Do we really care about caring?

Empathy & Compassion in Medical Education and practice

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Word Count: 5976

(Excluding Abstract, Bibliography and Appendices)

Acknowledgements

I would like to express my heartfelt gratitude to Dr Michael Flexer, my project supervisor, whose guidance and been supportive throughout this project. I would also like to thank Professor Giskin Day, course director of Medical Humanities Philosophy and Law at Imperial College London, for her support and encouragement whilst coordinating this project.

Abstract

There are extensive debates in medical pedagogy, surrounding introducing the art of medicine alongside biomedical science, through patient-centred care. Empathy and compassion are seen as central concepts to caring. However, they suffer from ambiguous definitions, often causing research to get entangled in semantics, rather than addressing their underlying conceptualisations.

My paper addresses this by creating a four-dimensional framework broadly encompassing key facets of both empathy and compassion, to investigate whether empathy and compassion can be practically taught and assessed, in an authentic and transformative way. Through a reflexive approach, I apply this framework to the first three years of formal medical curricula at Imperial College London and discuss with my personal reflections on the informal curriculum (hidden curriculum, assessment experiences, and culture of medical practice), to find points of contention. This exploration reveals the informal curriculum ultimately impacts students' caring capabilities greater than formal teaching and assessment. I propose shifts in the conceptualisations of empathy and compassion, to begin nurturing this caring culture.

In conclusion, by closely examining the formal and informal medical curriculum, this project sheds new light on the superficially understood concepts of empathy and compassion and their application to medical education, practice and beyond.

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Introduction

Is medical education preparing students to deliver a product of care (noun), or enabling them to genuinely care (verb)? Caring, having concern for another, is a multifaceted concept central to the practice of medicine. “Care is central to the reproduction of society and thus one of its bedrocks, part of a fundamental infrastructure which holds society together” (Dowling, 2022 p. 40). This project delves into the concepts of empathy and compassion, which are fundamental fellow-feelings allowing one to connect with another and are central to caring. Is there a risk these buzzwords have become overused, to the point where their application to medical education and beyond has become superficial? The medical ecosystem may have lost its roots, with an emphasis on the biomedical model over psycho-social healing, commercialisation and mechanistic systems becoming ever so prevalent (de Zulueta, 2013). Although these may have allowed for the scale and reach of healthcare impact, the art and humanisation of medicine have been placed on the back burner.

Empathy and compassion, as constitutive terms of care, have their own etymologies and contexts, which are overlapping and sometimes contradictory, making their distinctions unclear. Although these terms are ill-defined, they are often a focus of formal medical curricula, through domains such as: medical ethics and law, professional identities and behaviours, professional values and behaviours, and communication skills (Sofia, 2019). Introspecting on the last three years of my medical education at Imperial College London, I have noticed that assessments such as the Objective Structured Clinical Exam (OSCE), hidden curriculum from placement experiences (Hafferty & Franks, 1994) and culture of medical education and practice have had a greater impact on my caring capabilities than the formal curriculum.

In an already over-saturated curriculum, with minimal time to reflect on and challenge my learning experiences, I will take a reflexive approach to analyse the teaching and assessment methods that influence students to ‘learn to care’, in conjunction with my personal reflections.

This research aims to address the following questions:

- What conceptualisations of empathy and compassion are, formally and informally, communicated and assessed in medical education, and how?

- How could medical education be better designed to ensure health care is a caring practice?

Section I traces the etymology of empathy and compassion to investigate how variances in definitions have arisen, and a four-dimensional framework (cognitive, behavioural, moral and emotional) is designed to encompass these. Section II describes the methods taken to collate the education materials analysed, including acknowledgement of my positionality within this reflexive project. Section III integrates analysis of formal learning outcomes with personal reflections, in an interdisciplinary discussion to examine each dimension of the framework.

Through research and open-minded exploration, the project keeps the potential for refinement and development of the framework alive, with the purpose of transforming medical practice. Medical education should empower students to connect with patients, nurture a supportive environment where students can flourish to be compassionate and empathetic carers and cultivate a culture of care.

Section I: Empathy and Compassion Framework

Having concern for another originates from the ability to connect and relate to another; through recognising an emotion in the other, emotionally engaging with it to some degree and responding. As a family of terms, sympathy, empathy and compassion describe a wide range of psychological methods of doing so. Their ever-changing and interchangeable uses can be traced through their etymological records.

Sympathy is derived from the Greek 'sympatheia': 'syn' meaning 'with', followed by the root word 'pathos' meaning 'feeling', which combine to mean feeling-with the other. The original meaning of sympathy, as intended by Aristotle in his account 'eleos', regarded feeling-with others as creating a resonance between the subject and the other, which is closer to some current understandings of empathy (Aristotle as cited in Rosan, 2014). The meaning of sympathy deviated from the Greek root, when 'eleos' was translated as pity by Lain Entralgo, causing a shift in conceptualisation that has lasted through the ages (Rosan, 2014).

David Hume and Adam Smith, who were influential in their discussions of social and moral nature, used the term sympathy to refer to what many now consider empathy-related phenomena (Stueber, 2019). Robert Vischer coined the term 'Einfühlung' meaning feeling-into, in the contexts of aesthetics and theory of art. This is the method a viewer takes to project their feelings into an object, to animate it, which the viewer in turn experiences as radiating from the object (The Art Assignment, 2019). Theodor Lipps expands on Edward Titchener's translation of 'Einfühlung' to empathy, from perceiving art to the perception of other embodied people. Since then, researchers have explored empathy in various ways, leading to competing conceptualisations. For example, James Baldwin, who aimed to standardise psychological terminology, disagreed with the translation of 'Einfühlung' to empathy, rather preferring the term 'semblance' (Baldwin as cited in Lanzoni, 2018). 'Semblance' perhaps suggests his view that 'Einfühlung', as a form of regarding others, is an outward appearance of caring that may not reflect the reality of one's intentions.

Compassion and sympathy seem to share an etymological meaning, of feeling-with, although derived from different languages. 'Com' in Latin means 'together', followed by 'pati' meaning 'to suffer', alongside 'compati' being associated with 'pity', from the

Latin ‘pietas’ (Etymonline, 2021). However, the understanding of compassion as deeper than sympathy could be traced to Hebrew translations of the word: ‘rachamim’, which stems from the word for womb. Its association with childbirth implies compassion is a stronger feeling arising from “suffering and strength” (Rosan, 2014 p. 162).

Considering these continually evolving terms, they shift across the spectrum of feeling-for, feeling-in and feeling-with. They have also moved into and out of popularity according to their deployment for different contexts and cultures throughout history. For example, it is interesting to note the Google Ngram views of the 3 terms, depicting a rise in the use of ‘compassion’ in American English literature as more rapid relative to sympathy and empathy, than in British English Literature.

Figure 1 - British English Google ngram for Sympathy, Empathy and Compassion (Google Books Ngram, 2019)

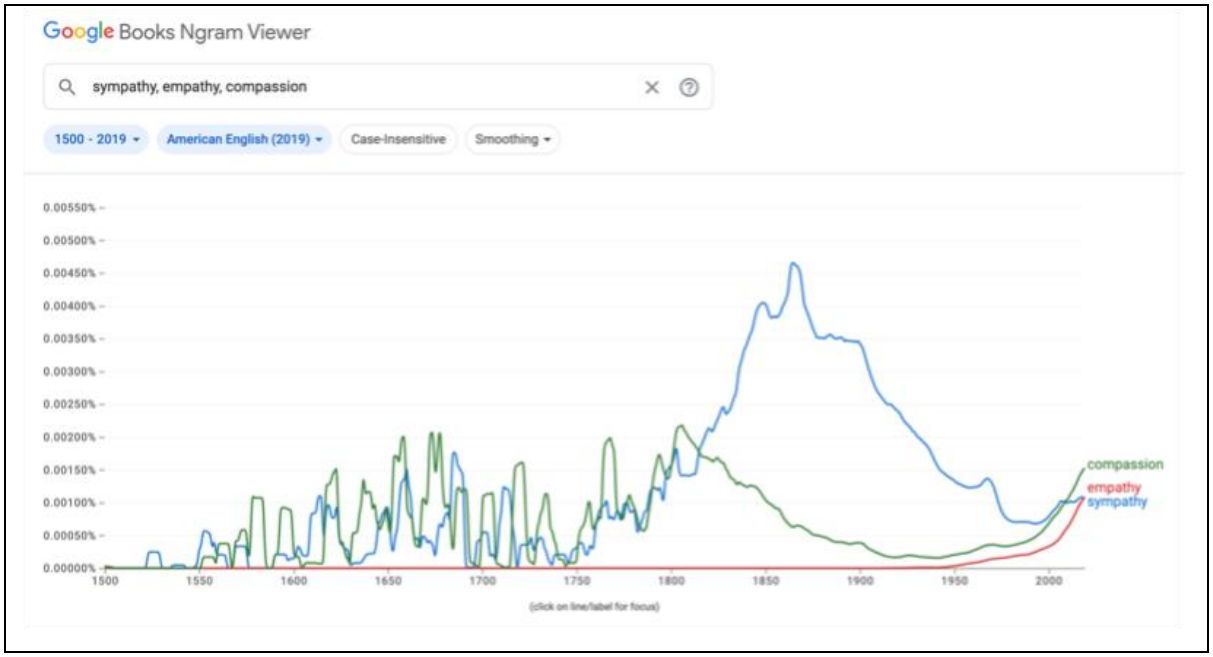

Figure 2 - American English Google ngram for Sympathy, Empathy and Compassion (Google Books Ngram, 2019)

Susan Lanzoni offers a refreshing perspective on the multifaceted dimensions of empathy and compassion throughout history (Lanzoni, 2018). Instead of getting caught up in semantic confusion, like much existing research does, Lanzoni suggests we should embrace the collective richness of these concepts. I will be studying their applications to the current context of medical education, institutional culture, and health-caring practices in the NHS.

