The Role of Empathy and Wisdom in Medical Practice and Pedagogy: Confronting the Hidden Curriculum

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The role of the virtues of empathy and wisdom in clinical practice is used to address two crises facing modern medicine—quality of care and professionalism. To that end, these virtues are initially explored individually and then collectively in terms of their synergistic relationship between them. Next, how empathy and wisdom guide and empower clinical practice, especially in terms of their synergistic relationship, is discussed vis-à-vis the two crises. The "Grand Rounds" scene from "Wt"—Margaret Edson’s 1999 Pulitzer prize-winning play—is used to illustrate how these virtues function with respect to providing quality care in a professional manner. The paper concludes with a discussion of the challenges facing the pedagogy of equipping medical students, residents, and even practicing clinicians with virtues like empathy and wisdom.

1. Introduction

In a study exploring the educational experiences of medical students, Coulehan and Williams from Stony Brook University Medical Center recount the story of a first-year student who arrives on campus with a heart full of empathy to meet patients’ needs. However, by the end of the student’s medical education she is no longer enthusiastic about medicine and serving patients but turns inward in order to survive the personal hardships, if not abuse, she faces daily as a medical student. In response to a questionnaire, she writes, "I’ve become numb. So much of what I do as a student is stuff that I do not fully believe it. And rather than try to change everything that I consider wrong in the hospital or the community at large." She confesses, "I just try to get through school in the hope that I will move on to bigger and better things when I have more control over my circumstances" [1, page 599]. Unfortunately, her story is common for many medical students.

In a recent study involving the educational experiences of medical students, Michalec reports that a knowledge gap exists between students and laypersons, with detrimental consequences for students’ ability to connect with others—especially with patients. "Preclinical students . . spoke not merely of having trouble communicating with laypersons because of distinctiveness of what they were learning," writes Michalec, "but that what they were learning was also powerful and was accompanied by a level of authority, according to their instructors" [2, page 274]. He goes on to note that the outcome of the knowledge gap between medical students and laypersons was a sense of superiority on the part of the students towards others, particularly patients, who lacked such knowledge. Finally, Michalec concludes that "this distancing may lead, in part, to the detriment of students’ levels of empathy due to a corrosion of their ability to take others’ perspectives" [2, page 10]. Such diminution in empathy is a common consequence of medical education.

Indeed, several studies report that medical students’ empathy declines during training to become physicians. For example, in a study utilizing the Jefferson Scale of Physician Empathy, Hojat and colleagues from Jefferson Medical College found that empathy significantly decreased over the first three years of medical school [3]. Likewise, in a study employing the Balanced Emotional Empathy Scale, Newton and coworkers from the University of Arkansas for Medical Sciences discovered that medical students’ empathy significantly declined after the first three years of training [4].
However, in a meta-analysis or systematic review of eleven studies on empathy in medical students, Colliver and associates from the Southern Illinois University School of Medicine concluded that the studies on the decline in medical student empathy “greatly exaggerated” its significance [5]. In rebuttal, both Hojat and Newton identified technical and analytic problems with Colliver and associates’ meta-analysis of the disparate studies examining medical student empathy. Undeniably, in a recent meta-analysis of 18 studies on medical student and resident empathy, Neumann and colleagues found a significant decline in empathy during formal training. They concluded, “empathy decline during medical school and residency compromises striving toward professionalism and may threaten health care quality” [6, page 996].

What is the impact of declining empathy on quality of care (QoC) and professionalism in medicine? Over the last several decades, the quality of American healthcare has drastically declined—resulting in what many claim is an urgent crisis for medicine. “The public has just begun to recognize,” writes McNeil from Harvard Medical School, “that despite the enormous achievements of American medicine and the American health care system, the quality of care in this country needs to be and can be improved” [7, page 1612]. A major part of the crises is that patients feel physicians simply do not connect with or do not listen to them at a personal level in order to address the emotional or existential dimensions of their illness. Empathy is certainly an essential factor for quality care, especially from the patient’s perspective. “In terms of patients’ own definitions of quality of care,” write Mercer and Reynolds, “empathy emerges as a key factor in primary care” [8, page S9]. Consequently, the decline in empathy of healthcare professionals is definitely an important contributing factor to the QoC crisis in medicine.

