Commentary: Identifying Attitudes Towards Empathy: An Essential Feature of Professionalism

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Abstract

Preserving and promoting empathy are ethical imperatives in medical education. The authors of this commentary propose that the “hidden curriculum” and mixed messages learners frequently receive during clinical rotations may erode humanistic traits essential to high-quality care. Three articles in this issue focus on assessing attitude towards empathy in the health care setting using the Jefferson Scale of Physician Empathy. The authors discuss salient points from these reports, reinforce the concept of empathy as a cognitive attribute, and offer recommendations for teaching and nurturing empathy in health professionals. In the reports, construct validity and reliability of the instrument were confirmed and were comparable with previous results, thus providing medical educators with a sound instrument to measure empathic attitudes in the context of patient care. The authors agree with the distinctions made in the three studies between empathy (described as a cognitive attribute) and sympathy (described as an emotional attribute) and believe that empathy as a cognitive skill can be role modeled, taught, and assessed. Barriers to empathic practice (lack of sufficient role models, failing to teach empathy as a cognitive skill, negative experiences, time pressures, overreliance on technology) can be remedied in medical education through interprofessional education and practice and institutional promotion of relationship-centered care, which maintains the centrality of the patient–clinician relationship while recognizing the importance of relationships with self and others.

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Preserving and promoting empathy are ethical imperatives in medical education. Yet medical education has been criticized “for emphasizing scientific knowledge over biological understanding, clinical reasoning, practical skill, and the development of character, compassion, and integrity.” The IOM has documented large gaps in quality of care resulting from ineffective communication between providers and patients, providers and other providers, and health care organizations and providers. These reports also document that effective, empathic communication positively influences health outcomes. We propose that the “hidden curriculum” and mixed messages learners frequently receive during clinical rotations may erode humanistic traits essential to high-quality medical care. Nurturing empathy in relationships is morally valuable and essential for effectively caring for our patients and ourselves as we engage in our work as health professionals. If empathy is to be as valued as other skills in medical education, it is important to identify how empathic attitudes are influenced during educational experiences.

Three articles in this issue report on empathy as it is expressed in patient care, assessing empathic attitudes using the previously validated Jefferson Scale of Physician Empathy (JSPE) and validating the JSPE in dissimilar groups and cultures (Japanese medical students and Italian physicians). In our commentary we (1) discuss salient points garnered from the papers, (2) attend to empathy as a cognitive concept, remarking on the distinctions between empathy and sympathy and their implications, and (3) offer recommendations for teaching and nurturing empathy in health professionals.

Overview of Relevant Outcomes

In their study Hojat and colleagues track longitudinal changes in medical student empathy to determine at what point in their training students report significant change. The authors review the research on empathy and make a compelling case for assessing empathy in a way that is specific and relevant to patient care. They define empathy “in the context of medical education and patient care as a predominantly cognitive (as opposed to affective or emotional) attribute that involves an understanding (as opposed to feeling) of patients’ experiences, concerns, and perspectives combined with a capacity to communicate this understanding.” They further add that “[a]n intention to help by preventing and alleviating pain and suffering is an additional feature of empathy in the context of patient care.”

In their longitudinal study of two cohorts of medical students, the authors found that scores on the JSPE declined during medical school. The greatest decline in empathy (and largest effect) occurred in the third year, regardless of gender or specialty interest. However, in every year women scored significantly higher than men, and except for scores at baseline, students interested in people-oriented specialties scored significantly higher than students interested in tech-oriented specialties. The magnitude of the decline (effects) was much smaller for women and students interested in people-oriented specialties, suggesting that these students’ attitudes were somewhat immune from erosion in empathy.
The other two studies focus on Italian physicians and Japanese medical students. The primary purpose of these cross-sectional studies was to confirm the psychometrics of the JSPE and explore differences in empathy between women and men.

In both studies, women scored higher on the JSPE than men. The difference in scores (three points) was smaller than the difference obtained for the U.S. students in all years except at the end of the second year, when it was about three points. In contrast to previous studies, the difference in empathy scores between male and female Italian physicians was not significant. The difference may be due to fewer women in the sample (60 women, 229 men), because this same magnitude of difference was statistically significant among Japanese and U.S. students.

Similar to the results of the U.S. study, Italian physicians in medical specialties scored higher on the JSPE than their colleagues in surgical specialties, although the difference was not statistically significant. This result might be due to the disproportionate number of surgeons in the sample (62 medical, 226 surgical), because once again the magnitude of the difference mirrors that for results that reached statistical significance.

One comparison between Japanese and U.S. students is especially noteworthy. Although the study by Kataoka and colleagues was cross-sectional, students in later years of the curriculum had more empathic attitudes, unlike U.S. students. We assumed that fifth-year students in Japan, though younger, were at an equivalent professional development stage (caring for patients) as third-year U.S. students. Looking at the JSPE scores from that perspective, the scores of the fifth-year Japanese students (105.4) were lower than the scores of the third-year U.S. students (109.1). The lower empathy scores could have roots in cultural preferences, maturity and life experiences, or communication styles. In addition, they could be a result of a curriculum with limited patient-care opportunities in the first four years of medical education. In the future, we may see these attitudes grow for two reasons. First, “in response to the mind-melting pressure on Japanese youth,” the Education Ministry has encouraged “students to reflect on the meaning and mission of their lives,” that is, the “education of the heart” by “remaking its education system to foster greater creativity, artistry and play.” Second, the increasing dissatisfaction with health care and the awareness that patients need to be more engaged with their clinicians have contributed to the transformation of Japanese medical education, which now includes communications skills training and assessment.

