

# Empathy can be taught and learned with evidence-based education

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Empathy is a reigning topic in healthcare because of its relationship to the aims of medical practice: improved health outcomes<sup>1</sup> adherence to treatment recommendations, improved quality of care and improved patient and provider experience.<sup>2</sup> At the same time, empathy reduces clinician burnout by providing meaningful connection with patients and alignment with the purpose of the medical profession: to reduce suffering and enhance well-being<sup>3</sup> while also reducing the risk of medical errors and malpractice claims.<sup>4</sup>

While many believe some people are empathic by nature, the capacity to act empathically is mutable and can be depleted in challenging times. Studies have shown that empathy decreases during medical training, and the science of empathy shows that empathy can be downregulated<sup>5</sup> and also upregulated by neuroscience-based interventions.<sup>6</sup> Certainly, the last nearly 2 years of practicing in a pandemic has beaten empathy out of many of us, due to the difficult working conditions, persistently high workload and personal anxieties. However, particularly in times like these it is important to pause and find ways to teach—or reteach it.

Empathy is a capacity that includes the ability to perceive the emotions and thoughts of others, the ability to process that input with perspective taking and self-regulation skills and the ability to experience empathic concern that ideally leads to empathic responses from the physician. When we teach empathy, we are not just asking healthcare providers to *act* like they care; we are teaching medical communication skills that result in a gratifying connection (on both sides) between the physician and their patients.

There are many offerings for physician training in empathy and most published studies of these suggest a benefit.<sup>7</sup> While acknowledging this evidence,

Pettit *et al* set out to create an emergency medicine-specific programme; however, they found no improvement in physician self-assessment of their empathy.<sup>8</sup>

To be sure, emergency medicine has several unique features, including rapid pace, high intensity interactions, lack of privacy, frequent interruptions and lack of pre-existing relationships between physicians and patients. However, given the variety of specialties (including some not known for their bedside manner) in which empathy teaching has been successful, the results of the emergency medicine intervention are surprising. Should we conclude that emergency physicians are inherently unteachable or inherently so empathic that interventions will show no difference? Are their working conditions so exceptional? And, does this mean further efforts to teach empathy are futile? I believe the answer is no.

To create their programme, the authors combined concepts from a review of influences on patient behaviours studies<sup>9</sup> a focus group study of patient preferences for communication<sup>10</sup> and aspects of an empathy training programme from our unit which was shown in a randomised trial to improve both physician and patient perception of empathy among physicians in medicine, general surgery, orthopaedic surgery, anaesthesia, psychiatry and ophthalmology.<sup>6</sup>

Interventions that teach empathy must consider the underlying neurobiology and physiology of empathy as well as interventions aimed at changing attitudes about empathy and skills and behaviours that lead to greater connection with patients that enrich both the patient and physician experience and are associated with fewer malpractice claims.

Creating new interventions that use only certain elements of a validated study in combination with elements from other programmes, as was the case in this emergency medicine study, might have eliminated key components to making a whole from the sum of the parts. Moreover, the programme included some previously unvalidated elements, making this paper more of a test of the programme than of the capacity of emergency physicians to learn empathy.

Underlying educational theory should also be considered when introducing a new intervention. Single meetings with one exposure to learning for several hours may not realistically achieve the same results as education delivered in multiple ‘doses’ to ensure repetition and retention of key concepts. The emergency medicine training was offered in one 3-hour sitting, whereas the evidence-based training programme that informed the emergency medicine was implemented in three separate 1-hour sessions, delivered over 6 weeks.<sup>6</sup> Providers often need to ‘practice’ just one piece of the training with real patients before moving on or may find that returning to the educational environment allows a real-life debrief that can be put into action the next time. And, repetition of key concepts, such as self-regulation skills is needed to learn the skills and to apply them to garner full benefits of the interventions.

The instruments used to measure empathy are equally important to the teaching interventions themselves because not all ‘empathy scales’ measure clinician empathy in a way that is applicable to all specialties. The authors of the emergency medicine study accurately point out that the Jefferson Scale of Patient Perception of Physician Empathy may be more appropriate for primary care and family medicine. This five-item questionnaire includes items about concern about the patient’s family and interest in the daily life of the patient. These items are more typically asked in primary care visits than in an ED setting, whereas the Consultation and Relational empathy (CARE) measure has broader applicability to any specialty.<sup>10</sup>

The use and utility of self-report measures is also relevant to this discussion. Most trials of empathy courses use self-report or the perception of a standardised patient or observer as an outcome measure. Less than 10% use the ratings of actual patients to determine success.<sup>6</sup> In both the emergency medicine study (quasi-experimental)<sup>8</sup> and the multispecialty trial (RCT),<sup>6</sup> the Jefferson Scale of Physician Empathy Self Report showed no difference in pre-post measures. However, the RCT also assessed outcomes using the CARE measure, which uses patient perceptions, and with this measure, a significant difference was found. Close examination of the Jefferson self-report measure reveals that many items refer to physician *attitudes* about empathy, rather than an ability to be empathic that would be perceptible by patients. Physicians can learn empathy skills that are perceived by patients without significant shifts in their

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attitudes. For example, physicians may not all agree that detecting patient emotions plays an important part in medicine, but if they learn how to accurately perceive their patients' affects they will be able to better address their patients' chief complaints and their chief concerns.<sup>5</sup> The lack of change in the Jefferson Self-report scale may, in part, be due to ceiling effects, or to the fact that attitudes may be difficult to change but advanced perception and responsive skills can be learnt and practiced clinically.

Empathic and compassionate care is highly desired by patients and is vital to good patient care and outcomes. Providing such care should be among the most important aims for medical professionals. Evidence suggests that empathy can be taught and learnt in a large variety of settings and disciplines, so it is important not to use this single study as verdict on whether empathy can be taught to, and learnt by, emergency room physicians. At a time in history when burnout and factors related to the pandemic present evident challenges to empathic care, using an evidence-based methodology to teach empathy has never been more important. Taking care of our medical professionals so that they have the support and tools to deliver empathic care in the first place, should be at the forefront of

every healthcare institution's mission. Our physicians and patients deserve nothing less.

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