Besides the QoC crisis, decrease in empathy is also associated with another crisis plaguing modern American medicine—professionalism [9, 10]. In fact, the two crises are intimately associated with one another. Professional behavior that comports to community standards is often associated with quality healthcare, while unprofessional behavior that fails to meet such standards generally results in poor quality healthcare and to patient harm and even death. Importantly, empathy is one of the hallmarks of the medical profession and is taught in the formal curriculum as such [11]. However, studies show that loss of empathy leads to a decline in professional behavior and an inability to deliver quality healthcare [6]. Moreover, medical students are keenly aware of the relationship between professionalism and quality care and the impact empathy has on both. For example, in a survey of medical students’ professionalism journals, Karnieli-Miller and associates found that medical students were cognizant of the need for empathy and good communication on the part of physicians to deliver quality healthcare in a professional manner [12].

What is at root for the loss in empathy during medical training? Even though the medical faculty may emphasize the role of empathy during the formal or explicit curriculum, students learn something different through an implicit or a hidden curriculum. Rather than championing empathy, this latter curriculum teaches students to detach from their patients. Lempp and Seale define the hidden curriculum as “the set of influences that function at the level of organizational structure and culture including, for example, implicit rules to survive the institution such as customs, rituals, and taken for granted aspects” [13, page 770]. The effects of this curriculum, according to Lempp and Seale, include adoption of a “ritualized” professional identity, especially in terms of hierarchical authority and, at times, bitter competition among peers. Other effects involve failure to learn the formal dimensions of “good doctoring,” resulting in loss of idealism and ethical integrity, and in adopting a stance of emotional neutrality often parading as emotionally detached concern or objectivity. The overall effect of the hidden curriculum on aspiring physicians is to dehumanize them as they attempt to survive the abuse and stress of the medical education system, which should be supporting them not only to become professionals who deliver quality healthcare but also to flourish as persons [14].

Medical commentators have proposed teaching virtues during medical school and residency to stem the tide of empathy loss due to the hidden curriculum and thereby to address the QoC and professionalism crises [15–19]. In this paper, the role of empathy and wisdom in clinical practice is used to address these crises. To that end, these virtues are initially explored separately and then jointly, especially in terms of their synergistic relationship, to guide and empower clinical practice vis-à-vis the QoC and professionalism crises. The “Grand Rounds” scene from “Wt”—Margaret Edson’s 1999 Pulitzer prize-winning play—is used to illustrate how empathy and wisdom, particularly with respect to their synergistic relationship, function to provide quality care in a professional manner [20]. The paper concludes with a discussion of the challenges facing the pedagogy of equipping medical students, residents, and even practicing clinicians with virtues like empathy and wisdom.

