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Making Meaning of Empathy:
A Qualitative Study of Empathy Education at UTMB

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Making Meaning of Empathy: A Qualitative Study of Empathy Education at UTMB

by

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Dedication

This work is dedicated to medical students at UTMB, who work to empathize with their patients each and every day, despite the challenges along the way.

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I wish to express my deepest gratitude to those who have been involved in this project from its beginning. My advisor, Dr. Rebecca Hester, has provided invaluable guidance and support throughout my time at the Institute for the Medical Humanities and in medical school. Dr. Kirk R. Smith offered a close reading of this work, which allowed me to improve the content and better develop my voice. Dr. Eric Avery provided physician insight into the idea of empathy and offered guidance on how to better address biological understandings of empathy. I also want to thank my parents for their continuing encouragement and love.

My appreciation also goes to the UTMB faculty for generously speaking with me about empathy and for working tirelessly to inspire students to become caring medical professionals. Most of all, I want to thank the medical students who opened up their hearts and spoke candidly about their experiences. They are the true heroes of this work.

Making Meaning of Empathy: A Qualitative Study of Empathy Education at UTMB

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Empathy has been emphasized as part of a larger professionalism initiative nationwide in medical education and has been a contentious topic insofar as there has been much academic debate over its definition and application in clinical settings. While recent research has focused on quantification of student empathy and ways to improve empathy education, there has been little critical analysis of what the term means to students and factors influencing this meaning-making process. Students at the University of Texas Medical Branch (UTMB), an academic health science center in Galveston, Texas, are taught about empathy formally through the Practice of Medicine courses and informally through modeling by physicians and other students. They then adapt and mold the concept based upon their own needs, experiences and social environments. Using a qualitative constructivist paradigm with a focus on the social aspects of empathy, I will explore how the concept of empathy is defined and operationalized by medical students at UTMB who volunteer at a student-run free health clinic. Through participant-observation and interviews, I will explore both the rhetoric and the reality of empathy, as experienced by the students, in order to contribute to the critical evaluation of this frequently used term.

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List of Abbreviations

UTMB	University of Texas Medical Branch
GSBS	Graduate School of Biomedical Science
TDC	Thesis and Dissertation Coordinator
POM	Practice of Medicine Course
HEP	Humanities, Ethics, and Professionalism Course
SP	Standardized Patient
IMH	Institute for the Medical Humanities
IRB	Institutional Review Board
SVC	St. Vincent's Clinic
OSCE	Objective Standardized Clinical Evaluations
AAMC	Association of American Medical Colleges
MSOP	Medical School Objectives Project

Chapter 1 Introduction

In the following pages, I examine how undergraduate medical students at the University of Texas Medical Branch (UTMB) in Galveston, Texas make meaning of their empathy education. I chronicle their struggles and triumphs in their quest to provide high quality healthcare and relate to their patients. The personal value systems of medical students, and the value systems of the faculty and students with whom they work, influence the definitions and meanings they give to the concept. Issues of power guide the meaning-making process as well. Students practice empathy in a setting in which they are constantly evaluated and judged and where they must worry about impressing attending physicians in order to get strong letters of recommendation for when they apply to their chosen residencies. Furthermore, larger political, economic, and social environments influence the students' meaning-making process. In particular, the curriculum at UTMB is influenced by a rise in market-based medicine, and this trend also influences how students understand empathy.

Empathy is a frequently discussed concept in the medical literature. Much focus has been on finding a fitting description, appropriate quantification tools, and hypothesizing reasons for measured declines in student empathy. Other scholars have researched how empathy may be taught, examining the effects of literature and medicine courses, meetings in small groups with faculty members, and communication skills workshops on students' self-reports of empathy.[1] Yet despite the research on teaching

[1] Johanna Shapiro, Elizabeth H. Morrison, and John R. Boker, "Teaching Empathy to First Year Medical Students: Evaluation of an Elective Literature and Medicine Course," *Education for Health* 17, no. 1 (March, 2004): 73-84, http://xa.yimg.com/kq/groups/18209225/785322773/name/Teaching+Empathy.pdf (accessed July 19, 2013); and Hannah Barnhill Bayne, "Training Medical Students in Empathic Communication," *The Journal for Specialists in Group Work* 36, no. 4 (December, 2011): 316-329, doi 10.1080/01933922.2011.613899 (accessed July 15, 2013).

empathy, little research has been done on students' interpretations of these lessons on empathy.

In this qualitative study, I examine the meaning-making process. I begin by giving an overview of the research design of the study, including a rationale for using a qualitative approach. In the second chapter, I summarize existing research on empathy, pointing out the lack of examination of students' interpretations of their formal empathy education in medical school. In the third chapter, I provide a working definition for empathy and analyze the formal course materials at UTMB within the first three years of medical school, illustrating how the lessons are heavily influenced by trends in market-based medicine that emphasize performance of empathy. In that chapter, I also examine materials provided in a course led by members of the Institute for the Medical Humanities at UTMB; this course emphasizes a critical approach to healthcare and understandings of empathy. Finally, in the last chapter I examine how students make meaning of their empathy education. I examine how they struggle with both formal and informal lessons and also examine the role that practice, particularly in the setting of a student-run free volunteer clinic, plays in developing their understandings. Their journeys to find individualized understandings of empathy and to interact with patients in ways that reflect those understandings should provide motivation for educators to continue to seek ways of teaching empathy that encourage students to connect with patients. In the conclusion, I make suggestions about how to better teach empathy to medical students, based on the students' opinions.

Chapter 2 Methodology

Building on the insights of Howard S. Becker and his *Boys in White* co-authors, I studied empathy in the current context of academic medicine where there is an increased emphasis on professionalism. Explaining that their purpose was "to discover what medical school did to medical students other than giving them a technical education," the group was interested in the ways in which medical students develop a professional identity.[2] The group approached its research using a qualitative methodology that "has at its goal an understanding of the nature of phenomena."[3] Instead of using tools meant to quantify data, this methodology uses a variety of means including participant-observation, interviewing, and the collection and analysis of texts such as field notes to try to understand how people experience some qualitative phenomena—in this case, empathy.[4] I employed these same methods.

Becker and his fellow researchers were committed to using what they called "unstructured techniques," which they define as techniques that allow research subjects to determine the meaning and form of the research questions being asked.[5] These techniques allow the opportunity to "discover what things were of importance to the people [they] were studying."[6] Continuing with the idea that the research must be conducted in such as a way to recognize the emergence of meaning arising from the subjects themselves, I undertook my research using a constructivist perspective.

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[2] Howard S. Becker, Blanche Geer, Everett C. Hughes, and Anselm L. Strauss, *Boys in White: Student Culture in Medical School* (Chicago, IL: University of Chicago Press, 1961; Piscataway, NJ: Transaction Publishers, 1977), 17. Citations refer to the Transaction edition.

[3] Kathleen M. DeWalt and Billie R. DeWalt, *Participant Observation: A Guide for Fieldworkers* (Walnut Creek, CA: Altamira Press, 2001), 2.

[4] Ibid.

[5] Becker, et al., *Boys in White*, 18.

[6] Ibid., 23.

Constructivism recognizes that realities are mental creations, influenced by social interactions and one's own experience, as well as that of the groups doing the constructing.[7] Acknowledging the social basis of knowledge, the constructivist approach requires that research be conducted in such a way that the participants may speak about their realities in their own terms and with language that makes sense to them.[8] This approach represents an attempt to capture the multiple realities of a phenomenon by trying to understand the subjective experience of those experiencing it.[9]

Using this approach, empathy is defined through the medical students' past experiences and current interactions with each other, their patients, their teachers, and with the researcher. This approach allowed me to understand how medical students interpret the information on empathy that had been presented to them and how they adapt that information for themselves, based upon personal experience. My role as researcher was to understand the meaning that medical students make in their own terms, comparing that meaning with the values espoused by the University of Texas Medical Branch (UTMB), and look for the symbolic value of this concept within medical education.

Becker, et al. conducted their qualitative research using participant observation, a method in which the researcher both observes and participates in the activities under scrutiny, recording field notes on the experience.[10] As Kathleen M. and Billie R. DeWalt explain, participant-observation allows the researcher to "develop a holistic understanding of the

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[7] Egon G. Guba and Yvonna S. Lincoln, "Competing Paradigms in Qualitative Research," *Handbook of Qualitative Research*, ed. Norman K. Denzin and Yvonna S. Lincoln (Thousand Oaks, California: SAGE Publications, 1994), 111.

[8] Kathy Charmaz, "Grounded Theory: Objectivist and Constructivist Methods," in *Strategies of Qualitative Inquiry*, 2nd ed., ed. Normank Denzin and Yvonna S. Lincoln (Thousand Oaks, CA: SAGE Publications, 1998), 275.

[9] Ibid., 272.

[10] Becker, et al., *Boys in White*, 22.

phenomena under study" and to become familiar with both explicit and tacit understandings of a phenomenon, which enhances the interpretation and collection of data.[11] This method has been tested in application to medical training: Robert K. Merton and his research group, who published *The Student Physician*, also utilized participant-observation techniques to uncover the ways in which medical students are socialized to become doctors.[12] As I wished to understand the rhetoric, symbolism, and experience of empathy, I chose participant-observation as the method best aligned with my goals.

Specifically, I undertook participant observation twice a week from June 5, 2012 through September 6, 2012 at St. Vincent's Student-Run Clinic (SVC), which delivers pro-bono healthcare services to indigent patients in Galveston, Texas through the volunteer work of health professions students and faculty preceptors from UTMB. Permission for the study was granted by the clinic's student directors. SVC offers many unique advantages for the study of empathy. Students who volunteer there are generally considered by UTMB faculty and by their fellow students as an especially empathetic group. Observing this population, I witnessed intellectually and ethically committed individuals struggling to define and operationalize empathy.

St. Vincent's was also an ideal site because of its patient population, often thought of as challenging by medical students because many have complex medical problems and arrive with multiple life struggles. Students work to relate to so-called "difficult" patients, heightening opportunities to observe empathy in practice. In addition, students enjoy an unusually involved role as healthcare providers at this clinic

[11] DeWalt and DeWalt, *Participant Observation*, 8, 92.

[12] Robert K. Merton, "Some Preliminaries to a Sociology of Medical Education," in *The Student-Physician: Introductory Studies in the Sociology of Medical Education*, ed. Robert K Merton, George G. Reader, and Patricia L. Kendall (Cambridge, MA: Harvard University Press, 1957), 43.

as it is student-run, with attending physicians serving primarily in advisory roles. During the first and second years of medical training, students may have little patient contact outside of this clinic. SVC is the place where they may first come to understand empathy in the clinical setting and to make meaning of theoretical lessons learned in class.

I conducted the participant-observation in the student lounge areas of the clinic as students waited to present their findings from patient examinations to faculty members. It is in this setting that students discuss patient encounters with each other and with attending physicians, often revealing their frustration, amusement, and confusion. These reactions are part of the process in which empathy was manifested or not by students. Of note, students often commented about their lack of empathy while near me, though these comments were usually said in a self-conscious and joking manner. Due to the sensitive nature of the clinical encounter and my desire to disrupt as little as possible the patients' experiences at the clinic, I did not enter examination rooms to directly observe interactions between students and patients. However, I did observe some interactions between patients and students that took place in hallways and other areas outside the exam room. In addition to primary care, SVC hosts specialty clinics in the areas of psychiatry, obstetrics and gynecology, neurology, rheumatology, and dermatology. I randomly selected the days I attended the clinic to get a broad sample of experiences. Throughout my research period, I was able to attend every specialty clinic.

I also conducted participant-observation once a week at sessions of the Humanities, Ethics and Professionalism class (HEP) that is part of the Practice of Medicine (POM) 2 course that medical students take in the second year of undergraduate medical training. HEP consists of five weekly small group sessions, each comprised of a

facilitator and eight to ten medical students, and one large group session at the beginning of the course when a burn victim speaks to students about his experience with the healthcare system and the culture of medicine. Faculty members and graduate students from the UTMB Institute for the Medical Humanities facilitate small group discussion of readings that each week focus on a theme relevant to humanities, ethics, and professionalism, including empathy, the experience of illness, medicine as a caring profession, patient autonomy, and physician paternalism.[13] HEP sessions last for two hours, and I observed a sample of those from the first week of July until the week of August 13, 2012. I attended the large group session at the beginning of the course, and I rotated between small groups each week in order to observe various group dynamics and teaching styles.

The HEP section of POM 2 offers students specific training in ethics and professionalism, two categories under which empathy is often taught. HEP is the place where empathy is most likely to be explicitly theorized by both faculty and students. The term empathy is explicitly used in the syllabus during week five, and the class that week was especially important for my study as it allowed me to understand how this concept is understood and conveyed by faculty and then dealt with by students within the classroom setting. During this week, I attended three HEP small group sessions, as I wished to get a fuller sense of how empathy was explicitly taught.

During participant-observation sessions at SVC and in HEP classes, I took notes that I typed up later as field notes. DeWalt and DeWalt explain how field notes allow observations in the field to become the "first step in analysis," as data produced by

[13] Institute for the Medical Humanities, *The Practice of Medicine Module 5: Humanities, Ethics, and Professionalism*, (course syllabus, 2012), 2, eclass.utmb.edu (accessed December 5, 2012).

interpretation of witnessed events.[14] My field notes consisted of detailed observations and analysis of participants, their interactions, conversations and jokes, and my interpretation of the dynamics underlying what I observed. To further the analysis, I searched for themes arising from the observations, reading over the field notes and noting excerpts that represented examples of the themes. Thus, the following excerpt from my field notes was noted as illustrative of "medical hierarchy:"

> Student A comes out and starts talking to Student B. Student A is talking about her Acting Internship in Internal Medicine and working with a "lazy" student. She said, as if reenacting the scene (though I'm not sure if she said this to the student): "Listen, you are scum on this hospital floor. I'm not much better, so you need to respect the hell out of people in order for them to do stuff for you."

Furthermore, the following excerpt was illustrative of the themes of "frustration in provision of care," "dealing with emotions," "challenging patient encounter," "role modeling," and "lack of resources for indigent care:"

> Student C comes back out a short time later and looks a little dazed. She asked the patient if she would want to become a patient of St. Vincent's, and the patient became angry. Student C explains to Student D how the patient doesn't understand why she has to become a patient when she just wants Protonix [a medicine for gastroesophageal reflux disease].
>
> Student D: "[The outside clinic that referred the patient] can't just pawn off patients on us. That's just us doing scut work for another clinic."
>
> Attending Physician A hears this exchange and tells Student C "These are the patients you'll remember all your life. They're frustrating. Just maintain your calm."

I also conducted interviews with medical students and faculty members involved in SVC and HEP, using a semi-structured approach based on that of Becker et al.; i.e. I prepared a list of questions that "left much room for the free expression of all kinds of ideas and did not force the student to stick to the original list of questions or to answer in

[14] De Walt and DeWalt, *Participant Observation*, 142-143.

predetermined categories."[15] H. Russell Bernard writes that this approach is best when working with people whose time is limited, which well-describes medical students and faculty members.[16] Additionally, this approach allows flexibility in adjusting questions to specific conversations. (I have attached an interview guide as Appendix A.) While I asked all the questions in my prepared list, I often added others as I worked to better understand the students' responses. For example, I added the question "How is empathy related to altruism?" after reflecting on HEP discussions of empathy, which involve comparisons with altruism. No interviewee received compensation for meeting with me. For the interviews, I contacted students who were in their second and third years of medical education and who I encountered at St. Vincent's in order to represent a variety of experiences developed at the clinic over time as well as to understand the influence that the HEP course (all interviewees had either taken the course or were currently enrolled) had on experiences of empathy. Many students volunteer at the clinic, but, based on my participant observation, I chose volunteers whom I determined to have volunteered at the clinic greater than five times. All students whom I approached agreed to be interviewed.

I contacted the students, usually via e-mail, and asked them to sit down with me for individual interviews. I interviewed five second-year students and five third-year students. All interviews took place outside of clinic hours, allowing time for processing of their experiences and for finding more comfortable meeting locations. Interviews lasted between thirty minutes and an hour and were recorded. After ten interviews, I felt that I had a better understanding of the experience of empathy for the students and

[15] Becker, et al., *Boys in White*, 29.

[16] H. Russell Bernard, *Research Methods in Anthropology: Qualitative and Quantitative Approaches* (Lanham, MD: AltaMira Press, 2011), 212.

decided that those ten interviews included enough information for the purposes of this study.

As mentioned above, regular volunteers at St. Vincent's are a distinct group who by their frequent volunteering have already shown increased dedication to treating underserved patients—although it should be noted that these students also report that they volunteer in order to develop better clinical skills (such as history-taking and improved physical examination maneuvers) and to reinforce information learned in class about disease processes. From my observations, I also learned that students volunteer at SVC because the service looks impressive on curriculum vitae and because it allows them to form relationships with faculty members whom they can later approach to write recommendations for residency programs.

In addition to the student interviews, I talked with five faculty members involved with undergraduate medical education to discuss their experiences teaching empathy to medical students. Some of these faculty members are small group facilitators for POM 2, and others are or had been involved with empathy education through lectures offered throughout the first three years of undergraduate medical training or through teaching in the clinics and hospitals at UTMB. Later I talked with one faculty member who was involved with the standardized patient training exercises at UTMB, asking her specifically about the use of standardized patients in empathy education. These interviews lasted from thirty minutes to one hour, took place at a time convenient for the faculty members, and were voice recorded with their permission. (I have attached an interview guide as Appendix B.) I hired a transcriptionist who transcribed all the interviews, and I coded all interviews using the same methods as for the field notes.

After these interviews, I felt I had developed a good understanding of the factors influencing empathy education at UTMB.

I received approval from the Institutional Review Board (IRB) at UTMB for this study, the elements of which are charted in Table 1.

Chapter 3 Review of Literature

STUDY RATIONALE

The large investment in research and education about empathy reflects the importance that academic medicine gives to the concept from the perspective of patient care. Yet the usefulness of the studies to date may be limited by their use of definitions and measurement tools that may not reflect how students understand the practice of empathy. The proposed study, which offers more of a 'bottom-up' than a 'top-down approach' and which uses qualitative rather than quantitative methods, examines how students create a personal definition of the term. Because it relies on how students define and use empathy, it provides information for evaluating studies of empathy in medical education.

The methodology for this study is influenced by previous work done in the social sciences on the socialization of medical students, which has focused on "the acquisition of attitudes and values, of skills and behavior patterns making up social roles established in the social structure."[17] As suggested by previous researchers, professional values are not passively internalized by students; rather, they are "assimilated" based upon students' experiences.[18] Research on the socialization process has diminished in recent decades, even though there is a need for a more thorough understanding of how medical students incorporate various attributes of professionalism, including empathy.[19] With this in

[17] Robert K. Merton, "Some Preliminaries to a Sociology of Medical Education," in *The Student-Physician: Introductory Studies in the Sociology of Medical Education*, ed. Robert K Merton, George G. Reader, and Patricia L. Kendall (Cambridge, MA: Harvard University Press, 1957), 41.

[18] Isabelle Baszanger, "Professional Socialization and Social Control: From Medical Students to General Practitioners," *Social Science and Medicine* 20, no. 2 (1985): 134, doi: 0277-9536/85 (accessed July 11, 2012).

[19] Frederic Hafferty, "Medical School Socialization," in *Blackwell Encyclopedia of Sociology*, ed. George Ritzer (Malden, MA: Blackwell Publishers, 2007), 2930-2931. Additionally, a search in any

mind, the present study is significant in that it studies empathy within a paradigm that recognizes how emotions, concepts, and practices occur dynamically. Information about this meaning-making process provides a better understanding of the place the term occupies in the culture of medicine. This knowledge can be used to improve the pedagogical practices of academic medical centers.

EMPATHY ENTERS MEDICINE

The concept of empathy has a long history within medicine, and review of the term provides insight into how it has changed and been implemented in medical education throughout the years. Analysis of the literature also illustrates that medical students' opinions have largely been omitted, suggesting a need for further studies to evaluate empathy from their perspectives.

The use of the term empathy dates to 1872 when Robert Vischer, a philosopher of aesthetics, utilized the word "Einfühlung" to describe the emotional response, or the act of "feeling into," a painting. George W. Pigman writes that the link between aesthetics and psychology is easily recognized with the knowledge that "the word 'aesthetics' derives from the Greek verb meaning 'to perceive.'"[20] The psychologist Theodor Lipps was responsible for bringing *Einfühlung* into psychology, and it was through reading his writings that Sigmund Freud gained familiarity with the concept.[21] "*Einfühlung*" entered

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scholarly database will produce articles generally written before 1990, such as Frederic W. Hafferty, "Cadaver Stories and the Emotional Socialization of Medical Students," *Journal of Health and Social Behavior* 29 (December, 1988): 344-356; and Leonard Reissman and Ralph V. Platou, "The Motivation and Socialization of Medical Students," *Journal of Health and Human Behavior* 1, no. 3 (Autumn, 1960): 174-182, http://www.jstore.org/stable/2955575 (accessed July 7, 2012).

[20] George W. Pigman, "Freud and the History of Empathy," *International Journal of Psycho-Analysis* 76, no. 2 (April, 1995): 239.

[21] Ibid., 240.

the English language as "empathy" in 1909 when Edward Titchener, a psychologist, translated it as "to 'feel' or 'find' one's way into another's experience."[22]

The concept gathered interest in the psychoanalytic community as experts debated the nature of empathy and discussed its utility in psychotherapy.[23] Sigmund Freud, for example, writes about empathy in his 1905 work *Jokes and Their Relation to the Unconscious*, explaining how in order to understand a joke the listener tries to see things from the joke teller's point of view.[24] In other works, he expressed his belief that empathy was absolutely necessary for analysis and discussed its relationship to ego integrity and identification, using the terms "empathy" and "identification" almost synonymously.[25]

Empathy continued to be debated amongst psychoanalysts after Freud. Ellen Singer More explains that in the 1950's and 1960's a newer generation of psychoanalysts wished "to enlist empathy into the project of reasserting the empirical, objective, fundamentally scientific character of psychoanalysis."[26] This was in line with mainstream medicine's growing interest in scientific research and so-called objectivity.[27]

Empathy's presence in mainstream medicine became most prominent in the 1960's when worries about the dwindling number of physicians choosing primary care

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[22] Elizabeth Ann Baxter, "Concepts and Models of Empathy: Past, Present, and Future," *Jefferson Journal of Psychiatry* 12, no. 2 (1995): 6, http://jdc.jefferson.edu/cgi/viewcontent.cgi?article=1383&context=jeffjpsychiatry (accessed September 25, 2012).

[23] The concept has also been discussed in the literature of phenomenology. See Edith Stein, *On the Problem of Empathy*, vol. 3, 3rd ed., *The Collected Works of Edith Stein* (Washington, D.C.: ICS Publications, 1989).

[24] Ellen Singer More, "Empathy Enters the Profession of Medicine," in *The Empathic Practitioner*, ed. Ellen Singer More and Maureen A. Milligan (New Brunswick, NJ: Rutgers University Press, 1994), 21.

[25] Pigman, "Freud and the History of Empathy," 250; and Ellen Singer More, "Empathy Enters the Profession of Medicine," 21.

[26] More, "Empathy Enters the Profession of Medicine," 29.

[27] Ibid.

specialties, coupled with a growing distrust of the medical profession within the general public, led medical educators to start emphasizing the emotional aspects of medical care.[28] In that context, empathy as "detached concern" became a way to talk about "effective and compassionate communication without sacrificing the profession's claims to neutrality and objectivity."[29] Empathy became desired over the term "sympathy," due to sympathy's association with femininity and Victorian sentimentality.[30] These feelings are evident even in E.E. Southard's 1918 article about empathy when he writes that "*sympathetic*, the adjective, seems to have built—so philologists say—on the analogy of *pathetic*."[31]

Jodi Halpern, author of *From Detached Concern to Empathy*, explains that this detached stance, which had been previously advocated by William Osler, was an "intellectualized stance" to empathy, one in which the physician used knowledge gained from previous experiences to "make inferences about the patient's feelings."[32] Charles Aring discusses this detached stance in an article in the *Journal of the American Medical Association* in 1958. In it, he emphasizes the importance of "maintaining one's own personality in any emotional climate," as opposed to "entering into the feeling of another and becoming similarly affected."[33] In their article on "detached concern" from 1963, psychiatrist Harold I. Lief and sociologist Renee C. Fox write, "The empathic physician is sufficiently detached or objective in his attitude toward the patient to exercise sound

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[28] More, "Empathy Enters the Profession of Medicine," 20, 30-31.

[29] Ibid., 31.

[30] Ibid., 22-26, 31.

[31] E.E. Southard, "The Empathic Index in the Diagnosis of Mental Diseases," *The Journal of Abnormal Psychology* 8, no. 4 (October, 1918): 200.

[32] Jodi Halpern, *From Detached Concern to Empathy: Humanizing Medical Practice* (Oxford, United Kingdom: Oxford University Press, 2001), 67-99.

[33] Charles Aring, "Sympathy and Empathy," *JAMA* 167, no. 4 (May 24, 1958): 449.

medical judgment and keep his equanimity, yet he also has enough concern for the patient to give him sensitive, understanding care."[34]

The focus on empathy later became part of a broader "professionalism" movement in medical schools, intended to help students develop a professional identity based loosely upon societal expectations of the profession. In 1998, the Association of American Medical Colleges (AAMC) Medical School Objectives Project (MSOP) identified the "general consensus within the medical education community" regarding the "knowledge, skills, and attitudes that students should possess prior to graduation from medical school."[35] Medical schools were encouraged to develop a curriculum that taught each of the objectives, but they were given no specific instructions in that article on how to achieve those goals.[36] In that project, empathy was mentioned under the section "physicians must be altruistic," but no definition of empathy or altruism given.[37]

Since then, some authors have chosen to focus on ways to improve education about empathy. These reports discuss modeling by attending physicians, educational methodologies borrowed from the humanities such as literature-and-medicine courses, and, more recently, courses which involve training in the neurobiology and physiology of empathy.[38] Some researchers postulate that medical student education about empathy is

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[34] Harold I. Lief and Renee C. Fox, "Training for 'Detached Concern' in Medical Students," *The Psychological Basis of Medical Practice,* ed. by Harold I. Lief, Victor F. Lief, and Nina R. Lief (New York, NY: Harper and Row, 1963), 12.

[35] "Medical Schools Objective Project," Association of American Medical Colleges, https://www.aamc.org/initiatives/msop/ (accessed March 28, 2012).

[36] Ibid.

[37] "Report 1: Learning Objectives for Medical Student Education: Guidelines for Medical Schools," *Academic Medicine* 74, no. 1 (January, 1999): 13-8, http://journals.lww.com/academicmedicine/Abstract/1999/01001/Learning_objectives_for_medical_student.10.aspx (accessed July 5, 2012).

[38] Johanna Shapiro, Elizabeth Morrison, and John Boker, "Teaching Empathy to First Year Medical Students: Evaluation of an Elective Literature and Medicine Course," *Education for Health* 17, no. 1 (2004): 73-84; and Helen Riess, John M. Kelley, Robert W. Bailey, Emily J. Dunn, and Margot Phillips,

influenced by a "hidden curriculum" in medical school, which emphasizes values such as entitlement, detachment, and non-reflective professionalism.[39] These values may seem contradictory to the explicit values, such as empathy, which are taught in the curriculum, and students then must work to understand these conflicting messages.[40]

RESEARCH ON EMPATHY

Since its introduction into medicine and medical education, there have been numerous areas of research in the subject of empathy. For example, there has been considerable debate over its proper definition. Mohammedreza Hojat writes that empathy's history is marked by "ambiguity, discrepancy, and controversy among philosophers, and behavioral, social, and medical scholars," and Johnathan Levy said the word has been "troublesome since it entered the language of psychology and psychiatry."[41] In an article discussing aspects of empathy related to the relationship between patient and psychoanalyst, Ralph R. Greenson defines empathy as "to share, to experience the feelings of another person," noting that this experience is in "quality… not the quantity" of feeling.[42] Lief and Fox explain it as "an emotional understanding of the patient, 'feeling into' and being on the same 'affective wave length' as the patient."[43]

"Empathy Training for Resident Physicians: A Randomized Controlled Trial of a Neuroscience-Informed Curriculum," *Journal of General Internal Medicine*, published electronically May 2, 2012, doi: 10.1007/s11606-012-2063-z (accessed July 5, 2012).

[39] Jack Coulehan and Peter C. Williams, "Vanquishing Virtue: The Impact of Medical Education," *Academic Medicine* 76, no. 6 (June, 2001): 600, http://journals.lww.com/academicmedicine/Abstract/2001/06000/Vanquishing_Virtue__The_Impact_of_Medical.8.aspx (accessed July 5, 2012).

[40] Ibid., 598-604.

[41] Mohammedreza Hojat, *Empathy in Patient Care: Antecedents, Development, Measurement, and Outcomes* (New York City, NY: Springer, 2007), 3; and Johnathan Levy, "A Note on Empathy," *New Ideas in Psychology* 15, no. 2 (1997): 179.

[42] Ralph R. Greenson, "Empathy and Its Vicissitudes," *International Journal of Psycho-Analysis* 41 (1960): 418.

[43] Lief and Fox, "Training for 'Detached Concern,'" 12.

Howard Spiro writes in a commentary published in *Academic Medicine* that "for clinicians, empathy is the spontaneous feeling of identity with someone who suffers-fellowship, if you will," while Hojat and his research group define empathy as a "cognitive attribute that involves an ability to understand the patient's inner experiences and perspective and a capability to communicate this understanding."[44] As this sampling of definitions suggest, one source of debate is in regards to the relative roles of cognition versus emotion in the practice of empathy.[45] This view was discussed in an article by Albert Mehrabian and Norman Epstein, who say that research in empathy has "followed two fairly distinct paths, based upon two different definitions of the empathic process:" one cognitive, the other emotional.[46]

The difference between empathy and sympathy has also been contested. In an article entitled "The Empathic Index in the Diagnosis of Mental Diseases," E. E. Southard defines sympathy as "feeling with another" while empathy depends on "how far we *read* or *feel ourselves into*" another.[47] He associates sympathy with "emotional attitude," whereas "effort of imagination" and a "conscious attitude" are important for empathy.[48] Howard Spiro, admitting that the line between empathy and sympathy is

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[44] Howard Spiro, "Commentary: The Practice of Empathy," *Academic Medicine* 84, no. 9 (September, 2009): 1177, doi: 10.1097/ACM.0b013e3181b18934 (accessed December 12, 2011); and Mohammedreza Hojat, Joseph S. Gonnella, Thomas J. Nasca, Salvatore Mangione, Michael Vergare, and Michael Magee, "Physician Empathy: Definition, Components, Measurement, and Relationship to Gender and Specialty," *The American Journal of Psychiatry* 159, no. 9 (September, 2002): 1563, doi: 10.1176/appi.ajp.159.9.1563 (accessed September 30, 2012).

[45] Suzanne Keen, *Empathy and the Novel* (Oxford, United Kingdom: Oxford University Press, 2007), 3-35; Spiro, "Commentary: The Practice of Empathy,"1177-1179; and Halpern, *From Detached Concern to Empathy*, 67-99.

[46] Albert Mehrabian and Norman Epstein, "A Measure of Emotional Empathy," *Journal of Personality* 40, no. 4 (December, 1972): 525, http://dionysus.psych.wisc.edu/lit/Articles/MehrabianA1972a.pdf (accessed September 30, 2012).

[47] Southard, "The Empathic Index," 200.

[48] Ibid.

unclear, says vaguely that "sympathy requires compassion but not passion."[49] One author notes that "whatever will be written about empathy applies in principle also to the concept of sympathy," explaining further that the term "sympathy" might have replaced "empathy" had the research been done years earlier.[50]

The relationship between empathy, altruism, and moral behavior has also been discussed in the literature. Robert Hogan writes that empathy is "an everyday manifestation of the disposition to adopt a broad moral perspective."[51] Using college students asking other college students for help on an assignment, Mehrabian and Epstein found a significant relationship between empathic tendency and helping behavior.[52] A group at the University of Kansas hypothesized a two stage model for empathy's role in helping behavior: "(a) Taking the perspective of a person in need tends to increase one's empathic emotional response; (b) empathic emotion in turn increases motivation to see that person's need reduced."[53]

Authors also disagree over the proper term to use in clinical settings: Is the word empathy appropriate, or are terms such as "clinical empathy" or "empathic understanding" better to use? There has been so much debate over the definition that some authors question the utility of the term. George W. Pigman starts out his article on the history of empathy by stating that "[t]the concept of empathy in psychological

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[49] Spiro, "Commentary: The Practice of Empathy," 1177.

[50] Lauren Wispé, "The Distinction Between Sympathy and Empathy: To Call Forth a Concept, A Word is Needed," *Journal of Personality and Social Psychology* 50, no. 2 (1986): 316.

[51] Robert Hogan, "Development of an Empathy Scale," *Journal of Counseling and Clinical Psychology* 33, no. 3 (1969): 307.

[52] Mehrabian and Epstein, "A Measure of Emotional Empathy," 534-539.

