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Chapter

Reflections in Medical Education: Empathy, Emotions, and Possible Pedagogical Resources for the Emotional Education of Medical Students

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Abstract

Outcomes, guidelines, and clinical trials are at the forefront of the current medical training. However, we observe well-trained technological physicians with a reduced humanistic perspective which leads to attitudes that lack ethics and professionalism. There is a growing concern about the human dimension of the future physician and how it can be taught or reinforced in the educational environment allowing to integrate technical science with the humanism. Empathy could bridge the gap between patient-centered medicine and evidence-based medicine. Role modeling and caring carefully for the emotional dimension of medical students are possible resources for preventing the erosion of empathy. Humanities and arts help in building a humanistic perspective of doctoring because they enable doctors to understand patients in their whole context. The inclusion of humanities in the curriculum occasions deep rethinking of what it means to be sick and what it means to take care of the sick.

Keywords: medical humanism, empathy, humanities

1. Introduction

1.1 Technology and humanism: finding a new balance

We live in an era in which outcomes, guidelines and clinical trials are at the forefront of medical training. We observe well-trained technological physicians with a reduced humanistic perspective which leads to attitudes that lack ethics and professionalism. It is necessary to overcome the dichotomy that scientific knowledge is objective, while everything that is subjective - of the subject, of the patient - is second-class information. This statement is not only false, but also an obstacle to alleviating suffering [1].

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

There is a growing concern about the human dimension of the future physician and how it can be taught or reinforced in the educational environment [2]. Medical students - often young people learning to be doctors as they develop as human beings - could have their attention captivated by emerging technology. It is up to educators to be attentive to overcome this challenge and facilitate a balance in student's education, using humanities and culture in general. It is well known that while technical dimension and knowledge grow through training and study, improving attitudes, developing virtues and incorporating values require reflection.

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

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

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

When we look at the actions that seek to humanization - without achieving it - we realize that the mistake is, perhaps, in seeking balance and not harmony. The balance assumes that the forces are antagonistic, that modern science supported by evidence has to be seasoned with humanitarian attitudes such as, for example, hearing the patient's history with love and feeling compassion. We recognize that this is already enormous progress and an advance on what, unfortunately, we contemplate daily, where the patient is a mere adjuvant that often disturbs the doctor's practicing. But that balance is insufficient, it lacks consistency. They are still two attitudes that do not mix, like water and oil. The clear water of the evidence, and the comforting oil. But each of them with its density and applied each to its time and in its moment. This "medical performance schizophrenia" is unsustainable in itself, it lasts for a short time, and when the doctor gets tired, he will pay attention to one to the detriment of the other.

Medical science, cutting edge medicine, demands a new humanism [6]. A position that knows how to place liver function and neurological sequelae in the same reasoning, with the meaning of life; transaminases and albumin combined with humiliation, suffering and loss. A science that is an art and therefore manages to place in the

same equation dimensions so different, that apparently do not mix. In truth, they are completely mixed in life: prothrombin and discouragement, neurotransmitters and tiredness of living, hepatocytes and indignation.

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

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

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

In this context, the narratives and life stories, now complete and harmonious - transaminases and distresses, albumin and heartbreak - have their true space and function: to approach the human being who suffers and awaits our care. Once more Marañón gives us a reflection in the perfect chord: "On several occasions I noted to those who work by my side, that a pure diagnostic system, deduced exclusively from analytical data, dehumanized, independent of the direct and endearing observation of the patient, it implies the fundamental error of forgetting the personality, which is so important in the etiologies and to stipulate the prognosis of the patient and teach us doctors what we can do to alleviate their sufferings" [11]. We know well from our own experience how difficult this harmony of action is: how to govern technique and humanism with expertise so we can offer a true symphony of health care [6].

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

Hans Jonas, with his ethics of responsibility [13], points out that what distinguishes human beings from animals is a tripod constituted by the tool, the image and the tumulus. The tool is the technique, and in this there is no doubt that we distinguish ourselves from animals, because when we are born, we quickly incorporate all the

techniques accumulated in the history that precedes us. Animals lack a scientific heritage, and each one has to be built from scratch, without taking advantage of the experiences of the ancestors of their species. We can evoke Ortega [14] when he says that the current tiger is the same tiger of thousands of years ago, and that only the human being is born on a history that precedes him, the history that sets together with the technique and the corresponding progress.

