PHYSICAN-AS-PATIENT LITERATURE: INTRODUCING AND FOSTERING A CULTURE OF EMAPTHY IN MEDICINE

A Thesis
Submitted to
the Temple University Graduate Board

In Partial Fulfillment
of the Requirements for the Degree
MASTER OF ARTS

---

by
Victoria Ann Wytiaz
May 2017

Thesis Approvals:

Nora Jones, PhD, Thesis Advisor, Center for Bioethics, Urban Health and Policy

ABSTRACT

The physician-patient dichotomy is reinforced continuously in medical education and medical practice. The physician possesses knowledge that will be used to help the patient in some way. However, as human beings, physicians are subject to the illnesses and diseases that affect their patients. Physicians moved by this role-reversal may feel compelled to record their experiences, leading to an accumulation of "physician-as-patient literature."

Five examples of "physician-as-patient" literature illustrate five fundamental lessons that can be adapted by physicians: relating to patient vulnerability, fostering hope for patients, mobilizing support systems, recognizing physical consequences of disease, and appreciating patient quality of life. By generalizing these individual stories, it is not necessary for physicians to experience the exact disease or illness they treat. Rather, they can draw from their unique life experiences to practice empathy.

The concept of empathetic medicine can be introduced in medical school training by integrating empathy education into scientific curriculum. Current practitioners can benefit from narrative exercises, reflection and physician self-disclosure in efforts to promote empathy. Medical practice requires solid relationships between human beings, physicians and patients. This basic principle is further emphasized in "physician-as-patient" literature and concerted efforts by institutions and individual physicians can lead to a foundation for a culture of empathy.

To my parents, for their constant support in all of my endeavors

To Nick and Becca, my siblings and my role models

To my urban bioethics class: thank you for your intellect, kindness and commitment to ethical medicine

TABLE OF CONTENTS

ABSTRACT ii

ACKNOWLEDGMENTS iii

LIST OF TABLES v

CHAPTER 1: PHYSICAN-AS-PATIENT LITERATURE: INTRODUCING AND FOSTERING A CULTURE OF EMPATHY IN MEDICINE 1

Introduction 1

Physican-as-Patient Literature: Lessons in Empathy 4

Relating to Patient Vulnerability 6

Fostering Hope for Patients 8

Involving Support Systems 9

Recognizing Physical Consequences of Disease 11

Appreciating Patient Quality of Life 13

Fostering Empathy: Medical Education, Narrative Medicine, and Physician Disclosure 15

Empathy in Medicine 16

Empathy through Narrative Medicine 19

Physician Disclosure 23

Limitations and Further Suggestions: Respecting Social Determinantof Health 26

Conclusion 28

BIBLIOGRAPHY 29

LIST OF TABLES

Table Page

1. Suggestions for Fostering Empathy…… 26

CHAPTER 1: PHYSICAN-AS-PATIENT LITERATURE: INTRODUCING AND FOSTERING A CULTURE OF EMPATHY IN MEDICINE

Introduction

The physician-patient dichotomy is one that is continuously reinforced both in medical education and medical practice. In medical school, students take part in simulated patient encounters, encouraged to maintain a professional but somewhat distant demeanor. The physician is viewed as the source of knowledge and every effort is made to perpetuate that image. In medical practice, the physician wears the white coat, an outward sign that they are different from the patients, clothed in hospital-issued gowns. The clear distinction between physician and patient is useful in that it offers a clear delineation of the expectations of each party. While there is rarely role-reversal in which the patient becomes a physician, the opposite is a rather frequent occurrence. Physicians are human beings and are necessarily subject to the same disease and illness that they manage in their patients. For some physicians, the experience of becoming a patient has a profound effect on their sense of self and how they approach their profession. Those that are especially moved by the illness experience may feel the impetus to share their revelations in written form, leading to the accumulation of "physician-as-patient" literature.

Two types of physician-as-patient literature exist and as such, different implications arise from the analysis of each. The first category of physician-as-patient literature address the notion of the "sick physician" and the challenges that arise from this seemingly paradoxical situation. This literature, however, is largely focused on the

immediate implications for the physician in their new role. Ingstad and Christie illustrate that the self-perception of sick physicians changes during illness as they believe that they ought not to have become ill and that they must undergo a rapid recovery.[1] Similarly, Henderson, et al. found that physicians who suffered from illness endorsed self-stigmatizing views that hindered their ability to cope with their infirmity.[2] While this type of analysis focuses on the negative aspects of the physician-as-patient scenario, few have sought to explore the constructive and favorable outcomes of this situation, especially as it relates to empathetic practice in medicine.

In the second type of physician-as-patient literature, physician authors approach their illness from a broader viewpoint, analyzing their experiences and the potential implications for their own practice of medicine, even after they are rid of their ailment. These physician-as-patient accounts overwhelmingly focus on humanistic and empathetic aspects of medicine rather than the technical or scientific. When the physician suffers through disease and illness, the patient experience becomes personal rather than observed. Indeed, this understanding through experience affects the physician's practice of medicine and can shape that practice intro an empathetic endeavor.

While these narratives are of value, such publications are not necessary for the physician to practice empathy in medicine. As human beings, physicians have the capacity for empathy, "the power of projecting one's personality into the object of contemplation, and so fully understanding it." This inherent human ability, however, may need to be fostered and cultivated at times throughout a physician's career, as the day-to-day responsibilities of practicing medicine become overwhelming and burdensome. To

this end, physician-as-patient narratives can serve as a foundation point for reinforcing the value of empathy in medicine.

