Can Compassion be Taught? Let's Ask Our Students

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BACKGROUND: Medical educators act on the belief that students benefit from formal and informal educational experiences that foster virtues such as compassion, altruism, and respect for patients.

OBJECTIVE: The purpose of this study is to examine fourth year medical students' perspectives on how, where, and by whom they believe the virtues associated with good physicianhood have been taught to them.

DESIGN: Fourth year students were assigned a two- to three-page essay that asked them to reflect on how their medical education had "fostered and hindered" their conceptions of compassion, altruism, and respect for patients.

PARTICIPANTS: All 112 students completed this assignment, and 52 (46%) gave us permission to use their essays for this study.

APPROACH: An inductive, qualitative approach was used to develop themes derived from students' essays.

RESULTS: Students' thoughts were organized around the idea of influences in three areas to which they consistently referred. *Foundational influences* included parents and "formative years," religious faith, and other experiences preceding medical school. *Preclinical education influences* comprised formal classroom experiences (both positive and negative effects). *Clinical education influences* included role modeling (both positive and negative) and the clinical environment (notable for emphasis on efficiency and conflicting cues). Students' essays drew most heavily on the effects of role modeling.

DISCUSSION: Medical students arrive at our doors as thoughtful, compassionate people. Positive role models and activities to promote critical self-reflection may help nurture these attitudes.

KEY WORDS: compassion; medicine; students.
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INTRODUCTION

> "Where Socrates appeared to argue that *no one* teaches virtues, Protagoras argues that *everyone* teaches them."[1]

Our assumption that compassion and other virtues can be "taught" is so firmly embedded in the medical school curriculum that we fail to question or examine it. Almost a half century of curriculum work in medical education rests on the belief that medical students benefit from experiences intended to move them toward being more compassionate caregivers and that there are places in the curriculum where these experiences should take place. Still, Fox's[2] observation on the teaching of virtues (or "professionalism" or "humanism" or "socially competent" caregiving) rings as true today as when she wrote it 17 years ago: these efforts—"magic bullets" she calls them—often seem largely compensatory in the everyday world of clinical medicine where time is short and the technical aspects of biomedicine are the focus of both teachers and learners.

In spite of Fox's wry observation, we prevail, those of us whose charge (and/or calling) focuses on teaching, inculcating, instilling, developing, fostering, or encouraging these various virtues. During the preclinical years and occasionally the clinical ones as well, medical educators develop lectures and seminars that specifically engage students in issues surrounding compassion, altruism, and respect for patients. These formal curriculum experiences most often arise from various disciplines including ethics, literature, narrative and cultural studies, as well as the behavioral and social sciences.

Once students enter the clinical domain, such curriculum time evaporates, and medical educators rely heavily, if not exclusively, on the perceived power of role modeling. Trainees learn at the bedside, in operating rooms and emergency departments, on rounds and during informal interactions, and in ambulatory settings; they learn by watching and listening and thinking about what they see and hear and by practicing over and over again the tasks at hand. Much of this is in the unscripted or hidden curriculum. The assumption is that we send students into clinical arenas to learn to be competent, caring physicians, and we send them there to learn from competent, caring physicians. We do not intentionally assign our students to incompetent, uncaring physicians because we think that they will learn profound lessons from negative role models. This point will become important later in our report of students' perceptions of role modeling.

The literature on role modeling is vast, but it is also contradictory when it comes to its perceived use as a strategy for students to learn to be more compassionate or respectful. Most who write about role modeling in medicine believe it to be one of most significant methods of forming professional character.[3–8] Yet, some focus on the *negative* dimensions of role modeling: the small, random chance that a student will be assigned to an "effective and positive" role model,[9] the expressed beliefs of students at two Canadian medical schools that "most of their teachers did not display…humanistic characteristics"[10]; the observation that students may choose

the wrong role models.[11] Finally, several articles question the very efficacy of any kind of role modeling.[12,13] In his still-quoted 1983 essay "Can Compassion be Taught?" (from which we borrow our title), Pence reasons that "merely *imitating* compassionate behaviour is not compassion." Furthermore, he writes,

> real compassion stems from deeper, internal attitudes and emotions. Where compassionate behaviour is imitated in this way, it may be done as much to please and identify with the senior physician as much as because the suffering of the patient *really matters*.... Morality is not learned the way one learns to play a flute or to do a tracheotomy by observing a "master" proficient in a certain craft or technique[1] (p. 190).

