Medical students’ experiences of shame in professional enculturation

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CONTEXT Despite the intentions of caregivers not to harm, medical encounters may involve intimidation and induce emotions of shame. Reflection is a critical part of professional learning and training. However, the role of shame in medical education has scarcely been studied. The aim of this study was to explore medical students’ reflections on shame-related experiences in clinical situations and to examine how they tackled these experiences.

METHODS A 24-credit course in Professional Development is held at the Medical School of Umeå University, Sweden. A 1-day seminar on the theme of shame, which involves individual reflections and group discussions, is held in term 9. Medical students were invited to individually consider and write down their memories of situations in which they had experienced shame in clinical encounters. Of a total of 133 students, 75 were willing to share their written reflections anonymously. Their essays were transcribed to computer text and analysed by means of qualitative content analysis.

RESULTS Three themes emerged. These included: Difficulties in disclosing shame; Shame-inducing circumstances, and Avoiding or addressing shame. Initially, students experienced problems in recalling shameful incidents, but successively described various situations which related to being taken by surprise, being exposed, and being associated with staff imprudence. Students disclosed shame avoidance behaviours, but also gave examples of how addressing shame provided them with new insights and restored their dignity.

CONCLUSIONS Students’ reflections on shameful experiences elucidated the importance of attitudes, manners, standards and hierarchies in clinical situations. These are important issues to highlight in the professional enculturation of medical students; our emphasising of them may encourage medical teachers elsewhere to organise similar activities. Opportunities for mentoring medical students in tackling shame and adverse feelings, and in resolving conflict, are needed in medical curricula.
INTRODUCTION

Medical encounters involve intimidating procedures. Some diseases, such as mental disorders and sexually transmitted diseases, are loaded with social stigma. Common clinical procedures, such as mammography or colonoscopy, can be perceived as uncomfortable and intrusive. Despite good intentions, interactions between doctors and patients may lead to misunderstanding, distrust and even humiliation. Feelings of awkwardness, embarrassment and shame, and perceptions of oneself as being less than one may have hoped to be are probably triggered in many doctor–patient encounters, although they are seldom discussed or studied and, according to Lazare, may even be ignored. Even less is known about medical students’ feelings of shame in clinical situations and their ways of dealing with these experiences.

The importance of shame in identity formation and in social interaction has been emphasised. Tomkins described shame as a primary (i.e. precognitive) affect involving instinctual, short-duration, physiological reactions and specific bodily responses, such as loss of eye contact and facial blushing. The central role of shame in the development of syndromes such as depression, addiction, sexual dysfunction and eating disorders has been elaborated. Nathanson emphasised the impact of shame on professional interaction with clients.

Shame, despite its negative associations, is of social and cultural importance as it is a pillar of meaningful human interaction and socialisation. According to Lazare, the ability to experience shame is healthy: ‘It means that we have ideals and a sense of pride and that we are social beings who care what others think about us.’ Theories emphasising the role of shame in social interaction imply that shame ought also to have some impact on the professional development and medical socialisation of medical students.

Upholding professional ideals has become an important issue in medical education in the last few decades. Professionalism is considered in terms of skills, knowledge and attitudes, always with the patient’s best outcome in mind. It implies an educational responsibility to define and assess professional competence and to endeavour to help students develop self-awareness, empathy, communication abilities and respect for the integrity and autonomy of the patient.

Students are taught universal ethical standards of good practice. However, they also adopt attitudes and behaviours influenced by their witnessing of the performance of senior doctors in clinical situations in hospital hierarchies. As conceptualised by Hafferty and Franks, the morality of a hidden curriculum, which may include undesirable manners and attitudes, is passed on to medical students in parallel with that of the official curriculum. Subtleties of the hidden curriculum are likely to be uncovered in situations involving embarrassment and shame. Students’ experiences of shame may represent indicators of fruitful medical socialisation; they may serve to foster a sense of what is right and wrong. Feelings of shame may also result from bystanders’ observations of humiliations and misconduct in health care. It is important to explore and discuss how such experiences are tackled. Yet, as far as we know, the specific issue of student experiences of shame has been scarcely elaborated in medical education research.

