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Exploring Empathy with Medical Students
A Qualitative Longitudinal Phenomenological Study

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Doctor of Philosophy
The University of Edinburgh
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Declaration

I hereby declare that:

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David Ian Jeffrey

Abstract

Contribution

The main contribution offered by my research is an increased understanding of medical students' perceptions of empathy and the factors that influence this. By using an innovative method in medical education research, the study contributes to research methodology.

Background

Empathy is accepted as a fundamental part of the patient-doctor relationship and essential for effective clinical care. Current societal opinions are that some healthcare professionals lack empathy and that medical students become less empathetic during their training, although the reasons for this are not understood. If this perceived decline is to be addressed, medical educators need to understand students' perspectives of the factors that influence their empathy.

Aims of the research

The study sought to gain a deeper understanding of the development of medical students' empathy and the factors influencing this during their undergraduate training. It is hoped that this understanding may lead to improvements in medical education and patient care.

Methods

Ethical approval for the study was granted by the University. A phenomenological approach was adopted, which involved listening to the students' views and experiences of their course. Serial, semi-structured, in-depth, interviews were conducted with sixteen medical students. Each year the student completed an hour-long interview over three years.

One group of eight students were followed during the preclinical years of the course (years 1-3) and the other group, during the clinical years (years 4-6). The interviews were audio-recorded, transcribed, coded using qualitative data

analysis software (N Vivo), and analysed using an interpretative phenomenological approach.

Findings

The students in the preclinical years described empathy as a personal attribute, emphasising its emotional dimension. In the clinical years, students viewed empathy differently: as a complex relational process with the patient, which varied in depth and quality according to the clinical context. They described the tensions between connecting with and detachment from a patient.

Students indicated influences which enhanced their empathy, including patient contact and positive role models. They also identified barriers to empathy, including: the medical school culture, a biomedical bias in the curriculum, a lack of patient contact, negative role models and teaching of professionalism as distancing from patients.

The preclinical group of students reported gaining in self-confidence during their course. The clinical group described how their empathy with patients had increased but they detected a conflict between empathy and efficiency.

Conclusions

The use of an innovative longitudinal, phenomenological approach in medical education research generated new understanding of a complex interpersonal view of empathy and highlighted aspects of a 'hidden curriculum'.

The students maintained that their contact with patients was the most useful way of developing empathy. They expressed a desire to connect emotionally with patients but were uncertain how to balance this connection with professional detachment. They described a marked biomedical emphasis in their course and perceived that teaching on professionalism encouraged a distancing from patients.

In contrast to the widely-reported opinion that there has been a decline in medical students' empathy, this study suggested that students perceived that their empathy increased during their training. However, some students had learned distancing behaviours to hide their empathetic feelings. In the light of this research, it is hoped that medical educators will develop ways of supporting students to deal appropriately with their own emotions and those of patients.

Lay Summary

Empathy, or seeing the world from the other person's point of view, is generally accepted as central to the patient-doctor relationship and essential for effective care. There are opinions voiced in our society that doctors lack empathy and that medical students lose their empathy during training.

Aims

This study sought to gain an understanding of how medical students talk about empathy, its influences and changes during their training. I hope that this understanding may inform medical educators and lead to improved education and patient care.

Methods

Ethical approval to carry out the study was granted by the University. I used a research method which involved listening to the students' experiences of empathy in their course at one UK medical school. I conducted a series of interviews over three years, following two groups of students: one group of eight students were followed during the preclinical, or science, years of the course (years 1-3) and the other group of eight students, during the clinical, or patient contact, years (years 4-6). The interviews were audio-recorded, typed out in full and analysed by breaking down the text into segments or 'codes'. The 'codes' were grouped into common themes, which make up the findings of this study.

Findings

Initially students described empathy as a personal attribute emphasising its emotional component. In the clinical years students developed a different view of empathy, as a relational process with the patient which varied according to circumstances. They described the process of empathising, identifying the tensions between connection with, or detachment from, a patient. The students

also discussed influences which enhanced their empathy, particularly contact with patients. They encountered barriers to empathy including: the medical school culture, the emphasis on science in their teaching and an assumption that professionalism involved distancing from patients.

The preclinical group of students reported that they gained self-confidence during their course, which they claimed, promoted their empathy. The clinical group described how working with patients improved their empathy.

Conclusions

The use of a new research approach in medical education revealed insights into empathy as a relationship between the student and patient. The students maintained that patient contact was most influential in enhancing their empathy. They suggested that the strong emphasis on science and the teaching of professionalism as detachment were barriers to empathy. In contrast to the assumed decline in medical students' empathy, this study suggested that students perceived that their empathy with patients increased during their training.

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Finally, I would like to thank my wife Pru for her support and encouragement: this thesis is dedicated to her.

Glossary and Abbreviations

Alexithymia	An inability to identify and describe emotions
Alterity	The recognition of another person as being separate from oneself
Anorexia nervosa	An eating disorder characterised by attempts to lose weight to the point of starvation
Biomedical	The application of the natural sciences to clinical medicine
Burnout	Emotional exhaustion, depersonalisation and a reduced feeling of job fulfilment
CARE scale	Consultation and Relational Empathy scale
CARE approach	Connecting, Assessing, Responding and Empowering approach
Compassion fatigue	A lessening of compassion over time associated with disengagement and symptoms of stress.
COPD	Chronic Obstructive Pulmonary Disease
COREC	Consolidated Criteria for Reporting Qualitative Studies
CPHS	Centre for Population Health Sciences
[...]	Ellipsis indicating omitted text in a quote.
EBM	Evidence Based Medicine
FY1	Foundation year one doctor
GMC	General Medical Council

Hidden curriculum	The unintended lessons which are learned such as the norms, values and ambience of the medical school, and which may conflict with the teaching and aspirations of the formal undergraduate curriculum.
IPA	Interpretative Phenomenological Analysis
JSPE	Jackson Scale of Physician Empathy
JSE-S	Jackson Scale of Empathy for Students
LGBT	Lesbian, gay, bisexual and transgender people
Lifeworld	The world as experienced
Likert Scale	A scale in which responses are scored along a range
MBChB	Bachelor of Medicine and Surgery degree
MVMSEC	Medicine and Veterinary Medicine Students' Ethics Committee
NHS	National Health Service
NICE	The National Institute for Health and Care Excellence
OSCE	Objective Structured Clinical Examination
PBL	Problem Based Learning
Phenomenology	A philosophy and a research methodology which is concerned with describing the experience of a phenomenon (e.g. empathy)
Phronesis	Practical wisdom
PQR	Phenomenological Qualitative Research

Prosocial	Voluntary behaviour intended to benefit another
Psychosocial	Relating to the interrelation of social factors and individual thought and behaviour
QLR	Qualitative Longitudinal Research
R&D	Research and Development
UK	United Kingdom
USA	United States of America

Note on terms

Empathetic or empathic are adjectives describing an ability to share another's feelings and were used interchangeably in the thesis. The word 'student' used in the thesis referred to a medical undergraduate student unless specified otherwise.

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Chapter 1: Introduction

“I just wish he [my doctor] would *brood* on my situation for perhaps five minutes, that he would give me his whole mind just once, be *bonded* with me for a brief space, survey my soul as well as my flesh, to get at my illness, for each man is ill in his own way.”

Intoxicated by my illness (Broyard, 1992,p.44)

1.1 Overview

This chapter summarises the background and establishes the argument for my thesis. It justifies the need to gain an understanding of medical students' views and experiences of empathy. The argument for the centrality of empathy in clinical practice is presented with a reflection on my motivation for engaging in this research. The aims of the study are clarified by defining the research problem to be addressed. The audience which this thesis addresses is considered, with a summary of the contribution that the thesis might make to the literature and to medical undergraduate education. The chapter concludes with an overview of the thesis.

1.2 The nature of empathy

In the scientific literature empathy is defined in a number of ways, one definition highlighted the emotional aspect of empathy;

“the natural capacity to share, understand and respond with care to the affective state of others” (Decety J, 2011,p.vii).

On the other hand, Hojat et al. (2009) took a cognitive view of empathy which excluded emotions but introduced a moral motivation to care.

“Empathy is 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. An intention to help by preventing and alleviating pain and suffering is

an additional feature of empathy” (Hojat et al., 2009,p.1183)

In medical practice and research empathy is largely viewed as a cognitive construct, leading to a form of professionalism described as ‘detached concern’ (Hojat et al., 2009, Kelly 2017, Halpern, 2001). Alternatively, empathy has been described by combining a number of processes, cognitive, affective, behavioural and moral, in a single concept (Morse et al., 1992). Batson (2011), took yet another view by describing eight different empathies, which are explored in Chapter Five.

To add to this conceptual complexity, empathy is often used interchangeably with terms such as compassion and sympathy (Sinclair et al., 2016). Batson (2011) argued that there was a need to clarify the complexity of empathy, and therefore, at the outset of my research I explored how the students described empathy.

The uncertainty about the definition of empathy has practical implications for research, education and clinical practice (Halpern, 2001, Shapiro, 2012).The various definitions of empathy in the literature share the capacity to understand another person’s thoughts and feelings, but differ widely as to whether this capacity includes sharing another’s feelings (Decety and Ickes, 2011, Batson, 2011).The debate surrounding the appropriate emotional content of empathy for clinical practice lies at the heart of my thesis. I sought to explore with the students how they viewed connection with, or detachment from, patients in their practice.

1.3 Why study empathy?

Empathy is an integral part of a trusting patient-doctor relationship (Neumann et al., 2012, Stepien and Baernstein, 2006, Derksen et al., 2013, Pedersen, 2009). The expression of empathy by healthcare professionals has resulted in improved clinical outcomes and increased patient satisfaction (Derksen et al., 2013, Kim et al., 2004). Empathy is also believed to have an ethical role in

motivating care and generating altruism (Noddings N, 1984, Batson et al., 1991). Pedersen summarised the clinical importance of empathy by explaining that it was needed to understand a patient's illness, their emotional reactions to it and to ascertain what is most important to them, in order to diagnose and treat them appropriately (Pedersen, 2010).

The General Medical Council (GMC), in defining their outcomes, standards and expectations for undergraduate medical education, highlighted the importance of treating patients as individuals (General Medical Council, 2015, General Medical Council, 2013). Interest in empathy in medical undergraduate education has increased over the past decades, although most research has been concerned with measuring medical students' empathy (Underman and Hirshfield, 2016, Batt-Rawden et al., 2013, Pedersen, 2009).

Despite a general acceptance in the literature of empathy's central role in the patient-doctor relationship some authors have cautioned that empathy has limits (Macnaughton, 2009, Smajdor et al., 2011). They have raised doubts about the extent to which one can understand what another person is thinking and feeling (Macnaughton, 2009, Smajdor et al., 2011). However, although it is true that we cannot know completely what it is to think and feel as another person, it is possible to try to imagine the world from the other person's point of view from a basis of our shared humanity. There are also concerns expressed in the literature that empathy, in particular its emotional component, might cause burnout in doctors and students, and that emotional empathy might lead to biased clinical judgements (Bloom, 2016, Smajdor et al., 2011). My thesis explored these concerns with the medical students.

1.4 The empathy gap

Although it is accepted that empathy is central to patient care, it is of concern that some high profile reports, such as the Mid Staffordshire NHS Foundation Trust public inquiry, revealed severe failings in patient care (Francis, 2010, Francis, 2013). The Parliamentary Health Service Ombudsman (2011) also

Chapter One

found a lack of compassion and a failure to recognise the humanity of frail elderly patients, stating in her report:

“the action of individual staff described here add up to an ignominious failure to look beyond the patient’s clinical condition and to respond to the social and emotional needs of the individual and their family.” (Parliamentary Health Service Ombudsman, 2011,p.8)

The Parliamentary Health Service Ombudsman concluded that breaches of care were widespread and recommended strongly that the NHS should respond to the failings in care identified in her report (Parliamentary Health Service Ombudsman, 2011).

The Francis Report also identified contributory factors to the gross failures of care; compassion fatigue, overwork, excessive demand, lack of continuity of care and a failure to see the patient as a fellow human being (Haslam, 2015, Francis, 2013). Although the appalling lapses in care described in these reports were not entirely due to a lack of empathy, there is a consensus amongst healthcare professionals that a lack of empathy in the provision of health care in the NHS is a problem (de Zulueta, 2013a, de Zulueta, 2013b, Cummings and Bennett, 2012, Cornwell and Goodrich, 2009, Francis, 2013, Parliamentary Health Service Ombudsman, 2011).

Francis (2013) responded to the lack of empathy in patient care by calling for a culture change in the NHS to include more compassionate care. His call for compassion was echoed by the Chief Nursing Officer’s recommendation to nurses in the United Kingdom (UK) (Cummings and Bennett, 2012). In a recent report, *Realistic Medicine*, from the Chief Medical Officer, NHS Scotland, Calderwood (2016) highlighted the need for a personalised approach to care and a change to shared decision-making. Berwick (2016) argued for a paradigm change in healthcare, in the United States of America (USA), to include listening carefully to the patients’ concerns.

The deficit of empathy in clinical practice may in part be due to medicine's dominant biomedical view prioritising technical progress, evidence-based medicine (EBM), targets and efficiency (Shapiro, 2012, de Zulueta, 2013a, de Zulueta, 2013b, Montgomery, 2006). Several authors suggest that healthcare professionals sometimes distance themselves emotionally from patients, by focusing on the biomedical facts, in a process which has been described by Agledahl et al. (2011), as 'existential neglect' or by Halpern (2001), as 'detached concern' (Pedersen, 2010, Montgomery, 2006).

A number of authors point to the context of health care creating a risk of dehumanisation and alienating clinicians from patients (Borgstrom and Walter, 2015, de Zulueta, 2013a, Zigmond, 2011, Haslam, 2015). Doctors have complained that their ability to practice empathetically is jeopardised by NHS bureaucracy, causing some patients to feel that their concerns were not addressed adequately (Howick and Rees, 2017, Greenhalgh et al., 2014).

The concerns about a lack of empathy in clinical practice are compounded by a perception, both in medical education research and in society, that medical students' empathy declines during their undergraduate training (Hojat et al., 2009).

1.5 A decline in medical students' empathy

A number of quantitative studies suggest that medical students' empathy declines during their training, particularly during the clinical years of the course (Hojat et al., 2009, Neumann et al., 2011, Pedersen, 2009, Batt-Rawden et al., 2013, Pedersen, 2010). However, other researchers have questioned whether this is indeed the case (Quince et al., 2011, Quince et al., 2016b, Colliver et al., 2010, Roff, 2015).

The authors of many of the reviews of quantitative studies on students' empathy point out that there is a need to understand the factors which might be influencing the supposed decline in empathy (Pedersen, 2010, Batt-Rawden et al., 2013, Quince et al., 2016a, Roff, 2015, Sulzer et al., 2016). They suggest that

qualitative research is needed to investigate this problem. I argue that a longitudinal, phenomenological methodology is best suited to gain an understanding of the students' views of empathy and the factors which influence possible changes in their empathy during their training.

1.6 The research problem

The main research problem which this study addressed was the need to gain an understanding of the influences on medical students' empathy and any possible changes in their empathy, during their undergraduate training.

The relatively few qualitative studies which have investigated medical students' empathy are mostly cross-sectional rather than longitudinal studies (Tavakol et al., 2012, Lempp and Seale, 2004, Eikeland et al., 2014). These qualitative studies identified some factors which enhanced or inhibited empathy but raised further questions as to how empathy changes during undergraduate training and the part played by subtle influences both inside and outside the formal curriculum (Lempp and Seale, 2004, Tavakol et al., 2012, Eikeland et al., 2014). The existing knowledge of the factors which are considered to influence medical students' empathy was critically appraised in my literature review (Chapter2) . The literature was revisited in the discussions of the findings from the students' interviews (Chapters 5-10).

1.7 My motivation for engaging in this study

I was a medical student fifty years ago and enjoyed a course which was divided into preclinical and clinical phases. I was fortunate to be taught by empathetic consultants who gave me an insight into the importance of respecting a patient's dignity. I was enabled to connect with patients emotionally and make their welfare my first priority. However, I recall being distressed at times by the arrogance of some senior clinicians who taught us by humiliation and appeared to disregard the emotional concerns of patients.

After qualifying, and gaining experience in a wide range of hospital posts, I became a general practitioner in a semi-rural practice. I thrived in general practice and recognised how much patients valued personalised continuity of care. During twenty years in general practice, I became more aware of the need for psychosocial care and developed a special interest in palliative care. I undertook and published a qualitative research project looking at the challenges faced by six general practitioners in delivering end-of-life care (Jeffrey, 2000). I was inspired by how selflessly these doctors worked with patients and the emotions expressed in their research interviews.

I believed that the NHS reorganisations in the 1990s threatened personalised care of patients in general practice, so I left and retrained to become a palliative care consultant in a Cancer Centre. There, I was involved in the interdisciplinary teaching of communication skills to medical students and healthcare professionals. Interdisciplinary teaching taught me how diverse specialities such as nursing, psychology and social work, view the patient's world. I became interested in studying the role of empathy in the patient-doctor relationship. I explored ways of using the medical humanities in teaching to enhance empathy and published a book on the use of drama to enhance compassion in healthcare professionals (Jeffrey and Jeffrey, 2013). I believe in delivering personalised care when working with patients. As a consultant representative on the Patient Group in the Cancer Centre, we instigated a project which led to the development of a Maggie's Centre at the hospital, which was designed to empower and support cancer patients.

My career was interrupted by heart disease and during this time I received care from empathetic doctors and nurses. In one clinic where I was being assessed for cardiac surgery, the cardiologist sat me down, and before explaining the technical details of the procedure, he took time to ask: "Would you tell me what it's like to have atrial fibrillation?"

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After successful heart surgery, I resumed my clinical career and was appointed as an academic mentor to a medical school with a remit to improve student support. I spent three years in close contact with medical students. I became intrigued by their transformations from entering medical school to becoming doctors. Colleagues led me to believe that medical students became cynical and less empathetic as their course progressed. However, this was not my impression of the students; they seemed as distressed by examples of a lack of care at the end of their course as they were at the outset. I wondered if something more subtle was at work with regard to their empathy and decided to research the phenomenon.

I have chosen to use a challenging methodology, phenomenology, which has been employed in nursing, psychology and social science research but is a new approach in medical education research. Phenomenology explores the way the world is experienced by the individual. It is a study of people and the meaning they give to their lived experience. In this phenomenological research, my beliefs and perspectives inevitably affect the generation of findings and their interpretation. In making my contribution explicit, I adopt reflexivity throughout the thesis and the use of the personal pronoun. I am not setting out to prove a hypothesis but starting an exploration in a quest for a deeper understanding of empathy and its influences in medical students.

I imagine phenomenological research as a creative craft like weaving. Developing this simile, the University is the hand-loom, a support structure, with the medical school culture, the vertical warp threads. The students' individual stories become the weft threads which, as a weaver, I select to cross the warp. The differing patterns which emerge from each student's story may be compared to the variety of weaves. The result of my thesis is not a finished piece of fabric but a sampler. The viewer, or reader, may resonate with some patterns but not others, but each contributes to the sampler and to the debate.

My thesis questioned the general acceptance of an empathy decline in medical students. It argued for the need to explore the students' perspectives and experiences in relation to empathy over time.

1.8 Purpose of this research

This research sought to generate a deeper understanding of medical students' perceptions of empathy and its influences as they progressed through their undergraduate training. The longitudinal qualitative phenomenological study attempted to allow students the space to discuss empathy in a confidential setting. Students could reflect on how they conceptualised empathy in relation to professionalism and practice. They also illustrated influences on their empathy, by describing specific experiences during their undergraduate education.

Interviewing students over a three year period established a foundation of trust between the researcher and student: a relationship which generated a new understanding of empathy and its development in the students' world. The data generated by the student-researcher interviews is discussed in relation to the literature, thus building on existing knowledge. I addressed the gaps that were identified in quantitative studies and integrated previous qualitative research.

1.9 Research Aims

The specific aims of this research were to:

1. Explore medical students' conceptualisation of empathy during the undergraduate curriculum.
2. Describe a range of students' views and experiences of factors influencing their empathy during their training.
3. Synthesise and interpret the findings to gain understanding of how and why medical students' empathy changes during their training.
4. Consider how this understanding might inform medical undergraduate training and improve patient care in the future.

1.10 Audience for the thesis

My first audience for this thesis are my examiners who will judge the clarity, validity and trustworthiness of my research. Medical educators, involved with undergraduate education, also may engage with the findings of my thesis. The insights gained from this work may also resonate with those involved in postgraduate medical training. Although the study is focused on empathy in medical students, the literature draws from research in nursing, counselling, social work and from the training of allied healthcare professionals, so may be of interest to these professionals and their teachers.

The General Medical Council (GMC) may be informed by this research in their approaches to patient-centred care, professionalism and undergraduate medical education.

Medical students may find this research of interest in their professional development in becoming both competent and caring doctors. Empathy affects all human relationships so this research in a wider sense may be of interest to policy-makers, patients and the public, who want to gain a deeper understanding of the medical students who will be their doctors in future.

1.11 Anticipated contribution of the research

The main contribution of my research is to gain an understanding of the ways in which medical students perceive empathy and the factors which influence their empathy during undergraduate education. The study also seeks to clarify the conceptual confusion surrounding empathy by providing a clear view of how students define the complexity of empathy.

By reviewing the existing literature and interpreting the data generated by the students this qualitative study builds on existing research. It addresses gaps identified in the literature and suggests possible directions for future research.

By using a longitudinal phenomenological method, innovative in medical education research, I seek to show how this research method may be used to

generate increased understanding of empathy and of the students' experience of their undergraduate training.

The thesis seeks to contribute to undergraduate medical education by providing those involved in the curriculum, with a range of perspectives and insights into the factors influencing medical students' empathy. Factors which students identify as enhancing empathy may be incorporated into curriculum planning, and barriers to empathy could be addressed.

The nature of this phenomenological study is to present findings which encourage debate and which could lead to new understanding. My conclusions are necessarily tentative but may resonate with the reader, and be transferable to other medical schools, contributing to the promotion of empathy in curriculum development and patient care.

1.12 Overview of the Thesis

Chapter 1 Introduction

This chapter introduced the background to the study and my motivation for engaging with the research. I outlined the thesis argument by defining the research problem and the aims of the study. I considered the audience that this thesis addresses and suggested possible contributions of the study to the literature, knowledge, medical education and practice.

Chapter 2 A Literature Review

A literature review clarified the phenomenon of interest: empathy. It informed my research questions and orientated the reader to the nature of the problem and gaps in our understanding. The literature review was condensed since the phenomenological interpretative tradition demanded that I remained open to the students' views in exploring empathy. However the literature is re-examined later in the thesis, in Chapters 5-10, after the findings have emerged from the students' interviews.

Chapter 3 Theoretical Framework: Methodology

This chapter outlined the theoretical background which lies at the heart of the thesis: the phenomenological and interpretative methodological approach. Phenomenology is both a philosophy and a research methodology which explores the lived experience of a phenomenon; in this study it is empathy. The methodological approach linked the research questions with the choice of methods in conducting the research and influenced every part of the thesis.

Chapter 4 Methods: The process of the research

This chapter described how the research was conducted and emphasises reflexivity throughout the process. The research design included, student sampling, the research setting and recruitment strategies. Alternative methods were considered and their reasons for rejection given. The process of

generating data from semi-structured interviews was discussed. The approach to data analysis, using Interpretative Phenomenological Analysis, was described. Ethical considerations in conducting research with medical students were debated. The chapter concluded with a reflection on ensuring the quality of the research.

Chapter 5 Students discussing the nature of empathy

This chapter explored how the students' discussed empathy in relation to their undergraduate experience. Rich data on the complexity of empathy as a relational construct were discussed at the conclusion of the chapter.

Chapter 6 Students discussing factors that enhanced empathy

In this chapter, the students described a variety of positive influences on their empathy at various stages of the course. These factors included; contact with patients, positive role models and support, and were discussed in relation to the literature at the end of the chapter

Chapter 7 Students discussing barriers to empathy: The medical school culture

The medical school culture includes the organisation and its values. Factors which the students identified as inhibiting their empathy included; a lack of empathy for students, competition, hierarchy , stress , little support and a lack of time. The students' descriptions made many of the features of the "hidden curriculum" explicit; these were discussed in the conclusion to this chapter .

Chapter 8 Students discussing barriers to empathy: The formal curriculum

The students identified other factors in the formal curriculum which they perceived as inhibiting their empathy; a lack of patient contact, negative role models, little emphasis on empathy, a biomedical bias and teaching

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professionalism as detachment. These barriers to empathy were discussed in relation to the literature at the conclusion of this chapter.

Chapter 9 Students discussing changes in empathy

Students described the development of their empathetic approach during their course. The preclinical students described gaining self-confidence. The clinical students' experiences were presented as individual stories. The majority of students perceived that their empathy had increased during their course. At the end of the chapter the students' claims regarding the development of their empathy were examined in relation to the current literature.

Chapter 10 Synthesis, Contribution and Implications

My thesis sought to broaden the understanding of empathy in medical education. In this chapter the findings of the research were synthesised and analysed in relation to my research aims. The contribution of the study to research, medical education and practice were described. I also discussed the limitations of the research and the challenges I encountered. I considered the implications of the thesis for research, medical undergraduate training and patient care. The chapter concluded with a final reflection on the study and a summary of the thesis.

Chapter 2: A Literature review

2.1 Overview

This chapter analyses the literature relating to empathy and its influences in medical undergraduate education. Four themes emerged from the analysis of the literature; the nature of empathy, measuring empathy, factors influencing empathy and teaching empathy. The literature review places my research in the context of previous work, critically appraises previous research, identifies gaps in our understanding and informs the development of my research questions.

2.2 Challenges of reviewing the literature: a reflection

My first challenge was to select the literature relevant to my research aims from the wide range of publications on empathy. From a phenomenological perspective I faced a dilemma between being familiar with the published literature while remaining open to the students' views (Vagle, 2016,p.71). Synthesising qualitative research presented challenges as definitions of empathy varied and research contexts differed. Qualitative studies of empathy in medical students were uncommon, with most being cross-sectional rather than longitudinal. Interpretative Phenomenological Analysis (IPA) has rarely been used in medical education research.

Qualitative studies of empathy adopted a variety of approaches including: ethnographic studies, interviews, focus groups and narrative research of students' reflections. The data generated from these different approaches were hard to synthesise. Qualitative research papers can be also be difficult to access using electronic indexing systems, since standard indexing terms do not exist in the same way as they do for quantitative reports. Furthermore, the methodology is often inadequately described in the titles or abstracts of their reports. To overcome these challenges I adopted the following strategy for the literature review.

2.3 The literature review strategy

My phenomenological approach to searching the literature on empathy was expansive and iterative. Rather than carrying out an exhaustive baseline systematic review, I carried out a condensed review of the literature. This enabled me to strike a balance between exploring every issue before conducting the research and providing the reader with sufficient background (Vagle, 2016, Haig and Dozier, 2003). This iterative approach involved continuing the literature review throughout the study, particularly after unexpected findings emerged from the students' interviews (Bates, 2002, Finfgeld-Connett and Johnson, 2013). The findings from my research are discussed in relation to the literature in Chapters 5-10.

2.3.1 The Themes of the Literature Search

The search strategy began by identifying four themes from the literature which addressed the aims of the research:

- Nature of empathy
- Measuring empathy
- Influencing empathy
- Teaching empathy

I searched the following bibliographic databases : Edinburgh University Library Discover ED, Web of Science, Medline, CINAHL, and PsychINFO, in an iterative fashion throughout the study. Key words for searching the bibliographic databases were identified using a mind-mapping exercise for each of these topics. I found that using simple broad-based terms, such as, "empathy", "compassion", "sympathy", "medical", "student", and "qualitative", were the most effective for identifying relevant research (Flemming and Briggs, 2007). Google Scholar was used for searching frequently cited authors. References in review articles were followed using "snowballing" techniques, which sometimes resulted in the serendipitous finding of a relevant article, which led to further pertinent articles (Finfgeld-Connett and Johnson, 2013).

I have tried to record my reflections and decisions to show how this process evolved but searching for qualitative reports can be unsystematic, there are “Eureka” moments which are difficult to record or retrospectively retrace (Barroso et al., 2003, Finfgeld-Connett and Johnson, 2013). I also checked recent articles by using alerts via e-mail and used EndNote as an electronic bibliographic manager.

Trustworthiness of the literature review was not based on ‘the more the better’ but rather continuing the review while the papers enriched my understanding of the relevant issues (Booth, 2010). Ending the review was a matter of pragmatic judgement as it was impossible to know, with such an extensive subject and disparate sources, what data had not been captured.

2.4 Themes of the literature review

Four themes emerged from the literature review, which matched my original search themes: the nature of empathy, measuring empathy, factors influencing empathy and teaching empathy.

2.4.1 Theme 1: The nature of empathy

Empathy emerged as a complex concept variously described as: feeling what another person feels, ‘caring about others’, imagining oneself in another’s situation, having the capacity to grasp the content of other people’s minds, and as a virtue in response to suffering (Batson, 2011, Coplan and Goldie, 2011). Since understanding how empathy is conceptualised was central to this study, I reviewed how the definition of empathy has evolved over the last century, contrasting this with the way in which it is now defined in a medical context.

2.4.1.1 Evolution of the concept of empathy

Theodor Lipps (1851-1914) adopted the term *Einfühlung* (feeling into) from aesthetics, to explain how people became aware of each other’s mental states, with an emphasis on emotional (affective) aspects of empathy (Lipps, 1903). *Einfühlung*, according to Lipps, was a process of imitation, or inner resonance,

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with the other person, an “emotional contagion” (Lipps, 1903). In 1909, Edward Tichener (1867-1927) used the Greek word *empathia* to translate *Einfühlung* and was first to introduce the term ‘empathy’ (Tichner, 1909).

From the outset empathy was seen as essentially involving emotions. However, early in the twentieth century the concept of empathy became associated with the concept of understanding, “*verstehen*”, in phenomenological philosophy. Phenomenologists such as Husserl (1859-1938), Stein (1891-1942) and Scheler (1874-1928) were concerned with the vexed question of intersubjectivity, the problem of other minds (Coplan and Goldie, 2011). For Husserl empathy was a unique mode of consciousness through which others’ thoughts, emotions and desires were directly experienced, enabling others to be experienced as ‘minded’ (Husserl, 1989, Stein, 1989). Husserl described empathy as an understanding of the meaning of the other person’s shared humanity (Hooker, 2015).

Stein further developed the concept of empathy by postulating that it not only enabled us to understand others, but also to understand ourselves as others experience us, adding a relational dimension to empathy (Stein, 1989). Stein described empathy as ‘happening’ to us, somewhat like falling in love, i.e., a process that could not be forced (Davis, 1990). She outlined a process of empathy in three stages: seeing the world from the other person’s point of view, a sudden ‘crossing over’ involving an emotional shift with deep understanding, and finally, regaining the self-other boundary (Stein, 1989, Davis, 1990).

From a clinical perspective, Carl Rogers (1899-1959), a founder of humanistic psychology, placed empathy at the heart of his patient-centred psychotherapy. (Rogers 1961). Rogers claimed that empathy occurred when the therapist viewed patients with an “unconditional positive regard” (Rogers, 1959) He proposed that when we empathise, we enter the world of the other and become at home in it, thus stressing the relational nature of empathy (Rogers 1961). He pointed out the risk of over-identifying with the patient, maintaining that this

could distort understanding and threaten the therapeutic process. He further argued that an empathetic encounter depended upon maintaining a 'self-other' distinction (Rogers 1961). I attempted to use this approach when interviewing the students in this research.

Kohut (1913-81) supported Rogers' views, suggesting that the mere presence of empathy possessed a beneficial effect in clinical settings (Kohut 1977, Kohut, 1984). Kohut, like Rogers, highlighted the risks of over-identifying with the patient, but also of the therapist projecting their own concerns on to the patient (Kohut, 1984).

Martin Buber (1878-1965) was also influential in promoting the affective elements of empathy in his description of an 'I/Thou relationship', rather than the objective 'I/It' in a process he called "dialogue" (Buber, 2004) In the process of "dialogue" one person becomes closely connected to the other in a moment of shared meaning (Buber, 1961). Rogers claimed that "dialogue" was the same as empathy, but Buber disagreed, pointing out that the moment of "crossing- over", as described by Stein, was a spontaneous event which could not be contrived (Rogers 1961, Buber, 1961, Stein, 1989).

Schutz (1899-1959) expanded the concept of empathy by focusing attention on the shared context where two subjects interact and affect each other in a face-to-face encounter, creating a 'we-relationship' (Schutz, 1967). Linking the context of the clinical encounter to an interpersonal view of empathy was relevant to my research which explored the students' experience in the context of the medical school.

There has also been a philosophical debate about interpersonal understanding in the "theory-of-mind" framework. This term is used to describe the ability to attribute mental states to ourselves and others, to interpret and explain behaviour in terms of mental states (Frith and Frith, 1999, Zahavi, 2010). The debate centres on two views; on one side the theory-theory of mind, and on the other, the simulation theory of mind (Zahavi, 2010). The theory-theory argues

that understanding of others involves a detached intellectual process, as in cognitive empathy, whereas the simulation theory maintains that we use our minds to “step into the shoes” of the other person and share their feelings, as demonstrated in affective empathy (Völlm et al., 2006). These early, relational, affective views of empathy may be contrasted with the way in which empathy is now generally viewed in a medical context.

2.4.1.2 Medical Empathy

Empathy has largely been conceptualised in the medical education literature as an innate, personal attribute, subject to measurement (Baron-Cohen, 2011, Hojat et al., 2009, Hojat, 2016). Less commonly, it has been described as a dynamic reciprocal process (Irving and Dickson, 2004). In contrast to the early phenomenological approaches which emphasise the emotional, relational and contextual nature of empathy, medical practice has largely adopted a cognitive view of empathy. Hojat et al. (2009) defined empathy in purely cognitive terms,

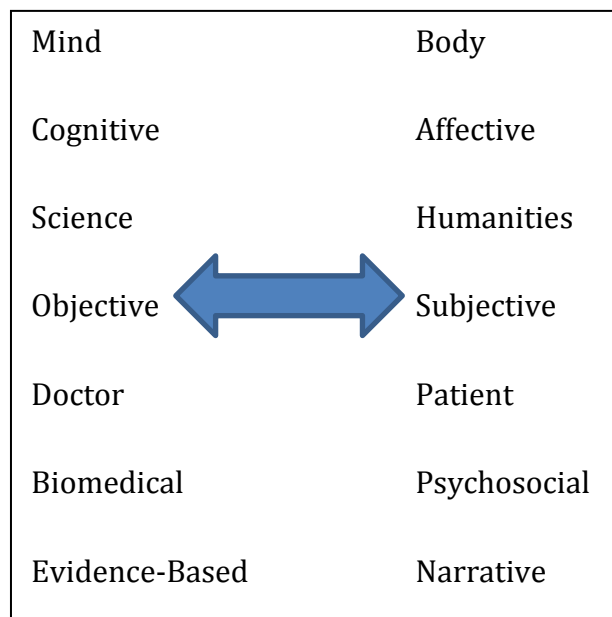
“Empathy is a predominantly cognitive (rather than emotional) attribute that involves an understanding (rather than feeling) of experiences, concerns and perspectives of the patient, combined with a capacity to communicate this understanding. An intention to help by preventing and alleviating pain and suffering is an additional feature of empathy in the context of patient care” (Hojat et al., 2009, p.1183)

I would suggest that this view, which excludes emotions, perpetuates a form of medical professionalism which has been described as ‘detached concern’ (Fox R and Lief H, 1963, Halpern, 2001, Kelly 2017). Hojat (2016), in his recent book, defends a cognitive definition of empathy by proposing that it helped to differentiate empathy from sympathy.

Empathy is often conceptualised in the literature in terms of polarities (Hojat, 2016). Montgomery explained that medicine is often depicted in the literature and in our society, as a science, separate from and opposite to emotional care. Taking this view may require a student to adopt one polarity or another

(Montgomery, 2006, Hooker, 2015). The various polarities discussed in the literature in relation to empathy are summarised in Figure 1.

Figure 1 Polarities and Empathy



Maxwell (2008), suggested it was unhelpful to view cognitive and affective empathy as polarities. He argued that the emotional aspect of empathy inevitably contained a cognitive element, as it involved an intentional sharing of emotions and was not simply a reactive distress. Maxwell (2008) suggested that the contrast between affective and cognitive concepts of empathy should not create opposing views but rather reflect which dimension of clinical empathy predominated in any interaction. I support this argument that these polarities need to be brought together to achieve appropriate empathetic care (Hooker, 2015).

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Hojat (2016), in advocating a cognitive view of empathy, claimed that by limiting empathy to its cognitive form enabled the construct to be studied and measured scientifically.

“we cannot scientifically study empathy in patient care unless an agreement exists concerning its definition and unless a psychometrically sound instrument is available to measure the defined concept” (Hojat, 2016,p.72)

Cognitive empathy is thus viewed as the ability of one individual to understand the experiences of another without evoking a personal emotional response (Neumann et al., 2012). A cognitive approach to empathy attempts to safeguard the objectivity and neutrality of scientific medical knowledge by depicting healthcare professionals’ emotions as an undesirable bias, requiring cognitive control (Hojat, 2016, Hooker, 2015, Pedersen, 2009). I would suggest that this position is counter-intuitive. One might imagine that it would be natural for doctors to adopt a form of empathy which included emotions, since much of medicine is concerned with the relief of suffering (Jeffrey, 2016a). Exploring the tension between cognitive and emotional empathy is at the heart of my research. I sought to explore whether a cognitive view of empathy continues to predominate in medical undergraduate education.

In contrast to the cognitive view, some authors have adopted a broader perspective, by including a number of diverse processes that are labelled as “empathy” (Batson, 2011, Irving and Dickson, 2004, Derksen et al., 2013). For example, from a nursing perspective ,Morse et al. (1992) divided the components of empathy into four dimensions:

- affective (the ability to subjectively experience and share in another’s psychological state or feelings)
- cognitive (the ability to identify and understand another person’s feelings and perspective from an objective stance)
- moral (an internal altruistic motivation)

- behavioural (communicating the response to convey understanding of another's perspective) (Morse et al., 1992)

These perspectives were further developed by Coplan and Goldie (2011), who viewed empathy as a unique kind of understanding through which we experienced what it was like to be another person, including their emotions, whilst maintaining a clear self-other differentiation. Empathy involved using one's imagination, which could be 'self' or 'other' orientated (Coplan and Goldie, 2011).

In taking a self-orientated perspective, I imagine what it is like for me to be in your situation, a form of identification (Bondi, 2014). Doctors who take a self-orientated perspective are at risk not only of personal distress, but compassion fatigue and eventually burnout (Kearney MK et al., 2009). In contrast, taking an other-orientated perspective, as in empathy, involves imagining undergoing the patient's experience (Halpern, 2001). This more sophisticated approach requires mental flexibility and an ability to regulate one's emotions. Bondi (2003), emphasised the importance of maintaining a self-other boundary, in a process of switching between observation and participation. Taking an other-orientated perspective prevents the doctor from losing sight of the patient as another person, despite having a deep engagement with them (Rogers 1961, Coplan and Goldie, 2011).

Broad definitions of empathy propose that the doctor has to try to understand the patient's world, share their feelings and communicate this understanding to them (Irving and Dickson, 2004, Derksen et al., 2013). Some authors have extended the broad view of empathy to include taking action to help the patient (Decety J, 2011). Mercer and Reynolds (2002) proposed such an expanded view of relational empathy, suggesting that empathy includes the ability to:

- (a) understand the patient's situation, perspective and feelings (and their attached meanings)
- (b) communicate that understanding and check its accuracy

(c) act on that understanding with the patient in a helpful (therapeutic) way (Mercer and Reynolds, 2002).

However Mercer and Reynolds (2002) did not clarify the extent of emotional sharing between the student and the patient. Questions arise: does the student share the feelings of the patient, merely identify them, understand them, or even ignore them? Halpern argued that a crucial part of empathy was to recognise what it feels like to experience something rather than merely labelling an emotional state (Halpern, 2003). My research sought to understand how the students viewed these questions.

In the 1980s second-wave feminist 'care ethics', added a moral dimension to empathy, maintaining that moral thought and action required both reason and emotion in attempting to understand the situation from another person's point of view (Gilligan, 1982, Noddings N, 1984, Slote, 2007). From this perspective, to care for another involved 'feeling with' the other person, which resonated with the concept of *Einfühlung*, and a relational view of empathy (Lipps, 1903, Stein, 1989). I sought to differentiate between relational empathy and detached concern by exploring which stance the students advocated as being most appropriate for effective care.

Viewing empathy as a relational process is less common in the medical education literature (Evans, 2012, Gerdes, 2011, Halpern, 2014). I suggest that taking a relational approach switches the focus of interest from the student's attributes to an exploration of the interaction between the student and patient. In this interaction, context becomes of particular significance. As Halpern (2014) suggested, there may be different empathies for specific clinical situations, depending upon the individual patient. She advocated that the student adopted a stance of 'engaged curiosity' in which understanding the patient's individual perspective was combined with emotionally engaged communication (Halpern, 2014).

2.4.1.3 Process of empathising

Batson (2011), captured the complexity of empathy by identifying eight related but distinct phenomena which are described as ‘empathies’ in the literature. He described the following eight ‘empathies’ before discussing the actual process of empathising with another person:

1. Knowing another person’s internal state, including thoughts and feelings : sometimes described as cognitive empathy (Wispé, 1986)
2. Adopting the posture of an observed other: motor mimicry (Lipps, 1903)
3. Coming to feel as another person feels: affective empathy, emotional contagion or sympathy (Hoffman 2000)
4. Projecting oneself into another’s situation: an aesthetic projection described as *Einfühlung* (Lipps, 1903)
5. Imagining how another is thinking or feeling: other-orientated perspective-taking (Batson et al., 1991)
6. Imagining how one would think and feel in the other’s place: self-orientated perspective taking (Batson et al., 1997)
7. Feeling distress at witnessing another’s suffering, personal distress (Batson and Shaw, 1991)
8. Feeling for another person who is suffering, empathic concern (Batson, 2011)

Batson’s eight phenomena, each a form of empathy, provide a helpful basis for investigating the process of empathising (Batson, 2011). The first six concepts are related to the question of how we know another person’s thoughts. The last two concepts, (concepts 7 and 8), are reactions to this knowledge, reflecting a caring response to suffering. It is not only other-orientated feelings (concept 8) which are a source of a caring response. A sensitive response may result from feeling as the other (concept 3), combined with an other-orientated perspective (concept 5) (Batson, 2011).

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Batson's model is helpful in distinguishing appropriate empathetic concern (concept 8) from harmful personal distress (concept 7) (Batson, 2011). I would suggest that empathetic concern is needed in clinical care and does not lead to burnout, whereas personal distress may result in distancing from the patient (Batson and Shaw, 1991). Batson (2011), claimed that taking a self-orientated perspective risked causing personal distress. In contrast, taking an other-orientated perspective was necessary for appropriate empathetic concern.

In the literature empathy is often conflated with compassion, sympathy and other pro-social behaviours, which further contributed to the difficulty in defining the construct.

2.4.1.4 Sympathy, Compassion and other Prosocial Behaviours

To establish the focus on empathy in my thesis, I briefly reviewed some of the main constructs which overlap with empathy in the literature (Jeffrey, 2016c).

Sympathy has been defined as experiencing another's emotions, as opposed to imagining those emotions and as a concern for the welfare of others (Stepien and Baernstein, 2006, Decety et al., 2010). Some authors argue that sympathy is a wholly distinct concept from empathy (Mercer and Reynolds, 2002, Hojat, 2016). However, I agree with those who argue that sympathy overlaps with the emotional component of empathy (Halpern, 2001). Although sympathy is related to affective elements of empathy, it differs in that it does not take an "other-orientated" perspective. Sympathy takes a "self-orientated" perspective, with identification with the other, which puts the listener at risk of personal distress (Batson, 2011).

Compassion shares many features of empathy and has been described as "a feeling of deep sympathy and sorrow for another who is stricken by suffering or misfortune, accompanied by a strong desire to alleviate the pain or remove its

cause” (Von Dietze E and A., 2000). Since empathy is often confused with compassion in the medical literature, Maxwell (2008), suggested using the term ‘compassionate empathy’ to capture the imaginative connotations of empathy and a feeling of distress in solidarity with the patient. Compassion, in its drive to alleviate suffering, also shares elements of altruism, although in many definitions of compassion a cognitive dimension is missing (Von Dietze E and A., 2000). Confusing the definitions of empathy and compassion is unhelpful to medical research and practice, and highlights the need for a common nomenclature (Howick and Rees, 2017, Riess, 2015).

Altruism is a motivation that is other-directed and manifested as an action (Burks and Kobus, 2012). Altruistic behaviours are often described as ‘going the extra mile’ (Stocks et al., 2009). Batson proposes an altruism-empathy hypothesis suggesting that empathy often evokes altruistic behaviour (Batson et al., 1991).

Emotional Intelligence, is a concept which comprises: self-awareness, managing emotions appropriately, motivating oneself, recognising emotions in others (a form of empathy), and handling relationships. Emotional intelligence therefore includes empathy but also embodies other psychological and behavioural concepts (Goleman, 1996).

Kindness may also involve empathy, but in modern life there has been a tendency to disparage kindness as being hopelessly idealistic and ineffectual (Philips and Taylor, 2009). However others have argued that kindness in a medical setting is no soft option, but inspires doctors to build relationships with patients and to treat them well (Ballatt and Campling 2011, Jeffrey, 2016b).

Generosity, a willingness to give of oneself, is also related to empathy and may be manifest in several ways in clinical practice; openness to others, providing comfort and a commitment to not abandoning the patient (Frank, 2004).

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Resilience has been described as a dynamic capability which may include empathy and which allows people to thrive on challenges (Howe et al., 2012). Resilience includes capabilities such as self-control, a willingness to engage support and persistence. It has been described as a key attribute in preventing burnout (Howe et al., 2012).

I would suggest that a broad view of the term 'empathy' is better suited than 'compassion' for medical education, research and practice. It has been researched in greater depth in the medical education literature and because empathy retains a cognitive component which compassion may lack (Jeffrey, 2016c).

The literature review has revealed the complexity of empathy and has established the need to explore how the medical students in my research viewed empathy.

2.4.1.5 The Necessity for Empathy in Clinical Practice

At the heart of my thesis was the assertion that empathy was of fundamental importance in the patient-doctor relationship and in patient care. Although empathy is valued as a general moral disposition in society this research examined empathy in a medical education context (Decety J, 2011, Krznaric, 2014). Pedersen emphasised the centrality of empathy to patient care ;

“Empathic understanding is needed not only to understand the patient’s illness or emotional reactions but also to understand adequately what is at stake for the patient and to diagnose and treat the patient adequately, to avoid acting against the patient’s will, and to throw into relief the patient’s and the physician’s horizon. Furthermore, keeping empathic understanding separate from the natural scientific aspects of medicine helps to sustain a stubborn misconception; that is, empathic understanding is radically different from other aspects of clinical understanding” (Pedersen, 2010,p.597).

There are many factors which contribute to the patient's clinical outcome, making it difficult to identify the impact of empathy. Historically, the patient-doctor relationship has been regarded as having important therapeutic effects (Balint, 1957, Di Blasi et al., 2001). A recent systematic review confirmed that the quality of the patient-doctor relationship had a small but significant effect on patient health outcomes (Kelley et al., 2014). Patients have described how much they desired empathetic care (Broyard, 1992, Little et al., 2001, Coulter, 2002, Wensing et al., 1998, Derksen et al., 2013).

Some research suggested that empathy could improve health outcomes, for example in certain patients with diabetes, pain and even the common cold (Hojat et al., 2011, Del Canale et al., 2012, Rakel et al., 2009, Neumann et al., 2007, Price et al., 2006). Perhaps the best understood process by which empathy improves health outcomes lies in the patient's perception of the doctor's concern and trust (Halpern, 2012, Ballatt and Campling 2011). The General Medical Council (GMC), emphasises the importance of trust and describes compassion as a professional skill that makes a good doctor (General Medical Council, 2015, General Medical Council, 2009, General Medical Council, 2013). In a trusting empathetic relationship patients may disclose more of their symptoms and concerns, leading to a more accurate diagnosis and to patients feeling involved in their care (Roter et al., 1998, Maguire et al., 1996, Coulehan et al., 2001, Derksen et al., 2013, Kim et al., 2004). Empathetic doctors who are trusted by patients can provide comfort, hope and a sense of control to patients, however serious their disease (Montgomery, 2006). Maxwell (2008), suggested that empathy could be seen as a core moral attribute. Hilfiker (2001), proposed that a fundamental goal of teaching ethics in medicine should be to foster empathy. Empathy broadly conceptualised becomes a way of seeing the world from the point of view of the patient, enabling students and doctors to perceive moral dimensions to clinical problems that they might otherwise ignore (Maxwell, 2008).

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There was some evidence that empathetic care resulted in less emotional distress, not only for patients, but also for doctors (Kearney MK et al., 2009, Jackson et al., 2008, Neumann et al., 2007, Hegazi and Wilson, 2013, Larson and Yao, 2005, Gleichgerrcht and Decety, 2014). Jackson et al. (2008), in a qualitative study of oncologists' involvement in end-of-life care, showed that doctors who were connected to patients felt more fulfilled and had less burnout than colleagues who used distancing tactics.

I argue that empathy is an integral part of effective medical practice, but, some authors have expressed a different view. Macnaughton (2009), described empathy as 'dangerous' and warned of "the way in which medicine can highjack complex ideas, confining them and defining them in its own terms and changing their meaning and impact". She favoured a cognitive model of empathy arguing that in clinical practice, "one person meets the other not as a fellow being but as a type of a person: as 'doctor or patient' (Macnaughton, 2009). I take a different view, arguing that empathy is a mechanism for ensuring that a student or doctor regards the patient as a fellow human being, and not solely as an object of clinical interest. Macnaughton developed her argument by claiming that a full experience of mutuality or understanding of another person was not possible (Macnaughton, 2009). The counter-argument from Halpern was that although a full understanding of another person may not be possible, this did not mean that people should be treated simply according to their role as patients in the clinical encounter (Halpern, 2001). Halpern (2001), maintained that it was possible, through adopting a broad open approach to empathy, to gain a better understanding of the patient's perspective.

Bloom (2016), in his book *'Against Empathy'*, defined empathy in purely affective terms, then asserted that this narrowly-defined empathy created a bias against patients. Instead, he proposed a form of 'rational compassion', which seemed similar to the broad form of empathy for which I have argued in this thesis. Critics of empathy tend to equate it with identification, but empathy, unlike identification, crucially retains a sense of a psychological boundary

between the self and the other (Macnaughton, 2009, Bondi, 2003, Watson and Greenburg, 2011). The nature of the self-other boundary is explored in depth with the students, since it is integral to the process of empathising.

Smajdor et al. (2011), argued that emotional connection with the patient was unnecessary, suggesting that politeness was sufficient to meet the patient's needs. They justified this surprising claim by suggesting that objectivity protected the doctor and that distancing from the patient was therefore essential in medical practice (Smajdor et al., 2011). However, rather than enforcing a choice between objectivity or connection with a patient, the authors conceded that they might co-exist by a switching between modes depending on the clinical context; a position I have explored in my thesis.

As Macnaughton suggested, there are limits to empathy, to understand others there is a need to consider a wider social and cultural context than can be supplied by empathy alone (Macnaughton, 2009, Stueber, 2006). Halpern proposed that doctors needed to approach this dilemma by being genuinely curious to learn more of the patient's experience (Halpern, 2001). She argued that clinical curiosity can help to prevent doctors from being naively sympathetic or projecting their own concerns on the patient. I support this view of empathy as a form of engaged curiosity which goes beyond surface emotions and seeks to understand the patient's experience, by adopting a phenomenological approach (Halpern, 2014, Vagle, 2016).

While Reiss acknowledged the benefits of empathy in clinical practice both to patients and doctors, she questioned whether empathy must entail an emotional cost to healthcare professionals (Reiss, 2015). However, I concur with Batson in suggesting that empathy, can be demonstrated as appropriate empathetic concern which need not necessarily include personal distress (Batson, 2011). The context of the encounter may also contribute to emotional overload rather than fostering empathetic concern; for instance , if time is short or the workload excessive, emotional distress may follow (Gleichgerrcht and

Decety, 2013). Empathy in clinical practice has been described as “emotional labour”, which requires both effort and a conducive environment to achieve the best result (Riess, 2015, Larson and Yao, 2005).

I have argued that it is necessary to explore empathy from the students’ perspective. However, research to date has been largely concerned with quantitative studies to measure medical students’ empathy.

2.4.2 Theme 2: Measuring medical students’ empathy

In contrast to the phenomenological approach adopted in my thesis, the majority of studies of empathy in medical students have used a quantitative methodology. By conceptualising empathy as a personal attribute they disregard relational and contextual aspects of empathy. Since I have argued that a qualitative approach is needed to understand the development of medical students’ empathy, it is relevant to examine some of the claims and limitations of the numerous quantitative studies. I would suggest that, rather than merely complementing the quantitative studies, my qualitative research offers a dynamic new approach to understanding the phenomenon of empathy.

Three systematic reviews have reported instruments available to measure empathy and presented evidence for their reliability and validity (Hemmerdinger et al., 2007, Pedersen, 2009, Sulzer et al., 2016).

Hemmerdinger et al. (2007), found 50 relevant papers describing 36 different instruments of empathy measurement, however, only eight demonstrated evidence of reliability and validity. Only one, the Consultation and Relational Empathy (CARE) scale was considered a useful measure of empathy from the patient’s perspective. It has been used as a tool for assessing the patient’s perception of empathy in primary care (Hemmerdinger et al., 2007, Mercer et al., 2004, Mercer et al., 2005, Price et al., 2006). Although the inclusion of the patient’s voice in an assessment of empathy is to be welcomed, the CARE measure is founded on a presumption of empathy as a property of the doctor alone. There is no acknowledgment that a consultation with low empathy rating

might be due to the fact that the patient was withdrawn or the context challenging (Alnoman, 2014, Howick et al., 2017).

In Pedersen's extensive review of 206 publications of empathy research in medicine, 171 related to quantitative methods and only 33 explored empathy through qualitative methods (Pedersen, 2009). He concluded that since self-reports may not correspond with empathy in practice, it should not be studied solely through quantitative approaches (Pedersen, 2009).

In a recent systematic review of 109 quantitative studies, Sulzer et al. (2016), found that 20% of studies failed to define empathy, and only 13% used the definition they provided in the study. The authors concluded that there was a need for greater understanding of the mechanisms that shape empathy (Sulzer et al., 2016).

2.4.2.1 The Jefferson Scale of Physician Empathy

Empathy has been most frequently studied in medical practice through the Jefferson Scale of Physician Empathy (JSPE), and the Jefferson Scale of Empathy - Student Version (JSE-S). These scales explore attitudes of medical students or doctors, using a self-assessment questionnaire, outside the clinical setting (Hojat et al., 2001). The questionnaire consists of twenty items on a seven point Likert scale. The JSPE originally, was not intended to explore the philosophical dimensions of empathy, nor the processes of empathising, but was intended as an approximate indicator of empathy (Hojat et al., 2001).

There are a number of limitations in studying empathy by this method. Measurement of empathy by self-assessment can generate inconsistencies due to a social desirability bias which might exist in medical students who wish to appear to be caring (Austin et al., 2007, Glaser et al., 2007). Although some correlations between self-reported and observed empathy have been shown, there have been conflicting results in using differing methods of assessing empathy. For example, a study showed self-assessed empathy, measured by the

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JSPE, decreased during the second and third years of the undergraduate course, whereas observed empathy during an Objective Structured Clinical Examination (OSCE) increased during the same period (Chen et al., 2010). Berg et al. (2011), found that there was no conclusive association between empathy score measured by the JSPE and simulated patients' evaluations. However it is possible that students may act differently in a simulated context or that simulated patients may give higher ratings to students who can 'play the game' in a high stakes examination setting (Berg et al., 2011). It may be that a person's beliefs in the importance of empathy are reflected in their practice. The reported decline in student empathy occurred at the same stage in the students education, when they entered the clinical years (Hojat et al., 2009).

The JSPE is based on an assumption that cognition is of a higher order than emotional aspects of care thus ignoring the social and cultural research showing the interconnection between cognition and emotion (Hooker, 2015, Kozlowski et al., 2017). Most of the JSPE questionnaire items surveyed students' attitudes towards empathy and related phenomena rather than empathy in practice. Furthermore the JSPE did not distinguish between empathy, compassion, active listening or other forms of engaged clinical care. Hooker (2015), argued that the JPSE tells us little that is meaningful about empathy but more about how the medical profession perpetuates myths about an emotionally invulnerable doctor (Hooker, 2015). Other authors have concluded that the self-reported instruments used to record empathy may not be measuring anything meaningful (Sulzer et al., 2016, Pedersen, 2009, Roff, 2015). I concur with their view and would suggest that the JSPE questionnaire, with its emphasis on cognitive aspects, is of little relevance to the clinical context. Indeed, I suggest most of the quantitative measures can be similarly critiqued. One may legitimately ask: "what exactly is the JPSE measuring? Is it a level, trait, capacity, resonance, skill or attitude?" (Hooker, 2015).

The literature review strengthened my argument that phenomenological qualitative research was needed to increase our understanding of empathy and

its influences in medical students (Roff, 2015, Quince et al., 2016a, Sulzer et al., 2016). I have suggested that quantitative methodologies oversimplify the nuanced contextual aspects of empathy. However, it seemed that a large number of quantitative studies demonstrated a decline in empathy in medical students (Neumann et al., 2011, Hojat, 2016, Pedersen, 2010). I explored the evidence for and against the suggested decline in medical students' empathy during their training.

2.4.2.2 The conflicting evidence for an empathy decline

An early quantitative study, using the Jefferson Scale of Physician Empathy (JSPE), concluded that empathy declined in medical school (Hojat et al., 2004). This led to a concern reflected in journal article titles such as, "Is there a hardening of the heart in medical school?", and an editorial entitled, "Decline in empathy in medical education; how can we stop the rot?" (Newton et al., 2008, Spencer, 2004).

In a longitudinal study in the USA, 456 JSPE self-assessments were completed five times over the duration of the course with the authors finding that there was a decline in empathy scores at end of third year, which continued to graduation (Hojat et al., 2009).

Research in other countries also reported a decline in medical students' empathy during their training (Newton et al., 2008, Chen et al., 2007, Kliszcz et al., 1998, Lim et al., 2013, Shashikumar et al., 2014, Shariat and Habibi, 2013, Austin et al., 2007, Youssef et al., 2014, Thomas et al., 2007, DiLalla et al., 2004, Stratton et al., 2008). Additionally, two systematic reviews of empathy in medical students concluded that empathy declined (Pedersen, 2010, Neumann et al., 2011). Konrath et al. (2010), surveyed American college students, concluding that an empathy decline had become a social phenomenon in young Americans.

