Chapter Three

FINDING EMPATHY IN ART: HEALTHCARE PROFESSIONALS AND THE MUSEUM EXPERIENCE

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ANOTHER DAY AS chaplain in an urban community hospital. A young mother births a nine-pound (4 kg) baby girl while twelve relatives camp joyously in the family room. A five-year-old boy, thrown from his bicycle as he raced to deliver his father's lunch forgotten on the kitchen counter, is carried into the emergency room needing stitches. New admissions are high, with many requests for pastoral visits. At 11 a.m., the trauma pager erupts. Within minutes, I arrive at the trauma centre, and the nurse directs me to a cubicle where two women wait, seated. As I enter, a gurney follows me, on which a young man lies motionless. Within moments, the two women are beside their son and grandson, respectively—victim of a shooting on this a mild, cloudy Wednesday morning. The young man's mother is rigid yet trembling, yearning for yet dreading the arrival of her son's body. Her grief engulfs the tiny cubicle.

Usually, at the end of such intense encounters, I sought self-care, spending time alone in the chapel or leaving the hospital. Often, I would make the quick jaunt to the Philadelphia Museum of Art (PMA), only a fifteen-minute drive.

The art museum featured thirty-minute "spotlight" tours. Each tour provided an opportunity to look more closely at a single work of art, to learn about the artist's style and about the history of the work and the artist. On one such visit, the guide selected a painting by John Singer Sargent, *Landscape with Women in Foreground* (Fig. 3.1). The quiet space; the community formed by viewers; the focused attention; the solitary, animated voice of the guide; the two women arm in arm in a muted landscape—all this allowed me to "enter" Sargent's serene country landscape and restore my emotional well-being. There I experienced the power of art to nurture and heal, and I saw how art might help to teach "close looking," allowing meaning to emerge.

After each visit, I left the museum calm and refreshed, a feeling I carried as I drove back to the hospital and resumed my work. I experienced the power of experiencing art to facilitate emotional growth and healing.

After several years of visiting the museum as an act of self-care, in 2001, the year of the September 11 terrorist attacks, I began training as a docent at PMA. As a docent, I created and guided museum tours, always with a focus on creating a welcoming, inclu-

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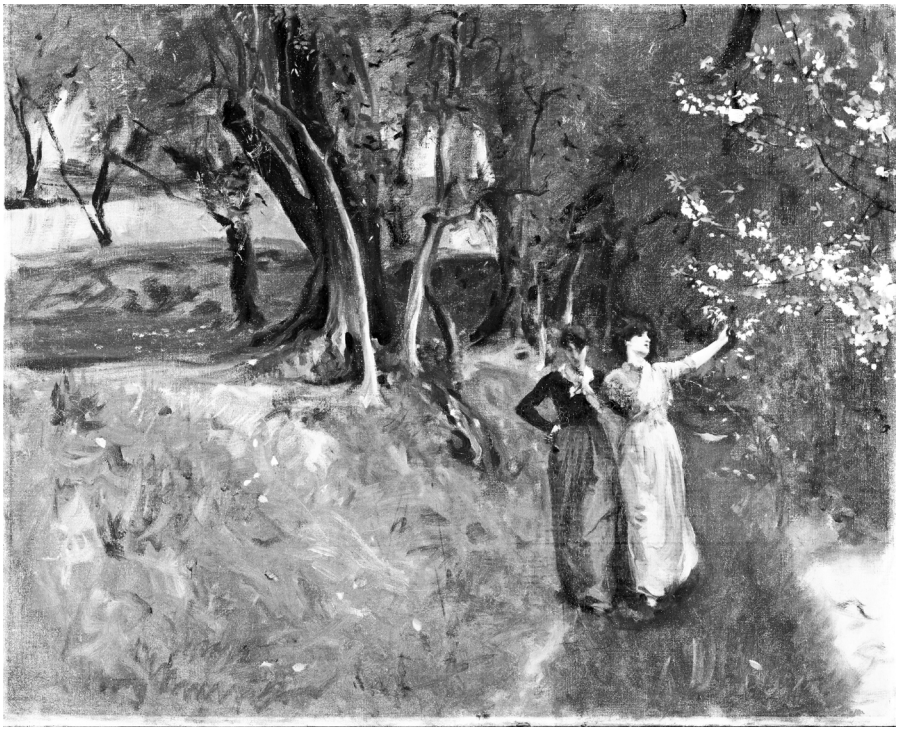