[53] Jay S. Coke, C. Daniel Batson, and Katherine McDavis, "Empathic Mediation of Helping: A Two-Stage Model," *Journal of Personality and Social Psychology* 36, no. 7 (1978): 753.

discussion has come to mean so much that it is beginning to mean nothing."[54] Another author calls for a new term to define concepts embraced by empathy. He suggests, "Involuntary Emotional Identification, Sympathetic Projection, and Sympathetic Understanding" to replace the various setting and meanings that empathy encompasses.[55] Anna Smajdor, Andrea Stöckle, and Charlotte Salter wonder if it is etiquette, rather than empathy, that best describes the qualities toward which physicians should strive.[56]

Another focus has been the measurement of empathy. Mohammedreza Hojat reports that Robert Hogan's Empathy Scale, Albert Mehrabian and Norman Epstein's Emotional Empathy Scale, and Mark Davis's Interpersonal Reactivity Index are the most frequently used tools.[57] Relying on self-report questionnaires, these measurement tools have faced much criticism due to lack of reliability and validation.[58] In an early article discussing the development of the Empathy Scale, Robert Hogan cites even earlier empathy measures, including Willard A. Kerr's Empathy Test from 1947 and Rosalind Dymond's Empathy Test, first published in 1948. Most of the scales measure empathy using varying definitions, and Hojat explains that the "results of studies attempting to determine correlations among different measures of empathy have not been encouraging,"[59] More recently, Hojat's scale, the Jefferson Scale of Physician Empathy, has gained much publicity due to its focus specifically on measuring empathy among healthcare providers.

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[54] Pigman, "Freud and the History of Empathy," 237.

[55] Levy, "A Note on Empathy," 182.

[56] Anna Smajdor, Andrea Stöckle, and Charlotte Salter, "The Limits of Empathy: Problems in Medical Education and Practice," *Journal of Medical Ethics* 37 (2011): 381, doi: 10.1136/je.2010.039628 9 (accessed December 16, 2011).

[57] Hojat, *Empathy in Patient Care*, 66.

[58] Ibid., 66.

[59] Ibid., 72.

Using these measurement tools, some researchers have focused on the influence of empathy on patient care. Hojat and his research group found that diabetic patients of physicians with high empathy scores were significantly more likely to have better Hemoglobin A1c scores (a measure of diabetes control) and LDL-Cholesterol levels.[60] A study by Sung Soo Ki, Stan Kaplowitz, and Mark V. Johnston showed that "the physician's empathic communication skills significantly and substantially influence patient satisfaction and patient compliance."[61] Research conducted by Melanie Neumann's group illustrated how empathy indirectly affected patient depression as well as quality of life by affecting patients' desires to obtain more information about their care.[62] Research using these measurement tools has also shown consistently higher empathy levels in female medical students, as well as in medical students who are interested in primary care specialties.[63] There has also been much research illustrating a decline in empathy throughout medical school, particularly during the third year of medical education.[64]

More recently, researchers have hypothesized about the neurobiological basis for empathy, which may involve mirror neurons. Jonas T. Kaplan and Marco Iacoboni write:

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[60] Mohammedreza Hojat, Daniel Z. Louis, Fred W. Markham, Richard Wender, Carol Rabinowitz, and Joseph Gonnella, "Physicians' Empathy and Clinical Outcomes for Diabetic Patients," *Academic Medicine* 86, no. 3 (March, 2011), 359.

[61] Sung Soo Kim, Stan Kaplowitz, and Mark V. Johnson, "The Effects of Empathy on Patient Satisfaction and Compliance," *Evaluation and Health Professions* 27 (2004): 237-244, doi: 10.1177/0163278704267037 (accessed July 5, 2012).

[62] Melanie Neumann, Marksu Wirtz, Elfriede Bollschweiler, Stewart W. Mercer, Mathias Warm, Jurgen Wold, and Holger Plaff, "Determinants and Patient-Reported Long-Term Outcomes of Physician Empathy in Oncology: A Structural Equation Modeling Approach," *Patient Education and Counseling* 69 (2007): 63-75, doi: 10.1016/j.pec.2007.07.003 (accessed July 5, 2012).

[63] Hojat, et al., "Physician Empathy: Definition, Components, Measurements, and Relationship to Gender and Specialty," 1563-1569.

[64] Mohammedreza Hojat, Michael Vergare, Kaye Maxwell, Geroge Brainard, Steven Herrine, Gerald A. Isenberg, Jon Veloski, and Joseph Gonnella, "The Devil is in the Third Year: A Longitudinal Study of Erosion of Empathy in Medical School," *Academic Medicine* 84, no. 9 (September, 2009): 1182-1191, doi: 10.1097/ACM.0b013e3181b17e55 (accessed July 5, 2012); and Neumann, et al., "Empathy Decline and Its Reasons," 63-75, among others.

> Mirror neurons provide a mechanism by which we can understand the actions of others by mapping the actions of other people onto our own motor system, thus allowing a shared representation of actions. Activating our own motor representation could allow us also to activate motivations and intentions that are associated with those actions. This 'resonance' with another individual can also be viewed as a form of empathy.[65]

A research team led by Laurie Carr explains further that communication between the action representation areas of the brain (superior temporal cortex) and the emotional processing part of the brain (the limbic system) is part of the process that allows us to understand and mimic others' emotional responses.[66] This means that as we observe others' actions, we represent those actions within our brains, which may help us to understand and empathize with them.[67]

In terms of this research, it is clear that previous studies about empathy have several significant deficits, particularly with regard to medical students' understanding of empathy. First, the studies do not focus on the impact of the personal history of the student as a platform for their understanding and use of empathy. Neither do they address the student's educational environment on his or her conceptualization of empathy and, indeed, do not even ask students how they conceptualize the term. Additionally, the research does not address the relationship between empathy and patient outcomes as the student understands this relationship. In other words, we have little understanding of whether and how students find empathy useful in the practice of medicine.

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[65] Jonas T. Kaplan and Marco Iacoboni, "Getting a Grip on Other Minds: Mirror Neurons, Intention Understanding, and Cognitive Empathy," *Social Neuroscience* 1, no. 3-4 (2006): 175, doi: 10.1080/17470910600985605 (accessed July 5, 2012).

[66] Laurie Carr, Marco Iacoboni, Marie-Charlotte Dubeau, John C. Mazziotta, and Gian Luigi Lenzi, "Neural Mechanisms of Empathy in Humans: A Relay from Neural Systems for Imitation to Limbic Areas," *PNAS* 100, no. 9 (April 23, 2003): 5497, www.pnas.org/cgi/doi/10.1073/pnas.0935845100 (accessed July 5, 2012).

[67] Helen Riess, "Empathy in Medicine—A Neurobiological Perspective," *JAMA* 304, no. 14 (October 13, 2010): 1604.

CRITIQUES OF EMPATHY

Though the researchers cited above overwhelmingly view empathy as positive, there are critiques of the concept. E. E. Southard's article hints at two possible criticisms: That we may only empathize with those similar to us and that empathy may lead to methods of oppression and stigmatization. As his interest is whether the psychiatrist can empathize with those possessing various psychopathologies, Southard systematically discusses each of the eleven groups of psychopathologies known at the time and whether the psychiatrist can empathize or not with these groups. This is an indicator of each group's "empathic index," which Southard states is valuable as a diagnostic marker and as an indicator for psychiatrists of their own emotional baggage.[68] The premise of Southard's article depends on a psychiatrist's ability to "homologize himself with [the patient], animate him… with his own type of soul, and see his own reflection in his difficulties."[69] He states, "We read ourselves or feel ourselves into these kindred persons on the basis of their resemblance to us—their touches of nature."[70]

Southard's insistence that empathy is based upon similarities raises the question of whether attempts at empathy may be projections of the physician's feelings onto the patient (a danger of which Freud was aware) or whether empathy is based upon false assumptions about similarities in emotional experience among people.[71] Along these same lines, Suzanne Keen explains that the critique of what she calls "false empathy" "stems from the conviction that humans do not share basic emotions, neither in the culturally diverse contemporary world, nor back in time, nor yet in prehistory on the

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[68] Southard, "The Empathic Index," 208, 213.
[69] Ibid., 206.
[70] Ibid.
[71] Pigman, "Freud and the History of Empathy," 248.

savannah."[72] She continues, saying that some people view empathy as "antipathy under the guide of compassion," with some believing that "a sense of shared feeling does violence to the object of one's regard and hurts the object through aggressive identification or projection."[73]

Additionally, Keen discusses five criticisms that postcolonial theorists have posed about empathy. First, she writes that these critics believe that empathy (as studied within the field of psychology) "depends upon generalizations about universal human traits" and draws conclusions based upon research studies using college student age populations.[74] They also take issue with neurobiological theories of empathy as they "[give] short shrift to both cognition and culture."[75] Furthermore, "the directional quality of empathy offends because an empathizer feels with a subject who may or may not be empowered to speak for herself, to correct misconceptions about her feelings, and to refuse the pitying gaze."[76] Finally, empathy may precede attempts at colonization or improvement programs because the belief in "knowing" how someone feels may lead the empathizer to claim leadership or ownership over those with whom they "empathize."[77]

This discussion also brings up the question of what occurs when one cannot empathize. Southard's use of the term and Keen's discussion of postcolonial theory seem to hint at the potential for further stigmatization for those patients with whom physicians cannot empathize and for physicians who cannot empathize with their patients.[78] The association of empathy with moral (or other forms of personal) development may be

[72] Keen, *Empathy and the Novel*, 160.
[73] Ibid., 159.
[74] Ibid., 162
[75] Ibid.
[76] Ibid.
[77] Ibid.
[78] Southard, "The Empathic Index," 206-213; and Keen, *Empathy and the Novel,* 162.

problematic as well, as it allows for those judged to be less empathetic to be labeled as 'less developed.' Combined with Southard's discussion of empathy as the process of relating to someone who is like oneself, the potential for harmful stigmatization is present, which may then contribute to unequal treatment.

MEDICAL PROFESSIONAL SOCIALIZATION LITERATURE

Socialization is a "process (sometimes involving rituals, ceremonies, and/or rights of passage) by which initiates/neophytes/'outsiders' acquire or internalize the norms (and normative behaviors, value systems (and related rationales supporting that value system), skills, and language (e.g., the culture) of a desired society, organization, or group."[79] Related to the present discussion, medical student socialization is the process by which medical students acquire the norms, values, and behaviors of the medical profession. There has been little research in recent decades on the socialization of medical students, and Frederic Hafferty writes that "forty years ago, the two most frequently cited studies on medical student training and socialization were Robert Merton and colleagues' *The Student Physician* (1957) and Howard Becker and colleagues' *Boys in White* (1961).[80] He goes on to say that this remains the case today.[81] Within the socialization literature, there has been much written on the development of a "professional identity" among medical students and the factors that contribute to this process.[82] Part of this identity

[79] Hafferty, "Medical School Socialization," 2930-2931.
[80] Ibid., 2930.
[81] Ibid.
[82] K.H. Pitkala and T. Mantyranta, "Professional Socialization Revised: Medical Students' Own Conceptions Related to Adoption of the Future Physician's Role—A Qualitative Study," *Medical Teacher* 25, no. 2 (2003): 155.

includes maintaining control of one's affect despite stressful and emotional experiences.[83] Though it is rare to encounter explicit discussion of empathy, research on the professionalization process and the management of affect relate to empathy since both influence how students view and interact with their patients.

Robert K. Merton in *The Student-Physician: Introductory Studies in the Sociology of Medical Education* writes that "[t]he profession of medicine… has its own normative subculture, a body of shared and transmitted ideas, values and standards toward which members of the profession are expected to orient their behavior."[84] Of the values of medical culture, he explains that "for each norm there tends to be at least one coordinate norm, which is, if not inconsistent with the other, at least sufficiently different to make it difficult for the student and the physician to live up to them both."[85] Throughout medical school, students learn to make sense of these contradictions and form "consistent and stable patterns of professional behavior."[86]

Merton goes on to list twenty-one values and their companionate, contradictory values. Under the heading "Values Governing the Physician-Patient Relationship," he lists the value:

> 8. The physician must be emotionally detached in his attitude toward patients, keeping 'his emotions on ice' and not becoming 'overly identified' with patients.
> *But:* he must avoid becoming callous through excessive detachment, and should have compassionate concern for the patient.[87]

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[83] Allen C. Smith, III and Sherryl Kleinman, "Managing Emotions in Medical School: Students' Contacts with the Living and the Dead," special issue, Sentiments, Affect, and Emotion, *Social Psychology Quarterly* 52, no. 1, (March, 1989): 57, http://www.jstor.org/stable/2786904 (Accessed March 28, 2012).

[84] Merton, "Some Preliminaries," 71.

[85] Ibid., 72.

[86] Ibid.

[87] Ibid., 74.

Merton's language here is similar to that used in the discussion of the "detached concern" form of empathy. Since making sense of the contradictions inherent in the concept of "detached concern" is part of the formation of a professional identity, Merton's inclusion of this value suggests that the development of empathy is part of the socialization process of medical students.

The authors of *Boys in White: Student Culture in Medical School* devote a chapter of their book to medical student's impressions of working with patients. The authors state that the student-patient relationship is influenced by aspects of medical student and medical professional culture, as well as the students' personal backgrounds.[88] Becker and his group, however, felt that the interactions are influenced most by the students' status as medical students and "with the limitations and… disabilities of that role."[89] The influence of what they termed "student culture" was illustrated by students' viewing patients as "interesting cases" or a waste of time based upon a patient's perceived educational value as well as by the role that anxieties and desires to impress attending physicians played in student-patient interactions.[90]

Harold I. Lief and Renee C. Fox's article "Training for 'Detached Concern' in Medical Students," deals with the ways in which medical students develop attitudes of detached concern toward patients as a consequence of some of their experiences in medical school."[91] They suggest that events such as the anatomy lab, autopsies, and various experimental and laboratory activities using urine, live animals, and blood

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[88] Howard S. Becker, Blanche Geer, Everett C. Hughes, and Anselm L. Strauss, *Boys in White: Student Culture in Medical School* (Chicago, IL: University of Chicago Press, 1961; Piscataway, NJ: Transaction Publishers, 1977), 313.

[89] Ibid., 314.

[90] Ibid., 327-338.

[91] Lief and Fox, "Training for 'Detached Concern,'" 12.

promote the socialization of "detached concern" in students. Lief and Fox also discuss defense mechanisms that students develop in response to the pressures and responsibilities of medical school and patient care, such as humor and an intense focus on the memorization of scientific facts; these strategies allow students to avoid reflection on the emotional aspects of an encounter through focusing on other aspects of patient encounters or medical education.[92] In other words, these defense mechanisms allow the students to maintain their "detached concern."

Jack Haas and William Shaffir published *Becoming Doctors: The Adoption of a Cloak of Competence* in 1987. Analyzing aspects of medical school—from application essays required for admission through classes and course assignments and, later, encounters with patients—Haas and Shaffir found that medical students "learn to adopt and manipulate the symbols of their profession… [creating] an imagery as being authoritative."[93] Furthermore, as part of their professionalization, medical students adopted a "symbolic-ideological cloak of competence" in which they minimized their inner and outer emotional reactions.[94] In a professionalization process marked by uncertainty and powerlessness, this "cloak of competence" allowed students to "gain a measure of control—not only social control of others but also to gain control of the self."[95]

More recent articles rearticulate these same ideas. Peter Conrad, reviewing first-hand accounts of medical education, writes, "There is almost nothing in medical training that encourages compassion, empathy, and 'care' for patients; indeed there is a great deal

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[92] Lief and Fox, "Training for 'Detached Concern,'" 16-21.

[93] Jack Haas and William Shaffir, *Becoming Doctors: The Adoption of a Cloak of Competence* (Greenwich, CT: Jai Press, 1987), 104.

[94] Ibid., 109.

[95] Ibid.

that militates against those qualities."[96] Allen Smith and Sherryl Kleinman note that medical school, despite not explicitly acknowledging feelings that students might have about the patients (and bodies) they encounter, nonetheless "provide students with supports and guidelines for managing their emotions."[97] They mention five emotion management strategies used by students, which allow students to "reproduce that [medical] culture, creating a new generation of physicians who will support the biomedical model of medicine and the kind of doctor-patient relationship in which the patient is too frequently dehumanized."[98] These strategies included transforming the contact into a scientific task, accentuating the positive aspects of the contact (including its educational value), "using" the patient (either through blaming the patient for causing certain emotions or empathizing) to avoid addressing their own emotions, "finding humor" in situations that make them uncomfortable to "relieve the tension without having to admit weakness," or avoiding patient contact all together.[99] Of empathizing with the patient, Smith and Kleinman mention that it "diminishes the students' discomfort and directs attention to the patient's feelings and circumstances."[100] Of course, empathizing with the patient may actually increase the students' discomfort as well.

As mentioned earlier, Halpern discusses how "detached concern" has been the form of empathy advocated by mainstream medicine. All the research discussed in this section emphasizes the detached nature of the students' interactions with patients. The authors emphasize the emotional control that students learn to acquire as they move

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[96] Peter Conrad, "Learning to Doctor: Reflections on Recent Accounts of the Medical School Years," *Journal of Health and Social Behavior* 29, no. 4 (December, 1988): 329.

[97] Smith and Kleinman, "Emotions in Medical School," 60-66.

[98] Ibid., 67.

[99] Ibid., 60-65.

[100] Ibid., 67.

through medical school. More than that, learning to manage their affect is part of the socialization process and vital for the formation of a "professional" identity. This suggests that empathy plays a role in this socialization process.

Chapter 4 Empathy Lessons: Mastering the Performance of Interpersonal Skills

It is important to describe both the settings and the actors involved in negotiating the meaning of empathy and how it should be embodied. I have chosen to use theatrical terminology to describe the ways that empathy is used in training students to convincingly 'play' doctor: as in a theatrical performance, students must memorize lines and body movements, learn to dissimilate their true emotions and act interested on cue, and they must rehearse scenes in advance. They have props and wardrobes, and there is a large supporting cast of characters, including peers, attending physicians, residents, other healthcare providers, and patients. In addition, there is an operating theater that is rarely discussed but whose influence is always felt; i.e. various cultural, social, professional, economic, institutional, and political forces that influence the care students provide and which they must negotiate in order to graduate and enter the residency of their choice. Empathy lessons help students develop the appropriate emotional response to patients as they internalize their roles as future physicians. The performance includes creating individual interpretations and making the role of doctor one's own. Performing empathy is an aspect of being a 'medical professional' and therefore becomes incorporated into lessons on professionalism in the undergraduate medical curriculum.

Empathy education provides medical students with a skillset or toolkit for playing the role convincingly. The toolkit gives students specific skills for handling patient encounters, teaching them what to say, what props to use, and how to dress while interacting with patients. With this circumscribed role, the toolkit is effective but omits overt discussion of larger imperatives—historical, structural, and economic—that affect

the medical profession and guide the lessons that students are taught through the curriculum. The result can be a disjunction between the content of formal education about empathy and the lived experience of it by students.

The empathy toolkit that is currently taught in academic medicine fits within the framework of market-based medicine that has come to dominate healthcare over the past few decades, particularly with the rise of managed care.[101] As Barbara Rylo-Bauer and Paul Farmer explain, "The orientation increasingly is one of selling 'product' rather than providing care, to 'consumers' and 'clients' rather than to patients, with a reliance on competition to control costs and encourage 'efficiencies.'"[102] This means that healthcare is increasingly seen as a commodity, which potentially limits access to care for poor and minority populations.[103] Under this model, maximization of profit, rather than the provision of good patient care, becomes a prominent goal. This market-based model values evaluation and accountability in order to monitor profit-making for the institution and physician at the cost of good, caring health care for the patient. This means that shortened appointment times, ordering of unnecessary tests, and a preference for insured patients becomes normalized. A focus on physician output and institutional income leads to empathy being taught to students in a way that serves the educational assessment needs of the institution as opposed to a more open-ended and less tangible and quantifiable approach that might meet the varied psychosocial needs of the patient: "Medicine as business is bound not by obligations of justice but, rather, those of economics and the

[101] Barbara Rylko-Bauer and Paul Farmer, "Managed Care or Managed Inequality? A Call for Critiques of Market Based Medicine," *Medical Anthropology Quarterly* 16, no. 4 (2002): 476, http://www.jstor.org/stable/25487792 (accessed November 14, 2012).

[102] Ibid., 479.

[103] Ibid., 477.

bottom line."[104] Faculty incentive plans are linked to these evaluation measures, too. In the end, the market-based model of medicine is used to appraise student achievement, including success at performing empathy.[105]

Market-based medicine models present challenges to traditional ideas about physicians' relationships "with patients, with each other, and with society."[106] When healthcare is a commodity, business ethics determine healthcare decision-making. This differs from the traditional professional ethics in many ways. Edmund Pellegrino writes that professional ethics "sees health care not as a commodity but as a necessary human good, its primary principle is beneficence, and it is patient-oriented."[107] Altruism is considered a part of professional ethics, as well.[108] Business ethics, on the other hand, is "investor—or corporate—oriented, its attitude is pragmatic, and it legitimates self-interest, competitive edge, and unequal treatment based on unequal ability to pay."[109] The contrasts in approaches to patient care mean that physicians are constantly faced with the task of balancing professional and business ethics, and the increasing normalization of market-based care has effects on the physician-patient relationship. When healthcare is seen as a commodity, access issues fade and the physician-patient relationship is

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[104] Rylko-Bauer and Farmer, "Managed Care or Managed Inequality?" 479.

[105] Charles Stiernberg, "Compensation and Incentive Plans for Physicians," (document available on the University of Texas Medical Branch website, published December 7, 2001), http://www.utmb.edu/otoref/Grnds/Compensation_11-2001/Compensation_11-2001.pdf (accessed December 10, 2012); and University of Texas System Board of Regents, "A Framework for Advancing Excellence Throughout The University of Texas System: Action Plan," (document available on the Framework for Advancing Excellence portion of the University of Texas System website, August, 2011), http://www.utsystem.edu/sites/utsfiles/news/assets/FrameworkActionPlan-08-25-11.pdf (accessed December 10, 2012).

[106] Edmund D. Pellegrino, "The Commodification of Medical and Health Care: The Moral Consequences of a Paradigm Shift from a Professional to a Market Ethic," *Journal of Medicine and Philosophy* 24, no. 3 (1999): 244, http://jmp.oxfordjournals.org/content/24/3/243.full.pdf+html (accessed December 4, 2012).

[107] Ibid., 254.

[108] Ibid.

[109] Ibid.

largely valued in terms of its ability to maximize profit. Physicians may feel that viewing the patient in this way increases access to care and improves quality of care.[110] However, turning healthcare into commodity ultimately dehumanizes the patient and leads to reduced access to care for those without health insurance.[111] In medical education, however, professional ethics are emphasized and explicitly discussed, while business ethics remain largely unacknowledged.

As UTMB moves to a corporate model of doing business, the "Highly Satis5ied" campaign and the faculty incentive plans are part of the configuration and marketization of medicine at UTMB, and empathy education itself becomes another tool to increase customer satisfaction, which ultimately increases profit for the institution. These imperatives are largely left out of classroom discussions, although they are ever-present through the "Highly Satis5ied" customer-service campaign, which links patient or "client" satisfaction to department budgets. National healthcare reforms have also brought renewed attention to the problems of the commercialization of healthcare (e.g. huge costs and poor outcomes) and to debates over whether healthcare should be viewed as a commodity or a "shared responsibility."[112]

In what follows, I discuss the settings and the cast of characters involved in staging empathy in medicine, and I provide a working definition of the term. For the purposes of this chapter, I will consider two general settings for students' education: UTMB School of Medicine coursework and clerkships on wards and in clinics and the St.

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[110] Pellegrino, "The Commodification of Medical and Health Care," 255-256.

[111] Rylko-Bauer and Farmer, "Managed Care or Managed Inequality?" 476-502; and Pellegrino, "The Commodification of Medical and Health Care," 243-266.

[112] Anja Rudiger, "From Market Competition to Solidarity: Assessing the Prospects of US Health Care Reform Plans from a Human Rights Perspective," *Health and Human Rights* 10, no. 1 (2008): 123-135, http://hhrjournal.org/index.php/hhr/article/viewFile/23/114 (accessed December 9, 2012).

Vincent's Student-Run Free Clinic. I have focused on these two settings due to the frequency with which they were cited in individual interviews with students about the part played by empathy in their medical education. Additional settings relevant to particular students will be discussed in the next chapter. With the settings and cast of characters established, I will examine the materials on empathy given to students in their coursework at UTMB and discuss faculty members' ideas about empathy education. I will also talk about the role that simulated and standardized patient activities play in student's empathy education and role performance. I will conclude by explaining the curricular aspects of the Humanities, Ethics, and Professionalism course at UTMB, highlighting how it both reinforces the toolkit provided to the students elsewhere in their medical education and also offers the possibility of expanding the discussion to incorporate less tangible and less quantifiable aspects of patient care.

OVERVIEW OF THE SETTINGS AND CAST OF CHARACTERS

At UTMB, formal education occurs in the classroom during lectures, small group sessions facilitated by physician and non-physician faculty members, in clinics, and on the hospital wards, and informally in extra-curricular settings such as St. Vincent's, which is staffed by UTMB medical, nursing, and health profession students, such as clinical laboratory science students, with attending physicians and residents from UTMB serving as preceptors. The clinic's patients are generally the uninsured who often have few other options for healthcare. At St. Vincent's, medical students are given the opportunity to rehearse their lines and practice playing the part of physician, as they begin to make meaning of and internalize their roles as empathetic healers. For this study, I interviewed five physician faculty members and one non-physician faculty

member who serve as the supporting cast for the students at UTMB. These six were chosen due to their current or previous involvement in medical school curricular planning in some form, such as for the Practice of Medicine (POM) courses, standardized patient exercises, and through the development of lectures, small group activities, and simulated patient exercises, as noted in the Methods chapter. These classes and activities were most frequently cited by students as being integral to their empathy education. Four of the five physician faculty members taught students in clinic, as well, and all five physicians facilitated POM small group sessions, which will be discussed in more detail later.

The cast is much larger than the faculty members, however. Students also learn lessons from their peers and from their interactions with patients. Students' lessons often occur in groups, ranging from lectures to the entire class of approximately 200 students to teams of two or three students working together on wards, and peers are generally part of the audience for students' performances in front of patients and attending physicians. The patients that students encounter at UTMB wards and clinics and St. Vincent's also help the students develop their roles as physicians. The patients whom students encounter in both settings are generally of lower socioeconomic status and often have an array of cultural differences from the students who are treating them; this means that students often perceive these patients as requiring empathy in order to understand them better. Language barriers are common at both St. Vincent's and UTMB, and patients in both settings often face numerous barriers to receiving healthcare, including economic constraints on their care. Students must also complete standardized and simulated patient encounters throughout their medical school experience, either with trained actors serving as patients or with interactive mannequins simulating patients

voiced by faculty members in another room or by pre-programmed, scripted recordings. Now that the stage has been set and an overview of the cast of characters provided, I will move on to consider more specific aspects of empathy education at UTMB, including course materials, faculty discussions, standardized patient exercises, and the Humanities, Ethics, and Professionalism course.

THE SYMBOLIC MEANINGS OF EMPATHY IN MEDICAL EDUCATION AT UTMB

Empathy was rarely recalled by interviewees as a competency explicitly taught as part of the medical curriculum at UTMB; yet all the students and physicians with whom I spoke believed that it was part of their education. Upon exploring their understandings of empathy education at UTMB, it became evident that students and faculty associated lessons learned about all aspects of the patient interaction and physician role-playing with empathy education, including what students should say to the patient, how they should touch the patient, how they should relate to patients, and how they should handle challenging encounters. This means that lectures on topics such as cultural competency, medical interviewing skills, and discussing bad news are all considered part of empathy education. Oftentimes, these lectures provided sample lines for the students to memorize, so that they could better play the role of an empathetic physician. Students were also given opportunities to rehearse their lines during activities assigned for class, such as role-playing scenarios in small groups or standardized patient exercises.

The students and faculty I interviewed most often referenced the POM 1 and 2 courses as containing the most explicit empathy education. POM 1 is taught during the first year of medical school, and POM 2 is a continuation of the course during the second year of medical education. There are also POM 3 and POM 4 activities, during the

students' third and fourth years of medical school, but these consist of once a month dinner discussions with faculty preceptors and participation is voluntary. Generally, the POM courses teach students lessons about behaving as a doctor and interacting with patients as a medical professional. It is illustrative of the use of the word empathy at UTMB (as a catch-all term for lessons dealing with patient interaction) that these courses are so strongly associated with empathy education.

The POM syllabi do not explicitly mention that empathy education is a learning objective for the classes; yet they do identify other aspects of the physician-patient encounter as within their domains. For example, the POM 1 Syllabus states that the course "addresses the development of knowledge, skills, attitudes, and behaviors that are necessary to practice both the art and science of medicine in an optimal manner."[113] The course is comprised of three components, which, according to the syllabus, are as follows:

> 1. Clinical skills acquisition including development of optimal listening and communication methods for effective history taking and the performance of a complete and accurate physical exam.
> 2. Understanding the ethical and professional, as well as cultural, age, gender, and ethnic issues of patients and the relevance of these to optimal patient care.
> 3. Development of abilities in clinical reasoning, including formulation of clinically relevant questions and ability to obtain and critically evaluate scientific evidence pertaining to basic science and clinical studies. This will include interest in and ability to conduct life-long, self-directed learning.[114]

As stated, POM 1 students learn physical exam and interviewing skills and are also given the opportunity to talk about challenging situations in the clinic, such as cultural differences, ethical dilemmas, and difficult patients. However, within course objectives,

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[113] Susan M. Gerik, Keith Bly, and Lem Aigbivbalu, *Practice of Medicine—Year One*, (course syllabus, 2009-2010), 3, eclass.utmb.edu (accessed December 5, 2012). This syllabus has since been updated and is no longer used.

[114] Ibid.

there is no mention of how economic or class differences may affect care, despite the fact that the marketization of medicine decreases access to healthcare for poor populations.[115] As mentioned above, the UTMB main campus is located among a large indigent population, and UTMB students volunteer at a student-run free health clinic that treats patients that cannot be seen at UTMB due to their inability to pay; class and economics, then, shape the setting of the students' education. Discussion of the economic aspects of healthcare is also left out of the objectives, leaving the impression that it has little to no relevance to 'optimal patient care' or clinical trials. All these topics fall within the realm of empathy education when it is understood as lessons in patient interaction.

The POM 1 syllabus authors add that an "excellent physician requires integrity, compassion, and knowledge," and the course materials are to help in the development of these qualities.[116] The students and faculty whom I interviewed often considered empathy and compassion closely related, which is another reason that POM is associated with empathy education. "Integrity, compassion, and knowledge" are similar to the qualities listed in the Medical School Objectives Project (MSOP) as ones which should be developed during medical school, though in that project, empathy education is listed under the section about the importance of altruism.[117] The various names and headings under which empathy falls is representative of the literature on the topic, which reflects variation and even confusion of terms.[118] For example, at UTMB, synonymous or

[115] Rylko-Bauer and Farmer, "Managed Care," 487-489.
[116] Gerik, et al., *Practice of Medicine—Year One*, 3.
[117] Ibid.
[118] Mohammedreza Hojat, *Empathy in Patient Care: Antecedents, Development, Measurement, and Outcomes* (New York City, NY: Springer, 2007), 3; and Johnathan Levy, "A Note on Empathy," *New Ideas in Psychology* 15, no. 2 (1997): 179.

conceptually similar terms such as altruism and professionalism are often preferred to empathy.

The POM 2 course directors list similar objectives in their syllabus and explain that "this course will expand your [the medical student's] basic knowledge and skills in history taking, physical examination, clinical problem solving, medical ethics, prevention, behavioral medicine, and evidence-based medicine."[119] The course includes many of the same topics as POM 1, including difficult patient encounters, cultural competency issues, and physical examination skills. These lessons cover the interpersonal aspects of the medical profession.

One second-year medical student described the association between discussions in POM 1 and lessons about empathy. In particular, she mentioned sessions with faculty members from the Institute for the Medical Humanities (IMH) during POM 1. These mostly non-physician faculty members would join the small group sessions in POM 1, which were facilitated by physician faculty members, to talk about special topics such as pharmaceutical company influence on prescribing practices, truth telling, and the use of social media. This student felt that these sessions were particularly focused on interacting with the patient.

> They definitely stressed trying to understand what's going on in your patients' lives, trying to understand what factors are affecting their health care including how they are feeling about their own health care and about their family situations and job and…money and I think, I think empathy was definitely a part of that.

This student explicitly makes the connection between discussions about the influences on healthcare provision and empathy education. Since small group sessions in POM 1 are

[119] Bernard Karnath and Cheryl Vaiani, *Practice of Medicine Year 2* (course syllabus, June 28, 2010- April 8, 2011), 5, eclass.utmb.edu (accessed December 5, 2012).

largely focused on teaching students physical examinations and basic interviewing skills, with the physician faculty facilitator as the intended audience, visits from IMH faculty members provided a place to discuss in further detail the experience of the student or healthcare provider, including more emphasis on medical culture, barriers to care, and biases and stereotypes about patients, which were linked to empathy in this student's mind.

Students were not the only ones who associated lessons on patient interaction with empathy education. One physician mentioned how empathy underlined many discussions about patients both in class and on the wards, adding that the word empathy was not generally used in conversations during the formal coursework of POM1 and POM 2. Still, she expected that the students were learning about empathy, though by another name.

> Well, we talk about… altruism, which is not exactly empathy, you know but it's sort of in that same ballpark. And, um, and I think we talk about it in a sort of a less tangible way than naming it. But it is part of the discussion. It's on the table for each of the patients that we see, like, in clinic and our standardized patients that come to the rooms and the taped patient encounters.