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In a review of studies reporting an empathy decline in medical students, Neumann identified a number of methodological problems including; low response rates, few longitudinal studies and a lack of information on gender and speciality (Neumann et al., 2011). Furthermore few of these studies gave details of the medical curriculum or the context of the research (Quince et al., 2016a, Quince et al., 2016b).

Roff (2015), however, disputed the reported decline in empathy. She pointed out that the evidence of an empathy decline in medical students was mainly based on research in the United States (Roff, 2015). Roff (2015), reviewed studies from a dozen countries outside the USA, which in contrast, showed a trend towards an increase rather than a decline in empathy, with the exception of studies by Shashikumar et al. (2014), from India, and Shariat and Habibi (2013), from Iran. A number of quantitative studies have reported either no change, or an increase in empathy in medical students during their training (Hong et al., 2012, Mahoney et al., 2016, Magalhaes et al., 2011, Tavakol et al., 2011, Rahimi-Madiseh et al., 2010, Mostafa et al., 2014, Bratek et al., 2015, Kataoka et al., 2009, Roh et al., 2010, Costa et al., 2013). A scoping review of 209 international quantitative studies concluded that there was no generalised international trend in changes in student empathy throughout medical school (Ferreira-Valente et al., 2016).

Colliver et al. (2010), in their review of eleven studies, questioned the reported decline in medical students' empathy. They re-examined the results by transforming them back to their original rating scales and then examined the relationship between the empathy ratings and response rates (Colliver et al., 2010). They discovered that there was only a very small decline in mean ratings which, due to the low and varying response rates, was of doubtful significance (Colliver et al., 2010).

In the UK, Quince et al. (2011) carried out a longitudinal study of Cambridge medical students between 2007 and 2010, using a self-reported annual

questionnaire which distinguished between affective and cognitive empathy (Quince et al., 2011). They found that neither men nor women appear to become less empathetic during medical education at Cambridge (Quince et al., 2011). Quince et al. (2016b) followed this study with a multi-centre, (15 UK and 2 international medical schools), cross-sectional comparison of students at the start of their course and as they approached the end of their training, using an online questionnaire survey. The authors concluded that there was no evidence of an empathy decline but that questions remained concerning the trajectory of changes in empathy during medical student training (Quince et al., 2016b). This was supported by an Australian study that concluded ;

“ a more sophisticated understanding of empathy in medical students is needed, with attention to issues that might adversely impact on this crucial aspect of their development.” (Mahoney et al., 2016,p.270)

My research is focused on addressing this gap in our understanding. My review next provides an overview of the qualitative research on medical students' empathy.

2.4.3 Theme 3: Influencing empathy: Qualitative studies

In this section I described the varied qualitative approaches to understanding the factors influencing medical students' empathy. The relatively few qualitative studies of medical students' empathy adopted differing conceptualisations of empathy and used cross-sectional approaches in differing contexts. They also had varied theoretical backgrounds, which were often not specified, and employed different methods of data collection (Batt-Rawden et al., 2013, Pedersen, 2009). The challenge for my literature review was to compare and to collate the findings of these studies. I began my review by discussing the themes (or factors) identified in a synthesis of eight qualitative studies of empathy using one-to-one interviews with medical students (Jeffrey, 2016d) (Appendix 1) In my qualitative synthesis, only one cross-sectional study adopted a phenomenological approach (Tavakol et al., 2012). I did not identify any longitudinal phenomenological studies of empathy in medical students in my

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literature search. I have expanded each theme identified in my synthesis by relating it to the wider literature: moving from the particular to the general.

My aim was to provide the reader with a background understanding which developed as the findings emerged from the students' interviews. Qualitative synthesis is a creative process and my interpretive phenomenological 'lens' influenced the collection, interpretation and understanding of the literature (Ring et al., 2011).

The following themes were identified in my synthesis and were expanded with reference to the wider literature (Jeffrey, 2016d): conceptual confusion, medical school culture, habitus, hidden curriculum, transitions, professional socialisation, developments in medical undergraduate education, biomedical emphasis, role models, patient contact, balancing connection and detachment, professionalism as detached concern, stress and support

2.4.3.1 Conceptual confusion

The synthesis revealed that students did not share a common understanding of empathy. In a Scandinavian study, it was reported that students viewed empathy as predominantly a cognitive construct which did not involve sharing feelings with a patient (Eikeland et al., 2014). In contrast, in another study, students suggested that empathy did involve connecting emotionally with the patient (Ratanawongsa et al., 2005). Students' views of empathy varied, some maintained that felt emotions would help them to be more effective doctors, while others defined empathy by contrasting it with sympathy. Empathy seen by some as a virtue, pointing to a need for humility and kindness in medical care (Eikeland et al., 2014, Ratanawongsa et al., 2005, Tavakol et al., 2012, Nogueira-Martins et al., 2006). The findings from these studies confirmed that there was a conceptual confusion surrounding empathy and endorsed the need for my research to clarify how the students viewed empathy.

2.4.3.2 The medical school culture

In adopting a phenomenological stance, I needed to consider the context when exploring the students' experience, their lifeworld (Husserl, 2012). The students' experience of their learning environment may be described as the culture of the medical school (Genn, 2001a). To understand the medical school culture I needed to assimilate the school's overall atmosphere, the behaviours that were encouraged and the style of life that was visibly expressed and felt by the students (Genn, 2001b).

The synthesis revealed that students perceived that they occupied a low position in the hierarchy of the medical school and experienced a pressure to compete (Lempp and Seale, 2004, Ratanawongsa et al., 2005). They described situations where showing feelings was discouraged by senior doctors, with the result that students became reluctant to show emotions (Eikeland et al., 2014). Instead, students linked their need to be professional with detachment from patients (Tavakol et al., 2012). The context of their clinical work also affected their ability to be empathetic, particularly when they were busy or lacked privacy (Tavakol et al., 2012). Lack of time was commonly cited as a challenge for establishing empathy with patients (Ratanawongsa et al., 2005, Tavakol et al., 2012, Eikeland et al., 2014). It was clear from these eight studies that exploring the medical school culture was a priority for my research.

Allen et al. (2008), undertook a qualitative study exploring the culture of the medical school and recruited 19 second-year medical students to keep weekly journal entries during the first five months of their medical apprenticeship. The themes that emerged from their reflections included; a competing discourse between empathy and efficiency, the objectification of patients, the power of the medical hierarchy and the institutionalized practice of "wounding" (Allen et al., 2008). The latter referred to routine practices where the patient was subjected to indignity or harm in the process of the students' learning (Allen et al., 2008).

2.4.3.3 The medical “Habitus”

The wider literature provided further insights into the medical school culture and its effects on students’ empathy. Sinclair (1997) considered the medical culture as the medical “habitus”. The “habitus” is the collectively created but individually expressed outlook and actions of students and doctors (Sinclair, 1997). This approach to understanding the constitution of students draws on Bourdieu’s concept of embodied dispositions and with it the production of a ritualised body, with a sense of mastery (Bourdieu, 1977). Bourdieu proposed that culture and individual psychology meet in the “habitus”, in which there is an individual cultural predisposition to perceive or know or act (Bourdieu, 1990). The “habitus” informs the individual’s learned but unreflective practices which are not only shaped by the culture but shape and perpetuate it (Bourdieu, 1990, Montgomery, 2006). My phenomenological research explored the students’ views and experiences within the “habitus” of the medical school.

2.4.3.4 Hidden curriculum

Hafferty (1998), took a more pragmatic approach in describing three parts of the learning environment: the formal curriculum, (which is stated and formally intended), the informal curriculum, (which is *ad hoc* interpersonal teaching between faculty and students) and the hidden curriculum, (which is a set of influences that occur in organisational culture involving understandings, customs and rituals) (Lempp and Seale, 2004). One possible consequence for students of defining curricula was that a tension can arise between the learning climate in reality and the ideal climate as envisaged in documents such as *Tomorrows Doctors* (General Medical Council, 2009). Lempp and Seale (2004), in their study of the hidden curriculum, identified positive role models, haphazard teaching, hierarchy, and competition as themes determining the medical school culture. It was the hidden curriculum, overlapping with the medical school culture, which was of particular interest in my research.

2.4.3.5 Transitions

The student leaves school entering a new environment which involves changes in their status and identity. This transition may be stressful not only because the student leaves their past but also because they are moving towards a role of responsibility, power and prestige (Haas and Shaffir, 1977). In a nursing context, this process has been described as 'doctrinal conversion' (Davis, 1968). On the other hand, in a longitudinal, observational study of college students, Perry (1968) identified a different trajectory of development: of moving from a concrete external authority base where the student sees the world in terms of polarities, towards perceiving knowledge as contextual and relativistic. The student slowly develops a sense of their own responsibility for learning. Perry (1968) described these transitions as a gradual process, involving nine stages rather than an epiphany, or doctrinal conversion. I sought to understand the students' views of the development of their empathy as they progressed through the course and whether they described any decline in their empathy with patients.

2.4.3.6 Professional socialisation

Medical education is an initiation into a practice which involves the whole student, their attitudes, values, beliefs, behaviour, emotions and ideas (Montgomery, 2006, p.167). Some authors have described the process of professional socialisation as one of osmosis, a passive absorption of the culture of the medical school and a shaping of the self to gain a professional identity (Montgomery, 2006). I explored students' professional socialisation within a range of experiences. I was aware that this process was superimposed on people with established and complex identities (Cruess et al., 2014). For some students, professional socialisation might involve the adoption of a different world-view and emotional orientations, a process which Monrouxe (2010) called 'identity dissonance'.

Haas and Shaffir (1977) proposed that changes in medical students began with the admission process when applicants adapted themselves to fit the perceived

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requirements of the University. Using data from participant observation and interviews, they found that faced with inordinate demands to display competence, students reacted by distancing themselves from patients, by adopting a “cloak of competence” (Haas and Shaffir, 1977). The authors argued that the symbols of the profession also separated them from patients (Haas and Shaffir, 1977).

Observational studies of professional socialisation, most of which were conducted many years ago in the United States, described how students adopted an increasingly detached professional image as they moved through medical school (Becker et al., 1961, Merton et al., 1957, Fox, 1957). These studies demonstrated that the cultural environment of the medical school was critical to the professional socialisation of the students. They also showed that there was little attention paid to the character of the individual student (Montgomery, 2006). Montgomery has argued that a culture of objectivity and detachment, described in these early studies, can combine with a neglect of the individual student to create an ethos of self-sacrifice (Montgomery, 2006,p.167).

A qualitative study in the USA that explored medical students encounters with cadavers and with living patients, found that students learned that they should not talk about their emotions, especially not to the medical faculty (Smith III and Kleinman, 1989). The study described students neglecting emotional issues, which led to the dehumanising of patients. Students adopted strategies for coping with their emotions including: objectifying the patient, emphasizing the satisfaction from practicing ‘real medicine’ and distancing themselves emotionally from patients (Smith III and Kleinman, 1989). Gordon also argued that medical undergraduate education was a process of assimilation into a culture of objectivity which did not foster empathy with patients (Gordon, 1995).

Smith III and Kleinman (1989), showed how the scientific approach can be used as strategy to manage emotions, since the standard way of presenting a case

history encouraged the student to think impersonally (Smith III and Kleinman, 1989). Sinclair (2004) developed this view by arguing that evidence-based medicine (EBM) fostered the notion of presenting the history as a 'case', rather than as an individual patient's story (Sinclair, 2004). It appeared that there was a tension in medicine between describing the scientific clinical condition and understanding the patient's lived experience (Good and Good, 1989).

2.4.3.7 Developments in medical undergraduate education

Since these early studies there have been changes in medical undergraduate curricula, as a result of initiatives such as the GMC's publication, *Tomorrow's Doctors*, which have led to an outcome-based approach to undergraduate medical education (General Medical Council, 2009). One consequence of these changes is that the professional socialisation of medical students is now more defined (Underman and Hirshfield, 2016). There have also been demographic changes in the medical student population with more female students and a racially diverse student community (Underman and Hirshfield, 2016). These developments have occurred against a background of changes in clinical practice such as: evidence-based medicine, increasing patient consumerism and a sophisticated technology which stresses a biomedical view of medical practice (Howick and Rees, 2017, Montgomery, 2006, Underman and Hirshfield, 2016). In view of these curricular developments, there is now a need for further sociological studies to investigate professional socialisation in medical students (Underman and Hirshfield, 2016). The question arises as to whether students are still being trained to adopt 'detached concern'. My study was conducted in a UK medical school with an international reputation for scientific research. Authors have commented that in such medical schools students may struggle to maintain a humanistic perspective (Conrad, 1988, Coulehan and Williams, 2003).

2.4.3.8 Biomedical emphasis

Within the eight studies included in the qualitative synthesis, it was found that students learned that empathy was not valued as much as biomedical learning

and the technical aspects of treatment (Michalec, 2011, Tavakol et al., 2012, Eikeland et al., 2014). The students were reported to have talked about an emphasis on clinical objectivity that implied a need to be detached from patients, since emotions were perceived to threaten rationality (Ratanawongsa et al., 2005, Eikeland et al., 2014). Some students expressed negative feelings about seeking the patients' views in case this provoked their emotions (Ratanawongsa et al., 2005). They described a strong emphasis on evidence-based medicine (EBM) and their need to absorb facts (Michalec, 2011, Eikeland et al., 2014). Some were reported to have experienced a gap between theory and practice in relation to the medical school's attitude to psychosocial care, creating an uncomfortable dissonance for the students (Nogueira-Martins et al., 2006).

Medicine's identification with science appeared to offer students and doctors a way of avoiding emotions and their implicit danger of subjectivity (Montgomery, 2006). The biomedical emphasis, in excluding psychosocial elements of care, promoted objectivity and detachment from patients (Halpern, 2001, Pedersen, 2010). My study explored the students' views of this tension between the biomedical and psychosocial elements of their course.

2.4.3.9 Role models

Positive, caring role models were described by students in the synthesis as an effective way of learning to empathise with patients (Lempp and Seale, 2004, Nogueira-Martins et al., 2006, Cutler et al., 2009). Students were reported to be distressed by negative role models, doctors who appeared insensitive, and lacking an interest in patients' psychosocial concerns (Lempp and Seale, 2004, Ratanawongsa et al., 2005, Nogueira-Martins et al., 2006). Students also highlighted the stressful effect of humiliation and bullying by poor role models, that they maintained, reduced their capacity for empathy (Lempp and Seale, 2004). In the UK, an ethnography describing the clinical teaching of year 4 students in the University of Edinburgh medical school, emphasised the significant impact of positive and negative role models on students learning

(Atkinson, 1976). My research sought to explore whether role models continued to influence the students' development of empathy.

2.4.3.10 Patient contact

The students, in some of the studies in the synthesis, regretted the lack of patient contact in the early years of their course (Ratanawongsa et al., 2005, Tavakol et al., 2012, Nogueira-Martins et al., 2006). They appreciated having time with patients to establish empathy (Ratanawongsa et al., 2005, Cutler et al., 2009). In particular, they claimed that providing end-of-life care to patients was a powerful way of developing empathy (Ratanawongsa et al., 2005). Students found that consultations with difficult patients, those with mental health problems and those in situations of conflict were challenging but helped to develop their empathy (Nogueira-Martins et al., 2006, Cutler et al., 2009, Tavakol et al., 2012, Eikeland et al., 2014). Students recognised a need to be accessible to patients in order to establish empathy (Nogueira-Martins et al., 2006). They found acting as a patient's advocate was helpful, and suggested that humility was related to empathy (Griswold et al., 2007, Eikeland et al., 2014). Storytelling was described by some students as an effective way to learn about empathy, echoing Charon's ideas for developing narrative competence (Griswold et al., 2007, Charon, 2001).

In the single phenomenological study of the synthesis, it was reported that students asserted that teaching of empathy was lacking, with some describing their communication skills training as a box-ticking exercise. They also reported that it was difficult to display empathy in group situations (Tavakol et al., 2012). Other studies reported that students described their lack of life experience as hampering their ability to empathise (Ratanawongsa et al., 2005, Eikeland et al., 2014).

To explore the effect of the patient experience in empathy, Wilkes and Hoffman (2002), conducted an observational study of nine second-year medical students who were admitted to hospital on three consecutive weekends for a day

including an overnight stay. The key themes which emerged from their study were a sense of loss of privacy and observing that nurses took time to talk and listen to 'student-patients', in contrast, they experienced coldness from the doctors. The study found that the students' primary concern after their experience was to improve the human aspects of the patient experience (Wilkes et al., 2002). My research explored the extent to which the patient experience was incorporated into the medical undergraduate teaching.

2.4.3.11 Balancing connection and detachment

Some studies in the synthesis suggested that students struggled to empathise because they did not know how to regulate their emotions (Eikeland et al., 2014, Ratanawongsa et al., 2005). Many students wanted to be both competent and empathetic but were uncertain how to balance an emotional connection with the patient with detachment in their clinical decision-making (Eikeland et al., 2014). Students suggested that a little distance from the patient's emotions might be appropriate but too much might lead to apparent indifference (Ratanawongsa et al., 2005, Eikeland et al., 2014). They were concerned that detachment implied that they did not engage in a genuine dialogue with the patient (Eikeland et al., 2014).

There was little discussion in the wider medical education literature about how students might manage their emotions (Meier et al., 2001, Coulehan, 1995). Shapiro suggested that medical education promotes professional alexithymia, a term used to describe people who have difficulty recognising, processing and regulating emotions (Shapiro, 2011). One possible result of such a learning environment is that medical students may deny their emotions (Jennings, 2009).

2.4.3.12 Professionalism: detached concern

The single phenomenological study included in the synthesis established a link between professionalism and distancing from patients. It raised the possibility that rather than any decline in empathy, students coped by making a less overt

demonstration of their own feelings (Tavakol et al., 2012). Despite the GMC requiring students and doctors to be both caring and competent, it appeared that medical professionalism continued to imply emotional detachment (General Medical Council, 2013, Kerasidou and Horn, 2016, Hilton and Southgate, 2007).

Many years ago Osler claimed that by excluding emotions doctors gained a special objective insight into the patient's suffering. He implied that empathy could be achieved through detachment (Osler, 1963). One consequence of adopting 'detached concern' as a model for medical professionalism is that the emotions of a doctor or patient may be perceived as a threat to the supposed need for objectivity and a risk to patient safety (Kerasidou and Horn, 2016, Hegazi and Wilson, 2013, Coulehan, 1995). There is now an accepted view that doctors should respond to the suffering of patients with objectivity and detachment (Montgomery, 2006). However the prevailing view has been challenged in this thesis and by several authors (Halpern, 2001, Shapiro, 2011, Spiro H et al., 1993, Coulehan, 2005). Halpern described how the model of detached concern prevailed in the medical culture despite the fact that there was little evidence that establishing an emotional connection with a patient led to a negative outcome (Halpern, 2001). I concluded from this debate in the literature that detachment was not necessary for sound medical judgement because emotional insights can and should inform clinical decision-making (Coulehan, 1995, Mayer et al., 2008, Halpern, 2001, Kozlowski et al., 2017). My research explored how medical students viewed appropriate empathy in terms of detachment from, or connection with, patients.

2.4.3.13 Stress

The qualitative synthesis revealed that students responded to stress by distancing themselves from patients to avoid being overwhelmed by emotions (Cutler et al., 2009, Eikeland et al., 2014). Some students described becoming accustomed to distress and even developing indifference (Eikeland et al., 2014).

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Cynicism was perceived by some students as an acceptable means of dealing with stress, rather than a cause for concern (Eikeland et al., 2014).

Student distress may be expressed in many ways, including stress, depression, burnout and compassion fatigue (Dyrbye et al., 2005). Burnout is a progressive loss of idealism, energy and purpose experienced by people in the helping professions (Kearney MK et al., 2009). It is characterised by emotional exhaustion, cynicism, detachment and a sense of ineffectiveness (Maslach et al., 2001). Compassion fatigue is described as being emotionally exhausted due to difficult patient encounters associated with need for empathetic listening (Nielsen and Tulinus, 2009). It shares features of post- traumatic stress disorder; hyperarousal, avoidance and re-experiencing (Kearney MK et al., 2009).

Authors have argued that if students and doctors are to provide empathetic care they should optimally be in a positive frame of mind and not stressed (Shanafelt et al., 2005, Zenasni et al., 2012) However, distress is commonly reported in medical students. (Firth-Cozens, 2001) Stress may also have a negative influence on empathy if students use coping strategies such as distancing (Dyrbye et al., 2005, Neumann et al., 2011).

Student distress has been linked to factors in the hidden curriculum; abuse by superiors, vulnerability, lack of support, and high workload. (Lempp and Seale, 2004) Neumann et al. (2011), speculated about factors in the formal curriculum contributing to distress; inappropriate learning environments, negative role models and lack of continuity (Neumann et al., 2011). My research explored the students' views of the effects of stress on their empathy.

2.4.3.14 Support

Social support is essential for maintaining physical and mental health with lack of support being a risk factor for psychological illness (Cacioppo et al., 2011, Reblin and Uchino, 2008, Ozbay et al., 2007). There was little in the literature

that described empathy between the faculty and medical students (Kerasidou and Horn, 2016) Students need to develop effective mechanisms of self-care and healthy ways of relieving stress to maintain their well-being (Coulehan and Williams, 2003, Kerasidou and Horn, 2016). The final theme of my overview of the literature concerned the teaching of empathy in the medical undergraduate curriculum.

2.4.4 Theme 4: Teaching empathy

There has been a tendency in undergraduate medical education to present empathy in isolation, as something different from clinical understanding (Pedersen, 2010, Shapiro, 2008, Foster and Freeman, 2008). There is also a debate in the literature whether empathy can be taught (Davis, 1990, Shapiro, 2012, Underman and Hirshfield, 2016). In a joint paper Downie argued that empathy should not be taught, since feelings might impair sound clinical judgement. He maintained that a doctor's friendly manner was sufficient, (Jeffrey and Downie, 2016)(Appendix 1). However, I took a different view, and suggested that enhancing empathy was a high priority (Jeffrey and Downie, 2016). I have briefly reviewed a variety of approaches that have been adopted to enhance student empathy, to form a context to explore the students' learning experiences.

Stepien and Baernstein (2006), reviewed the literature describing interventions aimed to foster empathy. They identified thirteen studies which described initiatives to enhance empathy, nine reporting a quantitative increase in student empathy and six reporting a qualitative increase (two studies measured both quantitative and qualitative outcomes). They concluded that, despite methodological difficulties, educational interventions could increase medical student empathy (Stepien and Baernstein, 2006). One limitation of the studies was that they did not consider that the students' ability to empathise might be affected by the clinical context. This weakness made it difficult to extrapolate these results to empathetic behaviour at the bedside (Stepien and Baernstein, 2006). The authors suggested that future research should be directed at

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understanding the components of empathy that improve patient satisfaction, clinical outcomes and physician well-being (Stepien and Baernstein, 2006). They suggested that such understanding might allow teachers to target their interventions on specific dimensions of empathy (Stepien and Baernstein, 2006).

Batt-Rawden et al. (2013), systematically reviewed the literature, from 2004 to 2012, on educational interventions which claimed to enhance empathy. They found fifteen quantitative studies and three qualitative studies with common methodological flaws, namely: a lack of a control group, single institution studies and measurement of attitudes rather than skills (Batt-Rawden et al., 2013). Fifteen articles reported significant increases in empathy and the authors concluded that educational interventions could be effective in maintaining and enhancing empathy but were uncertain as to their long-term effects (Batt-Rawden et al., 2013). They recommended that medical educators should consider using relationship-centred care as a foundation for their interventions to teach empathy (Batt-Rawden et al., 2013). They also called for controlled longitudinal studies to research the reported decline in empathy of medical students (Batt-Rawden et al., 2013) My research addressed this call for a longitudinal qualitative study although it was not a 'controlled' study in the positivist sense. Two further comprehensive reviews of empathy development, (Pedersen, 2010, Kelm et al., 2014), also identified a number of interventions in medical education which attempted to enhance empathy in medical students including:

- patient narratives and the creative arts (Shapiro et al., 2004)
- reflective essays and point-of-view writing (Shapiro et al., 2006a)
- personal illness narratives: using reflective writing (DasGupta and Charon, 2004)
- drama (Lim et al., 2011)
- communication skills training (Shapiro et al., 2009, Bayne, 2011)
- problem-based learning (PBL) (Karaoglu and Seker, 2011)

- patient interviews (Mullen et al., 2010)

Jackson et al. (2015), adopted a different approach, rather than simply addressing interventions directed at the student, they suggested that enhancing empathetic consultations required attention both to the student and the patient. Recently there have been initiatives in the UK to enhance empathy in healthcare settings as a response to the perceived need to humanize medical care (Shea and Lionis, 2014). One example is the online Connecting, Assessing, Responding and Empowering (CARE) approach developed at the University of Glasgow to enhance empathy in primary care staff (Bikker AP et al., 2012, Fitzgerald et al., 2014). In another innovative development, The Point of Care Foundation in the UK, have adopted Schwartz Center rounds, developed in the USA, which bring together hospital staff to discuss emotional and psychological care of patients in a group setting (Goodrich, 2012). Such facilitated group sessions with medical students might have a place in medical undergraduate education.

It appeared, from this review of educational interventions, that the consensus was that empathy could be enhanced or facilitated in a number of ways but as there were no long term studies, it was not possible to see if these effects were sustained. My research explored which elements of the curriculum were perceived by the students to influence their empathy.

2.5 Summary

From a review of the literature, it appears that there is no simple satisfactory answer to the question “What is empathy?” (Maxwell, 2008). However, a cognitive concept of empathy emerged as the predominant definition in a medical setting. I argue that this narrow view ignores the broad phenomenological view of empathy as a special form of understanding (Hooker, 2015).

My review of quantitative studies challenged the accepted view that medical students’ empathy declined during their undergraduate training. Whether there is a decline in empathy in students or not, there is a recognition of a need to

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understand the students' perspectives of the influences on their empathy during their training. My argument for adopting a phenomenological approach to gain a deeper understanding of medical students' empathy is supported by a number of authors (Pedersen, 2009, Charon, 2010).

There was evidence in the literature that the established culture in medical education favoured objectivity and detachment. The biomedical emphasis in medical practice encouraged a wariness of emotions and provided little guidance for students about how to balance emotional connection and detachment. The harmful effect of stress on empathy highlighted a need to provide appropriate support for students. The themes which emerged from these papers informed my research questions and helped to identify spaces for development in our understanding. These are explored with the students in the research. I return to these themes in chapters 5-10 where the findings from the student interviews are discussed in relation to the literature.

2.6 Spaces for development and the research aims

This section links the research aims with spaces for development and the themes relating to empathy identified in the literature review. The review informs the research questions and places my research in context.

2.6.1 Nature of empathy

My first aim was to explore medical students' conceptualisation of empathy during the undergraduate curriculum. Empathy has been defined in many different ways in the literature posing problems in research, teaching and practice.

There is a need to understand how students view appropriate empathy in a clinical situation and whether this changes through their training.

2.6.2 Influences on empathy

My second research aim was to describe a range of students' experiences of influences on their empathy during their training. The literature review identified a number of themes which tended to be described in terms of polarities. The review highlighted a lack of qualitative research in this area.

There is need to develop longitudinal qualitative research to gain an understanding of the influences on medical students' empathy during their training.

2.6.3 Changes in empathy during training

My third research aim was to synthesise and interpret the findings of my study to gain an understanding of how and why medical students' empathy changes during their training. The literature review revealed a genuine uncertainty about the widely held view of a decline in students' empathy during their training.

There is a need to gain an understanding of the students' views and experiences of any changes in their empathy during their training.

2.6.4 Implications for medical education and patient care

My final research aim was to consider how the findings of the research might influence medical undergraduate training and improve patient care in the future. Some authors have called for a culture change in medical education to incorporate empathy training. There is also a debate in the literature as to whether it is even possible to teach empathy. My research sought to gain an understanding of the students' views and experiences of their teaching in empathy and their ideas about how this might be enhanced.

There is a need to explore the implications of the students' views and experiences of factors influencing empathy for the medical education community and the wider public.

2.7 Research Questions

The research questions aimed to address these spaces for development in our understanding. My thesis sought to answer the following questions:

How do students talk about and experience the concept of empathy in relation to professionalism and practice?

What factors do medical students describe as influencing their empathy during their undergraduate medical training?

How do medical students' views and experiences of empathy change during their medical education?

Chapter 3: Theoretical Framework: Methodology

3.1 Overview

This chapter outlines the theoretical framework underpinning the research. I argue for an appropriate methodology to address my research aims. The theoretical framework, comprises: ontology, epistemology, theoretical (philosophical) perspective and methodology. This framework establishes a philosophical context for the study and the criteria by which the quality of the research may be judged. I explain the terms and the philosophical approaches which I adopt to answer my research questions. My methodology explores the reasons for choosing qualitative longitudinal and phenomenological interpretative approaches. It highlights the central importance of reflexivity. I justify the theoretical reasons for using Interpretative Phenomenological Analysis (IPA), as my approach to data analysis (Smith et al., 2009). The theoretical framework is described in detail since it underpins every aspect of the study and this methodology is new to research in undergraduate medical education.

3.2 Theoretical framework

Theories give researchers different lenses to look at complex problems, with each focusing on different aspects of the data, thus forming a framework for their analysis (Reeves et al., 2008, Cleland, 2015). As Crotty stated, “different ways of viewing the world shape different ways of researching the world” (Crotty, 1998,p.66). My theoretical framework set the scene for the study, influenced my literature review and informed my research questions. It also affected my choice of methods and the interpretation of data for analysis. Finally, it informed the tentative conclusions and established the criteria by which others might evaluate the quality of my work (Sandelowski, 1993).

3.3 Reflexivity: Initial thoughts

One of the challenging aspects of undertaking qualitative research has been the bewildering range of epistemologies, methodologies, methods and their

philosophical underpinnings. I found the terminology in the literature was at times confusing and often inconsistent, for example, terms such as interpretivism and constructivism are sometimes used interchangeably (Chen et al., 2011, McMillan, 2015, Crotty, 1998). However, my thesis was not concerned with developing philosophical theory, but rather with seeking to understand empathy and its influences from the medical students' perspectives. Therefore, I have not explored the complexity of the different uses of theoretical terms in the philosophical literature. Instead, I have tried to present a clear theoretical framework, derived from the literature, which supported my philosophical stance and study design (McMillan, 2015, Crotty, 1998, Mann and MacLeod 2015, Willig, 2013). I found it helpful in this process to explore why positivist scientific papers appear to be convincing yet qualitative research is often considered to be less reliable (Montgomery, 2006). I have been trained for over forty years with a realist ontology and a positivist epistemology, but I have discovered, in carrying out my research, a new way of viewing the world: phenomenology.

3.4 Ontology: Relativism

Ontology is concerned with what exists and is the study of being and the ways in which we perceive social reality (Mason, 2002). Broadly, there are two main ontological stances; realism, which assumes that facts have a fixed existence, are objective and waiting to be discovered, and relativism, which maintains that reality is socially constructed, dependent upon context, thus creating multiple realities (McMillan, 2015). These two ontologies form the foundations of quantitative and qualitative research respectively. Qualitative research is based on subjectivity and is concerned with how the social world is interpreted, experienced and understood (Cleland, 2015).

The majority of research into empathy in medical students has been quantitative and grounded in a realist ontology. Realism maintains that objective knowledge from hypothesis generation, e.g., a decline in students' empathy during training, can be discovered by scientific investigation using

positivist methods, e.g., a questionnaire survey and statistical analysis. However, I was interested in exploring and understanding the meaning of the students' experiences and views on empathy. I have therefore adopted a relativist ontology which accepts that the representation of things in the world is socially constructed and cannot be taken as a simple reflection of how things are (Mann and MacLeod 2015). Relativism acknowledges that the researcher influences the study and so demands that he/she be reflexive. I reflected on my assumptions and beliefs and how these affected the interpretation throughout the study (Finlay and Gough, 2008).

3.5 Epistemology: Constructivism

Epistemology refers to beliefs about the nature of knowledge in the social world (Mason, 2002). Epistemology not only connects with the ontology but justifies the methodology and methods used in the research process (Crotty, 1998). My epistemology includes the principles by which social phenomena, such as empathy, can be known and how the knowledge can be shown (Mason, 2002). Since epistemology is closely linked to ontology it is not surprising that there are two broad conflicting stances within epistemology: quantitative (positivism) and qualitative (constructivism). These make different assumptions about the world, they use different terms and have different criteria as to what constitutes proof (Cleland, 2015).

On one hand positivism proposes that knowledge about reality can be obtained through objective experiment and explanation of phenomena. A positivist view assumes one external reality and an impartial, objective observer. It explains empirical phenomena in terms of objective facts and generates hypotheses for future testing. However, I did not take a positivist stance in addressing my research questions because this approach could not reflect the complexity of human life, nor account for the context, the students' lived experience (Sandelowski, 1993, Carel, 2016).

I have instead adopted a constructivist view to address my research questions. This is an epistemology which proposes that knowledge is gained through subjective understanding and interpretations (Crotty, 1998, Mann and MacLeod 2015). Constructivism is concerned with making sense of the lived world, in my research, from the standpoint of the student (Mann, 2011). It maintains that meanings do not exist in some external world but are created by the subject's interaction with the world. As a result, multiple constructed accounts of the world can exist (Crotty, 1998). My constructivist approach accepted that learning is embedded in social life and a sharing of interpretative understandings (Charmaz, 2014). I sought to understand how the students interacted with patients, their peers, and teachers in a variety of settings. I then explored how these interactions changed during their course.

My epistemological approach refutes notions of the objective 'neutral' observer. I acknowledge subjectivity and my involvement in the construction and interpretation of data. My constructivist perspective influenced the relationship between myself and the students and the quality of data generated. Consequently I adopted a first person perspective in my reporting which emphasised the central role of reflexivity in my research (Finlay and Gough, 2008).

3.6 Theoretical perspective: Interpretivism

My Interpretivist perspective is closely linked to constructivism. This was the philosophical stance that informed the methodology and provided a context for the study (Crotty, 1998). Using Interpretivism, I described and interpreted the students' accounts and examined how they were related to their experience of the world around them (Finlay, 2011). There are a number of interpretivist perspectives and I chose phenomenology and hermeneutics (interpretation) as the most appropriate for my study (Mason, 2002).

3.6.1 Phenomenology

Phenomenology is a term which describes both a philosophy and a range of research approaches (Finlay, 2013). Phenomenology aims at gaining a deeper understanding of the meaning of our everyday, taken-for-granted, experiences as they are lived (Van Manen, 2016, p.9). It can also be described as a way of seeing how things appear to us through experience, from an individual's perspective (Finlay, 2013, Carel, 2016, Smith et al., 2009). Using a phenomenological method, I sought to understand the individual student's perspective of their education (Hopkins et al., 2017).

Phenomenology focuses on phenomena (what we perceive and experience) rather than the reality of things (what there is) (Carel, 2016). It asserts that any effort to understand the students' world has to be grounded in their experience of their social reality (Crotty, 1998). There are different approaches to carrying out phenomenological research, some focusing on description, others emphasising interpretation (Finlay, 2013). Finlay (2013) described five iterative processes which unite the diverse phenomenological research methodologies:

1. the phenomenological attitude (openness)
2. descriptions of experiences (the students' lifeworld)
3. implicit meanings (beyond the description)
4. reporting the phenomenon holistically
5. integrating the frames of reference (incorporating philosophical theory)

In adopting these approaches in my research I was conscious of tensions between: the particular/ the general, description/ interpretation and bracketing/ reflexivity. It was through crafting a narrative that these dimensions became integrated in my thesis (Hopkins et al., 2017).

3.6.2 Hermeneutics

Hermeneutics is concerned with the interpretation of the students' accounts. It developed as a separate strand from phenomenology but became united in the work of interpretative-phenomenologists such as Heidegger (Smith et al., 2009, Heidegger, 1962/1927).

3.7 Methodology: Linking research aims, theoretical perspective and choice of methods

My methodology linked the research aims to the theoretical perspective and justified my choice of methods to address the research questions (Merriam, 1998). The methodology justified the process I used to answer my research questions (Chapter 4). Because I was primarily interested in the students' experiences in relation to empathy and in exploring any changes in that empathy, I adopted both an interpretivist phenomenological methodology and a qualitative longitudinal research methodology.

3.7.1 The Case for a Qualitative Methodology

My qualitative research aimed to develop an interpreted understanding of the students' social world focused on their everyday experience in relation to empathy (McMillan, 2015, McLeod, 2011, Kvale and Brinkmann, 2009). A qualitative approach generated data which explored the construct of empathy and its influences, therefore addressed my research questions rather than testing a hypothesis (McMillan, 2015).

Qualitative research studies phenomena in their natural context, seeking to make sense of empathy in terms of the meaning students ascribe to it. This research aimed to understand connections and meanings rather than explain causal relationships (Cribb and Bignold, 1999). Although interpretative research may not generate neat parcels of knowledge, it can provide insights into the students' social world. Control and objectivity are associated with scientific positivist rigour. Rigour in qualitative research depends on reflexivity, which is the attempt to be self-aware and explicit about presuppositions and

prejudices. Qualitative research approaches are needed to explore subjectivities just as much as the quantitative approaches which try to control them (Cribb and Bignold, 1999).

3.7.2 The Case for a Qualitative Longitudinal Methodology

I was interested in understanding how students' views and perceptions in relation to empathy changed during their training, and therefore I adopted a qualitative longitudinal methodology. A longitudinal approach allowed the students' stories to develop and was a more appropriate methodology to capture change than the static 'snapshot' gained in cross-sectional research. A qualitative longitudinal approach has been under-used in previous research into empathy of medical students, perhaps because it is more challenging to carry out than a cross-sectional study (Murray et al., 2009, Pedersen, 2009). Qualitative longitudinal research, (QLR), implies a way of knowing the students' social world through time and so may increase understanding both by describing change and by including an interpretative element of the individual student's experience (Neale and Flowerdew, 2003, Holland et al., 2006).

A QLR methodology was more likely to reveal a nuanced in-depth understanding of empathy since it provided an opportunity for strengthening my relationship with the student, fostered trust, and gave students the chance to clarify or change their views (McLeod, 2011, Holland et al., 2006). The research also interrogated the data across time, both in the individual student's story, and in relation to the larger group in each year (Holland et al., 2006). This approach offered the best chance of gaining a coherent, nuanced understanding both of the individual student and the group of students in context. I sought to do justice to the wealth of data generated (McLeod, 2011). All qualitative research faces the challenge of convincing others of the credibility of the conclusions (Paley, 2017). In my justification for a qualitative longitudinal methodology I needed to present the students' voices and to integrate my voice in the thesis in a transparent way.

3.7.3 The Case for an Interpretative-Phenomenological Methodology

Husserl, Heidegger, Gadamer, Merleau-Ponty and Ricoeur are among the phenomenological philosophers whose thinking has informed my theoretical framework. As I have chosen to use an innovative approach, Interpretative Phenomenological Analysis (IPA), I have briefly summarised their contribution to my research, which strengthens my theoretical approach by providing a philosophical context to the study.

3.7.3.1 Husserl

Husserl, (1859-1938), one of the founders of phenomenology, sought to get back to the essence of the phenomenon itself, to the experiential content of consciousness (Husserl, 2012). Husserl promoted the relevance of experience and its perception in phenomenology, placing 'intentionality' at the centre of his work. The use of the word 'intentionality' did not mean what we choose or plan, but rather, it was used to signify how we are meaningfully connected to the world and the complex multi-layered experiences of everyday life (Vagle, 2016,p.27).

Husserl (2012), suggested that we 'bracket', or suspend, our assumptions or 'natural attitudes' by which we make sense of the everyday world, in a process of 'eidetic reduction', or epoche' (Husserl, 2012, Smith et al., 2009). Bracketing allows us to temporarily ignore the question of, "is it real?", but instead to ask, "how does this student experience her world?" (Bakewell, 2016). Husserl suggested that it was necessary to question one's pre-existing ideas about the phenomenon being investigated in order to achieve a deeper level of understanding and to avoid fitting experiences into pre-existing categories (Husserl, 2012). Reflection plays a role in making the researcher's pre-existing ideas apparent during any phenomenological research. Husserl's writing helped me to focus on balancing reflexivity with the challenge of bracketing my assumptions (Husserl, 2012).

3.7.3.2 Heidegger

Heidegger, (1889-1976) further developed the descriptive aspects of Husserl's phenomenology by moving towards a more interpretative position with a focus on understanding the perspectives of our involvement in the world (Heidegger, 1962/1927, Smith et al., 2009). Phenomenology is seeking after a meaning, some of which is concealed, by the interpretation of text, as a result, Heidegger linked phenomenology with hermeneutics (Moran 2000). In *Being and Time*, Heidegger explained how our being in the world involved both practical engagement, reflection and affective concern (Heidegger, 1962/1927, Moran 2000). He proposed the concept of *Dasein*, or our 'being-there', which implied that human nature was always situated and involved in some kind of meaningful context (Heidegger, 1962/1927). Intersubjectivity is a concept which describes this relatedness; it accounts for our ability to communicate and make sense of each other (Smith et al., 2009).

Heidegger therefore differed from Husserl in suggesting that one's preconceptions should not be bracketed off but an influence on the interpretative framework (Heidegger, 1962/1927, McLeod, 2011). His views made me rethink the role of bracketing in the interpretation of qualitative data. They helped me to see bracketing as both a cyclical process which linked with reflexivity and as something which can only partially be achieved (Smith et al., 2009).

3.7.3.3 Gadamer

Gadamer (1990/1960), in *Truth and Method*, developed Heidegger's work on preconceptions. He suggested that rather than declaring assumptions before interpreting the text, it was only possible to appreciate them fully once the interpretation was in progress (Gadamer, 1990/1960). He suggested that interpretation was a dialogue between the past and present where the world was revealed through mutual understanding, or a 'fusion of horizons' (Gadamer, 1990/1960). This means that any qualitative study is partly autobiographical. At the core of interpretative methods is the analysis of themes across the data.

Gadamer argued that understanding was generated by conversation (Gadamer, 1990/1960)

3.7.3.4 Merleau- Ponty

Merleau-Ponty,(1908-1961), argued that although we may attempt to bracket off some aspects of our way of seeing the world, it was impossible to assume a 'view from nowhere'; reinforcing the need for reflexivity (Merleau-Ponty, 1962, Ricoeur, 1996) (Langdridge, 2008). Merleau-Ponty (1962) argued that although we can experience empathy for another, we cannot share entirely the other's experience. Their experience belongs to their own embodied position in the world. These ideas implied that the conclusions I could draw from my research would be tentative .

3.7.3.5 Ricoeur

Ricoeur (1970), described two interpretative stances; a hermeneutics of empathy and one of suspicion. The empathy-based approach attempted to reconstruct the original experience in its own terms, while the suspicion -based approach used perspectives from outside, to shed light on the phenomenon. Larkin combined a hermeneutics of empathy with one of questioning to disclose the meaning of experience (Larkin et al., 2006). In the hermeneutics of questioning the analysis moved from representing what the participants said to include a reflection of my interpretation of the students' experiences. (Smith et al., 2009) Both the empathetic and questioning stances used in interpretation are included in IPA in the process of understanding. My analysis proceeded at different levels with each becoming more interpretative and yet based on a reading of the student's transcript rather than from the literature, thus differing from a hermeneutics of suspicion.(Smith et al., 2009, Ricoeur, 1970)

3.7.3.6 Bracketing and Reflexivity

Finlay (2008), suggested that the researcher needed to reflect on both prior and evolving understandings in order to be open. She described the phenomenological attitude as a reductive-reflexive dance where the researcher

adopts two stances between bracketing pre-understandings and exploiting them as a source of insight (Finlay, 2008). Therefore, the reader and I bring our assumptions to the thesis and cannot help but look at any new text in the light of our own prior experience (Smith et al., 2009).

Although I cannot escape my preconceptions, I tried to keep the students' voice as the focus of my research and continued my reflexivity through the whole study. Another implication of reflexivity for my research was that any discoveries I made depended upon the empathetic relationship that existed between me and the student. Interpretation was not a matter of imposing a set of pre-determined categories on the text but a readiness to discover new understanding. I studied their accounts and derived meaning through intuition and reflection (Chen et al., 2011). The quality of interpretation depended on my sharing some ground with the student, on the empathy that existed between us (Smith et al., 2009). This embodied intersubjective relationship was my primary access to world of the student. I acknowledge that the conclusions I drew from my interpretation can never be certain but I hope that the claims I made help the reader to gain new understanding.

3.7.3.7 The hermeneutic circle

The hermeneutic approach views the one who knows and the known as inter-related. Therefore, any interpretation involves an essential circularity of understanding, which is the hermeneutic circle (Tappan, 1997). Access to the students' experience was dependent on what the student told me; I then interpreted their account to understand their experience. My interpretation focussed on all aspects of the student's transcript not selected parts which supported my prejudices. I adopted an inductive approach moving from the details to a connected view without jumping to inferences (Gray, 2013). Attempting to take an insider's perspective is only part of the analytic process. The hermeneutic circle is also concerned with the dynamic relationship between the part and the whole at a number of levels (Smith et al., 2009). It is an iterative process which describes the process of interpretation in my

research. The description of the research method may give an impression of a linear progression of steps when in fact this circular process is a truer reflection of the interpretation. The data (text) is entered at different levels, all of which relate to each other and generate differing perspectives. The research also involved a double hermeneutic: my interpretation of the student's interpretation their experience. Indeed, when the reader interprets my thesis there is a third hermeneutic level.

3.7.3.8 Idiography

My phenomenological approach was also idiographic in that it was concerned with the particular (Smith et al., 2009). This was manifested by the depth of analysis of the student's individual experience.(Smith et al., 2009).However at the same time phenomenology is a relational philosophy which offers a concept of the person immersed in the world of material things and relationships (Heidegger, 1962/1927, Smith et al., 2009). Analysis of individual transcripts was intended to demonstrate the existence of phenomena not their incidence. It can indicate potential flaws in existing theoretical claims for a population, by revealing unexpected issues (Smith et al., 2009). I needed to question my assumptions ,as the experience of an individual student may illustrate significant aspects of the year group (Smith et al., 2009). Halling (2007), suggested that phenomenological research involved three levels of data analysis: the particular student's experience, common themes among the students, and finally a more abstract philosophical reflection on the nature of empathy.

3.7.4 The Case for Interpretative Phenomenological Analysis (IPA)

I have chosen Interpretative Phenomenological Analysis (IPA) as my approach to data analysis for its theoretical and practical application to answer my research questions. IPA was developed in the 1990's and has mostly been used in psychology and nursing research, but only rarely in medical education research (Smith et al., 2009). The value of such a study is to offer a detailed

nuanced analysis of particular instances of lived experience (Smith et al., 2009). IPA is a method which matches the complexity of empathy. As Larkin et al. (2006) point out, the analytic processes of IPA shares common features with other qualitative methods and so it is more appropriate to understand IPA as a stance from which to approach the qualitative data analysis rather than a distinct method (Larkin et al., 2006). IPA has three dimensions: phenomenological, interpretative (hermeneutic) and idiographic.

3.7.4.1 Phenomenological

IPA is phenomenological in that it enables the student's story to be expressed in its own terms as opposed to fitting into predetermined category systems (Smith et al., 2009). IPA necessarily involves reflection, the student makes sense of their experiences and I included reflexivity during interviewing and reading of their transcripts (Smith et al., 2009). In choosing IPA I was committed to listen to the students' views of their experience and to construct interpretations.

3.7.4.2 Interpretative (Hermeneutic)

The students' accounts reflected their attempts to make sense of their experience. My access to their experience was dependent on what they told me. I then needed to interpret their account to understand their experience by adopting a Heideggerian perspective. By using IPA I adopted Heidegger's view that phenomenology was interpretative from the beginning (Smith et al., 2009). Thus the students' accounts can be used thematically to reveal something real about the nature of empathy (Larkin et al., 2006).

3.7.4.3 Idiographic

IPA also is idiographic, situating students in their contexts and starting with a detailed examination of each transcript before moving to any general themes. (Smith et al., 2009) I wished to understand the particular experience was of the student and how it was understood (Smith et al., 2009) Adopting an idiographic approach involved seeking similarities and differences between the individual accounts.

3.8 Summary of Theoretical Framework

My research was based in a broadly phenomenological-interpretivist tradition (Smith et al., 2009, Finlay, 2009). Critics of the interpretivist paradigm often argue against its relativism (Paley, 2017). However, a phenomenological approach is not a matter of “anything goes”, but rather an acknowledgement that different people perceive differently and act differently. The range of perception is always determined by context and socialisation, a fundamental tenet of social constructivism (Smith et al., 2009).

IPA is best seen as an approach rather than a set of analytic steps . The value of an IPA study is to offer a detailed nuanced analysis of particular instances of lived experience, a method which matches the psychological complexity of empathy (Smith et al., 2009). As a phenomenological researcher I went beyond surface expressions or explicit meanings to read between the lines to access implicit knowledge and intuitions (Finlay, 2009). My responsibility was to hear what students said about their lives and meaning of their experience and to construct interpretations. I was not necessarily aware of all my preconceptions so reflexivity was essential (Hopkins et al., 2017). I hope the reader will also examine the stories from the perspective of their own experiential knowledge base, make their interpretations and consider possible implications for further work.

This chapter set out my theoretical framework which was appropriate to address my research questions. I have summarised this framework in Table1. My theoretical framework described the theories which underpinned my research, in the next chapter I have described the methods used to conduct the research.

Table 1 Theoretical Framework

Ontology	Relativist
Epistemology	Constructivist
Theoretical Perspective	Interpretivist -Phenomenology -Hermeneutics
Methodology	Qualitative Longitudinal Research Interpretative-Phenomenological Approach
Method	Interpretative Phenomenological Analysis -Phenomenological -Interpretative -Idiographic

Chapter 4: Methods: The process of the research

4.1 Overview

This chapter describes how I conducted the research to answer my research questions. I explain how I approached the research, my preliminary plans and the ways in which these changed during the study. The context of the study and the participating students are presented while maintaining their confidentiality. I explain how the data was collected, coded, stored and analysed and how I structured my data analysis to arrive at my choice of key themes. I reflect on the ethical challenges and methods of assessing the quality of the work. While the chapter focuses on practicalities, theoretical considerations underpin the work. I begin this section by revisiting the research questions and describing my use of reflexivity.

4.2 The Research Questions

My research questions addressed gaps in our understanding identified from the literature review. My thesis sought to answer the following questions:

How do students talk about and experience the concept of empathy in relation to professionalism and practice?

What factors do medical students describe as influencing their empathy during their undergraduate medical training?

How do medical students' views and experiences of empathy change during their medical education?

4.3 Reflexivity

4.3.1 A theoretical perspective

Reflexivity is the practice of reflecting on the ways in which my background, assumptions, beliefs and behaviour affect my research. It involves thoughtful analysis of the intersubjective dynamics between me and the students (Finlay and Gough, 2008). Subjective factors are commonly viewed as a bias in positivist quantitative research but I embrace subjectivity and see it as a way of enriching the qualitative data.

Reflexivity puts the research into context and can also be used as a way of auditing the research process, so transforming personal experience into knowledge which is open and accountable (Finlay and Gough, 2008). An iterative approach involved moving back and forth between the individual student, the cohort and me in multiple layers of meanings as new understanding emerged from the data. At a broader level, I reflected on the place of the study within the existing body of knowledge after presenting the findings on each of the themes (Finlay and Gough, 2008).

Any understanding from research informs the reader both about the students' views of empathy and about my own suppositions. Heidegger maintained that interpretation was an inevitable basic structure of our 'being in' the world (Heidegger, 1962/1927). The interpretative revelation of the phenomenon, empathy, and the reflexive uncovering of the self, are integral parts of the same process (Finlay and Gough, 2008).

I used reflexivity throughout the research when considering; my motivation, 'bracketing' and the researcher-student relationship. It was also involved in data generation, analysis, and in the assurance of the quality of the research.

4.3.2 Reflexivity: My motivation to carry out the research

I have been intrigued for many years by how students and doctors resolved the tension between connecting emotionally with patients while maintaining a detached distance from them. As a part of my training in general practice, psychiatry and palliative care I have been encouraged by role models to share feelings with patients and to be absorbed in exploring the emotional aspects of their illness. I was also interested in the processes of professional and emotional socialisation that students experienced from joining the medical school to graduating as doctors.

I was shocked to read of the appalling lapses in care and lack of empathy outlined in the Francis Report (Francis, 2013). I felt that one way of responding to the reported lack of empathy and compassion would be to explore the influences on medical students' empathy during their training, as they are the doctors of the future.

My beliefs at the outset of this project were also informed by quantitative questionnaire-based research, and generally accepted assumptions, which suggested that medical students' empathy declined during their training (Hojat et al., 2009). However, my experience as a mentor involved developing close relationships with students which led me to question these assumptions (Jeffrey, 2014). I listened as students spoke of their distress at witnessing poor communication with patients, lack of empathy and unethical behaviour by some senior doctors. I therefore wished to explore empathy and the factors influencing any possible change in medical students during their training. I have spent my professional life working with patients in a variety of clinical settings, so I welcomed an opportunity to work in an academic environment, to pause and reflect on my research problem.

4.4 The Study Design

In accordance with my interpretative-phenomenological stance I modified the study design as the research progressed. I have represented this as two distinct phases but in reality the study design was a process of iterative development.

4.4.1 Early planning

After reading reviews on the subject of empathy in medical students I perceived that there was very little qualitative research on this topic. I could find no longitudinal phenomenological studies of listening to the students' views and experiences (Batt-Rawden et al., 2013, Pedersen, 2009, Neumann et al., 2012). My preliminary literature review helped me to formulate about a dozen research questions which were subsequently refined to three. I was keen to use an innovative methodology in medical education research; Interpretative Phenomenological Analysis (IPA), which offered a flexible approach that fitted with my theoretical perspective and seemed suitable to answer my research questions.

Initially, I considered following a cohort of thirty medical students throughout the whole medical undergraduate course, using qualitative semi-structured interviews twice a year. I planned to include a focus group study of six academic staff to ascertain their views on the teaching of empathy. I also considered the possibility of forming a patient group to comment on the study design. However, my supervisors advised me that this plan was too ambitious as the numbers of participants would be too large for a phenomenological study. They reassured me that my fears of attrition were pessimistic. I accordingly reduced both the number of participants to sixteen and the frequency of interviews to once each year.

At my first year review, the panel examined my study design and advised that I focus exclusively on the students' views and experience. They suggested that the inclusion of the views of academic staff and patients might be considered as a

separate study. Furthermore, I discovered that the University was introducing a curriculum change to make the intercalated honours science degree compulsory, thus increasing the length of the medical curriculum from five to six years.

Consequently, I modified my plans and produced a more realistic study design, to accommodate these changes and suggestions. I planned to study two cohorts of eight students for three years. I have retained the year structure of the 'new' six year curriculum in my thesis.

4.4.2 Final study design

The study employed a prospective qualitative longitudinal phenomenological methodology. A purposive sample of two cohorts of eight medical students, were followed for three academic years of their undergraduate training, thus covering the entire curriculum. The cohorts fell into two groups:

- **Preclinical Group: (8 students)** Five students were followed from year 1 to year 3. However three students opted not to undertake the intercalated science year (year 3) and their data for year 4 was included in the Clinical Group.
- **Clinical Group: (8 students)** Eight students were followed from years 3 to year 6. Three students from the Preclinical Group entered year 4 and their data for this year was included in the Clinical Group.

Data was generated using in-depth, one-to-one interviews of students. The first interviews were carried out in the Spring 2015 to allow first year students a semester to settle into their new environment. The second interviews, nine months later, were held in the late Autumn of 2015 when the students had one semester in their new academic year. The last interviews, a year later, were held in the Autumn of 2016 so that they did not impinge on final year examinations in January. Data was generated from each academic year of the course with interviews being carried out over a period of almost two years.

Interviews with students were carried out in an office on the medical school premises and lasted 60-90 minutes. Interviews were audio-recorded and transcribed by an experienced medical administrator. Students were able to contact me, or my primary supervisor, via e-mail at any time during the study if they wished to discuss any issue.

4.5 Ethical Perspectives

4.5.1 Respect for the student

Conducting ethical research involved sustained reflection and review. (Saldana, 2013) I followed the ethical guidelines described by Karnieli-Miller et al. (2009), throughout my research: students should volunteer, understand the meaning of the study, the students' stories should not be distorted, their anonymity protected and their welfare should be the researcher's primary moral obligation. I did not offer any monetary incentives to the students but pointed out that in this longitudinal qualitative research they were acting as co-researchers and this experience might be useful for them. I was reassured by their uniformly positive feedback on participating in the research (Chapter 6).

4.5.2 Approvals

Formal ethical approvals for the study were obtained from the Centre for Population Health Sciences (CPHS) Level 2 Ethics Committee and the College of Medicine and Veterinary Medicine Students' Ethics Committee (MVMSEC). Copies of my ethics approval are included in Appendix 2. I received confirmation that I did not require NHS Ethics nor R&D approvals as my study did not involve patients. (Appendix 2) I found the process of gaining ethical approval generated useful suggestions about my letter to the students which were amended in the light of the ethics committee's advice.

4.5.3 Confidentiality

The need for anonymity and confidentiality of students potentially clashed with placing their accounts in the public arena. I decided that I would provide minimal information about the background of the students, by giving them a

pseudonym, guaranteeing their anonymity. I did not overtly identify the medical school where the study was carried out. I interviewed the medical administrator who undertook the transcribing and reinforced the need for complete confidentiality. I contacted the transcriber by e-mails to ensure that she had not been affected by the interviews. I met her at the end of the study and thanked her for her work. My supervisors were only aware of the students' pseudonyms. I took care to ensure that interview transcripts were held on the University password protected server in accordance with Data Protection Act and the University regulations (Holland et al., 2006).

4.5.4 Consent

Informed consent was a process which pervaded the whole research process. From the start I sought to inform students about the study (Appendices 3 & 4). I informed interested students in greater detail; including clarifying the time commitment and that they could leave the study at any time. Each student signed a consent form which was reviewed before every interview (Appendix 5). I considered the consequences of participating in the research for students, both in terms of the time spent and the personal consequences of recalling potentially stressful events (Holland et al., 2006, Thomson and Holland, 2003). Students were offered the opportunity to read their own transcript if they wished, but no student took up this offer.

4.5.5 Challenges

Researching the private views and experiences of students presented me with a number of ethical challenges. My greatest priority was the welfare and safety of the students participating in the study (Holland et al., 2006, Karnieli-Miller et al., 2009). I sought to create a trusting relationship in which the students were confident that I was listening to their concerns.