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

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

2. Meeting patients’ needs through empathy: an educational challenge

Empathy, a Greek word that implies understanding the feelings of another, came to the English language to designate the perception that someone has when contemplating a work of art. Only later, from 1918 onwards, Southard incorporates it into the scenario of the doctor-patient relationship as a tool that facilitates diagnosis and treatment [15]. Empathy has to do with deeply understanding the other and is a path to bridge scientific knowledge with compassion for better caring.

Empathy, one of the most studied humanistic attitudes today, is the cornerstone of ethical and humanized behavior and medical professionalism. Empathy has also been considered an essential element in any humanization strategy [16]. It is a personal quality necessary for understanding the inner experiences and feelings of patients. It represents the essence of the doctor-patient relationship. Developing meaningful interpersonal relationships between patients and physicians is important even for improving clinical outcomes [17].

Before entering the concept of empathy in the context of the patient- physician relationship, it is worth pausing to understand the term from a philosophical point of view. In this field, we cannot fail to cite the work developed by Edith Stein (1891 – 1942), a philosopher who developed his doctoral thesis on empathy. Macintyre [18] in his book on the philosophical action of Edith Stein comments that an essential feature of empathic awareness is the awareness of the feelings of others. The relationship we have with the feelings of others is analogous to the relationship we have with our own past feelings. We may notice what the other

is feeling, but we do not have to feel the same as him/her. The same is true when we remember our own feelings - even clearly - does not mean that we will feel the same way we have in the past. A deep understanding, real understanding, but no need to incorporate it. We can fully understand what we feel on one occasion, but we do not have to feel it equally at this time.

It takes caution to state that "I am putting myself in another's shoes." Yes, it is possible to do so, but with our own patterns (our feelings, our reactivity, our understanding of vital reality, our own biographical history) and not his own, so that I cannot truly understand. It is not enough to put ourselves hypothetically in the other's place and continue to be ourselves experiencing this place in which I place myself. One must also be detached from one's own standards to arrive at empathic knowledge. Regarding this perspective, Stein reminds us that empathy is not simply intuition, but an attitude that requires reflection, to turn back and again on ourselves and others, a course that enriches one's own and others' knowledge. It is not a spasm of knowledge, but something worked.

In the context of medical education, the concept of empathy has a broad and varied spectrum. Some authors consider empathy to be a predominantly cognitive quality: it would encompass an understanding of the patient's experiences and concerns combined with communication skills [19]. Irving and Dickson [20] define it as an attitude that contemplates behavioral ability along with the cognitive and affective dimensions.

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

Most of the authors with an affective-oriented approach presuppose that, during the empathic event, there is something that can be characterized as a partial identification of the observer with the observed. This aspect also becomes clear especially in Carl Rogers' definition, which describes empathy as being the ability "to sense the client's private world as if it were your own, but without losing the 'as if' quality". According to this definition, the differentiation between one's own experience and the experience of another is the decisive criterion for defining effective empathy [21].

It is necessary to distinguish empathy from sympathy [22] because this distinction, which is not just semantic, has important consequences in the doctor-patient relationship. The patient's emotions, which must be addressed, cannot become an obstacle to care. On the other hand, a sympathetic doctor may lack objectivity and professionalism. Empathy leads the physician to consider the quality of the patient's emotional experience, while simple solidarity focuses more on the intensity and quantity of suffering. Researchers conclude that empathy does not need limits, while sympathy does need to be moderated [23].

It is not easy to separate the emotional from the cognitive components that make up empathy. Even so, two conclusions can be drawn from this difficult navigation in the definitions and components of empathy. The first is that an excessive preoccupation with oneself (of the subject who intends to act empathically) is an obstacle to helping others [24]. It is necessary to detach from the image itself to understand the other and understand him as "another me". The second conclusion is that empathy could be an element of this necessary bridge to unite evidence-based medicine with patient-centered medicine. A personalization resource with broad diagnostic and therapeutic potential.

The question that arises at this point is whether it is possible to teach empathy, and what would be the teaching-learning process of this attitude [25, 26].

2.1 Teaching the non-teachable issues

It is worth remembering a classic study [27] designed to help choose candidates for medical schools, which emphasizes that those who have the potential to be good doctors, and not simply good students, should be chosen. In this way, 87 characteristics of a good doctor were classified, and classified according to the importance and ease of teaching-developing this characteristic. In this way, what the authors call the NTII was arrived at, an index that combines these two variables.