Figure 3.1. John Singer Sargent, *Landscape with Women in Foreground,* ca. 1883, oil on canvas, 25 × 30½ in. Philadelphia Museum of Art: 125th Anniversary Acquisition. Gift of Joseph F. McCrindle, 2002, 2002-49-1. Courtesy of the Philadelphia Museum of Art.

Figure 3.2. Pacecco de Rosa (Francesco de Rosa), *The Massacre of the Innocents*, ca. 1640, oil on canvas, 78 × 120¼ in. Philadelphia Museum of Art: Purchased with the John D. McIlhenny Fund, 1973, 1973-253-1. Courtesy of the Philadelphia Museum of Art.

sive, and engaging environment. I later began facilitating "spotlight talks," where participants were fewer and the environment more intimate and participatory. I also trained as a facilitator for a museum program called "ArtTalk," which provided art "tours" by telephone to people living in long-term residential care facilities and those who were homebound. Each participant received a loose-leaf binder of approximately fifteen colour prints of paintings from the museum's collection. The group would meet by phone to look closely at and discuss the images. The power of these "tours" was evident immediately. Participants commented enthusiastically on the paintings, asking questions and talking about the thoughts and feelings each image evoked in them.

At the end of the three-week program, participants provided feedback. The feedback was extraordinarily positive; participants often became devotees, participating in every "ArtTalk" offered as personal health allowed. To a hospital chaplain encountering the chronically ill, it was evident that "ArtTalk" became a form of spiritual care.

A decade later, my enthusiasm for these two programs would inform my decision to develop one using museum visits to help medical students learn about themselves as clinicians and develop empathy as well as self-care skills.

The Museum Experience: Medical Students

A medical student's initial encounters with patients can be as intense as those of a chaplain, as I described above. Some patient encounters push students toward an emotional newness, hurling them towards the far edge of experience. Such encounters can create attitudes and emotional predispositions that advance or hinder learning. A museum gallery can offer a sheltered place for self-care, respite, and renewal, and the contemplation of art can allow students to cultivate an inner self, integrating thoughts and feelings and helping them to function holistically as physicians. At the same time, close study of art can even help medical students develop clinical skills.

At first, I began taking medical students and family medicine residents to the museum to observe works of art. Several recent articles in medical literature had described or quantified the value of teaching observation to augment clinical skills. Some focused on the use of art to enhance clinical skills for students in other health professions, including physician assistants and occupational therapists. Irwin Braverman, dermatologist and educator at Yale University School of Medicine, published an article on the value of sustained and directed looking in enhancing visual acuity and pattern recognition.[1] Other medical researchers investigated the power of art images to teach observation[2] and to enhance both clinical skills and humanistic abilities, such as recognizing human suffering.[3]

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1 Irwin Braverman, "To See or Not to See: How Visual Training Can Improve Observational Skills," *Clinics in Dermatology* 29, no. 3 (May–June 2011): 343–46.

2 Johanna Shapiro, Lloyd Rucker, and Jill Beck, "Training the Clinical Eye and Mind: Using the Arts to Develop Medical Students' Observational and Pattern Recognition Skills," *Medical Education* 40, no. 3 (2006): 263–68.

