Chapter 5
Acknowledgement: The Antidote to Skillification (of Empathy) in Health Professions Education

Anne de la Croix, Grace Peters, and William F. Laughey

5.1 Introduction: Empathy and Education

> You want to study medicine. Ever since you were very young, you have wanted to help people. When you were 10, your next-door neighbour ended up in a wheelchair after a serious car accident. You loved your neighbour and often went over for a chat, and to see if you could help her. She always used to say that her doctors could learn a lot from you. You don't think you actually did anything. But the conversations with your neighbour started your fascination with illness and health. Since then, you haven't been able to imagine a more meaningful career than to work with people who are ill. You want to help them, to be there for them and their loved ones. You hope to get into medical school.

The challenge with a concept as complex as empathy is agreeing on a common definition. Without this, educators and researchers find themselves teaching and researching a variety of concepts, any of which may bear the label of 'empathy.' This, indeed, is the position in which we find ourselves: there is no one accepted definition of clinical empathy (Mercer and Reynolds 2002). There is a level of agreement that empathy is composed of cognitive, affective, action, and moral components, though researchers disagree as to the relative importance of these (Morse et al. 1992) and most attention is given to cognitive and affective components. For example, the Jefferson Scale of Empathy (JSE), emphasises the cognitive aspects of empathy,

A. de la Croix (✉)
Research in Education, Faculty of Medicine, Amsterdam UMC, location Vrije Universiteit Amsterdam, Amsterdam, The Netherlands
e-mail: a.delacroix@amsterdamumc.nl

G. Peters
Veterinary Communication for Professional Excellence, Colorado State University, Fort Collins, CO, USA
e-mail: Grace.peters@colostate.edu

W. F. Laughey
Hull York Medical School, University of York, York, UK
e-mail: william.laughey@hyms.ac.uk

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arguing that affective involvement is in the realms of sympathy, rather than empathy (Hojat et al. 2002). Halpern (2003), on the other hand, describes how feelings are central to our understanding of empathy, and that true empathy depends on a degree of emotional resonance with the other.

Of course, in HPE, 'the other' generally refers to the patient, though empathy for colleagues and students is also important. It is reasonable to consider whether empathy in the patient context is different from any other kind of empathy. In principle, we don't believe it is, but there are specific considerations. The concept of empathy includes the concept of opacity—the idea that whilst you may share the thoughts and feelings of another, you still retain your sense of self and don't become the other (Bizzari et al. 2019). This sense of self in a clinical situation is also a sense of professional self. This may modulate empathic reactions: for example, empathy for a relative may provoke tears, whilst empathy for a patient may, more often, be expressed in words of comfort for professional reasons. In addition, clinical empathy is driven by an ethos of care, and outcomes are more likely to carry health benefits, including the provision of emotional support, the desire to help problem-solve and the intention to prescribe or intervene in other therapeutic ways.

Whatever analogies or personal definitions we use for empathy, there is general agreement that empathy is connected to attentive listening. The psychologist Carl Rogers (1986) argued that for therapists to have empathy for clients they needed to actively listen and feedback thoughts and feelings. This link between listening and empathy has also been implicit within research with Simulated Patients (SPs) (Laughey et al. 2018). Indeed, whenever SPs talked about listening, they also talked about empathy, and vice-versa. SPs also detailed the types of attributes that allow patients to know that listening is taking place—attributes like eye contact; nodding; the mirroring of body language; asking the types of questions that indicate the clinician is hearing cues and picking up on them; summarising back to the patient to check understanding; and asking the kinds of open questions which help patients tell their story. Active listening combined with an interest in the whole illness picture, where clinicians explore not just the patient's symptoms, but how they affect the patient's life, and consider the patient's perspective—including the classic triad of ideas, concerns and expectations (ICE)—are at the heart of empathic, patient-centred approaches to communication (Kurtz et al. 2017).

