Empathy and Medical Education

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Empathy is the feeling generated in physicians by patients when "I and you" becomes "I am you."[1] Spiro, in his elegant recent message, called it "an almost magical phenomenon."[1] Freud defined it as "the mechanism by which we are enabled to take up any attitude at all towards another mental life"[2]; others said it was "a feeling of being at home with the object contemplated as a friend," and "it includes a merging of the viewer with the viewed."[2]

Empathy is experienced often by physicians when they can identify sufficiently with their patients so that they feel some of the same elation, frustration, depression and pain of those for whom they provide care. It is an emotion that must be distinguished from sympathy, the major component of which is a feeling of wanting to help or of feeling sorry for someone. Obviously, too much empathy impairs the diagnostic and therapeutic process; there is a fine line between an overwhelming and unproductive identification with the patient, and an unfeeling excess of distant objectivity.

Unfortunately the process of both undergraduate and graduate medical education seems almost designed to drive empathy from the student and resident. Medical educators teach science. We stress objectivity. The collection of data is paramount. The goal of undergraduate medical education is that the student acquire the necessary skills, habits, attitudes, values and knowledge sufficient to interview a patient, collect, synthesize and integrate the clinical data and formulate an appropriate diagnostic and therapeutic plan successfully.[3] Nowhere in this catechism (promulgated initially by the Association of American Medical Colleges) is there mention of empathy.

The student is transformed into a physician during the clinical clerkship—a crucial and central event in his or her education. This is preceded by a variable period of immersion in the basic sciences, sometimes attached to clinical problem solving. Success is measured by objective testing of data recall and problem-solving skills. The matrix from which all of these efforts emerge is one of competition. This is the framework around which the efforts of pre-med students, medical students and residents are centered. Competition pervades our system of medical education. Intellectual elitism is our standard; it is not the most compassionate or empathic student or resident but that student who achieves the highest grades on test scores whom we honor. It is no wonder that the lessons learned by our trainees are that the relationship with a patient has a low priority, that performance is measured best by grades, and that achievement is reflected by the prestige of the medical school and of the residency program at which the student is accepted for further training.[5]

Nowhere in this construct is there room for teaching or learning empathy—what Martin Buber has called "the I and thou." It is true that the threshold between empathy on the one hand and lack of caring on the other is fuzzy. Too much empathy, an excessive identification with the patient, could paralyze clinical efforts. For instance, the emotions generated even in the most hardened physician who cares for the child dying of leukemia, can overpower and suppress the critical need for objective clinical assessment and action. Such empathy becomes counterproductive. Osler told us to maintain equanimity; yet although there should be some emotional distance from the patient, this should not be so much as to remove passion from the encounter.

Unfortunately, today this balance is out of kilter. Too often, in the modern environment of catastrophic illness and technical overkill, we lose sight of the patient as an individual. Too often at morning report or on ward rounds students and residents are heard talking about taking "hits," joking or laughing at the expense of a patient, or ignoring simple and heartfelt needs for empathy.

Spiro feels that "the increased emphasis on molecular biology to the exclusion of the humanities encourages students to focus not on patients, but on diseases."[1] This is conventional and traditional wisdom, but interest in the humanities does not necessarily imply a humanistic or empathic physician.[5] There clearly is a difference between the humanities and humanism; those interested in the humanities might turn out to be humane and sensitive physicians, but this is more likely related to self-selection than it is to effective immersion in humanities, transforming a previously narrowly focused student into the compassionate and empathic clinician hoped for. A consistent cliche in this area is the belief that the compassionate physician cannot be scientifically minded. As Seymour Glick has stated, "focusing on the humanities as playing the pivotal role in compassion is misplaced and represents a misunderstanding of what humanities can and cannot accomplish. After all, the humanities, particularly the arts, are ethically neutral. They provide important aesthetic values but inherently embody few ethical values. Some of the world's most heinous crimes were perpetrated to the strains of Haydn and Mozart by individuals immersed in the works of Goethe and Heine."[4]

Selecting a pre-medical student with a broad background in the humanities, or requiring that medical students read poetry and critique modern literature should not imply that these acts will *create* a humane physician; there are countless examples of

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caregivers with no background or interest in the humanities who are empathic and understanding. It is likely that interest in the humanities and the potential for humanism go together.[3]

Finding a Connection

The single most important measure that we could take to teach empathy is to promote a connection between the patient and the physician. This can be taught by example and, perhaps, should even be required. Such a connection implies a human relationship and a transference of emotion from one person to the other. The history taker should no longer remain only a passive recipient of data whose role is to extract relevant objective information from the patient. He or she must first and foremost develop a true and clear identification with the patient as a person.