To go beyond any single definition, I searched literature breaking down empathy and compassion into their building blocks, to create a framework summarising their key dimensions. Taking inspiration from David Jeffrey's collation of 4 dimensions of empathy (Jeffrey, 2016), I took this further to include definitions of compassion (Sinclair et al., 2016), and expanded each into spectra that portray the varying degrees within (Cuff et al., 2016).

The cognitive dimension of empathy and compassion describes the ability to understand another person's point of view or experience. The behavioural dimension involves the ability to communicate, respond and act following one's understanding of the other's experience. The moral dimension represents the motivations and intentions

to care, behind the thoughts, actions and feelings. The emotional dimension conveys the ability to subjectively share in another's feelings.

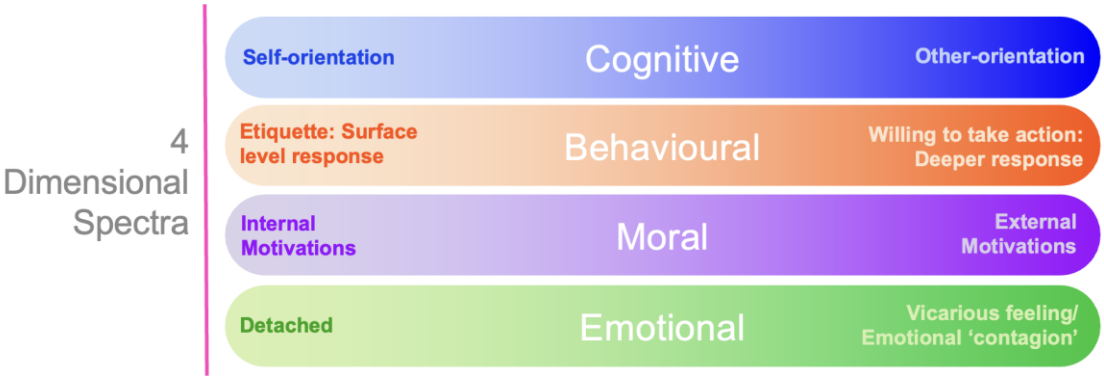

Figure 3 - 4 dimensional framework of Empathy and Compassion

These four dimensions are strongly interconnected, overlapping and influencing each other in diverse ways across contexts (Jeffrey, 2016). The varying ends of each spectrum will be explored in conjunction with insights from the formal curriculum and personal reflections from the informal curriculum. An interdisciplinary approach is taken to discuss these in relation to medical pedagogy, the medical gaze, care ethics and phenomenology.

Section II: Positionality & Methods

As a fourth-year medical student at Imperial College London, introspecting on my initial three years of medical education (Phase 1) has sparked insights I would like to explore. Phase 1 “focuses on the scientific basis of health and disease, and the foundations of clinical practice, including early clinical exposure” (ICSM Insendi, 2020). Yet it seems the teaching and learning opportunities to develop empathy and compassion in the formal curriculum (figure 3) are often overshadowed by examinations, the hidden curriculum and culture of medical school and practice.

Through a reflexive approach, I will ground critical insights from my journey of transforming self, within the elements of my formal medical curriculum they contend with. By connecting each personal reflection to elements of the formal curriculum, then the broader issues of caring in medical practice, I will examine the learning journey and highlight necessary points for change.

To investigate the formal medical education materials, the student-facing learning objectives available on the Sofia curriculum map will be examined (Sofia, 2019). Document analysis, informed by a reflexive thematic analysis approach (The University of Auckland, n/a), will be used to understand, and evaluate which conceptualisations of empathy and compassion are aiming to be taught. To cover conceptualisations that interweave throughout different modules in the curriculum, I focus on the domains that map to General Medical Council (GMC) outcomes (General Medical Council, 2020), which overarch Phase 1: Professional Values and Behaviours, Professional Skills, and Professional Knowledge. These domains are further divided into sub-domains, of which I will focus on: ‘Professional Identity and Behaviour’, ‘Quality Healthcare’, ‘Medical Ethics and Law’ and ‘Communication skills’ (ICSM Insendi, 2020). Figure 4 portrays the flow of methods used to explore and analyse the four dimensions of empathy and compassion within the formal curriculum learning objectives.

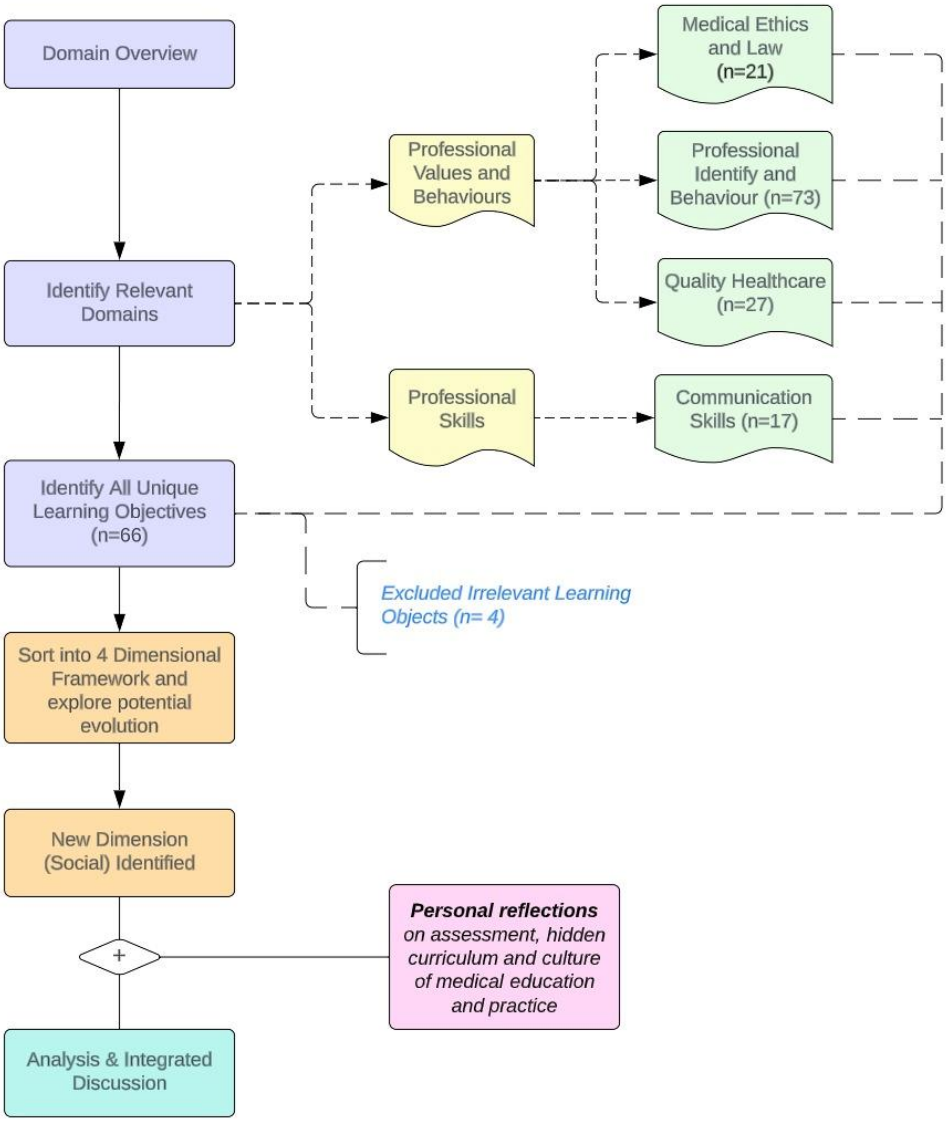

Figure 4 - Methods Flowchart

Reading through each learning objective, I consider how they map onto the framework developed from Section I, including the: Behavioural, Emotional, Cognitive and Moral dimensions of empathy and compassion, whilst keeping an open mind for further framework development (for full analysis of learning objectives see appendix 1).

Section III: Dimensions

Cognitive Dimension

Within medical education, mixed messages often surround “person-centred care” or “patient-centred communication”, which are commonly occurring learning objectives (appendix 1).