Thus, important and necessary characteristics for an excellent doctor are pointed out, which are very difficult to teach in medical school, or in further training. At the top of the list -important and difficult to teach characteristics- appear factors related to empathy: understanding of people, concern for others, idealism and compassion, service capacity, ability to persevere in difficulties with resilience, learning to establish priorities in care. All of these factors are important, but very difficult to teach - at least with the resources employed today in medical education.

Some neurophysiological studies provide some clues [28, 29] to resolve the dilemma of how to teach something that is difficult to teach. This is the case of empathy that can be fostered through examples. The so-called mirror neurons in the brain are involved in certain actions related to behavior and emotions. Contemplating another's attitudes, mirror neurons somehow evoke those same attitudes and emotions [30]. It is the simple case of children who, without having a clear perception of their own emotions, end up mirroring the emotions they contemplate in their parents. In this way, the example -of the teacher, the doctor preceptor- is a resource to provoke empathy in the student. Something is known, but now it has a neurophysiological basis [31, 32]. The mechanism of functioning of mirror neurons can be considered a prerequisite for empathy [33].

Several questions arise here: would not "imitated" empathy be something artificial that the patient perceives as such? Wouldn't this attitude end up being summarized in a checklist of routines that a physician must follow to build an empathetic attitude? The student's own experiences -which are even more powerful than a simple example- would be a condition for growing in empathy. In other words: is it necessary for a physician to go through personal and family suffering to be empathetic with the patient's suffering?

The experiences and biographical experiences are an important resource in medical education, when well used. Also, the example that promotes reflection and the construction of attitudes. Thus, establishing an educational setting where examples and experiences have space to be assimilated through reflection and facilitated discussion, seems to be a favorable resource to foster empathy. This model, which is classic -seeing doing, seeing acting, incorporating the example- is what is called Tag Along. A resource that has always been used, and that now, with modern communication tools, runs the risk of falling into oblivion. It must be rescued with a modern perspective. Along with this example-learning model, the experiences can be amplified through the arts. Humanistic education, cultural foundation, is necessary to promote those characteristics difficult to teach by traditional pedagogical methods. Literature, poetry, music, cinema bring resources that evoke experiences in students and allow for reflection [34].

Beside tag-alongs, some authors emphasize the importance of art, literature, cinema and reflecting over one's own life in developing empathy [35]. To give an example, it is worth quoting a literary classic about a rural doctor, (A Fortunate Man) [36] where empathy is magnificently described under the name of recognition: "The task of the doctor is to recognize the man. (..) I am fully aware that I am here using the word recognition to cover whole complicated techniques of psychotherapy, but essentially these techniques are precisely tools for furthering the

process of recognition. (...) To treat the illness fully, the doctor must first recognize the patient as a person. Good general diagnosticians are rare, not because most doctors lack medical knowledge, but because most are incapable of taking in all the possible relevant facts – emotional, historical, environmental as well as physical. They are searching for specific conditions instead of the truth about a patient which may then suggest various conditions. (...) A good doctor is acknowledged because he meets the deep but unformulated expectation of the sick for a sense of fraternity. He recognizes them. Sometimes he fails, but there is about him the constant will of a man trying to recognize”.

Role modeling, giving the right example to follow, caring carefully for the emotional dimension of medical students and for that using arts and humanities are possible resources for preventing the erosion of empathy. Because, at the end, is not just about to teach how to be empathetic -people that enter in a medical school already have quite a degree of empathy- but, mainly, to prevent of losing empathy through the so-called educational process that in many cases lacks this perspective [37, 38].

While teaching ethics requires establishing rules, guidelines and rational decisions, creativity and recognizing the role that emotions play in decision-making are also required. The educator has, therefore, to go beyond protocols and to have the creativity for bringing together objective guidelines, prudence, and wisdom, as well as incorporating the affective dimension. It is not possible to ignore emotions because they get involved in the decisions that ethical dilemmas imply. Furthermore emotions, when properly handled, become an essential tool. Therefore, opening space to share emotions in an environment with pedagogical support is to pave the way for a true education of affectivity that will transform into better patient care [39, 40].

