How do medical students without formal training in empathy development, understand and express empathy in the context of patient care?

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Background. Empathy is a crucial component of clinical practice and professionalism. Quantitative studies have reported empathy erosion in medical students. However, studies investigating medical students' perspectives on their understanding and behavioural expressions of empathy with patients are limited.
Objective. To explore medical students' perspectives on the nature, significance and expressions of empathy during their undergraduate training.
Methods. The study used a qualitative phenomenological approach. Twenty-five (out of 45) medical students were invited to participate. Semi-structured online interviews were conducted to elicit experiential details from participants. The recorded interviews were transcribed verbatim, and data were analysed using Braun and Clarke's thematic analysis method.
Results. Students described their beliefs and understanding of empathy and reflected on the process of empathising with patients. Most students defined empathy as having four interrelated and overlapping dimensions: cognitive, affective, behavioural and moral. In addition, they believed that empathising with patients was a bidirectional relational process, necessitating empathic inclination, adequate time, a non-judgemental approach and effective communication and listening skills.
Conclusion. Empathy is more than a personal attribute; it is a multifaceted, dynamic and bidirectional relational process. Adequate time, support, stress management strategies, formal training and encouragement from experienced teachers are crucial elements to fostering genuine or deep empathy in medical students. Furthermore, students should be trained in developing emotional regulation and maintaining an appropriate balance between professional detachment and empathic connections.

Afr J Health Professions Educ 2023;15(3):e661. https://doi.org/10.7196/AJHPE.2023.v15i3.661

Empathy is an essential element of physician-patient communication. The association between a physician and a patient largely depends on the physician's ability to empathise with or be receptive to the patient's emotional state.[1] A physician's empathy is associated with better diagnostic and clinical outcomes, higher patient satisfaction, better therapeutic compliance and lesser incidences of malpractice complaints.[1-5]

Empathy has been diversely defined in the medical education literature.[6] Some researchers describe empathy as an emotion,[7] some as a cognitive attribute,[8] and others consider it a personality attribute.[9] Furthermore, some authors have proposed a two-dimensional framework of empathy, including cognitive and affective components,[10] and others believe that empathy has three dimensions: cognitive, affective or emotional and action components.[11] Some researchers describe empathy by including four dimensions: emotive, cognitive, moral and behavioural.[12] There are researchers who claim that 'clinical empathy is a complex, multidimensional construct including understanding the patient, reflecting your understanding, checking whether you understand the patient right, and acting upon that understanding in a therapeutic way'.[13]

The diverse definitions of empathy share the fact that it is an ability to understand other persons' thoughts and feelings; however, these definitions differ widely on 'the ability to share those feelings'.[14] Although empathy is attracting more consideration in the medical field, the knowledge about medical students' perspectives on their understanding and behavioural expressions of empathy with patients is not well developed.[3,4] Moreover, many studies have confirmed an empathy erosion in medical students during their undergraduate education.[4,15-19] Therefore, investigating medical students' perspectives on various aspects of empathy is paramount to improving medical education and healthcare standards. Unfortunately, the exploratory studies considering students' views are limited, and quantitative studies employing self-administered questionnaires have not furnished a profound conceptualisation of the beliefs and experiences of students regarding empathy in the context of patient care. Therefore, the rationale for this research was to gain a conceptualisation of empathy and its expressions from medical students' perspectives.

The study was carried out at a medical school in Mauritius. Formal training to enhance empathy development in medical students does not form part of the medical curriculum. Therefore, the study intended to explore how medical students with no formal training in empathy development: (*i*) understand the nature of empathy; (*ii*) value empathy in patient care; and (*iii*) express empathy in diverse situations.

Methods

A qualitative descriptive phenomenological approach[20,21] was used to gain medical students' perspectives. Phenomenological exploration is based on the implicit knowledge and individual perceptions of persons who derive explanations from their own lived experiences. Phenomenology aims to illustrate the connotations of these experiences, including what the experiences were and how they were experienced.[6] In a descriptive phenomenological approach, the meanings extracted from participants' lived experiences can be described; therefore, interpretation of these meanings is unnecessary.[21]

Participant recruitment

Twenty-five (out of a total of 45) final-year MBBS students who had experience with patients initially participated in the study. The aim of the study was announced in class. Participation was not compulsory, and to eliminate potential bias, it was explained to the students that their participation would not influence them academically. Informed consent was obtained, and participant confidentiality was assured.