In one case where a student had mental health issues I advised her on resources for support within the University and from her general practitioner. I subsequently discussed my advice to the student with my supervisor while

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maintaining confidentiality. In view of my previous role in student support I found it quite difficult on this occasion to stay in a researcher 'observer' role and not to offer support myself. However, I was surprised when at the end of the study the student reported how useful it had been for her to have an opportunity to talk during the interviews.

In another situation a student was distressed in describing an episode where she had been humiliated by a consultant in front of a patient. I paused in my researcher role and spent some time reflecting on the episode with the student and helped to restore her self-esteem. My reaction was based on an ethical imperative to make the students' welfare my primary concern. It also developed the trust between us and facilitated our future conversations.

When students raised personal issues ethical dilemmas arose as to whether some material should be edited for the well-being of the students. When such occasions arose I discussed them with the participants to ensure that they were happy for me to include the material. In this way informed consent permeated the research process.

4.6 Research Setting: The medical school

The context of the research is of significance in a qualitative phenomenological study, I therefore describe the curriculum in some detail. The students attended a UK medical school which has an outstanding record in medical research. The stated aim of their undergraduate programme is to produce caring, competent, ethical and reflective doctors who make care of patients their first concern. The Programme Overview of the medical school lists the following distinctive features of the educational experience at this medical school including;

- an emphasis on the sciences and humanities underpinning clinical practice
- research skills and enquiry-led learning

- a blend of traditional and innovative teaching and learning methods that includes lectures, problem based learning, e-learning, simulation workshops, portfolio learning and clinical attachments.
- a personal tutor system to ensure students are well supported in their academic and professional development and know how to access pastoral support and career guidance.

4.6.1 The medical undergraduate curriculum

The curriculum structure is summarised in Table 2. In the preclinical years from 1 to 3 there is only a limited patient contact. In years 4 to 6 the curriculum takes students through the major systems-based clinical specialities in hospital and community-based attachments. By Year 6 students are regarded as ready to learn and contribute to the care of patients as apprentices under careful supervision.

In addition to the timetable, the curriculum can be described in terms of the intended learning outcomes of each part of the course. The medical degree (MBChB) outcome is defined through twelve programme learning outcomes each of which is addressed in every year of the course. The twelve outcomes are subdivided into: The Doctor as a Scholar and Scientist (4), The Doctor as a Practitioner (6) and The Doctor as a Professional (2). (General Medical Council, 2015)

The words 'empathy' or 'compassion' do not appear anywhere in the document describing the medical degree programme (MBChB) at this University. A recent curriculum change made the intercalated science honours degree compulsory, increasing duration of the curriculum to six years. The brief map of the curriculum describes the context of the medical education but the students' accounts provide a richer view of their perceptions of their teaching (Table 2).

Table 2 The Medical Curriculum

YEAR 1	Principles of Practice	Preclinical : Cardiovascular, Respiratory ,Locomotor Health Ethics and Society ; Problem Based Learning Year 1 Theme teaching
2	Principles of Practice	Preclinical: Neurosciences, Gastrointestinal, Genetics<renal endocrine and the virtual clinic Introduction to clinical practice, Problem based learning Year 2 theme teaching
3	Intercalated Bachelor of Medical Sciences(Honours)	Preclinical Science Honours degree
4	Process of Care	Clinical: Cardiovascular, Respiratory , Locomotor, Gastrointestinal, Psychiatry Year 4 theme teaching
5	Process of Care	Clinical: Haematology, Oncology, Renal, Neurosciences, Dermatology, Ophthalmology, Otolaryngology, General Practice, Obstetrics & Gynaecology ,Genitourinary Medicine, Psychiatry Year 5 theme teaching
6	Preparation for Professional Practice	Clinical: Child Life and Health, Medicine, General Practice , Medicine of Elderly, Surgery Student assistantship and Elective Year 6 theme teaching

4.7 Participants: Sixteen medical students

For reasons of confidentiality I have kept details of the students to a minimum to preserve their anonymity.

4.7.1 Sampling

The sampling was purposive and theoretically consistent with my phenomenological approach. I sought to recruit eight students in Year I from a total of 210 students and eight students in year 4 from a total of 230 students. I recruited on the basis of first-come-first-included as I wished to represent perspectives rather than a population (Silverman, 2013). I was aware that this method of sampling might favour students who were interested in the study topic but from a phenomenological perspective I regarded this as an advantage rather than a disadvantage. I aimed to recruit sixteen students in total, which is a large number for an in-depth phenomenological study. The number was chosen to account for possible attrition, which, as transpired, did not take place. This number of students allowed me to retain a close trusting relationship with each of them which was necessary to generate rich data (Flyvbjerg, 2006, McMillan, 2015).

My inclusion criteria were medical students who volunteered needed to be in year 1 or year 4 of their course, had read the information about the study (Appendix 4) and had signed the consent form (Appendix 5). There was a cooling off period of at least two weeks between the student agreeing to participate and the interview. Students were informed that they could leave the study at any time. Exclusion criteria were medical students in other years of the course or those in other faculties.

4.7.2 Recruitment

I was concerned that I would have difficulty recruiting as the students would be committing to three hour-long interviews over three academic years. I appreciated their commitment. After seeking permission from the year

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administrators and the undergraduate manager I posted a short invitation on the year 1 and 4 internet discussion boards. Three students responding to the discussion boards were sent a letter of invitation and an information sheet by email as approved by the University ethics committees. (Appendix 3&4) All three students decided to join the study. The year co-ordinators agreed to let me put up a poster on student notice boards advertising the study, as approved by the University ethics committees.

My most successful method of recruitment was a short presentation for two minutes before a scheduled lecture. Ten first year students responded, seven students were included in the study and three went on a waiting list. Each student that expressed an interest received a letter informing them of the details of the study and all of them chose to join the project. After one week I emailed those on the waiting list to thank them for their interest and to inform them that the study was full.

Recruiting fourth year students was more problematic as they are in groups in different clinical locations. I spoke before a lecture at which there were about 30 students and recruited two students to the study. The year 4 administrator also posted another reminder on the discussion board that there were two vacancies and one of these filled. One student joined after her friend had been interviewed. I also e-mailed the Medical Students' Committee to inform them of my study. They expressed interest in my research and put a notice on their Facebook page which resulted in another fourth year student joining the study.

In three weeks, eight first-year students, (6 female 2 male), and eight fourth-year students, (7 female 1 male), had consented to join the study. Although I was not making any claim that the group was representative of the whole year groups, I was pleased to have recruited a diverse group of three males and thirteen female students. The first year students in the preclinical group included an overseas graduate student, a British Asian and a student from Europe, the remainder were school-leavers from the UK. With the exception of

the graduate student, the school-leavers had attended care homes or GP surgeries for up to two weeks before joining university to gain experience. The fourth year students, in the clinical group, included one student who had completed their preclinical studies at another university. One student was Chinese, one a British Asian and one was from a European country, the remainder were UK based students. Six students in the clinical group had undertaken an intercalated honours science year. In order to respect their anonymity and to maintain confidentiality I have limited the demographic information about the participants so that they will not be recognisable to their peers or the medical school. The students required reassurance that they would not be identified in the thesis. To further protect confidentiality I assigned a pseudonym for each student, ensuring before their interview that they were happy with their allocated pseudonym. I chose names which did not indicate ethnic origin only their gender. The pseudonyms given to the preclinical group in year 1 were: Bill, Connie, Edward, Fiona, Helen, Jenny, Marilyn and Olive. In the clinical group in year 4 the pseudonyms given were: Amy, Diana, Gina, Ida, Kim, Lisa, Neville and Paula.

4.8 Data Generation

Data was generated by using semi-structured interviews which developed into student-led conversations as study progressed.

4.8.1 Semi-structured Interviews

The semi-structured research interview was a conversation in which knowledge was constructed in the interaction between me and the student which concurred with my theoretical framework (Kvale and Brinkmann, 2009). Rather than extracting 'objective facts' from the students in a realist manner I was in conversation with the student and listening to their views and experiences in an empathetic way (Vagle, 2016). I interpreted their stories to generate new knowledge and in the process, my own self-awareness increased.

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I started out with openness and genuine curiosity to find out more about the students' views on empathy and its influences. The quality of the interview, and so the quality of the data generated, depended on the empathy between myself and the student. The 'inter-view' was an intersubjective experience where both parties influenced each other (Kvale and Brinkmann, 2009). Because students had three in-depth interviews over three academic years they had a chance to reflect on their experiences.

Through my clinical practice I became sensitive to unconscious communication. In my research I used a student-centred, empathetic approach which was influenced by the work of Carl Rogers (Rogers, 2003). I allowed the students to express their feelings while I reflected on their responses and remained alert to the differences between myself and the student. This process has been described as an oscillation between observation and participation (Bondi, 2008, Bondi, 2003). Bondi (2014), suggested that moving psychologically between observer and participant created a space for reflection.

In this empathetic form of interviewing I tried to allow the students to feel free to express their views and to follow their agenda rather than conforming to respond to a series of pre-arranged questions. By allowing free conversations students talked about topics which I had not anticipated from my preliminary literature review. I believed that it was an advantage to be experienced in therapeutic interviewing since qualitative research interviewing shares many features of the clinical encounter, namely: respect for the other, empathetic listening and clarifying the stories (McLeod, 2011, Finlay, 2011). However the research interview also differs from the clinical situation, where the goals may be; to encourage behaviour change, reach a diagnosis, negotiate treatment options or to relieve suffering (Kvale and Brinkmann, 2009).

Interview verbatim data is a powerful way of understanding other people (Forrester, 2010). However, what a person says they feel bears a complex relationship to their embodied subjective experience (Bondi, 2014). Yet, despite

the limitations, interviews remain the best source of knowledge about the students' feelings (Hitchings, 2012). I have no training in psychoanalysis but psychoanalytic insights were used to support my reflexivity and enabled me to be sensitive to the power dynamics of the interview (Pile, 1991). I was present in the interview as a witness rather than an authority. Kvale and Brinkmann (2009), asserted that our understanding of other people's lived experience depended on conversation, reflecting Gadamer's views of the role of conversation in generating meaning (Gadamer, 1990/1960).

The interview topic list acted as a prompt to give some direction to the data generation. (Appendix 6) The flexibility of qualitative research allowed me to follow leads as they emerged. I tried to achieve a balance between being flexible and open, yet drawing a boundary when students strayed too far from the subject of empathy. I learned that part of acquiring the skills of qualitative research was by practice, by interviewing students and learning by experience.

4.8.2 Conducting the interviews

The methods of conducting the interviews were chosen to answer the research questions. Throughout the interviews I maintained ethical perspectives of consent, confidentiality and respect for the student.

4.8.2.1 Before the interview

Prior to each interview I sent an e-mail reminder to the student and offered alternative times in case they had to change their appointment. Interviews were carried out on medical school premises in a quiet room with table and chairs. The interviews were recorded and lasted between an hour and an hour and a half.

4.8.2.2 Setting the scene

I began by welcoming the student, thanking them again for their participation and asking them if they were comfortable to give me an hour of their time. I offered them a cup of tea or coffee as I aimed to create a warm, non-threatening

atmosphere in which they would be willing to share their experiences (Karnieli-Miller et al., 2009, Taylor and Bogdan, 1998).

The introduction defined the situation for the student, and set out the purpose of the interview. I reviewed their informed consent and gave the student an opportunity to raise any questions. I checked that they understood the subject of the interview and reminded them that I was interested in specific examples from their experience of the undergraduate course. I re-iterated the confidentiality of the meeting and that I had given them a pseudonym which I used during the interview. I explained that the recording of the interview would be transcribed. I checked to see that they had no further questions and then proceeded to record the interview.

4.8.2.3 Interview topics

I began by asking the student about their course and motivations for becoming doctors. I then moved to empathy and asked if they had any examples of teaching or clinical practice in relation to empathy. The student was encouraged to describe specific experiences and actions rather than giving general opinions about empathy. I occasionally returned to the semi-structured interview topic list if there was a long break in the interview. (Appendix 6) This formed a guide and prompt, but not every topic was raised in each interview. I followed the student's agenda and this proved a valuable strategy in revealing in-depth views and reflections on their experiences. Further questions arose in the light of the data generated by the students as the study progressed. The longitudinal format enabled me to clarify points from earlier interviews and to return to areas where there were inconsistencies to explore them in greater depth. Although I was immersed in the interview I was sensitive to cues that allowed me to follow lines of conversation which related to my research questions rather than following an interview schedule (Kvale and Brinkmann, 2009).

The strength of the interview was its privileged access to the student's perceptions of their everyday world (Kvale and Brinkmann, 2009). Open

questions were used but, on occasions, leading questions allowed an issue to be explored in greater depth. The student's non-verbal communication sometimes acted to supplement their stories. The student was encouraged to feel free to correct any false assumptions on my part during the interview. I have included an extract of an interview transcript to illustrate the process. (Appendix7)

4.8.2.4 Debrief

At the end of the interview I stopped the tape and asked the student if they felt comfortable and if there were any issues arising from their conversation. On a few occasions students had become distressed on recalling a humiliating experience or talking about mental health issues. I ensured that they knew about sources of support in the University and reminded them they were welcome to contact me if they had any questions or would like to talk about any issues arising from the interview. The debrief also ensured that the student was content with their interview and confirmed their permission to report the topics that emerged during the interview.

4.8.2.5 Follow-up

I made notes after each interview, e-mailed the student to thank them for their contribution to the research. At approximately four-monthly intervals I e-mailed them to keep in touch, to enquire about their progress and to thank them again for their continued interest in the research. Some students contacted me to ask about further interviews, discuss their elective choices or to share interesting papers about empathy, evidence of their motivation and interest in the research.

4.8.2.6 Reflexivity

I wrote notes after, but not during, each interview and followed up unanticipated lines of inquiry by noting topics for subsequent interviews. Since I defined the setting of the interview and posed the questions there was inevitably an inequality in the power between myself and the student. There was a possibility that some students might have said what they believed I

wanted to hear. However, as I was not involved in their teaching or assessment at the University I would suggest that our conversations reflected issues that were important to them.

I reflected on these issues in carrying out the interviews and in my interpretation of the transcripts. Listening to the recordings later and immersing myself in the transcripts, I could identify occasions when I had interrupted students or missed important cues. An advantage of the longitudinal study was I could return to the topic at the next interview and so correct some of my errors. I found that as the study progressed, students selected the topics and the interview became more of a conversation.

4.8.3 Transcribing

The transcribing was carried out by an experienced medical administrator, which allowed me to spend more time listening to the interviews and immersing myself in the transcripts. Transcription involves a transition from oral to written discourse during which non-verbal communication is lost. Transcribing is an interpretive act and concurred with my phenomenological interpretivist theoretical stance. To elucidate the meaning and increase readability I have edited the quotes from the students' transcripts in the thesis only to remove repetitions e.g. 'and', 'erm', 'um', 'like', 'so', 'you know', and other mannerisms of speech, which might have made the student identifiable to their colleagues. I use an ellipsis [...] in the quotes to indicate where text has been omitted. I have not corrected the grammatical errors in the quotes. I have used italics for the students' quotes throughout the thesis to highlight their contribution to the research. Since the focus of this phenomenological research is the students' views I have not included my voice in the quotes but included a transcript of a sample interview and made my assumptions clear in my reflexivity (Appendix 7)

4.8.4 The researcher- student relationship: the research alliance

I was a medical student over forty years ago, so I shared a common understanding with the students of their language and jargon. However, there are many differences in the medical curriculum and culture of today's students, who have been described as 'millennial learners' (Roberts et al., 2012). I had a genuine desire to understand the student experience and to represent their views. I respected the students and used empathy to develop my understanding of their views of empathy.

I had anxieties at the outset of my study around questions such as: "Will the students volunteer to take part? Will rapport be established? Will the students have anything to say?" I wanted my understanding to be challenged and to learn from the students. I tried to avoid an assumption that the students saw the role of a doctor in the same way as I did. I suggest that there are parallels between the patient-doctor relationship, namely a therapeutic alliance, and the researcher-student relationship, which could be called a research alliance.

In a longitudinal study there was an opportunity to develop a close trusting relationship between me and each student. This relationship fostered a safe atmosphere where they felt able to describe their experiences and also to express their feelings and emotions. However in this close relationship there was also a risk that they might reveal data that they did not plan to share. A friendly, trusting relationship with the student increased the richness of the research data but at times students exposed their vulnerability and voiced their distress.

I was reassured when the students felt confident enough to challenge my views or to correct my interpretation. In a wider sense the power relationship between myself and the student made me think about power relationships with the University. For instance, students described how they felt unable to challenge consultants or question their practice. They also talked about a

reluctance to give honest feedback for fear of repercussions from the medical school. This uncertainty was also revealed when they sought reassurance from me during the interview that their conversations were indeed confidential. I felt that it was helpful to our relationship that I had no part in their teaching or assessment.

I was aware of how my position as an older, experienced consultant might influence the students' responses. I respected the students as younger colleagues and felt privileged to listen to their experiences of the course I had a sense of responsibility to do justice to their stories.

4.9 Data Analysis

Despite reducing the number of interviews to 48, these generated a large amount of data. Data analysis began during the interview when I interpreted the meaning of their accounts, sought clarification and explored some issues in more depth. My notes made after the interview also contributed to my interpretation and analysis. The longitudinal design offered the opportunity for clarification and further exploration at the subsequent interviews.

Each recorded interview was transcribed and the analysis aimed to develop the meaning of the interviews. Analysis of the transcript was a way of continuing the conversation with the student. The challenge I faced was to reconstruct the original students' accounts into a story I wanted to share with my readers (Kvale and Brinkmann, 2009). In this phase I was aware of my responsibility to the students and to the medical school in interpreting the data. From a phenomenological and ethical perspective I carried out the data analysis without involvement of the students as I considered that it would be difficult to maintain confidentiality if they were involved in the analysis (Karnieli-Miller et al., 2009). It was also possible that students might be less willing to disclose

their views if they felt their peers were going to be involved in the data analysis. I would suggest that there was no need to expose the students to the data to increase the credibility of my research, it was my methodological thoroughness that gave this study credibility (Karnieli-Miller et al., 2009). I accepted that readers might have different interpretations of the students' accounts.

4.9.1 Interpretative Phenomenological Analysis (IPA)

Authors have emphasised that Interpretative Phenomenological Analysis (IPA) is not a proscribed single method for working with the data but is a flexible approach to data analysis rather than a distinct method (Smith et al., 2009, p.79, Larkin et al., 2006) Although my description listed a number of steps, in practice the analytic process was iterative, going back and forth from the data to my analysis, from the particular to the general.

4.9.2 The data analysis process: IPA (Figure 2)

The iterative process is described in detail in a number of steps which are summarized in Figure 2 (Smith et al., 2009):

1. I began by listening to the recording of each student's interview and correcting any "typos" in the transcript. A sample of a transcript is included (Appendix 7).
2. I re-read the transcripts, immersing myself in the content and making rough notes of important themes that emerged from the data. A theme refers to a specific pattern of meaning found in the data (Saldana, 2013).
3. I downloaded the transcript on NVivo 10, a computer software programme, that I used to store the data and for my coding (Bazeley and Jackson, 2013).
4. I carried out a close reading of the transcript, line by line, analysing the claims, concerns and understandings of the student. In doing so I identified emergent themes, commonalities and divergences (Saldana, 2013).

5. For each theme I created a keyword or code on N Vivo and stored the relevant part of the transcript within the code. I found it useful to include a few sentences of text to retain the context of the theme (Saldana, 2013). I began to conceptualise what was emerging in the data and to grapple with meanings (Saldana, 2013). I include a segment of transcript which illustrated the coding (Appendix 7)
6. As the themes developed in the story, I found that some parts could be coded within a number of themes. I wrote memos to remind myself of how the codes had developed recorded ideas about my interpretation and listed questions to follow up in the next interview.
7. A framework of codes was derived from the data, I include an example of a coding framework (Appendix 8). Initially there were around 100 codes, but gradually the framework reduced in number when relationships between them became apparent. It was important to my phenomenological approach that the coding framework emerged from the reading and re-reading of the transcripts and was not imposed on the data (Smith et al., 2009).
8. After each student's transcript had been coded, I wrote an individual interpretative summary of their story and the themes that had emerged.
9. Once I had completed a student's story, I moved to analyse another student's story in the same year of their study.
10. I repeated the analysis for each student year by year and completed an individual folder for each student with three years' of my summarised data analysis. I read and re-read these folders to become familiar with the data and my interpretations.
11. After completing the analysis of eight transcripts in each year of the course, I looked at the themes across each year in turn and could see where students had talked about certain topics. I wrote a summary of my interpretation of the views of the students in each year of the course developing six folders with an analysis for each year. This iterative process involved comparing not just the individual from one interview to

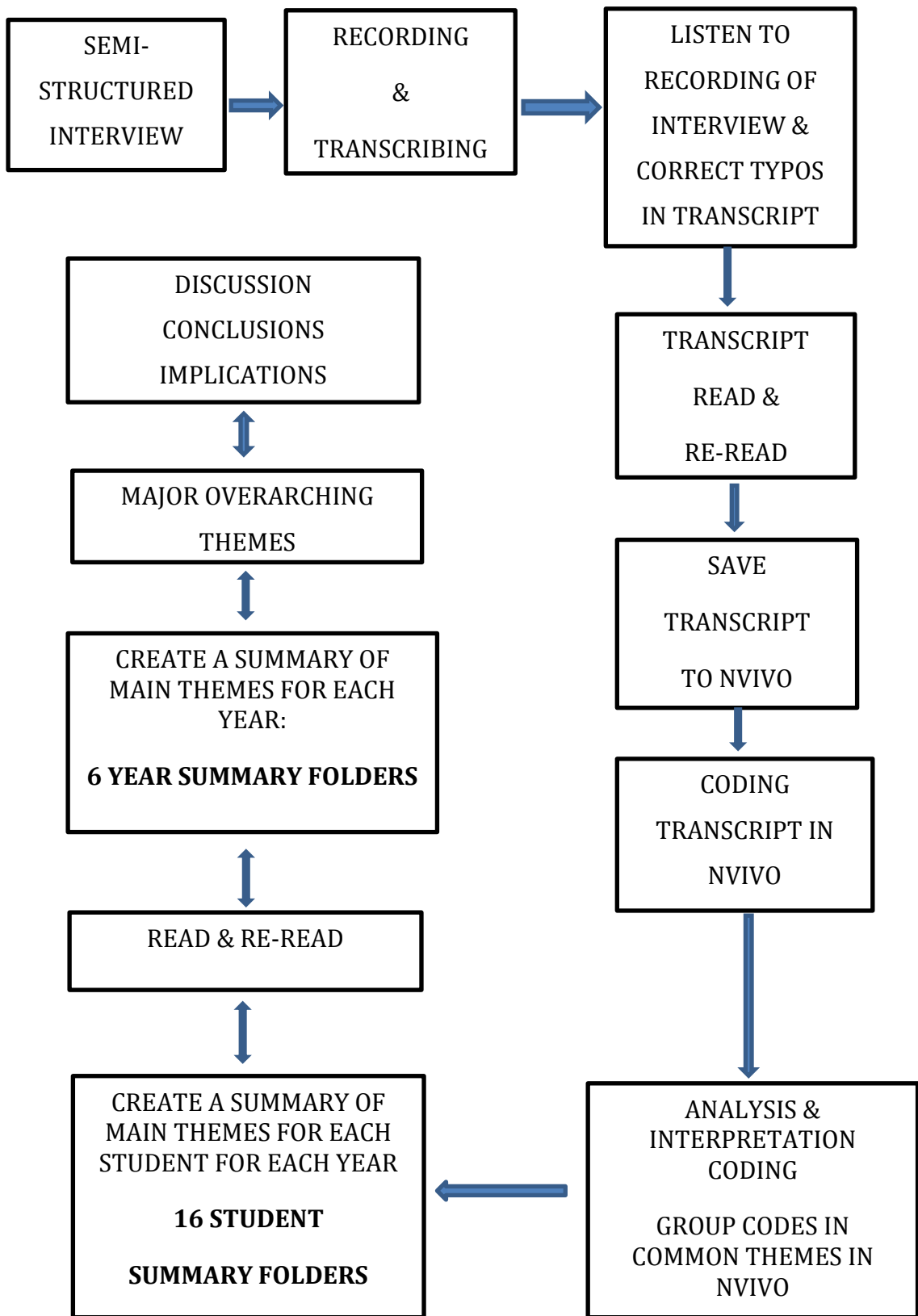
the next but also looking across each year in a cross-sectional way to gain understandings from the whole group. I was aware of the challenge to retain the idiographic focus of the individual student's voice, while making claims for the larger group.

12. Themes emerged as the data were scrutinized, generating new insights. Analysis was an iterative process with emergent themes informing future interviews. I was aware that I needed to develop analytic categories which tested my assumptions and did not merely reproduce them. As this was a longitudinal data analysis it also focused on how the student's views changed over time (Murray et al., 2009). As I constructed themes my interpretation was interactive as well as being iterative. The coding framework indicated themes which occurred frequently as well as the occasional responses. (Appendix 8) The nuances of the high frequency themes were explored in depth. The question arose as to how to process minority experiences of a particular theme. Since these might have expressed what many students took for granted, or articulated something that most members of the sample found difficult to voice.
13. Reflection of my perception and process led to a more interpretative approach involving the hermeneutic circle of moving between the part and the whole. In this way a framework evolved which illustrated the relationship between themes. My coding frameworks, notes and supervision reports form an audit trail of this analytic process. I found that discussion with my supervisors and presenting the analysis findings to colleagues helped to enhance the plausibility of my interpretation.
14. This process led to the development of a full narrative detailing the connections theme by theme. I used the students' own language extensively as their quotes reflected what they wanted to say and demonstrated my respect for their views. For reasons of space I have omitted my interview questions in the findings but include a sample of a transcript in the Appendix for the reader to judge my input and appreciate how the findings were constructed between the student and

me.(Appendix 7) My constructivist epistemology acknowledged that the interpretations I offered were tentative and that other researchers might interpret the data in a different way. This plurality of interpretation is legitimate in hermeneutics.(Smith et al., 2009) Rigour in the interpretation was demonstrated by including counterevidence. I was not involved in a biased subjectivity which merely reaffirmed my own presuppositions(Smith et al., 2009). My interpretation, was not a weakness but was a further test of the rigour of the research (Smith et al., 2009).

15. Finally a full narrative was developed with a commentary on the data generated which takes the reader through the interpretation theme by theme. The major overarching themes which emerged are described and discussed in relation to the literature.
16. The process of analysis is set out in Figure 2.

Figure 2 Data Analysis using Interpretative Phenomenological Analysis



4.9.3 Computer-assisted Data Analysis

Computer assisted data coding was helpful in moving between student's transcript and the whole story and to observe how changes evolved (Bazeley and Jackson, 2013). I used the software NVivo 10, because it was a relatively simple package that was supported by the University. I employed this software primarily to store my data and for coding. It allowed me to examine the patterning of themes across the range of interviews, and to group chains of association within interviews (Appendix 8). More specifically, the filtering functions of N Vivo10 allowed me to retrieve the patterns of codes prevalent in particular groups and display them as frequency charts (Appendix 9).

4.9.4 Note writing

Notes were kept in each student's individual folder that acted as prompts to analyse data and codes. I used these notes to explore meaning, thus forming an intermediate stage between data collection and writing drafts of the findings. They encouraged me take codes apart to compare and define links between them. I used a mind map format to develop a clustering of codes and found a whiteboard helpful to keep a visual picture of themes in front of me as I worked.

4.10 Quality of the Research

The research described a significant problem in clinical practice which was addressed by carefully considered research questions. The research had clear aims and was justified by the theoretical framework, including an appropriate methodology and methods. My perspectives were made clear throughout the study. The methods and their philosophical underpinning were described in detail. I used the Consolidated Criteria for Reporting Qualitative Research (COREQ) as checklist that ensured that I reported the most important aspects of my study methods (Tong et al., 2007).

4.10.1 Quality measures

Qualitative methods share an interest in analysing data to explore meaning rather than statistical differences or relationships. Notions of trustworthiness, strength and transferability of knowledge in social sciences are equivalent to reliability, validity and generalization in quantitative research (Kvale and Brinkmann, 2009).

4.10.1.1 Validity

Validation involved a complex interaction between the philosophical understanding of objectivity, the social sciences concept of validity, and the practical means of verifying interview knowledge. I reflected on the question of whether interview knowledge could be objective. Objectivity itself is an ambiguous term implying freedom from bias but my research included reflexivity about presuppositions (Kvale and Brinkmann, 2009).

Kvale proposed the concept of craftsmanship rather than validity in qualitative research (Kvale and Brinkmann, 2009). Craftsmanship involves the credibility of researcher, the questioning of findings and their interpretation. I have adopted this model of craftsmanship from the outset of my research by relating my phenomenological investigation with weaving.

Validity of qualitative research is concerned with whether my interpretations fit the description of the account. As there is no single correct interpretation the reader has to ask, 'Is the explanation credible'? The criteria for credibility include: my theoretical framework and explanations of how my research questions and data were generated. Questions of validity permeated the whole research process and included; the adequacy of study design and methods, trustworthiness of interviews, transcribing, analysing, logic of interpretation and validating by reflexivity (Miles et al., 2014). I further validated my research by using extreme cases and checking for alternative explanations. My work was also validated through negotiation with supervisors, academic staff, by publication and by presentation.(Appendix 1)

4.10.1.2 Reflexivity

Reflexivity was an essential component both of the interpretation of the data, the evaluation of the research methods and of the outcomes (Finlay and Gough, 2008). By engaging in reflexivity, which was not obsessive, I took responsibility for the interpretation of the data and accepted that the knowledge gained from the interviews was socially constructed.

4.10.1.3 Reliability: Trustworthiness

Reliability is related to reproducibility, consistency and the trustworthiness of the findings. While some areas of my research, such as the transcribing, were amenable to this concept of reliability. The concept of reliability is replaced in this research by the notion of trustworthiness of the researcher. As phenomenological-interpretative research is at its heart a creative endeavour, there was a need to follow one's intuition and not to stifle creativity (Kvale and Brinkmann, 2009). My transcripts, student summary folders and year summary folders, notes, supervision meetings and my reflexivity formed an audit trail and demonstrated my commitment, rigour and sensitivity to the research.

4.10.1.4 Transferability

Rather than generalising from my research, I sought to explore to the extent to which the findings at one medical school were transferrable to other institutions and students. Conclusions from interpretative-phenomenological research are necessarily tentative but I hope that the insights presented in this thesis resonate with my readers and particularly with those involved in medical education.

4.10.1.5 Transparency

I wished my thesis to report as precisely as possible the specific procedures and decision-making in order that the readers could assess whether the research had been performed conscientiously.

4.11 Other qualitative methods considered

I would suggest that many qualitative research methods are generic, for example, in using semi-structured interviews, coding of themes, ethical responsibility and writing which balances narrative and illustration (Holloway and Todres, 2003). I considered two other qualitative methods for studying empathy, answering my research questions and addressing my research aims; grounded theory and ethnography.

Grounded theory is concerned with developing a theory of how people make meaning together (Charmaz, 2014). It is often concerned with developing data into useful conceptual patterns and creating models. IPA overlaps with grounded theory methods which provide a frame for qualitative inquiry and guidelines for conducting it (Charmaz, 2014). Basic grounded theory strategies such as coding, memo writing and sampling are strategies which cross epistemological and ontological boundaries (Charmaz, 2014). Grounded theory is better suited for explanations at a conceptual level and for generating theory. However, my focus was on understanding the meaning the students' gave to empathy and its influences and was not concerned with developing a theory.

Ethnography is concerned with describing and understanding a particular social setting and is carried out by intensive fieldwork involving participant observation (Holloway and Todres, 2003). Although I have argued in my thesis that there is a need for such studies of medical students' professional socialisation, I rejected this method as I could not immerse myself in the students' world due to my age. The ethical barriers to obtaining consent and the practical difficulties of working in a variety of clinical settings over such a long period were further reasons why I rejected this approach. In my research I chose a phenomenological-interpretative approach which differed from a prescriptive method, conveyed a coherent epistemology and remained consistent yet flexible (Holloway and Todres, 2003).

4.12 Ending the research

At the end of the final interview with the student I thanked him/her again for their contribution to the study. I asked them for feedback about how they felt about the study, any aspects they had enjoyed and areas where it could have been improved for them. I informed them that I would send them an abstract of the thesis and they were welcome to read my thesis. I acknowledged that the interpretation of their stories was mine and I accepted responsibility for any errors. I said that they would be acknowledged anonymously in my thesis and they would receive an acknowledgment of their input to the study for their portfolios. I closed by offering them a chance to raise any other issues and reminded them they were free to contact me in the future by e-mail.

4.13 Summary

This chapter presented a detailed description of the way in which I conducted the study and was supplemented by further evidence of the process in a number of Appendices. Interpretative-Phenomenological Analysis conducted in this longitudinal way is a novel method in medical education research. The central importance of reflexivity was emphasised both for the data analysis and for establishing the trustworthiness of the study. The next five chapters present the findings of the study which are discussed in relation to the literature.

Chapter 5: Students discussing the nature of empathy

5.1 Overview

This chapter addresses my first research question;

How do students talk about and experience the concept of empathy in relation to professionalism and practice?

I sought to understand how the students viewed empathy. Two broad ways of conceptualising empathy emerged from their interviews; as a personal attribute or as a dynamic relational concept. In the early years students explored various dimensions of empathy: cognitive, affective, behavioural and moral. With clinical experience, students reflected on the process of empathising, highlighting the effect of the clinical context on empathetic practice. They were concerned that sharing feelings with patients may make them emotionally distressed, or interfere with objective clinical decision making. In the final years of their course the students reflected on this tension between connection with and detachment from patients and described the challenges they faced in regulating their empathy appropriately.

The narrative of the students' accounts follows the emerging themes rather than following an individual student's story through the course. This is theoretically consistent with my phenomenological approach, which is focussed on the phenomenon empathy and its influences. I hope that this approach will resonate with the reader, particularly medical educators. This account of the students' experiences and views is followed by a discussion relating the findings in the recent literature. The students began by explaining why they believed empathy was central to patient care.

5.2 The significance of empathy

Students related empathy to trust, a good patient-doctor relationship, with improved outcomes and satisfaction for patients. They suggested that

Chapter Five

empathising enabled a patient to voice their real concerns and so to be more involved in their care.

“if you feel that your doctor understands you then you are more inclined to talk about mental health issues, social issues”(Edward, Year1)

“they [patients] are much more likely to stay involved and stay telling you things and just generally being on board” (Fiona, Year 2)

Some students described empathy as a bridge between the doctor and the patient. This connection ensured that treatment decisions met the patient’s goals of care. Helen noticed that in a chemotherapy clinic some patients seemed to agree to the treatment plan without questioning.

“quite often patients[are] just going through with treatment just because it is what you do” (Helen, Year 1)

Although all students reported that empathy was central to their practice, Marilyn argued initially that the main priority of medicine was to improve the patient’s condition. However, later in the same interview, Marilyn modified her view agreeing that in certain contexts empathy assumed a higher priority.

“because caring won’t make them better”(Marilyn, Year 1)

“perhaps in palliative care you have reversal of empathy where in fact that becomes your priority”(Marilyn, Year 1)

Lisa claimed that empathy enabled the patient to feel acknowledged as a human being, not merely as an object of scientific interest, so differentiating medicine from a technical job. Neville asserted that empathy was a fundamental part of being a doctor.

“I think that if you don’t have any empathy then you see the patient as an object. What defines, well makes, medicine different from say being a mechanic” (Lisa, Year 4)

“I think the fundamental thing about being a doctor is the human interaction” (Neville, Year 4)

The students’ stories revealed empathy to be a complex construct.

5.3 The complexity of empathy

Students talked about the complexity of empathy describing it in terms of a personal attribute and as a dynamic two-way relationship, which depended on the context of the patient-student consultation. They explored the practicalities of the process of empathising with a patient.

5.3.1 A personal attribute

Students observed that some people seemed better at empathising than others. Kim linked this empathetic ability with their capacity for imagination, viewing empathy as a personal attribute.

“probably innate in that some people tend to have vivid imaginations and some people don’t” (Kim, Year 4)

5.3.2 The dimensions of empathy

The students described four dimensions of empathy: cognitive, affective, behavioural and moral.

5.3.2.1 Cognitive (understanding)

Students in the first year shared a variety of notions of empathy as a cognitive construct and described this as trying to see the world from the patient’s point of view.

“Empathy is trying to put yourself into someone else’s shoes and experience essentially for yourself what it is like to be in that situation. But I think true empathy is trying to understand it from their side it’s not about you but you are always the starting point” (Connie, Year 1)

It appeared from this account, that although empathy involved trying to see the world from the patient’s perspective, the process starts with the empathiser,

who is inevitably implicated in the encounter. Some students proposed that the cognitive dimension of empathy differentiated the construct from sympathy. They acknowledged limits to empathy, since it was not possible to know for certain what another person was thinking.

“interpret things from their point of view rather than feel sorry for them, which would be sympathy”(Gina, Year 3)

“because it is also hard to think what they are actually thinking”(Diana, Year 4)

5.3.2.2 Affective (emotional)

Although all students agreed that trying to understand the patients' view was their prime concern in empathising, there was less certainty when it came to discussing the emotional aspects of empathy. There were mixed views on whether it was appropriate to share feelings with the patient. Some students implied that empathy involved actually experiencing the patient's emotions. Others spoke of limiting emotional involvement to understanding the implications of the patient's feelings. Olive maintained that empathy involved a sharing of emotions and experiencing the feeling oneself, suggesting it was possible to know exactly how the other person was feeling. However, later she reflected on this view and suggested that some distance from the patient's emotion might be more appropriate, demonstrating the ambiguity shown by most students when discussing empathy and emotions. Other students argued that to understand a patient properly it was necessary to share feelings.

“I think it is just being able to put yourself in their shoes and know exactly how they are feeling and be able to take some of that upon yourself. And share whatever they are feeling” (Olive, Year 1)

“I don't think you necessarily have to feel anxious but I think you have to understand what their anxiety is doing to them or what their anxiety is causing them to feel”(Olive, Year 1)

"I would have to be able to understand properly what they are going through. I would have to try to imagine myself feeling some of their feelings" (Kim, Year 4)

Although many of the students suggested that sharing feelings with the patient was a part of empathy, they also were mindful that too much emotion might be overwhelming. Paula suggested that while it was appropriate to share the patient's feelings, it was not necessary to share the same intensity of emotion as that of the patient.

"I don't think you can be truly empathetic without [being] personally affected the way someone is feeling. Equally there is an element, you can't take on everything that the person is feeling. So you can be empathetic in being understanding toward them without necessarily feeling everything they feel" (Paula, Year 4)

However, in contrast to the majority of students, Marilyn advocated that doctors should remain detached from the emotions of the patient.

"Feeling what the patients feels no, no, no, no, no, no, no, no. So if we are going by that strict definition of empathy, don't do it! Don't do it." (Marilyn, Year 1)

5.3.2.3 Behavioural

The students attributed a behavioural quality to empathy, involving an action to help the patient. Diana linked empathy to altruism, as empathy engendered helpful action.

"You have to understand them in order then to take right actions appropriately". (Fiona, Year 2)

"doing something, something for somebody without necessarily without have any plans to get anything back from it" (Diana, Year 5)

Students also gave other examples of actions resulting from empathy; deciding how to present a treatment option to a patient or using empathy as a tool to aid

patient compliance. This example demonstrated that empathy might be used to direct the patient.

“a useful tool in order to try and convince maybe a person who has been say a lifelong smoker and has COPD, in order to change” (Jenny, Year 4)

5.3.2.4 Moral

Students talked about empathy as a moral construct; as a motivating force to provide care, or as a virtue of a good doctor.

“if you say ‘What qualities does a doctor need?’ Empathy is always one of the words that comes up” (Fiona, Year1)

In describing empathy as a personal attribute students focused on static abstract concepts. However, with clinical experience, a richer more nuanced picture of empathy emerged from their stories: empathy as a dynamic two-way relationship.

5.3.3 A relational view of empathy: The process of empathising

The commonest perspective among the students in the clinical group was of empathy as a relational process, rather than as a personal attribute. Empathy between two people was seen as being influenced by the context of the relationship.

“empathy takes two people and even if one person is the same, changing the other person is going to change the way that they are empathising” (Connie, Year 2)

Students explored this dynamic process by describing a series of steps which might be involved, beginning a willingness to empathise with the patient.

5.3.3.1 Approachability

All students expressed a willingness to empathise. They described this as being interested to learn more about the patient in a collaboration.

"If you are interested in a person and people in general and just interested in people being OK [...] then you will intrinsically feel that empathy and desire for relationship" (Olive, Year 2)

"ask what her concerns are?, what does she want to know?, what her understanding was at that point of time? Can we can we work together on this?" (Neville, Year 4)

They maintained that first impressions were the basis for establishing empathy, implying that patients made a rapid judgement as to how approachable they found the student. Diana described how a warm empathetic greeting could set the tone for the whole consultation with the patient, in establishing rapport.

"you make your first impression, first ten seconds you meet someone" (Gina, Year 4)

"giving the impression that they respect you and that they care about you as a person ,[...]give a handshake as they walk in, 'Hello ,how was your day?'. From there they think I'm a human being and they think that[...] they care about whether I'm in a good place or not and whether I can deal with what is going on right now" (Diana, Year 4)

5.3.3.2 Listening

Students suggested that empathy could be established merely by being present and prepared to spend time with the patient. Amy explained how she abandoned her medical agenda to sit listen to the patient.

"I just put my pen and paper aside, and stop writing every single thing, frantically trying to scribble all the history. I just thought OK, I'm going to listen to her and then she opened up, and she cried" (Amy, Year 4)

Students described empathetic listening as a key part of forming a connection with patients. Gina suggested that it also involved demonstrating to the patient that you have heard their concerns.

"being empathic and listening other patient they need to know that you have been doing that, to really feel like they

have gotten something out of the consultation” (Gina, Year 5)

Since students had emphasised the necessity for listening to the patient they described feeling distressed when pressure of time did not permit this. In this situation found that they had to balance their empathy with a competing demand to be efficient; they described a tension between empathy and efficiency. This tension was one of the major themes discussed by the students during the research.

“I would love to sit and listen, listen to that person. It is always finding that balance of efficiency, professionalism, making sure the patient is safe and also being a good human being” (Neville, Year 6)

5.3.3.3 Emotions

In the next step of empathising, the students discussed whether it was appropriate to share their feelings with the patient. Most students said that feelings were an integral part of empathy and should involve not just identifying and understanding the patient’s emotion but also sharing it to a degree. Some suggested that it was appropriate sometimes to show their feelings.

“I think it is important that they [patients] know that it has affected you” (Edward, Year 1)

Connie questioned whether it was even possible to understand an emotion without feeling it, implying that empathy could be emotionally exhausting and may require effort. She reflected how the patient viewed an empathetic doctor, proposing that sharing feelings was a way of demonstrating that she cared. She reflected on empathy as a response which acknowledged the other person and opened up opportunities to help the patient.

“We have some sort of emotional activity going on. It can be exhausting, it can be draining” (Connie, Year 2)

“Because if they empathise with me they are clearly interested in what is best for me, [...] and because of that I

can now open up to them further and also expect them to respond sensitively and appropriately and with the due empathy" (Connie, Year 2)

"it is about a response that lets them know you understand not just academically but you can personally connect with their situation. Which then opens up a number of opportunities for[...]for help"(Connie, Year 2)

On the other hand, Fiona exemplified the ambiguity many students felt about sharing feelings, initially arguing that it was not necessary to experience the patient's emotions, but a year later, describing emotions as being innate and shared.

"to be empathetic I don't think you have to take on the feelings as such. You have to understand them in order than to take right actions appropriately" (Fiona, Year 2)

"If someone is crying then definitely I start crying as well. Emotions are below, they are innate within us [...]I think there is that transfer of emotion" (Fiona, Year 3)

Neville claimed that he had to experience the patient's emotions to be a good doctor, using the metaphor of a roller coaster. He also maintained that the student need not experience the same intensity of the emotion as the patient.

"Unless you do that, unless you feel that roller coaster I don't think you are a good doctor" (Neville, Year 5)

"some accurate feeling, obviously you are not going to feel the same way he is you need to be able to appreciate what they feeling"(Neville, Year 5)

Kim described a more sophisticated process of switching between different forms of empathy, cognitive and affective, adapting the form of empathy to the needs of the individual patient.

"I think to be able to empathise properly with that person there has to be an emotional component [...] I suppose you can switch between the two [...] If you go and see a patient

you can apply a different method depending what is necessary for that patient”(Kim, Year 4)

Some students like Marilyn, expressed concerns about sharing emotions. Ida suggested that her role was to support the patient and was concerned that by sharing feelings she might burden the patient. Diana reflected that trying to control emotions completely would have a psychological cost to her.

“if I feel that patient would benefit from me showing that I really care then I might express that but I would be rather careful with it” (Marilyn ,Year 2)

“because they already have so much burden themselves I don’t want them to feel like have to take care of me because it should be the other way around” (Ida, Year 6)

“It is going to build up eventually isn’t it?[...] There is no point being like an emotionless almost a robot” (Diana, Year 5)

5.3.3.4 Vulnerability

Many of the students said that to be empathetic involved exposing some of their vulnerability. They suggested that they should act in a natural, friendly manner on the same level as their patients. They implied that doctors needed some common humanity and to be prepared to share their vulnerability, and claimed that patients appreciated doctors who were prepared to do this

“anytime you show emotional connection with another person you have in some way invested the way you feel in the way that they feel. That does to some extent put you, well make you vulnerable” (Connie, Year 2)

Other students admitted that their own lack of life experience and knowledge made them feel unsure. However Fiona pointed out that vulnerability could sometimes be an advantage, by placing the student on the same level as a patient, it could facilitate empathy.

“or you can turn it on head and say actually if you don’t have as much knowledge you are exactly same level as the patient”(Fiona, Year2)

Others suggested that some patients might be disturbed by a doctor showing vulnerability, but Olive said that she preferred a doctor to be open, suggesting that that this might lead to more understanding.

“If a patient is wanting their doctor to be completely bullet proof and all that kind of stuff it won’t help the patient for them to know actually that their doctors vulnerable too. But I think personally I would appreciate [the doctor] being open about that” (Olive, Year 1)

The students suggested that one way of sharing vulnerability was self-disclosure about their own experiences of illness. Olive warned that although this could be helpful but she could see dangers in making assumptions. In the clinical years, students became even more cautious about using self-disclosure, perhaps wishing to avoid burdening the patient.

“I think it can be really helpful for some patients. I don’t think it needs to be I had this exact same disease either” (Olive, Year 1)

“I have stopped doing, I used to share quite a lot of my own stories from own view point in order to kind of get a connection with people” (Jenny, Year 4)

Kim recognised that there was a balance to be achieved, that some self-disclosure might help to establish empathy but there was a difference between the patient-doctor relationship and that of friendship. Friends often shared their personal information but patients knew little about their doctors’ personal lives.

“With the doctor patient relationship it is quite difficult in a way because as doctor you got to know a lot about that patient but they don’t necessarily know very much about you at all” (Kim, Year 4)

5.3.3.5 Non-judgemental

Students maintained that they should strive to be non-judgemental and suggested that patients may confide more in them as students rather than doctors. Students found some patients were easier to empathise with than others, but felt obliged to try to empathise with every patient, as it affected the quality of care.

“if patients are nicer patients, if they are friendly to you and everyone around, it is easier to want to empathise with them, see their perspective and really address their needs. Obviously you still have to try even if you don’t like a patient it can’t influence your care” (Gina, Year 4)

Confronted with patients whose illness was due to an unhealthy lifestyle, Fiona distinguished between an initial ‘gut reaction’ to such patients, and a more reflective stance, which considered the possible reasons for their unhealthy behaviour. Marilyn thought she would become more judgemental as the course progressed and was surprised that she had not.

“your first gut reaction is yes this is because of life choices but then your second level of thinking is actually how free they were to make those choices ?” (Fiona, Year 1)

“I thought I would slowly develop a distaste for certain people, for groups of people, who drink and smoke and are obese and don’t even try and then come in for this and that” (Marilyn, Year 2)

The students identified patients with a number of clinical conditions which challenged their empathy and their need to be non-judgemental. These patients, who both challenged and developed their empathy, are described in Chapter 6.

5.3.3.6 Continuity of care

Olive, argued for the need for continuity in her relationship with a patient. Gina, too, reflected on the difficulty of gaining an idea of the patient’s experience from

the brief 'snapshot' she saw of them in the clinic. Paula expressed her sense of job satisfaction in having good relationships with patients.

"I think the continuous relationship is important and I think you can become more empathetic with people you know better" (Olive, Year 1)

"you only ever see a snapshot of that patient at that time and that life and what they say there"(Gina, Year 4)

"it is very fulfilling interacting with people that is what is enjoyable about the job"(Paula, Year 5)

5.3.3.7 Understanding

Students identified two stances for taking a perspective on the patient's world, either a self-or an other-orientated perspective. Students felt that empathy should involve taking the patient's perspective (other-orientated). Since, as Fiona argued, it would not necessarily help a patient for her to imagine how she would feel in their situation.

"there is no point in how you would, as in I would feel in that position because that is not going to help me treat that person better"(Fiona, Year 1)

Gina reflected that although she tried to take an other-orientated perspective, she tended initially to take a self-orientated view. Other students described a sense of being overwhelmed in empathising when they thought, 'what this would be like for me?' It appeared that taking such a self-orientated perspective could cause personal distress.

"you are trying to put it from their perspective but actually thinking how you would feel in that situation" (Gina, Year 4)

"Sometimes I just find yourself imagining, What if I had that?" (Paula, Year 4)

"I think it is not appropriate to imagine yourself in their place because that will mess you right up. It is not

appropriate to look at a dying cancer patient and think 'Oh my God, what if that was me?'" (Marilyn, Year 1)

Students were concerned not to project their own view on to the patient but tried to imagine things from the patient's perspective. Olive described this imaginative process as 'getting it'.

"I think it is very important to find out what's the priority, what the patient actually wants rather than what you want" (Amy, Year 4)

"I don't have to force myself to do all of this because I am on a ward and I 'get it' [...] So even though I don't have Mr Smith in front of me who has COPD, I can see how breathless he is. I can imagine" (Olive, Year 3)

Kim reflected on the role of her personal experience of illness in her perspective- taking in empathy, claiming that empathy was possible without having had the same experience as the patient. Paula suggested that empathising involved a pause, a step back, to try to appreciate the wider picture.

"I think empathy is where, without necessarily being through the situation yourself, you are able to understand what other people are going through and have some insight into how they are feeling and what they are thinking" (Kim, Year 4)

"sometimes to make a good clinical judgment maybe it is better to just look at the whole picture and step back and how you feel about it in order to be analytical and find the right solution" (Paula, Year 5)

5.3.4 Levels of empathy

Students suggested that empathy could also be expressed at different levels. After their first exams, they described a superficial level of empathy as 'fake' empathy. In this situation, the student displayed behaviours such as body language or tone of voice which suggested they were being empathetic but in fact they were not attempting to see the world from the patient's point of view.

Such 'fake' empathy might, for example, be displayed in exams with simulated patients such as the Objective Structured Clinical Examination (OSCE).

"we know that people are going to be looking for it when we are examined and that we need to clearly demonstrate it". (Connie, Year 2)

Although most students agreed that empathy could be faked, they emphasised that it was only valued when it was authentic. They argued that patients would soon detect 'fake' empathy, suggesting that a genuine approach would lead to a deeper understanding of the patient's needs, and to the delivery of appropriate care.

"if it is actually genuine then it will give you just a whole other level of understanding and hopefully that will give you a whole other level of treatment" (Olive, Year 2)

However, one student took a different view, claiming that as long as the patient felt that she was empathised with, then the authenticity of the empathy did not matter. She seemed to be suggesting that as long as the patient feels cared for it is less relevant what the doctor feels, so disregarding feelings of job satisfaction. For Marilyn, it was the patient's condition which was paramount.

"If you can behave empathetically and your patient feels happy, if your patient feels supported, if your patient feels you care. What you get is of no consequence" (Marilyn, Year 2)

In the clinical years students talked of another level of empathy, of detached concern, in which the cognitive elements of empathy predominated and affective elements were absent. Kim described seeing consultants who appeared to be detached from the patient.

"I see other extremes of practice where they don't introduce their name, themselves and they just go in" (Kim, Year 4)

Students also described a 'deeper' level of empathy which involved a greater understanding and a sharing of emotions.

“I think that empathy [involves] just [that] extra level of understanding, more emotions” (Fiona ,Year 2)

Some students reflected that these levels of empathy might be adapted to meet differing clinical contexts and the individual patient’s needs and they noticed that this adaptation does not always occur.

“Not every patient wants the same thing ,so we as doctors need to be adaptable and I think because we are not always aware of the patient experience ,we have our way of doing things and we do that for all patients”(Gina, Year 6)

From the students’ accounts, empathy emerged as a multi-dimensional, dynamic concept which differed in various clinical situations, some students stressing understanding but for others, sharing feelings was paramount. They saw the various dimensions of empathy interacting but altering in emphasis according to the context of the relationship and the needs of the patient.

Three major themes relating to the process of empathising emerged from their conversations; their perceived risks of emotional connection with patients, detachment as a coping mechanism, and the question of how to regulate emotions.

5.4 Process of Empathising Theme 1: The risks of emotional connection

While most students maintained that sharing emotions was an integral part of empathy, they also expressed concerns about the risks of this connection. These concerns related to two areas, that they might become overwhelmed by emotions, or that emotions might cloud objective clinical decision-making. Fiona saw a danger in becoming too emotional and suggested a need to develop mechanisms to cope with the emotions she encountered in practice.

“it could be potentially very bad for an individual to take on all that emotion and therefore generally develop coping mechanisms to deal with dealing with all these sort of emotional luggage that comes with it” (Fiona, Year3)

There was uncertainty amongst the students about the effect of emotions on clinical decision-making. Fiona acknowledged the risks of being too emotionally involved but emphasised that experiencing the feelings of the patient could inform clinical decisions.

“the patient’s emotions always have to be taken into account in your decision making but I feel you feeling them yourself doesn’t, you don’t need to. But I think you got to be able to. I don’t really think you can understand emotions without feeling them” (Fiona, Year 2)

On the other hand, Marilyn was clear in her view, that emotions may cloud judgement or even harm the doctor or the patient. She cited the general prohibition on doctors treating their own family as evidence for the need to avoid emotions in decision-making.

“it will cloud your judgment and it might not make you as good a physician” (Marilyn, Year 2)

“You are not going to make good judgement calls if you are biased, and you will be biased if you care too much” (Marilyn, Year 1)

Some students were concerned that by getting too involved with the patient they risked projecting their own feelings onto the patient.

“I think it is almost if you have too much empathy you may occasionally try to start to make decisions for the other people because you feel you understand them so much, when it is still their decision” (Bill, Year1)

Neville claimed that there was a widespread belief amongst medical students and doctors that emotions threatened objectivity. He rejected this belief, affirming that emotions should be taken into consideration in clinical decision-making.

“I think the biggest reason is because it interferes with their thought process of being objective and being evidence based” (Neville, Year 4)

*“but unless you understand what the patient wants you can’t do anything for them, any therapeutic intervention”
(Neville, Year 5)*

Students may respond to their perceived risks of emotional connection by distancing themselves from patients and by restricting their empathy to cognitive rather than affective domains. All of the students debated distancing or detachment as a strategy for coping with the stress of emotional connection.

5.5 Process of Empathising Theme 2: Detachment as a coping strategy

Students talked about neglecting emotional connection with the patient and restricting empathy to the cognitive domain, where the doctor became distant from the patient. However they expressed concerns that such distancing could cause stress. Olive feared that although connecting emotionally could lead to burnout, too much distancing could lead to ineffective patient care.

“I don’t think it leads to effective doctoring really, if you try and distance yourself too much” (Olive, Year 1)

Fiona was concerned that if a doctor was detached, there was a risk that the patient would not disclose their real concerns. Paula did not think detachment was appropriate, implying that doctors should be motivated towards working closely with patients.

“if they[patients]don’t feel like they are being listened to or understood then they will stop bothering to give the information” (Fiona ,Year 1)

“doesn’t seem very healthy to be entirely detached from patients [...]I think it would be wrong to be entirely detached from all the patients” (Paula, Year 3)

Olive and Marilyn also shared their reservations as to how effective such detachment would be as a coping mechanism, inferring that detachment could lead to its own stresses.

“no matter how much you try to distance yourself there must be something will upset you and resonate with you on an individual level” (Olive, Year 1)

“I think detachment might actually be a bit dangerous and unpleasant” (Marilyn, Year 1)

Kim questioned whether detached doctors found it more stressful to avoid exploring feelings, speculating whether their detachment was due to external factors or to the doctor’s personality. Lisa reflected that if she had to work in a detached way, she would feel unfulfilled and guilty. Some students noticed that doctors from certain specialities were more likely than others to exhibit detachment from their patients.

“maybe the people that don’t explore those type of things don’t find it stressful to not explore that but [...] what causes them not to go into it in the first place,? Whether it is [a] time constraint or an innate issue?”(Kim, Year 4)

“I probably feel that I could have done more. I hadn’t quite completely fulfilled what I really should have been doing that day” (Lisa, Year 4)

“surgeons, I suppose, would find it easier not to think too much about the patient under the covers” (Olive, Year 1)

Some students suggested that perhaps older patients might prefer doctors to be more detached, but considered that the majority of patients preferred doctors who connected with them.

“older generations expect a doctor to be like that and possibly strange or unnerving if they were not like that, they might not trust you, but most but with most patients they prefer to connect” (Bill, Year 1)

“the patients didn’t really appreciate the people who were very detached” (Fiona, Year 1)

The students debated the reasons why a doctor would behave in a detached manner. Jenny suggested that a detached doctor might save time as patients may be reluctant to approach them.

“if you look very disinterested and engaged in your environment people are more likely to leave you” (Jenny, Year 1)

Kim speculated about a number of reasons for doctors employing distancing tactics; their personality, workload, time pressures and a medical culture of immunity to feelings. There was a risk that in such a culture of, routines, targets and guidelines, doctors might forget that every patient was an individual.

“I suppose another part of it an immunity in a way you have done it so many times, it is so routine you forget that every patient is a new patient”(Kim, Year 4)

Another reason Kim suggested that doctors distanced themselves was as a form of self-protection from emotional distress. However Helen did not think that remaining cold and detached was best for the patient and questioned who was benefitting by being detached.