Essentially, the construct validity and reliability of the JSPE were verified and comparable with previous research results. The JPSE items performed similarly, and the factor analyses yielded the same three primary factors of “perspective taking,” “compassionate care,” and “ability to stand in patient’s shoes.” Hojat and his collaborators have provided medical educators with a sound instrument to measure empathic attitudes in the context of patient care.

Empathy as a Cognitive Attribute

Hojat and colleagues stress important distinctions between empathy and sympathy. They propose that expressing empathy, as opposed to expressing sympathy, is more objective and accurate, intellectual rather than emotional, altruistic, requires more effort but conserves energy, has more positive effects on the clinician (such as personal growth and career satisfaction), and leads to better patient health outcomes. These distinctions suggest that being predominantly empathic creates a more productive relationship between the patient and the caregiver, while being primarily sympathetic increases the potential for a less healthful and perhaps more codependent relationship. Despite the distinctions, the authors maintain that empathy and sympathy somewhat overlap. We agree. Although as a cognitive skill empathy can be enhanced through education, to be truly empathic and authentic in one’s expression of empathy (recognizing and then responding appropriately to a patient’s concern, worry, or fear) the clinician must have some affective impulse to sympathize.

In A Whole New Mind, Daniel Pink maintains that “empathy is neither deviation from intelligence nor the single route to it. Sometimes we need detachment [objectivity]; many other times we need attunement [receptivity]. And the people who will thrive will be those who can toggle between the two.” Hojat and colleagues found that higher empathy scores were associated with higher ratings of clinical competence and with being female. These findings support the
idea that clinicians who will thrive in their work will have the capacity for being able to toggle back and forth between objectivity and receptivity. In essence, effective clinicians attend to the patient’s whole story in tandem with clinical reasoning, which leads to a mutually satisfactory process and outcome.

It follows that empathy is a cognitive skill (with some basis in an affective domain) that can be taught, and that attitudes toward it can be reliably assessed. Will learners be more inclined to accept empathy as a cognitive skill that can be cultivated and evaluated? We believe that if we as medical educators provide learners with effective communication tools and multiple opportunities to practice these skills paired with constructive feedback, they will use them consistently and their attitudes will be preserved and enhanced. Thus, referring to Hojat and colleagues’ concern, we can begin to take the “devil out of the third year.”

Recommendations for Teaching and Nurturing Empathy

Hojat and colleagues offer a comprehensive array of causes contributing to a decline in empathy, underscored by students’ comments. We asked a few fourth-year students at our institution to reflect on why empathy may decline during the third year. Here is one insightful response supporting the notion that when empathy is not taught, not role modeled, and therefore not practiced as a cognitive skill, energy is lost and empathy may erode:

Part of the reason that empathy may decline is that we are not adequately debriefed on what we see during our clinical rotations. While we have lectures during first and second year about the loss of empathy, we stop having these discussions when they actually apply to us. It’s important to have these “previews” to prepare us, but it’s also important to continue the conversation during our third year. We’re all scared and confused, but the general consensus is that you are supposed to put on your big, brave doctor face and not talk about what you’re seeing .... We see upper level residents who have seen so many codes that they’re no longer affected by them. [On the other hand, we] never [have] an opportunity to discuss the fact that we have just witnessed our first death. The internalization of this experience may lead to apathy. We also see people make fun of patients or roll their eyes at them and, since we want to be included, we do it too. It’s a classic example of little kids watching big kids and acting like the big kids to be cool. We don’t know what we’re doing so we mimic what we see.

While we cannot address all causes offered by Hojat and colleagues and so poignantly expressed by the quote above, we are confident that barriers to empathic practice (lack of sufficient role models, failing to teach empathy as a cognitive skill, negative experiences, time pressures, overreliance on technology) can be remedied in medical education through institutional promotion of relationship-centered care, which is best realized through interprofessional education and practice. Principles of relationship-centered care maintain “(1) that relationships in health care ought to include the personhood of the participants, (2) that affect and emotion are important components of these relationships, (3) that all health care relationships occur in the context of reciprocal influence, and (4) that the formation and maintenance of genuine relationships in health care is morally valuable.” Relationship-centered care highlights the importance of balance between empathy (intellect) and sympathy (emotion). In this model, “relationships between patients and clinicians remain central, although the relationships of clinicians with themselves, with each other and with community are also emphasized.”

We need to explicitly “role model” for students what we value as important and send a clear message that expressing empathy is good for the patient, the clinician, and the community. This message can transform—for the better—the system in which we teach, evaluate clinical competence, and care for patients.

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References


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