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HAPPE—A pilot programme using humanities to teach junior doctors empathy in a palliative medicine posting

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Abstract

Introduction: Physician empathy is declining due to an unproportionate focus on technical knowledge and skills. The medical humanities can counter this by allowing connection with our patients. This is a pilot study that aims to investigate the acceptability, efficacy, and feasibility of a humanities educational intervention to develop physician empathy.

Methods: Junior doctors at the Division of Supportive and Palliative Care at the National Cancer Centre Singapore between July 2018 and June 2019 attended two small-group sessions facilitated by psychologists to learn about empathy using literature and other arts-based materials. Feasibility was defined as a completion rate of at least 80% while acceptability was assessed by a 5-question Likert-scale questionnaire. Empathy was measured pre- and post-intervention using Jefferson's Scale of Physician Empathy (JSPE) and the modified-CARE (Consultation and Relational Empathy) measure.

Results: Seventeen participants consented, and all completed the programme. Acceptability scores ranged from 18 to 50 out of 50 (mean 38, median 38). There was an increase in JSPE scores (pre-test mean 103.6, SD=11.0 and post-test mean 108.9, SD=9.9; t (17) =2.49, P=.02). The modified-CARE score increased between pre-test mean of 22.9(SD=5.8) and a post-test mean of 28.5(SD=5.9); t (17) = 5.22, P<0.001.

Conclusion: Results indicate that the programme was acceptable, effective, and feasible. The results are limited by the lack of longitudinal follow-up. Future studies that investigate the programme's effect over time and qualitative analysis can better assess its efficacy and elicit the participants' experiences for future implementation and refinement.

Keywords: *Empathy, Humanities, Literature, Palliative Medicine*

Practice Highlights

- The medical humanities can be used to teach empathy by facilitating reflective practice.
- This novel educational programme was acceptable, effective, and feasible.
- Limitations include the lack of longitudinal follow-up and the quantitative nature of assessment.
- Future studies should investigate the programme's effect over time and include qualitative analysis.

I. INTRODUCTION

Empathy can be defined as having feelings that are more congruent with another situation than one's own by recognising the perspectives of others (Hojat et al., 2002). Higher physician empathy leads to better patient care outcomes and satisfaction (Hall et al., 2002) and has also been associated with lower levels of physician burnout (Lee, Loh, Sng, Tung, & Yeo, 2018). However, studies suggest a worrying trend that empathy levels decline as training progresses for medical students and residents as well as a correlation between decreasing empathy and increasing burnout (Lee et al., 2018). The various reasons for such a decline were elicited in a recent systematic review and can be summarised into 4 main domains (refer Table 1) (Neumann et al., 2011).

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Domains of various reasons for empathy decline	Details
1. Individual variables	Personality traits, upbringing, and experiences during adulthood
2. Individual distress	Burnout, depression, and decreased quality of life are associated with decreased empathy levels.
3. Nature of medical practice	Uncertainties increase the vulnerability of the medical practitioner and lead to negative coping mechanisms like depersonalisation and detachment from patients.
4. Learning environment	Inadequate and inappropriate role models and the hidden curriculum cause moral distress and decrease empathy as a consequent of poor coping mechanisms.

Table 1. Reasons contributing to decline in empathy

The medical humanities are an inter-disciplinary field where the concepts, content, and methods from art, history, and literature are used to investigate the experience of illness and to understand the professional identity of healthcare providers (Shapiro, Coulehan, Wear, & Montello, 2009). It is hypothesised that experiences and perspectives illustrated by the medical humanities through stories depicted in novels, literature, drama, and poetry can promote the development of empathy by encouraging deep reflection, facilitating meaning-finding and comfort with uncertainty and providing new perspectives (Bleakley, 2015; Bleakley & Marshall, 2014; Dennhardt, Apramian, Lingard, Torabi, & Amtfield, 2016). The medical humanities have the potential to address the factors mentioned in Table 1.