Data collection

Medical students demonstrate empathy diversely in different patient care contexts. Hence, they create diverse individual frameworks of the nature of empathy,[22] and one-on-one semi-structured online interviews were held to gain the students' perspectives. Each interview lasted 60 - 80 minutes. The researcher (NC) was the key person in the participant recruitment and data collection activities. An interview guide (Table 1) was used to ask the relevant questions; nevertheless, the participants could guide the discourse. The study participants were encouraged to freely communicate their personal beliefs, views and experiences, and leading questions were avoided. Throughout the interviews, the researcher maintained the ethical aspects of consent, confidentiality and respect for the student.[14] Furthermore, to maximise objectivity and extract a pure and explicit illustration of the phenomenon, the researcher attempted to take an unbiased approach to the data by keeping personal beliefs and ideas 'bracketed'. The confidentiality of personal information was maintained by the secure storage of data and the use of a coding strategy to safeguard the participants' identities.

Data analysis

Data collection and analysis were carried out simultaneously; however, no further participants were recruited, as data saturation was achieved (no new information was uncovered) after interviewing recruited participants. As a prerequisite for analysis, data need to be in textual form; therefore, the authors transcribed each recorded interview and analysed data using the thematic analysis method of Braun and Clarke.[23] The data analysis process used an inductive rather than deductive approach.[20] The thematic analysis procedure included six steps.[23] The summary of the data analysis process is shown in Fig 1.

The standards for reporting qualitative research were used as a checklist to ensure that the essential elements of the study were illustrated.[24] The authors showed the anonymised transcripts to the study participants to validate the data. Additionally, they ensured the quality of the research by addressing the quality parameters (Table 2), such as credibility, transferability, dependability, and confirmability.[25,26]

Approval to conduct the study was obtained from the Health Research Ethics Committee, Stellenbosch University (ref. no. S20/03/064) and the Institutional Review Board, SSR Medical College, University of Mauritius (ref. no. 20-05-02).

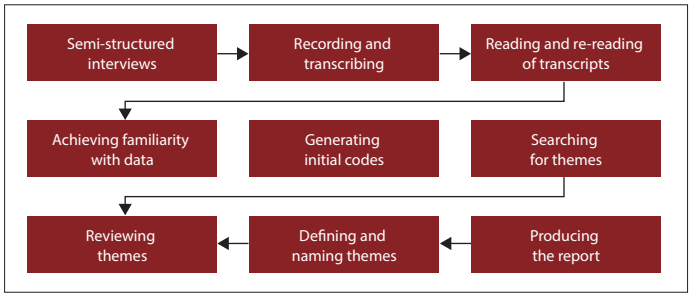

Fig. 1. Steps of data analysis.

Table 1. Interview guide

Question number	Question
1	What does it mean to be an empathic physician? Please give a few examples
2	How do you handle a patient's emotional state or feelings?
3	Can you describe any situation when it was difficult to empathise with the patient?
4	Can you describe any situation when dealing with patients' emotions and expectations was easier?
5	Have you ever felt any change in your personal behaviour after empathising with patients?
6	How do you differentiate between empathy and sympathy?
7	Is there any difference between personal empathy (generic) and empathy in the context of patient care?
8	Can you please explain the importance of empathy in the clinical field?

Thank you for your participation.
Your information will help us improve the standards of patient care.

Table 2. Themes and subthemes identified from the study

Serial number	Themes	Subthemes
1	Nature of empathy	Dimensions of empathy
		Empathy v. sympathy
		Empathy as a personal attribute
2	Significance of empathy	Relationship of trust
		Therapeutic compliance
		Holistic treatment
		Patients' satisfaction
		Personal satisfaction and motivation to excel
3	Empathising with patients	Informal conversations
		Listening skills
		Non-verbal cues
		Communication skills
		Sharing of emotions
		Emotional regulation
		Emotional disengagement
		Non-judgemental approach
		Fake empathy

Results

Students described their beliefs and understanding of empathy and reflected on empathising with patients. Three key themes were identified from students' perspectives: the nature of empathy, the significance of empathy in the clinical field and empathising with patients (Table 3). Students' unedited original responses are presented in the Annexure (https://www.samedical.org/file/2047).

