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Empathy in clinical practice: A qualitative study of early medical practitioners and educators

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Abstract

Objective: To explore the reasons for decline in empathy among physicians and to identify strategies for fostering empathetic clinical practice.

Methods: The qualitative study was conducted at the Aga Khan University Hospital, Karachi, from February to June 2017, and comprised focus group discussions involving separate sessions with medical students, residents and clinical teachers. Content analysis was used to analyse the verbatim transcripts for identification of codes which led to derivation of themes from the data. Consolidated criteria for reporting qualitative research was used to assess the quality of the study.

Results: Of the 109 subjects, 57(52.3%) were medical students, 30(27.5%) residents and 22(20.2%) clinical teachers. Of the 9 focus group discussions, 4(44.4%) were held with the students, 3(33.3%) with residents and 2(22.2%) with the teachers. Four themes that generated were delineating empathetic clinical practice, reasons for decline, challenges for promoting empathetic clinical practice, and recommendations for developing and facilitating empathetic clinical practice. All the participants unanimously agreed that there was a decline in empathetic clinical practice. Primary challenges included increased workload and time constraints inhibiting empathetic practice.

Conclusion: It is essential to teach empathetic clinic practice to students and residents during medical training while continuous professional development should reinforce the significance of empathetic clinical practice among medical practitioners and educators.

Keywords: Empathy, Clinical practice, Focus group discussions, Health professionals, Clinical teachers.

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Introduction

Empathy is a fundamentally a vital characteristic of the physician-patient relationship. Empathy is defined as the ability of the physician to recognise and understand a patient's perspective and experience, combined with the capacity to communicate this understanding to the patient.[1] This generates confidence and trust in the relationship, and promotes physician-patient satisfaction, and patient's ability to cope with stress.[2]

A number of studies have explored empathy using different measurement scales.[3] Majority of these studies indicate that there is a decline in empathy in medical students and residents as they progress in their clinical years.[4] One study[5] examined medical students' empathy and concluded that empathy scores in the pre-clinical years were higher than in the clinical years. Another study[6] examined changes in medical students' empathy across different medical years and reported decline in empathetic understanding as students advance in medical school. A subsequent study concluded that a significant decline occurs during the third year in which the focus is more on patient-centred activities.[7] It was reported that 75% of medical students become cynical as they progress through the medical school.[8] An Iranian study[9] measuring medical students' empathy reported a decline from pre-clinical to clinical trainees and interns. A study[5] measured mood variation and empathy during internship in medical students and concluded that enthusiasm was present in the beginning of the internship, but it soon turned into depression, anger and fatigue. One study[4] concluded that frequency of mood changes increased and empathy decreased during clinical years.

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COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	3
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	3
Occupation	3	What was their occupation at the time of the study?	3+Title page
Gender	4	Was the researcher male or female?	Title page
Experience and training	5	What experience or training did the researcher have?	3
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	3
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	4
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	3-4
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	3
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	3
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	3
Sample size	12	How many participants were in the study?	4
Non-participation	13	How many people refused to participate or dropped out? Reasons?	3
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	3
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	3
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	3
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	3
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	4
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	4
Field notes	20	Were field notes made during and/or after the inter view or focus group?	4
Duration	21	What was the duration of the inter views or focus group?	3
Data saturation	22	Was data saturation discussed?	4
Transcripts returned	23	Were transcripts returned to participants for comment and/or correction?	4
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	4
Description of the coding tree	25	Did authors provide a description of the coding tree?	4
Derivation of themes	26	Were themes identified in advance or derived from the data?	4
Software	27	What software, if applicable, was used to manage the data?	4
Participant checking	28	Did participants provide feedback on the findings?	4
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	4-7
Data and findings consistent	30	Was there consistency between the data presented and the findings?	4
Clarity of major themes	31	Were major themes clearly presented in the findings?	4
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	4

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. International Journal for Quality in Health Care. 2007. Volume 19, Number 6: pp. 349 – 357.

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Appendix: Consolidated criteria for reporting qualitative research (COREQ)

These studies have examined empathy using quantitative measures, but none of these studies have explored in depth the reasons for decline in empathy and strategies for improving it. It is imperative to fully understand the causes which inhibit empathy among medical students and residents as they advance in their clinical years, and to explore approaches to enhance empathetic clinical practice. The current study was planned to observe the perceptions of medical students, residents and clinical teachers regarding provision of empathetic clinical practice, to identify factors that hinder such an attitude, and to explore ways of sustaining and promoting empathetic clinical practice.