A. Individual Distress:

The medical humanities allow an avenue for physicians to express difficult emotions encountered in clinical practice like anxiety, guilt, and regret. Such emotions may be due to uncertain disease trajectories, ethical dilemmas, and physical exhaustion. The medical humanities allow such emotions to be expressed and discussed, with the intention to support physicians and decrease distress from burnout.

B. Nature of Medical Practice:

The uncertainties of medical practice and the consequent vulnerability of the medical practitioner affect empathy levels. Doctors may develop negative coping mechanisms like depersonalisation that may seemingly help meet the unrealistic expectation that medicine can always cure. To counter this, physicians must be given the time to share their clinical experiences in a safe environment and subsequently support each other by establishing relationships and reducing isolation (Batt-Rawden, Chisolm, Anton, & Flickinger, 2013; Feld & Heyse-Moore, 2006; Wear & Zarconi, 2016). Reflective writings and creative arts are some of the methods that have been used to facilitate such a process (West, Dyrbye, Erwin, & Shanafelt, 2016).

C. Learning Environment:

Palliative medicine has been touted to be able to provide an ideal environment to impart empathetic values in view of its patient-centred philosophy of care (Block & Billings, 1998; Othuis & Dekkers, 2003). This is achieved through the routine use of the humanities to understand the personhood of our patients and develop empathetic connections. History, art, music, and narratives define our patients' life experiences and influence their responses to disease and treatment. Learning through mentorship and role-modelling of such an approach to patient care allows junior doctors to appreciate the importance of using the humanities to achieve better patient care outcomes.

There is currently no conclusive evidence on the best method of teaching empathy or the best person to teach it. Where educators have tried to teach humanism and empathy in medicine, research done on its curriculum has been criticised in terms of clinical relevance and methodology (Birden et al., 2013; Ousager & Johannessen, 2010; Perry, Maffulli, Wilson, & Morrissey, 2011; Schwartz et al., 2009; Wear & Zarconi, 2016). However, the impact of the humanities on the factors that cause declining physician empathy levels illustrated above demonstrates that the medical humanities may be an important tool in teaching empathy. This pilot study has the potential to fill this gap by taking the first step in establishing the acceptability and feasibility of a pilot humanities education programme based on established conceptual frameworks. There were two specific aims to this pilot study: 1) To determine the acceptability and feasibility of the proposed curriculum; 2) To assess the efficacy of the HAPPE programme. The data collected will inform future studies on whether the humanities can be one of the best tools to use in teaching empathy.

II. METHODS

A. Intervention Design

The Humanistic Aspirations as a Propeller of Palliative medicine Education (HAPPE) programme was conceived to introduce and develop a novel curriculum in empathy for junior doctors undergoing a palliative

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medicine rotation. The overall goal of the study was to design an effective education programme based on the humanities to teach doctors empathy. Our study draws upon Schon's work of Reflective Practice (see Table 2; Schön, 1987).

Concepts of Reflective Practice	Planned activities during HAPPE	Expected Outcomes
"Reflection-in-action" – reflecting during an event and act on a decision "on the spot"	Discussion and awareness of perspectives that trigger powerful emotions and empathetic reflections and responses.	Recalls triggers, leading to empathetic change in behaviour and decisions in actual practice.
"Reflection-on-action" – reflecting after an event, process feelings and experiences, gain new perspectives.	Uses rich perspectives of patients, caregivers, and healthcare providers via humanities, leading to deep reflections.	Reinforces changes in practice "on the ground".

Table 2. Application of the Theory of Reflective Practice in the design of the HAPPE programme

Based on the theory of reflective practice, the components of the HAPPE programme are elaborated in Table 3. The principles listed are supported by existing research literature (Gibbs, 1988; Shapiro et al., 2009).