3 Stephen W. Russell, "Improving Observational Skills to Enhance the Clinical Examination,"

The nursing literature abounds with articles about the use of art in nursing practice. Most influential in my learning was the research published by Britt-Maj Wikström, Professor of Art, Health, and Empowerment at the University of Akershus, Oslo, Norway, and the Karolinska Institutet Solna, Stockholm, Sweden. Though her study populations varied from children to adults, Wikström's work focused on using the arts in nursing to facilitate expression, generate narratives, and teach empathy.[4]

Other educators have also explored the dialogue between the arts and development of observational skills, emotional intelligence, and empathy.[5] Having served as both a hospital and a hospice chaplain, then training medical students and family medicine residents, I was drawn to using the arts to help students and physicians in training "picture" the unseen realities of illness and dying that demand sustained looking and authentic responses from healthcare and spiritual care providers. The growth of art-based learning in medical education has resulted in the recognition of the value of a medical school partnership with museums.[6]

Medical Clinics 102, no. 3 (2018): 495–507; Charles L. Bardes, Debra Gillers, and Amy E. Herman, "Learning to Look: Developing Clinical Observational Skills at an Art Museum," *Medical Education* 35, no. 12 (2001): 1157–61; Sheila Naghshineh et al., "Formal Art Observation Training Improves Medical Students' Visual Diagnostic Skills," *Journal of General Internal Medicine* 23, no. 7 (2008): 991–97; Craig M. Klugman, Jennifer Peel, and Diana Beckmann-Mendez, "Art Rounds: Teaching Interprofessional Students Visual Thinking Strategies at One School," *Academic Medicine* 86, no. 10 (2011): 1266–71; Sona K. Jasani and Norma S. Saks, "Utilizing Visual Art to Enhance the Clinical Observation Skills of Medical Students," *Medical Teacher* 35, no. 7 (2013): e1327–31; Linda Friedlaender, "Enhancing Observational Skills: A Case Study; Collaboration between a University Art Museum and Its Medical School," in *Museums and Higher Education Working Together: Challenges and Opportunities*, ed. Ann Boddington, Jos Boys, and Catherine Speight (Farnham: Ashgate, 2013), 147–57; Pamela B. Schaff, Suzanne Isken, and Robert M. Tager, "From Contemporary Art to Core Clinical Skills: Observation, Interpretation, and Meaning-Making in a Complex Environment," *Academic Medicine* 86, no. 10 (2011): 1272–76.

4 Britt-Maj Wikström, "A Picture of a Work of Art as an Empathy Teaching Strategy in Nurse Education Complementary to Theoretical Knowledge," *Journal of Professional Nursing* 19, no. 1 (2003): 49–54; Wikström, "Nursing Education at an Art Gallery," *Journal of Nursing Scholarship* 32, no. 2 (2000): 197–99; Wikström, "Work of Art Dialogues: An Educational Technique by Which Students Discover Personal Knowledge of Empathy," *International Journal of Nursing Practice* 7, no. 1 (2001): 24–29; Wikström, "Works of Art as a Pedagogical Tool: An Alternative Approach to Education," *Creative Nursing* 17, no. 4 (2011): 187–94.

5 Kathleen Leitao, "Seeing the Forest and the Trees: Increasing Nurse Practitioner Students' Observational and Mindfulness Skills," *Creative Nursing* 20, no. 1 (2014): 67–72; Linda Honan Pellico et al., "Looking Is Not Seeing: Using Art to Improve Observational Skills," *Journal of Nursing Education* 48, no. 11 (2009): 648–53; Dawn Freshwater and Theodore Stickley, "The Heart of the Art: Emotional Intelligence in Nurse Education," *Nursing Inquiry* 11, no. 2 (2004): 91–98; Kirsten Jack, "Putting the Words 'I Am Sad' Just Doesn't Quite Cut It Sometimes!: The Use of Art to Promote Emotional Awareness in Nursing Students," *Nurse Education Today* 32, no. 7 (2012): 811–16; Wikström, "Work of Art Dialogues," 24–29.

6 Nancy C. Elder et al., "The Art of Observation: Impact of a Family Medicine and Art Museum Partnership on Student Education," *Family Medicine* 38, no. 6 (2006): 393–98.