The induction of empathy is dependent on the initial patient encounter and how it is structured. There are several mechanisms that can be established which can create and maintain empathy between the trainee and the patient:

1. Develop a connection by finding out who the patient is. This means that the usual and traditional way of taking a history by asking the name, the chief complaint, and the history of the present illness is misplaced. The first step should be for the student/resident to introduce himself or herself, and ask the patient for name and age and then say something like, "I'd like to get to know you a little bit before discussing the reason why you are in the hospital. Tell me about yourself." As meticulously as the experienced history taker would be in extracting information about the details of illness, so he or she must exploit this open-ended invitation to learn about the patient. This must provide a glimpse into the patient's life, personality, sensitivities and environment; it will generate the kind of empathic connection that is essential for the humane physician. Only after the historian determines that he or she knows the patient as a person—and it does not take very long to generate this sense—should the standard, traditional history be taken.
2. The trainee should focus on the most important symptom and relentlessly pursue it. Most patients will not fully describe the major reason for coming to the hospital without being prompted. For instance, if the patient complains of shortness of breath, far more time should be spent on the description of that symptom—what the patient experiences, how the patient perceives it, what emotions are engendered by it, what the patient fears about it—than in an unrelated and time-consuming pursuit of remote past illnesses. We see this most prominently in the student historian who has not yet learned to take a history efficiently; five or 10 minutes may be spent exhaustively searching for information about irrelevant family history in an elderly patient, but not adequately obtaining information about the principle symptom.

Why such a focus on the major complaint, even in excess of the need to understand it for clinical reasons? Because it generates empathic feelings even in the most hardened caregiver and because it provides the historian an opportunity to *feel for* the patient (compassion), *with* the patient (empathy), and *sorry for* the patient (sympathy).

3. During training each student or resident should have experience in what it feels like to be a patient. I would divide these into the following categories:

Loss of Identity Experiences

Each student should be required to be admitted to the hospital for a day, have all familiar bedclothes removed, and wear a hospital gown. He or she should have an enema and have a portion of abdominal or pubic hair shaved.

Gurney Experiences

Students and residents should lie face-up on an open gurney, with or without a thin blanket covering them, in a radiology department, apparently unattended and waiting for a procedure. No matter what the disability, the student or resident should lie perfectly flat, facing the ceiling. As an alternative site, the trainee on the gurney should be placed with the same attire in a patient and staff elevator during a busy time of the day when students, house officers, attending physicians, housekeeping personnel, crash carts, and various equipment are all transported at the same time. Preferably this should occur late in the day, when students and residents will be discussing "hits," difficulties with recalcitrant patients, and plans for the weekend. The acute diminution of personal worth and self-esteem generated by such experiences will be interesting and enlightening for the trainees.

Procedure and Disability Experiences

- Each student or resident must, during training, experience a series of rectal and/or pelvic exams, usually by groups of trainees. Furthermore, each student or resident must have at least one endoscopy performed (sigmoidoscopy or upper GI).

Each subspecialty trainee should be required to experience the following in their particular disciplines:

- The orthopedic fellow should be required to wear a non-weight-bearing cast for a week.
- The ophthalmology trainee should have his or her eyes patched to create temporary blindness for two days.
- The gastroenterology fellow should undergo jejunal biopsy and colonoscopy.
- The cardiology fellow should undergo right heart catheterization.
- The hematology/oncology trainee should undergo a bone marrow aspiration.
- The urology fellow should undergo a transrectal ultrasound examination of the prostate gland.

There will be other procedures and/or temporary disabilities with an acceptably low risk that should be identified as relevant for other trainees.

These are serious suggestions. It is remarkable how sobering such experiences can be for those who provide care. Unfortunately, periodic reinforcement may be necessary.

4. Each supervisor/teacher must be required to demonstrate empathy. This is not an outlandish suggestion—just as we each demonstrate the proper technique of auscultation of the heart or palpation of the abdomen, so should we be required to show that as practitioners and teachers we can and will develop empathy with our patients.

