



# Educating Physicians for the Aging World: A Humanistic Approach in Doctoring

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## Abstract

Outcomes, guidelines, and clinical trials are at the forefront of the current medical training. However, we observe well-trained technological physicians with a reduced humanistic perspective which leads to attitudes that lack ethics and professionalism. There is a growing concern about the human dimension of the future physician and how it can be taught or reinforced in the educational environment allowing to integrate technical science with the humanism that medical practice requires.

Although human suffering and death are a constant presence in medical practice, it is quite common to observe healthcare professionals having difficulties to deal with this subject. A training that goes beyond technique is needed, on how to face death professionally. It takes attitudes, values, how to deal with the meaning of life, understanding the vital moment, as well as modern techniques, procedures, and resources for the proper performance of this function. Palliative medicine is the modern approach to managing human finitude, and it should be incorporated into medical education. Family doctors, as specialists in people, have deserved participation in palliative training, because of their focus on continuity of care, prevention, and family study. Narratives in the suffering context led trainees to recognize how doctors can create and make the entire difference, and they learn that there is always something to do.

Empathy has a broad and varied spectrum and has two main attributes: emotional and cognitive. A prerequisite for developing both affective and cognitive empathy is that an individual should not be overly preoccupied with himself and his own concerns, because the willingness to help the other person decreases.

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Empathy could bridge the gap between patient-centered medicine and evidence-based medicine. Role modeling and caring carefully for the emotional dimension of medical students are possible resources for preventing the erosion of empathy.

Humanities and arts help in building a humanistic perspective of doctoring because they enable doctors to understand patients in their whole context. The inclusion of humanities in the curriculum occasions deep rethinking of what it means to be sick and what it means to take care of the sick. They also portray a tremendous spectrum of attitudes required for building ethics and professionalism, and they illustrate complex moral choices and stimulate comments and reflection.

Because usually feelings arise before concepts in the learners, the affective path is a critical way to the rational process of learning. Medical educators need to recognize that learners are immersed in a popular culture largely framed through emotions and images. Life stories and narratives enhance emotions and therefore lay the foundation for conveying concepts. Cinema is useful in teaching the human dimension of medicine. Movies provide a quick and direct teaching scenario in which specific scenes point out important issues, emotions are presented in accessible ways where they are easy to identify, and students are able to understand and recognize them immediately. The purpose of the film methodology is not only to evoke emotions but to help the audience reflect on these emotions and figure out how to translate what they learn into attitudes and actions. Reflection is the necessary bridge to move from emotions to behavior. Our experience affirms the effectiveness of using the movie clip methodology because of their brevity, rapidity, and emotional intensity. Bringing clips from different movies, to illustrate or intensify a particular point, fits well with this modern living state. By allowing reflections on emotions, participants in these sessions can learn to develop their reflective abilities and attitudes. These skills and attitudes, in turn, can help create more humanistic, and presumably more ethical, physicians.

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### Keywords

Medical humanism · Empathy · Palliative care · Narrative medicine · Cinema education · Humanities

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## 26.1 Technology and Humanism: Finding a New Balance

We live in an era where outcomes, guidelines, and clinical trials are at the forefront of medical training. We observe well-trained technological physicians with a reduced humanistic perspective which leads to attitudes that lack ethics and professionalism. Maybe this is because objective knowledge is considered scientific and valuable, whereas subjective information is thought to be “soft” and second-rate. For the relief of suffering, that conflict is not only false but an impediment [1].

Doctors exist to care for patients. Nevertheless, the frequent dissatisfaction of patients points more to the human deficiencies of medical professionals than to their technical shortcomings. Complexity comes mostly from patients, not from diseases. While technical knowledge helps in solving disease-based problems, the patient affected by these diseases remains a real challenge for the practicing doctor.

There is a growing concern about the human dimension of the future physician and how it can be taught or reinforced in the educational environment [2]. Emerging technology tends to monopolize students' attention and learning efforts, often at the expense of other important aspects of medicine. In addition, medical students are, in general, young people who are learning to be physicians at the same time as they are developing their adult personas. Medical educators must recognize this and provide ways for students to reflect on general subjects related to culture and the humanities from the medical perspective. Although technical knowledge and skills can be acquired through training with a little reflective process, it is impossible to refine attitudes, acquire virtues, and incorporate values without reflection.

Researchers on this subject [3] comment on the balance that always existed in medicine, between the two inseparable facets that compose it: medicine as science and medicine as an art. The vertiginous scientific advances would require, to maintain that balance, an extension of the scope of humanism, that is, a humanism at the height of scientific progress. And it would be this expansion of humanism, adapted to the current days, in a modern version.

When this humanist update is missing, it falls into a disproportion that is reflected in technically trained professions but with serious human deficiencies. Deformed professionals, with hypertrophy, without balance, who naturally do not conquer the confidence of the patient who expects a balanced doctor. It would be, therefore, a function of the university and the academic institutions, to expand the humanist concept in modern molds, without the aroma of mothballs, knowing how to open horizons and new perspectives. For achieving this goal, methodology, systematics, and relearning to do things are required; specially when these things are too many, wrapped in high technology, and commanded by the scientific progress that advances for seconds [4].

The French thinker Gustave Thibon [5] brings together in a volume a set of essays, to which he gives the title "Balance and Harmony." The balance is the composition of opposing forces, compromise solution, resulting from vectors that cancel each other out. Harmony is the perfect fit of the parts into a whole, so that they collaborate for the same purpose. And, quoting Victor Hugo, he comments: "Above balance is harmony, above the balance is the harp."

When we look at the actions that seek to humanization—without achieving it—we realize that the mistake is, perhaps, in seeking balance and not harmony. The balance assumes that the forces are antagonistic and that modern science supported by evidence has to be seasoned with humanitarian attitudes, for example, hearing the patient's history with love and feeling compassion. We recognize that this is already an enormous progress and an advance on what, unfortunately, we contemplate daily, where the patient is a mere adjuvant that often disturbs the doctor's practicing. But that balance is insufficient; it lacks consistency. They are still two

attitudes that do not mix, like water and oil: the clear water of the evidence, and the comforting oil. But each of them with its own density and applied each to its time and in its moment. This “medical performance schizophrenia” is unsustainable in itself, it lasts for a short time, and when the doctor gets tired, he will pay attention to one to the detriment of the other.

Medical science, cutting edge medicine, demands a new humanism [6]. A position that knows how to place liver function and neurological sequelae in the same reasoning, with the meaning of life, transaminases and albumin combined with humiliation, suffering, and loss. A science that is art and therefore manages to place in the same equation dimensions so different that apparently do not mix. In truth, they are completely mixed in life: prothrombin and discouragement, neurotransmitters and tiredness of living, and hepatocytes and indignation.

This seems to be the time to invoke the construction of harmony, and know how to play, with different strings to get the perfect chord. Balance is to assume a monotonic composition, science, art, a bit of albumin, and measured doses of affection. Harmony is to put each competence in its place and have the soul of an artist to know how to play in the harp of life—of that person who is unique—the strings of different shades. These are the chords that allow the doctor to travel the path between the sick person and the meaning that the disease has for the patient, which is way of being in life. A way of life that has its own language and must find, in the sensitive physician, the receiver necessary to properly decode the meanings. This implies for the doctor to have an attitude of active anthropology: humanism and anthropology are possibilities of his self-demand, challenges to his rational thought, levels of knowledge in style, and ascending aspiration of non-conformity [7].

