

Medicine as a Performance:  
Embodying Empathy in Contemporary Medical Practice

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*“One of the essential qualities of the clinician is interest in humanity,  
for the secret of the care of the patient is in caring for the patient.”*

– **Frances W. Peabody, M.D. (1881-1927)**

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## Introduction: Defining the Good Doctor

“What makes a good doctor?” The September 2002 issue of the popular medical journal *BMJ* sought to answer this question by posing it to their readers. Respondents from 24 countries wrote in to the Editor outlining the traits of their good doctor. According to physician Julio Sotelo, “a good doctor is simultaneously learned, honest, kind, humble, enthusiastic, optimistic, and efficient. He or she inspires total confidence in patients and daily renews the magical [doctor-patient] relationship that by itself constitutes good treatment for any kind of ailment and the best starting point for confronting all causes of pain and suffering.”<sup>1</sup> Bioethicist Paul Wolpe adds another element to this discussion by stating that “good doctors are humble doctors, willing to listen to their patients and gather together the full array of resources—medical, human, social, and spiritual—that will contribute to their patients’ healing.”<sup>2</sup> Louise Ward basis her perspective on a good doctor from her experience as a patient: “My real general practitioner became my expert best friend. He took an interest in me as a person and not as a set of symptoms. He knew when to speak and, more importantly, when to shut up...I felt empowered and never bullied into taking a course of action that I didn’t want to follow.”<sup>3</sup>

This question has been an ongoing conversation in contemporary medical practice. It has become more pertinent nowadays as complaints against physicians’ behaviors and attitudes towards patients are increasing. While healthcare continues to become more attuned to patient satisfaction, the performance of clinicians has come into heavy scrutiny. These criticisms cast a negative spotlight on the original purpose of twenty-first century healthcare’s focus on patient-centered care, which has the premise of providing care that is respectful of and in response to the patients’ needs and values.

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<sup>1</sup> Julio Sotelo, “Good doctors abound,” *BMJ* 325, no. 7366 (2002): 712.

<sup>2</sup> Paul R. Wolpe, “We are trying to make doctors too good,” *BMJ* 325, no. 7366 (2002): 712.

<sup>3</sup> Louise Ward, “A patient speaks,” *BMJ* 325, no. 7366 (2002): 714.

In response to this, medical profession has reignited an emphasis on returning to the roots of “compassionate care.” This campaign for compassionate care has highlighted an essential trait of a good doctor that several modern-day physicians are missing—empathy. As such, the main concept of this thesis is to assess the current call for empathetic behavior in modern day medicine and the ongoing conversations regarding this issue. By discussing the dominance of scientific knowledge in medical training, changing dynamics of the physician-patient relationship through the years, and shifts in sociocultural discourses regarding the roles of responsibilities of the doctor and patients, I present a detailed analysis of how these factors result in various critiques of physician’s status and behavior and what their implications are on reorganizing American medical teaching institutions to fit the needs of twenty-first century demands.

Originally derived from the German term *Einfühlung* that means to “feel into” or “feel onto,” empathy is defined as “the ability to understand and share the feelings of another.”<sup>4</sup> However, in the context of medicine, the word has an altered meaning; empathy is seen as a form of detached cognition and accordingly taught so to training clinicians. In 1963, sociologists Renée Fox and Howard Leif argued that this detachment allows medical students to not only dissect a cadaver without disgust but to also listen to patients carefully without becoming emotionally immersed and emotionally drained from each encounter.<sup>5</sup> However, this mode of interaction has recently been proved ineffective as a 2011 survey of 800 hospitalized patients found that only 53 percent felt that their physicians were empathic and caring towards them.<sup>6</sup> Another study found that doctors often

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<sup>4</sup> “Empathy,” Oxford Dictionary, accessed August 2, 2017. <https://en.oxforddictionaries.com/definition/empathy>.

<sup>5</sup> Lief and Fox hint that detached concern is equivalent with empathy, which “involves an emotional understanding of the patient, “feeling into” and being on the same “affective wave length,” as the patient; at the same time, it connotes an awareness of enough separateness from the patient so that expert medical skills can be rationally applied to the patient’s problems.” Howard I. Lief and Reneé C. Fox, “Training for ‘Detached Concern’” in *The Psychological Basis of Medical Practice*, ed. Howard I. Lief (New York: Harper & Row, 1963).

<sup>6</sup> Beth A. Lown, et al., “An Agenda for Improving Compassionate Care: A Survey Shows About Half of Patients Say Such Care is Missing,” *Health Affairs* 30, no. 9 (2011).

overlooked or dismissed patient's signs of distress or confusion, only providing empathetic responses 22 percent of the time.<sup>7</sup>

These shortcomings in satisfactory medical care not only are dismaying to patients but also to medical educators who have the vital responsibility of training and preparing our future clinicians. Multiple research studies have highlighted the far-reaching benefits of compassionate care for both physicians and patients (i.e. such as better ability to diagnose and treatment outcomes), and as such, instructors are exploring different ways of instilling more emotionally attuned empathetic behavior within our future clinicians. The premise of this thesis is to discuss how and why preceptors are reevaluating the traditional science-dominated medical curricula in order to cultivate of empathetic and compassionate behavior and attributes within future physicians. As an article in the New England Journal of Medicine stated, "How can we teach compassionate care as a learned skill in the same way that we teach the physical exam or the fundamentals of physiology?"<sup>8</sup>

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The process of becoming a physician in the United States is an extensive process that typically begins in one's undergraduate career. Pre-medical students must complete rigorous courses work in biology, anatomy and physiology, chemistry, and physics along with their laboratory components. Certain schools require that students take additional classes in mathematics, English, philosophy, psychology, and ethics as supplemental courses. Along with completing this prerequisite coursework, prior to beginning their medical school applications, students must extensively prepare for and take the Medical College Admission Test (MCAT). As of April 2015, this six and half hour standardized exam has four revised test sections: 1) Chemical and Physical Foundations of

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<sup>7</sup> Kathryn I. Polluck, et al., "Oncologist Communication About Emotion During Visits with Patients with Advanced Cancer," *Journal of Clinical Oncology* 25, no. 36 (2007).

<sup>8</sup> Katharine Treadway and Neal Chatterjee, "Into the Water—the Clinical Clerkships," *The New England Journal of Medicine* 364, no. 13 (2011): 1190-1193.

Biological Systems, 2) Critical Analysis and Reasoning Skills, 3) Biological and Biochemical Foundations of Living Systems, and 4) Psychological, Social, and Biological Foundations of Behaviors.<sup>9</sup> The updated MCAT assesses the students' ability with scientific problem solving, critical thinking, and writing skills, as well as understanding of science concepts and principles that are identified as important to the study of medicine. In addition to the coursework and MCAT, Students also must gain real world experience through shadowing a practicing doctor, volunteering in a hospital, contributing to scientific research, demonstrating leadership characteristics through their extracurricular activities. Application to medical school require students to complete a personal statement, write essays, fill out secondary applications, request letters of recommendation, and participate in interviews. In 2015, the average acceptance rate to medical school was 39.3%, with 52,550 individuals applying and only 20,631 being offered admission.<sup>10</sup>

Once gaining admission to medical school, work continues to build up. Students start with learning the basic sciences important to medical practice. Similar to undergraduate teaching methods, years one and two is comprised of lectures and labs that focus on the subjects of anatomy, physiology, cell biology, biochemistry, microbiology, pathology, and pharmacology. They also learn the basics of interviewing and examining the patient. At the end of the year two, students must take and pass the US Medical Licensing Exam (USMLE) Step 1, which emphasizes the knowledge of basic sciences that students should have mastered these last two years. Years 3 and 4 transitions to medical students completing clinical rotations, during which students work and learn in the hospital setting with real patients. Students often are trained by residents and assist them in particular specialties such as internal medicine, pediatrics, surgery, psychiatry, and emergency medicine. The

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<sup>9</sup> "About the MCAT Exam," *Association of American Medical Colleges*, accessed August 29, 2017. <https://students-residents.aamc.org/applying-medical-school/taking-mcat-exam/about-mcat-exam>.

<sup>10</sup> "Facts: Applicants, Matriculants, Enrollment, Graduates, MD-PhD, and Residency Applicants Data," *Association of American Medical Colleges*, accessed August 28, 2017. <https://www.aamc.org/data/facts>.

objective of these rotations is to give students a breadth of knowledge to help them consider potential career paths. At the end of their rotations, students must take and pass the USMLE Step 2 exam that has questions on clinical sciences and a completion of an examination and diagnosing of a standard patient. During their fourth year, students choose a specialty based on their personal interests, clinical experiences, and academic achievements and through the National Resident Matching Program, student discover at which teaching hospital they will complete their residency and which specialty they will embark upon.

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Medical education is currently undergoing its own series of changes in order to redefine what makes a good doctor. According to medical historian and physician Kenneth Ludermer, nineteenth and twentieth century medical educational changes focused on how to better train medical students to accurately diagnose patients and the development of advance technology and profession of scientific theories assisted educators in this endeavor. However, as twenty-first century medical education shifts to concentrate on how to cultivate empathetic behavior within students, especially since many third-year students are increasingly complaining of burnout. Instructors are realizing that the answer to this problem is not in the sciences, but rather in the disciplines of the arts and humanities. As a response to this call for compassionate behavior in clinicians, physician Rita Charon initiated the field of Narrative Medicine as an attempt to encourage medical students and professionals to develop the ability to acknowledge, interpret, and act on the stories of others. However, medical educators Gretchen Case and Suzy Willson state that performance theory is more effective in engaging the empathetic recognition of the student as it gives the opportunity to immerse oneself in the experience of being a compassionate clinician, which extends upon physician Abraham Verghese's concept that that medicine is a practice of art that has its own ritualistic components (i.e. the bedside examination) that clinicians need to embody in their work.

In this interdisciplinary thesis, I primarily draw on the theories of history, anthropology, sociology, and philosophy in relation to medicine to argue that instructors need to tap into the performative elements of medicine in order to effectively impart empathetic behavior within physicians. Particularly, theory and methods from the discipline of performance studies provide students with the opportunity to engage with and embody behavior associated with empathetic care. Performance studies is an interdisciplinary field that draws from the social sciences, humanities, and arts to focus both on the omnipresence and understanding of performance as a central element of social and cultural life. Using this perspective, students and professionals can assess the history and sociocultural background of medicine in order to better recognize the evolution of the multifaceted practice of medicine and the principal doctor-patient relationship.

In Chapter One, I outline the last hundred years of historical developments in medical education, highlighting the idea that medical education reformation is reflective of contemporary societal discourses regarding medical care. I start with the release of the famous Flexner Report in 1910, analyzing its significance in standardized and science dominated medical education. Using a sociological perspective, I further discuss the influence of greater societal relationships and institution powers on not only shaping clinical teaching objectives but in making medicine an elite and privileged practice and its lasting impact on the physician-patient relationship.

In Chapter Two, I examine the current decline of compassionate behavior among medical students, particularly in third year students. First, I analyze the implications the rise of patient autonomy in the 1960s, which served as the springboard for the demand for patient-centered care, and its ramifications on future medical training. Within the context of medical education, I discuss the possible factors that could lead to lack of empathy in students: experiencing burnout from a rigorous and competitive curriculum, developing detachment during cadaver dissections and clinical fieldwork, and improper exposure to proper role models. In response to these trends, I discuss how

the field of medical humanities marked its presence in curriculum as a possible solution to embed humanistic practices within future physicians. I also present an analysis of Narrative Medicine, the predominant form of empathetic teaching that is most used, which is based on the limitations of narrative analysis and state the need for a more embodied method of learning clinical skills.

In Chapter Three, I introduce performance studies, specifically the area of theater studies, as an innovative way for students to learn about the ritualistic aspects of medicine and the old-time physician-patient relationship, thus helping them to realize the compassionate origins of medicine and that physicians once performed this role as a “healer.” I point out the examples of performance in medicine to establish its intricate relationship, specifically that of the bedside examination as an example of a ritual that has been central in medicine but altered over the years. Furthermore, I argue that performance is a hidden curriculum in medical education that needs to be explicitly taught to students for them to realize that their physical movements and verbal language also play a key role in the clinical encounter. As such, I state that the tools of forum theater and role playing can assist in the development of professional identity and embodied practices of our future physicians and discuss how the program Performing Medicine serves as an example of how theater and clinical training can be linked together.

## Chapter One: Examining Historical Changes in American Medical Education

*The Gross Clinic* (1875) by Thomas Eakins is considered to be one of the greatest artworks ever commissioned. This portrait portrays Dr. Samuel D. Gross, an innovative surgeon and a leader in the field of medical intervention during his time, commanding the center of the canvas.<sup>11</sup> With his fingers covered in blood, Dr. Gross holds his scalpel up like a pen. In a brief moment of reflection, he faces away from the patient, pausing to think before making his next incision. Eakins portrays Dr. Gross as a role model to the students seated in the audience behind him, who are observing and learning from his movements, desiring to learn from the best in the field. On the table lays the patient, who is under scrutiny and barely recognizable. He is masked by the physicians inspecting him: he is inert, anesthetized, and visible only as an exposed body part. While the physician takes center stage in this graphic performance of medical expertise, the patient is left to play the most minor of parts.



**Figure 1.** Eakins, Thomas. *The Gross Clinic*, 1875, Philadelphia, Philadelphia Museum of Art.

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<sup>11</sup> The surgery that Dr. Gross is performing in the figure—removing pus to save a gangrenous leg—is one of the many surgical techniques that he founded. For more information regarding Dr. Gross' career timeline and professional achievements, refer to: Luis H. Toledo-Pereyra, "Samuel D. Gross: The Nestor of American Surgery," *Investigative Surgery* 19, no. 3 (2006): 141-145.

Classified by art historians as scientific realism, *The Gross Clinic* presents observers a glimpse into how medicine was taught to aspiring physicians during the late nineteenth century in the United States. Medicine of this period sought to align itself with the cultural authority of science and proclaimed the expertise of an almost omniscient doctor; this cultural dynamic is depicted in the painting. In reality, however, very little institutional infrastructure existed in medicine during Dr. Gross' time. In the United States, medicine was practiced by a heterogeneous group of healers, midwives, and those laying claim to the title *physician*. According to historian Elaine Breslaw, an individual who was perceived to have the ability to heal suffering was granted the patient's trust:

Nonetheless, the real power in the doctor's arsenal of cures was in his or her aura of authority and omniscience. Whether physician (university-educated or apprentice-trained), midwife, folk healer, shaman (Native American), or obeah or conjurer (African), the medical man or woman conveyed a sense of his or her ability to heal. That ability in reality had less to do with the prescribed potions and procedures than the power of suggestion...Patients endowed their medical practitioners (whether orthodox or folk) with enormous authority; they believed in that person's power to cure. The very suggestion of such a power worked to relieve symptoms.<sup>12</sup>

This explanation reflects a key characteristic of nineteenth century physicians—that medical professionals did not have an interest in science as a source of knowledge to cure. Medical knowledge of this time was based on rational wisdom combined with one's experience. Physicians' faulty understanding of the body, causes of diseases, and use of heroic depletion methods, such as cutting, bleeding, and purging, caused more harm than good.<sup>13</sup> Scientific understanding of medicine was yet to take root in this era of ritualistic medicine.

Nineteenth century American medical education paralleled the shambolic culture of medicine. Compared to modern educational standards, medical training for the majority of this period was haphazard and non-standardized as there was no homogeneity among the medical

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<sup>12</sup> Elaine G. Breslaw, *Lotions, Potions, Pills, and Magic: Health Care in Early America* (New York, NYU Press, 2012), 2-3.

<sup>13</sup> David Wotton, *Bad Medicine: Doctors Doing Harm Since Hippocrates* (Oxford University Press, 2007)

schools in the United States regarding core medical teaching objectives. Additionally, though Dr. Gross was a lecturer at the prestigious Jefferson Medical College, the vast majority of medical students were not so fortunate as to attend medical educational institutions that were affiliated with a university. Rather, these medical students enrolled in one of the many “proprietary schools” that existed in the United States during this time, small-time outfits that were owned by physicians, operated on a for-profit basis, and had no affiliation with a university.<sup>14</sup> Admissions criteria were non-existent and curriculum objectives were highly variable between schools. Students in these early proprietary schools enrolled in “anatomical lectures” and classes focused on “theory and practice of physik.”<sup>15</sup> The curriculum consisted mainly of anatomy, physiology, pathology, *materia medica*, chemistry, and the theory and practice of medicine. Students would sit through six to eight hours of continuous lectures in a large amphitheater, and after two years of coursework, students either received a Bachelor of Medicine (M.B.) or, upon successfully completion of a thesis, a Doctor of Medicine (M.D.) and then became eligible to publicly practice medicine.

Though poorly equipped, the American medical education aspired to compete with its advanced European counterparts in producing well-trained physicians, but it always fell short of achieving their academic rigor and scientific adeptness. Consequently, many American students preferred to travel to leading universities in the United Kingdom, France, and Germany for their education, where medical training focused on the early developments of the germ theory and the need to collect quantitative data for diagnoses. It was not until 1910 that the American medical educational system experienced its first notable revolution with the release of the Flexner Report, which called on medical schools to enact higher admissions and graduation standards—which were

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<sup>14</sup> Hans Karle, “How do we define a medical school?: Reflections on the occasion of the centennial of the Flexner report,” *Sultan Qaboos University Medical Journal* 10, no. 2 (2010).

<sup>15</sup> Mary D. McConaghy, “School of Medicine: Historical development, 1765-1800” last modified November 2010. <http://www.archives.upenn.edu/histy/features/1700s/medsch.html>.

modeled upon leading European universities' criteria—and to adhere to strict protocols of standardized science and research in their curricula. This prominent report laid the foundation for modern day medical education in the United States. This chapter focuses on the roughly hundred-year period between the Flexner Report and events that are taking place today that seek to improve medical education. Once again, a century after the release of the Flexner Report, American medical institutions are rethinking the paradigm of medical education in response to the rapid increase in knowledge of scientific medicine and the cultural shift from a patient-centered understanding of illness to a disease-centered one. However, this time, in an effort to better understand and attend to the health needs of twenty-first century Americans, educational reformers are tapping into a new and more implicit resource that is assisting them in reinventing the medical curriculum—social critiques and discourses involving patients' experiences within medicine and healthcare. As such, a central premise of this thesis is that reforms in medical education tend to reflect contemporary societal discourses regarding medical care and treatment and in turn, medical institutions shift their curriculum and resources in order to adhere to their societal obligations and responsibilities.

This chapter chronicles the major developments in American medical education and physician training from the beginning of the 1910s to the early 2000s, with special attention to educational changes that centered on the performative aspects of medicine: in particular, the physician-patient relationship. I argue that medical education has undergone a paradigm shift from time-based to competency-based educational standards in order to make a more integrated scientific and clinical educational experience for physicians, who then in turn are expected to implement these new outlooks to their clinical encounters with patients.<sup>16</sup> The chapter is organized into three

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<sup>16</sup> Through personalized learning, competency-based education model focuses on students moving to higher levels of learning after demonstrating mastery of concepts, objectives, and skills, regardless of the time taken to master them. For more information, refer to Jason R. Frank, et al., "Competency-Based Medical Education: Theory to Practice," *Medical Teacher* 32, no. 8 (2010).

sections. First, I analyze the effects of the Flexner Report on twentieth-century medical education reformations. I specifically point out how the emphasis on scientific medical knowledge in the training medical students during this period had profound and largely negative implications for the physician-patient relationship. Next, I discuss how the rise of scientific knowledge and better understanding of disease mechanisms resulted in students approaching clinical examination from a detached perspective, often ignoring the patient's involvement. Lastly, I evaluate how an assessment introduced in 1975 to improve patient interaction and care—the Objective Structured Clinical Examination (OSCE)—led to a paradox in which medical students learned to pre-rehearse their roles as doctors in a mechanistic manner, rather than learning to be adaptable to the clinical encounter as it unfolds. Thus, as competency-based medical education becomes the standardized model, two key trends dominate clinical skill training—empathetic medicine and humanistic care. This chapter examines the effectiveness of this method of teaching for future physicians by addressing a key question: how can physicians-in-training prepare to flexibly inhabit the prescribed roles of being compassionate healers?