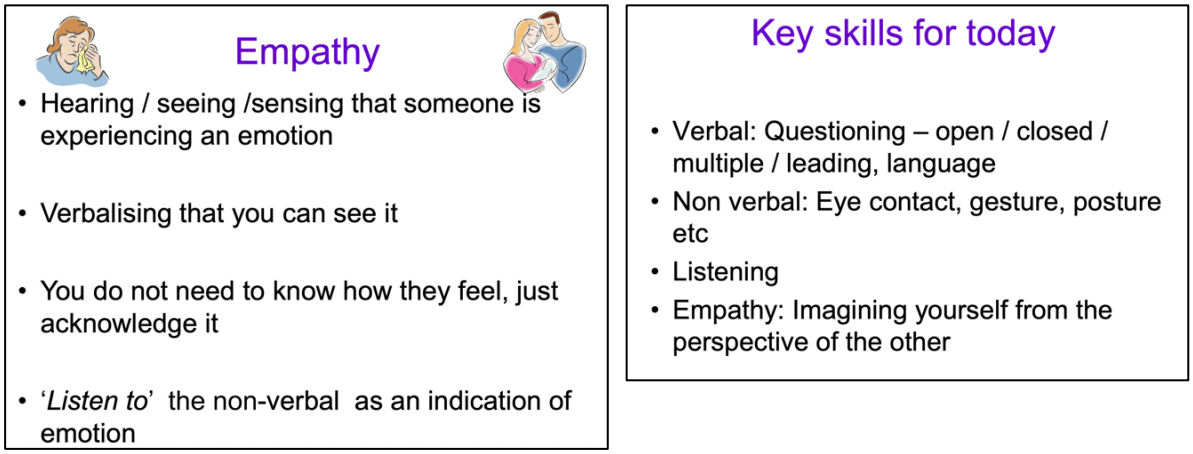

Figure 5 - Clinical Communication (Phase 1a, Session 1: Understanding communication) (ICSM Insendi, 2019)

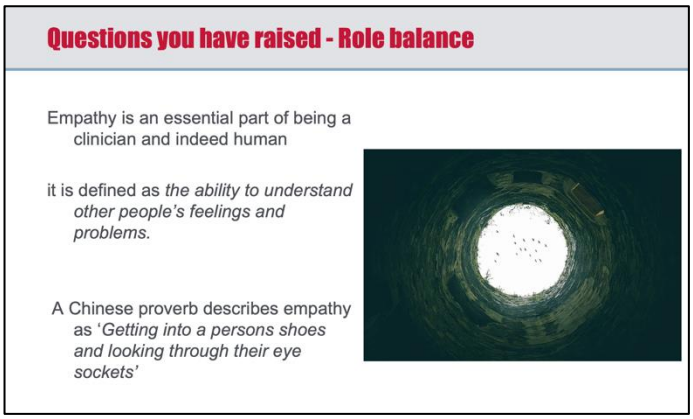

Figure 6 - Clinical Communication (Phase 1a, Session 7: Reflection on Patient Care II - Observation of Clinical Communication) (ICSM Insendi, 2019)

When examining these PowerPoint screenshots from communication skills lectures corresponding to the “patient-centred communication” learning objectives (appendix 1), differing conceptualisations of empathy are communicated to students.

Conceptualising empathy as “getting into a person's shoes and looking through their eye sockets”, represents self-oriented perspective-taking, through imagining oneself in the other’s situation or context. Appendix 2 gives an insight into the complex mental gymnastics I experienced when trying to put myself in the shoes of a patient, whilst practising history-taking with my peers.

This self-oriented perspective-taking in empathy echoes Susan Sontag's observations in the field of war photography, that visual imagery can never fully replace first-hand experience (Sontag, 2004). Similarly, role-playing as a patient cannot fully replicate their lived experience. While one mentally places themselves in the shoes of another and attempts to see through their "eye sockets," they are still viewing the other's situation through their own subjective lens, coloured by personal beliefs and values. Leslie Jamison characterises this as "hypothetical self-pity projected onto someone else" (Jamison, 2015 p. 23), drawing parallels to the root of empathy in 'Einfühlung'. This intense imagination potentially leads to caring behaviours, as the observer anticipates the needs they would have in the imagined situation. However, this would be based on a critical assumption that the other's feelings and needs align with those the observer imagines them to have. Imagination in this way almost creates a quasi-third person in the interaction, ‘the imagined other’.

In the context of a Healthcare Practitioner (HCP) attempting to view the patient’s illness, their positionality through the medical gaze means they will never fully grasp the patient’s perspective. The medical gaze encompasses how a clinician’s view creates power relations between them and the patient, surveys the patient and shapes the spaces where medicine is practised (Foucault, 2010). Hierarchy is introduced when the clinician places their agency above the patient’s. By trying to enter the patient’s life world, the patient is turned into a ‘docile body’ caught in the clinical gaze (Lupton, 2006 p. 101). Martin Buber argues there are two basic modes of human relationships, the ‘I-It’ and the ‘I-Thou’ (Buber, 1958). The ‘I-It’ form of interaction objectifies the other person, as a means to an end, which can be ordered, coherent and even efficient. For example, as seen by the categories used to code a patient’s narrative, after taking a history in general practice. However, this can be dehumanising, and lead to harmful assumptions.

The imaginative process of placing oneself in another's situation is subject to one's own biases of the perceived relatability and deservedness of the other. When there are perceived similarities in background, it is likely that identifying with the other's experience will be easier. This presents a barrier to healthcare for under-represented and minority patient groups, whose characteristics and experiences are not reflected by the HCPs caring for them. Additionally, for rare or chronic conditions, or those unexperienced by the HCP, an incommensurable gap arises. It may be unfathomable for the HCP to relate to any perceived similarity with the patient.

Shifting to an other-oriented conceptualisation of empathy and compassion can transcend these biases which cause gaps in care. The 'I-Thou' relationship recognises the uniqueness of each person's context, emphasising deep awareness and acceptance of the mystery of the other, rather than an imagination into their world. Whilst acknowledging the differing contexts of both people, there is an underlying understanding of their shared humanity. I would argue that pairing overarching similarities, 'anchored' in each other's common humanity, could allow us to empathically resonate, beyond trying to relate to specific visual or experiential cues from the other (Rosan, 2014).

In this way, caring across differences can be possible. 'The Care Manifesto' proposes a "promiscuous and experimental caring kinship" (Chatzidakis et al., 2020 p. 56) that is non-discriminatory, and allows an orientation towards others, that transcends boundaries of distance and proximity. Communicating to students a unified approach to understanding the perspectives of others, by being deeply aware of each other's contexts, can help to minimise confusion. This approach will prepare students for future medical practice, helping them recognise nuances in a patient's narrative that may be overlooked with a self-oriented approach. Simulated communication skill sessions and imaginative peer-to-peer OSCE practice (appendix 2) can propagate self-oriented imagination. So, efforts should be made within the medical curriculum to shift from these to real, embodied experiential caring opportunities.

Behavioural Dimension

The OSCE, introduced in 1979, revolutionised medical assessment (Harden & Gleeson, 1979), comprising a series of timed stations where students perform standardized tasks, including history-taking. OSCEs aim to address examiner subjectivity by utilising standardised actors and examiner audiences, and have gained recognition as the "gold standard" for evaluating medical students' clinical competency (Azim Majumder et al., 2019). When assessing history-taking, three areas are evaluated: establishing rapport and empathy, history-taking techniques, and enquiry into key points of the patient's medical history (Harden & Gleeson, 1979). Appendix 3 describes my counter-intuitive thoughts about doing more mock OSCEs than gaining real placement experience, even though that is precisely what OSCE stations are attempting to simulate.

The contrast between the formal curriculum's communication of the behavioural dimension of empathy, and its assessment in the OSCE is significant. Learning objectives such as: “communicate sensitively” and encompassing different forms of communication through “spoken, written and digital” within different interactions with “patients, relatives, carers and colleagues”, are narrowed to fit the highly regimented OSCE stations (appendix 1).

While 'shows empathy' is part of the OSCE mark scheme to foster students' skill development, the exam fundamentally revolves around a "social drama" (Hodges, 2003) (as reflected in appendix 3). OSCE stations not only attempt to represent external realities of clinical practice, but bi-directionally play a powerful role in influencing these realities. The presence of the OSCE extrinsically motivates changes in students' behaviours and attitudes, impacting their professional growth beyond formal examinations (Hodges, 2003).

As the exam impacts a student's course progression, they inevitably adapt their behaviour to meet the perceived expectations of examiners and standardised patients, whilst assuming the role of ‘the doctor’. Goffman's dramaturgical model of social interaction proves useful for understanding the socially constructed realities assessed through the OSCE (Goffman, 2022). Students prepare for OSCEs through faculty or peer-led simulations, by memorising ‘illness scripts’ (Charlin et al., 2000), ready to fit

the mark scheme check boxes and represent themselves in the most favourable light. Their main motivation to express any sentiments of care, in the context of the OSCE, becomes to pass, rather than to genuinely connect to the actor patient.

This can influence a student's behaviour beyond the OSCE, where they may favour this form of caring in real practice, for example: 'I am so sorry to hear that'. Havi Carel reflects on this thin veil of etiquette as a "banal social convention" (Carel as cited in Tomlinson, 2013), where hollow words form a ''McDonalds style" of empathy (Smajdor et al., 2011). This 'thinner' form of empathy may be all that is possible in the bureaucracies of healthcare, as there is a systemic banality that "permeates our everyday carelessness" (Chatzidakis et al., 2020 p. 14). Treating patients in this templated performative way harkens back to James Baldwin's conceptualisation of 'semblance' from Section I, undermining the sensitivity needed in caring relationships and limiting creativity arising from genuine connection.

The OSCEs may also limit the possibilities that students consider to be care, by equating caring with curing a disease. After completing a history, when asked for 'next steps', the expected answers are in relation to: further examinations, bedside, blood or imaging tests. Willingness to act or take the 'next step', as part of empathy or compassion, is influenced by one's perceived controllability (power to change the situation) and perceived efficacy (the positive impacts of the change) in the situation (Condon & Makransky, 2022).

