset by difficult pain experiences may struggle to report this experience in the moment, while clinicians who witness pain regularly may have developed strategies to distance themselves from these difficult experiences.[13,14] The purpose of this study is to characterize surgical patients' experiences of pain as witnessed and recorded by medical students.

METHODS

We analyzed 341 reflective essays written by third-year medical students at the University of Wisconsin School of Medicine and Public Health over the course of 24, 8-week rotations, consisting of 4 weeks of general surgery and 2, 2-week rotations on a subspecialty surgery service. We asked students to tell the story of 1 patient whose pain they had witnessed at any time during their 8-week rotation. Students were asked to consider (1) the type of pain the patient was experiencing; (2) how the patient's pain could have been minimized; (3) the patient's response to pain and mental preparedness for pain; (4) their personal reaction to witnessing a patient in pain; and (5) how the surgical team addressed the patient's pain (Appendix).

The Institutional Review Boards at UW and the University of Michigan reviewed this study and deemed it exempt. Although most students did not reveal patient identity, we removed any protected health information and all student and clinician identifiers prior to analysis.

Analysis

We used qualitative content analysis to analyze each written transcript inductively, i.e., without a prior conceptual framework or predetermined codes. Using a process called constant comparison, each author generated and attached codes to items, activities, sentiments, and constructs as they emerged in the data. We met frequently as a group to adjudicate and revise the coding schema, and to develop a taxonomy to faithfully capture concepts and trends as they existed in the data.[15] We used *NVivo* (version 10, QSR International, Doncaster, Australia) software to record group consensus about identified themes, revising categories along the way to capture important nuance and refine the meaning of each category.[16,17] We then used mapping and construct charts to perform higher level analysis focusing on the content specifically related to patient pain. Our analysis focused on the multiple dimensions of pain using the student descriptions of the patient's experience to synthesize and categorize the wide variety of experiences the students reported. Our process allowed us to clarify patterns, explore differences and variability, and ensure that identified concepts were accurately represented in the data.[18] After reviewing 3 years of student essays, we observed complete thematic saturation. We have not identified novel constructs or additional types of episodes during ongoing educational sessions.

RESULTS

Out of 341 essays, we identified 332 unique patients for whom we could reliably identify the surgical service caring for the patient. We discarded the 11 essays in which students did not describe the story of 1 patient in pain but rather explored these issues more generally without a patient narrative. Students chose to write about patients from all surgical teams (Table 1). They reported on a range of surgical procedures including oncologic resections, amputations, creation of ostomies, cardiothoracic, and pediatric surgical procedures. Further, students described pain in a manner that went far beyond standard conceptions of surgical pain, i.e., incisional or

TABLE 1. Characteristics of Patients Described in Student Essays

Patient Characteristics	*N* (%)
Age	50.2 ± 21.1 years (mean)
Female	143 (46)
Surgical service	
Acute care	56 (17)
Burn	15(5)
Cardiac	9 (3)
Colorectal	36 (11)
Community	8 (2)
Minimally invasive	16 (5)
Orthopedic	12 (4)
Otolaryngology	19 (6)
Pediatric	16 (5)
Plastic	10 (3)
Surgical oncology	29 (9)
Thoracic	23 (7)
Transplant	31 (9)
Trauma	9 (3)
Urology	12 (4)
Vascular	22 (7)
Veterans Affairs Hospital	9 (3)

visceral, and were broad and multidimensional, spanning a range of physical, emotional, psychological, and existential distress.

Physical Pain

Student testimonies exposed wide reaching physical suffering ranging from generalized discomfort to descriptions of anguish and excruciating pain. Students described their patients' experiences as distressing and at times unbearable both to the patient and to the student. One student wrote of a patient who "cried out and writhed in agony," while others witnessed patients grimacing, twisting, and "mak[ing] all sorts of noises." Students acknowledged that postoperative treatments were designed to foster healing and recovery, yet the treatments generated an experience of "torture" and "trauma."