As mentioned previously, empathy is mentioned under the heading "Physicians Must be Altruistic" in the MSOP and this physician's conflation of the terms perhaps reflects the same reasoning as that used in the MSOP.[120] Another physician who had previously been involved in POM curricular development agreed that empathy was not discussed explicitly throughout the course and added that empathy education was couched in discussions about professionalism and altruism. As illustrated here again, empathy

[120] "Report 1: Learning Objectives for Medical Student Education: Guidelines for Medical Schools," *Academic Medicine* 74, no. 1 (January, 1999): 13-8, http://journals.lww.com/academicmedicine/Abstract/1999/01001/Learning_objectives_for_medical_student.10.aspx (accessed July 5, 2012).

education is associated with lessons on altruism, compassion, and professionalism through the students' education.[121]

The understanding of empathy as covering topics on patient interaction continues into the third and fourth year of medical education when students are working in the hospital and clinics. The faculty members with whom I spoke said that there were often moments, such as during rounds or when seeing patients throughout the day, when informal lessons about empathy were taught. One physician explained that, while empathy was not mentioned specifically, it entered into discussions that occurred on the wards about the patient's experience of healthcare.

> Just, you know, having concrete discussions about what the experience is for the patient. You know, in the context of their families before they come into the hospital, in the dynamic between the family and the healthcare providers while they're in, and then the specific experience of their illness and evaluation, and feeling or not.

Yet discussions where the experience of the patient occurs would often happen only after patients were perceived as noncompliant or challenging, and patients are labeled as noncompliant and challenging when their behavior does not comport with medical advice.[122] Emphasis would be placed on trying to understand why a patient or patient's family was interacting with the healthcare team in a way that seemed counterproductive, and strategies to increase cooperation would be discussed as well. Discussions about compliance are also discussions about the "proper roles of patients and physicians" and about power hierarchies, two influences which have been largely ignored in the medical

[121] This is reflected in the literature. See Mohammedreza Hojat, *Empathy in Patient Care*, 3; and Johnathan Levy, "A Note on Empathy," *New Ideas in Psychology* 15, no. 2 (1997): 179.

[122] See R. Brian Haynes, *Compliance in Health Care* (Baltimore, MD: Johns Hopkins University Press, 1979).

literature, though they are discussed in the social sciences.[123] Furthermore, compliance discussions have a large economic component, as "pharmaceutical companies use compliance today as a promotional strategy to increase market share and product sales," meaning that compliance becomes a large part of the rhetoric of advertising.[124] Faculty members and students associate these teaching moments in the hospital with empathy education due to their emphasis on communication. They also teach students how to navigate market-based care. Additionally, there was very little discussion about medical culture or how efforts to increase cooperation or compliance could become manipulative. James A. Trostle writes, "The compliance literature at its most coercive teaches physicians how to manipulate their patients' behavior without questioning their own beliefs or increasing their patients' understandings."[125] Students might sense these dynamics but are not given much opportunity to explore them within the curriculum.

Empathy lessons were not confined to learning how to interact with patients, however. One non-physician faculty member explained how empathy education was about teaching the students how to interact with all members of the healthcare team; empathy education is professionalism education.

> Associated [with] if not actually teaching empathy is [teaching them] how to conduct themselves in a small group when they deal with patients… faculty, attendings, other levels… so you kind of teach them the rules of… appropriate behavior, if you will.

Empathy education for this faculty member encompassed other relational aspects of being a medical student and included the means by which students were expected to learn

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[123] James A. Trostle, "Medical Compliance as an Ideology," *Social Science and Medicine* 27, no. 12 (1988): 1299, http://dx.doi.org/10.1016/0277-9536(88)90194-3 (accessed November 26, 2012).

[124] Ibid., 1299.

[125] Ibid.,1305.

proper behavior in situations arising with other members of the healthcare team. Empathizing with these members of the team, particularly when deemed "behaving appropriately," suggests that students should recognize the hierarchical structures of the healthcare team and know their place within it in order to correctly play the role of doctor.[126] Authors in one article reported that "[s]tudents' professionalism has been questioned when they disagree with a team on a patient history, question the appropriateness of a consent process, report duty hours violations, make an unpopular choice of health insurance for themselves, request their own academic records, or ask for a remedy to a grading error."[127] Professionalism, then, is used to promote student compliance with institutional rules. The same authors noted that professionalism issues regarding resident and faculty were "protected by an established hierarchy of medicine."[128] The paradox is that students must be empathetic and compassionate with their patients, while the medical hierarchy emphasizes compliance and normative behavior that can be at odds with empathy.

These quotations reflect the recent links between professionalism violations and disciplinary measures.[129] 'Professionalism' violations, determined subjectively and

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[126] See Howard S. Becker, Blanche Geer, Everett C. Hughes, and Anselm L. Strauss, *Boys in White: Student Culture in Medical School* (Chicago, IL: University of Chicago Press, 1961; Piscataway, NJ: Transaction Publishers, 1977), 240-241 for more discussion on the place of the student within the hierarchy and how it relates to their training opportunities in the clinic.

[127] Andrew H. Brainard and Heather Brislen, "Viewpoint: Learning Professionalism: A View from the Trenches," *Academic Medicine* 82, no. 11 (January, 2007): 1011, doi: 10.1097/01.ACM.0000249911.79915.4d (accessed November 26, 2012).

[128] Ibid., 1010.

[129] See Patrick Duff, "Teaching and Assessing Professionalism in Medicine," *Obstetrics and Gynecology* 104, no. 6 (December, 2004): 1363-1364, doi: 10.1097/01.AOG.0000146287.86079.d9 (accessed November 23, 2012); Maxine A. Padakis, Carol S. Hodgson, Arianne Teherani, Neal D. Kahatsu, "Unprofessional Behavior in Medical School Associated with Subsequent Disciplinary Action by the State Medical Board," *Academic Medicine* 79, no. 3 (March, 2004): 244-249, doi: http://medicine.osu.edu/sitetool/sites/pdfs/studentaffairspublic/Unprofesssional_Behavior_State_Medical_Board.pdf (accessed November 26, 2012); and Valerie Fournier, "The Appeal to 'Professionalism' as a

including a variety of behaviors such as dress code violations, failure to turn in course evaluations, cheating on examinations, and violations of patient privacy, lead to disciplinary action (generally in the form of failing grades and notes in the students' records). The discipline, however, is intended to encourage the student to abide by what are deemed professional values.[130] Though these disciplinary measures are supposed to help students internalize the values of the larger medical profession, upon closer scrutiny, the space between the values of medicine and those of the market blur. For example, behaviors such as wearing one's uniform, arriving on time, and maintaining the privacy of one's patients are also good for customer satisfaction and are only distantly related to qualities such as altruism, which were originally associated with the professionalism movement. In fact, one author encouraged internal medicine physicians to commit themselves to the professionalism movement as a way to market themselves to customers and compete with other specialties.[131] This author wrote, "The values and culture must reinforce this expert clinician as a valuable product."[132] This is despite the professionalism movement's original development in opposition to market-driven trends

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Disciplinary Mechanism," *The Sociological Review* 47, no. 2 (1999): 280-307, doi: 10.1111/1467-954X.00173 (accessed November 26, 2012) for more examples.

[130] Maxine A. Padakis, Helen Loeser, and Kathleen Heady, "Early Detection and Evaluation of Professional Deficiencies in Medical Students: One School's Approach," *Academic Medicine* 76, no. 11 (November, 2001): 1100-1106, http://ecommons.med.harvard.edu/ec_res/A94E728C-7B25-4633-9F53-CE36DA29F3A8/Workshop_2_papadakis-healy.pdf (accessed November 26, 2012); and William H. Shrank, Virginia A. Reed, and G. Christian Jernstedt, "Fostering Professionalism in Medical Education: A Call for Improved Assessment and Meaningful Incentives," *Journal of General Internal Medicine* 19, no. 8 (August, 2004): 887-892, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1492501/ (accessed November 26, 2012).

[131] Richard Ervin, "Strategic Business Planning for Internal Medicine," *The American Journal of Medicine* 101, issue 1 (July, 1996): 98, http://dx.doi.org/10.1016/S0002-9343(96)00068-X (accessed July 26, 2012).

[132] Ibid.

in medicine.[133] Institutional imperatives that support the maintenance of this hierarchical structure and particular behaviors towards patients and other healthcare professionals are left out of the discussion in the classroom, and a paradox exists in the fact that students must be empathetic with patients while existing within a framework of rigid hierarchies within medical education.

As illustrated here, empathy education at UTMB encompasses anything and everything having to do with the interpersonal aspects of medicine. It is a rhetorical device, and students must engage in the interpretive work after curricular discussions to figure out their own individualized, lived understandings of it. Yet its use as rhetorical device has real consequences for the students, the patients, and the institution at large. Students are evaluated on their empathy skills, and their success in medical school depends on these evaluations. Empathy education also plays a role in guiding students in internalizing the values of the medical profession. This has a large impact on patient care as medicine becomes more profit-focused and healthcare becomes more of a commodity.[134] As I will discuss next, empathy education at UTMB is focused on teaching students a toolkit to guide them towards perfecting their performance as physicians. This toolkit fits within a larger culture that values evaluation to illustrate success; toolkits allow everyone—students and teachers alike—to feel successful once they are 'mastered.'

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[133] Richard L. Cruess, Sylvia R. Cruess, Sharon E. Johnston, "Professionalism: An Ideal to Be Sustained," *The Lancet* 356 (July 8, 2000): 156-159, doi: 10.1097/01.blo.0000229273.20829.d0 (accessed November 26, 2012).

[134] Rylko-Bauer and Farmer, "Managed Care," 467-502; and Kirk L. Smith, Rebecca Saavedra, Jennifer l. Raeke, and Alice Ann O'Donell, "The Journey to Creating a Campus-Wide Culture of Professionalism," *Academic Medicine* 82, no. 11 (November, 2007): 1015.

Yet this toolkit removes from discussion many of the imperatives guiding the students' performances and shaping the outcomes of patient encounters, a neglect that can cause students distress and contribute to feelings of burnout. These feelings work against lessons about professionalism and empathy that medical educators seek to instill in students.[135] Student distress has been linked to decreased academic performance, academic dishonesty, cynicism, substance abuse, and suicide.[136] The decline of students' empathy scores throughout medical school has been well-documented, and the cynicism that replaces empathy "may serve as a buffer against, anxiety, fear of failure, and exposure to human suffering," but "ultimately erode[s] professionalism."[137] One article cites the refusal to care for "chronically ill, elderly, and terminal patients" as a potential effect of a decline in professional values.[138] The lack of explicit conversation about the paradoxes and power hierarchies in medicine can run counter to the empathy lessons students are receiving and are supposed to internalize. In the next section, I will discuss the course materials presented to students throughout their classes, illustrating how scripts and staging guidelines are provided to the students, which, instead of serving as starting points for discussion, have the effect of circumscribing conversations about larger imperatives influencing medical practice.

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[135] Liselotte N. Dyrbye, Matthew R. Thomas, and Tait D. Shanafelt, "Medical Student Distress: Causes, consequences, and Proposed Solutions," *Mayo Clinic Proceedings* 80, no. 12 (December, 2005): 1613-1622, https://medinfo.ucsd.edu/specialties/wellbeing/Documents/Medical%20Student%20Distress%20Causes%20Consequences%20and%20Proposed%20Solutions%202005.pdf (accessed December 4, 2012).

[136] Ibid., 1616-1617.

[137] Ibid., 1616.

[138] Ibid.

FORMAL EMPATHY EDUCATION: READING THE SCRIPTS

Looking at the course materials presented to the students throughout their medical education informs a better understanding of the contents and teaching of the 'empathy toolkit' to students. The materials presented in this chapter appeared in lectures and handouts throughout POM 1 and POM 2. As will be seen, a toolkit mentality is emphasized, and there also appears a conscious attention to guide the students towards perfecting their performance as empathetic physicians. Yet the skillset does not fully equip students to deal with the variety of challenges they will encounter as physicians, particularly when market-based imperatives conflict with their own personal or professional beliefs. Furthermore, it encourages students to treat situations more or less uniformly, not with curiosity or creativity. Patient encounters fall into general groups for which they have scripts to follow. This strays from the patient-centered approach to patient care discussed in much of the empathy literature.[139]

POM 1 and 2 have similar components. They consist of lectures to the entire class on subjects ranging from clinical signs of illness to basic information on Medicare and Medicaid. Lectures are also presented on interpersonal skills, and, as mentioned above, these lectures are closely linked with students' understandings of their empathy education. For example, one lecture in POM 2 is entitled "Skills to ADDRESS Challenging Clinical Encounters" and presents the following acronym for handling uncomfortable experiences in clinic:

[139] See Jodi Halpern, *From Detached Concern to Empathy: Humanizing Medical Practice* (Oxford, United Kingdom: Oxford University Press, 2001); and Ralph R. Greenson, "Empathy and Its Vicissitudes," *International Journal of Psycho-Analysis* 41 (1960): 418-424 for examples of the patient-centered approach.

Acknowledge
Discuss the patient's perspective
Disarm /Decompress
Reflect
Empathize
Set boundaries
Seek support /resources[140]

The slides in the PowerPoint presentation, which is posted on the course's website for students to download, cover each of these letters and give an example patient scenario with appropriate student response. On the slide entitled "Empathize," for example, students are told to "[b]e patient centered," "reinforce positives," and that "we all want to feel understood," which again reflects the use of empathy as a general term to talk about patient interaction.[141] The case example for empathy is of a recently divorced mother who brings in her children to clinic quite frequently despite their clean bills of health each time.[142] The suggested student response is "I can see that you are worried, it must be very hard to be a single mom."[143] This example illustrates how the presentation provides a script for students to memorize for use in various challenging encounters (and also appears to present single motherhood as somewhat pathological).

However, articles in the empathy literature about communication of empathic concern often give examples of appropriate lines to use. The authors of one article entitled '"Let Me See If I Have This Right…:' Words That Help Build Empathy" list general categories of empathic communication, giving various phrases that a physician could use which reflect these categories. For example, under the heading "Identifying

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[140] "Skills to ADDRESS Challenging Clinical Encounters," (lecture from the Practice of Medicine—Year 2 course, August 19, 2010), slide 7, eclass.utmb.edu (accessed November 21, 2012). This lecture has since been changed and no longer offers specific phrases for students.

[141] Ibid., slide 23.

[142] Ibid.

[143] Ibid., slide 24.

and Calibrating the Emotion," the authors cite the phrases "Tell me how you're feeling about this," and "I have the sense that you feel strongly, but I'm not sure I understand exactly what the feeling is. Can you tell me?" as reflective of this category.[144] However, providing students sample lines distracts from the individualized nature of empathy and empathic interactions, and students may find these lines inappropriate.

The POM 2 lecture also defines challenging encounters for the student, explaining how these occur with patients who are angry, seductive, dependent, drug-seeking, noncompliant, and worried, among others.[145] Students are even shown a chart that illustrates the various components of a difficult patient encounter, which are "situational issues," "physician characteristics," and "patient characteristics," listing various things falling under these three categories.[146] However the lecture fails to contextualize why it is important for the institution and profession to handle difficult patients in particular ways, such as avoiding lawsuits, maintaining a large patient list, and obtaining high customer satisfaction ratings, all of which lead to greater profit. Furthermore, the question arises of whether possessing these tools for identifying and handling difficult patient encounters leads to better medical practice or better patient outcomes.

This discussion also largely leaves out the students' personal attributes which may lead to certain situations being perceived as difficult and may influence the students' responses. The chart mentioned above does present a list of three physician characteristics which contribute to a difficult patient encounter, which include "angry or

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[144] John L. Coulehan, Frederic W. Platt, Barry Egener, Richard Frankel, Chen-Tan Lin, Beth Lown, and William H. Salazar, '"Let Me See If I Have This Right…' Words That Help Build Empathy," *Annals of Internal Medicine* 135, no. 3 (August 7, 2001): 222, doi: 10.7326/0003-4819-135-3-200108070 (accessed December 7, 2012).

[145] "Skills to ADDRESS Challenging Clinical Encounters," slide 6.

[146] Ibid., slide 5.

defensive physicians," "fatigued or harried physicians," and "dogmatic or arrogant physicians."[147] However, there is no discussion of the larger forces leading to these feelings or how to identify when one is behaving in these ways. Furthermore, this is only a section of one slide; the rest of the presentation is framed in such a way that the patient is perceived to be the problem.

Acronyms are common during the students' education, and "ADDRESS" is not the only one presented to students during POM 2. An often-mentioned one by the students was from the "Delivery of Bad News" lecture. This acronym was "SPEAK THE TRUTH," which provides the students with a step-by-step guideline for delivering bad news to patients.

> **S**etting the stage
> **P**repare yourself
> **E**valuate what the patient knows
> **A**sk permission to give "the news"
> **K**eep "the news" simple and concise
> **T**herapeutic silence
> **T**alk about the diagnosis, prognosis, and answer question
> **R**espond with empathy
> **U**nify support team
> **T**otally commit yourself
> **H**elp outline a plan[148]

Though the students are not presented with exact lines to memorize, they are provided with verbal suggestions throughout the course of the lecture and in their small group sessions. As will be explained in more detail later, one student from each small group has the chance to practice the acronym in front of a standardized patient, which is taped and then shown to the small group to be critiqued.

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[147] "Skills to ADDRESS Challenging Clinical Encounters," slide 5.

[148] "Delivery of Bad News," (lecture from the Practice of Medicine—Year 2 course, March 1, 2012), slide 6, eclass.utmb.edu (accessed November 20, 2012).

The "Delivery of Bad News" lecture differed from the others in that it gave a slight history of the lecture, which the lecturer explained was added due to poor performance by the students, both in front of patients and on national licensing exams. However, the institutional reasons for being concerned with student performance (including incentive programs) were left out of the history despite a slide in the PowerPoint presentation listing the "New Delivery of Bad News Criteria," which reads like a presentation to an accreditation board.[149]

As part of the course materials for POM 1 and POM 2, the students are also given lists of questions for the medical interview and are asked to perform a specific series of physical exam maneuvers (often memorized in a specific order) on which they will be graded throughout the semester. These include the six attributes of pain and the review of systems, standard parts of the medical interview. Again, these lists serve as scripts that the students will rehearse and later perform for peers, patients, and other members of the medical profession.

There are advantages to the use of checklists and scripts in clinical settings. The use of checklists has been linked to lowered numbers of deaths in the operating room and decreased catheter-related bloodstream infections.[150] They have also been hypothesized to decrease diagnostic error by encouraging physicians to "decrease reliance on memory,

[149] "Delivery of Bad News," slide 3.

[150] Alex B. Haynes, Thomas G. Weiser, William R. Berry, Stuart R. Lipsitz, Abdel-Hadi S. Breizat, E. Patchen Dellinger, Teodoro Herbosa, Sudhir Joseph, Pascience L. Kibatala, Marie Carmela M. Lapitan, Alan F. Merry, Krishna Moorthy, Richard K. Reznick, Bryce Taylor, and Atul A. Gawande, "A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population," *New England Journal of Medicine* 360 (January 29, 2009): 491-499, doi: 10.1056/NEJMsa0810119 (accessed December 5, 2012); and Peter Provonost, Dale Needham, Sean Berenholtz, Davd Sinopoli, Haitao Chu, Sara Cosgove, Bryan Sexton, Robert Hyzy, Robert Welsh, Gary Roth, Joseph Bander, John Kepros, and Christine Goeschel, "An Intervention to Decrease Catheter-Related Bloodstream Infections in the ICU," *New England Journal of Medicine* 355, no. 26 (December 28, 2006): 2725-2732, http://www.nejm.org/doi/pdf/10.1056/NEJMoa061115 (accessed December 5, 2012).

consider a comprehensive differential diagnosis for common symptoms, step back…to examine [their] thinking process, develop strategies to avoid predicable bias, and recognize [their] altered mood state… to reduce their negative consequences."[151] Despite their positive attributes, these lists also dictate boundaries of communication with patients since the students are graded on their abilities to ask these questions in a prescribed way as outlined by these lists. They may also be linked to customer satisfaction ratings, as at least one study found that "[p]rimary care physicians with no [malpractice] claims oriented patients to the process of the visit more often than physicians with claims" using phrases similar to the ones listed in these interview guides.[152] An interest in customer satisfaction is not bad, as it may point out areas of patient care on which physicians can improve. However, customer satisfaction surveys are a rather superficial measure of the physician-patient relationship and stray from the deeper connection discussed in literature on empathy.[153]

Furthermore, in the POM 1 syllabus, the students are given interviewing guidelines, which include tips such as "attend to your [own] nonverbal signals," which is followed by the advice to "attend to your patient's nonverbal signals."[154] As mentioned above, nonverbal communication is often discussed in the literature on empathy.[155] The

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[151] John W. Ely, Mark L. Graber, and Pat Croskerry, "Checklists to Reduce Diagnostic Errors," *Academic Medicine* 86, no. 3 (March, 20122): 308, doi: 10.1097/ACM.0b013e31820824cd (accessed December 5, 2012).

[152] Wendy Levinson, Debra L. Roter, John P. Mullooly, Valeria T. Dull, and Richard M. Frankel, "Physician-Patient Communication: The Relationship with Malpractice Claims among Primary Care Physicians and Surgeons," *JAMA* 277 no. 7 (1997): 558, doi: 10.1001/jama.1997.03540310051034 (accessed November 18, 2012).

[153] See Jodi Halpern, *From Detached Concern to Empathy.*

[154] Gerik, et al., *Practice of Medicine—Year One*, 41.

[155] Richard F. Haase and Donald T. Tepper, "Nonverbal Components of Empathic Communication," *Journal of Counseling Psychology* 19, no. 5 (1972): 417-424; and Jodi Halpern, "What Is Clinical Empathy," *Journal of General Internal Medicine* 18, no. 8 (August, 2003): 670-674, doi: 10.1046/j.1525-1497.2003.21017.x (accessed December 5, 20120.

importance of nonverbal communication has also been emphasized in the customer service literature found in business journals.[156] One article reports, "It is commonly known that employees' display of affective characteristics such as friendliness, responsiveness, and enthusiasm, positively influences customers' overall evaluation of service consumption experiences and perceptions of service quality."[157] Yet the links between positive nonverbal signals and a happy customer are rarely noted explicitly throughout the students' education, despite articles that discuss empathy as it relates to patient satisfaction and compliance.[158] Patient satisfaction and compliance, however, are not synonymous with empathetic interaction, as empathy involves a deeper connection than that revealed by surveys or conformity to treatment regimens.

This POM 1 guide also provides sample scripts, as well. Students are told to complete their interview by asking the patient "Are there any other problems you'd like to discuss?" or "Do you have any other questions or concerns?"[159] Furthermore, under the bullet point, "Remember Social Niceties," students are given the following stage instructions, complete with sample lines:

> Take a few minutes at the beginning and the end of the interview to interact with the patient as you would any new person. Smile, introduce yourself, or engage in brief small talk. Comments such as "Have you been waiting long?" or "Did you find the office OK?" can relax the patient before launching into the official interview.[160]

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[156] D.S. Sundaram and Cynthia Webster, "The Role of Nonverbal Communication in Service Encounters," *Journal of Services Marketing* 14, no. 5 (2000): 278-291, http://www.res.otaru-uc.ac.jp/~js/downloads/MKTF2002-PDF/Oct-10/The%20role%20of%20nonverbal%20comm.pdf (accessed December 11, 2012).

[157] Ibid., 278.

[158] Sung Soo Kim, Stan Kaplowitz, and Mark V. Johnston, "The Effects of Physician Empathy on Patient Satisfaction and Compliance," *Evaluation and the Health Professions* 27, no. 3 (September, 2004): 327-251, doi: 10.1177/0163278704267037 (accessed April 24, 2012).

[159] Gerik, et al., *Practice of Medicine—Year One*, 41.

[160] Ibid., 41.

The paragraph reads like the general instructions given to actors for improvised scenes, and their brevity precludes addressing the complex nature of physician-patient interactions. For example, there is not discussion regarding the barriers to recognizing one's nonverbal signals or of the culturally constructed nature of "social niceties" such as eye contact and a strong hand shake.[161] This may leave the student puzzled when patients do not respond positively to their performance.

Students are also required to complete site visits during which they are asked to spend time in various clinical environments, performing physical exams and interviews and presenting to residents and attending physicians at these sites. These exercises are aimed at building clinical skills as well as preparing students for their roles during the third and fourth year of medical education. In POM 1, students are graded on multiple criteria, including appearance, responsibility, dependability, and interactions with patients and staff, with grades ranging from "Exceeds Expectations" to "Unacceptable."[162] This criteria illustrates how empathy education encompasses topics related to interacting with the patient. It also mimics the faculty comment that explained how empathy education involved learning to interact with faculty and staff, as well as patients. These visits give some students their first taste of interacting and empathizing with patients in their new role of healthcare provider. For both POM 1 and POM 2, site visits allow students more opportunities to 'rehearse their lines,' both in front of patients and in front of their small groups, when they present a patient seen in clinic to the group.

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[161] Norbert Elias, *The Civilizing Process: Sociogenetic and Psychogenetic Investigations*, rev ed., ed. Eric Dunning, Johna Goudsblom, and Stephen Mennell, trans. Edmund Jephcott. (Oxford, United Kingdom: Blackwell Publishers: 1994, 2000).

[162] Gerik, et al., *Practice of Medicine—Year One*, 51.

For POM 1 and 2, the students are placed into small groups of nine or ten students, which meet every other week and are led by faculty members, generally from the School of Medicine. In these small group sessions they practice their physical examination and interviewing skills. They also discuss various issues involving clinical medicine, such as dealing with difficult patients or cultural barriers to care, in more detail and with the guidance and experience of practiced physician facilitators. Students often mentioned a series of videos, the *Worlds Apart* series, associated with cultural differences in healthcare, viewed during these small group sessions, as part of their empathy education, since they dealt with patient interaction. However, these videos minimize differences between individuals who may identify themselves as belonging to the same cultural group and encourages students to make generalizations about groups of people based upon the video. For example, one segment features a Puerto Rican immigrant who prefers to use home remedies to treat her multiple chronic diseases, including diabetes and hypertension. After watching, students may approach patient encounters with Hispanic patients with the assumption that all prefer home remedies to medications prescribed by physicians, rather than with the idea that each patient's cultural understandings of medicine should be explored individually. This strays from empathy literature that is focused on the individualized nature of patient care.

The small group sessions include many activities aimed at improving students' performance as physicians. In POM 1 there are specific 'role playing activities,' in which one character will play the patient role while the student interviews him or her and attempts to develop a differential diagnosis. The syllabus for POM 1 lists the script for the student playing the character, while the student playing the medical student/physician

brings his own script, located elsewhere within the course materials, in order to complete the physical exam and interview. Standardized patients make appearances in both POM 1 and POM 2, as well, and students take turns interviewing and performing physical exams with these patients. As discussed above, students also critique each other's skills within this class, as they watch each other's taped encounters with standardized patients.

The evaluation criteria for these classes are also helpful for examining understandings of empathy. Students complete examinations on their physical exam and interviewing skills, which are called Objective Standardized Clinical Evaluations (OSCEs). Within these tests, students are encouraged to think about the patient's comfort by properly draping sheets covering the standardized patient's body, exposing only the body part being examined. Students are also told to wash their hands, which, beyond improving hygiene, is said to increase the comfort level of the patient. These two things, related to empathy through the patient interaction model, are part of the evaluation and students can lose points if these are not done properly. Students are given checklists and grading criteria for the physical exam and taught to perform all the objectives in a specific order to ensure that the grader gives proper credit. The question arises, however, of whether following a series of behaviors and scripts is the same as having empathy.

Furthermore, students receive professionalism scores throughout POM 1 and POM 2. For POM 1, students are told that "[i]n order to be considered for an exceptional rating, the student must have participated in an extra inter-professional activity, e.g., service project that demonstrates altruism, sound ethical practice, and/or cultural

sensitivity, AND write a 1-2 page reflection paper describing the activity."[163] To explain further, a list of professional behavior is given:

> • Demonstrates sense of responsibility by performing expected roles such as site visits, family home visits, assigned projects, and small group activities.
> • Demonstrates respect and consideration for patients, standardized patients, colleagues, and faculty.
> • Demonstrates cultural, ethnic, and gender sensitivity.
> • Accepts and provides constructive critique.
> • Consistently strives for excellence.
> • Demonstrates integrity and confidentiality.
> • Allows or facilitates others to demonstrate skills and understanding.[164]

Students sense that these definitions of empathy and professionalism have been created, in part, due to a need to evaluate them, yet this is rarely explicitly discussed in class. There is also no discussion about the history of the professionalism movement in the formal curriculum, though there are optional lecture series on the subject on campus that students may attend. Here, too, the confusion regarding terms such as altruism, cultural competence, and professionalism is evident, as they are all used interchangeably. Looking at the course materials for POM 1 and POM 2, it is clear that the students are provided with scripts of appropriate lines to be used with patients. These scripts become part of the toolbox that is supposed to help students interact with, and hence empathize with, any patient that they may encounter.

As guidelines, scripted encounters are a helpful starting point in developing empathy, particularly for students without well-developed interpersonal skills who may be unsure how to approach a patient encounter. Furthermore, and as discussed above, checklists may also improve the quality of patient care. Yet the toolbox approach is not

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[163] Susan M. Gerik, Keith Bly, and Lem Aigbivbalu, *Grading System and Evaluations Revised*, 3, eclass.utmb.edu (accessed December 5, 2012). This grading system has since been updated and is no longer used.

[164] Ibid., 3.

sufficient to allow the students to navigate the complex interactions they will have in clinic with patients. There is little discussion about medical student culture, cultural differences in healthcare, or about larger institutional imperatives influencing the form of empathy taught in school.

A question that arises consequent to the emphasis on performance is whether the performance of empathy is sufficient to guarantee an effective provider-patient encounter. Is performing in an empathic manner the same as authentic empathy, and, if it is not, is feigning empathy a good enough substitute? These questions have been posed in the literature with regard to the performance of professionalism. Charlotte E. Rees and Lynn V. Knight explain that behavior is an unpredictable measure of professionalism, as students and other healthcare providers may feel pressure to behave in certain ways despite feeling differently.[165] Frederic Hafferty asserts that behaving professionally is not a sufficient outcome of medical education; that students must internalize medical professional values. It is this internalization that "provides the necessary stability and generalizability when one has to step outside the realm of textbook medical practice and confront situations of uncertainty and ambiguity."[166] Yet, with the great influence of market-based values on students' education, will they internalize market values instead of those traditionally associated with medical professionalism? What does internalization of market-based values mean for patient care? Applying this discourse to empathy means that outward manifestations of empathy may not be sufficient for evaluation and suggests

[165] Charlotte E. Rees and Lynnv Knight, "Viewpoint: The Trouble With Assessing Students' Professionalism: Theoretical Insights from Sociocognitive Psychology," *Academic Medicine* 82, no. 1 (January, 2007): 46-50, http://e.itg.be/oldlinqed/images/stories/QA/studentassessment/attitude/rees-professionalism.pdf (accessed November 27, 2012).

[166] Frederic W. Hafferty, "Professionalism—The Next Wave," *The New England Journal of Medicine* 355, no. 20 (2006): 2151, http://www.nejm.org/doi/pdf/10.1056/NEJMe068217 (accessed November 27, 2012).

that present modes of teaching particular empathetic behaviors may not provide students with the tools needed to negotiate effectively the vast array of situations that they will encounter. In the next section, I will examine faculty members' discussions of course materials on empathy at UTMB.

LESSONS FROM FACULTY: TEACHING STUDENTS THE SCRIPTS

As mentioned previously, curricular discussions about empathy allow faculty members to advocate specific understandings about the physician-patient encounter while also giving students the opportunity to practice their roles. In this section, I will argue that the faculty advocate a 'toolbox' understanding of empathy. Once the students have all the tools, they can then play their roles convincingly, a benefit to the patient and to the institutional goals of the medical school. As part of the toolbox, students are given scripts for interactions with patients and provided guidance on using various medical 'props,' such as the stethoscope, sphygmomanometer, and ophthalmoscope. Students are also given advice on their wardrobe, from the white coat to 'professional clothes' consisting of dress slacks, knee-length skirts, collared shirts, and ties. These lessons teach students how to interact with patients as members of the medical profession and are instrumental to institutional goals; e.g. teaching empathy in terms of specific skills make it easier to evaluate 'success,' an important aspect of curricular components in medical education today.[167]

[167] Searching "assessment" of any of the topics mentioned in this paper produces hundreds of results, including Ronald M. Epstein and Edward M. Hundert, "Defining and Assessing Professionalism," *JAMA* 287, no. 2 (2002): 226-235, doi: 10-1001/pubs.JAMA-ISSN-0098-7484-287-2-jrv10092 (accessed November 27, 2012); and Patrick Duff, "Teaching and Assessing Professionalism in Medicine," 1362-1366.

Empathy taught as a skill set has been discussed before in the literature on empathy. For example, Helen Riess's work on empathy education advocates teaching students about various neural pathways for empathy and communication skills, and she illustrates how this knowledge led to patient-interpreted increases in empathetic behavior.[168] Jodi Halpern discusses empathy as a skill, as well, though she discusses the clinical technique of empathy in a more nuanced form than the emphasis on appropriate behavior in the UTMB curriculum. She writes that "the benefit of the model of empathy as emotion-guided imagining… is that it permits a focus on developing some specific skills, rather than simply exhorting physicians to have compassion."[169] She says that, rather than encouraging students to will themselves to be empathetic, cultivating curiosity may still lead to the development of empathetic feelings.[170] The concern is that the toolkit or skillset circumscribes curiosity by encouraging students to draw conclusions about their patients and categorize them into groups. Furthermore, Halpern believes that teaching students to be more attentive to verbal and nonverbal cues can lead to empathetic feelings as well.[171] For Halpern, then, empathy is a skill that can be developed.