I revised "Death, Dying and Bereavement," a course that I had been teaching in the medical humanities, to include works of art to help students develop emotional awareness of "self" and "other." Fourteen medical students enrolled in this elective. The museum waived admission fees, offered support from a museum educator who provided educational materials for and co-facilitated engagement with selected works of art, asking only that we respect gallery space and other visitors. We visited twice for two and a half hours over the course of one semester (ten weeks). The art pieces observed were selected because their content facilitated storytelling and invited students to explore their emotional responses to visual depictions of loss and their own perspectives on loss. The experience allowed students to understand how their perspective affected their response to others. Overall, students determined that they had participated in a program that was important, especially given their lack of firsthand experience with death and dying. One student noted that this course was the first time she had been asked to use an empathic voice to support a person who was suffering.

I later designed and taught a course entitled "Training the Physician's Eye: Enhancing Clinical Skills through Art Observation" in which medical students practised a special kind of seeing to improve clinical skills by looking at works of art. The goal was to improve their visual acumen, promote inquiry and critical thinking, and develop caring skills to enhance patient encounters. At the museum, students practised visual observation and meaning-making from observing the nonverbal (a key skill to understanding what patients are telling us but not saying). The intent was for students to increase emotional awareness, to recognize suffering in others, to gain confidence in regulating their own suffering, and to increase competence as well as empathy in the doctor-patient relationship.

Students often remarked that guided looking allowed them "to see more than they had ever seen in a work of art." *The Massacre of the Innocents*, a painting by Pacecco de Rosa (Francesco de Rosa) at PMA (Fig. 3.2), depicts an event described in the Christian Bible in which Herod, the Roman-appointed king of Judea, fearing the arrival of the baby Jesus as a threat to his power, ordered the slaughter of all male children in Bethlehem under the age of two. Jesus, a Jew, was prophesied to become the long-awaited king of Judea, the "messiah" who would rescue Israelites from Roman persecution.

While viewing this painting, students noticed the colours, the soldiers, their beards, the activity, and the energy of the painting before they noticed the pain. When I asked them to look closely at the faces and asked, "What do you see?," the students began, not immediately but over time, to be able to talk about the pain. "Some of the mothers have their hands outstretched as if they could make a difference, as if they could hold back the sword or the soldier that wields it." Seeing the expression on the face of one mother, a student imagined a mother asking, "Why are you doing this?" "You can definitely sense the feeling of helplessness at her dead child who's openly bleeding on the ground." And another remarked, "I'm looking at the [woman] at the top. It seems … she doesn't know what to do. And the other ones too … they're putting their hands out … they're trying to stop but there's this inability to know how to save your child … it seems like it's almost inevitable." The students were able to recognize emotional pain in others, which is the beginning of empathy, another major element

for quality care that requires visual skills. To be fully present to a patient, a physician must understand emotions and feelings that a patient may express nonverbally. Careful looking at art is one method to develop such skills.

I intentionally began to structure lessons to develop other skills during this process. Students were asked to look, look closely, and look again for several minutes. Patience was required. I then asked students to name what they saw. Consistently, rather than merely *naming*, students *interpreted* what they saw. They would call a round blue object sitting atop a head a "hat," and a line from a hand to the ground a "cane"; I would then ask them to describe only what their eyes could see—for instance, not a "hat" but rather a tube-shaped object curving down on the sides. Medical students must learn to describe and analyze what they see while resisting the tendency to quickly name and interpret; they must appreciate specificity and avoid hasty conclusions, allowing time to gather information to reach accurate conclusions. All these visual skills are critical in the clinical care of patients.

Students were also expected to describe to the group what they saw, using clear, descriptive language, to ask questions about the painting, and also to listen closely and try to understand what others said. Listening is another important skill that enables empathy. At times, students had differing opinions and responses to a painting, providing an opportunity to teach respect for differences. Sometimes there is no one "right" answer, and students saw they could learn from each other if they approached an encounter with an open mind and heart.