In a philosophical inquiry into the nature of empathy, Davis (1990) argues that empathy is akin to a process of 'crossing over' in which a person suddenly finds they are closely aligned to another, a crossing that simply happens when the conditions are right and that cannot be forced. In those moments of eye contact, attentive listening, and striving to understand the perspective of the other, there will be empathic opportunities when thoughts and feelings resonate. Davis likens it to falling in love, again something that cannot be forced.

An analogy that is often used to capture the essence of empathy is "the ability to put yourself in somebody else's shoes", or "the ability to put yourself in somebody else's story" (Laughey et al. 2018, 665). Whilst this a helpful metaphor, it does not capture the full scope of the concept. Empathy has efferent as well as afferent components (Morse et al. 1992). It is all very well for a clinician to experience empathy for a

patient, but unless they communicate this back, the patient may never know. A fuller analogy may therefore be, 'the ability to let somebody else *know* that you have put yourself in their story'. This is, perhaps, why SPs generally welcome the so-called 'empathetic statement' (Laughey et al. 2018). Empathic statements usually take the form of brief statements of empathy, such as, 'I'm sorry to hear that', or 'I imagine that must be difficult for you'. These are one of the ways doctors demonstrate to patients that empathy is being felt. However, SPs also urge caution—it is easy to detect when an empathic statement is being forced out, essentially delivered in such a way that it is clear it is not sincerely meant. This problem of fake empathy is a significant one, and contemporary approaches to medical education are unwittingly exacerbating it (Laughey et al. 2020b).

There is good evidence that students freely admit to faking empathic statements (Laughey et al. 2020a). In teaching, they are encouraged to make statements of empathy even at times when they are not feeling empathic; they also witness their supervisors and peers making similarly hollow statements. In assessment, they feel the surest way to 'tick the empathy box' is through the liberal application of empathic statements, which in the pressured setting of an Objective Structured Clinical Examination (OSCE) assessment are almost always forced, rather than natural. This is a situation that students feel uncomfortable with—the disconnect between the giving of empathy and the feeling of it. This problem has been termed 'empathic dissonance' and defined as "the mental discomfort experienced by the act of making expressions of empathy that are not sincerely felt" (Laughey et al. 2020a; 2020b, 428).

The difficulty with insincere statements of empathy is that they cut across other efforts to create the empathic moment. This casts doubt on any attempts by educators to encourage students to force empathic statements, including the advice of the four habits model (advocated by one of the USA's leading health care providers, Kaiser Permanente)—this model recommends clinicians make at least one empathetic statement per encounter (Frankel and Stein 1999). Whilst the spirit of this advice may be well meant, if it results in clinicians trying to force an empathetic moment, the delicate conditions that encourage empathic 'crossing over' may be undermined. Using models and 'grids' to force specific behaviour, however well intended, can lead to a process we call *skillification.*

5.2 Skillification

> You got into medical school. It is wonderful and you love it. It is also hard, hard work. The study load is incredible, and you need to work a job on the side to make enough money. The exposure to suffering, illness and disease can be confronting, and learning about the limits of health care is tough and can dampen your spirits. Your OSCEs are coming up, in which you need to demonstrate your competencies. You desperately need to pass the test, and start looking at the score list for the different stations in the OSCE. You start preparing, by practicing empathic expressions.

It is beautiful that the call to humanize medicine has been heard in medical education. A 'good doctor' has ample clinical knowledge and is skilled in doing a physical examination or a surgical procedure, but, in recent decades, there is agreement that there should be more: a doctor should be a pleasant person to interact with, for colleagues and patients alike. The 'human touch' of physicians has found its way into medical education in many shapes and forms, and the growing attention to empathy is one of them. Empathy is a beautiful concept and is one of many concepts that has been introduced to medical education to humanize medicine and stress the importance of connection. Other such concepts include patient-centredness, compassion, reflection, collaboration, and communication. Yet when complex concepts—characterized by their elusive nature—are applied in medical education, they are forced to take on a different form to survive in the field. Indeed, the science of medicine requires a positivist paradigm, where things can be known (see Chapter 10 for expansion on this). But when elusive concepts appear within positivism, the Tyranny of Metrics forces complexity into neat grids (Muller 2019). Empathy turns from a 'fuzzy' concept into a set of phrases to utter in an exam, something you can 'do', rather than experience or create.