Toombs expands the possibilities of care from curing to healing, acknowledging when allopathic treatment may not suffice (such as, with patients experiencing chronic illness, or students not having the professional capabilities to prescribe medication). Holistic healing encompasses 4 domains: "the medical good, the patient's perception of the good, the good for human beings, and the spiritual good" (Toombs, 2019). Even if the allopathic approach cannot meet the patient's medical good, shifting focus to the other three aspects of healing can help a patient feel fulfilled. Expanding the goal of caring in medicine, from curing to healing, reduced challenges HCPs grapple with (perceived controllability, and perceived efficacy) when deciding whether to act, allowing them to feel fulfilled too.

OSCEs need to be reassessed to question whether they are doing more harm than good. Rather than promoting students to ‘act like they care’, through simulation, opportunities could be created for students to engage in real acts of care, such as volunteering with charities linked to GP practices. Although these may not be directly centred around medical practice, they could allow students to re-imagine the possibilities of care and learn from allied professionals who serve in diverse settings.

Moral Dimension

Following on from discussing the impact of assessment on students' professional behaviours, it is important to further consider their moral and professional identity development during the liminal period of medical school. The intentions and motivations behind the actions and thoughts are necessary to address.

Many suggest that doctors have a 'special moral obligation' in contrast to other professionals, which has become exaggerated through the division of doctors from other forms of healers, granting them a higher social status (Smajdor et al., 2011). The extensive list of ethical principles in the learning objectives under the professional values and behaviours module of the curriculum (appendix 1) based on the GMC's outcomes for graduates, could suggest that doctors are required to have a higher moral ground than the public (General Medical Council, 2020). However, this distinction creates a disconnect between medical professionals and patients, reinforcing a binary division. It also leads to hierarchical dynamics within multidisciplinary teams, where doctors may implicitly overshadow the contributions of other team members, such as nurses and healthcare assistants, as seen in personal reflections in appendix 4.

The formal curriculum teaches students about the moral dimension of empathy and compassion through various approaches, such as "the Hippocratic tradition, on principle-based moral theories, and/or on virtue-based theories" (Hafferty & Franks, 1994). Yet, there are several real scenarios not accounted for within the formal curriculum, that occur between wards or in the corridors on clinical placements, in the 'hidden curriculum', which may influence a student's moral development greater. During my third-year surgical placement, I encountered an interaction between a surgeon and scrub nurse that challenged the principles of 'Teamwork' and 'Fundamentals of clinical communication' that are highlighted within the learning objectives, and 'Respect for Colleagues' section that is outlined in the GMC's 'Working with colleagues' guideline (appendix 4).

Hierarchical dynamics in multidisciplinary teams still pervade and are amplified in high-stress situations. With this surgical scenario, the patient's safety clearly took precedence, over other principles of respect, teamwork and fundamentals of clinical

communication (appendix 4). Although it is understandable why this occurred, this represents how experiences in the hidden curriculum could alter the priorities that students may place on these principles when developing their professional identity.

The challenge this example presents to moral and ethical teaching within the medical curriculum is that a top-down prescriptive approach cannot account for the shifting balances between these principles that occur in real practice. The power relations intrinsic to interactions between students and healthcare communities, allow norms of medical society to be “actualised” (Goldie, 2012). While juridical power persists in medical education (e.g. “Professional Obligations” in appendix 1), there has been a shift in Western medical society to regulatory power (Foucault as cited in (Goldie, 2012). Power is dissipated throughout, rather than only being handed down by a governing body. Students start to self-govern their ways of being, based on rules and norms they internalise.

Expanding the boundaries of the formal medical curriculum to include reflexive practice from the hidden curriculum and insights from students' first-hand experience is crucial. A bottom-up approach is needed to balance the moral distress arising from real-life scenarios conflicting with taught ethical principles. Students could be guided through Schwartz rounds and de-briefings after real events, rather than through imagined simulated scenarios. Through encountering and reflecting on ethical challenges firsthand, students can develop a personalised portfolio of meaningful encounters that shape what caring means to them.

As Goldie describes, a post-modernist view on the formation of a professional identity, an organisation’s culture is not only structured by the ‘habitas’ – “habitual, patterned and thus pre-reflexive way of understanding and behaving that helps generate and regulate the practices that make up the social life of the school” (Goldie, 2012). It also involves individuals creating their own meanings of their institutional culture through their own experiences and contexts. So professional identities cannot only be transmitted down through the formal curriculum, but also created from the bottom-up. Students can be guided by educators through their professional transformation, to develop values and behaviours that are authentic to them (Leedham-Green et al., n/a).

In this way, motivations for caring could transition from external regulatory pressures to originating from intrinsic sources on the moral dimension spectrum of the empathy and compassion framework (Figure 3).

Emotional Dimension

The emotional dimension of empathy sparks debate among students and HCPs. Some students view empathy as compromising objectivity and professionalism. Prioritisation of disease-centric knowledge, rather than illness or person-focused education, in medical education, may lead students' professional identity to align with this priority (Costa-Drolon et al., 2020).

This emotional facet of empathy and compassion is often overlooked by medical educators and professional bodies defining empathy as 'detached concern'. Professional empathy is viewed as unidimensional, solely cognitive, contrasting the 'feeling-into' or 'feeling-with' conceptualisations from Lipps and Smith (Stueber, 2019) (Section I). Halpern argues that empathy is recognising "what it feels like to experience something", an emotional resonance, rather than simply knowing the emotional state of the other (Halpern, 2003). Reflecting on a personal experience from my second-year medical placement, the tension between remaining detached and emotionally engaged became apparent (appendix 5).

Detachment and vicarious feeling represent opposing ends of the emotional dimension spectrum. Being moved by another's experience enriches one's own experience of practising medicine, making the vocation of healthcare particularly meaningful (Tomlinson, 2013). However, expecting HCPs to feel every emotion of the patient, by being infected by an 'emotional contagion' (Cuff et al., 2016), may shift their focus away from the patient's true experience to their own parallel emotional story that imaginatively mirrors that of the patient. Jamison argues this form of empathy is 'solipsism', where one's own 'hypothetical self-pity' is projected onto someone else (Jamison, 2015 p.23). Although under the guise of fellow-feeling, vicarious feeling can end up being self-oriented, possibly unnecessary and can hinder responding in an ethically sound way (Bloom, 2018). For example, emotionally identifying with a patient during a surgical procedure could hinder the surgeon from performing the procedure. As Leslie Jamison reflects on her experience of getting a pacemaker implanted, "assurance was evidence of empathy, insofar as he understood that assurance not identification, was what I needed most" (Jamison, 2015 p.17); sensitivity, flexibility, and attunement, rather than identification, to develop the ability to anticipate what a patient

may need, goes beyond being an “echo” of their fear, into rather the “opposite” (Jamison, 2015).

Conceptualising empathy as vicarious feeling is still prevalent, as seen within the learning objectives: “Emotional well-being”, “Self-care” and “Challenging communication” (appendix 1). Perhaps, this conceptualisation of emotional contagion has propagated the idea that emotionally engaging with others can eat away from one’s own emotional capacity, which justifies why compassion and empathy are often depicted as quantities that can run out.

‘Compassion fatigue’ stems from this conceptualisation, as it could be described as a combination of ‘secondary traumatic stress’ ‘cumulative burnout’ (Cocker & Joss, 2017), and ‘vicarious trauma’ (Pearlman & Mac Ian, 1995). Vicarious trauma, as a result of the ‘vicarious feeling’ side of the emotional dimension spectrum, is defined as “the transformation that occurs within the therapist… as a result of empathic engagement with client’s trauma experiences” (Pearlman & Mac Ian, 1995). As such, this feeds into viewing compassion as a “limited-capacity resource that cannot be extended indefinitely”, like a gas tank that can run out (Cameron as cited in Pierdziwol, 2022). In a society with a rise in neo-liberal market values (Chatzidakis et al., 2020), where medicine is viewed as a business, healthcare as a transaction and the patient as a customer (Tomlinson, 2013), it is clear how this extends to viewing compassion as in a rationed economy.

A novel conceptualisation of compassion from the ‘motivational model’ proposes viewing it not from “the perspective of the gas tank” but “from the perspective of the driver, who can make active decisions” about whether to change speed or course (Cameron et al., 2017). Jamison reflects: “I believe in intention and I believe in work.”, that “genuine” is not the opposite of “unwilled” (Jamison, 2015 p.23). It is possible that one’s inability to feel emotion may not be caused by their finite tank of compassion passively running out, but because they are actively shielding themselves. In this way, compassion is not a quantity, but rather a quality that arises out of interaction, where one actively weighs their priorities to decide what extent of emotion to feel.

Therefore, students could be guided to view compassion as a quality that is an active, dynamic choice to regulate emotional feeling along the spectrum of detached to vicarious feeling. Although individual coping strategies may help short-term recovery from intense interactions, this places the onus on the individual to protect their 'reserves' and does not address the underlying reasons for the choices the HCP makes. Community welfare is increasingly pushed aside for individualised "Self-care" and "Self-compassion" (as reflected in the learning objectives, appendix 1). This may just be a "sticking plaster" (Chatzidakis et al., 2020, p. 11) on larger institutional and system-level problems, which require a radical paradigm shift in culture and curriculum to prioritise care.

Social Dimension

One dimension fundamentally missing from the initial framework, that overarches the other four, and allows the framework to function is the social dimension. The components of empathy and compassion can only take place within caring interactions. As seen from the learning objectives, personal reflections and discussion of dimensions, there are four core caring interactions: the HCP-patient relationship, the HCP's relationship with their colleagues, HCP's relationship with themselves, and society's relationship with HCPs. It is imperative to conceptualise a more collective empathy and compassion, that goes beyond any one of these individual interactions, to integrate systems, social and political contexts (Cao, 2020).

