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Does empathy manifest in medical students' palliative care reflective reports?: A qualitative study

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Abstract

Introduction: Clinical empathy involves the ability to understand problems of patients, their perspectives as well as feelings, and to act based on one's understanding of the medical problems, in a therapeutic manner. The process of empathy may be divided into the following responses: a) *Emotive*: the ability to subjectively experience and share another's psychological state; b) *Moral*: the altruistic force that motivates the practice of empathy; c) *Cognitive*: the ability to objectively analyse another person's feelings and perspectives; and d) *Behavioural*: Communicative response to convey another person's perspective.

Methods: The objective of the study was to find out whether Semester 9 medical students of the IMU had documented an empathetic response following their 'student-patient interaction' when they visited the Hospice in Seremban and homes of patients who were under palliative care. Following the visit, students submitted a reflective report to their mentors. The author had analysed 58 such consecutive reports that were submitted during the period May 2013 to November 2016.

Results: All 58 students sympathized with the plight of their patients, but only 12 of them had expressed empathy. Expression of empathy in these 12 reports was captured in the following number of instances: *Emotive* - 5, *Moral* – 5, *Cogni*tive – 7, *Behavioural* – 2; some expressing more than one component of empathy.

Conclusion: The study showed that reflective report writing is a 'window of opportunity' to find out whether medical students expressed empathy. Its potential as a teaching/learning tool needs further exploration.

Key words: *Empathy, Palliative Care, Medical Students, Reflective Reports*

Practice Highlights

- Clinical empathy improves healthcare.
- Training medical students and doctors to be empathetic is achievable.
- Exposure of medical students to settings where palliative care is given can be considered a window of opportunity to invoke empathy.
- Reflective reports following visits to settings where palliative care is given can be a useful tool to detect empathetic encounters.

I. INTRODUCTION

Ability to express empathy and sympathy are good qualities that all humans should possess. Empathy is the ability to share someone else's feelings or experiences by imagining what it would be like to be in their situation, whereas sympathy is understanding and care for someone else's suffering (McIntosh, 2015). The ability to express empathy is a reflection of emotional intelligence

(Goleman, 1995). These qualities should be developed to a high level in care givers like healthcare personnel. During an era where science and technology seem to take precedence in medical care, paying more attention to empathy would help to redress the imbalance (Bleakley, 2005). Studies have shown that empathy helps to develop better therapeutic relationships (a close and consistent bonding that develops between the client and the health

care provider) leading to significant outcomes for both psychotherapies and for active and placebo pharmacotherapy (Krupnick et al., 1996). Development of better therapeutic relationships lead to enhancement of physician satisfaction as well (Haas et al., 2000).

There is also evidence to show that training and retraining of physicians are beneficial in enhancing their empathetic behaviour (Bonvicini et al., 2009). Training has also shown to improve competency and expression of empathy and communication, leading to improvement in patient satisfaction (Schrooten & de Jong, 2017). Being empathetic helps to develop better insights to human experience of illness, disability and medical interventions (Gordon, 2014). Therefore, it is desirable to focus attention on ways of developing empathy in medical students.

Empathy plays an important role when looking after patients who are under palliative care. Such patients need the devotion and attention of the care-giver more than the disease of patients. Most patients who are under palliative care do not have complex situations such as those warranting extensive investigations or intensive care and they can be looked after by the usual care-giver such the family physician, without being referred to a dedicated palliative care team (Watson, Lucas, Hoy & Wells, 2009). Therefore, training in palliative care is important for healthcare personnel and the impact of such training improve if included in the undergraduate curriculum (Billings, 1997).

The study was undertaken in the International Medical University (IMU) of Malaysia (Student Information, Regulation & Code of Conduct, 2016). Although the University is a private institution, students have their clinical training in state hospitals where they see a mix of patients from three ethnic groups (Malay, Chinese and Indian). Students communicate with their patients in any of the four languages - Bahasa Malaysia, Mandarin, Tamil or English. IMU students are from a higher and middle income strata with a narrow social and cultural background. In addition, they have received education in schools in the capital or in bigger towns in Malaysia. Therefore, they are likely to have limited experience of values, attitudes, needs and concerns of the less affluent general public.