Theme 1: Nature of empathy

Students began by describing their understanding of the meaning of empathy. Then three subthemes were identified from their narratives: dimensions of empathy, empathy v. sympathy and empathy as a personal attribute. Students had diverse perspectives on the meaning of empathy; however, they variably described the four dimensions of empathy: cognitive, affective, moral and behavioural.[13] Some students defined all four dimensions of empathy, while others mentioned only one or more of the dimensions. Students mentioned the moral dimension less often and had mixed opinions regarding the affective aspects of empathy. Some felt that it was appropriate to share feelings with patients, while others argued that it was inappropriate.

Furthermore, students expressed confusion between empathy and sympathy and had conflicting opinions on empathy as a personal attribute. However, despite lacking complete clarity on the nature of empathy, all students agreed that empathy was an essential component of patient and doctor communication and should be developed in medical students.

Theme 2: Significance of empathy in the clinical field

Students demonstrated a clear understanding of the relevance of empathy in the clinical context. The following subthemes were identified: relationship of trust, therapeutic compliance, holistic treatment, patient satisfaction, personal satisfaction and motivation to excel. Students described that they could comfortably engage the patients through empathic connections to extract sensitive information from them. They felt empathy enabled them to consider patients as human beings and not merely as tools to extract information. They identified that empathic behaviour was essential for promoting patients' mental wellbeing and satisfaction. They also felt that empathic behaviour improved therapeutic compliance. Almost all the students emphasised imparting holistic treatment to the patients. Additionally, they related empathy with their personal satisfaction and motivation to excel.

Table 3. Quality parameters of the data

Credibility	Transferability	Dependability	Confirmability
A clear description of methodology, methods and steps involved in data analysis and interpretation	Comprehensive explanations of the research design, data collection, data analysis and referencing to pertinent literature	Iterative data collection, analysis and respondent validation	'Thick' descriptions, entailing comprehensive information of the research
Member checks, feedback from participants and prolonged engagement with data			

Theme 3: Empathising with patients

Students felt that expressing empathy was a dynamic and bidirectional relational process that could be influenced by numerous factors. The subthemes identified were: informal conversations, listening skills, non-verbal cues, communication skills, sharing of emotions, emotional regulation, a non-judgemental approach and fake empathy. Students thought that making the patient comfortable before any formal conversation was crucial. They could set the tone for the formal consultation by showing eagerness and concern. Listening to patients, assuring them and spending time with them were essential to establishing empathy. However, students felt that listening to patients adequately was not always possible, especially during rushed case presentations and examinations.

Students described the importance of non-verbal cues and effective communication skills in building empathic relations. Some students felt that sharing their feelings with patients showed their concern, while others disagreed and emphasised disengagement from emotional connections. Some students described experiencing personal distress in emotionally disengaging from patients. They expressed that emotionally disengaging was sometimes tricky, especially for terminally ill patients. However, students explained that they were more emotionally sensitive and vulnerable in the early years of the undergraduate course and learnt to control their emotions with time. Most students expressed their understanding of the harmonising association and disengagement from the patient. They admitted that attaining that balance was crucial.

Students further explained that they were primarily non-judgemental in their interactions with patients; however, difficult, abusive and rude patients challenged their ability to empathise. Nevertheless, despite challenges, they understood the relevance and maintained non-judgemental approaches in their communications with patients. Students described different levels of expressing empathy with patients. Sometimes, they were profoundly engaged, but at other times they faked empathy through facial gestures, body language or speaking politely without experiencing a concern for the patients. Some students explained that they pretended to be empathic during examinations or when they had a shortage of time. Early in the course, some mentioned that they faked empathy because the teachers instructed them to be empathic. Others said they faked empathy when distressed owing to personal issues. A few students even said that they always expressed fake empathy and had not yet developed adequate skills to empathise with patients. Most students concurred that empathy could be faked, but they felt patients could recognise when they were not genuinely empathic towards them. Nevertheless, all the students showed a willingness to express empathy and felt that empathy should be genuine.