Students were also prompted to identify their own as well as others' emotional responses to art. The importance of being able to name feelings became increasingly evident when students studied Vincent van Gogh's painting *At Eternity's Gate*.[7] In this image, students perceived the pain and sorrow of a grief-stricken man, as the artist most likely intended. Others, invited to use their imaginations, suggested the man might be puzzled or frustrated, or might even be laughing uncontrollably.

How a person perceives the feelings of others through visuals differs from one viewer to another, depending on the person's unique beliefs and experiences.

> we do not merely see the visual representation of a girl who covers her face with her hands, but … we see this representation of gestures as an expression of grief or sorrow. We recognize that she undergoes an experience of intense emotional turmoil. She is not merely sitting there, but the way in which she sits there shows us how she feels. Thus, the painting moves us; it is as if the image reaches out towards us and touches us. The expressivity of the girl is something that we do not only see immediately, but it is also something that we feel. Or rather, it is something that we recognize through feeling.[8]

The journey to empathy begins when students notice how the work of art makes them feel.

Equally important is to help students understand that not only do we each react to images with differing thoughts and feelings, we also each have a personal *response*

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7 Vincent van Gogh, *Treurende oude man* (At Eternity's Gate), 1890. https://krollermuller.nl/en/vincent-van-gogh-sorrowing-old-man-at-eternity-s-gate.

8 Gustav Jørgen Pedersen, "Empathy and Aesthetics: Edvard Munch and the Paradox of Pictorial Thinking," *Kunst og Kultur* 101, no. 4 (2018): 208–23.

Figure 3.3. Violet Oakley, *Untitled [Portrait of a Woman]*, n.d., charcoal and pastel, 20¼ × 12½ in. Courtesy of Woodmere Art Museum, Philadelphia, PA: Gift of Ofelia Garcia, 2011.

to those thoughts and feelings. Some of our own emotional responses we find acceptable, while others we are reluctant to reveal. Understanding this requires repetition. Students may experience a wide variety of emotions—some for the first time. As the instructor, I encouraged students to experience all their feelings and thoughts, knowing they are part of the human family and that experiencing a particular feeling does not demand acting on that feeling.

For example, a student viewing Violet Oakley's *Untitled* [*Portrait of a Woman*] (Fig. 3.3) at the Woodmere Art Museum (Philadelphia) might see herself in the woman depicted; or a student might see his or her own mother or aunt, or a family member who died recently, and learn to feel loss and pain without becoming overwhelmed by or denying those feelings. Learning these skills while viewing art in a museum provides a safe environment where students can recognize, tolerate, and process such feelings.

As a practical matter, close looking takes time. The class met at the museum in small groups of five to ten. Sessions could be intense, lasting three hours, with students standing or sitting in front of each painting for fifteen minutes. I instructed the students to look, and look again, before describing their observations. Sessions were ideally scheduled either on a day when the museum was closed to the public or during less crowded daytime hours. Scheduling also depended on the availability of museum educators to co-teach.

The Museum Experience: Family Medicine Residents and Persons Living with Dementia

ARTZ Philadelphia brings together persons living with dementia and their care providers to look at and talk about art while building a supportive, enriching community for participants.[9] As a member of the behavioral science faculty in the Drexel University

9 ARTZ Philadelphia is dedicated to enhancing the quality of life and well-being of people living with dementia and their care partners through joyful interactions around arts and culture, https://www.artzphilly.org/.

College of Medicine family medicine residency program, I believed this program could help third-year family medicine residents, completing their community medicine service-learning experience, to increase their comfort in patient interactions. Through participation in ARTZ Philadelphia, they learned more about dementia symptoms and management, explored their own emotional self-awareness and mastery, and furthered their skills in compassionate care.

I was especially drawn to this organization after I experienced an unfortunate situation with a care provider for a client of mine who was dying of Alzheimer's disease. His wife could not accept his terminal diagnosis. She searched for a doctor who could provide her even a glimmer of hope. Eventually, she found a specialist who appeared receptive. At their meeting, he asked a myriad of questions about her husband and she provided an exhaustive account of his illness and treatment. The physician then told her, "I think we can find out the cause of this illness." Enthusiastically, thinking he was offering hope for a cure, she asked, "When can we do that?" The doctor replied, "during the autopsy. I can definitely find out." Unintentional cruelty, but cruelty nevertheless! Because this physician was evidently unaware of the wife's feelings of desperation, he could not respond empathically. Unfortunately, when a physician dismisses, ignores, or cannot recognize the presence of pain in another, they contribute to that person's distress.

