Empathy in the Clinical Encounter: A Study of Situational and Dispositional Empathy Levels as Associated with Clinical Training and Practice

by

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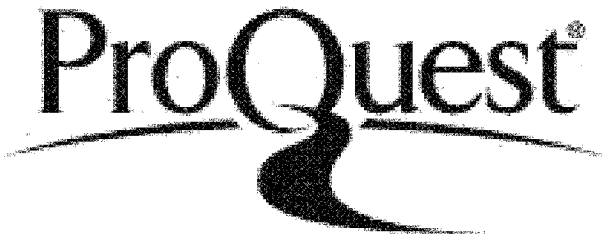

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ABSTRACT

Research in practitioner empathy has suggested that levels of empathy decline over time in both medical trainees and practicing professionals. Specifically, empathy erosion has been found to occur in the earliest years of medical training and identity development. The erosion of empathy can be linked to the de-emphasis of its practice in curriculum and can overshadow effects of acute skill and general knowledge acquisition. While absence of empathic practice may be more common in technology-based versus person-centered orientations, its effects can be felt nonetheless with significant consequence on both patient experience and prognosis. Understanding the erosion effect in medical school can help us realize the function and impact empathy, or lack thereof, has on practitioners and their patients, while simultaneously affording us an opportunity to make use of this dissonance in early curriculum-based exposure.

This study examined levels of situational and dispositional empathy in first and fourth year medical students. Empathy erosion and/or development are examined in relation to medical school curriculum, choice of medical specialization, and gender. The sample consisted of first and fourth year medical students at Weill Cornell Medical College. The population of students at the time of the survey distribution totaled 195 (100 first year; 95 fourth year students) and 71 responses were obtained (35 first year responders and 36 fourth year responders). The sampling objective was to achieve an accurate representation of students developing their identity in the field during different phases of training. All responders participated by completing an online survey that included a measure of situational empathy (Jefferson Scale of Physician Empathy-

Student Version), a measure of dispositional empathy (Caruso-Mayer Empathy Scale), a curriculum questionnaire, and a demographic questionnaire.

Results revealed that empathy is indeed eroding over the course of medical training. Differences in situational empathy approached significance ($p < .07$), such that fourth year students displayed lower levels of empathy compared to first year students; this occurred in accordance with our prediction. We did not expect a change to occur in dispositional empathy, as this has been found to be a stable personal attribute, and as predicted, none was found.

Emphasis of curriculum was carefully examined and it was determined that among the several variables, empathy was afforded the least importance. Those choosing a person-oriented specialty showed significantly higher levels of dispositional empathy compared to those seeking careers in technology-oriented specialties ($p < .05$). In addition, students pursuing person-oriented specialties showed higher levels of situational empathy, but this difference did not reach statistical significance ($p < .1$).

Other important findings include the significant difference between males and females insofar as dispositional empathy levels. Female students showed significantly higher levels of dispositional empathy ($p < .02$), and were discovered to be more likely to pursue person-centered specialties than their male counterparts. Interestingly, all students were most eager to pursue a specialty that allows for direct one to one contact with patients. This desire to engage in close contact with patients, elucidates the need for medical school curriculum to more assiduously focus on skills that relate to interpersonal exchange and bedside manner.

Research has long been needed to examine medical training programs and other contributing variables more closely as efforts to inform curriculum and specifically target empathetic training are increasingly valued and recognized as indispensable in the practice of medicine. Improvement in empathic skills training will likely result in overall improvement in patient care and clinical outcomes.

CHAPTER I

INTRODUCTION

Overview

Recognizing, understanding, and accepting patient suffering is a starting point for acting with patients to alleviate it. Clinical empathy, which encompasses this collaborative effort, is reasoning that is simultaneously cognitive and emotional. It recognizes that practitioners are unavoidably "sympathetically immersed" when making decisions about patients, but also that they must learn to use reason, emotional responses and their imaginations for optimum therapeutic impact (Halpern, 2001).

There are many factors that create obstacles to the formation and establishment of these all-important empathic encounters. Clinical burdens such as burnout, stress, and limited time allotted to building relationships are a few. Nevertheless, research makes us increasingly aware of empathy's invaluable role. It increases the patient's sense of "satisfaction," adherence with therapeutic regimens, and increased psychological and physiological well-being (Kim, Kaplowitz, & Johnston, 2004). Some argue that empathy plays a key role in practitioner satisfaction as well, reducing burnout and increasing job satisfaction (Halpern, 2001).

For empathy to be understood, present, and practiced by health care professionals requires vigilance and research. This study is designed to promote the efficacy and awareness of clinical empathy and to advocate for its inclusion in health care training. This research is an investigation, using the covariation of two or more variables. It determines correlations between both situational and dispositional empathy expressed

by health care trainees during clinical encounters with their patients, and how these variables correlate to their choice of specialization and training program. Such data was disaggregated so as to examine the influence of such variables as age, gender, and other demographics. Several theoretical frameworks such as Self- Determination Theory (SDT) of psychological health and well-being (Deci & Ryan, 2008), Astin's involvement theory (1984), and Hoekstra's social exchange theory (1958) are discussed with regard to their promotion of empathic communication and rapport. This study presents implications and suggestions for future research, use by medical school admissions, and for instructor-practitioners interested in improving doctor/patient relationships and health care delivery within the United States.