Medical Students Development of Empathic Understanding of Their Patients

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Medical Students’ Empathic Understanding of Their Patients

Traditionally, students have been advised to avoid “getting too close” to patients for fear that it would interfere with clinical decision making, but we think that students naturally identify with their patients and that this empathic identification may be a useful milestone in students’ professional development.

Medical students learn to interact with their patients while members of a ward team, with little or no formal curriculum. Learning about doctor–patient interactions is mostly left to the students, or they might learn it by emulating interns, residents, and faculty. Concerned about this lack, we examined more than 180 narrative accounts of students’ important interactions with patients, and we looked at 20 of them in depth. The accounts are called “critical incident reports.” We gave the students an open-ended assignment to write about an important event that influenced their learning on the wards at the beginning, middle, and near the end of their third year. We used the reports for small groups of students and faculty who met weekly throughout the third year to reflect on the meaning and implications of their experiences on the ward.

We found a single overarching characteristic—the students’ strongly empathic identifications with their patients.

Critical Encounters

To a remarkable degree, the medical students put themselves in their patients’ shoes, which surprised us because we had expected them to keep their distance from their patients. Yet their identification with their patients emerged again and again in the stories.

He was my first patient of my third year of medical school and I will call him John. He carried the dual diagnosis of schizoaffective disorder and polysubstance abuse. Each previous admission displayed a similar scenario: the patient’s drug use (cocaine and alcohol) had gotten out of control and he had begun to have “those thoughts” once more. At first, he didn’t want to speak to me, probably because I was just another “cruel human being” who was after him in his delusional world. After a week of my attempting to earn his trust, he finally began to teach me what it was like to “be” John. I learned that there were reasons for the way John was feeling and thinking. I’m not referring to the scientific deductive reasoning applied to illness in the medical model. This is the reasoning that I have been trying to master ever since I started medical school, and of course it is immeasurably valuable. What I am referring to is the emotional understanding of my patient. What John was showing me as I delved more deeply into his thoughts was the intense emotions of someone who had been ravaged by the “cruel world” in which he lived as a child. The details are not important. What I learned was that those intense emotions can stir up emotions in myself, a phenomenon that is very intense and extremely tiring.

This story shows an empathic identification with the patient that was not necessarily comfortable but that helped the student to understand his patient. We found no evidence in the reports that the identification hindered the students or patient care. Rather, the students’ learning to understand patients’ experiences through empathy often improved their relationships with patients. A student encountering an AIDS patient wrote:

Working with Denise (a 14-year-old honor student who acquired HIV infection at birth) significantly changed my outlook towards patients with AIDS. The AIDS patients I had worked with previously had all been IV drug abusers. Although at the time I thought I was treating them with complete respect and sympathy, in retrospect I realize I did not acknowledge the full pain of their situation because part of me blamed them for putting themselves at risk by a behavior that was within their control. Denise’s situation, however, was enough like my own that her suffering powerfully hit home. She helped me to realize on an emotional level that despite the source of infection, AIDS is extremely devastating to anyone’s life. My interactions with Denise evoked thoughts of what it must be like to feel the joys of life and then at a young age learn that you may die shortly. Before meeting Denise, I thought about such situations, but in abstract terms.

Another student gained understanding of her patient, “a fresh-faced, frightened young woman, all alone,” with abdominal pain during pregnancy. Again, identification led to insight, and also to more effective care:

While we talked I noticed something in the back of my mind about her accent and manner. There was something familiar about it, though at the time I couldn’t say what. She said she worked for the food service at terminal E at the airport. “Oh, that’s my
terminal. That’s where I fly home.”
“Where’s home?” she asked me. “Milwaukee,” I responded. “Oh,” she said excitedly, as if I were an old friend, “I’m from . . .” and she named a small town in western Wisconsin. She asked me if I knew her home town and I said “sure.” Suddenly she started talking about being homesick for her family, especially she said because her husband wasn’t very excited about the pregnancy. Slowly, as we talked, out came a saga of persistent abuse.

The student adds:

This interaction was extremely important to me. While it looks like a plain bit of narration, it was one of the first times that I felt like "a real doctor," that is to say, the kind of doctor I would like to be. I felt competent in dealing with her medical issues and, though it would have been easy enough not to ask about her home situation, I did.