Humanism is thus a source of knowledge that the doctor uses for his profession [8]. Knowledge as important as those acquired by other paths that help you in the desire to take care of the human being who is sick. Humanism in medicine is not a temperamental question, an individual taste, not even an interesting complement. All that would lead to place “humanist attitudes” on the scale, to compensate for the excesses of science. Humanism as harmony, as musical virtuosity, is, for the doctor, a true work tool, not a cultural appendix. It is a scientific attitude, weighing the result of a conscious effort of learning and methodology [9, 10].

The doctor’s inspiration will often come from the cord of compassion that vibrates easily in a heart willing to help. That will be the note that will give the tonality for the further development of its performance, for the harmonic chords of clinical reasoning. Gregorio Marañón, a humanist doctor and a profound connoisseur of this harmonic symbiosis, warns: “The doctor, whose humanity must always be alert within the scientific spirit, must first count on individual pain; and although he is full of enthusiasm for science, he must be willing to adopt the paradoxical position of defending the individual, whose health is entrusted to him, against his own scientific progress” [11].

In this context, the narratives and life stories, now complete and harmonious—transaminases and distresses, albumin, and heartbreak—have their true space and function: to approach the human being who suffers and awaits our care. Once more

Marañón gives us a reflection in perfect chord: “On several occasions I noted to those who work by my side, that a pure diagnostic system, deduced exclusively from analytical data, dehumanized, independent of the direct and endearing observation of the patient, it implies the fundamental error of forgetting the personality, which is so important in the etiologies and to stipulate the prognosis of the patient and teach us doctors what we can do to alleviate their sufferings” [11]. We know well from our own experience how difficult this harmony of action is: how to govern technique and humanism with expertise so we can offer a true symphony of health care [6].

The first step that the doctor must take if he wants to humanize medicine is admitting that he must humanize himself first. And for this, he cannot give up his efforts to reflect, to look for solutions, and to find resources that allow him to integrate technical science—which grows every second—with the humanism that medical practice requires [12].

Hans Jonas, with his ethics of responsibility [13], points out that what distinguishes human beings from animals is a tripod constituted by the tool, the image, and the tumulus. The tool is the technique, and in this there is no doubt that we distinguish ourselves from animals, because when we are born, we quickly incorporate all the techniques accumulated in the history that precedes us. Animals lack a scientific heritage, and each one has to be built from scratch, without taking advantage of the experiences of the ancestors of their species. We can evoke Ortega [14] when he says that the current tiger is the same tiger of thousands of years ago and that only the human being is born on a history that precedes him, a history that sets together the technique and the corresponding progress.

The second element that distinguishes us from animals is the image, which includes the ability that mankind has to represent reality through art. Art and humanities are ways to better know the reality in which the human being is immersed and to know himself, in his bodily and spiritual dimension. Finally, the third leg of the tripod is represented by the tumulus. Only the human being has an awareness of transcendence, and the representation of death is what puts him in contact with a dimension that extends beyond his own being.

It is not difficult to conclude that if, as far as technique and progress are concerned, being noticeable the distance between mankind and animals, the other two elements of the tripod have been atrophied; and if not for that reason we necessarily become animalized; there is no doubt that the human equilibrium presents itself with dangerous instability. The man—the doctor, in the case at hand—stops frequenting the arts and humanities and deprives himself of ways of knowing the world and loses the ability to admire and feel that most of the phenomena that surround him are independent of him. And, not least, he loses the sense of transcendence, the spiritual dimension, the sense of eternity, and the duration of time around him and his own. The consequences are alarming, because of not frequenting “the tumulus, door of transcendence,” it becomes difficult to maintain the sense of mission, and the need to feel useful in this world, as part of the happiness we pursue. This reflection opens the way to the next point: the necessary contingency of the human being, surrounded by suffering and death.

## 26.2 Regarding Suffering and Death: Are We Educating Doctors for Immortal Patients?

Human suffering and death are a constant presence in medical practice. However, it is quite common to observe healthcare professionals having difficulties to deal with this subject. Death is a phenomenon that disrupts medical practice. However, it can't be seen just as an unhappy event that keeps doctors from having a good performance [15]. Doctors commonly forget that death is a real possibility and usually consider it a failure. We can observe physicians that, although able to use high-level technology, do not feel comfortable in dealing with incurable patients, in which the scientific knowledge does not work and their technical skills are not enough. As a result of our predominant model of teaching and practice of medicine, the idea that there is nothing to do for terminal patients can be deeply rooted in some medical students and doctors. Nevertheless, clinical experience with such patients is essential in medical education because doctors will commonly face this situation in their activities [16].

While we ask ourselves why this happens in medical education, the reflection raises a paradoxical theme: will we be training future doctors to take care of immortal patients, in which the possibility of suffering and death are contradictions that are not considered?

This paradox leads us to the classical aphorism that represents the doctor's mission. "Heal a few times, relieve often, always comfort," a famous statement, repeated countless times and credited to professors, leading exponents of medicine, and even Hippocrates himself. However, it is reasonable to think that the father of medicine would not have simplified the function of the physician, much less spelled out the known postulate in that order. In ancient Greece there was little that could be healed and much that could be relieved with comfort. I like to imagine that Hippocrates would have formulated the aphorism in reverse order: always comforting, relieving when it is possible, and sometimes—very few—provide the cure, a more Copernican than Hippocratic turn that sheds light on these considerations.

Of course, people keep dying. This is the destiny of the human being. However, technical progress inevitably makes us think that we have gained ground in the fight against death. In fact, it is true. We won more battles, we postponed the invasion, but in the end, we will always lose the war. It's a matter of time. After all, who is the doctor to whom patients do not die? Death is the only certain thing about human happening, and the doctor is in the way of this obligatory exit. All his skill will be in knowing how to "dilute his technique" in a humanitarian vehicle so that everyone—patient, family, and himself—can digest, with meaning and transcendence, the natural contingency of life, for which the more accurate science will always be insufficient [15].

Let's return to our aphorism. What can one expect when the doctor's recommended order is to heal, relieve, and ultimately comfort? It is logical to think that I am moving from the most important to the least, to the detail. When I can't heal, I must relieve. And when I can't even relieve, I have just to provide comfort.

Proceeding in this sequence inevitably presents relief and comfort as a consolation prize (to the doctor) that has come across an incurable, painful, terminal illness.

The basic mistake is not to contemplate the epidemiology (incidence, prevalence) of these terms. While comfort is something that should always be done, due to the very high prevalence, healing has a much lower prevalence. It would be logical then that the process of medical practice contemplates this proportion to produce better doctors. Doctors who always know how to comfort—because they have learned that this comes first—and depending on the case and the illnesses they face, also know how to cure when it is possible. That is to say, since healing is not so frequent and life is inexorably moving to its end, it would be necessary to demand from the doctor the other skills, which are much more frequently used. A doctor who does not know how to comfort or relieve cannot be credited as such, should not have a medical degree, or cannot be able to act professionally. In short, the order in which the factors are taught does alter the final product [17].