Fostering reflection is a permanent objective for educators who intend to go beyond the simple transmission of knowledge. Creating favorable environments for joint reflection allows us to get to know the students better, personalize teaching by adapting it to each one, and implement the pedagogical excellence that knows how to unite intellectual creation with the art of teaching. Art is necessary for dealing with the student’s unexpected questions. The humanities help to polish this artistic dimension of medical education [41].

3. Why do we need humanities for educating patient-centered doctors?

3.1 Humanities in medical education: from emotions to ethical attitudes

To care implies comprehending the human being and the human condition and for this endeavor, humanities and arts help in building a humanistic perspective of doctoring. Humanities must be included in medical education, not as a simple appendix or a diletantism, but with the same emphasis as teaching internal medicine, differential diagnosis, or complex case discussions. They are a tool that educates physicians, understanding the patient as a whole -as the person’s own unit- to provide the best care for that specific patient [42].

A doctor without humanism would be nothing more than a mechanic of people. To provide effective care, it is essential to incorporate the human dimension into medical practice [43]. This is the role of the humanities that bring the necessary balance to the reductionism related to positive science. Approaching the patient only with “technical objectives” resources will possibly lead to inefficiency in care. Technical progress requires constructing a new, modern, updated medical humanism to provide the necessary balance [44].

When incorporated into medical education, the arts and humanities allow us to approach human emotions, both patient and physician. The humanities make us

think about the human being, about illness, about terminality, about transcendence. They lead us to reflect on the attitudes necessary to build professionalism and ethics in medical practice. The wide variety of issues raised with pieces of art, film clips, songs, and music, intuitively help in the decision that involves complex moral choices. As a well-known researcher put it, “the humanities are like the midwife who helps in the birth of human experience, with its mysteries and its certainties”. When cinema, poetry, music is used, student’s emotions arise easily, and teachers can take advantage of this scenario to broaden perspectives and educate affectively. The characters that appear in the performing arts, and the values they carry, impact as an example, they are a learning path. Being attentive to the awakening of emotions in students is an expression of affection and love from the teacher, which strengthens learning more than a theoretical model [45].

Typically, students’ emotions precede concept construction. Affective intuition precedes emotion. First, the heart gets involved, then the rational process helps to build learning. This is the normal path, in medical education and in life, to assimilate sustainable concepts and values. But this does not mean that teaching should be limited to simple emotions [46]. Students, who are usually immersed in a culture where feelings and visual impact prevail, awaken to learning that, later, will be solidly leveraged, through the necessary reflection. Emotions are thus the gateway to learning processes, a shortcut, a runway for higher educational flights [47].

The arts and humanities, impregnated with narratives, arouse emotions, and prepare the ground for the transmission of concepts. Using students’ empathetic language, moving in the familiar terrain of the emotions that the student feels, acts as a facilitator that allows to provoke reflection and suggest attitudes. The teacher’s role is that of a catalyst for the process that takes the student from emotions, through reflection, to incorporate attitudes and values.

The teacher’s role is to identify emotions and then stimulate reflection. Based on this experience of reflected emotion, it is possible to generate attitudes that modulate behavior [48]. Through an environment that allows for reflection, the development of qualities that will enrich personal development becomes possible.

On the other hand, teachers also use emotions - although little time and space are left to discuss them. When this reflective environment is provided among teachers -a faculty development scenario-, joint reflection leads to improving teaching methods and understanding with the students themselves [49]. Teacher meetings are often monopolized by addressing problems, and problematic students. Little time remains to reflect and help each other, and thus build resources for better teaching performance. Here, too, the medical humanities are an effective resource. After all, any process that aims to humanize medical education must include reflection at all levels, both among professors and students, in addition to facilitating the environment and making time for this reflection to be regular and fruitful [50].

3.2 Narrative medicine: reloading a millenary resource for caring

A predominantly biomedical focus attributed to teaching and practice in health sciences contributes to a dehumanization process. Any strategy that intends to address the issue depends on the presence of well-educated health professionals from both the technical and humanistic points of view. The greatest deficits concern humanistic education. Research about the effectiveness of using narratives as a didactic resource in humanistic education points out issues related to the concealed curriculum and the importance of medical students’ exposure to a patient-centered teaching model that gives priority to ethical reflections [51].