Subjects and Methods

The qualitative study was conducted at the Aga Khan University Hospital, Karachi, from February to June 2017, and comprised focus group discussions (FGDs) involving separate sessions with medical students, residents and clinical teachers. Purposive sampling was used for selecting final year medical students, residents in their final year of training and clinical teachers. The medical students and residents in the last year of training were selected because in the final years of undergraduate and postgraduate programmes, they would have a better understanding of provision of empathetic clinical practice and its related issues. Clinical teachers selected had more than five years of clinical and teaching experience and were also currently involved in clinical practice and teaching. Participants were approached via email. No relationship was established with the participants prior to the commencement of the study. All the participants approached provided informed consent to participate, and there were no dropouts.

FGDs were held as they help participants to identify and clarify their views compared to individual interviews.[10] The structure for FGDs was developed based on a review of the literature, and the format was semi-structured questions flexible enough to allow for the introduction and discussion of further relevant topics.[11] All the FGDs were conducted in meeting rooms at the university campus, each with an average duration of 52 minutes (range: 40 - 90 minutes). Sessions were moderated by a researcher who had training in qualitative research and conducting FGDs, and was not a clinical teacher. The facilitator summarised the key findings after every session to gain agreement of the participants. When the researchers felt that the data saturation was reached, data collection was stopped and, therefore, FGDs were not repeated for the group.

All FGD sessions were audio-taped and transcribed verbatim. The transcripts were independently analysed manually for the identification of codes by all the researchers. The coding categories were checked and refined. Two members of the research team were not clinical faculty members and were not involved in their teaching, assessment or evaluations. This eliminated any chance of introducing bias on the basis of pre-conceived ideas. The identified codes resulted in the derivation of themes from the data. Consensus on the themes was reached after discussion among the researchers. The trigger questions served as orientation for coding, and subthemes were identified in an iterative process, which ensured that themes were comparable across groups. The trustworthiness of the data was ensured by member-checking after each FGD, and independent analysis of the transcripts.[11] Also, the consolidated criteria for reporting qualitative research (COREQ) checklist was used to ensure the quality of study (Appendix).[12]

Results

Of the 109 subjects, 57(52.3%) were medical students, 30(27.5%) residents and 22(20.2%) clinical teachers. Of the 9 FGDs, 4(44.4%) were held with the students, 3(33.3%) with residents and 2(22.2%) with the teachers. Each focus group session included a minimum of 7 participants and maximum of 15 participants, in addition to the facilitator and a note-taker.

Four distinct themes were generated: empathetic clinical practice, reasons for decline, challenges for promoting empathetic clinical practice, and recommendations for developing and facilitating empathetic clinical practice (Table). There was consistency between the data collected and the themes that emerged. No other minor theme emerged.

Empathetic clinical practice was defined as feeling someone's pain by putting oneself in their shoes. In clinical practice, empathy is about being truly aware of the feelings of others and although most of the time these feelings are of suffering and pain, there are times of happiness and joy also.

"The ability to feel that you are in that person's shoes while treating them, to understand in depth what they go through,

Table: Challenges and Recommendations.

Themes	Sub-themes	Supporting statements
Defining empathy	Feeling someone's pain	Keeping yourself in other person's place
	Kind	You are thoughtful of what the other person is going through
	Sensitive	Its imagining if it was happening to you
	Compassionate	You are considerate of their pain and grief
	Caring	You feel concerned for the patient
Reasons for decline in empathy	Increased workload	There is too much workload here- no check and balance
	Lack of time	We are always short of time for everything
	Unrealistic objectives	In this competitive environment we are striving for best and then setting deadlines which are hard to meet
	Lack of reflection	None of us for a moment sit and think how did I do today
	Diverse background, culture and schooling	Diversity in students makes it more difficult to inculcate empathy
	Lack of awareness in doctors about being empathetic	No one knows what empathy is or if they know its forgotten
	Becoming more commercial	We are becoming more business orientated
	Excellence in academic performance	We are more focused on knowledge and grades than empathy
	Desensitization	It becomes part of routine seeing so many critical patients
Challenges	Overall workload	Multiple responsibilities makes it difficult to manage effectively
	Increased influx of patients	From some years there is increased patients and less doctors now
	Changing the mindset	Some may disagree that empathy is important as long as work is done effectively
	Ensuring empathetic clinical practice is followed	Its difficult that everyone will practice empathetically, it will become sympathetic
	Lack of time	We don't have time to be empathetic
Recommendations	Role model	Empathy must be role modeled
	Encourage reflective practice	Develop a habit of self-analysis
	Curriculum	I don't think I have ever been formally taught about empathy
	Workshops, training sessions and inspirational talks	Give awareness about empathy to all
	Increase resources	Need to increase doctors, staff, units, etc
	Devoted time	There should be time for rounds clinics and dedicated teaching sessions
	Decrease workload	Distribute responsibilities according to individual's interest
	Monitor to implement empathy	Continuous monitoring is needed to implement it
	Feedback	One can learn and improve with continuous practice
	Evaluation system	Should be tested on their ability to empathize

both physically and psychologically, in that disease state especially the chronic ones." (Teacher#3)

There was a general consensus among all the participants that empathetic clinical practice had declined. Although a number of reasons were responsible for this decline, increase in workload and time-constraints were identified as prime reasons.