A recent work [18] explains these shortcomings in the education of medical students and, consequently, of the doctors who enter the labor market. The author, a renowned surgeon, talks about the misunderstanding of the medical student who joins college wanting to take care and over time forgets the patients because he is too busy with medicine. Gawande explains the reasons for the distraction: “What concerned us was knowledge. Although we knew how to show compassion, we could not be sure that we would be able to properly diagnose and treat our future patients. We paid college tuition to learn about the body’s internal processes, the complex mechanisms of its pathologies, and the wide range of discoveries and technologies accumulated throughout history to prevent them. We had no idea we needed to think more than that. (...). Be helpful to others, but also technically competent and able to solve intricate problems. Competence brings us security, a sense of identity. I dedicate myself to a profession whose success is based on its ability to fix. If your problem can be fixed, we know exactly what to do. But what if you can’t? The fact that we do not have adequate answers to this question is disturbing and causes insensitivity, inhumanity and great suffering.”

Medicine is not an exact science and necessarily has flaws that can only be repaired with love and dedication. When this is not understood, when a doctor presents medicine in its technological fantasy as an exact science, it must also pay the consequences of failure. In the case of an engineer, a bridge he builds will not fall (unless earthquakes or unforeseen occur) if his calculations are accurate, and such accuracy is not difficult to achieve. If the doctor wants to present himself as a technician, such as a people mechanic, he must accept the punishment if he does not make the right calculations to “fix the damage.”

Medical error is above all a shortcoming in the humanistic field. What protects the doctor is the patient’s confidence; but the patient loses it when the professional appears as a brilliant technician but unable to approach the patient and tune with his affection. When the patient notices that the doctor lacks the human dimension and presents himself as an expert concerned solely with repairing the malfunctions, he will ask for satisfaction and demand compensation if the practitioner cannot keep his promises. When we explore the patient’s complaints about the doctor’s attention,

we always find insufficiency in the affective ground. We then found that all that “medical error” started because “the doctor didn’t even examine me” or “the doctor didn’t explain anything about what could happen” and “didn’t pay attention to what I was talking about.” The blow that is accused is always in the soul, not the technical deficiency: this comes later, to embody the process. It is worth recalling an example cited by Mendel in his classic book, *Proper Doctoring*: “The patient may stop taking a medication because he realizes that it is bad for him. We must take into account these intuitions of the sick. The doctor who is not humble and does not pay attention to patients is the best candidate for a lawsuit.” [19]

In a correct synthesis, Marañón [20] clarifies the theme further: “The sin of doctors in recent years has been to abdicate all that our mission had of fullness, generosity, and priesthood—to use a commonplace—and try to convert it in a scientific profession, that is, as exact as that of the engineer or the architect. [...]. In the end, everything will turn against the doctor himself, because, even if he wants to, his science will be embryonic, full of gaps and inaccurate aspects. These flaws can only be filled by love. Its exclusively scientific prestige will inevitably be subject to serious and continuous breakdowns. And that is why the doctor will be deprived of the cordial respect of his patients and of society itself, who will not accept his mistake generously but will peek at his flaws, pursuing him wherever he is.”

A training that goes beyond technique is needed, to know how to face death professionally. It takes attitudes, values, how to deal with the meaning of life, understanding the vital moment, as well as modern techniques, procedures, and resources for the proper performance of this function. The physician must have a “healthy nonconformity” with the technique, an attitude that pushes him to seek, in his training and professional practice, other dimensions that will be essential to face situations that are beyond technical boundaries. This is how the structure of the professional, technical, and humanist is built at the same time, capable of taking on these challenges.

Death management is a technical function of the physician to prepare for and the wrong order in which the factors of the aphorism previously mentioned are usually presented does not help. This is a peculiar technique as it should not modify the final outcome of the intervention. It does change the process of how the situation evolves. In other words: everyone will die someday; the difference is in the way they die. Then comes the technical, managerial function of the doctor [21].

Death management always means asking yourself what is best for the patient before taking “usual” measures such as unnecessary hospitalizations, ICU transfers, obstinate, and naturally ineffective therapies when the dying process occurs. Ask yourself, before taking it, what I expect from this measure, this prescription. And, in dialogue with the family, make the decision personally, without dividing responsibilities, assuming the conduct with professional character. Managing death implies the simultaneous care of the patient and the family. The family raises questions that are “of little technical character” but of vital importance. They want to know, for example, if the patient is suffering and if anything else can be done. And they always require explanations of what is happening.



The physician cannot get tired of repeating the explanations knowing that it takes time for the family to digest the situation [22]. The doctor's words are a resource that facilitates this process of adaptation, and he cannot spare them. It is not a question of explaining a pathophysiological problem but of making a vital understanding, with all the burden of normal feelings in the situation, which is happening to the dying relative. It takes time and patience. Letting the family participate in the process of dying with the patient eliminates many doubts and burdens of conscience a posteriori. When the family is participating, seeing, and touching the patient, one does not wonder after he passed away if he could have done anything more for him, as they experienced the whole evolution. Consider here a reflection on the unnecessary distance from the family in ICUs, limited visits, and all this universe that deserves a particular approach.

Patients know more than the doctor thinks they know. It is an added sense of vital realism that the condition of dying gives them. That's why you expect from the doctor realism, comfort, and professional support. Both the patient and the doctor are harmed by their attitude that they "give up" because it is a "terminal case," as well as the one who intends to deceive the patient as if nothing serious was happening. The physician requires a thoughtful, realistic attitude, imbued with the virtue of prudence in true paradoxical balancing. And, considering that, be active, participate in the process. That is why it is worth remembering the words of a humanistic doctor, an expert in ethical questions: "A truly dignified death is not only the absence of external tribulation. Dignity in the face of death is not conferred by something external but arises from the greatness of mood with which one faces this unique situation. Therefore, to die with dignity means not just being patient, but being an agent. Be active, participate in the process" [23].

It is not superfluous to warn that, curiously, those who technically try all the resources to prolong life, "even against common sense," are the first to give up the patient when he/she goes into terminal phase and "refer the case to someone else." It is increasingly rare to see "super specialists" with the dying patient when there are no more therapeutic resources to employ. This attitude can be justified by feeling a certain discomfort of "not doing anything for the patient," which is not true. In fact, with their presence the doctors are doing a lot. It turns out that simply doing something that, while not being quantifiable, seems not to be useful. This is logical, as the utility was wrongly evaluated with purely technical parameters. The fact that this attitude cannot be measured in milligrams and therapeutic doses does not speak against the importance of it. A mother's love for her sick child cannot be represented in therapeutic dosages, but its efficacy is undeniable. The doctor should be there with love, but as a doctor—not like the mother—and here is the key to his professionalism.

To perform this function professionally requires realism and competence: competence to eliminate pain, control symptoms, and offer a quality of life. These are the elements that introduce us to palliative medicine, a modern approach to

managing human finitude, which presents itself as the best antidote to the easy and unethical solution of euthanasia. When a patient who suffers says, “Doctor, I don’t want to live,” he is basically saying, “Doctor, I don’t want to live this way.”

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### **26.3 Palliative Care: A Humanistic Approach to Human Contingency**

Palliative medicine is the study and management of patients with illness in which cure is no longer possible and an end point of death is expected within a finite period of time. The focus is on the control of symptoms and maximizing patient’ self-defined quality of life [24, 25].

The complex goal of relief suffering can’t be one-dimensional but must include the four human dimensions of human experience: physical (pain, dyspnea, cough, constipation, delirium), emotional (anxiety, depression, grief), social (financial concerns, unfinished business), and spiritual (guilt, sadness, worthlessness). To provide this complete assistance, palliative care is usually made by an interdisciplinary team [24].