Donald Schon’s model of learning considers reflection as a critical part of professional learning and training. Self-awareness is the individual’s tendency to pay attention to his or her own emotions, attitudes and behaviour in response to specific situations. Reflection is intimately connected to self-awareness and together they help doctors, as well as medical students, to examine belief systems and values, deal with strong feelings, make difficult decisions and handle interpersonal conflicts. Schon distinguished between reflection in action (thinking about what one is doing in the middle of performing an action) and reflection on action (thinking about an experience at a time separate from that event). The most vexing problems often need reflection on action if they are to be disentangled. Self-reflective skills are taught in some medical schools, but this area is not yet an explicit part of most curricula.

The theories presented above – about shame, professional development and reflective learning models – constitute the conceptual framework of this study.

The overall aim of this study was to explore medical students’ reflections on shame-related experiences in clinical situations. Specific study questions were: How do students talk about shame? What kind of situations come up in their narratives? How do students tackle their experiences?
**METHODS**

**Setting and participants**

Professional Development is a 24-credit course that runs throughout medical education at Umeå University, Umeå, Sweden. This course engages students during terms 1–11. The aim of the course is to enhance student self-awareness, empathy and ability to communicate with patients, relatives and staff. The course includes training in identifying and handling affects and emotions, and training in consultation skills and leadership.

During term 9, a 1-day seminar on shame in medical encounters is held. Students are encouraged to write short essays about their experiences of shame in clinical situations in order to reflect upon this topic. The instruction for the assignment is: ‘Sit by yourself and reflect upon a clinical situation(s) in which you, the patient or anybody else experienced shame, or a situation which you experienced as shameful. Write about this event and describe what happens/happened in your body while reflecting and writing about this memory.’

Two subsequent classes during the autumn and spring terms in 2007/2008 (133 students, 60% women) were asked to participate in this study by sharing their essays for analysis. Respondents were guaranteed anonymity. Seventy-five students agreed to act as our informants.

**Analysis**

We chose a qualitative method for the analysis as such methods are appropriate for an inductive exploration of experiences. In our approach to the students’ narratives, we strove to be open-minded by asking: ‘What is going on here?’ The analysis was systematically conducted according to qualitative content analysis. First, all three authors independently read the same 18 transcribed, anonymous narratives and applied a system of open coding in which each sentence (or unit) was analysed and coded and keywords, expressions and emerging ideas were noted in the margin. The researchers then met to compare and discuss the codes and sort them into preliminary categories. Subsequently, the first author conducted the main codings of all 75 narratives. Throughout the analysis a notebook was used to maintain continuous notes in order to better understand the underlying meanings of the texts. In multiple sessions with all three authors, the categories were successively modified and condensed until consensus was reached. To improve its credibility and to ground the analysis, the narratives were reread to confirm, reject or reformulate category labels. To check the trustworthiness and validity of our coding procedure, we also invited a group of researchers who were uninvolved in the study to analyse 12 narratives and thereby scrutinise our analysis findings. Finally, the categories were sorted into the three salient themes that responded to the specific research questions. Table 1 gives an example of the analysis procedure.

**RESULTS**

The texts were rich in examples and expressions indicating that the students had understood the assignment. The students reported shame-provoking incidents from various health care arenas, such as reception areas, consulting rooms, rounds and operating theatres. The analysis resulted in the emergence of the three main themes of: Difficulties in disclosing shame; Shame-inducing circumstances, and Avoiding or addressing shame.

| Table 1 Illustration of the coding procedure with an example of a meaning unit, its codes, categories and emerging theme |
|---|---|---|---|
| **Meaning unit (quote)** | **Codes** | **Categories** | **Emerging theme** |
| 'Newly arrived on the ward, there was a 65-year-old, shy and quiet man... and at the round the senior doctor remarks, loud and clear, with a certain sarcasm in his voice: “Well, how much does this old man drink?” It was not just the train of spectators, but also said in a four-bed ward room in a small provincial town’ | Newly arrived | Taken by surprise | Shame-inducing circumstances |
| | Shy | Being exposed |
| | The round | Staff imprudence |
| | Doctor remarks |
| | Sarcasm |
| | Alcohol |
| | Train of spectators |
Difficulties in disclosing shame

Several students described initial problems in remembering any shame-related situation from their clinical training:

‘When I got the assignment to reflect upon shame, I had difficulties in recalling.’

They thought that shame was difficult to capture:

‘Shame is...a special emotion as it is extremely difficult to communicate and acknowledge.’

However, when the students were given time for reflection, suddenly their stories became full of not only technical details, but also of abundant descriptions of feelings and inner experiences.