Principles	Component of HAPPE
1. Facilitating factors of reflective practice include a safe environment, conducive settings, and trained facilitators.	1. The sessions are facilitated by two trained clinical psychologists who are experienced in conducting support group sessions for both patients and staff. 2. To ensure psychological safety for intimate sharing, all participants are provided explicit consent for the study. The project was submitted for the institution review board review but was exempted. 3. The sessions are conducted via small-group discussions and ground rules are set before the start of each session (see Appendix A). 4. Data collected is blinded to the investigator.
2. Reflective practice is propelled by materials and modalities that provide rich perspectives and trigger strong emotions and empathetic personal inquiry.	1. Arts-based materials are used to prompt deep reflection and facilitate by examining multiple perspectives and challenging expectations and vulnerabilities of junior doctors. 2. The novel *The Death of Ivan Ilyich* is chosen in view of its ability to elicit deep reflections about suffering and care. The interpretation of the apparently ambiguous piece of fictitious literary piece based on the learner's personal beliefs can stimulate personal growth, develop non-judgmental attributes as well as improve coping with uncertainty in medical practice.

Table 3. Components of the HAPPE programme designed according to the theory of reflective practice.

Acceptability was measured by a Likert-scale questionnaire (see Annex 1). Feasibility of the curriculum was defined as a completion rate of at least 80%. The efficacy of the curriculum was measured by the self-reported Jefferson Physician Empathy Scale (JSPES) (Hojat et al., 2001) as well as the third-party reported modified-Consultation and Relational Empathy (CARE) Measure (Mercer, Maxwell, Heaney, & Watt, 2004).

B. Study Design

This was a quantitative study that assessed the acceptability, feasibility, and effectiveness of the HAPPE programme pre- and post-intervention. Participants: All junior doctors who rotated through the department between 1st July 2018 and 30th June 2019 were invited to participate in this study. About 30 junior doctors (residents and medical officers) rotate through the division of palliative medicine as part of their postgraduate training yearly. The junior doctors have varying levels of prior training and exposure to palliative medicine. These junior doctors worked in palliative care teams each consisting of a consultant, registrar/resident physician, and a nurse who assess and manage patients with palliative care needs. The duration of each rotation ranged from 1 to 6 months. An independent research coordinator provided the participants with information regarding the study and took written consent from each participant face-to-face.

C. Intervention

The HAPPE programme consisted of two 1.5-hour sessions during office hours of small group discussions held at the National Cancer Centre Singapore (NCCS) facilitated by two clinical psychologists 1-week apart. The two facilitators are senior psychologists who are trained in counselling and group facilitation and regularly encounter complex clinical scenarios in communications and grief. The programme was repeated throughout the year at regular intervals for all new junior doctors rotated into the department. The junior doctors were considered to have completed the curriculum in its entirety when they attend both sessions of the HAPPE programme during their posting.

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In the first session, a brief introduction on the novel, The Death of Ivan Ilyich was presented by the facilitators (Charlton & Verghese, 2010; Florijn & Kaptein, 2013). There was no need for the learners to read the entirety of the novel before the session. The sections of the novel used are found in Annex 2.

The learners were asked the following questions that addressed the tenets of empathy. (standing in patient's shoes, compassionate care, and perspective-taking):

1. What was described about Ivan Ilyich's life preceding his illness that you think was important to know if you were his doctor?
2. Why do you think Ivan Ilyich was so distressed before he died?
3. How different do you think you will feel if you were Ivan Ilyich?

In the second session, learners were asked to bring along any arts-based material (paintings, literature, music, drama) and share with the class their reflections on why the material was chosen and how appreciation and/or critique of the art piece helped them develop empathy and patient-centred care. The participants brought materials available from the internet like photographs, paintings, illustrations from magazines, and references to non-fiction books that they had previously read.

Prompting questions included:

• Why was the material chosen?
• How did the material trigger reflections on the concept of empathy?
• What were some of the emotions elicited when reflecting on the concepts of empathy using the materials?