Returning to the setting of UTMB, one faculty member described the skill set framework in discussing the role that POM played in teaching empathy. Building on the idea that empathy education encompasses all lessons on the interpersonal aspects of the physician-patient relationship, this faculty member explained how coursework was aimed

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[168] Helen Riess, John M. Kelley, Robert W. Bailey, Emily J. Dunn, and Margot Phillips, "Empathy Training for Resident Physicians: A Randomized Controlled Trial of a Neuroscience-Informed Curriculum," *Journal of General Internal Medicine,* published electronically May 2, 2012, doi: 10.1007/s11606-012-2063-z (accessed July 5, 2012).

[169] Jodi Halpern, *From Detached Concern to Empathy,* 129.

[170] Ibid., 130.

[171] Ibid., 131.

at providing students the tools to deal with various patient encounters and to interact professionally with other members of the healthcare team. This included rules regarding 'professional' wardrobe and activities aimed at increasing cooperation between different healthcare workers.

> And…I think that again it has a lot to do with how we teach patient interview and physical exam skills. So in the second year we are teaching them challenging patients, so, um, angry patients, depressed patients, patients that are, you know, that they are having to ask difficult questions. Um, sexual questions, patients that are seductive, um, you know, all of those are…sort of how to, you know, get a patient to talk to you and tell you the information that you need to know. And so part of that is…how, you know, how best to accomplish that sort of trusting relationship, and I think empathy has a lot to do with that.

The goal of the encounter is to both gain information and build a trusting relationship, which becomes the 'accomplishment.' Furthermore, the trusting relationship is confirmed through the patient's compliance with the physician's treatment suggestions.[172] However, the language of goals and accomplishment also suggests the influence of a market-based model of medicine focused on evaluation. A positive physician-patient interaction becomes another line on the checklist for achieving optimal patient care in the eyes of the institution. The trusting relationship is important because it increases customer satisfaction and the belief that the physician is being empathetic, while ratings on customer satisfaction determine physicians' job security and salary bonuses.[173]

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[172] John Schneider, Sherrie H. Kaplan, Sheldon Greenfield, Wenjun Li, and Ira B. Wilson, "Better Physician-Patient Relationships Are Associated with Higher Reported Adherence to Antiretroviral Therapy in Patients with HIV Infection," *Journal of General Internal Medicine* 19, no. 11 (November, 2004): 1096-1103, 10.1111/j.1525-1497.2004.30418.x (accessed December 5, 2012); and Geoffrey C. Nguyen, Thomas A. LaVeist, Mary L. Harris, Lisa W. Fatta, Theodore M. Bayless, and Steven R. Brant, "Patient Trust-In-Physician and Race are Predictors of Adherence to Medication Management in Inflammatory Bowel Disease," *Inflammatory Bowel Disease* 15, no. 8 (August, 2009): 1233-1239, doi: 10.1002/ibd.20883 (accessed December 5, 2012).

[173] Marshall H. Becker and Lois A. Maiman, "Sociobehavioral Determinants of Compliance with Health and Medical Care Recommendations," *Medical Care* 13, no. 1 (January, 1975): 10-24, http://www.jstor.org/stable/3763271?origin=JSTOR-pdf (accessed November 19, 2012); and Jo Silvester,

Furthermore, customer satisfaction reduces the number of malpractice lawsuits: Higher numbers of patient complaints have been correlated with higher numbers of risk management episodes in the literature.[174] Customer satisfaction is also associated with increased profits for larger businesses, such as UTMB.[175] Yet these larger profit-driven imperatives are largely left out of the discussion, as are questions about medical authority.

Unlike Halpern, who believed that empathy could be taught, some faculty members with whom I talked felt that empathy, when defined as a feeling, could not be taught. This, in part, led to lessons on empathy being taught in a toolbox form. Skills were teachable; feelings were not. One physician faculty member explained this mindset, discussing how, since she could not teach true empathetic feelings, she saw her job as teaching students the skills to avoid offending the patient. She felt that it was up to the students themselves to develop the appropriate empathetic feelings.

> I think social filters can be taught. You know, how somebody acts and how they really feel, don't necessarily have to match, and I think we can teach people how to mind their manners. But, um, I don't, I don't know if we can teach them to feel differently. I think life maybe can. You know, like if somebody is put in a situation where they're suffering, or they see somebody that they really love suffer, then that might impart… empathy. But I don't think that a teacher can write it on the chalkboard, or even have it, you know, a line item on an evaluation form and make it happen that way.

Fiona Patterson, Anna Koczwara, and Eamonn Ferguson, '"Trust me…' Cognitive and Behavioural Predictors of Perceived Physician Empathy," *Journal of Applied Psychology* 92, no. 2 (March, 2007): 519-527, doi: 10.1037/0021-9010.92.2.519 (accessed November 19, 2012).

[174] Henry Thomas Stelfox, Tejal K. Gandhi, E. John Orav, and Michael L. Gustafson, "The Relation of Patient Satisfaction with Complaints Against Physicians and Malpractice Lawsuits," *JAMA* 118, no. 10 (October, 2005): 1126-1133, doi: 10.1016/j.amjmed.2005.01.060 (accessed August 6, 2013); and Gerald B. Hickson, Charles F. Federspiel, James W. Pichert, Cynthia S. Miller, Jean Gauld-Jaeger, Preston Bost, "Patient Complaints and Malpractice Risk," *JAMA* 287, no. 22 (June 12, 2002): 2951, doi: 10.1001/jama.287.22.2951 (accessed November 18, 2012).

[175] Kenneth L. Bernhardt, Naveen Donthu, and Pamela A. Kennett, "A Longitudinal Analysis of Satisfaction and Profitability," *Journal of Business Research* 47 (2000): 161-171, http://elmu.umm.ac.id/file.php/1/jurnal/J-a/Journal%20Of%20Business%20Research/Vol47.Issue2.2000/5228.pdf (accessed November 19, 2012).

As part of the teaching of social filters, she described discussions in the classroom and on the wards about how patients may be feeling. She mentioned mock scenarios where students are asked to 'rehearse' what they might say in difficult scenarios with patients. Her comments speak to teaching students how to play the role of doctor convincingly, and in such a way as to not get the larger institution of medicine in legal trouble. Offending the patient, after all, is more likely to lead to lawsuits, and, as mentioned previously, decrease profits.[176] For example, one study found that "noclaims primary care physicians laughed and used humor more often during visits than claims primary care physicians, indicating warmth and friendliness."[177] Empathy, then, is not simply about care of the patient. Rather, care of the patient is also part of caring for the institution, and caring for the institution is important for preserving jobs in the current economic climate.

Defensive medicine, defined as "medical responses undertaken to avoid liability rather than to benefit the patient," factors largely into healthcare decisions today.[178] One study estimated that five to nine percent of the United States' healthcare budget for acute myocardial infarctions was the result of defensive medicine.[179] Despite its ubiquity, Richard E. Anderson writes that it "violates the Hippocratic oath, does violence to the

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[176] Stelfox, et al., "The Relation of Patient Satisfaction," 1126-1133; and Gerald B. Hickson, et al., "Patient Complaints and Malpractice Risk," 2951.

[177] Wendy Levinson, Debra L. Roter, John P. Mullooly, Valeria T. Dull, and Richard M. Frankel, "Physician-Patient Communication: The Relationship with Malpractice Claims among Primary Care Physicians and Surgeons," *JAMA* 277, no. 7 (1997): 558, doi: 10.1001/jama.1997.03540310051034 (accessed November 18, 2012).

[178] Richard E. Anderson, "Billions for Defense: The Pervasive Nature of Defensive Medicine," *Archives of Internal Medicine* 159, no. 20 (1999): 2399, http://archinte.jamanetwork.com/article.aspx?articleid=485164 (accessed December 4, 2012).

[179] Daniel Kessler and Mark McClellan, "Do Doctors Practice Defensive Medicine?" *The Quarterly Journal of Economics* 111, no. 2 (1996): 353-390, doi: 10.2307/2946682 (accessed December 5, 2012).

physician-patient relationship, and is manifestly self-serving for the physician."[180] Laura D. Hermer and Howard Brody explain that this is because "defensive medicine is meant more to offer economic and psychological benefit to the physician than to the patient."[181] When doctors practice defensive medicine, they align their prescribing practices with the interests of the institution, which may or may not be what is best for the patient. This seems to have little to do with considering the patient's point of view and other understandings of empathy. Instead, doctors maintain their jobs by aligning with institutional imperatives rather than the interests of the patient.

Another physician faculty member described her role as teaching students the skills to properly express empathetic feelings. She also believed that students either possessed empathy or they did not, and that students who possessed empathy often were unsure of how to interact with patients in a manner reflective of their feelings.

> [S]ometimes they're just scared to respond to [their empathetic feelings] because it's, like, I'm a doctor, how is a doctor supposed to respond? I mean, they have had empathy with significant others and family members and best friends and, you know, probably neighbors before, so they know what empathy is, and they feel it, but then it's like they've never been exposed as a physician to know what's allowable or not allowable for you to engage in an empathetic conversation with a patient… I don't think they know what's ok… in the role of being a doctor.

This quote exhibits the paradoxical conundrum for students of maintaining professional distance while still remaining empathetic and attuned to the patient. Rather than letting their emotions guide their speech, students are provided 'lines' which allow them to stay emotionally detached yet appear concerned. The socialization of 'detached concern' in medical students has been discussed in the literature, including activities (such as

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[180] Anderson, "Billions for Defense," 2399.

[181] Laura D. Hermer and Howard Brody, "Defensive Medicine, Cost Containment, and Reform," *Journal of General Internal Medicine* 25, no. 5 (May, 2010): 470, doi: 10.1007/s11606-010-1259-3 (accessed December 5, 2012).

anatomy lab) that, according to the authors, help students to internalize this mindset.[182] Though students need some guidance regarding appropriate empathetic behaviors and phrases, the profession, by emphasizing the importance of scripts and lines, also creates an atmosphere of artifice between the physician and patient that students struggle to negotiate.

Comments made by this physician and those previously quoted also speak to larger imperatives that reflect the interests of the larger institution. Offending a patient is a poor economic choice, and one that puts the institution and physician at risk. For example, physician apologies for medical errors not only make patients feel better but also decrease the number of malpractice claims.[183] Offending a patient may also affect patient compliance.[184]

Teaching appropriate behavior encourages conformity, another factor that may benefit the institution by encouraging acceptance of the status quo. The emphasis on conformity limits students' abilities to advocate for their patients and speak up in situations that they find distressing, especially since this behavior is not role-modeled or actively encouraged. In fact, advocating for the patient in non-institutionally approved ways may be punished, as illustrated by Andrew H. Brainard and Heather Brislen's

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182 Harold I. Lief and Renee C. Fox, "Training for 'Detached Concern' in Medical Students," *The Psychological Basis of Medical Practice*, ed. by Harold I. Lief, Victor F. Lief, and Nina R. Lief (New York, NY: Harper and Row, 1963); and Allen C. Smith, III and Sherryl Kleinman, "Managing Emotions in Medical School: Students' Contact with the Living and the Dead," special issue, Sentiments, Affect and Emotion, *Social Psychology Quarterly* 52, no. 1 (March, 1989): 55-69, http://www.jstor.org/stable/2786904 (accessed March 28, 2012).

183 Aaron Lazare, "Apology in Medical Practice: An Emerging Clinical Skill," *JAMA* 296, no. 11 (2006): 1401-1404.

184 Edward E. Bartlett, Marsha Grayson, Randol Barker, David M. Levine, Archie Golden, and Sam Libber, "The Effects of Physician Communications Skills on Patient Satisfaction, Recall, and Adherence," *Journal of Chronic Disease* 37, no 9/10 (1984): 755-764, http://dx.doi.org/10.1016/0021-9681(84)90044-4 (accessed December 5, 2012); and Judith A. Hall, Debra L. Roter, and Nancy R. Katz, "Meta-Analysis of Correlates of Provider Behavior in Medical Encounters," *Medical Care* 26, no. 7 (July, 1988): 657-675, http://www.jstore.org/stable/2765489 (accessed December 5, 2012).

article in which many of the professionalism offenses listed were instances in which students resisted authority. Yet the role of the institution in empathy education is largely left out of the conversations, leaving students struggling to make sense of these imperatives themselves, a situation which could result in students being unable or unwilling to think in terms of what is best for their patients and instead think in terms of what is best for the institution. In other words, students are encouraged to internalize the practice of defensive medicine (whether they actually do is the subject of my next chapter).

There are other reasons that empathy is taught as a skill set besides a belief amongst some faculty that empathetic feelings are not teachable. As alluded to above, empathy as a toolbox or skill set is easier to evaluate by patients, physicians, and administrators. Empathy code words, such as professionalism and communication, appear on the students' evaluation measures during POM 1 and POM 2 as well as the students' clinical performance evaluations during their third and fourth years. These evaluations are completed by various healthcare professionals with whom the students come into contact, such as small group facilitators and attending physicians and residents with whom the students work throughout their times in various clinics and on the wards. Empathy is generally measured on a number scale, though the criteria and number assignment is subjective and dependent on the evaluator (see Appendix C for an example clinical evaluation form).

These evaluation measures end up linked to faculty incentive plans and larger institutional measurements of achievement, such as national rankings, which, in turn, serve to increase financial allocation. For example, the University of Texas Board of

Regents approved an action plan to promote a "Framework for Advancing Excellence throughout The University of Texas System" which listed incentive-based compensation strategies under its goals to promote faculty, administrator, and staff excellence.[185] Within this same section, the regents planned to "strengthen annual performance evaluation" to "better define performance levels."[186]

Though this is only a general overview of the lessons about empathy as spoken by faculty members, some themes are evident. Empathy education was part of the process of learning to play the role of doctor, complete with lessons on wardrobe, props, and the delivery of certain scripts. Along these same lines, empathy was viewed as a skill set. Yet underlying motives behind some education, such as legal woes or institutional structures, were rarely discussed. The lack of discussions of these factors leaves students less equipped to deal with them, particularly when larger market-based imperatives compete with personal or professional values. These situations cause considerable moral distress, and students should have a framework within which to think about these problems. As evident throughout these discussions, physician educators play a major role in the formal education of medical students. In the next section, I will take up these issues further as I discuss the lessons taught about empathy through simulated and standardized patient exercises.

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[185] University of Texas System Board of Regents, "A Framework for Advancing Excellence throughout The University of Texas System: Action Plan," (document available on the Framework for Advancing Excellence portion of the University of Texas System website, August, 2011), http://www.utsystem.edu/sites/utsfiles/news/assets/FrameworkActionPlan-08-25-11.pdf (Accessed December 10, 2012).

[186] Ibid.

STANDARDIZED AND SIMULATED PATIENT EXERCISES: REHEARSING EMPATHY

After students receive their scripts, it is time to rehearse their roles, and UTMB has many opportunities built into the curriculum for rehearsal. In these controlled practice settings, students can recite their lines and carry out staging techniques. They don their wardrobe and work with medical props, with 'real' patients in the form of trained actors or interactive life-like models on whom to practice their skills. In this section, I will discuss two types of mock clinical encounters: those with standardized patient (SPs) who are actors paid to play a certain role so that students may practice their clinical skills, and those with simulated patients, which are mechanical models that are sometimes pre-programmed and sometimes operate in real-time voiced by faculty facilitators. The actors are instructed to provide feedback to the students, a process not so far removed from the customer satisfaction surveys so prevalent in medical centers now. Students' videos are also watched and assessed by faculty to look for those who lag behind their peers in their performance skills, and hence may serve as a liability to the institution.[187]

In these practice encounters, there is little discussion of the larger imperatives influencing these activities, and students learn to perform their roles while internalizing the values of market-based medicine as the norm; 'good' behavior here becomes viewed as 'good medicine.' Faculty discussions of these exercises, perhaps unconsciously, reflect these larger imperatives while still emphasizing that these practice exercises serve as learning opportunities, which exist outside of the normal pressures of medical school.

[187] Debra Roter, "The Patient-Physician Relationship and Its Implications for Malpractice Litigation," *Journal of Health Care, Law, and Policy* 304 (2006): 304-314, http://brando.med.uiuc.edu/depts_programs/sciences/clinical/internal_med/residency/curriculum/art%20of%20communication/Roter%20(2006).pdf (accessed December 5, 2012).

However, students are watched and evaluated at every moment throughout these exercises, and the results are tied to grades for class.

The mixed purposes of these practice exercises can leave students confused and anxious. That the students are performing is rarely mentioned explicitly, and there is no discussion of the various audiences for whom students must negotiate their performance. This presents another challenge to students who must negotiate various audiences and goals for these activities. Are they to be focused on honing their skills with the patient or honing their skills for their grades? How are these two related? As these questions suggest, the emphasis on performance means that the focus is perhaps less on the patient and more directed towards the progress of the student and of the goals of the institution, a situation which differs from the personalized, emotion-laden discussion of empathy in the literature.[188] Furthermore, the question arises whether *performance* of empathy is sufficient. We can probe further and ask, sufficient for whom—the patient or the institution. Asking these questions means analyzing the forces at work—skills the students are rarely taught. Students then face the task of making meaning of their education without the proper analytical tools.

Activities using SPs occur throughout students' four years of medical education, and students and faculty often cite these encounters as teaching empathy. They have also been cited in the literature as part of efforts to teach and evaluate empathy and communication skills.[189] This is due to their association with opportunities for students

[188] See Jodi Halpern, *From Detached Concern to Empathy*; and Greenson, "Empathy and Its Vicissitudes," 418-424 for examples of personalized understandings of empathy.

[189] Helen R. Winefield and Anna Chur-Hansen, "Evaluating the Outcome of Communication Skills Training for Entry-Level Medical Students" *Medical Education* 34, no. 2 (February, 2000): 90-94, doi: 10.1046/j.1365-2923.2000.00463.x (accessed November 27, 2012); and Mike Rose and Luann Wilkerson, "Widening the Lens on Standardized Patient Assessment: What the Encounter Can Reveal

to improve their skills at playing the physician role, and, in particular, the interpersonal skills related to this role. The theater metaphor, though implicit in many other aspects of medical education, is foregrounded and especially appropriate in the cases of SPs. For example, standardized patients are given a 'script' beforehand that provides background information about their character. Since students may ask a variety of questions about the patient's personal background, due to the social and family history portions of the medical interview, these scripts are very detailed. Standardized patients are provided grading and evaluation criteria for the students and trained to give appropriate feedback to the students. In fact, the SPs are also instructed not to break character while providing feedback to the students; hence, they must critique in the voice of the character. These encounters with SPs are video-recorded by cameras located in the mock exam rooms in which these encounters take place; they are located discretely so as to not take away from the 'reality' of the scene. Yet students know they have an audience for their performances, even outside of the SP: these videos are watched by faculty members—some are associated with the SP Center at UTMB and others are associated with the various courses in which SP encounters take place—and evaluated for grades and to identify students who have fallen behind their classmates.

One faculty member described how empathy played a role in these encounters, at least so far as the evaluation of the encounters.

> They're not evaluated for points, you know. They're things that we look at and, you know, when you are giving sort of a global overview of the student, it's the kind of stuff that you say, "That was really nice," and then when we're working with [standardized] patients and training [standardized] patients, we'll say, you know….occasionally a student will do this and that's, like, really good, and if

about the Development of Clinical Competence," *Academic Medicine* 76, no. 8 (August, 2001): 856-859, http://journals.lww.com/academicmedicine/Fulltext/2001/08000/Widening_the_Lens_on_Standardized_Patient.23.aspx (accessed November 27, 2012).

> you're giving them feedback, you should say to them, you know, "I really appreciated when you did this or said this or attended to this."

Forms of empathy are evaluated for points, and empathy, as judged by visual and verbal cues in the videos, is of particular interest to faculty members watching the videos. However, when the focus is on the microscopic aspects of empathy expression, the larger scene in which the interaction takes place and the purposes that the interaction serves may be missed. This faculty member felt that SPs provided a unique opportunity for students to develop an appropriate clinical persona in response to a variety of clinical situations. She explained that during POM 1 these encounters are focused on providing the student the necessary practice time with a 'real' patient. By POM 2, however, students are confronted with more challenging encounters, such as patients who flirt with them, rude and angry patients, and patients to whom they must break bad news. Throughout these encounters, this faculty member was concerned with how the students were relating to the SPs.

> One of the things that's very transparent is… interpersonal skills reigns… One of the things we've been really interested in looking at is, um, connections with the patients, even though we recognize that this is an artificial setting and, you know, it's a little bit different than when you're in the clinic. The fact is these are live, breathing human beings, so we are not asking you to, like, pretend you're something you're not. We are asking you to come in here and be a student and interview a patient, right? And so, I think, we've actually looked, um, at some of the students' abilities to connect with patients… Little things that students do, um, [to] make sure the patient is comfortable, draping appropriately, you know, when a patient is in pain, making sure they're attending to the pain… the sorts of more subtle things that you do because you actually care about a human being, not because it's going to get you points on a test.

In looking for signs of students connecting with patients, this faculty member described watching and listening for visible and verbal signals. However, the cameras record at a point quite distant from the patient and student, making it somewhat difficult to judge

subtleties of movement and nonverbal communication. Since these encounters are usually evaluated by faculty members and, sometimes, peers, they encourage students to exaggerate their behaviors in order to receive credit for them. In fact, students are taught to describe their actions during the physical exam portion aloud, specifically so that faculty members grade them appropriately.

Within this faculty member's discussion, there is a mix of messages about performance. She acknowledges the artificiality of the encounters, though expects that the student is able to ignore this and function like a medical student would in a regular encounter, though it should be noted that students are likely to perform at their best for faculty members, due to their desire to receive high evaluations. Differences between performing for one's patient and performing for a grade are not discussed in the curriculum, and students must figure out what this means in relation to relating to their patient.

It is also worth noting that the faculty member's concern was focused on how the student is relating to the patient, with no acknowledgement of larger institutional goals dependent on this connection or literature relating lower malpractice claims and higher satisfaction to perceived expressions of concern and care.[190] These issues frame SP activities, and students must grapple with them as they work to connect with patients in these SP encounters. Standardized patient activities also raise questions about the value of authenticity in empathetic interactions.

[190] Gerald B. Hickson, James W. Pichert, Charles F. Federspiel, and Ellen Wright Clayton, "Development of an Early Identification and Response Model of Malpractice Prevention," *Law and Contemporary Problems* 60, no. 1 (Winter, 1997, Medical Malpractice: Influences and Controls): 7-29, http://www.jstor.org/stable/1191993 (accessed July 27, 2012).

Videos of SP encounters are often shown in the students' small group sessions during POM 1 and POM 2 to be critiqued by their peers and by faculty members. One second-year medical student described the empathy education gained through watching taped simulated patient encounters during POM classes.

> And when we, like, watch videos in POM 1 of med students who go… A lot of times our facilitators would bring out, "You did a really good job of saying this or that or responding in this way when the patient said their father had died. Just [say], oh, I'm sorry and then pause for a moment before moving on." So they kind of, like, try to draw that out and make you recognize [that] that's a good thing. Good doctors do this. Even though they didn't say you know, you are being empathetic.

Though his small group facilitator did not specifically mention empathy, this student associated the lessons on good patient interactions with empathetic care. Associating praise from the facilitator with good patient interaction techniques, this student learned what empathetic behavior should look like in the setting of the doctor-patient relationship. This suggests how discussion about the SP encounters serve as acting lessons: based on the facilitator's words and lessons learned in class, the student honed in on how best to play the role of physician—what lines to use, what gestures to make, et cetera.

Students have other experiences with SPs, as well. These include visits by SPs to the students' small group sessions in POM 1 and POM 2 so that students may rehearse their physical exam and interviewing skills there, in front of a live audience. Standardized patients are also used for OSCE-like examinations in all four years. In fact, SP activities are so common that students begin to recognize the various SPs and remember them from previous times interacting with them, during which they were acting as a different character. This experience takes away from the students' ability to

perceive these experiences as true to life, hence emphasizing the performance aspects, despite faculty assertions that they should treat these as 'real' cases.

As alluded to above, factors relating to empathy are part of the evaluation process for the SP activities. For example, students are evaluated on their communication skills, including both verbal and nonverbal communication. This includes whether they ask questions in such a way that the patient is able to understand and whether the pace of interview was comfortable for the patient.[191] According to the POM syllabus, they are graded on whether or not they made eye contact with the patient, "appeared interested and attentive," and "listened and responded to the patient's nonverbal communication."[192] The cultural construction of these social niceties is not discussed. Furthermore, students are evaluated on their ability to demonstrate respect and concern for the patient and their attitude, as illustrated by the following grading criteria found in the POM 1 syllabus:

> 6. **CONCERNS AND COUNSELING**: (Solicited questions from patient; Acknowledged and addressed the patient's concerns; Gave patient information when requested; Offered information to patient if appropriate.)
> 7. **DEMONSTRATED RESPECT AND CONCERN FOR PATIENT**: (Sensitive to patient's physical comfort, sensitive to patient's emotional comfort; ***When a physical exam is included:*** Washed hands; draped patient correctly.)
> 8. **ATTITUDE:** (Fully engaged in encounter; Showed genuine concern and compassion; Nonjudgmental; Self-confident; Secure.)[193]

These attributes are reflective of a general understanding of empathy as relating to the interpersonal aspects of the physician-patient relationship, such as communication skills, nonverbal signals, and awareness of patient's needs. Empathy, according to the criteria listed here, includes giving proper counseling and showing concern and more mechanical behaviors such as washing one's hands and draping the gown over the patient so as to not

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[191] Gerik, et al., *Practice of Medicine—Year One*, 156.
[192] Ibid.
[193] Ibid.

reveal too much of the patient while performing a physical exam. Students are given a numerical score for all these attributes. For examinations, the score is on a scale from 0 to 100, and for in-class evaluations, students are scored on a scale from 1 to 5.[194]

Not seen in these criteria are the self-reflective, personalized understandings of empathy advocated by both Jodi Halpern and psychoanalysts. Instead, the criteria for empathy are those that are most easily observed and evaluated. Criteria that emphasize observation and evaluation have been criticized by academic faculty, who claim that these criteria change the culture of academics by changing what curricular innovations are attempted.[195] For example, Sally Findlow explains that auditing procedures mean that faculty members are less likely to be forthright about mentioning risks associated with new approaches to established educational programming, and the process of minimizing risk may limit innovation itself.[196] She continues to say that differing understandings between business and education about quality and standards lead to tensions, with business models emphasizing observable changes within short periods of time (often one fiscal year), which may not be achievable in educational innovation programs.[197] Furthermore, market-driven models mean that professors are faced with new understandings of their role in academics. Findlow explains, "In having to make choices about adapting their work to the demands of the system, the staff… [confronted] deeper questions about where they positioned themselves and their work in relation to their

[194] Susan M. Gerik, et al., *Grading System and Evaluations Revised,* 1-2.

[195] Sally Findlow, "Accountability and Innovation in Higher Education: A Disabling Tension?" *Studies in Higher Education* 33, no. 3 (June, 2008): 313-329, doi: 10.1080/03075070802049285 (accessed August 20, 2013).

[196] Ibid., 318-319.

[197] Ibid., 321.

institution."[198] Evaluation becomes linked to other institutional concerns, such as identifying students who may fall behind. As graduation rates and test scores are used to get research funding and enhance faculty and student recruitment, evaluation (and ensuring student success) is important for the university's survival.[199]

Beyond these concerns, the SP exercises emphasize the aspects of performance in a way unparalleled by other activities. In the case of the SP encounters, the students' performances are taped and watched by others. The students are evaluated based on their performance of specific body movements, phrases, and the believability of their expression of concern and connection with the 'patient.' In light of the emphasis on proper performance, we can ask whether enacting a convincing performance is the goal of empathy education and whether this leads to a desirable physician-patient relationship. Probing this, we can query 'desirable to whom:' the institution, the physician, or the patient?

Simulated patient activities also present more opportunities for students to rehearse their roles. I have separated discussion about simulated patients from standardized patient experiences because of their differentiation at UTMB. Simulated patients are machines, often pre-programmed or operated by faculty members. They are most often used to teach students about various heart and lung conditions. The machines can often mimic heart sounds, lung sounds, and blood pressures that students might not encounter routinely in clinic, allowing the students to more easily identify them. They are also used when medical professionals need to practice handling various clinical

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[198] Findlow, "Accountability and Innovation," 320.

[199] A link from the prospective students page on the UTMB website links to reports including graduation rates, costs of education, pass rates for licensing exams, and enrollment numbers. One can even find an online institutional resume at http://www.thecb.state.tx.us/apps/resumes/, which includes this website.

scenarios—often emergent ones—such as when the patient's heart or lungs stop functioning. The models can adjust their measured blood pressures and responses based on the administration of mock medications and other forms of medical treatment and hence present an opportunity for students to test their clinical knowledge in a way that cannot be mimicked with (healthy) human actors.

Simulated patients are used throughout the students' education, and these pose their own challenges to empathy education. During a 'clinical skills week,' during which soon-to-be-third year medical students are trained in skills needed to perform in the clinic and hospital, such as presenting patient histories during rounds, starting intravenous lines, and suturing skills, the students are given opportunities to run through case scenarios using simulated patient models. These activities include a scenario where one is asked to administer fluid to a patient who is throwing up, start a nebulizer for a young boy suffering from an asthma attack, and treat an unconscious diabetic patient who has extremely low blood sugar, among other cases.

As a medical student, I took part in these activities in numerous instances and was confused when my group was told to pretend that these models were true 'alive' patients. We were, in fact, reprimanded whenever we broke from character, laughing or expressing exasperation at the activities, which were generally far beyond our levels of expertise. For example, for one scenario, my group had to be told by a faculty facilitator that the sound that the machine was making was a vomiting sound; we were unable to figure this out after listening to it for ten minutes. We were later reprimanded during the asthma case for not keeping the patient warm (not placing the hospital sheet over its body), despite the fact that many of us in the room were extremely hot and felt that the air

conditioning was not turned on high enough. We were often reminded to speak kindly to the machines, as these were 'real' patients, despite the fact that faculty and nursing staff were both inside the rooms and outside in the hall, laughing at the confusion of the medical students—a situation which was decidedly not realistic.

Activities with simulated activities provide students opportunities to rehearse their roles, though without acknowledging the performance aspects of it. Experiences working with the machines felt very unrealistic to the students, yet students were scolded for acknowledging this. They were unsure regarding what lessons they were expected to take away in regards to empathy and patient care. Furthermore, activities such as these beg the question of whether by learning to treat machines like true patients, 'real' patients get treated like machines.

Activities involving standardized and simulated patients present unique opportunities for students to practice their performance skills. However, students must grapple with various audiences, and there is no discussion of the multiple people for whom students must perform. This silence reflects the lack of acknowledgment of the larger imperatives influencing these activities, such as customer satisfaction and other factors related to market-based models of medicine. Yet students sense these and are rarely given the tools and language to fully explore these areas. In the next section, I will discuss one place where these larger imperatives are acknowledged and where students have the opportunity to gain guidance and a framework for negotiating these imperatives. The course materials I will discuss move away from a checklist approach to explore other issues, which allows the space for less circumscribed discussion and less emphasis on the 'right answer.'

HUMANITIES, ETHICS, AND PROFESSIONALISM: A DIFFERENT APPROACH

I have discussed how empathy education at UTMB was framed in terms of skill sets. I have also argued that profit-driven values of market-based medicine influence the curriculum, a fact which is not always mentioned but certainly felt by students and faculty alike. The emphasis on performance and evaluation raises questions about the relationship of the medical student to the patient. For whom is the student performing, and what are the consequences of this for the physician-patient relationship and for empathy? With such emphasis placed on proper performance, what happens when elements of the performance conflict with other personal and professional values? Without explicit discussion of these issues, students are left grappling with them on their own, a situation which results in stress and anxiety. Moral distress has the result of undermining the professional values that medical education seeks to instill.[200] However, providing the students with time for reflection and guidance in negotiating complex situations would help to ease this tension. Nonetheless, this is largely lacking in most empathy education at UTMB.

The Humanities, Ethics, and Professionalism (HEP) portion of POM 2 provides exposure to discussions about these larger imperatives, and this course attempts to help the student develop a framework from which to approach problems that arise in clinic. HEP, which takes place during the first seven weeks of the POM 2 course, presents students with an opportunity to talk about their own anxieties and bring up conflicts that arise within their education. Reading assignments and discussion topics address the profession of medicine in a more critical manner, and students are encouraged to speak out about issues that trouble them.

[200] See Dyrbye, Thomas, and Shanafelt, "Medical Student Distress," 1613-1622.

Though the class has proven to be a step in the right direction, at times it suffers from the same deficiencies as the rest of curriculum. Though most classes have an environment that encourages students to speak about troubling subjects, some facilitators create a more lecture-style format that is less nurturing of reflection and debate. The varied educational backgrounds of the faculty mean that the emphasis on these larger issues varies between groups. Furthermore, students are not always able to carry on discussions on larger imperatives due to their lack of training in the subject, as most have bachelor's degrees in the sciences and lack an appreciation for how knowledge and 'truth' are produced. The course's short duration means that many topics are not explored fully and lessons learned may not be retained. Indeed, anecdotal evidence tells us that students largely forget about what they learn as they progress through their third and fourth years. Some even forget that they took the class. Despite its shortcomings, the class offers an opportunity to consider the vast array of factors influencing the physician-patient relationship and the role of the medical student. In this section, I will illustrate how the class proves to be different from the empathy education received elsewhere and how the class better prepares students to cope with the vast array of situations that they will encounter.

