ABSTRACT

The Pedagogy of Clinical Empathy: Formation of the Physician

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Clinical empathy is a lively topic of discussion in the contemporary medical literature. Research indicates that empathetic physicians receive higher patient satisfaction ratings, as well as improved patient health outcomes, compared to non-empathetic clinicians. Consequently, clinical empathy appears to be instrumental in providing quality patient care. If empathy is essential for improving healthcare outcomes, should not medical students learn to be more empathetic? To address this question, we first explore the distinction between clinical sympathy and empathy. Then, two essays from the medical literature are used to compare the empathetic with the non-empathetic physician. Next, we examine the pedagogical issues involved in teaching empathy to premedical and medical students, as well as to residents. Finally, we conclude by discussing the imperative for training clinicians to deliver quality empathetic healthcare.

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THE PEDAGOGY OF CLINICAL EMPATHY: FORMATION OF THE PHYSICIAN

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CHAPTER 1

Introduction

Clinical empathy is an important factor in providing the best quality healthcare possible.[1] Indeed, recent research indicates that empathetic physicians receive higher patient satisfaction ratings, compared to non-empathetic clinicians.[2] Moreover, empathetic physicians—in contrast to their non-empathetic colleagues—experience better clinical outcomes. Thus, clinical empathy appears to be important for providing quality and effective patient healthcare.

But, if empathy is essential in improving health outcomes, should not the medical curriculum incorporate courses to equip students with empathetic clinical skills? To address this question, we initially explore the distinction between clinical sympathy and empathy. Two essays from the medical literature are then used to compare and contrast empathetic and non- empathetic clinicians. We next examine the pedagogical issues involved in teaching empathy to premedical and medical students, as well as to residents. We finally conclude by discussing the imperative for equipping clinicians with empathetic skills to provide quality healthcare.

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[1] SPIRO, H. M.; MCCREA CURNEN; M. G.; PESCHEL, E. *Empathy and the Practice of Medicine: Beyond Pills and the Scalpel*. New Haven, CT: Yale University Press, 1996.

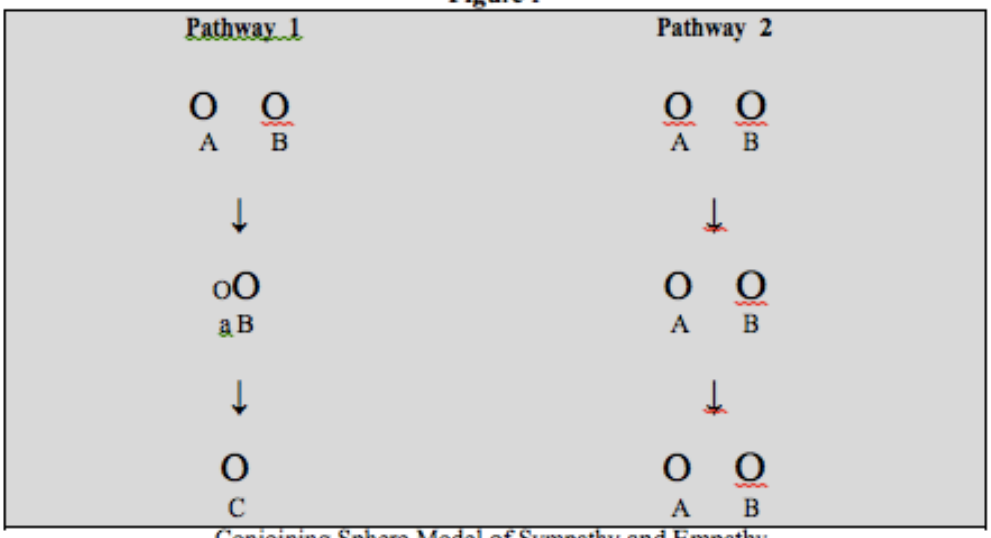
[2] PEDERSEN, R. 'Empirical research on empathy in medicine—A critical review'. *In*: *Patient Education and Counseling*, 76(3), 2009, p. 307-322.

CHAPTER 2

Sympathy and Empathy Distinction

In the medical literature, clinical sympathy and empathy are often distinguished from one another.[3] For example, clinical sympathy is described as simply an awareness of another's problem or situation and the existential Angst associated with it, while empathy represents not only an awareness of the problem but also the desire to relieve or resolve it.[4] We contest that this distinction is an obstacle to the pedagogy of empathy, especially in medicine. To surmount this obstacle, we propose a Conjoining Spheres Model (CSM) for the operational relationship between clinical sympathy and empathy.

Figure 1



Conjoining Sphere Model of Sympathy and Empathy.