According to World Health Organization, palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual. Palliative care provides relief from pain and other distressing symptoms; affirms life and regards dying as a normal process; intends neither to hasten or postpone death; integrates the psychological and spiritual aspects of patient care; offers a support system to help patients live as actively as possible until death; offers a support system to help the family cope during the patient’s illness and in their own bereavement; uses a team approach to address the needs of patients and their families, including bereavement counseling, if indicated; will enhance the quality of life and may also positively influence the course of illness; is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy; and includes those investigations needed to better understand and manage distressing clinical complications [26].

The evidence shows that the lack of palliative care training can be negative to doctors and patients. Medical educators agree about the need of teaching such a discipline, which has been introduced in some medical schools’ curricula around the world. In the USA a survey had demonstrated that most medical schools do not provide palliative care knowledge during graduation. The researchers suggested the implementation of a palliative guideline in the medical curriculum [27]. In our country, Brazil, palliative care is an “emergent specialty,” that is performed by clinicians, a few oncologists, or family doctors. We believe that, because of the inherent characteristics of family medicine, the training of residents of this specialty in palliative care is indispensable [28].

Experts agree that experientially based and developmentally appropriate ethics education is needed during medical training to prepare medical students to provide excellent end-of-life care [29].

Because many doctors did not receive any kind of formal training in communicating skills and palliative care, they are not able, for example, to give bad news properly. Medical students don't learn anything about how to deal with the feelings that emerged in such a context. On the contrary, they are told to keep distance from the patient and relatives, never touch or kiss them, not sit on their beds, and just use technical gesture [30]. Realizing that such attitude does not work, the trainees became receptive to the new approaches they were presented to and could, day by day, learn to face death, pain, and suffering as naturally as possible, as events related to human life, but without losing a respectful attitude.

The medical educators noted a necessity or the importance to teach palliative care and are trying to improve this in medical school. There are evidences showing that the lack of palliative care training can be negative to doctors and patients. For example, an ineffective doctor-patient communication can affect the patient's satisfaction [27]. The barriers for an adequate care are from three types: no specific training, personal attitudes against death, and political disinterest [31].

### **26.3.1 Family Doctors and Life Stories in Palliative Care: A Successful Educational Scenario**

The reason to have a family doctor in a palliative care service becomes clear if we understand the principles of family medicine that is a specialty focused on the person. The field of action of family medicine is primary care, medical education, and leadership. The family doctor is a specialist in people [32]. Family medicine participation in palliative care occurs because both specialties focus on continuity of care, prevention, and family study. Family medicine's philosophy promotes doctors that have the objective to improve health and quality of life. The doctor-patient relationship doesn't end with some incurable and death disease, even with the patient's death, because the relationship with the family goes on after that [31].

Medical students and residents usually do not learn how to deal with the feelings that emerge when caring for dying patients. On the contrary, they are more likely to be told to keep a certain distance from the patient and their relatives [33]. Realizing that this kind of attitude is harmful, the trainees are usually receptive to new approaches.

A lived experience in a didactic palliative care ambulatory clinic (PCAC) addressed to medical students and residents showed us that such a clinical setting can provide a unique training apprenticeship. The teaching involved specific issues like controlling pain symptoms but went beyond to include the more subtle aspects of caring for dying patients. Residents and students could learn that family physicians need skills in palliative care since they frequently encounter dying patients. They realized that family members play an important role in a patient's end-of-life period and must also receive support. They could learn to face death, pain, and

suffering as naturally as possible as events that are part of human life but without losing a respectful attitude.

The young doctors usually started the training in the PCAC in a fearful way, feeling that there was nothing to do in the situations they are about to face. Nevertheless, their evolution in such scenery was surprising. The PCAC promoted a very special apprenticeship and brought deep and wide insights for SOBRAMFA's educational projects. Such an apprenticeship could be also extended to other settings of practice and improved the student's and resident's performance in circumstances not so complex. The learning was related to technical issues like the control of symptoms but went far beyond. This included being attentive to the subtle aspects involved in patients' care. Residents learned that, concerning family doctors, to get skills related to palliative care is a very important task since they frequently must face patients in such conditions. They developed discernment for recognizing the proper moment to send terminal patients to hospital or hospice and could realize that family members play an important role in patient's end-of-life period and must receive the proper support in order to help them effectively [34].

It was evident that the outcomes outlined here, in some way, were a consequence of the application of a narrative approach at the PCAC. Beyond the technical and pharmacological support offered to patients, the application of narrative as a therapeutic and didactical tool is one of the resources explored. A text recommended for reading was considered fundamental and clarifying—"Just Listening: Narrative and Deep" Illness by Arthur Frank. In this article, the author teaches us that by listening to terminal patients with empathy and compassion, we can make them feel they are not alone, a frequent sentiment they experience, which allows them to transform their chaos stories into quest stories, in which their illness becomes a teaching condition for all involved in the situation. For him, quest stories are stories of transcendence. When terminal patients find an attentive listener and a compassionate witness, they have the opportunity to organize the chaos produced in their lives by the illness and to find a meaning that allows them to accept life unconditionally. At the first readings of the mentioned article, some of the trainees manifested an apparent doubt and thought that those conceptions could not be effective in real life. But, in the course of time, they could realize that Frank's ideas are actually applicable in palliative care. And, for them, the author became very appreciated, a model to be followed [35].

For all participants in that scenario of practice, it was difficult to deal with so many emerging chaos stories, exactly the ones that the doctors would like to ignore, because such stories make them feel a sensation of incapacity and emphasize the questions that have no answer. After such experiences, the students and doctors often need to share narratives and to tell their own stories in order to transcend chaos into quests of their own. After a discussion related to the technical aspects of consultations, the activities in the clinic were closed with an exercise of reflective writing. Such exercise was effective in promoting reflection and an excellent tool for dealing with chaos stories [36]. The reflective writing [37]—an element of narrative methodology—played a key role in promoting reflection and demonstrated to be an excellent instrument for helping trainees to deal with pain, suffering, and death.

Nowadays, more and more authors agree that the use of talking and writing in prose or poetry to express feelings that one has difficulty to deal with has a healing effect [38, 39], which is entirely consistent with our practice in palliative care clinic.

This approach has motivated the creation of many stories during the 3 years of palliative care ambulatory' activities, stories told, written and rewritten by patients, students, patients' family members, doctors, and residents. The feelings, interpretation, and points of view of each involved in a story certainly influence the way he/she will present it. The different people involved in a given story experienced it according to their own perspectives and interpretations. The same situation can acquire unexpected meanings for each one of us and usually provides unbelievable lessons of life. When health professionals listen to their patients with empathy and compassion, they participate in the creation of a new script in which one can detect elements of overcoming and transcendence demonstrating that the course of the story was changed. Even though the end of a palliative care story is immutable—the inexorable death—it can be written in diverse ways. Certainly, the drift of the changes can depend on the way the patient-doctor and family-doctor relationships are constructed. And a great apprenticeship was that when there is apparently nothing to do, one can still listen [36].

Narratives in the suffering context led trainees to recognize little facts and changes and how doctors can create and make the entire difference. And first of all, they need to learn that there is always something to do. Doctors can help their patients with their technical knowledge and experiences. But we can do more, being really present and interested in patients; use our honesty, humility, and compassion; listen with attention; and fight for our patients; they know how to utilize our help [40].

