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Recognition, reflection, and role models: Critical elements in education about care in medicine

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ABSTRACT

Objective: Medical education can be described as a socialization process that has a tendency to produce doctors who struggle to convey to patients that they care. Yet, for people who are suffering, to enjoy the quality of life they are entitled to, it is important that they feel cared for as people, rather than simply attended to as patients.

Method: This article addresses how we teach medical students the art of caring for the person rather than simply treating the disease—a question particularly relevant to end-of-life care where, in addition to the physical needs, attention to the psychosocial, emotional, and spiritual needs of the patient is paramount. Following an overview of what it is to care and why it is important that patients feel cared for, we investigate how we learn to care and develop caring human relationships, describing the development and display of empathy in adulthood and the developmental impact of human interaction.

Results: We outline evidence of situational barriers to effective education about care in medicine including role models, ward culture, and the socialization process.

Significance of results: We then propose a model for medical education based on patient contact, reflection, self-care, role model development, and feedback that will see students learn the art of human care as well as the science of disease management.

KEYWORDS: Care, Medical education, Empathy, Role modeling, Socialization

INTRODUCTION

"Care" is a nebulous concept that is broadly applicable to many areas of life. In the context of medicine, care absorbs a range of rich and complex meanings, designating something that is deeply important and at the same time difficult to define. Yet despite its recognized importance, and perhaps partly because of it elusive nature, caring has been and remains a neglected part of modern medical training. This article highlights key psychological and sociological elements in the development of a person's ability to care and shows how these may be built into a medical school curriculum.

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THE NATURE OF CARE

Good quality care has been characterized as individualized, patient focused, and related to need, provided "humanistically" through the presence of a caring relationship by staff who demonstrate involvement, commitment, and concern (Attree, 2001). Caring has behavioral and motivational elements (MacLeod, 2000). It has physical manifestations but also psychological, spiritual, and social dimensions. For example, some studies report that after receiving a diagnosis of cancer the areas of greatest need for a

patient and/or family are care availability and quality of disease management, good information, sympathetic communication, and regaining control of their lives (Carter et al., 2004).

In the modern medical context there is a tendency to view care in terms of technical expertise and skill with pharmaceutical agents to "make well" again (Glick, 1993). This tendency cannot be solely attributed to medical practitioners and institutions. Even in studies carried out in the early days of the technical revolution in health care, when people with cancer were asked to assess their perceptions of caring behaviors of nurses, they consistently ranked the most important caring behaviors as those showing competence and knowledgeable technical skills and abilities (Larson, 1984). Conversely, when the same tool was used to measure cancer nurses perceptions of what *they* thought would make the patient feel cared for, the nurses ranked expressive humanistic behaviors highest: listening, comforting, and expressive sensitivity (Larson, 1986). So, although the "techno-procedural" model of care is most often characterized as a product of modern medicine, it can also be attributed to the interests or needs of patients. This suggests that it is a model that is deeply rooted and that comprehensive change will be needed if it is to be displaced.

The nontechnical, more "humane," conception of medical care is grounded on a broad view of medicine and the lives of patients. A person being cared for will have differing needs as the illness changes or progresses. Indeed, when the need for physical care is more pronounced, a higher degree of intimacy tends to ensue, and this can become a basis for health care professionals to introduce aspects of spiritual or psychological care. Although those who are acutely ill will tend to focus on the immediate tasks and treatments provided (e.g., giving the right medication for pain at the right time), if their survivorship is not long lasting, the patient may look for a closer, more meaningful relationship (Bassett, 2002). Part of the drive behind the need to feel cared for derives from the need to feel secure. Health care is a frightening and foreign experience for many and engenders feelings of fear, anxiety, and insecurity. It is one of the tasks of health professionals to try to make people feel more secure and to restore a sense of control over their lives.