[3] SVENAEUS, F. 'The relationship between empathy and sympathy in good health care'. *In: Medicine, Health Care and Philosophy,* 18(2), 2014, p. 267-277.

[4] HALPERN, J. 'What is clinical empathy?' *In*: *Journal of General Internal Medicine,* 18(8), 2003, p. 670-674

As shown in the Figure illustrating CSM, the physician is represented as sphere "A" and the patient as sphere "B". In pathway 1 - the empathetic pathway - as the physician begins to respond with sympathy towards the patient, sphere "A" becomes sphere "a" as it moves closer to sphere "B" in proximity - especially both psychologically and emotionally. The motion towards sphere "B" is defined as sympathy or a "feeling with" - to acknowledge its etymological origins. The physician is seeking to draw closer to the patient in order to make the best possible clinical decision vis-à-vis the patient's illness experience. As sphere "a", i.e. the sympathetic clinician, moves closer to sphere "B", it decreases in size, which indicates that in order to initiate an empathetic interaction the clinician needs to surrender external *bias*, information, or knowledge that might hinder or obstruct the empathetic response. As sphere "a" merges with sphere "B", an empathetic response is triggered. Eventually, sphere "a" and sphere "B" merge and form sphere "C" - a robust therapeutic relationship. This is the platform on which empathy can be experienced fully between both physician and patient.

In pathway 2, the non-empathetic pathway, the physician does not seek to sympathize, and especially not to empathize, with the patient. With respect to CSM, sphere "A" remains the same and does not move closer to sphere "B".[5] As a result, neither the sympathetic nor the empathetic response is launched between physician and patient. Finally, other pathways are possible in which a physician sympathizes with, or draws closer to, the patient forming sphere "a", i.e. the sympathetic clinician, but

[5] Obviously, pathway 2 does not exhibit the conjoining of the spheres as illustrated in pathway 1, but we include it as part of CSM for contrast with pathway 1.

for one reason or another the sympathetic physician never commences with an empathetic response fully to form sphere "C" with the patient, or does not fully engage in empathy and consequently only partially or incompletely forms sphere "C" with the patient.

There is support for CSM within the contemporary philosophy of medicine literature. For example, Jochanan Benbassat and Reuben Baumal's describe the expression of clinical empathy as a process in which the physician recognizes the patient's medical need and moves toward meeting it.[6] In terms of CSM, this initial movement is seen as sympathy that eventually leads to an empathetic response; but, as noted above, it need not lead to this response - i.e. the physician may not ultimately conjoin with the patient empathetically.

Also, Fredrik Svenaeus champions the idea behind the initial sympathetic movement between physician and patient accordingly, *Sympathy is to be understood as the driving force of* the empathy *process, a part of its form rather than its content* (p. 269).[7] According to Svenaeus, this initial sympathetic movement is critical ultimately for an empathetic response. The proposed CSM extends his insight by providing an operational representation for the proximal relationship between sympathy and empathy.

6 BENBASSAT, J.; BAUMAL, R. 'What is empathy, and How can it be promoted during clinical clerkships?', *In*: *Academic Medicine,* 79(9), 2004, p. 832-839.

7 SVENAEUS, F. *Op. cit*., p. 269.

Two essays from the medical literature admirably illustrate pathways 1 and 2 of CSM. First, Richard Weinberg's *Communion* exemplifies pathway 1 or the empathetic pathway.[8] Weinberg, a gastroenterologist, describes his clinical encounters with a young-adult female patient, who had consulted several physicians for "chronic abdominal pain", but they were unable to treat her effectively. Over several consultations, Weinberg forges a sympathetic relationship with the patient, which eventually develops into an empathetic one. In terms of CSM, Weinberg moves from sphere "A" to sphere "a". After establishing the sympathetic relationship, the patient confides in Weinberg about a recurring nightmare. Using past clinical experiences, along with emotional attunement and intelligence, he asks the patient whether she had been sexually assaulted. She then recounts how her older sister's boyfriend had raped her when she was a young teenager. After this consultation, Weinberg and the patient form a robust therapeutic relationship based on empathy in which he was able to treat her effectively. Again, in terms of CSM the clinician and patient conjoin to form sphere "C".

CSM's pathway 2 or non-empathetic pathway is illustrated by Mary O'Flaherty Horn's essay, *The Other Side of the Bed Rail*.[9] Horn, a physician herself, describes the uneasiness of shifting from clinician to patient and her first-hand experience with a non-empathetic clinician.

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[8] WEINBERG, R. B. 'Communion'. *In: Annals of Internal Medicine,* 123(10), 1995, p. 804-805.

[9] HORN, M. O. 'The other side of the bed rail'. *In: Annals of Internal Medicine,* 130(11), 1999, p. 940-941.