The two clinical psychologists employed techniques that encouraged personal sharing in a safe environment. Participants were reassured that their sharing was confidential, and they were free to leave the session at any point in time if they felt uncomfortable. Sharing was encouraged by picking up themes of similarities and contrasts between participant's sharing, asking questions with the intention to clarify, reflect and hypothesise, progressing from "participant to facilitators communication" to "between-participants communications" and progressing from talking about "Ivan Ilyich" to "themselves if they were Ivan Ilyich or Ivan's doctor or Ivan's family member/friend" to "themselves".

This study was submitted for review in the Institutional Review Board but was exempted in view of its nature as a medical education project.

D. Outcomes Assessment

To assess acceptability, the junior doctors were asked to complete a questionnaire post-intervention (see Annex 1). Feasibility was defined as at least 80% of junior doctors completing the curriculum in its entirety.

The assessment of efficacy is investigated using 2 scales pre- and post-intervention:

1. The Jefferson Physician Empathy Scale (JPES) is a self-reported 20-item empathy measure based on a seven-point Likert scale designed to assess empathy in physicians. It has been validated, has an alpha coefficient of 0.87 for internal consistency, and is the most widely used in literature. There are ten positively worded items and ten negatively worded items, and the negatively worded items will be reverse scored on a Likert scale of 7 (strongly disagree) to 1 (strongly agree). Scores can range from 20 to 140 with higher scores indicating participants to be more empathic.

2. As there were currently no validated tools for the assessment of empathy of palliative care doctors, the Consultation and Relational Empathy (CARE) Measure was chosen. It is a 10-item patient-rated questionnaire developed and validated to assess a physician's level of empathy and patient-centred care when used by patients, with an alpha coefficient of 0.92 for internal consistency. However, as the enrolment of patients for this purpose for the study was not possible, this measure was modified with permission from its developer, to generate third party-rated outcomes from the junior doctors' team members (consultant, registrar or resident physician and the nurse) (see Annex 3). As the participants work in small teams of not more than three, all their respective team members were invited to perform the assessment. They will observe interactions between the junior doctors and their patients during their daily work and rate the 10 items that are each described in the questionnaire. No prior training is needed.

III. RESULTS

A total of 17 junior doctors agreed to participate in the study and all of them completed the programme and assessments. Out of a full score of 50, the acceptability score ranged from 18 to 50. The median and mean were both 38.

The JPES scores pre-test had a range of 77 to 123 out of 140. The mean was 103.6 (SD 11). Post-test, the JSPE scores ranged from 93 to 132. The mean value was 108.9

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(SD 9.9). This gave a paired t-score difference of 2.49 with P value of 0.02.

The modified-CARE score pre-test had a range of 12 to 31 out of 50, a mean of 22.9 (SD 5.8). Post-test, the scores ranged from 17 to 37, with a mean of 28.5 (SD 5.9). This gave a paired t-score difference of 5.22 with a P value of <0.001.

IV. DISCUSSION

This is a quantitative pilot study conducted to investigate the acceptability, efficacy, and feasibility of a novel educational intervention based on the humanities to teach empathy to junior doctors in a palliative medicine rotation. It is the first project under the Humanities Initiative Programme (HIP) at the Division of Supportive and Palliative Care (DSPC) at the National Cancer Centre of Singapore (NCCS). The results of this pilot study are encouraging and are consistent with other similar pilot studies that investigated the efficacy of a humanities-based programme in medical education and will propel the development of the HIP (Perry et al., 2011). The positive results regarding acceptability and feasibility are important as they suggest that the implementation of such an intervention on a larger scale that spans across disciplines is possible. The increase in empathy scores demonstrates the efficacy of the programme, although further analysis is needed to investigate whether such a change is due to other factors as the intervention is relatively short and effects may not be sustainable.