This background provides at least some of the context in which medical students find, or are thought to find, both the formal content and the more informal attitudinal and behavioral manifestations of virtues deemed important for them to develop throughout their training as physicians. While it is true that most of these virtues "are also among those required for living a good life…we seem to expect that those who take up the challenge of [medicine] will have developed these particular virtues to a greater extent and will act upon them more consistently than most other people"[14] (p. 340).

The purpose of this study is to examine fourth year medical students' perspectives on how, where, and by whom *they* believe the virtues associated with good physicianhood have been taught to them at one Midwest medical school.

METHOD

At the Northeastern Ohio Universities College of Medicine (NEOUCOM), we were fortunate to have all of our fourth year students together in a new required capstone course ("On Professing") right before graduation in April, 2006, and recognized the opportunity for us to learn much from them by inviting them to express their views freely without the ubiquitous threat of grades. We did so in an assigned two- to three-page essay that asked students to reflect on how their medical education had "fostered and hindered" their conceptions of compassion, altruism, and respect for patients. Writing this essay was a course requirement, although allowing them to be used for research purposes was voluntary. We include in our analysis only essays whose authors consented to their use. All identifiers were removed except for gender, and analysis did not begin until after graduation. This project was approved by NEOUCOM's Institutional Review Board.

We began our inquiry not in a vacuum but with reading the literature on role-modeling and what medical humanities scholars and other medical educators have written about the development of compassion and respect for patients in medical trainees.[16–18] But when we analyzed their essays, we were interested in how malleable *students* believed they were regarding the acquisition of those virtues. Thus, our students' words and phrases, their ideas developed through examples, and the attitudes that emanated from their essays form the basis of the themes we develop here.

We did line-by-line readings of each essay several times and attempted to establish themes independent of the other author, themes that were remarkably similar once we compared our interpretations. It was our repeated immersion into the essays that brought forth these interpretations, what is known as an "immersion/crystallization" approach to data analysis,[18] whereby both of us, in repetitive, reflective cycles of rereading the text, began to "see" ways to organize and interpret students' language. While arguably there are other ways to organize these data, we believe that the schema we selected below faithfully captures what students wrote while providing readers a useful conceptual framework for considering these issues.

RESULTS

Of the 112 students who completed this essay for the course requirement, 52 (46%) allowed us to use their essays for this research. Compared to the gender composition of the class, fewer men (40% for study, 49% overall) participated than women (60% for study, 51% overall). The racial/ethnic identities of the participants were consistent with the rest of the class.

We reorganized the data around the idea of *influences* in three areas to which students consistently referred. First, *foundational influences* describe the early factors students cite as having an impact on their conceptions of compassion, altruism, and respect for patients, typically influences that predate their entry into college or medical school. These include parents, their own experiences, and their faith. Second, *preclinical education influences* include classroom and curriculum phenomena experienced during the preclinical years along with the preclinical environment itself. Third, *clinical education influences* include role models and the clinical environment.

We include the number of times students cited each influence in their written essays, but we do so with caution. In any given paper, a student was likely to name one or more of these influences, sometimes in contradictory ways. The most frequently cited influence was role modeling, which forms the most extensive part of this section.

Foundational Influences

Within this category, most students cited their parents or the way they were raised, using words like "instill" or "foundation" to trace their attitudes toward compassion, altruism, and respect for patients. Seven named parents or more globally their formative years as influences; seven mentioned experiences outside medical school such as international travel; two mentioned their religious faith. One student wrote that "so much of my ideas of altruism, compassion, and respect… were formed before I walked into the COM's front doors. To delete this foundation would disservice my sacrificing, nonphysician, nonmedical school parents, who initially instilled these values in me."

Another student wrote the following discouraging statement about this writing assignment and many of our efforts throughout the curriculum:

> When I read about this assignment to write about how my medical education has affected my altruism, compassion, etc., I actually became angry…This class is a great example of how this topic has been shoved down our throats too many times. I can no longer take it and I am exploding as I am writing this paper.…My medical education over the past four years has not changed my concepts on altruism, compassion, and respect but rather it has made me dislike discussing them. Most of my ideas were already developed years earlier in high school and college.…I had, as most of our class had, developed these much earlier than medical school.