Discussion

This study aimed to gain insight into medical students' perspectives on their understanding of empathy, the value of empathy in patient care and their empathic expressions with patients during their undergraduate training. The students conceptualised empathy in diverse ways. For example, some students believed empathy was mainly cognitive, entailing imagining and understanding the patient's perspective without sharing or experiencing the patient's emotions. This cognitive view of empathy also resonates with the description of empathy provided by several researchers.[15,27-29]

The students had conflicting views on the affective aspect of empathy. Some disagreed with a physician's emotionless, detached stance and felt that empathy involved experiencing and sharing patients' feelings. They noted that patients' experiences often moved them and argued that empathy involved an affective understanding of patients' perspectives.[30] In contrast, a few students described the sharing of feelings with patients as inappropriate. They were concerned that the sharing of emotions with patients might cause emotional distress or loss of objectivity in their clinical judgement.[14]

Nevertheless, most students described a broader view of empathy as having four dimensions: cognitive, affective, moral and behavioural, concurring with the four-dimensional model of empathy described by several authors.[12,13] They described the interdependence and overlapping of these dimensions of empathy in clinical settings.[14] Some students felt that the cognitive and behavioural aspects (action) of empathy were more important than the other dimensions.[31] However, some thought that the behavioural part of empathy was more crucial in expressing empathy with patients. Their views resonate with those of authors who state that empathy necessitates action and 'empathy without action is not empathy'.[32] A noticeable finding was that most students did not often discuss the moral aspects of empathy.[13]

A few students defined empathy by comparing it with sympathy. They felt that sympathy and empathy were distinct concepts,[13] and sympathy could cause fatigue and personal distress.[33] Studies have reported that sympathy involves taking a self-orientated perspective that can cause emotional overwhelming or personal distress to the physician.[15] Some students considered empathy as a personal attribute. Their views, illustrating empathy as an attribute – a possession – that they either had or did not have, agree with the medical education literature on empathy.[22,27] Some students identified empathy as a skill that could be developed. Many researchers believe that the cognitive aspect of empathy, which is an active skill, can be attained and developed.[27,34] However, most students perceived that all dimensions of empathy, including skills, attitudes and moral concerns, could be developed.[32]

On questioning students on the significance of empathy in clinical practice, they explained several outcomes of their empathic behaviour with patients. They explained that empathy was central to building a good relationship with patients. Research reveals that empathic communication empowers patients to address their health problems.[35] Students felt they could bridge the gap between doctors and patients to promote therapeutic compliance. These findings agree with the results of several researchers.[36,37] All students agreed that empathic behaviour was highly desirable for critically and mentally ill patients.[14] Furthermore, students felt that empathic behaviour was essential for promoting the holistic treatment of the patient.[38]

Most students were personally satisfied and motivated owing to their empathic behaviour with patients. The literature shows that several favourable outcomes for the patient and physician relate to empathy, including better patient satisfaction, physician wellbeing and professional satisfaction, and lower extent of burnout, depression and anxiety in physicians.[3-5] Students described empathising as developing a rapport with the patient to gain a deeper perspective of the patient. Their interest in building a rapport indicated their willingness to empathise. Willingness to empathise is the first step toward establishing empathy.[39] Students' views on developing rapport with patients resonate with the relational model. This model features the importance of inherent interest or eagerness and willingness to care for others.[40]

Students mentioned that their initial gestures were especially crucial for establishing empathy. The literature describes the initial concern as 'empathic resonation'.[41] Some students felt that their empathic resonation occurred simply by being with the patient.[14] Students described using a soft respectful tone, warm greeting, informal, casual conversations and simple language for building rapport and setting the environment for discussion with the patients. Their views on respectful talks between themselves and the patient agree with the opinions of several researchers.[32,42]

Some students described it as challenging to obtain complete information from patients without engaging them in casual conversation. They further explained that sometimes they used non-verbal cues to express empathy with patients. The literature also shows that oral communication and non-verbal signs such as a gentle touch, greetings or a warm look help to express empathy.[14,43-45] Students suggested that merely listening to patients, assuring them and spending time with them, helped to establish empathy. They further indicated that demonstrating to patients that their concerns had been heard, had an effect on patients.[13,46] Patients perceive empathy through attention, care, effective listening, communication and consideration.[45] The literature also supports students' views. It is stated that 'communication of understanding' entails mutual co-operation between doctor and patient.[47] Therefore, the patient's perception of the doctor's empathic understanding is crucial for empathic engagement.