In the IMU, medical students are not timetabled to undergo dedicated training in clinical empathy. However, sensitization to some concepts of empathy during sessions on 'Professionalism and Ethics' is expected to occur within the formal curriculum. During evaluations, such as Mini - CEX, clinical long case or OSCE, little attention gets paid to evaluation of empathetic behaviour, except when the student's conduct is unprofessional. Generally, in most medical schools, focus on teaching and assessment of medical sciences is given greater priority than on issues dealing with social sciences (Gordon, 2014). A SWOT (Strengths – Weaknesses – Opportunities - Threats) analysis done in the IMU in 2017 showed that the curriculum of most of the programs, including Medicine focused the students' attention on skills, and not on the holistic care of patients (Babar et al., 2017). IMU medical students are taught to write reflective reports from the first week at the medical school, and their reflective reports are assessed during formative assessments in the Pre-clinical Phase in Semesters 1, 2 & 5 (Sow, 2010). In the Clinical Phase, reflective writing is revisited by the Posting Coordinator, a few weeks prior to their hospice visit in Semester 9 (Final Year), in the Internal Medicine Posting. Medical students are expected to acquire empathetic behaviours through role modelling of good professional conduct of their teachers, mentors, seniors and all healthcare personnel in their clinical working environment (Cruess, 2008). During bedside teaching sessions and ward rounds, attending physicians may elaborate on special ethical and professional aspects regarding patients under consideration, thereby 'leading by example'. At the same time, episodes of unprofessional conduct of students are pointed out to student/s concerned with attention paid to the sensitive nature of the issues. In addition, exemplary professional behaviour of students is rewarded openly for the benefit of their peers. Some of these encounters may centre on situations requiring empathetic behaviour by healthcare personnel including students (Cruess, 2008). The teachers are expected to use such opportunistic situations to inculcate empathy in students.

Visiting the Hospice and patients under palliative care at home is considered a situation where there is ample room for invoking sympathy and empathy. Taking this background into consideration, the author undertook an analytical study of reflective reports written by IMU final year medical students after their visits to the Hospice and homes of patients under palliative care to find out whether they were able to express any empathetic behaviour.

II. METHODS

During their 6-week posting in Internal Medicine in the 9th semester (final year), students are expected to pay a visit to the hospice in Seremban, Malaysia, and also visit patients in the neighbourhood who are under palliative care, on the same day. These visits were supervised by doctors and nurses from the hospice. Following these visits, they were expected to write a reflective report of

about 500 words, in English, regarding an interaction with patients they had seen, and submit the reports to their mentors for scrutiny. As a convenient sampling pilot study, an analysis of 58 consecutive reflective reports by the author's mentees were reviewed during the period May 2013 to November 2016. In addition to approval from the Institutional Review Board of the IMU (IMU-Joint Committee), permission from students was obtained to perform an analysis of their anonymised narratives.

Component	Definition
Emotive	The ability to subjectively experience and share in another's psychological state and intrinsic feelings
Moral	An internal altruistic force that motivates practice of empathy
Cognitive	The ability to identify and understand another person's feelings and perspectives, from an objective stance
Behavioural	Communicative response to convey the understanding of another's perspective

Table 1. Components of empathy from Morse et al. (1992)

As the study is a qualitative study, a discourse analysis of narrations given in reflective reports was done to identify four themes that will fall into four components of empathy described by Morse et al. (1992) who have pointed out, that the empathetic process can be divided into four components: emotive, moral, cognitive and behavioural. Student reflective reports were analysed to find evidence of reflection that would correspond with any of the categories mentioned by Morse et al. (1992) as shown in table 1 above.

III. RESULTS

Although all 58 students sympathized with the plight of their patients, only 12 of them expressed empathy in their reflective reports. Two examples of expression of sympathy are noted here: "*It saddens me to see such a thin and cachectic lady who is bedbound and just counting her seconds away. … I did my best in providing her some reassurance and help her to a more comfortable position in bed*" (Reflective report #14). Another student comment: '*Due to lung involvement, she was breathless, all the time requiring oxygen. The bone metastases also make her writhe in pain, but syrup morphine given every 4 hours has made the symptoms bearable. Although she does not look depressed, she seems to be struggling with all these symptoms. I feel that the visit from Hospice helped her to voice out her concerns, and as appropriate, those will be addressed. This would provide the support that she needs'* (#25). These comments showed that students were emotionally detached from the mental suffering patients with terminal cancer were enduring, with attention being given only to their physical discomforts. These reflections show that students understand patient needs and express sympathy by addressing their needs, though falling short of empathizing as students' minds do not seem relive the experiences of their patients.

The instances of expression of empathy in these 12 reports (20%) captured under the four components (emotive, moral, cognitive & behavioural) described by Morse et al. (1992) are given below in table 2. Some students expressed more than one component of empathy. Narrations expressing empathy are discussed in the next section.

Components of empathy	Emotive Moral Cognitive	Moral Cognitive Behavioural	Emotive Cognitive	Emotive Behavioural	Moral Cognitive	Emotive	Moral	Cognitive
No. of reports	1	1	1	1	1	2	2	3

Table 2. Empathetic responses of students based on components of empathy. Morse et al. (1992). (n = 58)

IV. DISCUSSION

One important reason as to why the majority of students refrained from reporting about empathetic encounters could be that they had resorted to distancing tactics. It has been shown that many doctors do not get close to their patients' psychological suffering to ensure their own emotional survival (Maguire, 1985).

