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### **How education must reawaken empathy.**

Unless you are a visiting your local general practice clinic where you may be recognised by friends and neighbours, it is unlikely that you will come away from a modern health service with the feeling of having had a warm and empathic encounter with a nurse or doctor. As a patient in an outpatient clinic, one needs to endure time that undulates between long waiting times, with single, brief and hurried encounters with clinicians. There will be complex machinery, crowds of people – other patients, visitors and hospital staff – generating noise and making demands. The experience is likely to leave you feeling as though you were treated more like an object than a unique individual with personal and important concerns. To cope with this situation, and cope with its negative impacts, one needs to understand the peculiar mechanism of dehumanization that works sometimes as a blessing and a curse for medical workers.

Doctors and nurses learn through socialisation and role modelling that, to be a clear decision maker unencumbered by too many emotions, they are expected to treat people like they are cases, or collections of symptoms. You become desensitised to the many harrowing aspects

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of humanity seen every day. Care is often delivered to a body without acknowledgment that this is a body, a human being who has emotional and spiritual needs. Distance has the added benefit of allowing clinicians to continue to care for case after case, and to go home at the end of a shift feeling as though they have dispensed care reliably and efficiently.

Many healthcare workers think that to be professional and deliver high quality health care they need to be dispassionate and distanced. They misguidedly conclude that this is necessary to protect them from the distress they may suffer from their work. This is despite the evidence demonstrating the positive results for both patients and the health care professionals when empathy, a more passionate and engaged ontology, is communicated.

Studies have shown that whilst empathy may be prevalent in medical students, for example, at the start of their programmes, it declines with exposure and interaction with patients in the clinical setting. Neumann *et al* (2011) suggests this could be due to the belief that to survive personally and professionally they need to treat patients objectively and dispassionately; however, they are objectifying people and dehumanising them. It is suggested that burnout and depression as students move through their programs could contribute to this decline in empathy (Neumann *et al* 2011).

The curse of dehumanization is that clinicians, having been trained so well to treat people without emotion, or sometimes with a false bonhomie, find it difficult to think and practice using both emotion and reason. Evidence for this is the many cases of institutional neglect such as observed in Mid-Staffordshire in the UK (Francis 2010). More than 300 deaths were directly linked to this neglect. This was an extreme case but every day patients and their family and friends experience and witness acts of indifference and inattention such as those in the review recently conducted at a major teaching hospital in Australia that reported numerous issues where patients were left lying in dirty beds, given the wrong food or no food

at all (<http://www.watoday.com.au/wa-news/fiona-stanley-hospital-patients-injured-not-fed-left-in-dirty-beds-review-20150723-giisbo.html>; retrieved 7 December 2016). Stereotyping of people who are older, have a disability, a mental illness, or who act in ways considered deviant (such as those who self-harm or overuse alcohol) is common among clinicians, and is an example of dehumanization. In more overt examples, clinicians have also been known to exploit, mock, deny people their right to liberty (<http://www.news.com.au/national/nursing-home-horrors-uncovered/story-e6frfkvr-1226016507730>; retrieved 7 December 2016) and, even to kill them (Field, 2007; Foth, 2013).

Dehumanization happens throughout society, suggesting that health care workers are just part of a general trend in a society that is damaged and uncaring. However, nurses and doctors need to be paragons of care; it is their career choice to work in that context. Many doctors and nurses, for instance, still take an oath pledging to respect the privilege in their healing role and to remember that there is an art to medicine and nursing just as there is a science, and that ‘warmth, sympathy and understanding must outweigh the surgeon’s knife’ (<http://www.medicinenet.com/script/main/art.asp?articlekey=20909>; retrieved 7 December 2016)

Managers who confront the reality of neglect or abuse in health care seem to demonstrate a lack of understanding of the root cause of dehumanization. Their solutions inevitably involve staffing restructure, sackings and new appointments, additional reporting mechanisms, or the demand that mandatory training be added to an already crammed annual staff development program. None of these strategies are effective in the long term because they are individual solutions to a structural problem.

Health care professionals need a new ontology – to consciously humanise the service and new learning. We think the health humanities offers exciting potential.

Todres *et al* (2009) have attempted to quantify that humanization by suggesting 8 dimensions to whether a health service is dehumanized or humanized:

Objectification	Insiderness
Passivity	Agency
Homogenization	Uniqueness
Isolation	Togetherness
Loss of meaning	Sense making
Loss of personal journey	Personal journey
Dislocation	Sense of place
Reductionist body	Embodiment

Educators also need to teach a new set of competencies, what Metzl & Hansen (2014) describe as structural competence: the ability to recognise, articulate and act on, the ways social, political, medical and economic forces support marginalisation of vulnerable groups, compound their inequalities and poor health experiences, and delay equality and well-being.

In new learning, health care workers need to practice the judicious use of strategies that produce or reduce distance and proximity to the patient, whichever is needed. In this, we acknowledge that distancing strategies do have a place in the health-world. There is a delicate balance between reason and emotion, distance and proximity, silence and communication, logic and empathy. Distancing is, for instance, helpful in separating the patient's problem from the person who has it; but proximity brings the possibility of being able to deeply listen, to really hear the personal and unique concerns of the other, and finally to demonstrate sincere understanding.

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