Anguish and Vulnerability

Students revealed pain associated with daily routines, such as dressing changes, that led to despair (Table 2). They described how these routines "brought [the patient] to tears" and were "exquisitely painful ... despite pre-medication." One student recounted his patient's meek plea, "How much longer will it hurt like this?" The students reported that nasogastric (NG) tubes were extremely uncomfortable and irritating. For example, "[Her] greatest source of pain was her NG tube. For

TABLE 2. Students Described Severe Pain and Suffering for Surgical Patients

	Representative Quotes From Students
Students described patients with extreme physical suffering	"Throughout the procedure our patient cried out and writhed in agony from the searing pain in his chest."
	"[The patient was] miserable with nausea, vomiting, numerous ports and tubes and needle sticks."
	"She described the pain she felt afterward as similar to 'having a baby, except it doesn't end.'"
Students reported high levels of patient distress	"The patient was practically shedding tears, complaining of pain, as [we] changed her dressing."
	"For the first [few] nights the patient would wake himself up groaning and screaming in pain. Despite the epidural and PCA opioids, he did not receive relief."
	"He frequently winced, yelled and at times had tears in his eyes. He would often apologize for being so loud and dramatic, but it was clear to me that he was expressing his true pain."
Students witnessed patients in pain who had lost hope	"He had been told after the procedure about the extent of his disease and that his survival was less than two years. Understandably, there was a feeling of hopelessness."
	"There has been a growing sadness and pleading in her tone during our early morning discussions that could be loosely summarized as, "how long will this go on?"
Students revealed patient desperation and despair	"[He had] so much pain that he became at times hostile and combative with hospital staff and removed his surgical dressings and knee brace."
	"At one point he had asked if there was any way he could go back under anesthesia he was in so much pain."
	"He was writhing in agony as he coughed and moaned in pain while begging us to stop."

days, I had to assure her of the benefits and necessity of the tube as she begged me to remove it." This was particularly evident for patients who needed to have their NG tube placed on multiple occasions, as 1 student wrote about a patient with a ruptured appendix, "she would cry and beg the team not to."

Students described situations that left patients feeling exposed, embarrassed, and vulnerable. For example, a male patient, "bent forward over an exam table with his pants down and a group of strangers behind him observing ..." Another student acknowledged "...embarrassment...that horrible feeling" experienced by a woman who had developed a foul-smelling abdominal enterocutaneous fistula. Students saw major alterations in body image that defeated patients' self-esteem, identity, and confidence. One patient was "extremely unhappy with her self-image" following major oropharyngeal cancer resection. She "was afraid of how people would look at and judge her." Students saw patients exposed and vulnerable based on their illness or treatment, which led to reliance on others, changes in their ability to navigate interpersonal relationships, or contribute socially. For example, another patient required amputation for frostbite, "[he] knew he'd struggle to find work not being able to get full use out of his hands" as this represented a "radical change in his functionality and the options available to him in his future."

Loss of Control

Students saw physical limitations related to surgery and restrictions imposed by the surgical team that made patients feel they had lost control of their bodies and their circumstances. Patients who were restricted from movement lost the freedom to interact with their environment or to do things on their own. Students believed these restrictions had impact on patient identity. Further, students noted patients who found themselves newly dependent on others for simple tasks experienced agitation and depression. For example, "[He] had obviously been a very independent person before the surgery, and he desperately wanted to be able to walk around and take care of himself." Students noted that hospitalization disrupted patients' normal routines. They saw it was difficult for patients to sleep and called attention to hardships imposed by dietary restrictions like nothing by mouth or liquids only.

Students described patients in extremely constrained positions that caused "back pain, hip pain and generalized fatigue on top of the pain from [the] incisions." One student described a burn patient who was extremely confined as he was required to lay on his side, making eye contact with visitors "almost impossible. His neck ached relentlessly" and he had "little to no mental stimulation." Another wrote of a patient trapped and stuck by his pain, restricting his ability to find comfort, "this guy was in pain...the incision on his back that he was forced to lay on [was] excruciating for him." Students noted that physical constraints had impact beyond physical discomfort because they disrupted patients' ability to interact with the world. While students recognized that patients were often restrained to support their best interests, when this was done overriding patient objections, it also felt dehumanizing, like a violation of personhood.

Regret and Sadness

Students worried that pain experienced by surgical patients led to regret. Patients with uncontrolled pain expressed remorse about their decision to have surgery. For example, 1 patient "made several comments ...such as 'I just didn't think it would be like this' and 'If I had known it was going to be like this, maybe I wouldn't have done it.'" This was particularly true for patients with multiple complications whose struggles were linked to the duration of their suffering; "He would grow tremulous, anxiously asking about his symptoms, often saying 'I can't do this anymore' ...questioning his decision to have the surgery." This pain also led to self-blame from patient-perceived failure to seek timely intervention. One patient wondered "what if she had sought care earlier; could it all have been avoided and was it her fault?"