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

Medicine as Art recognizes that each patient is unique. Not only from the perspective of the disease that attacks him/her, but in the way that pathology "becomes incarnate and concretized": this is an illness, being sick [52]. The disease is always personalized, installed in someone who will become sick "in their own way", according to their personal being. A bifocal perspective is necessary, which manages to unite in artistic symbiosis the attention to the disease - with all the technical evolution - and to the patient who feels sick - with the vital understanding that entails. This is a person-centered medical performance, simultaneous exercise of science and art [53].

Listening carefully is a skill that the doctor needs to heal [54]. This requires the rescue of the ancient resources of medical art [55]. Patients show subtle clues about their experience with the condition, but doctors often ignore them because we hear only "the voice of medicine" and have trained us to ignore the emotional side, that is, the "voice of the patient's life." [56].

Already in the middle of the twentieth century, Gregorio Marañón [11]—paradigm of art and science—warned of the danger of using purely technical tools without knowing the patient, without listening carefully, without really caring about him: "It must be admitted that ordinary medicine is usually reduced, or to problems that are easy to solve, or completely insoluble for the most gifted man of wisdom. The fundamental thing in any case is that the doctor be with his five senses in what he is, and not thinking about other things." When the doctor sits and listens to the patient, he is communicating a humanistic attitude for excellence. Today we have sophisticated technology - important - but we are losing the pleasure of sitting down and hearing narratives of life. We lack chairs or, perhaps, patience to sit and listen.

A well-known researcher in medical humanities quotes: "we are midwifing a medicine that makes contact with the mysteries of human experience along with its certainties—a medicine that appreciates the deep beauty of health, the silence of health, the wisdom of the body, and the grace of its genius. It is an arch to far times and places, a site for all the living and the dying that go on; it is a link to what it means to be human" [57].

Teaching through humanities includes several modalities in which art is involved [58]. Literature and theater [59], poetry [60], opera [61] are all useful tools when the goal is to promote learner reflection and construct what has been called the professional philosophic exercise [62]. Teaching with movies is also an innovative method for promoting the sort of engaged learning that education requires today [63, 64]. For dealing with emotions and attitudes, while promoting reflection, life stories derived from movies fit well with the learners' context and expectations. Teaching with films engages the emotions and could serve as a great launching point for discussions of both the emotions and ethical scenarios [65–67]. The crucial role

of teaching is to help frame these discussions in such a way as to foster reflective practice among clinicians and clinicians-in-training.

4. Teaching with movies to foster reflective practice

A film is the favored medium in our current culture, teaching with cinema is particularly well-suited to the learning environment of medical education. Cinema is the audiovisual version of the narrative, framed in emotions and images. A reality very close to the language of the student who is inserted in this emotional and visual culture and which makes it easier for him to enter the world of his interlocutor: the patient, with all the circumstances that surround him.

We know of the pedagogical power of narratives, something secular that comes from classical Greece, where stories were resources to teach ethics and values [68]. Cinema, illustrating stories in a modern way, helps to expand life experiences, to get to know the human being. On the other hand, film stories act as a catharsis of emotions - something that Aristotle already warned with stories in Greek education. Emotions are revealed, brought out, and capable of being sorted, educated, through reflection. This is the core of the use of cinema in the education of affectivity.

Cinema provides a fast and straightforward teaching setting [69]. The scenes suggest important issues, emotions appear, students can better understand the universe of affection, which is often tumultuous. It is common for them to transport the projected scene to their own reality, to their own lives, because they act as an emotional wake-up call that evokes daily realities, not only from the medical learning environment, but from life itself. And in the same way, the experiences they have in the pedagogical environment with cinema are then taken to their daily lives, as a resource that helps to remember all that learning. Cinema, therefore, works as an emotional alarm that facilitates the student's posture in analogous situations they face in their daily lives.

For teaching ethics, we can follow the rational method, approaching the theoretical basis to refine attitudes, acquire virtues and incorporate values. But this classic method of medical deontology classes finds an alternative path when using films. In cinema, the examples are accompanied by a strong emotional charge, leading the viewer to accept or reject that attitude presented. Reflection also accompanies this experience; and from reflection comes the desire to incorporate an attitude, not just intellectually, but beginning from emotions as a starting point. When individual reflections are amplified by facilitated discussion, the motivations, and incentives in the construction of ethics also grow in the group of students.