### *Flexnerian Revolution: Establishing the Foundation for Modern Medical Education*

The creation of the modern-day American medical educational system was a long and arduous process. During the twentieth century, the top priority of medical institutions was to transform and improve the quality of education that students received. According to sociologist Paul Starr, the transformation of medical education gave also professionals an opportunity to strengthen the authority and thereby consolidate power for the medical profession overall:

Social structure is the outcome of historical processes. To understand a given structural arrangement, like professional sovereignty, one has to identify the ways in which people acted, pursuing their interests and ideals under definite conditions, to bring that structure into existence. In the nineteenth century, the medical profession was generally weak, divided, insecure in its status and its income, unable to control entry into practice or to raise the

standards of medical education. In the twentieth century, not only did physicians become a powerful, prestigious, and wealthy profession, but they succeeded in shaping the basic organization and financial structure of American medicine.<sup>17</sup>

Agencies and organizations such as the American Medical Association (AMA) and the Association of American Medical Colleges (AAMC) were established in the late nineteenth century to oversee the accreditation and curriculum overhauls of medical schools, implement and codify state licensing laws, and regulate admission requirements. However, these organizations alone did little to standardize medical education in the United States. Rigorous medical reforms in part were initiated and propagated by the release of education reformer Abraham Flexner's 1910 *Carnegie Foundation Bulletin Number Four*, better known as the Flexner Report, which assessed the then-current state of medical educational affairs. Funded by the Carnegie Foundation for the Advancement of Teaching, this report chastised North American medical schools for their focus on profit rather than excellence in care and rebuked the profession for its remarkably low standards that resulted in the "over-production of uneducated and ill trained medical practitioners."<sup>18</sup>

In order to understand the lasting impact of the Flexner Report, it is first crucial to acknowledge why and how the study was commissioned. In 1908, the AMA requested that the Carnegie Foundation survey what was being taught at American medical schools, which was motivated by the AMA's creation of the Council on Medical Education (CME) earlier that year as a way to promote their reformist agenda.<sup>19</sup> The CME was created to implement two core principles: first, that medical schools should have standardized minimum admission requirements; and second, that medical curricula should consist of a total of four years: two devoted to the basic sciences of

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<sup>17</sup> Paul Starr, "The Social Origins of Professional Sovereignty" in *The Social Transformation of American Medicine* (New York: Basic Books, 1982): 8.

<sup>18</sup> Abraham Flexner, "Carnegie Foundation Bulletin Number Four," (New York: Carnegie Foundation, 1910): 10.

<sup>19</sup> Richard E. Brown, "Reforming Medical Education: Who Will Rule Medicine?" in *Rockefeller Medicine Man: Medicine & Capitalism in America* (Berkeley and Los Angeles: University of California Press, 1979): 135-188.

anatomy and physiology and the other two dedicated to practical clinical experience in a teaching hospital. As Starr has argued, the new standards were an attempt to raise the societal profile of doctors, by appealing to a more affluent and educated group of students to consider a career in medicine. Furthermore, according to medical historian Roy Porter, this bid for institutional power was the foundation of the start of the medical-industrial complex:

Modern medicine has been able to root, spread and propagate itself in this way in part because it changed its objectives. Traditionally the physician patched up the sick individual; but medicine gradually asserted a more central role in the ordering of society...The more medicine seemed scientific and effective, the more the public became beguiled by the allure of the medical beneficence, regarding the healing arts as a therapeutic cornucopia showering benefits on all, or like a fairy godmother, potentially grating everybody's wishes.<sup>20</sup>

The AMA hoped that the alignment of medicine and science would elevate the practice of tending to diseased individuals while bringing the power, status, and privileged autonomy that came along with working in elite profession. This was a sharp contrast with the rag-tag image that the proprietary schools had created, where any “causal strollers from the highway” could attempt to become a practicing physician.<sup>21</sup>

While Flexner's name became synonymous with the reform of medical education after the release of the report, it is also important to note that Flexner himself had no prior knowledge or experience in medicine. Flexner was a strategic hire made by Henry Prichett, the President of the Carnegie Foundation, to lead the survey because of his outsider perspective to the medical world. Prichett understood that many medical schools fell far short of scientific ideals: “While European medical schools—for example, those of Germany—are practically comparable in faculties and standards, American schools range from the highest to the lowest conception of medical education

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<sup>20</sup> Roy Porter, *The Greatest Benefit to Mankind* (New York: W.W. Norton & Company, 1997): 629-630.

<sup>21</sup> Flexner, *Carnegie Bulletin*, 22.

and medical ideals.”<sup>22</sup> Pritchett thus envisioned that Flexner’s study would be an effective document for advocacy measures as well.<sup>23</sup> His selection of Flexner as the lead surveyor exemplified his view that medical schools at the time did not themselves have the ability or the tools to effectively evaluate the current state of medical education or to oversee system-wide reform.

With this objective in mind, Flexner carried out this investigation to assess the quality and teaching methods at 155 North American medical schools. After preliminary visits to a few medical institutions, Flexner reiterated Pritchett’s disparaging views regarding the affairs of medical education. In the following excerpt from his report, Flexner noticed that American medical students rarely, if ever, actually engaged in the performance of medicine. Instead, they were passive recipients of ambiguous knowledge and mere onlookers to clinical practice:

Each day students were subjected to interminable lectures and recitations. After a long morning of dissection or a series of quiz sections, they might sit wearily in the afternoon through three or four or even five lectures delivered in methodical fashion by part-time teachers. Evenings were given over to reading and preparation for recitations. If fortunate enough to gain entrance to a hospital, they observed more than participated.<sup>24</sup>

These proprietary medical schools produced doctors who not only varied greatly in their scientific understanding of human physiology but who also had extremely minimal opportunity in their training to engage with patients. These “rule-of-thumb” physicians learned medicine from textbooks and lacked the applied lab training that would allow them to develop critical scientific skills. Flexner, by contrast, prized the scientific physician “who evaluated patients carefully, who performed tests only when they were dictated by a patient’s particular circumstance, who modified his preliminary impressions on the basis of test results or the response to therapy, who realized the limits of his

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<sup>22</sup> Henry Pritchett, “Progress in Medical Education,” *Journal of American Medical Association* 60, (1913): 743-747.

<sup>23</sup> For more information regarding Pritchett’s view on the state of medical education in the United States, refer to: Steven L. Kanter, et al., “Henry Pritchett and His Introduction to the Flexner Report of 1910,” *Academic Medicine* 85, no. 11 (2010): 1777-83.

<sup>24</sup> Abraham Flexner, *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching* (Boston: Updyke, 1910), 63.

knowledge, and who had the capacity to keep up with changing medical practices.”<sup>25</sup> Accordingly, the medical trainees who adhered to these ideals of clinical and scientific practice would become physicians who could successfully gain autonomy and authority over their patients.

In particular, Flexner was especially impressed with the practices he observed at the John Hopkins School of Medicine, which he found to be “a small but ideal medical school, embodying in a novel way, adapted to American conditions, the best features of medical education in England, France, and Germany.”<sup>26</sup> This “Hopkins Model” was considered by medical professionals of the time as the gold standard that all American medical schools should emulate—in particular, the Hopkins’ commitment to effective integration of scientific and clinical training.<sup>27</sup> The Hopkins model involved two main concepts: first, that medical observations could be documented and analyzed solely in physical, chemical, and biological terms; and second, that scientific methods of analysis should apply to both medical practice and research. Based on this model, the Flexner Report outlined six central recommendations for institutions to adhere to: reduce the number of medical schools, increase the prerequisites to enter medical training, teach physicians to practice in a scientific manner, engage medical professionals in research, allow medical schools to have partnerships with teaching hospitals to allow clinical instruction, and strengthen the state regulation of medical licensure and regulation.<sup>28</sup> In the early decades of the twentieth century, this approach was applauded as the single best model of medical training as it allowed students to learn the scientific principles needed for successful practice and provided them opportunity to apply their bench training at patients’ bedsides.

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<sup>25</sup> Kenneth Ludmerer, “Abraham Flexner and Medical Education,” *Perspectives in Biology and Medicine* 54, no. 1 (2011): 9.

<sup>26</sup> Abraham Flexner, *Abraham Flexner: An Autobiography* (New York: Simon and Schuster, 1960): 74.

<sup>27</sup> For more information regarding the history of medical practices and education at John Hopkins Hospital, refer to A. McGehee Harvey, et. al., “A Model of Its Kind: A Century of Medicine at Johns Hopkins,” *JAMA* 261, no. 21 (1989): 3136-3142.

<sup>28</sup> Flexner, *Carnegie Bulletin*.

The release of the Flexner Report catalyzed the public's interest in the developments of the medical world and helped consolidate the collective power of organizations and agencies that shape the quality and curriculum of medical institutions in the United States. However, Flexner made no tangible intellectual contribution to how physicians should be taught; in fact, his recommendations echoed pedagogical concerns that had developed earlier in medical institutions during the 1870s and the 1880s. Rather his report helped shift medical education reform from an intra-professional affair to a broader social investment involving the greater public. The public became increasingly attentive to the fact that while clinical practice had improved significantly since the nineteenth century, the actual practice did not accurately reflect the state of scientific medical knowledge of the time. A key finding in the Flexner Report stated that medical schools were not translating the existing knowledge into medical practice. Accordingly, Flexner argued in his report that medical schools were the equivalent of public trusts, and that—with increased knowledge and more effective treatments—it was unacceptable for physicians to receive substandard training.

Additionally, the Flexner Report “exuded such indignation and moral outrage” that it prompted a newfound civic engagement in the matters of medical affairs; it now mattered to the broader citizenry how their doctors were trained.<sup>29</sup> The public reacted by investing money in medical education and demanding the end of proprietary schools, which was accomplished through the establishment of stringent state licensing laws. These laws mandated that these for-profit proprietary schools would no longer be accredited. These once autonomous institutions began to be closely affiliated with universities and teaching hospitals in order to gain agency and public support. As such, by making the report accessible to the public, the AMA succeeded in abolishing proprietary schools and consolidating control over medical education in the United States through the CME's

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<sup>29</sup> Kenneth M. Ludmerer, *Time to Heal* (New York: Oxford University Press, 1999): 5.

standards. This reorganization resulted in medical education not only becoming standardized but also dramatically improving its quality and benchmarks.

Flexner's views on restructuring medical teaching institutions overlapped with the public's increasing faith in utilizing scientific solutions to societal problems. The human body, like the social body, was understood to be an intricate organism; as such, medical students needed to be "trained to regard the body as an infinitely complex machine."<sup>30</sup> However, the report set in motion a learning environment that was solely focused on knowledge acquisition and disease diagnosis; it ignored a crucial aspect of clinical medicine—the physician-patient relationship. As we shall see, there were a host of unintended consequences to viewing the object of medical scrutiny not as a person but as a composite of parts that were imperfectly functioning under an exclusively scientific lens. For example, a significant result of adopting such teaching philosophies was the dehumanizing medical separation of a patient's body and identity.

### *Rise of Scientific Knowledge: Effects on Medical Training and Physician-Patient Dynamics*

While the Flexner Report focused on restructuring medical curricula, another important development from the late nineteenth century also affected how medicine was practiced: an increased scientific understanding of disease etiology and biological processes. At the turn of the nineteenth century, medicine witnessed the emergence of the new fields of histology, pathology, and microbiology; these in turn helped to elucidate the germ theory of disease and a biochemical-based understanding of physiology. Doctors became better equipped to pinpoint the origins of the pathology and properly treat it. Effective new drugs, such as antibiotics, were brought to the mainstream market and surgical techniques became more humane and refined, thus encouraging and empowering physicians who had been previously stymied by a lack of treatments for common

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<sup>30</sup> Flexner, *Medical Education in the United States and Canada*, 63.

ailments. A major epistemological shift occurred as “it became clear that experimental methods [of science] could be applied to the study of disease and therapeutics, not just the condition.”<sup>31</sup>

The development of a science-based medical practice was a sharp contrast from the narrative-based and guesswork nature of medicine in the eighteenth century, which literary historian Lilian Furst explains below:

Lacking both sound knowledge and tools for probing examination, medical men had to rely solely on their senses by observing their patients and listening to the recital of their complaints. They would scrutinize their patients’ appearance, looking at skin color, and paying attention to signs of wasting or bloating; they would feel the pulse to assess its rate and strength, and they would closely inspect the urine. Yet even the evaluation of this visible specimen would be largely guesswork, stemming at best from comparison with previous similar cases...Patients’ narratives of their symptoms were a central part of the transaction between doctor and patient.<sup>32</sup>

Prior to the nineteenth century, the average doctor had few diagnostic tools for their immediate use other than their senses. Doctors instead served as active listeners and observers while patients recited their symptoms and feelings to them, which served as crucial pieces of the diagnostic puzzle. However, at the beginning of the nineteenth century, the introduction of new medical technology started to become tools of assistance during examination. For example, the stethoscope, which was invented by René Laennec in 1816, was the first major instrument that assisted doctors in hearing sounds from within the body, specifically that of the heart and lungs; this enabled physicians to observe and collect various patterns of the heart’s rate and pace, allowing them to draw distinctions between different sounds without a patient’s testimony.<sup>33</sup> Additionally, the improvement of microscopes during the 1830s and 1840 permitted scientists, such as Rudolf Virchow (who in 1858

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<sup>31</sup> Ludmerer, 9.

<sup>32</sup> Lilian Furst, “From Speculation to Science” in *Medical Progress and Social Reality: A Reader in Nineteenth-century Medicine and Literature* (Albany: University of New York Press, 2000): 3.

<sup>33</sup> Abdallah Fayssol, “René Laennec (1781–1826) and the Invention of the Stethoscope,” *American Journal of Cardiology* 104, no. 5 (2009): 743-744.

published his findings regarding disease processes in his notable *Cellular Pathology* and is also credited with coming up with the cell theory), to get a refined view of diseases at the minute level of the cell.<sup>34</sup> These newfound medical innovations, when paired with the budding scientific knowledge of the time, led to a more defined categorization of diseases. With a better conceptualization of ailments, specifically regarding the *disordered function* of diseases, physicians performed their profession at more refined and intricate levels, thus frequently disregarding the patient's narrative.<sup>35</sup>

In the realm of medical education, educators faced the challenge of how to incorporate and properly teach these new knowledges to students. The core curriculum was comprised of two years of lab-based scientific classes followed by two years of clinical instruction in the teaching hospital wards.<sup>36</sup> However, individual institutions differed on subject emphasis, amount of required instructional hours, and what educators deemed important to teach in their classrooms. Medical historian Kenneth Ludermer describes the dilemma as follows:

They incessantly debated details: topics to include in the lectures, the proper distribution of time between didactic and practical work, the number and types of laboratory experiments, the proper number of students to assign to each cadaver or laboratory bench, the most desirable ratio of instructors to students, the best way to bridge the gap between the laboratory and clinical courses, when and how to introduce students to patients, and how to achieve the best balance between the study of rare diseases that might have heuristic value and that of common illnesses routinely seen in everyday practice.<sup>37</sup>

The traditional teaching materials of lectures and textbooks quickly became outdated and the memorization of minuscule details was no longer an effective tool for learning medicine. Medical educators acknowledged that accommodating the vast wealth of information and new diagnostic

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<sup>34</sup> Myron Schultz, "Rudolf Virchow," *Emerging Infectious Diseases* 14, no. 9 (2008): 1480-1481.

<sup>35</sup> Furst, 8.

<sup>36</sup> Medical education curricula of the early twentieth century "was designed to familiarize students with the structure, function, and behavior of the human organism in health and disease, to acquaint them with the causes, physiological disturbances, and natural history of the various diseases, to provide an introduction to principles of therapeutics and surgery, and to present the environmental and social influences that affect health, illness, and recovery." Ludermer, 66.

<sup>37</sup> Ludermer, 67.

practices called for a shift towards a competency-based education and away from a time-based education. That is, medical education required a procedural, rather than a substantive, emphasis; this meant that students should strive to become lifelong learners and that pedagogy needed to focus on problem solving and critical thinking. The concept of “learning by doing” was integrated into the teaching philosophies at medical schools to make sure students were behaving as, as Flexner put it, curious “thinkers, [and] not a parrot.”<sup>38</sup> The integration of these methods was reflective of the broader societal movement of “progressive education” of this time period. Pioneered by the University of Chicago philosopher John Dewey in the 1880s, this educational movement reasoned that problem-solving, self-learning, and critical thinking were crucial traits for every student to carry into real-world situations in a rapidly changing culture.<sup>39</sup> Flexner was an avid supporter of Dewey, affirming that “though medicine can be learned, it cannot be taught,” thus indicating that didactic lectures would not suffice and that students had to be actively engaged through involvement in clinical activities.<sup>40</sup> As a result, students spent more time engaging in anatomical dissections, conducting research in scientific laboratories, completing clerkships in clinical settings, and observing physicians at teaching hospitals. Medical students were expected to demonstrate flexible thinking and reasoning skills, the capacity to generalize, and the ability to evaluate information. As such, practical clinical experience became the ultimate pedagogical methods for medical educators to employ in order to ensure that students acquired both useful empirical knowledge and experience

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<sup>38</sup> Flexner, *Carnegie Bulletin*, 55.

<sup>39</sup> American educational systems during the twentieth century were followed the ideals of “progressive education.” John Dewey proposed that educational should be designed based on the theory of experience, which is based on two central principles of continuity and interaction. Continuity is “the notion that humans are sensitive to (or are affected by) experience.” Dewey believed that humans learn something from every experience, regardless of it being a positive or negative experience. As such, an individual’s accumulated learned experience influence’s their future experiences. Interaction “builds upon the notion of continuity and explains how past experience interactions with the present situation, to create one’s present experience.” Understanding these two concepts would allow educators to enable students to have a meaningful educational experience. James Neill, “John Dewey, the Modern Father of Experimental Education” last modified Jan. 26, 2005. <http://www.wilderdom.com/experiential/ExperientialDewey.html>.

<sup>40</sup> Abraham Flexner, “The Curriculum in America” in *Medical Education; A Comparative Study* (New York: The MacMillan Company, 1925): 146.

for their future medical practices. That said, these idealistic objectives of making medical students “flexible learners” were at times more of a vision rather than an obtainable practice, as the availability of resources and facilities and the quality of medical educators varied between medical schools.

Scientific advances in the nineteenth century not only transformed medical education but also impacted the physician-patient relationship. As previously mentioned in this chapter, before the twentieth century, the physician in the United States often occupied an uncertain class status. This change in professional prominence occurred when higher standardized requirements for medical school admissions were enacted, medicine became increasingly aligned with science and its advancements, and physicians were required to practice in conformity to a prescribed professional code of ethics.<sup>41</sup> These reforms elevated the societal role of the physician, who gained greater authority and autonomy and demanded more respect as “the experts with the power to cure or at least to alleviate suffering.”<sup>42</sup>

In the ever-fluctuating physician-patient relationship, patients were subjected to physicians’ decisions and examinations regarding their body; believing that physicians were the only ones who could save them from their pain and suffering, patients were more willing to relinquish autonomy during the clinical examination. Starr details how such clinical relationships are often considered necessary for the healing process:

The sick are ordinarily not the best judge of their own needs, nor are those who are emotionally close to them. Quite aside from specialized knowledge, professionals possess an advantage in judgement. Furthermore, effective therapeutic measures frequently require not only difficult and even repellent tasks, such as violating the integrity of the body, but also rechanneling the unconscious urges of some patients to be sick and to be cared for...Professionals are ideally suited for this role because they refuse to indulge such tendencies in patients without threatening their relationships with them. And so professional

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<sup>41</sup> Starr.

<sup>42</sup> Furst, 17.

authority facilitates cooperation in recovery besides compensating for the often impaired and inadequate judgment of the sick.<sup>43</sup>

Sociologists Thomas Szasz and Marc Hollender have provided useful terms for defining the different models of the physician-patient interactions that can unfold in a clinical setting: activity-passivity, guidance-cooperation, and mutual participation.<sup>44</sup> Historically, most physician-patient relationships followed the relatively egalitarian guidance-cooperation model, in which the physician recommends a treatment plan and the patient cooperates accordingly. However, as these redefined roles came into practice, the physician-patient relationship shifted from guidance-cooperation towards the paternalistic model of activity-passivity. Under this new regime of scientific medicine, patients had little say in the narrative that is produced regarding their illnesses, as the physicians sought out the biomedical causes and explanations of their diseases—a practice of diagnosis that was a product of the new medical school curricula.

This type of detached behavior exhibited by physicians matched with the “doctor knows best” theory. While physicians attempted to consider the patient’s requests and feelings regarding their illness and treatment, physicians ultimately have the final say as they are deemed to have the utmost knowledge in their field of medicine and healing. According to medical ethicist Jay Katz, there is a reason why doctors dominate the decision-making process:

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<sup>43</sup> Starr, 5.

