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What Is Empathy, and How Can It Be Promoted during Clinical Clerkships?

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ABSTRACT

The ability of medical students to empathize often declines as they progress through the curriculum. This suggests that there is a need to promote empathy toward patients during the clinical clerkships. In this article, the authors attempt to identify the patient interviewing style that facilitates empathy and some practice habits that interfere with it.

The authors maintain that (1) empathy is a multistep process whereby the doctor's awareness of the patient's concerns produces a sequence of emotional engagement, compassion, and an urge to help the patient; and (2) the first step in this process—the detection of the patient's concerns—is a teachable skill. The authors suggest that this step is facilitated by (1) conducting a "patient-centered" interview, thereby creating an atmosphere that encourages patients to share their concerns, (2) enquiring further into these concerns, and (3) recording them in the section traditionally reserved for the patient's "chief complaint." Some practice habits may discourage patients from sharing their concerns, such as (1) writing up the history during patient interviewing, (2) focusing too early on the chief complaint, and (3) performing a complete system review. The authors conclude that sustaining empathy and promoting medical professionalism among medical students may necessitate a change in the prevailing interviewing style in all clinical teaching settings, and a relocation of a larger proportion of clinical clerkships from the hospital setting to primary care clinics and chronic care, home care, and hospice facilities, where students can establish a continuing relationship with patients.

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Some humanistic attitudes, such as empathy, decline on repeated measurements as students progress through the medical school curriculum from preclinical training to the clinical clerkships.[1–4] The hospital teaching setting has been blamed for this decline. It has been claimed that "North American medical education favors an explicit commitment to traditional values of empathy, compassion, and altruism—and a tacit commitment to an ethic of detachment, self-interest and objectivity"[5]; that "moral virtues like idealism, conscience and compassion can be easily snuffed out by contradictory environments [the hospital wards]"[6]; and that "to expect medical students during their medical clerkships to learn empathy in [the hospital] environment . . . is unreasonable—and indeed they do not."[7] These claims are supported to various degrees by the findings of recent surveys showing that less than half of Canadian medical clerks and residents agreed that their teachers displayed humanistic characteristics,[8] that 23% of U.S. medical residents thought that they had become less humanistic during their training, and that as many as 61% reported becoming more cynical.[9]

The erosion of students' and residents' humanistic attitudes during their clinical training is a source of concern for medical educators because these attitudes are believed to be important components of patient care. Respect, competence, and empathy were the three most common attributes of "professionalism"[10] listed by Canadian residents,[11] and doctors' affective attitudes ("The doctor understood how I was feeling") have been repeatedly identified as major determinants of patient satisfaction with medical care.[12] Further-

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more, encouraging patients to share their distress, in and of itself, can be therapeutic and may help doctors to understand better their patients' expectations, focus their treatment and prevent doctors' arrogance and prejudice toward certain patients.

One of the most-studied professional attributes of doctors is empathy, and it is frequently used as a measure of humanistic attitudes.[13] In this article, we review the methods used for measuring and teaching empathy to medical students. We then suggest that attempts to sustain empathy during the clinical clerkships should focus on students' ability to gain an insight into the patient's concerns, feelings and sources of distress. We propose approaches that may reinforce this ability and suggest possible causes for the observed decline in students' empathy during their passage through the curriculum.

MEASUREMENT AND TEACHING OF EMPATHY

The word *empathy* has been variably identified with putting oneself *cognitively* into another person's psychological perspective,[14] or with an *affective* response to another person's plight.[15] Others have equated empathy with *compassion*,[7] a sense of "*we*" rather than "*I and you*"[16] and "*an openness to, and respect for the personhood of another.*"[17] This conceptual diversity explains the difficulties in measuring empathy. Attempts to quantify it have used self-assessments,[18–21] peer ratings,[7,20,22] patient ratings,[18] pencil-and-paper psychometric tests,[18,22–26] and various rating scales of observed behavior during interviewing.[20,27,28] However, none of these seem to capture the entire range of cognitive, emotional, and behavioral components of empathy. For example, pencil-and-paper tests were found to correlate with peer ratings[20] but not with observed behavior,[20] patient ratings,[18] and self-assessments.[18] Observed behavior has been reported to correlate with self-assessments by some authors[28] but not by others.[20]

