

Modelling empathy in medical and nursing education

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Abstract

Medical and nursing student numbers are expected to increase significantly in NZ over the next few years. The ethical, and professional and clinical skills' training of trainee health practitioners is a central and crucial component in medical and nursing education and is underpinned by a strong commitment to improve patient health and well being. In this discussion we reflect on the virtue of empathy and the importance of role modelling in the education of nurses and doctors. We endorse the claim that as medical educators, *how* and *what* we teach matters.

Over the past several decades, the moral domain of medicine has assumed an increasingly prominent role in the healing, care, and treatment of patients. No longer is it appropriate (if it ever was) that the focus centre predominantly on the disease or illness that a patient presents with (for instance, patients as problems to be solved). Now there is greater recognition for the psychological, cultural, emotional and spiritual aspects of a patient's wellbeing.^{1,2}

Within the New Zealand context, recognition of this can be evidenced in a number of different ways from the development and implementation of the Health and Disability Code of Consumers' Rights (in response to the Cartwright Report in 1988³), to greater emphasis placed on respecting the preferences of patients in the area of decision-making at the end of life (for instance in promoting advance directives), and respect for cultural diversity.

The nursing profession adopted the concept of cultural safety into its undergraduate degree programme in 1992. Cultural safety includes recognition of the rights of all patients and their families, respecting their unique cultural identity, and ensuring their needs and expectations are met and safeguarded.⁴

In 2010 Ron Paterson (then New Zealand's outgoing Health and Disability Commissioner) commented, in the *New Zealand Medical Journal*, on some of the lessons learnt from complaints to the Commission, and the implications these lessons may have for medical education.⁵

His insights included remarks on the importance of effective communication, the virtues of courtesy, kindness and empathy in one's relationships with patients, the ability to be self-reflective and open to criticism, and the significance of teamwork and clinical leadership.

In the article he claimed; "*First, how we teach may be as important as what we teach. Our behaviour as educators matters. Do our tutorials and lectures (and later our ward rounds and teaching sessions) model good communication? Do students see courtesy and kindness in the approach of teachers*"?⁵ (pg 9)

Informing and steering his focus and subsequent discussion in the paper were the complaints made to the Health and Disability Commission over a ten year period when he was Commissioner. When we consider the publically available reports detailing complaints against health practitioners, it is troubling to reflect that some of them involve grievances about a lack of professionalism (notably poor communication skills) and concerns around a lack of courtesy, empathy and team work.⁶

The Commissioner noted in the 2011 Annual Report that “*consumers complain about the attitude and manner of the provider, communication with families, the adequacy and accuracy of information, informed consent, and communication of test results*”⁶ (pg 9).

Paterson went on to comment in his paper that “*as educators, we should teach medical students about the nature of suffering and the value that patients place on courtesy, kindness and empathy*”⁵ (pg 7)

Medical and nursing student numbers are expected to increase significantly in NZ over the next few years. The ethical and professional and clinical skills’ training of trainee health practitioners is a central and crucial component in medical and nursing education and is underpinned by a strong commitment to improve patient health and well being (as well as continued public confidence and trust in the health care system).

We endorse Paterson’s challenge that *how* and *what* we (as medical educators) teach matters and expand on the *how* by claiming that the virtue of empathy can, and must, be reflected in medical and nursing education through appropriate role modelling. Congruence is vital—if medical and nursing students are expected to develop patient-centred attitudes and skills, those teaching them should be student-centred themselves.⁷

What is empathy?

We use the concept of empathy to refer to a cognitive attribute that involves an understanding of the inner experiences and perspectives of the patient as a separate individual combined with a capacity to communicate this understanding to the patient.⁸ In other words, empathy is the ability to emotionally identify *with* others—to feel what they are feeling⁹—and to convey that sense of identity to the patient.

To be empathetic is to have altruistic concern for others, and thus is demanding because it requires health practitioners to listen and connect with others. In essence it requires them to step into the other’s shoes. It is a quality needed by both nurses¹⁰ and doctors.¹¹

Within the literature, whilst there is considerable disagreement about how the concept of empathy is understood, and whether it can - or even should - be taught to medical and nursing students, there is widespread agreement empathy is a crucial and significant part of the relationship a patient has with a health care practitioner.^{2,11,12} Modelling empathy towards students, and being empathetic with patients is an important aspect of good medical care.

Hornblow and colleagues argue that empathetic skills ought to be taught in medical education and that it should not be assumed that such skills will be automatically acquired in the course of clinical training.¹³

The Medical Council of New Zealand states in its guide '*Good Medical Practice*' that working in partnership with patients entails listening to them and responding to their concerns and preferences. It is this emphasis on listening and responding to patients that is at the heart of Paterson's call to elevate the virtue of empathy within medical and nursing education.

The Nursing Council of New Zealand requires that student applicants (for State Final exams leading to registration) demonstrate four core competencies. The third domain of competencies—Interpersonal Relationships—requires of nurses that they '*demonstrate respect, empathy and interest in the client*'. This has to be demonstrated and maintained in practice before a student may be judged competent to nurse.¹⁴

Student nurses preceptored by experienced Registered Nurses are required to meet Nursing Council competencies which go to the core of ensuring the Registered Nurse workforce has a culture of excellence in nursing practice. It goes without saying that communication skills including empathy are high on the list of 'must achieve'.