2. Empathy and Wisdom

In this section, the virtues of empathy and wisdom are examined individually, beginning with a discussion of empathy and then following with one on wisdom. Next, the synergy between the two virtues that results from a reciprocal feedback relationship between them is discussed to address the QoC crisis and its associated professionalism crisis in the ensuing section. The synergy between these two virtues is especially critical for addressing the crises in that empathy drives clinicians to utilize wisdom to relieve pain and suffering in a caring and competent fashion. The origin of this synergy is illustrated in terms of a reciprocal feedback relationship between empathy and wisdom. As empathy drives clinicians to be wise and insightful in their clinical reasoning and decision making, the outcome of such clinical practice feeds back onto empathy and promotes and augments clinicians’ capacity to be empathic, which in turn leads clinicians not just to continue to make wise clinical decisions, but possibly even better or wiser decisions, as they become experts in their medical practice.
2.1. Empathy. Empathy is generally considered a dispositional trait or ability and/or a mental capacity to feel and/or comprehend—to a limited extent—another person's emotional situation or state. Although no consensus over its definition exists presently, evidence from recent neuropsychological studies, including behavioral, lesion, and neuroimaging experiments, indicate two systems involved in empathy [21, 22]. The first is an emotional system, which comprises the perception and recognition of emotional contagion. The system's neural substrate includes the inferior frontal gyrus and inferior parietal lobe, along with the anterior cingulate and anterior insular cortices. Its neurochemical mechanism consists of the neuromodulator, oxytocin. The second system is cognitive, which involves the mental capacity to understand or comprehend another's mental state—that is, “theory of mind.” The system's neural substrate includes the ventromedial and dorsomedial prefrontal cortices, along with the temporoparietal junction and medial temporal lobe. Its neurochemical mechanism consists of the neurotransmitter, dopamine. Although both systems depend on separate neuronal structures and are dissociable in certain personality disorders, recent neuropsychological research indicates interaction between them—although considerable research needs to be conducted to understand that interaction.

For healthcare professionals, empathy is an important element in providing quality healthcare [6, 8, 23–25]. It affords such professionals the opportunity not only to enter the patient's world of illness and eventually to experience it but to assist the patient in recovering from the illness. For example, in a review of the literature on the role of empathy in primary care delivery, Mercer and Reynolds [8] report that empathic healthcare practice overwhelmingly improves clinical outcomes. Although measurement of empathy varies from study to study, empirical research certainly confirms the positive benefits of empathic consultation in healthcare settings. Moreover, Zinn [25] advocates a role for empathy in healthcare through the notion of the “empathic physician.” Via empathy, not only does the physician enter the patient's world, but also the patient can share that world and its burdens with the empathic physician. This sharing of the world by both the patient and physician, claims Zinn, is the root of empathy's therapeutic potential. The physician may realize that therapeutic potential through use of appropriate language to engender in the patient deeper awareness of the illness and its meaning, as well as impact on the patient's life.

As for defining general empathy, healthcare commentators have also yet to reach consensus in defining clinical empathy. Definitions often range from simply borrowing the patient's feelings about the illness experience to actually possessing those feelings, even if only vicariously [26–28]. Halpern [26], for example, defines empathy in terms of the clinical encounter as an emotional attunement with the patient's world of suffering. Through attunement, the healthcare worker understands dimensions of the patient's suffering that allow for effective treatment. Halpern explains how empathic physicians achieve effective treatment through “associative reasoning,” which involves physicians connecting not only emotionally, but also cognitively, with a patient. Through this connection or association, physicians can focus on the patient's illness story and come to understand what that story signifies or means to the patient. Morse and colleagues [28] identify two additional components of empathy, besides the emotive and cognitive. The first is motivational, which represents a receptive and an at-hand attitude towards a person in pain. The second is behavioral, in which the caregiver responds verbally in reassuring the person in pain that the caregiver understands and intends to act on behalf of the person in order to relieve the pain.

An operating definition for clinical empathy, utilizing Halpern's and Morse and colleagues' work, involves an affective and a mental reaction to another's suffering in which a person enters into that suffering, with an ability to assess what is required to relieve it. In other words, it is caring about a person's suffering in order to care for that person. Caring is at root of an empathetic response. Like general empathy discussed above, clinical empathy can be divided into two systems: affective and cognitive. Affective clinical empathy is an emotive reaction (feeling or passion) to another's suffering, that is, a caring about. Hence, it involves not only the feelings for or an emotional response to the one suffering but also a more fundamental passion for those who suffer. This passionate response is the root cause motivating empathic people to respond initially to pain and suffering in the world. Cognitive clinical empathy represents a rational capacity (logical or conceptual) to assess the reason for another's suffering in order to relieve it, that is, a caring for. As for affective clinical empathy, it exhibits two dimensions. The first is rational, which pertains to the logical and conceptual analysis of the reasons behind another's pain and suffering. The second is behavioral, which involves an ability to act to relieve that pain and suffering.