The physician-as-patient narratives described here differ from other forms of patient narratives. In terms of publication, physician-as-patient literature may be presented as a group of essays published in a book available for commercial purchase. Single narratives from physicians describing their patient experience may also be presented in medical journals, often in the "ethics" section of these publications. Both of these forms of publication have the potential to reach large and varied audiences, both within and outside the medical community.

In contrast, other patient narratives do not routinely find their way to magazines, books or journals. Rather, these narratives can be found online, in patient forums created as support groups for certain illnesses. They may also be published in patient information brochures, given to newly diagnosed patients in an office setting. As such, these narratives are likely only read by a small minority, often those with a certain illness or perhaps their family members. Physician-as-patient literature is no more valid a form of expression than other forms of patient narratives, but at present, it is more visible, especially to other physicians.

Physician-as-patient literature ultimately provides the initiation point for physicians to think critically about their own human experiences and how those relate to the experiences of their patients. [3] In each of the physician-as-patient accounts discussed below, the physician author experiences a specific illness and that experience results in a heightened awareness of the value of empathy in medicine. Yet, each of these narratives

offers the opportunity for generalizations that every physician, regardless of their illness history, can adopt as they work towards empathetic medicine.

These stories are related here because they illustrate five fundamental lessons to be adapted by physicians: relating to patient vulnerability, fostering hope for patients, mobilizing support systems, recognizing physical consequences of disease and appreciating patient quality of life. Medical students will gain an appreciation for a strong empathetic foundation in medicine as they embark on four years of academic study and clinical experience. Current practitioners will be reminded of the central role that empathy plays in their chosen profession and be encouraged to commit or re-commit to an empathetic approach to medicine. Even patients will benefit from the lessons found in physician-as-patient literature as they find their own emotions and experiences in accounts related by their physicians. Finally, the lessons gleaned from this literature can also allow for efforts directed at a culture of empathy in medicine that begins with medical school education, where empathy education traditionally lags behind scientific education, culminating in diminished empathy by the end of medical school. These lessons can continue to be of value throughout medical practice in physician narrative exercises and the practice of self-disclosure.

Physican-as-Patient Literature: Lessons in Empathy

The examples of physician-as-patient literature presented here serve as examples for physicians who desire an empathetic approach to medicine. What they share is a central figure, the physician, experiencing a certain illness or disease. Where they differ is in the lessons that can be learned from each experience, although all can be related to

empathy. The following stories include diagnoses of multiple sclerosis, bipolar disorder, cancer and inflammatory bowel disease. This wide variety of selections serves to illustrate that empathy is vital to the physician-patient relationship in all aspects of medicine and as such deserves to be discussed and fostered by all physicians. In addition, the nature of the literature covers multiple mediums, including academic journal articles, newspaper opinion pieces and essay collections. The selections below represent this variety: a health blog discussion, relatable and easily accessible; a journal for patients with bipolar disorder, reaching a specific group of patients and practitioners; *The New York Times,* a publication read by millions daily; an academic medical journal, targeting those physicians who may not seek out other more main-stream outlets; and a book compiled of multiple narratives, providing shear volume for the interested reader. Such diversity in dissemination of information demonstrates that empathy in medicine is a concern that multiple populations of readers share.

Narratives are not foreign to physicians. Beginning in medical school, case scenarios take the form of narrative accounts, describing the patient, their past history, current symptoms and more. Exam questions are designed in this fashion in order to give the examinee a complete story of the theoretical patient. However, the physician-as-patient narratives differ in that the end goal is not a diagnosis or treatment plan, but an understanding of shared experiences. As such, these accounts deserve an alternate means of analysis and through this method, the lessons of empathy can be obtained. The narratives represented in physician-as-patient literature, can be analyzed using narrative theory which contends that the narrative is a basic strategy for understanding fundamental elements of human experience. Chambers, in the precis to his book *The Fiction of*

Bioethics, examines features of narrative discourse that shape the way medical ethics cases are received and discussed.[4] In order to frame the physician-as-patient narratives that follow, three concepts described by Chambers will be employed: characters, filter and closure. The discourse of character focuses on the attributes and descriptions of the protagonist, antagonist and other narrative players and how those elements impact the story. Filter refers to the mediating function of a character's individual perspective, impacting what is included in the narrative. Finally, closure is reached in a narrative when the experience has been completed and nothing more is required of the reader. These three features of narrative theory and discourse can facilitate a more thorough appreciation of the depth of physician-as-patient literature.

Relating to Patient Vulnerability

Anne Brewster, an internist in Boston, suffers from multiple sclerosis, an autoimmune disease of the central nervous system that most often has a relapsing and remitting course with diseases flares interspersed with symptom-free periods. When one of her long-term patients presented with signs and symptoms similar to that of her own, Brewster ordered the tests that confirmed the diagnosis of multiple sclerosis in her patient.

This sequence of events prompted Brewster to recall her own diagnosis and the accompanying emotions:

> I remembered lying in the MRI machine, trying to ignore the loud banging of the magnet, the closeness of the walls around me, and my own terror. I remembered the moment of diagnosis. I was alone, and was told rather abruptly to hurry up and finish having my children so that I could begin treatment. When I left the office I sat in my car and cried. I was overwhelmed by fear, anger, and shame.