After receiving an initial diagnosis of Amyotrophic Lateral Sclerosis or Lou Gehrig's disease, she elects to consult a specialist to confirm the diagnosis. The consulting clinician, Dr. L, treats Horn as though she is simply a machine with broken parts. The clinician's lack of humanistic care causes her considerable distress and shame. An empathetic or even a sympathetic relationship was never established between patient and clinician. In terms of CSM, both Horn and Dr. L simply remained two separate spheres—spheres "A" and "B"—during the consultation process.

CHAPTER 3

Medical Education

We propose that formal pedagogical initiatives for teaching clinical empathy should begin with premedical studies. Traditionally, premedical students must complete specific coursework in the natural sciences, such as Biology, Chemistry, Physics, Biochemistry, and Organic Chemistry.[10] Unfortunately, humanities courses are generally not required. But with the recent change in the Medical School Admissions Test (MCAT) within the United States, premedical students are expected to take introductory Sociology and Psychology courses. Moreover, a limited number of humanities courses, such as Medical Ethics and Critical Thinking, are also beneficial in preparing for the new MCAT. It is these changes in the MCAT that provide an opportunity to develop courses that begin to equip premedical students with the skills necessary for practicing empathetic clinical medicine.

Humanities courses provide premedical students with the opportunity to ask existential questions pertaining to a patient's illness experience, such as: What does it mean to suffer from an illness? What is disease? What is disability? What is health? When is it morally acceptable to intervene at end of life? The pursuit of such questions is instrumental in providing premedical students with the chance to appreciate the value of the art and practice of empathetic medicine. For the empathetic

[10] MEDICAL SCHOOL ADMISSIONS REQUIREMENTS. *Preview. Internet*, https://services.aamc.org/msar/home#null

physician is a healer who is competent not only in the science of medicine but also in its art.

A significant number of Medical Humanities courses are designed around the discussion of literature. Through literary analysis, premedical students learn to immerse themselves in the patient's narrative. In terms of CSM, students begin to engage in the process of becoming sphere "a" or sympathetic. Specific observations, challenges, and different perspectives are brought to light, as students engage in such analysis; and, they appear to develop not only a greater empathetic character but also "a greater appreciation for the art of medicine."[11] The two essays by Weinberg and Horn illustrate the power of literary analysis for introducing premedical students to the role of empathy in providing quality medical care.

In *Communion*, Weinberg narrates an initial clinical encounter with the patient. As he was taking her medical history, Weinberg *questioned her…studied her with growing fascination. She was anxious and withdrawn, but nonetheless she projected a desperate courage* (p. 804).[12]

In terms of CSM, he was transforming from sphere "A" to sphere "a". This inquisitive approach, as Weinberg took the medical history, illustrates that he was focused on more than just logging information into a computer system. The interaction was not disinterested but interested concern for the patient, which she, in turn, recognized. Such interest allowed him to pose more probing questions about the patient's illness experience.

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[11] MCLELLAN, M. F.; JONES, A. H. 'Why literature and medicine?' *In*: *Lancet,* 348(9020), 1996, p. 109-111.

[12] WEINBERG, R. B. *Op. cit.*

His sympathetic concern was soon to transform clinical consultations into empathetic therapeutic opportunities with the patient, i.e. forming sphere "C".

In contrast to Weinberg's empathetic interaction with the patient, Horn, in *The Other Side of the Bed Rail*, describes her uncomfortable experience meeting Dr. L for the first time. Dr. L lacked conscious ability to sense how unsympathetic and demeaning he was treating her. His robotic responses were further evident as Horn states that Dr. L's expressions "made it clear that he had no further interest" in her other than as a pathological specimen (p. 941).[13] In terms of CSM, the clinician remained sphere "A" and the patient sphere "B".

The desire for deeper understanding and questioning, as evidenced with Weinberg's essay, is precisely what Medical Humanities programs can provide premedical students. We are proposing that the pedagogy of clinical empathy should commence with such programs. Through the coursework within these programs, students begin to learn to process observations and to pose deeper questions regarding clinical practice, as it pertains to the patient's illness experience. Medical Humanities programs are essential in preparing premedical students to develop empathetic interactions with patients later in medical school and throughout their medical careers.

Part of the reason for beginning to equip premedical students with empathetic skills is that once these students matriculate to medical school the workload, especially in the clinical sciences, increases dramatically.