2.2. Wisdom. Like empathy, wisdom is also an important virtue in the practice of medicine [16, 29]. For example, Pellegrino and Thomasma claim wisdom or prudence—their preferred term—is critical for achieving the goals of medicine. For them, wisdom is necessary to "discern what means are most appropriate to the ends, how to balance the benefits and harms in clinical interventions, and how to put the moral and the technical issues in a proper relationship with each other" [16, page 86]. In addition, prudence is required, according to Pellegrino and Thomasma, to square successfully and effectively both the affective and technological dimensions of medical practice. The wise or prudent physician can navigate these dimensions of both the heart and the head. The prudent physician includes—in a wise and caring manner—the patient's physical and existential needs in a treatment plan, which generally meets these needs. Moreover, the wise or prudent physician's clinical judgments include a decision tree, according to Pellegrino and Thomasma, with algorithmic processes, which include not only clinical observations and laboratory results, but also the existential concerns of patients and their personal contexts. Importantly, the prudent physician not only achieves the goals of medicine, which is to meet the clinical needs of patients sanctioned by society, but also, in meeting those needs through wisdom, that physician also practices a type
of medicine that results in a fulfilled clinical practice for the physician.

Traditionally, according to the ancient Greek philosophers, wisdom is generally either theoretical or practical [30]. Theoretical wisdom is concerned with the fundamental or universal principles or laws that govern the world. The theoretically wise person is someone who grasps the eternal or necessary truths or intelligibility, since the goal of theoretical wisdom is nothing less than truth itself. Practical wisdom, however, concerns the specific meaning or significance of a person's actions. Thus, the practically wise individual is someone who grasps the meaning of the here and now and knows how to act in a common-sense manner. According to the above, “just as theoretical wisdom included both a knowledge of first principles and an ability to demonstrate, practical wisdom includes both a correct desire for the ultimate end of conduct and an ability to calculate the proper means to that end” [30, page 179]. For the purpose of the present discussion, wisdom represents the ability or capacity to grasp not only the intelligibility of events or phenomena but also their meaning or significance.

An important dimension of wisdom, especially as it relates to medicine as a key virtue, is its relationship to competence. Just as care is an integral component of empathy, so is competence for wisdom—particularly in the practice of clinical medicine. A gap exists between affective and cognitive clinical empathy in that a person who is motivated to act to relieve suffering must be capable of bringing about that relief. Filling that gap requires competence on the part of the empathic person. Although a person may authentically empathize with another person, the empathic agent cannot genuinely help another unless the agent is competent to do so. Competence in medical practice is a major concern of both patients and professional healthcare providers [31]. Although definitions of competence vary, clinical competence in general or broadly construed refers to an “ability to perform a task” according to specific standards or criteria, often defined by a community of professional practitioners [32, page 252]. The performance depends upon acquisition of specialized knowledge and the application of that knowledge through specific skills. The wise and empathic agent then is able to utilize these technical skills competently to relieve another’s pain and suffering.

2.3. Reciprocal Feedback Relationship. In this subsection, the reciprocal feedback relationship between empathy and wisdom is examined, in order to address the QoC and professionalism crises. At one level, the two virtues complement one another as a clinician attends to the patient’s medical needs. On the one hand, as a wise healthcare provider, the clinician provides the best competent medical care, not only in terms of knowing why (theoretically) this is the best care but also how (practically) to appropriate that care for the individual patient. On the other hand, as an empathic healthcare provider, the virtuous clinician provides such competent and wise healthcare in a caring manner, with respect to incorporating the patient’s illness story. Through that story, the empathic clinician draws alongside the patient compassionately and enters into the patient’s world of suffering caused by illness, and, when conditions demand it, the clinician even sacrifices altruistically his or her comfort for the patient’s welfare. By caring for the patient, because the patient is a person who is inherently worthy of such care, the clinician meets the patient’s ultimate need—healing. Hence, the clinician employs the virtues of empathy and wisdom harmoniously to complement one another.