<sup>44</sup> There are three basic models of the physician-patient relationship proposed and described by sociologists Thomas Szasz and Marc Hollender. The first model is the *activity-passivity*. This relationship is analogous to a parent-infant relationship and is paternalistic in nature. The patient is figured as helpless, in need of the physician’s expertise in order to begin the path to recovery and to regain autonomy. The second model is *guidance-cooperation*, which is similar to the interactions between a parent and child. Unlike the previous relationship, this takes into consideration that the ill patient has feelings and thoughts regarding their condition but is willing to “cooperate” with the physician who is wiser and more knowledgeable about the best course of action for treatment and recovery. The physician, who is still superior in this model, “guides” the patient to good health. The last model outlined is *mutual participation*, which states that both the patient and physician are equal in terms of power, independence, and satisfaction. The patient not only has a greater voice in the relationship, but they also have a greater responsibility to assume in terms of their health outcomes. Thomas Szasz and Marc Hollender, “A Contribution to the Philosophy of Medicine: The Basic Models of the Doctor-Patient Relationship,” *A.M.A. Archives of Internal Medicine* 97, no. 5 (1956): 585-592.

Patient participation in decision making will not easily become a reality. Physicians' apprehension of, and resistance to, breaking with their millennia-long tradition of solitary decision making express not only their understandable reluctance to depart from familiar practices but also their concern that joint decision making will bring to the public's and patients' attention vexing problems about the state of the art and science of medicine. Doctors believe that such problems should not be discussed with lay persons; that a better appreciation of the uncertainty of medical knowledge will only make patients anxious and confused. Thus, the idea of sharing the burdens of decisions with patients will create new tensions; it will allow bring to the surface old tensions that solitary decision making has obscured.<sup>45</sup>

Furthermore, Starr notes that patients may develop a psychological dependence, further creating a power differential between the expert clinician and lay person being treated: "The authority to interpret signs and symptoms, to diagnose health and illness, to name diseases, and to offer prognoses is the foundation of any social authority the physician can assume."<sup>46</sup> Clinicians became the ones who constructed, shaped, and sometimes screw, patients' narratives regarding their health and illnesses in ways that allowed them to retain power and authority over the patient, thus leaving the patient in a powerless position in regards to their own medical decision making and making them completely became dependent on the physician.

Though a vocal supporter for scientific medicine, physician Sir William Osler, who was one of the founding professors of the John Hopkins Hospital, sought to address this polarizing medical professional behavior by directly teaching his medical students at the patient's bedside.<sup>47</sup> While a good grasp of scientific knowledge was the first step toward being a successful physician, Osler also believed that a physician's bedside manner was equally as important in being an adept clinician. should be based on Victorian morals, specifically on the ideas of behaviors and duties of a

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<sup>45</sup> Jay Katz, "Sharing Authority: The Willingness to Trust" in *The Silent World of Doctor and Patient* (New York: The Free Press, 1984): 83.

<sup>46</sup> Starr, 14.

<sup>47</sup> More for information regarding "Father of Modern Medicine" Sir William Osler, refer to: Michael Bliss, *William Osler: A Life in Medicine* (Oxford: Oxford University Press, 1999).

gentleman. His methodology of teaching at the bedside would help medical students realize both the humanistic and scientific aspects of medicine and to see that “the practice of medicine is an art based on science.”<sup>48</sup> For example, Osler typically had third year medical students collecting patient histories, performing physical examinations, and conducting lab tests to allow students to have immediate clinical experience with patients and as an attempt to equalize the relationship dynamics between the physician and patient. “Listen to your patient, he is telling you the diagnosis,” he famously told his students.<sup>49</sup> As we shall see, Osler’s concept of teaching at the bedside becomes a central pedagogical tool in medical education in the twenty-first century, as a way for medical students to embody and practice compassionate care.

### *Becoming Familiar with the Unknown: Teaching Uncertainty in Medical Education*

One of the key components of a competency-based medical education is regular assessment and in the mid-twentieth century, teaching institutions faced another dilemma: how were students going to be tested on their performance as a doctor?<sup>50</sup> Medical schools sought to develop milestones, tangible markers of achievement that would mark a student’s level of medical skill in a developmental continuum that would document the student’s growth and progress, and this eventually extended from measuring factual knowledge to observing students’ clinical performance. Though medical students routinely took traditional oral and written examinations that measured their mastery of scientific medical knowledge and comprehension, following Flexner’s ideology, educators wanted both a more standardized and a more dynamic and integrative way of assessing medical students’ performances and behavior of in the clinical encounter. In 1975, the Objective

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<sup>48</sup> Barry D. Silverman, “Physician Behavior and Bedside Manners: The Influence of William Osler and the Johns Hopkins School of Medicine” *Proceedings* 25, no. 1 (2012): 58.

<sup>49</sup> Bliss.

<sup>50</sup> NEJM Knowledge+ Team, “What is Competency-Based Medical Education?” last modified June 15, 2017. <https://knowledgeplus.nejm.org/blog/what-is-competency-based-medical-education>.

Structure Clinical Examination (OSCE) was introduced by a group of physicians in response to the need for a more active form of assessment and as a solution to the biases that were found within the traditional clinical examinations.<sup>51</sup> The main concept behind the OSCE is that with the aid of a checklist, instructors can objectively observe and evaluate students who complete a series of clinical tasks with trained actors serving as. Students are examined on predetermined criteria on hypothetical clinical situations and are assessed on skills that include problem solving, communication, decision-making, diagnostic methods, and patient management abilities. The OSCE has quickly become an assessment that all medical students in first take during their second year of medical school and then throughout their third year, fourth year, and residency.

What makes the OSCE unique is its versatility, objectivity, reproducibility, and ability to give feedback to medical students regarding areas of weakness and to faculty about areas of poor teaching.<sup>52</sup> Many educators view the OSCE as a performance-based complement to cognitive knowledge testing, which is reflected in its grading criteria: “It must be concise, well focused and unambiguous aiming to reward actions that discriminate a good performance from a poor one. The marking scheme must take cognizance of all possible performances and provide scores according to the level of the student’s performance.”<sup>53</sup> However, students’ knowledge is simply tested in compartments and not tested on their ability to treat patients holistically; nor are students encouraged to be flexible and adaptive during clinical examinations. While the checklists allow increased reliability and objectivity for examination, the standardization makes students approach the clinical examination in a detached, routinized manner—on the presumption that an encounter

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<sup>51</sup> Ronald M. Harden, “Assessment of Clinical Competence using Objective Structure Examination,” *British Medical Journal* 1, (1975), 447-451.

<sup>52</sup> Carol Carraccio and Robert Englander, “The Objective Structured Clinical Examination: A Step in the Direction of Competency-Based Evaluation,” *Archives of Pediatrics & Adolescent Medicine* 154, no. 7 (2000): 736-741.

<sup>53</sup> Marliyya Zayyan, “Objective Structured Clinical Examination: The Assessment of Choice,” *Oman Medical Journal* 26, no. 4 (2011): 219-222.

with a standardized patient can be broken down systematically into a series of repetitive procedures and steps. Specifically, in the OSCE, standardized patients are given a pre-constructed clinical scenario to act out for students in order to reduce variability between the assessors examining students' performances. However, this comes at a cost for the training of medical students as "these encounters risk being scripted such that they reinforce particular ideas about proper behavior for both doctor and patient but do not also allow for personal and situational variables," thus leading to prescribed and impersonal interactions between patient and clinicians and the possible perception of lack of empathetic behavior.<sup>54</sup> Thus, students mimic the denoted behaviors of empathy rather than understanding and imagining when, why, and how to employ empathetic behavior.<sup>55</sup>

Students learn to perform to the standards that are expected of them, memorizing rehearsing their performance multiple times prior to their evaluation. After passing the OSCE, it has been observed that the student's confidence is increased and their anxiety is reduced, which is a resulting benefit of the "teaching to the test" approach.<sup>56</sup> Students build up this false sense of optimism, as most of the textbook-like, generic situations that the standard patients enact are not representative of the diverse clinical encounters that would be encountered. Presented below are sample OSCE scenarios that are given to students who are completing primary care clerkships in order to prepare for the exam<sup>57</sup>:

*A 51-year old man comes into the office for right shoulder pain, progressive over the last 3 weeks, aggravated by his work sanding car hoods. Perform a focused physical exam of the shoulders, explaining what you are doing, what you are looking for, and what you are finding as you go.*

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<sup>54</sup> Gretchen A. Case and Daniel J. Brauner, "The Doctor as Performer: A Proposal for Change Based on a Performance Studies Paradigm," *Academic Medicine* 85, no. 1 (2010): 160-161.

<sup>55</sup> Ronald M. Harden, "Revisiting "Assessment of Clinical Competence using an Objective Structured Clinical Examination (OSCE)," *Medical Education* 50, no. 4 (2016): 376-379.

<sup>56</sup> Carraccio.

<sup>57</sup> To view the full set-up of the sample OSCE practice scenarios presented to students, including Patient, Student, and Assessor roles, visit: "Primary Care Clerkship Practice Exams." *University of Wisconsin School of Medicine and Public Health*, accessed November 16, 2017. <http://www.fammed.wisc.edu/files/webfm-uploads/documents/med-student/pcc/practice-osce-scenarios.pdf>.

*Mr. Jones, a 27-year-old previously healthy man, is seen with a 1-day history of low back pain. You obtained his history and learned that the pain is non-radiating, worse with bending/ twisting, and not associated with any bladder/ bowel incontinence. He has no symptoms or signs of systemic illness. It started after he helped a friend move some furniture. Aspirin and a hot shower have helped transiently. His exam showed moderate right paralumbar muscle tenderness, normal lower extremity strength and reflexes. You discussed this with your preceptor, who agrees with you that this seems like an uncomplicated back muscle strain and asks you to now present your assessment and plan to the patient.*

*A 17-year old young man comes in for follow-up of his asthma, which was diagnosed by spirometry on your first visit with him 2 months ago. He was prescribed a fluticasone (steroid) inhaler, to use 1 puff twice a day, and albuterol inhaler with a spacer as needed. He was recommended to check peak flow twice a day; his maximum peak flow was 600. Assess his control and use of peak flow meter (borrow one if possible) and counsel the patient on use of an Asthma Action Plan.*

While these presented sample scenarios from the OSCE involve patients from various genders, age groups, and backgrounds, they fail to acknowledge that clinical encounters in medicine are varying and fluid, with patients often presenting more complex problems that cannot be reduced to specific narrative descriptions of symptoms. Furthermore, the OSCE do not assess the students' ability to deal with the uncertainty of real-life circumstances that exceed a checklist. The physician has to be adept and quick to think about how to address unexplained anomalies that present themselves during the clinical examination, something that is beyond the purview of the OSCE.

During the early 1980s, a new component of medical training was introduced in educational standards by sociologist Renée Fox, which she called "training for uncertainty."<sup>58</sup> She argues that such preparation is "an important part of professional socialization and the acquisition of professional values" in the medical field.<sup>59</sup> In her paper she further writes:

Whether he is trying to visualize an anatomical entity, studying gross or microscopic specimens in pathology, utilizing the method of percussion in physical diagnosis, or taking a personal history in psychiatry, the preclinical student is being asked to glean whatever information he can from the processes of looking, feeling, and listening. In all these situations, students are often expected to see before they know how to look or what to look

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<sup>58</sup> Renée Fox, "Training for Uncertainty" in *Essays in Medical Sociology: Journeys into the Fields* (New Brunswick, New Jersey: Transaction Books, 1988).

<sup>59</sup> Paul Atkinson, "Training for Certainty," *Social Science & Medicine* 19, no. 9 (1984): 950

for. For the ability to “see what you ought to see,” “feel what you ought to feel,” and “hear what you ought to hear,” students assure us, is premised upon “a knowledge of what you’re supposed to observe,” an ordered method for making these observations, and a great deal of practice in medical ways of perceiving.<sup>60</sup>

Medical students must learn and master a tremendous amount of material in a short time, then put their knowledge into practice during assessments. Under these conditions, many students resort to memorization and regurgitation of textbook facts, but the majority of medical conditions are often ambiguous and there are limitations to what one can memorize. Lost in the whirlwind of mass memorization, students are not given time, and often opportunity, to learn about how organize this information in order to become a skilled diagnostician. Similar to the OSCE, students learn to ace the test and examinations without giving much thought about the meaning behind their actions. While performing as they “ought to” allows students to be perceived as competent physicians, as Fox argues, medical students need to adapt and be comfortable with not always knowing the diagnosis, treatments, and outcomes; in short, medical students need learn to “draw the line between [their] own limitations and those of medical science.”<sup>61</sup>

### *Coda: Training Physicians to Return to Compassionate Care in the Modern Medicine*

The history of medical education and the reforms that have occurred within have been heavily dominated by the sciences; rarely did medical educators venture to consult other disciplines and pedagogical practices as possible solutions. The Flexner Report served as the catalyst for the start of the modern American medical educational system, but it can no longer serve as the foundation for current day reforms as current clinical problems are focused on the behavior of the clinicians and not about the ability to apply their knowledge. While the late nineteenth and early

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<sup>60</sup> Fox, 26.

<sup>61</sup> Fox, 27.

twentieth century medical educational restructuring focused on standardizing curriculum and implementing criteria for medical schools to gain accreditation by the AAMC, medical educational reform in the twenty-first century seeks to instill in physicians the capacity for empathetic behavior and compassionate care as “clinical empathy was once dismissively known as ‘good bedside manner’ and regarded as far less important than technical acumen.”<sup>62</sup> As the concepts of clinical empathy and compassionate care in healthcare have come into the spotlight, students need to perform the role of physicians who are not only adept with their scientific knowledge but who are also “healing agents.”

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<sup>62</sup> Sandra G. Boodman, “How to Teach Doctors Empathy,” last modified March 15, 2015.  
<https://www.theatlantic.com/health/archive/2015/03/how-to-teach-doctors-empathy/387784/>.

## Chapter Two: The Call for Empathetic Behavior in Modern Healthcare

While *The Gross Clinic* (1891) involves Dr. Gross performing surgery on his patient, in Sir Luke Fildes' iconic painting *The Doctor*, the central protagonist is a male physician who is intently gazing at his patient, a sleeping ill child. This intimate scene takes place not in a hospital or clinical setting, but in the family's home, a modest and humble cottage. Calm and collected, the physician carefully observes the child with only his eyes—no other instruments assist him in his examination. The only suggested presence of scientific medicine in the scene are a small bottle and mortar and pestle-like tools on the table near the physician. Additionally, though the child's parents are obscured in the background of the painting, they nonetheless add a component of despair and helplessness.<sup>63</sup> A small table lamp, the only source of light in the room, illuminates the faces of the physician and child, making their relationship the focal point of the painting. *The Doctor's* depiction of a bedside physician has become one of the most recognizable images in the history of medicine, widely praised for its thoughtful portrayal of the physician-patient relationship.<sup>64</sup>

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<sup>63</sup> Similar to the current climate of access to healthcare, quality of healthcare obtained in Victorian England was limited by the financial resources of the patient. The passage of the Medical Act of 1858 established compulsory standards for physician's training while simultaneously transforming the role and status of the British physician—the physician became both the family doctor and the specialist in primary care. As such, “by carefully depicting the lifestyle of poverty, and emphasizing the clear limitations of then-modern medicine, Fildes pursued both his desire to portray commonplace subjects with realism, and to reflect a near spiritual reverence of physicians.” Linda K. Friedlaender and Gary E. Friedlaender, “Art in Science: The Doctor by Luke Fildes: Putting the Patient First,” *Clinical Orthopaedics and Related Research* 473, no. 11 (2015): 3355-3359.

<sup>64</sup> Jane Moore, “What Sir Luke Fildes' 1887 Painting the Doctor Can Teach Us About the Practice of Medicine Today,” *British Journal of General Practice* 58, no. 548 (2008): 210-213.



**Figure 2.** Fildes, Luke. *The Gross Clinic*, 1891, London, Tate Britain.

While there is a notable status difference between the physician and the family, there is a humanizing quality expressed by the physician's body language. Sitting in close proximity to the child, the physician leans in toward his patient, echoing the posture of the iconic sculpture *Le Penseur* (more commonly known as *The Thinker*).<sup>65</sup> The physician constructed by Fildes is to be perceived as an equal partner to the caring parents, affectively involved in the stake of the child's health outcomes. Fildes's construction of the physician's body language and facial expression and skillful use of light and perspective highlights a proper depiction of quietly compassionate and empathetic behavior. While one can debate whether Fildes' portrayal of a good doctor is realistic or historically accurate, this ideal depiction of tact and medical etiquette powerfully illustrates an essential feature of the doctor-patient relationship: what would come in the twenty-first century to be termed *patient-centered care*.

Additionally, it is important to note Fildes's painting was commissioned by British industrialist Sir Henry Tate, who only had one requirement: that the artist create a painting

<sup>65</sup> Completed in the 1880s, *Le Penseur/The Thinker* is a sculpture by Auguste Rodin of a male figure sitting on a rock with his chin resting on one hand while deep in thought and contemplation. This image is often used to represent philosophy. As Rodin himself described: "What makes my Thinker think is that he thinks not only with his brain, with his knitted brow, his distended nostrils and compressed lips, but with every muscle of his arms, back, and legs, with his clenched fist and gripping toes." "The Thinker (*Le Penseur*)," *National Gallery of Art*, accessed December 30, 2017. <https://www.nga.gov/collection/art-object-page.1005.html>.

that depicted some form of social importance.<sup>66</sup> When examining *The Doctor* in its historical context, another renowned painting comes to mind—*The Gross Clinic* by Thomas Eakins (which was examined at the beginning of Chapter One). *The Doctor* was created in 1891, about twelve years after the completion of *The Gross Clinic*; however, Fildes does not focus on the scientific medical advancements of the late nineteenth century as Eakins did. Critics Linda and Gary Friedlaender note that Fildes’s painting pushes back against the emerging scene of scientific medicine during the time; in truth, Fildes manipulated the scene, deviating from an accurate depiction of healthcare in late nineteenth century Britain in order to put a spotlight on his specific agenda—the doctor’s professional and personal commitment to his patient. The late nineteenth century was actually a time of significant medical progress that brought with it both public appreciation as well as skepticism, and even the reluctance of some physicians to accept new theories of infection and antisepsis.<sup>67</sup> In *The Gross Clinic*, Eakins depicts the skillful surgeon, Dr. Samuel D. Gross, performing a surgical procedure on a patient while also demonstrating the surgeon’s “complete lack of aseptic technique.” Similarly, missing from *The Doctor* are the stethoscope, sphygmomanometer, thermometer, and microscope that were well-established instruments of medical practice in the 1890s. It was, however, Fildes’ intention to reinforce or reestablish an esteem for physicians, rather than acclaim for advancements in medical science.

Appearing in the historical period when the scene of medical care began to shift from the home to the clinic, this painting constructs a nostalgic conception of patient-centered care that persists into the twentieth and twenty-first century. The painting distills medicine to a central dyad, in which a physician practices humanistic care for the patient’s benefit in order to facilitate recovery

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<sup>66</sup> S. Wilson, Simon, *The Tate Gallery: An Illustrated Companion to the National Collections of British & Modern Art* (London, UK: Tate Gallery Publications, 1990).

<sup>67</sup> Friedlaender, 3357.

from illness and maintenance of health. The shadowy story that lies behind the painting's idealism is that while patients are the recipients of medicine, in the context of scientific medicine, they are often forgotten or sidelined as the "disease" while the physician's expertise takes center stage. In 1927, in his famous article "The Care of the Patient," physician Francis Peabody exhorted physicians about the central role of the patient in the practice of successful medicine:

In all your patients whose symptoms are of functional origin, the whole problem of diagnosis and treatment depends on your insight into the patient's character and personal life, and in every case of organic disease there are complex interactions between the pathologic processes and the intellectual processes which you must appreciate and consider if you would be a wise clinician....The good physician knows his patients through and through, and his knowledge is bought dearly. Time, sympathy and understanding must be lavishly dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine. One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient.<sup>68</sup>

Disease, for Peabody, found unique expression in each individual patient. In the absence of effective treatments (sulpha drugs and antibiotics were still a decade in the future), the best medicines available were time and attention. Dr. Peabody noticed a great irony occurring in the culture of medicine: despite the improvements in medical training discussed in Chapter One (i.e. managed care, better treatment regimes, institutional policies governing medical practice), the physician-patient was continuing to decline.<sup>69</sup> Physicians were at risk for placing scientific inquiry above a personal relationship with their patients and would thus lose the desire to relate to individual that they were treating.<sup>70</sup> As such, Peabody advocated early in the twentieth century for the blending of medical science with the sympathetic understanding of the patient's life. He emphasized that getting to know the patient was a major component of the art of medicine. Though the word empathy does not appear in his article, Peabody advocates "time, sympathy, and understanding" and highlights the "personal bond" between doctor and patient, making it clear that empathetic behavior is a required

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<sup>68</sup> Francis W. Peabody, "The Care of the Patient," *JAMA* 313, no. 18 (2015): 1868.

<sup>69</sup> Porter, *The Greatest Benefit to Mankind*.

<sup>70</sup> Porter, *The Greatest Benefit to Mankind*, 683.

quality for a “wise clinician.” In short, a physician’s *behavior*, not just his scientific expertise, should be open to scrutiny.