ARTZ Philadelphia provided medical students with immersion in the lives of persons living with dementia and their care partners through a partnership program with the Drexel University College of Medicine. The organization's "ARTZ at The Museum" program provided opportunities for museum and classroom experiences that allowed students to witness and appreciate intimate and tender moments, normally unseen, in the lives of those who are relegated to the margins, moments that escape students' attention in practise settings.

Residents need to feel comfortable with a patient. Developing comfort is necessary to allow resident physicians to interact as equal partners with those for whom they care. The program enabled the formation of partnerships—often demanding that residents step out of the doctor role, which can be a defensive posture for those who feel uncomfortable or underconfident in engaging with people with dementia.

ARTZ Philadelphia-sponsored museum visits, co-led with the organization's founder and executive director,[10] were part of a pilot program that took second- and third-year family medicine residents out of the office or hospital setting for a required community medicine rotation. Assigned readings first exposed students to the literature on clinical and person-centred, arts-based interventions to treat people living with dementia. Two community-based experiences then allowed students to interact with patients with dementia to increase their knowledge and clinical skills, empathy, compassion, and inclusiveness toward these patients.

10 Susan Shifrin, the editor of this volume, is the founder and executive director of ARTZ Philadelphia.

Students first visited a memory care unit where they learned about the ARTZ Philadelphia program, participated in facilitated art-based group activities, and met with ARTZ Philadelphia and care facility staff. Next, they visited an art museum to observe and interact with people living with dementia and their family care providers while participating in facilitated conversations about works of art. Residents reported being "curious" and "apprehensive" or "nervous about meeting care partners" and "people living with dementia." Most were initially hesitant to participate. Yet one student remarked after the program, "I get … how looking at art together was a way to connect to patients on a more emotional level … as people." Another: "I always thought that people with dementia were passive or incapacitated in ways. It was interesting to see that one man… trying to use words about the painting…and even though his words didn't line up … I understood him."

Residents' feedback suggested that the rotation opened their eyes. One expressed surprise and a touch of humility about looking at art with the patients: "They saw things in those paintings that I completely missed. In a way I feel the dementia allowed for the participants to view the art with a "free" mind—rather than being analytical about the paintings. They spoke from their hearts and found meaning within themselves rather than looking for the "right answer" to the meaning of the paintings." Another said that the program served as "a good reminder that patients are whole people."

Visits to the memory care unit and museum lasted two to three hours each. The instructor scheduled post-visit sessions in which students were encouraged to notice and question preconceived notions they might have brought to each visit and challenged them to grow by supplementing their textbook and classroom learning with firsthand experience. The program was designed to build students' trust in themselves as learners by immersing themselves in an unfamiliar culture and "seeing" and responding to what they saw.

Residents were thus able to develop relationships with and participate as "echoers" for community members with dementia in these programs, establishing a dynamic of "being present with" and "learning from" prospective patients. All students and residents participating in ARTZ Philadelphia began cautiously, then ultimately embraced the unique and stimulating gallery environment.

Although residency program directors perceived the art museum experiment as valuable, the rotation was discontinued due to competing educational priorities.

The Museum Experience: Students Preparing for Medical and Healthcare Professions

When the pilot program for family medicine residents at Drexel University College of Medicine was discontinued, ARTZ Philadelphia and the Sidney Kimmel Medical College at Thomas Jefferson University launched the "ARTZ @ Jefferson" program to provide the opportunity for repeated interactions between healthcare students and people living with dementia. "ARTZ @ Jefferson" combined study and classroom learning, art observation, group participation, and discussion. The program was designed to allow people living with dementia and their care partners to mentor students about their lived experiences.