Students noticed heightened suffering when experiences seemed unexpected (Table 3). One patient flatly stated, "I was just not prepared to deal with this," while another student remarked that a patient "wasn't prepared for her procedures, nor for the pain the operations caused." Students observed these reactions in patients with both predictable outcomes and unexpected adverse events. One patient who underwent an abdominoperineal resection was particularly unprepared, "He knew the surgery was going to be painful, but was surprised in the days post-op that he was left without an anus." After developing an enterocutaneous fistula another patient anguished, "so I went through all of this for nothing?" Patients' distress appeared unmitigated by preoperative conversations yet some students believed there was opportunity for improvement.

Students witnessed patients receiving bad news and struggling to manage life-limiting illness. One student wrote "[the] weight of that information on the patient just s[u]nk him into the bed and into depression. He had a face of disbelief and I could tell that he was weighing his mortality in his mind." Another student noticed, "morning after morning... less and less hope." For a patient who suffered at the end of life, one student worried how "the [surgery], in part, contributed

TABLE 3. Students Believed Surgical Patients were Unprepared for the Pain Associated With Surgical Intervention

	Representative Quotes From Students
Students felt that patients didn't anticipate what it would be like to recover from surgery, or that it was impossible to explain consequences of surgery	"Although he had been told what to expect before the surgery, he commented that there was no way he could have anticipated what it would actually feel like." "I do not think the patient was mentally or physically prepared for the pain that he would endure, but I don't think anyone could have been prepared for such a huge operation." "She was mentally and physically prepared for some pain following surgery, however she was not prepared for the pain of a pneumothorax, annoyance of supplemental oxygen, constant fatigue, and inadequate pain management for her fibromyalgia."
Students felt that patients did not have appropriate expectations due to poor communication from the surgical team or they experienced unexpected postoperative events	"I don't think this patient was well prepared for this pain because during obtaining consent we made it sound like a super simple procedure" "I do not believe that she was prepared for this pain and her expectations of the future with and without the surgery were not readily apparent." "I do not think he could have completely prepared for the possibility of this level of pain after his surgery due to the fact that an open procedure was presented as only a possibility" "Certainly, his circumstance is outside any typical informed consent and I doubt that he was prepared for such a long-term complication."

to her death." Another reported that "[the patient] had been swept up in what everyone else thought was best rather than what was the best choice for him" while another observed "She hadn't had a chance to say goodbye."

Coping

Students reported strategies patients used to cope with pain. Some decorated their hospital rooms and used distraction to manage pain. For example, "[The patient] acknowledges that the more comfortable that she feels in her environment the easier it is to tolerate her pain" while another student reported, "small acts of kindness, like the nurse placing a cool washcloth on [the patient's] forehead" eased the patient's pain. Students observed patients using humor to cope. One patient joked about a dressing, referring to it as a "stylish fish-net" while another patient regularly teased about her plans to "... 'grab her bedrails so she wouldn't punch me.'" Other patients, "needed to regain some control, so they became active participants in the wound cleaning process." Students also highlighted the importance of family support: "Nothing could have prepared her for the pain, sickness, disfigurement, and loss of productivity that she experienced during her month in the hospital, but she endured it through her intrinsic strength and the support of her family and friends."

DISCUSSION

When asked to tell a story about a surgical patient in pain, medical students report vivid descriptions of physical agony, emotional distress, and patient regret. These accounts bear witness to routine surgical interventions—including NG tubes, dressing changes, and bedside procedures—as a significant source of patient suffering. Students identified the emotional consequences of surgical illness including disappointment, alterations in self-image, loss of autonomy, vulnerability, and embarrassment that are distressing to both patients and students, and at times overshadow more typical manifestations of physical pain. Students also uncovered factors including loss of control, prolonged hospitalization, and uncertain prognosis that contribute to patient suffering in a way that is difficult to address with standard pain management strategies. This unique vantage point of medical students who have not been indoctrinated to standard conceptions of physical pain and pain scores allowed them to view and characterize pain broadly and identify multiple dimensions of pain that exist but are seldom described in the course of surgical care.

Students frequently praised the surgical team for their kindness and compassion, yet their descriptions of the patient experience are disturbingly graphic as they reveal profound physical and emotional suffering. Although the exercise was designed to identify memorable events as opposed to everyday occurrences, their

descriptions assert cause for concern. These data suggest that surgical patients have substantial unmet needs with respect to symptom management and emotional support that, if better addressed, could improve the patient experience of surgical care. These observations have important implications for surgeons, educators, and patients.