At the turn of the twenty-first century, there has been a return to the concerns raised by Peabody about physicians treating their patients; specifically, it came into question whether clinicians are demonstrating empathetic behavior towards their patients as the physician-patient relationship came into examination. As portrayed in Fildes’s painting, a little more than a hundred years ago, physicians had few remedies to offer patients but were able to offer their time and attention. Now, despite a close connection between medicine and science resulting in a wide array of pharmaceutical and other treatments, patients appear to crave a humanistic touch but are not experiencing it from their clinicians. Reports have indicated that patients are feeling frustrated, overwhelmed, and neglected during their medical experiences. In a 1994 qualitative research study that examined the question “What prompts patients to sue doctors or hospitals?”, it was found that problematic physician-patient relationships were identified in 71% of the 45 malpractice depositions that were studied.<sup>71</sup> Another study conducted in 2001, found that of the analyzed 29 grievances filed by patients, 38% were due to failure to fulfill expectations of examination and treatment, 20% failure to promptly diagnose, and 17% due to perceived rudeness by the physician.<sup>72</sup> In light of these complaints, and in regards to the societal contract between the medical profession and the public, the physician’s behavior has come into inspection.<sup>73</sup> Specifically, the virtue of empathy is now being

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<sup>71</sup> The study found that “the decision to litigate was often associated with a perceived lack of caring and/or collaboration in the delivery of health care,” with the key issues being identified of perceived physician unavailability, discounting patient and/or family concerns, inadequate delivery of information, and lack of understanding the patient and/or family perspective. Howard B. Beckman, et al., “The Doctor-Patient Relationship and Malpractice: Lessons from Plaintiff Depositions,” *Archives of Internal Medicine* 154, no. 12 (1994): 1365-1370.

<sup>72</sup> The study concluded that “most grievances were filed by younger women against newly encountered physicians and were related to inadequate communication or alleged delay in diagnosis.” Edward C. Halperin, “Grievances Against Physicians: 11 Years’ Experience of a Medical Society Grievance Committee,” *Western Journal of Medicine* 173, no. 4 (2000): 235-238.

<sup>73</sup> The clinical practice of medicine has always been rooted within a social context, as society decides and allocates the resources to the healthcare sector and in return, physicians must deliver upmost care to patients. For more information regarding the historical evolution and current day interpretations and implications of the social contract, refer to: Dinesh Bhugra, “Medicine’s Contract with Society,” *Journal of the Royal Society of Medicine* 107, no. 4 (2014): 144-147.

regarded as a core part of medical professionalism that needs to be addressed in order for them to understand their role as compassionate healers in contemporary healthcare.

This chapter examines one of the central issues engrossing twenty-first century medicine and medical education—the perceived decline of empathy among physicians and the resulting wide range of solutions that seek to re instill this aspect of medical care. Once again, medical education is understood to be both the source of the problem and a catalyst for potential reforms. Increasingly, studies are reporting that many medical students become cynical and experience burnout as they progress through medical school—as many as 75% of medical students became more cynical about academic life and the profession during their time in medical school.<sup>74</sup> Ironically, many are pointing to the very reforms described in Chapter One as the very source of today’s empathy problems. As one research team has written, “the emphasis of modern medical education on the doctor’s emotional detachment, affective distance and clinical neutrality can be misinterpreted or misplaced, thus contributing to a decline in empathy among medical students, and ultimately influencing doctors’ compassion.”<sup>75,76</sup>

As such, this chapter analyzes the problem of empathy in American medical care in the modern context. The first section examines how broader social movements have served as unique opportunities for patients to reevaluate their role in the physician-patient relationship and to

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<sup>74</sup> Harnett K. Sheehan, et al., “A Pilot Study of Medical Student ‘Abuse’: Student Perceptions of Mistreatment and Misconduct in Medical School,” *Journal of American Medical Association* 263, no. 4 (1990): 533-537.

<sup>75</sup> Mohammadreza Hojat, et al., “An Empirical Study of Decline in Empathy in Medical School,” *Medical Education* 38, no. 9 (2004): 935.

<sup>76</sup> American medical education “favors an explicit commitment to traditional values of doctoring—empathy, compassion, and altruism among them—and a tacit commitment to behaviors grounded in an ethic of detachment, self-interest, and objectivity.” As such, medical students respond to this conflict differently: “Some re-conceptualize themselves primarily as technicians and narrow their professional identities to an ethic of competence, thus adopting the tacit values and discarding the explicit professionalism. Others develop non-reflective professionalism, an implicit avowal that they best care for their patients by treating them as objects of technical services (medical care).” Jack Coulehan and Peter Williams, “Vanquishing Virtue: The Impact of Medical Education,” *Academic Medicine* 76, no. 6 (2001): 596-605.

consequently express their rights to equal participation and autonomy in medical care discussions. Section two defines the core concept of empathy and analyzes it in terms of medicine; specifically, why in the wake of new treatments for once fatal diseases and high-tech medicine, potentially positive transformations in patient care, the concept of empathy has become so important. Section three examines the causes for the perceived decline in empathy within clinical training: these include the influence of the scientifically-orientated curriculum, the stress of qualifying and licensure examinations on students with over-developed work ethics, the hierarchical nature of medical school, the power of the “hidden curriculum” involving role models. The fourth and last section shifts focus to how medical educators are currently addressing the situation by integrating pedagogy from the arts and humanities—which has also resulted in the rise of the interdisciplinary field of medical humanities—in an effort to train medical students to display empathetic behaviors. An examination of Narrative Medicine, a popular approach to medical care with a governing premise that “the care of the sick unfolds in stories,” is conducted in regards to its strengths and limitations of the use of narrative in changing the way medical trainees approach their interactions with patients.<sup>77</sup> Ultimately, this chapter demonstrates that in order for physicians to realize their role as compassionate healers, a union between the hard sciences and the arts and humanities needs to occur in the medical curriculum.

### *Twentieth-Century Social Movements: Discourses of Patient Autonomy*

In the early years of twentieth-century, according to medical historian Roy Porter, patients touted science as the main mechanism by which they should be treated:

...because it was the new thing, but also because it gave [patients] the impression of commanding the doctor's attention when he used his stethoscope or sphygmomanometer, when he rapped and tapped and listen. The rituals of scientific, diagnostic medicine spelt out

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<sup>77</sup> Rita Charon, “Narrative and Medicine,” *The New England Journal of Medicine* 350, no. 9 (2004): 862-864.

the message that care was being dispensed, and hence strengthened the bond between physician and patient. They well-respected [physician] in 1870 or 1900 or 1930 were those who could impress upon patients that they were skillful, serious, attention upright; they knew what they were doing, and could be trusted. In that sense the Hippocratic physician was very much alive.<sup>78</sup>

Patients would plead with physicians to “do something” to cure their ailments and diseases, expecting that physicians had access to some secret panacea (i.e. potion, tonic, or medicine) to alleviate their suffering. However, Porter explains that for physicians, the period before the development of effective drugs was also a time of medical nihilism—little did patients know that the medicines of this time were not as effective as the patients’ perceived them to be. “[Doctors of] medicine have little or no control over the duration of course of the disease, which, like other self-limited affection, practically takes its own time to disappear,” wrote the Johns Hopkins physician William Osler, about the efficacy of medicinal treatments available in the nineteenth century.<sup>79</sup> While patients wanted immediate relief, prior to the widespread use of sulpha drugs and antibiotics, physicians realized that often the best they could do was to explain the causes of illness as a way to help patients understand what was happening in their bodies. According to Porter, the importance placed on the patient’s experience gave birth to the patient-as-a-person movement, an important trend in medicine that existed alongside the more scientific approaches, which were discussed in Chapter One, and continued throughout the twentieth century:

In this logical dilemma was born the patient-as-a-person movement, a doctrine that would run through primary care from the 1880s until the Second World War. The patient could not be helped with medicines, although these would be given anyway, but with the psychological support of the doctor. In seeing the patient as ‘a person’ and not just ‘a case of disease’ they physician was able to approach him in an understanding and sympathetic manner that was *in and of itself therapeutic*.<sup>80</sup>

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<sup>78</sup> Porter, *The Greatest Benefit to Mankind*, 680.

<sup>79</sup> “Do the Salicylates Cure Rheumatism?” *Northwestern Lancet* 18, (1898): 340.

<sup>80</sup> Roy Porter, *The Cambridge Illustrated History of Medicine* (Cambridge: Cambridge University Press, 2001): 143.

The movement's central idea was that medicine would not help the recovery of the patient as much—rather the psychological support from the physician to the patient was deemed to be a more crucial element for healing. Physician Robert Centor perceives the archetype of the sensitive physician as arising from a sense of therapeutic inefficacy:

Here was born the reputation of the 'old time GP' as being someone willing to sit and listen to his patients, to give them time to tell their stories, and advise them patiently about how to cope with their problems. It was not that the old-time doc was necessarily a more sensitive and humane individual than his predecessors or his successors, merely that he was the therapeutically desperate and realized that he had nothing to give them except such psychological benefits as inherently resided in the consultation.

As Osler believed, physicians that supported their patients and agreed with their sentiments experienced good outcomes with them: “The good physician treats the disease but the great physician treats the patient.”<sup>81</sup>

However, medicine of the late nineteenth century did not practice that ideology and Osler and other physicians alike were waging a losing battle to promote compassionate care due to budding developments in the refinement of the practice of medicine. Medicine of this period forgot that individuals were “social beings as well as sick bodies.”<sup>82</sup> This holistic practice of medicine, which involved the central and crucial role of the patient being involved in their treatment process, was largely sidelined by the better diagnostic practices that came with advancing technology of the time period. First, the rise of better and potent therapeutic agents, such as sulpha drugs and antibiotics quipped clinicians with powerful antidotes to disease, bolstering their authority and marking the rise of modern medical treatment as they developed a sense of therapeutic self-confidence and the ability to treat the disease without necessarily acknowledging the patient.<sup>83</sup>

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<sup>81</sup> Robert M. Centor, “To Be a Great Physician, You Must Understand the Whole Story,” *Medscape General Medicine* 9, no. 1 (2007): 59.

<sup>82</sup> Porter, *The Greatest Benefit to Mankind*, 682.

<sup>83</sup> Porter, *The Greatest Benefit to Mankind*, 686.

Physicians were able to prescribe medication to cure the patient, and as a result, the humanistic aspects—which had been relegated to the “merely” psychological—seemed less imperative to the treatment process. Second, the clinical encounter began to take place in institutional settings. Rather than unfolding in the patient’s home, as depicted in Filde’s *The Doctor*, patients were required to travel to impersonal, sterilized hospitals and physician’s offices to have their examinations. In the 1950s, house calls accounted for 40% of all clinical encounters, but by the 1980s, they only accounted for only 0.6% of such encounters.<sup>84</sup> Patients sought care at places where physicians had authority, but as a result, they were subjected to rules and policies in unfamiliar institutions, making them feel intimidated or anxious.<sup>85</sup> Lastly, primary care was increasingly supplemented, and sometimes supplanted, by the rise of specialties within medicine. Specialists tended to concentrate on the organs and processes that were in their realm of expertise, rather than focusing on treating the patient as a whole. In the late nineteenth century and early in the twentieth, any physician could claim status as a “specialist,” as sociologist Paul Starr notes, “World War I accentuated the sense that specialty practice needed standards. In its examinations of physicians who claimed to practice a specialty, the military found many unqualified. Of the ophthalmologists, for example, 51 percent were rejected.”<sup>86</sup> In response to this, medical education began to include specialist training. Medical students started focusing on a few topics to gain a better in-depth understanding of certain biological processes rather than exerting energy on learning a little about the general physiological

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<sup>84</sup> Bruce Leff and John R. Burton, “The Future History of Home Care and Physician House Calls in the United States,” *Journals of Gerontology - Series A Biological Sciences and Medical Sciences* 56, no. 10 (2001): M603-M608.

<sup>85</sup> House calls provided an opportunity for physicians to gain insight on patients’ living situation and environment, thus giving them additional context to the factors influencing their illness. Furthermore, the clinical encounter unfolding in a familiar setting to the patients provides a stronger foundation for the physician-patient relationship. One family physician writes comparing an office visit to a house call: “As we have less and less time to spend with patients during office visits, it can become more difficult to feel personally rewarded for another ear infection well treated. Compared with this, when I go into my patients’ homes and see them in the most personal and vulnerable state, I get a sense of walking on hallowed ground. Even visits for simple problems take on a meaningful hue.” Brent J. Herritt, “The House Call: Past, Present and Future,” *University of Toronto Medical Journal* 89, no. 3 (2012): 175-177.

<sup>86</sup> Starr, 224.

processes, while the establishment of the medical residency system became a widely recognized move to make medicine more specialized.<sup>87</sup>

In the 1960s, discourses regarding how to train doctors were very focused on the most effective way to apply newfound scientific knowledge in clinical practice. This collective shift had the effect of concentrating physician power and influence within the profession, which Starr describes as follows:

Doctors and other professionals have a distinctive basis of legitimacy that lends strength to their authority. They claim authority, not as individuals, but as members of a community that has objectively validated their competence. The professional offers judgments and advice, not as a personal act based on privately revealed or idiosyncratic criteria, but as a representative of a community of shared standards. The basis of those standards in the modern professions is presumed to be rational inquiry and empirical evidence.<sup>88</sup>

This basis of communal legitimacy further gave sociocultural authority to physicians as they were able to leverage cultural authority through “the construction of thorough definitions of fact and value” and had “the authority to interpret signs and symptoms, to diagnose health or illness, to name diseases.”<sup>89</sup> However, as a result of this, patients, along with their autonomy, became demoted in the physician-patient relationship. Specifically, referring back to Thomas Szasz and Marc Hollender’s descriptions of physician-patient relationships, the twentieth century physician-patient relationship tended to follow the activity-positivity model. This relationship “is entirely paternalistic in nature; this is analogous to the parent-infant relationship... [Szasz and Hollender] argued that this model is not an interaction, as the person being acted upon is unable to actively contribute. The patient is

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<sup>87</sup> The rise of the technical nature of medicine and the expansion of medical knowledge in the early twentieth century tempted physicians to master a single discipline within medicine. This was further enhancement the benefits that came with speciation: shorter hours, fewer house calls, and greater prestige and income. Todd Sagin, “A Short Guide to the Specialty Certification of Physician,” *American Association of Physician Specialists Foundation, Inc.*, last modified August 2013. <http://www.aapsfoundation.org/pdf/monograph-rev-9.pdf>.

<sup>88</sup> Starr, 17.

<sup>89</sup> Starr, 13.

regarded as helpless requiring the expert knowledge of the doctor.”<sup>90</sup> This type of interaction was a significant departure from the eighteenth and nineteenth century practices of medicine, when the patient’s involvement, and especially their firsthand testimony about symptoms and suffering, was considered central to the diagnostic process.

To ignite change within the medical system, the patient-autonomy movement in the 1960s and 1970s was the first step in gradually making physicians more aware that patients were equal partners with them in the clinical decision-making process. According to author David Rothman, the patient autonomy movement was reflective of the broader social movements were simultaneously occurring during the mid- to late twentieth century:

In retrospect it is clear that the social movements of the 1960s and 70s set the tone and the goals for much of the reform agenda for the closing decades of the 20th century, and probably, for the foreseeable future as well. Civil rights, women’s rights, gay rights, children’s rights, and the center of our attention here, patient rights, all rose to prominence in the 60s and 70s, and all shared a similar mind set.<sup>91</sup>

The culture at large helped to catalyze “a dogged rejection of the principles of beneficence” and to:

...instill distrust of constituted authority—whether in familial, educational, community, political, or medical institutions. The movements shared an unwillingness to accede to the discretionary authority of whites, men, husbands, parents, clinical investigators, mental hospital superintendents, elected officials, and of course, doctors, especially when they were males practicing obstetrics, gynecology, or psychiatry.<sup>92</sup>

In the context of medicine, the action initiated by patient advocacy groups was the first direct challenge to the model of activity-passivity interaction between physicians and patients. As physicians became more conscious about their interactions with patients, the values of “autonomy” and “consent” became an essential part of patient care and were accordingly so taught to medical student. In the essay “Whose Body Is It, Anyway?”, physician and author Atul Gawande challenged

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<sup>90</sup> R. Kaba and P. Sooriakumaran, “The Evolution of the Doctor-Patient Relationship,” *International Journal of Surgery* 5, no. 1 (2006): 60.

<sup>91</sup> David J. Rothman, “The Origins and Consequences of Patient Autonomy: A 25-Year Retrospective,” *Health Care Analysis* 9, no. 3 (2001): 255.

<sup>92</sup> Rothman, 256.

medical ethicist Jay Katz's argument regarding patient autonomy, which critiqued clinicians for encouraging patients to relinquish their autonomy to them and rather emphasized a mutualistic and informed dialogue between both groups, by describing the implications of the revival of the emphasis on patient autonomy during his medical training:

By the time I attended, in the early 1990s, we were taught to see patients as autonomous decision makers. "You work for them," I was often reminded. There are still many old-school doctors who try to dictate from on high, but they are finding that patients won't put up with that anymore. Most doctors, taking seriously the idea that patients should control their own fates, layout the options and the risks involved. A few even refuse to make recommendations, for fear of improperly influencing patients. Patients ask questions, look up information on the Internet, seek second opinions. And they decide.<sup>93</sup>

Rather, in response to this, Gawande urged that physicians should meld their expertise with patient autonomy. Rather than telling patients what treatment to take, he suggested that practitioners should help patients articulate their unique values and then help to tailor the medical care to fit with a patient's individual proclivities.

To make this an official movement, in 1988, the former Picker/Commonwealth Program for Patient-Centered Care, now known as the Picker Institute, generated the term "patient-centered care" to "call attention to the need for clinicians, staff, and health care systems to shift their focus away from diseases and back to the patient and family. The term was meant to stress the importance of better understanding the experience of illness and of addressing patients' needs within an increasingly complex and fragmented health care delivery system."<sup>94</sup> In a research study, the institute

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<sup>93</sup> Gawande in his essay criticizes the idealistic concept of informed consent in relation to patient autonomy. He does that agree with Katz's philosophy in *The Silent World of Doctor and Patient* that patients should be given final say in their treatments, even over the physician's recommendations. Rather he states that a part of respecting autonomy, for patients, is knowing to cede autonomy to the physician: "patients frequently don't want the freedom that we've given them." He suggests that both physicians and patients need to learn the art of medicine, specifically knowing when to submit and when to assert oneself in the clinical encounter. Atul Gawande, "Whose Body Is It Anyway?" *The New Yorker*, (1999): 84-90.

<sup>94</sup> The Picker Institute was founded in 1986 and is a non-profit organization that is devoted to developing a patient-centered approach to healthcare. Michael J. Barry and Susan Edgman-Levitan, "Shared Decision Making - the Pinnacle of Patient-Centered Care," *New England Journal of Medicine* 366, no. 9 (2012): 780.

concluded that the following eight characteristics are important to a successful physician-patient relationship:

...respect for the patient's values, preferences, and expressed needs; coordinated and integrated care; clear, high-quality information and education for the patient and family; physical comfort, including pain management; emotional support and alleviation of fear and anxiety; involvement of family members and friends, as appropriate; continuity, including through care-site transitions; and access to care.<sup>95</sup>

These recommendations addressed policies and procedures, as well as the psychosocial dimensions of patients' experience. The important takeaway from the Picker study was this: "Successfully addressing these dimensions requires enlisting patients and families as allies in designing, implementing, and evaluating care systems." As such, with the main focus on physicians being attentive to patient and giving them equal power and ownership in the interaction and decision-making process, this type of care has intention of shifting the physician-patient model to be more reflective of the mutual participation model.

### *Introduction of Empathy in Medicine and Its Shortcomings*

In terms of medical education, the shift to patient-centered care meant that institutions needed to graduate physicians who are not only adept at diagnosing and treating the diseases but who are also were compassionate healers. In order to successfully achieve the balance between to these two roles, physicians had to demonstrate and embody the characteristic and emotional trait of *empathy*. The Society for General Internal Medicine and the National Institute of Health define empathy as "the act of correctly acknowledging the emotional state of another without experiencing the state oneself."<sup>96</sup> However, a crucial element is missing from this definition, as it does not adequately acknowledge the role of emotional resonance in this action of mutual understanding.

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<sup>95</sup> Barry, 780.

<sup>96</sup> Jodi Halpern, "What is Clinical Empathy?" *Journal of General Internal Medicine* 18, no. 8 (2003): 670.