Methods for teaching empathy have consisted mainly of lectures, role-playing exercises, and supervised practice in interviewing skills for medical students,[24,26] practicing physicians,[21,27] and nurses.[23] Others have tried to promote empathy by discussions after encounters of patients with entry-level students,[7] clerks in the department of psychiatry,[19,22] and residents in psychiatry.[28] Still others have attempted to make care-providers share a patient's experience by admitting family practice residents for one day to hospital[29] or by asking first-year students to follow ("shadow") patients throughout their management.[30] Finally, it has been pointed out that to be empathic, it is not necessary for health professionals to suffer themselves or observe suffering. They can learn this vicariously from the literature, and, indeed, this view has prompted some medical schools to include courses of literature into their programs.[16]

With few exceptions (such as those discussed by Moorhead and Winefield,[24]), these teaching methods have been reported to enhance empathy when their outcomes were evaluated by self-assessments,[19,21,28–30] psychometric tests,[23,24,26,28] and rating scales of observed behavior during patient interviews.[21,23,27,28] Nevertheless, students' empathy was found to decline when repeated measurements were made as they progressed through the four-year curriculum at North American medical schools,[1–4] thereby suggesting the need to reinforce students' awareness of the importance of empathy during the clinical clerkships.

Most teaching programs of interviewing skills and cultural competence[31] aim also at improving students' ability to empathize with their patients. However, we know of only one reported attempt to specifically address empathy during a clinical clerkship.[19] It consisted of once-weekly group discussions of students' interpersonal (student–student and student–patient) experiences during a six-week psychiatric clerkship. Most students described these discussions as the most significant learning experience that they had during their clerkship in psychiatry, and reported an increase in self-assessed empathy. Using paper-and-pencil scales and peer assessment, the authors of that study found that students who participated in the group experience had higher empathy scores than students who did not, and that the differences persisted for six months.[22] These findings suggest that students' ability to empathize with patients can be reinforced during the clinical clerkships.

THEORETICAL BASIS OF TEACHING EMPATHY DURING CLINICAL CLERKSHIPS

Like some authors[32] but unlike others,[7,13,17] we define empathy as a multiple-phase process rather than as a single event. Empathy begins with gaining an insight into the patient's concerns, feelings and sources of distress. This insight is followed by *engagement*,[32] i.e., identification with these feelings. In turn, this produces compassion, i.e., a feeling of discomfort produced by the distress of another person. Compassion leads to a desire to remove the cause of distress or at least to alleviate it.

It has been argued that each of these steps has mediating variables that influence whether empathy progresses or an alternate terminal point is reached.[32] For example, the first step is mediated by the patient's ability to convey his distress, and by the doctor's ability to encourage the patient to do so. To move from an insight into the patient's concerns to engagement requires the doctor to self-transpose into another person's situation and to identify with the suffering of people of different backgrounds and values.[6] Engagement may progress to compassion and an attempt to help.

However, the insights provided by engagement may be used to harm or manipulate others, e.g., some people make pointed barbs in anger when they grasp emphatically what makes another person most vulnerable.[33]

The first step in the acquisition of empathy is especially important, because a failure to identify a patient's concerns inevitably precludes its development, just as ignoring a key symptom may result in a missed diagnosis. We believe that the ability to encourage the patient to convey his distress is a teachable skill, while the subsequent steps are mainly related to the personality traits of each individual student. Therefore, we suggest that attempts to promote empathy during the clinical clerkships should focus on the student's ability to gain an insight into the patient's concerns, feelings and sources of distress.

We are aware that limiting the teaching of empathy to a skill-based approach does not reflect the entire process of empathy, and that it is important to teach empathy comprehensively, acknowledging both its behavioral and attitudinal components.[34] Nevertheless, we suggest that the important theoretical and attitudinal components of empathy should be subjects of discussions throughout the curriculum, while the clinical clerkships should focus on providing students with an opportunity to apply these principles. Just as students are shown during the clinical clerkship the appropriate way to palpate a spleen, so they must also be shown how to conduct an interview in a way that encourages the patient to share her concerns, and should be shown how to avoid interviewing habits that may prevent that sharing from occurring.