This learning scenario stimulates learner reflection. In life, important attitudes, values, and actions are taught using role modeling, a process that impacts the learner's emotions. Since feelings exist before concepts, the affective path is a critical shortcut to the rational process of learning. While technical knowledge and skills can be acquired through training with a little reflection, reflection is required to refine attitudes and incorporate values. As already explained, this methodology with the cinema does not intend only to provide "sentimental, emotional education", but to provoke reflection that leads to incorporating attitudes. Reflection is, without a doubt, the bridge that allows the transition from emotions to attitudes. This universe is not limited to the solution of purely medical issues, but it reaches out to life, awakens desires for integrity. Education with cinema does not intend to offer results - something like the moral of the fable, to show the right way to behave - but rather to provoke the reflection that leads to lasting attitudes [70]. To foster reflection is the main goal in this cinematic teaching set. The purpose is not to show the audience how to incorporate a particular attitude, but rather to

promote their reflection and to provide a forum for discussion. And this works for any kind of audience, despite cultural background or language [71].

This is possible when reflection and discussion are allowed in the pedagogical environment where cinema is instituted. Doubts and dilemmas often emerge about the professional role, ethical attitudes, reporting of good examples – and some that are not edifying- for which the student usually does not have space in the curriculum. It is precisely this attitude, thinking and reflecting relentlessly, and not giving in to mediocrity, that Hannah Arendt suggested as prevention so as not to fall into the banality of evil [72].

Film education is also useful for continuing training with doctors, so that they learn to deal with their own emotions. Little attention is paid -both in the undergraduate and graduate curriculum space- to the education of emotions. When emotions -especially negative ones- are not ventilated and dealt with, the most common is to assume an attitude of emotional closure with the patient, a distance that leads to a lack of competence in care and destroys professionalism [73].

Cinema offers a wide range of possibilities for learning to deal with negative attitudes and values. Without necessarily solving dilemmas, it offers the opportunity to reflect calmly, with emotional detachment. The film allows us to go beyond illustrations of theories and principles so that we can develop a range of emotional and interpretive skills, including habits of the heart. Discussions among colleagues are exciting and enriching that make us reflect on who we are and who we want to be [74].

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

4.1 The movie clip methodology: using wisely short time teaching

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

Although, in education with cinema some use medical films-as a case discussion- it is not the usual pedagogical resource that we are discussing here [75], Our goal is to go beyond the medical scene to immerse into the human reality, where attitudes, emotions and responses emerge. Therefore, it is not medical-themed films that we have used the most in our pedagogical scenario. However, the “translation” of human problems to the medical environment is done with enormous facilities by students.

Do you use a whole movie or just some scenes? Here comes another usual question. The answer depends on what you want to point out, the time you have at your disposal, and the outcomes you expect. Our experience affirms the effectiveness of using the movie-clip methodology in which multiple movie clips are shown in rapid sequence, along with facilitator comments while the clips were going on [76]. Using clips with scenes from different movies is, in our experience, more profitable than projecting entire movies. Besides, the time available is not always a lot. With a few minutes, it is possible to raise many questions, all saturated with emotions, when the clips are used with agility. The facilitator’s comments enhance the reflection, amplifying it. They are not an obstacle to following the scenes presented, but, in our

experience, they function as a resource that facilitates shifting the reflection from the clip's report to life itself. As someone in the audience once commented: "the comments are not about the film, nor about the teacher's experience... It's something that goes in between and touches our lives".

The comments are not sought for student agreement, but only intended to provoke individual reflection. In essence, the facilitator's comments are their own reflections made aloud.

The most used resource in our experience are scenes from different films, with varied themes, which when presented together provoke a real flood of emotions. They are not projected according to a thematic background, but varied, showing a wide spectrum of attitudes. The joint reflection and discussion about this collection of scenes are what causes the real learning. Several previous publications have covered the methodology in detail, and the appendix of many of them contains a list of films, with suggested scenes to be used and comments [77].

Proving the effectiveness of this methodology is something that often arises in the academic community, especially in international congresses and various presentations. It should be remembered that excellent education does not imply measuring -with the usual metrics- all pedagogical tools. It is known that many of the so-called "intangible themes" are difficult to assess, although it is possible to see the results. Thus, themes such as empathy, ethics, compassion, and commitment -which are factors of professionalism- can be pointed out and promoted with the resource of education with cinema. Without a doubt, esthetic education -this is the core of the humanities- necessarily completes the education of physicians. They are, in Pascal's words, "the reasons of the heart, which reason is not capable of understanding".

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

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

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