The objectives of providing skills for an initial approach to terminal patients and families, promoting reflection about difficult themes, and breaking blockages that prevent students to deal properly with terminal patients were fulfilled. Trainees could learn that when doctors act with goodwill, humility, compassion, and honesty, patients and their families always benefit. The medical educators noted the need to foster reflection among young doctors, and this could be done through narratives, especially in a palliative care setting since the lack of palliative care training can be negative to doctors and patients [41]. The technical knowledge provided in palliative care ambulatory clinic allied to the creation of an ambiance propitious to reflection made it, in an educational way, a unique setting to a continuum learning that is essential for family doctors' schooling.

The proper management of terminal outpatients in a holistic way; the abolition of the idea that palliation is not a failure of treatment and an uninteresting demand; the understanding that when prolonging life and healing patients with interventional approaches is no longer indicated and palliation is the only possible conduct, to work under such a perspective is a very significant objective; and the apprenticeship that, concerning terminal patients and their families, there is always something to do are the lessons that all participants in this didactic life experience will take to live. It is important to remember that for us, SOBRAMFA's doctors who supervised the activity, the learning was also enormous. And over the years, we could get many

teachings about life, death, pain, suffering, transcendence, empathy, compassion, friendship, peace, and liberation which inspire us still today in the practice and teaching scenarios of palliative care in which we work today. And it is necessary to emphasize that, over the years, we have been able to incorporate many teachings about life, death, pain, suffering, transcendence, empathy, compassion, friendship, peace, and liberation, which still inspire us today in the scenarios of palliative care practice and teaching in which we act today.

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## 26.4 Meeting Patients' Needs Through Empathy: An Educational Challenge

Empathy, from the Greek *empathēia*, means understanding someone else's feelings. In the English vocabulary, empathy was used initially to describe the observers' feeling when interfacing with artistic expression. Afterwards, the term was related to understanding people, and in 1918, Southard incorporates the word empathy into the doctor-patient relationship, as a resource for facilitating diagnosis and therapeutics [42]. Empathy has to do with deeply understanding the other and is a path to bridge scientific knowledge with compassion for better caring.

Empathy, one of the most studied humanistic attitudes today, is the cornerstone of ethical and humanized behavior and medical professionalism. Empathy has also been considered an essential element in any humanization strategy [43]. It is a personal quality necessary for understanding the inner experiences and feelings of patients. It represents the essence of the doctor-patient relationship. Developing meaningful interpersonal relationships between patients and physicians is important even for improving clinical outcomes [44].

Before entering into the concept of empathy in the context of the patient-physician relationship, it is worth pausing to understand the term from a philosophical point of view. In this field, we cannot fail to cite the work developed by Edith Stein (1891–1942), a philosopher who developed his doctoral thesis on empathy. Macintyre [45] in his book on the philosophical action of Edith Stein comments that an essential feature of empathic awareness is the awareness of the feelings of others. The relationship we have with the feelings of others is analogous to the relationship we have with our own past feelings. We may notice what the other is feeling, but we don't have to feel the same as him/her. The same is true; when we remember our own feelings—even clearly—it does not mean that we will feel the same way we have in the past. A deep understanding, real understanding, no need to incorporate it. We can fully understand what we feel on one occasion, but we do not have to feel it equally at this time.

It takes caution to state that “I am putting myself in another's shoes.” Yes, it is possible to do so but with our own patterns (our feelings, our reactivity, our understanding of vital reality, our own biographical history) and not his own, so that I cannot truly understand. It is not enough to put ourselves hypothetically in the other's place and continue to be ourselves experiencing this place in which I place myself. One must also be detached from one's own standards to arrive at empathic

knowledge. Regarding this perspective Stein reminds us that empathy is not simply intuition, but an attitude that requires reflection, to turn back and again on ourselves and others, a course that enriches one's own and others' knowledge. It is not a spasm of knowledge but something worked.

In the context of medical education, the concept of empathy has a broad and varied spectrum. Some authors consider empathy to be a predominantly cognitive quality: it would encompass the understanding of the patient's experiences and concerns combined with communication skills [46]. Irving and Dickson [47] define it as an attitude that contemplates behavioral ability along with the cognitive and affective dimension.

Most authors place empathy on the affective dimension, giving it the ability to experience the other person's experiences and feelings. In this case it can be deduced that the ability to be empathic implies a spontaneous feeling of identification with the suffering person, a process in which emotion is involved.

The majority of the authors with an affective-oriented approach presuppose that, during the empathic event, there is something that can be characterized as a partial identification of the observer with the observed. This aspect also becomes clear especially in Carl Rogers' definition, which describes empathy as being the ability "to sense the client's private world as if it were your own, but without losing the 'as if' quality." According to this definition, the differentiation between one's own experience and the experience of another is the decisive criterion for defining effective empathy [48].

Other authors [49] stress the importance of making a distinction between sympathy and empathy; in particular, arguing that such a distinction has significant implications for the relationship between patients and clinicians because joining with the patient's emotions can impede clinical outcomes. Moreover, a clinician who is merely sympathetic in the clinical encounter can interfere with clinical objectivity and professional effectiveness. The sympathetic doctor cares about the quantity and intensity of the patient's suffering, while the empathetic doctor cares about understanding the quality of the patient's experience [46]. These authors' general conclusion is, therefore, that sympathy must be restrained in clinical situations, whereas empathy does not require a restrictive boundary [50].

In practice, separating emotional from cognitive attributes is very difficult. However, two conclusions might be drawn from our discussion of definitions and our questions regarding the right location (affective, cognitive, or both) in which empathy occurs.

First is that a prerequisite for both affective and cognitive empathy is that an individual should not be overly preoccupied with himself and his own concerns, because, if the experience is to a greater extent focused on the individual himself, then the willingness to help the other person decreases [51]. Only through self-awareness is it possible to see the behavior of the observed person as an expression of his emotional state and to make a mental distinction between oneself and the "other self." The second conclusion is that empathy could bridge the provide gap between patient-centered medicine and evidence-based medicine, therefore representing a profound therapeutic potential.

And here we come to the educational issue. Can empathy be taught? Is it possible to establish a learning process for empathy? The constant question is always if empathy can be taught [52, 53].

### 26.4.1 Teaching the Non-teachable Issues

A classic study published years ago comes to mind [54]. This study was mainly designed to help medical school admission committees to better select college students for medical school. The authors of the study emphasized that it is probably more important to select college students who will be superior physicians than to select those who will be excellent medical students. Based on a previous publication, subjects were asked to rank order list of 87 characteristics of a superior physician considering the importance of each characteristic and how easily it could be taught. Those ratings were validated by high correlations across several subgroups. The importance and the teachability ratings were combined into a non-teachable important index (NTII) that provides a rank order of traits that are important but cannot be taught easily.

This study aimed to determinate the important qualities of a superior physician that cannot easily be taught in medical school or later training. The authors proposed to select college students for medical school not only on the basis of academic achievements, but also on the basis of characteristics identifiable in the college student that predict excellence in the physician who many years later will emerge from our educational system.

The NTII generated by this study gives equal weight to the importance and to non-teachability. The top of the list comprises qualities closely related to empathy: understanding people, sustaining genuine concern for patients, motivated primarily by idealism, compassion, and service; oriented more toward helping people than making income; enthusiasm for medicine and dedication to his work; and ability to get the heart of a problem and to separate important points from details and adaptability. All those qualities score high in the NTII index, which means very important and difficult to teach. This is the real challenge for teaching empathy.