There are other limitations to this study. The study is limited by the small number of participants in a single institution and deficiencies of a self-assessed rating scale (Boud & Falchikov, 1989). The possible reasons that the enrolment rate is low include lack of awareness about the concept of the humanities and its role in medical education and difficulty with balancing time between clinical duties and educational activities. The programme was also novel and junior doctors may be hesitant to enrol due to uncertainties about the nature of the programme.

The limitations of self-assessment tools are mitigated by the employment of a third-party empathy measure that allowed triangulation of results, but caution should remain about the clinical significance of the results. Inherent biases by fellow team members and difficulty in having adequate time and making effort for observation and accurate grading of the participants in a busy clinical service may render third-party assessment unreliable. Ideally, an independent party observing the participants during their daily work may reduce biases. Stealthy observations may also avoid both conscious and unconscious alteration in behaviour from the participants' awareness of being observed. Unfortunately, this was not logistically possible in this study.

The use of a modified-CARE measure which has not been validated for use by fellow colleagues of the doctor may also render the increase in scores post-intervention less reliable and valid.

Lastly, the indication for programme feasibility is set at 80% based on the investigator's discretion. This is due to a lack of data about standards on feasibility from existing studies of humanities-based educational programmes. It could be possible that there are other measures of feasibility that are more valid.

Future research will need to address the choice of outcome measures including assessment of feasibility and empathy scores. Discrete studies for the design and validation of such measures will grant important rigor to future studies in this field.

Studies that utilise qualitative research methodology could also provide rich data that answers questions about the choice of materials and facilitators. Possible methods include thematic analysis (Braun & Clarke, 2006) and narrative inquiry – a developing methodology of investigating lived experiences in the context of place, sociality, and time (Clandinin & Connelly, 2000). This will help the investigator assess the suitability and transferability of the HAPPE programme to other disciplines with varying participant demographics and how further refinement in design and methods can improve efficacy and sustainability.

A. Moving Forward

As this was a pilot study, the investigator had chosen to focus on only quantitative parameters to achieve the aims of the study. It is recognised that qualitative analysis will provide richer data on the experiences of the participants and further guide implementation and refinement of programmes based on the humanities and there are ongoing projects that have started within the institution based on the need to address this gap of the pilot study.

Research done on humanities programmes in medicine has commonly been criticised in terms of methodology. A literature review of arts-based interventions in medical education found poor designs of methodology (Perry et al., 2011) while another study on needs assessment noted only a minority of studies describing outcome measures beyond learner satisfaction (Taylor, Lehmann, &

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Chisolm, 2017). Publications have also been criticised for the lack of a conceptual basis in the design of interventions. This pilot study aimed to address some of these challenges by clearly stately the conceptual theory of reflective practice that impacts the study results. In addition, the Gagne Instructional Plan guided lesson planning with the steps of gaining attention, informing the learner of objectives, stimulating recall, presenting stimulus, and providing learning guidance achieved (Gagne, Briggs, & Wager, 1988). However, the lack of validated and relevant assessment outcomes remains. Future research should focus on developing suitable assessment tools that can achieve their aims without stifling the responses of participants. One possible approach may be the adoption of formative assessments that focus on feedback, in contrast to summative tools that typically impact outcomes of appraisals (Taras, 2008).

Finally, there is a paucity of studies that employ the humanities as educational resources in the Asia-Pacific region. This is despite the rich multi-cultural nature of the societies in this region, many with deep-rooted and unique practices in the arts. The investigator of this study hopes that this pilot programme will inspire like-minded medical educators in the region to embark on similar projects within their institutions and develop the arts as an educational tool for the benefit of both healthcare professionals and patients.

V. CONCLUSION

This pilot study has produced encouraging results regarding the use of humanities in medical education. The humanities have the potential for multiple functions in medicine and perhaps most importantly serve to bridge the gap between biomedical sciences and the "art of medicine" (Best, 2015; Chew, 2008; Ong & Anantham, 2019). Further research in this field will provide guidance on the development of a robust educational intervention that adheres to the best practices of medical education research.