> I envisioned the worst, thinking of everything I would have to give up, certain of the wheelchair in my future.[5]

Brewster recognized the seemingly harsh nature of the diagnostic work-up and the shock that a final diagnosis could deliver. This recollection led Brewster to confide in her patient and to share her own struggles with multiple sclerosis. Brewster notes that her patient was receptive to this expression of empathy and Brewster herself came to acknowledge that the personal experiences of physicians play a part in physician-patient interactions and that "the white coat does not protect [physicians] from humanity.[5]

The filter of this narrative account plays an important role as the story is relayed through Brewster's own perspective. She describes her own memories of fear that accompanied her diagnosis of multiple sclerosis and extrapolates from this what her patient must be feeling. Neither Brewster nor the reader is aware of the actual emotions of the Brewster's patient, but through Brewster's filter as a similar, vulnerable patient, these feelings can be imagined. Brewster also notes that her patient was relieved to hear her physician's confession. This aspect of Brewster's filter illustrates the reciprocity that her act of disclosure entails, emphasizing that her act was intended to empathize with and empower her patient.

Brewster provides a unique account in which she can directly relate to her patient as they share the same diagnosis. However, the vulnerability that she describes is a state of the human condition that does not limit itself to certain diseases. Nearly without exception, every physician can recall a time when they themselves felt "fear, anger, and shame," whether in relation to illness or not. Perhaps the physician has experienced vulnerability in medical school, doubting their competence and their ability to persevere.

During their time in medicine, the physician may have endured shame and helplessness when they were unable to prevent a negative patient outcome. Indeed, conjuring up memories of vulnerability is not a comfortable process and may be met with suspicion by many physicians. However, it is this sharing of human experience that allows physicians to express empathy in their patient encounters and drawing from one's personal history of vulnerability can be as especially effective tool when a physician is tasked with delivering potentially upsetting and fear-inducing information.

Fostering Hope for Patients

As an undergraduate student, Beth Baxter began to notice changes in herself. She was sleeping less and avoiding any interaction with her classmates. This behavior continued in medical school and at one point, Baxter began to believe that she was the subject of secret messages on the radio which led her to leave home and become a missing person. Subsequently, Baxter was hospitalized and diagnosed with bipolar disorder.

With proper psychotherapy and medication, Baxter was able to complete medical school and sought to pursue a career in psychiatry. For Baxter, this was an inevitable choice of specialty. "A psychiatrist had a lot of hope in me," she relates, "and that hope was really important."[6] Baxter notes that in her psychiatric practice, she empathizes with her patients and the fact that those with mental illnesses may experience a lack of hope that they will have better days. With this knowledge, she focuses her therapeutic strategy on enabling patients to realize that they have the capacity to recover from the darkest moments of mental illness.

Baxter's account is notable for its use of characters, another element of narrative discourse. Baxter not only includes herself and the patients in her current psychiatric practice in her story. Rather, she is deliberate in her mention of the psychiatrist involved in her own care, a physician who offered her hope in an otherwise desperate situation. Many physician-as-patient narratives represent a limited number of characters, often times only the physician themselves. Yet Baxter's specific attention to her own psychiatrist suggests that empathy in medicine can be observed and perpetuated by other physicians.

Hope can be a powerful motivational force, both in recovery from illness and in multiple facets of life. Baxter had a psychiatrist who displayed hope in her condition and ability to flourish as a physician and in recalling that experience, Baxter was able to provide hope for her own patients. For physicians who encounter patients suffering from a lack of hope, it would be beneficial for them to consider their own life course, especially those moments when they may have felt disheartened. For most, this will lead to the realization that some individual in their life supported them and offered hope to propel them through a difficult time. By mentally reliving those experiences, it is possible for the physician to empathize with a patient in a particular despondent state, even if they lack a common diagnosis.

Involving Support Systems

What Eric Manheimer knew intellectually as a physician did not prepare him for what was in store for him as a patient with throat cancer. He understood that chemotherapy would be part of his treatment had no way to comprehend the profound

impact the treatment would have on his life. For Manheimer, his world was "shrinking to a small, sterile, asteroidal universe between the interminable nausea and the chemobrain that left [his] head both empty and feverish, between survival and death."[7]

Manheimer admits that during one particular hospitalization, he decided that he had had enough and began to refuse any further radiation or chemotherapy. While his doctors were unable to influence his decision, Manheimer recalls that his wife was able to change his mind.

> My doctors couldn't override it or persuade me to change my mind, but, luckily, my wife, Diana could and did. From my mental cocoon in the hospital bed, I could sense Diana at my side. 'You're going to finish the treatment,' she said softly. She wheeled me down herself to finish my radiation treatments in the basement of the hospital…When neither doctor nor patient can make the right decision, it is vital to have a caring family.[7]

Manheimer's story is unique in that is does not offer a traditional form of closure, an aspect of narrative theory. Closure traditionally occurs when the action of the narrative is completed and questions by the reader have been answered. Manheimer ends his account at what appears to be the climax of the story, when his support system is able to convince him to continue cancer treatment. This lack of closure, however, offers the reader the opportunity to pause and consider the potential consequences of the decision made by Manheimer's family. Such an exercise encourages the reader to more fully experience the uncertainty that Manheimer himself felt as the patient.