As I mentioned previously, HEP differs from other courses that the students take throughout their medical education in many ways. For instance, the small group sessions are taught entirely by faculty members from the Institute for the Medical Humanities (IMH). The IMH at UTMB is "committed to moral inquiry, research, teaching, and professional service in medicine and health care."[201] According to the website, IMH

[201] "About Us," Institute for the Medical Humanities, accessed December 6, 2012, http://imh.utmb.edu/.

faculty work to "integrat[e] perspectives from the humanities, social sciences, and the arts…to enhance health and well-being."[202] Its faculty members have diverse academic backgrounds, such as literature, law, history, anthropology, and political science. Though there are some physicians who are associate members of the IMH, these faculty members also have outside training in other areas, such as the visual arts or philosophy. There is currently only one full-time teaching faculty member with a medical degree at the IMH, though at the time of the study there was one other who taught one graduate course a year but has since retired. In contrast, most of the students' other classes are taught by physicians and faculty with doctoral degrees in scientific subjects.

The reading materials for HEP also differ markedly from those for the students' other classes. Before each small group session, students are expected to read articles taken from literature, medical journals, and newspapers. Reading for other classes usually consists of textbook reading in scientific fields. Rarely do students read medical journal articles throughout their other coursework, and there is no other course where they are required to read articles taken from non-medical sources. Students, in general, do the majority of the reading each week, and most claim that they enjoy the assignments, though many complain that the reading is too much.

Although the students often work in small groups throughout their first two years of medical school, HEP has an unusually unstructured format in which students are given more freedom to discuss their concerns. Although some faculty members use a more lecture style of facilitation, students, in general, are encouraged to give their opinions but are challenged to think about the assumptions behind them. Each week in HEP has a

[202] "About Us," Institute for the Medical Humanities, accessed December 6, 2012, http://imh.utmb.edu/.

broad theme, discussion of which is facilitated by the small group leader. These themes also differ from those covered in other parts of POM 2 and the rest of the medical curriculum, as the topics are less focused on teaching medical students skills and more focused on allowing students to explore various topics related to their future role as physician. Specifically, the course objectives are as follows:

> 1. Understand and critically assess their own personal and cultural values in relation to the values of peers, patients, and non-physician caregivers.
> 2. Increase knowledge of the core professional values and virtues inherent in medical practice.
> 3. Increase understanding of the psychological and behavioral aspects of health, disease, death, disability, suffering, healing and helping.
> 4. Demonstrate a basic level of skill in analyzing, interpreting, communicating, and problem solving with respect to ethical problems in medical training and professional practice.
> 5. Identify and discuss ethical, affective, and humanistic dimensions of the doctor-patient encounter and the professional responsibilities associated with this relationship.[203]

As illustrated here, the majority of the objectives are focused on having students ponder issues at a deeper level. Three of the five objectives ask students to consider various dimensions and values of medicine—cultural, psychological, personal—which contribute to the provision of care. This provides room for consideration of aspects of medical culture that are often left out of other classroom discussion. The focus here is not so much on helping the students perfect their performance, as helping the students consider the factors influencing that performance.

The course consists of six small group sessions and one large lecture. Each week has corresponding reading assignments and an overview in the syllabus. Themes included "Week 3: Medicine as a Caring Profession," "Week 4: The Experience of

[203] Institute for the Medical Humanities, *The Practice of Medicine Module 5: Humanities, Ethics, and Professionalism*, (course syllabus, 2012), 4, eclass.utmb.edu (accessed December 5, 2012).

Illness," and "Week 7: Patient Autonomy and the Goals of Medicine."[204] Dax Cowart, a burn victim who was medically treated without his consent, also comes to speak to the students about patient autonomy and medical paternalism. The theme for each week remains generalized, and facilitators are expected to lead discussions based upon their own expertise.

Though students and faculty alike associated the entire course with empathy education, week five was specifically devoted to "Empathy in Clinical Practice."[205] Reading the syllabus overview of the class that week, the emphasis is on the role that stereotyping plays in medical practice. The syllabus reports, "Resorting to quick conventional labels is a constant temptation in the often impersonal setting of a university teaching hospital when introducing patients during the standardized clinical case presentation… It is tempting to think that stereotyping can streamline the process of caregiving. In fact, it slows the process down."[206] Students are asked to consider how stereotypes influence behaviors like prescribing practices and varying treatment of certain groups of patients such as minorities or the poor. Activities focus on bringing awareness to the day-to-day assumptions based upon appearances and their own personal histories. Issues such as class differences in access to care and the economics of medical practice, though largely overlooked in POM 1 and other parts of POM 2, are explicitly discussed in HEP classroom discussions.

In this short statement taken from the syllabus, there is discussion about barriers to empathic engagement with a patient and a more critical look at medical practice.

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[204] Institute for the Medical Humanities, *The Practice of Medicine Module 5: Humanities, Ethics, and Professionalism*, 2.

[205] Ibid.

[206] Ibid., 17.

These are things that do not fit well within the toolbox methodology taught elsewhere in medical school, as they begin to address the instances where the toolbox does not work as well. Furthermore, the "impersonal setting of a university teaching hospital" also introduces awareness of the institutional structure and the barriers that it brings to the physician patient relationship.[207] Streamlining processes are often related to monetary concerns, as physicians may feel more pressure to move quickly through patient appointments and rounds as pressure rises for them to make more profits.

Students are given the following reading assignments to prepare for class during the week on empathy. As illustrated, they come from a variety of sources, such as literature and newspapers:

> 1. Hellerstein, David, "Touching," in *On Doctoring: Stories, Poems, Essays,* Richard Reynolds, M.D., and John Stone, M.D., eds., Simon & Schuster, 1991, pp. 395-398.
> 2. Lo, Bernard, *Resolving Ethical Dilemmas: A Guide for Physicians, Fourth Edition*. Lippincott, Williams & Wilkins, 2009, pp. 182-189.
> 3. Williams, William Carlos, "A Face of Stone," in *The Doctor Stories*, New York: New Directions Books, 1932, pp. 78-87.
> 4. Lundy Braun, Anne Fausto-Sterling, Duana Fullwiley, Evelynn M. Hammonds, Alondra Nelson, and Susan Reverby (2007): "Racial Categories in Medical Practice: How Useful Are They?" *PLoS Med* 4.9:e271, 1423-1428.
> 5. Satel, Sally, "I Am a Racially Profiling Doctor," *New York Times*, Rpt. May 5, 2002, www.newyorktimes.com.[208]

All the articles draw attention to the assumptions that physicians make about patients in clinic and the ways that these affect patient care. In Hellerstein's story, the attending physician, who is a gynecologist, is cynical about the sources of his patients' pelvic pain and assumes that they are exaggerating it. The physician in "A Face of Stone" assumes that his patients are greedy and rude based upon their Jewish appearance, though after

[207] Institute for the Medical Humanities, *The Practice of Medicine Module 5: Humanities, Ethics, and Professionalism*, 17.

[208] Ibid., 18.

taking time to hear the family's story, particularly the mother's, he begins to reconsider his first impressions. Both physicians are largely considered unempathetic, though the small groups often remark that the physician in "A Face of Stone" begins to empathize by the end of the story. Furthermore, the assumptions that the physicians make are considered to be the cause of this lack of empathy.

Discussing empathy in a way that challenges the assumptions made by students is a very different approach than the toolbox method taught elsewhere in the curriculum. Students are asked to consider the characteristics of the physician-patient interactions within the stories, including gender, class, and historical factors. Though the stories mentioned above were written decades ago, similar factors arise within the physician-patient relationship today; for example, the manner in which gender (of both physician and patient) affects how physicians communicate with patients and how access to care for the poor continues to be a problem, particularly with the rise of market-based medicine.[209]

During the week on empathy, students also view a slideshow depicting people from stigmatized populations, including a picture of multiparous woman, a woman suffering from anorexia, several transgendered persons, and two men in jail. Students are asked to discuss their first impressions of these pictures, and facilitators are supposed to lead discussion based upon these comments, helping students to explore their own prejudices and other obstacles to empathy. Discussions in HEP tend to bring more awareness to barriers to empathy on the part of the physician and the larger medical

[209] Carma L. Bylund and Gregory Makoul, "Empathic Communication and Gender in the Physician-Patient Encounter," *Patient Education and Counseling* 48 (2002): 207-216. Published electronically November 2, 2009. http://dx.doi.org/10.1016/S0738-3991(02)00173-8 (accessed July 3, 2012); and Rylko-Bauer and Farmer, "Managed Care or Managed Inequality?" 476.

culture than those in other parts of POM 1 or POM 2. Furthermore, students are not provided with sample lines and asked to rehearse their performance based upon discussions in class. The class, instead, is focused on fostering reflection.

HEP facilitators often take the opportunity to pose questions, which are intended to help students to reflect on larger issues influencing care. For example, during discussion of the Hellerstein and Williams stories, one facilitator wished to discuss the role that gender played. Specifically, she wanted the class to explore whether the rudeness might have been interpreted differently if the interaction was between female doctors and male patients. She also desired that the students consider the stereotypes about gender that continue in this country.

> Facilitator asks, "What about men?" (She wanted to know cultural norms about men.)
>
> The class says that they are powerful.
>
> Facilitator repeats, "Powerful."
>
> The facilitator adds that this answer reflects patriarchal power relationships that have gone back over the centuries. She then wants more examples of stereotypes/cultural norms about men. There is silence in the class. The facilitator then encourages the students to think about medical research, but there is more silence in response to this question, as well. The facilitator answers the question by saying that drugs were developed using male bodies and that heart transplants were done on male patients. She adds that this has caused problems for female patients wishing to benefit from the drugs/procedures.
>
> One student says that all prosthetics are one size.
>
> Facilitator responds, "Until recently, what gender dominated the medical profession?"
>
> The class says men.

This facilitator was asking the students to consider the role that gender plays in healthcare provision, a subject that many of the students had not considered. Other facilitators brought up aspects of the medical training experience, such as stress and ways of categorizing patients for diagnostic purposes, which lead to physicians behaving rudely and making assumptions about their patients.

Various facilitators brought up issues of power as well, and they discussed the ways that hierarchies within medicine and society influence empathy and healthcare provision, more generally. The readings helped guide discussion on these topics. For example, the student in Hellerstein's story must wrestle with his relationship with his attending physician and his feelings that this physician is treating patients poorly. The article is illustrative of the hidden curriculum; lessons about empathy and professional values are undermined by physicians who exhibit very different qualities in clinic. Many authors hypothesize that exposure to this curriculum decreases feelings of empathy.[210] This brings up numerous questions to be explored. How can a student empathize when his or her grade is dependent on an attending physician who is not appreciative of a student behaving empathetically? How do students continue to empathize amidst poor role modeling? Discussing these articles provides an opportunity to explore these issues and draws awareness to issues of power that affect how students empathize with their patients.

The relevance of class and race to healthcare access and empathy are also discussed in HEP, a topic which speaks to issues of power in medicine as well. In "A Face of Stone," the physician's patient population is poor and many are immigrants, and the physician serves as the gatekeeper to their care. This is not so different from the students' work at St. Vincent's, where poverty and economic constraints play a role in the care that students are able to provide. Patients there often have few other places to receive care. Furthermore, the doctor in "The Face of Stone" sees his patients as being in a different class from him, a feeling which causes him to resent them perhaps because of their need for care. Issues of class are prevalent at UTMB, as most patients that students

[210] Coulehan and Williams, "Vanquishing Virtue," 598-604.

see are poor and have few other options to receive healthcare. How these issues affect feelings of empathy towards a patient is an important issue, as resentment may inhibit one's ability to listen to a patient's concerns and treat him or her adequately.

Many of the groups also discussed the aspects of physicians' lives—stresses, too many patients, long hours—that have the potential to decrease the quality of care for their patients. This presented an opportunity to discuss aspects of medical culture that make it difficult to empathize with patients, as well as the negative ways that stereotyping (as the physicians do in Hellerstein's and Williams's stories) influences care. Though these ideas were at the base of discussions on interpersonal skills and patient interviewing found elsewhere in the curriculum, medical culture is not explicitly discussed, with the result that students are not fully aware of the ways they are being socialized in medical school and trained to think in particular non-empathetic ways about patients.

As illustrated in the above excerpt, where the facilitator's questions were often met with silence, students are sometimes unsure of how to discuss these larger issues because they are used to having the right answer given to them and because of the complexity of these issues. Not all facilitators encourage critical discussions, however. Furthermore, some facilitators still adopt the toolbox approach. One facilitator, in explaining the utility of HEP, told her small group, "HEP introduces broad themes and gives you tools—tools that go on notecards in the file cabinet in your brain, organized around certain themes that helps you to clarify [for the future]." Yet as illustrated elsewhere in this section, the objectives and reading materials for HEP encourage students to think in ways that go beyond the toolbox about medicine. Relating to one's patient was generally discussed as a process that continually changes and which is

influenced by far-reaching sources. Power, the market, medical culture, social identity—these were some of the topics of discussion in HEP.

Looking at the students' education at UTMB, it is clear that they receive a variety of messages about empathy. Favoring a toolbox approach and an emphasis on performance, the educational curriculum leaves out explicit discussion of the larger imperatives influencing it, such as how good performance of empathy reflects larger institutional concerns with profit-making and risk management. These interests have consequences for patient care, as business models may be at odds with more patient-centered models. HEP, however, presents the possibility of addressing these issues. Not only is it a place where students can voice their concerns, but its themes require students to evaluate medical culture and medical norms. The course is only seven weeks, however, and the experience differs from small group to small group and from year to year, reducing the course's influence on the overall educational experience. Still it represents a step towards approaching medicine at a meta-level and providing guidance to students as they make meaning of empathy.

CONCLUSION

In this chapter, I have discussed the education that students at UTMB receive about empathy. I have illustrated how faculty and course materials approach this broad topic with a toolbox mentality and an emphasis on performance. Lectures, syllabi, and course handouts provide sample scripts and directions for prop management and staging of performances. Standardized and simulated patient activities provide the opportunity to rehearse lines. These lessons favor a formulary approach to patient care; patients are placed into various stereotypes and students are taught to memorize lines for each of

these scenarios. This elides differences between patients and healthcare providers and is at odds with the literature on empathy and discussions in HEP, which stress personalized aspects of health care.

While I believe that scripts are necessary in order to provide students general guidelines, lessons in this form leave out discussions of larger influences on healthcare and the personalized nature of the physician-patient relationship. In particular, the rise of market-driven medicine has led to an emphasis on quantification of outcomes, profit and evaluation, with healthcare increasingly becoming treated as a commodity. Empathy is taught with an eye towards assessment, which means that visible and verbal signs of empathy are emphasized. Profit-driven forces mean that physicians only have limited amounts of time to spend with individual patients and may make decisions based on monetary concerns rather than patient concerns when these are at variance. Issues of power have also been neglected in the curriculum even while they structure how the lessons are taught and how empathy is performed.

Teaching empathy in this way has real consequences for students and the patients. Is performing empathy enough or should we expect students to internalize empathy as well? What happens when students' empathy causes them distress because it pulls them towards one decision while other concerns, such as the institution's profits, pull them towards another? Are we training students to be advocates for the patient or for the institution? Students are not provided guidance or a framework for working through paradoxes inherent to their education, and patient care issues fade to the background while institutional risk and profit management take center stage. Furthermore, students

sense these bigger issues; struggling through them often causes undo stress and anxiety, which can, in turn, cause students to disregard professional values taught in school.

HEP provides a place for students to begin to explore these issues and consider empathy in new ways, though the course is only seven weeks and the atmosphere of the class differs between small groups, two factors which limit its potential impact. In the next chapter, I will discuss how students work to make meaning of these lessons on empathy and will illustrate how the discussions in HEP are important in addressing students' concerns about relating to patients in their future roles as doctors. I will show how students work to individualize the lessons learned in class and how they addressed problems that arose throughout their clinical experience. After discussing the meaning-making process, it will be clear that more classes with conversations about the larger forces influencing medical care are needed to relieve students' anxiety over role performance and to help them better address the myriad of experiences they will eventually encounter as physicians. Students' expression of empathy is intimately related to how they negotiate these larger forces. Providing space for discussion about the conflicting imperatives and paradoxes within their education is important in order to help students express empathy in ways that are most comfortable for them and work best for their relationships with their patients.

Chapter 5 Making Meaning of Empathy

In the last chapter I set the stage for the lessons on empathy that medical students receive at UTMB. I noted how the curriculum emphasizes the performance of empathy, complete with scripts and guidance on wardrobe, props, and staging. Empathy is taught in a toolkit form, teaching students the skills to master their performance as 'empathetic physicians.' However, teaching empathy in this way can foreclose discussion of larger imperatives influencing healthcare. Market-based imperatives, for example, can markedly affect performance—exhibiting qualities such as concern is associated with decreased risk management episodes and higher profits in hospitals—yet the relationship between the market and empathy is rarely discussed. Students are aware of these imperatives, as the frequent discussion of cost management in clinic combined with a recent customer satisfaction campaign at UTMB has brought much attention to UTMB's business model. However, the influence of these factors on the relationship between physician and patient is not often discussed, and students are left to make meaning of all the messages about empathy presented to them.

One question that arises with teaching empathy in this way is where the patient fits into the discussion. With an emphasis on performance, patient-centered care can fall to the background in the name of larger institutional concerns. A toolkit approach to empathy means that students learn to approach patients with scripts, and it encourages them to categorize patients into groups and make assumptions in order to best guess which script to use. This contradicts much of the literature on empathy that emphasizes

an individualized approach that takes into account concerns of both the patient and the physician.[211]

When empathy is taught with an eye to performance based on the values of market-based medicine, students are more likely to internalize those values rather than those of professionalism. This affects how they view patient care, as 'good' doctoring becomes judged based on the interests of market-based medicine, such as large profits and high customer satisfaction ratings. Will students be able to advocate for their patients, in their patients' terms, or will they become another appendage of the institution, only promoting healthcare that fits within market-based models of medicine? How will they negotiate a position in between these two often contradictory positions?

My focus in this chapter is on the students' perspectives, as they sit at the intersection of market based medicine, patient centered care, and the future of medical practice. How do they make meaning of their education when they must negotiate so many factors? Students are aware of these tensions and struggle to make meaning of lessons about empathy for themselves. In this chapter, I will explain student opinions on their education and talk about the ways in which they negotiate lessons. I will begin by talking about their opinions of the formal course materials presented to them through class and how they interpret those lessons, illustrating how they appreciate some perspectives while dismissing others. I will also discuss how they make meaning of the informal lessons taught to them through role modeling and teaching in the hospital and how they develop their own sense of good doctoring within the confines of these lessons.

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[211] See Jodi Halpern, *From Detached Concern to Empathy: Humanizing Medical Practice* (Oxford, United Kingdom: Oxford University Press, 2001); and Ralph R. Greenson, "Empathy and Its Vicissitudes," *International Journal of Psycho-Analysis* 41 (1960): 418-424 for examples of the individualized approach to empathy.

Continuing on, I will discuss how students view the emphasis on performance. Finally, I will talk about students' understandings of an embodied sense of empathy, with particular emphasis on the role that St. Vincent's plays in that.

I want to emphasize one aspect that influences their negotiation, and that is a root desire to help the patient. Within discussions of empathy and the variety of factors the students have to juggle, there was a recurring theme of trying to make meaning within a framework of good patient care. This was not always easy. Conflicts between values of the market and required activities for class meant that students often felt forced to behave in ways that they believed were not in their patients' best interests. Yet, in their minds, some of these behaviors were necessary in order to be able to provide care at all. Students were given little guidance to help cope with these situations, and their struggles hint at the complexity of the negotiation process. Their insistence on good patient care and a personalized understanding of empathy, however, offers promise for a generation of physicians who do not simply internalize market driven values but look critically at the institutional factors influencing their care.

INTERPRETING FORMAL LESSONS: ACCEPTANCE AND DISMISSAL

In the last chapter, I described how students were presented with a toolbox mentality. The idea was that using certain tools, such as scripts, would help them perfect their performances. I emphasized how the toolbox mentality was linked to institutional concerns with evaluation and cost management of care. The point of the chapter was to show how these issues were rarely explicitly mentioned through the course of the students' education.

Students are not blank canvases, however, and those I interviewed constantly took the lessons they learned in class and worked to figure out how to incorporate these lessons into their patient care. Some lessons fit easier than others, and the students were quick to note when the things they learned did not seem to fit the reality of their everyday existence or their beliefs about good patient care. The students appreciated some of the lessons while dismissing others. Above all, they worked to make meaning of the lessons in relation to the healthcare they were providing their patients, attempting to interpret their patients' responses and build a repertoire of behaviors that worked best for their style of doctoring.

Some interviewees found lessons learned in class to be useful. One third-year medical student explained an experience that she had in clinic where the "Breaking Bad News" lecture (discussed in the previous chapter) proved helpful. This lecture, given in POM 2, provides students an acronym for the steps of telling a patient bad news, such as a terminal diagnosis or poor test results. Students are later tested on the acronym on their exams, and one student in each small group has a taped standardized patient encounter where they are asked to break bad news, using the steps learned previously. This video was watched and critiqued in class.

This particular student had an opportunity to give bad news to a patient while on a clinical rotation as part of her third year of medical school. It was an incident that she felt could have gone better had she been able to use the steps contained within the acronym. She had the following to say about the utility of the "Breaking Bad News" lecture:

> And I sort of, I had an experience last week where I had to do it (break bad news), and I didn't even know the patient had no idea (about the bad news). And I sort

> of walked right into the trap, and I realized I had not set the stage. I didn't know that I was going to be the person doing that. No one had told me that, and I started to understand why the different steps exist.

While the "Breaking Bad News" lecture was at times ridiculed by the students I interviewed as containing so many steps as to be impossible to memorize (the acronym "SPEAK THE TRUTH" has thirteen letters), this student felt the steps would have been helpful towards accomplishing her understanding of good patient care, had she been able to use them. The student was referencing the first step in the acronym, "Setting the Stage," in explaining what went wrong in the patient encounter. She did not know that the patient had not been told the news and, hence, had not prepared the patient before relaying the diagnosis. In class, "setting the stage" entails students turning their cell phones off and ensuring they are in a quiet space with the patient. (Achieving quiet is often difficult in a hospital setting.) The next steps involve asking the patient what he or she knows about his or her condition before asking permission to share the news. My interviewee implied that these steps had not occurred either.

This student felt disappointed in the encounter, and she thought that this contributed negatively to the quality of care that the patient received. Yet many of the factors leading to the encounter were out of her control. Some form of miscommunication had occurred in which she thought the patient already knew the news (she thought the attending physician or residents had talked to the patient). Episodes of miscommunication and disconnectedness between various levels in the hierarchy are common in the hospital setting.[212] However, the "Breaking Bad News" lecture did not

[212] Jack Coulehan, "Today's Professionalism: Engaging the Mind but not the Heart," *Academic Medicine* 80, no. 10 (October, 2005): 892-898, http://www.medschool.lsuhsc.edu/Pediatrics/clerkship/forums/cases/Engaging%20the%20mind,%20but%20not%20the%20heart.pdf (accessed December 6, 2012).

seem to address this common reality of the hospital, and the student was not able to follow the scripts that were provided due to these circumstances.

The student appreciated the acronym because it provided her with a guideline for approaching a difficult situation with a patient. She felt that the steps aligned with her own feelings of empathy and understandings of desirable care for the patient. The guidelines could then be adapted to her strengths while delivering bad news. However, more discussion within that lecture about the larger forces that may impede providing empathetic care to patients, such as miscommunication and time constraints, may have been beneficial and helped prepare her better for the realities of the hospital, where patient care is often negatively affected by attending physicians' and residents' busy schedules and the lack of communication between and within patients' healthcare teams. Additional lessons on these issues might have allowed her to explore ways to handle situations such as the one above in ways that cause her less distress and anxiety.

Situations in which the patient is lost amidst the general everyday hustle and bustle of the hospital occur often, and medical students may be the first to find instances of miscommunication and then are the ones who handle the interpersonal fallout. Another third-year medical student whom I interviewed discussed a patient whose lab results indicated a poor prognosis of his cancer diagnosis. Her team had discussed telling the patient the results, and the student was under the impression that the attending physician or residents had gone to see the patient earlier in the day to tell him the news. However, when the student went to check on the patient later that day to see how he was coping with the news, she found that the patient had not been told. This student felt bad

that nothing had been mentioned to the patient and immediately apologized and then told the patient the lab results.

Instances like this one send students messages about the goals and priorities of healthcare in a large institution, and students must try to negotiate empathy amidst the reality of time and monetary pressures and the patient-centered emphasis of class. The "Breaking Bad News" lecture, despite being indicative of the evaluative tendencies and risk management strategies of market-based medicine, discusses the list in terms of these steps being helpful to the patient, and students like the ones discussed above found these steps useful and complementary to her own innate sense of what is good for the patient. However, in reality, the students mentioned above found that the steps did not always occur, and the emphasis on timeliness of relaying the news is not a reality in the hospital. How do students work through these contradictions, and what does empathy mean within the context of conflicting messages about patient care?

The second student said that she assumed that her team had been busy and forgot to give the news. This is not a surprising finding; market-based imperatives in medicine have led to cost-management strategies such as shorter patient visits and increased caseloads per physician, so that physicians have less time to discuss test results and students often spend more time with patients than the physician.[213] One study found that doctors in the hospital spent only four minutes and seventeen seconds per day communicating with each patient and twenty seconds per day talking with the patients'

[213] Robert Kuttner, "Market-Based Failure—A Second Opinion on U.S. Health Care Costs," *The New England Journal of Medicine* 358, no. 6 (February 7, 2008): 550, http://healthcoalition.staging.suminc.ca/archive/nejm2008.pdf (accessed December 10, 2012).

relatives.[214] Doctors need to bill for this time, so they are cognizant of the fact that their time is literally money. This may have detrimental effects on physician well-being, as another study illustrated that "higher patient-to-attending physician ratios and patient-to-resident ratios are associated with perceptions of insufficient time for patient care and increased provider stress." [215]

The students' description of their experiences illustrates how situations they encounter in the hospital cause them distress. As literature on student anxiety and distress relates these feelings to lower empathy as well as unprofessional behavior, and in so far as diminished empathy and poor interpersonal skills have been linked to poor quality of patient care, their distress is problematic. Students benefit from conversations about the larger influences on patient care and the flexibility to talk about these issues in class, which is provided explicitly in HEP, and implicitly other places in medical education. Providing a guideline for these encounters does not always provide time for exploring the context in which 'bad news delivery' encounters occur. Yet despite my interviewees' frustration during the encounters mentioned above, these students still felt empathy for their patients, still felt strongly that it was important for good healthcare provision, and worked to use their empathy to guide their interpersonal skills.

Situations like the ones mentioned above are also reflective of the hidden curriculum in medical education. The "hidden" curriculum," "informal curriculum," and "tacit values" of medical education often are used interchangeably, and all refer to "those

[214] Gerhild Becker, Dorothee E. Kempf, Carola J. Xander, Felix Momm, Manfred Olschewski, and Hubert E. Blum, "Four Minutes For a Patient, tWenty Seconds for a Relative—An Observational Study at a University Hospital," *BMC Health Services Research* 10 (April, 2012): 94, doi:1 0.1186/1472-6963-10-94 (accessed December 10, 2012).

[215] Nicholas S. Ward, Richard Read, Bekele Afessa, and Jeremy M. Kahn, "Perceived Effects of Attending Physician Workload in Academic Medical Intensive Care Units: A National Survey of Training Program Directors," *Critical Care Medicine* 40, no. 2 (February, 2012): 402, 10.1097/CCM.0b013e318232d997 (accessed December 10, 2012).

aspects of the curriculum and the socialization process that instill professional values and a sense of professional identity, but do so without explicitly articulating those issues (of professional values and identity)."[216] Wayne Woloschuk, Peter H. Harasym, and Walley Temple explain, "Student observations of various clinical and hallway encounters, indicating how their mentors, for example, maintain personal-professional boundaries and interact with ancillary health personnel, speak implicitly about what is valued."[217] These implicit values often are contradictory to those explicitly taught through formal course activities. For example, Jack Coulehan and Peter C. Wiliams write that medical school teaches students the tacit values of "detachment, entitlement, and non-reflective professionalism" that seemingly contradict the overt discussion of empathy and a caring ethic.[218]

The hidden curriculum influences students' educational experience in many ways. One study found that nearly half of medical students had been "placed in a situation in which they had felt pressure to act unethically, and sixty one percent of the students surveyed reported that they had seen a clinical educator behave unethically."[219] Strikingly, the students also reported that "the ethical problems they encounter were rarely discussed or resolved with clinical teachers."[220] The hidden curriculum has also

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[216] Jack Coulehan and Peter C. Williams, "Vanquishing Virtue: The Impact of Medical Education," *Academic Medicine* 76, no. 6 (June, 2001): 600, http://journals.lww.com/academicmedicine/Fulltext/2001/06000/Vanquishing_Virtue__The_Impact_of_Medical.8.aspx (accessed December 2, 2012).

[217] Wayne Woloschuk, Peter H. Harasym, and Walley Temple, "Attitude Change During Medical School: A Cohort Study," *Medical Education* 38, no. 5 (May, 2004): 531-532, doi: 10.1046/j.1365-2929.2004.01820.x (accessed December 2, 2012).

[218] Coulehan and Williams, "Vanquishing Virtue," 600-601.

[219] Lisa K. Hicks, Yulia Lin, David W. Robertson, Deborah L. Robinson, and Sarah I. Woodrow, "Understanding the Clinical Dilemmas That Shape Medical Students' Ethical Development: Questionnaire Survey and Focus Group Study," *BMJ* 322 (March 24, 2001): 709, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC30097/ (accessed December 12, 2012).

[220] Ibid., 709.

been linked to lower empathy scores as students progress through their medical training.[221]

Returning to the students' experiences mentioned above, the hidden curriculum sent the message to the students that relaying bad news in a timely fashion was not important since attending physicians and residents delayed informing patients, despite an explicit discussion about this in the "Delivery of Bad News" lecture. Yet the students' empathy led them to believe that delayed discussion of bad news was not good patient care. As mentioned above, frustration inherent to the process of negotiating empathy amidst the hidden curriculum may cause the emotional hardening discussed in the literature, with the result of decreasing overall feelings of empathy and students' empathetic actions.[222] This may mean that they may be less aware of patients' desires and needs, and, as a result, be less able to provide healthcare based upon these needs.[223]

Some students felt that the formal curriculum regarding empathy was not sufficient. Many of the students whom I interviewed said that they did not feel that empathy could be taught, at least in medical school. Many associated it with something they learned while growing up, through church or role modeling from their parents. Therefore, they found that education in medical school was either redundant or unhelpful. One second-year medical student reiterated these ideas when she explained to me where

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[221] Melanie Neumann, Friedrich Edelhauser, Diethard Tauschel, Martin R. Fischer, Markus Wirtz, Christiane Woopen, Aviad Haramati, and Christian Scheffer, "Empathy Decline and Its Reasons: A Systematic Review of Studies with Medical Students and Residents," *Academic Medicine* 86, no. 8 (August, 2011): 996-1009, http://bevwin.pbworks.com/w/file/fetch/50334489/Empathy%20decline%20%26%20its%20reasons.pdf (accessed December 6, 2012).

[222] Mohammedreza Hojat, Michael Vergare, Kaye Maxwell, Geroge Brainard, Steven Herrine, Gerald A. Isenberg, Jon Veloski, and Joseph Gonnella. "The Devil is in the Third Year: A Longitudinal Study of Erosion of Empathy in Medical School," *Academic Medicine* 84, no. 9 (September, 2009): 1182-1191, doi: 10.1097/ACM.0b013e3181b17e55 (accessed July 5, 2012); and Neumann, et al., "Empathy Decline and Its Reasons," 996-1009.

[223] Halpern, *From Detached Concern to Empathy*, 94.

she thought students acquired true lessons on empathy, which she contrasted with the activities in POM.

> I don't, honestly… think empathy is something you really learn. I think it's more something that, I don't know, you either have it or you don't. And it's kind of something you learn, I guess, growing up, just like you would learn patience or, I don't know, like trust or something like that. But I would just say it kind of comes with time and, you know, like, an understanding that people go through different things and just feeling for them and not being, like, cold.

The belief that empathy cannot be taught was expressed by faculty members at UTMB, as shown in the last chapter. This belief was perhaps due to the intangibility of empathy. Quantification is valued in a market-based ethics system, and this influences the creation of an assessment system for intangible concepts such as empathy. Hence, education that is based on this kind of ethics ends up in the form of tools and visible, quantifiable measures of empathy.[224] There is a large difference between the individual experience of empathy (often discussed in the literature) and empathy that is measurable and performed for a grade.[225] This student's remark hints at a recognition by the students that modes of teaching that emphasize these quantifiable aspects are insufficient to the realities of the experience of empathy for the student. It is important to reflect upon the question of whether you can teach empathy.

The students whom I interviewed had some ideas about this. Many of the students expressed that reading articles, without accompanying discussion, was not an effective way to teach empathy. One second-year medical student explained her feelings about some of the reading assignments for HEP.

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[224] See Sally Findlow, "Accountability and Innovation in Higher Education: A Disabling Tension?" *Studies in Higher Education* 33, no. 3 (June, 2008): 313-329 for further discussion on the influence of the market on university culture and innovation.