Some neurophysiological studies bring certain clues [55, 56] to solve the dilemma of how to teach something that is difficult to teach. Even though empathy is a nontraditional teaching content, it might be promoted through examples and role-taking through which the neurophysiological indicators of empathy could be activated. There are some neurons in the brain which can control certain actions (e.g., behavior or emotion) in the body and can even be activated if the same action is observed in another person. Known as mirror neurons, these nerve cells respond spontaneously, involuntarily, and even without thinking [57]. Mirror neurons use the neurobiological inventory of the observer in order to make him feel what is taking place in the person that he/she is observing by way of inner simulation. Various experiments conducted by the so-called “social neurosciences” document the functioning of the mirror neurons with regard to the empathic perception of the other



person [58, 59]. The functioning of mirror neurons is, therefore, an essential prerequisite for empathy [60].

Nevertheless, another question rises up in this mirroring role model theory: is a subsequently learned empathic ability authentic, or does it give a patient the impression that it is an artificial and superficial behavior (i.e., a routine checklist of empathic actions that a clinician is simply required to go through)? Do clinicians need to have previous experience being patients themselves or to witness their family/friends being patients in order to be more empathic? These questions can have great implications for medical education and medical care considering that empathy seems to be a determinant of quality in medical care because it enables the clinician to fulfill key medical tasks more accurately, thereby leading to enhanced health outcomes.

Those who are involved in medical education know that a broad range of biographical experiences and situational factors influence the development and promotion of empathy. Part of these experiences could be the role model teaching scenario, in which students and young doctors are inspired by the teacher's attitudes in dealing with patients. The tag-along model allows medical students to incorporate attitudes, behaviors, and approaches to real patients and identify emerging issues useful for their professional future [61].

Beside tag-alongs, some authors emphasize the importance of art, literature, cinema, and reflecting over one's own life in developing empathy [62]. Literature has plenty of examples and choosing appropriately is always a dilemma. In *A Fortunate Man* [63], a classic book about the story of a country doctor, there is a broad description of empathy, here called recognition. "The task of the doctor is to recognize the man. (...) I am fully aware that I am here using the word *recognition* to cover whole complicated techniques of psychotherapy, but essentially these techniques are precisely means for furthering the process of recognition. (...) In order to treat the illness fully, the doctor must first recognize the patient as a person. Good general diagnosticians are rare, not because most doctors lack medical knowledge, but because most are incapable of taking in all the possible relevant facts—emotional, historical, environmental as well as physical. They are searching for specific conditions instead of the truth about a patient which may then suggest various conditions. (...) A good doctor is acknowledged because he meets the deep but unformulated expectation of the sick for a sense of fraternity. He recognizes them. Sometimes he fails, but there is about him the constant will of a man trying to recognize."

Role modeling, giving the right example to follow, caring carefully for the emotional dimension of medical students, and for that using arts and humanities are possible resources for preventing the erosion of empathy. Because, at the end, it is not just about teaching how to be empathetic—people that enter a medical school already have quite a degree of empathy—but, mainly, to prevent of losing empathy through the so-called educational process that in many cases lacks this perspective [64, 65].

On the other hand, to teach ethics implies setting rules, guidelines, and rational decision-making. But it also requires creativity and acknowledgment of the affective aspects of our decision-making processes. We need, as teachers, to go beyond

instructions and perform a caring model pursuing excellence. Is it possible to get together prudence, wisdom, and creativity for a new ethics teaching model? [66]. Usually, ethical inquiries come involved in emotions, and those emotions cannot be ignored. Actually, they should be included in the learning process as an essential tool. To share emotions, in an open discussion surrounded by a friendly learning scenario, creates the path for affective education and fosters empathy that empowers patient care [67].

Teaching reflection is a goal for educators who want to move beyond transmitting subject matter content. These teachers believe that they will better understand their students and the nature and processes of learning if they can create more supportive learning environments. Effective teaching is often both an intellectual creation and a performing art [68]. Excellence in teaching requires innovation and risk-taking in dealing with sometimes unanticipated learner response. This is at the core of education and where the humanities and the arts have a place in responding to the challenge of teaching.

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## **26.5 Why We Need Humanities for Educating Patient-Centered Doctors?**

### **26.5.1 Humanities in Medical Education: From Emotions to Ethical Attitudes**

To care implies comprehending the human being and the human condition, and for this endeavor, humanities and arts help in building a humanistic perspective of doctoring. They provide a source of insight and understanding and enable doctors to understand patients in their whole context. For this reason, arts and humanities are not just appendages of the medical knowledge but necessary tools and sources of information for proper doctoring. They should be as much a part of medical education as training in differential diagnosis or medical decision-making [69].

Without humanism doctors would not be physicians but simply mechanics [15] (technicians who try to fix the immediate presenting problem, and nothing else). Teaching how to effectively take care of people requires creating methods that address the human aspects of medicine [70]. Humanities also offers a counterpart to the necessary reductions of the natural sciences. The unit of medicine is the particular patient, always irreducible. We know that medicine runs into trouble when individual persons are examined only with instruments that reduce specific meanings to simplistic data [71]. A new balance is needed to incorporate a modern perspective in medical humanism.

Arts and humanities, because they enhance an understanding of human emotions, are useful resources when incorporated into medical education. The students' emotions easily emerge through arts like movies, music, poetry; and teachers can impact student learning by broadening their perspectives of student development. In life, the most important attitudes, values, and actions are taught through role modeling and example, a process that acts directly on the learner's emotions. Because

people's emotions play a specific role in learning attitudes and behavior, educators cannot afford to ignore students' affective domain. Certain types of learning have more to do with the affection and love teachers invest in educating people than with theoretical reasoning [72]. Usually feelings arise before concepts in the learners. Understanding emotionally through intuition comes in advance. First, the heart becomes involved, and then a rational process clarifies the learning issue. Thus, the affective path is a critical way to the rational process of learning.

To educate through emotions doesn't mean that learning is limited to values and attitudes exclusively in the affective domain. Rather, it comes from the position that emotions usually come before rational thinking, especially in young students immersed in a culture where feelings and visual impact prevail. Thus, medical educators need to recognize that learners are immersed in a popular culture largely framed through emotions and images [73]. Since emotions and images are privileged in popular culture, they should be the front door for learners' educational processes. Emotions are a kind of bypath to better reach the learners, a type of track for taking off and moving more deeply afterwards, which requires fostering reflection on the learners. The point is to provoke students to reflect on those values and attitudes [74], with the challenge here to understand how to effectively provoke students' reflective processes.

Life stories and narratives enhance emotions and therefore lay the foundation for conveying concepts. When strategically incorporated into the educational process and allowed to flow easily into the learning context, emotions facilitate a constructive approach to understanding that uses the learners' own empathetic language. Furthermore, in dealing with the students' affective domain, the struggle in learning comes close to the pleasure felt, and it is possible to take advantage of emotions to point out attitudes and foster reflection over them.

The instructor's role consists not just in pouring out emotions but in catalyzing the process by which the audience moves from the emotions to immerse themselves in personal reflection and begin to generate concrete ideas for how, in specific and concrete ways, they can incorporate the lessons they've learned from the emotional experience into their daily lives. These experiences are real educational footprints and become open doors for generating attitudes that modulate behavior [75]. The first step in humanizing medical education is to keep in mind that all humans, including medical students, are reflective beings. They need an environment that supports and encourages this activity to refine attitudes, construct identities, develop well-rounded qualities, and enrich themselves as human beings.