Instead, an alternative definition was proposed in 2003 by physician and author Jodi Halpern:

clinical empathy “is the physician’s ability to recognize and understand a patient’s perspective and experiences and convey such an understanding back to the patient.”<sup>97</sup> Halpern was one of the first advocates who stated that emotional attunement is the key aspect of being an effective physician, as this form of mutualistic and affective understanding involves physicians’ emotional attunement with both the patient’s verbal and non-verbal language:

Emotional attunement operates by shaping what one imagines about another person's experience. In trying to imagine what the patient is going through, physicians will sometimes find themselves resonating. This is not an additional activity to imagining, but rather a kind of involuntary backdrop to it. Further, resonance is not a special professional skill, but a part of ordinary communication. While listening to an anxious friend, one becomes anxious, while talking with a coworker, one feels heavy, depressed feelings. Importantly, attuning to patients does not always involve resonating with strong feelings, but often is a subtle nonverbal sense of where another person is emotionally.<sup>98</sup>

She urges that attunement is part of everyday communication, and is thus important in the clinical context, as well. In order for a patient to know that the physician is actively listening to them, the physician must be able to properly understand the patient’s narrative and to reflect back to the patient their understandings. By responding empathetically, physicians alleviate suffering for the patients by making them feel validated and more comfortable in confiding with the physician.

Multiple studies have stated that empathy is a clinical skill that physicians need in order to untangle and respond to patients’ thoughts and feelings in order to make a stronger clinical diagnosis.<sup>99</sup> By bringing to bear an attunement to the situation unfolding in front of them, doctors help patients to feel respected, validated, and satisfied with the clinical encounter. Physicians

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<sup>97</sup> Halpern, 670.

<sup>98</sup> Halpern, 673.

<sup>99</sup> According to Halpern, there are five ways for physicians to encourage empathy during patient-physician conflicts: “recognizing one’s own emotions, attending to negative emotions over time, attuning to patients’ verbal and nonverbal emotional messages, and becoming receptive to negative feedback.” Jodi Halpern, “Empathy and Patient–Physician Conflicts,” *Journal of General Internal Medicine* 22, no. 5 (2007): 696-700.

experience an increased diagnostic accuracy and find their patients to be more compliant; for patients, this results in increased satisfaction and less emotional distress, thus increasing their quality of life and treatment outcomes.<sup>100</sup> However, some researchers resist this conclusion, arguing that mandating the physician to show empathy for all patients is emotionally draining and time consuming and they further argue that detachment allows physicians to objectively analyze the patient.<sup>101</sup> To counteract this, other studies have shown that patients prioritize affective concern as much as technical competence from their physicians.<sup>39</sup> For many patients, a “good doctor” was equated with being a good listener, a key characteristic of being an empathetic physician.<sup>102</sup> Patients want physicians to acknowledge and understand the non-medical aspects of their condition through a compassionate lens and are demanding to be treated as a person, not as an illness. As such, empathy has become a central component of humanistic medicine that needs to be implemented and practiced in twenty-first century healthcare.

However, patients frequently report that do not receive empathetic and compassionate care from their physicians. A survey conducted in 2011 found that only 53% of 800 hospitalized patients felt that their physicians were empathic towards them.<sup>103</sup> Rather, physicians exhibited poor bedside mannerism and were detached and rushed during the clinical encounter, making patients feel uncomfortable and distanced from them. As of 2007, the average length of time that a physician spends with a patient is roughly 15.7 minutes, compared to 18.3 minutes in 1999, reflecting the deterioration of intimacy in the physician-patient relationship.<sup>104</sup> As patients become classified by their diseases and transform into numbers, graphs, and anatomic images based off their disease, they

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<sup>100</sup> Melanie Neumann, et al., “Empathy Decline and its Reasons: A Systematic Review of Studies with Medical Students and Residents,” *Academic Medicine* 86, no. 8 (2011): 996-1009.

<sup>101</sup> W. Zinn, “The Empathic Physician,” *Archives of Internal Medicine* 153, no. 3 (1993): 306-312.

<sup>102</sup> Roslyn Schwartz, “Doctor as Story-Listener and Storyteller,” *Canadian Family Physician* 53, no. 8 (2007): 1288-1289.

<sup>103</sup> Beth A. Lown, et al., “An Agenda for Improving Compassionate Care: A Survey shows about Half of Patients Say such Care is Missing,” *Health Affairs* 30, no. 9 (2011): 1772-1778.

<sup>104</sup> Ming Tai-Seale, et al., “Time Allocation in Primary Care Office Visits,” *Health Services Research* 42, no. 5 (2007): 1871-1894.

feel like their clinical encounter and this the physician-patient relationship continues to be an impersonal interaction and business-like transaction, with no room for personal interaction.

### *Dehumanizing of Medical Students: Decline of Empathy in Clinical Training*

In 2016, physician Davis Jeffery argued that empathy and the “humanization” of medical care are of particular concern in the wake of high-profile incidents. According to Jeffery, “the medical culture does not consistently support the practice of empathy, it becomes easy for doctors to see empathy as ‘nice’ but not an essential part of practice.”<sup>105</sup> During the late nineteenth and twentieth centuries, compassionate detachment was the dominant model in teaching physician-patient interpersonal relations. This theory describes the doctor’s concern for their patient while concurrently being consciously aware of their own emotional distance required from the patient; this “distance” was deemed necessary for the personal durability of physicians in order to cope with the emotional demands of practicing medicine.<sup>106</sup> In contrast to compassionate detachment, empathy is seen “as the backbone of a meaningful physician-patient communication and...is a complementary state of separateness and sharing, which makes empathy...a crucial element in healing.”<sup>107</sup> While doctors are increasingly becoming aware of the distinction between these two approaches to care, medical educators are observing that this decline of empathetic behavior is not only exhibited by physicians but also from medical students during their clinical training.

Instructors primarily point to the medical curriculum’s rooted emphasis on scientific thinking and analysis as a reason for the lack of empathetic behavior—specifically, the depersonalized way students are taught to examine the human body. According to physician

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<sup>105</sup> Davis Jeffrey, “Clarifying Empathy: The First Step to More Humane Clinical Care,” *British Journal of General Practice* 66, no. 643 (2016): E143-E145.

<sup>106</sup> Herrman L. Blumgart, “Caring for the Patient,” *The New England Journal of Medicine*, no. 270 (1964): 449-456.

<sup>107</sup> Mohammadreza Hojat, et al., “The Jefferson Scale of Physician Empathy: Development and Preliminary Psychometric Data,” *Educational and Psychological Measurement* 61, no. 2 (2001): 351.

Howard Spiro, “students begin their medical education with a cargo of empathy, but we teach to see themselves as experts, to fix what is damaged, and to ‘rule out’ disease in their field.”<sup>108</sup> In order to objectively assess the pathology of diseases that can ravage the human body, medical students are initiated into a mode of detachment during the clinical examination. Embracing what philosopher Michel Foucault termed the concept “the clinical gaze,” at the start of their medical training, students disregard their own feelings to embrace a form of numbness that their science-dominated curriculum trains them to adopt; students are taught to focus on the diseases, not the patients.<sup>109</sup> Spiro further argues that the body is presented in a technical, scientific manner to medical students and this in turns conditions them to solely observe and dissect the physical body from a solely technical standpoint:

Medical students begin their education with the dead body and the living cell; they learn that the patient is passive and that the cells are alive. Dissection of a cadaver in medical school teaches primacy of the eye over the ear, for cadavers do not complain, and no one has to listen. It is then that students first learn to harden themselves against empathy.<sup>110</sup>

In the introductory anatomy courses, these lifeless cadavers are typically medical student’s first clinical interaction with a stranger’s body and with death. The dissection of these cadavers mark the start of medical students’ process of desensitizing and detaching—or more aptly the “de-empathizing”—that is required of physicians to make objective clinical decisions. Medical students often do not get the opportunity to interact with patients until the start of their clinical training in their third year, and often this interaction is quite limited. Furthermore, during the transition from

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<sup>108</sup> Howard M. Spiro, “Empathy: An Introduction” in *Empathy and the Practice of Medicine*. ed. Howard M. Spiro (New Haven and London: Yale University Press, 1993): 6.

<sup>109</sup> The term “medical gaze” was create to convey the dehumanizing medical separation of the patient’s body from their identity when observed by the physician. He stated that physicians’ new powers of diagnosis were dependent solely on their “gaze” to better understand the disease within the patient. Physicians who observed bodies carefully could see the hidden “truth” of the disease. This process led physicians to gain more power and status, since no one could challenge their perceptions of disease. Michel Foucault, *The Birth of the Clinic* (New York: Vintage, 1964).

<sup>110</sup> Howard M. Spiro, “What is Empathy; Can it be Taught?” in *Empathy and the Practice of Medicine*. ed. Howard M. Spiro (New Haven and London: Yale University Press, 1993): 9.

scientific education to clinical training, the practice of medicine transforms from being a one-way interaction between the medical student and the lifeless body to a shifting experience of not only demonstrating intellectual knowledge but also performing verbal and non-verbal roles of the physician. Medical students are faced with interacting and having a conversation with a dynamic living individual—the patient. As discussed in Chapter One, students cannot study the body and memorize clinical interactions with patients like they do with the Objective Standardized Clinical Exam (OSCE). A study found that the student could receive a high OSCE score simply by asking and checking memorized items without adequate clinical reasoning<sup>111</sup>: “Present results showed that clinical reasoning score was not correlated with OSCE score—meaning that OSCE (especially with a checklist scoring system) could not differentiate students who asked appropriate history questions with appropriate clinical reasoning from others who asked history questions with insufficient clinical reasoning.”<sup>112</sup> Students become aware that there is no set formula to interacting with patients and rather than each interaction is highly variable and cannot be rehearsed ahead of time.

One culprit of the decline of empathy that researchers are studying is clinician “burnout,” which has a precise definition as presented:

Burnout is a syndrome of emotional exhaustion, cynicism, and low professional efficacy that occurs frequently among individuals who do ‘people work’ of some kind. Burnout is defined as a response, which may be inappropriate, to chronic emotional and interpersonal stressors in the workplace. The term may be applied to individuals who engage in activities that are psychologically similar to work, such as students. Burnout Syndrome among students has the following three dimensions: 1) emotional exhaustion (due to educational demands), 2) cynicism (indifference/apathetic attitude toward academic activities), and 3) low professional efficacy (perception of incompetence as a student).<sup>113</sup>

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<sup>111</sup> Clinical reasoning is defined as “thinking through the various aspects of patient care to arrive at a reasonable decision regarding the prevention, diagnosis, or treatment of a clinical problem in a specific patient. Patient care includes history taking, conducting a physical exam, ordering laboratory tests and diagnostic procedures, designing safe and effective treatment regimens or preventive strategies, and providing patient education and counseling.” David Hawkins, et al., *Clinical Reasoning* (Tomales, CA: Foundation for Critical Thinking, 2010).

<sup>112</sup> Wan B. Park, et al., “Does Objective Structured Clinical Examinations Score Reflect the Clinical Reasoning Ability of Medical Students?” *American Journal of the Medical Sciences* 350, no. 1 (2015): 67.

<sup>113</sup> Edméa Fontes de Oliva Costa, et al., “Burnout Syndrome and Associated Factors among Medical Students: A Cross-Sectional Study,” *Clinics* 67, no. 6 (2012): 573.

A 2004 study found that 61% of medical residents reported becoming cynical during their postgraduate training.<sup>114</sup> It is important to consider the effects of the demands of medical school and the culture of medical on the individual student. Medical school represents four years of hard work, high levels of stress, and a constant dedication to continuous learning. Though written in 1958, the article “The Fate of Idealism in Medical School” presents applicable and relevant themes regarding the culture of medical education that can be applied to contemporary times. Sociologists Howard Becker and Blanche Geer write about the first-year medical student experience, which tends to not only be overwhelming for new medical students, but also deceiving:

The medical students enter school with what we may think of as the idealistic notion, implicit in lay culture, that the practice of medicine is a wonderful thing and that they are going to devote their lives to service to mankind. They believe that medicine is made up of a great body of well-established facts that they will be taught from the first day on and that these facts will be of immediate practical use to them as physicians. They enter school expecting to work industriously and expecting that if they work hard enough they will be able to master this body of fact and thus become good doctors. In several ways the first year of medical school does not live up to their expectations. They are disillusioned when they find they will not be near patients at all, that the first year will be just like another year of college. In fact, some feel that it is not even as good as college because their work in certain areas is not as thorough as courses in the same fields in undergraduate school.<sup>115</sup>

While students excelled in their high school classes and undergraduate courses and ranked highly academically in order to get into medical school, after entering medical school, they quickly realize that they are competing against other students who are equally as intelligent, goal-oriented, and motivated as them. The competition to do well in classes is high as everyone desires the best grades in order to gain the slight edge needed in gaining internships.<sup>116</sup> Along with achieving high marks in their coursework, medical students are expected to complete laboratory research, attend

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<sup>114</sup> Niku K. Thomas, “Resident Burnout,” *JAMA* 292, no. 23 (2004): 2880-2889.

<sup>115</sup> Howard S. Becker and Blanche Geer, “The Fate of Idealism in Medical School,” *American Sociological Review* 23, no. 1 (1958): 50-56.

<sup>116</sup> Ludermer.

supplementary seminars and lectures, and complete community service projects—all of which add additional layers of pressure and stress to excel in all aspects of their academic careers. As such, when they start on the journey to medicine, medical students are optimistic and enthusiastic, filled with a genuine interest to serve and help others; however, as their education progresses, they become cynical. This is ironic given the fact that medical schools state that their mission to bolster and nurture human qualities within our future clinicians.

Additionally, studies have also pointed out that significant change in empathy scores occur after students start to delve more into clinical and patient-care activities in their third year—a time when the development and maintenance of empathy for future practice is considered to be most essential. In 2009, an empirical study was conducted at Jefferson Medical College that involved administering the Jefferson Scale of Physician Empathy (JSPE), a popular quantitative measurement of empathic behaviors for medical students and healthcare professionals, to 456 medical students at five different points in their educational career.<sup>117</sup> The results showed that empathy scores did not fluctuate during the first two years of medical school; however, they declined significantly at the end of the third year and stayed at this relatively low level until graduation.<sup>118</sup> Furthermore, a study conducted in 2009 found that during their third year, “students on hospital ward rotations were

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<sup>117</sup> In 2001, researcher Mohammadreza Hojat realized that there was an absence of empirical investigation of physicians’ empathetic behavior and its implications for patient. This was due to the lack of a viable research instrument that would allow researchers to objectively “measure the concept in this setting, to empirically study its development, and to investigate its variation and correlates in different stages of medical education and among different groups of medical students and physicians.” Supported by psychometric evidence, he developed the Jefferson Scale of Empathy, which is a scale administered to healthcare students and professionals in order to examine the relationship between self-reported empathy and their actual survey results. To learn more about the development and methodologies of this system of empathy measurement, refer to: Hojat, “The Jefferson Scale of Physician Empathy: Development and Preliminary Psychometric Data.”

<sup>118</sup> There was an interesting observed difference in changes of the mean JSPE for respondents pursuing people-oriented specialties (e.g., family medicine, internal medicine, pediatrics, emergency medicine, psychiatry, obstetrics–gynecology) and those pursuing technology-oriented specialties (e.g., anesthesiology, pathology, radiology, surgery, orthopedic surgery)—students pursuing people-oriented specialties consistently scored higher in all years of medical school than their counterparts and the “effect size of the decline in empathy from year 0 to year 3 was more than double for those who chose technology-oriented specialties.” Mohammadreza Hojat, et al., “The Devil is in the Third Year: A Longitudinal Study of Erosion of Empathy in Medical School,” *Academic Medicine* 84, no. 9 (2009): 1182–1191.

likely to experience burnout than their peers on outpatient or consult services, intensive care unit (ICU)-based rotations or research,” thus indicating that the learning environment is one of the critical factor on burnout.<sup>119</sup> Furthermore, heavy demands and requirements placed upon medical students, paired with their desire to be the best performer, can cause students to quickly lose sight of their original passion for entering the medical field. Medical students start to feel burnt out that is “characterized by a triad of emotional exhaustion, depersonalization, and a decreased sense of accomplishment.”<sup>120</sup> These studies suggest that students experience a metamorphosis through their medical training experience which can be described as “traumatic de-idealization” and “dehumanization.”<sup>121</sup> Thus, the very structure of the medical curriculum has come under fire, as medical students have collectively expressed the following reasons for burnout that they experience in third year: lack of proper role models in medical training, high volume of materials to learn with a short of period of time, high levels of stress to perform well, inadequate preparation to transition to real-life clinical situations, intimidating learning environment, and sleep deprivation.<sup>122</sup>

Lastly, a growing number of studies cite that the detached, and at-times insensitive, behaviors of clinicians are key influences in promoting medical students’ decline in empathy, as students tend to mimic their work ethic off of the professionals they interact with on a daily basis. Research shows that as many as 90% of medical graduates remember role models who shaped their professional attitudes.<sup>123</sup> A role model is defined as an individual who “teaches primarily by example and helps to shape professional identity and commitment through promoting observation and comparison,” and as such, role models have the ability to inspire, teach by example, and elucidate

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<sup>119</sup> Dyrbye, 276-278.

<sup>120</sup> Waguih IsHak, et al., “Burnout in Medical Students: A Systematic Review,” *The Clinical Teacher* 10, no. 4 (2013): 243.

<sup>121</sup> IsHak, 245.

<sup>122</sup> Liselotte N. Dyrbye, “The Learning Environment and Medical Student Burnout: A Multicentre Study,” *Medical Education* 43, no. 3 (2009): 274-282.

<sup>123</sup> Scott Wright, et al., “The Impact of Role Models on Medical Students,” *Journal of General Internal Medicine* 12, no. 1 (1997): 53-56.

admiration and impersonation from students.<sup>124</sup> It is important to note that students are often not paired with professionals or educators; the role models that medical students decide to follow often occur by chance, as part of what medical educators have termed “the hidden curriculum.”<sup>125</sup> The influence of the role model is discussed as follows:

Role models also play a substantial part in determining how students...become socialized into the world of medicine. Each year of medical training raises new challenges, beginning with the need to feel comfortable talking and listening to patients, progressing to touching them, and ultimately to accepting responsibility for life-and-death decisions. At a time when the scientific mission of academic medicine seems to outweigh its commitment to the needs of individual patients and society as a whole, physicians who teach have the potential to rectify this imbalance by setting an example for students.<sup>126</sup>

From 1993 to 1994, psychiatrist and anthropologist Simon Sinclair observed a group of medical students and found that they embodied characteristics of physicians who had status and respect from their colleagues.<sup>127</sup> However, medical professionals who students identify as their role models may not explicitly realize that their students are observing them as it has been reported that 61% of medical students had witnessed unethical behavior by physicians at least once.<sup>128</sup> Ideally, professionals need to exhibit the qualities of a “good doctor,” which should reflect attentive listening skills, clear communication skills, a proper worth ethic, and compassionate and empathetic behavior towards patients. In reality, most professionals that students are exposed to early in medical school are overworked, burdened by their work demands, frustrated with the institutional policies

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<sup>124</sup> James B. Reuler and David A. Nardone, “Role Modeling in Medical Education,” *Western Journal of Medicine* 160, no. 4 (1994): 335.

<sup>125</sup> The hidden curriculum refers to the “processes, pressures and constraints which fall outside... the formal curriculum, and which are often unarticulated or unexplored. It has been argued that hidden aspects of the curriculum are especially important in professional education, which characteristically includes prolonged periods of exposure to the predominant culture.” Heidi Lempp and Clive Seale, “The Hidden Curriculum in Undergraduate Medical Education: Qualitative Study of Medical Students’ Perceptions of Teaching,” *BMJ* 329, no. 7469 (2004): 770-773.

<sup>126</sup> Reuler, 335.

<sup>127</sup> Simon Sinclair, *Making Doctors: An Institutional Apprenticeship* (Oxford and New York: Berg, 1997).

<sup>128</sup> Chris Feudtner, et al., “Do Clinical Clerks Suffer Ethical Erosion? Students’ Perceptions of their Ethical Environment and Personal Development,” *Academic Medicine* 69, no. 8 (1994): 670-679.

that they must adhere to, and motivated by financial incentives.<sup>129</sup> Students start to emulate this behavior, sometimes unconsciously, to the point where it becomes a part of their own practices. The one deemed benefit of this imitation is that “it helps students’ initial coping with the overwhelming challenges of clinical rotations, which have been described as ‘how to survive in a threatening environment and how to please authority figures.’”<sup>130</sup>

### *Cultivating Empathetic Behavior: Introduction of Medical Humanities*

To address the low rates of empathy and compassionate behavior exhibited by students and practicing clinicians, medical educators in the 1970s turned to the arts and humanities for inspiration and for possible answers. Social historian Brian Dolan has observed:

It has been claimed that the *raison d'être* of the medical humanities is to remind us that modern medicine can and should look beyond its technological fixation and reductionism to reconnect with the conditions of disease and cultural contexts of illness, as well as the myriad ways people cope with it. It is an antidote to the alleged dehumanization of modern medical education which is overly basic-science centered and fails to foster empathic patient care.<sup>131</sup>

A growing emphasis was placed on the field of medical humanities as “[its] relevance in medical education highlight[ed] the value-laden dimensions” of medical practice that students needed to understand and implement in their practices.<sup>132</sup> Medical humanities is intrinsically interdisciplinary: “History of medicine, bioethics, narrative medicine, medicine in literature, creative writing, and various social sciences (for example, medical anthropology and sociology) are aspects of medical humanities programmes.”<sup>133</sup> There is a practical side to medical humanities, as well: “It also

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<sup>129</sup> Lukas P. Milder, “Clinicians Should be Aware of their Responsibilities as Role Models: A Case Report on the Impact of Poor Role Modeling,” *Medical Education Online* 19, no. 1 (2014): 1-4.