The students further mentioned that sometimes listening to the patients for an adequate time was not possible, especially during rushed case presentations and examinations. Many researchers have reported similar findings.[14,22,48] Adequate time is required to establish deep empathy with patients. Students start distancing themselves from patients under time constraints, and empathy consequently becomes superficial.[44]

Most students described the significance of oral communication skills in expressing empathy. Researchers have reported the positive impact of communication skills in improving empathic relations with patients.[49] Understanding the patients' perspectives accurately and communicating efficiently are the two goals of clinical empathy.[43] Physicians capable of communicating effectively are more proficient in making their patients feel better.[45] Students debated the concept of sharing emotions with patients. Some felt that emotionally engaged physicians communicated more efficiently with patients.[43,50] Moreover, they felt that a close empathic association with a patient engenders trust and enables patients to disclose their deep-seated concerns.[44]

A few students thought that the emotions of a physician could be perceived as a threat to clinical judgement and thus a risk to the patient's wellbeing.[14,51] Despite their conflicting opinions on sharing emotions with patients, most students thought that emotional connection and detachment should be optimally balanced.[32,52] Some students said they struggled to maintain balance, and to disengage emotionally was sometimes exceedingly challenging. These findings concur with those of several studies.[22,48] Furthermore, students failed to understand the difference between empathic involvement and personal distress. Empathic involvement is essential to professionalism, whereas personal distress can be self-destructive.[44] For an adequate expression of empathy, students must learn how to control their emotions.[48,53]

The students noted that they were more emotionally sensitive and vulnerable in the early years of the medical course; however, they had learnt to manage their emotions through positive role-modelling and encounters with patients. These findings align with the results in the literature.[48]

Students explained that some difficult and rude patients challenged their empathic and non-judgemental approach. However, they attempted to identify the possible cause of their deviant behaviour instead of becoming judgemental.[14]

In describing different levels of expressing empathy, students explained that sometimes they were profoundly engaged, but at other times they faked empathy owing to a lack of time, pressure from teachers, ongoing personal stress or lack of ability to express empathy. Several researchers have described fake empathy.[14,43] However, students demonstrated their willingness to express empathy and felt that empathy should be genuine. They observed that patients could recognise when they were not genuinely empathic towards them. Empathising can only be successful if patients perceive the emotional expressions of the physician to be accurate and similar to their own emotions.[54]

From the students' perspective, empathising is a dynamic, bidirectional and relational process affected by several factors. Some researchers have also reported the relational aspect of empathy.[14,54]

Conclusion

Medical students need clarity on the diverse aspects of empathy. Empathising with patients necessitates empathic inclination, emotional regulation, adequate time, a non-judgemental approach and effective listening and communication skills. Therefore, it is imperative to promote the development of these essential empathising abilities in medical students for effective outcomes.

Recommendations for future research

The relational concept of empathy needs to be further explored. Qualitative studies that examine student and educator perspectives on medical students' expressions of empathy should be sought. Furthermore, qualitative studies exploring patients' experiences and views on medical students' empathic behaviour can also help to conceptualise empathy from a broader perspective.

Declaration. None.

Acknowledgements. We want to thank the study participants for their interest, patience and commitment to the research and Mr Siddhant Arora for helping to transcribe the interview responses.

Author contributions. EA guided and supervised the study, helped to analyse and interpret the data, critically reviewed the contents and assisted with writing the manuscript. Sarah Chhabra assisted in transcribing and analysing the responses and writing the manuscript. All authors critically reviewed the manuscript and approved the final version. NC developed the study design, recruited and interviewed the study participants, transcribed and analysed the responses, developed conclusions and wrote the article. Sahil Chhabra assisted in data analysis, interpretation and development of meaningful conclusions.

Funding. None.

Conflicts of interest. None.

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Accepted 17 May 2023.