William Osler described a competent carer as someone who can bring a sense of *aequanimitas* to his or her patients. A physician does this by appearing dependable, confident, sympathetic, and able to deal with uncertainty (Bliss, 1999). This does not mean that the physician must presume to be able to deal with all the problems that patient is experiencing, but rather that he or she must show a commitment to working through the problems with the patient and a confidence that some kind of hope is available. This caring is not a one-way relationship of carer and cared for, but a reciprocal relationship that is fundamentally intersubjective (Watson, 1979).

In our view, medicine must take up an understanding of care such as that offered by Osler if it is to sustain its ethic of helping patients in their suffering and avoid being reduced to the provision of technical and pharmaceutical therapies. However, in order to train doctors in an intersubjective model of caring, medical educators must face up to a number of challenges. They must, for example, understand the kind of skills that make caring, intersubjective relationships possible and how these skills can be developed. They must also recognize the kind of risks that are involved in engaging intimately with suffering patients and consider how support can be given to doctors who undertake such work.

EMPATHY AND THE CAPACITY TO CARE

To support the development of caring medical students, it is important to recognize the capacity to care that they, as individuals, bring with them to the health care context. Each student begins medical school with his or her own latent propensity to care and experiences of having given and received care. Part of caring involves the ability to display empathy and relate to others.

Empathy is the capacity to enter the subjective world of another. It involves our shared concepts and shared human nature (Gillett, 1993). Empathy is considered here as having an affective and a cognitive component. It is the capacity to feel as the other person is thought to feel ("emotional match-making"; Darwall, 1998). In addition, it involves the abilities to reflect on why the other may feel that way and to show this understanding (Reynolds & Scott, 2000). Together these two aspects of empathy demonstrate that it is not purely a behavioral response to another person's emotional state but also affective in nature. They also show that, unlike sympathy, empathy has an understanding component that introduces a balance between sharing and separation.

Not only is empathy safe and permissible, it is the key to a caring patient—doctor relationship—the art of medicine. Showing empathy predicts the reduction of negative patient symptoms and improved patient experiences and satisfaction (Reynolds & Scott, 2000). Rather than a separate component of what it is to be a doctor, the capacity to empathize positively predicts global ratings of clinical competence among medical students (Hojat et al., 2002), as well as diagnostic accuracy and patient compliance (Roter et al., 1997; Coulehan et al., 2001).

Underpinning the ability to empathize is the development of an understanding of the mind—a person's own and those of others—often referred to as a theory of mind (TOM; Perner et al., 1994). As TOM develops, a person's ability to perceive another's thoughts and feelings continues to deepen and grow. Rather than reaching a cut-off point, a person's understanding of the mind continues along a developmental trajectory, possibly over the course of his or her life. But, like all development, this growth of understanding requires an environment with practical opportunities for learning about and reflecting on how the mind works (Perner et al., 1994). In other words, the more social interaction a person engages in, the deeper their understanding of others' thoughts and feelings.

Assuming that medical students and graduates develop TOM to a level deemed normal for the population, why are we not seeing more empathetic doctors in practice? Studies have shown that patients often find medical staff cold and detached (Branch, 2000). Bellini and Shea (2005) reported that over 3 years of their clinical internships, interns' empathy levels decline in the first year and remain low thereafter. So how is empathy developed and nurtured in medical students and clinicians? What predicts its decline or absence in behavior?

In line with the theoretical model that we have presented here, we propose that empathy can be "taught" by extending the students' existing abilities to grasp the thoughts and feelings of others and that this is done through interpersonal development. This does not necessarily have to be exclusively through clinical encounters; medical humanities courses attempt to introduce concepts of empathetic understanding using art, literature, and music (MacLeod, 2000).

ATTACHMENT THEORY AND THE CAPACITY TO CARE

A separate but related capacity is that of forming human relationships. According to attachment theory, how a person relates to another can be predicted by their experiences of care from infancy throughout their development. Such experiences contribute to the formation of mental models of care that are evident in how the person relates to others. These models are particularly predictive of styles of interaction during times of unpredictability or threat where feelings of helplessness arise, for example, during illness, loss, and some other forms of change (Hunter & Maunder, 2001; Thompson & Chiechanowski, 2003). At such times, a person's need for care and feelings of safety and consistency tends to increase. An understanding of attachment styles can aid our interpretation of social behavior in the contexts of health care education and clinical interaction.