As a patient with cancer, Manheimer experienced the incredible difficulty that comes with making medical decisions. Even his medical knowledge did not equip him with the ability to endure chemotherapy without suffering and as a result of his intense treatment, he notes that he was unable to make the proper decision in the moment

of desperation. For Manheimer, it was his supportive family that was able to assist him in choosing to accept further treatment, ultimately leading to recovery and remission.

It is true that nothing but the personal experience itself can give one the sense of the gravity of cancer treatment. However, this fact does not preclude empathy in physicians managing the treatment of cancer in their patients. Physicians as humans are social beings and as such, they do not make decisions in a vacuum. For example, the decision to enter medical school may have been influenced by family members. Likewise, the decisions made in day-to-day medical practice are shaped by scientific evidence and recommendation from colleagues. Given this experience of consulting other opinions in decision-making, it is entirely possible for physicians to empathize with their patients in a similar process. Patients in a time of crisis may not fully appreciate the entirety of the information presented by the physician and it is the responsibility to the physician to recognize this and show empathy by involving the existing support system of the patient.

Recognizing Physical Consequences of Disease

Physicians are taught about the side effects of certain medical treatments and are careful to relay this information to their patients so that there are no surprises. Dr. Moushumi Lodh understood that chemotherapy can lead to hair loss, that steroids contribute to weight gain and that breast cancer carries the possibility of breast removal as treatment. When she was diagnosed with breast cancer, however, she came to appreciate the impact these physical changes had on her life and her sense of self-worth.

Lodh recalls one instance in which her young son advised that Lodh not attend a school function because she did not "look good." Lodh herself relates that "with a weight gain of 20 kg due to steroids, a wig as [her] crowning glory and a silicone breast implant, [she] often shuddered to look in the mirror."[8] For Lodh, the physical manifestation of her illness became a focus of much mental anguish, despite the fact that her breast cancer was being successfully treated.

Lodh's narrative makes use of a filter that represents both her own concerns and those of her young son. By incorporating the perspective of another member of her family, Lodh is able to further the idea that physical manifestations of illness are indeed important elements to consider. Lodh herself experiences all aspects of her disease, the mental, physical and emotional effects that cancer has on her life. However, the added filter of her son proves that the outward visible signs of disease and illness are not trivial and should be discussed and addressed by the empathetic physician.

Physicians tend to endorse black-and-white thinking when it comes to disease and health. Treating the disease is good and anything that contributes to the eradication of that disease is likewise good. However, as Lodh experienced, the ramifications of those treatments can cause significant distress and social impairment, both of which provide the physician with the opportunity to recall similar experiences and to proceed with empathy.

Physical appearance plays a role in all aspects of the hierarchy of medicine. Prospective medical students and residents strive to conform to an image of professionalism during the interview process and take great care in their grooming and clothing selection for these events. As a practicing physician, appearance is likewise

important in so far as it is the first thing noticed by both patients, colleagues and superiors. In reality, physicians are not immune to the social importance placed on physical importance and in this way, they are able to empathize with patients who may experience changes to their outward appearance due to an illness or treatment. Recalling the function of physical appearance in their own lives and in society in general, physicians can be sure to empathize with the frustration of patients as they endure sometimes rapid and alarming bodily changes.

Appreciating Patient Quality of Life

The management of chronic illness differs somewhat from that of acute disease states. R.F. Spooner, a physician that suffers from Crohn's disease and treats patients with similar inflammatory bowel diseases, recognizes this difference and how that difference in management manifests itself in patient experience of recovery.

> With chronic illness, it is often the resolution of practical problems that makes the difference between worthwhile life and life not enjoyable enough to live…I cannot emphasize enough the importance of attending to the subtleties of living with disease. It is often mundane work, work that we, as physicians, would prefer to relegate to assistants. But physicians need to identify ways that can improve the life of their patients to help them move to symbiosis with their disease.[9]

Spooner was diagnosed with Crohn's disease as an adolescent and throughout his life, he evaluated his health based on his functionality, rather than by an absence of disease markers or laboratory values trending in the right direction. Spooner wanted to be able to keep up with his brothers on the basketball court and have the energy to study in order to become a physician. In experiencing the routine struggles of

chronic illness, Spooner came to empathize with his patients and their desire for practical, tangible results of disease management.

In Spooner's narrative, closure does not take the form of eradication of disease or elimination of all suffering due to Crohn's disease. Alternatively, closure is obtained on a smaller-scale, in finding solutions to the daily struggles faced by those with chronic illnesses. By modifying the expected narrative discourse of closure from curing a disease to living fully a life with disease, Spooner offers insight into a new way of understanding diseases management. Empathetic medicine need not be solely focused on a "magic bullet" therapy. Rather, empathy can be practiced with each patient encounter in efforts that work toward improving quality of life.

It may appear to the physician that attending to the subtleties of chronic illness is work out of the scope of their profession. However, as Spooner notes, physicians that can help patients with their daily struggles create a bond with their patients that enables them to work in a partnership as they manage their disease throughout their life.

In this case, empathy takes the form of the physician recognizing that daily living in and of itself can be a challenge for those with chronic illness. For the patient with Crohn's disease, this may take the form of having a flare-up that prevents participation in athletics; for the physician, this may be an unexpected meeting preventing attendance at a family gathering. Empathy in the management of chronic disease may appear to be a daunting task for the physician. Rather, it can be a rather simple exercise that consists of recognizing and inquiring about the day-to-day goals of

the patient, drawing upon personal daily struggles and working in tandem to improve patient quality of life.