<sup>130</sup> Kelly R. Morton, “Why does Moral Reasoning Plateau during Medical School?” *Academic Medicine: Journal of the Association of American Medical Colleges* 71, no. 1 (1996): 5-6.

<sup>131</sup> Brian Dolan, “History, Medical Humanities and Medical Education,” *Social History of Medicine* 23, no. 2 (2010): 394.

<sup>132</sup> Wayne Shelton, “A New Look at Medicine and the Mind-Body Problem: Can Dewey's Pragmatism Help Medicine Connect with its Mission?” *Perspectives in Biology and Medicine* 56, no. 3 (2013): 429.

<sup>133</sup> Shelton, 430.

embraces the creative arts, so that music, painting, reader's theatre, and dance are considered expressive of medical humanities. Anything that touches on 'the human condition', 'the humanizing process' or 'the humanist philosophy' becomes relevant."<sup>134</sup>

One of the main catalysts for humanities approaches was clinician burnout; it was believed that "the introduction of humanities was thought to provide the needed antidote" and would help physicians adopt a more humanistic and balanced approach to medicine.<sup>135</sup> At this time, humanities scholars became directly involved in medical education, playing an important role in engaging conversations regarding urgent ethical dilemmas arising from the new medical technologies, such as the use of dialysis machines and respirators. Today, medical educators hold on to the scientific curricular model proposed in Flexner Report discussed in Chapter One, but also seek to supplement students' more technical approach to medical care by the inclusion of arts and humanities approaches. A 2017 study published in the *Journal of Internal Medicine* found that students who were involved in the arts and humanities during medical school exhibited significantly higher levels of positive physician attributes like empathy, tolerance of ambiguity, wisdom and emotional intelligence while also reporting lower levels of burnout.<sup>136</sup>

This paradigm shift, involving a link between science and humanism in medical education, is continuing to occur in current medical teaching institutions. The argument for what has come to be known as medical humanities or health humanities often urges reclamation on humanistic and ethical concern regarding patients' care has been lost. A new synthesis is being sought, in which the original patient-centered aspects of medicine from the early nineteenth century are brought into

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<sup>134</sup> Shelton, 430.

<sup>135</sup> Shelton, 429.

<sup>136</sup> Salvatore Mangione, et al., "Medical Students' Exposure to the Humanities Correlates with Positive Personal Qualities and Reduced Burnout: A Multi-Institutional U.S. Survey," *Journal of General Internal Medicine* (2018): 1-7.

relation with the procedures and protocols of scientific medicine. As physician Stanley Reiser explains it:

The grains of science should not be sought at the expense of humaneness—not anywhere in life, but especially not in medicine, this remarkable social institution whose members must daily prove themselves worthy of a crucial trust: that they will never take advantage of the vulnerability that is the hallmark of the patients which appear before them. Recall that the Hippocratic doctors, whose values shaped the practice of medicine as we know it, would not teach medicine to those who would not first agree to abide by an ethical code. They know what we should remember: that without the empathy gained through ethical concern, the agents and knowledge of medicine are dangerous and untrustworthy.<sup>137</sup>

In order to regain the ethical concern that is required for empathetic practices, educators working on the model of compassionate care see it as the foundation on which scientific medicine is built. This biopsychosocial model is “the only model that can satisfactorily meet, not just the demands imposed by compassion, but those required by the exactitude of science. A failure of compassion will inevitably lead to poor science in medicine because it ignores data critical to the patient’s care.”<sup>138,139</sup> Under this new framework, there is a synergistic relationship between science and humanism, more specifically between medicine’s biological and psychosocial components. There is a radical reworking built into this approach, which rejects the mind-body dualism that has been a core premise of medical curricula, that the body is its own separate entity independent of the mind.<sup>140</sup> In

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<sup>137</sup> Stanley J. Reiser, “Science, Pedagogy, and Empathy” in *Empathy and the Practice of Medicine*, ed. Howard M. Spiro (New Haven and London: Yale University Press, 1993): 130.

<sup>138</sup> Shimon M. Glick, “The Empathetic Physician” in *Empathy and the Practice of Medicine*, ed. Howard M. Spiro (New Haven and London: Yale University Press, 1993): 90.

<sup>139</sup> The biopsychosocial model is an interdisciplinary approach that systematically considers biological, psychological, and social factors and their interactions and influences in understanding health and illness. For more information regarding the conceptual models and principles behind the biopsychosocial model, refer to: Francesc Borell-Carrió, et al., “The Biopsychosocial Model 25 Years Later: Principles, Practice, and Scientific Inquiry,” *Annals of Family Medicine* 2, no. 6 (2004): 576-582.

<sup>140</sup> Seventeenth century French philosopher René Descartes gave the first account of the mind/body dualism, better known as Cartesian dualism. The central concept behind this idea is that “human beings consisted of two quite unlike substances which could not exist in unity. Mind was unextended, an immaterial but thinking substance and body was an extended, material but unthinking substance. The body was subject to mechanical laws; however, the mind was not.” For more information regarding the relationship of the mind/body dualism in medicine and a critique of its implementation in medical practice, refer to: Neeta Mehta, “Mind-Body Dualism: A Critique from a Health Perspective,” *Mens Sana Monographs* 9, no. 1 (2011): 202-209.

this model, patients are not merely hosts to diseases, but persons who experience suffering in particular cultural conditions. It follows that ethical and effective medical treatment must attend to all aspects of the patient's complex personhood.

While implementing this biopsychosocial model as a way to achieve the goals of patient-centered care, educators are simultaneously including courses related to the medical humanities to also address the problems of clinician burnout and declining empathy decline. Traditional medical curricula include a foundational course in clinical communication and work ethics, but these tend to be formulaic and memorization-based. As such, educators are looking for innovative and non-traditional ways of re-centering the medical encounter on the patient, who is to be understood holistically—and the medical humanities serves this function:

Turning, secondly, to the value of the humanities in personal development, we can say that the educational process touches the student more deeply at a personal level than does the training process. Education is not just concerned with what someone can do, but about what kind of people they become as a result of their education. Developing as a certain kind of person is important for the good doctor because medical practice is not just concerned with knowledge and skills but is also concerned with a humane and sympathetic approach to people.<sup>141</sup>

Methodologies from the medical humanities allow for students to not only refine their observation, listening, and critical thinking skills, but provides an opportunity for medical students to reflect and explore non-clinical elements to medicine and the physician-patient relationship as:

[They] demand an emotional response from their readers and in doing so they will allow the students to discover their own hidden values and prejudices, and to challenge them. This will encourage the kind of self-understanding ("fine awareness") which is essential for the development of mature human beings who are attuned and sympathetic to the perspectives and values of other people.<sup>142</sup>

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<sup>141</sup> Jane Macnaughton, "The Humanities in Medical Education: Context, Outcomes and Structures," *Medical Humanities* 26, no. 1 (2000): 26.

<sup>142</sup> Macnaughton, 26.

The arts and humanities engage with medical students' personal development, perspectives, and ethics, thus strengthening their foundation for humane judgement in the clinical encounter. For example, paintings may bring out the non-verbal ways in which feelings or attitudes can be expressed; literature teaches about both written communication and the nuances of communication between people; history demonstrates the importance of evidence, how it skewed by perspectives, and how transient medical knowledge can be; philosophy urges students to order their thoughts, construct an argument, and reach a logical conclusion.<sup>143</sup> These skills are increasingly seen essential to competent medical care, as equally as important as the physiology or histology, for cogently pulling together data for the purposes of analysis and diagnosis.

### *Rise of Storytelling: Narrative Medicine is Humanistic Medicine*

Though the arts and humanities encompass a broad variety of methods and pedagogies, one notable discipline has come to dominate the curriculum—Narrative Medicine. Pioneered by physician and literary scholar Rita Charon at Columbia University in 2000, this approach claims that attentiveness to people's narratives prompts humane and effective clinical practice, research, and education. In order to care for the sick with compassion, Narrative Medicine affirms two key points: first, that clinicians need to absorb, interpret, and act on their patients' stories; and second, that a teaching model connects medicine with literature is valuable for clinician training.<sup>144</sup> Narrative Medicine has been heralded as an effective approach to cultivating empathy while also fitting comfortably within science-based clinical training programs. Charon describes the program's philosophy in relation to empathetic development as follows:

Exercise in narrative competence would help doctors to (1) recognize the complex and contradictory narratives of illness; (2) increase the accuracy of their observations and interpretations of physical signs, behavior, and emotional concerns; (3) be moved by the

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<sup>143</sup> Macnaughton.

<sup>144</sup> Rita Charon, *Narrative Medicine: Honoring the Stories of Illness*, (New York: Oxford University Press, 2008).

stories of suffering; (4) make themselves available to accompany patients through their troubles; and (5) as a bonus, more fully allow meaning into their own lives. Let me suggest three methods for increasing narrative competence and therefore the capacity for empathy. The first is to write; the second is to read the third is to recognize the ways in which medicine strikes home.<sup>145</sup>

Thus, through various writing and reading exercises and workshops, medical professionals and students are given the opportunity to reflect upon their medical practices and can take on the perspective of the patient in order to better understand their clinical encounters. By drawing on imaginative knowledge, Charon urges that writing allows professional and students empathize with the patient by considering their perspective and reconstructing the experience. Similarly, she argues that by reading complex literary works, students gain the skill of taking on various narrative perspectives and understanding the world through another's terms. The overall impact of these exercises is for students to cultivate empathetic behavior by allowing for themselves to feel and be moved by stories of human experience that goes beyond the clinical diagnosis and terminology.

As a critique of this method, I claim that, while Narrative Medicine engages with the concepts of storytelling, conversation, and reflection, this discipline tends solely focus on the imaginative work of the clinician, who brings to bear their expertise on the patient, and largely ignores the patient's lived experience. Additionally, Narrative Medicine may, ironically, be constrained by the limits of narrative. In the article "Limits of Narrative: Provocations for the Medical Humanities," medical humanities researcher Angela Woods argues that not everybody sees their life in terms of a story: "Constituting an identity requires that an individual conceive of his [sic] life having the form and the logic of a story—more specifically, the story of a person's life—where 'story' is understood as a conventional, linear narrative."<sup>146</sup> To Woods, human experiences, as they

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<sup>145</sup> Rita Charon, "The Narrative Road to Empathy" in *Empathy and the Practice of Medicine*, ed. Howard M. Spiro (New Haven and London: Yale University Press, 1993): 151.

<sup>146</sup> Marya Schechtman, *The Constitution of Selves*, (Ithaca: Cornell University Press, 1996): 96.

are lived, can be chaotic, contradictory, and may resist being put into a beginning, middle, and end: “As Yiannis Gabriel notes, ‘while stories can be vehicles of contestation, opposition, and self-empowerment, they can also act as vehicles of oppression, self-delusions, and dissimulation.’<sup>147</sup> As such, Wood believes that narratives generally “tidy up” the messiness that accompanies the greater experience of illness:

As Mark Freeman has noted in relation to qualitative research more generally, there is ‘widespread concern that ‘narratives are untrue to ‘life itself’. Whether this is cause for alarm (the data are distorted!) or celebration (a toast to the imagination!) depends on who is offering the critique.’ The issue of whether narratives are ‘true’ of course immediately prompts us to ask ‘for whom, and in what situation?’.

Woods’s perspective questions one of Narrative Medicine’s normative claims that “self-expression through narrative is fundamentally healthy and desirable, particularly in the case of illness.”<sup>148</sup> This is a direct challenge to sociologist Arthur Frank’s philosophy, which believes that the ill person (who is a “narrative wreck”) must instill the help of humane medicine in order to help them tell their society; this ideology suggests that narratives can only take a finite number of versions.<sup>149</sup> However, this idea can be contested in that narratives are not the only form of expression of one’s experience and are not only limited to a few linear interpretations. Though Narrative Medicine remains the dominant model of teaching humanistic care to medical students, more research needs to be done in order to better understand the limits of this teaching discipline and of narrative in general.

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<sup>147</sup> Angela Woods, “The Limits of Narrative: Provocations for the Medical Humanities,” *Medical Humanities* 37, no. 2 (2011): 73-78.

<sup>148</sup> Woods, 5.

<sup>149</sup> Frank states in current day medicine, illness is a form of “colonialization”—specifically, that the ill person not only hands over their body to the physician but also their illness narrative. He argues that the ill person needs to reclaim the authority to tell their own story and to construct a new life narrative from the “narrative wreckage” that was caused by their illness. He categorizes patients’ illness narratives into three main themes: (a) restitution narratives, in which the plot involves returning to one’s previous state of health; (b) chaos narratives, in which all life events are conditional and no one is in control; and (c) quest narratives, in which illness is a spiritual journey. Arthur Frank, *The Wounded Storyteller* (Chicago: University of Chicago Press, 2013).

*Coda: The Need for Embodiment in Medical Training*

Though Narrative Medicine has grown to be an encompassing term that includes poetry, photography, and visual arts as expressive forms, its emphasis on storytelling brings with it limitations for cultivating medical students' empathetic behavior in a cerebral manner. As Halpern noted in her definition of empathy, there is a component of emotional attunement that the physician must possess in order to compassionately relate to the patient. As it will be discussed in Chapter Three, as professionals who are entrusted to attend to the suffering human beings, future physicians need to experiment with the embodied experience of being a compassionate healer. To help instill these humanistic competencies, medical educators need draw in theory and concepts from a more interdisciplinary and broader set of disciplines beyond just narrative—the field of performance studies is well suited to achieve this task.

### Chapter Three: Using Performance Studies for Compassionate Training

Founded in 1995, London-based theater company Clod Ensemble is known for its interdisciplinary and provocative performances that explore the condition of the human form in various conditions and environments. Their performance piece *Under Glass* (2007) is described to be “at once museum exhibit, gallery and medical laboratory.”<sup>150</sup> On the same stage are eight giant-sized specimen jars, each containing one or two performers engaged in a series of movements and activities. Though the jars are placed in close proximity, and the eight performances occur simultaneously, the tiny dramas enclosed in each container occur in isolation. The performers are isolated and vulnerable, separated from each other and the audience by the containers, analogous to medical specimen being preserved in a laboratory for analysis and diagnosis. Each glass jar, cabinet, and test tube contains its own human specimen: “a woman in a jam jar, a couple negotiating their space in a bed-like Petri dish, a shy ‘wallflower’ pinned behind a glass panel, a man clockwatching in his office, a woman on the phone in a test tube observing the disintegration of village life.”<sup>151</sup> Each “specimen” explores their movements and freedom within their constrained container. In a way, this exploration provides a means of experimentation for the specimen—they struggle within their spaces, measuring and testing themselves within their confines. At times, they are aware that their bodies and selves are on display and proceed to demonstrate themselves: “In these moments, the performer-specimens were complicit in their own display, comfortable in themselves and in their own revelation.”<sup>152</sup> At other times, however, the performance reveal a different dynamic, where the performers seem acutely uncomfortable and are hesitant or introverted within their containers.

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<sup>150</sup> Gianna Bourchard, “The Pain of ‘Specimenhood,’” in *Performance and the Medical Body*, ed. Alex Mermikides and Gianna Bouchard (London: Bloomsbury, 2016): 141.

<sup>151</sup> “Clod Ensemble *Under Glass*,” *Performing Medicine*, accessed February 18, 2018. <http://performingmedicine.com/project/under-glass-clod-ensemble>.

<sup>152</sup> Bourchard, 145.

Others never realize that they are being looked upon; in these cases, the glass vessel serves as a one-way window for the audience to see into their world.

In the program notes for *Under Glass*, performance studies professor Kéline Gotman writes about her experience of watching this performance as “uncanny” since the “[performance] shifts the gaze, makes us squint, wonder, turn our heads this way and that, to gain a new perspective, a new slant, a new angle.”<sup>153</sup> What makes *Under Glass* unique as an artistic piece is its engagement with the visualization techniques used in medicine, particularly in the practice of autopsy. These techniques are employed in order to make the audience to cast an objectifying gaze on the performers and take on the perspective of a curious medical professional. Drama professor and author Gianna Bouchard also writes about this from her experience of watching the performance: “The slow revelation of the performers in their jars certainly invoked anticipation and inquisitiveness, as we couldn’t quite see enough to fully determine what we were being shown, at least at first. Some of the specimens were very close, whilst others were distant and raised up, and some were below us, lying down, morphing into strange shapes, as though under a microscope.”<sup>154</sup> Through this performance, members of the audience are conscripted to participate—at times uncomfortably—in the detached, one-way scrutiny of human beings. *Under Glass* dramatizes how the body, when dehumanized and displayed as a specimen, reinforces the status and power of medicine.

Interpreting *Under Glass* in this manner draws on the theories and methods of the discipline of performance studies, which is defined by performance theorist Jon McKenzie as follows:

Performance studies is an interdisciplinary field of research that draws from the social sciences, the humanities, and the arts. It focuses on the pervasiveness of performance as a central element of social and cultural life, including not only theater and dance but also such forms as sacred rituals and practices of everyday life.”<sup>155</sup>

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<sup>153</sup> Bouchard, 146.

<sup>154</sup> Bouchard, 147.

<sup>155</sup> Jon McKenzie, “Performance Studies,” accessed November 23, 2017.

[https://www.brown.edu/Departments/Joukowsky\\_Institute/courses/architecturebodyperformance/files/257077](https://www.brown.edu/Departments/Joukowsky_Institute/courses/architecturebodyperformance/files/257077).

It is a method of inquiry that affirms the foundational dimension of performance to all human behavior and emotion.<sup>156</sup> Performance studies is well adapted to the medical context, as the human body interacting with its particular milieu is the dynamic object of analysis. In this final chapter, I argue that integrating performance itself, along with this interdisciplinary area of inquiry, may offer an important supplement to the practice of Narrative Medicine within medical education. Medicine is more than a site of textual interpretation; it involves practice, exemplified by the clinical exam, as an intense site of ritual and performance. In the book *Performance and the Medical Body*, Alex Mermikides hints at the power that performance holds compared to narratives: “With embodied pathologies, stories are also told by the body: the appearance and actions of these bodies convey ‘stories’ that might enhance, undercut or replace the spoken narrative.”<sup>157</sup>

Before looking at the relationship between performance and medicine, it is important to understand the history and development of performance studies. This field emerged as part of the changing intellectual and artistic landscape of the mid- to late-twentieth century. Performance studies first took root in the United States in the 1940s and the 1950s, when social scientists started employing theater as a model for studying the uses of language, ritual, and everyday interactions. In the 1960s, experimental theater embraced the concept of ritual in performance to explore the boundaries between theater and ritual and between art and life.<sup>158</sup> Furthermore, the social reformations of the 1960s and 1970s—civil rights protests, the antiwar movement, women’s marches—highlighted the transformative aspects of social movements and helped contribute to performance studies as a viable research paradigm. The later translated to the arts and social sciences converging to produce and formalize the subfield of cultural performance. McKenzie writes:

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<sup>156</sup> McKenzie.

<sup>157</sup> Alex Mermikides and Gianna Bourchard, introduction to *Performance and the Medical Body*, ed. Alex Mermikides and Gianna Bouchard (London: Bloomsbury, 2016): 7.

<sup>158</sup> McKenzie.