We call the problem behind empathic dissonance and fake empathy '*skillification*.' We define skillification as the process of defining, delineating, and inevitably reducing features of human communication in order to measure their use and assess how students use them. A similar process has been described by Nimmon (2020) as 'technification'. It starts with creating clear definitions and continues with descriptions of what a particular concept 'looks like' in practice. These traits are then translated into an observation grid, an assessment matrix, or a checklist. Common communication skills,[1] for example, include tasks like open-ended questions, reflective listening, summaries, and empathic statements. The emphasis on observable behaviours as skills is concerning, as it may be teaching the natural empathy out of students and moving them to a forced and unconvincing representation of empathy. It is also concerning as communication becomes a very specific endeavour, dampening diverse ways of expression and disadvantaging non-native speakers (Atkins and Roberts 2018). Skillification translates aspects of connection into tickable boxes of visible behaviour, which, in the process, disregards diversity and humanity—it is a reductionist approach. This way of working is of key importance in other parts of health professions (protocols for patient safety, ways of working in operating theatres), yet does not work when applied to 'unmeasurables' such as communication, empathy, and reflection.

[1] Communication, however, is so much more—Prof. John Skelton at the University of Birmingham in the UK consistently rejected the word 'skills'. Rather, in his department, teaching was all about 'clinical communication'—part of the reason his team thrived was because that concept was left undefined. We argue that leaving the precise meaning of complex concepts such as 'empathy' undefined might prevent skillification. It will however present the field with a different set of issues,namely: how to deal with ambiguity and how to measure progress of the undefined? This might be tricky, but we feel it is preferred over the danger of the current skillification: cynicism towards empathy, and a bad reputation of such a meaningful concept.

Reflection is another rich and complex concept that has been reduced to a checklist of visible behaviours devoid of personality. In requiring students to reflect on an activity, often in written assessed reflections, "reflective zombies" arise because of the dominating urge to make concepts measurable (de la Croix and Veen 2018, 394). Students learn to move through the visible behavioural steps that they have learnt to mean 'being reflective,' possibly without actually reflecting in their own unique way. A consequence is that reflection is falling into disrepute for being a meaningless check-box exercise. This is ironic, since reflection was first introduced into medical education to add richness, depth, and value. The skillification of reflection is similar to what we described is happening with empathy: empathy is operationalised as a list of visible (often verbal) behaviours, allowing (or forcing?) students to 'perform' empathy without experiencing it or living it. Literature about 'gaming-the-system' (Rees and Knight 2007; Mak-van der Vossen et al. 2019; De Leng et al. 2019) is fascinating, as it shows that students know what they need to show to progress and succeed in a specific context. Gaming-the-system behaviour can be linked to the (sometimes seemingly invisible, yet dominant) epistemological stance in the field: if measurement criteria are clear, students will steer towards those criteria when being observed or assessed. We fear this hinders learning about oneself and about human connection, so called 'transformative learning' (Mezirow and Taylor 2009), in which personal differences need to be explored and affective learning plays a big role.