In the reflections upon ‘shame’, words such as ‘embarrassment’, ‘neglect’, ‘humiliation’ and ‘disgrace’ were used often. The narratives used many terms of negation (i.e. ‘in-‘ and ‘un-‘ words), such as ‘insufficient’, ‘insensitive’, ‘uncomfortable’, ‘unwarranted’, ‘unprofessional’ and ‘unpleasant’. The students also used phrases and idioms such as ‘I wanted the ground to open up and swallow me’ and ‘with his trousers down’ to describe their own or other persons’ feelings of shame. They described different bodily reactions as noticeable manifestations of shameful feelings in terms such as ‘I felt sick’, ‘I was totally speechless’, ‘I could hardly breathe’ and ‘Everything turned black’.

Shame was described as an uncomfortable and adhesive feeling:

‘Now, afterwards, I still feel ashamed about the way I answered.’

Quite a few students commented that their uneasy emotions and bodily symptoms returned as they recalled the actual shame-related situation or event:

‘I willingly admit that, though more than 6 months have passed, I feel an icy lump in my stomach when I write down the memories.’

Shame-inducing circumstances

We categorised three specific shame-inducing circumstances: being taken by surprise; being exposed, and being a bystanding observer of an act of imprudence by a staff member.

Being taken by surprise

In the narratives, shame was often preceded by surprise. The shame-related event had often taken place on the student’s first day or week in a certain ward or clinic. The students were therefore beginners and the examples they gave showed that they were astonished at what they were confronted with:

‘I could not believe my eyes.’

Several students experienced shame when they were required to perform procedures for which they were not ready:

‘I felt so stupid that, in front of everybody, I had to do an assignment I was not prepared for.’

Students also referred to situations they had found shameful on behalf of patients and which related to patients being unprepared:

‘In effect he just pulled down her trousers and started to examine her.’

Other accounts referred to patients who were insufficiently informed about treatment plans and were thus taken by surprise:

‘No-one had told her that she was being admitted to a cancer clinic.’

Being exposed

Shame was also associated with being looked at and inspected in front of others. The more spectators – ‘the more eyes’– that were involved in the shame-related event, the more shameful it became, according to the students. The ward round was described as especially delicate in view of the ambivalent expectations of students to attend and take part and at the same time to appear non-existent and invisible.

Medical student exposure to shame chiefly concerned insufficient skills and knowledge on the part of the students. Students had experienced shame-inducing reprimands from seniors. This example was given by a student who described an event that occurred as she was about to perform a defibrillation for the first time. When she admitted her insecurity to the senior doctor, he took her aside and said: ‘Never ever again, in front of a patient, admit that you are not experienced; that is unprofessional.’ The student commented:
‘I experienced my worst shame ever.’

Students also related shame to the asymmetry of power in the positions of the people present and to the hierarchy of the medical culture, which produces inequalities. Patients, students and junior doctors were perceived as subordinate:

‘It feels as if the medical service is a little special in its hierarchic system, where a senior doctor can very easily humiliate and kick downwards.’

This student recalled and was upset by witnessing the exposure of a junior doctor:

‘The senior doctor said that the junior doctor did wrong, and that he was incompetent, and he did so in the presence of both staff and patients.’

Students also saw that patients, too, could feel ashamed and belittled when seeking medical attention whenever attitudes of superiority and power were communicated, such as when a patient was told:

‘You should be grateful; it’s a privilege for you to be here on this ward.’

However, students’ references to shame experienced by patients chiefly concerned situations of bodily exposure in which patients find themselves. Students perceived that examinations of intimate parts of the body were shame-inducing:

‘We have to ask our patients to undress and touch them in a way that they would never allow any other human being to do.’

Students also gave examples indicating that diseases linked to patient behaviour, such as smoking and drug abuse, were shame-prone. Obesity, skin defects and symptoms relating to defecation or the genital organs were regarded as more shame-provoking than others. For instance, when examining a patient’s symptoms of the penis, one student reflected:

‘I think he experienced it as an insult – not directly from my behaviour or my clumsy way of examining him – but just by being in a hospital with pain in the most holy of organs.’

The narratives conveyed the students’ impression that just being in the patient role – in which one is vulnerable and dependent – entailed a risk for experiences that induce shame. Students concluded that being ill per se is shame-provoking:

‘Disease in itself involves shame experienced on a scale that extends from the shame pertaining to having crab lice to that of having a fractured finger, not to mention the shame of seeking medical attention for a condition that does not need care.’