On another level, however, the relationship between empathy and wisdom may at times represent more than simply their combination or complementation. Specifically, it can also represent a relationship between these two virtues that when in combination transcends the properties of each virtue individually. The relationship between the two virtues, then, is synergistic in that wisdom guides and regulates empathy, and, in turn, empathy engages and deepens wisdom. In other words, wisdom vis-à-vis empathy empowers the clinician to make the best and wisest decisions because it is the caring thing to do for the patient, and empathy vis-à-vis wisdom enables that clinician to care for the patient's needs affectionately and effectively because it is the wisest thing to do. The synergy between empathy and wisdom, for example, impels the wise clinician to maintain and enhance competence through continuing education even when no patient need is evident. Rather, the anticipation of such future need motivates the virtuous clinician. In turn, the resultant synergy between the two virtues motivates the clinician to care for the patient even when the patient has no need of medical care. Consequently, this synergy makes wisdom empathic and empathy wise. The clinical outcome is not just comprehensive healthcare but a full and rich holistic healthcare, which restores not only the patient's health as best as possible but also the patient's dignity and integrity.

Importantly, the synergistic interaction between empathy and wisdom, as depicted below, involves reciprocal feedback between the two virtues:

Empathy → Wisdom.

Beginning with empathy, the virtuous clinician is motivated to connect with patients to meet their individual healthcare needs, especially the possible cure of disease or restoration of health or, more importantly, integrity. That connection involves not just a desire to care about patients but a genuine feeling that prompts the clinician to care deeply about them. But, such empathy is not misguided or misguided. Rather, wisdom informs and shapes it so that the clinician can meet a patient's medical needs, competently and efficiently. It operates not only with respect to the technical dimension of clinical practice in judiciously utilizing medical technology correctly but also with respect to its ethical dimension in discerning the right or good way of engaging that technology. By informing the clinician's empathy for patients and their needs, the wise clinician can ultimately empathize with them by meeting their healthcare needs in a technically correct and ethically good manner. The outcome is not only patients who feel truly taken care of but also clinicians who feel that they are fulfilling their role as professional healthcare providers. Finally, empathy further motivates clinicians to make even more wise clinical decisions in the care of patients.
and to a deeper care for them. The result is an expansion of a clinician’s empathy for more or demanding patients. The synergy between empathy and wisdom, then, is an outcome of a reciprocal feedback relationship in which empathy and wisdom enhance each others’ properties to achieve what each cannot achieve separately.

3. Addressing the QoC and Professionalism Crises

The virtues of empathy and wisdom, including their synergistic relationship, provide the clinician the necessary resources and skills to deliver the best possible healthcare in a professional manner, thereby addressing both the QoC and professionalism crises facing contemporary medicine. For the QoC crisis, the virtues allow the clinician to treat the patient as a whole person rather than simply as a diseased body part, to focus on a patient’s rich illness narrative or story rather than limiting the patient to a modest medical history, and to seek not only treatment that results in a possible cure and return to health but also therapy that leads to healing and, most importantly, to restoring the patient’s dignity. For the professionalism crisis, the virtues operate in shifting the authority structure from a hierarchical to heterarchical one, in replacing a dominance model for the patient-physician relationship with a partnership one, and in substituting an attitude of cooperation for one of competition. In this section, after discussing how empathy and wisdom addresses these crises, the “Grand Rounds” scene from “W;t” [20] is used to illustrate how the virtues operate.