The performing arts provided a perspective for framing and analyzing social, personal, and communicative phenomena, while the social sciences provided conceptual tools for theorizing the social and psychological dimensions of performance. More specifically, theater provided a formal model for identifying and describing cultural performances across the landscape of social life, while ritual provided a functional model for understanding the role these activities might play in even wider social processes.<sup>159</sup>

According to performance studies theorist Richard Schechner, the rise of agency of this field marked a shift from performance as entertainment to performance as a transformative mode that had “efficacy”—the ability to feed back into and transform the greater social life.<sup>160</sup>

While the Oxford Dictionary defines “performance” simply as “the action or process of carrying out or accomplishing an action, task, or function,” it does not capture the levels of behavioral components that are a part of it.<sup>161</sup> In his introductory chapter, Schechner explains that performance can be broken down into various components that move from more embodied to more cognitive—being, doing, showing doing, and explaining showing doing: “‘Being’ is existence itself. ‘Doing’ is the activity of all that exists... ‘Showing doing’ is performing: pointing to, underlining, and displaying doing. ‘Explaining ‘showing doing’ is the work of performance studies.’”<sup>162</sup> The fourth term, the reflexive effort to understand the actions unfolding around us as performance, takes embodied and relational activities off the stage and into everyday life. As Erving Goffman outlines:

A “performance” may be defined as all the activity of a given participant on a given occasion in which serves to influence in any way any of the other participants... When an individual or performer plays the same part the same audience on different occasions, a social relationship is likely to arise. Defining social role as the enactment of rights and duties

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<sup>159</sup> McKenzie.

<sup>160</sup> Richard Schechner, *Performance Studies: An Introduction*, (New York: Routledge, 2013).

<sup>161</sup> “Performance,” *Oxford Dictionary*, accessed February 1, 2018.

<https://en.oxforddictionaries.com/definition/performance>.

<sup>162</sup> As Schechner further writes: “Being may be active or static, linear or circular, expanding or contracting, material or spiritual. Being is a philosophical category pointing to whatever people theorize is the “ultimate reality.” Doing and showing doing are actions. Doing and showing are always in flux—the world of the pre-Socratic Greek philosopher Heraclitus, who said, ‘No one can step twice into the same river, nor touch mortal substance twice in the same condition.’” Schechner, 22.

attached to a given status, we can say that a social role will involve one or more parts and that each of these different parts may be presented by the performer on a series of occasions to the same kinds of audiences or to an audience of the same performances.<sup>163</sup>

Using Goffman's expanded definition of performance, we can analyze the culture of medicine through the lens of performance studies affords a nuanced perspective on how the physician-patient relationship unfolds in the clinical context. As such, medical educators can utilize this discipline to address the concerns of empathetic behavior. Introducing the insights of performance studies into the curriculum can cause a paradigm shift, by teaching medical students "to identify and critique the professional roles that they play daily and to choose their words and gestures deliberately so that their interactions with patients become more empathetic, compassionate, and thoughtful."<sup>164</sup>

I argue that non-clinical classes need the techniques from theater and drama, particularly those of forum theater and role playing, in order understand for students to understand the performative aspects that are embedded within the practice of medicine—in particular, the dual role that physicians play as healers with respect to their patients. In the first section, I draw parallels between performance and medicine, pointing out ways that physicians embody roles similar to that of a performer. In the second section, using physician Abraham Verghese's works in relation to performance studies' concept of rituals, I argue that an understanding of the early roots of medicine as a ritualistic practice encourages physicians to use more physical and emotional dynamism in their clinical practices and interact with patients in a more engaging manner. Lastly, I discuss how the "hidden curriculum" in medical education—in which preceptors' model behavior that is often problematic, running contrary to a stated commitment to compassionate care—needs to be acknowledged, critiqued, a corrected through embodied learning and role play. I provide examples

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<sup>163</sup> Erving Goffman, *The Presentation of Self in Everyday Life* (New York: Random House, 1959): 15-16.

<sup>164</sup> Gretchen A. Case and Daniel J. Brauner, "The Doctor as Performer: A Proposal for Change Based on a Performance Studies Paradigm," *Academic Medicine* 85, no. 1 (2010): 159.

of how performance theory is tied into clinical teachings through the classes and workshops put on by program Performing Medicine, a London-based theater arts organization that is a subset of Clod Ensemble that uses methods from the arts to help medical students and health professionals develop skills essential to clinical practice, in order to demonstrate the impacts of such teaching methods on medical training.<sup>165</sup>

### *Performance in Medicine: Transformation of Physicians as Performers*

According to Performing Medicine Artistic Director Suzy Willson, “both medicine and theater arts are social, visual, and cultural practices.” These nuanced elements of medicine are what have given medicine its multi-dimensionality in terms of how the body is perceived. Though not always acknowledged by medical education historians, art has played an important role in the scientific advancement and understanding of medicine, which Willson describes as follows:

The visual arts, theater, choreography, writing, body representation, institutions and disciplines influence each other multi-directionally. Our understanding of anatomy is shaped by the mapping of organs and diseases onto the anatomized body in the seventeenth century. Our understanding of neurology in the nineteenth century is mediated through the photography...The flourishing of physiology at the turn of the twentieth century has a complex relationship with cinematic techniques.<sup>166</sup>

Similarly, the theater arts can provide a visual story of how the multifaceted history and culture of medicine unfolds. There are many examples of medicine represented in theater and drama—George

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<sup>165</sup> Performing Medicine is an innovative program that works in collaboration with medical schools and hospitals to address particular non-clinical needs required for a successful physician-patient interaction. Performing Medicine created courses for medical students, foundation year doctors, and health professionals that use techniques and methodologies from the performing arts, literature, and visual arts. Associate artists from a wide range of backgrounds and disciplines (i.e. performance, art, voice, photography, movement) serve as course instructors and facilitators. Participants are taught and practice skills such as non-verbal communication, resilience, vocal clarity, leadership, teamwork, comfort with diversity and difference, reflection, and observation and listening skills. These artists directly instruct and work with students and practitioners, giving students a chance to work with experts in their respective fields and an opportunity to engage with thought processes that extend beyond the clinic in order to assist medical students and practicing professionals to reconnect and tap into the true essence of being a doctor.

<sup>166</sup> Suzy Willson, “Performing Medicine: A Theater of Body” (thesis dissertation, Queen Mary University of London, 2009), 73.

Bernard Shaw's play *The Doctor's Dilemma*, Mikhail Bulgakov's short story-turned-show *A Young Doctor's Notebook*, Margaret Edson's play-turned-movie *Wit*, David Lang and Mark Dion's opera *anatomy theater*, and countless American television dramas such as *House M.D.*, *ER*, *Scrubs*, and *Grey's Anatomy*. Moral dilemmas, medical ethics, patient's experience, and end-of-life questions are some themes explored, investigated, and redefined in these dramas. These works usually end by providing a key takeaway message or lesson for the viewers about what the experience taught to the protagonist (usually a physician, resident, or medical student). Cultural critic Candace Gauthier argues that:

Medical drama provides an opportunity for the perception of particulars in terms of choices within the health care context and their consequences for oneself and for others. This form of narrative engages the viewer emotionally as well as cognitively. It develops and exercises moral imagination through identification with the characters portrayed...<sup>167</sup>

Through an aesthetic distance, the viewers see the power of physicians as they try (and sometimes fail) to communicate with their patients and make clinical decisions.

Additionally, the clinic itself is a site of performance in which there are countless examples of theatricality: the hospital as a stage, the operating room as a theater, the white coats as a costume, the stethoscope and sterilized instruments as props, the surgeon as the hero, the nurses and assistants as cast members.<sup>168</sup> Typically, the central dramatic relationship is between the physician and the patient. How this relationship plays out has an important influence on how the patient perceives the physician's relationship with them, how they interpret the information presented, and ultimately, how they cope and manage with their illness. There is growing evidence that the

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<sup>167</sup> Aesthetic distance is the combination of emotional engagement and the detachment necessary for critical reflection. Candace C. Gauthier, "Television Drama and Popular Film as Medical Narrative," *Journal of American Culture* 22, no. 3 (1999): 23.

<sup>168</sup> Willson, "Performing Medicine," 73.

performative elements of the clinical examination—communication skills, body language environment, character—largely influence patient outcomes.<sup>169</sup>

Furthermore, in his perspective paper “Doctors as performance artists,” clinician Michael O’Donnell extends the analogy of medicine as a performance into everyday clinical practice. He reflects on his observations of his father’s professional behaviors, who was also a physician, noting that his father transformed into the role of a performer in the presence of patients and adapted his performance depending on the situation. “[M]ost often he would play the kindly, wise, and sympathetic counsellor,” O’Donnell writes. “Sometimes the cheery motivator driving away dull care, sometimes the cool assessor defining decisions his patients needed to make.”<sup>170</sup> He urges that playing a role expands the doctor’s awareness of others’ points of view:

I’ve also concluded that the source of this empathy—the ability to see the world as it appears in the eyes of their audience—is the same for doctors as it is for the actors and writers with whom I’ve worked in the second phase of my career. For most human actions, I suggest, you can define two reasons: a good reason and a real reason. Performers, be they actors, writers, or doctors, seek out life’s real reasons and, if they’re lucky, discover the person who lurks behind the social façade.<sup>171</sup>

When connecting with patients, it is important for physicians to understand the patient’s motivations, and to comprehend that patients, play the dual role of audience to the physician’s performance and participant in the drama. In order for a performer to win the trust of an audience, the audience must find the performance believable: “an actor working at full pitch operates with the substance of his or her own life...The degree to which a performance is convincing often reflects the extent to which the actor is able to draw truthfully on his or her own essence.”<sup>172</sup> In the context

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<sup>169</sup> Moria Stewart, “The Impact of Patient-Centered Care on Outcomes,” *The Journal of Family Practice* 49, no. 9 (2000): 796-804.

<sup>170</sup> Michael O’Donnell, “Doctors as Performance Artists,” *Journal of the Royal Society of Medicine* 98, no. 7 (2005): 323.

<sup>171</sup> O’Donnell, 323.

<sup>172</sup> Caryl Churchill, “Display of Artistic Integrity” last modified June 22, 2001. <https://www.theguardian.com/theguardian/2001/jun/23/guardianletters1>.

of medicine, the physicians who play their role poorly cannot establish a meaningful relationship with their patient.

### *Medicine as a Ritual: Analyzing the Bedside Examination*

As keynote speaker at the 2014 Stanford School of Medicine commencement, physician and medical education reformer Abraham Verghese cautioned graduating medical students about allowing technology to push them away from the patient's bedside. He advised that students need to look at the time-honored connection of the physician-patient relationship and that the clinical exam affirms the tactile and almost sacred nature of this bond:

Whenever you enter a [patient's] room, be conscious of the legacy, of this unbroken chain extending back centuries—how in standing before a patient, you stand there as the latest incarnation of this lineage, and you have behind you generations of physicians...from Paracelsus, Osler, Curie, Shumway...You are also participating in a timeless ritual...when you get to examine a patient. You are in a ceremonial white gown. They are in a ceremonial paper gown. You stand there not as yourself, but as the doctor. As part of the ritual they will allow the privilege of touching the body...The ritual properly performed earns you a bond with the patient...The ritual is timeless, and it matters.<sup>173</sup>

As Verghese emphasizes, the practice of medicine possesses its own series of actions which are performed in a given place and according to a set sequence. As such, the practices of medicine are classified as a ritual, which the anthropologist Victor Turner defines as “a stereotyped sequence of activities involving gestures, words, and objects, performed in a sequestered place, and designed to influence preternatural entities or forces on behalf of the actors' goals and interests.”<sup>174</sup> Combining this definition of ritual with the core ideologies of performance studies, the performance of medicine is understood through a theater-based framework that simplifies and orders various

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<sup>173</sup> Tracie White, “Respect the rituals of medicine,” Verghese tells graduating students” last modified June 16, 2014. <https://med.stanford.edu/news/all-news/2014/06/respect-the-rituals-of-medicine--verghese-tells-graduating-stude.html>

<sup>174</sup> Victor W. Turner, “Symbols in African Ritual,” *Science* 179, no. 4078 (1973): 4.

routines that arise in clinical practice through categorization and meaning making.<sup>175</sup> Dismissing these unspoken theatrical conventions of medicine takes away from the rich history of medicine that highlights its long-standing purpose of healing and its symbolic importance as a rite of passage of health restoration.

A notable act of ritualistic performance that the doctor demonstrates is the bedside examination, better known as the physical examination. The clinical definition of the physical examination as “the process of evaluating objective anatomic findings through the use of observation, palpation, percussion, and auscultation”; it is “a unique situation in which both patient and physician understand that the interaction is intended to be diagnostic and therapeutic.”<sup>176</sup> Similar to many rituals, the bedside evaluation usually takes place in a specific environment—the private, specially furnished examination room within a clinic or hospital. While the patient strips down to a status-neutralizing gown and lies upon the examination table, the physician dons the powerfully symbolic white coat and stands adjacent to the table, upright whereas the patient reclines. Extending medical ethicist Jay Katz’s ideas regarding the physician-patient relationship discussed in the previous chapters, this ritual involves patients granting permission to the physician, allowing them to touch and observe them. The clinician gains authority to lead the bedside examination that they were taught as residents—first starting at the head, making their way down the body, eventually ending at the extremities. Physicians’ observations are translated into the technical Latin-based language of medicine, which carries associations of sacrament, power, and academic exclusivity: these elements are embedded in the ritual.<sup>177</sup>

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<sup>175</sup> Catherine Bell, *Ritual: Perspectives and Dimensions* (New York: Oxford University Press, 1997): 156–157.

<sup>176</sup> Earl W. Campbell, Jr. and Christopher K. Lynn, “Chapter 4: The Physician Examination,” in *Clinical Methods: The History, Physical, and Laboratory Examinations*, (Oxford: Butterworth-Heinemann, 1976): 37.

<sup>177</sup> Henrik R. Wulff, “The Language of Medicine,” *Journal of the Royal Society of Medicine* 94, no. 4 (2004): 187–188.

Yet Verghese writes about the benefits of the bedside examination for physicians if carried out properly:

The process can be dehumanizing if done poorly, but when done well, it can signal the beginning of the transition from illness to wellness. Indeed, the willingness to disrobe and allow touch—markers of vulnerability— indicate the patient’s acceptance that this ritual is important for the transfer of knowledge. A patient who has disrobed could feel shortchanged if the doctor’s examination feels like an afterthought, an abbreviated or perfunctory component of the clinical encounter. When done well, the bedside evaluation helps to preserve *person-ality*—both the embodied identity of the patient and their humanity—and it validates the patient’s complaint by focusing attention on the soma.<sup>178</sup>

Clearly, much is at stake in this ritualized encounter between practitioner and patient. Through the years, the enactment of the bedside examination has greatly changed due the rise of empiricism and the advancement has scientific knowledge in medical practice. The role of technology in diagnosis and treatment has tended to sideline the element of physical touch; even when palpations and other hands-on techniques are used, too often these can seem mechanized, a mere series of actions that a clinician must complete for the patient.<sup>179</sup> Before the advent of machines like MRIs, angiograms, and PET scans, nineteenth-century physicians relied on the bedside examination as the primary technique of diagnosis. To gain the patient’s trust, the physician had to perform in a certain manner—trustworthy, attentive, and most importantly, compassionate—in order to gather the necessary verbal clues from the patient that they were not able to see, hear, or feel during the bedside examination. While this still holds true, many physicians do not currently exhibit this behavior. In his book *Medical Education and the Changing Order*, physician Raymond Allen argues that with the rapid extension of laboratory tests of greater accuracy, there is a tendency for some clinicians and hence for some students in reaching a diagnosis to rely more on laboratory reports

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<sup>178</sup> Abraham Verghese, “The Bedside Evaluation: Ritual and Reason,” *Annals of Internal Medicine* 155, no. 8 (2011): 551.

<sup>179</sup> To read about how the term “physical diagnosis” has evolved from 1880 to the present and was documented in teaching texts, refer to: Abraham Verghese, et al., “History of Physical Examination Tests and the Conception of Bedside Diagnosis,” *Transactions of the American Clinical and Climatological Association* 122, (2011).

and less on the history of the illness, the examination and behavior of the patient and clinical judgment.<sup>180</sup> Rather than working to gain the trust of their patients, clinicians often rely on technology and modes of visual imaging to give them the missing clues to a diagnosis.

In his 2009 editorial, “In praise of the physical examination,” Verghese makes a compelling argument that the physical examination provides reason and ritual to medical care as doctors who are skilled at the bedside examination make better use of diagnostic tests.<sup>181</sup> Too often, it is the virtual patient—the “iPatient” who lives in the electronic medical record—who doctors seem to care more about.<sup>182</sup> This is a mistake, for merely treating the iPatient “can't begin to compare with the joy, excitement, intellectual pleasure, pride, disappointment, and lessons in humility that trainees might experience by learning from the real patient's body examined at the bedside.”<sup>183</sup> Patients, too, appreciate the ritual. Increasingly, patients complain that “my doctor never touched me” during the clinical encounter; the bedside examination is becoming a lost art as the person is no longer the primary focus of the clinical encounter.<sup>184</sup> However, some argue that, as medical technologies grow ever more sophisticated, the physical exam may become obsolete. According to physician Colin Phoon, though it is theoretically possible to replace the physical examination with technology (as discussed in Christine Gorman’s article “Will Robots Make House Calls?”), such an idea is both impractical and undesirable:

Disenchanted with the medical establishment, the public has clamored for physicians who care and who spend time with them; this author believes that the desire to return to the

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<sup>180</sup> Raymond B. Allen, *Medical Education and the Changing Order* (New York: The Commonwealth Fund, 1946).

<sup>181</sup> Abraham Verghese and Ralph I. Horwitz, “In Praise of the Physical Examination,” *BMJ* 339, no. 7735 (2009): 1385-1386.

<sup>182</sup> Verghese writes about the “iPatient” as follows: “The patient is still at the center, but more as an icon for another entity clothed in binary garments: the iPatient. Often, emergency room personnel have already scanned, tested, and diagnosed, so that interns meet a fully formed iPatient long before seeing the real patient. The iPatient's blood counts and emanations are tracked and trended like a Dow Jones Index, and pop-up flags remind caregivers to feed or bleed. iPatients are handily discussed (or “card-flipped”) in the bunker, while the real patients keep the beds warm and ensure that the folders bearing their names stay alive on the computer.” Abraham Verghese, “Culture Shock—Patient as Icon, Icon as Patient,” *New England Journal of Medicine* 359, (2008): 2749-2751.

<sup>183</sup> Verghese, “Culture Shock,” 2751.

<sup>184</sup> Verghese, “The Bedside Evaluation.”

“good old days” of medical practice will include physical examination as an integral part. It is still part of the doctor-patient relationship and still desired by patients, in spite of technological advances.<sup>185</sup>

As the culture of medicine shifts to patient-centered care, it is pertinent that clinicians understand the values of performing a proper bedside examination and apply the appropriate behaviors and language that fulfills the performance of this old-age ritual, thus strengthening the patient-physician relationship and meeting patients’ clinical expectations.

### *Performance in the Medical Curriculum: Teaching the “Hidden Curriculum”*

In a 2006 speech made to the American College of Physicians, physician Jock Murray remarked on the degradation of the medical professionalism and how there was a growing cynicism about how medical practitioners behaved towards patients. He recommended a new emphasis on professionalism in the culture of medicine “not as an attempt to protect physicians’ power and status...but a call to practice medicine in patients’ best interests.”<sup>186</sup> These thoughts are no different than the ones proposed by Osler and Verghese—that when the disease is studied, the humanity of the patient is often lost. As previously discussed in Chapter Two, medical education and training shapes this understanding of physicians. As such, to return to the roots of compassionate care, medical educators must teach bedside evaluation from a framework of ritual and embodiment. This can be achieved by integrating performance theories into courses that focus on clinical care and bedside mannerism and by explicitly teaching the “hidden curriculum,” which is broadly defined as “the attitudes and values conveyed, most often in an implicit and tacit fashion, sometimes unintentionally, via the educational structures, practices, and culture of an educational institution.”<sup>187</sup>

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<sup>185</sup> Colin K. L. Phoon, “Must Doctors Still Examine Patients?” *Perspectives in Biology and Medicine* 43, no. 4 (2000): 588.

<sup>186</sup> Sliverman, “Physician Behavior and Bedside Manners,” 58.

<sup>187</sup> Frederic W. Hafferty, et al., “The Role of the Hidden Curriculum in ‘On Doctoring’ Courses,” *AMA Journal of Ethics* 17, no. 2 (2015): 129-137.

Under this new educational framework, studying medicine requires addressing and analyzing how clinical roles, relationships, and actions unfold within differing clinical contexts.