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[13] HORN, MO. *Op. cit.*

For during the first two years, medical students are learning the necessary clinical information to become technically competent physicians. However, during the last two years medical students enter the clinic to begin practical rotations. Benbassat and Baumal make several recommendations for equipping medical students with empathetic skills. One recommendation involves the art of taking a patient's history. They propose a shift from the perfunctory questions of the disease- centered interview to open-ended questions of a patient-centered interview. The clinician's listening and communication skills are vital for engaging in a sympathetic response, as depicted by sphere "a" in CSM, and ultimately drawing closer to the patient to initiate empathy. Another recommendation to promoting empathetic patient-physician relationships is to place medical students in a primary care setting for clinical clerkship. Placing students in this setting allows them to interact directly with patients. Audrey Young supports this recommendation with the observation that patient narratives are a key component of quality patient care.[14]

There is concern within the contemporary medical literature, however, over the pedagogy of empathy in medical school. For example, one concern is the fear that teaching empathy may cause greater problems and result in patient harm. Anna Smajdor and colleagues voice this concern, asserting that "doctors do not necessarily benefit patients by entering their world view and feeling their pain or embarrassment" (p. 381).[15] However, their concern is addressed in terms of Weinberg's empathetic

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[14] YOUNG, A. *What Patients Taught Me:* A Medical Student's Journey. Seattle: Sasquatch Books, 2004

[15] SMAJDOR, A.; STÖCKL, A.; SALTER, C. 'The limits of empathy: Problems in medical education and practice'. *In: Journal of Medical Ethics,* 37(6), 2011, p. 380-383

response to the patient's emotional turmoil, which allowed him to make an accurate diagnosis and to engage in effective therapy that resulted in the patient's healing. Thus, the patient benefited from him joining in her perspective, i.e. conjoining spheres "a" and "B" to form sphere "C". Contrasting Weinberg's experience with Horn's experience in *The Other Side of the Bed Rail,* illustrates the injurious impact a non-empathetic clinician can have on a patient. By not entering the patient's experience of illness, a doctor may actually cause the patient harm and add to the patient's suffering - as in Horn's case.

Unfortunately, during medical school and residency, a definite decline in empathy has been documented, which has been called the "hardening of the heart".[16]Several curricular initiatives have been implemented to address and possibly to reverse this decline. For example, Bruce Newton and colleagues initiated a pedagogical innovation called "art-making" in which family medicine clerkship students were instructed to reflect on a clinical encounter with a patient and then to write a poem, to create a picture, to write a reflection essay, or to have a discussion with a fellow student about it.[17] They found that understanding the patient's perspective is foundational for assisting medical students to become empathetic physicians. As one student testified,

> It had never occurred to me that there was so much room for imagination and creativity in thinking of a person, patient, or illness…there's no such

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[16] NEWTON, B. W.; BARBER, L.; CLARDY, J.; CLEVELAND, E.; O'SULLIVAN, P. 'Is there hardening of the heart during medical school?' *In: Academic Medicine*, 83(3), 2008, p. 244-249.

[17] POTASH, J. S.; CHEN, J. Y.; LAM, C. L.; CHAU, V. T. 'Art-making in a family medicine clerkship: How does it affect medical student empathy?' *In*: *BMC Medical Education,* 14(247), 2014, DOI**:** 10.1186/s12909-014-0247-4

thing as a black and white world—but rather the difference in our perceptions (p. 4).

Another pedagogical innovation is viewing films, which has been found to have a transformational influence on medical students and residents.[18] Through watching films, students can visualize the physician's impact on the patient's illness experience. Although films may appear idealistic and impractical, they do allow medical students and residents to evoke and engage emotions, which are often suppressed in their clinical training, and to address them in constructive rather than destructive ways. Finally, requiring residents to spend time as "fake" patients - i.e. to have them dress in hospital gowns and to reside in hospital rooms as patients - is another innovation to address the decline of empathy in residents.[19] Horn certainly illustrates the transformational experience of becoming a patient and the influence the experience had on her perspective.

[18] SHAPIRO, J.; RUCKER, L. 'The Don Quixote effect: Why going to the movies can help develop empathy and altruism in medical students and residents'. *In: Families, Systems, & Health,* 22(4), 2004, p. 445-452.

[19] SCHECK, A. 'Putting residents in patients' gowns enhances empathy'. *In: Emergency Medicine News,* 23(8), 2001, p. 28-29.

CHAPTER 4

Conclusion

In sum, it is imperative that premedical and medical students - along with residents - develop the ability and capacity to appreciate perspectives external of the basic and clinical sciences, which are directed towards the arts and humanities of clinical practice. During premedical studies, Medical Humanities programs in particular provide the resources and opportunities to promote critical thinking skills, which allow students to empathize with patients. The medical school curriculum can then utilize what students learn in these programs to enhance empathetic responses, which can continue into residency particularly through the guidance of empathetic mentors, and to reduce the current decline in empathy during the clinical years. Finally, the pedagogy of empathy is a lifelong process for practicing physicians, which enables them to provide comprehensive and quality patient care.

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