For surgeons, these observations suggest a need to increase awareness of patient suffering and develop a more sophisticated response to symptom management. As students noted, small acts of kindness markedly reduced patient suffering. Surgeons with the ability to express empathy and explore patients' emotional concerns may find their patients need fewer medications or advanced pain consultation. Surgeon commitment, communication skills, and empathy are all part of a shared process with constant room for improvement and re-evaluation. For those surgeons who struggle with this, literature supports that empathy can be enhanced through education.[4,19]

In 1983, Saunders introduced the concept of total pain, recognizing that the physical, emotional, social, and spiritual experiences of illness equally contributed to the experience of distress and suffering.[20,21] This framework for pain is applicable to the surgical patient population but is unfamiliar to most surgeons. Surgeons need skills to identify patient distress, including a brief assessment of patient anxiety and depression, and strategies to address patients' psychosocial and spiritual needs including fear, anger, grief, regret, and sadness.[22,23] Although most surgeons prescribe antibiotics or treat postoperative hyperglycemia without consulting specialists, few have this type of learned skill to manage patient pain and emotional distress. Such an approach can be easily introduced for use on daily rounds, which may be conducted efficiently and with minimal effort.

For patients with more complex needs, palliative care specialists can manage refractory symptoms, multifaceted depression, existential distress, and complicated grief. In comparison to other clinicians, surgeons are less likely to utilize palliative care services and often engage specialists only when patients are so near the end of life there is little time to address these needs.[24-26] Many surgical patients would benefit from earlier and more frequent consultation of specialist-provided palliative care, which has benefits for all patients living with serious illness, regardless of the life-limiting nature of their disease. Additionally, implementing ancillary services designed to promote nonpharmacological approaches to pain management such as acupuncture, music and pet therapy, healing touch and guided meditation could improve the patient experience, and has been shown in some studies to reduce pain scores and opioid use.[27-31] Additionally, patients with complex emotional or psychological components to their pain, such as those experiencing significant alterations in their functional status or body image, may benefit from ancillary services such as health psychology. Given the limited mental health resources in an inpatient hospital setting, it is important for surgeons to have an understanding of the patient experience in order to identify those needing additional services and those who can receive emotional support from their primary surgical team, family, or spiritual leaders.

In addition to addressing pain postoperatively, it is important for surgeons to recognize the importance of setting expectations and shared decision making preoperatively during the informed consent process. A 2014 study by Ankuda et al. surveyed 1034 patients following the informed consent process and found 13% had major deficits including not understanding the risks and benefits of the procedure and in 33% had minor deficits including not addressing patient values, preferences or goals.[32] Several researchers have investigated therapeutic strategies to improve surgeon communication and patient understanding during preoperative counseling. In the Best Case/Worst Case Model, visual aids and scenario planning are used to help the patients anticipate which outcomes are most and least likely with a given treatment. As a result, families of elderly patients have realistic expectations in the postoperative period and can decide if these outcomes are concordant with the patient's wishes.[33] Likewise, pediatric surgeons have found significant improvement in postoperative pain and patient preparedness for the Nuss procedure for pectus excavatum with preoperative consultations ranging from 60 to 80 minutes focused on the expectations of surgery and recovery, patient mindfulness, and stress and anxiety reduction.[3] Given our findings, further research focusing on the preoperative interventions and shared decision-making as a means to improve postoperative pain may be warranted. However, despite even the best preoperative teaching, it may still not be possible for a patient to completely understand or prepare for postoperative pain, especially in the setting of unexpected complications, but strong communication may go a long way to improve the patient experience.

For surgical educators, there are curricula to provide surgical trainees, who are typically on the front lines of pain management, with foundational skills.[34,35] Much time and effort is invested in cultivating surgical knowledge, technical dexterity, and treatment decision-making, but far less energy is devoted to pain management, communication skills, and support for patients' emotional needs.[36] Poorly-controlled pain has been documented as high as 80% in surgical patients,[37] and has led to over-reliance on opioids for postoperative pain. Given the demands to restrict opioid prescribing, efforts to support