Summary

Spiro has said, "computed tomographic scans offer no compassion and magnetic resonance imaging has no human face. Only men and women are capable of empathy."[1] Empathy is an essential and required part of our roles as caregivers. We must enhance this natural emotion that exists in each of us; we can do so by carefully designing a curriculum, much as we would for

learning about the physiology of the liver.

The roots of our need for detachment and equanimity go back to Sir William Osler, but the pendulum has swung too far, and the need for retention of millions of data bits overwhelms our souls. Although excessive emotion is destructive and counterproductive, we must not suppress our passion—but control it. The best physician both *feels* with the patient and prescribes *for* the patient at the same time. To do one without the other is inadequate care. As medical educators our task is clear.

References

1. Spiro H. What is empathy and can it be taught. *Ann Intern Med.* 1992;116:843-846.
2. Freud S. Group physiology and the analysis of the ego. In: Stracheyj. *The complete works of Sigmond Freud*. London, England: Hogarth Press; 1955: Vol 18.
3. Schatz IJ. Changes in undergraduate medical education-a critique. *Arch Intern Med.* 1993;153:1045-1051.
4. Glick S. Humanitarian medicine is a modern age. *N Engl J Med.* 1981;304:1036-1038.
5. Schatz IJ. On the quest for the humane physician. *Hawaii Med J.* 1994;53:196-198.

Nonclinical Use of Medical Skills: Beneficence Lost?

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The first time that I was asked to probe a rectum to search for sequestered drugs remains fresh in my memory. The correctional lieutenant, commander of the watch, seemed more menacing than the convict suspect as I attempted to explain my refusal to participate. "Yes, I am employed by the prison, but I am a physician. My profession's code of ethics prevails."[1-2]

It may have been the first demand to apply my medical skills to a body-cavity search but the issue of nonclinical use of medical skills was not new to me. The incident took place at San Quentin Prison, site of California's gas chamber. State regulations call for doctors to pronounce cessation of vital signs during executions. Before accepting a position at the prison, I sought assurance that I would not be expected to work in the death chamber in the event of an execution.

The ethical principle in these examples is beneficence. We physicians use our special skills for the good of our patients.

It could be argued that there are times when our skills must be applied for the good of the community. Retrieval of sequestered drugs, for example, might benefit the prison community by preventing access to harmful substances, needle sharing and accumulation of debts. However, Jonsen et al argue that competing ethical responsibilities must be prioritized and the patient's medical interests receive greater weight than public good.[3]

Beneficence is grounded in a fundamental medical premise: The patient must trust the physician.[4] The physician's skills signify life or death, health or illness; violation of the trust disrupts the patient-doctor relationship. The physician loses the opportunity to intervene and help the patient with his or her substance abuse, the opportunity for a potentially more sustained benefit than a one-time interruption of drug trafficking.

Doctors' involvement in executions might seem a clear-cut misuse of clinical skills. However, it was not until 1980 that the American Medical Association resolved that physicians should not participate in executions.[6] Most states that execute have statutory or regulatory requirements for physicians to be present.[7] Even after the AMA pronouncement, some physicians have argued there is a role for doctors at executions because the death penalty is legal.[8]

Determination of competence to be executed is still controversial. The AMA awaits action by the American Psychiatric Association on whether it is prohibited participation in executions. In 1986, the United States Supreme Court decided that it is cruel and unusual punishment to execute condemned people who, because of mental illness, do not understand their wrongdoing or the consequences of the penalty.[9] (Prior to 1986, this was also customary law.) Psychiatrists are asked to render opinions on measures of competency, opinions that can contribute to the killing of the person whom they examined.[10]

One argument that favors psychiatrist involvement in competency-to-be-executed assessments (and other judicially mandated evaluations) is that forensic medicine is a bona fide field of specialty in which doctors do not have patients. Forensic psychiatrists and others serve important legal functions and work as objective experts for the courts and other quasi-legal entities. Beneficence is not an issue.[11]

Could this be a slippery slope?

What then about demands for application of medical skills in the interest of the military, a prison, or an industry?[12-13] The primary mission of these institutions is defense and war, detention and punishment, or manufacturing and production, not medical care of soldiers, prisoners, or workers. These institutional missions could easily corrupt professional values if doctors readily used their skills to serve military, prison, or industrial purposes.

Other demands for physicians' clinical skills are more insidious. Some may arise from the adversarial nature of the legal system. There is a tendency to cast many societal decisions as polar, an individual's needs against the public good. The medi-