In order for physicians to effectively perform the ritual of the bedside examination, they themselves first need to be aware of their own embodiment. Performing Medicine Lead Associate Artist Carly Annable-Coop she describes her observations regarding medical students' physical movements and interactions:

My main observations [were] that they're not very connected in their bodies, particularly first years. I think they haven't even understood that they actually have their own body, so they can be quite awkward...spatially with their bodies and how they use them in terms of their own physicality and, and also how they interact with, with people as well. When we look at basically how do you introduce yourself, how do you come across? I think that they, they can appear quite uncomfortable and there's the old student that it very naturally confident and you know, they have that. But I think my main observations is those are all quickness and un-comfortability in their kind of bodies and with each other.<sup>188</sup>

To address students' discomfort with the performative aspects of medicine, Performing Medicine emphasizes the physicality of the practice of medicine through the body: "Perhaps the more understanding and awareness we have of our own bodies—how they function and change in relationship to the environments they inhabit—the more clearly and skillfully we will be able to relate to and care for others."<sup>189</sup> As such, in order for students to become comfortable with the physical elements of practicing medicine, a core mission of Performing Medicine is to bring about a "Foucault moment" in medical training when the traditional clinician's gaze is challenged—the gaze known for the objectification of the body. In the chapter "Bodies of Knowledge/Knowledge of Bodies," author David Armstrong places the Foucault moment of medicine in the context of changing ideology and perceptions of the body in medical sociology and history during the twentieth century, with a shift to exploring the clinician's gaze and the physician-patient relationship from the

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<sup>188</sup> Carly Annable-Coop (Lead Associate Artist of Performing Medicine) in discussion with author, June 2017.

<sup>189</sup> Suzy Willson, "Clod Ensemble: Performing Medicine," *Performance Research* 19, no. 4 (2014): 31.

patient's perspective and encourage students to understand the "lived experience" of illness.<sup>190</sup> Just like how drama students are given tools to perceive how society works, to socially and philosophically analyze information, and to develop ethical, moral and political critical thinking skills to assist them to make their performances dynamic, medical students can spark a Foucault moment within their clinical training through engagement with performance studies. This moment allows for clinical discourses regarding the body can be reassessed and reinterpreted through engaging with the lived experience. As such, students should be given time and space to engage with various skills and critical thinking methods, which allows students to first understand their own behaviors and the behaviors of others in various situations and contexts before molding and sitting into a prescribed set of behaviors and reactions.<sup>191</sup>

In 2011, medical educator Gretchen Case claimed that performance theories provide mechanisms for recognizing and therefore altering how medicine is actually practiced.<sup>192</sup> Medical students and patients alike follow the cultural and social scripts regarding how they should behave in the clinical setting. For example, medical students learn the "correct" procedure required for history taking and asking the patient the appropriate questions to get the information needed; patients recite the "correct" answers with the hope of getting the medical care they desire. Analyzing these pre-modeled interactions through performance theories allows medical students to "understand that their own role includes witnessing the performance of the patient and of the other persons involved in the patient's care [so that they] can create empathy through thoughtful listening and

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<sup>190</sup> In *Madness and Civilization*, Foucault argued that the rise of rationality was the first step in consolidation of power for institutions. According to Willson, "by claiming that the rhetoric of humanism can lead to self-deception, Foucault robbed us of a consoling story...close to the hearts of the medical profession...Foucault's rejection of the rhetoric of liberal humanism proved so divisive among medical scholars and doctors" that historians Colin Jones and Roy Porter held a conference to analyze and "seek converges between Foucauldian and orthodox historians. Jones and Porter published a book titled *Reassessing Foucault*. Willson, 32.

<sup>191</sup> Willson, "Performing Medicine: A Theatre of Body," 34.

<sup>192</sup> Case.

observation.”<sup>193</sup> The importance of role modeling once again comes into play, as studies have concluded that role modeling without consideration of context is not an adequate form of instruction.<sup>194</sup> Another example of a performance that medical students complete during their training is rounds. Students are considered the equivalent of “new performers” who observe physicians (who are the “experienced performers”) and unconsciously incorporate their preceptors’ techniques and attitude from what they see happening in front of them or recognizing important teaching moments and mindlessly mimic these behaviors in their own practices.

The problem is that so many behaviors and practices are absorbed unconsciously. One approach is to have better models. Verghese states that “to help students and trainees learn the ritual [of bedside examination] and maintain its tradition, we need teachers who perform it well and convey its value.”<sup>195</sup> Case takes this idea a step further by stating that “performance studies offers a construct for conscious learning by insisting that the practice of role modeling and other techniques meant to guide a physician’s development must be accompanied by analysis of structure, content, and context.” She goes on to explain the value of identifying what is observed:

Performance is not based on concealing or falsifying oneself using scripted discourse but, rather, on revealing one’s inner response to the Other. Even theatrical acting, which freely acknowledges the stage, comes from imagining the lives and circumstances of others. Once we acknowledge that performance occurs in everyday spaces, such as hospitals, we can begin to engage in critical discourse about these performances.<sup>196</sup>

Rather than just merely observing good behavior, students should critically engage with the *why* of the performance that they are seeing in order to recognize, analyze, and even critique the terms of the clinical encounter. This mode of reflexive analysis allows medical students to understand the

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<sup>193</sup> Nuala P. Kenny, et al., “Role Modeling in Physicians’ Professional Formation: Reconsidering an Essential but Untapped Educational Strategy,” *Academic Medicine* 78, no. 12 (2003): 1203-1210.

<sup>194</sup> Lempp and Seale.

<sup>195</sup> Verghese, “The Bedside Evaluation,” 551.

<sup>196</sup> Case, 158.

limits of certain behaviors in specific contexts and how they need to adapt their roles in real time depending on the situation—similar to the genre of improvisation in theater.

As I discussed in Chapter One, the most pertinent example of performance in medical training is the Objective Standardized Clinical Exam (OSCE), specifically at the stations involving the use of standardized patients. Ideally, the standardized patient provides medical trainees the opportunity to “come to face to face with the totality of a patient, with [their] stories, [their] physical symptoms, emotional responses to illness, and attitudes toward doctors, and stress in coping with the illness.”<sup>197</sup> Yet while standardized patients provide students with an interactive and simulating the method of teaching-learning and assessment and serve as a transition to the real the real patient, many standardized patients can be manipulated for educational purposes.<sup>198</sup>

Furthermore, researchers Céleste Brotheridge and Alicia Grandey observe that emotional exhaustion is the core of burnout and that certain “people-oriented” professions that involve a large amount of personal interaction and require personal attention, such as medicine, nursing, and social work, demand a significant amount of emotional labor. Burnout is not based on the “acting [they] have to do at work, but it’s the *way* [they] try to act that predicts whether [they] are going to suffer from burnout or not.”<sup>199</sup> They found that those who engaged in deep and meaningful performance, termed “deep” acting, responded that their emotionally-demanding jobs were personally rewarding, compared to those who were “surface acting.”<sup>200</sup> Another recent article draws upon these ideas regarding the two styles of acting and suggests that medical professionals should teach students how to behave in the physician-patient relationship by simply mimicking outward signs of empathy.

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<sup>197</sup> Pathiyil R. Shankar and Neelam R. Dwivdei, “Standardized Patient’s View About their Role in the Teaching-Learning Process of Undergraduate Basic Science Medical Students,” *Journal of Clinical and Diagnostic Research* 10, no. 6 (2016): 1.

<sup>198</sup> Graceanne Adamo, “Simulated and Standardized Patients in OSCEs: Achievements and Challenges 1992-2003,” *Medical Teacher* 25, no. 3 (2003): 262-270.

<sup>199</sup> Raj Persaud, “The Drama of Being a Doctor,” *Postgraduate Medical Journal* 81, no. 955 (2005): 277.

<sup>200</sup> Céleste M. Brotheridge and Alicia A. Grandey, “Emotional Labor and Burnout: Comparing Two Perspectives of ‘People Work,’” *Journal of Vocational Behavior* 60, no. 1 (2002): 17-39.

However, Case states that this is a dangerous suggestion of how medical school should integrate theatrical acting in relation to teaching the clinical encounter:

This use of theatrical acting obscures the fact that performance techniques provide philosophies, theories, and exercises for developing imaginative skills. Method acting and other performance practices should be employed only to develop greater capacity for empathy, as opposed to proficiency in simply generating the appearance of empathetic response. Miming empathy does not suffice; the students' goal should be to experience empathy.<sup>201</sup>

Rather, she suggests implementation a different conceptualization of method acting that involves the actor embodying the circumstances, mannerisms, and emotional feelings of the character they portray, as another performance technique that educators can use when teaching clinical communications. This approach allows practitioners to embody and understand the role of the patient:

...[this] is opposed to the idea of faking an emotion that is not felt by the actor. Rather, the actor uses his or her own life experiences to help develop the character's emotional responses. Those responses are not learned by rote but are, instead, inextricably and uniquely tied to the "given circumstances." The Method, in its many manifestations, encourages the actor to use the "magic if" to consider how he or she would feel if the character's circumstances were his or her own—in short, to empathize.

For medical students, method acting provides a creative opportunity for students to take on the roles of being patients. Rather than writing about the patient's experience, this method allows students to enact the conditions and emotions of the patient to achieve emotional resonance with the person that they are portraying. As this form of method acting in medical training provides students with a platform to engage and develop their empathetic imagination in regards to being a compassionate healer.<sup>202</sup>

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<sup>201</sup> Case, 161.

<sup>202</sup> Case defines empathetic imagination as follows: "empathetic imagination is a cognitive skill set that helps one to imagine the experiences and responses of another person. Empathetic imagination as a concept took hold in the European Age of Enlightenment, although some philosophers trace its roots to earlier centuries. Empathetic imagination allows one to *think with* the Other by *thinking as* the Other." Case, 159.

Building upon Case's ideas, Willson states that methods from performance studies, specifically that of applied theater, should be used for clinicians and students to embody and learn about the *experience* of being a compassionate clinician. Applied theatre is a broad term that describes the use of drama in participatory ways and often in non-traditional settings to address social issues. It is the use of theater as a tool for exploration: "...a kind of shorthand to describe forms of dramatic activity that primarily exist outside conventional theater institutions, and which are specifically intended to benefit individuals, communities and societies."<sup>203</sup> Role playing is the basis of all dramatic activity involving the ability to suspend disbelief by stepping into another character's shoes. When integrated together with forum theater, these two strategies serve as catalysts for conversation in the audience regarding behavior and communication styles. Pioneered by Augusto Boal as a part of *Theatre of the Oppressed*, forum theater is described as followed:

A play or scene, usually indicating some kind of oppression, is shown twice. During the replay, any member of the audience ('spect-actor') is allowed to shout 'Stop!', step forward and take the place of one of the oppressed characters, showing how they could change the situation to enable a different outcome. Several alternatives may be explored by different spect-actors. The other actors remain in character, improvising their responses. A facilitator is necessary to enable communication between the players and the audience.<sup>204</sup>

Compared to the more conventional means of theater, in the words of Boal, "this kind of theatre is expressly 'subjunctive'; that is, it represents a version of reality that is experimental, asking 'what would...?' rather than stating 'this is.'"<sup>205</sup> This approach, which is oriented towards practice rather than interpretation, offers an explicit counter to Narrative Medicine. This strategy breaks the barrier between the performer and audience and gives the audience a more active role in directing the performance and seeing how events can evolve based on their recommendations. It enables performers to test out various courses of behaviors that could be applicable to their everyday

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<sup>203</sup> Nicholson, 2.

<sup>204</sup> David Farmer, "Role Play," last modified December 24, 2014. <https://dramaresource.com/role-play>.

<sup>205</sup> David Farmer, "Forum Theatre," last modified December 22, 2014. <https://dramaresource.com/forum-theatre>.

actions. For medical students, forum theater could serve as an opportunity to let them to modify their behavior and experiment with how to best respond to dramatized clinical encounters with empathy and compassion. Annable-Coop highlights the importance of such interactive exercises as serving as a contrast to the lecture-based courses that the students take:

[Students have] had the empathy lecture because every single person will say “Empathy, empathy, empathy...” And, then we do with them and particularly is to kind of go, “What does empathy look like?” They go, “Oh, I've got to show empathy,” but how do you show empathy? So, you know, things like being present, being still, being calm, looking somebody in eye, listening...I think they see it very much as a kind of a take books checklist exercise. “I must show empathy.” But actually, how do you practice empathy and to break it down of going well, what, what does that mean?<sup>206</sup>

Workshops put on by Performing Medicine gave students an opportunity to apply their clinical communication lectures in practice and to start understanding what compassion looks like in practice. It also served as compassionate care does only apply to the patients, but to others who are working in the healthcare setting alongside the students.

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In the summer of 2017, I observed first-hand the impact of forum theater in the clinical training of medical students. I present a descriptive sample of my field notes taken while observing a delivery entitled “Preparing for Clinical Placement,” in which fifth year medical students participated in a forum theater workshop put on by Performing Medicine at Bart and The London School of Medicine and Dentistry. These students were transitioning to begin their Foundation Program in the fall of 2017.<sup>207</sup> Associate artist Sylvan Baker and physician Hugh Grant-Peterkin are the performers

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<sup>206</sup> Annable-Coop, interview.

<sup>207</sup> In the United Kingdom, medical students begin their training immediately at the undergraduate level, which typically lasts for five or six years. After their undergraduate training, newly qualified doctors then transition to a two-year foundation program training in which they follow a structured program and practical experience and study before continuing onto specialist training.

while Annable-Coop serves the role of the moderator of this workshop. Grant-Peterkin plays a senior physician and Baker's advisor. Sylvan is a first-year foundational doctor (FY1):

Grant-Peterkin plays overwhelmed and stressed FY1 doctor who wants support and mentorship from his senior doctor. Hugh is the senior doctor who is not attentive to the needs of Baker—he is constantly dismissing him as “incompetent” because of being “young and naïve.” The tensions and miscommunications between the two characters are heavily exaggerated, and the students in the audience were very much aware of this. “Sir, can you give me feedback about this situation with the patient?” Baker asks in a timid voice. “In a minute, in a minute,” Grant-Peterkin hastily responds while looking at his cellphone, sitting at his desk, not making eye contact with Grant-Peterkin. The students immediately take a note of this and one says “Stop!” Annable-Coop steps forward and asks, “What’s wrong in this scene?” The student immediately responds, “Sylvan needs to be more assertive in gaining the [general practitioner]’s attention.” “How can he do that?” Annable-Coop poses the question back. Another student raises their hand and chimes in, “He can change the tone of his voice. Not too pushy, but you know, make himself heard.” “Or he could possible stand tall, not hunched back and make eye contact. Oh, and stop playing with the pen in your hands,” another student tagged along. Baker took the students’ advice into consideration and the scene started again.

Interaction as such unfolded between Baker and Grant-Peterkin multiple times, in multiple scenarios. Every few moments into the role play, Annable-Coop would step into the center of room and pause the scene, posing the following various rhetorical questions to the students: “Now what is happening in this scene?” and “If you were in [Baker’s] position, how would you feel?” Still in character as the student, Baker steps toward the audience transition into a reflective state and ask students for advice and feedback about how he could address the situation. Through the interactive nature of this performance, students quickly became engaged in this role play. “He should confer with the rest his peers regarding how their mentors treat them,” one student stated. “Maybe his body posture needs to be changed so that his senior doctor takes him seriously,” another student suggested. This continued for the next twenty minutes until the last scene was presented in which Grant-Peterkin acknowledged his faults and promised to correct his behavior towards Baker as a mentor.

These students were indirectly given control of the role play through their suggestions to Baker regarding his verbal communication, body posture, and what could possibly be his next course of action. The uniqueness of forum theater allowed for students to participate in the outcomes of the role play and to see firsthand how different situations and outcomes can play out by students critiquing his behavior in an analytical lens. While this was not an interaction between a physician and patient, the interactions between a senior physician and medical trainees are also equally important; it usually is indicative of how the medical trainee would also treat their patients and colleagues. Furthermore, students tend to forget that their interactions involve both verbal and non-verbal communication that has an effect on others around them. “I think one of the things that's in sort of performative, a participatory work is that it's not just, it's not just head stuff and neither is medicine, medicine, interpersonal business, which means there's emotion and effect in play,” stated Baker. “And I think that many medical students and practitioners either choose to not look at that or don't think about it.”<sup>208</sup> Sometimes these forms of displayed behaviors are dismissed by medical professionals and students as a part of the norm, but by participating in the audience as active observers, students are made aware of the improper behaviors, reflect on it through discussion, and can begin to rectify their own practices.

### *Coda: Importance of Performance Theory in Medical Training*

While one semester elective classes focused on various strands of theatrical performance (i.e. dramatic readings, role playing, and improvisation and storytelling) are slowly being introduced into medical school curricula, I promote Case and Willson’s idea that these methods and approaches need to be made more prevalent throughout the four years of medical school, a time which students are training and rehearsing the performance of being a doctor; for physician as “to emphasize one

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<sup>208</sup> Sylvan Baker (Associate Artist with Performing Medicine) in discussion with author, July 2017.

style of acting over any other mode of performance—or to suggest that there is only one way of showing empathy—limits actors and doctors to a practice of regurgitating learned responses rather than developing their own ways of being empathetic.”<sup>209</sup> Performance studies serves as a tool to help future clinicians perform their newfound knowledge and prestige duties in humanistic and compassionate manner. Medical student Clara Belessiotis, who took part in Performing Medicine’s courses during her clinical training, reflects about how the courses made her aware of the behavioral aspects of medicine and how it impacted her practices:

It highlighted the importance of your voice and your body language in [the clinical context] ...like the communication skills classes, it's more like things like making eye contact. Your body's this way, practicing, and actually in some ways like those words can end up feeling empty if they're not like backed up with the and the specific movements. So just for me like in terms of my own practice that's been helpful in terms of like dealing with people are upset or you're like giving bad news to you and things like that and made it as maybe a bit more comfortable.<sup>210</sup>

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<sup>209</sup> Case, 162.

<sup>210</sup> Clara Belessiotis (Former student with Performing Medicine) in discussion with author, July 2017.

## **Conclusion: Being a Good Doctor**

In this thesis, I have examined how medical education reforms are receptive to the current social discourses about patient's experiences in the healthcare system and analyzed how central debates regarding observed decline of empathetic behavior in physicians have had profound implications on the contemporary training of medical students. I ultimately proposed the solution that a more integrative and multidisciplinary answer is needed to address the performative elements of medical practice that have come into recent scrutiny, and that this solution lies in the field of performance studies. By documenting the last hundred years of America medical education history, I have shown that clinical training has been consistently dominated by scientific knowledge and pedagogy. Late nineteenth and twentieth century medical curricula changes reflected the rising scientific and technological advancements of the time and it was widely acknowledged that a good doctor was also a good diagnostician who had the ability and insight to isolate the origins of the patient's disease. However, in the late twentieth century, patients gradually lost their participatory role in the clinical encounter as a result of the medical gaze. In response to this, they began to critique the behavior—more aptly, the performance—of their physicians. As such, according to patients, a good doctor is one who is attentive to both their physical and emotional needs; a good doctor is one who embodies empathy.

As twenty-first century medical education seeks to cultivate more empathetic behavior within its future clinicians, educators need to tap into the patient's, rather than the physician's, description of a good doctor in order to improve how the performative aspects of medicine are taught to students. While the integration of the discipline of medical humanities within the curriculum provides students with creative tool to gain a humanistic lens in to the culture and workings of medicine, I suggest that a shift from Narrative Medicine to performance studies as the dominant mode of teaching compassionate care is required. Performance studies as a discipline

presents the opportune platform for students to learn about the embodied components of humanistic medical practice. In particular, performance studies provides the methods of forum theater and role playing. As demonstrated by the examples that I presented from the program Performing Medicine, through this discipline, students are not only given tools to understand the ritualistic and healing pasts of medicines to better understand the sacred physician-patient relationship, but they are also given the stage to practice behaving as a good doctor before embarking on their medical careers.

Through the perspectives of history, sociology, anthropology, and philosophy, this research examines the how the establishment of modern day medicine and the evolution of the physician-patient relationship affected the formation of modern day medical training. As twenty-first century medicine is currently undergoing a new period of transformation that involves the implementation of a multidisciplinary team care, development of personalized medicine, increased access to online medical information and healthcare records, and enactment of the Affordable Care Act, American healthcare is flourishing and growing at rapid rate.<sup>211</sup> According to a 2016 report released by the United States Bureau of Labor Statistics, “employment in the health care and social assistance sector is projected to add nearly 4.0 million jobs by 2026, about one-third of all new jobs. The share of health care and social assistance employment is projected to increase from 12.2 percent in 2016 to 13.8 percent in 2026, becoming the largest major sector in 2026.”<sup>212</sup>

By acknowledging the multifarious factors that allowed for the consolidated power of medicine and the rise of physicians’ elite status, medical professionals can take the proper interventional measures to ensure that the practice of medicine stays mindful of its original purpose of healing individuals. With the rising numbers of clinicians expected to enter the workforce in the

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<sup>211</sup> William H. Frist, “Health Care in the 21<sup>st</sup> Century,” *The New England Journal of Medicine* 352, (2005): 267-272.

<sup>212</sup> “Employment Projects: 2016-26 Summary,” *United States Department of Labor*, last modified October 24, 2017. <https://www.bls.gov/news.release/ecopro.nr0.htm>.

upcoming years and the current system of medical training undergoing reorganization, it is more important than ever to return to the fundamental question of “What makes a good doctor?”

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