Care has been in crisis for a long time, with the COVID-19 pandemic bringing essential workers, universal vulnerabilities and inherent interdependence, which are often deprioritised in neoliberal societies, into sharp focus (Laurin & Martin, 2022). Care ethics, as a political framework suggested by Joan Tronto, enlightens how caring is still viewed on the individual rather than societal scale. Caring is universal and essential to life; it is not just within the domain of nursing or between a HCP and a vulnerable patient, it includes any intention which hopes to improve our collective world and lives.

Professional hierarchies that are ingrained into healthcare create power imbalances between physicians and their colleagues, HCPs and their patients, and also between paid HCPs and carers and unpaid carers. It seems that the value granted to the carer decreases the closer they get to physically taking care of another, in comparison to physicians who often play the role of determining a high level 'care' plan (Laurin & Martin, 2022). Providing a product of care (as the noun) is seen as a physician's role, implying a one-directional and depleting quantity.

However, recognition of the reciprocal relationality between all those involved in healthcare and beyond can allow caring (as the verb) to be conceptualised as self-replenishing and self-perpetuating. Advocacy is essential to flattening the hierarchies, to recognise the interrelated needs of all groups involved, and transform healthcare into a truly caring practice. Co-creating caring communities can be facilitated though spaces for political discussions between stakeholders (Chatzidakis et al., 2020).

By realising one's actions as activism, a transformation of the medical culture can take place. Medical students need to be empowered, as the next generation of doctors, to recognise their common humanity with those they interact with, care for, care about and care with. This can encourage them to take a stand against unjust practices and working conditions, which cause harm to not only them but their patients, and ultimately cultivate a real-world, embodied, situated culture of care.

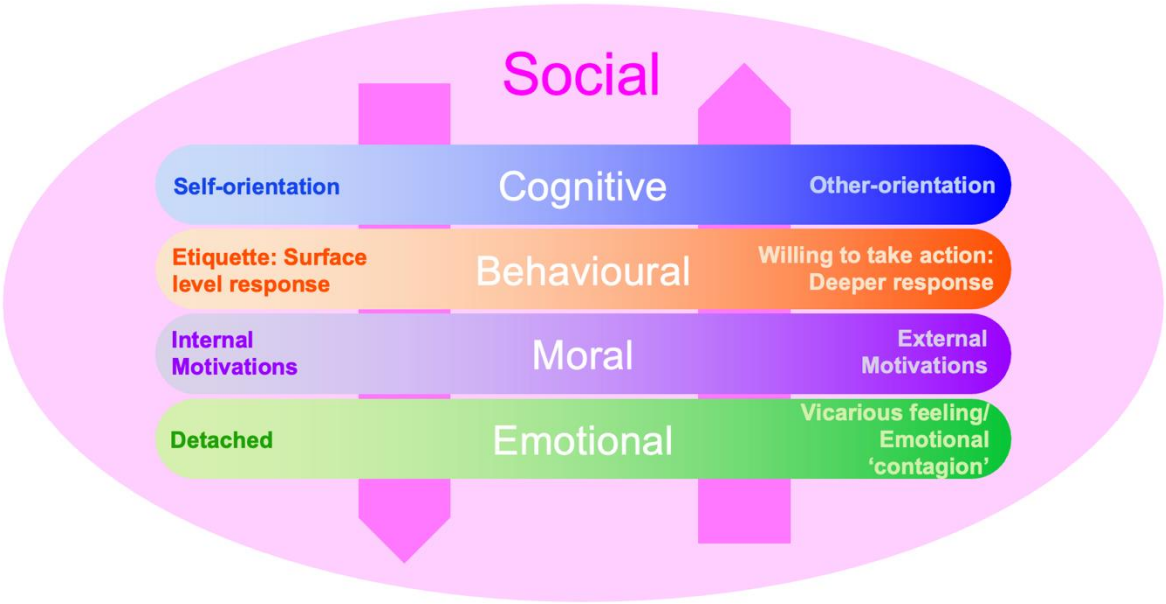

Figure 7 - Framework Evolution with the fifth dimension, Social

Conclusion

To conclude, I have explored the four initial dimensions of empathy and compassion (cognitive, behavioural, moral and emotional) through the formal and informal medical curriculum, to find a fifth social dimension which encompasses all of the others. Within each dimension, I propose a shift in conceptualisation to transform medical education to ensure healthcare is a more caring practice.

Within the cognitive dimension, the shortcomings of a self-oriented imaginative approach are highlighted and an other-oriented deep awareness of the contexts of those in the interaction is suggested, to respect the agency of the other and not assume their needs.

The behavioural dimension investigates the impact of OSCEs on student behaviour, extending beyond exams to future practice. I propose moving away from merely assessing empathy, which encourages students to ‘act like they care’, and instead offering students opportunities for immersion in real acts of caring.

The moral dimension delves into how the hidden curriculum and culture of medicine shape students’ professional identity and value development, more than formal ethics teaching. Enabling students space to reflect on and challenge ethical conundrums they encounter in real practice, will allow them to define their own understanding of caring.

The emotional dimension challenges the ‘detached concern’ form of professional empathy, emphasising the importance of emotional knowledge in clinical practice. Compassion needs to be reimagined as a quality arising from intentional interaction rather than a depleting and ‘fatiguing’ quantity. I consider how the onus should not only be based on the individual to cope, but rather on the institution to prevent states of emotional exhaustion in the first place.

The social dimension considers the politics of care, mutual interdependencies, viewing caring as bi-directional, and the need to empower the next generation of doctors to strive for a culture of care in medicine.

Figure 8 – 'Common Threads' challenges viewers to unravel their preconceived notions of empathy and compassion, to re-imagine an interwoven form of caring. It encourages viewers to take off their masks to be genuinely curious about those they interact with.

Through this project, I created an art piece as praxis, to actualise the concepts of empathy and compassion, which are nebulous and difficult to define with language, into a physical object. Making meaning through this organic method involving clay and crochet gave me a newfound appreciation for this method of thinking, which complemented the complexities I grappled with in my writing.

To conclude, it is necessary to consider the strengths and limitations of this project. My positionality as a fourth-year medical student immersed in the medical curriculum at Imperial College London has allowed me to offer nuanced insights. However, my limited practical experience in the NHS could mean some of the suggested new conceptualisations may not be practically applicable or possible to extrapolate to the working world. As a single student within a large cohort, I was unsure if my personal reflections were generalisable enough to discuss and learn from. By integrating my personal reflections with literature and formal curriculum data, I have reflexively drawn

out key discussion points, to make these individual insights relevant and broadly applicable to students' learning experiences across medical schools.

This project certainly calls for diverse perspectives in the future, including fellow students and educators (ranging in health education backgrounds), HCPs, patients, and unpaid carers. These varying individual nuances and interpretations of care require exploration to apply to nurturing more caring communities in the greater healthcare ecosystem.

Additionally, the nature of care, empathy and compassion, is indescribable through exact definitions and words. While I have attempted to capture the varying definitions in the four-dimensional framework, there are inevitably other cultural and linguistic perspectives I may have missed. Future research into comparing conceptualisations of empathy and compassion across contexts will be enlightening. Drawing from Eastern religions, like Buddhism and Hinduism where compassion is central to moral psychology, it would be fascinating to learn about compassion training models that could be implemented into medical education and practice.

Through this research, I have learnt that empathy and compassion as components of caring are huge concepts that cannot be boxed into a formal curriculum of teaching and assessment. They seep into and are influenced by all aspects of medical students' lives, such as the hidden curriculum and the medical culture they are immersed in. Rather than being entangled by their definitions and attempting to teach and assess these qualities and virtues, changing the medical culture so they can be cultivated should be the aim. Overall, although my research has space to further transform, it has taught me to critically engage with my education and to consider the biases and influences that shape not only my identity but the culture, communities and interactions around me.

Medical education should empower students to feel with their patients, and fully embrace caring for and being cared for. Nurturing reflective and reflexive practice, just as in this project, where students feel supported to make mistakes and learn through the process, can allow for the growth of a culture of care in medicine, where students can flourish to be authentic and embodied carers.

Bibliography

Art and Empathy. (2019) Available at: https://www.youtube.com/watch?v=zOW4YVEaTKI (Accessed: 26 May 2023).

Azim Majumder, A. *et al.* (2019) 'An evaluative study of Objective Structured Clinical Examination (OSCE): Students and examiners perspectives', *Advances in Medical Education and Practice*, Volume 10, pp. 387–397. doi:10.2147/amep.s197275.

Bloom, P. (2018) *Against empathy: The case for rational compassion*. London: Vintage Books.

Buber, M. (1958) *I and thou / with a postscript by the author added ; translated by Ronald Gregor Smith*. Edinburgh: T. & T. Clark.

Cameron, D. *et al.* (2017) *The ends of empathy: Constructing empathy from value-based choice* [Preprint]. doi:10.31234/osf.io/d99bp.

Cao, E. (2020) *Meanings of empathy for a politics of care*, *S Y N A P S I S*. Available at: https://medicalhealthhumanities.com/2020/06/11/meanings-of-empathy-for-a-politics-of-care/ (Accessed: 26 May 2023).

Charlin, B., Tardif, J. and Boshuizen, H.P. (2000) 'Scripts and Medical Diagnostic Knowledge', *Academic Medicine*, 75(2), pp. 182–190. doi:10.1097/00001888-200002000-00020.