Examples of reflections extracted to fit each of the above components of empathy from four different reflective reports are given here:

Emotive: "*During my hospice visit, I met a cancer patient and during the conversation, I realized that the patient has accepted the fact that this is what life has to offer her and that's it! I learnt that a moment of*

blankness flashes in front of you at the instance of knowing that you have an incurable illness and you are dying. It does not hit you until it really hits you!!" (#55). The above remarks by the student indicate that he understands the plight of the patient who is suffering from cancer and he attempts to share the intrinsic feeling of his patient.

Moral: "*Empathy comes from the understanding of the patient which involves a lot of communication with the patient.... These cannot be mastered through textbooks. We need to cure patients... Hear what they hear, see what they see – this offers a better outcome in our management plan*" (#18). The student seems to be intrinsically motivated to help the patient as he realizes the importance of better communication in comforting and healing his patient.

Cognitive: " *...patient's wife as a caretaker was going through the thick and thin with her loved one. It has once again enlightened me that beyond treating the patient physically, we need to understand about the pain and social issues they are going through*" (#11). Here, the student is weighing pros and cons from patient's perspective about suffering that the wife of the patient is going through due the husband's illness, before reacting to the situation.

Behaviour: "*I felt unhappy with the doctor as I felt the way he said it was harsh, and the doctor was not being empathetic with what the family members have to go through. As I was consoling a family member, he told me that what the doctor said has killed his hopes and he was very hurt*" (#62). Here, the student is delivering a communicative response to console them after understanding the bad experience that the family has gone through.

The reflective reports that were analysed seem to indicate that there were opportunities to express empathy for students visiting the hospice and the homes of patients who were on palliative care. Although it is hard to observe all student-patient interactions specifically, for explicit empathy, an attempt had been made in this study pick-up whatever they had reflected as empathetic experiences and expressed in writing.

None of the reports had a composite of all four components described by Morse et al. Few reports had two or three components. Although most students did not express a note of empathy in their reports, it does not necessarily imply that they were not empathetic during their interactions with patients as they may not have documented all their feelings. Paucity of documentation of empathetic encounters could have occurred because students themselves may not have been aware that they had gone through such an experience. Due to lack of fluency in writing skills, some students may have confined writing about empathetic encounters to one or two components instead of four, or not written at all.

Failure to include all four components described by Morse et al. does not necessarily mean that there was no empathy. At the same time, one has to bear in mind that not all doctor-patient interactions necessarily involve empathy. It is possible that most students engaged with their patients for a shorter period, thereby giving lesser opportunities for deeper engagement and fewer empathetic opportunities. Furthermore, paucity of documentation of empathetic encounters could be due to lack of fluency in expressing such situations within the word limit of 500 imposed on them.

Often, non-verbal communications manifest as empathy during interactions with patients and these would not get noticed unless such encounters were observed directly or through video recordings. Therefore, observing medical students during such interactions is important to be able to judge whether they actually engaged with patients, empathetically. Although direct observation of students would have been a better way to ascertain such engagement, there are some issues that we need to consider. Firstly, whether there was sufficient trained faculty to oversee them? Secondly, whether observing them too closely could have hampered their rapport building and closer engagement with patients? Thirdly, part of the cognitive component of empathy may not be observable as the thinking process is not always explicit.

Despite these constraints, reflective writing has many advantages as a learning tool. These include, the creation of opportunities to make permanent records of some events that may be forgotten, opening opportunities to prioritise and identify what was important to commit oneself to learning and to take action, helping to breakdown incidents to components to facilitate analysis, helping to take a step back and analyse and evaluate the incident in a balanced manner by considering different perspectives and finally, enabling to share thoughts and feelings (Jennifer, 2006).

Does reflection improve clinical behaviour? There is no evidence to answer this question, because there are no comparative studies between reflective and non-reflective practitioners with respect to the ways they conduct in the clinical environment. However, reflection and development of self-awareness can pave way to

improving clinical practice and guide educational efforts. This is a generalization of concept of reflective thinking as described by Gibbs in his six-stage reflective model which shows how better understanding and deep learning can take place by reflection (Gibbs, 2013). Does reflection improve patient care? Here again, there is no comparative data to answer the question. However, awareness of uncertainties and reflections about such situations has the potential to improve patient care.

Will reflective writing on patients who are on palliative care enhance the development of empathy in medical students? Although there is presumption in the literature that reflection enhances competence, there is no literature to support or refute it (Mann, Gordon & MacLeod, 2009). Despite absence of such evidence we hope that students improve their clinical behaviour and clinical practice by their empathetic engagement.

