2024, Volume 56, Issue 10, 690-691, e-ISSN 1938-3800

Family Medicine

LETTER TO THE EDITOR

The Growing Divide Between Teaching Empathy and Being Empathetic

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HOW TO CITE: Sarkar A. The Growing Divide Between Teaching Empathy and Being Empathetic. *Fam Med.* 2024;56(10):690-691.
doi: 10.22454/FamMed.2024.376434

PUBLISHED: 23 October 2024

KEYWORDS: curriculum development, medical education, clinician-patient relationship

TO THE EDITOR:

As is the annual tradition for clerkships across the country, our undergraduate medical education committee recently explored gaps within our curriculum. Coincidentally, our local team was considering an empathy-building module similar to the clerkship activity described in Blalock et al's brief report on the Social Emotional Noticing Tool.[1] I was hooked from their opening sentence, which lamented declining opportunities for third-year medical students to notice empathetic behaviors during their clerkships. I have similarly witnessed a seemingly obligate decline in social and emotional skill-building amid busier clinical environments and COVID-19's near-eradication of physical touch. Admittedly, nearly every request from a student to "observe" me gets redirected into encouragement to see their own patient. I tell myself this approach ensures students maximize their clinical participation, but it's possible I'm sublimating internal stresses of workflow efficiency.

I especially appreciated the authors' assertion that teaching and learning represent complex, interwoven processes in which both the learner and instructor play critical roles. Just this past week I gave two patients hugs—almost brazenly attempting to role model empathy for observing students. In my attempt to organically be empathetic rather than to didactically promote empathy, I was reminded of Biesta and van Braak's refutation of the assumption that teaching interventions should cause learning.[2] In that article, the Dutch thought leaders described teaching as a presentation of opportunities that may or may not be associated with observed educational gains in our students. I appreciate the authenticity of Blalock et al's study, which recruited only 8 of 170 students willing to measure their empathy. Undoubtedly, countless other clerkship students experienced furtherance in their social and emotional awareness, but it's almost as if their unmeasured growth doesn't count.

Within our local curriculum renewal, it has felt prohibitively challenging to build a short empathy seminar that would both advance students' communication skills and produce demonstrable evidence of patient-facing impact. In Blalock et al's report, a dissatisfied student grumbled that they were trained only to identify missing empathy and not to rectify it. I imagine there is growing concern among educators that students acquiring knowledge isn't adequate without learners reporting accomplishment by applying knowledge. We balked at the need to pay $3,000 to license the empathy scale most cited in the literature.[3] I felt tinges of moral injury that I wouldn't pursue creation of a seminar simply because I couldn't easily evaluate the educational effectiveness of that seminar. It's perhaps a reality of medical education that although faculty can conceptualize what empathy means in practice, those actions might be best left described as a "global attitude" rather than a "measurable, behavioral skill."[4]

Programmatic assessment "success" seems to progressively equate to the production of measurable learning outcomes. I appreciate the reminder from Blalock et al's uncomplicated manuscript that beyond students' willingness to reflect on empathetic behaviors in a research context, teaching faculty should still aspire to deepen their performance of patient-responsive care. If not for scholarly aspirations of teaching empathy, being empathetic as a family physician is its own reward.

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