Fostering Empathy: Medical Education, Narrative Medicine, and Physician Disclosure

The body of physician-as-patient literature is unique in that it offers a role-reversal scenario in which the individual physician is able to live the experiences that their patients live daily. For these physicians, such an experience was thought-provoking enough to prompt reflection and publication and in many cases, the over-arching theme of this literature is an appreciation for empathetic medicine. Given this tendency toward empathy, physician-as-patient literature becomes more than just interesting reading, serving as examples that offer generalizable themes that physicians, as human beings, can adopt in their own practice. While this is a valuable resource in cultivating empathy in medicine, a more thorough approach must be adopted if empathy is to be fostered and maintained.

Three strategies may be useful in building upon the lessons from physician-as-patient literature with the goal of promoting empathy. The first of these is the emphasis on empathy teaching throughout medical school. Second, the practice of narrative medicine has the potential to allow physicians, as they embark on their practice, to reflect upon their experiences and apply those experiences to patient encounters. Finally, the notion of physician disclosure can be a useful tool in a culture of empathetic medicine when it is used with the intention of patient benefit. The practical applications suggested by these strategies are summarized in Table 1. Through a multi-faceted approach, empathy can take on a more prominent role in medicine.

Empathy in Medical Education

At its core, the practice of medicine is a profession of service. As is the case in all human service endeavors, humanistic values and empathy must be of primary importance. In this vein, the Medical School Objectives Project of the Association of American Medical Colleges[10] includes "enrichment of interpersonal skills and empathy" in its objective list for undergraduate medical education. Despite this deliberate mention of empathy in medical education goals, a longitudinal study involving 456 medical students revealed that there is a significant decline in empathy during the third year of medical school.[11] The third year of medical school represents the transition period for students as they leave the classroom and enter the hospital floors and clinics, encountering patients for the first time. The suggestion that empathy declines at this critical time leads to the assumption that empathy is not adequately addressed in the first two years of medical school and that empathy is not modeled or fostered on the wards.

Introducing empathy into early medical education can serve to alleviate its deficit in the clinical years of medical school. In order to achieve this goal, a two-pronged approach may prove successful. Indeed, physician-as-patient narratives illustrate the fact a dual perspective can be beneficial. In their physician role, these writers rely largely on their scientific knowledge. As patients, they communicate the humanistic aspects of medicine, most specifically the value of empathy, and incorporate this revelation into their own practice, complementing their scientific knowledge base. Medical school classes are comprised of a wide diversity of students and each may have a particular bias to either the scientific or humanistic aspect of the physician duality. As such, teaching

empathy from both perspectives has the potential to reach to majority of students in the first two years of medical school, appealing to a holistic approach to medical education.

Empathy can be described as the ability to understand and respond to others' emotional states in an effort to contribute to compassionate behavior and moral agency.[12] With this description, neuroscience has recently sought to elucidate the neural mechanisms of empathy, illustrating that specific brain circuits are associated with empathy. To this end, Helen Reiss, a practicing neuroscientist, developed a protocol based on the neurobiology of emotions. This program was designed for residents and focused on detecting subtle non-verbal signs of emotions in themselves and their patients and to respond in ways that provided support.[13] The training involved utilizing videos of clinical interactions with real-time physiological responses using skin conductance tracings so that residents could see the concordance or discordance between themselves and their patient. In a subsequent study, this neurobiological training program correlated to improved ratings of physician empathy by patients.[14]

Undergraduate medical students arrive at medical school with an educational background heavily based on science, but medical school itself requires a combination of this scientific knowledge and humanistic awareness. The protocol developed by Reiss could be modified to be of use to first and second year medical students. For example, simulated patient encounters are vital in the early years of medical school. Video recordings of these encounters, coupled with real-time recordings of physiological responses could serve as educational tools for students before they enter the clinical years. Furthermore, a brief introductory course before these sessions that

highlights the neurobiological mechanisms of empathy and its neural circuits may reach a sub-set of students who learn best when information is presented in a fact-based manner.

In contrast, empathy can also be presented as a humanistic topic, emphasizing the universality of the human experience rather than the neuroscience of empathy. To this end, Shapiro, et al. sought to study the relationship between a literature-based course in the first year of medical school and student understanding of the patient perspective.[15] The course consisted of small-group reading and discussion sessions co-taught by a psychologist and a primary care physician faculty member. The format of the class included poetry, skits and short stories addressing the following topics: listening to patients, sexuality, cross-cultural issues, lifestyle modification/non-compliance and geriatrics. Participants were asked to reflect upon the course immediately after its conclusion. The authors found that this brief course resulted in improved student self-reported empathy and their attitudes toward the humanities as useful tools in their medical education. However, as the authors themselves note, this reported change in thinking must be translated into actual changes in behavior as medical students enter their clinical years of study. Therefore, it may be useful for medical schools to track student empathy through self-reporting at the end of each clinical experience. It is not uncommon for medical students to be required to assess their faculty instructors and their learning experience through institution-specific surveys. Adding a set of questions addressing empathy and its representation in a given clinical rotation could allow medical schools to gauge the impact of their early empathy-directed interventions.