Preclinical Education Influences

Students generally cited two aspects of their preclinical education as having an influence on their conceptions of altruism, compassion, and respect. The first included formal classroom experiences in bioethics, behavioral sciences, and the medical humanities. Some students lauded such classes that "did much to enhance [their] ability to consider other people's life situations and opinions before implementing a course of action in their medical care." However, four students argued that the behavioral science courses did *not* promote these virtues but instead, "the act of 'appearing altruistic' was nurtured over and over again." Another student stated it simply: "I am not compassionate because someone told me to be or because I was forced to read touchy feely articles.…I do not feel that papers or articles or any other forms of forced written/busy work have helped me to become a better person."

The second preclinical educational influence was the academic environment or culture itself, one which some students perceived to be anti-altruistic. Six students cited pressures to do well on exams, to earn a high class rank, and to "crush the boards" as factors that "wreak havoc on a driven, competitive, and hard-working student" during the preclinical years. One student observed that "with every test score with graphs and standard deviations that were posted…it was a constant reminder that competition and personal gain were the essence of medical school. Knowledge to succeed in medical school was the 'end all,' not knowledge to help people battle diseases and decrease suffering." One student argued that this phenomenon is ubiquitous in an environment where "personal success is recognized in so many ways as compared to acts of kindness which can easily go unnoticed. For me, attempting to put others first in a culture of competitiveness has in a way sometimes required swimming against the tide." Another student wrote about learning to hide her emotions during the early years of medical school, noting that

> other students' nearly impenetrable façade fooled many until the utility knife of medical school opened it, sometimes for all to see. Some cracked and many became jaded. Relationships were lost, weeks went by with no time off even when taking time off. It took its toll and at times seemed macabre play; discussions of compassion and respect…did not include us.

Clinical Education Influences

Role Models

Positive role models. Twenty-seven students described positive role models who had had an affirming influence on their conceptions of compassion, altruism, and respect for patients. One wrote about feeling "nurtured … beyond anything I thought I could achieve"; another described physicians who "selflessly teach me, talk to patients, and serve on endless committees…[who] invest in me, physicians who may not even know my name…[who] have shown me altruism, far deeper than I ever thought possible." Another wrote more widely about her role models, who "went beyond their prescribed roles and gave freely of themselves, sometimes sacrificing their precious free time and sometimes taking a few seconds to give a few words of encouragement. It felt like water in the desert." One student referred to the "subtleties of the connections" these physicians had with their patients:

> A surgeon who holds his patient's hand while she undergoes anesthesia, ensuring that his face and voice are the last comforting sensations she experiences before surgery. A family practitioner, with an extremely packed schedule, who gives just what a patient who has just lost a family member needs—time to listen. An ob/gyn who, after diagnosing a miscarriage, sits with his patient, respectfully answering questions and offering consolations, remembering that although he has gone through this very same event with many couples before he never forgets the shock and hurt that they experience.…It is physicians like these that I have gained the most from.

Negative role models. Twenty seven students—some of them the same 27 cited above who described positive role models—recalled negative role models they had encountered in their clinical education. Some admitted that negative role models added to their own cynicism and disappointment, while others held them up as examples of physicians they did not want to become. One student wrote of these contradictions in her training, having had many attendings who embodied the kind of doctor she aspired to be even as she encountered those who were "flat, bitter, impatient, rude, loud, and opinionated about everything except for what is best for the patient.…I have taken those bad experiences and turned them into positive ones that will help me to become the physician I want to become."

Another wrote of how she and her classmates had similarly learned from bad examples who illustrated

> the consequences of neglecting our patients.…They have shown us the lack of respect we will receive, not only from our patients, but from our colleagues, future students, and staff. They have shown us the ugly side of medicine, the breaks in a relationship so special we wonder why these physicians chose this profession. They have shown us the consequences, which are written on their faces and on their interactions, of an unhappy attitude and an unhappy life. So, although they may exemplify all that may make us cynical and frustrated, they have also, by example, taught us the cost of doing so: the loss of our patients—their trust, their spirits, and their bodies.

Another sadly summarized where she was at the end of her medical education: "The discussion we had in class about the [compassion] 'pilot light' still being lit even after the flame goes out is a true scenario for me. I told my small group that my flame has been stomped on, peed on and sprayed with a fire extinguisher but the pilot light is still lit and the potential is still there."