patients need to also include strategies for multimodality pain management, such as nerve blocks or epidurals, adjunctive medications (e.g., acetaminophen, NSAIDS, topical analgesics), and physical modalities (e.g., rest-ice-compression-elevation) and rehabilitation, and evaluate the impact of opioid and nonopioid treatments on the patient experience. Without formal education in pain management and prevention of medication-related toxicity, residents are left to passively absorb treatment strategies with questionable efficacy. Unfortunately, there is a paucity of data in the current literature comparing curriculum aimed at improving the patient pain experience, making it difficult to recommend an optimal provider group or method of education. That being said, effective curriculum provides a multidisciplinary approach involving pharmacy, nursing, mental health providers, and surgical providers.[38,39] In fact, hospital-wide programs which engage all stakeholders, similar to the initiative described by Lester et al. have been found to be particularly effective.[40] Given the field of pain management is constantly changing with the introduction of new treatment modalities and medications, continuing education throughout the career of a surgeon is necessary.[39] Several programs describe introducing a curriculum of multimodality pain management into medical school and residency training, often in conjunction with nursing or pharmacy students.[41,42] In terms of palliative care skills training, which emphasizes symptom management, communication, and empathy, several surgeon courses have been described in the literature. Most surgeons do not receive formalized education and what exists is highly variable across institutions with little evidence that the current training improves patient outcomes.[43,44] Training programs that include didactics on the management of specific symptoms (e.g., pain, nausea, and depression) and diseases (e.g., malignant bowel obstruction and wasting syndromes) would provide trainees with the ability to improve surgical care and minimize suffering.[45]

For patients, efforts to promote resilience through reinforcement of coping strategies, encouragement of family support, and positive clinician interactions can improve the experience of surgery. Students noted that patients who developed their own coping strategies seemed less imperiled by their pain and others have shown that patients who actively participate in their own care exhibit greater perceived control of their health, less depressive symptoms, and improved health outcomes.[46,47] Moreover, interventions that support resilience for patients and families can reduce distress and improve the overall experience with serious illness.[48-50] This presents an important opportunity for future study with surgical patients.

Our study has both strengths and weaknesses. Although students uncovered remarkable patient experiences, these student accounts are not necessarily representative of surgical patients' experiences generally and may only embody their own recollection of events. As a result, like many qualitative studies, our findings are based on data gathered from deliberate sampling based a specific criterion. Students are likely to chronical the most extreme patient interactions they had during their rotation in order to achieve the learning objectives of their assignment. Still, the students have chronicled rich descriptions of what they witnessed and their observations provide much-needed insight into the patient experience of surgery. We recognize the patient's account and the surgical team's perceptions of what occurred would likely be different. Although we are unable to link these essays directly to the patient record and recorded pain scores, students have reported conversations they had with patients and events they witnessed that serve to uncover experiences around surgical care that may not have been discovered otherwise. It is important to understand the medical students' interpretation of and reaction to surgical patients' pain as it could impact their education or choice in medical specialty. Furthermore, our analysis highlights potential educational opportunities to teach physicians to recognize and discuss suffering and distress with their patients. Finally, these essays are collected from a single academic medical center where some experiences might be unique to the institution. However, we conducted the same educational experience with medical students at the University of Michigan and found that students there characterized patient pain similarly. Likewise, regardless of clinical experience, we found similar responses across all cohorts of students rotating on surgical services over the three year period.

CONCLUSIONS

Students on the surgical service describe substantial pain and suffering, highlighting a range of unmet patient needs. Although the experience of pain by surgical patients is unavoidable, the assessment of the gravity of these patient experiences is frequently overlooked. The students' graphic descriptions highlight a critical need for surgeons to recognize and respond to patients' physical and emotional distress, consult specialist palliative care for patients with complex needs, and support patient resilience and coping throughout the entire episode of surgical care. Such an approach will undoubtedly improve the patient experience around surgical care.

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SUPPLEMENTARY INFORMATION

Supplementary material associated with this article can be found in the online version at doi:10.1016/j.jsurg.2019.04.008.

APPENDIX

Appendix: Medical student assignment

Student Name: _____

"Surgery Hurts"

In Surgery, we often don't fully consider how painful it is for patients to have an operation. We put people through quite a lot in order for them to "get well" (NG tubes, being NPO for long periods, incisions, diarrhea, ICU care etc.)

During your Surgery rotation, pay attention to an instance where pain was inflicted on a patient as part of the surgical treatment. Then write a one-page self-reflection essay about that experience. This should be no more than one page. In your essay you may want to pay attention to the following:

1. Describe the burdens of the treatment vs the benefits it provided—what trade-offs were made?
2. Describe the pain and how the patient felt during the treatment
3. Describe how well the patient was prepared for the pain (mentally and physically). Do you feel the patient's expectations of how painful the procedure would be compared with their actual experience?
4. How could the pain be minimized in the future?
5. Explain your perspective on the experience—how did you feel the treating team dealt with the patient's pain? Was the pain worth it in your option? And was the treating team sensitive to the patient's pain?
6. What did you feel when you saw this patient in pain?
7. What do you feel in general when you see patients hurting?

There are no right or wrong answers here, the idea is to consider how you respond to watching others in pain and how the people you are working with react to patients in pain. This should not be an essay about pain management but rather an essay about the challenges of being a physician and watching people hurt.