“I think it is self-protective [...] it is definitely easier not to take on the patient’s problems, not explore what they are feeling”. (Kim, Year 4)

“I think there is a tricky balance somewhere on there because I don’t think it is safer to stay cold and distant I think it detrimental to the patient to stay cold and distant.” (Helen, Year 1)

Paula argued that in some situations, it may not be necessary to explore the patient’s feelings, cognitive empathy alone might be appropriate. Marilyn implied that there was a balance to be achieved in effective empathy.

“maybe there is an argument for patients who are presenting with something that is quick and simply to fix and you can just maybe don’t need to go any more than that” (Paula, Year 6)

“You have to have some kind of distance but there is a big difference between that and not caring at all.” (Marilyn, Year1)

Students often linked detachment with professionalism and this aspect is considered in detail in chapter 8. The third theme related to the process of empathising was how an appropriate balance between connection and detachment could be achieved.

5.6 The Process of Empathising Theme 3: Balancing Connection and Detachment- The Self–Other Boundary

Students described a tension between connection with and detachment from the patient. They were concerned to achieve an appropriate balance to meet the patient’s needs and yet not to become overwhelmed. They reflected on how regulating distressing emotions were an integral part of a doctor’s role.

“you have to be empathetic to do medicine[...]but not too empathetic”(Paula, Year 5)

“you need to keep your empathy in check but that doesn’t mean that you can’t have any, but you need some control over it. You need some level of distance” (Marilyn, Year 2)

The students admitted that many found achieving this balance was difficult, particularly if they had a personal experience of the patient’s illness or were stressed.

“I think part of the challenge of medicine is not to take these things to heart, you have to kind of be able put them aside a little bit and draw lines. But I think sometimes that is really, really difficult to do” (Kim, Year 6)

“if there is something that is very personal, like you have had a personal experience of it is more difficult to maybe maintain that distance”(Kim, Year 6)

The students viewed detachment as inappropriate yet appreciated that in order to have an emotional connection with patients there needed to be a mechanism to regulate their empathy: a self-other boundary.

The students described a satisfactory empathetic approach as one where an appropriate psychological boundary existed between themselves and the patient. This was not to distance themselves but to recognise where the self ends and where the other person's problems are situated.

“you have to learn from the patient and learn from what they felt but progress through [the] medical and not get bogged down in every patient's emotion” (Kim, Year 4)

They discussed practical ways of developing this self-other boundary; compartments, patient experience, reflection, curiosity, resilience and support.

5.6.1 Compartments

Marilyn described a process of 'compartmentalisation', which did not mean complete detachment from emotions, but acknowledged a degree of distance. Fiona explained that 'compartmentalisation' included ways of achieving a balance between work and her personal life.

“there are detached doctors but I think they are terrible. I think more compartmentalisation is important” (Marilyn, Year 1)

“Leave work at work and then you have your home and your family and friends and people to support you and I think that is compartments” (Fiona, Year 3)

5.6.2 Patient experience

Some students suggested that the setting of boundaries between detachment and connection came with clinical experience. Olive compared the skill of empathising with learning to drive, suggesting that the self-other boundary became instinctive with experience.

“I think as you go through your training and you build and meet more and more patients and deal with more of these situations you build that how, what works best” (Fiona, Year 3)

“It is just like if you are driving ,you have to think about every single action you are doing, I am changing gears de de de and suddenly you have been driving a few years and doesn’t require so much thinking” (Olive, Year 3)

5.6.3 Reflection

Students described the importance of reflecting on experiences as part of the process of setting a self-other boundary. Creating a self-other boundary involved both greater self-awareness and a natural sense of the other person as being distinct from oneself. This process involved developing mechanisms of emotional control which required effort at first, but later became a natural response.

“Being empathetic in the long term is being able to pause and reflect and appreciate the circumstances of someone other than yourself. It breeds resilience and I think it is something that comes as you mature and [...] it is dynamic and [...] your own perception of empathy changes as you get older and as you see things”(Gina, Year 6)

5.6.4 Curiosity

Students suggested that taking an interest in patients, in a form of clinical curiosity, was another mechanism of maintaining the self-other boundary.

“you have to have professional boundaries but that doesn’t mean you can’t attempt to really explore what a patient sees” (Gina, Year 6)

“it is a little a distance but it is a perspective of the other person. You are not completely immersed in it”(Neville, Year 6)

5.6.5 Resilience

A few students talked about empathy and resilience in relation to an appropriate self-other boundary. Some saw resilience as being empathetic

without burdening oneself with emotions, linking it with detached concern.

*“I think that is part of resilience is to be able to be empathetic without burdening yourself with everything”
(Fiona, Year 2)*

Gina argued that resilience was a ‘bandwagon’ that medical educators were jumping on at present. She implied that there was a risk of equating resilience with distancing from the patient’s emotional distress.

“resilience is one of the words they throw about when talk about coping with life as a doctor” (Gina, Year 6)

*“you need to build up a certain level of tolerance where everything you see doesn’t shake you which I guess is almost kind of almost putting up a wall and stepping back”
(Gina, Year 6)*

5.6.6 Support

The students talked of how stress could reduce their empathy and their need for support. Helen implied that taking on the problems of others can be overwhelming and there was a need for support as a part of regulating their empathy.

*“in order to be able to empathise you have to an extent take on someone’s problems [...]you can’t do that endlessly and relentlessly every day without somebody doing it for you”
(Helen, Year 3)*

5.7 Reflexivity

At the start of the research I thought the students’ main interest would lie in how to define empathy. However, of much greater interest to the students was empathy as a relational process. I shared their uncertainty about how to achieve a balance between connecting with and detachment from the patient, learning from the students as they explored the nature of a self-other boundary. My way of achieving a balance between connection and detachment has mainly been achieved by clinical experience with patients and support from mentors. I was

struck by the variety and depth of the students' views of empathy which enriched this research.

5.8 Discussion: the complexity of empathy

The definition of empathy has consequences for patient care. If empathy is equated with detached concern there is a risk of encouraging distancing behaviour in medical students (Hardy, 2017). The students adopted two perspectives of viewing empathy; as an attribute (intrapersonal), and as a relational construct (interpersonal).

5.8.1 Empathy as an attribute (Intrapersonal)

In the pre-clinical years, many students viewed empathy as a static attribute. This view concurred with much of the medical education literature on empathy, describing empathy as an attribute, as a possession, which the student either had or did not have (Hojat et al., 2004, Neumann et al., 2012, Tavakol et al., 2012). An intrapersonal view of empathy underpins the theory behind most of the quantitative research directed at measuring empathy (Hojat et al., 2009). However, a static view of empathy does not clarify how empathy is experienced and disregards the impact of context on empathy (Marshall and Hooker, 2016, Campos et al., 2011).

In the preclinical years, students tended to describe empathy in terms of polarities, of affective and cognitive dimensions, a view often adopted in the literature (Baron-Cohen, 2011, Hojat, 2007). Hooker argued that framing the complexity of empathy in terms of polarities perpetuated the notion of scientific medicine as separate from and opposite to emotional care (Hooker, 2015). While students understood the significance of cognitive aspects of empathy, they were uncertain about the extent to which they should share emotions with the patient. This reflected the dominant cognitive view of empathy in medical

undergraduate education. Such a cognitive view of empathy contributes to a professional stance of 'detached concern' (Halpern, 2001, Kelly 2017, Hooker, 2015). Eikeland et al. (2014), found that some students believed they should be like scientists, unbiased and capable of detached observation, with the result that some students in their study became cynical observers.

In contrast, the students in my research were convinced of the benefits of empathy in its broad dynamic form which included affective dimensions. They rejected the notion of a doctor as a cold detached observer of facts and were distressed when they saw such physicians in practice. Halpern, like the majority of students in my study, viewed empathy as essentially an affective mode of understanding, where the empathising student was moved by the patient's experience (Halpern, 2003).

Students identified behavioural and moral facets of empathy which concurred with Morse's model of four dimensions of empathy (Morse et al., 1992). Some students discussed the moral quality of empathy linking it with a duty of care (Gilligan, 1982, Noddings N, 1984, Slote, 2007) Others described empathy as a virtue of a good doctor (Macintyre, 1985, Maxwell, 2008) Pedersen claimed that all doctors had a moral duty to strive for an appropriate understanding of each patient (Pedersen, 2008). He argued that empathy was necessary in order to apply ethical principles such as respect for autonomy (Pedersen, 2008).

Svenaesus (2014), like some students in this study, argued that empathy was a source of moral knowledge. He maintained that it was the feeling component of *phronesis* (practical wisdom), and a motivation for acting in a good way.

The students developed their ideas on empathy by further suggesting that the dimensions of empathy interact in a variety of clinical situations, for instance in surgery or palliative care. They described empathy as a flexible construct which might change to meet the patient's needs. Some students described this process as calibrating their empathy, concurring with Maxwell's view that affective and cognitive dimensions were interdependent (Maxwell, 2008).

5.8.2 Empathy as a relational construct (Interpersonal)

A surprising finding in my study was that the students in the clinical years did not talk about empathy as an attribute, but rather as a process occurring in a two-way relationship. They described empathy as a dynamic emotional resonance: a dialogue between themselves and the patient, a view supported by some authors (Halpern, 2001, Main et al., 2017, Kupetz, 2014). This view of empathy is also supported by Hollan (2008), and by Warmington (2012) who claimed that there was a need for ongoing dialogue for true empathy.

Warmington (2012), described these processes as 'attentiveness' and respectful dialogue. A relational view of empathy acknowledged that the emotions and thoughts of one person influenced the other in a two-way process and was affected by the context of their encounter (Campos et al., 2011, Hooker, 2015).

A new insight was also gained from students who suggested that empathy involved action to help the suffering patient (Håkansson and Montgomery, 2003). Motivation to act is thought by some authors to be a feature of compassion which differentiated it from empathy (Chochinov, 2007). However in my study, students saw empathy as both a motivating force and a practical action, thus moving beyond Batson's empathy-altruism binary towards a view of empathy as a response to suffering (Batson, 2011). Expanding the concept of empathy to include action to relieve suffering, maintains the focus on the patient rather than the student and takes account of the social context of the patient's illness (Garden, 2009). Garden (2009) suggested that recognising a patient's suffering was a starting point for empathy with action, in which the student explored the patient's experience of illness and their social situation, before acting with them to alleviate suffering. Warmington (2012), also claimed that an empathetic response involved both engagement and a commitment to help the patient.

The students' relational perspective of empathy developed with their contact with patients and reflected Stein's early phenomenological work on relational empathy (Stein, 1989). Students' views moved beyond the polarities of affective

and cognitive domains to integrate behavioural and moral facets of empathy which interacted in differing ways depending on the patient's needs and the context of the situation (Sulzer et al., 2016). The students' stories suggested that empathy was something they did, rather than something they had (Marshall and Hooker, 2016, Zaki and Williams, 2013).

A relational view of empathy implied that the student's success in empathising with a patient partially depended on the openness of patient and on the context of their meeting (Halpern, 2001, Main et al., 2017). Feedback from the patient can help a student to develop a greater understanding of the patient's lifeworld and this was reflected in the students' views on the value of continuity to empathy (Main et al., 2017). Some students claimed that their lack of life experience sometimes limited their ability to empathise. However this implied that the patient's experiences were understood from the student's perspective rather than that of the patient (Hardy, 2017). Gallagher suggested that students need narrative competency which allowed them to interact with the patient in a joint process of making sense of the world (Gallagher, 2012, Hardy, 2017).

5.8.3 Context of empathy

In contrast to descriptions of empathy in the literature, the students emphasised the influence of context on the empathetic process (Marshall and Hooker, 2016). In discussing the process of empathy in the context of clinical practice the debate moves beyond arguments over how this complex concept should be defined into deeper thinking about the nature of the patient-student relationship (Marshall and Hooker, 2016, Derksen et al., 2013, Irving and Dickson, 2004, Coplan and Goldie, 2011).

Empathy is often described in the literature as something which occurs between a doctor and a patient but not as something which is influenced by time, location or other aspects of context (Marshall and Hooker, 2016). In contrast, the students have emphasised the central importance of context in descriptions of empathising with patients. Therefore, my phenomenological study is less

concerned with what characteristics the students 'have', but rather focuses on what happens in the student-patient relationship: the process of empathising (Marshall and Hooker, 2016).

5.8.4 The process of empathising

The process of empathy has been described as a performance, rather similar to surface acting, exhibiting empathetic postures without engaging in feelings (Larson and Yao, 2005). However, in my study most students described empathy as a means of gaining a special depth of understanding of patients, not from a detached external position, but from a more engaged stance of participant-observer, entering into the patient's lifeworld (Hooker, 2015). This was reflected both by their interest in the process of empathising and by their wishes to connect with patients, a finding reflected in another phenomenological study (Tavakol et al., 2012). Svenaeus (2015), also maintained that empathy depended upon on the willingness of an individual to take an interest in the other person.

It seemed from the students' accounts that empathy required face-to-face contact with another person and that first impressions were central to this, ideas which accord with Lipps' original concept of *Einfühlung* (Lipps, 1903). Suchman et al. (1997), described this initial contact with a patient as an 'empathic opportunity', while Barrett-Lennard (1981), termed the initial concern 'empathic resonance'. Some students in the clinical years pointed out that this resonance might occur by merely being present with the patient, reflecting the concept of 'attentiveness' in empathy described by Warmington (2012). Attentiveness involved the student's openness both to the patient's feelings, and to their own emotions (Warmington, 2012). Norfolk et al. (2007), described a relational model of empathy for developing rapport with patients in which they depicted empathy as a skill. Their model also highlighted the

students' innate interest in the patient and their motivation to care for them which can be described as empathetic concern (Norfolk et al., 2007).

5.8.4.1 Sharing feelings

The majority of students argued that sharing feelings was necessary for empathy, although some were less certain. One student claimed that a doctor should not share emotions with a patient. She maintained that she would rather be treated by a competent, brusque surgeon than a kindly less competent one. She was employing a reductive argument, perpetuating a binary perspective of empathy. McNaughton pointed out that such dichotomies merely fostered the marginalisation of emotion in professionalism and practice (McNaughton, 2013). The emotional aspect of empathy was usually considered in the literature from the perspective of the patient but some students also considered that it was appropriate to show patients that they too were affected by emotion (Håkansson and Montgomery, 2003). This was further evidence that they did not favour a detached construction of empathy (Marshall and Hooker, 2016).

The relegation of emotions as unsafe in clinical training has contributed to a lack of a study of the humanities in medical education and so further diminished their visibility in training (McNaughton, 2013). In this medical school there was little formal input of the humanities in the curriculum, other than a single self-selected module available to a few students. Although emotional sharing in empathy was regarded by some authors as essential to empathising, the dominant message the students received was that detachment and objectivity were more appropriate (Greenson, 1960, Halpern, 2001, Gillies and Sheehan, 2005). McNaughton asked a pertinent question, 'Where has the idea originated that to be a good doctor one must remove emotion from reason, or so dilute it for the patient's benefit, to result in detached concern?' (McNaughton, 2013, Halpern, 2001). Patients also appeared to want their doctors to demonstrate empathetic concern (Mercer and Reynolds, 2002). Broyard (1992), described his experience as a patient, saying of his doctor;

“To the typical physician, my illness is a routine incident in his rounds, while for me it’s the crisis of my life. I would feel better if I had a doctor who at least perceived this incongruity.” (Broyard, 1992,p.45)

Most students maintained that true empathy required not only understanding the patient’s emotion but experiencing it to some degree. Some students reflected that an emotional understanding was necessary for clinical judgement and to develop a healing relationship. Some refined this view by describing experiencing as having a ‘taste’ of the patient’s emotion rather than taking on the full force of their suffering. In this way they were aware of the quality of the patient’s emotion without its potentially overwhelming intensity. Agosta (2014), supported this view by claiming that in empathy, the student took a sample of the suffering of the patient without over-identifying with the other person. Decety and Lamm (2011), maintained that empathetic concern inevitably resulted in a sharing of emotion, in that the student felt the pain of the patient, while remaining aware that it was the other’s pain.

The literature supported the students’ views that emotionally engaged doctors communicated more effectively with patients. As a consequence patients were engaged with treatment decisions (Halpern, 2014, Girgis and Sanson-Fisher, 1995, Kim et al., 2004, Kozlowski et al., 2017). It appeared that empathy began with the student being open to becoming affected by the patient’s emotions (Marshall and Hooker, 2016, Clark, 2010). Gillies and Sheehan (2005) suggested that emotions enabled a doctor to focus on his or her work and were not primitive forces, but should be used by the doctor to guide her responses in a particular context. Empathy, by most of the students’ descriptions seemed to reflect Buber’s I-Thou relationship rather than the objectifying I-It relationship and so involved them in experiencing some of the patient’s suffering (Buber, 2004).

The students identified patients who challenged their empathy .Halpern explored empathy and emotion-sharing when there was conflict in the doctor-patient relationship.(Halpern, 2007) She addressed the question of how doctors

could empathise when feeling negatively towards patients, suggesting that self-awareness and reflection were the key steps in this situation (Halpern, 2007).

5.8.4.2 The risks of emotional connection

While most students said that they wanted to connect with patients emotionally, some expressed concerns that engaging with emotions might lead to stress and burnout and so affect their 'objective' clinical judgement. At the heart of this debate was the need to clarify the difference between appropriate empathetic concern and personal distress which may result from over-identifying with the patient (Decety and Lamm, 2011). There is evidence from the neurosciences, sociology and psychology that that cognition is connected to emotions which contribute to decision-making. (Immordino-Yang and Damasio, 2007, McNaughton, 2013, Kozlowski et al., 2017). However, the idea that emotions are disruptive, and need to be controlled, is deeply ingrained in medical education and practice. (Montgomery, 2006) Heyhoe et al. (2016), recently reviewed how emotions contributed to clinical decisions and concluded that they played an integral part in patient safety. Furthermore, Irving and Dickson (2004), argued that decreasing distancing, either as physical space or as psychological involvement, tended to increase the level of perceived empathy.

While some students observed doctors using detachment as a coping strategy, many claimed that they would feel stressed and unfulfilled if they were compelled to work in such a way. These views concurred with research which suggested that empathetic doctors had more job satisfaction and less burnout than colleagues who coped by detachment from patients (Kearney MK et al., 2009, Zenasni et al., 2012) . It seemed from the literature that even if doctors tried to suppress their feelings by distancing themselves from patients, they could not avoid having emotional attitudes towards patients (Larson and Yao, 2005). (Agosta, 2014) argued that without empathic understanding students experienced burnout. He claimed that without affective empathy they behaved with detached concern, in which case , they were at risk of drawing the wrong conclusions about the patient's experience (Agosta, 2014). He further argued

that in using detached concern, the patient became an association of symptoms, rather than a struggling human being worthy of respect (Agosta, 2014). Charon suggested that narrative medicine has highlighted the importance of engagement with the patient which included an ability to be moved by the patient (Charon, 2001).

5.8.4.3 Vulnerability

The students maintained that they wanted to share vulnerability with patients in the process of empathising. Krznaric emphasised that empathy inevitably exposed our vulnerability and involved sharing part of oneself with others (Krznaric, 2014). Some students suggested that self-disclosure of their own experiences of illness could be helpful in establishing empathy. However, one student reflected that, in the clinical years, she had become more wary of sharing details of her own illness. In some sense this self-disclosure was an essential part of the relational aspect of empathy in that the empathetic student sensed when such self-disclosure was appropriate (Gelhaus, 2012). Although personal experience of suffering may have informed the student's empathy, it should not be assumed that the patient necessarily shared the same feelings.

Students referred to power differences when empathising with patients, reminiscent of Foucault's concept of 'the gaze' which described medical ways of knowing that put the student or doctor in the position of an observer of the patient and their disease (Bleakley and Bligh, 2009). This positioning objectified the patient, making them a passive source of scientific interest and was dehumanising (Marshall and Hooker, 2016). Some students described empathy as a bridge, between the doctor and patient, which tended to neutralise the power differences between them. However if empathy is simply viewed as a desirable extra, and marginal to the more important biomedical aspects of disease, there is a risk of perpetuating the distanced medical 'gaze' (Marshall and Hooker, 2016) There was also a risk that empathy could become a tool by which the doctor exercised power (Mayes, 2009). For instance, one student

described how she used empathy as a tool to effect changes in a patient's smoking habit.

Ricoeur, explored the connection between vulnerability and empathy. He argued that although there are differences between people we are bound together in a search for mutual recognition and understanding (Ricoeur, 1992). He claimed that we are simultaneously capable and vulnerable, blurring role boundaries that assigned competence to doctors and vulnerability to patients. He further asserted that selfhood and otherness cannot be separated, that to be able to see oneself as another implied being able to see another as oneself, so the suffering of others becomes our suffering (Ricoeur, 1992) His philosophy challenges scientific objectivity in offering an ethics of imperfection which fosters empathy.

5.8.4.4 Listening: a space for empathy

The students talked about the fundamental role of empathetic listening. Agosta (2014) claimed that empathy provided a space for engaging with the patient and resolving problems in an ongoing interactive process. He maintained that in this way what was previously unknown is revealed by empathy by combining understanding, interpretation and listening (Agosta, 2014).

5.8.4.5 Non-judgemental

Students emphasised the need to be non-judgemental in empathising, to avoid favouring a group of patients. Critics of empathy have pointed to the danger of prejudice as a consequence of empathy, but the students' descriptions illustrated their wish to be non-judgemental in their empathising (Bloom, 2016). Some students reflected that while they might have an initial critical thought when confronted with patients who appeared to have brought on their own medical problems. However, after a pause for reflection, they appreciated that they needed to explore the possible reasons for the patient's behaviour rather than being judgemental. In this they also acknowledged that the process of empathising cannot completely exclude, or bracket, subjectivity. What

seemed to be significant in the students' stories was an 'empathetic pause', to reflect on one's own prejudices, and to gain in self-awareness, rather than suggesting that it was possible, or desirable, to remove subjectivity from empathy .

5.8.4.6 Understanding

In a 'detached concern', or cognitive, model of empathising, understanding is situated within the student rather than the patient (Halpern, 2001). However, cognitive understanding was described by the students as an interpersonal activity. Both the student and the patient are engaged in a construction of meaning through an iterative process to gain understanding (Hooker, 2015). Empathy cannot achieve an identical or complete understanding of the other person but, as Bondi (2014) argued, in reaching out and connecting with the other and accounting for differences in perspectives, empathy can be of great value. Students reflected this in their comments of the way in which empathy could spread through a team. They described empathy as a bridge between the doctor and the patient, equalising power between them, and so facilitating the patient to voice their deepest concerns. Shapiro (2008), argued that if working out how to bridge the inevitable distance between a doctor and a patient was at the heart of good medical practice, then empathy was the most important of the professional virtues.

5.8.4.7 Levels of Empathy

As they moved through the course the students also described differing levels of empathy which varied according to the context. Bayne et al. (2013), developed a relational model of empathy in which they differentiated two levels of empathy, initial empathy, which was exemplified by customer service, and genuine empathy, that was applicable to holistic care. Halpern considered levels of empathy by describing differing empathies for differing clinical contexts (Halpern, 2014).

At one end of a spectrum of empathy, students described 'fake' empathy in OSCE exams where they showed empathetic behaviours without trying to understand the patient's view. Jamison (2014), pointed out the difference between being assessed for empathy and the nuanced nature of true empathy in practice. Indeed, students described how their genuine empathy diminished when they were being assessed. Fake empathy has been compared to surface acting in which empathetic expressions are adopted without any change in the student's emotions or understanding of the patient (Larson and Yao, 2005). Students described the next level of empathy as 'detached concern' which did not attempt to make an emotional connection with the patient (Halpern, 2001). Agosta took a stronger position by dismissing detached concern as being a professionally motivated lack of empathy (Agosta, 2014).

In contrast, authentic empathy was at the other end of the spectrum. Only one student argued that as long as the patient felt cared for, the feelings of the student or doctor were irrelevant. The others maintained that patients would detect empathy which was not genuine. Authenticity seems more akin to deep acting where the actor feels the emotions rather than merely altering their emotional expressions (Larson and Yao, 2005). Larson claimed that the scope of empathy goes far beyond the communication skills of surface acting (Larson and Yao, 2005). True empathy involved connecting with the patient both cognitively and emotionally, acting to help the patient with a feeling of responsibility for their duty of care (Macintyre, 1985). True empathy was not only a sharing of feelings and understanding, but it was also a way of responding to the patient (Svenaesus, 2015). Empathy conceptualised at this level involved recognition of the patient as a fellow human being and developing a sense of fraternity. Agosta (2014), described this deep form of empathy as enabling one person to humanize the other by recognising and acknowledging the possibilities for transformation and healing in the other. This feeling of a shared humanity can create a sense of security in situations of great uncertainty, for instance, in end-of-life care (Svenaesus, 2014).

5.8.4.8 Emotional regulation: Balancing connection and detachment

Central to this research has been finding that the students struggled to achieve an appropriate balance between detachment from, and connection with, a patient. They discussed how to create a psychological self-other boundary and so to find an appropriate balance.

Resilience was described as one mechanism for achieving a balance but the students were concerned that it might lead to detachment. They also suggested that achieving an appropriate self-other boundary might come with clinical experience and greater self-awareness. The self-other boundary was explored by Frank (2004), who described the idea of alterity and its relationship to dialogue. Alterity involved the recognition of the other person as being separate from oneself and allowed the possibility of genuine dialogue and true empathy (Warmington, 2012). In an empathetic encounter both the student and the patient were enabled to have a voice and in so doing their alterity was respected (Frank, 2004). Bondi (2014), developed these ideas by claiming that there should be an ongoing sense of the alterity of the other. She suggested that this was an unconscious process in which the student was both a subjectively engaged participant in a two-person relationship, but was also an observer of that relationship. This process allowed the student to be subjectively absorbed in the patient's narrative as well as maintaining a capacity to step back and reflect on that absorption (Bondi, 2014).

The students described how in spite of being aware of the dangers of personal distress in taking a self-orientated perspective, they sometimes had an initial thought of, 'What might this be like for me?' (Batson, 2011). This thought was followed by a more considered, other-orientated perspective, 'What is this like for the patient?' Taking an other-orientated perspective was claimed to be part of forming a psychological boundary with the other person and was thought to be an essential part of empathising. These views resonate with the work of Rogers (1961), who claimed that although empathy should involve a deep

engagement with the patient, it did not mean that the student lost sight of where the self ends and the other begins. He stressed that empathy involved entering the perceived world of the other person 'as if' one were the other person, but without ever losing the 'as if' condition (Rogers, 1959). Bondi (2008), also described a self-other boundary which resonates with this view. In true empathy the student was emotionally engaged with the patient and at same time she was able to reflect on these emotions, knowing that they originated in the other person (Halpern, 2001). In retaining a sense of the self-other boundary empathy differed from identification which can result in personal distress and burnout (Decety and Ickes, 2011).

Agosta (2014) approached the problem of emotional regulation from a Heideggarian perspective by adopting a broad sense of empathising which he claimed was a powerful resource against suffering and burnout. He argued that if a student was overwhelmed and experienced burnout from engagement with the patient's suffering then she was not using empathy properly. He suggested that in this situation the student should recalibrate their empathy. This was reflected in the students' descriptions of adjusting their level of empathy to meet the patient's needs. Conversely, if the students found that they were behaving in a detached way, Agosta suggested that they needed to increase their empathetic receptivity (Agosta, 2014). Indeed, a student described a "massive wake-up call" when she realised how medicalised she had become in her interactions with patients. Agosta (2014), described the boundary between self and the other as a permeable boundary, able to be crossed by emotions and experience.

To maintain the delicate psychological balance between detachment and connection the students described their need to be self-aware, to reflect on their work and to have access to support. (Balint, 1957, Bondi, 2014) Students described how they were less empathetic when stressed and how much they needed and appreciated support. Marshall and Hooker (2016), suggested that

stress may inhibit emotional engagement and that conversely support, which reduces stress, allowed students to be more open to emotions.

5.8.5 The phenomenology of empathy

If empathy is conceptualised, as suggested by the students, in a dynamic, relational way it challenged the positivist notion of measuring empathy by a questionnaire. I have argued that the students have adopted a phenomenological approach to empathy in learning from engaging with the experience of the patients (Hooker, 2015). Such a process of active connection with the experiences of another person is central to empathy and to phenomenology (Main et al., 2017). Empathy becomes a special form of understanding and extends to become a way of being. The students acknowledged, with one exception, that empathy was central to medical practice a view that concurred with Hooker's argument that, "empathy is one of the key hallmarks of good doctoring" (Hooker, 2015).

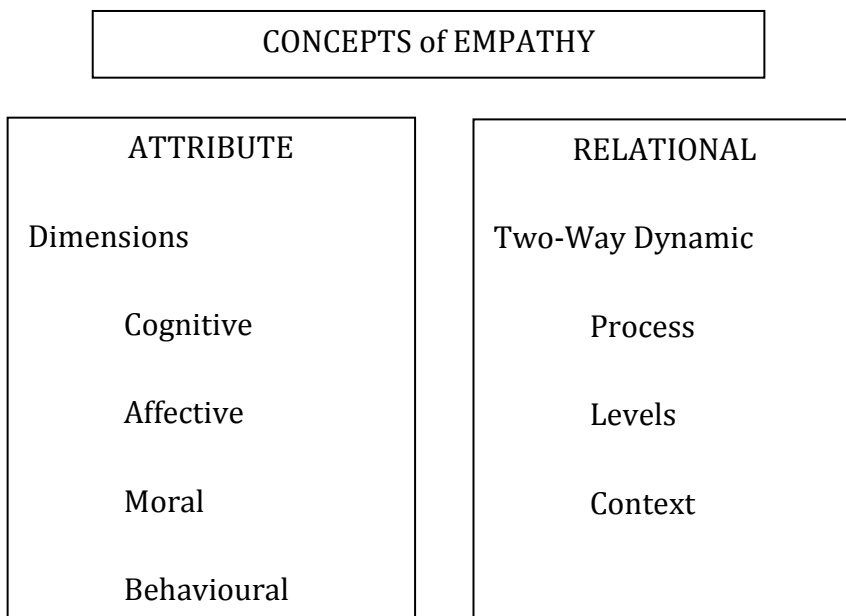
5.9 Summary

The students discussed the complexity of empathy in its differing dimensions, levels and the influence of context. The most striking finding was their emphasis on empathy as a dynamic relational construct which was dependent on the context of the student-patient relationship. Empathy seemed to generate a dynamic understanding between the student and the patient. It involved the capacity to participate deeply in the patient's experience while not losing sight of the fact that it was not one's own experience but that of another person. Students identified a tension between detachment from, and connection with, patients. They found that emotional regulation was difficult. Halpern maintained that empathy elevated a doctor's work from just a job to a profession in which she contributed to the meaningfulness of people's lives (Halpern, 2001). I have summarised the complexity of empathy in Figure 3

Chapter Five

In their conversations students emphasised the influence of context on empathy. In the next three chapters this was explored in greater depth as the students described the factors which influenced their empathising with patients.

Figure 3 The Complexity of Empathy



Chapter 6: Students discussing factors that enhanced empathy

6.1 Overview

The next three chapters address my second research question.

What factors do students describe as influencing their empathy during their undergraduate medical training?

In my phenomenological account of the students' views I have categorised the factors as either tending to enhance or inhibit empathy. In this chapter I describe the students' views on factors which they felt enhanced their empathy including; patient contact, positive role models, reflection, teaching and support. I include their feedback about participating in my research and how this may have influenced their empathy. A discussion of the findings from the students' interviews in relation to the literature concludes the chapter.

6.2 Background

The students described their course as being clearly divided into preclinical (years 1-3) and clinical phases (years 4-6). Although there is some patient contact in the first three years, I have retained their division in my thesis because they attributed great significance to patient contact in their development of empathy.

6.3 Patient contact

Students asserted that face-to-face contact with patients was the most effective way of enhancing their empathy. They described experiences with patients in differing contexts; Gina found work experience in a deprived community instructive, as the doctors had radical approaches to social deprivation. Diana reflected that she did not meet socially deprived people in her life outside medicine, so felt less equipped to empathise with them. The students suggested that listening to patients' experiences and sharing their feelings enhanced their empathy.

“it was just completely different to anything I had seen in my placements here. Everyone there had very different almost more radical approach. [...]They were big on social prescribing and they were piloting this programme of having a community links worker and empowering patients [...]so that was very eye opening for me”(Gina, Year 6)

“I just don’t meet people who are affected because their benefits are cut off” (Diana, Year 6)

“I think to enhance it [Empathy] on your way through medical school it is about taking on patient experiences and taking on what patients have told you about what they are feeling” (Kim, Year 4)

Gina enjoyed the responsibility of running her own consultations in general practice despite her initial apprehension. She came to appreciate that the patients did not expect her to know everything but valued her attention.

“It is still scary. But actually you realise more and more when you are interacting with people it is not that they expect you to know everything medically. They just a lot of time having someone there to listen and appreciate what is said” (Gina, Year 5)

Neville proposed that patient contact was central to developing empathy. He suggested that students should be like airline pilots, clocking in air miles, by logging their time spent with patients.

“I think medical students should have to do a certain number hours clocked off” (Neville, Year 5)

In the final years, students became focused on the needs of the patient rather than viewing them as learning resources. They described visiting the wards to listen to patients rather than ‘hunting for signs’.

“They are just hunting for respiratory signs in a respiratory ward. There was time so I thought of hunting for signs, I chat to the patient as well.” (Amy, Year 6)

“I would love to hear from patients as actual people and not just feel like I am going to listen to the murmur and then [laugh] off to my next tutorial.”(Gina, Year 6)

All the students expressed a wish for more time with patients, wanting to empathise with them and to learn more about their view of the world. Neville reflected on how patients had to repeat their story to different members of staff and students when they came to hospital. He suggested that there might be a better way of understanding the patient's history than subjecting them to such repetition.

"They must have told that story to their GP, to the primary assessment doctor, to nurses who clerk them in, to the doctors that clerk them in, to the people on the ward, the consultant who sees them on the post take, it is seven or eight times they told story [...] must be so frustrated, [there] must be a better way [we] can do this." (Neville, Year 6)

In talking about their experiences with patients, students revealed their developing empathy. One clinical context which exemplified their empathy with patients was their first experience of a patient's death. Connie was unprepared for this, but found that the experience made her reflect on her empathy as she tried to see things from the differing perspectives of the patient, family, doctors and nurses. She was impressed by the way the nurses' empathy extended to treating the patient's body with respect. She found the experience both shocking and moving. She was upset in recounting the circumstances of the patient's death, that had occurred six months earlier.

"I mean that was my first time that I had really experienced seeing patients die and I wasn't really prepared for it" (Connie, Year 3)

"I feel like that was eye opening for me in terms of trying to understand what it is to be a patient and what it is to be the patient's family and what it is to be nurses and doctors as well ,especially nurses, because they [the patients] establish a relationship with nurses" (Connie, Year 3)

"one of the nurses opened the window because, I won't say superstition, a routinely done thing, that you open the window and for some people think it is the way soul is escaping"(Connie, Year 3)

Connie described her feelings of sadness and shock of being in the patient's room immediately after he had died.

“to see this patient's slippers on the floor or clothes they laid out for the next day it is it is extremely apparent it like a juxtaposition like patient's expectation of life and the reality [of] their dead body lying there in the room that was very shocking [...] the patient's phone went off as they were trying to clean up the body. And it just this moment of silence in the room when everyone just pauses and kind of gasps as we hear the phone ringing knowing that this patient is never going to be able to pick that up” (Connie, Year 3)

It was clear from her story and others that although students were emotionally moved by a patient's death, these intimate experiences developed their empathy. They also talked about other patients whom they found both challenged, and yet paradoxically, enhanced their empathy. For example, Lisa and Amy said that they found it hard at times to empathise with psychiatric patients. While Paula, claimed that she had become more empathetic as a result of her experience with patients with mental health problems.

“in terms of hallucinations or schizophrenia it is much more difficult to keep yourself in their shoes and appreciate what they are going through” (Lisa, Year 5)

“There were a lot of communication barriers and at first I felt really awkward. I was asking questions [...] and they would not be able to respond or understand and come to a point” (Amy, Year 5)

“it is easy initially to look at people who are suffering from depression and anxiety [...]and think that it self-inflicted. I have less of that opinion having seen it and I think actually that is an illness like any other illness” (Paula, Year 6)

Students described a range of emotional situations which challenged their empathy. They claimed that strong emotions made empathising more difficult, but found that after a pause for reflection, that they were able to explore the underlying reasons for the patient's distress. For example, Helen found it difficult to listen when a patient with advanced cancer was angry, but on

reflection, she considered that the patient's anger was understandable.

"she was angry at the whole situation and just looking for things to blame. [...] she wasn't angry at the consultants really, she was just angry at the situation. I think it is understandable" (Helen, Year 1)

Sometimes, students found it hard to empathise with patients whose illnesses had resulted from unhealthy lifestyles. Marilyn wondered why some obese patients did not care for themselves, but then she reflected on the possible underlying causes for their condition.

"my empathy completely disappeared for a few moments and I just thought ,dear God you have gotten so fat you can't breathe. How does that happen?" (Marilyn, Year 4)

"And then it took me second and I went, are they really unwell,? are they really depressed?, [...] do they not have financial capacity?" (Marilyn, Year 4)

Students also reflected on their feelings of helplessness, or even of guilt, when there was no obvious medical solution to the patient's problems.

"you want to be able to offer something [...] and when you can't that is quite a vulnerable place to be as well. You feel a bit guilty not being able to do something when you feel you should or could" (Paula, Year 6)

Sometimes it was the context of the clinical encounter which made empathising difficult but students found that addressing these situations enhanced their empathy. Ida described a consultation with a patient in handcuffs and was impressed that the doctor did not appear to be influenced by the man's crime.

"She [consultant] said she makes a point about not asking why they are accompanied by police because she doesn't want it to influence her care" (Ida, Year 4)

The students found such positive role models enhanced their empathy.

6.4 Positive role models

Diana described sitting in an outpatient clinic with a breast surgeon whom she considered to be an excellent role model. After breaking bad news of a diagnosis of breast cancer, he gave the patient time, allowed her to go outside for a cigarette and ended the consultation with a hug. After the patient left, the surgeon took time to explain to Diana why he had behaved in this way and this impressed her.

“he said afterwards when he sat down when she had left, he was in theory not supposed to hug patients but you could tell with that woman that was you needed to do as a human being. So I thought that was interesting that was the first time I had seen a surgeon talk about the importance of communication skills” (Diana, Year 4)

She also noted also that this surgeon extended his empathy to his colleagues by treating his team and juniors with respect.

“he was like that with his staff as well, the team was like that and trainees and everything. And so that was really inspirational for me” (Diana, Year 4)

Students identified a variety of characteristics of good role models, the most common of which were; enthusiasm, humility and humanity.

“I think that is because they are sort of people that are passionate about the things” (Fiona, Year 2)

“it probably made her feel better because she [the consultant]kept on apologising probably feel guilty about not being able to do a perfect procedure” (Edward, Year 4)

Neville gave an example of a doctor who balanced connecting emotionally with a patient with her clinical decision making. Despite being upset, the doctor was empathetic as Neville described her sharing emotions with the patient and her family.

“It was re-occurrence of her cancer and her son and her husband where there as well. They all started crying and I think the doctor was really professional about it as well. I think there is a fine line to being cold and a fine line

between cold and being professional. And I think she had that line very well.” (Neville, Year 4)

“I am sure that when she broke that news to the patient she was devastated at having to share the news with that patient. You could tell by the way she sat, her body language, her, her tone of voice, her choice of words and her clinical knowledge it was professional [...] at the same time I am here for you. I am not, not against you we are in this together. We are going work through it”. (Neville, Year 4)

Kim, suggested that good role models were the exceptions rather than the rule.

“you don’t necessarily get as much exposure with to the ones who spend time with patients it depends on you stumbling on one of their clinics”(Kim, Year 6)

Paula, in a bedside teaching session, was impressed when the patient was included in the teaching by the consultant: this respected the patient’s dignity and humanity. It also reflected the transition, in the students’ eyes, of the patient as a resource for their learning to a unique human being.

“He also then said to the patient while we were there, “We are going to talk through your clinical history but I want you as a patient to listen and see if you pick up anything new from this”. [...] I thought that was including a patient in that was a really nice way of making it a valuable time for them as well as us” (Paula, Year 5)

6.5 Reflection

Students commented that the University encouraged reflection. For example, Olive said that she was encouraged to reflect on her experience but like several students found written reflection less helpful than discussing her experiences with others. Students talked about reflection in relation to empathy, feelings and stress. Bill said that there was an emphasis on a prescribed form of reflection which he did not find helpful in cultivating empathy.

“one of the problems with the university they always try to get you to reflect”(Bill, Year 3)

“they do teach you need to reflect you need to think more deeply about the kind of situations” (Olive, Year 1)

“I don’t think writing is my best kind of strength and essay writing I am better just learning fact and things” (Olive, Year1)

Connie enjoyed talking about her experiences, valuing verbal reflection and recognising a connection between reflection, self-awareness and empathy. She claimed that she had become more reflective as the course progressed. Sometimes she wrote a reflection as a way of coping with stress but preferred discussing it with other students. Fiona pointed out the advantages of reflecting on her experiences in enhancing learning. Neville described how reflection could be difficult but was necessary to enhance empathy.

“when I am feeling very overwhelmed I do write things down just keep an on and off diary when I am really struggling, but actually I don’t know how much it helps. I would rather share it with someone because then I can get reassurance and I can get feedback” (Connie, Year 3)

“I think it is not just the exposure it is the reflecting on the exposure and what happened” (Fiona, Year 2)

“it is very hard to be reflective, it is very hard to look into oneself and criticise why and critically think [...], why did I do that? and the more we talk about it I think the easier it becomes to analyse why and analyse empathy and the difficult things” (Neville, Year 4)

Neville reflected on this as he talked about seeing patients being given a diagnosis of lung cancer in the clinic. He reminded himself that every patient was unique and worthy of respect. He described part of empathising as pausing to reflect on the wider context of each patient

“as more and more people are given a diagnosis you do get that feeling that this is just another case but then you have go to stop yourself and say “No, no, this is a patient this is an individual with a family and much wider effects” and stopping and taking look at big picture is important” (Neville, Year 5)

Gina reflected on her practice and noticed that she sometimes became too involved in the patient's story.

"I reflect on my own self and practice that is where I need to learn most.[...] the doctor's perception of that consultation of what had been happening could be completely different to me and I would be taking everything they had said completely at face value and I was totally into their story"
(Gina, Year 5)

A small number of students talked of how their own experience of illness had affected their empathy and their feelings about the course. For example Marilyn talked about her mental health problems,

"But last semester I had an episode of depression which I needed medication for which took a long time to get and I think that it overshadowed being able to have a proper unbiased opinion of the course itself" (Marilyn, Year 1)

Fiona reflected that her own experience of illness had given her greater insight into the patient's perspective. I respected the fact that she did not wish to elaborate on this.

"I did have some health problems and it did make me realise how experiencing something yourself definitely changed the way [...] you understood certain things more. I really don't want to go into it but I understood things more"(Fiona, Year 2)

Students also talked about the teaching in the formal curriculum which they found had a positive influence on empathy

6.6 Teaching

Despite the fact that students mostly claimed that there was little teaching on empathy in the curriculum, they discussed positive influences on their empathy of problem based learning (PBL), communication skills training, simulation and lectures. Some students like Paula, described a positive experience in an introductory lecture in which the lecturer referred to emotional problems.

“this semester introductory lecture was brilliantly done [...]he just spoke about it a little bit and mentioned occasions where he had been upset about a patient and had been told that was actually that made him a better doctor and he was encouraging us” (Paula, Year 5)

The students appreciated acknowledgement of emotions and receiving encouragement, but generally felt that formal communication skills training did not enhance their empathy. However Ida claimed that working with simulated patients had helped her because she was able to get into role.

“I always find it quite easy to forget that it is just an actor and kind of properly get into and then it is really good fun” (Ida, Year 5)

Students also commented on the medical school culture which had both positive and negative influences on their empathy.

6.7 Medical School Culture

The culture, or ambience, of the medical school includes the organisational influences and the process of socialisation in becoming a doctor. The first year students recalled how apprehensive they were before coming to university and how relieved they were to find a friendly atmosphere in the medical school. Most of the students commented on the friendliness of the other students throughout the course.

“university is about learning and becoming a doctor but my friends and I get on really well and that has been a big part of university as well.” (Neville, Year 4)

In the clinical years students compared the differing cultures of the larger, teaching hospitals with the smaller, more inclusive, peripheral units. Students claimed that sometimes they did not feel part of the team in the main teaching hospital but felt included in the smaller rural attachments.

“in the [large hospital] I just feel like a student. I am here to learn and I don’t feel I am part of the team.” (Amy, Year 5)

"Whereas in [the smaller hospital] he [the doctor] was very keen to involve me and introduced me as a doctor in training instead of medical student and he allowed me to help him" (Amy, Year 5)

Amy noticed that it was not just the students, but the patients, who were affected by the formality of the main teaching hospital and consequently were less likely to communicate.

"The patients [are] more chatty as well, talk to me and stuff. In [the large hospital] not so much. I think just difference in culture." (Amy, Year 5)

Kim was made more aware of the tensions which existed in the larger hospitals by observing that in smaller hospitals doctors and nurses had a better working relationship. Many students appreciated being valued by the hospital staff .

"the nurses were really friendly, the doctors were really friendly [...] it actually surprised me to find the nurse and doctor relationship was so good" (Kim, Year 6)

"I hadn't realised that there was such a tension in other places until I went there [smaller hospital] and all of a sudden everyone was on the same level and people were very much going out of their way to help others" (Kim, Year 6)

"they actually made me in some ways feel as part of their group because they will take me for a coffee when they had a break and things like that" (Jenny, Year 2)

The students described how their confidence improved when they felt part of a team. Kim remembered a nurse saying goodbye to her when she had finished her rural attachment on a Scottish island. Olive appreciated being valued by the medical school but was not sure whether an organisation could be described as empathetic.

"When I was leaving one the nurses said "you will always have a home here". It is things like that, the little things, that make a place really nice" (Kim Year 6)

"But from my understanding of empathy it's built around relationships and people. And so to say the medical school

showing empathy, I can see individual professors and things if needed could show me empathy on an individual level for specific things [...] But I don't think students will look for that empathy from the medical school" (Olive, Year 2)

Students described how feeling valued, supported and part of a team enhanced their empathy.

6.8 Support

Lisa emphasised the importance of a supportive environment if she was to be empathetic to others. She pointed out that she was much better at empathising and exploring the patient's agenda when she felt comfortable. When she lacked confidence she was more likely to stick solely to the medical agenda. Other students also linked improved self-confidence with enhanced empathy.

"I think that if you feel comfortable in what you are doing you can explore these ideas a lot more. Whereas if you are under confident, bit nervous then you much rather stick to then I am here to take your history and stick to that" (Lisa, Year 4)

"I think if you have got a good environment and feel supported you are more likely to have that interaction with patients" (Lisa , Year 4)

The variability of the support offered by the personal tutors in the medical school was a common theme.

"I think it depends who you have. [laughing] I definitely thinking about all supervisors I had before maybe two out of ten of them I would probably be happy to discuss something like that with" (Diana, Year 5)

"one of my flatmates had a member of family that died and it wasn't even slightly close member of family, it was the whole concept of him just dying just seemed to throw her and the university were absolutely brilliant. They just rearranged everything for her and sent her all the lectures"(Helen, Year 2)

"that was really really nice and kind that sticks out for me that do actually care and you can speak to certain people in

different roles and they do actually have that level concern for your health" (Olive, Year 3)

Students described how they found dealing with dying patients a source of stress. Paula gave an example of a doctor providing informal support to a student after a patient's death, which she described as most helpful but unusual.

"She was quite taken aback that they said that because I have said that is rare." (Paula, Year 4)

However, it seemed that most of the students did not find their support in the personal tutor system but sought informal support from friends and family. Connie found that sharing experiences with other students was helpful because they seemed to care about her. Helen explained she would talk to family or friends before seeking support from the personal tutor system. Kim found support from being part of a clinical team and being able to share clinical problems.

"to have people who I know care about me a lot just understanding what I was going through and how I was feeling that day really helped I think to kind of decompress a lot of the emotions had been gathering during the day"(Connie, Year3)

"I would probably explore other options first, talk to my friends and parents first" (Helen, Year 1)

"I think our year is very good at maintaining a culture of support [...]we are all in it together" (Neville, Year 6)

"I had a patient open up quite a lot to me yesterday and it was nice quite nice to know that I had the consultant to report back to" (Kim, Year 5)

Students also used other informal mechanisms of support such as reflection and trying to maintain a balance between their work and life outside medicine, a process described by Fiona as 'compartmentalisation'.

"I like to reflect on my feelings like write them down. I'm quite an expressive kind of personality so in the past when I had time, I would draw"(Amy, Year 4)

“Leave work at work and then that you have your home and your family and friend and people to support you and I think that is kind of compartments” (Fiona, Year 3)

A number of students including Bill and Paula derived their support from their religious faith.

“I have possibly quite a good set of support network at the local mosque” (Bill, Year 3)

“I am very involved in the church too and I think there is a lot of support there” (Paula, Year 4)

The students also talked about how taking part in the research study had been a positive influence on their empathy.

6.9 Participation in the study

All the students said that they had enjoyed taking part in the research. They appreciated the opportunity to reflect on empathy and to have someone listen to their specific experiences as they progressed through medical school. Many commented that the informal setting of the interviews enabled them to express their feelings freely.

“I think I have really really enjoyed it. I think also being able to vocalise a lot of my feelings and the way that I understand empathy and all the other things that go on.[...] I have benefited from it definitely even though it has not been many interviews it is good to kind of pause and take check of what has been going on and how things have shaped the way you feel now and reflect on that” (Connie, Year 3)

“I think what has been nice, you’ve given me an opportunity of being reflective as in think stopping and thinking about things and questions and having to articulate. I think as we said this difficult thing to put in words and how to articulate concepts and values and I think that is where sort of it shows how much easier is to put things in context and give an example” (Fiona, Year 3)

“every time I come I wonder, ‘What we will speak about today?’. And I just don’t know.[...] I am always glad to know that you are doing this research and that is something it is

chance to talk and be heard and it's a chance to reflect I suppose as well."(Olive, Year 3)

Marilyn was concerned that because she was enabled to speak so freely that she had strayed from the topic. She implied that she might get into trouble if she spoke freely to the university staff.

"I worry a bit when I come and see you and I thought about this before I came. I was like every time I go and see him I end up rambling. I am having once yearly therapy session. Because I can speak freely to you .I used to think I can just speak to staff in an honest way. Bad plan, it bites you in the ass" (Marilyn, Year 4)

"I think if you had formulated questions that I had to answer I find it annoying. I'm a chatter. I like to have a blether and I kind of like you. You are non- judgemental. You have got a nice face. I like to talking to you" (Marilyn Year 4)

Marilyn was depressed at the time of her first interview but insisted that she wanted her views included. However she did express some concern that she might be sanctioned by the medical school.

"I think it is fine.[...]I think it is really not to go through life erasing these things as they are real part of medical school. They are a real part of our health and I think it would be disingenuous not to include it. So I mean obviously I don't want to get in any trouble with the medical school" (Marilyn,Year4)

All the students said that inclusion in the study had made them think more about empathy and their development during the course.

"it has been good I think it has helped stimulate things I haven't really thought about before [...] I found it quite thought provoking"(Lisa, Year 6)

"I think it has been good actually because I since the first interview since then I think I have grown a lot and become much more aware of this other side of medicine ,which thinking about things beyond the hard clinical stuff" (Gina, Year 6)

“it has been really helpful to think of empathy more than I normally would have done” (Ida, Year 6)

“I really enjoyed it[...] no no I have. Not just for the tea. It has been quite interesting to reflect and it is nice to have someone to listen to you in a way” (Kim, Year 6)

6.10 Reflexivity

One of the advantages of a longitudinal approach was that I was able to build an empathetic relationship with each of the students. This allowed the students to talk about difficult issues of their stress, coping with dying patients, humiliation and to share positive experiences of their achievements and interests. The students were sometimes moved emotionally in discussing the influences on their empathy. On occasions I had to provide support which I felt was consistent with my ethical obligation to safeguard the welfare of the student. Some students talked about their own experience of illness and this was ethically challenging and I was careful to remember my role was that of a researcher not their physician. When students did not want to explore their personal experience of illness in this research I respected this choice. Some students with stress and depression used the interview as an opportunity to talk about their difficulties and, after listening, I suggested appropriate avenues for support.

Students were particularly concerned about confidentiality when discussing emotional issues. This is a challenging area in reporting findings of qualitative research. For example, I read an earlier thesis, an ethnography of the students in the medical school which I had attended some years before (Atkinson, 1976). Although the author had changed names, the identities of the consultants he described were apparent to me from his detailed descriptions of their mannerisms.

I was disappointed by the fact that although the beneficial effects of support on student well-being and empathy are accepted, there is still a widespread reluctance among students to seek that support because of perceived negative connotations of doing so. I believe that support is fundamental to being able to

connect emotionally with patients and that it should be a routine part of the student experience.

I shared the difficulties expressed by some students of recording their reflections in writing. I find it much easier to reflect in conversation with a colleague or mentor than to write about my experiences. I am frustrated by my difficulty in conveying the richness of their experiences by the written word. However, a core part of phenomenological research is to write and to make my position in the research explicit.

The nuanced issues around the perceived culture of the medical school were topics which lend themselves to a phenomenological inquiry. I had originally planned to describe my findings in terms of the hidden, informal and formal curricula but decided that it might appear that I had applied a framework and made the findings fit these topics. Instead, I tried to arrange the themes of the influences into broad categories, positive and negative which focused on the students' views rather than my preconceptions. I was surprised that they talked more freely about the barriers rather than positive influences on empathy. I reflected that they welcomed the opportunity to explain and discuss what they perceived to be negative rather than positive aspects of the course.

6.11 Discussion: Enhancing empathy

The students' views of the factors enhancing their empathy reflected the importance of the context of the clinical encounter in establishing empathy.

6.11.1 Patient contact

The students identified that their face-to-face contact with patients was one of the most influential ways of developing their empathy, which was also a prominent finding in other studies (Winseman et al., 2009, Egnew and Wilson, 2010). In view of this finding, it is of particular concern that there appears to be a decline in bedside teaching (Elder and Verghese, 2015). Medical students spend fewer hours in contact with patients, partly because of reduced in-

patient stays , increasing class sizes and a greater use of simulated patients(Elder and Verghese, 2015, Egnew and Wilson, 2010).

The students described how their own experience of illness enhanced their empathy with patients and conversely how their lack of life experience limited it, findings which are supported in the literature (Woolf et al., 2007, DasGupta and Charon, 2004).The students described how their empathy developed in challenging clinical situations such as in the care of dying patients and those with psychiatric disorders, which concurred with the findings of earlier qualitative studies (Ratanawongsa et al., 2005, Cutler et al., 2009).

In the early years students enjoyed having time to spend with a limited number of patients (Ratanawongsa et al., 2005, Cutler et al., 2009). A systematic review concluded that early patient contact in undergraduate training enhanced empathy (Littlewood et al., 2005). Students in my study said that they had little patient contact in the first three years of their course which they described as being largely focused on the biomedical aspects of disease.

In their descriptions of contact with patients, students adopted a phenomenological stance. They wanted to connect with patients and talked about their interest in the patient's experience of their illness, confirming the findings of another qualitative study (Eikeland et al., 2014). Janssen et al. (2008), suggested that students should be supported, in their contact with patients, by experienced clinicians, with an opportunity for reflection and feedback. This was endorsed by Boudreau et al. (2007), who described an initiative in undergraduate education designed to put the patient and their illness at the heart of learning rather than focusing on the current disease-centered model of medical education. Another qualitative study of students' views concluded that students wanted opportunities to be directly observed by experienced clinicians in their relationships with patients and to be given feedback on their relationship skills (Egnew and Wilson, 2010). Some students in my study reflected that it would be beneficial to have time with patients and

to receive feedback, without feeling that they were being assessed by their clinical tutors. They described the pressure of assessment as fostering competition rather than empathy. Students stressed that contact with real patients rather than actors, or simulated patients, enhanced their empathy. Their views concurred with the findings in another study (Egnew and Wilson, 2010).

6.11.2 Role models

In the clinical years students described their contact with positive role models as being inspirational and promoting their empathy which was also the finding of a survey of Canadian medical students (Byszewski et al., 2012). The students described how closely they watched clinical teachers in practice and how much this influenced their attitudes, which resonated with the findings of other studies (Haas and Shaffir, 1987, Winseman et al., 2009, Curry et al., 2011).

However, one student in my study reported that such empathetic role models were the exception rather than the rule. A lack of positive role models has been suggested as a factor in causing students to have unrealistic expectations of how a doctor should behave (Chen et al., 2007). It has also been suggested that academic staff no longer build their reputations on clinical teaching expertise but are now judged on their ability to secure research grants and publish scientific papers (Elder and Verghese, 2015). Authors have suggested that it was beneficial for clinical tutors to possess appropriate teaching skills, to improve their impact as positive role models (Burgess et al., 2015, Shapiro, 2012).

The students described enthusiasm and empathy as characteristics of positive role models, which were attributes cited in another study (Burgess et al., 2015). They particularly appreciated when experienced doctors admitted their vulnerability and showed emotions. This was in contrast to the generally accepted notion that the expression of emotions by doctors was a sign of weakness or incompetence (Kerasidou and Horn, 2016). Students claimed that when their teachers explicitly shared the emotional aspects of a situation it was

a powerful way of learning (Passi et al., 2013). Rees et al. (2013) suggested that role models could use their stories to give examples of the dangers of suppressing emotion: burnout and detachment from the patient. Some of the role models the students described challenged stereotypes, such as a breast surgeon who demonstrated humanity, extending his respect for patients to the healthcare team.

Students described how positive role models also demonstrated ways of balancing connection and distancing with the patient to develop emotional regulation. Doctors who took time to attend to the students' welfare after a patient's death were also appreciated. These findings are similar to those in a study which found that students identified positive role models as doctors who encouraged them (Lempp and Seale, 2004). Another study in the USA found excellent role models were those who stressed the importance of the doctor-patient relationship and taught psychosocial aspects of medicine (Wright et al., 1998). A qualitative study involved medical students asking patients "What kind of doctor would you like me to be?" (Walsh et al., 2016). Patients overwhelmingly sought doctors with good personal qualities, including empathy and good communication skills, with only 8% of patients emphasizing medical knowledge (Walsh et al., 2016).

6.11.3 Reflection

The students claimed they had difficulties with written reflection but acknowledged that reflection was integral to the process of empathizing. They said that they would value an opportunity to be able to talk to a patient, reflect and receive feedback without feeling that they were being assessed (Janssen et al., 2008). They valued the opportunity for verbal reflection, as an opportunity to share their concerns with colleagues and the teaching staff. Students described reflection as a strategy for coping with stress, and so enhancing their empathy.