For addressing the QoC crisis in modern medicine, first the virtues of empathy and wisdom allow the clinician to treat the patient as a whole person rather than simply as a diseased body part. The virtuous physician realizes that the patient is more than simply a biological or pathological specimen but a person who resides in a multifaceted context, which has important implications for treating the patient successfully. To ignore that context is to risk providing substandard care. By treating the whole patient, however, the clinician provides quality care that meets the patient's medical needs in a comprehensive, rather than a truncated, manner that narrowly concentrates simply on pathology. Next and associated with the above, the virtuous physician focuses on a patient’s rich illness narrative or story, rather than limiting the patient to a modest medical history. By listening to that narrative and incorporating it into both diagnosis and treatment, a clinician provides quality healthcare that addresses both the patient’s physical or bodily and emotional or psychological needs. Finally, the virtuous physician strives not only to treat the patient with the goal of a possible cure and return to health but also to provide therapy that leads to healing and, most importantly, to restore the patient’s dignity. In sum, the virtues of empathy and wisdom address the QoC crisis through equipping the physician to provide a standard of care that leaves not only the patient with a feeling of being cared for but also the clinician with a sense of job well done.

For addressing the professionalism crisis in modern medicine, first the virtues of empathy and wisdom assist the clinician in moving from an authority structure that is hierarchical in nature to one that is heterarchical or wirearchical. Rather than believing the physician is the final authority for treating patients, the virtuous physician shares that authority with other healthcare professionals who are invaluable resources for treating patients. In other words, the authority structure represents a network of healthcare givers who form a team rather than a pyramid, with the physician at the top. Such a structure allows the physician to define relationally or socially medical professionalism in terms of other professionals rather than apart from them. Next and related to the shift in authority structure, the virtues substitute an attitude of cooperation for one of competition, especially among peers. Rather than acting to promote oneself at the expense of others, whether peers, allied healthcare providers, or even patients, the virtuous physician recognizes that an attitude of competition only impedes patient care and promotes merely self. Cooperation helps to define professionalism collaboratively or collectively by providing a professional attitude in which physicians respect the talents of others by supporting rather than demeaning them. Finally, and related to the other two, empathy and wisdom assist to replace a dominance model for the patient-physician relationship with a partnership model. For example, rather than dictate treatment with little regard for patient preferences, the virtuous clinician empowers the patient to participate actively in treatment. Importantly, the partnership model defines medical professionalism in terms of service to the patient by putting the patient at the center of the patient-physician relationship, in alliance with the physician.

The "Grand Rounds" scene from Edson’s play W;t [20, pages 30–35] is used to illustrate how the virtues of empathy and wisdom, along with their synergistic relationship, operate. First, the scene is reconstructed briefly as the playwright wrote it, and then how the clinicians’ behavior could be altered to provide quality care in a professional manner, if that behavior was shaped by the virtues, is discussed. The scene begins with the chief of medical oncology, Harvey Kelekian, and five clinical fellows, including senior fellow, Jason Posner, entering the Vivian Bearing’s room. Bearing is a professor of English and has stage-four metastatic ovarian tumor. She is undergoing chemotherapy and is currently receiving the second cycle. Kelekian acknowledges Bearing’s presence, and Posner inquires perfunctorily how she is “feeling” today to which she responds “fine.” Posner then exposes Bearing’s abdomen and recites the facts of her case, often palpating anatomical areas of involvement. After recitation of the clinical facts, Kelekian asks the fellows what side effects are associated with the drugs used to treat Bearing’s cancer. One fellow begins to answer only to be cut short by Posner, who dismissively retorts that the side effect “goes without saying.” The playwright notes that the other fellows resent Posner, as he belittles their attempts to list the chemotherapeutic drugs’ side effects. At last, Kelekian asks if any other side effects are evident, to which the fellows are unable to answer. Kelekian asks them to use their eyes and after the fellows fail to provide the correct answer, he points out the patient’s hair loss. The fellows protest that this side effect is obvious, and Kelekian calls on Posner to expound, who then begrudgingly
complies. The scene concludes with Kelekian urging Bearing to receive the “full dose” of the chemotherapeutic drugs and to “keep pushing the fluids.” Finally, he admonishes Posner to perform his clinical duty and thank Bearing for her cooperation, which Posner does mechanically. Bearing is left with her abdomen exposed and comments on how “grand” the experience was and how the behavior of the participants reminded her of a graduate seminar—“Full of subservience, hierarchy, gratuitous displays, sublimated rivalries.”