While medical students have necessarily completed a rigorous scientific course of study, many students may have either pursued a major in humanistic studies or

express interest in the arts. Incorporating a literature course serves the purpose of catering to another subset of learners and also allows for medical students to better appreciate the role that humanistic study can play throughout medical education and medical practice. Shapiro et al have shown that even a brief eight-session course can impact immediate attitudes toward empathy. It is true that medical education has a full curriculum, but sessions can be easily incorporated, perhaps by replacing one "doctoring" session each month with a literature class or by beginning the sessions during the first year student orientation. Early incorporation of empathy training from both a neurobiological and humanistic perspective, coupled with regular assessment of empathy as experienced during the clinical years, will maximize the percentage of receptive students and will represent a holistic approach to the subject of empathy in medicine.

Empathy through Narrative Medicine

In "The Narrative Road to Empathy," Rita Charon describes two types of knowledge: logico-scientific and narrative.[16] The former type of knowledge is hypothesis-driven, relies on mathematics and the sciences and its language must be non-ambiguous and reliable. In contrast, narrative knowledge is focused on the motivations and consequences of human actions, seeking to understand events as they are contextualized in time and place. Logico-scientific knowledge is easily placed in medicine in disease pathology, diagnostic reasoning and treatment efficacy. Narrative knowledge is likewise vital to medicine, but its role may be diminished at times. An empathetic physician is one that seeks narrative knowledge from their patient, striving to understand the patient within their own reality.

Scientific knowledge is gleaned throughout medical school and physicians are encouraged to continue this type of learning by reading evidence-based medical journals and attending continuing education presentations. As previously mentioned, empathy can also be addressed in medical school, but it too should be fostered throughout the entirety of a physician's practice. Charon proposes that physician writing exercises can improve narrative competence. She cites an example in which she took on the persona of a patient and wrote an account from that patient's perspective. In doing so, she reports "access to that imaginative knowledge, and with it to empathetic knowledge of the patient."[16]

Physicians are often asked by patients to offer their personal recommendation. In order to do so effectively, the prudent physician would carefully consider the decision at hand, taking into account major risks and benefits (survival and death rates) as well as minor practical implications (quality of life and disability). In an effort to explore the nature of physician recommendation, Ubel et al. presented two clinical scenarios, each with two treatment alternatives, to general internists and family medicine specialists.[17] When the physician made the decision for themselves, it was more likely for them to choose the option with a higher death rate but lower risk of disability. In contrast, when was tasked with making a recommendation for a potential patient, the physician more often chose the treatment alternative with a lower risk of death but a higher probability of disability and poor quality of life. This suggests that physicians, when considering themselves as the patient, are better able to appreciate the multiple consequences of treatment modalities and how those outcomes will impact their day-to-day lifestyle. It may be that when offering treatment recommendations for patients,

physicians focus on more definitive outcome measures, such as survival rates, and neglect quality of life measures that will indeed be important to the patient. Through narrative medicine practice, both in the written form exemplified by Charon and in thought-exercises in which the physician becomes the patient, it may be possible for the physician to more fully empathize with their patient and with the magnitude of the decision-making process.

The narrative practice championed by Charon can be adopted and modified to fit the diverse needs of physicians practicing in multiple specialties. For example, the oncologist tasked with delivering a poor prognosis to a patient would benefit from taking pencil to paper and writing a possible reaction to the news as if the physician were the patient. In this exercise, the physician may well identify subtleties of receiving difficult information and thus tailor their presentation based on this empathetic understanding. In a similar way, an endocrinologist frustrated with the non-compliance of an elderly diabetic patient may find empathy with that patient in writing down the potential burdens faced by that patient. In so doing, the endocrinologist will discover new questions to ask their patient in order to address barriers and work towards solutions in an empathetic manner. This practice, in a sense, is an exercise in physician-as-patient literature, although in a simulated manner and without wide-spread publication. Nonetheless, the principle holds true that by relating to human experiences and expressing those revelations, physicians can further their practice of empathy.

Another way to improve narrative competence in medicine in an effort to promote empathy involves physician journaling. The nature of the practice of medicine in such that physicians encounter powerful and emotional events on a regular basis.

Although it behooves the physician to be able to compartmentalize to the extent that they can continue to provide care, it is unreasonable to expect that as human beings, physicians can neglect their emotional experiences. Levine, et al. sought to explore the impact of prompted narrative on physicians.[18] Prompts included: "Describe a time in your clinical work when you felt that your core values were threatened" and "Identify a negative or disappointing clinical experience." The authors discovered that when these prompts were followed, the study participants reported successful reflection and an improved sense of their core values, priorities and motivation to improve as physicians.

Physicians writing and reflecting on their own experiences can be just as instrumental in fostering empathy as is writing from a patient perspective. In order to practice empathy, a physician must be aware of their own biases and values so that they can fully integrate themselves into the patient narrative. These written reflections need not be extensive. An appropriate time to introduce such exercises may be during residency, when physicians are still part of a training program and can be guided. By instituting weekly or monthly journaling "workshops," residency programs can equip their physicians with the tools for career-long reflection. After years of practice in this written endeavor, physicians will likely be able to reflect internally and in the moment during patient encounters. If, during residency, the physician can simultaneously learn how to manage illness and disease and how to manage their own emotions, empathy can be fostered alongside clinical medicine.