Note on Contributor

OEK is a consultant at the Division of Supportive and Palliative Care in the National Cancer Centre of Singapore. OEK reviewed the literature, designed the study, engaged the facilitators for the programme, analysed results, and wrote the manuscript.

Ethical Approval

This study was submitted to the institution's review board but received an exemption due to its nature as an educational intervention (CIRB Ref: 2018/2276).

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Declaration of Interest

The author declares no conflict of interest in this study.

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Appendix A

Questionnaire on acceptability of the intervention.

Please kindly rate the following questions from a scale of 0 (fully disagree) to 10 (fully agree).

1. The curriculum was useful in the development of humanistic values

0 1 **2** 3 4 5 6 7 8 9 10
Fully disagree *Fully agree*

2. The time taken to complete the curriculum is reasonable.

0 1 2 3 4 5 6 7 8 9 10
Fully disagree *Fully agree*

3. You would recommend continuing this curriculum for future junior doctors.

0 1 2 3 4 5 6 7 8 9 10
Fully disagree *Fully agree*

4. The assessment of humanistic values before and after the curriculum is easy to complete.

0 1 2 3 4 5 6 7 8 9 10
Fully disagree *Fully agree*

5. The assessment tool accurately reflects your levels of humanism.

0 1 2 3 4 5 6 7 8 9 10
Fully disagree *Fully agree*

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Appendix B

The Death of Ivan Ilyich – sections used for the proposed curriculum.

"In the province Ivan Ilych soon arranged as easy and agreeable a position for himself as he had had at the School of Law. He performed his official task, made his career, and at the same time amused himself pleasantly and decorously. Occasionally he paid official visits to country districts where he behaved with dignity both to his superiors and inferiors, and performed the duties entrusted to him, which related chiefly to the sectarians, with an exactness and incorruptible honesty of which he could not but feel proud. In official matters, despite his youth and taste for frivolous gaiety, he was exceedingly reserved, punctilious, and even severe; but in society he was often amusing and witty, and always good-natured, correct in his manner, and *bon enfant*, as the governor and his wife — with whom he was like one of the family — used to say of him.

In the province he had an affair with a lady who made advances to the elegant young lawyer, and there was also a milliner; and there were carousals with aides-de-camp who visited the district, and after-supper visits to a certain outlying street of doubtful reputation; and there was too some obsequiousness to his chief and even to his chief 's wife, but all this was done with such a tone of good breeding that no hard names could be applied to it. It all came under the heading of the French saying: "Il faut que jeunesse se passe." It was all done with clean hands, in clean linen, with French phrases, and above all among people of the best society and consequently with the approval of people of rank.

So, Ivan Ilych served for five years and then came a change in his official life. The new and reformed judicial institutions were introduced, and new men were needed. Ivan Ilych became such a new man. He was offered the post of examining magistrate, and he accepted it though the post was in another province and obliged him to give up the connections he had formed and to make new ones. His friends met to give him a send-off; they had a group photograph taken and presented him with a silver cigarette-case, and he set off to his new post.