Consistent with literature involving an attachment perspective on health care and behavior, here "attachment" will be described according to a taxonomy of three main styles: secure, insecure-avoidant, and insecure-anxious (Birnbaum et al., 1997). Those with a secure style of attachment behave in ways that reflect a perception of their figures of care, or attachment figures (e.g., parents, partners, other close supports), as people who will be reliable and available to provide effective care when needed.

Insecure-avoidant is a style of attachment that is made apparent by compulsively self-reliant behavior. Such behavior is typical of a person who does not believe someone will be available to help them in times of difficulty. Such an individual often appears to others as cold, competitive, highly controlled, or unemotional. They tend to be low in affective expression.

Those showing insecure-anxious styles of attachment behave in a clingy, anxious manner as a result of lacking faith in their own ability to cope with uncertainty or stress.

Relation to Health Context

Attachment theory can provide valuable insight into situations where caring is paramount. In an institutional setting, patients are typically vulnerable and searching for security. Stresses to heighten a patient's vulnerability and need for attachment include their role as an ill person, the uncertainty of their well-being, the requirement placed upon them to trust strangers, their separation from loved and reliable people, and the novel context.

In a similar way, for students who have only recently begun their clinical training, the very nature of the clinical context combined with the high demands placed upon them and the nature of interaction of those around them makes for uncertainty. When patients and students interact with one another in such potentially stressful contexts, the probability that their interaction will be tense, unpleasant, or disorganized is greater.

Clinicians need far more than a diagnosis in order to understand the perceptions, experiences, and resulting behavior of the person who is ill (Hunter & Maunder, 2001). To an illness experience a person brings her own self—a whole, unique being with a collection of experiences and predispositions that shape how she experiences and behaves in her situation.

Thompson and Ciechanowski (2003) have shown that a sound understanding of a patient's attachment style makes effective primary care more likely.

For example, when a person is dying, his quality of life and the grieving process experienced by family and loved ones can be negatively affected by conflict and confusion in the context of his relationships. To avoid this, Petersen and Koehler (2006) propose that clinicians can use their interpretation of the attachment patterns within the family and integrate appropriate psychological care for those involved in the illness experience.

In addition to focusing on the attachment experiences and styles of patients, Thompson and Ciechanowski (2003) remind us why we must consider those of the doctors caring for them. A doctor's experiences of care, his or her resulting attachment style, and the levels of support that colleagues and senior figures provide the doctor can make an important difference to the experiences and outcomes of a person under that doctor's care in the context described above. Arguably, this is because of the impact these factors have on the doctor's ability to display the aforementioned sense of *aequanimitas* underpinning her development of caring relationships with her patients. A secure clinician is unlikely to become overwhelmed or controlling when faced with the clingy or anxious behavior typical of insecure-anxious patients. Patients who see their doctor as caring are more likely to be both satisfied and to comply with plans for managing their illness (Thompson & Ciechanowski, 2003).

It is important to consider not only the care that students learn to give, but also the care they receive in the process of learning. To better prepare students for the demands and potential stresses of being in an unfamiliar context and playing a new role in which they must also care for people who are ill, their vulnerabilities and tendencies regarding social interaction warrant consideration. With such awareness, educators and team members will be able to better support the student in his preparation for patient encounters and reflection on his clinical experiences. Likewise, self-awareness of their own tendencies will enable students to better understand and manage their approaches and reaction to experiences with patients in the clinical context.

Situational Barriers to Care

Role Models

To a great extent, students learn from their clinical teachers' role modeling (Weissman et al., 2006). Educators must recognize the potential that role models have to affect learning and change for better or worse.