Paucity of reporting about empathetic engagement in students' reflective reports can also be due to various factors such as lack of fluency in writing style, limited information confined to what student wanted to make explicit to the mentor, student's emotional state at the time of writing and the purpose of the report as well as whether it was written for an academic purpose or not (Jennifer, 2006). Would rewards such as awarding marks for summative assessment for reflective care reports make a difference in the manner and the extent to which students would express empathy in their reports? A reward is likely to create a bias in report writing and reporting of empathetic feelings can be overplayed. It is easier to change attitudes than behaviour. Although, enforcement of reflective report writing may make students more mature and humanistic, students who already possess these qualities are more likely to benefit (Khan, 2008). Students may also find it difficult be empathetic in certain situations due limited real-life experiences thereby making it more challenging to get into 'patient's own boots'. However, as they mature and practice as doctors, they can be expected to nurture empathetic behaviour in a habitual manner.

If students were allowed to share their experience following their visit to hospice and homes of patients on palliative care would it nurture the development of empathy? There is no evidence to show that empathy can be further developed by such means. However, when nurses shared their experiences among themselves by storytelling it was shown to promote better understanding and insight in nursing practice (Day, 2012).

Currently, IMU students are scheduled to visit the Hospice in only their final year. Would it be more beneficial to give them an earlier exposure? Patient-centred listening is essential to end-of-life communication and this skill should be emphasized earlier in medical education (Miranda, 2017). Our students are scheduled to visit the Hospice and patients under palliative care for only one-day in their training. Should they be given opportunities for more visits and more time to talk to their patients to help deepen understanding and closer engagement? Should students see more patients for the sake of varied experience? Early exposure to varied experiences would allow more opportunities for deep learning by reflection (Kolb, 1984). Student are also likely to enhance empathetic skills if the emphasis during training was around patient-centred clinical encounters (Branch et al., 2001). Successful learning on how to reflect can be better achieved by facilitating the context, safe atmosphere, good mentorship and supervision, peer support and providing time to reflect (Mann et al., 2009). Therefore, feedback from mentors is likely to benefit students by improving skills of reflection. Although skills of reflection can improve with training, it is hard to predict as to when it would change attitudes and behavior. It is noteworthy that English language proficiency as assessed by standardized tests alone were a poor indicator for judging medical communication skills (Chur-Hansen, Vernon-Roberts & Clark, 1997) and this observation may be useful in interpreting reflective reports from a group of medical students with varying competencies in English.

Although this study utilized components of empathy as detailed by Morse et al., several other tools have been cited in the literature to find out evidence of clinical empathy. Some of these are based on video recording of doctor-patient encounters and others are based on questionnaires (Hojat, Axelrod, Spandorfer & Mangione, 2013). Questionnaire-based studies were more likely to find out students' orientation towards being empathetic rather than empathetic communication (Bylund & Makoul, 2005).

Lack of triangulation seems to be a limitation in this study. Use of another analytic process such 'focus group discussion' could have increased the validity of findings. Whether an element of subjectivity and bias may have occurred as the study was done only by one person is debatable. Greenhalgh (2010) argues that *'Since I wrote the first edition of this book, inter-rater variability has become less credible as a measure of quality in qualitative research. Appraisers of qualitative research increasing seek to assess the competence and reflexivity*

of a single researcher than confirm that the findings were checked by someone else (p. 166)'. As discussed earlier, other limitation of the study would include, failure to pen-down all empathetic encounters due to factors such as lack of fluency in written communication skills, word limit on reflective essays, limited time for student-patient interactions and failure to realize that empathetic encounters have actually taken place.

V. CONCLUSION

Building empathy in healthcare is known to improve the quality of care. Training doctors to be empathetic is achievable. Although all students in this study had expressed sympathy, it would have been desirable to see more students expressing empathy. The study showed that reflective reports following visits to the hospice and home visits to patients who are under palliative care were useful documents to find out whether students expressed empathy during their encounters with these patients. Despite limitations with regards to the ability to capture empathetic opportunities through reflective reports due factors such as 'word limit in essays', lack of fluency in written communication skills, lack of realization that empathy has actually being invoked and forgetting to pen-down empathetic encounters; the exercise of going through these reports seems to offer a 'window of opportunity' to see whether students express empathy. The potential of reflective reports to find out whether medical students invoke empathy during encounters with patients under palliative care needs to be explored further.

Notes on Contributors

Professor Pilane Liyanage Ariyananda contributed to the conception and design of the study, as well as to the acquisition, analysis and interpretation of data, and preparation of the paper. The author is a specialist in Internal Medicine with wide clinical and academic experience and has been a mentor and teacher to medical undergraduates and postgraduates over 35 years.

Ethical Approval

Permission was obtained from the students and the Institutional Review Board (Project ID No.: IMU 383/2017) to analyse and publish narratives after anonymization.

Declaration of Interest

The author has no competing interests.

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