The program incorporated all the educational elements needed to develop the skills we call empathy—learning to see, to describe, to work collaboratively with others, to recognize emotions in oneself and others, to communicate with relative comfort, and to be open and curious. Through their recurring interactions with program mentors, students were engaged in humanistic learning. They learned the importance of preserving the dignity of people living with chronic illness; of understanding and appreciating the care provider's burden; of appreciating alternative modes of communication, not necessarily reliant on verbal exchange; and of creating and maintaining supportive community.

The "mentoring" that students received in the ARTZ Philadelphia program was as precious as a jewel. The persons living with dementia and their care partners became "living human documents" enabling holistic education for students through these sacred encounters. Conversing one-on-one over time, students cultivated empathic relationships with their mentors. The museum provided the context for students to engage with a sense of safety, ease, and comfort—a prerequisite to an encounter in which all who are present become human first. Immersion in the mentoring program offered students the opportunity to develop vital skills foundational in their training and practice as health professionals.

Students first met for a one-hour session with their ARTZ Philadelphia mentors in an art gallery for a group conversation about works of art, facilitated by ARTZ Philadelphia's director. After this session students were each assigned an ARTZ Philadelphia mentor. This joint meeting served as the first of several encounters. Students maintained written journals for reflection and critical thinking after each meeting with their mentors. Journals were submitted to instructors at the end of the course.

Simultaneously, in classroom sessions, small groups of students, through facilitated peer interaction, explored their feelings, thoughts, and uncertainties about encountering someone living with dementia. Listening curiously and respectfully to others' experiences and points of view was strongly encouraged, promoting self-awareness, growth, and integration of the knowledge they had gained in their patient encounters.

This program modeled for health professionals the importance of inviting and valuing a patient's perspective—to imagine what it might be like to walk in that person's shoes—and, when seeing patients, to build rapport by communicating understanding and compassion. One student was surprised by the ease, a sense of freedom, with which the care partners and persons living with dementia interacted with each other in contemplating a painting together. Another commented on the "effect of a pleasant environment to encourage interaction." One student noticed her own reaction "to beauty … when guided to do so."

Students learned that they could communicate compassion and respect not merely by acting as a polite professional but by actively listening and responding to persons living with dementia, knowing that success in treatment rests largely in gaining the person's trust. As one student said: "I can see that powerful seeing … looking into a person's eyes … making contact with the person and not their illness … which might be disturbing to us … is giving care." These students learned to use curiosity and imagination in their care encounters with persons living with dementia and their loved ones. In their

clinical training ahead, these students would be better equipped to encounter persons living with dementia with openness to their experience, feelings, and concerns.

Conclusions

The museum-based experiences described here were invaluable to students and physicians-in-training. The opportunity to observe works of art in a museum gallery allowed learners to observe without time limits, to look for meaning beyond merely describing content, to use their imaginations, and to engage in creative dialogue and self-expression. Works of art can promote self-awareness and cultivate emotional intelligence as viewers symbolically witness the human struggle with illness, suffering, and death.

Perhaps most important, the vibrancy, beauty, and expressive nature of art allowed students to merge heart and mind, crucial to developing and enhancing clinical skills. In a safe, nonjudgmental environment, students could notice their own emotional and attitudinal responses to depictions of suffering, and risk sharing those responses with others. A relationship between a patient and healthcare provider requires trust and the ability to interact with curiosity, respect, kindness, and empathy. The museum became the context for students to learn about themselves as healers and healthcare providers to others.

Though the programs faced challenges such as student schedules, transportation, and funding, museum-based programs are clearly worth repeating and expanding to other medical and healthcare specialties. A trained art educator or a healthcare or spiritual care professional is helpful although not required to facilitate an art-based program that teaches clinical skills. What is needed is a relationship with a museum that shares the mission of the program, institutional support to offset museum costs, a facilitator skilled in facilitating small groups, and the ability to select narrative art works that match the intentions of the program.

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