Chatzidakis, A. *et al.* (2020) *The Care Manifesto: The Politics of Interdependence*. London: Verso Books.

Cocker, F.M. and Joss, N. (2017) 'Compassion Fatigue among healthcare, emergency and Community Service Workers: A systematic review', *PsycEXTRA Dataset* [Preprint]. doi:10.1037/e510112017-001.

Condon, P. and Makransky, J. 'Compassion, Wisdom and Training' (2022) *The Contemplative Science Podcast*. Available at: https://open.spotify.com/episode/3vrnbUFHBkNpyywld6fpgW?si=6a379759e0fb485a&nd=1 (Accessed: 26 May 2023).

Costa-Drolon, E. *et al.* (2020) 'Medical students' perspectives on empathy: A systematic review and metasynthesis', *Academic Medicine*, 96(1), pp. 142–154. doi:10.1097/acm.0000000000003655.

Cuff, B. *et al.* (2016) 'Empathy: A Review of the Concept', *Emotion Review*, 8(2), pp. 144–153. doi:https://doi.org/10.1177/1754073914558466.

de Zulueta, P. (2013) 'Compassion in Healthcare', *Clinical Ethics*, 8(4), pp. 87–90. doi:10.1177/1477750913506484.

Doshi, A. (2018) *Mark's abdominal pain*, *OSCE Stations*. Available at: http://osce-stations.blogspot.com/2018/02/marks-abdominal-pain.html (Accessed: 26 May 2023).

Dowling, E. (2022) *The care crisis: What caused it and how can we end it?* London, London: Verso.

Etymonline (2021) *Compassion (n.)*, *Etymonline*. Available at: https://www.etymonline.com/word/compassion (Accessed: 26 May 2023).

Foucault, M. (2010) *The Birth of the Clinic: An Archaeology of Medical Perception*. London: Routledge.

General Medical Council (2020) *Standards and outcomes - GMC*, *Outcomes for graduates*. Available at: https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes (Accessed: 26 May 2023).

Goffman, E. (2022) *The presentation of self in everyday life*. London: Penguin Books.

Goldie, J. (2012) 'The formation of professional identity in medical students: Considerations for educators', *Medical Teacher*, 34(9). doi:10.3109/0142159x.2012.687476.

Google Books Ngram (2019) *Google books Ngram Viewer*, *Google Books*. Available at: https://books.google.com/ngrams/graph?content=sympathy%2C%2Bempathy%2C%2Bcompassion&year_start=1500&year_end=2019&corpus=en-GB-2019&smoothing=3 (Accessed: 26 May 2023).

Google books Ngram (2019) *Google books Ngram Viewer*, *Google Books*. Available at: https://books.google.com/ngrams/graph?content=sympathy%2C%2Bempathy%2C%2Bcompassion&year_start=1500&year_end=2019&corpus=en-US-2019&smoothing=3 (Accessed: 26 May 2023).

Hafferty, F.W. and Franks, R. (1994) 'The hidden curriculum, ethics teaching, and the structure of Medical Education', *Academic Medicine*, 69(11), pp. 861–71. doi:10.1097/00001888-199411000-00001.

Halpern, J. (2003) 'What is clinical empathy?', *Journal of General Internal Medicine* [Preprint]. doi:10.1046/j.1525-1497.2003.21017.x.

Harden, R.M. and Gleeson, F.A. (1979) 'Assessment of clinical competence using an Objective Structured Clinical Examination (OSCE)', *Medical Education*, 13(1), pp. 39–54. doi:10.1111/j.1365-2923.1979.tb00918.x.

Hodges, B. (2003) 'OSCE! variations on a theme by Harden', *Medical Education*, 37(12), pp. 1134–1140. doi:10.1111/j.1365-2923.2003.01717.x.

ICSM Insendi (2019a) *Imperial College School of Medicine - Clinical Communication (Phase 1a, Session 1: Understanding communication)*, *Insendi*. Available at: https://icsm.insendi.com/programmes/zhVZWNfQK/courses/rlmYsk2BRL/weeks/yAGzfLYIwN/screens/0MTqdbhRPt (Accessed: 26 May 2023).

ICSM Insendi (2019b) *Imperial College School of Medicine - Clinical Communication (Phase 1a, Session 7: Reflection on Patient Care II - Observation of Clinical Communication)* , *Insendi*. Available at: https://icsm.insendi.com/programmes/zhVZWNfQK/courses/rlmYsk2BRL/weeks/yAGzfLYIwN/screens/ZXafpluQCQ (Accessed: 26 May 2023).

ICSM Insendi (2020) *Imperial College School of Medicine - MBBS Phase 1b 2020-2021 Programme information*, *Insendi*. Available at: https://icsm.insendi.com/programmes/aNpmyl7w1/overview (Accessed: 26 May 2023).

Jamison, L. (2015) *The empathy exams*. Audible Studios on Brilliance.

Jeffrey, D. (2016) 'Empathy, sympathy and compassion in healthcare: Is there a problem? is there a difference? does it matter?', *Journal of the Royal Society of Medicine*, 109(12), pp. 446–452. doi:10.1177/0141076816680120.

Lanzoni, S.M. (2018) *Empathy: A history*. New Haven: Yale University Press.

Laurin, A.-C. and Martin, P. (2022) 'Towards democratic institutions: Tronto's Care Ethics Inspiring Nursing actions in intensive care', *Nursing Ethics*, 29(7–8), pp. 1578–1588. doi:10.1177/09697330221089093.

Leedham-Green, K. and Iedema, R. (no date) 'Developing professional identity in health professional students ', in A. Knight (ed.). Available at: https://spiral.imperial.ac.uk/bitstream/10044/1/89847/2/Professional%20Identity%20Chapter%20Leedham-Green%20Knight%20Iedema%20SUBMITTED%20VERSION.pdf (Accessed: 26 May 2023).

Lupton, D. (2006) "Foucault and the medicalisation critique," in A.R. Petersen and R. Bunton (eds) Foucault, Health and Medicine. London: Routledge, p. 101.

Pearlman, L.A. and Mac Ian, P.S. (1995) 'Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists.', *Professional Psychology: Research and Practice*, 26(6), pp. 558–565. doi:10.1037/0735-7028.26.6.558.

Pierdziwol, A. (2022) 'Beyond compassion fatigue: Motive-based approaches to sustaining compassion in palliative care', *Religions*, 14(1), p. 50. doi:10.3390/rel14010050.

Rosan, P.J. (2014) 'The varieties of ethical experience: A phenomenology of empathy, sympathy, and compassion', *Phänomenologische Forschungen*, 2014(1), pp. 155–190. doi:10.28937/1000107781.

Sinclair, S. *et al.* (2016) 'Sympathy, empathy, and Compassion: A grounded theory study of palliative care patients' understandings, experiences, and preferences', *Palliative Medicine*, 31(5), pp. 437–447. doi:10.1177/0269216316663499.

Smajdor, A., Stockl, A. and Salter, C. (2011) 'The limits of empathy: Problems in medical education and Practice', *Journal of Medical Ethics*, 37(6), pp. 380–383. doi:10.1136/jme.2010.039628.

Sofia (2019) *Sofia Curriculum Map MBBS Medicine (2019)*, *Sofia Curriculum Map*. Available at: https://medicine.sofia.imperial.ac.uk/map/a100/student (Accessed: 26 May 2023).

Sontag, S. (2004) *Regarding the pain of others*. Harmondsworth: Penguin books.

Stueber, K. (2019) *Empathy*, *Stanford Encyclopedia of Philosophy*. Available at: https://plato.stanford.edu/Entries/empathy/ (Accessed: 26 May 2023).

The University of Auckland (no date) *Doing reflexive ta*, *Thematic Analysis*. Available at: https://www.thematicanalysis.net/doing-reflexive-ta/ (Accessed: 26 May 2023).

Tomlinson, J. (2013) *Doctors and empathy*, *A Better NHS*. Available at: https://abetternhs.net/2013/12/20/empathy/ (Accessed: 26 May 2023).

Toombs, S.K. (2019) 'The healing relationship: Edmund Pellegrino's philosophy of the physician–patient encounter', *Theoretical Medicine and Bioethics*, 40(3), pp. 217–229. doi:10.1007/s11017-019-09490-z.

Appendix 1

Cognitive

- Cognitive (overall)

1	Reflection: Document your experiences and development as a medical student.
2	Reflection: Apply the principles of reflection to clinical encounters and demonstrate engagement with a portfolio for learning.
3	Uncertainty: Demonstrate how uncertainty can stimulate creativity and problem-solving approaches in science.