The Clinical Environment. The clinical environment was cited most often as a place where negative cues influenced students' conceptions of altruism, compassion, and respect. Ten students wrote of the fatigue and overwork that sours one's attitudes toward one's work; six noted how they learned that efficiency—"an assembly line mentality"—trumps just about everything in clinical settings, prompting a focus on patients' diseases, not patients themselves:

> It is easier to shut off your emotions and get through the work as efficiently as you can.…As a result, I started falling into a trap. That is, quick, superficial greetings to the patient, not sitting down in the room, a cursory physical exam, not taking the time to explain what is happening to the patient. The trap can be a myriad of events, but it all boils down to putting yourself, your time, and your work before the needs of your patient. I began to realize that this was happening and that yes, I was taking the easy way out.

The following student aptly summarized the effect of the medical education milieu on the development of compassion, altruism, and respect for patients:

> Four years of rigorous training to properly categorize, generalize, diagnose, and care; every day focused on the next objective exam, be it written or the spontaneous pimping lurking near every chart. While it always seemed that taking patients' hands, sitting down and comforting them was important, it was not ever as important as learning the technical skills necessary for treatment.…The focus in medical school is to make the grade, and the message is clear that the lower a person's score the less competent and less of a doctor that person is.

In general, students believed that while mixed messages and contradictions abound everywhere in the clinical environment, they were in a position to pick and choose influences and that important lessons could be learned from the negative cues. But such lessons are often learned and perhaps best learned from frequent and systematic processing of one's feelings, particularly regarding conflicting messages. For this, there is little time, as one student wrote:

> The busier we become and the more important we view ourselves, the less time we have for introspection and reflection, both of which are necessary for character growth and virtue development.…Adults can and do learn…when they are teachable, humble, receptive, and faced with new knowledge that creates disequilibrium.

DISCUSSION AND RECOMMENDATIONS

There are several limitations to this study. Only 46% of our students agreed to participate in this study. We did not attempt to verify our conclusions using another data source (triangulation) and, because of the timing of analysis, we were unable to ask students to comment on our conclusions (member check). Other investigators might have organized the themes differently or perhaps even recognized different themes. We make no claim that our findings can be generalized to all medical students, but we do believe that this study adds to an ever-expanding compendium of knowledge on the development of professional identities, specifically those related to the virtues of altruism, compassion, and respect for patients. These limitations provide a research opportunity to medical educators that could be addressed, for example, in a longitudinal study tracing students' thoughts on compassion using various media (journals, required essays, focus groups, videotapes, etc.) as they progress from admission through graduation.

That said, our students' candid remarks in their capstone essays indicate that despite our best efforts at creating formal curriculum experiences to nurture ongoing development of altruism, compassion, respect for patients, and reflective thinking on their roles and responsibilities as physicians,

roadblocks appear in predictable places that systematically undermine such efforts, many of them in the hidden curriculum. Their observations of how and where these virtues were directly and indirectly taught by human example, the formal curriculum, and the learning environment offer medical educators a richer milieu in which to theorize our efforts. For example, students' comments could be read as hidden curriculum phenomena, as key to professional development or as a curriculum issue tied most directly to the medical humanities.

In fact, a 2003 theme issue of *Academic Medicine* confirms a very explicit link medical educators make between engagement with the humanities and the acquisition of virtues such as compassion, empathy, altruism, and the like, all currently conflated with professionalism. Throughout North and South America and Europe, what we share, according to these site-specific descriptions, is the belief that such inquiry can help students develop a "moral imagination"[19] and "self-reflective disposition",[20] "foster habits of discourse on social and moral issues in medicine"[21]; and "engender…empathy for the patient's experience of illness".[22] These beliefs have become conventional wisdom, in spite of the fact that most of us in the medical humanities are leery about assumptions that what we teach makes students "better people with the 'right' character".[23] Still, anyone designing curricular experiences for students in these domains must surely believe—or at least *hope*—that such efforts have a positive rather than negative effect on students' thinking, attitudes, and values regarding their relationships with patients.

However, we believe our students' writing was most persuasive regarding the effect of role modeling on their attitudes. How clinical faculty treat and talk about patients, how they interact with others providing care, how they characterize a life in medicine—all these have profound effects on students. But a few positive role models in any clinical setting will not do the trick. As Pence argues, students do not learn from the "Master of Compassion (or the chief role-model thereof). It is developed or not by the 'shape' of the medical environment.…The overall medical context in which students thrive or stagnate is more important than the efforts (however noble) of any one individual"[1] (p. 190). Jack Coulehan, who believes firmly in the power of role modeling even as he recognizes the merits of Pence's argument, still urges environmental change *via* role modeling:

> The first requirement for a sea change in professionalism is to *increase dramatically* the number of role model physicians at every stage of medical education. By role model physicians I mean full-time faculty members who exemplify professional virtue in their interactions with patients, staff, and trainees; who have a broad, humanistic perspective; and who are devoted to teaching and willing to forego high income in order to teach.…Their presence would dilute and diminish the conflict between tacit and explicit values, especially in the hospital and clinic. The teaching environment would contain fewer hidden messages that say "Detach" while at the same time overt messages are saying "Engage." What trainees need is time and humanism[3] (p. 896).