A driver for these unwanted side-effects (empathic dissonance, zombies, gaming-the-system, etc.) in medical education is the urge to assess and measure everything. This is a strong urge in any educational setting, but, perhaps, it is even stronger in medical education. This makes sense, as monitoring and measuring have clear merits: it gives us insight in health care needs and can help in controlling quality—both very important when it comes to preserving life and avoiding death. The epistemological hierarchy is strong in medicine, and it privileges positivist, seemingly 'objective' research. However, the influence of this positivist paradigm extends to domains where it, perhaps, should not meddle. The epistemological hierarchy maintains that only knowledge that can be objectively measured is worthwhile knowledge. And our complex concepts pertaining to humane medicine have had to conform to this orientation to gain legitimacy. But applying checklists and measuring tools to empathy and reflection, for example, can have negative effects on the way medical students' humanity is allowed to develop, as everything has to be demonstrated, everything has to be 'countable'. The urge to measure complex concepts (i.e., empathy, reflection, professionalism, communication, collaboration, etc.) according to well-defined gold standards that often take the shape of rubrics, checklists, or questionnaires, might lead to superficial learning and the eventual dismissal of complex concepts.

It is an ongoing dilemma in education –how to teach and assess 'the human touch' without creating zombies, without stimulating gaming-the-system behaviour, and most of all, without limiting the diversity of viewpoints and personalities in the classroom, and the authenticity of future doctors. Students strongly associate empathy with virtue, something that makes you a better person and a reason why you came to medical school (Laughey et al. 2021). Without a certain *ethos*, students are not prepared or willing to undertake the time, mental, and emotional labour into

developing connections with patients. Students need to be prepared to make a habit of adopting that listening agenda and deploying those attributes of hearing the patient—it's not just having the skills to do them, it's having the ethos, the drive, the "ought." Skills alone are not enough, yet, somehow, they have become the focus. Scholars have attempted to overcome skillification by conceptualising empathy as a position or a stance, but, ultimately, empathy in medical education is deeply entrenched in a discourse of skillification that essentializes communication rather than envisions it as a life-constituting activity.

If we can reset, and move away from skills and towards attributes, we may firm up the belief in the value of empathy, or, at least, stop driving this cynicism towards it. The reductionist, technicist approach causes more harm than good when it comes to teaching empathy (and reflection, communication, etc.). We argue that digging around in philosophy and embracing philosophical complexity is necessary. One philosophical notion in particular, namely *acknowledgement*, feels like the right antidote to skillification.

5.3 Acknowledgement

> You made it. You are a doctor. And sometimes you actually get to do what you wanted: help people and be there for them. Every day, you get to use a snippet of knowledge, a little trick, or a spark of insight from your training. And every day you learn more. One day, you meet a lady who ended up in a wheelchair after a serious car accident. She reminds you of your neighbour. You are not able to cure her or help her in her new life with a disability. These are the limits of medicine. Instead, you sit and talk to her while she waits to be picked up. You listen to her story without saying anything. She feels your concern and care. She thanks you. You don't think you actually did anything. But you are making things better. Through connection. By acknowledging.

We propose the notion of acknowledgement as an antidote to the skillification of empathy in medical education. Importantly, we are not suggesting acknowledgement replaces empathy to become the new "pièce de resistance," as we fear this leads to an inevitable breakdown whereby medical educators then distil and assess "acknowledgement." Historically, acknowledgement goes by many names and finds itself among many traditions—Bateson's (1972) notion of validation, and Buber's (1988) description of confirmation, to name a few. Yet, we present a *philosophical* portrait of acknowledgement, inspired by Michael Hyde's ontological theorization and clarification, to generate a conversation about how we conceptualize and teach human connection in health professions education.

Michael J. Hyde in his book *The Life-Giving Gift of Acknowledgment* (2006) defines acknowledgement as "any communicative behaviour that grants attention to others and thereby makes room for them in our lives" (1). Indeed, acknowledgement is an observable behaviour, but it is the *ontological nature* of that behaviour that

distinguishes it from becoming a check-box exercise. Acknowledgement is a moral and ethical act rooted in the metaphysics[2] of relationality.