- Self vs Other-orientation

3	Illness: explain with examples the importance of understanding the lived experience of illness.
2	Communication and self: Recognise the potential impact of self on communication, including attitudes, values and beliefs; identify personal strategies to address this.
4	Personal characteristics: Describe how personal characteristics may impact on team working.
3	Disability and impairments: Describe impairment and different models of disability and their application to the healthcare setting, with consideration of stigma, prejudice and discrimination.
3	Biopsychosocial model: Describe the biopsychosocial model and the need to take account of the lived experience of illness.
2	Person-centred care: Describe key principles of person-centred care, and how these relate to exploring a person's understanding, values and preferences, including shared decision-making, social prescribing and health literacy.
3	Diversity and inclusivity: Explain how respect for diversity and inclusivity can affect clinical practice and health outcomes.
1	Patient-centred communication (i): Recognise and demonstrate the communication skills integral to effective interaction with patients, relatives, carers and colleagues, including verbal and non-verbal communication, listening skills, empathy and compassion.
1	Patient-centred communication (ii): Identify key communication skills that can be used to elicit the patient's understanding of their condition and treatment options including their concerns, values and preferences.
1	Recognise the principles of communication surrounding a fitness to work consultation
1	Challenging communication: Communicate sensitively, clearly and effectively with patients, carers and patient representatives when delivering bad news
1	Mental well-being: Identify methods to monitor the level of stress you experience and your mental well-being, and self-care strategies to reduce stress and improve mental well-being.
1	Autonomy: Evaluate the concept of respect for patient autonomy and identify situations in which it may be affected by other considerations

- Recognition of differing contexts of/ from patients

1	Communication barriers (i): Recognise barriers to communication including language, culture, literacy, cognitive, psychiatric, learning disability or physical disability and identify ways in which they can be overcome.
1	Student identity, values and beliefs: Recognise one's own values and beliefs and reflect on personal biographies.
1	Communicate sensitively, clearly and effectively with children and young people
1	Unconscious bias: Explain what is meant by unconscious bias, and describe how this can influence clinical interactions and health outcomes.
1	Student identity, values and beliefs: Identify your own values and beliefs and reflect on personal biographies.
1	Communication theory: Recognise the relevant psychosocial theory underpinning clinical communication.
1	Adaptability and resilience: Describe the concept of adaptability with examples of resilience and emotional intelligence.
1	Diversity and equality: Explain how respect for diversity and equality can be recognised and promoted in healthcare settings.

Behavioural

- Behavioural (overall)

1	Adaptability and resilience: Describe the concept of adaptability with examples of resilience and emotional intelligence.
1	Reflection: Document your experiences and development as a medical student.
2	Reflection: Apply the principles of reflection to clinical encounters and demonstrate engagement with a portfolio for learning.

- 'Empathy'

2	Fundamentals of clinical communication: Communicate professionally, effectively and empathically with patients, their relatives, carers and colleagues using different modes of communicating including spoken, written and digital.
1	Patient-centred communication (i): Recognise and demonstrate the communication skills integral to effective interaction with patients, relatives, carers and colleagues, including verbal and non-verbal communication, listening skills, empathy and compassion.

- Different modes of communication

2	Fundamentals of clinical communication: Communicate professionally, effectively and empathically with patients, their relatives, carers and colleagues using different modes of communicating including spoken, written and digital.
1	Patient-centred communication (i): Recognise and demonstrate the communication skills integral to effective interaction with patients, relatives, carers and colleagues, including verbal and non-verbal communication, listening skills, empathy and compassion.
1	Patient-centred communication (ii): Identify key communication skills that can be used to elicit the patient's understanding of their condition and treatment options including their concerns, values and preferences.
1	Impact of clinical communication: Describe the impact of communication on a patient's experience of healthcare and on health outcomes.
1	Recognise the benefits and risks and process of communication with patients and colleagues through technology enabled communication platforms. How to maintain professional standards and respect confidentiality
1	Communicate sensitively, clearly and effectively with children and young people
1	Challenging communication: Communicate sensitively, clearly and effectively with patients, carers and patient representatives when delivering bad news
1	Communication theory: Recognise the relevant psychosocial theory underpinning clinical communication.

- Sensitivity

2	Communication barriers (ii): Communicate sensitively and effectively with colleagues and patients regarding sensitive issues such as alcohol, sexuality, relationships, safeguarding, lifestyle choices and behaviour change.
1	Recognise the principles of communication surrounding a fitness to work consultation
1	Communicate sensitively, clearly and effectively with children and young people
1	Challenging communication: Communicate sensitively, clearly and effectively with patients, carers and patient representatives when delivering bad news

- Taking action

1	Communication barriers (i): Recognise barriers to communication including language, culture, literacy, cognitive, psychiatric, learning disability or physical disability and identify ways in which they can be overcome.
1	Challenging communication: Speaking up - communicate sensitively, clearly and effectively with colleagues and seniors when you are concerned something is wrong/inappropriate

Moral

- Moral (overall)

1	Challenging communication: Speaking up - communicate sensitively, clearly and effectively with colleagues and seniors when you are concerned something is wrong/inappropriate
1	Reflection: Document your experiences and development as a medical student.
2	Reflection: Apply the principles of reflection to clinical encounters and demonstrate engagement with a portfolio for learning.

- Professionality

2	Fundamentals of clinical communication: Communicate professionally, effectively and empathically with patients, their relatives, carers and colleagues using different modes of communicating including spoken, written and digital.
3	Confidentiality: Explain and apply the professional guidance relating to confidentiality including use of social media.
6	Professional behaviour: Demonstrate appropriate professional behaviour as a medical student.
9	Honesty: Describe, with examples, and discuss the academic and professional honesty of a medical student.
2	Leadership: Describe the characteristics of an effective leader.
1	Recognise the benefits and risks and process of communication with patients and colleagues through technology enabled communication platforms. How to maintain professional standards and respect confidentiality
1	Professional behaviour: Demonstrate professional behaviour as a medical student
1	Professional identity: Analyse the reasons for and against respecting the personal values and beliefs of health professionals when these may impact on patient care
1	Personal limits: Discuss how to recognise personal limits and how to seek help when safety might be compromised.
3	Raising concerns: Discuss how to raise concerns through informal and formal systems, for example about bullying and harassment.

- Moral/ Ethical Principles

4	Consent: Demonstrate the ability to apply the principles of informed consent to a patient for history taking, performing clinical examination and collecting bedside observations.
9	Autonomy: Explain the value of bodily integrity and personal autonomy, and factors that undermine autonomy in the learning environment.
6	Patient safety: Describe human and systemic factors relevant to monitoring and improving patient safety and approaches to address these, and apply principles of infection control, safeguarding, information governance, ethics, confidentiality and effective teamworking.
9	Honesty: Describe, with examples, and discuss the academic and professional honesty of a medical student.
3	Confidentiality: Explain and apply the professional guidance relating to confidentiality including use of social media.
2	Consent: Apply the principles of informed consent to a patient for history taking, performing clinical examination and collecting bedside observations.
3	Dignity: Explain the meaning of 'dignity' applied to patient, carer and medical professional experiences.
1	Recognise and demonstrate the principles of capacity assessment
1	Ethics and social justice: Discuss the basis of public health ethics and ideas of social justice.
1	Autonomy: Evaluate the concept of respect for patient autonomy and identify situations in which it may be affected by other considerations
1	Autonomy: Demonstrate respect for autonomy in clinical practice

- Professional obligations

3	Quality improvement: Describe principles of clinical governance, quality improvement, social accountability, and the ethical and professional obligations of a medical student to the local community and UK public.
3	Role and responsibilities: Describe the role and responsibilities of the medical student.
2	Professional obligations: describe the ethical and professional obligations of a medical student to the local community and UK public.
1	Professional identity: Analyse the reasons for and against respecting the personal values and beliefs of health professionals when these may impact on patient care

- Law

1	Vulnerable patients: Apply the Mental Capacity Act and analyse how it protects the interests of vulnerable adult patients

Emotional

- Emotional (overall)

1	Adaptability and resilience: Describe the concept of adaptability with examples of resilience and emotional intelligence.
1	Reflection: Document your experiences and development as a medical student.
2	Reflection: Apply the principles of reflection to clinical encounters and demonstrate engagement with a portfolio for learning.

- Challenging interactions - impact on self

2	Challenging communication: Recognise the potential impact of communication in challenging circumstances with patients and families on self; identify personal strategies to address this.
2	Self-care: Demonstrate awareness of the need to self-monitor, self-care and seek appropriate advice and support to maintain your own physical and mental health.
2	Compassion and self-compassion: Describe the concept of compassion in the care of self and others.
2	Emotional well-being: Discuss the personal and emotional impact of clinical practice on medical professionals and students and identify strategies for managing this impact.
2	Adaptability: Describe concepts such as resilience and emotional intelligence, time management and coping with negative stress.
1	Challenging communication: Communicate sensitively, clearly and effectively with patients, carers and patient representatives when delivering bad news
1	Mental well-being: Identify methods to monitor the level of stress you experience and your mental well-being, and self-care strategies to reduce stress and improve mental well-being.
1	Personal limits: Discuss how to recognise personal limits and how to seek help when safety might be compromised.
1	Managing workload: Identify methods to monitor your workload and the effect this has on your physical and mental health, and identify methods to manage your workload to promote well-being.

Social

- Social (overall)

3	Raising concerns: Discuss how to raise concerns through informal and formal systems, for example about bullying and harassment.
1	Communication theory: Recognise the relevant psychosocial theory underpinning clinical communication.
1	Reflection: Document your experiences and development as a medical student.
2	Reflection: Apply the principles of reflection to clinical encounters and demonstrate engagement with a portfolio for learning.
2	Environment: Describe the role of the physical environment in relation to health behaviours and outcomes.

- HCP <-> Self

2	Challenging communication: Recognise the potential impact of communication in challenging circumstances with patients and families on self; identify personal strategies to address this.
3	Dignity: Explain the meaning of 'dignity' applied to patient, carer and medical professional experiences.
2	Self-care: Demonstrate awareness of the need to self-monitor, self-care and seek appropriate advice and support to maintain your own physical and mental health.
2	Compassion and self-compassion: Describe the concept of compassion in the care of self and others.
2	Adaptability: Describe concepts such as resilience and emotional intelligence, time management and coping with negative stress.
1	Mental well-being: Identify methods to monitor the level of stress you experience and your mental well-being, and self-care strategies to reduce stress and improve mental well-being.
1	Personal limits: Discuss how to recognise personal limits and how to seek help when safety might be compromised.
1	Managing workload: Identify methods to monitor your workload and the effect this has on your physical and mental health, and identify methods to manage your workload to promote well-being.