Providing students with a space for dialogue may be one way of nurturing reflection, empathy and of reducing stress (Ramesh, 2013, Lutz et al., 2013, Branch, 2010). Time for reflection is needed to help to make the implicit explicit (Cruess et al., 2008). Lutz et al. (2013), suggested that reflective practice required a secure space, a supportive group of students and an encouraging trainer. Other authors have suggested the need to develop a self-care plan to maintain empathy and prevent burnout. Such a plan might include mentoring, support, interests outside work, reflective writing and social networks (Sanchez-Reilly et al., 2013).

It appeared from the students' stories that empathy also had a spatial dimension, in terms of the closer the contact both physically and emotionally to the patient the deeper the empathy. From the students' stories it seems that this close contact is balanced by the need to pause, and step back to allow reflection on the patient's experience. This process of moving between the specific individual and drawing on wider past experience resembles the hermeneutic circle.

6.11.4 Teaching

Students claimed that there was little formal teaching about empathy. However one student appreciated a lecturer discussing subjects that were likely to generate emotions. Students identified the medical school's explicit commitment to empathy and altruism but paradoxically were exposed to an implicit culture of detachment and objectivity (Coulehan and Williams, 2001). It seemed from their stories that the medical education process promoted emotional detachment, with little attention to the emotional needs of students (Jennings, 2009, Shapiro, 2012). These issues are discussed in detail in Chapter 8

6.11.5 Medical school culture

In discussing the ambience or culture of the medical school students had little to say about positive influences on their empathy. They compared cultures in large teaching hospitals, which they perceived as formalized, and a more informal

approach in smaller hospitals. In these smaller units they found they were more likely to be valued and to be made to feel part of the team (Weaver et al., 2011). They suggested that such an environment increased their sense of well-being and their ability to empathise. The students' preference for smaller teaching hospitals was reflected in another study (Bennett et al., 2010). One student also noticed that the patients seemed more inclined to be open and comfortable in discussing their concerns in the smaller units.

6.11.6 Support

Students talked of the value of support in enhancing their empathy. The University provided a personal tutor for each student but their experience with these tutors varied. Some described receiving good support but the majority of students in this study found that they received little help from the tutor but instead approached family, friends or religious groups for informal support. They acknowledged that despite the university encouraging them to seek help, they were reluctant to access this for fears of being seen to be weak, or that it might have an adverse consequence on their future careers (Jeffrey, 2014).

Students valued being made to feel part of the clinical team and given responsibility. They found that when they were supported in such an environment they had the self-confidence to be more empathetic and to address emotional issues with the patient. Authors also suggest that increasing emotional support can reduce clinical detachment and foster true empathy (Austen, 2016, Kerasidou and Horn, 2016). Janssen et al. (2008), argued that to care for another, a person needed to receive care and support for themselves.

6.11.7 Research participation

The students described how taking part in the study had enhanced their empathy by providing a space for reflection and an opportunity to discuss emotional and psychosocial issues in a setting in which they were not being

assessed. Kumagai and Naidu (2015), claimed that creating such a space in the curriculum was central to fostering reflective practice.

6.12 Summary

Students had less to say about positive influences on their empathy than the barriers which they encountered during their training. They did report that patient contact, positive role models and an opportunity for reflection were all factors which enhanced their capacity to empathise. They identified that being valued and made to feel part of a clinical team also enhanced their well-being and empathy. I now discuss the findings relating to negative influences on their empathy in Chapters 7 and 8.

Chapter 7: Students discussing barriers to empathy: The Medical School Culture

7.1 Overview

This chapter addresses my second research question:

What factors do students describe as influencing their empathy during their undergraduate medical training?

The culture of the medical school determines the learning environment and influences the professional socialisation of the student (Hafferty, 1998). The students described a number of themes relating to culture of the medical school.

7.2 A conforming culture

Some students, in the early years, claimed that they were expected to follow a proscribed process in the medical school, which they described as a 'herd mentality'.

"It is almost herd mentality where you go along in your profession" (Bill, Year 3)

At the start of their course they said that they lacked autonomy. Later they maintained that they were left to fend for themselves. Marilyn, an overseas student, claimed that she had to conform to the mould of a British citizen, whom she described as being timid and formal. She claimed that the culture in the medical school discouraged interaction between students and teaching staff.

"I am stressed out by the lack of autonomy [...] I like to be in an environment where I felt people assume the best of me and I don't feel that" (Marilyn, Year 4)

"where for two years they [students] are spoon fed and then for the clinical years they are left to roam and, if you want help you have to go and ask for it" (Marilyn, Year 4)

"we want all of you to all act like in appropriate middle class British person and interact in that way which is hierarchy, confrontational avoidant" (Marilyn, Year 4)

As part of this conforming culture, students were inclined to keep silent for fear that their lack of medical knowledge would be exposed in their clinical teaching. Others expressed concerns that the conforming culture might inhibit some students from seeking support.

“I think that fear of being wrong doesn’t help their learning. I think it makes interaction close to impossible.” (Marilyn, Year 4)

“it feels a little like a dystopian setting, you are in the medical school and they see all and they have a say in all and this is how you are to act XYZ.. I don’t think it is healthy for all of us as students [...] .it discourages people who are struggling from seeking help or speaking out in a lot of aspects”. (Gina, Year 6)

7.3 A lack of empathy

If empathy is to be fostered, it might be expected that the medical school would be empathetic towards the students, but they told a different story. Bill claimed that the university was primarily interested in whether he passed exams rather than taking a personal interest in him. Fiona perceived empathy to be a ‘buzz word’, but questioned whether it was incorporated into the values of the medical school. Gina reflected that the medical school did not respect students as individuals.

“all the university, from my point of view, will see and know, Do I pass my exams?” (Bill, Year 2)

“I think it is seen as a buzz word and potentially shown given quite high precedence, but whether that is translated into actual values I think is sometimes different” (Fiona, Year 3)

“That you have no chance to really feel like yourself. I struggle with feeling being a medic reconciles in medical school, the way we are examined, and the way we are, doesn’t make allowances for you to be to be professional but in your own individual way that reflects you as a person. [...] it just feels very like a conveyor belt you got to stick to” (Gina, Year 6)

Other students also gave examples of their experiences of being treated without empathy by some medical school staff. Diana described the strain of looking after her terminally ill grandmother. She said that after her grandmother's death there was lack of empathy from the staff of the teaching practice. She had to make up the time she had taken to attend the funeral.

“my grandmother died two weeks ago. And my placement was OK about it, but they were not great. [laughs] I said ‘Sorry that I had to miss a day and half because I am going to funeral. [...] I will make up the time’ and they said, ‘OK, we will get rid of your day off then’”(Diana, Year 6)

Gina also described a harsh attitude to sickness absence by the medical school, and suggested that this might be one reason why students avoided seeking support from the medical school.

“if you missed 3 days at that placement then you have to make that up in your holidays” (Gina, Year 6)

“easy to see how people feel there is no hope so they wouldn't even bother trying approach medical school” (Gina, Year 6)

Ida resented deadlines and described being “put through hoops” by the administration, which she found to be stressful.

“I do feel like they give us a lot of hoops to jump through. Things that are not necessary that for some reason that they want us to do. It does feel like they only do it to put some pressure on us”(Ida, Year 5)

7.4 A competitive culture

Competition was described by students as the antithesis of collaboration and inhibited their empathy. They indicated that there was a competitive culture which was most noticeable in the early pre-clinical years but faded during the clinical years. They suggested that in the early years this reflected influences from school and the intense competition to enter medicine. Students noticed that the medical school encouraged competition from the outset.

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“the body of medical students are competitive but I think that comes with getting into medicine is very competitive” (Edward, Year 2)

“The marks you get for first and second year they have a weighting towards the results when you graduate” (Bill, Year 3)

On the other hand, Helen commented that there was also a sense of camaraderie as everyone was trying to get through the course. She was reassured by meeting older students who told them that they had struggled in the first year. Connie described the focus on exams as narcissistic rather than fostering empathy.

“but all you need to do is pass, so therefore there is camaraderie about getting each other through” (Helen, Year 1)

“I think trying so hard to do so well in exams can be incredibly narcissistic because it is focussing on your own performance so much” (Connie, Year 2)

Helen suggested that those students with the top grades were not necessarily the most empathetic.

“This sounds really bitchy but [they] do very well at medical school and you look at think I wouldn’t want to talk to you, you are a bit scary. Yeah. But they get top grades” (Helen, Year 2)

Neville also implied that competition was not helpful in encouraging the development of empathetic doctors. Students felt pressure to perform well not just from the medical school, but from their families.

“Ultimately it does come down to your grades and that sucks. That is really, really bad because not what it should be about in my opinion. We are in there to learn to be good human beings. Learn to be good doctors to be able to look after patients yet we don’t, [the] kind of environment some people create is unnecessary” (Neville, Year 4)

“the pressure to perform well and to succeed at things and that is not just pressure by medical school, it is from peers and from family and from within yourself” (Connie, Year 2)

They claimed that due to the lack of feedback from the medical school they resorted to comparing themselves with their peers, so further encouraging the competitive culture.

“if you had advice from higher up it would make it so much easier, because when you don’t, the only reference points you have looking around at other people” (Helen, Year 3)

Gina suggested that highly competitive students risked burnout and gave an example of students trying to outdo their colleagues.

“I don’t try and judge my achievements on how other people are doing. I try and step out of that and if you got into that it would be far too stressful environment and you would burn out [...] But there are certainly others who are like I want to be the best and would jump in front of you to get into a clinic or tell you it was elsewhere to get in” (Gina, Year 4)

“I know if they were struggling I guess they wouldn’t necessarily let on because it can be quite a competitive dog-eat-dog attitude amongst medical students to each other sometimes” (Gina, Year 4)

However not everyone was competitive, Kim claimed that there was less competition in the clinical years. Paula was not so sure, concluding that there was great variability among the students with regard to competitiveness throughout the course.

“I think probably in first and second year it was because it was more lecture year, [...] I think being on clinical attachment you are not competitive” (Kim, Year 4)

“I think it hugely varies within our year probably” (Paula, Year 5)

Students also talked of the effects of power relations within the medical school on their ability to empathise with patients and colleagues.

7.5 Power

The students described power differentials which influenced their empathy in several contexts; the doctor-patient relationship, a fear of challenging authority, bullying and in the denigration of certain specialities. The hierarchy embedded in the medical school and in their clinical environment seemed to inhibit their empathy.

“when you write an email to someone[...] How should I address them ? Should I call them doctor so and so or should I call them by their first name.? I expect they expect me to call them by first name and I am not sure. They sort embed the hierarchy” (Fiona, Year3)

However, Fiona also reflected that hierarchy did not always affect empathy adversely, since being of a lower status as a student, could sometimes be an advantage. Olive argued that the relationship between empathy and power was complex and might depend more on the person’s personality than their status.

“I think sometimes a patient might feel more comfortable and therefore more open and honest therefore empathy is kind of more facilitated with perhaps someone who is slightly more junior” (Fiona, Year 2)

“but what the patient feels if they are speaking to someone who seems really big and authoritative maybe they won’t see that the doctor being empathetic ,or maybe that more depends on the general character of the person rather than necessarily level of powers that they have” (Olive, Year 2)

Many students claimed that they were unable to challenge some consultants who appeared to lack empathy for patients. Ida described feeling distressed when a patient’s dignity was not respected by a consultant. She suggested that the students’ reluctance to challenge their seniors was shared by some patients. Ida explained that she did not challenge the authority of consultants as she could not afford to jeopardise her progress and admitted that that she was not aware of the whole picture. Students gave a number of other examples where they felt distressed by a doctor’s lack of empathy with a patient yet felt unable to say anything.

"It does vary some are more approachable than others. But for the most part it would be very difficult to question anything they did or say anything" (Paula, Year 4)

"he[consultant] wasn't the person you can tell that to but I have actually heard lots of other students tell very similar stories and I have not heard a single time they did actually say something to the doctor about it. I don't feel like as medical students we are in the right position to do" (Ida, Year 4)

"they [the patients] have said that that he was a bit threatening or very strict." (Ida, Year 4)

"I feel like the patient has more to say but the person I was with [consultant] didn't want to talk to him anymore" (Amy, Year 5)

"really uncomfortable.[...] And I was on the verge of wanting to say something to them as this is terrible. There were two others students there at the time and we both left, I don't know I just think that wasn't right that wasn't addressed" (Paula, Year 5)

"I feel like people would say to each other if they thought scientifically something was a bit wrong and wouldn't say and there personal aspects they wouldn't say that". (Ida, Year 4)

The students were made aware of a hierarchy of specialities by some teachers. For example, Gina described derogatory comments about general practice, illustrating the low esteem for this speciality which was perpetuated in the medical culture and absorbed by some students.

"There is still that attitude that it is not academic to be a GP, it is an easy option. People only do it for work life balance. Women go and do it so they can have babies and work part time that kind attitude that kind of dismissive overgeneralised thought. And you do see it in your peers and you do see it in teaching" (Gina, Year 6)

Power can be abused and some students described being bullied or humiliated. Lisa gave an example, when she had been humiliated on a ward round by a cardiologist and felt she could not return to the patient. Lisa was still visibly

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distressed as she recounted this experience. She reflected that her humiliation had made her resolved not to behave in this way in the future with her colleagues.

*“But she introduced me and saying that I was going to be a doctor in a couple years’ time and it was rather scary since I got to this stage and couldn’t read an ECG and that kind of thing. So it makes you feel a bit small [nervous laugh]”
(Lisa, Year 4)*

“it is not very nice, no. It kind played on my mind the rest of the day. And obviously two days later it is still [...] I did find as well that I don’t feel like I could then go back to that patient and have a normal conversation” (Lisa Year 4)

Paula described consultants who were intimidating and embarrassed staff and students. She maintained that this humiliation was not malicious. On the other hand, Marilyn claimed that she was not afraid to speak out, but was aware that this did not fit in with the university’s wish to retain a hierarchy in the medical school.

“there are intimidating consultants and I have seen them embarrass junior doctors for example sometimes medical students, but never in a malicious way” (Paula, Year 4)

*“I am outspoken,[...] and people don’t like that. People don’t like it when you look at them like you are on same level. Like you are just two people. They want a hierarchy”
(Marilyn, Year 4)*

Just as students described feeling intimidated by consultants and failing to raise their concerns, some patients were intimidated by doctors. Kim implied that both the consultants and students are on a spectrum of approachability.

*“I think there is probably spectrum of approachability”
(Kim, Year 5)*

7.6 Time: Balancing empathy and efficiency

Many students suggested that establishing empathy required spending an appropriate amount of time with the patient.

*“I think when you have more time with your patients you can empathise with them more because you learn more about them. And you learn more about them as people”
(Kim, Year 6)*

In the clinical years, the students claimed that in order to practice efficiently, they had to spend less time with patients. It was apparent that a tension existed between empathy and efficiency. They also claimed that a shortage of time created stress, which reduced their empathy. Bill described how a lack of time made him adopt a more detached manner, becoming focused on his own behaviour rather than on the patient.

“because we had so many to see I was getting really kind of brusque in my attitude towards them to get things done in talking to them less” (Bill, Year 3)

“when I was under time constraint and when I was thinking over things in my head it was almost less about me examining the patient but more me running over my head, Have I done this correctly ?” (Bill, Year 3)

On the other hand, Olive suggested that empathy could be established, at least at some level, fairly quickly and she did not feel limited by time.

“I don’t think you can put a stop to empathy by a simple time limit”(Olive, Year 2)

Kim argued that exploring the patient’s feelings would take more time. She found it unsatisfactory when she neglected to explore the patient’s emotional needs, claiming that she would feel inhibited if allowed only ten minutes for a consultation. She wondered whether people who did not explore feelings did not necessarily lack time, but lacked an empathetic approach.

“I don’t think I would appreciate it as much if it was just ten minutes per clinic appointment. But then maybe the people

that don't explore those type of things don't find it stressful to not explore that. I suppose that whether what causes them not to go into it in the first place whether it is time constraint or whether an innate issue" (Kim, Year 4)

Some students in the clinical years described a culture of a lack of time, Gina noticed that the workload seemed to squeeze out the human aspects of care during her general practice experience.

"just seeing that in action and just how relentless it is. It feels very like something is lost and then the opportunities you do have where you know that bit of extra time and a human touch would be beneficial to that person is often not possible ,which is really sad" (Gina, Year 6)

Several students were distressed by rapid ward rounds in surgical specialities. For instance, Lisa was aware that psychological issues were not addressed in any depth on some surgical ward rounds. Neville noticed the speed of some orthopaedic surgeons' ward rounds left some elderly patients confused. He suggested that it was shortage of time which constrained doctors from giving a satisfactory level of psychosocial care.

"they are going through their ward round they are desperate to get to theatre. [...] I think it is mostly time or people just, for them going back to surgery ,what is important is to fix this broken leg, not worry they are not you know feeling a bit down on the side anything like that" (Lisa, Year 5)

"the lack of communication , the brashness , or the speediness of their ward round leaves patients confused. They talk amongst themselves rather than address the patient and I thought that was quite poor. [...] I just wish they had given her more time and actually talked to her rather to themselves" (Neville, Year 6)

"I think all the doctors I have seen are very caring individuals and they want to care but they don't have the time to do that. [...] I genuinely do feel unfortunately that we don't give patients that aspect of the care. [...] But us as doctors are notoriously bad at not giving patients enough time" (Neville, Year 6)

In bedside teaching, the emphasis was also on efficiency rather than empathy. Kim explained how her feedback to a consultant about a patient's history had to be concise and focus on the medical issues. She suggested that spending time with a patient was not valued by the tutors.

"there is very much a time restriction there and you do have to learn to be very concise especially you are being taught how to feed back to a consultant" (Kim, Year 5)

"I don't think it is really said you go and spend any time with patient it is a very valuable thing to do" (Kim, Year 5)

Students were concerned that the drive for efficiency not only threatened their empathy but could lead to clinical errors.

"You have to be efficient with the way manage your time and therefore empathy gets thrown to the back" (Amy, Year 6)

"Whereas the time pressured and you miss things" (Kim, Year 6)

"time and maybe having other things on your mind not concentrating as fully as you should and picking up on cues" (Lisa, Year 6)

Time shortage was also related to stress and to reducing empathy. Students highlighted how time and stress affected their empathy.

"When you have less time you don't get to know people and you get stressed" (Kim, Year 6)

7.7 Stress

The students agreed that they were less empathetic when they felt stressed. They described some effects of stress; causing them to withdraw from patients and to lose concentration.

"I can feel less willing to listen to long winded anecdotes" (Ida, Year 6)

"you can't actually concentrate on the patient" (Olive, Year1)

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“if you are stressed [...] then you probably are not going to be so empathetic” (Olive, year 3)

The majority of students saw stress as unhelpful, but a few reflected that in some situations being stressed might create a bond with the patient.

“You see other people who are going through difficulties and because you know that you are suffering or having a hard time yourself you feel much more connected to that person” (Connie, Year 2)

Students identified many causes of stress including; shortage of time, workload, assessment and competition. They also identified clinical issues which caused them stress, such as caring for dying patients, observing poor practice, and their own mental health problems. Lisa described a cycle in which a doctor with less time became stressed, had less empathy and spent less time with the patient. She suggested that a combination of the workload, time pressures and stress encouraged doctors to behave without empathy. Most students talked about the stress of exams and assessment.

“just the work load, the situation, the amount of stress on you and how much you have got to get through that dictate how long you can spend” (Lisa, Year 4)

“Last semester at exam time I think I must have been incredible stressed yeah. [...]got very little sleep and saw very little of the outside world, of the outdoors in general. That was very much an environment cultivated by all the medical students” (Olive, Year 2)

Amy talked of her stress when a patient she knew died unexpectedly. She felt sad and guilty and found it difficult to find anyone with whom to share her feelings.

“I went on Sunday to check how he did and unfortunately they told me he passed away the night before and I just felt really sad”(Amy, Year 5)

“I still remember what I said to the patient the day before surgery. I told him don’t worry you will be fine. You will be

in good hands and I reflect on what I said. Hmm” (Amy, Year 5)

Diana claimed that the medical culture demanded that they concealed their stress from others, sometimes even physically, hiding in a ‘crying cupboard’.

“these other students or junior doctors had very much required a ‘crying cupboard’ and found one and it had become a thing in the department that existed” (Diana, Year 6)

A number of students talked about their own mental health during the course including depression, grieving, anxiety and disillusionment.

“I have been either depressed or physically a bit unwell or incredibly stressed or any combination thereof plus sleep deprivation” (Marilyn, Year 4)

“I was struggling towards the end of second year when I realised that like it is all about management, management treatment, management, blah, investigation so it was very core science” (Amy, Year 4)

“It was all over the place. Doing a placement on top of that wasn’t that great obviously just because it was a tough few weeks” (Diana, Year 6)

The students talked about a variable system of personal support in the medical school.

7.8 Lack of Support

Students indicated that stress influenced their empathy, therefore it was relevant to listen to their views of the support offered by the medical school. They described the support as variable, depending on the individual personal tutor. Edward spoke for several students who had not found their personal tutor helpful.

“Some people say the exactly same thing as me , it is less than useless. Some people say they are fantastic” (Edward, Year 2)

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Several students had not even met their personal tutor and some had experienced unhelpful meetings. For example, Helen described a meeting with a personal tutor who was pleasant, but so distracted by work that she felt guilty for bothering him.

"I have not seen mine yet. I think no one I have spoken to have ever said they would go to their personal tutor" (Olive, Year 2)

"I felt bad for him because he is an acute medicine consultant [...] He seemed really busy and he welcomed me into his office and there are stacks of paper everywhere and his pager kept going off and then but he was really nice tried to ignore it and stuff and asking how are you feeling. Clearly like just go back on the ward "[laughing] (Helen, Year 1)

Amy did not receive any support after a patient died unexpectedly.

"I did go back to ask the surgeon what when wrong and was it expected? He just gave a sigh and 'that is what happens'. And I was like oh, OK. He does not want to talk more about it" (Amy, Year 5)

Students said that they were reluctant to seek support from personal tutors but preferred informal sources of support. Connie said that she did not want to burden someone else with her problems. Whereas in first year she might have gone to someone and to vent her feelings, she was now conscious of their needs and was more resilient.

"I think part of it is also needing to learn to not burden people too much with your own emotions, because it can be burden" (Connie, Year 3)

"And being able to stand on your own two feet sometimes with the way you are feeling and needing to lean on someone all the time. I think that comes with maturing and growing into an adult and learning to be more responsible" (Connie, Year 3)

Although personal tutors were available to provide support students felt there was a stigma in seeking support and some students were worried that it might

impact adversely on their future careers.

“I think you’ve probably got a cohort of people who don’t probably like to admit they are struggling” (Fiona, Year 3)

“I think people worry about seeking support is how it may impact future careers” (Gina, Year 4)

In contrast others accepted that seeking support was sensible and suggested that the university needed to emphasise the confidentiality of the support system.

“being able to seek support shows a level of maturity of mind, it is a good thing that people actually address things rather get to the point they are putting themselves or others, in a risky situation” (Gina, Year 4)

Students also identified administrative barriers in arranging a meeting with their tutors and a lack of clarity about the provision of pastoral support. The students claimed that there was a lack of guidance from the university on coping with emotional stress and they would welcome more support.

“I don’t know if most people are comfortable putting it in the words in an email that they need help. I think it formalises something they don’t want to be formal” (Bill, Year 3)

“the personal tutor first of all says, “I am not your mum. So if you have got worries, I am not the one who has to deal with this”(Olive, Year 3)

“I don’t think anything is said, medicine is really tough sometimes and this is how you do it and this is the support network that is here. [...] Even if it is, ‘Here is method how to switch off at the end of the day take five minutes” (Kim, Year 5)

7.9 Other influences in the medical school culture

The students spoke about other factors contributing to the medical school culture including; alcohol, loneliness and social media.

A factor which the students said affected their socialisation was a culture of alcohol consumption by some medical students, particularly in the first two years of the course. Marilyn suggested the drink culture did not exclude students from socialising, but Connie felt excluded by it.

“I don’t want to bring it up ,but these students drink so much.[laughing] I mean I can’t imagine it to be professional to drink on a Wednesday night and go out and then get a lecture the next morning. But they do” (Marilyn, Year 2)

“I think a lot events centre around alcohol but I think the students are a very friendly bunch. So if someone came along and wanted to have a good time and just wasn’t drinking they wouldn’t be pushed into it.” (Marilyn, Year 2)

“I definitely feel like there are a lot of activities I can’t partake in because of the amount of drinking” (Connie, Year 1)

Diana gave a vivid example of facilitating a tutorial with six students who were still under the influence of alcohol.

“I am a PBL tutor [...] I come to a tutorial next morning and I am trying to work and all of my six students are hungover or still drunk” (Diana, Year 5)

One of the surprising findings in this study was that some students reported loneliness to be a significant problem despite describing their peer group as friendly. Some overseas students in particular found it difficult to integrate with their peers, describing how cliques were established in the medical school.

“after the introduction week ,almost everyone seemed to have their own little group” (Jenny, Year 1)

“And at first I guess coming from international background you want to come and mingle with everyone and that was a big struggle because I don’t do alcohol, I don’t go clubs, I

don't pub whatever, and as hard, I guess as hard as you try to fit in, it is difficult when [...] there is nothing I can talk about" (Amy, Year 4)

Even in the later years of the course some students still felt isolated.

"I just don't get along I suppose" (Marilyn, Year 4)

"because sometimes [a] placement can be quite lonely" (Kim, Year 5)

"I don't think I have that many friends in the medical school" (Ida, Year 6)

Students were fairly dismissive of the influence of social media on their ability to empathise. They used social media to arrange meetings and share work information. They claimed that social media presented an unreal image of people and suggested that it was unwise to share emotional information. They implied that social media did not enhance their empathy. However, since it provided anonymity, Marilyn suggested it might enable people to share concerns, but she described an episode of bullying on Facebook.

"I think it makes easier for practical people to communicate [...] but I don't think it makes you more connected" (Edward, Year 2)

"it is very different to face to face communication. [...] people don't put their life and soul and personal emotions on social media which I think is a very good thing" (Fiona, Year 2)

"you paint a picture of yourself on social media that is not the same as who you are" (Paula, Year 5)

"It lends itself to people opening up to other people when they might be too nervous. It lends itself to people to be mean to each other. It lends people to asking for help when they might not otherwise do. So it is not a simple good or bad" (Marilyn, Year 2)

"last week one of the students got really drunk and decided it would be funny to post an incredibly, incredibly rude comment on Facebook on the medics page" (Marilyn, Year 1)

7.10 Reflexivity

At times I became anxious in the interview when a student was straying away from a discussion of empathy, but when I reflected on the transcript, I could appreciate a wider picture by allowing them to follow their agenda.

I was disappointed by the fact that the students had much more to say about the negative factors than the positive. It is part of the value of a phenomenological inquiry that it explores the taken-for-granted everyday world of the students. It might be argued that given this opportunity to talk in a confidential setting that students might naturally be inclined to dwell on the negative influences. However, I do not think that this is the case in my study, as the majority of students were highly motivated and interested in the research.

I shared the students' apprehension in reporting negative findings, wondering how the medical school might receive this information. However, my ethical duty is to report the findings without distortion as far as possible. It seemed to me that even in conducting the research in a part-time manner I also was aware of a cultural prohibition in the medical school on giving negative feedback.

7.11 Discussion

7.11.1 Background

If a medical school is to nurture students' empathy, those involved in curriculum development may wish to adopt the factors identified by students as enhancing their empathy. They might seek to break down barriers to empathy cited by students particularly in regard the medical school culture and teaching in the curriculum (Chapter 8).

The students talked about a number of themes in relation to the medical school culture which they described as inhibiting their empathy: a conforming culture, a lack of empathy for students, competition, stress and a lack of support. They also were aware of time constraints which inhibited their empathy. Some students discussed the influence of alcohol, loneliness and the impact of social

media on their empathy. Their comments related to a medical school with an international reputation for research excellence but which was rated poorly in comparison to other universities in a recent student survey of teaching quality and student experience (National Student Survey, 2017).

7.11.2 Medical school culture

Many studies consider the medical school culture, or hidden curriculum, from the perspective of medical educators, but few have investigated the views of students (Bandini et al., 2017). The students identified a number of key areas in the medical school culture which they described as barriers to their empathy. Forty years ago, Atkinson carried out an ethnography at Edinburgh Medical School, noting the complexity of the organisation and describing differing sub-cultures, for example in central and peripheral teaching hospitals (Atkinson, 1976). The year four students in his study described a lack of patient contact and claimed that the teaching staff had little knowledge about them as individuals (Atkinson, 1976,p.480).

7.11.3 A conforming culture

Students described a conforming culture of the medical school in which they were expected to conform and not to question the curriculum. They were reluctant to criticise or to seek support. These findings shared similarities to a study which identified the acceptance of hierarchy and the adoption of a ritualised professional identity as part of the hidden curriculum (Lempp and Seale, 2004). It seemed that there was a disparity between the medical school's stated aspirations to promote diversity and the students' experiences of greater standardisation and conformity (Frost and Regehr, 2013). It also appeared to the students that the faculty did not appear to acknowledge this tension and so it was not addressed (Frost and Regehr, 2013). One of the advantages of my phenomenological approach was that it made some of the problems in the hidden curriculum explicit.

7.11.4 A lack of empathy

A striking finding in this research was the students' widely held view that they were not shown empathy by the medical school. They described harsh attitudes of teaching staff to sickness absence and bereavement indicating that the medical school treated them, at times, with suspicion rather than as colleagues needing support (Back, 2016,p.32). Other authors have made the case for students needing more empathy from the faculty and their teachers before they can truly understand how to establish empathetic connections (Bayne, 2011, Karnieli-Miller et al., 2011, Janssen and MacLeod, 2010). A recent study showed how curricular change, in this case introduction of small group work and academic communities, enhanced the students' sense of connection with faculty (Brandl et al., 2017).

7.11.5 Competition

There was a consensus that the competitive culture in the medical school was not conducive to developing empathy. Students felt that competition was encouraged by the medical school from the beginning of the course but tended to wane in the clinical years. They realised that their position in the year relative to their peers determined their chance of being appointed to one of the popular foundation year posts. Other studies have identified competition as a feature of the hidden curriculum (Lempp and Seale, 2004, Nogueira-Martins et al., 2006). Marcum (2013), suggested that a competitive culture risked patient care.

7.11.6 Power

The hierarchy within the medical school contributed to the conforming culture (Lempp and Seale, 2004). Students described episodes when they were distressed to observe doctors behaving without empathy but felt constrained from challenging a consultant's behaviour (Rees and Monrouxe, 2011). Students in other studies have described distress when they witnessed a lack of empathy, and similarly felt powerless to challenge authority (Monrouxe et al., 2014, Rees et al., 2013, Monrouxe and Rees, 2012).

Students described a hierarchy of specialities in the medical school where general practice was denigrated and seen to be less prestigious than other specialities such as surgery. Baker et al. (2016), speculated that the widespread denigration of general practice in medical schools might contribute to the problem of recruitment to the speciality. The medical school in this study had a low rate of graduates entering general practice perhaps reflecting its reputation for biomedical scientific research (Goldacre et al., 2004). It is paradoxical that specialities with low levels of patient contact tend to be regarded as the most prestigious (Hinze, 1999). High prestige specialties such as surgery, have been found to attract less empathetic doctors and low prestige specialties, such as general practice or palliative care, more empathetic doctors (Hojat et al., 2005).

Abuse of power by humiliation or bullying had the effect of undermining the students' confidence and empathy with patients (Lempp and Seale, 2004). A study of medical students in the UK revealed 20% of students experienced bullying on their clinical attachment (Timm, 2014). Rees and Monrouxe (2011), found that commonly students took no action in response to bullying. It seems to some authors and to the students that awareness by the medical faculty of abuse of students in medical education had resulted in little effective change (Rees and Monrouxe, 2011, Timm, 2014).

7.11.7 Lack of time: Empathy vs Efficiency

Most of the students in the clinical years felt that their empathy was inhibited by a lack of time. It could be questioned whether it is reasonable to expect empathetic relationships with patients given the demands of medical practice in the NHS today (Halpern, 2014). Students reflected on their experiences in the early years when they met very few patients but had plenty of time to listen to them and contrasted this with the clinical years when they perceived a tension between empathy and efficiency. Other qualitative studies on medical students' empathy have also identified a shortage of time as a barrier to empathy (Ratanawongsa et al., 2005, Nogueira-Martins et al., 2006, Tavakol et al., 2012,

Eikeland et al., 2014) Conversely, students claimed that having more time helped to establish their connection with patients (Cutler et al., 2009).

Students described a link between their perceived lack of time and stress which in turn reduced their empathy. They gave descriptions of patients being treated abruptly on ward rounds and described how distressing they found this. There was uncertainty about the extent to which distancing behaviour was due to a shortage of time or to the doctor's personality.

Students reported how they felt rushed when presenting a patient's story on a ward round, where the emphasis was on stating medical facts concisely and so neglected psychosocial issues. They observed that a shortage of time could lead to medical errors. Verghese (2008), has argued that spending time with patients, listening and carefully examining them might avoid unnecessary tests and procedures. Bauer (2008) suggested that while fast medicine is appropriate in emergency situations, there may be a place for slow medicine in many of the illnesses which evolve chronically. Wear et al. (2014), also challenged the culture of speed in medical education and practice. They described a 'slow medical education' where instead of a rush to efficiency, there was a commitment by the faculty to provide time for students to reflect about their experiences (Wear et al., 2014).

Christakis and Feudtner (1997), proposed that a possible factor in the dehumanising of doctors and students was the transient nature of relationships during training. They argued that temporary relationships lacked human connection both with patients and colleagues resulting in a pressure to do something. In this way 'efficient' doctors may become alienated from patients (Christakis and Feudtner, 1997). Furthermore, they indicated that students who do spend time with patients risk being regarded as inefficient (Christakis and Feudtner, 1997). It has been argued that a doctor should spend more time in establishing empathetic relationships and that those responsible for the

doctor's workload should restructure their timetables to allow for such empathy (Hardy, 2017).

The students' conversations around levels of empathy suggested a way forward in this dilemma. Sometimes understanding a patient's situation appropriately to meet their needs did not require the clinician to engage in a deeper level of empathy than simply acknowledging the patient as a human being who is valued (Halpern, 2014). A relational view of empathy, acknowledged that appropriate empathy can be achieved by different levels of empathizing which depended on the clinical situation.

Finally, it can be argued that allowing the patient to create a narrative is not as time consuming as may be assumed (Hardy, 2017). It has been shown that allowing a patient to establish their story takes approximately two minutes, for 78% of those patients (Langewitz et al., 2002). However, Marvel et al. (1999) showed that doctors interrupted the patient's story after a mean of 23 seconds. Therefore there could be scope for doctors who possess 'narrative competence' to allow patients to complete their story in a short time within an empathetic relationship.

7.11.8 Stress: the crying cupboard

The students claimed that they tended to distance themselves from patients when they felt stressed. The heavy clinical workload and shortage of time led to reduced empathy and a risk of clinical errors and further stress, findings that were confirmed in a survey of practicing physicians (Ahrweiler et al., 2014).

Although some stress is a normal part of training, it can be associated with both psychological and physical illness (Dyrbye et al., 2005, Dyrbye et al., 2010). The authors suggested that strategies for coping with stress that involved detachment from the patients correlated with depression and anxiety and poor mental health. In contrast, strategies that involved engagement, support and expression of emotion enabled students to respond in a healthy way (Dyrbye et al., 2005). The students described a culture which discouraged any admission of

stress. One student talked about a cupboard on a ward which was known by the doctors and students as the 'crying cupboard', inferring it was necessary to hide away on one's own rather than to display emotion or to seek support.

Students were concerned that by connecting emotionally with some patients that they might be at risk of burnout. Burnout, a stress related syndrome, is characterized by exhaustion, depersonalization and a diminished sense of accomplishment, and was related to lower medical student empathy (Brazeau et al., 2010, Thomas et al., 2007) On the other hand, there was evidence that well-being was positively correlated with higher levels of empathy (Thomas et al., 2007). Jennings (2009), maintained that burnout arose when the medical culture was unresponsive to people. This argument concurred with the students' perceptions of not being shown empathy by the medical school.

Zenasni et al. (2012), suggested three alternative hypotheses in exploring the possible relationships between empathy and burnout; burnout prevents empathy, empathy creates burnout and empathy prevents burnout. There are a number of quantitative studies which show that burnout is associated with a decline in empathy (Shanafelt et al., 2005, Brazeau et al., 2010, Paro et al., 2014). There is a belief that empathy can lead to burnout which is one reason for the prevalent medical culture of detached concern (Zenasni et al., 2012, Halpern, 2001). However, adopting 'detached concern' rather than protecting the student from stress, may instead lead to burnout (Ekman and Halpern, 2015). The literature suggests that empathy prevents burnout since it is claimed that emotionally engaged physicians were fulfilled and so had greater effectiveness (Halpern, 2001). One study found that oncologists who incorporated both biomedical and psychological approaches viewed provision of end-of-life care as satisfying (Jackson et al., 2008). In contrast, participants who described primarily a biomedical role reported a more distant relationship with the patient and a sense of failure (Jackson et al., 2008). The authors concluded that the latter group had an increased risk of burnout, while those who connected empathetically were protected from burnout (Jackson et al.,

2008). Other research also supported this view (Harrison and Westwood, 2009, Kearney MK et al., 2009) .

It appeared from these studies that burnout resulted in a decline in empathy and that empathy may protect against distress and burnout. However, some students were concerned that by sharing feelings and connecting emotionally with patients that they risked burnout, reflecting a prevalent belief in medical practice (Zenasni et al., 2012, Halpern, 2001). However at the same time most said that they would not feel fulfilled if they had to work in a detached manner a view, reflected in Epstein's study (Epstein, 2014) .

The students described resilience as facilitating their engagement with patients, although some were concerned it implied some distancing. Resilience can be seen as more than the ability to adapt to change and achieve goals in the face of adversity (Epstein, 2014). Resilience can also involve empathy, humility and managing uncertainty (Epstein, 2014).

7.11.9 Lack of support

Since students identified stress as a prominent inhibitor of empathy the provision of support for students would appear to be essential. Providing support for medical students is a GMC requirement of a medical school (General Medical Council, 2009). Jennings (2009), claimed that student burnout can be attributed to a medical school culture that failed to value medical students. He called for medical schools to create learning environments that respected the integrity of students and nurtured them as professionals and people (Jennings, 2009). This suggestion was supported by Benbassat (2014), who concluded, in a narrative review of the literature on well-being, that medical training caused emotional distress. Other authors have also made the case for a nurturing learning environment in medical schools (Dyrbye et al., 2005).

Students agreed that the level of support provided by the medical school depended largely on the personality of the individual personal tutor. They noted that some tutors were uncertain of their role. The students acknowledged that

the University provided support but they expressed concerns about appearing weak or that seeking support might affect their career progression. Others were concerned about the confidentiality of the support system and found administrative barriers in arranging meetings with busy clinicians. Other authors also found that support offered by the medical school may not be accessed by students for fear of stigma or the effect on their grades (Chew-Graham et al., 2003). Students in another study appreciated the opportunity to discuss difficult issues in relating to patients in an informal setting but students in my research reported difficulty in accessing such support (Nogueira-Martins et al., 2006).

7.11.10 Other factors inhibiting empathy in the culture of the medical school

It was surprising that some students talked about a drinking culture in the early years which alienated them from social events. A study of second year students at one medical school, found that 50% of medical students reported exceeding recommended safe levels of alcohol consumption (Pickard et al., 2000).

International students in particular, felt socially isolated, partly because they did not drink alcohol. Three students in the study admitted that they felt lonely, even in the final years of the course.

Students were ambivalent about the use of social media, being wary of any emotional self-disclosure and one student described being bullied on social media. Students claimed that they used social media to share teaching resources and arrange meetings. There have been concerns that young people are becoming less empathetic as a result of using social media (Twenge, 2013, Konrath et al., 2010). However a survey of Dutch adolescents suggested that using social media improved both their cognitive and affective empathy (Vossen and Valkenburg, 2016). A survey of medical students at one university found that social media use was widespread but the majority were unaware of GMC guidance on its appropriate use (Kang et al., 2015, General Medical Council., 2013).

7.12 Summary

The context of the learning environment is critical for fostering a relational form of empathy. This exploration of the context or culture of the medical school revealed a number of factors which the students described as inhibiting their empathy. Some of these factors; a conforming culture, a lack of empathy for students, a shortage of time and a culture of alcohol have not been widely reported in the medical education literature in relation to empathy. The study confirmed earlier reports of the influence of competition, hierarchy, stress and the need for support. As some authors have pointed out, awareness of these influences does not appear to have led to many changes in the medical school culture (Rees and Monrouxe, 2011). In the next chapter I explored barriers to empathy arising from teaching in the curriculum.

Chapter 8 Students discussing barriers to empathy: The curriculum

8.1 Overview

This chapter also addresses my second research question:

What factors do students describe as influencing their empathy during their undergraduate medical training?

Students identified the main barriers to empathy in the curriculum as: a lack of patient contact, negative role models, the biomedical teaching bias and learning professionalism as detachment from patients. The findings are described and followed by a discussion.

8.2 Can empathy be taught?

Some students, who viewed empathy as an attribute, claimed that empathy could not be taught, but others argued that their empathy might be enhanced by teaching. Gina speculated that different dimensions of empathy might be amenable to teaching,

"I am sceptical about the extent to which teaching styles can change underlying empathy" (Marilyn, Year 2)

"It is the encouragement of it though, rather than, this is how to be empathetic" (Olive, Year 2)

"Maybe the idea of seeing it from their perspective maybe that can be taught" (Gina, Year 4)

Although some students were doubtful initially whether empathy could be taught, by the end of the course, some were convinced that teaching empathy was possible.

"many aspects of empathy can be taught. Yes, definitely, there are things that can be done" (Neville, Year 6)

8.3 Lack of teaching about empathy

Several students commented that there was little teaching on empathy during their training. They suggested that the lack of emphasis on empathy was related to a lack of patient contact.

“I wouldn’t say that much kind of formal or even informal kind of on this subject at the moment but I think that is because we haven’t seen many patients yet” (Fiona ,Year 1)

Connie wondered whether the lack of teaching on empathy was because the University assumed that medical students would be naturally empathetic.

“Empathy can get occasionally missed off and I think it is because take it for granted we are going to connect with patients” (Connie, Year 2)

Students noticed that their teachers placed more emphasis on their clinical skills and factual issues.

“It gets drilled into you some clinical facts but I don’t think empathy is driven into us nearly enough” (Connie, Year 2)

They identified specific gaps in their teaching such as emotional regulation and empathising with minority groups.

“We have never had someone sit there and maybe talk about the idea of empathy as a concept or maybe sort of the boundaries in communication and how much you want to attach and invest in patients and how much is appropriate. [...] I think it would be something beneficial” (Gina, Year 4)

“LGBT on the other hand, again we don’t get taught about it”(Olive , Year 3)

Students differentiated teaching on empathy from teaching of communication skills. They suggested that learning about empathy was something that was acquired after clinical experience with patients and from observing good practice.

“I don’t think we have had formal teaching on it. I mean we have had clinical communication teaching but these are hard things to teach. [...] they are skills and attributes you pick up as you go along” (Neville, Year 4)

“probably just by seeing, just experience with real patients and seeing other people and copying what they do [...] I suppose it is not something really be taught, it is more something you learn by watching others” (Lisa, Year 4)

Fiona reflected on the problem of meeting the differing needs of students and the pressure on the curriculum which made teaching empathy in isolation a lower priority for the University.

“empathy teaching it comes very naturally to some people but some people it might be something they might need slightly more time on and also support [...] you can’t get a class and split, [...]. You can’t do that so you have got to give the same teaching to everyone” (Fiona, Year 2)

Students claimed that they were not taught about empathy or about emotional regulation. Some students identified parts of the formal curriculum which attempted to teach them empathy as a separate topic but discussed the limitations of these approaches. They suggested that there were missed opportunities to introduce the patient’s experience into their teaching. For instance, some students were sceptical of problem-based learning, (PBL), as a way of teaching empathy, implying that discussion of the nuanced nature of empathy was overlooked. This sense that the University was missing chances to incorporate empathy into teaching was a common theme.

“I don’t deny that PBL could be a good opportunity to think about empathy but I have not in my experience of PBL over the last year I have really barely had any discussions on empathy and on how the patient feels” (Connie, Year 2)

“We didn’t do anything, for example, about how the patient would cope with this kind of thing,” (Bill, Year 2)

Students also noticed that the patient’s experience was often omitted from their lectures, which focused instead on the diagnosis and management of disease and sometimes promoted a defensive style of practice.

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"I think what was strange he didn't mention anything about the patient's experience" (Bill, Year 2)

"we have had lots of lectures about covering your own back[...] I think people are worried about getting too emotionally involved" (Helen, Year 2)

However, when lectures did include the patient's experience they did not appeal to every student. Some students, according to Olive, took longer to appreciate that medical education should be centred on the patient's experience rather than revising for exams.

"it was something poignant, it was something that half people you would speak to say 'Yeah that was really glad got to hear that', other half, 'Oh well we got this to be revising for and we have been taken out of here'" (Olive, Year 3)

Much of the students' communication skills training was with simulated, rather than real patients; many students referred to the artificial nature of these consultations. However, some students did find this method useful, provided they adopted the role.

"having an actor is better than nothing. At the same time, it is also a slightly false situation" (Paula, Year 4)

"I think you have to really get yourself in that frame of mind and some level convince yourself that is actually happening" (Olive, Year 2)

Other students implied that the formal communication courses did not develop their empathy, but seeing patients was more useful. Gina claimed that teaching empathy was more complex than the medical school acknowledged.

"we do have communication skills workshops we have sort have had the last year we have simulated patient. [...] but I don't know how much of that actually influenced me" (Gina, Year 4)

Some students speculated whether communications skills training with simulated patients possibly encouraged them to develop a form of fake

empathy. Gina argued that communication skills can be taught to help those who find it difficult to express themselves but saw genuine empathy as an attribute.

“everyone has varying degrees of how open they are and that is not a bad thing. That is why we teach communication skills, because you can portray yourself in a way that you behave and interaction that appears empathic even if you’re not particularly , not that you are a cold bad person who doesn’t feel anything” (Gina Year 5)

8.4 Lack of patient contact

The students regretted their lack of patient contact in the first three years of their course.

“this university has very very little patient contact in the first two years so the fact we are seeing loads patients in the clinical years is normal. What is not normal is how few we saw for our first two years here” (Marilyn, Year 4)

“from first semester in first year we do meet these patients but there is absolutely no doubt that when you go from second year to new year four then that is the clinical change that happens.” (Olive, Year 3)

The first year students wanted more patient contact and argued that it was an effective way to develop empathy. Their limited patient contact was focused on taking an effective history and clinical examination rather dealing with emotions. They implied that their teaching encouraged them to view the patient as a resource for them to practice their clinical skills.

“it all seems to be about getting the most out of the patients rather than any this how you should feel like a deeper thing” (Olive, Year 1)

However, a few students had reservations about increasing the patient contact earlier in the course. Connie explained that she was more concerned with the scientific elements of the history rather than dealing with any psychosocial concerns of the patient.

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"I was probably more preoccupied that I got everything they were saying written down or making sure that I had asked the right questions or that I understood conditions well enough" (Connie, Year 3)

Another theme which arose from the students' stories was their lack of exposure to patients from minority groups or different cultures. Some students suggested that perhaps cultural issues were ignored by their tutors for a fear of appearing racist. Helen suggested that this might explain the apparent reluctance of some tutors to help foreign students with their communication skills.

"They [lecturers] made a few jokes about religion and I suppose loads of people do that" (Bill, Year 3)

"I don't think we have ever discussed it. Discussed anyone being homeless"(Olive, Year 3)

"I think people are worried about coming across as being racist or anti or against the foreign student and foreign doctors they are scared to flag up" (Helen, Year 3)

"if she had been communicating in her native language she would have been fine with talking to patients. It was because of her unfamiliarity with nuance and body language and stuff in our language and that was reason. But obviously that can't be highlighted, as obviously that is not her fault. I think it is a catch- 22" (Helen, Year 3)

The students also described problems of continuity and in accessing patients on some wards which made empathising difficult.

"I think that is the difficulty with medical school curriculum as the rotations are so short and you might see a patient on the wards for a few days and follow their case through but for the most part you are just seeing a consultation with a patient" (Gina, Year 4)

"there are certain wards that have reputations for being OK to go to and others don't" (Paula, Year 4)

Students were aware of their lack of life experience and claimed that this challenged their empathy.

“it is difficult because we are only twenty year-old protected children and they have really long lives with lots dramatic things happening and we can never understand how that would be” (Ida, Year 4)

Sometimes language and cultural differences hampered an empathetic approach. For instance working through a translator could inhibit empathy.

“it is going to be more difficult to try and connect with the patient and try and understand normally for cultural reason but the language barrier is a mountain” (Neville, Year 5)

“certainly if they are speaking through a translator. I think it can be difficult to completely get across what they are feeling, what you are feeling” (Lisa, Year 4)

The first contact with a patient begins with listening to their story and exploring the patient’s ideas, concerns and expectations.

8.4.1 Ideas, Concerns and Expectations (ICE)

Students described how their approach to taking a history was formulaic at first but later became more flexible. They noticed that the focus of history-taking was on asking questions rather than a more receptive empathetic approach.

“our teaching was more focussed on the questions you would ask the patient rather than the way you would interact the patient” (Neville, Year 4)

They reflected on becoming more adaptable in their approach to history-taking. At an early stage their focus was on gathering the medical facts. In the clinical years, some students found they were having a conversation with the patient.

“I think that is a really important part of learning to take history at the beginning of the year and if you learn to do it well enough you quite happy to break away from it” (Kim, Year 4)

A part of the patient’s history which is particularly concerned with empathy is exploring their point of view. They need to be asked about their ideas of what is happening to them, giving them an opportunity to talk about their concerns and

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expectations. 'Ideas, concerns and expectations' have been incorporated into formal teaching of history-taking by the acronym ICE. Students found it strange that were expected to add ICE on to the end of their consultation. It was considered as a separate entity and was assessed as such in the OSCE.

*"ideas, concerns ,expectations, is one the most interesting and most valuable part of the history ,because you get an idea how they see it and that is almost like empathy."
(Fiona, Year 3)*

*"We get marks for ICE and I think that has coloured people's view on it. [...] it has turned into something, Oh I must do ICE then I will get marks, and I think that is poor"
(Fiona, Year 3)*

Some students suggested ICE should inform the whole consultation not just the end, arguing that it could be difficult to be presented with demands from the patient at the end of the consultation.

"how is that helpful to get all that information just at the end?" (Edward, Year 4)

On the other hand, Jenny liked a structured view of history taking and saw ICE as something to include in exams. She admitted that she might not ask about ICE in clinical practice, if short of time.

"I do use it sometimes. I don't use it every time I talk to someone just because it takes an extra ten minutes." (Jenny, Year 4)

Many students referred to ICE as a tick-box exercise which had lost its significance for empathising. Olive summarised their views,

"I suppose it is an important thing that you do get patients' ideas, concerns and expectations. But we so often joke about it. [...] You don't think about the fact that concerns can actually be something really concerning to the patient, but actually they have taken three months to come into the GP surgery and they finally come in. Because this concern that has been keeping them up every night until they decided to book appointment, or expectation they might be able to go home that day and have some peace of mind that

they don't have cancer. and these are such important things but because [they] teach us, tick off ideas will get a mark, expectations double mark "(Olive, Year 3)

Students claimed that much of the teaching of empathy was also a tick-box exercise; focused on preparing for exams rather than addressing patients' concerns.

"very box ticky because they're preparing us for our exams" (Marilyn, Year 2)

"[on a] surgical ward round it is very much kind of ticking boxes, firing through, so sometimes I don't feel that there is that kind of connection or asking the patient kind of any of their opinions or anything" (Lisa, Year 4)

In the clinical years the students reflected on the harmful effects of negative role models on empathy.

8.5 Negative Role Models

While students encountered good role models they were distressed to witness occasional poor practice where doctors did not empathise with patients. For example, Marilyn was shocked by the way a neurosurgeon discussed possible surgery with a patient with a history of poor mental health.

"this surgeon tells her she can drop dead at any minute and she needs to have surgery and that surgery has 10% chance of death. Without giving them any space to process, without making sure they are OK, handing them the paperwork, saying it all in the same tone as if he was ordering a latte from Starbucks" (Marilyn, Year 4)

Marilyn wondered if surgeons needed empathy and explained that perhaps certain personality types sought specialties which required less empathy.

"I think it is a self-selecting thing. People who really want to have long term relationships with patients, people who love patient contact, people who interested in giving comfort don't become surgeons" (Marilyn, Year 2)

Amy was distressed by bedside teaching where the patient was ignored and

doubted whether this was acceptable to treat a patient in this way.

“a shock to the system when having bedside teaching. [...] most of the bedside teaching was spent around the end of the bed looking at the patient chart discussing about the patients results, referring to patient as ‘HE’ instead of speaking to the patient directly.[...]I felt really, hmm, bad about it” (Amy, Year 5)

8.6 Biomedical Bias

There was a consensus amongst the students that the course had a strong scientific biomedical bias and that psychosocial issues were neglected. Students implied that the scientific bias started at recruitment where medical schools were rated for research rather than teaching.

“I think our course is very scientific and very traditional in the way they have premedical years and the medical years. [...] But yeah, scientific from the start” (Olive, Year 2)

There were lectures in first year on Health, Ethics and Society, (HES) ,which focussed on psychosocial issues. However, at this stage students had minimal contact with patients so found it difficult to appreciate the significance of their teaching.

“I remember at the time everyone [...] would be, why are we doing this?, how this is going to help us when we are doctors?” (Gina, Year 4)

“Why did we get all that teaching when it didn’t make sense?” (Neville, Year 6)

Students also argued that the lack of patient contact in the first three years put too much emphasis on biomedical science. They acknowledged that science was important, but suggested it was the balance with psychosocial aspects of care which was skewed.

“there is much focus on the science and probably maybe because medicine has to be such a knowledge base thing and you are supposed to base everything on research and [the] latest literature and it has to be cutting edge. [...] It is

almost as if they have completely left out anything to do with the actual patient” (Bill, Year 2)

Students suggested that the University wanted to produce academic doctors although it professed to create ‘caring competent doctors’. They argued that the introduction of the compulsory honours intercalated science degree provided further evidence of the medical school’s commitment to a scientific agenda.

“I think they will ideally love to produce doctors who are very research orientated definitely, but also efficient and patient centred” (Amy, Year 4)

“When the conversation how all the biological stuff has finished and all done with, then maybe give some quick consideration to what happens when they leave the hospital or leave GP surgery. [...] things like empathising with patients, understanding their situation and really how this one consultation slots into the rest of their life. It just it gets pushed back whether intentionally or not, it gets pushed back” (Connie, Year 2)

“I think they[medical educators] go ‘first of all here is the problem this is how you sort it out’, then they will consider, ‘and by the way there are emotional aspects to this’” (Paula, Year 5)

Fiona, on the other hand, had a different perspective and said that she felt more confident in knowing some of the basic science before meeting people.

“I personally like knowing a bit more before I actually meet people” (Fiona, Year 2)

Other students like Diana and Amy thought the scientific agenda was also exemplified by the many evidence-based guidelines. Diana described the way surgeons are driven by these guidelines and suggested this may inhibit discussion. Amy wondered whether one reason why some treatments were continued inappropriately in dying patients was because doctors slavishly followed guidelines.

“there aren’t many things we actually have to make the proper decision it is the right thing to do, there is NICE

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guideline for everything, so just have to go down that route" (Diana, Year 4)

"I think a lot is just so many guidelines and you just are just follow step one, step two, step three, step four. You don't think so much [about the] patient anymore just think in terms of guidelines. And that is how we are taught in medical school as well, to follow guidelines" (Amy, Year 5)

It appeared that even in the clinical attachments the emphasis of teaching was on symptoms and signs rather than the psychological needs of the patient. Paula admitted that she would feel awkward raising emotional issues in a tutorial as it might be seen as a sign of weakness and suggested that the attention to psychological factors was tokenistic.

"Even innocuous things like oh there is a good murmur on the ward, everyone go listen to the murmur" (Gina, Year 6)

"that would almost be feel out of place actually to start talking in tutorials how do personally feel like you are. I don't know, it is a sign of weakness" (Paula, Year 4)

"they just throw an essay at you occasionally, and that is how addressing that you have done it[psychosocial care]" (Paula, Year 6)

Other students described being distressed by the biomedical bias of the curriculum. For example, Amy decided not to undertake an intercalated science degree as she felt she was losing her motivation to be a doctor during the pre-clinical years.

"A large part of me decided against intercalating because the first years dried me up a bit and I thought if I go out for a third year intercalating and science and whatever I might actually lose touch with medicine" (Amy, Year 4)

Paula claimed that the emphasis on the biomedical paradigm was present throughout the curriculum. She claimed that she had never received feedback from her tutors on how she related to a patient. Gina described NHS hospital medicine as dehumanising and was surprised by the numbers of patients who appeared uninformed about their condition.

“they are much more interested, Did you hear that? Or, Did you find that? [...]. I haven’t had feedback how I related to a patient” (Paula, Year 5)

“the amount of people I have come across who really have no idea why they are there and what is happening” (Gina, Year 6)

“it seems like this intrinsic thing ,remembering these are people, is almost lost, just through the way everything is organised”(Gina, Year 6)

Gina wondered if the biomedical bias would ever change, reflecting on the demographic differences which existed between patients and their doctors. She also commented on the curriculum changes which made the course even more scientific and competitive.

“It’s so difficult because that kind of thinking and approach needs to come from the top down. So if it is not coming through medical curriculums how is it ever going to really change?” (Gina, Year 6)

“changes to curriculum they are moving towards research excellence we produce research excellence. Who is going to get the most publication and be a highly published alumni?” (Gina, Year 6)

Students have described their relational view of empathy with an emphasis on emotional connection. They were concerned that they were taught professionalism as a form of detachment from the patient.

8.7 Professional distance

The students perceived that professionalism was taught as being detached from patients. They received conflicting messages from the medical school, an overt message to connect with patients, and yet in practice they observed doctors who remained detached from the patient’s emotional concerns.