**Bystander observation of the imprudence of staff**

The students in our study had – as bystanders – noted certain behaviours and attitudes on the part of ‘the shamer’. They recalled actions they had found offensive to patients or to themselves, which included the making of sarcastic remarks, being rude and deficiencies in responding to patient needs. These included incidents such as when a patient was harshly instructed to ‘Take off your bra’ 10 seconds after she had entered the consultation room, and a doctor was heard to comment ‘That’s size 42D, isn’t it?’ to a patient undergoing a breast examination. Similarly, overly pushy dialogue delivered in the process of history taking was felt to be disrespectful:

‘The psychiatrist immediately began, unexpectedly forcefully, to penetrate the patient’s social situation.’

In their recall of humiliating situations, students often commented on how doctors behaved. In some essays, doctor behaviour was depicted as representative of negative role-modelling and the student’s conclusion was that this was not behaviour to imitate:

‘I am on the morning round. The doctor is quite unpleasant towards the patients. He does not listen to them. He does not seem to consider their worries seriously, and does not answer their questions. Several times he acts ignorant, and all this I am part of. I would like to run back to the patients and explain.’

At the same time, students felt they were being given messages about the traditions and working conditions they were about to inherit and which they would be required to shoulder through subtle explanations or excuses such as: ‘We have so many patients daily that we have no time to sit and talk and explain to them all.’

Informants reported that whenever they witnessed a shameful event provoked by a doctor, they felt as if they themselves were the shamer, although they were not actually involved in the sequence:

‘I was ashamed because I thought the woman associated me with the doctor; I took the blame for his nastiness.’

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Just the fact of wearing a white coat or even of being in the same room as the doctor when the shaming occurred appeared to have caused many of our informants to experience shame by association.

Avoiding or addressing shame

Common ways of reacting to feelings of shame involved escaping or avoiding the situation, as indicated by comments such as: ‘Most of all I wished the earth to swallow me’ and ‘I just wanted to run away.’ Students also described reactions of ‘mental shutdown’ and an inability to act:

‘I became totally paralysed.’

Other ways of avoiding feelings of shame involved putting them away, storing them in the body or enduring them, indicated by the use of phrases such as ‘swallow injustices’ and ‘hold out instead of taking hold of it’.

Informants suggested that shame-related experiences during practice may have an impact on their future choice of specialty. For instance, one student, who had been scolded during an operation for having lost hold of an abdominal hook, concluded:

‘A shameful experience like this certainly contributes to an unwillingness to choose surgery as a future specialty.’

The dependence of the student within the doctor–student relationship was described as hindering students from addressing shame and speaking freely:

‘It is also difficult to put your foot down, as you are in an inferior position and dependent on your tutor.’

However, choosing not to protest represented an act of self-preservation that in itself provoked shame:

‘...but as I selfishly chose to protect myself, and not the future medical students, I felt ashamed.’

Some students reflected upon what they could learn from the shameful incident and how addressing experiences of shame might induce tactfulness and awareness in future situations:

‘I will bear this in mind, this feeling of shame, how these elderly people were treated, to remind me.’

Students emphasised the need for and value of having someone to talk to after being part of a shameful situation. Sometimes, when going through what had happened, they found the initiative to act:

‘I talked to my classmate and then I decided to pluck up my courage to go and talk to the patient.’

Tackling feelings of shame required a certain amount of reflection, clarity and courage. A few students reported that their efforts to clear up embarrassing situations had been fruitful. By expressing and venting their feelings, their own dignity had been restored and new insights gained:

‘At a later meeting with the senior doctor, I told him exactly what I had felt... Maybe it was an eye-opener for him?’

DISCUSSION

This study gives insights into how medical students might face and tackle shameful experiences in clinical situations during their education. Students conveyed initial problems in recalling shame, but, when given time for reflection, they soon disclosed various scenarios they had experienced as shame-inducing. A common experience referred to the occurrence of shame when the student was taken by surprise. Respondents described how they themselves, or patients, were not sufficiently prepared for what was going to happen. Another theme concerned the exposure of nakedness and inferiority in the medical hierarchy. Students gave examples of the shame-provoking behaviours of staff and pondered on how they might avoid such behaviour themselves. There is much for medical educators to learn from the students’ descriptions of experiences of shame.