[225] See Halpern, *From Detached Concern to Empathy*; and Greenson, "Empathy and Its Vicissitudes," 418-424.

> I think that as much as they can try to get us to read an article and talk about a situation, I think that unless you are actually practicing it or unless, until you are put in a situation, I don't think you're really gonna, like, I don't think you can learn empathy from reading an article. Or, an article isn't going to sway you to be empathetic.

Her comment warrants further analysis. First, as Johanna Shapiro, Jack Coulehan, Delese Wear, and Martha Montello write in their article about incorporating the humanities in medical education, "As any medical educator will tell you, it is in the nature of medical students to complain about their curriculum."[226] Indeed, students complain about most aspects of their medical curriculum (even outside of the humanities).[227] However, because of the stress associated with other classes (this student was particularly stressed the day of our interview because of an upcoming exam on heart sounds), any reading that will not appear on an exam seems especially frustrating to them.

Yet this student's comments may also be reflective of the place of HEP within UTMB's curriculum and the larger culture of medicine surrounding the humanities. As opposed to the emphasis placed on other aspects of medicine, students have only seven weeks (and only two hours each week) of HEP. This is significantly shorter than other courses. As a result, students often do not remember that they have taken the course by their fourth year of medical school and remember very little (if anything) about the readings, making the course, in some students' minds, unhelpful. Furthermore, such a short time spent on the humanities and social studies sends the message to students that these subjects are less important than other coursework throughout their medical

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[226] Johanna Shapiro, Jack Coulehan, Delese Wear, and Martha Montello, "Medical Humanities and Their Discontents: Definitions, Critiques, and Implications," *Academic Medicine* 84, no. 2 (February, 2009): 192, doi: 10.1097/ACM.0b013e3181938bca (accessed December 13, 2012).

[227] Susan Miles and Sam J. Leinster, "Medical Students' Perceptions of Their Educational Environment: Expected Versus Actual Perceptions," *Medical Education* 41, no. 3 (March, 2007): 265-272, doi: 10.1111/j.1365-2929.2007.02686.x (accessed December 12, 2012).

education, such as lessons in the basic sciences, despite faculty insistence in individual interviews of the value of these areas to medical practice. Yet as Shapiro, Coulehan, Wear, and, Montello write, students will complain about any type of incorporation of the humanities into their curriculum, regardless of length of the curriculum or year of school.[228]

Critiques of the overall value of the humanities within medical education have been discussed in the literature. Shapiro and her colleagues write about the frequent complaints of students regarding humanities education, grouping the critiques into two areas: Critiques about its content and critiques about its teaching methods. With regards to content, the authors write that students complain that the humanities are not practical because they "can't provide student physicians with concrete skills (such as learning how to start an IV) that are useful in clinical practice."[229] Furthermore, because the material is so different from other subjects covered in medical schools, students become frustrated at trying to develop skills in such diverse areas, leading them to question the content of the education.[230] With regards to the teaching methods, the authors mention that students distrust information coming from perceived "outsiders" without medical experience (such as faculty members with graduate degrees in the humanities and social sciences), question where these courses would best be placed within the curriculum, and are uncomfortable exploring their own vulnerability through the reflective exercises commonly assigned in humanities courses.[231]

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[228] Shapiro, et al., "Medical Humanities," 194.
[229] Ibid., 193.
[230] Ibid.
[231] Ibid.

The dismissal of the role of readings in teaching empathy by the student discussed above may be reflective of some of these beliefs. For example, the articles that are assigned in HEP are qualitatively different from those found in other parts of their education, and this student's frustration may be due to her unfamiliarity with reading them and discussing the issues that are brought up through reflection. Yet the articles' distinction from other readings may be why they can contribute to empathy education. The readings present perspectives (such as the patient's or the social scientist's) to which the students might not be exposed. Patients may be reluctant at times to tell their physicians their deepest thoughts, and, when they do, students may not have the time to explore them as they might through reading assignments. Though these issues may make some students uncomfortable, hearing these perspectives may also help build empathy as well as provide useful starting points for discussion in class.[232] Furthermore, the course being taught by non-physicians and occupying such a small place within their education may have led this student to discount it as well. Some students may have simply found the course to be unhelpful.

Finally, it is worth emphasizing that the student complained about the readings and not the discussions associated with the readings. Though the readings provided jumping off points for discussion, it was during class that students were able to voice their concerns, ask questions, and talk about the topics for each week. Many of the students I interviewed and most that I observed in HEP enjoyed the in-class discussions

[232] Rita Charon, "Reading, Writing, and Doctoring: Literature and Medicine," *The American Journal of the Medical Sciences* 319, no. 5 (May, 2000): 285-291, http://uu6jc8mv6v.scholar.serialssolutions.com/?sid=google&auinit=R&aulast=Charon&atitle=Reading,+writing,+and+doctoring:+literature+and+medicine&title=American+journal+of+the+medical+sciences&volume=319&issue=5&date=2000&spage=285&issn=0002-9629 (accessed December 13, 2012); and Johanna Shapiro, Elizabeth Morrison, and John Boker, "Teaching Empathy to First year Medical Students: Evaluation of an Elective Literature and Medicine Course," *Education for Health* 17, no. 1 (2004): 73-84.

about the readings and felt that they learned something from them. Additionally, POM 3 and POM 4, in which students are asked to read and reflect on articles and their clinical experiences once a month with a clinical faculty member facilitator, are much beloved courses among third and fourth-year students. This student's comments point to the fact that readings alone are not sufficient to teach empathy; readings, discussion, and hands-on experience are all necessary.

Another student echoed some of these points when he insisted that UTMB needed more empathy training because many medical students did not come in with strong backgrounds in interpersonal relations. This third-year medical student had majored in business in college and worked in the business world for some time before coming to medical school and felt that he had learned more about empathy there due to the emphasis on the interpersonal dynamics of business throughout his four years in college.

> I feel like too many students come out, like, unaware…of empathy and how to relate to patients in just normal day to day… interactions with them… I think it's something that should be taught, you know, even in the undergraduate level more so, because they always expect, you know, [that] the majority of the medical students [have] science undergraduate degrees, you know… I mean, chemistry, biology, physics. Most of the time… they don't get enough teaching…in communication and rhetoric, and it kind of translates into medical school because then they put us in, like, these POM classes or the HEP classes, and they think [that] one hour every couple of weeks is going to teach somebody how to talk to somebody, and it's not. No, it's not.

In this student's opinion, activities in POM were too few to enact change in any of the students, and this sentiment was echoed by other students, as well. The interviewee's comments suggest that a couple of hours a week was not only not enough to change students' attitudes, but it certainly was not enough to counter the lessons they were learning about empathy through the hidden curriculum.

A further point that was often brought up in interviews was that some form of experiential learning was necessary for teaching empathy and that classroom work alone was not sufficient. One second-year medical student compared the lessons learned through the POM courses with those learned through seeing patients at St. Vincent's, particularly through watching physicians interact with the patients.

> I tend to get annoyed at it (lessons in class) frequently 'cause it's taking time away from things that I think are more important. Or [there are] more effective ways to teach it. Like, I really wish that a component of POM was St. Vincent's, and that they had people go. I feel like you could learn so much just by going and seeing how [the] doctors that are volunteering their time [there] interact with patients.

This student thought that the lessons learned through POM were better taught through role modeling by the attending physicians who volunteered their time at a community clinic and through seeing patients themselves. The idea that St. Vincent's should be a required part of POM was echoed by other students I interviewed. They felt the experience with the patients there had expanded their clinical practice and, in particular, improved their skills at interacting with patients of different backgrounds.

The students' emphasis on experiential learning may reflect issues that I discussed above surrounding the place of the medical humanities within medical education. The students' opinions may also point to the traditional emphasis on clinical experience in medical school and to the desire for students to find clinical role models. Furthermore, all of the students with whom I talked were regular volunteers at St. Vincent's and felt strongly that time there had influenced their understandings and expression of empathy.

Yet upon closer scrutiny, the lessons learned through St. Vincent's and through HEP have similarities. In particular, St. Vincent's provided opportunities for teaching moments, where students could discuss with faculty members and each other aspects of

the free clinic—such as the structural barriers influencing the patients' care and the economics of healthcare. These discussions mimic conversations in HEP and represent the process of both inquiring about and negotiating the various imperatives influencing medicine. The atmosphere at St. Vincent's is more relaxed, and students often feel more comfortable to voice their concerns and ask questions. This is similar to the open atmosphere created in HEP where students are encouraged to speak and give their opinions.

In this section, I have discussed students' opinions on the formal education that they received through their classwork. Though students found some of the tips useful and fitting with their own understandings of empathetic patient care, some lessons did not address all the realities of the students' clinical experiences, such as the frequency of miscommunication episodes in the hospital. This led to periods of distress for the students whose empathy for the patients led them to believe that they were providing a poor quality of care. Distress and depression have been linked to decreased empathy in the literature, which is problematic as empathy is often noted to be important for patient care. Yet the students I interviewed continued to let empathy guide their courses of action with their patients, despite frustrating circumstances. This empathetic response may decrease throughout their time in medical school because of the stress and frustration of working within this educational environment.

Students had opinions about how to improve their education. Some students felt that there should be greater discussion about empathy and interpersonal relations in medical school. As these topics are only discussed a couple of hours a month in POM 1 and HEP is only a seven week course, this comment is not surprising. Though some

complained about the readings assigned in HEP, explaining how these could not teach empathy, upon closer scrutiny the students' critiques may have been reflective of larger influences on their education, such as questions about the value of the humanities to medicine—especially medicine driven by tangible, market-based outcomes. Furthermore, many of the students valued experiential learning as part of their empathy education. Most of the students with whom I talked mentioned the importance of St. Vincent's to their understandings of empathetic patient care because they were able to work with patients themselves and watch physicians who had a clear dedication to community health model empathy for them. St. Vincent's presents opportunities for discussion of larger influences on healthcare that were in clinic, and due to the emphasis on clinical education and role modeling in medical education, it is not surprising that students valued these forms of education as well. I will take up these forms of informal education in the next section.

INFORMAL LESSONS: FINDING PERSONAL MEANING IN LIGHT OF THE HIDDEN CURRICULUM

Frederic W. Hafferty writes that much of what is learned is taught informally through the hidden curriculum.[233] He explains that "interpersonal interactions" with faculty and other students, including praise and criticism received on the wards, and role modeling by attending physicians and residents, are illustrative of values that often contradict those taught explicitly through formal curricular materials.[234] As Coulehan and Williams explain further:

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[233] Frederic W. Hafferty, "Beyond Curriculum Reform: Confronting Medicine's Hidden Curriculum," *Academic Medicine* 73, no. 4 (April, 1998): 403, http://harvardmacy.org/Upload/pdf/Hafferty%20article.pdf (accessed December 2, 2012).

[234] Ibid., 404.

> The explicit curriculum stresses empathy and associated listening and responding skills, the relief of suffering, the importance of trust and fidelity, and a primary focus on the patient's best interest. Tacit learning, on the other hand, stressed objectivity, detachment, wariness, and distrust of emotions, patients, insurance companies, administrators, and the state.[235]

Informal education sends powerful messages to students about how they should interact with patients and what behaviors allow them to be accepted by their colleagues. They also serve to guide students' future behaviors and their understandings of the medical profession. Coulehan and Williams cite the example of a student who had entered medical school passionate about various community health issues and eager to make a difference in her patients' lives. However, the authors contend that as a result of her medical school experience, which they say consisted of a "lack of nourishment and exposure to defoliants" through the informal curriculum, the student "adopted new values, developing a narrower view of life" and decided that the best thing she could do for her patients was concentrate first on her own needs.[236]

AT UTMB, as well, the informal means by which students learn about empathy are important factors in the students' understandings of empathetic healthcare, especially since they may undermine the formal lessons taught in class. Part of the meaning-making of empathy education involves trying to understand empathy within the context of both the formal and informal lessons taught about it. How do students negotiate these lessons about empathy? How can they remain empathetic despite tremendous pressure to feel or behave otherwise? Does empathy remain important to them?

One third-year medical student talked to me about lessons about empathy that she believed were taught informally on the wards during the third and fourth year of medical

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[235] Coulehan and Williams, "Vanquishing Virtue," 600.
[236] Ibid., 599.

school. She said that some rotations were known for having attending physicians that, according to her peers, did not encourage students to get to know their patients. She explained further that students believed this was due to the physicians' impatience regarding hearing personal information about their patients. Rather, they expected students to be brief, saying little more than the patients' vital signs. This student believed that some students took away the message that empathizing with the patient was unimportant in some specialties.

> STUDENT. I mean, I haven't encountered, like, a situation in which someone thought I was too caring. I haven't gotten to that point yet…. This is my only my third rotation and so far… people have let me just talk to patients and let me, like, really express, like, oh I really want to help them, or feel bad for them, or things like that… But, I don't know, I mean… From things I hear, I think there might be… [resistance to expression of empathy]. In the future, I might have some sort of resistance to, I suppose, caring too much or whatever, but I haven't yet.
>
> INTERVIEWER. What have you heard that you think that there's going to be some resistance to caring too much?
>
> STUDENT. Um, just, I guess, sort of in some rotations you just don't…really have time to really look at everything that the person has to say. It's just, like, what is relevant right now, what is relevant to us right now that we are going to do? Like, it's like social history. *Whatever*. Family history. *Whatever*… What's relevant at hand? What are we going to do? But let's ignore everything else. That's what I've heard, but I haven't experienced it yet, so I hesitate to talk about it.

This student felt that rotations like these sent the message that empathy was not important to patient care, and many students I interviewed discussed the idea that certain specialties were known for devaluing the interpersonal aspects of patient care—sometimes explicitly. For example, during a meeting about signing up for rotations for the following year, I witnessed one surgeon who stood up and reported that on his rotation they did not care about the psychological and social aspects of care, unlike some of the other rotations. He then began to chuckle. The comment was greeted by laughter by the

students, who, unsure whether he was joking or not, matched his tone and laughed along with him.

Students face the task of creating their own understanding of empathy in light of experiences such as these that often provide contradictory messages. Some physicians praise students for taking the time to listen to their patients, while others give the impression that this information is not important. One third-year student mentioned a family medicine practitioner whom she described as very empathetic with her patients, taking the time to get to know them and their lives. She reported the following about this physician:

> My preceptor was amazing, and she was just a brilliant role model for what a person should do in an outpatient clinic—just the way she spoke to her patient and, like…tried to help them for everything, tried to…like, figure out what their support system was, what kind of stressor they had. She was just great. Her patients were hugging her.

Despite her positive experience in this rotation, this student experienced other rotations that did not present such wonderful role models, and she anticipated having others in the future. This is an example of how formal and informal lessons must be negotiated, as this student made meaning of empathy at the intersection of the rules taught in school and the informal lessons illustrated through role modeling. Empathy was important to this student, and she appeared to desire to continue working on her expression of empathetic thoughts as well as other aspects of doctoring, regardless of the rotation.

Students make meaning of empathy at the juncture of formal and informal education and larger institutional imperatives. When placed with faculty members who do not appear to value empathy, students must decide between insisting on the importance of gathering a social and family history and risk receiving unfavorable

evaluations, eliminating these parts of the history during certain rotations, and abandoning empathy altogether. Students are aware that after they graduate they face even more decisions about empathy, as physicians face more and more demands on their time, and studies that have shown the decline in the amount of time that physicians spend with patients has been linked to declining job satisfaction.[237] Many students posed the question in HEP of how they could be empathetic when they had to see a patient every fifteen minutes. They worried that restraints placed on them by economic concerns would negatively influence the quality of care and level of empathy that they could provide. These are difficult issues to discuss, yet students desired to explore them as part of their meaning making processes.

Students also are taught lessons informally through the restrictions imposed on them in the hospital. UTMB has a contract to provide care to those in the Texas Department of Corrections and Justice (TDCJ) system and has a special hospital to do so. This hospital, which is attached to John Sealy Hospital, has a very different environment than the 'free world' hospital, as the rest of John Sealy Hospital is called. Guards stand in all the halls. There are strict dress codes, particularly for female students. Students are not allowed to bring in cell phones, and there are stern rules for interaction with the inmates.

All students have to see patients in the TDCJ Hospital throughout their time in medical school, and the experience raises questions about empathy, such as how to be

[237] David C. Dugdale, Ronald Epstein, and Steven Z. Pantilate, "Time and the Patient-Physician Relationship," *Journal of General Internal Medicine* 14, S1 (January, 1999): S34-S40, doi: 10.1046/j.1525-1497.1999.00263.x (accessed December 13, 2012); and Mark Linzer, Thomas R. Konrad, Jeffrey Douglas, Julia E. McMurray, Donald E. Pathman, Eric S. Williams, Mark D. Schwartz, Martha Gerrity, William Scheckler, Judy Ann Bigby, and Elnora Rhodes, "Managed Care, Time Pressure, and Physician Job Satisfaction: Physician Worklife Study," *Journal of General Internal Medicine* 15, no. 7 (July, 2000): 441-450, doi: 10.1046/j.1525-1497.2000.05239.x (accessed December 13, 2012).

empathetic with a patient who is in jail and has lived a life that is very different from theirs. The rules of the TDCJ also provide strict limits as to how the students may empathize with the patients there. For example, students may not be in most patients' rooms without a guard and are not allowed to sit down next to a patient (they must stand at all times). Students often struggle with these constraints while they may believe that these rules inhibit their abilities to get to know a patient. Many also feel the rules are overly harsh in light of how sick many of the patients in the hospital are. Others feel that the rules illustrate a view of the patients as less than human and serve as further punishment for the inmates.

One third-year medical student told me about an experience in the TDCJ Hospital where she was prohibited from providing the quality of care that she desired due to restrictions in the hospital, which she thought were inhumane.

> STUDENT. I get in trouble for it [empathy] in the prison.
> INTERVIEWER. By whom?
> STUDENT. I mean, not in trouble, but I…get, like, terrible looks from the nurses…. I wanted to clip one of my patient's toenails today. I just need to cut the toenail. It's…necrotic. It's … falling off. It's bloody all over… He's already got diabetic neuropathy. I mean he's got chronic osteomyelitis of the great left toe and the toe next to it. That's the nail that fixing to fall off, and it's not looking so good, and…it really just needs to be trimmed so it doesn't catch on a sock or a bed sheet and rip. And then we have an open wound… Anyway, I need to cut a toenail. The nurses won't do it 'cause they don't cut toenails, which is fine. I'll cut the toenail, but they won't let me do it. They won't let me have a pair of clippers in the prison hospital, so I might end up, like, sneaking a pair from the free world and then, like, following him to his procedure on Monday and just kind of, like, ninja-clipping it. But, like, I don't think normal people do that. I don't think normal people think about [how] I'm going to have to ninja-clip a toenail, but, these are the things I do 'cause I think it will make him happy and I think, like, it needs to be clipped because he doesn't need another infection…He's got way too many things going on to get another infection.

The student lamented how "apparently it would take an act of Congress to get a pair of toenail clippers into this man's room." The student had two concerns about the toenail.

First, it was a health risk for the patient, as it could lead to an open wound that would pose significant infection risk due to the patient's diabetic neuropathy. Second, the student was looking after the patient's well-being, as the toenail bothered the patient.

Yet the restrictions in the hospital about clipping toenails appeared to ignore both these concerns. Certainly the fact that some of the patients in the hospital have previously committed violent crimes and have the potential to do so in the future should be taken into consideration. However, another possible message sent by the restrictions was that somehow the patients in the jail were dangerous villains who might take a toenail clipper and injure their doctor, nurse, or themselves or, alternatively and as likely, did not deserve to have their toenails trimmed at all. However, this student saw the inmate as a suffering patient whose well-being could be improved by a small action on her part.

This student negotiated these conflicting messages about empathy (those in class and those illustrated by the rules in the prison hospital) by dismissing the rules that suggested that she should treat the inmates differently than her 'free world' patients. Her decision represents the process of meaning-making in light of many conflicting imperatives. Yet her decision could have had disciplinary consequences, and she believed that she was not liked among the nurses due to her beliefs. Her behavior is admirable in terms of aligning with understandings of the literature, but not all students would be brave enough to take on such a plan.

As alluded to by discussion of the hidden curriculum, role modeling is a powerful teaching method in medical school. One study found that faculty members identified as "outstanding teachers of humanism" taught "humanism and professional values almost

exclusively through role modeling."[238] Most of the students and faculty I interviewed emphasized that a significant portion of their empathy training came through role modeling. In the last section, I noted one student who said he had learned a lot about empathy through watching physicians at St. Vincent's interact with the patients there. He believed that the lessons learned from these physicians were stronger than those taught formally in the curriculum. Another medical student, in her third year, explained how role modeling affected her understanding of empathy.

> Um, I think that most of my education in medical school about empathy is, um, more of [on] a role model basis…I'm sure we've been, you know, taught about it in [the] Practice of Medicine class, but it doesn't really stick. I think it's one of those things that is very inherent, but the most important thing is having a good role model where you see somebody being empathetic and with good bedside manner, and that's where you get it.

Her comments echo Hafferty and others' about the potential power of the hidden curriculum due to the strength of role modeling in medical education. One study showed that ninety percent of medical students acknowledged a role model during their medical education, and sixty-one percent of the students reported that "their relationship with their role model resulted in personal growth and development."[239] Role modeling has also been linked to students' choice in specialties.[240]

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[238] Peter F. Weissman, William T. Branch, Catherine F. Gracey, Paul Haidet, and Richard M. Frankel, "Role Modeling Humanistic Behavior: Learning Bedside Manner from the Experts," *Academic Medicine* 80, no. 7 (2006): 661-662, doi: 10.1097/01.ACM.0000232423.81299.fe (accessed December 8, 2012).

[239] Scott Wright, Annie Wong, and Carol Newill, "The Impact of Role Models on Medical Students," *Journal of General Internal Medicine* 71 (1997): 53-56, http://depts.washington.edu/fammed/files/Role%20Model%20Impact.pdf (accessed February 8, 2013).

[240] Karen E. Hauer, Steven J. Durning, Walter N. Kernan, Mark J. Fagan, Matthew Mintz, Patricia S. O'Sullivan, Michael Battistone, Thomas DeFer, Michael Elnicki, Heather Harrell, Shalini Reddy, Christy K. Boscarin, and Mark D. Schwartz, "Factors Associated with Medical Students' Career Choices Regardin Internal Medicine," *JAMA* 300, no. 10 (September 10, 2008): 1154-1164, doi: 10.1001/jama.300.10.1154 (accessed December 13, 2012); and Charles H. Griffith, John C. Georgesen, and John F. Wilson, "Specialty Choices of Students Who Actually Have Choices: The Influence of Excellent Clinical Teachers," *Academic Medicine* 75, no. 3 (March, 2000): 278-282,

Though I was expecting students to discuss bad role models based upon the literature on students' and residents' dissatisfaction with educators on the wards, I often heard stories about physicians at UTMB whom the students found to be empathetic and who navigated the complexities of medical practice in ways that the students respected.[241] Many students that I interviewed talked about particular physicians at UTMB whom they viewed as being very empathetic with their patients. These anecdotes were told with tones of admiration, which speaks to the value that the students placed on empathy and the fact that they were seeking ways to incorporate empathy into their care. Rarely did I hear much elaboration about role models perceived as bad by the students. Students sought role models in many of their clinical experiences, a process which one third-year student discussed along with the teaching methods of these role models.

> Yeah, like um, just watching attendings, watching residents talk to patients and then you sort of decide which are, like, good role models to follow, and which kinds of people you want to emulate. And sometimes they do, like, [take] aside…the students, attendings do, and kind of try to do that—talk about it [empathy] in a didactic sense, and they try to say, you know, you always try to do what's best for the patients.

The process of searching for role models occurred throughout the students' medical school experiences in the clinic, on the wards, and in the classroom. However, this student expressed to me that it was not as simple as finding a role model and copying his

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http://uu6jc8mv6v.scholar.serialssolutions.com/?sid=google&auinit=CH&aulast=Griffith+III&atitle=Specialty+choices+of+students+who+actually+have+choices:+the+influence+of+excellent+clinical+teachers&title=Academic+medicine&volume=75&issue=3&date=2000&spage=278&issn=1040-2446 (accessed December 13, 2012).

[241] See Claude Beaudoin, Brigitte Maheux, Luc Cote, Jacques E. Des Marchais, Pierre Jean, and Laeora Berkson, "Clinical Teachers as Humanistic Caregivers and Educators: Perceptions of Senior Clerks and Second-Year Residents," *CMAJ* 159, no. 7 (October 6, 1998): 765-769, http://www.canadianmedicaljournal.ca/content/159/7/765.full.pdf (accessed December 13, 2012); and Brigitte Maheux, Claude Beaudoin, Laeora Berkson, Luc Cote, Jacques Des Marchais, and Pierre Jean, "Medical Faculty as Humanistic Physicians and Teachers: The Perceptions of Students at Innovative and Traditional Medical Schools," *Medical Education* 34 (2000): 630-634, doi: 10.1046/j.1365-2923.2000.00543.x (accessed December 13, 2012).

or her behaviors and expressions. Rather, students adapted desirable behaviors to their own strengths, developing a personalized method of behaving empathetically with patients. Role models exhibited a range of behaviors and interactions with patients that the students could contemplate and modify when seeing patients themselves.

The lessons learned through role modeling were vast, and the students often compared these to what they were taught in the Practice of Medicine course. One third-year medical student described a clinical experience she had during her first year of medical school. As part of the Practice of Medicine course she was assigned to shadow a physician who taught her a lot about how to interact with one's patients.

> STUDENT. And [during] my first clinical experience [during] first year, we, um, worked with one doctor and, you know, you just [had] first learn[ed] how to take histories… [This doctor] was a really good role model for me 'cause he's a really warm guy, and I got into medical school thinking, you know, I should be really polite, call everyone, you know, "Miss," "Ma'am," … and just not be very personal… and I think after watching [him], I was, like, that's not necessarily exactly what's right. That's not what they are trying to teach us in… the Practice of Medicine [course].
>
> INTERVIEWER. What did he… do that made you think that?
>
> STUDENT. Well, I just remembered, 'cause he did [treated] a lot of breast cancer…and he's a surgeon. He just, you know, [sat] up on the examination table, you know…next to the patient… It's like…you know, kind of, like, a casual thing. It's not like your doctor's sitting in the patient's spot, right? And you know [he] use[d] touch like, you know, physicians do. And I don't know where I got it into my head [that] you had to be formal, but I was like, "Hey, his patients, you know, really open up to him and really appreciate what he does."

Role modeling allowed her to better understand the lessons from POM; the lessons about empathizing and interacting with the patient learned in class came to life as the student watched the older physician interact with his patients. She found that this physician's style of interaction and expression of empathy was well-received by his patients, and the patients' reactions caused her to reconsider her understandings of empathy and the physician-patient interaction. This student said that she preferred expression of empathy

in a more relaxed manner—sitting next to the patient, calling him or her by first name—and so by role modeling these behaviors, this physician illustrated to her that this more informal approach was allowed within the medical profession.

As illustrated here, students learn lessons about empathy through informal means as well as through formal curricular materials in class. Rules and restrictions for behavior provide students with an understanding of the institution's view of patients. This understanding is at times accepted and at other times rejected by the students, as they work to negotiate their own ideas of empathy with those of the larger institution. Role modeling also provides rules of acceptable behavior, though in a less constrained way; students adapt behaviors and expressions learned through physician role modeling to their own strengths and desires.

Students value empathetic interactions with patients and look for role modeling of empathy in the clinical setting. Yet they are faced with many conflicting messages about empathy and the role it should play in healthcare. The hidden curriculum offers a powerful challenge to empathy education, and the students recognize that their status as students pose limitations to how they can interact with patients. For example, they are dependent on faculty members for grades that then determine the residency programs to which they can apply. This means that students often have to perform for the physicians in particular ways, an issue that I will take up in the next section.

PERFORMING 'UP:' THE INFLUENCE OF PERFORMANCE ON STUDENTS' EXPRESSIONS OF EMPATHY

Their status as medical students means that they are always under evaluation, and, as Haas and Shaffir write, medical students "remain acutely aware of their limitations,

and are highly sensitive to a perceived need that they must meet a variety of role expectations."[242] As I discussed in the last chapter, students are often graded by residents and attending physicians on their performance in clinical activities. They receive scores for professionalism and behaviors related to empathy, such as listening and expressing concern for a patient. These clinical evaluation measures often contribute significantly to the students' rotation grades in their third and fourth year, as well as their course grades in their first and second year. Students are also evaluated in informal ways, by faculty members and their peers, and the results of this evaluation process largely determines acceptance within the professional community.

The emphasis on evaluation means that students at times feel pressured to empathize with their patients in certain ways in order to gain high grades or acceptance. These empathetic expressions may differ from their own understandings of empathy or beliefs about desirable patient care. The aspect of performance is an important part of students' meaning making regarding empathy, particularly since, as some authors discuss, performance helps students to internalize certain values of the medical profession. Haas and Shaffir write that throughout medical school students "develop an increasingly sympathetic outlook towards their future profession" and that the "students became less able to voice criticisms of what they see as they adopt the role of those they will emulate in the future."[243] This is potentially problematic in light of the frequent reports of declining empathy values and the prevalence of poor role models.[244] Assuming

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[242] Jack Haas and William Shaffir, *Becoming Doctors: The Adoption of a Cloak of Competence* (Greenwich, CT: Jai Press, 1987), 77.

[243] Ibid., 77-78.

[244] Bruce W. Newton, Laurie Barber, James Clardy, Elton Cleveland, and Patricia O'Sulivan, "Is There a Hardening of the Heart During Medical School?" *Academic Medicine* 83, no. 3 (March, 2008): 244-249, http://casemed.case.edu/caml/pages/JournalClub08/March-DWolpaw.pdf (accessed December 14,

that empathy leads to certain behaviors within the physician-patient relationship (such as expression of concern or therapeutic touch), changes in empathy and performance for poor role models might lead to different forms of physician-patient encounters for the students that are potentially detrimental to the physician-patient relationship.

The prominence of performance by medical students has been discussed in the literature. Shaffir and Haas write that "[p]rojection of the right image is recognized by students as being as important as technical competence."[245] They illustrated how, in order to foster an image of dependability and competence, students develop performance strategies such as covering up mistakes and "taking initiative" through taking on additional clinical responsibilities and studying patient conditions without being asked in clinic.[246] Mary-Jo DelVecchio Good discussed the importance of the appearance of competence in her book on medical culture entitled *American Medicine: The Quest for Competence*. She explains that competence is a "fundamental symbol in the practice and politics of American medicine," continuing to say that medical students begin to develop an acute sensitivity to being perceived as competent in medical school through the evaluation and observation that occurs there.[247] This leads to students performing in such a way as to appear competent to attending physicians and residents.[248]

One third-year medical student explained how performance was a major part of her day on clinical rotations, as she often was unsure of how to behave with patients or

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2012); Hojat, et al., "The Devil is in the Third Year:," 1182-1191; Neumann, et al., "Empathy Decline and Its Reasons," 996-1009; Beaudoin, et al., "Clinical Teachers," 765-769; and Maheux, et al., "Medical Faculty," 630-634.

[245] Haas and Shaffir, *Becoming Doctors*, 74.

[246] Ibid., 73.

[247] Mary-Jo DelVecchio Good, *American Medicine: The Quest for Competence*, Berkeley and Los Angeles, CA: University of California Press (1995, 1998): 144.

[248] Ibid., 148-149.

what she should do next throughout her day but felt that she should act like she knew what she was doing. As she perceived asking too many questions as annoying to the attending physicians and residents, she had learned to behave as if she were a competent medical professional. This required that she adopt methods of appearing confident and making decisions for herself in regards to her time management without the direction of the attending physician. She gave the following description of her experience:

> Just when you are not sure about things and you just really can't go bug your resident or somebody else… it's just like pretend like you know what you are doing if it's not gonna hurt anyone. Geez**.**

Yet being perceived as competent appears to have more to do with impressing attending physicians than it does with empathizing with the patient, and performance may be detrimental to patient care, as students are focused on impressing their attending physician rather than listening to and addressing their patients' needs. Such an emphasis on performance suppresses the idea that empathy is about the patient since in that context empathy is more reflective of the needs of the institution and evaluation of the student than about the individualized needs of the patient. Of course, if the student is performing for an empathetic physician, it may have the effect of improving the students' interactions and feelings of empathy towards the patient. Students may also perform for their patients, as suggested by Haas and Shaffir, although their accounts describe students acting confident in front of their patients because that was the students' understanding of how a physician behaved.[249] This, again, seems to have more to do with professional expectations than with the patient. Furthermore, students feeling like they must make decisions on their own could increase mistakes being made in healthcare and may be

[249] Haas and Shaffir, *Becoming Doctors,* 78-79.

detrimental to communication between levels of the hierarchy, though it also may increase students' clinical abilities at a faster pace and prepare them for the responsibilities they will have once they graduate. However, added responsibilities may also have the effect of causing more episodes of stress and anxiety for students, which influence empathy as well.[250]

Seeing patients is inextricably linked to evaluation during school, and the students recognize this as influencing their expression of empathy. Students found that requirements for class and worries about grading sometimes led them to behave in ways that conflicted with their feelings of empathy for the patient. These situations were met by ambivalence on the part of students, who worried that the quality of care they were providing was poor because of the shifted focus from the patient to success in medical school. One second-year medical student explained how her behaviors with patients changed when she volunteered at St. Vincent's because of a lesser focus on grades and assignments.

> I think sometimes whenever I'm with patients for school or outside St. Vincent's, um, it's much more of a just go through this list, get this right… it's not a sit down and have this patient tell you about themselves. It's a have them go through their review of systems and answer this set of questions.