The need for every human being to be acknowledged is fundamental to relationality, as Levinas (1969) states, "the social relation… is the ultimate event" (221; emphasis added). Hyde takes up Levinas' claim in stating that it is the

> …ontological structure of existence that *makes possible acknowledgement*…the originating force for the human propensity to wonder about 'who we really are' and 'where we really come from'. (10)

Acknowledgement is an act that was first done for us—whether explained through the Big Bang, the Creation narrative, or any other generative myth (as Hyde unpacks)—some opening brought about existence *and* the ability to question it.

The fact that we question our existence makes it possible for us to acknowledge and cultivate the existence of others. Hyde develops acknowledgement through Heidegger's notion of being (*da-sein*):

> …that place, "there" ("da"), where being ("sein") can show itself to a consciousness that can not only feel, see, and hear its presence in the materials of everyday life, but can also reflect on and articulate understanding of the perceived event. (39)

In other words, it is our self-reflexive capacities to question existence that are embedded with the foundations of acknowledgement. In discussing being, Heidegger (1962 [1927]) claims that the human is, "distinguished by the fact that, in its very being, that being is an issue for it" (32; as quoted by Hyde 2001, 38). But our own existential concerns are not enough as when we reflect on our being, we find that it is interwoven with the existence of Others. We are only able to question our existence through the acknowledgement of others—without which, where might we find the language to even think (Jaynes 2000)?

Therefore, we ought to carry on the dialogic process of acknowledgement that was first afforded to us, as, without it, social death is inevitable. Hyde illustrates the importance of acknowledgement by asking, "what would life be like if no one acknowledged your existence?" The isolation, loneliness, anxiety, suffering, and loss of such an existence demonstrates what Hyde calls "social death." Social death occurs through repeated communicative refrains (i.e., avoiding a smile, moving past someone, dismissing a plea, etc.) and institutionalized forms of discrimination (i.e., racism, sexism, ageism, etc.). We are all in need of acknowledgement; it is a recursive process that frees humanity from the despair of social death through attentive communicative action. We offer acknowledgement to others as a life-giving act. This goes beyond mere recognition, or noticing, to a sustained openness towards others, "even if, at times, things become boring or troublesome" (Hyde 2006, 4). Most importantly, acknowledgement steers through the questions of empathic resonance and invites us to cultivate a space for being together through sustained openness, attention, and communicative action.

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[2] *The Oxford Dictionary of Philosophy*, 2nd edition, defines metaphysics as 'the branch of philosophy that deals with the first principles of things, including abstract concepts such as being, knowing, identity, time, and space' (Blackburn 2005).

As we move through the world, we come face to face with others who issue calls for response (that no one else can respond to in that particular moment). Hyde poses a question-and-answer sequence—"Where art thou?"/"Here I am"—to show the impact of our responsiveness in the continuous unfolding of acknowledgement in our existential existence. In coming face to face with others, there is the possibility of response, which is "the essential human deed" (Stambaugh 1992). Barad (2003) turns to the phrase "response-ability", as in the ability to respond and a moral obligation to do so. Acknowledgement is that essential communicative act whereby we grant attention to others and make room for them in our lives. Hyde emphasizes the verbal and non-verbal dimensions of acknowledgement, but, like Barad (2003) (see Chapter 12 for more detail on Barad's ontological approach), adds that communicative acknowledgement, "needs what it brings into being for the sake of ourselves and others: a space, a place, the planet's crust at the very least" (18) extending beyond human activity to the post-human affective entanglements of intra-activity (using Barad's vocabulary; see also Iedema 2011). Acknowledgement is a cultivating activity that creates space for others—physically and metaphysically.

Existential disturbances demand we question the nature of being, which are inherent to clinical practice. When coming face to face with life-changing illnesses or accidents, how we understand and make sense of world shifts. As Hyde (2006) eloquently states,

> …the face of a dying person speaks to us a fact of life that most people would rather forget. In avoiding their presence, we deny them the respect of acknowledgement and thereby run the risk of contributing to their pain and suffering of their social death. (185)

In moments of existential instability, the "call of conscience" rings out—"where art thou?" To answer this call of conscience ("here I am") we acknowledge, we show up, and stay open. Interestingly, this is not unlike the moral approach to empathy described by Halpern (2001), who uses the term 'compassionate curiosity': a drive to remain engaged with patients and stay curious about their situation. It is not a cognitive, affective, or epistemological process (like "stepping in another's shoes"), but an ontological one.