In addition to conveying considerable knowledge about shame, health-related stigma and the potential medical effects of these issues, this study discloses the recurrent experiences of shameful incidents of medical students. Shame is an affect that reveals our values, hopes and aspirations, which is a good reason why the theme of shame ought to be a highlighted in medical school curricula.

The difficulties in disclosing shame and the descriptions of how students re-experienced feelings of shame when recalling them may explain in part why shame-inducing situations are left unaddressed. Davidoff described shame as ‘the elephant in the room’ and as ‘something so big and disturbing that we don’t even see it, despite the fact that we keep bumping into it’. Left unaddressed, humiliation may
persist and may even be fostered in the medical context, thus becoming part of the hidden curriculum.\textsuperscript{15}

Decades ago, Lazare\textsuperscript{3} explored determinants of shame-inducing events, the vulnerability of the subject, and the social context of shameful situations. He emphasised the importance of the ambience of the hospital and its staff: ‘Physicians and nurses need to work with administrators to create an atmosphere in which patients feel welcome, cared for and respected.’\textsuperscript{12} Correspondingly, Malterud and Hollnagel have ascribed humiliation to the social context: ‘It is no longer a question of some good guys and some bad guys, but a matter of behaviours and beliefs in the medical culture.’\textsuperscript{25}

Certain chronic health conditions, such as HIV/AIDS, leprosy, tuberculosis, mental illness and epilepsy, are recognised as stigma-related in many societies globally.\textsuperscript{5} However, as students in our study mentioned, illness in itself might trigger feelings of shame. In societies in which success and high achievements are normative goals, ill health, shortcomings and the loss of body control may breed feelings of low self-esteem, vulnerability and shame. Therefore, a heightened awareness of these issues can help doctors diminish both their patients’ and their own experiences of shame.\textsuperscript{3}

Students recalled humiliating situations that arose in encounters that involved, for instance, obesity, smoking and alcohol consumption. These examples may mirror the patient’s shame over a condition related to self-control \textsuperscript{26} and trigger embarrassment in unaccustomed students. Alternatively, patient embarrassment may reflect the attitudes and awkwardness of senior doctors and the latter’s failure to deal with these situations in a respectful way. Students who have witnessed embarrassing examinations of breasts and genital organs call for ‘universal precautions’ to be applied in delicate situations. Tutoring by senior staff should include preparing students as well as patients in advance, explaining why and how examinations and procedures will be carried out, and asking for patients’ informed consent. Teaching practice ought to include discussions with students about how to perform intimate examinations in gentle and empowering ways.

Students’ experiences may partly reflect the fact that they are unaccustomed to witnessing such procedures and it may be that patients are not, in fact, as embarrassed as students perceive. Nonetheless, the fresh perspective provided by viewing these events through the eyes of students may pinpoint norms of behaviour in health care that are taken for granted. For instance, many students linked humiliations in ward rounds to the number of people present. This may represent an incentive for discussions about the ethics of the ward round and about what can be said and exposed in ‘public’ without causing humiliation.

Students described their own experiences of shame and what they perceived as patients’ experiences of shame. To a certain degree, these descriptions referred to parallel processes (i.e. the same sorts of circumstances induced shame in both students and patients: being taken by surprise; being exposed, and being on the downside of a power imbalance). For the students, the process of coming to realise such parallels may facilitate the development of sensitivity and empathy in relation to patients. Then again, as bystanders the students identified with the doctor and felt they were or at least were to be ‘a part of’ the upper level in the medical hierarchy. This ambivalence in the student role and the ethical considerations associated with it combine to represent a good starting point for discussions of medical standards and good manners.

Shameful emotions are powerful modulators of behaviour. However, such modulation may not progress in the most desirable direction if the immediate reactions to shame, such as feelings of stupidity and incompetence, are not recognised, considered and counteracted. Shame has been identified as a universal dynamic in education and is primarily considered detrimental to learning.\textsuperscript{27} Yet shame and embarrassment are foundation stones of moral behaviour.\textsuperscript{28} Malterud & Hollnagel\textsuperscript{25} have elaborated on how objectivism and emotional distance in the medical environment can lead to moral neutralisation and indifference. Medical care is built on traditional hierarchic systems that are prone to establishing an asymmetric distribution of power that can create feelings of uncertainty and breeding grounds for shame-related experiences.\textsuperscript{24}