Thus, our first recommendation points to Coulehan's belief that a "sea change" in the number of clinical medical educators who, at every step of the curriculum, embody "broad, humanistic perspectives" at every step with patients *and* trainees.

Still, making sure students have plenty of positive role models is not enough. That is, role modeling cannot speak for itself, or as Kenny, Mann, and MacLeod suggest, "silent modeling is inadequate as a strategy",[5] (p. 1206). Physician role models must engage in an ongoing discussion with students regarding *what* they are doing and *why*. Kenny and colleagues describe a landscape most of us recognize—an environment where there is little or no discussion with students of what represents positive or negative role modeling and few experiences for them to evaluate what is happening to them. Indeed, we all "lack an adequate understanding of the process through which learners respond to models and of how practitioners of varying quality and commitment exert their influence"[5] (p. 1205).

In not one of their capstone essays did students describe clinical experiences where they were able to talk openly with their faculty about what they articulated so bluntly in writing for us. Admittedly, we did not ask that question explicitly, but had there been such experiences, we trust that that students would have mentioned them as fostering or hindering their conceptions of compassion, altruism, and respect. Other than with each other, where *do* students talk about and try to understand their teachers who refer to patients as "rocks" and "wastes," teachers who are "flat, bitter, impatient, rude, loud, and opinionated about everything except for what is best for the patient," or teachers with "generally bad mojo"? Similarly, do students' positive role models "debrief" with them about what just went on with a patient, making explicit their values and justifications for particular behaviors? In her study of physicians who try to role model empathy, Johanna Shapiro reported their use of open-ended questions to trainees after patient encounters such as "What did you notice? What was going on? What was I trying to accomplish? …[or] What specifically did you do to show empathy toward this patient?"[24] (p. 326).

Thus, our second recommendation involves designing opportunities for critical self-reflection in safe spaces with trusted faculty throughout the curriculum. Branch[25] writes persuasively of such experiences as necessary for the moral development of medical students. He suggests that medical students sometimes experience delays or even regression in their moral development in clinical environments where they are conflicted between doing what they believe to be right for their patients and following the conventions demonstrated by their superiors to "fit in" as members of the health care team. Fearing reprisals that could negatively impact their academic advancement, it is conceivable that when so conflicted, students subjugate their own moral impulses and thus come to operate in a state of "sustained adolescence" with respect to their moral development. Research examining the effects of required reflective experiences on medical students throughout the undergraduate curriculum offers another fertile area of inquiry in the development and maintenance of compassion.

It becomes critical that we not only ensure our students' participation in self-reflective work through these important

rites of passage, but that we continue to develop and sustain, through faculty development and encouragement, a community of faculty who are poised consistently to support and mentor them along the way. Such faculty would also embody how maintaining *meaningful* relationships with patients is one of the critical routes to career satisfaction spanning a life in medicine,[26–28] in contrast to the *depersonalization* associated with burnout.[29–30] Discussing their experiences with faculty who love to teach and whose values reflect compassion and respect for patients, students are reminded that what they observed might or might not be "the appropriate way to behave and that their impulses to protect and respect their patients are valid"[31] (p. 9). Sharing their experiences with such faculty is also an opportunity to discuss their perceived powerlessness when confronted with behaviors and attitudes that fly in the face of their own sensibilities or that contradict what they have been taught elsewhere.

Finally, here and throughout the curriculum, we will be looking with new critical scrutiny for evidence of what the one capstone essay quoted above accused us of doing—"shoving" this topic "down their throats"—and we urge medical educators elsewhere to do the same. We believe that medical students *do* arrive at our doors as thoughtful, compassionate people—with a "pilot light" already burning strongly. It is our calling to nurture this compassion, remaining mindful of students' lived experiences and striving to understand *their* particular narratives and the complex, conflicting messages they receive everyday in an environment we create and sustain. As one of our thoughtful students wrote, "This is the task that is given to us: To take a profession that is built on our egos, on competition, and to turn it into something that is not about us." This is our task as educators as well.

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