This student is referring to the checklists provided to students during POM 1 and POM 2 and the class assignments (often patient write-ups) that accompany patient visits during these courses. Students are expected to ask certain questions and perform physical exam maneuvers and write up these findings, and this student found that these requirements

[250] Neumann, et al., "Empathy Decline and Its Reasons," 996-1009; and Liselotte N. Dyrbye, Matthew R. Thomas, and Tait D. Shanafelt, "Medical Student Distress: Causes, Consequences, and Proposed Solutions," *Mayo Clinic Proceedings* 80, no. 12 (December, 2005): 1613-1622, https://medinfo.ucsd.edu/specialties/wellbeing/Documents/Medical%20Student%20Distress%20Causes%20Consequences%20and%20Proposed%20Solutions%202005.pdf (accessed December 4, 2012).

drew her focus away from the patient and towards the completion of checklists. Though I have mentioned that checklists are important and beneficial in some senses, the expectation by the faculty is that the lists serve as guidelines only. However, this student found the requirements so burdensome that it was hard to focus on empathizing with the patient.

Sometimes this focus on performance leads to feelings of moral distress. Moral distress is defined as the "negative feelings that arise when an individual believes he or she knows the morally correct response to a situation, but cannot act because of hierarchical or institutional constraints."[251] These experiences are common within medical practice; one study illustrated how about half of all medical students had experienced every item on a list of examples of events that might cause moral distress (such as witnessing a physician treat a patient or another student poorly or discharging a patient before the student thought the patient was healthy enough to leave) at least once.[252]

One student discussed an episode of moral distress she experienced during POM 2. The class has assigned clinical experiences where students are asked to perform a full medical history and physical on a patient in the hospital. The patient is assigned to the student by a member of the patient's healthcare team, and, once assigned, the student usually sees the patient without much further direction. However, sometimes the patients do not wish to be examined by a student or are in too poor a condition to undergo the

[251] Kimberly D. Lomis, Robert O. Carpenter, and Bonnie M. Miller, "Moral Distress in the Third Year of Medical School: A Descriptive Review of Student Case Reflections," *The American Journal of Surgery* 197, no. 1 (January, 2009): 107, https://www.med.unc.edu/transclerk/files/MoralDistress.pdf (accessed December 14, 2012).

[252] Catherine Wiggleton, Emil Petrusa, Kim Loomis John Tarpley, Margaret Tarpley, Mary Lou O'Gorman, and Bonnie Miller, "Medical Students' Experiences of Moral Distress: Development of a Web-Based Survey," *Academic Medicine* 85, no. 1 (January, 2010): 111-117, doi: 10.1097/ACM.0b013e3181c4782b (accessed December 14, 2012).

sometimes two-hour long examinations. This third-year student described an experience she had while completing this assignment that had caused significant distress for her.

> Uh, I was…very distraught, I had a patient who was in the ER with an asthma attack that I was asked to do a full H and P [history and physical] on. And, I really did sit there for two hours and go through her entire life history and try and do as many physical exam maneuvers on her as possible while she was getting a nebulizer treatment. At one point, [she] fell asleep on me. She was so physically exhausted [that] I just didn't really feel it was an appropriate patient for someone [to interview] who is not going to contribute [to the patient's care]. And even when I found [abnormal] things [in the H and P], I never could find the resident to correct them. I actually did ask the nurses, "Oh, by the way, she's not on this medication. Is there someone I can talk to about this?" It didn't matter [that I had figured that out], and so I felt really guilty about it, and I…sort of justified it [the H and P] as it was my learning experience. I had to learn to do an H and P.

The student felt that she had to perform the full physical examination in order to earn a good grade. All her efforts to decrease her stress were unachievable, as she could not get in touch with the resident or attending physician in charge to explain her findings or be assigned another patient. She believed her actions were unempathetic, and her behavior, in spite of this, was distressing to her. This experience is especially troubling since repeated episodes of moral distress have been linked to declining empathy levels, meaning that aspects of the medical curriculum appear to undermine the qualities that medical education seeks to instill in students.[253]

Evaluation results are linked to future career goals, another reason that students may be focused on performance. For example, one third-year student who wanted to go into a surgical specialty had been told that she needed to behave in a certain manner in order to accomplish that goal.

[253] Neumann, et al., "Empathy Decline and Its Reasons," 996-1009; and Dyrbye, Thomas, and Shanafelt, "Medical Student Distress," 1613-1622.

> I think, I think, um, not outright aspects, but, I think, there is a culture and an expectation, and, especially [since] I want to go into surgery…so the female surgeon, there's, like, the expectation should be really tough, and, like, you don't ask questions. You figure things out. And, you know, you are meticulous [in the] things you ask… More and more I kind of shape myself [into] being that person than perhaps I naturally am.

Yet this student understood the stakes of her performance in regards to herself and her patient. She knew that she needed to get letters of recommendations from the surgeons with whom she worked as well as do a series of interviews for residency. Both required that she behave a certain way in order to project the right image of a future female surgeon, which she described as someone who is serious, focused, and a bit stern.

Earlier in the interview, however, she had emphasized how empathetic she was with her patients. She liked to talk with her patients, and she described herself as emotional and desirous of a close relationship with them. For this student, the 'surgeon personality' seemed, at times, to not lend itself to the kind of empathetic healthcare she wanted to provide. She said that she tried to work on balancing the serious 'surgeon personality' with her more natural way of interacting with her patients, a process which informed the way she makes meaning of empathy.

> INTERVIEWER. How does that work itself out, like, when you are seeing patient, and you said that you…give yourself to it and get kind…of [get] emotionally pulled into the patient's story. How do you balance those two?
>
> STUDENT. I mean it is hard. I try to personally keep…you know, the emotional tie. I try not to take that home… When I'm in the patient's room, that's when it's [the emotional tie] directly related to their care. When I go home, that's…it. And I think being able to give that thirty minutes, however long it is, pretty thoroughly, I think, works and isn't too much…
>
> INTERVIEWER. So it's more kind of around peers and attendings that this sort of kind of tough female surgeon [is revealed]…
>
> STUDENT: Well, I mean it [performing as a surgeon] can be tough and how to do some bedside manner, too, you know.

Her idea that surgeons exhibit certain personality traits may be on target. One study illustrated that there was a dominant surgeon personality, based upon the results of the Revised NEO Personality Inventory.[254] The authors write, "Assertiveness and activity traits were common to both genders [of surgeons] and describe people who are dominant, forceful, and socially ascendant."[255] Both male and female surgeons also scored lower on the compliance trait, meaning that they are "more likely to be aggressive, more likely to prefer competition to cooperation, and they have no reluctance to express anger when necessary."[256] The authors also noted that, based upon their scores in the "conscientiousness" category, "As a group, they are capable, sensible, effective, and prudent."[257] Though this student may not be able to change her personality, she could change the behavioral manifestations of it, and this was a struggle she undertook everyday.

Students also performed in class, which was evident during discussions about empathy in HEP, though HEP facilitators often successfully moved the conversations out of the realm of performance. The examples I list below represent students' initial responses to questions asked in HEP regarding empathy, and I have included these examples due to their exhibition of the role that performance plays in the meaning-making of empathy. The benefit of courses such as HEP is that they allow students to

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[254] James McGreevy and Deborah Wiebe, "A Preliminary Measurement of the Surgical Personality," *The American Journal of Surgery* 184, no. 2 (August, 2002): 121-125, http://uu6jc8mv6v.scholar.serialssolutions.com/?sid=google&auinit=J&aulast=McGreevy&atitle=A+preliminary+measurement+of+the+surgical+personality&title=American+journal+of+surgery&volume=184&issue=2&date=2002&spage=121&issn=0002-9610 (accessed December 14, 2012).

[255] Ibid., 122-123.

[256] Ibid., 123.

[257] Ibid.

move beyond performance and consider their own feelings and opinions, which I discussed in the previous chapter.

When students were shown pictures of members of stigmatized populations and asked for their responses during HEP, the students were often quiet at first and their responses seemed guarded. One student, when asked to describe a picture of an elderly woman, instead discussed the furniture in the room with the woman, saying, "She looks like she's sitting on a nice sofa." The student did not comment on the woman's clearly adolescent hairstyle or about possible stigmatization of the elderly (which was the point of the exercise); he avoided mentioning these emotionally-laden aspects of the photo, perhaps because they might suggest bias or lead to discussion about vulnerability. Conversations about feelings and vulnerability do not fit in well with the students' perceptions of medical competence, and they are not often discussed in medical school, except in HEP and some other small group activities. As Edwenna R. Werner and Barbara M. Korsch write, "[B]ecause of the denial of the very existence of the doctor's feelings, when a student does speak of his feelings—to faculty, hospital staff, or even to his peers—he may be made to feel unusual, immature, mistakenly chosen."[258] In other words, students may risk rejection by peers by bringing emotions into discussions about patient care. Furthermore, students may feel as if discussing their feelings is out of context, since medicine is not a place where physicians express emotions with ease. This creates a paradox, as students are asked to perform care and demonstrate empathy without showing emotion.

[258] Edwenna R. Werner and Barbara M Korsch, "The Vulnerability of the Medical Student: Posthumous Presentation of L.L. Stephens' Ideas," *Pediatrics* 57, no. 3 (March 1, 1976): 321-322, http://pediatrics.aappublications.org/content/57/3/321.full.pdf+html (accessed August 3, 2013).

The students' responses to this exercise were also often heavily focused on diagnosing the persons in the images with various physiological and psychiatric conditions, another clue to the overriding dynamic of performance in the discussions. In clinic it is commonplace for attending physicians to ask students questions about diagnostic markers or probable diagnoses for nearby patients, and the students are rewarded for presenting the 'correct' answer. Given the frequency of those types of exercises, it is not surprising that the students would provide diagnoses when presented with the slides. For example, when presented with a slide of a woman who was suffering from anorexia, the students' responses diagnosed her with a drug abuse problem, body dysmorphic disorder, and various types of eating disorders. This process reinforced relationships to the patient commonly found in the medical profession: namely, the view of the patient as an 'other' not like himself or herself and a medicalized understanding of suffering. These understandings inform how students empathize with their patients. Conversations like the ones mentioned above also shifted the focus away from barriers to empathy and from discussion about the vulnerability of the students.

A focus on performance and a shift away from discussions about feelings and empathy is detrimental to discussions about empathy, though not unexpected. Jodi Halpern (2011) discusses the long neglected place of emotion in medical care, and she devotes much of her book to talking about the role that emotions play in empathy and in patient care, in general. She writes, "the fundamental justification given for detachment in medicine is the argument that it enables doctors to understand their patients' emotional experiences accurately, free of their own emotional bias."[259] Yet Halpern argues that "by critically using these subjective sources of information physicians will take fuller

[259] Halpern, *From Detached Concern to Empathy*, 17.

histories and engage in more effective communication."[260] Furthermore, unexamined emotions may inhibit the students' abilities to empathize effectively with the patient.[261]

The students' avoidance of talking about their emotions also lends itself to the idea of empathy as "detached concern," and, indeed, the students often expressed, inside the HEP classrooms, as well as in individual interviews, this understanding of empathy which Lief and Fox suggest is developed throughout medical school.[262] Students seemed concerned about remaining scientifically objective and not committing ethical violations, which they believed were caused by getting 'too close' to one's patient. These concerns are emphasized throughout the medical curriculum through exercises such as anatomy lab, which desensitizes the students and, therefore, may be linked to performance. Students learn that behaving in ways that reflect objectivity and emotional distance is rewarded in class. Given this, there was much insistence among students that some form of detachment was necessary for medical professionals.

> One student answers the question posed by the facilitator, "Is detachment unhealthy?" She says that it's okay to a point if to avoid a conflict of interest, to do your job, etc. (She didn't give further explanation.) However, it's too much detachment if you are not providing the proper level of care for the patient or not helpful to the patient. She didn't give any more details about what a "proper level of care" is or how one could determine this.

Along with the description of "detached concern," the quote is also notable for its obscured message. The student used many institutional buzz words, such as "conflict of interest" and "proper level of care," found in conflict management seminars yet I was still left wondering how the student would negotiate empathy amidst so many concerns, an

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[260] Halpern, *From Detached Concern to Empathy*, 39.

[261] Halpern, *From Detached Concern to Empathy*, 1-13; and Greenson, "Empathy and Its Vicissitudes," 418-424.

[262] See Harold I. Lief and Renee C. Fox, "Training for 'Detached Concern' in Medical Students," in *The Psychological Basis of Medical Practice*, ed. Harold I. Lief, Victor F. Lief, and Nina R. Lief. *(*New York City, NY: Harper and Row, 1963), 12-35.

issue she did not address explicitly. Remaining vague allowed the student to avoid discussing her own emotional vulnerability. Discussing "detached concern" may serve to help students internalize this understanding of empathy. The next question that arises from this is whether this is ideal for patient care. This, indeed, is a question that has been debated for some time, and that I will not attempt to answer here.[263]

In this section I have discussed how students' desires to perform for faculty and patients influences their understandings of empathy. Though performing for empathetic physicians may encourage students to empathize with their patients, many of the experiences described by the students illustrated examples of how performance inhibited their abilities to empathize with patients. The students found these encounters inauthentic and deeply troubling with regard to the messages about the value of empathy to patient care. Episodes where the pressure to perform impedes actions based on feelings of empathy cause the students distress and may also encourage students to internalize behaviors and values that stray from their own feelings of empathy and understandings of good patient care and from the values that are taught in the curriculum. Furthermore, repeated episodes of anxiety and stress have been linked to declining empathy levels. Yet students did not always feel as if they needed to perform, and all the students with whom I talked developed their own senses of embodied empathy through their clinical work, mostly at St. Vincent's. I will discuss their embodied understandings of empathy in the next section.

[263] Halpern, *From Detached Concern to Empathy*; and Charles Aring, "Sympathy and Empathy," *JAMA* 167, no. 4 (May 24, 1958): 449.

EMPATHY IN PRACTICE: STUDENTS' WORK AT ST. VINCENT'S

All of the students with whom I spoke talked about the experience of being empathetic with patients, particularly at St. Vincent's. Working with patients guided students' understandings of empathy and its practice, and these encounters with patients informed students' understandings of empathy in ways that they often could not articulate and in ways that differed from understandings they gained through class activities. In this section I will discuss empathy as an embodied practice. That is to say that empathy cannot be understood as simply a cognitive (or even emotional) understanding of a concept, and the body plays a major role in the meaning making process for students. Empathy is understood, in part, through experiencing it through the body and with patients.

Charles Taylor writes, "Our bodily know-how and the way we act and move can encode components of our understanding of self and world."[264] This encoding is often outside of our conscious understanding, and our bodies reveal meaning-making that we cannot articulate. Embodied understanding, then, encompasses the idea that our bodies play a role in our meaning making in the world. Taylor explains further:

> I know my way around a familiar environment in being able to get from any place to any place with ease and assurance. I may be at a loss when asked to draw a map or even to give explicit directions to a stranger. I know how to manipulate and use the familiar instruments in my world, usually in the same inarticulate fashion.[265]

This embodied meaning extends to our understandings about our relationships with other people. Taylor writes, "My sense of myself and of the footing I am on with others are in

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[264] Charles Taylor, "To Follow a Rule…" in *Bourdieu: Critical Perspectives*, eds. Craig Calhoun, Edward LiPuma, and Moishe Postone (Chicago, IL: University of Chicago Press, 1993), 50, http://books.google.com/books/about/Bourdieu.html?id=13fqL4FBGr8C.50 (accessed January 24, 2013).

[265] Ibid.

large part embodied also. The deference I owe you I carried in the distance I stand from you, in the way I fall silent when you start to speak, in the way I hold myself in your presence."[266] Particularly with regard to the students' volunteer work at St. Vincent's, this quote encourages us to look at how students' behaviors reveal the ways that they are empathizing with patients. Taking Taylor's lead, we could view students' meaning-making of empathy as occurring through their bodily interactions with patients—by where they sit, what they wear, and how they touch the patient. Feelings of empathy are intimately connected to the body and are experienced by the person within a body in relation to other bodies.

One third-year student talked about the process of learning to effectively express empathy at St. Vincent's, illustrating the role of the body in her meaning making process and the ways that students' meaning-making is individualized.

> STUDENT. Uh, I don't think…I've changed as far as empathy. I think I'm better at showing my empathy to patients. So I think I'm getting better at letting them know that there is somebody who cares for them, which is a hard spiel.
>
> INTERVIEWER. How do you let them know?
>
> STUDENT. Um, I mean there's a lot of body language involved in it that that I try to demonstrate, like, sitting down and letting them finish their sentences and even speak. Ah, it's just… letting them know whenever I walk into an encounter, talking about what the process is, making them an active participant in their own health care. And then always, before I walk out of the room, I just remind them, you know, my name's [student's name], and I'm going to be down the hall. If you guys think of anything or need anything, you can just holler, and I'll come back. So, I think there are little things you can do to let people know that they are being heard.

Within her description is the belief that cognition is not the only aspect of empathizing with patients; the body is involved in the meaning-making, as well. From knowing when to begin speaking to signals portraying a willingness to listen, this student emphasized the

[266] Taylor, "To Follow a Rule…," 50.

importance of practice with the body in developing an empathetic rapport with patients. While the students' curriculum addresses some of these bodily expressions of empathy (for example, students are taught about 'therapeutic touch,' about eye contact, and actions to make the patient more comfortable), the students must make personal embodied meaning of these lessons and learn how to express empathy individually.

The role of the bodily expression of empathy was mentioned by many of the students in individual interviews. To all of them, empathy was expressed through how they interacted with the patients, and these bodily responses were part of the meaning-making process and represented their interpretation of empathy. Furthermore, the students recognized that empathy was embodied in individualized ways. This meant that behaviors done by one student did not always work as well when another student mimicked them, requiring that they practice and develop unique approaches to expressing it with their patients. They especially valued their time volunteering at St. Vincent's in helping them to develop their understandings of empathy because this was where many of them had gained the majority of their clinical experiences during their first and second years of medical school. The scripts that they were provided in class were helpful, but they needed experience, too, in order to find personal understandings of empathy.

Another third-year medical student described the importance of practice with patients in guiding her understandings of what it meant to be empathetic and how to express empathy in ways that worked best for her and her patients. She believed herself to be too reserved and worried that her patients would not perceive her as empathizing with their struggles. Because she had been on clinical rotations recently that had not

allowed her much time with patient care, she had been working on developing a better approach with patients through her work at St. Vincent's. She explained the process:

> I feel like I am…like, I'm not very good at expressing… Like, oh, you know, I'm not going to walk into the room like my family medicine preceptor [and] just hug the patient, be all like bubbly and then effusive or whatever. But, uh, I feel like you can really care for them and not express it, but, of course, it is better to try to figure out a way to express it, and that's what I try to do. I've been trying to do this, and I hope that, like, just by watching various other people I could figure out a way to express it for myself and not necessarily go around hugging people or anything, whatever. But, I mean, you know, it is better to let them know that you care about them and you want to help them than to have them thinking, oh, you know, "They're just completely… the doctor is completely poker faced and just neutral," and they don't really know what you are thinking…

This student's discussion of the importance of bodily expression of empathy emphasizes that a feeling or idea about empathy is only part of the puzzle, and there is an equally important component of the body in understanding empathy, which this student felt did not come as naturally to her. At St. Vincent's, she was able to practice different approaches with patients and push herself to find the best way to express her empathy with patients. Her discussion points to the fact that understanding how to express empathy through the body is part of the meaning making to students.

Implicit in these students' quotations is the idea that empathy involves intimate connections and linkage between the mind and the body—that the two work together to inform their understandings of what it means to empathize with their patients. Taylor's thoughts, as well, encourage us to think even deeper and no longer view the separation between cognition and body; both work together to influence the meaning making process through their indistinguishability. These connections are perhaps made more evident when we think of how the body may express stereotypes or biases that the mind

has not quite grasped or the way that certain sights and smells may invoke bodily reactions.

As I have mentioned before, the patients at St. Vincent's are generally poor and have few other options for healthcare. They may present themselves in ways that are unfamiliar to the students volunteering there. For example, patients often use phrases to describe their medical issues that are foreign to the students. The phrase "falling out," which refers both to temper tantrums or losing consciousness, is used by many of the patients there but is not taught to medical students throughout their training. One student recounted the frustration on the part of his patient when he asked what she meant when she used the phrase, an experience which, to the student's exasperation, did not result in any clarification. The patients at St. Vincent's also may dress differently, smell differently, and interact differently than the students do with each other or with their peers. In other words, the patients embody cultures that differ from the students' cultures. These embodiments may invoke reactions in the students that do not align with the students' cognitive understandings of empathy and also influence their responses to the patients. Students may sit farther away from a patient who smells strangely or who has scars on his or her arms from previous drug abuse. Yet these responses, too, are part of the students' understandings of empathy and contribute to the students' meaning-making of the concept.

One second-year student found that his experiences at St. Vincent's were helpful in allowing him to both recognize and address biases and negative reactions to patients. He had the following to say about his time at St. Vincent's:

It's…an opportunity to practice to see patients who are difficult and to

> learn how to overcome your own biases and your innate reactions to negative things from the patient and to be able to learn how to cope with that and to still have empathy.

While this student underscores the importance of grappling with one's biases as a way of better expressing and feeling empathy, he also hints at the interplay between body and cognition in the meaning-making of empathy. He alludes to the fact that certain biases and stereotypes that we embody may exist with feelings of empathy, and that the body's reactions help the mind to better understand empathy.

Students' embodied practice of empathy is reflective of the larger structural forces influencing their meaning-making as well, and represents their interpretation of those forces. Through their postures, gestures, and interactions with patients they make meaning of the variety of factors that influence their understandings of empathy. Pierre Bourdieu talks about the idea of embodiment through his discussion of habitus. By habitus, Bourdieu means to reveal the ways in which we embody larger structural forces. He writes that our actions are not the results of a simple cause and effect process nor the result of free will.[267] Rather, our behaviors are representative of historical processes that provide the structures in which we live. He writes, "the habitus could be considered as a subjective but not individual system of internalized structures, schemes of perception, conception, and action common to all members of the same group or class and constituting the precondition for all objectification and apperception."[268] In other ways, we absorb the structuring forces in our lives and exhibit them through our bodies and behaviors. He explains further:

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[267] Pierre Bourdieu, "Structures and the Habitus," in *Outline of a Theory of Practice*, trans. Richard Nice (Cambridge, UK: Cambridge University Press, 1977), 72-95 73.

[268] Ibid., 86.

> The structures constitutive of a particular type of environment… produce habitus, systems of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles of generation and structuring of practices and representations which can be objectively "regulated" and "regular" without in any way being the product of obedience to rules, objectively adapted to their goals without presupposing a conscious aiming at ends or an express mastery of the operations necessary to attain them and, being all this, collectively orchestrated without being the product of the orchestrating action of a conductor.[269]

By this he means to say that people do not feel as if they are obeying rules or following a leader. Rather, we internalize the structures (political, social, economic) that influence and determine our livelihood and then behave in accordance with them. This process is not conscious, not directed by any specific person, and produces patterns of behavior deemed 'normal.'

So then the students in their bodily expressions of empathy represent larger structural influences, including those learned in school, from their personal backgrounds, and from larger social forces. Students may embody the hierarchies of medicine, the societal beliefs about persons who cannot afford their healthcare, and market-driven institutional pressures, among others. These factors influence their expressions of empathy and their interactions with patients by, for example, leading them to dress in certain ways, touch the patient in certain ways, and use certain phrasing known to the medical profession. Students' empathy with patients, for example, occurs while the students are wearing a specific wardrobe (the white coat) and using specific scripts (as discussed in the last chapter), and these bodily manifestations take part in the meaning-making of empathy for the students while being representative of larger structural influences on medicine.

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[269] Bourdieu, "Structures and the Habitus," 72.

These ideas become particularly evident in the context in which empathy is used, which is when patients are perceived as 'different' or as 'other.'[270] Students' behaviors with patients at St. Vincent's, then, manifest their understandings of empathizing with an 'other.' While students try to empathize amidst a rhetoric of compassion for those who are different from us, they are often not provided the space to discuss the challenges associated with empathizing with those that lead far different lives from their own. The process of trying to make meaning then is manifested through their interactions with patients, and their bodies represent the intersection of these larger structural forces with their individualized understandings.

One third-year student hints at these ideas when she discusses St. Vincent's.

> Well, it [volunteering at St. Vincent's] could either help or it could hurt. I see it going both ways. I think that for some people it could hurt because we do get a lot of drug seeking behavior, a lot of, you know, malingering, people who…really just want attention or really just want some pain killers that are coming in, and that can be very jading for a patient or for a student. Um, and I also think there's… a lot of people who come in who have had really, really tough lives, and if you try to get to know them I think that that's a great opportunity to see how the other half are living and how does a person get to the point where they are indigent and need a free clinic like St. Vincent's. And…I'm not saying it's, like, their fault, and I think [that] usually it isn't, but just seeing what the system is doing in the community living.

While some students may find St. Vincent's to be a place where they can learn to recognize and confront their biases, this student recognizes that St. Vincent's may also serve to reaffirm stereotypes for students and help them to better internalize certain embodiments of the medical profession and of empathy. For example, seeing drug-seeking patients numerous times at St. Vincent's may lead to the impression that most of the patients there struggle with substance abuse issues or, more broadly, that most poor

[270] Suzanne Keen, "Contesting Empathy," in *Empathy and the Novel (*Oxford, United Kingdom: Oxford University Press, 2007), 145-168.

people have problems with substance abuse (ideas which are still held by members of the medical profession). This, then, affects the students' abilities to empathize with patients and influences patient encounters. For example, students may be more suspicious of patients asking for pain-reducing medications or may be more worried about blood-borne transmissible illnesses, leading to an unwillingness to touch the patient or dismissing the patient's complaints of pain.

The students often found that the role of biases in healthcare was not addressed substantively in class, as discussed in the last chapter.[271] For example, though students are encouraged to not judge patients based upon their appearances, these issues are handled in ways that gloss over the realities of everyday clinic life. Students must try to understand how their own biases influence healthcare while also being presented with (and being asked to memorize) case examples that largely associate various diseases with different races.[272] Furthermore, as mentioned above, certain smells, accents, phrases, and behaviors may stir up negative emotions in students and cause students to identify these patients as 'other.'

Students are also confronted with biases everyday on the wards through role modeling by physicians. On one rotation, my attending physician said in an exasperated tone to an unfunded Hispanic patient who had been admitted to the hospital under his service that the patient was fat and had abdominal pain because he had eaten too many tortillas and drank too much beer. The patient, on the other hand, felt that his abdominal

[271] Instead, students were presented lectures on "challenging patients" and phrases and behaviors that could be used in difficult clinical situations. HEP, however, provides deeper discussions about identifying personal biases and their effects in the clinical setting.

[272] Sandra Turbes, Erin Krebs, and Sara Axtell, "The Hidden Curriculum in Multicultural Medical Education: The Role of Case Examples," *Academic Medicine* 77, no. 3 (March, 2002): 209-216, http://uu6jc8mv6v.scholar.serialssolutions.com/?sid=google&auinit=S&aulast=Turbes&atitle=The+hidden+curriculum+in+multicultural+medical+education:+the+role+of+case+examples&title=Academic+medicine&volume=77&issue=3&date=2002&spage=209&issn=1040-2446 (accessed January 29, 2013).

pain had been caused by a medication that had been prescribed to him by a previous doctor and became frustrated that the physician dismissed this explanation in favor of one which reflected stereotypes about Hispanic and poor patients. These issues are addressed in a critical manner in HEP and elsewhere in the curriculum, but students found that St. Vincent's presented learning opportunities in a hands-on setting that they did not have in class. While volunteering at St. Vincent's, students are able to take the time to talk with patients, working to resolve tensions and frustrations that may arise during appointments. This time with patients allows students to explore their own prejudices and the effects of prejudices on medical care, so that instead of blaming the patient and the patient's culture when conflict arises (such as what occurred in my anecdote), the students are better able to empathize and work with patients to arrive at more satisfactory resolutions.

As discussed in Charles Taylor's work and by the students above, the body has an understanding of empathy, and it plays a large role in the meaning-making process. The body may embrace stereotypes and stigmas and embody larger structural influences in ways that are intimately connected to our experiences in the world. As I mentioned previously, students may not desire to sit near a patient who they perceive as dirty or immoral. They may desire to wear gloves during all parts of the physical examination due to a fear of contamination by their patients. These bodily behaviors and worries influence students' understandings of empathy and reflect their interpretations of larger structural factors. The students with whom I spoke and observed discussed their experiences of St. Vincent's as being vital to their meaning-making process because it was a place where they could develop and refine their bodily expressions of empathy. The students discussed the importance of learning when to listen, when to speak, and

when and how to touch the patient, which they could practice at St. Vincent's. These were all aspects of empathizing with the patient that each student had to develop individually, and without hands-on experience, their understandings of empathy would be incomplete.

IN CONCLUSION: THE COMPLEXITY OF MEANING-MAKING

In the last chapter, I discussed how students are taught empathy in a toolbox format, which is influenced by larger institutional, market-based imperatives regarding profit-making. I have illustrated in this chapter how students make meaning of the lessons they learn in school about empathy and the factors that they juggle as they work to develop personalized, embodied understandings of empathy. Students learn at the intersection of numerous factors (institutional, economic, personal backgrounds), and their interpretations reflect numerous influences on the interactions with their patients.

I discussed in this chapter how students interpret the formal lessons they learned in class in various ways. At times they appreciate and utilize the things they were taught, while also desiring more frank discussion about institutional issues that impede their enactment of the scripts that they learned in class. Students also discussed the challenges of making meaning amidst numerous role models who sent varying messages about the role of empathy in patient care. As students are evaluated at all times in the clinical setting, performance played an important role in their meaning-making as well, and students were conscious that proper behaviors determined their grades and ultimately their residency choices. Students also valued experience in their meaning-making of empathy, as they learned that cognition was not the only aspect of empathy; that the body played an important role in their understanding and expression of the concept. These

experiences raise many questions about empathy and what it means for students to practice it in the clinical setting. The students themselves asked whether empathy could and should be taught at all in medical school. Furthermore, how could they continue to be empathetic amidst poor role models and a hidden curriculum that discourages forming connections with patients?

All of the students with whom I spoke valued empathy and believed it to be vital for patient care. Their resilience and desire to find personalized meaning is admirable, particularly in light of the numerous factors with which they struggle, as discussed in this chapter. They all recognized that everything learned in school required their own interpretations, and they worked to practice empathy in ways that worked best for them and their patients. Their experiences illustrate the need for deeper discussions that allow students to address and reflect on their meaning-making processes, particularly in light of declining empathy levels and the association of lower empathy with lower physician and patient satisfaction.

I have discussed in this chapter how students make meaning of the lessons they learn in school about empathy, and I have presented places where the curriculum fails to address the factors influencing the students' meaning making processes. For example, in the "Delivery of Bad News" lecture there was limited discussion about the institutional settings that would make the completion of the steps difficult. Students realized through their work at St. Vincent's that biases and stereotypes were playing a larger role in empathy than they had imagined, far beyond the lectures on cultural competency that they had received through school. Furthermore, their bodies played a larger role in empathy than addressed in lectures, and students were left with the responsibility to

understand and learn how their bodies were influencing their feelings of empathy and portrayal of empathy with patients. In the conclusion to this thesis, I will further address how empathy education may be improved and expanded upon in the medical curriculum.

Chapter 6 Conclusion

As I write this conclusion, I reflect upon the last two years in which I completed the research for this study and have since returned to medical school. Market-based medicine is an everyday reality for medical students at UTMB. They witness their attending physicians and residents struggle through learning to code their clinical encounters for billing purposes, they quote the UTMB "Satis-5-ied" campaign in response to questions regarding challenging patient encounters (we should do what "satis-5-ies" our patients, they reply, complete with hands holding up five fingers), and they mourn with their resident physicians as patients are discharged from the hospital without adequate follow-up because they have no health insurance. I watched my classmates roll their eyes as we were told by one physician educator that empathy is an upper-level skill that we were not expected to master. In the same lecture, we were taught that we should focus on pausing ten seconds after breaking bad news because that is what would be evaluated in our exams. Yet in another lecture by a different attending physician we were told that we should never break bad news to a patient as a medical student. However, as my research illustrated in the last chapter, the realities of the hospital often mean that students are left handling tough clinical situations, such as helping a patient cope with bad news, and the lack of organization in the hospital may mean that a student accidently reveals a poor prognosis before the patient has heard it from a physician.

Since beginning this research, I have become a student director at the student-run St. Vincent's Clinic in Galveston, and, in that position, have attempted to incorporate more reflective discussions into the day-to-day activities there, often feeling resistance

from students who find the reflection too painful or pointless, given the funding-related realities plaguing the clinic. What good does it do to reflect on how we are treating the patients when this is the only care that these patients receive? How can we have time to reflect when we are under-funded and have so many patients to see? These are the questions that are pervasive in the clinic, and I struggle with these questions as well because the clinic *is* under-funded and we *do* have many patients to see.