“one of the things you hear all the time is that doctors should have a professional detachment” (Edward, Year1)

“we get lectures on professionalism and it is always is[...]keep a safe distance” (Helen, Year 2)

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*“you have to keep your communication completely formal”
(Bill, Year 3)*

“I think the way we are taught to be professional does not account for necessarily always being empathetic” (Paula, Year 4)

The students argued that maintaining a professional distance was inappropriate. Some students suggested that although some degree of detachment was essential, being warm and empathetic was compatible with professionalism. Sometimes professionalism was viewed as a form of stoicism, a cold, emotional detachment.

“professionals definitely need to have compassion they need to be warm and friendly people to a certain extent and there is a boundary where that becomes unprofessional . I think there is a spectrum of behaviours where things can become unprofessional. I think some doctors can be very stoic I think that would not necessarily be perceived as unprofessional by a lot of patients” (Connie, Year 1)

*“I think there might be a misconception amongst people that if you have to be professional you have got not be emotional, not show that side of yourself to patients”
(Neville, Year 4)*

Marilyn was also critical of the call to be professional and emphasised the importance of context in relation to empathy. While Diana implied professionalism numbed her emotions. Paula considered that professionalism was inadequately addressed in the curriculum.

“there are going to be patients that strike a chord with me and ‘Is it professional?’. Pfft professional, professional. They are keen on us all being so damn professional. There are some patients who will appreciate that and there are some patients who need you to be strong for them. It depends on the patient” (Marilyn, Year 2)

“I think sometimes professionalism numbs, numbs human emotional function” (Diane, Year 6)

"[on]occasions throw in something about professionalism but it is more so kind of an assignments or it is not a huge thing" (Paula, Year 4)

Gina suggested that there was an unrealistic standard of medical professionalism expected of students.

"the way they talk about professionalism is almost like you are under scrutiny to be this sort of sub-perfect human being." (Gina, Year 6)

Much of their clinical teaching occurred in a group setting and students described how this affected their empathy.

8.8 Group effects

The students described feeling self-conscious when they demonstrated empathy with a patient in front of their peer group. Helen said it was easier to share vulnerability with a patient in a one -to -one situation rather than in a group. She also suggested that males are affected more than females by the inhibiting effect of showing empathy in front of one's peers. Other students avoided emotional issues when they were in a group.

"in order to empathise with patients you have to expose your own vulnerability a little bit and that can that can feel like a scary thing to do in front of people you know" (Helen, Year 3)

"I think the group thing affects boys more than it does girls. I think for whatever sort of social reason it seems more almost socially acceptable for girls to show emotions than boys" (Helen, Year 3)

"I would probably be a bit more removed" (Edward, Year 4)

Kim described the problem of demonstrating empathy in front of consultants. Being watched did not prevent her feeling for the patient but it did inhibit her demonstration of that feeling. She further suggested that the patient also may have felt inhibited and unable to express her concerns.

“because you have people watching you and it makes you very much more aware of your body language, it doesn’t necessarily influence the thoughts that are going through your head. I think it maybe influences the rapport you can build with that patient if there were several people in the room. That obviously influences how much the patient opens up to you and what you gain from the consultation. Then that influences maybe your idea what the patient’s thinking and feeling” (Kim, Year 4)

“They [consultants] are judging you on how quickly and concisely you can take a history” (Kim, Year 4)

Ida said that she avoided emotional issues in front of a group to protect the patient. Though she had empathy for the patient she felt that she was unable to show these feelings.

“But if there are a lot of other people around and I know that the other students are impatient to hear history and I probably wouldn’t spend a long time exploring feelings of the patients. And also I wouldn’t want to put the patient into the position having to talk about their feelings in front of so many people” (Ida, Year 6)

The final parts of the formal curriculum which the students described as influencing their empathy were assessment and feedback.

8.9 Assessment

Students described assessment as causing them stress which diminished their empathy. The medical school had a strong emphasis on assessment. From the start of their course, students were made aware that their marks counted towards their final grade and affected their career prospects. This generated a competitive stressful culture.

“So they break that down for every exam and every essay. So I suppose maybe the idea you can feel where you are in the year” (Bill, Year 3)

“when it comes to assessments you just end up preoccupied. Am I doing the right thing? not necessarily, am I getting better at knowing the person in front of me?” (Connie, Year 3)

Bill recounted that when he was being assessed he disengaged from the patient because he was aware the judgement might affect his future. Connie found she could forget that she was being watched once her focus was on the patient rather than on her performance. She implied practice was crucial in relieving the stress of assessment.

“I wasn’t interacting with the patient as a doctor-patient interaction in an informal way” (Bill, Year 3)

“actually once to get into it once you have focus on your patient you focus on their condition you sort of forget that you are being examined you forget someone is watching and critiquing you” (Connie, Year 3)

Students had a range of views as to whether the medical school assessed empathy. Lisa implied that empathy was not assessed by the medical school, and suggested that there ought to be some assessment of empathy. On the other hand, Paula claimed that empathy was assessed in their exams. Some students assumed that because empathy was not given many marks that it was not considered as important as having factual knowledge.

“You are not really getting marked on your empathetic approach to the patients so perhaps get pushed to the side during OSCEs” (Lisa, Year 4)

“I do get the impression [it’s] what they look for in exams as well” (Paula, Year 6)

“The exams really mostly focus on clinical knowledge. Do you know this? Do you know that? and empathy seems to be, I don’t know, a couple marks that I mean, sure important, there are marks for it. It does not give impression that it is that important” (Connie, Year 2)

Amy suggested that the OSCEs encouraged a fake empathy. Kim claimed that OSCEs were not an effective way of assessing their empathy, because of the shortage of time.

“I guess in OSCE you are kind of trained to just OK, cut to the chase, just ask the questions you are supposed to ask and then ticks and that is it” (Amy, Year 4)

“they try sometimes assess your empathy towards a patient. But I think it can be difficult to demonstrate it in an OSCE you have a clock sitting here with the time on it” (Kim, Year 4)

8.10 Feedback

Students maintained that there was a lack of helpful feedback from the medical school. Helen described a lack of encouragement and unsatisfactory feedback, which she suggested contributed to a competitive culture.

“You work and work for these exams and then nine out of ten times the feedback is not out in time or your results are not out in time which is a big kick in the teeth” (Helen, Year 3)

“You never get feedback personal feedback about areas of medicine you[have] done well in or areas that you can. All you get encourages [you] to compare yourself to other people, because all you get is your exam result and where that is on the bar graph or on the curve” (Helen, Year 3)

Some students suggested that their feedback to the university did not result in change. Others admitted that they would be fearful of giving the university honest feedback, because of their concerns about confidentiality.

“when you speak to other students in previous years who are older than us then it doesn’t seem not much has changed. Or it doesn’t really seem taken into consideration” (Bill, Year 3)

“it is quite difficult to give honest feedback and you are not entirely sure who is going to and where it is going” (Kim, Year 6)

8.11 Reflexivity

I remembered my own experiences of being a medical student were similar to these students’ descriptions of the teaching curriculum. I reflected that initially my interest in medicine was limited to the scientific and technical aspects of reaching a diagnosis and recommending treatment. It was only after I had

entered general practice that I really appreciated the central role of psychosocial care in meeting the patient's needs.

I was surprised that the students thought their teaching of professionalism encouraged detachment. I do not imagine that this is the message their medical educators wish to communicate. An approach to patients which is warm and friendly should not be considered unprofessional. Indeed, the students bravely developed their relational view of empathy by prioritising patient contact and rejecting the detached form of professionalism in their own practice.

8.12 Discussion: Barriers to teaching empathy in the curriculum

8.12.1 Overview

The students identified a lack of emphasis on empathy in their teaching, which they interpreted as a reflection of its unimportance to the medical faculty. Such attitudes were reflected in another study (Woloschuk et al., 2004). Students reported that they wanted more patient contact and identified missed opportunities in their curriculum to include the patient experience. They described teaching experiences relating to empathy, including for example, Ideas, Concerns and Expectations (ICE), and a tick-box approaches to teaching psychosocial care.

They highlighted the inhibiting effect on their empathy both of negative role models and the strong biomedical emphasis of their teaching. Characterising professionalism as a form of detachment from patients which further inhibited their empathy. The students explained how much of their clinical work was carried out in groups which also tended to constrain them from exploring emotional issues with patients. It was felt that the strong emphasis on assessment within the medical school created a barrier, but paradoxically students were reluctant to give feedback to the University on these issues for fear that it would affect their progress.

8.12.2 Can empathy be taught?

The students were uncertain as to whether empathy could be taught, reflecting a debate in the medical education literature (Wear and Zarconi, 2008, Jeffrey and Downie, 2016). However, most authors agreed that empathy can be influenced by education but were less certain whether any changes in empathy were sustained (Stepien and Baernstein, 2006, Pedersen, 2010, Batt-Rawden et al., 2013, Kelm et al., 2014, Kiosses et al., 2016, Georgi et al., 2014).

8.12.3 Teaching of empathy: Patient contact

Successful teaching requires an understanding of the students' needs, beliefs, values and learning styles (Roberts et al., 2012). Students described a lack of teaching of empathy, or opportunities to discuss the subject with experienced clinicians (Lempp and Seale, 2004). They identified missed opportunities to involve the patient's experience in their teaching; in problem-based learning, lectures and group discussions. It was considered that communication skills training did not enhance empathy but risked the development of fake empathy. Such training usually involved simulated patient encounters, in which a trained lay person role-plays a patient (Underman, 2015). Authors have pointed to the limitation of teaching empathy with simulated patients (Bleakley and Bligh, 2008, Wear and Varley, 2008). They have argued that there is a risk that if communication with the patient is taught simply as a skill to be acquired and assessed, then resulting relationships with patients may be shallow and mechanistic (Marshall and Bleakley, 2009). However others have pointed out that if the students can imagine that the experience is real, such teaching gave them an opportunity to practice empathy in a safe environment (Underman, 2015). However, allowing students to practice their communication skills with real patients does not mean that they should necessarily start with complex tasks, such as breaking bad news (Wear and Varley, 2008). A tension exists between authenticity and artificiality, most of the students proposed that fake consultations generated fake empathy. It appears that both the simulated patient and the student put on a performance rather than empathising (Perrella,

2016). If empathy cannot exist in this artificial environment it casts doubt on the validity of assessing empathy in an OSCE situation with simulated patients (Perrella, 2016).

A study of the effect of simulated consultations on medical students' empathy found that the debriefing after the research encounter gave the students an opportunity to discuss the student-patient relationship (Schweller et al., 2014). The authors concluded that it was this discussion, outside their research, that influenced students to become more empathetic with patients (Schweller et al., 2014). Wear and Varley (2008), suggested that true empathy was not a simulation, nor simply a competence, but a treasure to have and to receive, reflecting a transcendent quality to empathy.

The students identified face-to-face contact with real patients as one of the most effective ways of enhancing empathy. They claimed that the minimal patient contact in the first three years was a lost opportunity to develop their empathy. These findings are supported by other studies (Lempp and Seale, 2004, Ratanawongsa et al., 2005). In a study of students' pre-clinical experiences the authors found a gap between theory and practice in the students' desire for patient contact (Nogueira-Martins et al., 2006). In the same study students' described their teachers' lack of interest in psychosocial care as another factor which inhibited empathy (Nogueira-Martins et al., 2006). They noted that a lack of continuity of contact with patients risked the development of detachment (Montgomery, 2006).

Students identified a lack of exposure to patients from ethnic minority groups, different cultures and LGBT people. Wayne et al. (2011), suggested that treating patients from disadvantaged backgrounds was associated with students' negative attitudes and an intolerance of ambiguity. However, the students in this research wanted to engage with people from differing cultures and backgrounds. A study of cultural awareness in medical students, in the context of caring for refugees, also found that they were interested in cross-cultural

communication (Griswold et al., 2007). Cutler et al. (2009) found medical students' interaction with patients with psychiatric problems could enhance their empathy. Millennial learners (students who turned 18 in the year 2000) are characterised as being accepting of diversity (Roberts et al., 2012).

Students in my research talked about patients who challenged their empathy reflecting the findings of another study which concluded that medical students found emotional issues were one of the most challenging aspects in their encounters with patients (Bower et al., 2009).

8.12.4 Taking a history

Taking a history is a skilled act which requires the capacity to empathise with the patient and then to recount her story in a medical narrative (Montgomery, 2006,p.50) Teaching students to be suspicious of anecdote is yet another mechanism for inhibiting the influence of emotions. The biomedical emphasis in the way students are taught to take a history is exemplified by the marginalisation of the acronym ICE; ideas, concerns and expectations.

Empathy involves engaging with the patients' ideas, concerns and expectations (ICE) of their illness and its treatment (Tate, 2005). Students' described how these areas of taking a history were relegated to the end of their consultation and sometimes omitted. The separation of information gathering from emotional issues in history-taking was a feature of another qualitative study (Ohm et al., 2013). It seemed to students that their clinical teachers were not interested in the details of the patient's experience which were not established markers of disease (Montgomery, 2006). This further accentuated the biomedical model, relegating the psychosocial concerns to an optional add-on to the 'proper' history, and resulting in further distancing from the patient.

8.12.5 Negative role models

Students identified negative role models, describing doctors who showed little regard for the psychosocial concerns of the patient, particularly on surgical ward rounds. They felt distressed for the patient but were unable to speak out.

Hicks et al. (2001), found that 61 % of students had witnessed a clinical teacher acting unethically. In another study, students who had witnessed unethical behaviour were more like to behave unethically themselves, and to believe that their ethical values deteriorated during training (Feudtner et al., 1994).

Bombeke et al. (2011) found that when students encountered negative role models they also lost their focus on the patient. However, one student in the research, who had been humiliated by a consultant, said her experience had made her resolved not to behave in a similar fashion when she became a doctor. Students implied that they encountered more negative than positive role models. Shapiro (2011), also reported a lack of positive role models who incorporated emotions into medical education.

8.12.6 Biomedical bias

The students described an emphasis in their teaching on the biomedical, or scientific, aspects of medicine, to the detriment of addressing the psychosocial aspects of patient care. The dichotomy between the biomedical and psychosocial was found in other studies (Pedersen, 2010, Michalec, 2011, Tavakol et al., 2012, Eikeland et al., 2014).

Forty years ago, the problems of a reductionist positivist view in medical practice and its resultant disease-orientated, biomedical model were identified by Engel (1978). He proposed a change to a patient-orientated biopsychosocial model of medical care which included psychosocial issues as well as the purely scientific (Engel, 1978). Bloom (1989), also argued that academic scientific medicine paid tokenistic regard to the humanities in medical education. Montgomery developed these arguments by acknowledging the benefits of biomedicine, but proposed that clinical medicine be seen as an interpretative practice rather than as a science (Montgomery, 2006,p.5).

The students' stories showed that the biomedical model persisted in this curriculum, neglecting psychosocial aspects of care (Montgomery, 2006, Epstein, 2014). Lectures on psychosocial care were delivered in the first year,

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when the students, with little patient contact, could not fully appreciate their importance. They also found that the lack of patient contact in the first two years of the course combined with a compulsion to take an intercalated science degree in the third year further emphasized this university's commitment to scientific academic medicine and the development of a 'biomedical gaze' (Pedersen, 2010). This scientific stance reflected the dominant discourse where medicine became concerned largely with giving objective advice rather than connecting with the patient (Hardy, 2017). Hardy (2017), warned that the suppression of empathy may become seen as a desirable skill for a physician. Such physicians, who embody this scientific attitude, can be role models for students who then risk losing empathy with patients (Hardy, 2017). It seems therefore, that adopting the scientific biomedical model exclusively can contribute to detachment and a lack of empathy.

Students reflected this dichotomy between the biomedical and psychosocial approaches. It appeared to them that the patient's experience seemed to be added on at the end of lectures in a tokenistic fashion, if it was addressed at all. Students described how, during ward rounds, clinicians appeared to be concerned with symptoms and signs rather than the psychological needs of patients. These findings resonated with other studies where students reflected on medicine's tendency to objectify patients, "lumping" them into disease categories. Students realized they often lost sight of the uniqueness of the individual and identified a clinical environment focused on efficiency (Head et al., 2012, Wear and Zarconi, 2008).

Other qualitative studies have also found that students learned that empathy was not as important as biomedical learning and the technical aspects of treatment (Eikeland et al., 2014, Ratanawongsa et al., 2005). The students in these studies talked about the emphasis in their teaching on a need to be objective and detached from the patient (Eikeland et al., 2014, Ratanawongsa et al., 2005).

In some studies students, like those in this research, commented that evidence-based guidelines also were a mechanism for emphasising the scientific aspects of medicine rather than the patient's experience (Eikeland et al., 2014, Michalec, 2011). Eikeland et al. (2014), suggested that a strong emphasis on scientific facts might alienate students from their own feelings, undermining opportunities for reflection. Montgomery however, argued that evidence-based medicine needed to be incorporated with clinical experience in the practice of clinical judgement (Montgomery, 2006).

In my research, the biomedical emphasis in the curriculum seemed to have two main effects on the students:

- It caused the students distress by neglecting psychosocial aspects of the patient's suffering which some authors have described as dehumanizing (Sheikh et al., 2013).
- It resulted in them appearing distanced from patients who were sometimes seen as objects of intellectual interest.

The association between the biomedical approach and distancing from patients was a finding in a qualitative study of oncologists' approaches to end of life care (Jackson et al., 2008). The authors found that doctors who combined both biomedical and psychosocial aspects of care described having a connected relationship with the patient (Jackson et al., 2008). However, doctors who described primarily a biomedical role reported a more distant relationship with the patient (Jackson et al., 2008). Montgomery concluded that the biomedical emphasis caused an unnecessary impersonal form of clinical practice, dissatisfied patients and disheartened doctors (Montgomery, 2006,p.5).

As the main focus of their medical educators was the students' knowledge base, they lacked adequate feedback on their empathy. Without this feedback, students in another study assumed empathy was of lesser importance to the medical school than biomedical aspects (Michalec, 2011).

However, there was a minority of students who welcomed the biomedical emphasis in this curriculum, which they claimed gave them more confidence when they came into contact with patients in year four. They acknowledged that both the biomedical and psychosocial elements were necessary for effective patient care but claimed that the balance between them was not appropriate in their course. Some students were not hopeful of the university redressing this imbalance, particularly in view of the recent change to make the intercalated science year compulsory.

8.12.7 Professional distance

Medical professionalism has, like empathy, been defined in many different ways, for example,

“a set of values, behaviours, and relationships that underpins the trust the public has in doctors” (Working Party of the Royal College of Physicians, 2005)

The Royal College of Physicians Report proposed that doctors were committed to; integrity, compassion, altruism, continuous improvement, excellence and working in partnership with members of the wider healthcare team (Working Party of the Royal College of Physicians, 2005). The GMC also listed the duties of a doctor in Good Medical Practice (General Medical Council, 2013).

It is paradoxical that while descriptions of professionalism include humanistic values such as empathy, students gain an impression of professionalism as distancing from patients (West and Shanafelt, 2007). The debate in the literature around medical professionalism mirrors much of that surrounding empathy: a lack of definition and uncertainty as to whether it can be taught or assessed (Levenson et al., 2008, Rogers and Ballantyne, 2010, Cruess et al., 2014). Perhaps the issue of the patient’s trust in the doctor lies at the heart of both empathy and professionalism. Empathy is thought to engender trust. Professionalism is predicated on a need to establish public trust in doctors (Hafferty and Castellani, 2011).

Doctors have acquired professional identities, so that they come to think, act and feel like a physician, since at least the time of Hippocrates (Cruess et al., 2014). However it is only recently that studies have analysed the nature of this identity. Some authors describe “nostalgic professionalism” which emphasises the altruistic role of the individual physician (Cruess et al., 2014). They have also argued for a professional identity which embraced teamwork (Cruess et al., 2014). However, as students are observing professionalism as distancing from patients, I suggest that elements of “nostalgic professionalism” might be usefully incorporated into a more humane form of a virtue-based professionalism.

The professed values of the medical school creating compassionate doctors did not resonate with the students’ experiences of professionalism as distancing from the patient. Ekman and Krasner (2016) claimed that a culture of empathy aversion in medical education had generated a professional stance of ‘detached concern’, which neglected the emotional experience of the patient. Halpern (2001), has argued for a form of professional empathy which included emotional based reasoning (Ekman and Halpern, 2015). Other authors have also argued for the role of emotions in clinical decision-making (Decety and Fotopoulou, 2014, Isen et al., 1991, Kozlowski et al., 2017).

8.12.8 Emotional regulation: Balancing detachment and connection

The fundamental ambivalence of empathy is the risk it exposes to the students when sharing their vulnerability and emotions with others; so there is a need to find a balance between empathy and detachment (Ballatt and Campling 2011). If students are to empathise they must connect with patients in this uneasy state, but to do so they need the support and guidance of experienced doctors (Ballatt and Campling 2011, Bleakley and Bligh, 2008).

My research indicated that the dominant discourse in medicine was still scientific detachment, distance, control and neutrality, features described in medical education twenty years ago (Cribb and Bignold, 1999). Almost every student maintained that distancing was inappropriate and instead wanted to

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connect with patients. However, they voiced concerns about being emotionally overwhelmed and that their clinical judgement might be jeopardized with such an emotional connection with patients. Professional detachment as a form of self-preservation was found in another qualitative study (Ratanawongsa et al., 2005).

It is relevant to question why some students adopted distancing tactics such as detached concern (Jones, 2010). Brody (1997) argued that if doctors were detached the patient's suffering remained without meaning and healing was impeded. Detachment may be adopted as a mechanism to prevent burnout and remain composed when faced with emotionally challenging situations (Kerasidou and Horn, 2016). Although studies have suggested that even if doctors try to suppress their feelings they must have emotional attitudes towards patients (Halpern, 2007).

Students became aware of a divergence between those who continue to strive for academic recognition where others concentrated on meeting the needs of the patient. An emphasis on objectivity may lead students to strive towards competence in practice, neglecting a humanistic approach (Allen et al., 2008, Cribb and Bignold, 1999, Evans et al., 1993, Coulehan and Williams, 2001).

A risk of promoting empathy as a kind of detached concern, is that empathy may be continue to be seen as a set of cognitive skills rather than as a virtue of a good doctor (Shapiro, 2012, Winefield and Chur-Hansen, 2000). There is also a risk that if empathy is viewed as a performance rather than a deeply held commitment, it could become selective and restricted to likeable patients (Shapiro, 2012). Authors have described the relationship between a doctor and patient as essentially an emotional connection (Coulehan, 1995, Coulehan, 2009, Bub, 2007). A detached form of practice may deprive doctors of emotional fulfilment in their practice and could become an inbuilt attitude which eventually spreads into their personal life (Montgomery, 2006).

It seemed from the students' stories that there was a lack of understanding of the distinction between appropriate empathetic concern and harmful personal distress (Decety and Meyer, 2008). An empathetic response results if an affective emotional resonance between the student and patient is combined with cognitive reflection and the maintenance of an appropriate self-other boundary. However if a self-orientated perspective is taken by the student, the result is personal distress and distancing from the patient (Ekman and Halpern, 2015)

Emotional regulation is the ability to modify one's emotional experiences and responses in context (Shapiro, 2013, Gross and Thompson, 2007). The students claimed that they lacked guidance on how to regulate their emotions, so risked being emotionally overwhelmed in connecting with patients. In a study by Meitar et al. (2009), students who expressed their emotions and addressed the emotions expressed by the patient were most likely to demonstrate empathy. Shapiro maintained that in the absence of appropriate support, about managing emotions, students might resort to distancing from patients (Shapiro, 2008). She suggested a paradigm that helps students to develop a tolerance for imperfection in themselves and others, an acceptance of shared emotional vulnerability and which values the existence of difference (Shapiro, 2008). Halpern (2001), suggested that empathy was therapeutic because it relied on a doctors' ability to understand the patient's emotional point of view rather than having intense positive feelings towards the patient (Halpern, 2001). In empathy, she claimed, one was emotionally engaged with the other and at same time was able to reflect on the emotions, knowing that they originated in the other person (Halpern, 2001).

8.12.9 Other factors in the formal curriculum

Students described difficulties in showing empathy in a group setting. This was because of embarrassment in raising emotional issues in front of others but was also motivated by protective feelings for the patient. It is possible that if bedside clinical teaching is conducted in small groups that students may appear to lack

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empathy when they are in fact experiencing emotional concern for the patient (Elder and Verghese, 2015).

Students remarked on the emphasis on assessment within the medical school and claimed this had the unwanted effects of encouraging competition and diminishing empathy. They perceived that the focus of assessment was on their factual knowledge rather than on their empathy. This emphasis was aggravated by a lack of feedback from their tutors on their empathetic skills, leaving them with the option of comparing themselves to their peers so promoting the competitive culture. Paradoxically, despite wanting feedback, students described how they were fearful to give the medical school their views because of a perceived lack of confidentiality.

8.13 Summary

The students' accounts revealed a number of factors in the curriculum which they experienced as inhibiting their empathy. They implied that there was a lack of teaching or emphasis on empathy in the formal curriculum. Students remarked on the minimal patient contact in the first three years of the curriculum. Instead they described a biomedical emphasis of their teaching which, by neglecting psychosocial issues, contributed to a distancing from the patient. The students perceived that their teaching of professionalism was also promoting distancing rather than connecting emotionally with patients. They spoke about their distress at observing negative role models, doctors who did not empathise with patients and maintained a detached approach. They also discussed a formulaic, tick box approach to taking a history, which they suggested diminished the importance of empathy. From their stories a common thread emerged from their teaching; detachment from the patient with the suppression of emotions. However, they did want to connect emotionally with patients but seemed to lack guidance on how to do this

In the Chapter 9 students talked about how their empathy changed during their training.

Chapter 9: Students discussing changes in their empathy

9.1 Overview

This chapter addresses my third research question,

How do medical students' views and experiences of empathy change during their undergraduate medical education?

Students described changes in both their conceptualisation and experience of empathy. In the early years they saw it largely as an attribute but with clinical experience came to regard it in a relational way. (Chapter 5) Some students in the preclinical years felt increasing confidence in practicing empathy as their course progressed, while others claimed that there was no change. The students in the clinical years described, not only increased self-confidence, but a greater empathy with patients. Although no student described a decline in their empathy, some illustrated how they concealed their empathy in certain clinical contexts.

To depict these changes in empathy, I have described eight student stories from the clinical group. Their reflections were influenced by their entire undergraduate experience. They also speculated on how their empathy might be influenced after graduation. The findings are discussed in relation to the literature at the end of the chapter.

9.2 The Preclinical Group: Finding 'a doctor's voice'

Students recalled their apprehension about their first contact with patients. Initially they considered that some patients were uncommunicative but they found it was because they were unable to empathise with them. At first Helen considered empathy as a performance, describing how she felt as though she was pretending to be a doctor. However as she gained in confidence she found her 'doctor's voice'.

“every time I put my stethoscope on I felt like a kid playing dress up” (Helen, Year 3)

“I think at the start I was so not nervous but flustered and not sure. Actually patients don’t want to open up to you if you are a bit unsure of what you are asking and why you are asking and they don’t feel like they can trust you” (Helen, Year 3)

“you find, your almost, a doctor voice” (Helen, Year 3)

The preclinical group of students talked about the transitions they experienced from school to university. Some described this as a process of maturing but others, like Bill, felt that they were being ‘moulded’ by the medical school to become a certain type of doctor.

“[pause] I don’t think mature is the right word [laughing] [...] It is almost rather than you are maturing by yourself, you are being guided onto a path. So it is a weird thing, I have matured but almost I don’t feel it is always an independent thing” (Bill, Year 3)

Connie compared this process to child development and described how she became more aware of the influence of context on empathy and the need to focus on the other person rather than herself. She implied that although it might appear from her behaviour that she had become more distant from patients at times, she still experienced the same emotions and felt empathy with patients.

“Professionalism isn’t the opposite of empathy, but imagine it in the same way as a child growing up. A child will cry at anything and everything when it is not their way or sad or whatever. Whereas when you mature and become an adult you learn that sometimes you can’t just make a situation about you, that you need to feel and understand what other people are going through and that the way you conduct yourself needs to change” (Connie, Year 3)

“I just think it is learning how you are expressing your emotions and again learning not it is not about you in a lot of these situations. That doesn’t mean neglect your feelings but know there are other priorities at the same time” (Connie, Year 3)

Edward, who did not opt for the intercalated third year, had experienced one semester of the fourth year with increased clinical contact with patients. He described how his empathy had become both more refined and medicalised. He talked about differentiating between patients and people. He claimed that this did not mean he was less empathetic but acknowledged that when short of time, others might imagine he lacked empathy.

“I think my empathy is probably more refined than it was. I have more of an idea how an interaction to go and I tend to think of patients as patients, than just people you can meet in the street that happened to be in front of you” (Edward, Year 4)

“My feelings towards people who come in as patients haven’t really changed but I think outwardly if you were to watch me interact with patients I am probably less likely to jump in and go the personal stuff. I will still do it but it would have to be in right context” (Edward Year 4)

Fiona considered that her attitude to empathy might have developed gradually throughout the course. She reflected that with increasing clinical competence she might have more space for empathy.

“I don’t think differently but [...]if there was it would be a gradual thing which I wouldn’t be able to lay a finger on” (Fiona, Year 3)

“You have to think about skills a lot but actually if you practice and practice and practice, it becomes automatic [...] that means you have you slightly more [...] space.” (Fiona, Year 3)

Connie described her empathy as being ‘buried’ during the early years of the course, but she now felt more confident making her empathy apparent.

“at least it is not as buried down, it comes to the surface a lot more” (Connie, Year 3)

“I have also just through my time at university definitely feel like the way that I express emotions not just to patients, to other people, has really changed” (Connie, Year 3)

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Olive compared the difference between being resilient yet empathetic, or maintaining a cold, distant approach to patients. She claimed that resilience need not result in being colder towards patients. She claimed that 'colder' implied a loss of empathy but in fact she felt that her empathy had increased with more patient contact.

“you can be harder but don't need to be colder. I think you can [be] harder more you are resilient, you are more able to deal with these things. You don't get knocked back by every challenge” (Olive, Year 3)

“colder would be the lack of empathy, the lack of care, the lack of compassion. I would hope that as people progress through their medical career they become harder and more resilient. I would hope that as people see more patients and have greater understanding of what it means to be a patient and what different experience they have had they can be warmer” (Olive, Year 3)

Olive noticed that for some students the focus had changed from themselves to the patient, a process she described as 'getting it', though this realisation might not be achieved until the clinical years of the course.

“for some people it always been a lot more about the patient, 'I am really interested in learning about this because I know it is actually going to help me be a good doctor. I am not that bothered de de because I might get an extra few marks it doesn't seem that important', and some people would be able to say that very very clearly, and whereas for others, it still at this stage about stuffing facts into your brain” (Olive, Year 3)

It was however, in the clinical years, that students described the most changes in their empathy.

9.3 The Clinical Group: The patient-student relationship.

Students in the latter years of the course felt greater confidence and increased empathy with their contact with patients. Their stories illustrated differing facets of their perceived changes in empathy as they reflected on their progress through their course and looked forward to working as doctors.

9.3.1.1 Kim

Kim said that she was fairly confident about her clinical competence and so felt less vulnerable. She suggested that this was partly due to having less factual material to learn. She contrasted her learning process in lectures where facts were 'thrown at you' with working on the wards where she 'picked things up' and understood the meaning of the new information.

"I suppose in a way I feel less vulnerable [...] I felt that I knew it less when we were in the lectures because the so much being thrown at you at once. Whereas especially when you have had a week or so on the wards you are starting to pick things up and take things in" (Kim, Year 4)

Kim, with increased self-awareness, reflected on her empathy when she attended a care course. She realised how 'medicalised' she had become as she tended to plunge in and ask patients direct intimate questions. She recognised that there was an appropriate time for direct questions and that it was not always the best approach.

"it was massive wake-up call and exactly how medicalised you become after two years of medical school and 6 months on the ward" (Kim, Year 4)

"I think because you are so used you going in and saying, you got lanyard around your neck that says third year medical student on it, and you can go in and say to somebody, "Tell me about your bowel habits today" (Kim, Year 4)

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Kim realised that she was causing embarrassment by asking intimate questions too early in the consultation. However, she reflected that while she might find such questioning straightforward, the patient might take a different view.

“one of the things about empathy is that immunity that you gain as you go through. [...] when you are going through medical training you are told to ask about bowel habits, you think this isn't going to be very easy [...] when they are telling you just go in and ask about it. You are thinking, ‘Oh God I couldn't, I don't know if I will ever be able to do that’” (Kim, Year 4)

“And then after a placement on the GI ward you are quite happy you and sort of get over the initial embarrassment about asking difficult questions.[...] But I think one of the things to remember you have got to not be embarrassed. But you have got to remember the patients might be embarrassed by you asking the questions” (Kim, Year 4)

She described how clinical experience with patients deepened her empathy but she still found it emotionally challenging. She appreciated the need to spend time with patients to establish empathy and described how taking a history enabled her to see a bigger picture.

“I think sometimes it has not diminished in that I still find myself getting quite I find it difficult let go of things sometimes. And I still find it very emotionally challenging in certain aspects” (Kim, Year 5)

“I mean the point of taking a history is that you build a picture of this person and I think that the more time you spend the more the more picture you can paint and that goes hand in hand with more you understand of them the more you can empathise” (Kim, Year 5)

She was aware that some people suggested that medical students became more cynical through their training, but she was unsure whether this was true. She talked about ways she had developed her empathy by remembering each patient was an individual with differing needs.

“people say you become more cynical and I think in some ways that maybe is true. Um but then I don’t know” (Kim, Year 6)

“things that weren’t routine or normal to you before you come university is suddenly quite normal. Dealing with seeing with people that are acutely unwell becomes normal, keeping calm in situations you are definitely have been very upset about is quite normal” (Kim, Year 6)

“you have got to remember for each family that is not normal, that is new, that is quite challenging”. (Kim, Year 6)

9.3.1.2 Ida

Ida found that she now did not feel so overwhelmed when working with patients as she had been at the start of the course. However, she implied that there might be a risk of losing affective empathy in developing her resilience. Ida described how in gaining confidence she had become more empathetic and ready to explore the patient’s concerns. She reflected that she no longer saw patients simply as teaching resources.

“I think it is becoming easier and easier to do that but especially in the beginning I think you know felt the same thing as they did and , they were sad I wanted to kind cry with them” (Ida, Year 4)

“I am definitely more confident about more in the way that I am now quite happy to give out control of the chat [...] I am quite happy to let patients to take up a bit more control. And think they appreciate that they like it better” (Ida, Year 5)

“some of us would go to the wards and say ‘are there any interesting patients’? Some doctors have said ‘every patient is interesting’” (Ida, Year 6)

9.3.1.3 Amy

Amy described how she became disillusioned with medicine due to the scientific bias of the first years. However, she flourished in the clinical years as her empathy with patients developed. She felt she had a greater commitment to patients, a trend she shared with other students.

“in the clinical years when you get to see patients and how this problem affects them and affects their life and why you need to treat these problem it become more colourful”(Amy, Year 5)

“I think priorities have shifted since first year. Definitely people are more keen to get involved in things related to medicine” (Amy, Year 5)

Amy said that she had become more practical and gave an example of admitting a patient with anorexia nervosa who was acutely unwell. She reflected that in the early years she might have spent a long time exploring the patient's psychological issues but, in final year, she realised that attending to the urgent medical problem was her first priority.

“I didn't dwell [on] ‘how is the mood?’ I mean I did ask but quite quickly I suppose and tried to be empathic in my approach but it would not have been but perhaps two years ago I would have sat down really interested in her history [...] I just tried to be more practical and efficient about it, to treat medical problems” (Amy, Year 6)

She was now more confident working in a team and talking to patients and said that in final year she had a feeling that of things were coming together.

“a few years ago in the clinical environment in year four we were trying not to step on toes and try to be hidden away in a sense. But now I think I am more comfortable working in a team, I am more comfortable talking to patients” (Amy Year 6)

9.3.1.4 Lisa

Lisa also claimed that her empathy improved during the clinical years. Prior to this she was focused on the disease rather than the person. However she qualified her claim by hinting that empathy was still an extra to the main medical agenda.

“Whereas now having nine months of meeting patients it is gotten better. Maybe my confidence has grown more so I feel I can venture into more empathetic area rather than doing what I am there for really”(Lisa, Year 4)

Lisa described seeing the patient as a person rather than a learning tool and having more confidence to explore the patient's ideas. She suggested that her increased confidence had created more space for empathy with the patient.

"I think now we are much more involved with patients and things so maybe seeing them in the beginning and getting to know them a bit more. And I think the more you know someone the more you can have empathy for them" (Lisa, Year 6)

"A lot more than seeing patients as learning tools rather than the patient as a person" (Lisa, Year 6)

"Whereas maybe before you kind of always worried about oh what is this, what questions do I ask in history etc . Whereas now those things come a lot easier and now scope to ask or think about other things" (Lisa, Year 6)

9.3.1.5 Paula

Paula found that experience on the wards in meeting patients had helped develop her empathy. She remembered how nervous she was at the outset of the course. She described her increased confidence with patients and also of relating more closely to her colleagues in a process of professional socialisation

"I was nervous about starting them because the first two years are 'sciencey' [...] This year it become second nature to be on the ward and talk to patients" (Paula, Year 4)

"I have gained a lot of confidence in terms of being able to approach a patient and speak to them and continue the conversation not worrying about that at all in the same way I would have been at the start" (Paula, Year 6)

"I now also relate better to other medics who are at the same stage as me we can appreciate what we doing is quite intense and seeing lot of real life, which I struggle sometimes to explain to people outside of medicine"(Paula, Year 6)

Paula commented that most of the change in empathy occurred in the clinical years and reflected how she had learned to control her emotions.

“On oncology I thought it was quite a heavy few weeks because of the kind of things you were seeing and I thought that is quite tough going through that which might suggest that there is empathy there that I was processing what I was seeing” (Paula, Year 5)

A recent experience with a patient who died made her wonder whether she had become a bit hardened to the situation. However, she suggested that her lack of emotion on this occasion might have been because she did not know the patient.

“I was surprised that I didn’t feel more upset by it then I did. And I still don’t really know why that is the case. I think it is probably there is an element of self-defence you can’t get upset every time you see something like that, and also I didn’t know that patient” (Paula, Year 6)

Paula implied that although she still felt empathy, the pressure for efficiency affected her relationship with the patient. She thought that the need to present the patient’s problem to the consultant in a concise manner might make her appear less empathetic.

“possibly being a little less empathic when I think about the volume of patients I might have been sent to see” (Paula, Year 6)

“I see the patients myself and the goal of being able to present and exam back to someone and then do something about it. [...] I don’t think that I am not empathetic with them because of that but I think it does maybe slightly change the way I will relate to them” (Paula, Year 6)

9.3.1.6 Gina

Gina suggested that her empathy had developed with maturity and described a shift to a greater commitment to patients. She now appreciated the relevance of the psychosocial lectures in first year.

“I think as you get more clinical experience you because a lot of what we did in first and second year was about the consultation process and social psychosocial model or whatever and appreciate that illness has many dimensions for the patient and you should be appreciative of that and

you should be able to empathise with a patient.” (Gina, Year 5)

Gina claimed that her empathy had developed from maturing and from her own experience of illness rather than any specific influence of the course. However, she reflected that having more clinical responsibility and contact with patients had influenced her empathy

“I think for me the fact just being older and becoming an adult and having to do adult things like living away from home and even the mundane tasks that you think about that is real life for the average person and then like I said being ill and stuff that has influenced me more than I have been taught or has been addressed on the course” (Gina, Year 4)

“A lot more getting involved and a bit more responsibility seeing patients” (Gina, Year 5)

Whilst almost all the students claimed that their empathy had increased, Gina reflected that she might have become more cynical about some things, but emphasised that did not mean she was hardened towards patients. She said that it would be easy to become cynical and tired by the workload, but not by the patients. She perceived a common feeling of disillusionment amongst her peers.

“I think there are a lot of things that I am more cynical about. But I don’t think that means I am hardened. I was cynical about things because I don’t want to become more hardened. I want to still remain capable of seeing human side and remembering everyone’s perception is not my own so the way I see things isn’t the way things are necessarily” (Gina, Year 6)

“it would be very easy to become disillusioned and cynical and I think a lot of my peers people have. I have been speaking to particularly fifth year [...] everyone was feeling quite disillusioned and worn out and I think it is easy to see how people can become sort of just fatigued by the volume of things” (Gina, Year 6)

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Gina had developed an interest in the psychosocial aspect of medicine and reflected that her attitude to these issues had changed completely after contact with patients.

“I have become aware of all these other things , because I was smart I used to think I had to do something scientific, one of the medical specialties, because they were somehow superior and less to do with social sciences or community based approach which is complete nonsense. [...]now that is what I want to do” (Gina, Year 6)

9.3.1.7 Diana

Diana said that her empathy has increased and found encouragement and feedback helped to give her confidence. She reflected on how anxious she was about talking to patients for the first time and how much this has changed with experience.

“the thing that terrified me the most coming into first year of med school and sitting at the end of a sick old man at the end of their bed and try and work out what to do and what to say and now especially since gen med [general medicine] I found that so useful because I had to do that over and over on my own” (Diana , Year 6)

“I had really good tutors who held my hand for the first two days and then really pushed me after that and just said that is not good enough you need to make a plan [...] so now I feel that I have had the feedback to say that I am OK at it” (Diana, Year 6)

“as you go through medical school your exposure to distressing things and needing empathy and feeling things about stuff increases” (Diana, Year 6)

In the clinical years she gained experience in other people’s lives, patients from very different backgrounds. Diana was aware that she came from a privileged background and that this could be a disadvantage in empathising with people.

“fourth, fifth and sixth years you spend large amount of time in hospital and I think to a certain extent with that increased exposure you see, you just become more aware people’s problems”(Diana, Year 6)

“for a lot of people they have grown up in a middle class background they have not had any exposure with people who struggle with money, who have grown up around drugs, around crime and things like that and understand how those people’s lives work and function” (Diana, Year 6)

“And in the beginning of uni I think I was, I hope I was, a nice person, I would treat them exactly same way but maybe I understand them a bit more out of contact just people in complete different back ground to you” (Diana, Year 6)

She said that her empathy had increased but was unsure how much was due to maturing rather than the medical course.

“I think the core is still there but it difficult to tease out what is just growing, being older 18 to 23 rather than what is medical training” (Diana, Year 6)

“certainly, [I] have changed, hopefully for the better” (Diana, Year 6)

9.3.1.8 Neville

Neville reflected on developing empathy as a lifelong process which depended on patient contact and evolved in the light of that experience. He sought to understand rather than making judgements. Neville implied that that empathy was part of life skills picked up outside the formal curriculum and discussed the transitions between adolescence and adulthood. Neville felt more competent with experience and concluded that his empathy has developed during the course.

“Everyone who applies to med school is yeah I know what empathy is, and until you actually interact with a patient and you see it yourself I don’t think you fully understand. And it is a lifelong process you will continue to change your views of it [...] as you meet patients or they say certain things, share their experiences and that will change your views of how you should interact with them” (Neville, Year 4)

“just more understanding, more understanding of the bigger picture. Because when you are naive about the

situations I think it is easy to make those judgements and not take a step back. I think that comes with maturity that there are other reasons why people might be doing the things they are doing” (Neville, Year 4)

“Not just within a clinical environment but with your friends out in the pub. They are life skills you learn how to be human. As young student coming into university from high school you feel. I don’t think I was equipped with those skills and you have to learn to live” (Neville, Year 4)

“the more people you see the more you understand what sort of problem they might have and then you kind of gear your questioning towards that. And I think everyone subtly knows that it just need to put the time in and there are no short cuts, there is no short way around this and you need to sit down and see people” (Neville, Year 5)

Neville’s views had changed in that he now appreciated the importance of the psychosocial aspects of patient care and that there was more to medical practice than pure science. He described how he balanced efficiency and empathy and felt that his empathy has become refined.

“I came into medical school the view thinking that medicine was all about science, how wrong was I. [laughs] The science is a given but what makes a good doctor is much more than that” (Neville, Year 6)

“I feel at times I have been efficient but when the time is right it is also important to be that human being” (Neville, Year 6)

“it is that concern for another human being , a more professional level, if I was to see myself back in high school I just wouldn’t appreciate these things. [...] I do try and do that for every patient I go and see” (Neville, Year 6)

Neville now maintained that empathy could be taught and he suggested that incorporating the humanities could be useful for its development.

“there was first year students there and were told to read some history, some medical history in humanities this is all useless yadda yadda yadda. And maybe I would have said the same thing back then but now with the reflection of

four or five years of medical school behind me, I enjoy that”(Neville, Year 6)

Neville summed up his empathy development and the major influences on his empathy; role-modelling, experience with patients and reading novels.

“I think if I had to sum up my change in medical school I think it is seeing role models, getting the experience and actually reading books and putting all that in makes such a difference. It is not just one thing which changes you it’s a whole complement of different things that influences how you are as a human being.[...] I have been fortunate to actually been exposed to these things. It is tough for young people to see difficult issues or dealing with death but actually having going through it and reflect on it I think and I hope that it will put me in a better position to be a good doctor and look after people”(Neville, Year 6)

9.4 Future concerns

The students’ accounts of changes to their empathy suggested that it had developed and evolved to adapt to differing clinical contexts. The students were also concerned not to lose empathy during their years as foundation doctors. Looking ahead Gina had some fears for her empathy when working as a Foundation Year 1 doctor (FY1). She was aware of the risk losing empathy but said that her self- awareness might be a mechanism of preserving it.

“that it is a concern, seeing how intense working as a junior it can be, be easy to see how you can become a bit disenchanted with the system, and the work and got no time to do a million tasks, how easy it would be to just end up just going through the motions and not really thinking about things and ever stop and taking the time. I think yeah definitely that is a worry in the future. But it is something to keep myself aware of” (Gina, Year 4)

Paula expressed concerns about whether her judgement would be clouded by her feelings in the future.

“morally I think I would like to be empathetic to each patient that I meet but I feel that by being this career that may actually change. I think, I probably would find it very difficult to be taking on the feelings of an another person. If

I did that with every patient I do think I would struggle to do my job with a clear head because you have a responsibility to do your job” (Paula Year 4)

Many students expressed worries that their empathy might be limited by the pressure of time when working as a foundation doctor. They all had hopes that in the future they would spend time with patients.

“one privilege of medical school we have the time just to sit and chat but what I have seen is that the FY1 do try really hard to make sure to talk to patients” (Ida, Year 4)

Paula talked about the risks of becoming stressed in the future. But Lisa said that she was looking forward to her foundation years and working in a team who would provide mutual support.

“So I am anticipating it being stressful, [laugh] it will be” (Paula, Year 5)

“I am actually quite looking forward it. Probably more than a lot of people. I think a lot of people find it quite scary. I think I have had quite a bit of experience and I am not too worried about asking the nursing staff” (Lisa, Year 4)

The students’ stories and concerns revealed the significance that they gave to empathy and their wish to preserve it in future although they were wary that difficult working environments in the future might threaten their expression of empathy.

9.5 Reflexivity

In thinking about the changes described by the students both in the way they regarded empathy and in their wish to connect emotionally with patients I recognised that I had changed my views as a result of listening to their stories. I began this thesis with a strong positivist background in medicine but have always been drawn towards the psychosocial elements of patient care. This study has made me aware of phenomenology, firstly as a research method, which accessed the students’ experience, but also as a philosophy, an approach which can be adopted in clinical practice and in medical education. My change of

view, like many of the students' described their empathy development, has been a gradual process rather than an epiphany. In reading the individual stories quoted in this chapter it was apparent that these students remained empathetic and committed to patient care. If their empathy had developed, as they show in their stories, I wonder how much more their practice and well-being would be enhanced if the barriers they identified were addressed. I shared the concerns expressed by some students that 'resilience' implied distancing and wonder whether it might be more appropriate in future to seek to develop the students' well-being rather than enhancing 'resilience'.

9.6 Discussion

9.6.1 Empathy Based Medicine

A striking finding in this study was that students described their empathy as developing rather than declining. This was apparent after contact with patients. This finding is in marked contrast to the reports from quantitative studies of students' empathy declining in the clinical years of the course (Newton et al., 2008, Chen et al., 2007, Hojat et al., 2009). My research findings concurred with the quantitative research which reported either no change or an increase in empathy in medical students during their training (Magalhaes et al., 2011, Mahoney et al., 2016, Quince et al., 2011, Quince et al., 2016b). Although it was significant that students in my study claimed that their empathy had not declined but in most cases had actually increased, phenomenological research is concerned more with understanding their rich nuanced descriptions rather than quantifying the changes experienced by the students. A recent study concluded that it was necessary to investigate the distinct components of empathy to better understand empathy changes in training.(Smith et al., 2017)

Millennial learners are said to demonstrate a tendency to narcissism but these students told a different story, of an increasing interest in the other person (Twenge, 2013). American surveys of preclinical medical students concluded that there was a loss of idealism during their training (Morley et al., 2013, Mader et al., 2014). However, in my study the students claimed the reverse was

true, they were becoming more sensitive to patients' needs, were enthusiastic about becoming doctors and wanted to include psychosocial aspects in their work.

A cross-sectional study, with a group of seven students in years 3 and 4 in a UK university also showed some of these changes in students' empathy (Tavakol et al., 2012). The students in the phenomenological study carried out by Tavakol et al. (2012), regarded empathy as a personality trait rather than in a relational way. Some students described that their empathy had not declined but their high clinical workload resulted in less overt demonstrations of empathy while others felt, like most of the students in my study, that their empathy had increased with patient contact (Tavakol et al., 2012). Their findings concurred with the views of some students in my research who identified a tension between empathy and efficiency, a tension described in other qualitative studies (Allen et al., 2008, Eikeland et al., 2014).

Tavakol et al. (2012), also suggested that students experienced a more affective type of empathy at the beginning of their studies but focused on a cognitive version as training progresses, implying that they were becoming more detached in their relationships with patients. However, as the researchers did not interview students at the beginning of the course it was difficult to draw these conclusions from cross-sectional 'snapshots' of the curriculum (Tavakol et al., 2012).

Students in my study gave a wealth of examples relating to greater sensitivity with patients despite their perceived barriers to empathy in the curriculum. They described how they had developed a more 'practical' form of empathy which involved appreciating the patient's emotions but at the same time focusing on the immediate medical problem. Their stories revealed a greater self-awareness of their relationship with patients. The relevance of the psychosocial lectures delivered in the first year was appreciated when students reached the clinical years.

9.6.2 Student-focus to Patient-focus

The students described how initially they were self-conscious and nervous when talking to patients. Also, in early years, they described 'hunting for signs' in 'interesting' patients on the ward. Other studies have noted that some students regarded patients as cases, or learning resources, rather than people, which they suggested was one of the factors accounting for an empathy decline (Tavakol et al., 2012, Allen et al., 2008, Christakis and Feudtner, 1997). However in my study students described how their relationship with patients deepened in a process some described as 'getting it'.

Students acknowledged that the context of their encounter affected the level of empathy which they actually displayed, rather than how they felt emotionally. This tension between their empathetic attitude and more distanced behaviour when constrained by time reflects one of the many problems in assessing empathy (Rees and Knight, 2007). Conrad (1988) proposed that in medical schools which emphasised technical aspects of medicine rather than caring, students struggled to maintain a humanistic perspective. He claimed that towards the end of their training some students shifted their perspective to become doctor-orientated rather than patient-orientated, a claim refuted by my research (Conrad, 1988). It may be that students in my study were more humanistic in their outlook than some of their peers but all of them described a shift in perspective from being student-orientated to patient-orientated.

Some students felt they were playing a role as 'doctor', resonating with descriptions of surface acting, in which the student appears empathetic but does not share any emotion with the patient (Larson and Yao, 2005). Students described competence as creating a space for empathy, others called this process 'finding a doctor's voice.' (Rosenfield and Jones, 2004). Another study also found that in striving to accumulate factual knowledge students lost sight of the psychological aspects of care (Haas and Shaffir, 1977). Although students in my study described instances where they seemed less emotionally connected to

patients, they reflected on these experiences and adjusted their behaviour. They retained their motivation to have a close empathetic relationship with patients.

Students differentiated between developing resilience, or as they described it, as being 'harder', while at the same time developing empathy, by being warmer with patients. Some also agreed that they may have become more cynical about certain issues, for instance the medical school's responsiveness to change or their increasing workload. However they claimed that this form of cynicism did not affect their empathy with patients. In a Scandinavian study, some students described cynicism as an accepted coping strategy (Eikeland et al., 2014). My findings contrasted particularly with the early studies of professional socialization which reported a development of cynicism (Becker and Geer, 1958, Merton et al., 1957). In view of these different findings there is now a need for further qualitative social science research into the process of professional socialisation.

9.6.3 Intrapersonal to interpersonal empathy

In the pre-clinical group empathy was largely described as an attribute, an intrapersonal construct. In the clinical group there was little talk of empathy in this way but rather as an interpersonal relational construct. (Chapter5).

A study of medical students' views on professionalism had parallels with the findings in my study (Monrouxe et al., 2011). In both studies students had differing understandings of the phenomena, empathy and professionalism. Students who had delayed contact with patients had a restricted view of professionalism focused on dressing and acting as a professional (Monrouxe et al., 2011). However those who experienced early patient contact developed a more sophisticated concept of professionalism (Monrouxe et al., 2011). The authors concluded that becoming a professional was an interpersonal and complex activity which needed to be nurtured in the formal curriculum (Monrouxe et al., 2011). These findings mirror those in my thesis in relation to empathy.

9.6.4 Emotional connection

Students claimed that they were more sensitive to patients' needs as they progressed through the course. This contrasted with early findings of students becoming more detached to retain objectivity (Coombs and Powers, 1975). An American study found that students demonstrated a number of strategies for coping with emotions including: objectifying the patient, accentuating the comfortable feelings that come from "real medicine", blaming patients, humour and distancing (Smith III and Kleinman, 1989). It has been argued that medical school education is a process of assimilation into a culture of objectivity (Gordon, 1995).

In stark contrast to these studies, the students in my study wished to connect emotionally with the patient and to expose their own vulnerability. Students in the clinical years came to understand the place of psychosocial care in medicine. Some students noticed that their empathy had become more 'practical'. They claimed that although they might postpone a discussion of psychosocial issues in order to manage the medical problems, they retained their empathetic concern for the patient. All students stressed that they wanted to continue to develop their empathy, but expected that it might be threatened by their working conditions in the future, reflecting similar concerns expressed by students in another study. (Nogueira-Martins et al., 2006)

9.6.5 Transitions

Students described transitions during their undergraduate experience. Some described a process of maturing from school and assuming adult responsibilities, while other described a process of moulding by the medical school culture. These resembled the gradual transitions described by Perry in a study of college students (Perry, 1968). Other students in my study seemed to have an epiphany described by some as 'getting it', or speaking with 'a doctor's voice', where they suddenly grasped what being a doctor involved, a process resembling 'doctrinal conversion' (Davies, 2014). Some students described the development of empathy as a lifelong process which was influenced by many

factors outside the medical curriculum including for example, their own experience of illness. This view is supported by research suggesting that empathy developed in a bell-shaped curve through life with a peak in late middle-age (O'Brien et al., 2012).

9.7 Summary

The preclinical student group linked their increased self-confidence and clinical competence with being more empathetic. However, they described how, by hiding their feelings, they might appear less empathetic. For some students the focus of their empathy was more 'other' directed, they learned to appreciate that patients were people with needs, rather than viewing them as teaching resources.

Students in the clinical cohort, who reflected on six years of training, mostly said that their empathy had increased. Some students described the process of 'getting it', where they changed their view of patients as people whose needs should be addressed. This change was 'a massive wake-up call', or epiphany, for some, and for others, a gradual process of experience which occurred mostly in the clinical years. In their stories, students demonstrated that they wanted to connect and empathise with patients. They reflected their distress when the context of their work prevented them from doing so, expressing apprehension about retaining empathy when under pressure of time as foundation doctors.

Chapter 10: Synthesis, Contributions and Implications

10.1 Overview

This chapter synthesises the findings of my study in relation to my research questions. The main contribution of my research was to increase our understanding of the way in which students conceptualised empathy and to consider the factors in the curriculum which influenced their empathy. The overarching theme that emerged from the students' stories was the tension between emotional connection with, and detachment from, patients. The limitations of this phenomenological research are discussed. The contributions of this study to research, medical undergraduate education and to patient care are defined. Although any conclusions drawn from a phenomenological study are necessarily tentative, the implications of my findings for research, education and practice are debated. The chapter concludes with a final reflection and summary statement.

10.2 Synthesis of the findings

The findings from my research are summarised in addressing each of the research questions. My first research question was;

How do students talk about and experience the concept of empathy in relation to professionalism and practice?

The study showed that initially, the students adopted an intrapersonal view of empathy, regarding it as an individual attribute. Later, with clinical experience, students took a different view of empathy, describing it as an interpersonal construct, which was dependent on the context of their contact with patients.

In exploring the relational concept of empathy students described, in detail, the process of empathising with a patient. They reflected on establishing rapport, sharing emotions and the setting of an appropriate self-other boundary. They

suggested that the different dimensions of empathy might combine flexibly to meet the needs of the individual patient. Some students described varying levels of empathy might be appropriate for differing clinical situations. They discussed how their empathy was affected by the context of their consultation with the patient.

The students' rejected 'detached concern' as an appropriate model of medical professionalism. Instead, they expressed a wish to connect emotionally in empathising with patients. They described the benefits of empathy not only to patients, but to themselves.

My second research question was;

What factors do medical students describe as influencing their empathy during their undergraduate medical training?

My research identified a range of factors which the students described as influencing their empathy. Their stories made explicit a variety of implicit influences in the hidden curriculum.

Students described their clinical experience with real patients as the most significant positive influences on their empathy. The opportunity to develop a patient–student relationship was central to empathising and was enhanced by support from experienced clinicians. Such positive role models were clinicians who were willing to discuss emotional aspects of care, share their vulnerability and provide support to students. Students observed their clinical tutors' behaviour closely and described their impact on their own style of consultations with patients.

Students talked more about negative rather than positive influences during their training. They perceived barriers to empathy which distanced them from patients, primarily a conforming, competitive culture in the medical school in which they did not feel that they were valued as individuals.

A more detailed analysis revealed a number of other barriers to their empathy including: a lack of patient contact, negative role models, a biomedical bias to their teaching and learning professionalism as 'detached concern' for patients. They suggested that their communication skills training with simulated patients encouraged a 'fake' empathy.

However, despite these negative influences in the curriculum, a majority of students preferred to connect emotionally with patients. Some voiced concerns that sharing emotions might cause burnout or affect their objective clinical judgement. Others appreciated that sharing emotions might lead them to a fuller understanding of the patients' world, which would improve not only the care of the patient but also their job satisfaction. These students suggested that emotions should inform their clinical decision-making.