"We are always pushed with time, as we have to see patients within a specified time. We don't have the time to think and go through what the patient is going through in terms of their emotions, so we just quickly take the history, diagnose, manage and move on." (Teacher# 8)

A misconception that was highlighted during the discussion was that empathy is a trait which requires separate time. *"Empathy requires time and we don't have it." (Teacher# 8)*

However, participants recognised that this concept was misleading and that empathy is a "feeling" which is assumed to be taught and practised during medical training and expected to be ingrained into clinical practice.

Decline in students and residents empathetic behaviour was also attributed to diverse background, culture and schooling. It was identified that empathetic practice varied across individuals and disciplines.

"It is a trait which varies from individual to individual and in some specialties is practised more compared to the others." (Resident# 11)

Participants indicated that gradual sustained exposure to critical patients and maintaining composed attitude also promotes desensitisation.

"Since the beginning of the year, we get to see sick patients and get desensitiszed. We are dealing with very serious patients all the time and we don't have the time to empathise with each patient." (Student #14)

It was recognised that lack of reflection and setting

unrealistic objectives induces stress which in turn makes the individual more robotic and this behaviour is learned by residents and students as well.

"We are becoming more robots than human beings, and the decline in students is because they don't see empathy happening." (Teacher#14)

In terms of challenges for promoting empathetic clinical practice, one of the primary challenges identified was increased workload followed by time-constraints for implementing empathetic clinical practice.

"As far as faculty is concerned, patient load is a huge constraint. For residents, because we are expecting them to develop full competencies, some of which require hours of practice and work, adding empathy as an attribute would be a challenge, again because of the time and the load that they have in terms of teaching and learning. For students, curricular constraint will be there to add it in as a separate thing." (Teacher # 20)

Students were of the opinion that empathy is there but due to the nature of the environment, workload and time-constraints it cannot be practised.

"Over time it is not empathetic but sympathetic as it becomes more of a routine. For example suturing for the first time will be different while now for us it is a very casual task." (Student #37)

"You want to practise it, but somehow it gets lost amidst the chaos of time and patients." (Student# 11)

It was also indicated that seeking agreement and commitment from everyone that empathetic practice should be followed would be a paramount challenge.

"It's difficult to make everyone agree that empathetic clinical practice is important. It would be a challenge that this initiative is taken as a positive one." (Resident #27)

When it came to recommendations for developing and facilitating empathetic clinical practice, some of the respondents believed that empathy is an innate trait which cannot be developed, while others suggested that it can be developed. It was further suggested that empathy is a cognitive trait with emotions comprising behavioural science and psychological components.

"I think the cognitive part is to be taught and emotional part is inherent. You can teach people to work around their deficiency but you cannot give it to them. So empathy is not to feel; it is more to understand." (Teacher #12)

Developing positive role models and supportive institutional policies were considered essential for medical students, residents and junior clinical teachers.

"This has to be adopted as a culture, it has to be a part of organisational culture, not only should the directors be doing it but the organisational policies and culture should be aligned with it." (Teacher #15)

To sensitise about empathy and prevent its decline among health professionals, it was suggested to have workshops, training sessions and inspirational talks to reinforce this attribute. Other suggestions were increasing the number of doctors, ensuring availability of time for rounds and clinics, increasing the number of theatres and beds, decrease workload, and register a specific number of patients only. It was also proposed to be included as a reflective practice among teachers, students and residents.

It was recommended that empathy should be formally taught during medical school training.