Likewise, faculty members use their own emotions in teaching, so learning proper methods to address their affective side is a complementary way to improve their communication with students. Therefore, excellent teachers develop their teaching skills through constant self-evaluation, reflection, the willingness to change, and the drive to learn something themselves [76]. Faculty face challenges when they teach and have few opportunities to share them and reflect with their peers. Usually when teachers discuss educational issues with their colleagues, they often spend most of the time talking about problems instead of nurturing themselves. As teachers, we need to state new paradigms in education, learn how to share

our weaknesses and frustrations, and find resources to keep up the flame and energy for a better teaching performance. Humanities could be incorporated in faculty development strategies because they provide a useful peer reflective scenario [77].

### **26.5.2 Narrative Medicine: Reloading a Millenary Resource for Caring**

A predominantly biomedical focus attributed to teaching and practice in health sciences contributes to a dehumanization process. Any strategy that intends to address the issue depends on the presence of well-educated health professionals from both the technical and humanistic point of view. The greatest deficits concern humanistic education. Research about the effectiveness of using narratives as a didactic resource in humanistic education point out issues related to the concealed curriculum and the importance of medical students' exposure to a patient-centered teaching model that gives priority to ethical reflections [78].

It is true that narratives are an important educational topic in the context of family medicine. Narrations, life stories, which allow us to contemplate the patient's world, meet him as a person, so that we can take care of him in a competent manner. There is also a tendency to think that the narrations are just a complement to positive science, which is not possible to measure with laboratory results. Thus, it would be just a methodology that broadens a way of aiming to reach out to the person and focus on her care, without deterring the illness that affects her. That perspective takes the risk of being "complementary," that is, the soft edge of what really matters. The dissociation between science and art remains, as two forces that act synergistically, but in parallel, and therefore never found themselves. The medical action that would fall would be condemned to these complementary positions, in which competency and compassion never meet.

Medicine as art recognizes that each patient is unique. Not only from the perspective of the disease that attacks him/her, but in the way that pathology "becomes incarnate and concretized": this is an illness, being sick [79]. The disease is always personalized, installed in someone who will become sick "in their own way," according to their personal being. A bifocal perspective is necessary, which manages to unite in artistic symbiosis the attention to the disease—with all the technical evolution—and to the patient who feels sick, with the vital understanding that entails. This is a person-centered medical performance, simultaneous exercise of science and art [9].

To listen carefully is a skill that the doctor needs to heal [80]. This requires the rescue of the ancient resources of medical art [81]. Patients show subtle clues about their experience with the condition, but doctors often ignore them because we hear only "the voice of medicine" and have trained us to ignore the emotional side, that is, the "voice of the patient's life" [82].

Already in the middle of the twentieth century, Gregorio Marañón [11]—paradigm of art and science—warned off the danger of using purely technical tools without knowing the patient, without listening carefully, without really caring about

him: “It must be admitted that ordinary medicine is usually reduced, or to problems that are easy to solve, or completely insoluble for the most gifted man of wisdom. The fundamental thing in any case is that the doctor be with his five senses in what he is, and not thinking about other things.” When the doctor sits and listens to the patient, he is communicating a humanistic attitude par excellence. Today we have sophisticated technology—important—but we are losing the pleasure of sitting down and hearing narratives of life. We lack chairs or, perhaps, patience to sit and listen.

The inclusion of humanities in the curriculum occasions deep rethinking of what it means to be sick and what it means to take care of the sick. They also portray a tremendous spectrum of attitudes required for building ethics and professionalism. We need to be creative in using arts and humanities to effectively reach our students. This is why brief readings, pieces of art, music, and movie clips have a proper place in medical educating. They illustrate complex moral choices and stimulate comments and reflection. A well-known researcher in medical humanities quotes: “we are midwifing a medicine that makes contact with the mysteries of human experience along with its certainties—a medicine that appreciates the deep beauty of health, the silence of health, the wisdom of the body, and the grace of its genius. It is an arch to far times and places, a site for all the living and the dying that go on; it is a link to what it means to be human” [83].

Teaching through humanities includes several modalities in which art is involved [84]. Literature and theater [85], poetry [86], and opera [87] are all useful tools when the goal is to promote learner reflection and construct what has been called the professional philosophic exercise [88]. Teaching with movies is also an innovative method for promoting the sort of engaged learning that education requires today [89, 90]. For dealing with emotions and attitudes, while promoting reflection, life stories derived from movies fit well with the learners’ context and expectations. Teaching with films engages the emotions and could serve as a great launching point for discussions of both the emotions and ethical scenarios [91–93]. The crucial role of teaching is to help frame these discussions in such a way as to foster reflective practice among clinicians and clinicians in training.

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## 26.6 Teaching with Movies to Foster Reflective Practice

As film is the favored medium in our current culture, teaching with cinema is particularly well-suited to the learning environment of medical education. Cinema is the audiovisual version of storytelling. Movies provide a narrative model framed in emotions and images that is also grounded in the student’s familiar, everyday universe and stimulates a reflective attitude in the learner. We know that in the clinical setting, the life histories of patients are a powerful resource in teaching. Similarly, when the goal is promoting reflection that includes both cognitive and emotional components, life histories derived from the movies are well-matched with the students’ desires and expectations.

Life stories are a powerful resource in teaching. In ancient cultures, such as classical Greece, the art of storytelling was often used to teach ethics and human values [94]. Stories are one reasonable solution to the problem that most people, especially young people, can only be exposed to with a limited range of life experiences. Storytelling, theater, literature, opera, and movies all have the capacity to supplement learners' understanding of the broad universe of human experience. Exposure to life experience—either one lived or one lived through story—provides what Aristotle called catharsis. Catharsis has a double meaning, each of which deals with human emotion. Catharsis literally means to “wash out” the feelings retained in the soul. It also implies an organizing process in which the person sorts through orders and makes sense of emotions. In short, in the normal course of events, people keep their feelings inside, storing them in an untidy fashion, but don't think about them. Catharsis helps empty one's emotional drawers and reorganizes them in ways that provide a pleasant sense of order and relief.

Cinema is useful in teaching the human dimension of medicine [95] because it is familiar, evocative, and nonthreatening for students. Movies provide a quick and direct teaching scenario in which specific scenes point out important issues, emotions are presented in accessible ways where they are easy to identify, and students are able to understand and recognize them immediately.

In addition, students have the opportunity to “translate” movie life histories into their own lives, and into a medical context, even when the movie addresses a non-medical subject. Movie experiences act like emotional memories for students' developing attitudes and remain with them as reflective reference points while proceeding through their daily activities, including those related to their role as future doctors. Students identify easily with film characters and movie “realities” and through a reflective attitude gain new insights into many important aspects of life and human relationships. The educational benefit also is expanded by the phenomenon of students' “carrying forward” into their daily lives the insights and emotions initially generated in response to cinema experience. In other words, the movie teaching scenario acts like “an alarm” to make learners more aware when similar issues and situations occur in their daily lives.

For teaching ethics and the human matters of doctoring, which implies refining attitudes, acquiring virtues, and incorporating values, one can employ the purely rational method favored by ethics lectures and deontology courses. But movies offer another path: exposing learners to particular examples with strong emotional consequences to either follow or reject. The movie scenes lead the learners to reflect on where their own attitudes and responses will lead, not only intellectually but emotionally, both for themselves and others. In this way, bringing examination of emotional responses and their consequences into the discussion serves as an effective shortcut that helps reconnect learners with their original idealistic aspirations and motivations as physicians.