List 1

Proposed Methods for Promoting the Ability of Medical Students to Elicit the Patient's Feelings, Distress, and Concerns

Ensure as much privacy as possible when interviewing the patient. "Break the ice" by expressing sustained respect and interest throughout the interview, e.g., maintain eye contact and a body posture slightly bent forward.

Listen carefully to the patient's account of her history and do not interrupt her for at least two minutes. Encourage the patient's spontaneous narrative by nodding and permit the patient to take control of the interview.

Watch for indirect verbal and nonverbal clues of the patient's feelings. Respond with an accurate and explicit acknowledgment of the patient's emotions, distress, and concerns. Encourage the patient to talk not only about his symptoms, but also about his personal and family situation, preferences, and feelings.

Toward the end of the interview, if appropriate, ask one or more of the following questions:

Of all your problems, which is the one that worries you most?
Do you have any preferences or suggestions about what your management should be?
Do you have any ideas regarding what caused your illness?
What are your plans for the future?
How does all this make you feel?
How did you/your family feel when you were told about your illness?

Encourage the patient to ask questions about his disease and his main concern(s) by asking *Do you have any questions regarding your condition?*

GAINING INSIGHT INTO THE PATIENT'S CONCERNS

We believe that the doctors' awareness of the patient's concerns is facilitated by (1) conducting a "patient-centered" interview, thereby creating an atmosphere that encourages patients to share their concerns and feelings; (2) enquiring further into the patient's concerns; and (3) recording these concerns in the written history.

Conducting a Patient-Centered Interview

The most important way for a doctor to create an atmosphere that encourages patients to share their concerns is to express a willingness to listen to them by conducting the interview using a "patient-centered" style.[35–37] A patient-centered interview begins with a question such as "Could you tell me why you have come to see me?" and is characterized by the doctor's expressing sustained respect and interest throughout the interview, thereby encouraging patients to share their concerns, expectations, and desires for health-related information. The doctor maintains eye contact, listens to the patient's account of her history for about two minutes without interruptions, encourages the patient's narrative by nodding, and permits the patient to take control of the interview and talk not only about her symptoms, but also about her personal and family situation, preferences, and sources of distress. After the patient concludes her narrative in response to the opening question, the doctor proceeds by asking other open questions ("Could you tell me more about your chest pain," ". . . about your past health," ". . . about your family"), thereby inviting the patient to elaborate in those areas where she may not have given sufficient information in her narratives. Closed questions ("Did the pain radiate to the arm?") are asked only toward the end of the interview, in order to further define the patient's symptoms and concerns (List 1). The patient-centered interview ends with the doctor repeating to the patient what he has understood to be the main points of his history, as well as the chief complaint and the main concern so that there will be no misunderstanding as to what the patient actually said and what the doctor understood.

Unlike the patient-centered interviewing style, a "disease-centered" interview is controlled by the doctor right from its beginning, and consists mainly of asking closed questions, which are guided by the doctor's hypotheses regarding the

patient's disease.[35] The questions focus on the patient's symptom matrix, past history, personal habits, and family background, and end with a system review. A disease-centered interviewing style is incompatible with empathy, because interrogated patients are unlikely to share concerns. They are too busy trying to understand and respond accurately to the doctor's questions.

It is the disease-centered approach to interviewing that dominates in hospital wards and outpatient clinics, probably because it is believed to be more efficient for data gathering and more appropriate for clinical settings that impose limits on the duration of the doctor–patient encounter. We believe that this view is erroneous. A disease-oriented approach to interviewing has not been shown to take less time than a patient-oriented interview,[38,39] and both of them are similarly constrained when time is limited. However, they differ in priorities. Disease-centered interviews focus on symptom identification and are characterized by closed questions; when time is limited, a disease-centered interviewer usually forgoes the patient's perspective. Patient-centered interviews emphasize listening to the patient's spontaneous narrative for up to two minutes; when time is limited, a patient-centered interviewer could leave out the complete system review. Therefore, we feel that a patient-centered interview is appropriate in all clinical encounters, with the exception of those with unconscious or unresponsive patients.