"We are not really taught about empathy, we are focussed on medical knowledge and grades. I think medical schools and residency programmes should focus on empathy. This can be taught with video clips, debates on such topics with facilitators, a guided discovery of this is what we are talking about and once you get it in early years, then it will be there." (Resident #29)

Discussion

The results would be of interest to policy-makers and those in leadership roles who aspire to promulgate empathetic clinical practice among students, residents and clinicians. The conceptual understanding of empathetic clinical practice of realising and putting oneself in others' shoes to feel their pain and suffering was similar among all three groups. This finding is similar to other studies in which empathy was recognised as constituting both cognitive and effective domains.[13]

A number of reasons were identified for decline in empathetic clinical practice. A primary factor and persistence challenge identified by teachers and residents was increased workload in terms of administrative, clinical services and teaching responsibilities, and lack of time to address these responsibilities effectively. Existing studies have identified similar findings.[14] To address this challenge, the present study suggested creating a system where there is balance of responsibilities for clinical teachers i.e., overall workload should be reduced, dedicated time for clinical teaching should be increased, and there should

be additional hiring of doctors and related staff to prevent burnout. Existing evidence also supports that organisations can play an important role by designing interventions to facilitate physicians in their responsibilities.[15]

In the present study, students and residents felt that continued stress to meet academic schedules and deadlines leave little room to think about empathetic clinical practice. Existing evidence also supports that general life stressors in combination with medical school stressors lead to burnout which overall adversely affects their health.[16] Findings from the present study propose reduced workload for students and protected time for academics. Nurturing positive learning environment, focussing on problem-solving, teaching stress management skills and providing social support has been reported by other studies.[17]

One of the interesting findings of the present study was that continued exposure to patient care fosters desensitisation. This desensitisation stems from the fact that persistent and continuous exposure to patient care renders the doctor habitual. Additionally, more focus is on ensuring patient safety and well-being rather than on delivery of empathetic clinical practice. Existing evidence also indicated similar findings that students excel to be competent doctors, but, during that process, lose their ability to empathise with the patients.[18]

Findings from the present study indicate that students' background, culture and schooling may influence empathetic clinical practice. This is supported by literature which found that demographic and socio-economic background of medical students influenced their empathy levels.[19] Similarly, another study demonstrated cultural variation in empathic concern and perspective taking across 63 countries.[20]

Another important finding was that promulgation of commercialisation in medical practice is responsible for the overall decline in empathetic clinical practice. Evidence also indicates that commercialisation has led to decline in physician collegiality, promoted de-professionalisation, and endangered medical ethics.[21] This commercialisation is not only present at the physician level, but also gradually observed in residents and medical students. Hence, a trickledown effect takes place from the seniors to the juniors, and, therefore, a gradual change towards decline in empathy in the entire healthcare system is observed. One of the possible ways to address this could be to constitute policies which delineate the extent of commercialisation between universities and teaching hospitals, while institutions should put in place stringent policies to foster empathetic clinical practice.

Another important finding of the study is that practitioners may agree that empathy is important, but practising empathetic clinical practice may not be perceived as significant by all practitioners. A study argued that doctors can be competent in their treatment without being empathetic.[22] Additionally, evidence indicates that demonstration of empathetic clinical practice varies from people-orientated specialty to technology-orientated specialty, and across gender.[23]

To address this decline, the present study recommended integrating empathy as a longitudinal theme in undergraduate and postgraduate curriculum. Additionally, it was suggested to arrange workshops, seminars and discussions among residents, teachers and students for sustaining empathetic clinical practice. Also, continuous efforts are needed to reinforce the importance and practice of empathy during medical training and continuous professional development. There are commonly available teaching materials also that highlight the importance of empathy. Other studies recommended working with positive role models and doing practical discussions around psychosocial impact of illness to create awareness about empathy.[24] Findings from the present study also suggested ensuring repetitive reflective practice among clinicians, residents and students to foster empathetic clinical practice. Evidence also supports the role of reflective practice in facilitating empathy.[25] Findings from the study also propose to keep evaluation system for sustaining empathetic clinical practice. Providing feedback for continuous improvement of empathetic clinical practice can be managed, but continuous monitoring and later evaluating it for all students, residents and clinicians will be difficult. Empathy is a multi-dimensional concept comprising cognitive and effective domains and when we talk of developing it and breaking it down into observable behaviour, it may be possible to develop the cognitive aspect but to what extent will it be possible to develop the affective domain remains questionable.

The strength of the current study is that it explored in depth the reasons for decline in empathy, and identified ways of promoting empathetic clinical practice. Limitation of the study is FGDs which have a tendency to give more

space to the stronger voices that dominate the discussion. However, the current study made every effort to be inclusive and to allow all the participants to express their opinions.

Conclusion

Empathy is an integral component of clinical practice. There is a gradual decline in empathetic clinical practice among practitioners, but this is becoming widespread in medical students and residents. It is essential that during medical training, students and residents should be taught empathetic clinic practice, while continuous professional development should reinforce the significance of empathetic clinical practice among medical practitioners and educators. Empathy is a skill that can be learnt, and is not excessively time-consuming. The students need to be made aware of false beliefs in relation to empathy as well as commonly available teaching materials highlighting the importance of empathy. Institutions need to make concentrated efforts to ensure that empathetic clinical practice is followed.

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