Physician Disclosure

Each of the previous strategies for promoting empathy in medicine, medical school courses and the practice of narrative medicine, focuses on either simulated patient encounters or physician self-reflection. While useful tools, they are, in a sense, preparation strategies that can equip the medical student of physician with the skills necessary to act with empathy toward patients. The final method to advance a culture of empathy in medicine focuses on physician disclosure of personal experiences. This approach differs from those addressed previously in that it cannot truly be practiced or anticipated. It requires a unique physician-patient interaction in which the physician feels that they can directly relate to the emotions of the patient in that moment. Despite the difficulty in preparing for or planning for self-disclosure, physicians ought to be aware of the risks and benefits of such an action and how to best use this strategy to foster empathy.

Malterud and Hollnagel address physician self-disclosure and the ramifications in "The Doctor Who Cried: A Qualitative Study About the Doctor's Vulnerability."[19] They sought to examine the reactions of patients who have had the experience of a physician sharing a personal story with them during an office visit. The authors present one example in which a patient expressed anxiety about her ongoing divorce proceedings, especially about the fate of her children. The physician involved very briefly admitted that she herself went through a divorce and her children were currently with her ex-husband. The discussion did not proceed further in this direction, but the patient reported that the physician appeared to be a "confident survivor of a complicated problem" and represented a "safe platform" to discuss her source of anxiety.

In another story, a frustrated patient related to her physician that she believed her panic attacks were not being taken seriously. Presented with this information, the physician chose to describe, in great detail, her own first panic attack and its consequences. The patient reported that after this encounter, she received a "new level of insight and empathy" from this doctor when compared to her previous physician interactions.

These two instances of physician self-disclosure reveal the fact that despite the notion of a hierarchy in medicine in which the physician is devoid of human emotion, physicians are able to express their own vulnerability. In the previous examples, this disclosure led to positive patient experiences of empathy. Also evident is the spontaneity of physician self-disclosure. It is nearly impossible to predict when a certain patient will evoke a personal experience or emotion in the physician. As such, the physician will be taking a risk when they do chose to share with a patient, uncertain of the reaction that will ensue. Yet, much of the patient-physician encounter involves calculated risk-taking behavior, including how and when to deliver bad news and when to escalate or scale-back treatments. Moral knowledge is not separable from clinical judgement, and the physician's perception and exposure of emotions are essential in understanding patients and the relational nature of medicine.[20] Just as they utilize their scientific knowledge to choose best practices, so too should physicians exercise emotional judgement when an opportunity for genuine empathy is present.

Empathy has been defined by many, using different words and adjectives that appeal to the individual's own understanding of the concept. One such definition addresses empathy in the most basic of terms, perhaps making it a nearly universal

description: Empathy is "the feeling that persons or objects arouse in us as projections of our feelings and thoughts. It is evident when 'I and you' becomes 'I am you,' or at least 'I might be you.''[21] Defined in this way, empathy does not require that an individual re-live an exact experience. Rather, it implies that empathy can be achieved through sincere and deliberate efforts to appreciate another's lived reality.

This is the manner in which most physicians will be able to practice empathy. Physician-as-patient literature offers examples of unique instances in which the physician experiences nearly mirrors the patient experience. Through these accounts, themes of empathy emerge as teaching points for all physicians. Lessons gleaned from a sampling of this literature include relating to patient vulnerability, offering hope to patients, mobilizing patient support systems, appreciating physical manifestations of disease and attending to the practical subtleties of disease.

Table 1. Suggestions for Fostering Empathy

Strategy Proposed	Practical Application
Empathy teaching in medical school	1. Real-time recordings of physiological responses during simulated patient encounters 2. Literature courses with skits, short stories and poetry co-taught by a physician and psychologist
Practicing narrative medicine	1. Writing a simulated action-reaction scenario in which the physician imagines themselves as the patient 2. Journaling guided by prompts to reflect on emotions and biases during patient interactions
Physician self-disclosure	1. Validating the anxiety of a patient by revealing a social commonality (divorced, caring for children, etc.) 2. Increasing awareness to patient responses to self-disclosure and tailoring future disclosures accordingly

Limitations and Further Suggestions: Respecting Social Determinants of Health

Becoming a patient allows the physician to appreciate the experiences of their own patients. The doctor with multiple sclerosis can understand the disease states of the patient with multiple sclerosis in a way that extends beyond the traditional physician-patient relationship. However, the patient sitting in the office of the physician is defined by more than their presenting illness. As an individual human being, each patient represents a culmination of a life's worth of unique circumstances and trials. For many patients, these include negative social determinants of health, such as poverty, a lack of education, and poor social support systems. These factors necessarily impact health and

shape the ways in which diseases manifests itself. Therefore, when the physician aims to draw upon their experiences as a patient, it would be prudent to respect the given patient within their own individual social context. This indeed presents a challenge for the physician, especially when the physician is working within a population with a distinctively different ethnic, economic and educational background then their own.

It would be unrealistic to expect that medical students and physicians have first-hand experiences of every negative social factor that influences the health of their future or current patients. However, as discussed above, physician-as-patient literature shows that the physician need not suffer from a particular disease to practice empathetic medicine. Rather, lessons can be found in the experiences of others and fostered through continuing education and reflection. In a similar way, empathy and an appreciation for the determinants of health outside of the biological can be achieved through changes at and before the level of medical school.