Indeed, we can envision resistance to this sustained openness to others and the practitioners' need for acknowledgement. We colloquially hear practitioners say, "if I connect with everyone, I'll burnout," or, "I can't be dependent on my supervising clinician or my patient to acknowledge me, because I'll be dissatisfied." Acknowledgement is not a one-to-one activity, but a:

> …caress of a 'suffocating embrace' that is always challenging us to overcome its inherent pain and suffering by way of action– the very thing whose constant performance [acknowledgement] sooner or later incites fatigue and weariness and thereby leads us back to the suffocating embrace…human beings can take control of themselves, and even in the face of horrifying circumstances display courage and responsibility. (Hyde 2006, 121–122)

The metaphysical conditions of acknowledgement push us to acknowledge others and pull us from others so we may sustain aside from their acknowledgement. Being in the waves of existence does not negate the necessity of acknowledgement to our existence—in the throws we act, even if we float for a moment.

The philosophical orientation of acknowledgement redirects us from questions of knowing (epistemology) to questions of being (ontology) (see Chapter 10 for full considerations of these terms). It is not about whether acknowledgement (i.e., empathy, patient-centred communication or whatever we want to call it) *authentically* occurs, or how we can *know* a medical student or physician accomplishes it. When we occupy ourselves with such questions—as the discourse of skillification requires—we become stuck in a black box of beetles (mental unknowables) that ultimately impinge how medical students might connect with patients. We can never know whether acknowledgement or empathy are authentically experienced (Wittgenstein 1963; Veen et al. 2020). In fact, Heidegger's ontological shift *presupposes inauthenticity* and invites self-reflection in the process of becoming (as being would have us to do) as a way through it. As Veen (2021) states, "the path to authenticity is to reflect on the ways in which I am always already in some way inauthentic" (144). For human connection in medical practice, it is questioning, 'How am I connecting or not really or even faking it? Why? What is that doing? What else is there?'

As human beings, we are often calling into question our own existence, or witnessing disruption in the lives of others (Hyde 2018). Attuning our consciousness to the calls from others ("where art thou") and acknowledging the humanity before us ("here I am") to genuine depths of care is profound. The *ethos* of acknowledgement fosters the abilities for us to know together through shared space and attention, as well as provides the opportunity for us to self-reflect on that relationality. Acknowledgement creates a dialogic space for us to dwell together and deliberate, which foregrounds collaborative agency and humanizes the Other before us. As clinical educators, we envision this deeper existential meaning as one that philosophy offers medical education, if only to start the conversation about what we are doing *is doing*.

5.4 Conclusion

> You have been practicing medicine for 10 years now. After roughly 10 years of training and 10 years of practice, you start thinking about what has helped you the most in the way you communicate with patients. You remember one or two communication techniques from medical school. A few impressive consultations between a consultant and a patient, that you observed during your clinical rotations, have stuck with you. But the most important contribution to being a 'good communicator' is harder to pinpoint. It is the movies you watched, the friends you made, the books you read, the way you relate to your family, the many different patients you met, the travels you made, the emotions you felt, the conversations you had. Communication is contact. And contact is acknowledgement. Of others – and of oneself.

In this chapter, we illustrated the challenge of empathy in medical education, how skillification works, and how it can turn a rich and meaningful concept into a superficial 'skill'. This worrying trend robs medical students of truly learning about humane health care and can make us all cynical about complex concepts in medical education as the meaning is 'skillified' out of them. We propose the concept of acknowledgement as an antidote to skillification.