All of the students voiced a need for guidance on how to achieve an appropriate balance between connection and detachment in the student-patient relationship. They also expressed the need for support when they were engaging emotionally with patients. They identified a number of consultations which both challenged and developed their empathy: talking to dying patients and to those with mental health problems. The students expressed a need for more guidance on empathising with people from differing ethnic backgrounds and cultures.

Students stressed that time was essential to build an empathetic relationship. The students identified a tension between empathy and efficiency in their clinical work. They also emphasised the negative effect of stress on their ability to empathise with patients.

My third research question was;

How do medical students 'views and experience of empathy change during their medical education?

Rather than describing empathy as a personal attribute, students developed a relational view of empathy in the clinical years. This reflected a shift in their focus to connect with the patient. The students' stories revealed that despite the barriers which they described, their empathy was enhanced during the course. They wanted to connect emotionally with patients in order to appreciate their concerns. This finding is in contrast to the alleged decline in empathy reported in the literature as happening during their undergraduate training.

Students maintained that they had developed their sensitivity to patients in the clinical years. However, they admitted to adopting behaviours, on occasions, to hide their empathy in the interests of efficiency, revealing the tension which existed between empathy and efficiency.

My analysis revealed a common thread in the students' stories: the tension between empathy and detached concern.

10.3 An over-arching theme of the research: Empathy or detached concern?

The over-arching theme in my thesis identified by the students, was the tension between connecting with patients emotionally, in relational empathy, and distancing themselves, by adopting 'detached concern'. At the heart of the medical undergraduate learning experience is the patient-student relationship. Students indicated that if this is to be an effective relationship, they needed to be encouraged to build an empathetic dialogue with patients. Students described a need for help in regulating their emotions: by distinguishing between appropriate empathetic concern and harmful personal distress; by creating an appropriate self-other boundary. Emotional engagement also

depended on a learning environment which valued time spent with patients and which fostered continuity of care. They stressed that they wanted to have close relationships with patients but perceived that they had to act in a detached way in order to appear professional.

10.4 Limitations of the research

Paley (2017,p.17), criticised phenomenological qualitative research on the basis that 'bracketing' was impossible and that meaning-attribution problematic. In particular he argued that a phenomenological analysis was simply a reflection of the researcher's own priorities (Paley, 2017,p.31). However, Paley in his criticism of phenomenology adopted a positivist stance, which was not theoretically consistent with a qualitative methodology (Paley, 2017).

In Western society the positivist ideas of science prevail to an extent that science is assumed to represent uninfluenced reality beyond interpretation (Montgomery, 2006). Perhaps it is not surprising then that medicine distrusts anecdotes. Yet, paradoxically, clinical medicine begins with a patient's story. Phenomenological research and clinical medicine rely both on a negotiation, between the individual story and the background evidence, and on interpretation (Montgomery, 2006).

One of the inevitable limitations of research in the social sciences is that it can never be possible to know fully what another person is thinking and feeling. However the fact that a perfect understanding is not possible does not invalidate the knowledge generated by thorough, sensitive qualitative research.(Finlay and Gough, 2008) I have acknowledged, from my Heideggarian perspective, that it was not possible to remove all my assumptions about empathy. However, a phenomenological study demands reflexivity to make the researcher's position explicit. Paley seemed to ignore the fact that the aim of phenomenological qualitative research is to find meaning through the entire phenomenological research process, using interpretation and the relationship between the perceiver and the perceived (Sohn, 2017).

My study was concerned with the students' experiences during their undergraduate education. Early influences on their empathy such as their upbringing and schooling, although potentially significant, were not investigated. The study was limited to a small number of a self-selected sample of students in one medical school in the UK. My method of recruiting students who volunteered for the study on a self-selected purposive basis was designed to recruit students who were motivated by the subject and were ready to commit to a study over three academic years. I anticipated that there would be attrition in the numbers of students volunteering for the research but found that they all attended every interview. The students who volunteered for the study were already engaged with the topic of empathy and so were probably not representative of all the students in the year group. Indeed, sometimes they sent e-mails to ask for an interview or to send interesting references. Their feedback indicated that participating in the study had increased their awareness of empathy. Rather than viewing their subjectivity as a bias my theoretical approach and my research was enriched by their interest and commitment. My phenomenological research was concerned with exploring their subjective perspectives rather than achieving a representative sample.

There is scope to explore the relationship of gender, culture and power to the development of empathy, areas which were not considered in depth in my study. I suggest that further phenomenological studies are needed to deepen our understanding of the effects of these factors on empathy.

I would have preferred to follow the students through the whole course but the length of the curriculum, with the inclusion of the compulsory intercalated science year, made this impractical. However, the students divided conveniently into preclinical and clinical groups which made a longitudinal study feasible.

I did not transcribe the audio-recordings of the interviews but employed an experienced and skilled transcriber as I believed this would ensure accurate transcripts for the data analysis. It is possible that I would have gained further

insights by carrying out the transcribing myself. I did not seek the students' feedback on my data analysis. In adopting a phenomenological stance I accepted responsibility for the interpretation and have been transparent in my reporting of the analysis. I offered the students an opportunity to read their transcripts though none took up this offer. However, my thesis is intended to contribute to a debate.

The study was limited to exploring the views of medical students and their experiences in the context of their medical education. It was beyond the remit of the study to consider the views of patients or the medical educators.

Quantitative studies were not included in this thesis as the phenomenological theoretical approach underpinning the study explores understanding rather than measurement of empathy. My phenomenological study was concerned with the medical students' everyday experiences, therefore research in the neurosciences, describing neural pathways involved with empathising, was not discussed in my thesis but is described in *The Social Neuroscience of Empathy* (Decety and Ickes, 2011). Integrating the neurosciences with social sciences is a new approach in research into empathy which has helped to validate, at a neurological level, the distinction between personal distress and empathetic concern (Decety and Ickes, 2011).

10.5 Contribution to research, education and practice

The main contribution offered by my research is to increase understanding of the ways in which medical students perceive empathy and the factors which influence their empathy during their undergraduate training. By using an innovative method in medical education research the study also contributes to research methodology.

10.5.1 Contribution to research methodology

The study responded to a need identified by many quantitative researchers for further qualitative research into the development of medical students' empathy.

This is the first report in the literature of a longitudinal, phenomenological, interpretative approach to study empathy in medical students. It is also an innovative study, in its exploration of empathy, a construct which is integral to a phenomenological approach. This study has demonstrated how such an approach to data analysis can be used to gain new insights into the students' views and experiences of empathy.

10.5.2 Contribution to new understanding

The study contributed to a greater understanding of the complexity of empathy. It showed that students developed a relational view of empathy rather than viewing it as simply a personal attribute. This relational approach can be contrasted with the focus in the medical education literature which conceptualises empathy as a measurable personal attribute.

The study explored the process of empathising, highlighting key areas including; rapport, sharing emotions, vulnerability and the self-other boundary. The students discussed how such an appropriate boundary might be formed and emphasised their need for guidance in this process from experienced clinicians

The research demonstrated that the widely-accepted belief that medical students lose empathy during their training concealed a more complex picture. They suggested that rather than losing empathy in the clinical curriculum, it developed as they focused on the student-patient relationship. However, on occasions they suggested it was necessary to hide their empathy.

The study revealed the impact of the context of the meeting between a patient and a student on the development of an empathetic relationship. In their stories the students identified a number of factors in the explicit and hidden curricula which influenced their empathy.

10.5.3 Contribution to medical undergraduate education

The students identified a number of factors which they reported as influencing their empathy. Their insights may inform medical educators who wish to ensure

that medical graduates are both competent and caring. The key factors from my research may be summarised as follows:

- The patient student relationship

Students identified patient contact as the most influential factor in enhancing their empathy. Conversely, they described their lack of patient contact as inhibiting their empathy. Despite the rhetoric from the medical school concerning the desirability of patient-centred education, students identified missed opportunities to involve patients in their training. They further identified factors affecting their empathy including; a decline in bedside teaching and a greater emphasis on simulation both for teaching and assessment of clinical skills.

- Role models

This research confirmed earlier findings which have shown how both positive and negative role models can influence students' empathy. (Lempp and Seale, 2004)

- Biomedical bias to teaching

The students identified a lack of teaching on empathy in the curriculum and limited guidance on managing their emotions or those of the patients. In the medical school there appeared to be an increasing emphasis on biomedical science and a corresponding neglect of the psychosocial elements of care. Students described how the emphasis on the biomedical aspects of patient management contributed to an emotional distancing from patients

- Professionalism as distancing from patients

The students perceived that their teaching on professionalism was directed towards detachment from patients.

- The medical school culture

The research adds to our understanding of implicit factors that affect empathy in the hidden curriculum by making them explicit. These included; the competitive environment, negative role models and a lack of psychological support or empathy for the students. There are other influences which affected the climate of the medical school, many of which lie outside the University, reflecting government policies and the interface between the University and the NHS. These aspects of medical education lie outside the scope of this study (Genn, 2001b).

- Stress and support

Student support was considered to be essential for students to flourish and to enable them to be empathetic. The study demonstrated that the students perceived support to be variable and dependent on the commitment of the personal tutor. The students were ambivalent about resilience, some describing it as incorporating empathy, while others argued that it implied detachment from patients.

10.5.4 Contribution to clinical practice

It may appear that medical education research loses sight of its ultimate aim which is to improve patient care (Cleland, 2015). The study contributed to practice by identifying elements of teaching which enhanced the students' empathy, and barriers which could inhibit it. The students acknowledged empathy as an essential part of being a good doctor. They identified their relationship with patients as being central to developing empathy and expressed their wish to be empathetic doctors. They hoped that their working conditions in the future would allow them to develop empathetic relationships with patients.

The students also identified clinical situations which both challenged and developed their empathy, for example in psychiatry and end-of-life care. They identified a potential tension between empathy and efficiency in clinical

practice, highlighting the importance of time and continuity in developing empathetic relationships with patients.

10.6 Implications for research, education and practice

My final research aim was to consider how the new understanding generated by the research might inform future medical undergraduate training and so improve patient care. I am cautious about making recommendations from my phenomenological research. I hope that my interpretation of the implications of my findings might resonate with my readers and so act as a stimulus for improvements in medical undergraduate education and stimulate new approaches for future research.

10.6.1 Implications for research

The study demonstrated that Interpretative Phenomenological Analysis (IPA), used in a longitudinal context, was a useful method for gaining understanding of the students' world. My research suggested that the focus of future research in clinical empathy should explore empathy as a two-way relationship with the patient, rather than being an attribute of the student or doctor. It seems that rather than repeating quantitative measurements of empathy it would be more productive to carry out further longitudinal phenomenological research to explore the effects of the explicit and hidden curricula. There is a need to research the views of students in other medical schools, their medical educators and patients.

10.6.2 Implications for medical undergraduate education

The implications for medical undergraduate education can be broadly described in two parts: changing the culture and introducing specific interventions to enhance empathy.

10.6.2.1 Culture change

Medical undergraduate education is intimately linked to clinical care in the NHS. When situations arise such as the lapses in care described in the Francis Report, questions must be raised about the role and responsibility of medical education in creating the climate in which they occurred (Francis, 2013). This research suggested that there needs to be a change in the culture of this medical school to remove the identified barriers to empathetic relationships between patients and students.

The study suggested that the medical school, which has an excellent reputation for biomedical research, needs to focus attention on psychosocial care. There is a need to give this subject the same value as the scientific elements of the curriculum. Medical education, and clinical practice, needs to integrate both the science and humanity of patient care by allowing students to express empathy with patients. Patients value empathetic and humane doctors.

The study demonstrated that the medical school could do more to support and show the students that they are valued. There is a need to address the contextual issues identified in my research and acknowledge the central role of patients in medical education (Halpern, 2001, Shapiro, 2012, Bleakley and Bligh, 2008). Placing the patient-student relationship at the heart of medical undergraduate education and increasing the students' opportunities for contact with patients would help them with the process of emotional regulation. Students need time with mentors to provide feedback on difficult emotional issues arising in practice (Bleakley and Bligh, 2008). Medical educators need to reflect on the reasons why students gained a perception of medical professionalism as distancing themselves from patients.

Some students in the study were pessimistic that the medical school would listen to their views or that any change would occur, a view reflected by some authors in the literature (Bloom, 1989, Burks and Kobus, 2012). Forty years ago,

in a seminal paper advocating a biopsychosocial approach to medicine, Engel wrote,

“Nothing will change unless or until those who control resources have the wisdom to venture off the beaten path of exclusive reliance on biomedicine as the only approach to health care.” (Engel GL, 1977)

I have shown how students are willing to empathise and to adopt a phenomenological approach to the patient. It is possible that by incorporating phenomenology into the medical education culture, students would be enabled to use their innate curiosity to empathise with patients and to explore with them the meaning of their illness. A philosophical foundation of phenomenology embraces openness and uncertainty, so fostering empathy. Such an approach accepts imperfection and by adopting patient-centred narrative approach, allows students to connect more closely with patients (Shapiro, 2008). A shared willingness to feel and convey empathy may result in a culture shift in medicine from detached concern to adopting a broad view of empathy as a dynamic relational process.

10.6.2.2 Specific interventions to enhance empathy

Efforts to improve the training of students to be more empathetic need to take account of the context of their clinical encounters with patients.

- Patient experience

A relational view of empathy has implications for the students' education; it prioritises the patient's experience as a source of learning. The students suggested a number of ways in which patients could be more involved in their education. The simplest approach would be for students to have more contact with patients from the beginning of the course. Psychosocial issues and empathy could then be addressed in the context of a relationship between the student and the patient with mentoring from an experienced doctor rather than in didactic teaching (Monrouxe et al., 2011). Other initiatives could include a greater emphasis on the patient experience during the lectures and patient

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involvement with problem based learning which then becomes patient-based learning (Bleakley and Bligh, 2008).

- Reflective practice

Students tended to restrict their understanding of reflection to written contributions in their portfolios. However in their interviews they highlighted the central role of reflection in the process of empathising. This research suggests that students would appreciate an opportunity to reflect on their practice with experienced clinicians, especially when not being assessed.

- Guidance on setting boundaries

The students identified a need for guidance on how to balance their emotional connection with appropriate detachment. They wanted to learn how to maintain an appropriate self-other boundary and to develop deep collaborative working relationships with patients. Experienced practitioners can mentor students by providing time for them to discuss their difficulties.

- Removing barriers

The students described ways in which their empathy was inhibited and these barriers require attention. For example, medical educators could incorporate emotional connection into medical professionalism and value students as colleagues. Good role models are inspirational but poor ones perpetuate a distancing form of practice (Bleakley and Bligh, 2008). Vulnerability needs to be acknowledged to allow humane empathetic behaviours to flourish. Students need to be encouraged to give honest feedback on both good and bad practice. Humiliation and bullying should not be tolerated, not even in light-hearted banter. Students should feel that they can report these issues without affecting their academic progress.

- Providing support

The study has demonstrated that students described being less empathetic when stressed. They described the provision of personal support in the

University as variable and gave reasons for their reluctance to seek such help. The implication for the medical school is that students need motivated personal tutors with a willingness to engage with them.

- Introducing the humanities into the curriculum

Students in this medical school had very little opportunity to engage with the medical humanities in the curriculum. Many authors have shown the potential for the humanities to promote empathy in medical students. There is scope for inclusion of this aspect in this curriculum (Batt-Rawden et al., 2013, Shapiro et al., 2006b, Charon, 2001).

If these suggestions resonate with the readers and local medical educators, the lessons from this research may also be shared with other medical schools and other healthcare professionals.

10.6.3 Implications for clinical practice

This research suggested a number of approaches which may be adopted by medical schools to encourage students to be more empathetic with patients and their colleagues. However an inter-personal view of empathy implied that the context of the relationship is also of importance. It is not sufficient to train students to be empathetic and then expect them to work sensitively in situations where they are stressed, lack time or receive little support. However, if psychosocial issues are given a higher priority, the empathy gap may be reduced (Francis, 2013).

My research has demonstrated that clinical practice and phenomenology share characteristics; a willingness to try and see the world from the other person's point of view and a commitment to reflexivity. Thirty years ago Schön (1987,p.321) argued that there was a need to incorporate phenomenology into teaching and clinical practice, other researchers have echoed his call (Van Manen, 2016, Vagle, 2010, Carel, 2016, Montgomery, 2006) I hope that my

thesis, which describes the students' views, may contribute to achieving this aim.

10.7 Final Reflection

The students' stories have been woven together to reveal new patterns of understanding of empathy. I have been privileged to listen to the stories of their experiences. I have learned much from the students who remained caring empathetic people throughout the research. My new understanding has answered the research questions and those which arose during my earlier work as a mentor for medical students. I hope that my reporting of the students' stories does them justice and will contribute to curriculum changes which foster empathy. Engaging with phenomenology has taught me to listen, engage with the student and to reflect on their perspectives.

“there are no short cuts, there is no short way around this, and you need to sit down and see people” (Neville, Year 5)

10.8 Summary of the thesis

My longitudinal phenomenological study has shown that medical students developed a relational view of empathy as they moved through their course. In contrast to the reported decline in empathy, the students described that their empathy with patients increased during their training. They have identified their contact with patients as the most powerful way of enhancing their empathy. They described a number of barriers in their curriculum which inhibited their empathy, including, the medical school culture, a cognitive view of empathy, a biomedical bias and promoting professionalism as distancing oneself from patients. Students in this study wanted to exercise their clinical skills and to have safe way of connecting with patients emotionally. Good medical practice should not involve detachment but an appropriate level of emotional engagement which respects the patient and addresses their needs. The students' stories may inform medical educators and those responsible for curriculum reform, to ensure that their graduates are both competent and caring. The nurturing of empathetic students will enable patients to receive more appropriate care and will help to address the perceived empathy gap which exists in clinical practice.

References

- AGLEDAHL, K. M., GULBRANDSEN, P., FØRDE, R. & WIFSTAD, Å. 2011. Courteous but not curious: how doctors' politeness masks their existential neglect. A qualitative study of video-recorded patient consultations. *Journal of Medical Ethics*, 37, 650-654.
- AGOSTA, L. 2014. A rumor of empathy: Reconstructing Heidegger's contribution to empathy and empathic clinical practice. *Medicine, Health Care and Philosophy*, 17, 281-292.
- AHRWEILER, F., NEUMANN, M., GOLDBLATT, H., HAHN, E. G. & SCHEFFER, C. 2014. Determinants of physician empathy during medical education: hypothetical conclusions from an exploratory qualitative survey of practicing physicians. *BMC Medical Education*, 14, 122-134.
- ALLEN, D., WAINWRIGHT, M., MOUNT, B. & HUTCHINSON, T. 2008. The wounding path to becoming healers: medical students' apprenticeship experiences. *Medical Teacher*, 30, 260-264.
- ALNOMAN, N. 2014. *Consultation and Relational Empathy (CARE) Measure in Medical Students*. PhD, University of Dundee.
- ATKINSON, P. 1976. *The clinical experience: an ethnography of medical education*. PhD, Durham University.
- AUSTEN, L. 2016. Increasing emotional support for healthcare workers can rebalance clinical detachment and empathy. *British Journal of General Practice*, 66, 376-377.
- AUSTIN, E. J., EVANS, P., MAGNUS, B. & O'HANLON, K. 2007. A preliminary study of empathy, emotional intelligence and examination performance in MBChB students. *Medical Education*, 41, 684-689.
- BACK, L. 2016. *Academic Diary: Or Why Higher Education Still Matters*, London, Goldsmiths.
- BAKER, M., WESSELY, S. & OPENSHAW, D. 2016. Not such friendly banter? GPs and psychiatrists against the systematic denigration of their specialties. 66, 508-509.
- BAKEWELL, S. 2016. *At the Existentialist Café: Freedom, Being & Apricot Cocktails.*, London Chatto & Windus.
- BALINT, M. 1957. *The Doctor his Patient and the Illness.*, London, Tavistock Publications.
- BALLATT, J. & CAMPLING, P. 2011. *Intelligent Kindness*, London, RCPsych Publications.
- BANDINI, J., MITCHELL, C., EPSTEIN-PETERSON, Z. D., AMOBI, A., CAHILL, J., PETEET, J., BALBONI, T. & BALBONI, M. J. 2017. Student and faculty reflections of the hidden curriculum: How does the hidden curriculum

- shape students' medical training and professionalization? *American Journal of Hospice and Palliative Medicine*, 34, 57-63.
- BARON-COHEN, S. 2011. *Zero Degrees of Empathy*, London, Allen Lane
- BARRETT-LENNARD, G. T. 1981. The empathy cycle: Refinement of a nuclear concept. *Journal of Counseling Psychology*, 28, 91-100.
- BARROSO, J., GOLLOP, C., SANDELOWSKI, M., MEYNELL, J., PEARCE, P. F. & COLLINS, L. 2003. The challenges of searching for and retrieving qualitative studies. *Western Journal of Nursing Research*, 25, 153-178.
- BATES, M. J. 2002. Toward an integrated model of information seeking and searching. *The New Review of Information Behaviour Research*, 3, 1-15.
- BATSON, C. 2011. These Things Called Empathy: Eight Related but Distinct Phenomena. In: DECETY, J. & ICKES, W. (eds.) *The Social Neuroscience of Empathy*. Cambridge, Massachusetts.: MIT Press.
- BATSON, C. D., BATSON, J. G., SLINGSBY, J., HARRELL, K. L., PEEKNA, H. M. & TODD, R. M. 1991. Empathic joy and the empathy-altruism hypothesis. *Journal of Personality and Social Psychology*, 61, 413-426.
- BATSON, C. D., EARLY, S. & SALVARANI, G. 1997. Perspective taking: Imagining how another feels versus imaging how you would feel. *Personality and Social Psychology Bulletin*, 23, 751-758.
- BATSON, C. D. & SHAW, L. L. 1991. Evidence for altruism: Toward a pluralism of prosocial motives. *Psychological Inquiry*, 2, 107-122.
- BATT-RAWDEN, S., CHISOLM, M. S., ANTON, B. & FLICKINGER, T. E. 2013. Teaching empathy to medical students: an updated, systematic review. *Academic Medicine*, 88, 1171-1177.
- BAUER, J. L. 2008. Slow Medicine. *The Journal of Alternative and Complementary Medicine*, 14, 891-892.
- BAYNE, H., NEUKRUG, E., HAYS, D. & BRITTON, B. 2013. A comprehensive model for optimizing empathy in person-centered care. *Patient Education and Counseling*, 93, 209-215.
- BAYNE, H. B. 2011. Training medical students in empathic communication. *The Journal for Specialists in Group Work*, 36, 316-329.
- BAZELEY, P. & JACKSON, K. 2013. *Qualitative Data Analysis with NVIVO*, London, Sage.
- BECKER, H., GEER, B., HUGHES, E. & STRAUSS, A. 1961. *Boys in White: Student Culture in Medical School*, Chicago., University of Chicago Press.
- BECKER, H. S. & GEER, B. 1958. The fate of idealism in medical school. *American Sociological Review*, 50-56.
- BENBASSAT, J. 2014. Changes in wellbeing and professional values among medical undergraduate students: a narrative review of the literature. *Advances in Health Sciences Education*, 19, 597-610.

- BENNETT, D., KELLY, M. & O'FLYNN, S. 2010. Are the bigger hospitals better: DREEM on? *Irish Journal of Medical Science*, 179, 515-519.
- BERG, K., MAJDAN, J. F., BERG, D., VELOSKI, J. & HOJAT, M. 2011. A comparison of medical students' self-reported empathy with simulated patients' assessments of the students' empathy. *Medical Teacher*, 33, 388-391.
- BERWICK, D. M. 2016. Era 3 for medicine and health care. *JAMA*, 315, 1329-1330.
- BIKKER AP, MERCER SW & P., C. 2012. Connecting, Assessing, Responding and Empowering (CARE) :a universal approach to person-centred, empathic healthcare encounters. *Education for Primary Care*, 23, 454-457.
- BLEAKLEY, A. & BLIGH, J. 2008. Students learning from patients: let's get real in medical education. *Advances in Health Sciences Education*, 13, 89-107.
- BLEAKLEY, A. & BLIGH, J. 2009. Who can resist Foucault? *Journal of Medicine and Philosophy*, 34, 368-383.
- BLOOM, P. 2016. *Against Empathy : The Case for Rational Compassion*, London, The Bodley Head.
- BLOOM, S. 1989. The medical school as a social organization: the sources of resistance to change. *Medical Education*, 23, 228-241.
- BOMBEKE, K., VAN ROOSBROECK, S., DE WINTER, B., DEBAENE, L., SCHOL, S., VAN HAL, G. & VAN ROYEN, P. 2011. Medical students trained in communication skills show a decline in patient-centred attitudes: An observational study comparing two cohorts during clinical clerkships. *Patient Education and Counseling*, 84, 310-318.
- BONDI, L. 2003. Empathy and identification: Conceptual resources for feminist fieldwork. *ACME: An international E-journal for critical geographies*, 2, 64-76.
- BONDI, L. 2008. On the relational dynamics of caring: a psychotherapeutic approach to emotional and power dimensions of women's care work. *Gender, Place and Culture*, 15, 249-265.
- BONDI, L. 2014. Understanding feelings: Engaging with unconscious communication and embodied knowledge. *Emotion, Space and Society*, 10, 44-54.
- BOOTH, A. 2010. How much searching is enough? Comprehensive versus optimal retrieval for technology assessments. *International Journal of Technology Assessment in Health Care*, 26, 431-435.
- BORGSTROM, E. & WALTER, T. 2015. Choice and compassion at the end of life: A critical analysis of recent English policy discourse. *Social Science and Medicine*, 136, 99-105.
- BOUDREAU, J. D., CASSELL, E. & FUKS, A. 2007. A healing curriculum. *Medical Education*, 41, 1193-1201.

- BOURDIEU, P. 1977. *Outline of a Theory of Practice*, Cambridge, Cambridge University Press.
- BOURDIEU, P. 1990. *The Logic of Practice*, New York, Stanford University Press.
- BOWER, D. J., YOUNG, S., LARSON, G., SIMPSON, D., TIPNIS, S., BEGAZ, T. & WEBB, T. 2009. Characteristics of patient encounters that challenge medical students' provision of patient-centered care. *Academic Medicine*, 84, 74-78.
- BRANCH, W. T. 2010. The road to professionalism: Reflective practice and reflective learning. *Patient Education and Counseling*, 80, 327-332.
- BRANDL, K., SCHNEID, S. D., SMITH, S., WINEGARDEN, B., MANDEL, J. & KELLY, C. J. 2017. Small group activities within academic communities improve the connectedness of students and faculty. *Medical Teacher*, 1-7.
- BRATEK, A., BULSKA, W., BONK, M., SEWERYN, M. & KRZYSTA, K. 2015. Empathy among physicians, medical students and candidates. *Psychiatr Danub*, 27, 48-52.
- BRAZEAU, C., SCHROEDER, R., ROVI, S. & BOYD, L. 2010. Relationships between medical student burnout, empathy, and professionalism climate. *Academic Medicine*, 85, 33-36.
- BRODY, H. 1997. Who gets to tell the story? Narrative in postmodern bioethics. In: NELSON, H. (ed.) *Stories and their Limits: Narrative Approaches to Bioethics*. London: Routledge.
- BROYARD, A. 1992. *Intoxicated by my illness: and other writings on life and death*, New York, Fawcett Columbine.
- BUB, B. 2007. Focusing and the Healing Sequence: reclaiming authentic emotions as an aid to communication and well-being in medicine. *Explore: The Journal of Science and Healing*, 3, 413-416.
- BUBER, M. 1961. *Between Man and Man*, London, Collins.
- BUBER, M. 2004. *I and Thou*, London, Continuum.
- BURGESS, A., GOULSTON, K. & OATES, K. 2015. Role modelling of clinical tutors: a focus group study among medical students. *BMC Medical Education*, 15, 17-26.
- BURKS, D. J. & KOBUS, A. M. 2012. The legacy of altruism in health care: the promotion of empathy, prosociality and humanism. *Medical Education*, 46, 317-325.
- BYSZEWSKI, A., HENDELMAN, W., MCGUINITY, C. & MOINEAU, G. 2012. Wanted: role models-medical students' perceptions of professionalism. *BMC Medical Education*, 12, 115-124.
- CACIOPPO, J. T., HAWKLEY, L. C., NORMAN, G. J. & BERNTSON, G. G. 2011. Social isolation. *Annals of the New York Academy of Sciences*, 1231, 17-22.

- CALDERWOOD, C. 2016. Realistic medicine: Chief Medical Officer's Annual Report 2014–15. Edinburgh: Scottish Government.
- CAMPOS, J. J., WALLE, E. A., DAHL, A. & MAIN, A. 2011. Reconceptualizing emotion regulation. *Emotion Review*, 3, 26-35.
- CAREL, H. 2016. *The Phenomenology of Illness*, Oxford, Oxford University Press.
- CHARMAZ, K. 2014. *Constructing Grounded Theory*, London, Sage.
- CHARON, R. 2001. Narrative medicine - A model for empathy, reflection, profession, and trust. *JAMA*, 286, 1897-1902.
- CHARON, R. 2010. Commentary: calculating the contributions of humanities to medical practice—motives, methods, and metrics. *Academic Medicine*, 85, 935-937.
- CHEN, D., LEW, R., HERSHMAN, W. & ORLANDER, J. 2007. A cross-sectional measurement of medical student empathy. *Journal of General Internal Medicine*, 22, 1434-1438.
- CHEN, D. C. R., PAHILAN, M. E. & ORLANDER, J. 2010. Comparing a Self-Administered Measure of Empathy with Observed Behavior Among Medical Students. *Journal of General Internal Medicine*, 25, 200-202.
- CHEN, Y.-Y., SHEK, D. T. & BU, F.-F. 2011. Applications of interpretive and constructionist research methods in adolescent research: philosophy, principles and examples. *International Journal of Adolescent Medicine and Health*, 23, 129-139.
- CHEW-GRAHAM, C. A., ROGERS, A. & YASSIN, N. 2003. 'I wouldn't want it on my CV or their records': medical students' experiences of help-seeking for mental health problems. *Medical Education*, 37, 873-880.
- CHOCHINOV, H. 2007. Dignity and the essence of medicine: the A, B, C, and D of dignity conserving care. *BMJ*, 335, 184-187.
- CHRISTAKIS, D. & FEUDTNER, C. 1997. Temporary matters: the ethical consequences of transient social relationships in medical training. *JAMA*, 278, 739-743.
- CLARK, A. J. 2010. Empathy: An integral model in the counseling process. *Journal of Counseling & Development*, 88, 348-356.
- CLELAND, J. 2015. Exploring versus measuring: considering the fundamental differences between qualitative and quantitative research. In: CLELAND, J. & DURNING, S. (eds.) *Researching Medical Education*. London: John Wiley & Sons Ltd.
- COLLIVER, J. A., CONLEE, M., VERHULST, S. J. & DORSEY, J. K. 2010. Reports of the Decline of Empathy During Medical Education Are Greatly Exaggerated: A Re-examination of the Research. *Academic Medicine*, 85, 588-593.

- CONRAD, P. 1988. Learning to doctor: Reflections on recent accounts of the medical school years. *Journal of Health and Social Behavior*, 29, 323-332.
- COOMBS, R. & POWERS, P. S. 1975. Socialization for Death: The Physician's Role. *Journal of Contemporary Ethnography*, 4, 250-271.
- COPLAN, A. & GOLDIE, P. (eds.) 2011. *Empathy: Philosophical and Psychological Perspectives*, Oxford: Oxford University Press.
- CORNWELL, J. & GOODRICH, J. 2009. Exploring how to enable compassionate care in hospital to improve patient experience. *Nursing Times*, 105, 14-21.
- COSTA, P., MAGALHAES, E. & COSTA, M. J. 2013. A latent growth model suggests that empathy of medical students does not decline over time. *Advances in Health Sciences Education*, 18, 509-522.
- COULEHAN, J. 2005. Today's Professionalism: Engaging the Mind but Not the Heart. *Academic Medicine*, 80, 892-898.
- COULEHAN, J. 2009. Compassionate solidarity: suffering, poetry, and medicine. *Perspectives in Biology and Medicine*, 52, 585-603.
- COULEHAN, J. & WILLIAMS, P. 2003. Conflicting professional values in medical education. *Cambridge Quarterly of Healthcare Ethics*, 12, 7-20.
- COULEHAN, J. & WILLIAMS, P. C. 2001. Vanquishing virtue: The impact of medical education. *Academic Medicine*, 76, 598-605.
- COULEHAN, J. L. 1995. Tenderness and steadiness: emotions in medical practice. *Literature and Medicine*, 14, 222-236.
- COULEHAN, J. L., PLATT, F. W., EGENER, B., FRANKEL, R., LIN, C.-T., LOWN, B. & SALAZAR, W. H. 2001. "Let me see if I have this right...": words that help build empathy. *Annals of Internal Medicine*, 135, 221-227.
- COULTER, A. 2002. Patients' views of the good doctor. *BMJ*, 325, 668-669.
- CRIBB, A. & BIGNOLD, S. 1999. Towards the reflexive medical school: the hidden curriculum and medical education research. *Studies in Higher Education*, 24, 195-209.
- CROTTY, M. 1998. *The Foundations of Social Research: Meaning and Perspective in the Research Process*, London, Sage.
- CRUESS, R. L., CRUESS, S. R., BOUDREAU, J. D., SNELL, L. & STEINERT, Y. 2014. Reframing medical education to support professional identity formation. *Academic Medicine*, 89, 1446-1451.
- CRUESS, S. R., CRUESS, R. L. & STEINERT, Y. 2008. Role modelling—making the most of a powerful teaching strategy. *BMJ*, 336, 718-721.
- CUMMINGS, J. & BENNETT, V. 2012. *Compassion in practice: Nursing, midwifery and care staff: Our vision and strategy*. London NHS England.

- CURRY, S. E., CORTLAND, C. I. & GRAHAM, M. J. 2011. Role-modelling in the operating room: medical student observations of exemplary behaviour. *Medical Education*, 45, 946-957.
- CUTLER, J., HARDING, K., MOZIAN, S., WRIGHT, L. L., PICA, A. G., MASTERS, S. & GRAHAM, M. J. 2009. Discrediting the notion "working with 'crazies' will make you 'crazy'": addressing stigma and enhancing empathy in medical student education. *Advances in Health Sciences Education*, 14, 487-502.
- DASGUPTA, S. & CHARON, R. 2004. Personal illness narratives: Using reflective writing to teach empathy. *Academic Medicine*, 79, 351-356.
- DAVIES, N. 2014. Empathic nursing: going the extra mile. *Practice Nursing*, 25, 198-202.
- DAVIS, C. M. 1990. What is empathy, and can empathy be taught? *Physical Therapy*, 70, 707-711.
- DAVIS, F. 1968. Professional socialization as subjective experience: The process of doctrinal conversion among student nurses. In: BECKER HS, GEERB, REISMAN D & RS., W. (eds.) *Institutions and the Person*. Chicago: Aldine.
- DE ZULUETA, P. 2013a. Compassion in 21st century medicine: Is it sustainable? *Clinical Ethics*, 8, 119-128.
- DE ZULUETA, P. 2013b. Responding to the Francis Report Some simple but radical suggestions. *Journal of Holistic Healthcare*, 10, 20-22.
- DECETY J 2011. *Empathy: From Bench to Bedside*, Cambridge, Massachusetts., MIT Press.
- DECETY, J. & FOTOPOULOU, A. 2014. Why empathy has a beneficial impact on others in medicine: unifying theories. *Frontiers in Behavioral Neuroscience*, 8, 1-11.
- DECETY, J. & ICKES, W. 2011. *The Social Neuroscience of Empathy*, Cambridge , Massachusetts., MIT Press.
- DECETY, J. & LAMM, C. 2011. Empathy versus Personal Distress: Recent Evidence from Social Neuroscience. In: DECETY, J. & ICKES, W. (eds.) *The Social Neuroscience of Empathy*. Cambridge, Massachusetts: MIT Press.
- DECETY, J. & MEYER, M. 2008. From emotion resonance to empathic understanding: A social developmental neuroscience account. *Development and Psychopathology*, 20, 1053-1080.
- DECETY, J., YANG, C.-Y. & CHENG, Y. 2010. Physicians down-regulate their pain empathy response: an event-related brain potential study. *Neuroimage*, 50, 1676-1682.
- DEL CANALE, S., LOUIS, D., MAIO, V., WANG, X., ROSSI, G., HOJAT, M. & GONNELLA, J. S. 2012. The Relationship Between Physician Empathy and Disease Complications: An Empirical Study of Primary Care Physicians

- and Their Diabetic Patients in Parma, Italy. *Academic Medicine*, 87, 1243-1249.
- DERKSEN, F., BENSING, J. & LAGRO-JANSSEN, A. 2013. Effectiveness of empathy in general practice: a systematic review. *British Journal General Practice*, 63, 76-84.
- DI BLASI, Z., HARKNESS, E., ERNST, E., GEORGIU, A. & KLEIJNEN, J. 2001. Influence of context effects on health outcomes: a systematic review. *The Lancet*, 357, 757-762.
- DILALLA, L. F., HULL, S. K. & DORSEY, J. K. 2004. Effect of gender, age, and relevant course work on attitudes toward empathy, patient spirituality, and physician wellness. *Teaching and Learning in Medicine*, 16, 165-170.
- DYRBYE, L. N., THOMAS, M. R., POWER, D. V., DURNING, S., MOUTIER, C., MASSIE, F. S., JR., HARPER, W., EACKER, A., SZYDLO, D. W., SLOAN, J. A. & SHANAFELT, T. D. 2010. Burnout and Serious Thoughts of Dropping Out of Medical School: A Multi-Institutional Study. *Academic Medicine*, 85, 94-102.
- DYRBYE, L. N., THOMAS, M. R. & SHANAFELT, T. D. 2005. Medical student distress: causes, consequences and proposed solutions. *Mayo Clinic Proceedings*, 80, 1613-1622.
- EGNEW, T. R. & WILSON, H. J. 2010. Faculty and medical students' perceptions of teaching and learning about the doctor-patient relationship. *Patient Education and Counseling*, 79, 199-206.
- EIKELAND, H. L., ORNES, K., FINSET, A. & PEDERSEN, R. 2014. The physician's role and empathy - a qualitative study of third year medical students. *BMC Medical Education*, 14, 165-173.
- EKMAN, E. & HALPERN, J. 2015. Professional distress and meaning in health care: Why professional empathy can help. *Social Work in Health Care*, 54, 633-650.
- EKMAN, E. & KRASNER, M. 2016. Empathy in medicine: Neuroscience, education and challenges. *Medical Teacher*, 39, 164-173.
- ELDER, A. & VERGHESE, A. 2015. Bedside matters-putting the patient at the centre of teaching and learning. *JR Coll Physicians Edinb.*, 45, 186-187.
- ENGEL, G. L. 1978. The biopsychosocial model and the education of health professionals. *Annals of the New York Academy of Sciences*, 310, 169-181.
- ENGEL GL 1977. The need of a new medical model: a challenge for biomedicine. *Science*, 196, 129-36.
- EPSTEIN, R. M. 2014. Realizing Engel's biopsychosocial vision: resilience, compassion, and quality of care. *The International Journal of Psychiatry in Medicine*, 47, 275-287.

- EVANS, B., STANLEY, R. & BURROWS, G. 1993. Measuring medical students' empathy skills. *British Journal of Medical Psychology*, 66, 121-133.
- EVANS, M. 2012. Feeling my way: emotions and empathy in geographic research with fathers in Valparaíso, Chile. *Area*, 44, 503-509.
- FERREIRA-VALENTE, A., MONTEIRO, J. S., BARBOSA, R., SALGUEIRA, A., COSTA, P. & COSTA, M. J. 2016. Clarifying changes in student empathy throughout medical school: a scoping review. *Advances in Health Sciences Education*, 22, 1-21.
- FEUDTNER, C., CHRISTAKIS, D. A. & CHRISTAKIS, N. A. 1994. Do clinical clerks suffer ethical erosion? Students' perceptions of their ethical environment and personal development. *Academic Medicine*, 69, 670-9.
- FINFGELD-CONNETT, D. & JOHNSON, E. D. 2013. Literature search strategies for conducting knowledge-building and theory-generating qualitative systematic reviews. *Journal of Advanced Nursing*, 69, 194-204.
- FINLAY, L. 2008. A Dance Between the Reduction and Reflexivity: Explicating the "Phenomenological Psychological Attitude". *Journal of Phenomenological Psychology*, 39, 1-32.
- FINLAY, L. 2009. Debating Phenomenological Research Methods. *Phenomenology & Practice*, 3, 6-25.
- FINLAY, L. 2011. *Phenomenology for therapists: Researching the lived world*, Chichester, John Wiley & Sons.
- FINLAY, L. 2013. Unfolding the phenomenological research process: Iterative stages of "seeing afresh". *Journal of Humanistic Psychology*, 53, 172-201.
- FINLAY, L. & GOUGH, B. 2008. *Reflexivity: A practical guide for researchers in health and social sciences*, Chichester, John Wiley & Sons.
- FIRTH-COZENS, J. 2001. Medical student stress. *Medical Education*, 35, 6-7.
- FITZGERALD, N. M., HEYWOOD, S., BIKKER, A. P. & MERCER, S. W. 2014. Enhancing empathy in healthcare: mixed-method evaluation of a pilot project implementing the CARE Approach in primary and community care settings in Scotland. *Journal of Compassionate Health Care*, 1, 1.
- FLEMMING, K. & BRIGGS, M. 2007. Electronic searching to locate qualitative research: evaluation of three strategies. *Journal of Advanced Nursing*, 57, 95-100.
- FLYVBJERG, B. 2006. Five misunderstandings about case-study research. *Qualitative Inquiry*, 12, 219-245.
- FORRESTER, M. A. 2010. *Doing qualitative research in psychology: A practical guide*, London, Sage.
- FOSTER, W. & FREEMAN, E. 2008. Poetry in general practice education: perceptions of learners. *Family Practice*, 25, 294-303.

- FOX, R. 1957. Training for uncertainty. *In: MERTON, P., READER, G. & KENDALL, P. (eds.) The Student Physician.* Cambridge, Massachusetts: Harvard University Press.
- FOX R & LIEF H 1963. Training for "Detached Concern". *In: LIEF, H. (ed.) The Psychological Basis of Medical Practice.* New York: Harper Row.
- FRANCIS, R. 2010. The Independent Inquiry into Care Provided by Mid-Staffordshire NHS Foundation Trust, January 2005-March 2009. London: HMSO.
- FRANCIS, R. 2013. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary*, London, HMSO.
- FRANK, A. 2004. *The Renewal of Generosity*, Chicago, University of Chicago Press.
- FRITH, C. & FRITH, U. 1999. Interactive minds-A biological basis *Science*, 286, 1692-1695.
- FROST, H. D. & REGEHR, G. 2013. "I am a doctor": negotiating the discourses of standardization and diversity in professional identity construction. *Academic Medicine*, 88, 1570-1577.
- GADAMER, H. 1990/1960. *Truth and Method*, New York, Crossroad.
- GALLAGHER, S. 2012. Empathy, simulation, and narrative. *Science in context*, 25, 355-381.
- GARDEN, R. 2009. Expanding Clinical Empathy: An Activist Perspective. *Journal of General Internal Medicine*, 24, 122-125.
- GELHAUS, P. 2012. The desired moral attitude of the physician:(I) empathy. *Medicine, Health Care and Philosophy*, 15, 103-113.
- GENERAL MEDICAL COUNCIL 2009. Tomorrow's Doctors: Outcomes and standards for undergraduate medical education. London: General Medical Council.
- GENERAL MEDICAL COUNCIL 2013. Good Medical Practice. London: General Medical Council.
- GENERAL MEDICAL COUNCIL 2015. Outcomes for graduates (Tomorrow's Doctors). London: General Medical Council.
- GENERAL MEDICAL COUNCIL. 2013. Doctors' Use of Social Media. London: General Medical Council.
- GENN, J. 2001a. AMEE Medical Education Guide No. 23 (Part 1): Curriculum, environment, climate, quality and change in medical education—a unifying perspective. *Medical Teacher*, 23, 337-344.
- GENN, J. 2001b. AMEE Medical Education Guide No. 23 (Part 2): Curriculum, environment, climate, quality and change in medical education—a unifying perspective. *Medical Teacher*, 23, 445-454.

- GEORGI, E., PETERMANN, F. & SCHIPPER, M. 2014. Are empathic abilities learnable? Implications for social neuroscientific research from psychometric assessments. *Social Neuroscience*, 9, 74-81.
- GERDES, K. 2011. Empathy, sympathy, and pity: 21st-century definitions and implications for practice and research. *Journal of Social Service Research*, 37, 230-241.
- GILLIES, J. & SHEEHAN, M. 2005. Perceptual capacity and the good GP: invisible, yet indispensable for quality of care. *British Journal of General Practice*, 55, 974-977.
- GILLIGAN, C. 1982. *In a Different Voice: Psychological Theory and Womens' Development*, Cambridge, Harvard University Press.
- GIRGIS, A. & SANSON-FISHER, R. W. 1995. Breaking bad news: consensus guidelines for medical practitioners. *Journal of Clinical Oncology*, 13, 2449-2456.
- GLASER, K. M., MARKHAM, F. W., ADLER, H. M., MCMANUS, P. & HOJAT, M. 2007. Relationships between scores on the Jefferson Scale of physician empathy, patient perceptions of physician empathy, and humanistic approaches to patient care: a validity study. *Medical Science Monitor*, 13, 291-294.
- GLEICHGERRCHT, E. & DECETY, J. 2013. Empathy in Clinical Practice: How Individual Dispositions, Gender, and Experience Moderate Empathic Concern, Burnout, and Emotional Distress in Physicians. *PloS One* [Online], 8. Available: <http://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0061526&type=printable> [Accessed 29th January 2018].
- GLEICHGERRCHT, E. & DECETY, J. 2014. The relationship between different facets of empathy, pain perception and compassion fatigue among physicians. *Frontiers in Behavioral Neuroscience*, 8, 1-9.
- GOLDACRE, M. J., TURNER, G. & LAMBERT, T. W. 2004. Variation by medical school in career choices of UK graduates of 1999 and 2000. *Medical Education*, 38, 249-258.
- GOLEMAN, D. 1996. *Emotional Intelligence: Why can it matter more than IQ?*, London, Bloomsbury.
- GOOD, M. J. D. & GOOD, B. J. 1989. Disabling Practitioners - Hazards of Learning to be a Doctor in American Medical Education. *American Journal of Orthopsychiatry*, 59, 303-309.
- GOODRICH, J. 2012. Supporting hospital staff to provide compassionate care: Do Schwartz Center Rounds work in English hospitals? *Journal of the Royal Society of Medicine*, 105, 117-122.

- GORDON, L. 1995. Mental health of medical students: the culture of objectivity in medicine. *The Pharos of Alpha Omega Alpha-Honor Medical Society.* , 59, 2-10.
- GRAY, D. 2013. *Doing Research in the Real World*, London, Sage.
- GREENHALGH, T., HOWICK, J. & MASKREY, N. 2014. Evidence based medicine: a movement in crisis? *BMJ*, 348, g3725.
- GREENSON, R. 1960. Empathy and its vicissitudes. *The International Journal of Psycho-Analysis*, 41, 418.
- GRISWOLD, K., ZAYAS, L., KERNAN, J. B. & WAGNER, C. M. 2007. Cultural awareness through medical student and refugee patient encounters. *Journal of Immigrant and Minority Health*, 9, 55-60.
- GROSS, J. J. & THOMPSON, R. A. 2007. Emotion regulation: Conceptual foundations. In: GROSS, J. (ed.) *Handbook of emotion regulation*. New York: Guilford Press.
- HAAS, J. & SHAFFIR, W. 1977. The Professionalization of Medical Students: Developing Competence and a Cloak of Competence. *Symbolic Interaction*, 1, 71-88.
- HAAS, J. & SHAFFIR, W. 1987. *Becoming Doctors: The Adoption of a Cloak of Competence*, Greenwich, Conn., JAI Press
- HAFFERTY, F. W. 1998. Beyond curriculum reform: confronting medicine's hidden curriculum. *Academic Medicine*, 73, 403-7.
- HAFFERTY, F. W. & CASTELLANI, B. 2011. Two Cultures: Two Ships: The Rise of a Professionalism Movement within Modern Medicine and Medical Sociology's Disappearance from the Professionalism Debate. In: PESCOLIDIO, B. (ed.) *Handbook of the Sociology of Health, Illness, and Healing: A Blueprint for the 21st Century*. New York: Springer.
- HAIG, A. & DOZIER, M. 2003. BEME guide no. 3: systematic searching for evidence in medical education--part 2: constructing searches. *Medical Teacher*, 25, 463-484.
- HÅKANSSON, J. & MONTGOMERY, H. 2003. Empathy as an interpersonal phenomenon. *Journal of Social and Personal Relationships*, 20, 267-284.
- HALLING, S. 2007. *Intimacy, Transcendence, and Psychology: Closeness and Openness in Everyday Life*, Basingstoke, Palgrave Macmillan.
- HALPERN, J. 2001. *From Detached Concern to Empathy: Humanizing Medical Practice.*, Oxford, Oxford University Press.
- HALPERN, J. 2003. What is clinical empathy? *Journal of General Internal Medicine*, 18, 670-674.
- HALPERN, J. 2007. Empathy and patient-physician conflicts. *Journal of General Internal Medicine*, 22, 696-700.

- HALPERN, J. 2012. Gathering the patient's story and clinical empathy. *The Permanente Journal*, 16, 1.
- HALPERN, J. 2014. From idealized clinical empathy to empathic communication in medical care. *Medicine, Health Care and Philosophy*, 17, 301-311.
- HARDY, C. 2017. Empathizing with patients: the role of interaction and narratives in providing better patient care. *Medicine, Healthcare and Philosophy*, 20, 237-248.
- HARRISON, R. L. & WESTWOOD, M. J. 2009. Preventing vicarious traumatization of mental health therapists: Identifying protective practices. *Psychotherapy: Theory, Research, Practice, Training*, 46, 203.
- HASLAM, D. 2015. More than kindness. *Journal of Compassionate Health Care*, 2, 6-9.
- HEAD, B. A., EARNSHAW, L. A., GREENBERG, R. B., MOREHEAD, R. C., PFEIFER, M. P. & SHAW, M. A. 2012. "I will never forget": What we learned from medical student reflections on a palliative care experience. *Journal of Palliative Medicine*, 15, 535-541.
- HEGAZI, I. & WILSON, I. 2013. Maintaining empathy in medical school: It is possible. *Medical Teacher*, 35, 1002-1008.
- HEIDEGGER, M. 1962/1927. *Being and Time* Oxford, Blackwell.
- HEMMERDINGER, J. M., STODDART, S. D. R. & LILFORD, R. J. 2007. A systematic review of tests of empathy in medicine. *BMC Medical Education*, 7, 24-24.
- HEYHOE, J., BIRKS, Y., HARRISON, R., O'HARA, J. K., CRACKNELL, A. & LAWTON, R. 2016. The role of emotion in patient safety: Are we brave enough to scratch beneath the surface? *Journal of the Royal Society of Medicine*, 109, 52-58.
- HICKS, L. K., LIN, Y., ROBERTSON, D. W., ROBINSON, D. L. & WOODROW, S. I. 2001. Understanding the clinical dilemmas that shape medical students' ethical development: questionnaire survey and focus group study. *BMJ*, 322, 709-710.
- HILFIKER, D. 2001. From the victim's point of view. *Journal of Medical Humanities*, 22, 255-263.
- HILTON, S. & SOUTHGATE, L. 2007. Professionalism in medical education. *Teaching and Teacher Education*, 23, 265-279.
- HINZE, S. W. 1999. Gender and the body of medicine or at least some body parts:(Re) constructing the prestige hierarchy of medical specialties. *The Sociological Quarterly*, 40, 217-239.
- HITCHINGS, R. 2012. People can talk about their practices. *Area*, 44, 61-67.
- HOFFMAN, M. 2000. *Empathy and Moral development: Implications for Caring and Justice*, Cambridge, Cambridge University Press.

- HOJAT, M. 2007. *Empathy in Patient Care: Antecedents, Development, Measurement, and Outcomes*, New York, Springer.
- HOJAT, M. 2016. *Empathy in Health Profession Education and Primary Care*, New York, Springer.
- HOJAT, M., LOUIS, D. Z., MARKHAM, F. W., WENDER, R., RABINOWITZ, C. & GONNELLA, J. 2011. Physicians' empathy and clinical outcomes for diabetic patients. *Academic Medicine*, 86, 359-364.
- HOJAT, M., MANGIONE, S., NASCA, T. J., COHEN, M. J. M., GONNELLA, J. S., ERDMANN, J. B., VELOSKI, J. & MAGEE, M. 2001. The Jefferson Scale of Physician Empathy: Development and preliminary psychometric data. *Educational and Psychological Measurement*, 61, 349-365.
- HOJAT, M., MANGIONE, S., NASCA, T. J., RATTNER, S., ERDMANN, J. B., GONNELLA, J. S. & MAGEE, M. 2004. An empirical study of decline in empathy in medical school. *Medical Education*, 38, 934-941.
- HOJAT, M., VERGARE, M. J., MAXWELL, K., BRAINARD, G., HERRINE, S. K., ISENBERG, G. A., VELOSKI, J. & GONNELLA, J. S. 2009. The Devil is in the Third Year: A Longitudinal Study of Erosion of Empathy in Medical School. *Academic Medicine*, 84, 1182-1191.
- HOJAT, M., ZUCKERMAN, M., MAGEE, M., MANGIONE, S., NASCA, T., VERGARE, M. & GONNELLA, J. S. 2005. Empathy in medical students as related to specialty interest, personality, and perceptions of mother and father. *Personality and Individual Differences*, 39, 1205-1215.
- HOLLAN, D. 2008. Being there: On the imaginative aspects of understanding others and being understood. *Ethos*, 36, 475-489.
- HOLLAND, J., THOMSON, R. & HENDERSON, S. 2006. *Qualitative Longitudinal Research: A Discussion Paper*, London, South Bank University.
- HOLLOWAY, I. & TODRES, L. 2003. The status of method: flexibility, consistency and coherence. *Qualitative research*, 3, 345-357.
- HONG, M., LEE, W. H., PARK, J. H., YOON, T. Y., MOON, D. S., LEE, S. M. & BAHN, G. H. 2012. Changes of empathy in medical college and medical school students: 1-year follow up study. *BMC Medical Education*, 12, 122-127.
- HOOKER, C. 2015. Understanding empathy: why phenomenology and hermeneutics can help medical education and practice. *Medicine, Health Care and Philosophy*, 18, 541-552.
- HOPKINS, R. M., REGEHR, G. & PRATT, D. D. 2017. A framework for negotiating positionality in phenomenological research. *Medical Teacher*, 39, 20-25.
- HOWE, A., SMAJDOR, A. & STÖCKL, A. 2012. Towards an understanding of resilience and its relevance to medical training. *Medical Education*, 46, 349-356.

- HOWICK, J. & REES, S. 2017. Overthrowing barriers to empathy in healthcare: empathy in the age of the internet. *Journal of the Royal Society of Medicine*, 1-6.
- HOWICK, J., STEINKOPF, L., ULYTE, A., ROBERTS, N. & MEISSNER, K. 2017. How empathic is your healthcare practitioner? A systematic review and meta-analysis of patient surveys. *BMC Medical Education*, 17, 136-145.
- HUSSERL, E. 1989. *Ideas Pertaining to a Pure Phenomenology and to a Phenomenological Philosophy. Second Book: Studies in the Phenomenology of constitution.*, Dordrecht, Kluwer Academic Publishers.
- HUSSERL, E. 2012. *Ideas: General introduction to pure phenomenology*, London, Routledge.
- IMMORDINO-YANG, M. H. & DAMASIO, A. 2007. We feel, therefore we learn: The relevance of affective and social neuroscience to education. *Mind, Brain, and Education*, 1, 3-10.
- IRVING, P. & DICKSON, D. 2004. Empathy: towards a conceptual framework for health professionals. *International Journal of Health Care Quality Assurance*, 17, 212-220.
- ISEN, A. M., ROSENZWEIG, A. S. & YOUNG, M. J. 1991. The influence of positive affect on clinical problem solving. *Medical Decision Making*, 11, 221-227.
- JACKSON, P., EUGÈNE, F. & TREMBLAY, M.-P. B. 2015. Improving empathy in the care of pain patients. *AJOB Neuroscience*, 6, 25-33.
- JACKSON, V., MACK, J., MATSUYAMA, R., LAKOMA, M. D., SULLIVAN, A. M., ARNOLD, R., WEEKS, J. C. & BLOCK, S. 2008. A qualitative study of oncologists' approaches to end-of-life care. *Journal of Palliative Medicine*, 11, 893-906.
- JAMISON, L. 2014. *The Empathy Exams*, London, Granta.
- JANSSEN, A. L. & MACLEOD, R. D. 2010. What can people approaching death teach us about how to care? *Patient Education and Counseling*, 81, 251-256.
- JANSSEN, A. L., MACLEOD, R. D. & WALKER, S. T. 2008. Recognition, reflection, and role models: critical elements in education about care in medicine. *Palliative & Supportive Care*, 6, 389-95.
- JEFFREY, D. 2000. *Cancer: from Cure to Care*, Manchester, Hochland and Hochland.
- JEFFREY, D. 2014. *Medical Mentoring: Supporting Students, Doctors in Training and General Practitioners*, London, Royal College of General Practitioners.
- JEFFREY, D. 2016a. Clarifying empathy: the first step to more humane clinical care. *British Journal of General Practice*, 66, 101-102.
- JEFFREY, D. 2016b. A duty of kindness. *Journal of the Royal Society of Medicine*, 109, 261-263.