Identifying the Patient's Concerns

In some cases, a patient-centered interview will in and of itself prompt the patient to describe his concerns during the spontaneous narrative. However, in most cases, identifying these concerns requires recognition that they are present, but that the patient may not directly express them. A study of doctor–patient interactions found that patients seldom verbalized their emotions directly and spontaneously, but rather tended to offer instead only clues, and they expressed their emotional concerns only if invited to elaborate. In some cases, the doctor responded with an explicit acknowledgment. However, in most cases, doctors allowed clues of concern to pass without acknowledgment, returning instead to a diagnostic exploration of symptoms.[40] Ignoring hints of the patient's concerns may result from a variety of mediating variables, such as a reduced tolerance on the part of the students or doctors to the patient's expressions of affect and emotions[41] and their failure to interpret verbal and nonverbal clues of patients' anxiety and depression.[42] We have previously observed that medical students are often embarrassed when confronted with patients who express themselves emotionally.[43] Students may need reassurance that their reluctance to explore concerns and feelings is normal, and that the acquisition of an insight into patients' concerns is a legitimate field of inquiry and essential for a therapeutic doctor–patient relationship.

Finally, in some patients, the doctor may fail to detect any clues to concerns, emotions and sources of distress throughout the interview. In such cases, the patients' concerns may be elicited toward the end of the interview by asking one or more open-ended questions such as: "Is there anything else that has been bothering you?" or "Of all you told me, what makes you worry most?" or "What do you think caused your disease?" (List 1).

Recording the Patient's Concerns

Most introductory textbooks of clinical medicine[44, p10, 45, p6, 46, p22, 47, p14] recommend including in the recorded history a section on the personal and psychosocial history of the patient that provides information about his environment, current life situation, education, significant past experiences, personal relationships, habits, occupation, home conditions and a brief doctor's assessment of the patient's personality. Two textbooks also refer to the patient's concerns and sources of distress.[36,48] Morgan and Engel,[36 p192] suggest including into the recorded history the patient's current life situation, unresolved problems and sources of concerns. Weed[48] recommends adding to the recorded history a section entitled "The Patient's Profile" that includes how the patient describes herself and what her state of mind is.

Despite these recommendations, our experience in teaching medical students during the clinical clerkship in medicine has indicated that the patient's concerns are almost never included in his record, and we suspect that they rarely reach the students' awareness. We have previously proposed a classification of the various sources of patients' concerns[49] and argued that they may or may not be identical with the chief complaint. For example, a patient's chief complaint may be "pain in the chest on exertion for the last three months," or "low back pain during the last week," and these may also be his main concern. However, the patient's main concern, in the case where chest pain was the chief complaint, may differ, e.g., it may be whether he needs the bypass surgery that was recommended to him ("Perhaps I should have a second opinion?"), other fears ("I am afraid of dying," "I think things will never be the same again"), or how the disease will affect his lifestyle ("Shall I be able to travel?" "Shall I be able to resume my work?"). The patient's main concern, in the case where low back pain was the chief complaint, may be her teenage son's trouble with the police ("Well, doctor, since you ask . . . my main worry, right now, is my boy").

Table 1

Interviewing Habits That May Encourage or Discourage Patients from Sharing Concerns, Feelings, and Sources of Distress with Their Physicians

Do	Don't
Postpone the write-up of the patient's history until the end of the interview.	Take extensive notes while the patient is talking.
Watch for indirect verbal and nonverbal clues of the patient's feelings and concerns. Inquire further for patient's sources of concerns and distress. Make a verbal summary of the patient's story at the end of the interview to check that you understood what the patient has told you, reach an agreement with the patient in defining his or her main concerns, and record the patient's main concern(s) in the section traditionally reserved for the "chief complaint."	Focus on the chief complaint early in the interview.
Use open-ended questions (*Is there anything else that has been bothering you?*). Ask closed questions (*Did the pain radiate to the arm?*) only toward the end of the interview, in order to further define the patient's symptoms and concerns. Given time constraints, consider resorting to a complete system review only with those patients who are unresponsive to attempts to sustain their narrative.	Ask a quick succession of closed questions.