Medical students can enter their education with preexisting attitudes to certain types of patients and conditions. Predictors of such attitudes include their related experiences and knowledge and their role models (Branch, 2000; Brorsson et al., 2002; Wilkinson et al., 2006). A senior role model expressing cynicism or negativity toward a particular aspect of medicine is likely to trigger development of similarly negative attitudes among students. Given the strong desire among many doctors to cure—often at the expense of caring, patient-centered behavior—negative attitudes are more likely to develop in relation to care for the dying or chronically ill (Branch, 2000; Brorsson et al., 2002). For example, tracing students across their education, Brorsson et al. (2002) showed that, as they gained experience, students lost interest in conditions that lacked a cure, were chronic, and affected the patient's appearance or behavior (e.g., dementia, mental illness). On the other hand, increasing interest was shown in diseases with advanced and recently developed treatment options—the types of diseases that a doctor can gain more immediate reward and "success" from managing.

Ward Culture and Socialization

Related to role models is, as described by Branch (2000) and others, "ward culture." This culture, for the student, can often be indifferent, cold, and hostile. Upon entry, students' ideals are challenged as they struggle to accommodate to the "ward team's" style of behavior.

Socialization, related to ward culture and role models, is another potential element determining students' approach to care. It appears to shape their concepts of reward, success (Brorsson et al., 2002), and patient-centered care.

Throughout their education, medical students experience pivotal opportunities, often referred to as "rites of passage" to participate in some challenging yet role-defining situations (Hafferty, 1991). These formative experiences (i.e., those connected with life, with birth, with death, and with the human condition) separate medical students from the public at large.

Some of these experiences are likely to be upsetting for students. Their reactions to breaking bad news or interacting with someone who is dying, for example, are likely to be compounded by their own uncertainty of what to say or do around patients in such settings. To regulate their vulnerability and uncertainty, students may seek safety and acceptance in their new culture by adopting behavior and attitudes modeled therein. Often detached and distant, these can come at the expense of behaving with empathy and a willingness to care (Hafferty, 1991; James & MacLeod, 1993). Students' circumstances appear to

limit the opportunity and reward for nurturing and developing their natural inclinations to care.

Reflecting on how they learned to care for people who are dying, doctors reported that their education failed to provide adequate preparation. Instead, they remember reaching a genuine understanding of what it is to care by being with patients themselves (MacLeod, 2001). So why do we not see more encouragement and modeling of this in educational settings? Possibly because of the lack of rewards and challenges that this approach to care presents.

Ways to learn from and manage challenging situations include reflecting on one's experiences and receiving support through mentoring and supervision. Unfortunately, the promotion of such self-care in medicine is insufficient (Branch, 2000). How can students and doctors be expected to maintain their moral values and care for others when they are not encouraged to care for themselves? To make supervision and mentoring effective, a student must learn to uncover their thoughts and feelings and then feel comfortable expressing and sharing them with others. They need to see reflection as a normal part of their everyday practice.

Promoting a Culture of Care in Medical Education

Characterizing the Context and Students

Before introducing changes to a medical school and hospital it is important to identify informal and hidden curricula (Haidet et al., 2005; Jaye et al., 2005). These are powerful in shaping students' and role models' attitudes and can act as barriers to affecting positive change.

To deliver the most appropriate interventions and meet students' learning needs it is also important to gain awareness of what students bring to the learning environment. This includes exploring students' experiences of death, anxieties, attachment styles, and attitudes and preconceptions of a doctor's role. Educators need to be aware of beliefs, anxieties, past experiences, and attachment tendencies that may contribute to the student's maintenance and development of their natural capacity to relate to others, empathize, and care (Novack et al., 1999).

Fostering Empathy

For medical education to meet its goal of creating caring doctors, it needs to foster self-awareness, personal well-being, and humanistic development.

Patient Contact: Patients as Teachers

Early opportunities for patient contact nurture appropriate attitudes and a greater understanding of such patients and reinforce didactic learning. This demands a change from the current circumstances in medical education that distract students from care as they struggle to survive and conform to the culture that surrounds them.