- HCP <-> Patient

2	Communication barriers (ii): Communicate sensitively and effectively with colleagues and patients regarding sensitive issues such as alcohol, sexuality, relationships, safeguarding, lifestyle choices and behaviour change.
6	Patient safety: Describe human and systemic factors relevant to monitoring and improving patient safety and approaches to address these, and apply principles of infection control, safeguarding, information governance, ethics, confidentiality and effective teamworking.
3	Dignity: Explain the meaning of 'dignity' applied to patient, carer and medical professional experiences.
2	Fundamentals of clinical communication: Communicate professionally, effectively and empathically with patients, their relatives, carers and colleagues using different modes of communicating including spoken, written and digital.
2	Challenging communication: Recognise the potential impact of communication in challenging circumstances with patients and families on self; identify personal strategies to address this.
3	Decision-making: Describe and rationale the approach to shared decision-making.
3	Disability and impairments: Describe impairment and different models of disability and their application to the healthcare setting, with consideration of stigma, prejudice and discrimination.
3	Biopsychosocial model: Describe the biopsychosocial model and the need to take account of the lived experience of illness.
2	Person-centred care: Describe key principles of person-centred care, and how these relate to exploring a person's understanding, values and preferences, including shared decision-making, social prescribing and health literacy.
2	Multidisciplinary healthcare: Describe the multidisciplinary approach to healthcare.
2	Compassion and self-compassion: Describe the concept of compassion in the care of self and others.
2	Leadership: Describe the characteristics of an effective leader.

1	Patient-centred communication (i): Recognise and demonstrate the communication skills integral to effective interaction with patients, relatives, carers and colleagues, including verbal and non-verbal communication, listening skills, empathy and compassion.
1	Communication barriers (i): Recognise barriers to communication including language, culture, literacy, cognitive, psychiatric, learning disability or physical disability and identify ways in which they can be overcome.
1	Impact of clinical communication: Describe the impact of communication on a patient's experience of healthcare and on health outcomes.
1	Recognise the principles of communication surrounding a fitness to work consultation
1	Communicate sensitively, clearly and effectively with children and young people
1	Challenging communication: Communicate sensitively, clearly and effectively with patients, carers and patient representatives when delivering bad news
1	Reciprocal learning: Design an event that demonstrates reciprocal learning, in collaboration with patient and/or community groups.

- HCP <-> Colleagues

2	Communication barriers (ii): Communicate sensitively and effectively with colleagues and patients regarding sensitive issues such as alcohol, sexuality, relationships, safeguarding, lifestyle choices and behaviour change.
6	Patient safety: Describe human and systemic factors relevant to monitoring and improving patient safety and approaches to address these, and apply principles of infection control, safeguarding, information governance, ethics, confidentiality and effective teamworking.
3	Dignity: Explain the meaning of 'dignity' applied to patient, carer and medical professional experiences.
2	Fundamentals of clinical communication: Communicate professionally, effectively and empathically with patients, their relatives, carers and colleagues using different modes of communicating including spoken, written and digital.
4	Personal characteristics: Describe how personal characteristics may impact on team working.
3	Decision-making: Describe and rationale the approach to shared decision-making.
2	Teamwork: Describe effective teamwork and strategies to manage the challenges to effective teamwork with peers and other disciplines.
2	Multidisciplinary healthcare: Describe the multidisciplinary approach to healthcare.
2	Compassion and self-compassion: Describe the concept of compassion in the care of self and others.
1	Patient-centred communication (i): Recognise and demonstrate the communication skills integral to effective interaction with patients, relatives, carers and colleagues, including verbal and non-verbal communication, listening skills, empathy and compassion.
1	Teamworking: Demonstrate communication with seniors e.g. presenting patients, handover
2	Leadership: Describe the characteristics of an effective leader.

- HCP <-> Society (system)

2	Professional obligations: describe the ethical and professional obligations of a medical student to the local community and UK public.
6	Patient safety: Describe human and systemic factors relevant to monitoring and improving patient safety and approaches to address these, and apply principles of infection control, safeguarding, information governance, ethics, confidentiality and effective teamworking.
3	Healthcare planning and improvement: Describe how data, information and intelligence can inform health system planning and healthcare improvement.
1	Communication barriers (i): Recognise barriers to communication including language, culture, literacy, cognitive, psychiatric, learning disability or physical disability and identify ways in which they can be overcome.
1	Ethics and social justice: Discuss the basis of public health ethics and ideas of social justice.
2	Leadership: Describe the characteristics of an effective leader.
3	Quality improvement: Describe principles of clinical governance, quality improvement, social accountability, and the ethical and professional obligations of a medical student to the local community and UK public.

- Personal Biases

2	Communication and self: Recognise the potential impact of self on communication, including attitudes, values and beliefs; identify personal strategies to address this.
4	Personal characteristics: Describe how personal characteristics may impact on team working.
3	Diversity and inclusivity: Explain how respect for diversity and inclusivity can affect clinical practice and health outcomes.
1	Communication barriers (i): Recognise barriers to communication including language, culture, literacy, cognitive, psychiatric, learning disability or physical disability and identify ways in which they can be overcome.
1	Student identity, values and beliefs: Recognise one's own values and beliefs and reflect on personal biographies.
1	Unconscious bias: Explain what is meant by unconscious bias, and describe how this can influence clinical interactions and health outcomes.
1	Professional identity: Analyse the reasons for and against respecting the personal values and beliefs of health professionals when these may impact on patient care
1	Student identity, values and beliefs: Identify your own values and beliefs and reflect on personal biographies.

Appendix 2 (Personal Reflection: Cognitive)

An approach often used to consolidate this concept in students' minds, is role-playing, a highly used method of teaching and learning in communication skills. Within the formal curriculum, students role play as medical students, prospective doctors, and practice their communication skills with actor patients. Students take this on further into their own informal methods of preparation for their practical examinations (OSCEs). With no actors available, students take on the persona of a patient often through a condensed form of notes resembling medical notes, using resources such as OSCE blogspot, which reduces a fictional patient's expansive life-world into bullet-pointed lists (Doshi, 2018). When I have actively put myself in the character of the patient, to practice history-taking with my peers, I find myself inherently comparing the experience to my own real experiences as a patient. Forcing myself into the fictive life-world of another meant I was unable to appreciate the nuance of experience the patient would have lived. The grief that may have welled up in the patient who's father had recently died, when my peer asked 'Are your parents alive and well?', was not an emotion I could replicate. This meant I was making assumptions and pretending a form of emotion, projected from my own life experiences, rather than getting closer to the patient's true experience.

Appendix 3 (Personal Reflection: Behavioural)

Walking into my 3rd year OSCE exams, I felt a pit in my stomach. Although I had spent countless hours on the wards and in GP practice, speaking to patients and really getting to know them – I knew I had not prepared well enough for the actual OSCE. Walking into the simulation, I became increasingly aware of how strikingly different this was to my real encounters with patients. Maybe I should have done more mock OSCEs and spent less time on the wards was a question I found myself asking. I felt like I was walking on stage, a performer, frantically scrambling to remember the right questions to ask, the right words to say to the actor patient when they disclose their pain, and the right expressions to emphasise – exaggerated enough for the examiner to observe and tick the box for 'shows empathy'. The panic and pressure of both the actor patient and examiner watching me, alongside remembering the right body language and expressions, meant sometimes I actually forgot to listen to the person in front of me.

Appendix 4 (Personal Reflection: Moral)

I had observed quite an intense surgery. When the hemicolectomy surgery had started (laparoscopically), it was initially thought that the tumour that was being resected was a T3 tumour. However, once they looked further, the surgeons realised it was worse than they had expected. This meant the surgery had to be converted into an open procedure. As the tumour had progressed further than expected, it had also created its own blood supply. These friable new vessels meant that the patient was at a much higher risk of having a bleed - which is exactly what happened.

Although the surgeon was initially calm, there was rising tension when the procedure had to become open. When the patient was bleeding however, it was clear the surgeon was under pressure and stressed - especially when he became frustrated and annoyed at the scrub nurse who did not know how to use the 'vascular giving set'. In the shoes of the scrub nurse, I am not sure if I would have been able to handle the situation. However, the nurse understood the surgeon's position, and handed over the task to another scrub nurse who was more experienced.

Appendix 5 (Personal Reflection: Emotional)

A patient recently presented to their GP with gradual loss of appetite, which had later been confirmed to be caused by gastric cancer. The insidious onset meant that they were not sure if there was something much worse happening beneath the surface; and therefore, they presented to their GP later on in the progression of the cancer. Although they have a strong support network at home, social distancing rules have led to them losing that sense of contact.

Their life had turned upside down in the space of a few months, resulting in loss of independence and ultimately loneliness in the hospital. It became apparent the extent to which this diagnosis affected their mental health, as they were tearful through the conversation – and mentioned that nobody understands their situation but themself. The reassurance from family and healthcare professionals did not make their situation any better.

This is the first time I have taken a history from a patient who is visibly emotional, which I was unprepared for. This interaction enabled me to reflect on how I would approach such a conversation with my own relatives – and if my words were aligning to that, or if I was trying to be too detached.