We suggest replacing the section on the chief complaint in the patient's recorded history with a new section entitled Patient's Main Concern(s), preferably expressed in the patient's own words. Since a detailed description of the patient's main symptoms or signs is included in the statement of the present illness, to delete the chief complaint, when different from the patient's main concern, would not entail any loss of information. The advantage of recording the patient's concerns is that it brings them to the doctor's awareness, thereby triggering the subsequent steps of the empathy process. Furthermore, while the chief complaint is restricted to symptoms and signs only, the patient's concerns include all possible sources of the patient's distress and needs for help. In the case of a patient whose main fear is the coronary artery bypass operation that has been recommended, the doctor may review the necessity of surgery, rather than make a needless change in the patient's medications. In the instance of a mother whose main concern is her teenage son's trouble with the police, the doctor may offer support, understanding and sensible advice. He may also make the wise decision to postpone the investigation of the low back pain, which was the patient's chief complaint, until after the resolution of the trouble with the police.

By making the main concerns, rather than the chief complaint, the point of departure for the subsequent patient management, doctors may considerably expand their ability to help their patients. The elucidation of the symptom matrix is important because it provides the student or doctor with the clues for fitting the patient into a known diagnostic category, i.e., in finding the answer to the question "What makes this patient *similar* to others with the same disease?" On the other hand, gaining an insight into the patient's concerns also makes students ask themselves "What makes this patient *unique*?" It is a major challenge to medical education to help students come to terms with these two precepts of care and realize that making a diagnosis and understanding the patient should not be seen as separate and mutually exclusive endeavors.

BARRIERS TO EMPATHY

Some practice habits may discourage patients from sharing their concerns. These habits are (1) writing up the history during patient interviewing, (2) focusing on the chief complaint too early in the interview, and (3) performing a complete system review by asking a series of quick closed questions (see Table 1).

Writing Up the Medical History While Interviewing

A doctor may either write up the history as the patient speaks or postpone this until after the interview is completed. The advantage of the former option is that it reassures the doctor that she has recorded the history without having missed any of the details, and it also provides a feeling of efficient use of time. However, recording the history while the patient is talking has several disadvantages. First, some patients may fail to disclose their concerns when faced with a doctor who is recording their thoughts as they speak, rather than looking directly at them. Second, the write-up of detailed notes while interviewing prevents eye contact with the patient and observation of his body language. Consequently, the students or doctors may miss the patients' nonverbal clues, and the patients may erroneously conclude that the students or doctors lack interest and respect toward them.

Finally, recording the history while patients are talking forces the students or doctors to control the interview. Rather than listening to the patients' narratives and permitting them to control the interview, the students or doctors must conduct the interview in the sequence of the standard recorded history, i.e., chief complaint, present illness, past, social, occupation, environmental and family history, and system review, and this inevitably results in a disease-centered interviewing style. Consequently, we agree with the recommendation given in most introductory textbooks of medicine (e.g.,[36 p291, 43 p3, 45 p10, 46 p8]) that a doctor should first listen to the patient's entire history, make a verbal summary of the patient's story at the end of the interview, reach an agreement with the patient in defining her chief complaint and main concern, and only then write the history, using the sequence of the standard recorded history and not the sequence that was employed by the patient.

Focusing Too Early on the Chief Complaint

The main drawback in recording the history while the patient is talking is that it requires that the students or doctors identify the chief complaint (e.g., "pain in the chest") early in the interview, because this appears at the beginning of the standard recorded history. This prompts an immediate quest for additional symptoms by asking closed questions (e.g., "Did the pain radiate to the arm?"), and this in turn explains the observation that the average time interval between the onset of patients' narratives and their being interrupted by the doctor was only 18 seconds.[50]