The erosion of empathy

Several studies have explored the alleged erosion in empathy amongst medical students^{8,15-17} nursing students¹⁸⁻²⁰ and in other health disciplines.^{21,22}

A recent study in which self-reported empathy levels were examined in students from five health disciplines (dentistry, pharmacy, medicine, veterinary medicine and nursing) found that the decline in self-reported empathy scores began during the first year of training.²³

The authors argue that whilst some of the decline may be attributable to a 'settling in' period (moving from an idealistic approach to one that is increasingly realistic in the medical setting), the decline may also reflect greater responsibilities and an increased workload (time pressures and fatigue).

It is also likely that empathy is eroded when students and junior staff become socialised into a culture whereby the implicit messages received are strongly contrary to the formal curriculum. This 'hidden' or 'silent' curriculum is powerful because often the most influential and lasting lessons learned are those that are conveyed in the corridors, at the bedside, and on the ward.²⁴⁻²⁸ In their paper, Christakis and Feudtner discuss some of the cases reported by medical students in their ethics class.

When students witness patients being attended to with little in the way of empathetic concern by more senior health professionals, they may end up relinquishing such virtues as being redundant or superfluous to the medical setting.

It is well documented within the literature that implicit attitudes and behaviour towards patients and junior medical staff (trainee doctors and nurses) from some senior health professionals leave much to be desired.^{29,30-33.}

Role modelling empathy

A number of studies have explored role modelling in medical education.³⁴⁻³⁸ and the importance it has on shaping behaviours and attitudes. Weissman et al studied (via qualitative observation) twelve clinical teachers who were identified as excellent teachers of humanistic care by medical residents enrolled in four medical universities in the United States.³⁶

The authors found that the clinical teachers taught humanistic and professional values such as respect, patient care, empathy, and sensitivity, “*almost exclusively by role modelling*” (pg 662).

They relate an encounter between one of the clinical teachers and a patient who had recently been transferred to a different floor. She was distressed and weeping when seen by the clinician. He asked her why she was crying - was it pain that was causing her such distress? She replied that it wasn't, she was worried that her daughters would be unable to find her when they visited the hospital and found she had moved. Recognising her distress and seeking to understand what was causing it resulted in someone phoning her family to let them know where she was.

The authors identified as important a number of elements that were observed by the clinical teachers in their teaching: nonverbal communication such as touch and eye contact; overt demonstrations of respect such as asking permission of the patient and introducing oneself; building a personal connection such as recognising the patient outside the context of patient care rounds; eliciting and addressing patients affective response to illness; and attending physicians self awareness (pg 664). “*Implicitly, teachers assumed that learners would recognise, accept, and ultimately embody desirable behaviours*” (pg 664-5).

Yet the assumption that modelling desirable behaviours and attitudes will be explicitly understood by learners may be premature if these elements of learning are not stated unequivocally.

Egnew and Wilson³⁷ explore how medical students learn doctor-patient relationship skills in their medical education. They found that much of the teaching of these relationship skills was not concerted or coordinated and that whilst the majority of learning in the hospital environment occurred through modelling, it wasn't necessarily structured or clear.

One student commented that, “*we're getting thrown in the deep end and we just have to find out for ourselves...*” (pg 202). Commenting in a similar vein, another student said, “*we're little sponges and we're trying to suck up everything that we possibly can*” (Ibid).

Reuler and Nardone comment that medical educators “*should affirm the enormous influence role models have on education. Positive role models pass on perspectives that may have broad and long-term effects for both patients and physicians*”³⁸ (pg 336). They argue these effects can be both positive and negative and that role models are important because they are a substantial part of how students are socialized into the world of medicine. This is also affirmed by Kenny et al.³⁵

Wright and colleagues³⁹ explored the possible associations between role models that were encountered in medical school and students' later choice of clinical field. They

concluded that personality, clinical skills and competence, and teaching ability were most important in the selection of a role model, while research achievements and academic position were least important.

Personality ranked first and included qualities such as compassion, integrity, social conscience, accessibility and leadership.

Nursing students also reinforced the importance of positive role models in a study that explored the value of role modelling in teaching and learning within the clinical setting.⁴⁰ Donaldson and Carter found that good role models had tremendous influence not only on the clinical learning environment, but also on students' confidence and competence.⁴¹

Role modelling the kinds of attitudes, skills and behaviours expected of health practitioners lies at the centre of medical education and in the development of a culture of excellence. Yet as Paice and colleagues note, "*being a role model is serendipitous; there is no training programme, appointment panel or certificate. That you have been a role model for a young colleague can come as a surprise, either flattering or alarming depending on your conscience*"⁴² (pg 709).

Concluding comments

As students progress through their medical and nursing training they spend significant periods of time under the supervision of senior staff who teach, supervise and grade their performance. It is well documented that senior staff who teach students have a crucial role in the development of particular attitudes, skills, and behaviours.

When Paterson asks, "*do our tutorials and lectures (and later our ward rounds and teaching sessions) model good communication? Do students see courtesy and kindness in the approach of teachers*"?⁵ (pg 6), he is really drawing attention to the importance of modelling good communication, courtesy, empathy, and kindness in the relationships a student has with a health professional during their medical education.

It is perhaps self-evident to state that the kinds of attitudes, behaviours and skills we want to see and develop further in our students must be explicitly identified and taught. Role modelling is one important way of achieving this.

The challenge for those of us who teach, supervise and work alongside medical and nursing students is to reflect on and re-examine our own values, attitudes and behaviours, be prepared to receive critical and constructive feedback from students, and seek to improve our own performance so that we exemplify excellence in medical and nursing education.

Competing interests: None declared.

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