An innovative approach to end-of-life care using the voices of family carers reinforces the power of real-world learning. Turner et al. (2000) showed that meeting carers had a "profound" effect on students to the extent that some said they were "changed" by the experience and felt it would significantly influence their professional behavior.

Patient Contact: The Need for Reflection

Despite the risks around engaging with patients, it is possible to professionally deliver and manage an intimate approach to care. Intimacy can have significant rewards for both the patient and doctor. Becoming involved with the patient's life world is crucial to understanding them and, therefore, how best to care for them. Such experiences are optimized by opportunities for reflection. Reflection is fundamental to learning from experience (Plack & Greenberg, 2002). Reflection can be on content or process and can solidify learning by allowing students to see how their experiences fit into the wider context of their training. It highlights the areas from which they gained the deepest insights and encourages active consideration of their future approaches to care.

Where appropriate, reflection can be an effective component of formative or summative course assessment. This allows it the status it warrants on the basis of its educational benefits and allows teachers to monitor students' experiences and needs for support.

For example, in their community-based practice component, fourth year students in a New Zealand medical school spend time with patients in the hospice program and their families. They learned about these people's values, beliefs, and experiences and community-based care resources in use (MacLeod et al., 2003). They documented their observations about the patients' care, the patients' stories, and personal reflections on their own reactions to the experience and made an oral presentation followed by group discussion. By reflecting on, as opposed to simply describing, the experience, students developed new understandings of death and dying and greater self-awareness. They reflected on their own lives and beliefs, emotional reactions, support needs, and future intentions regarding their approaches to care.

Self-Care

To care for another, a person must receive care and support for themselves. Supervision and mentoring

are two key components of self-care. Supervision may come from student counseling services and external support or teachers who are appropriately informed. With appropriate self-care, a person can learn to manage, rather than avoid, the challenge of caring for another (MacLeod, 2001). Through personal and group-based reflection, students are more likely to gain the optimum benefits from supervision and mentoring as they become more comfortable exploring and articulating their own thoughts and feelings, anxieties, and support needs.

Role Model Development

To support students in their development as caring doctors, role models must demonstrate appropriate communication behavior with both students and patients. Where there is need for improvement, several options exist, including individual support programs to identify and address learning and performance needs (Cohen et al., 2005), periodic reinforcement of core clinical communication skills that reinforce patient centeredness, and demonstration of empathy (Coulehan et al., 2001). Similar approaches apply to nurturing students' development of communication skills.

Reflection and Feedback

Reflection must be modeled as an important part of medical practice throughout a doctor's career. This begins with having faculty systematically incorporating reflection throughout the curriculum as part of learning and assessment. By reflecting on both content and process, they can gain a deeper understanding of what and how teachers are teaching, the effect it has on students' learning, and how teaching and learning might be improved. Teaching portfolios, structured group discussions, and feedback from colleagues promote such reflection (MacLeod, 2004). Critical reflection in small groups has a range of benefits. Group members will become more comfortable and familiar with reflection and self-expression while sharing experiences, impressions, values, and attitudes. When delivering a successful program of clinically based education about care at the end of life one multiprofessional teaching team involved met regularly to reflect on the content, progress, and impact of their teaching and the feedback they received, making revisions where necessary (MacLeod & Robertson, 1999).

Constructive feedback from others complements self-reflection. Feedback from colleagues and students can inform faculty of the impressions they receive from them as role models on the ward. Faculty need to be aware of, and know how to avoid conforming to, negative aspects of ward culture. With feedback, faculty can reflect and better understand how their current practice relates to their goals as educators.

Caring for people who are suffering is an ongoing challenge. It is crucial that clinical teachers have the personal and professional support required to continue to care and therefore demonstrate care as role models. In addition to reflection, part of ensuring quality role modeling is facilitating the provision of supervision and mentoring or peer support for faculty.

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