It can be argued that an early focus on the chief complaint is justified by studies of clinical problem-solving, which have indicated that doctors generate a set of competing diagnostic hypotheses at an early stage of the doctor–patient encounter, and that these hypotheses are subsequently tested and confirmed or disproved in the course of the remaining part of the history, physical examination and laboratory work-up.[51] Therefore, the identification of the chief complaint and the formulation of the history of the present illness are the first steps in this "hypothetico-deductive" problem-solving strategy, because they form the preliminary diagnostic hypotheses, which guide a focused diagnostic and therapeutic effort. However, the hypothetico-deductive diagnostic strategy is relevant only for understanding the process of clinical reasoning but not for guiding an empathic medical interview. Furthermore, the chief complaint may be one of the last things to clearly emerge in the course of the doctor–patient encounter,[52] and a premature definition of it may actually mislead doctors' diagnostic reasoning.[53]

Performing a Complete System Review at the Interview's End

When the doctor performs a complete system review at the end the interview, he asks a series of quick, closed questions aimed at ascertaining the presence or absence of specific symptoms. The system review has two purposes. First, it teaches the student to associate symptoms with various organ systems and thereby encourages a focus on an anatomic diagnosis for these symptoms. Second, it may uncover important symptoms, which the patient failed to mention in her narrative. Indeed, attempts to determine the yield of performing a complete system review revealed that it led to new diagnoses in 5%,[54] 7%,[55] and 10.5%[56] of the patients.

On the other hand, it has been claimed that the large amount of irrelevant information supplied by performing a complete system review may complicate the diagnostic process,[57] and that the high degree of variability in the interpretation of the patient's symptoms[58] may breed misunderstanding. It has been our impression that some novice students perform the system review as a substitute to listening to the patient's narrative, thereby producing an atmosphere of detachment and formality that is detrimental to an expression of empathy, respect, and humility. Furthermore, there is evidence that an inquiry into the patient's beliefs, checking for understanding, and addressing emotions and psychosocial issues early in the course of the interview decrease the number of new problems that may emerge in the final moments of the visit.[52] In other words, an appropriately conducted patient-centered interview may, in and of itself, identify all of the patient's problems without having to resort to performing a complete system review.

These uncertainties justify a quest for more definitive evidence on the tradeoff between the benefits and undesirable consequences of performing a complete system review in *the context of a patient-centered interview*. Pending the results of such a study, we recommend that students be told that given the same time constrains, listening to and encouraging the patient's narrative may be more informative and therapeutic than a closed-question interrogation. Some instructors may wish to advise students to replace the complete system review by open questions, such as "Is there something else that has been bothering you?" and to resort to the performance of a complete system review only in those patients who are unresponsive to the interviewer's attempt to sustain their spontaneous narratives.

CONCLUSIONS

We, along with other authors,[6] disagree with the view that humanistic attitudes are best taught by encouraging students

to imitate role models. Students may choose the wrong role models,[8] and merely imitating a certain type of behavior may be done only to please rather than because the behavior really matters. Similarly, we disagree with the view that it is possible to select for moral values among medical school applicants.[7] Even if admission committees could identify an ability to empathize among entry-level medical students, the hospital environment would most likely eradicate this ability.[6]

We feel that promoting empathy during the clinical clerkships requires two main teaching interventions. The first one is reinforcing the skills in communication that were taught during the preclinical phase of the curriculum by reemphasizing the importance of conducting a patient-centered interview, enquiring further into the patient's concerns, writing up the history after interviewing and recording the patient's concerns in the written history, and refraining from focusing too early on the chief complaint. Such a change would entail the eradication of some well-entrenched clinical practice habits, particularly in hospital teaching settings.

A continuing relationship with a patient over time is more conductive for establishing empathy and humanism than the short-term relationships in the hospital setting or in consultants' outpatient clinics. Therefore, a second approach to enhancing students' empathy toward patients during the clinical clerkships would require a relocation of a larger proportion of clinical clerkships from the hospital setting to primary care clinics and chronic care, home care, and hospice facilities. The importance of an empathic attitude and a patient-centered orientation in those settings is increasingly being emphasized,[59] and they may provide students with an opportunity to observe preceptors who conduct patient-centered interviews, elicit from patients their concerns and sources of distress, and postpone the write-up of the history until after the interview. We believe that both of these changes should be considered if we want students and practicing physicians to adopt the basic tenets of professionalism during their training.[10]

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