In order to obtain a place in medical school, certain educational requirements must be achieved and financial obligations fulfilled. As a result, a medical school class may often by homogenous in terms of social, economic and educational backgrounds. This lack of diversity can further hinder empathetic medicine in terms of relating to patients and their social determinants of health. If, at the undergraduate level, pipeline programs were initiated to identify and work with potential medical school candidates of a variety of backgrounds through the application process, a more diverse class may be achieved. Just as physicians-as-patients present their experiences, so too can medical students relate to other students their challenges in arriving at medical school. By broadening the shared social knowledge of students during their academic years, it will

be possible for students to work towards empathy in their clinical years and beyond, recognizing the diversity of experiences that exist even among their peers.

Conclusion

Empathy in medicine can be taken beyond physician-as-patient literature and ought to be a more prominent point of emphasis throughout medicine. In the early years of undergraduate medical education, empathy can be fostered in a two-pronged approach that appeals to both the neuroscientific and the humanistic mind. In clinical practice, efforts in narrative medicine include writing exercises aimed at exploring patient struggles and experiences as well as the physician's own emotions. Finally, physician self-disclosure can be an instrument of empathy when employed with the same discernment that governs clinical decision-making.

Empathy need not be a nebulous concept, thought to be unattainable in the context of medicine. The practice of medicine hinges on the relationship between human beings, the relationship between patient and physician. This commonality, brought to light through physician-as-patient literature, provides the starting point for empathetic medicine. With a rigorous approach on the part of educational institutions and individual physicians, medicine can begin to lay the foundation for a culture of empathy.

REFERENCES

Association of American Medical Colleges. Medical School Objectives Project. Retrieved from: http:/www.aamc.org/meded/msop.

Chambers, Todd. "The Fiction of Bioethics: A Precis." American Journal of Bioethics. 1.1 (2001): 40-23.

Charon, Rita. "The Narrative Road to Empathy." Empathy and the Practice of Medicine. Ed. Howard Shapiro. New Haven: Yale UP, 1993.

Harris, J. "The Evolutionary neurobiology, emergence and facilitation of empathy." Empathy in Mental Illness. Ed. Farrow TFD and Woodruff PWR. Cambridge: Cambridge University Press, 2007.

Henderson, et al. "Shame! Self-stigmatisation as an obstacle to sick doctors returning to work: a qualitative study." BMJ. 2.5 (2012).

Hojat, Mohmmadreza, PhD, et al. "The Devil is in the Third Year: A Longitudinal Study of Erosion of Empathy in Medical School." Academic Medicine. 84.9 (2009): 1182-191.

Hunter, KM. "Narrative, Literature and the clinical exercise of practical reason." Journal of Medical Philosophy. 21 (1996): 303-320.

Ingstad and Christie. "Encounters with illness: The perspective of the sick doctor." Anthropology and Medicine. 8.2-3 (2001): 201-210.

Levine, Rachel et al. "The Impact of prompted narrative writing during internship on reflective practice: a qualitative study." Advances in Health Science Education. 13 (2008): 723-733.

Lodh, Moushumi, and Natasha Das. "A Physician's Personal Experience with Breast Cancer: An Interview." South Asian Journal of Cancer. 2.1 (2013): 50-52.

Malterud, Kirsti, MD, PhD and Hollnagel, Hanne, MD, PhD. "The Doctor Who Cried: A Qualitative Study About the Doctor's Vulnerability." Annals of Family Medicine. 3.4 (2005): 348-352.

Mandell, Harvery N., and Howard M. Spiro. When Doctors Get Sick. New York: Plenum Medical Book, 1987.

Manheimer, Eric D. “When Doctors Become Patients.” The New York Times. 2 Sept. 2011. Retrieved from: http://www.nytimes.com/2011/09/03/opinion/when-doctors-become-patients.html

Reiss, Helen, MD et al. “Improving Empathy and relational skills in otolaryngology residents: a pilot study.” Otolaryngology Head and Neck Surgery. 144.1 (2011): 120-122.

Reiss, Helen, MD et al. “Empathy Training for Resident Physicians: A Randomized Controlled Trial of a Neuroscience-informed Curriculum.” Journal of General Internal Medicine. 27.10 (2012): 1280-1286.

Shaprio, J et al. “Teaching Empathy to First Year Medical Students: Evaluation of an Elective Literature and Medicine Course.” Education for Health. 17.1 (2004): 73-84.

Selzer, Richard. “Foreword.” Empathy and the Practice of Medicine. Ed. Howard Shapiro. New Haven: Yale UP, 1993.

Solovitch, Sara. “Conspiracy of Silence. When the Psychiatrist Has Bp.” BpHope BP Magazine Community. 8 Feb. 2007.

Spiro, Howard M. “What is Empathy and Can It Be Taught?” Empathy and the Practice of Medicine. Ed. Howard Shapiro. New Haven: Yale UP, 1993. Print.

Ubel, Peter A. MD, et al. “Physicians Recommend Different Treatments for Patients Than They Would Choose for Themselves.” Archives of Internal Medicine. 171.7 (2011): 630-634.

Zimmerman, Rachel. “Boundary Issues: A Doctor with MS Confides in her Patient.” 16 Oct. 2015. Retreived from: http://commonhealth.legacy.wbur.org/2009/10/boundary-issues-a-doctor-with-ms-confides-in-her-patient