What the above scene illustrates is often called “pimping” in which an attending physician (Pimper) asks demanding questions of residents and medical students (Pimpes) [33, 34]. The outcome is often humiliation and degradation on the part of the Pimpee. How would this scene play out if the clinicians were empathic and wise, especially the oncology chief? First, Kelekian would not simply acknowledge Bearing’s presence upon entering the room but genuinely inquire about her physical and mental health, thereby modeling for the clinical fellows empathic concern for the patient’s wellbeing. After all, the chemotherapy has left her hairless and he might inquire as to how she feels about the side effect. Next, instead of asking the fellows tricky and banal questions about the drug’s side effects, the wise chief would afford each fellow an opportunity to respond without interruption from the other fellows. In so doing, the chief would provide a safe environment in which he could teach the fellow and the fellow, in turn, could learn without fear or intimidation. In addition, the wise chief would include the patient’s participation in describing the side effects’ impact upon her health, thereby helping the fellows to enter the patient’s illness world and to engage the patient empathically. As an empathic and a wise clinician, Kelekian would not only provide quality healthcare for the patient in a professional manner, but he would model such professional care for the fellows who, in turn, would then be able to provide such care to patients. In sum, the virtues equip the clinician to enter empathically the patient’s world and to make wise clinical judgments and decisions as to how to treat the patient and not simply the disease. Lastly, in terms of the synergistic relationship between empathy and wisdom, as the chief of oncology is truly motivated to empathize with the patient he provides competent and wise medical care that allow him to treat the patient caringly, which, in turn, feeds back onto his motivation to empathize and promotes deeper empathy for the patient with an outcome of quality medical care delivered in a professional manner.

4. Teaching Empathy and Wisdom

As noted above, the virtues of empathy and wisdom, along with their synergistic relationship, can help to address the QoC and professionalism crises; however, the question arises as to how medical students can be taught these virtues. Although modest debate surrounds whether virtues can be taught, unless effort is made to teach them students might learn vices by default—especially through the hidden curriculum. Teaching empathy and wisdom can be incorporated into the medical curriculum, both explicitly and implicitly. Explicitly, the virtues can be taught as part of the formal medical curriculum in terms of innovative classes and seminars. In addition, mentoring relationships between medical faculty and students can serve to support and supplement the formal curriculum and to provide students with individual attention to personal issues and questions that arise during their education to become physicians. Implicitly, the medical faculty can teach empathy and wisdom through a hidden curriculum in terms of the virtues animating the social structure of medical schools and their associated teaching wards. An important means for teaching them implicitly is through role modeling in which medical professionals exhibit the fruit of the virtues. In this section, explicit strategies for teaching empathy and wisdom are examined, followed by implicit strategies.

The question facing medical pedagogy, especially in terms of the explicit formal curriculum, is not simply whether the medical faculty should or can teach virtue to medical students but rather how. This paper’s goal is not to develop specific types of courses or their content but rather to outline a general strategy for incorporating virtue, especially empathy and wisdom, into the medical curriculum. Although the faculty cannot teach and students cannot learn virtues as directly as medical or scientific facts, it can set the conditions for learning and practicing virtue throughout the curriculum in innovative courses that make virtue practically relevant to clinical practice. The faculty must design courses that introduce early on in the student’s educational experience the nature and types of virtues required for practicing medicine, which meets the patient’s physical and emotional or psychological needs. When students understand general virtue theory and are aware of the array of virtues available, the faculty can then design courses in the student’s formal training that instantiate the virtues and translate them from the classroom into the clinic. For example, Case and Brauner [35] introduced a “performance studies paradigm” to assist medical students in developing an “empathic imagination.” Importantly, these courses must provide realistic conditions taken from actual clinical experience that instructs and challenges students to incorporate virtues into medical practice. Without such practical relevance, students simply will not take seriously the importance of virtues for practicing medicine.