The students’ remarks about how they tackled shame by avoiding or by addressing it are worthy of note. They described how the student position, in which the student is dependent on the superior doctor, hindered them from speaking out and acting during shameful incidents. Avoidance and silence may serve as obstacles to the processing of the witnessing of shame and thus may hinder the witness from taking responsibility for mistakes and apologising for them.\textsuperscript{29–33} Accounts of avoidance and silence highlight a need for student forums in which delicate issues and malpractice can be discussed.
The description by students of their immediate reaction, that of the flight impulse, may in Schön’s terminology be considered as representing a reflection on reactions in action. However, the resolution of vexing problems also requires reflection on actions after the event and shame is especially difficult to metabolise and address without help. The students in our study said that they achieved emotional relief and cognitive insights by reflecting on shameful events together with fellow students. By discussing the topic of shame, students and teachers can develop medical cultures that re-establish an atmosphere of respect, comfort and welcome from the perspective of the patient.

Shame is often described as the opposite of pride. Probyn, however, suggested that a prerequisite for shame is ‘interest’; we react with shame in contexts in which we are engaged in a situation and are eager to do the right thing. Debriefing after a mistake or an embarrassing situation can enable the person involved to benefit from going through what happened, recalling his or her own actions and reactions and reflecting on possible alternative ways of handling the situation. Shame can thereby serve as a commitment device. This line of reasoning implies that students’ reactions to and reflections on shame can be seen as incentives for professional development, whereas ignoring them may induce alienation and an indifferent attitude.

Limitations of the study

The findings in this qualitative research study are not to be considered as proof, but as descriptions and interpretations that – like a torch – shed light on a formerly unexplored area. Criteria of scientific rigour have been considered. The coding procedure was systematic. The categories and themes were completed by applying a process of constant comparison between researchers and by interplay between data and emerging concepts. For instance, when a category was labelled, we returned to data to ground it and we submitted the data to questions such as: Was ‘being exposed’ a trait in all narratives? We searched for negative cases as we sought to establish whether the narratives included descriptions of shame experienced among superiors or whether they always applied to subordinates.

A group of researchers not involved in the study were also invited to code, categorise and discuss the data. Their impressions confirmed our findings. Participation was voluntary and 44% of the students invited chose not to share their written experiences of shame. We do not know the reasons for their refusal, but they may have implications for our findings. It may be that the abstainers had no experiences of shame to discuss. It may be that they considered their experiences too painful to share. They may have been afraid of betraying themselves, a patient or a superior doctor. We cannot speculate about what was not revealed and therefore dark corners may remain unexplored and items undetected in this area.

The mean age of the group of students invited to participate in term 9 of their medical education was 25 years; around 60% of them were women and about 4% were immigrants (i.e. born outside the country of the study). However, as we had committed ourselves to maintaining the anonymity of respondents, we were unable to connect the specific narratives to demographic information on the informants and therefore cannot speculate about the impacts of age, gender and ethnicity on shame-related experiences. This may be an interesting topic for further study.

Moreover, our findings come from one medical school. Here, too, circumstances can be specific. As with other qualitative research findings, the transferability of the findings is very much up to the reader. Is it reasonable to expect that students in another part of the world experience the same difficulties in disclosing shame and may they too need the help that can be provided by including reflective tasks and discussion into their curricula? Can the findings pertaining to shame-inducing circumstances be recognised in other medical settings, such as nursing schools or paramedic training?

CONCLUSIONS

Students’ reflections on shameful experiences elucidated the importance of attitudes, manners, standards and hierarchies in clinical situations. These are important issues to highlight in the professional enculturation of medical students and may encourage medical teachers elsewhere to organise similar activities. The same sort of circumstances induced shame for students and patients and included being taken by surprise, being exposed and being on the downside of an imbalance of power. Realisation on the part of students of the fact that such processes occur in parallel may facilitate the development of empathy and respect in relation to patients. To develop the technical, ethical and emotional prepa-
ration of medical students before they are confronted with patients in exposing and intimate situations may reduce the risk of humiliation in the clinical encounter. Opportunities for mentoring medical students in their attempts to tackle shame and adverse feelings, and in resolving conflicts, are required in the medical curriculum.

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Ethical approval: The Ethics Committee of Umeå University decided that as the data on which the study is based are anonymous student essays and not patient data there was no need for a formal ethical application to the Committee. Thorough ethical considerations were made in the collection and handling and use of data. Students were informed about the study and that participation was voluntary and anonymous.

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