This learning scenario stimulates learner reflection. In life, important attitudes, values, and actions are taught using role modeling, a process that impacts the learner's emotions. Since feelings exist before concepts, the affective path is a critical shortcut to the rational process of learning. While technical knowledge

and skills can be acquired through training with little reflection, reflection is required to refine attitudes and incorporate values. The purpose of the film methodology is not only to evoke emotions but to help the audience reflect on these emotions and figure out how to translate what they learn into attitudes and actions. Reflection is the necessary bridge to move from emotions to behavior. The goal is to move beyond a specific medical solution to reach a human attitude in life that requires integrity and wholeness [96]. To foster reflection is the main goal in this cinematic teaching set. The purpose is not to show the audience how to incorporate a particular attitude, but rather to promote their reflection and to provide a forum for discussion. And this works for any kind of audience, despite cultural background or language [97].

Fostering reflection stimulates discussion about the interaction of health with the breadth of human experience, and this discussion often elicits profound conflicts and concerns about their future professional roles and as human beings. A new learning process is created, and through it the students are involved in an ongoing process of learning spread into their daily life. The movie teaching methodology stimulates their reflection and, through accessing learners' emotions, offers new paths to the rational process of learning. This is how we can foster reflective practice for the future doctors. A process that is at the core of ethical decisions: never giving up with reflection and never giving in with mediocrity, which in Hannah Arendt's words leads to the banality of evil [98].

Dealing with cinema education is also useful to lead clinicians and students in getting familiar with their own emotional responses, an issue often neglected in medical education. Little effort is exerted to develop emotional honesty in medical students or residents, either in terms of their own affective responses or in terms of their awareness of others' emotions. When students experience negative emotions and nothing is done to construct a real affective education, learners sometimes decide to adopt a position of emotional detachment and distance, and this comes to attitudes lacking professionalism [99]. Narrative films can provide valuable access to viewers' affective lives by "lighting up" disruptive or disturbing parts of the self that might otherwise be ignored or neglected. Because the characters portrayed in movies are "not real," learners can be more honest about their reactions than if they were discussing actual patients. This emotional honesty becomes a starting point for exploring emotional responses.

Movies allow us to go beyond the illustrations of theories and principles, so that we might develop not only a range of rational and analytic skills but also a range of emotional and interpretative ones, including those habits of the heart. The standard models of ethical decision-making so commonly taught in medical school classrooms, the step-by-step approach seeking for an answer, maybe one answer to a particular dilemma are somehow disrupted by the films, opening doors to multiple questions and may never fully resolve an issue [100]. Discussions among and with students and colleagues, independent of their level of knowledge and experience, are thought-provoking and can be intensely personal, transforming ethics education into a pendulous experience that oscillates from scientific debate to an exciting and often uneasy voyage of moral inquiry. This educational scenario forces us to reflect

on who we are, who we have become, and who we long to be. Before doctors we are human beings, and this is what lies at the bottom of any ethical decision.

In this sense, film, as art, can affect the root of our being. Using film clips in a structured way allows for new opportunities in ethics education. Here comes the specific methodology using movie clips.

### **26.6.1 The Movie Clip Methodology: Using Wisely Short Time Teaching**

Which movies are useful for teaching this or that point? This is a common question people ask. The answer could be something like this: “What you get out of a film often depends upon what you bring to it.” Useful movies for teaching whatever you want are those that are valuable to you and those that touched you and lead you to reflect. I can share what movies touched me and why, but I am not able to say what will impress you and be part of your life. When a movie seems remarkable for the educator, we always find the way to incorporate our teaching set. So you need to build your own experience before sharing it with your audience. Keep in mind what you want to teach, the specific ethical dilemma.

Using medical movies is similar to presenting a specific case—like problem-based learning—and discussing it. This is valuable, but not what we are trying to achieve. In our method [101], what matters is not the case or the situation that demands a particular answer. Our goal is to move beyond a specific medical solution to reach a human attitude in life that requires integrity and wholeness. We move from technical responses to deep reflection on how to call forth the best learners have inside themselves. The specific translational process is intentionally left up to learners as they encounter their own lives as doctors and as people.

Do you use a whole movie or just some scenes? Here comes another usual question. The answer depends on what you want to point out, the time you have at your disposal, and the outcomes you expect. Our experience affirms the effectiveness of using the movie clip methodology in which multiple movie clips are shown in rapid sequence, along with facilitator comments while the clips were going on [102]. Teaching with clips in which several, rapid scenes, taken from different movies are all put together, works better than viewing the whole movie. Nowadays, we live in a dynamic and fast-paced environment of rapid information acquisition and high emotional impact. In this context it makes sense to use movie clips because of their brevity, rapidity, and emotional intensity. Bringing clips from different movies, to illustrate or intensify a particular point, fits well with this modern living state.

The value of instructor commentary during the viewing of clips is a conclusion based on our own experience. Although the sudden changing of scenes in the clips effectively evoke participants' individual concerns and fosters reflection in them, making comments while the clip is playing acts as a valuable amplifier to the whole process. Because learners are involved in their personal reflective process, they may at times disagree with the facilitator's comments and form their own conclusions. But this doesn't matter and may even be desirable. In fact, participants note that



divergent comments are particularly useful to facilitate the reflecting process. The effect is a rich generation of perspectives and points of view, which in turn trigger multiple, often, contradictory emotions and thoughts in the viewers. In this context, learners' have an intensely felt need for reflection about what they have just seen.

A model involving film clips might foster a more holistic approach to ethics education. Using films, specifically short clips of films, to prompt and frame discussions would be of value for medical ethics education. By allowing reflections on emotions, participants in these sessions can learn to develop their reflective abilities and attitudes. These skills and attitudes, in turn, can help create more humanistic, and presumably more ethical, physicians. There is a selection of movies, time counting scenes, and comments in the appendix from some of these publications.

The academic community requests proof of the effectiveness of a new technique before advocating or even supporting its widespread application. Educators have long ago learned that the measurement of success in teaching remains an elusive, controversial, and at the least quite an ambiguous goal. We should not confuse quality teaching with successful teaching, one that produces learning as is understood exclusively in its achievement sense. At this point, we can envision why those "intangibles" topics, difficult to teach and to assess, in which ethics, empathy, compassion, and commitment are included, could be endorsed through the cinema education methodology. What we can say is that acquiring a taste for the aesthetic provides an additional dimension to medical learning and that even when morality is at issue, a reason is an ideal tool for understanding. Maybe, in Pascal's words, this has something to do with those "reasons from the heart, those reasons that our mind is not able to understand."

In cinema education the educational outcomes don't materialize simply from watching movies. People attend cinema all the time, and see the same scenes, and while they might have similar emotions, the reflective process is lacking. This is where the competence and the teaching skills of the facilitator come into play, that is, by putting all the scenes together and fostering reflection through comments and personal thoughts, even as unanswered open questions are introduced. That is the teacher's role.

There is still a remaining question. Does this movie teaching methodology depend on the charisma of the presenter, or can it be well developed by anyone? There is no definitive answer. All we can say is, if you love movies and if you like to teach deep from your heart, you deserve to try this. Try it and wait for the surprises!

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