An important means for teaching virtues like empathy and wisdom in medicine is through mentoring relationships between medical faculty and students, which are well recognized and accepted in the healthcare professions [36–41]. Taherian and Shekarchian provide the following comprehensive definition for mentoring: “a process whereby an experienced, highly regarded, empathic person (the mentor) guides another usually younger individual (the mentee) in the development and re-examination of their own ideas, learning, and personal or professional development” [42, page e95]. They identify several important benefits of the mentoring relationship, especially in terms of allowing the mentee to mature and develop into a mature healthcare provider. Virtues are certainly an important component of that maturation process, and a mentor can facilitate the acquisition and development of virtues by the mentee necessary for virtuous medical practice.
Besides the explicit formal curriculum, the implicit informal curriculum, especially the hidden curriculum, is also critical for teaching medical students the role of virtues in clinical practice. Medical faculty who are empathic and wise realize the humiliating and derogatory nature of “pimping” and strive to provide a safe environment in which to engage students in a friendlier but still challenging Socratic method of teaching on the clinical wards. The virtues of empathy and wisdom, then, would reshape and transform the institutional culture or hidden curriculum to make it a positive, rather than a negative, reinforcement for learning medicine. For example, the virtuous physician would ask developmentally appropriately questions of medical students and not intentionally promote bitter competition among students through questioning them on rounds. An important component of this reshaping or transformation is the medical faculty, who serve as role models of virtues. Role modeling is a key component in medical pedagogy [43–47]. Specifically, the virtues of empathy and wisdom would help to promote three important features of role modeling, including clinical competence, teaching skills, and personal qualities of the role model [48]. Through role modeling, students would observe first-hand the benefits of clinical medicine practiced by virtuous physicians.

Finally, measuring and assessing the impact of teaching virtues to medical students and residents is an important issue for implementing empathy and wisdom into medical pedagogy and practice. For example, Mercer and colleagues developed a Consultation and Relational Empathy (CARE) instrument for measuring the impact of empathy on clinical outcomes [49]. The CARE instrument is a ten-item questionnaire based on a wide-ranging definition of empathy, which the patient completes after consultation with a clinician. The researchers found that the instrument was valid and reliable for measuring the patient's experience of empathy during the consultation, which has been subsequently confirmed in systematic review of various instruments utilized to measure physician empathy [50], and they suggested its use in medical pedagogy. Indeed, a recent study employed it to assess a resident training program in empathy and reported that residents undergoing the program were more empathetic from the patient's perspective than those who did not [51]. Although this study is promising, certainly additional research is required to investigate the role of empathy, including wisdom, in medical pedagogy and practice.

5. Conclusion

In sum, empathy and wisdom addresses the QoC and professionalism crises by enabling physicians to enter into a patient's illness experience, in order to engage, understand, and help manage the world of illness, with the outcome of providing quality professional healthcare that often exceeds minimal community standards necessary not only to treat but also to heal the patient. Although the introduction of virtues like empathy and wisdom into the medical curriculum is not immune from serious challenges, however, as Daniel Sulmasy warns, "there is really no morally acceptable alternative. We need to create environments that cultivate professional virtue in our schools, and in our practice settings" [52, page 515]. Otherwise, one of the alternatives to teaching virtue intentionally is teaching vice unintentionally. The proposal of incorporating empathy and wisdom into medical education and practice transforms the clinical culture, so that virtuous clinicians deliver quality healthcare in a professional manner.

References