It is these experiences that have illustrated to me the poignancy and urgency of reflecting on empathy education. I raised several questions in the course of this thesis, including the role of performance and the market in empathy education. The term empathy at UTMB is used to signify a set of interpersonal skills and tools that may be used to produce a satisfied customer. Formal empathy training at UTMB focuses on teaching students phrases and body movements to help students perform empathy in patient interactions; their performances are then evaluated through simulated patient encounters or more informally by faculty in clinics or on the wards. This way of approaching empathy education is used by other medical schools, which offer communication skills training courses and interpersonal skill training inventions to help foster empathetic interactions with patients; these have varying results on students' self-assessment of empathy.[273]

[273] Katrien Bombeke, Sofie Van Roosbroeck, Benedicte De Winter, Luc Debaene, Sandrina Schol, Guido Van Hal, and Paul Van Royen, "Medical Students Trained in Communication Skills Show a Decline in Patient Centered Attitudes: An Observational Study Comparing Two Cohorts During Clinical Clerkships," *Patient Education and Counseling* 84 (2011): 310-318, doi:10.1016/j.pec.2011.03.007 (accessed July 14, 2013); Clotilde Fernandez-Olano, Julio Montoya-Fernandez, and Antonio S. Salinas, "Impact of Clinical Interview Training on the Empathy Level of Medical Students and Medical Residents," *Medical Teacher* 30, no. 3 (April, 2008): *322-324*, doi: 10.1080/01421590701802299 (accessed July 14, 2013); and Juhani Tiuraniemi, Riitta Laara, Tuul Kyro, and Sari Lindeman, "Medical and Psychology Students' Self-Assessed Communication Skills: A Pilot Study," *Patient Education and Counseling* 83 (2011): 152-157, doi:10.1016/j.pec.2010.05.013 (accessed July 14, 2013).

As I pointed out in the first chapter, one question that arises from this research is whether having students master an empathy skill set should be the goal of empathy education. Does empathy involve the performance of certain body gestures and voice inflections, or does it also require the internalization of the caring values of the medical profession? Many faculty members whom I interviewed for this study believed that skills were all that could be taught to students throughout the course of medical school because it was impossible to teach a student to *feel* empathy towards a patient. Additionally, academic requirements for the evaluation of medical students often mean that outward manifestations, which are easily observed, become the focus of teaching rather than discussion and self-reflection.[274] Against the views of some faculty at UTMB, however, Frederic Hafferty asserts that medical education should value more than good performances, writing, "It is not sufficient for students to acquire the knowledge, skills, and outward behavior necessary for practicing medicine;" rather, students must have a "general commitment not only to learning and excellence of skills but also to medical behavior and practices that are authentically caring" because that is what it means to be a "medical professional."[275]

Empathy education instead might involve discussion about how to develop deeper, more personalized connections with patients. As discussed earlier in my thesis, many scholars cite definitions for empathy that signal emotional linkages between the physician and patient; these understandings of empathy are often left out of education

[274] Delese Wear, "On Outcomes and Humility," *Academic Medicine* 83, no. 7 (July, 2008): 625-626, doi: 10.1097/ACM.0b013e318178379f (accessed July 17, 2013).

[275] Frederic W. Hafferty, "Professionalism—The Next Wave," *The New England Journal of Medicine* 355, no. 20 (2006): 2151, http://www.nejm.org/doi/pdf/10.1056/NEJMe068217 (accessed November 27, 2012).

focused on skills and outward behavior.[276] If we aim to talk about the emotional aspects of empathy, do skills training exercises teach students how to form and tolerate these connections with patients, or, if not, is there a way to incorporate emotional training into the existing skills framework? The authors of one study developed empathy didactic sessions for medical students that aimed to increase empathetic communication skills.[277] These sessions devoted much time to students' reflection on their emotional interactions with patients, with the rationale that "group process… can increase empathic ability in medical students or interns, as well as allow students to identify their own emotions, motivations, and reactions to patients."[278] The two-session course resulted in increases in self-reported empathy scores and illustrates the potential for skills training to also help foster emotional connections with patients.[279]

Finally, should empathy education include critical reflection on the non-medical influences affecting physicians' relationships with their patients? A recent systematic review on empathy education concluded that "[m]oving forward, educational scholars and researchers should consider addressing the widely reported characteristics of the decline in empathy, including psychological factors such as stress and fatigue, the 'hidden curriculum,' unstable learning environments, loss of idealism, and the perceived need for detachment."[280] Hafferty, too, suggests that professionalism education should

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[276] See Jodi Halpern, *From Detached Concern to Empathy: Humanizing Medical Practice* (Oxford, United Kingdom: Oxford University Press, 2001); and Ralph R. Greenson, "Empathy and Its Vicissitudes," *International Journal of Psycho-Analysis* 41 (1960): 418-424.

[277] Hannah Barnhill Bayne, "Training Medical Students in Empathic Communication," *The Journal for Specialists in Group Work* 36, no. 4 (December, 2011): 316-329, doi 10.1080/01933922.2011.613899 (accessed July 15, 2013).

[278] Ibid., 324-325.

[279] Samantha A. Batt-Rawden, Margaret S. Chisolm, Blair Anton, and Tabor E. Flickinger, "Teaching Empathy to Medical Students: An Updated, Systematic Review," *Academic Medicine* 88, no. 8 (August, 2013): 5.

[280] Ibid.

begin by addressing aspects of the medical environment that inhibit students from internalizing professional values, writing that the "focus on behavior may neglect our pedagogical responsibility to assess and transform the learning environments our students must navigate."[281] The political and economic environments that shape students' education and views towards patient care must be acknowledged within the curriculum as well. Yet many physicians are not comfortable leading these discussions, and collaboration with other departments to supplement physician knowledge may be difficult to organize. This means that addressing these issues may be time-consuming. In addition, the fact that most physicians are being pressured to increase their clinical productivity means that they will have little extra time to attend faculty development trainings.[282]

In considering these questions we must take the lead from the students by asking for student involvement while developing future empathy curriculum. Students are required to fill out course evaluations after each course at UTMB, and faculty members should be attentive to the input provided in these evaluations. Students' input regarding future empathy education at UTMB is vital, and it is clear from my research that students are deeply concerned with how they are relating to their patients and have ideas about what improvements could be made to their empathy education. At least one medical school has used student input to guide the coursework in empathy. At Rutgers University's Robert Wood Johnson Medical School, students were asked along with

[281] Hafferty, "Professionalism—the Next Wave," 2152.

[282] Arno K. Kumagai, "A Conceptual Framework for the Use of Illness Narratives in Medical Education," *Academic Medicine* 83, no. 7 (July, 2008): 654, doi: 10.1097/ACM.0b013e3181782e17 (accessed July 17, 2013); and Ana Catalina Triana, Michael M. Olson, and Dorothy B. Trevino, "A New Paradigm for Teaching Behavior Change: Implications for Residency Training in Family Medicine and Psychiatry," *BMC Medical Education* 12 (2012): 64, doi: 10.1186/1472-6920-12-64 (accessed July 16, 2013).

residents and faculty to develop a curriculum that would help students maintain empathy during their third year of medical school. The result of their work was a "Humanism and Professionalism" course in which students were given time to "debrief about the emotionally intense events they experienced and to share observations about positive and negative role models."[283] Students in this study suggested that they would like to share reflective comments on anonymous blogs on a password-protected system, which later became a requirement for the course.[284] Students reported that they were overall satisfied with the course and that "it helped them identify positive and negative role models and prevent burnout," though the course did not appear to effect declines in empathy.[285] However, the fact that the students were satisfied with the course is significant, since many such courses have met with disproval by students.[286] Students' traditional objections to courses involving the medical humanities and interpersonal skills include that they lack relevance, that it is not fair for students to be evaluated on skills that are not part of the traditional science curriculum, and that humanities courses should be offered as electives and not required courses.[287]

My study represents a first step in asking students for feedback regarding their empathy education. Students were given a chance to discuss their feelings about their empathy education and the factors that shaped their understandings about this hard to define concept. Most students that I interviewed believed that it is important to teach the

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[283] Susan Rosenthal, Brian Howard, Yvette R. Schlussel, Dana Herrigel, Gabriel Smolarz, Brian Gable, Jennifer Vasquez, Heather Grigo, and Margit Kaufman, "Humanism at Heart: Preserving Empathy in Third-Year Medical Students," *Academic Medicine* 86, no. 3 (March, 2011): 351.

[284] Ibid., 351-352.

[285] Ibid., 353.

[286] Johanna Shapiro, Jack Coulehan, Delese Wear, and Martha Montello, "Medical Humanities and Their Discontents: Definitions, Critiques, and Implications," *Academic Medicine* 84, no. 2 (February, 2009): 192-198, doi: 10.1097/ACM.0b013e3181938bca (accessed July 17, 2013).

[287] Ibid., 193.

basics of medical interviewing, such as the review of systems. However, they often expressed frustration when empathy education ended with scripts of appropriate lines to say in challenging clinical encounters and with little acknowledgment of barriers to empathetic interaction, such as short appointment times, the pressures of being evaluated by residents and attending physicians with varying understandings of empathy, and cultural differences between student and patient.

Students are not alone in calling for greater discussion of barriers to empathy. The importance of acknowledging factors, such as preconceived notions about race and gender and the hierarchical structure of the hospital, has been discussed by medical education scholars who have urged greater consideration of barriers to empathy.[288] Melanie Tervalon and Jann Murray-Garcia suggest that increased "self-reflection and self-critique" is needed at both the personal and institutional levels in order to produce thoughtful, culturally competent physicians, adding that "the same processes expected to affect change in physician trainees should simultaneously exist in the institutions whose agenda is to develop cultural competency through educational programs."[289]

Education that provides opportunities for students to think about the difficulties of empathizing with patients while working within the profit-focused modern medical environment will facilitate discussions that are more relevant to the struggles my interviewees described to me. Students' understandings of empathy are constantly developing, and better guidance and acknowledgement of this process is essential. All of

[288] See Batt-Rawden, et al., "Teaching Empathy to Medical Students," 1-7; and Hafferty, "Professionalism—the Next Wave." 2151-2152.

[289] Melanie Tervalon and Jann Murray-Garcia, "Cultural Humility Versus Cultural Competence: A Critical Distinction Defining Physician Training Outcomes in Multicultural Education," *Journal of Health Care for the Poor and Underserved* 9, no. 2 (May, 1998): 122, doi: 10.1353/hpu.2010.0233 (accessed July 17, 2013).

the students I interviewed mentioned times in which they felt unprepared for and frustrated by the barriers they faced in connecting with patients, such as institutional rules regarding incarcerated patients, class requirements that seemed at odds with the patient's needs, and poor role modeling. It became clear while talking with the students that maintaining the discussion at the level of performance created student frustration by minimizing the complexity of the patient interactions they encountered throughout their training.

UTMB already has places in the curriculum where these discussions may occur in a more formal way, such as the numerous small group sessions throughout the Practice of Medicine courses, as well as problem based learning sessions throughout the first and second years. These small group meetings provide opportunities for students to hear physicians reflect on the lessons taught during the small group sessions. The physicians' comments are often candid, and students are allowed to ask questions in a low-stress environment.

The benefits of small group sessions in empathy education have been discussed by other empathy educators. Bayne says the following about the small group sessions that occurred during the empathic communication course at one medical school:

> Group members seemed to particularly connect along the theme of current stressors and the limitations of time on empathic behavior. Students became passionate when describing shared experience of being restricted by the medical hierarchy, and thus feeling limited in the ways they could practice and apply empathic skills. Many students expressed frustration over being unable to engage with patients beyond completing a checklist of symptoms. Eager to please medical residents, students rushed through patient interviews so as not to delay the rest of their team. Many of these students saw empathic communication with patients as a drain on time and, more importantly, their own reputations with more senior professionals."[290]

[290] Bayne, "Training Medical Students in Empathic Communication," 325.

Her comments illustrate how students were able to discuss many of their own frustrations with medical education and the effects that institutional barriers had on empathizing with patients. As I mentioned above, students mentioned similar frustrations to me, and the passion with which they discussed these issues indicated to me that these would be good topics to discuss with the mentorship of a faculty member.

The benefits of small groups sessions in which medical professionals can discuss patient encounters candidly have also been demonstrated through the development of Balint groups for general practitioners. These groups consist of four to ten physician members who meet over several years, learning to "implement basic psychodynamic principles with special attention to the physician-patient relationship."[291] Members of these groups describe patient encounters, which are discussed with emphasis on "the story and the feeling it arouses [in order] to facilitate new ways of understanding the physician-patient relationship."[292] These groups have been illustrated to "improve the physician-patient relationship and may foster a patient-centered approach" and are well-received by their physician participants.[293]

Though UTMB has many small group sessions set up throughout the students' four years of medical education, deeper exploration of the barriers to empathy and the causes of the barriers to empathy provide better preparation for the realities that students face in the hospital every day, more so than rehearsals of scripts for use in challenging patient encounters. For example, as part of POM 1 and POM 2, students are asked to see patients and do write-ups. These experiences are often discussed in the small groups, but

[291] Dorte Kjeldman and Inger Holmstrom, "Balint Groups as a Means to Increase Job Satisfaction and Prevent Burnout Among General Practitioners," *Annals of Family Medicine* 6, no. 2 (March 1, 2008): 139, doi: 10.1370/afm.813 (accessed July 18, 2013).

[292] Ibid.

[293] Ibid., 143.

students are rarely asked questions such as how it felt to interact with the patient, whether it was hard to empathize with the patient, and what barriers there were to empathizing. Yet these are important questions that must be addressed in order for students to understand their own prejudices and roadblocks to interacting with patients. Students should also explore what factors keep them from seeing a patient as a person with whom they should or could empathize.

After the student directors discussed the challenges of interacting with patients at St. Vincent's, including culture differences between ourselves and the patients and our own feelings of guilt about the services we were not able to provide our patients, we started asking these questions to the undergraduates who volunteer at St. Vincent's as part of wrap-up sessions and have found the resulting conversations enriching, both for our volunteers and the student directors leading them. In the future, we hope to include our faculty volunteers in these conversations, as the mentorship provided by the faculty and their discussions of how they cope with the emotions that arise in clinic would be valuable learning experiences for the students as they learn to develop their own approaches to patient care in our clinic. David Buchanan and Renee Witlen encourage these conversations in clinics such as St. Vincent's, saying that "[i]deally, both the implicit and explicit curricula of student-run clinics could be sources of desirable ethics and professionalism education."[294] They add that the attending physician's involvement in discussions with students is important and "may determine whether students become

[294] David Buchanan and Renee Witlen, "Balancing Service and Education: Ethical Management of Student-run Clinics," *Journal of Health Care for the Poor and Underserved* 17 (2006): 480.

discouraged, inspired, complacent, or actively engaged in addressing the social conditions they observe."[295]

As the students move into their third and fourth years and exercise the elective opportunities provided by POM 3 and POM 4, small group sessions focus on providing time for the students to talk among themselves and with group facilitators about challenges in providing medical care. Each month students are given a topic and reading assignments, asked to write an essay, and then meet for dinner to discuss what they have read and written. Monthly topics include cultural competency, professionalism, physician burnout, and billing. POM 3 and POM 4 provide opportunities for students to reflect on their experiences and hear others do so as well. This reflection can serve as a useful adjunct to the scripts and props taught through formal course lectures while also allowing students to express their frustration at barriers to patient interactions and other aspects of their everyday clinical lives. Yet discussion can sometimes remain superficial. Pushing students to explore their own feelings about the medical profession would provide them with a better foundation to face challenging situations in their future medical practice, and, from my experience interviewing students, would give them a much appreciated opportunity to talk about their own frustrations and emotions.

Additionally, this guidance should take place on the wards and during the students' clinical rotations, along with the small group sessions that are already in place. For example, when attending physicians discuss the role of the market in education and the larger healthcare environment before, after, or during rounds or clinical encounters, students can see and learn about how their peers and role models struggle with the values of market-based medicine and those who suffer as a result of a profit-driven institution.

[295] Buchanan and Witlen, "Balancing Service and Education," 480.

Lester Friedman writes that, with the rise of managed care, physicians find themselves in "uneasy circumstances that threaten their financial stability, contest their most cherished ideals, and challenge their professional choices."[296] Students are aware of this changing culture and deserve to have this addressed in frank ways so that they may learn to cope with the changing healthcare environment. Time allotted to process some of the emotions brought up throughout the course of a patient encounter may decrease moral distress, which has been shown to result in declines in empathy.[297]

When attending physicians feel comfortable asking students to discuss their experiences with patients throughout the course of the week, such as after seeing patients in clinic or in the emergency room, students will, in turn, become more comfortable addressing issues related to patient care with them. While morning rounds are already a lengthy process, simply acknowledging times such as when a patient is stirring up negative emotions among team members or when a patient's care is affected by his or her lack of health insurance and discussing how these issues influence our empathy would not add much extra time to rounds and could serve as useful conversation starters for times set aside for more in-depth discussion after rounds. However, not all attending physicians and residents desire to have these deep conversations. Faculty development workshops that focus on helping attending physicians and residents learn how to start these conversations would help them feel more comfortable leading discussions on more

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[296] Lester D. Friedman, "The Precarious Position of the Medical Humanities in the Medical School Curriculum," *Academic Medicine* 77, no. 4 (April, 2002): 322, http://journals.lww.com/academicmedicine/Fulltext/2002/04000/The_Precarious_Position_of_the_Medical_Humanities.11.aspx (accessed July 17, 3013).

[297] Liselotte N. Dyrbye, Matthew R. Thomas, and Tait D. Shanafelt, "Medical Student Distress: Causes, Consequences, and Proposed Solutions," *Mayo Clinic Proceedings* 80, no. 12 (December, 2005): 1613-1622, https://medinfo.ucsd.edu/specialties/wellbeing/Documents/Medical%20Student%20Distress%20Causes%20Consequences%20and%20Proposed%20Solutions%202005.pdf (accessed December 4, 2012).

abstract topics. Collaborations with the Institute for the Medical Humanities during these workshops would provide attending physicians and residents guidance on how to better work through 'larger-picture' questions of changing medical practices and hierarchies. Faculty members at the IMH have extensive expertise in dealing with meta-level questions and, in particular, questions that are more philosophical in nature. Physicians need role models and interlocutors with whom they can explore these larger issues influencing healthcare. The role modeling of collaboration is equally as important for students, especially given the increased emphasis on translational medicine.

More than just being incorporated into faculty workshops and the Humanities, Ethics, and Professionalism course, the medical humanities should be better incorporated into the overall medical school curriculum. Friedman writes that, rather than thinking of the medical humanities as an addition to the medical education curriculum, the medical humanities should be incorporated into the courses from the first day of medical school, "contextualiz[ing] the other components of medical training and practice."[298] He insists that the medical humanities "functions as indispensable preparation for a full, rich, and meaningful perception of medicine as a profession and its place within the surrounding culture."[299] Furthermore, the inclusion of the medical humanities in the medical student's training "remains pivotal in helping to shape his or her entire future, both as a compassionate practitioner and as a reflective human being."[300] To date, however, most activities involving the medical humanities and empathy are not integrated fully into the medical curriculum but represent isolated activities or courses, such as point-of-view writing exercises that occur occasionally throughout the students' education or elective

[298] Friedman, "The Precarious Position," 322.
[299] Ibid.
[300] Ibid.

courses in literature and medicine.[301] Studies on the integration of medical humanities into medical education have illustrated improvements in students' empathy, but authors are quick to point out that it is unclear what long-lasting effects these activities have on empathy or even if the feelings of empathy translate into empathetic interactions with the patient.[302]

Having more collaboration opportunities between the IMH and physicians, such as more frequent POM 1 and 2 co-facilitation by an IMH faculty member and physician faculty member or more IMH involvement in rounds, would provide occasions for exploration of the context in which medical care is provided and of the physician-patient relationship which, as described in this thesis, are topics of interest to medical students. Finally, fuller integration of the IMH and humanities into medical education would mean that courses such as HEP would have a greater impact, as they will no longer be perceived as isolated attempts to humanize physicians but rather as part of a continuous infusion of the humanities into medical education at UTMB.

New initiatives are already in place with the goal of better integrating the humanities into medical education from the pre-medical through continuing medical education after residency. The Association of American Medical Colleges has announced that changes to the Medical College Admissions tests will better incorporate

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[301] See Kumagai, "The Conceptual Framework," 653-658; Johanna Shapiro, Lloyd Rucker, John Boker, and Desiree Lie, "Point-of-View Writing: A Method for increasing Medical Students' Empathy, Identification, and Expression of Emotion, and Insight," *Education for Health* 19, no. 1 (March, 200): 96-105, http://www.meded.uci.edu/medhum/presentations_mh/POINT-OF-VIEW%20WRITING%20ARTICLE.pdf (accessed July 19, 2013); and Johanna Shapiro, Elizabeth H. Morrison, and John R. Boker, "Teaching Empathy to First Year Medical Students: Evaluation of an Elective Literature and Medicine Course," *Education for Health* 17, no. 1 (March, 2004): 73-84, http://xa.yimg.com/kq/groups/18209225/785322773/name/Teaching+Empathy.pdf (accessed July 19, 2013).

[302] See Batt-Rawden, et al., "Teaching Empathy to Medical Students," 1-7; Shapiro, et al., "Point-of-View Writing," 96- 105; and Shapiro, et al., "Teaching Empathy to First Year Medical Students," 73-84.

ethics and the humanities.[303] The Transformation in Medical Education (TIME) Initiative, "a student-centered, clinically focused program designed to increase the effectiveness of medical education while shortening its duration" will change medical education in Texas.[304] The initiative aims to develop a model of premedical and medical education that includes four elements: a pre-health professions program, competency-based education, professional-identity formation, and non-traditional fields of study.[305] In particular the Professional Identity Formation portion incorporates the humanities by asking students to reflect on readings and artwork with the goal of developing key traits, such as altruism, empathy, and curiosity—all traits believed to be a part of one's professional identity. Another pilot project in Texas aims to link up undergraduate college campuses with medical schools, offering coursework and shared faculty resources so that students receive medical humanities education that is appropriate to each learning stage and that is better coordinated across learning levels.[306]

Finally, many of the students with whom I spoke mentioned incidences of poor role modeling or incidences where they worried that behaving in certain ways, such as not filling out course evaluations or bringing car keys or a watch to a simulated patient activity, could result in disciplinary action or poor grades. Medical educators should be aware of these pressures and address them with students. While some educators believe that the various stresses facing students, including worries about impressing attending physicians and matching to their residencies of choice, help prepare students for their

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[303] Association of American Medical Colleges, "The MCAT2015 Exam for Students," https://www.aamc.org/students/applying/mcat/mcat2015/ (accessed July 20, 2013).

[304] "Transformation in Medical Education," University of Texas System, http://www.utsystem.edu/initiatives/time/ (accessed July 20, 2013).

[305] Ibid.

[306] Thanks to Dr. Howard Brody and Dr. Mark Clark for discussing current curricular initiatives within the University of Texas system with me.

future careers as physicians, a frank discussion of these circumstances may help to build understanding between students and educators and provide opportunities to develop curricula that address the faculty members' concerns while remaining a positive learning experience for students. Additionally, students should also be given methods to object when attending physicians or residents are setting poor examples or when students feel pressured to perform in ways that do not align with their intuitive sense of what is right for the patients. Those avenues exist at UTMB; however, students are often unaware of them or feel as if saying anything is risky and may result in disciplinary measures or lower grades. Though the student government has created surveys that attempt to address these issues, the effects of these surveys are still to be determined as there has never been any further discussion of them with students. By creating an environment in which students feel powerless to say anything if they are mistreated or see patients mistreated, lessons about empathy are undermined, and the poor role modeling, mixed with frustration, may lead to decreased empathy for patients.[307] Students already have avenues where they may file anonymous complaints on a professionalism website, and they are encouraged to talk to course and clerkship directors if they encounter a problem throughout their education. Students remain tentative about using the professionalism website, however, as the consequences of filing a complaint seem unclear—both for the student and the object of the complaint, and the hierarchies of medicine mean that it is often difficult for students to have open discussions with attending physicians about problems or poor role modeling. Students recently have reported that the portion of the website for complaints is not functional any longer. Creating an environment where there

[307] Dyrbye, Thomas, and Shanafelt, "Medical Student Distress," 1613-1622.

is space for critique and discussion would allow students to regain some power and voice when they encounter situations that they find distressing.

This thesis was meant as a project to give a voice to the students amidst the vast number of lessons on empathy and the copious empathy education literature they are exposed to during their time in medical school at UTMB. What became apparent throughout the research process was the students' determination and courage in their journey to becoming empathetic physicians. Over and over again in individual interviews students talked about how they desire to connect with patients and provide a high quality of care.

As a student myself, I recognize how they strive and sometimes suffer. Poor role modeling, the hidden curriculum, and stresses over residency placement make it all the more difficult for them to empathize with patients. Furthermore, little discussion in the curriculum about student suffering means that students are unable or unwilling to acknowledge their stresses and frustration. It also means that students are forced to learn to be empathetic in an environment that is often not empathetic with them.

I do not mean to discount the educators with whom I spoke. Those whom I interviewed are passionate about medical education and desire to nurture students' skills with patients. Many of them must teach within a larger institutional context that values quantification and evaluation, necessitating the modes of teaching that UTMB has adopted. It is important to recognize that faculty values and teaching methods are shaped within this context, too.

I hope that this thesis brings to life the struggles and triumphs of the students in making meaning of empathy in relationships with their patients. I also hope that it can

stimulate discussion regarding ways to achieve better empathy education in medical school, as I think it is obvious that the students deserve and crave this.

Appendix A Questions Asked in Student Interviews

I will obtain demographic information on the people I will interview, such as age, gender, race, year in medical school, college, and hometown.

1. How did you find out about St. Vincent's? Why do you volunteer at St. Vincent's? How often do you volunteer?
2. What are some of the biggest challenges about working at St. Vincent's? About medical school?
3. How do you use empathy in your volunteer work at St. Vincent's?
4. What education do you receive in medical school about empathy? Have you learned about it elsewhere?
5. Describe empathy. What does it mean to you?
6. How is empathy related to bedside manner?
7. Do you think empathy is a helpful feeling for approaching patient care? Is it necessary?
8. On a scale from 1-10, the role that empathy plays in my healthcare provision would be…? On a scale from 1-10, how empathetic do you think you have been during your volunteer times in the clinic?
9. On a scale from 1-10, what is an ideal level of empathy for a physician? How does one achieve that?
10. Does volunteering at St. Vincent's Clinic affect empathy? If so, how?
11. What *does* affect empathy? (being well-fed, tired, is it on a patient by patient basis?)
12. Does one learn to be empathic? How so? Where? When?
13. When you are with a patient, how do you gauge your level of empathy? Do you even think about it? What about when you are watching other students interact with their patients? Do you consider their levels of empathy?
14. When is it most difficult to be empathetic?
15. When do you think you are most empathetic? Why?
16. How does your empathy affect patient treatment adherence or outcome?

Appendix B Questions Asked in Faculty Interviews

1. Please describe your professional role at UTMB.
2. Do you volunteer at St. Vincent's Clinic?
3. Describe empathy. What does it mean to you?
4. How is empathy related to bedside manner?
5. Do you think empathy is a helpful feeling for approaching patient care? Is it necessary?
6. On a scale from 1-10, the role that empathy plays in my healthcare provision would be…? On a scale from 1-10, how empathetic do you think you have been during your volunteer times in the clinic?
7. On a scale from 1-10, what is an ideal level of empathy for a physician? How does one achieve that?
8. Does volunteering at St. Vincent's Clinic affect empathy? If so, how?
9. Do you think empathy can be taught?
10. What is taught about empathy in medical school? Is it mentioned explicitly or do you find that it is taught more through example?
11. Do students learn about empathy outside of school?
12. How do you think that students understand empathy? Is it something you find that they care about?
13. Do you think there are aspects of the medical educational experience that make it difficult for students to practice empathy?
14. What is the ideal way to teach empathy?

Appendix C Sample Clerkship Evaluation

Clerkship Evaluation

Internal Medicine Clerkship Evaluation of

School Year: 2010-2011
Period: 3
Evaluator: Resident
Evaluator Capacity: Pink Tm. Resident
Service: General Inpt.
Form Opens: 6/28/2010
Closes: 9/17/2010
Length of Contact: more than 14 days

1.	HISTORY TAKING SKILLS
History Taking Skills: 4 - Outstanding	Consistently: ■ asks questions in a logical sequence ■ develops chief complaint fully ■ explores sensitive information professionally ■ data is accurate/correct
	Inconsistent performance of skills: ■ History incomplete or inaccurate ■ Misses key information or chronology unclear
Comments: takes accurate history even from difficult patients	

2.	PHYSICAL EXAMINATION SKILLS
Physical Examination Skills: 4 - Outstanding	Consistently: ■ performs PE or MSE maneuvers appropriately ■ able to perform complete exam for relevant area ■ able to distinguish normal from abnormal findings
	Inconsistent performance of skills: ■ cannot perform PE or MSE maneuvers correctly ■ does not perform complete exam ■ misses important abnormal findings
Comments: obtains accurate PE information.	

3.	COMMUNICATION SKILLS
Written Communication Skills: 4 - Outstanding	Consistently: ■ writes complete, thorough, well organized H&P ■ incorporates pertinent positive/negative information ■ daily notes are up to date, legible ■ data is accurate/correct
	Inconsistent performance of skills: ■ H&P disorganized, incomplete and/or missing important data ■ data inaccurate ■ does not update notes ■ does not incorporate team thinking ■ writing illegible

Verbal Communication Skills: **4 - Outstanding**	Consistently: ■ presents data in appropriate, logical sequence without commentary ■ uses proper medical terminology ■ focuses daily presentation to key info and tolerates interruptions w/o losing flow
	Inconsistent performance of skills: ■ disorganized in presentation ■ missing important data ■ data inaccurate ■ does not use proper medical terminology
Patient Education Communication Skills: **4 - Outstanding**	Consistently: ■ establishes rapport with even the most difficult patients/families ■ changes and adapts communication style for individuals in distress, or with emotional impairment ■ uses appropriate language for patient/family understanding
	Inconsistent performance of skills: ■ ineffective communicating or establishing rapport with patients/family ■ not easily understood by patient/family ■ insensitive to patient/family emotional state
Comments: establishes good rapport with his patients and their families. Presentations are organized.	

4.	PROBLEM-SOLVING SKILLS
Fund of Knowledge: **3 - Competent, Satisfactory**	Consistently: ■ Demonstrates thorough knowledge of common medical problems ■ understands basic pathophysiology ■ able to suggest appropriate diagnostic and therapeutic plan for level of training ■ shows evidence of outside reading
	Inconsistent performance of skills: ■ fund of knowledge spotty/sparse ■ demonstrates thorough knowledge of common medical problems ■ spotty/sparse knowledge of broad Tx categories ■ sparse knowledge of Dx tools ■ no evidence of outside reading
Application/Problem-Solving: **3 - Competent, Satisfactory**	Consistently: ■ appropriately interprets data to develop thorough, defensible assessments ■ able to problem-solve in a logical fashion ■ uses basic science principles in problem-solving ■ able to understand and interpret the important elements of hx/pe ■ appropriately prioritizes problems and DDx
	Inconsistent performance of skills: ■ has difficulty developing assessments with appropriately broad and defensible DDx ■ does not use a logical pattern to problem-solve ■ can not apply basic science principles ■ difficulty interpreting data ■ has difficulty with prioritization of info
Comments: appropriately interprets patient information and data.	

5.	PROFESSIONALISM
Professionalism: **4 - Outstanding**	Consistently: ■ demonstrates responsibility for patients and learning activities ■ Demonstrates thorough knowledge of common medical problems ■ actively participates in team activities ■ demonstrates respect for patients, healthcare professionals, peers, and staff ■ demonstrates honesty and integrity
	Inconsistent performance of skills: ■ appears disinterested in learning ■ chronically late ■ demonstrates disrespect of patients, healthcare professionals, peers, and staff ■ accepts constructive criticism/feedback poorly ■ does not demonstrate interest in improving skills ■ fabricates data ■ does not know patients

Comments:
professional, responsible, prepared

6.	GENERAL COMMENTS
	Student is a very affable individual who works hard every day. He helps the team function and assists the residents whenever he can. He demonstrates a deep fund of knowledge and can effectively educate his patients. From a month of observation, I believe he will perform very well in his residency.

7.	OVERALL PERFORMANCE
	Serious weaknesses noted in one or more areas. Student would clearly benefit from remediation.
	Some weaknesses noted. Performance is below that expected for a student at this level; student might benefit from remediation.
	Performance at expected level for training. Competence demonstrated in ALL skills areas necessary to pass clerkship objectives.
	Performance above level of training in some areas. Excellence demonstrated in some skill areas, competency in all other areas.
✓	Performance consistently above that expected for this level. Excellence demonstrated in ALL skill areas.

Return

Table 1: Research Overview

Method	Number of Hours	With Whom	Duration	Purpose
Participant Observation at SVC	4 hrs/ wk	Medical students in clinic	2 hrs per clinic day, 2 days/wk	Understand how second and third-year medical students negotiate empathy in clinic
Participant Observation in HEP classes	2 hrs/wk	POM small groups	2 hrs, 1 day per week	Understand what is taught to medical students about empathy
1:1 interviews	10	Medical students, outside of clinic	1 30 min. to 1 hr session	Understand how second and third-year medical students conceptualize empathy
1:1 interviews	5	Faculty members	1 30 min. to 1 hr session	Understand how faculty members perceive their role in teaching empathy

Table 2: Timeline

Date	Activity
March 1, 2012—September 8, 2012	Conduct Student and Faculty Interviews
June 5, 2012—September 6, 2012	Participant Observation at St. Vincent's Clinic
July 1, 2012—August 15, 2012	Participant Observation in HEP Classes
August 10, 2012—October 15, 2012	Transcribe, Code, Analyze
October 16, 2012—October 31, 2013	Complete Thesis

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