Some identifications were uncomfortable for students, but in the cases that we examined psychological pain did not come from overidentification but rather from the personal and moral struggle when they have difficulty empathizing. Witnessing suffering was particularly upsetting. A student wrote:

Since it was hard for me to see an unrelated person splayed out, naked, and invaded by numerous tubes, I can imagine the intense feelings Mrs. G’s husband probably had when he came to sit with his wife in this state. A particularly upsetting event highlighted for me how intensive-care patients are often reduced to impersonal objects. A consult team was discussing Mrs. G’s case outside her room, and Mr. G walked out in search of information about his wife’s current condition. The team did not even acknowledge his presence. Many of the patients were dying and little could be done to change their course. In these cases, health-care workers should put more emphasis on alleviating the patient’s and family’s personal suffering instead of focusing so heavily on numbers and medical treatment.

And, when students progressed in coming to grips with this suffering, it was because, not in spite of, knowing and identifying with the patients.

Not much later my intern told me that Mrs. D had died. I had a hard time believing it. I walked into the room, where two nurses were stripping Mrs. D’s body of IVs, blood-stained johnnies, and bandages, to see a dead person for the first time. The only other experience where I had palpably experienced death was during the first year when I was exposed to my cadaver for anatomy class. It was a much easier encounter because I had not known the person, she came almost pickled, and her corpse was wrapped in several areas so that it hardly resembled a human body. But, this was quite different. Mrs. D’s face was blue, her eyes were open, she had hematomas everywhere, and she was not stiff. One of the nurses asked me to stay and then proceeded to change the sheets, put a new johnny on Mrs. D, and close her eyelids. She switched on a soft overhead light, put Mrs. D in a position that looked like she was sleeping soundly, and then left. I wasn’t embarrassed to cry, but it certainly helped me to know that my intern also felt the same way. There were tears in her eyes. After the family left, she told me that someone had once impressed on her the importance of following up on a death with a sympathy note to the family. I was stunned. These were things that were not written anywhere yet were so important. I knew that my intern would make a great doctor and that she was the person I would have taking care of my parents. I couldn’t quite list her personal attributes but I would be able to list her professional abilities on a piece of paper. She was a conscientious and caring person whom I would trust with a life, and she would know how to appreciate and care for it well.

Showing compassion is to give support or comfort while sharing another person’s feelings of suffering. To respect someone is to treat him or her with consideration and esteem. To link empathetic understanding with action—conveying esteem or offering support—would be one way for students to subsume emotional identification with the patient into their professional work. Such linkages have been noted in many articles and books and are evident in all the examples here. Another example is from the student who encountered Mrs. D after death who, at another point in her story, “. . . couldn’t resist the urge to hold [Mrs D.’s] hand as I had done several times in the past.” Respect was demonstrated elsewhere in her story when the student described how the intern came back “to talk with the family about such a difficult topic as death after being through [an intensive, exhausting experience] less than half an hour earlier. . . .”

Students’ empathy for their patients or families also enabled them to recognize lack of respect or compassion when they encountered it, for example, in the case of Mrs G.’s husband, who was ignored by the consult team. In another report, empathy created a painful struggle that seemed to be appropriate and valuable, when a student had to inflict suffering in the course of a comatose patient’s care.

As I tried to insert the tube into Mr J.’s nose, he began to retch and cough . . . I became worried that I was hurting him . . . on my fourth attempt . . . I was finally successful, yet as I was advancing the tube, Mr J.’s hand lifted up and grasped at the tube, pulling it out of his nose. I was astonished. Was this a willful movement, his way of saying that he was in pain? All I know was that placing the tube in his nose was one of the most disturbing acts I have ever performed.
It seems important not to get this student to function without feeling disturbed but rather to maintain his compassion for an incommunicative person as he becomes more inured to performing tasks such as this one.

**Becoming a Doctor**

We think that the critical incidents address the students' tasks of becoming doctors by integrating empathic understanding into their professional work. We believe the small-group process, in which students' papers were discussed, facilitated this task. The reader should imagine the power of stories like these when read aloud in a group of students and faculty. The students disclosed their heartfelt thoughts and feelings about patients, so much so that their empathy and efforts to make it part of their profession are evident. The stories also imply the high degree of trust in the group necessary for students to share such experiences with the faculty and each other. The value of this approach derives in part from the students' personal commitment to share their beliefs and values with each other. Their natural tendency to empathize with their patients could therefore be acknowledged and examined while placing it within the context of a doctor's professional life. This empathy, properly integrated and grounded, may be a bulwark against the emotional erosion of difficult times to come.

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