As examining magistrate Ivan Ilych was just as commeilfaut and decorous a man, inspiring general respect and capable of separating his official duties from his private life, as he had been when acting as an official on special service. His duties now as examining magistrate were fare more interesting and attractive than before. In his former position it had been pleasant to wear an undress uniform made by Scharmer, and to pass through the crowd of petitioners and officials who were timorously awaiting an audience with the governor, and who envied him as with free and easy gait he went straight into his chief 's private room to have a cup of tea and a cigarette with him. But not many people had then been directly dependent on him — only police officials and the sectarians when he went on special missions — and he liked to treat them politely, almost as comrades, as if he were let- ting them feel that he who had the power to crush them was treating them in this simple, friendly way. There were then but few such people. But now, as an examining magistrate, Ivan Ilych felt that everyone without exception, even the most important and self-satisfied, was in his power, and that he need only write a few words on a sheet of paper with a certain heading, and this or that important, self-satisfied person would be brought before him in the role of an accused person or a witness, and if he did not choose to allow him to sit down, would have to stand before him and answer his questions. Ivan Ilych never abused his power; he tried on the contrary to soften its expression, but the consciousness of it and the possibility of softening its effect, supplied the chief interest and attraction of his office. In his work itself, especially in his examinations, he very soon acquired a method of eliminating all considerations irrelevant to the legal aspect of the case and reducing even the most complicated case to a form in which it would be presented on paper only in its externals, completely excluding his personal opinion of the matter, while above all observing every prescribed formality. The work was new, and Ivan Ilych was one of the first men to apply the new Code of 1864."

"It occurred to him that what had appeared perfectly impossible before, namely that he had not spent his life as he should have done, might after all be true. It occurred to him that his scarcely perceptible attempts to struggle against what was considered good by the most highly placed people, those scarcely noticeable impulses which he had immediately sup-pressed, might have been the real thing, and all the rest false. And his professional duties and the whole arrangement of his life and of his family, and all his social and official interests, might all have been false. He tried to defend all those things to himself and suddenly felt the weakness of what he was defending. There was nothing to defend.
"But if that is so," he said to himself, "and I am leaving this life with the consciousness that I have lost all that was given me, and it is impossible to rectify it — what then?"

He lay on his back and began to pass his life in review in quite a new way. In the morning when he saw first his foot- man, then his wife, then his daughter, and then the doctor, their every word and movement confirmed to him the awful truth that had been revealed to him during the night. In them he saw himself — all that for which he had lived — and saw clearly that it was not real at all, but a terrible and huge deception which had hidden both life and death. This consciousness intensified his physical suffering tenfold. He groaned and tossed about and pulled at his clothing which choked and stifled him. And he hated them on that account."

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Appendix C

<u>Modified Consultation and Relational Empathy (CARE) Measure</u>

Name of medical officer/resident: ___________________
Date of assessment: _ _/_ _/_ _ _ _ (DD/MM/YYYY)

Please rate the following based your observation of the doctor for the past 1 week.
Underline/highlight the most appropriate rating. Please answer every statement.

How good was the doctor at:

1. Making the patient feel at ease
(introducing him/herself, explaining his/her position, being friendly and warm towards patient, treating patient with respect; not cold or abrupt)

0	1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent	Does not apply

2. Letting the patient tell his/her "story"
(giving patient time to fully describe his/her condition in his/her own words; not interrupting, rushing or diverting him/her)

0	1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent	Does not apply

3. Really listening
(paying close attention to what patient was saying, not looking at the notes or computer as patient was talking)

0	1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent	Does not apply

4. Being interested in the patient as a whole person
(asking/knowing relevant details about patient's life, patient's situation; not treating patient as "just a number")

0	1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent	Does not apply

5) Fully understanding the patient's concerns
(communicating that he/she had accurately understood patient's concerns and anxieties; not overlooking or dismissing anything)

0	1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent	Does not apply

6) Showing care and compassion
(seeming genuinely concerned, connecting with patient on a human level; not being indifferent or "detached")

0	1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent	Does not apply

7) Being positive
(having a positive approach and a positive attitude; being honest but not negative about patient's problems)

0	1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent	Does not apply

8) Explaining things clearly
(fully answering patient's questions; explaining clearly, giving adequate information; not being vague)

0	1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent	Does not apply

9) Helping the patient to take control
(exploring with patient what patient can do to improve patient's health himself/herself, encouraging rather than "lecturing" patient)

0	1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent	Does not apply

10) Making a plan of action with the patient
(discussing the options, involving patient in decisions as much as patient want to be involved; not ignoring patient's views)

0	1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent	Does not apply

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