Table 5.1 Practice points

1	Rethink and reconsider assessment practices
2	Talk about complex concepts and their meaning (and do not define them strictly)
3	Make use of patient participation in the curriculum
4	Invest in medical humanities
5	Create acknowledgement between teachers and learners

We are *not* trying to replace the concept of empathy with the concept of acknowledgement. Rather, by allowing acknowledgement to inform the underlying philosophy of connection, we can combat skillification and revitalise concepts like empathy, connection, and communication. We envisage medical education to rest on a healthy underground of acknowledgement.

This is all well and good to philosophize about, but health professions educators are people of action. So, what can we *do* to move toward a learning culture that is antithetical to skillification? We believe that there are five areas of key importance when designing curricula in which students are allowed to let their humanity grow and develop. They are summarised in Table 5.1 and elaborated on below.

First, as assessment and measurement lie at the heart of skillification problems, it is worth having a closer look at what needs to be assessed and *why*. The natural tendency in education is to start with learning outcomes and ways to check if these are obtained. An assessment and quality control plan might be high on the list of actions to undertake when designing curricula. However, for more intangible aspects of development and growth, such as empathy, some free space in the curriculum might be more suitable. We would like to challenge educators to think about assessment-free areas in the curriculum, as well as develop arguments that justify them within a tyranny of metrics and positivism.

Second, we need to take a close look at the way in which "traveling concepts" (Bal 2009, 13) such as reflection, professionalism, empathy, communication, collaboration, leadership, are operationalised in the field of medical education. This requires philosophical and critical analysis of the field. We need to ask each other, and our students: what does patient-centredness mean to you? When did you experience empathy? When and how do you reflect? In the humanities, philosophy, and social sciences, talking about complex concepts is standard practice. It is a very different model to that of stating empathy can be defined as this and it sounds like that. Inviting a dialogue based on lived experience is a fertile ground for cultivating unique humanity.

Third, to stimulate connection and contact, students might benefit from taking the patient's perspective. Involving patients in both the pre-clinical and clinical part of medical school is advisory. Wonderful examples of patient participation in education are luckily not hard to find, for example: GP trainees joining patients as partners in medical consultations (Mol et al. 2019), medical students visiting the homes of families with a special needs child to learn about the life with disability (Anderson

et al. 2019). These meetings can help forge bonds between future health care professionals and patients, will stimulate acknowledgement and make it easier for students to understand the patient perspective.

Although conversations with patients can be fruitful, witnessing them in aesthetic form can be transformative. The poems, stories, plays, and art that has been created around medical practice offers a starting place for conversations about complexity. Art has the power of 'making strange' (Kumagai and Wear 2014) and allows for deep learning that stretches beyond the cognitive level. In the words of painter Georgia O'Keeffe: "I found I could say things with color and shapes that I couldn't say any other way - things I had no words for." Interpretation is inherent to art, as is how we interpret and make sense of ourselves in relation to it. Reflection on ourselves, on others, on relationships, requires changes in perspective, which the arts and humanities specialise in. Good art changes us, and perhaps in further integrating the medical humanities, we can begin to cultivate physicians who consider their own relations to the profession (Finn et al. 2021).

Finally, and perhaps most importantly, as health professions educators we should be the givers and receivers of the life-giving gift of acknowledgement. Acknowledgement as a space-creating activity can be used to create a clear space where students feel welcome as their whole selves, including their everyday concerns and contingencies. Perhaps in doing so, we reconsider how we are pushing such intense pressures (perhaps only because we've experienced this sort of brutal indoctrination ourselves). Hyde has much to say about education and acknowledgement function, so it is with his words we leave you this final consideration:

> …by giving others the right and appropriate attention, listening and remaining open to them, and thereby creating a dwelling place… to feel at home while they discuss matters of importance and learn to care for one another's ideas. Genuine acknowledgement requires nothing less than entertaining this process of engagement. (Hyde 2006, 182)

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