- JEFFREY, D. 2016c. Empathy, sympathy and compassion in healthcare: is there a problem? Is there a difference? Does it matter? *Journal Royal Society Medicine*, 109, 446-452.
- JEFFREY, D. 2016d. A meta-ethnography of interview-based qualitative research studies on medical students' views and experiences of empathy. *Medical Teacher*, 38, 1214-1220.
- JEFFREY, D. & DOWNIE, R. 2016. Empathy-Can it be taught? *J.R.Coll Physicians Edinb.*, 46, 107-112.
- JEFFREY, E. & JEFFREY, D. 2013. *Enhancing Compassion in End-of-Life Care Through Drama : The Silent Treatment*, London, Radcliffe Publishing.
- JENNINGS, M. 2009. Medical student burnout: Interdisciplinary exploration and analysis. *Journal of Medical Humanities*, 30, 253-269.
- JONES, A. M. 2010. Could kindness heal the NHS? *BMJ*, 340, 1363.
- KANG, J., DJAFARI MARBINI, H., PATEL, P., FAWCETT, N. & LEAVER, L. 2015. Survey of medical students' use of social media. *The Clinical Teacher*, 12, 373-377.
- KARAOGLU, N. & SEKER, M. 2011. Looking for winds of change with a PBL scenario about communication and empathy. *Healthmed*, 5, 515-521.
- KARNIELI-MILLER, O., STRIER, R. & PESSACH, L. 2009. Power relations in qualitative research. *Qualitative Health Research*, 19, 279-289.
- KARNIELI-MILLER, O., VU, T. R., FRANKEL, R. M., HOLTMAN, M. C., CLYMAN, S. G., HUI, S. L. & INUI, T. S. 2011. Which Experiences in the Hidden Curriculum Teach Students About Professionalism? *Academic Medicine*, 86, 369-377.
- KATAOKA, H., KOIDE, N., OCHI, K., HOJAT, M. & GONNELLA, J. S. 2009. Measurement of Empathy Among Japanese Medical Students: Psychometrics and Score Differences by Gender and Level of Medical Education. *Academic Medicine*, 84, 1192-1197.
- KEARNEY MK, WEININGER RB, VACHON MLS, HARRISON RL & BM., M. 2009. Self-care of Physicians caring for Patients at the end of Life "Being Connected....A Key to Survival". *JAMA*, 301, 1155-1164.
- KELLEY, J. M., KRAFT-TODD, G., SCHAPIRA, L., KOSSOWSKY, J. & RIESS, H. 2014. The influence of the patient-clinician relationship on healthcare outcomes: a systematic review and meta-analysis of randomized controlled trials. *PloS One*, 9, e94207.
- KELLY, J. 2017. When I say...empathy. *Medical Education*, 51, 573-574.
- KELM, Z., WOMER, J., WALTER, J. & FEUDTNER, C. 2014. Interventions to cultivate physician empathy: a systematic review. *BMC Medical Education*, 14, 219-230.

- KERASIDOU, A. & HORN, R. 2016. Making space for empathy: supporting doctors in the emotional labour of clinical care. *BMC Medical Ethics*, 17, 8-13.
- KIM, S. S., KAPLOWITZ, S. & JOHNSTON, M. V. 2004. The effects of physician empathy on patient satisfaction and compliance. *Evaluation and the Health Professions*, 27, 237-251.
- KIOSSES, V. N., KARATHANOS, V. T. & TATSIONI, A. 2016. Empathy promoting interventions for health professionals: a systematic review of RCTs. *Journal of Compassionate Health Care*, 3, 7-29.
- KLISZCZ, J., HEBANOWSKI, M. & REMBOWSKI, J. 1998. Emotional and cognitive empathy in medical schools. *Academic Medicine*, 73, 541-541.
- KOHUT, H. 1977. *The restoration of the self*, New York, International Universities Press.
- KOHUT, H. 1984. *How Does Analysis Cure?*, Chicago, University of Chicago Press.
- KONRATH, S. H., O'BRIEN, E. H. & HSING, C. 2010. Changes in dispositional empathy in American college students over time: A meta-analysis. *Personality and Social Psychology Review*, 15, 180-198.
- KOZLOWSKI, D., HUTCHINSON, M., HURLEY, J., ROWLEY, J. & SUTHERLAND, J. 2017. The role of emotion in clinical decision making: an integrative literature review. *BMC Medical Education*, 17, 255-268.
- KRZYNARIC, R. 2014. *Empathy: A Handbook for Revolution*, London, Random House.
- KUMAGAI, A. K. & NAIDU, T. 2015. Reflection, dialogue, and the possibilities of space. *Academic Medicine*, 90, 283-288.
- KUPETZ, M. 2014. Empathy displays as interactional achievements—Multimodal and sequential aspects. *Journal of Pragmatics*, 61, 4-34.
- KVALE, S. & BRINKMANN, S. 2009. *Interviews: Learning the Craft of Qualitative Research Interviewing*, London, Sage.
- LANGDRIDGE, D. 2008. Phenomenology and critical social psychology: Directions and debates in theory and research. *Social and Personality Psychology Compass*, 2, 1126-1142.
- LANGEWITZ, W., DENZ, M., KELLER, A., KISS, A., RÜTIMANN, S. & WÖSSMER, B. 2002. Spontaneous talking time at start of consultation in outpatient clinic: cohort study. *BMJ*, 325, 682-683.
- LARKIN, M., WATTS, S. & CLIFTON, E. 2006. Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, 3, 102-120.
- LARSON, E. & YAO, X. 2005. Clinical empathy as emotional labor in the patient-physician relationship. *JAMA*, 293, 1100-1106.

- LEMPP, H. & SEALE, C. 2004. The hidden curriculum in undergraduate medical education: qualitative study of medical students' perceptions of teaching. *BMJ*, 329, 770-773.
- LEVENSON, R., DEWAR, S. & SHEPHERD, S. 2008. *Understanding Doctors*. London: The Royal College of Physicians, The King's Fund.
- LIM, B., MORIARTY, H. & HUTHWAITE, M. 2011. "Being-in-role": A teaching innovation to enhance empathic communication skills in medical students. *Medical Teacher*, 33, 663-669.
- LIM, B. T., MORIARTY, H., HUTHWAITE, M., GRAY, L., PULLON, S. & GALLAGHER, P. 2013. How well do medical students rate and communicate clinical empathy? *Medical Teacher*, 35, 946-951.
- LIPPS, T. 1903. *Asthetik*, Leipzig, Germany, Leopold Voss Verlag.
- LITTLE, P., EVERITT, H., WILLIAMSON, I., WARNER, G., MOORE, M., GOULD, C., FERRIER, K. & PAYNE, S. 2001. Preferences of patients for patient centred approach to consultation in primary care: observational study. *BMJ*, 322, 1-7.
- LITTLEWOOD, S., YPINAZAR, V., MARGOLIS, S. A., SCHERPBIER, A., SPENCER, J. & DORNAN, T. 2005. Early practical experience and the social responsiveness of clinical education: systematic review. *BMJ*, 331, 387-391.
- LUTZ, G., SCHEFFER, C., EDELHAEUSER, F., TAUSCHEL, D. & NEUMANN, M. 2013. A reflective practice intervention for professional development, reduced stress and improved patient care--a qualitative developmental evaluation. *Patient Education and Counseling*, 92, 337-45.
- MACINTYRE, A. 1985. *After Virtue*, London, Duckworth.
- MACNAUGHTON, J. 2009. The dangerous practice of empathy. *Lancet*, 373, 1940-1941.
- MADER, E. M., ROSEAMELIA, C. & MORLEY, C. P. 2014. The temporal decline of idealism in two cohorts of medical students at one institution. *BMC Medical Education*, 14, 58-69.
- MAGALHAES, E., SALGUEIRA, A. P., COSTA, P. & COSTA, M. J. 2011. Empathy in senior year and first year medical students: a cross-sectional study. *BMC Medical Education*, 11, 52-59.
- MAGUIRE, P., FAULKNER, A., BOOTH, K., ELLIOTT, C. & HILLIER, V. 1996. Helping cancer patients disclose their concerns. *European Journal of Cancer*, 32, 78-81.
- MAHONEY, S., SLADEK, R. & NEILD, T. 2016. A longitudinal study of empathy in pre-clinical and clinical medical students and clinical supervisors. *BMC Medical Education*, 16, 270-278.

- MAIN, A., WALLE, E. A., KHO, C. & HALPERN, J. 2017. The Interpersonal Functions of Empathy: A Relational Perspective. *Emotion Review*, 9, 358-366.
- MANN, K. & MACLEOD, A. 2015. Constructivism: learning theories and approaches to research. In: CLELAND, J. & DURNING, S. (eds.) *Researching Medical Education*. London: John Wiley & Sons.
- MANN, K. V. 2011. Theoretical perspectives in medical education: past experience and future possibilities. *Medical Education*, 45, 60-68.
- MARCUM, J. A. 2013. The Role of Empathy and Wisdom in Medical Practice and Pedagogy: Confronting the Hidden Curriculum. *Journal of Biomedical Education*, 2013, 1-8.
- MARSHALL, G. R. E. & HOOKER, C. 2016. Empathy and affect: what can empathied bodies do? *Medical Humanities*, 42, 128-134.
- MARSHALL, R. & BLEAKLEY, A. 2009. The death of Hector: pity in Homer, empathy in medical education. *Medical Humanities*, 35, 7-12.
- MARVEL, M. K., EPSTEIN, R. M., FLOWERS, K. & BECKMAN, H. B. 1999. Soliciting the patient's agenda: have we improved? *JAMA*, 281, 283-287.
- MASLACH, C., SCHAUFELI, W. B. & LEITER, M. 2001. Job burnout. *Annual Review of Psychology*, 52, 397-422.
- MASON, J. 2002. *Qualitative Researching* London, Sage
- MAXWELL, B. 2008. *Professional Ethics Education: Studies in Compassionate Empathy*, New York, Springer.
- MAYER, J. D., SALOVEY, P. & CARUSO, D. R. 2008. Emotional intelligence: new ability or eclectic traits? *American Psychologist*, 63, 503-517.
- MAYES, C. 2009. Pastoral power and the confessing subject in patient-centred communication. *Journal of Bioethical Inquiry*, 6, 483-493.
- MCLEOD, J. 2011. *Qualitative Research in Counselling and Psychotherapy* London, Sage.
- MCMILLAN, W. 2015. Theory in healthcare education research: the importance of worldview. In: CLELAND, J. & DURNING, S. (eds.) *Researching Medical Education*. London: John Wiley & Sons.
- MCNAUGHTON, N. 2013. Discourse (s) of emotion within medical education: the ever-present absence. *Medical Education*, 47, 71-79.
- MEIER, D. E., BACK, A. & MORRISON, R. 2001. The inner life of physicians and care of the seriously ill. *JAMA*, 286, 3007-3014.
- MEITAR, D., KARNIELI-MILLER, O. & EIDELMAN, S. 2009. The impact of senior medical students' personal difficulties on their communication patterns in breaking bad news. *Academic Medicine*, 84, 1582-1594.

- MERCER, S., MCCONNACHIE, A., MAXWELL, M., HEANEY, D. & WATT, G. 2005. Relevance and practical use of the Consultation and Relational Empathy (CARE) Measure in general practice. *Family Practice*, 22, 328-334.
- MERCER, S. W., MAXWELL, M., HEANEY, D. & WATT, G. C. 2004. The consultation and relational empathy (CARE) measure: development and preliminary validation and reliability of an empathy-based consultation process measure. *Family Practice*, 21, 699-705.
- MERCER, S. W. & REYNOLDS, W. J. 2002. Empathy and quality of care. *Br J Gen Pract*, 52, S9-S12.
- MERLEAU-PONTY, M. 1962. *Phenomenology of Perception*, London, Routledge.
- MERRIAM, S. 1998. *Qualitative Research and Case Study Applications in Education*. , San Francisco, Jossey-Bass.
- MERTON, R. K., READER, G. & KENDALL, P. L. 1957. *The Student Physician: Introductory studies in the sociology of medical education*, Cambridge, Mass., Harvard University Press.
- MICHALEC, B. 2011. Learning to cure, but learning to care? *Advances in Health Sciences Education*, 16, 109-130.
- MILES, M. B., HUBERMAN, A. M. & SALDANA, J. 2014. *Qualitative Data Analysis: A Methods Sourcebook*, London, Sage.
- MONROUXE, L. V. 2010. Identity, Identification and Medical Education: Why should we care? *Medical Education*, 44, 40-49.
- MONROUXE, L. V. & REES, C. E. 2012. "It's just a clash of cultures": Emotional talk within medical students' narratives of professionalism dilemmas. *Advances in Health Sciences Education*, 17, 671-701.
- MONROUXE, L. V., REES, C. E., ENDACOTT, R. & TERNAN, E. 2014. 'Even now it makes me angry': health care students' professionalism dilemma narratives. *Medical Education*, 48, 502-517.
- MONROUXE, L. V., REES, C. E. & HU, W. 2011. Differences in medical students' explicit discourses of professionalism: acting, representing, becoming. *Medical Education*, 45, 585-602.
- MONTGOMERY, K. 2006. *How Doctors Think: Clinical Judgment and the Practice of Medicine*, Oxford, Oxford University Press.
- MORAN , D. 2000. *Introduction to Phenomenology*, London, Routledge.
- MORLEY, C. P., ROSEAMELIA, C., SMITH, J. A. & VILLARREAL, A. L. 2013. Decline of medical student idealism in the first and second year of medical school: a survey of pre-clinical medical students at one institution. *Medical Education Online* [Online], 18. Available: <https://doi.org/10.3402/meo.v18i0.21194> [Accessed 29th January 2018].

- MORSE, J. M., ANDERSON, G., BOTTORFF, J. L., YONGE, O., O'BRIEN, B., SOLBERG, S. & MCILVEEN, K. 1992. Exploring empathy : a conceptual fit for nursing practice? *Image: The Journal of Nursing Scholarship*, 24, 273-280.
- MOSTAFA, A., HOQUE, R., MOSTAFA, M., RANA, M. M. & MOSTAFA, F. 2014. Empathy in undergraduate medical students of Bangladesh: psychometric analysis and differences by gender, academic year, and specialty preferences. *ISRN Psychiatry*, 2014, 1-8.
- MULLEN, K., NICOLSON, M. & COTTON, P. 2010. Improving medical students' attitudes towards the chronic sick: a role for social science research. *BMC Medical Education*, 10, 84-91.
- MURRAY, S. A., KENDALL, M., CARDUFF, E., WORTH, A., HARRIS, F. M., LLOYD, A., CAVERS, D., GRANT, L. & SHEIKH, A. 2009. Use of serial qualitative interviews to understand patients' evolving experiences and needs. *BMJ*, 339, b3702.
- NATIONAL STUDENT SURVEY. 2017 National Student Survey 2017. *Times Higher Education Supplement* [Online]. Available: <https://www.timeshighereducation.com/student/news/national-student-survey-2017-overall-satisfaction-results>
[Accessed 27.12.17].
- NEALE, B. & FLOWERDEW, J. 2003. Time, texture and childhood: the contours of longitudinal qualitative research. *International Journal of Social Research Methodology*, 6, 189-199.
- NEUMANN, M., EDELHAEUSER, F., TAUSCHEL, D., FISCHER, M. R., WIRTZ, M., WOOPEN, C., HARAMATI, A. & SCHEFFER, C. 2011. Empathy Decline and Its Reasons: A Systematic Review of Studies With Medical Students and Residents. *Academic Medicine*, 86, 996-1009.
- NEUMANN, M., SCHEFFER, C., TAUSCHEL, D., LUTZ, G., WIRTZ, M. & EDELHAUSER, F. 2012. Physician empathy: definition, outcome-relevance and its measurement in patient care and medical education. *GMS Zeitschrift für medizinische Ausbildung*, 29, 1-21.
- NEUMANN, M., WIRTZ, M., BOLLSCHWEILER, E., MERCER, S., WARM, M., WOLF, J. & PFAFF, H. 2007. Determinants and patient-reported long-term outcomes of physician empathy in oncology: A structural equation modelling approach. *Patient Education and Counseling*, 69, 63-75.
- NEWTON, B., BARBER, L., CLARDY, J., CLEVELAND, E. & O'SULLIVAN, P. 2008. Is There Hardening of the Heart During Medical School? *Academic Medicine*, 83, 244-249.
- NIELSEN, H. & TULINIUS, C. 2009. Preventing burnout among general practitioners: is there a possible route? *Education for Primary Care*, 20, 353-359.

- NODDINGS N 1984. *Caring : A Feminine Approach to Ethics and Moral Education* Berkeley CA, University of California Press.
- NOGUEIRA-MARTINS, M. C. F., NOGUEIRA-MARTINS, L. A. & TURATO, E. R. 2006. Medical students' perceptions of their learning about the doctor-patient relationship: a qualitative study. *Medical Education*, 40, 322-328.
- NORFOLK, T., BIRDI, K. & WALSH, D. 2007. The role of empathy in establishing rapport in the consultation: a new model. *Medical Education*, 41, 690-697.
- O'BRIEN, E., KONRATH, S. H., GRÜHN, D. & HAGEN, A. L. 2012. Empathic concern and perspective taking: Linear and quadratic effects of age across the adult life span. *Journals of Gerontology Series B*, 68, 168-175.
- OHM, F., VOGEL, D., SEHNER, S., WIJNEN-MEIJER, M. & HARENDZA, S. 2013. Details acquired from medical history and patients' experience of empathy--two sides of the same coin. *BMC Medical Education*, 13, 67-74.
- OSLER, W. 1963. *Aequanimitas*, New York, Nortop.
- OZBAY, F., JOHNSON, D. C., DIMOULAS, E., MORGAN III, C., CHARNEY, D. & SOUTHWICK, S. 2007. Social support and resilience to stress: from neurobiology to clinical practice. *Psychiatry*, 4, 35.
- PALEY, J. 2017. *Phenomenology as Qualitative Research: A critical analysis of meaning attribution*, London Taylor & Francis.
- PARLIAMENTARY HEALTH SERVICE OMBUDSMAN 2011. Care and Compassion? : Report of the Health Service Ombudsman on Ten Investigations Into NHS Care of Older People. London: HMSO.
- PARO, H. M. S., SILVEIRA, P. S. P., PEROTTA, B., GANNAM, S., ENNS, S. C., GIAXA, R. R. B., BONITO, R. F., MARTINS, M. A. & TEMPSKI, P. Z. 2014. Empathy among Medical Students: Is There a Relation with Quality of Life and Burnout? *PloS One*, 9, e94133-e94133.
- PASSI, V., JOHNSON, S., PEILE, E., WRIGHT, S., HAFFERTY, F. & JOHNSON, N. 2013. Doctor role modelling in medical education: BEME Guide No. 27. *Medical Teacher*, 35, e1422-e1436.
- PEDERSEN, R. 2008. Empathy: A wolf in sheep's clothing? *Medicine, Health Care and Philosophy*, 11, 325-335.
- PEDERSEN, R. 2009. Empirical research on empathy in medicine-A critical review. *Patient Education and Counseling*, 76, 307-322.
- PEDERSEN, R. 2010. Empathy development in medical education - A critical review. *Medical Teacher*, 32, 593-600.
- PERRELLA, A. 2016. Fool me once: The illusion of empathy in interactions with standardized patients. *Medical Teacher*, 38, 1285-1287.
- PERRY, W. 1968. *Forms of Intellectual and Ethical Development in the College Years* New York, Holt, Rinehart and Winston Inc.

- PHILIPS, A. & TAYLOR, B. 2009. *On Kindness*, London, Hamish Hamilton.
- PICKARD, M., BATES, L., DORIAN, M., GREIG, H. & SAINT, D. 2000. Alcohol and drug use in second-year medical students at the University of Leeds. *Medical Education*, 34, 148-150.
- PILE, S. 1991. Practising interpretative geography. *Transactions of the Institute of British Geographers*, 16, 458-469.
- PRICE, S., MERCER, S. & MACPHERSON, H. 2006. Practitioner empathy, patient enablement and health outcomes: a prospective study of acupuncture patients. *Patient Education and Counseling*, 63, 239-245.
- QUINCE, T., THIEMANN, P., BENSON, J. & HYDE, S. 2016a. Undergraduate medical students' empathy: current perspectives. *Advances in Medical Education and Practice*, 7, 443-455.
- QUINCE, T. A., KINNERSLEY, P., HALES, J., DA SILVA, A., MORIARTY, H., THIEMANN, P., HYDE, S., BRIMICOMBE, J., WOOD, D. & BARCLAY, M. 2016b. Empathy among undergraduate medical students: A multi-centre cross-sectional comparison of students beginning and approaching the end of their course. *BMC Medical Education*, 16, 92-102.
- QUINCE, T. A., PARKER, R. A., WOOD, D. & BENSON, J. A. 2011. Stability of empathy among undergraduate medical students: A longitudinal study at one UK medical school. *BMC Medical Education*, 11, 90-99.
- RAHIMI-MADISEH, M., TAVAKOL, M., DENNICK, R. & NASIRI, J. 2010. Empathy in Iranian medical students: A preliminary psychometric analysis and differences by gender and year of medical school. *Medical Teacher*, 32, 471-8.
- RAKEL, D. P., HOEFT, T. J., BARRETT, B. P., CHEWNING, B. A., CRAIG, B. M. & NIU, M. 2009. Practitioner empathy and the duration of the common cold. *Family Medicine*, 41, 494-501.
- RAMESH, A. 2013. A call for reflection: Medical student driven effort to foster empathy and compassion. *Medical Teacher*, 35, 69-70.
- RATANAWONGSA, N., TEHERANI, A. & HAUER, K. E. 2005. Third-year medical students' experiences with dying patients during the internal medicine clerkship: A qualitative study of the informal curriculum. *Academic Medicine*, 80, 641-647.
- REBLIN, M. & UCHINO, B. N. 2008. Social and emotional support and its implication for health. *Current Opinion in Psychiatry*, 21, 201-205.
- REES, C. E. & KNIGHT, L. V. 2007. The trouble with assessing students' professionalism: theoretical insights from sociocognitive psychology. *Academic Medicine*, 82, 46-50.
- REES, C. E. & MONROUXE, L. V. 2011. "A morning since eight of just pure grill": a multischool qualitative study of student abuse. *Academic Medicine*, 86, 1374-1382.

- REES, C. E., MONROUXE, L. V. & MCDONALD, L. A. 2013. Narrative, emotion and action: analysing 'most memorable' professionalism dilemmas. *Medical Education*, 47, 80-96.
- REEVES, S., ALBERT, M., KUPER, A. & HODGES, B. D. 2008. Why use theories in qualitative research. *BMJ*, 337, 631-634.
- RICOEUR, P. 1970. *Freud and Philosophy: An essay on Interpretation*, New Haven, Yale University Press.
- RICOEUR, P. 1992. *Oneself as Another*, Chicago, University of Chicago Press.
- RICOEUR, P. 1996. *Lectures on ideology and utopia*, New York, Columbia University Press.
- RIESS, H. 2015. The impact of clinical empathy on patients and clinicians: understanding empathy's side effects. *AJOB Neuroscience*, 6, 51-53.
- RING, N., JEPSON, R. & RITCHIE, K. 2011. Methods of synthesizing qualitative research studies for health technology assessment. *International Journal of Technology Assessment in Health Care*, 27, 384-390.
- ROBERTS, D. H., NEWMAN, L. R. & SCHWARTZSTEIN, R. M. 2012. Twelve tips for facilitating Millennials' learning. *Medical Teacher*, 34, 274-278.
- ROFF, S. 2015. Reconsidering the "decline" of medical student empathy as reported in studies using the Jefferson Scale of Physician Empathy-Student version (JSPE-S). *Medical Teacher*, 37, 783-786.
- ROGERS, C. 1959. A theory of therapy, personality and interpersonal relationships as developed in the client-centered framework. In: KOCH, S. E. (ed.) *Psychology: A study of science: Formulations of the person and the social context*. New York: McGraw-Hill.
- ROGERS, C. R. 1961. *On Becoming a Person*, London, Constable.
- ROGERS, C. R. 2003. *Client Centered Therapy*, London, Constable.
- ROGERS, W. & BALLANTYNE, A. 2010. Towards a practical definition of professional behaviour. *Journal of Medical Ethics*, 36, 250-254.
- ROH, M.-S., HAHM, B.-J., LEE, D. H. & SUH, D. H. 2010. Evaluation of Empathy Among Korean Medical Students: A Cross-Sectional Study Using the Korean Version of the Jefferson Scale of Physician Empathy. *Teaching and Learning in Medicine*, 22, 167-171.
- ROSENFELD, P. J. & JONES, L. 2004. Striking a balance: training medical students to provide empathetic care. *Medical Education*, 38, 927-933.
- ROTTER, D. L., HALL, J. A., MERISCA, R., NORDSTROM, B., CRETIN, D. & SVARSTAD, B. 1998. Effectiveness of interventions to improve patient compliance: a meta-analysis. *Medical Care*, 36, 1138-1161.
- SALDANA, J. 2013. *The Coding Manual for Qualitative Researchers*, London, Sage.

- SANCHEZ-REILLY, S., MORRISON, L. J., CAREY, E., BERNACKI, R., O'NEILL, L., KAPO, J., PERIYAKOIL, V. S. & DELIMA THOMAS, J. 2013. Caring for oneself to care for others: physicians and their self-care. *The Journal of Supportive Oncology*, 11, 75-81.
- SANDELOWSKI, M. 1993. Theory unmasked: The uses and guises of theory in qualitative research. *Research in Nursing and Health*, 16, 213-218.
- SCHÖN, D. A. 1987. *Educating the reflective practitioner: Toward a new design for teaching and learning in the professions*, San Francisco, Jossey-Bass.
- SCHUTZ, A. 1967. *The Phenomenology of the Social World*, Evanston, Illinois, Northwestern University Press.
- SCHWELLER, M., COSTA, F. O., ANTÔNIO, M. Â. R., AMARAL, E. M. & DE CARVALHO-FILHO, M. A. 2014. The Impact of Simulated Medical Consultations on the Empathy Levels of Students at One Medical School. *Academic Medicine*, 89, 632-637.
- SHANAFELT, T., WEST, C., ZHAO, X. H., NOVOTNY, P., KOLARS, J., HABERMANN, T. & SLOAN, J. 2005. Relationship between increased personal well-being and enhanced empathy among internal medicine residents. *Journal of General Internal Medicine*, 20, 559-564.
- SHAPIRO, J. 2008. Walking a mile in their patients' shoes: Empathy and othering in medical students' education. *Philosophy, Ethics, and Humanities in Medicine*, 3, 10-21.
- SHAPIRO, J. 2011. Perspective: Does Medical Education Promote Professional Alexithymia? A Call for Attending to the Emotions of Patients and Self in Medical Training. *Academic Medicine*, 86, 326-332.
- SHAPIRO, J. 2012. The Paradox of Teaching Empathy in Medical Students *In: DECETY, J. (ed.) Empathy: From Bench to Bedside*. Cambridge, Massachusetts: MIT Press.
- SHAPIRO, J. 2013. The feeling physician: educating the emotions in medical training. *European Journal for Person Centered Healthcare*, 1, 310-316.
- SHAPIRO, J., MORRISON, E. & BOKER, J. 2004. Teaching empathy to first year medical students: evaluation of an elective literature and medicine course. *Education for Health* 17, 73-84.
- SHAPIRO, J., RUCKER, L., BOKER, J. & LIE, D. 2006a. Point-of-view writing: A method for increasing medical students' empathy, identification and expression of emotion, and insight. *Education for Health: Change in Learning and Practice*, 19, 96-105.
- SHAPIRO, J., RUCKER, L. & ROBITSHEK, D. 2006b. Teaching the art of doctoring: An innovative medical student elective. *Medical Teacher*, 28, 30-35.
- SHAPIRO, S. M., LANCEE, W. J. & RICHARDS-BENTLEY, C. M. 2009. Evaluation of a communication skills program for first-year medical students at the University of Toronto. *BMC Medical Education*, 9, 11.

- SHARIAT, S. V. & HABIBI, M. 2013. Empathy in Iranian medical students: measurement model of the Jefferson scale of empathy. *Medical Teacher*, 35, 913-8.
- SHASHIKUMAR, R., CHAUDHARY, R., RYALI, V., BHAT, P., SRIVASTAVA, K., PRAKASH, J. & BASANNAR, D. 2014. Cross sectional assessment of empathy among undergraduates from a medical college. *Medical Journal Armed Forces India*, 70, 179-185.
- SHEA, S. & LIONIS, C. 2014. Introducing the Journal of Compassionate Health Care. *Journal of Compassionate Health Care*, 1, 7.
- SHEIKH, H., CARPENTER, J. & WEE, J. 2013. Medical student reporting of factors affecting pre-clerkship changes in empathy: a qualitative study. *Canadian Medical Education Journal*, 4, e26-e34.
- SILVERMAN, D. 2013. *Doing Qualitative Research: A Practical Handbook*, London, Sage.
- SINCLAIR, S. 1997. *Making Doctors: an Institutional Apprenticeship*, Oxford, Berg
- SINCLAIR, S. 2004. Evidence-based medicine: a new ritual in medical teaching. *British Medical Bulletin*, 69, 179-196.
- SINCLAIR, S., NORRIS, J. M., MCCONNELL, S. J., CHOCHINOV, H. M., HACK, T., HAGEN, N. A., MCCLEMENT, S. & BOUCHAL, S. R. 2016. Compassion: a scoping review of the healthcare literature. *BMC Palliative Care*, 15, 6-22.
- SLOTE, M. 2007. *The Ethics of Care and Empathy*, London, Routledge.
- SMAJDOR, A., STÖCKL, A. & SALTER, C. 2011. The limits of empathy: Problems in medical education and practice. *Journal of Medical Ethics*, 37, 380-383.
- SMITH III, A. C. & KLEINMAN, S. 1989. Managing emotions in medical school: Students' contacts with the living and the dead. *Social Psychology Quarterly*, 52, 56-69.
- SMITH, J. A., FLOWERS, P. & LARKIN, M. 2009. *Interpretative Phenomenological Analysis: Theory, Method and Research*, London, Sage.
- SMITH, K. E., NORMAN, G. J. & DECETY, J. 2017. The complexity of empathy during medical school training: evidence for positive changes. *Medical Education*, 51, 1146-1159.
- SOHN, B. K. 2017. Phenomenology as Qualitative Research: A Critical Analysis of Meaning Attribution. *Issues in Mental Health Nursing*, 38, 528-529.
- SPENCER, J. 2004. Decline in empathy in medical education: How can we stop the rot? *Medical Education*, 38, 916-918.
- SPIRO H, CURNEN M, PESCHEL E & D., S. J. 1993. *Empathy and the Practice of Medicine*, New Haven, Yale University Press.
- STEIN, E. 1989. *On the Problem of Empathy (The Collected Works of Edith Stein Vol 3)*, Washington DC, ICS Publishers.

- STEPIEN, K. A. & BAERNSTEIN, A. 2006. Educating for empathy - A review. *Journal of General Internal Medicine*, 21, 524-530.
- STOCKS, E. L., LISHNER, D. & DECKER, S. K. 2009. Altruism or psychological escape: Why does empathy promote prosocial behavior? *European Journal of Social Psychology*, 39, 649-665.
- STRATTON, T. D., SAUNDERS, J. A. & ELAM, C. L. 2008. Changes in medical students' emotional intelligence: An exploratory study. *Teaching and Learning in Medicine*, 20, 279-284.
- STUEBER, K. 2006. *Rediscovering Empathy: Agency, Folk Psychology and the Human Sciences* Cambridge Mass, MIT Press.
- SUCHMAN, A. L., MARKAKIS, K., BECKMAN, H. B. & FRANKEL, R. 1997. A model of empathic communication in the medical interview. *JAMA*, 277, 678-682.
- SULZER, S. H., FEINSTEIN, N. W. & WENDLAND, C. L. 2016. Assessing empathy development in medical education: a systematic review. *Medical Education*, 50, 300-310.
- SVENAEUS, F. 2014. Empathy as a necessary condition of phronesis: a line of thought for medical ethics. *Medicine, Health Care and Philosophy*, 17, 293-299.
- SVENAEUS, F. 2015. The relationship between empathy and sympathy in good health care. *Medicine, Health Care and Philosophy*, 18, 267-277.
- TAPPAN, M. B. 1997. Interpretive psychology: Stories, circles, and understanding lived experience. *Journal of Social Issues*, 53, 645-656.
- TATE, P. 2005. Ideas, concerns and expectations. *Medicine*, 33, 26-27.
- TAVAKOL, S., DENNICK, R. & M., T. 2012. Medical students' understanding of empathy: a phenomenological study *Medical Education*, 46, 306-316.
- TAVAKOL, S., DENNICK, R. & TAVAKOL, M. 2011. Empathy in UK medical students: differences by gender, medical year and specialty interest. *Education for Primary Care*, 22, 297-303.
- TAYLOR, S. J. & BOGDAN, R. 1998. *Introduction to Qualitative Methods: A Guide and Resource*. 3rd ed. New York John Wiley.
- THOMAS, M. R., DYRBYE, L. N., HUNTINGTON, J. L., LAWSON, K., NOVOTNY, P. J., SLOAN, J. A. & SHANAFELT, T. D. 2007. How do distress and well-being relate to medical student empathy? A multicenter study. *Journal of General Internal Medicine*, 22, 177-183.
- THOMSON, R. & HOLLAND, J. 2003. Hindsight, foresight and insight: the challenges of longitudinal qualitative research. *International Journal of Social Research Methodology*, 6, 233-244.
- TICHNER, E. 1909. *Lectures on the Experimental Psychology of the Thought Processes*, New York, Macmillan.

- TIMM, A. 2014. 'It would not be tolerated in any other profession except medicine': survey reporting on undergraduates' exposure to bullying and harassment in their first placement year. *BMJ Open* [Online], 4. Available: <http://dx.doi.org/10.1136/bmjopen-2014-005140> [Accessed 29th January 2018].
- TONG, A., SAINSBURY, P. & CRAIG, J. 2007. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, 19, 349-357.
- TWENGE, J. M. 2013. The evidence for generation me and against generation we. *Emerging Adulthood*, 1, 11-16.
- UNDERMAN, K. 2015. Playing doctor: Simulation in medical school as affective practice. *Social Science and Medicine*, 136, 180-188.
- UNDERMAN, K. & HIRSHFIELD, L. E. 2016. Detached concern? : Emotional socialization in twenty-first century medical education. *Social Science and Medicine*, 160, 94-101.
- VAGLE, M. D. 2010. Re-framing Schön's call for a phenomenology of practice: a post-intentional approach. *Reflective Practice*, 11, 393-407.
- VAGLE, M. D. 2016. *Crafting Phenomenological Research*, London, Routledge.
- VAN MANEN, M. 2016. *Researching lived experience: Human science for an action sensitive pedagogy*, London, Routledge.
- VERGHESE, A. 2008. Culture shock—patient as icon, icon as patient. *New England Journal of Medicine*, 359, 2748-2751.
- VÖLLM, B. A., TAYLOR, A. N. W., RICHARDSON, P., CORCORAN, R., STIRLING, J., MCKIE, S., DEAKIN, J. F. & ELLIOTT, R. 2006. Neuronal correlates of theory of mind and empathy: a functional magnetic resonance imaging study in a nonverbal task. *Neuroimage*, 29, 90-98.
- VON DIETZE E & A., O. 2000. Compassionate Care: a moral dimension of nursing. *Nursing Inquiry*, 7, 166-174.
- VOSEN, H. G. & VALKENBURG, P. M. 2016. Do social media foster or curtail adolescents' empathy? A longitudinal study. *Computers in Human Behavior*, 63, 118-124.
- WALSH, S., ARNOLD, B., PICKWELL-SMITH, B. & SUMMERS, B. 2016. What kind of doctor would you like me to be? *The Clinical Teacher*, 13, 98-101.
- WARMINGTON, S. 2012. Practising engagement: Infusing communication with empathy and compassion in medical students' clinical encounters. *Health*, 16, 327-342.
- WATSON, J. & GREENBURG, L. 2011. Empathic Resonance:A neuroscience perspective. In: J, D. & ICKES, W. (eds.) *The Social Neuroscience of Empathy*. London: MIT Press.

- WAYNE, S., DELLMORE, D., SERNA, L., JERABEK, R., TIMM, C. & KALISHMAN, S. 2011. The Association Between Intolerance of Ambiguity and Decline in Medical Students' Attitudes Toward the Underserved. *Academic Medicine*, 86, 877-882.
- WEAR, D. & VARLEY, J. D. 2008. Rituals of verification: The role of simulation in developing and evaluating empathic communication. *Patient Education and Counseling*, 71, 153-156.
- WEAR, D. & ZARCONI, J. 2008. Can compassion be taught? Let's ask our students. *Journal of General Internal Medicine*, 23, 948-953.
- WEAR, D., ZARCONI, J., KUMAGAI, A. & COLE-KELLY, K. 2014. Slow Medical Education. *Academic Medicine*, 90, 289-293.
- WEAVER, R., PETERS, K., KOCH, J. & WILSON, I. 2011. 'Part of the team': professional identity and social exclusivity in medical students. *Medical Education*, 45, 1220-1229.
- WENSING, M., JUNG, H. P., MAINZ, J., OLESEN, F. & GROL, R. 1998. A systematic review of the literature on patient priorities for general practice care. Part 1: Description of the research domain. *Social Science and Medicine*, 47, 1573-1588.
- WEST, C. P. & SHANAFELT, T. D. 2007. The influence of personal and environmental factors on professionalism in medical education. *BMC Medical Education*, 7, 29-38.
- WILKES, M. & HOFFMAN, J. 2002. Students benefit from experience of hospitalization *Medical Education*, 36, 586-587.
- WILKES, M., MILGROM, E. & HOFFMAN, J. R. 2002. Towards more empathic medical students: A medical student hospitalization experience. *Medical Education*, 36, 528-533.
- WILLIG, C. 2013. *Introducing Qualitative Research in Psychology*, Maidenhead, McGraw-Hill Education (UK).
- WINEFIELD, H. R. & CHUR-HANSEN, A. 2000. Evaluating the outcome of communication skill teaching for entry-level medical students: does knowledge of empathy increase? *Medical Education*, 34, 90-94.
- WINSEMAN, J., MALIK, A., MORISON, J. & BALKOSKI, V. 2009. Students' views on factors affecting empathy in medical education. *Academic Psychiatry*, 33, 484-491.
- WISPÉ, L. 1986. The distinction between sympathy and empathy: To call forth a concept, a word is needed. *Journal of Personality and Social Psychology*, 50, 314.
- WOLOSCHUK, W., HARASYM, P. H. & TEMPLE, W. 2004. Attitude change during medical school: A cohort study. *Medical Education*, 38, 522-534.

- WOOLF, K., CAVE, J., MCMANUS, I. C. & DACRE, J. E. 2007. 'It gives you an understanding you can't get from any book.' The relationship between medical students' and doctors' personal illness experiences and their performance: a qualitative and quantitative study. *BMC Medical Education*, 7, 50-58.
- WORKING PARTY OF THE ROYAL COLLEGE OF PHYSICIANS 2005. Doctors in Society. Medical Professionalism in a Changing World. *Clin Med (Lond)*, 5, S5-40.
- WRIGHT, S. M., KERN, D. E., KOLODNER, K., HOWARD, D. M. & BRANCATI, F. L. 1998. Attributes of excellent attending-physician role models. *New England Journal of Medicine*, 339, 1986-1993.
- YOUSSEF, F. F., NUNES, P., SA, B. & WILLIAMS, S. 2014. An exploration of changes in cognitive and emotional empathy among medical students in the Caribbean. *International Journal of Medical Education*, 5, 185.
- ZAHAVI, D. 2010. Empathy, Embodiment and Interpersonal Understanding: from Lipps to Schutz. *Inquiry*, 53, 285-306.
- ZAKI, J. & WILLIAMS, W. C. 2013. Interpersonal emotion regulation. *Emotion*, 13, 803.
- ZENASNI, F., BOUJUT, E., WOERNER, A. & SULTAN, S. 2012. Burnout and empathy in primary care: three hypotheses. *British Journal of General Practice*, 62, 346-347.
- ZIGMOND, D. 2011. Five executive follies :How commodification imperils compassion in person healthcare. *Journal Holistic Healthcare*, 9, 7-10.

Appendices

APPENDIX 1 Papers published during the research

Some of my work in this thesis has been published in peer-reviewed journals:

JEFFREY D 2017 Communicating with a human voice: developing a relational view of empathy. *Journal of the Royal College of Physicians of Edinburgh*, 47,266-270.

JEFFREY, D. 2016. A meta-ethnography of interview-based qualitative research studies on medical students' views and experiences of empathy. *Medical Teacher*, 38, 1214-1220.

JEFFREY, D. 2016. Clarifying empathy:the first step to more humane clinical care. *British Journal of General Practice* 66, 101-102.

JEFFREY, D. 2016. A duty of kindness. *Journal of the Royal Society of Medicine*, 109, 261-263.

JEFFREY, D. 2016. Empathy, sympathy and compassion in healthcare: Is there a problem? Is there a difference? Does it matter? *Journal Royal Society Medicine*, 109, 446-452.

I also contributed to a joint discussion paper

JEFFREY, D. & DOWNIE, R. 2016. Empathy-Can it be taught? *Journal of the Royal College of Physicians of Edinburgh*, 46, 107-112.

Communicating with a human voice: developing a relational model of empathy

D Jeffrey⁴

Abstract

The medical profession has adopted a cognitive model of empathy, or detached concern, in its professionalism and practice. As a consequence there is now an empathy gap which has been demonstrated by lapses in patient care in the UK. There may also be an empathy gap developing in medical students during their training. This paper argues for the adoption of a relational view of empathy which embraces emotional and moral dimensions of the concept, acknowledges the importance of the clinical context and prioritises the relationship between the doctor and patient. A relational model extends to encompass the patient's family and all members of the healthcare team. By exploring the process of empathising in clinical practice I develop a relational model that is more appropriate for modern patterns of patient care and medical education than detached concern. Adoption of a relational model of empathy in training and practice can help bridge the empathy gap.

Keywords: doctor–patient relationship, empathy, medical education, professionalism

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Introduction

We are two beings, and we have come together in infinity... for the last time in the world. Abandon your tone and take a human one! At least for once in your life speak in a human voice. Not for my sake, but for your own.

Demons, Fyodor Dostoevsky

In the wake of high-profile public reports in the UK identifying an empathy gap in clinical care, there have been calls for more empathy in healthcare.^{1–3} Conflicting evidence of a decline in medical students' empathy during their training potentially widens the empathy gap.^{4–6}

Medicine's positivist philosophy, prioritising technical progress, fosters a cognitive form of empathy: 'detached concern'.^{9,10} Detached concern is now widely adopted as an appropriate form of empathy in medical professionalism, practice and training.^{11–15} I argue that a relational view of empathising, embracing emotional and moral dimensions and acknowledging the importance of placing the doctor–patient relationship at its core, including the family and healthcare team, is more appropriate for medical education and practice.^{16–20} I hope to stimulate debate and to suggest ways of bridging the empathy gap in practice and medical education, and so enhance patient care.^{22,23,24}

Empathy

Differing definitions of empathy highlight its varied dimensions; some focusing on understanding the patient's

view (cognitive), others on sharing feelings (affective).^{13,22,24} The complexity of empathy is described elsewhere; here I argue for a broader approach which embraces empathy's cognitive, affective, behavioural and moral aspects.^{18,19,25–28} Empathy may also be seen as a personal attribute or as a relational concept, depending on the context for its expression.^{25,21,22} Empathy may occur at superficial or deep levels according to the clinical context.²⁹ For instance, during an OSCE examination with a simulated patient, a superficial level of empathy may suffice, but in planning end of life care with a patient and their family, a deeper level is required. When explaining the technicalities of an operation to a patient, the cognitive dimension of empathy predominates, but when responding to a euthanasia request, affective and moral dimensions dominate the dialogue.

Practising empathy

The 'empathy cycle' is a dynamic process in which both patient and doctor learn more about each other over time in an iterative deepening of their relationship.²⁰ Although the focus of this paper is empathy in the doctor–patient relationship, empathy extends to involve all relationships between the patient, family and healthcare team. Empathising comprises a series of steps which interact, according to the context of the relationship, in a subtle psychological dance involving connection and detachment. Interrogating this process may help us to understand the empathy gap and to develop more humane clinical teaching and care. The first step is showing concern for the patient.

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Concern

Empathy begins with an individual's willingness to empathise.^{34,35} This initial concern or 'empathic resonance' between a doctor and patient ensures that empathy is an interpersonal phenomenon from the outset.^{36,37} Suchman describes this moment as 'empathic opportunity'.³⁸ Emotional resonance is automatic and may involve mirror neurones.³⁹

Students and doctors want to empathise with patients and feel frustrated when prevented from doing so;²⁰ patients want their doctors to demonstrate empathy.²⁰ Broyard, describing his experience as a patient, said of his doctor:

*'I just wish he would give me his whole mind just once, be bonded with me for a brief space, survey my soul as well as my flesh, to get at my illness, for each man is ill in his own way.'*²⁰

The empathetic doctor is trying to see the world through the patient's eyes using imagination, curiosity and listening skills. Letting go of our assumptions forms part of our willingness to empathise. The doctor may adopt Carl Roger's therapeutic stance of 'unconditional positive regard' for the patient, giving the patient their full attention.³⁸

Attention

A deep level of empathy requires face to face contact with the other person. Patient contact is an important way of bridging the empathy gap.³¹ Empathy can be enhanced by simply being present, by giving the other person the focus of one's full attention. Empathy cannot occur while the doctor is gazing at a computer screen.

Norfolk et al. describe a relational model for developing rapport in the consultation in which empathy is construed as a skill.²⁴ Their model highlights the importance of innate interest or curiosity and being inclined to care for others.²⁴ Empathic motivation, attention, listening skills and understanding combine to increase rapport.²⁴ Empathy as a relational concept deepens with continuity of care,²⁴ which is difficult to achieve in the UK; many patients feel they cannot relate to 'their' general practitioner.²⁸

Attention involves active listening as a doctor seeks the underlying hidden agenda each patient brings, listening to their story and allowing time to pass. Time is necessary to establish deep empathy which takes account of the patient's context. When time is short there is a risk that the doctor distances themselves from the patient and empathy then becomes superficial rather than deep.

Connection (affective)

Doctors have always struggled to balance emotional connection (affective empathy) and detached professional concern (cognitive empathy) in their relationships with patients.^{3,10,14} A close empathetic relationship with a patient

encourages trust and allows patients to confide their deepest fears. Empathy involves feeling with the patient to gain an understanding of their suffering.²⁰ It inevitably exposes the doctor's vulnerability and involves sharing part of oneself with the other person.²⁰ If we are to bridge the empathy gap we need to develop a medical culture which acknowledges the doctor's vulnerability.⁴⁰

Empathic concern results in a sharing of emotion, the doctor feels the pain of a patient while remaining aware of the self–other boundary.⁴¹ This appropriate empathic concern can be distinguished from personal distress. Stress may result from taking a self-orientated perspective ('how would I feel in this situation?') which can lead to identification and becoming overwhelmed. Reducing stress, by providing support, may diminish the empathy gap by allowing students and doctors to be open to emotions and so to enhancing their empathy.⁴² Giving time to students and doctors to discuss difficult emotional situations with a mentor or in a group setting may be one way of providing such support.

Doctors may fear emotional connection because they are concerned their clinical judgement may be less 'objective' or that they will become overwhelmed and burn out. These concerns may lead them to distance themselves from patients, mistakenly feeling that detachment is part of being professional. Personal experience of suffering may inform the doctor's empathy but care is needed to avoid making assumptions that the patient necessarily shares the same feelings. A crucial aspect of affective (emotional) empathy is to share feelings rather than merely labelling an emotional state.

Detachment is not necessary for reliable clinical judgement since emotional insights can inform clinical decision-making.^{43,44} Moreover, it has been suggested that empathetic doctors have more job satisfaction and less burnout than detached colleagues.^{44,45} Even if doctors try to suppress their feelings by distancing themselves, they cannot avoid having emotional attitudes towards patients.⁴⁶

Understanding (cognitive)

While I argue for adopting emotional-based reasoning instead of detached concern, the cognitive area is a core dimension of empathy.²⁰ Imagination, or perspective taking, is integral to empathising. The doctor adopts an other-orientated perspective where they are trying to see the world from the patient's point of view. In the detached concern form of empathising, understanding occurs within the doctor. In a relational model, understanding is an interpersonal activity depending on the doctor and the patient who also gains an understanding of the doctor's world.

Some authors have pointed out that it not possible to fully understand what another person is thinking or feeling.⁴⁷ Doctors need the humility to accept that empathy cannot achieve a complete understanding of the other person's world view, but in making the effort to reach out and connect with

the other and taking account of differences in perspectives, empathy can still be of great value.¹²

Communication skill (behavioural)

Non-verbal communication skills include eye contact, touch, facial expression and other body language communicating concern.¹³ Reflecting the patient's feeling is an important verbal tool in conveying empathy along with the sensitive use of language and self-disclosure.¹⁴ These behaviours, however, are only part of the art of practising empathy which is a nuanced process requiring authenticity.

Authenticity

The acronym 'ICE', designed to explore patient's Ideas, Concerns and Expectations, acts as a reminder to cover these areas of the consultation.¹⁵ There is a risk students may perceive ICE as something to be ticked on the end of history-taking to gain a few marks in an exam. This behaviour can lead to a form of pseudo-empathy where the doctor or student exhibits behaviours which appear to convey empathy but do not engage with the patient. This pseudo-empathy has been compared to surface acting, in which empathic expressions are adopted without any change in the doctor's emotions or understanding of the patient.¹⁶ Patients can easily detect the 'have a nice day' approach of pseudo-empathy.

Self-other boundary

Self-other differentiation implies that although empathy should involve a deep engagement with the patient, this does not mean the doctor loses sight of where the self ends and the other begins. Carl Rogers emphasised that empathy involved entering the perceived world of the other person 'as if' one were the other person, but without ever losing the 'as if' condition.¹⁷ Rogers' account conceptualises empathy as an experience which paradoxically combines closeness and distance, similarity and difference.¹⁸ Empathy creates a space which enables the doctor and patient to convey respect and recognition.¹⁹ In empathy, the doctor is emotionally engaged with the patient and at same time is able to reflect on these emotions, knowing that they originate in the other person.²⁰ In retaining a sense of the self-other boundary, empathy differs from identification which can result in personal distress and burnout.²¹ Empathy requires effort, is often emotionally draining and empathic failures are likely to occur.^{22,23} To maintain this delicate psychological balance between detachment and connection, the doctor needs to be self-aware, to reflect on their work and to have access to support. A self-aware doctor understands that their own feelings and the part they play in counter-transference are an integral part of their empathy.^{24,25}

Responding (moral)

Empathy has a moral dimension, since appropriate understanding of the patient is necessary before being in a position to apply ethical professional principles in practice.¹² Pedersen does not imply that 'appropriate' means perfect

or complete understanding but rather it is sufficient for the participants. The doctor and patient participate in a dialogue and reflect on their understanding.¹² Empathy is a source of moral knowledge and an essential component of practical wisdom (phronesis) and of care ethics.²⁶⁻²⁷ Care implies both a moral attitude and activity.²⁸ A relational model incorporates empathy as an integral part of medical understanding and as a motivating concern to care.²¹ Empathy includes action and a shared sense of fraternity.^{14,29} A shared humanity creates a sense of security in situations of great uncertainty. Empathy has also been conceptualised as a virtue, i.e. a desirable character trait.^{11,29,30}

Support

Doctors and medical students need support in enhancing their empathetic skills, and this may involve addressing some of the barriers blocking their innate empathy.^{4,31} Doctors need to develop the self-awareness to recognise the difference between empathic concern, which is an essential part of professionalism, and personal distress, which can be self-destructive. However, it is not good enough to provide doctors with training or exhortations to be more empathetic and then expect them to work in an environment that does not support empathy. Support and mentoring needs to be available for all doctors and medical students, not just reserved for those perceived to be struggling.³²

Teaching empathy

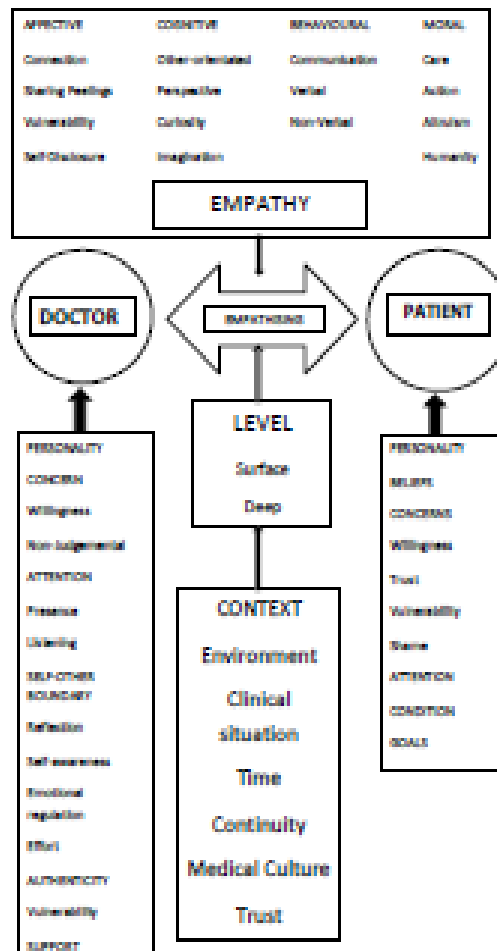
It is beyond the scope of this paper to review the many initiatives which have been used to enhance empathy in students and doctors.^{33,34} Role modelling, mentoring and the use of the medical humanities are all considered to be helpful in enhancing empathy.³

Conclusions

Fifteen years ago, Jodi Halpern, in her seminal work *From Detached Concern to Empathy: Humanizing Medical Practice*, suggested that doctors should adopt a model of empathy which included affective dimensions instead of detached concern.³⁵ I echo her plea and argue that by analysing the process of empathising, a broad model of empathy emerges which moves beyond detached concern to a more dynamic relational model. In this model, empathising is a creative process which changes and develops with experience. The relational model extends to the doctor's relationships with the patient's family and to other members of the healthcare team. As empathy develops, practice becomes more patient-centred. If doctors are to establish close therapeutic relationships with patients they need to be given time to establish empathy, to acknowledge the individuality of the patient and to properly address their concerns.³⁶ Time, presence, feelings, curiosity and imagination combine in empathy to recognise the person, and not simply their illness (Figure 1).

Doctors need courage to enter the interpersonal world and to practise their empathetic skills. Empathy is not

Figure 1 A relational model of empathising in the doctor-patient relationship



something that just happens to us, it is a choice we make to pay attention, to extend ourselves and it requires effort.¹² A willingness to feel and convey empathy may result in a culture shift in medicine from detached concern to a broader relational view of empathy as the way of seeing the world from the patient's point of view.

I argue that appropriate empathy in modern clinical care is neither detachment from patients nor being overwhelmed by emotions. It is an iterative process of emotional resonance and curiosity about the meaning of a clinical situation for the patient.^{13,14} This broad form of empathy involves the capacity to participate deeply in the patient's experience while not losing sight of the fact it is not one's own experience but that of another person.¹⁴ Halpern maintains that empathy elevates a doctor's work from just a job to a profession in which they contribute to the meaningfulness of people's lives.¹⁵ Perhaps every doctor, clinical teacher and medical student needs to ask themselves 'Do I speak with a human voice?' 🙏

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References

- 1 Francis R. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary. London: The Stationery Office; 2013.
- 2 Health Service Ombudsman. Care and Compassion? A Report of the Health Services Ombudsman on Ten Investigations into NHS Care for Older People; 2011.
- 3 Cummins J, Bennett V. Compassion in Practice: Nursing, Midwifery and Care Staff, Our Vision and Strategy. 2012. <https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf> (accessed 15/04/15).
- 4 Bell-Rawden SA, Chiscolm MS, Arton B et al. Teaching empathy to medical students: an updated, systematic review. *Acad Med* 2013; 88: 1171–7.
- 5 Hojat M, Vergara MJ, Maxwell K et al. The devil is in the third year: a longitudinal study of erosion of empathy in medical school. *Acad Med* 2009; 84: 1182–91.
- 6 Neumann M, Edelhauser F, Tauschel D et al. Empathy decline and its reasons: a systematic review of studies with medical students and residents. *Acad Med* 2011; 86: 996–1009.
- 7 Roff S. Reconsidering the 'decline' of medical student empathy as reported in studies using the Jefferson Scale of Physician Empathy-Student version (JSPE-S). *Med Teach* 2011; 33: 783–6.
- 8 Quince TA, Kinnearley C, Hales J et al. Empathy among undergraduate medical students: A multi-centre cross-sectional comparison of students beginning and approaching the end of their course. *BMC Med Educ* 2016; 16: 92.
- 9 Shapiro J, Nixon LL, Wear SE et al. Medical professionalism: what the study of literature can contribute to the conversation. *Philos Ethics Humanit Med* 2013; 10: 10.
- 10 Halpern L. From Detached Concern to Empathy: Humanizing Medical Practice. New York: Oxford University Press; 2001.
- 11 Gohhaus P. The desired moral attitude of the physician: (i) empathy. *Med Health Care Philos* 2012; 15: 103–13.
- 12 Gillon R. Restoring humanity in health and social care – some suggestions. *Clin Ethics* 2013; 8: 105–10.
- 13 Pedersen R. Empathy: A wolf in sheep's clothing? *Med Health Care Philos* 2008; 11: 325–35.
- 14 Werhaneil D. The inhumanity of medicine. *BMJ* 1994; 309: 1671–2.
- 15 GMC. Tomorrow's doctors: Outcomes and standards for undergraduate medical education. 2009.
- 16 Menor SW, Maxwell M, Hooney D et al. The consultation and relational empathy (CARE) measure: development and preliminary validation and reliability of an empathy-based consultation process measure. *Fam Pract* 2004; 21: 699–705.
- 17 Donker F, Bensing J, Lagro-Janssen A. Effectiveness of empathy in general practice: a systematic review. *Br J Gen Pract* 2013; 63: e75–84.
- 18 Morse JM, Anderson D, Betts JF et al. Exploring empathy: a conceptual fit for nursing practice? *Image J Nurs Sch* 1990; 24: 273–80.

- 19 Irving F, Dickson D. Empathy: towards a conceptual framework for health professionals. *Int J Health Care Qual Assur Inc Leadersh Health Serv* 2004; 17: 212–20.
- 20 Ekman E, Halpern J. Professional distress and meaning in health care: why professional empathy can help. *Soc Work Health Care* 2015; 54: 633–50.
- 21 Sulzer SH, Feinberg NW, Wendland CL. Assessing empathy development in medical education: a systematic review. *Med Educ* 2016; 50: 300–10.
- 22 Ekman E, Knauer M. Empathy in medicine: neuroscience, education and challenges. *Med Teach* 2017; 39: 164–73.
- 23 Baron-Cohen S. *Zero Degrees of Empathy*. London: Allen Lane; 2011.
- 24 Coplan A, Goldie P, editors. *Empathy: Philosophical and Psychological Perspectives*. Oxford: Oxford University Press; 2011.
- 25 Jeffrey D. Clarifying empathy: the first step to more humane clinical care. *Br J Gen Pract* 2016; 66: 101–2.
- 26 Mercer SW, Reynolds WJ. Empathy and quality of care. *Br J Gen Pract* 2002; 52: 59–61.
- 27 Jeffrey D. Empathy, sympathy and compassion in healthcare: is there a problem? Is there a difference? Does it matter? *J R Soc Med* 2016; 109: 446–52.
- 28 Maxwell S. *Professional Ethics Education in Compassionate Empathy*. New York: Springer; 2008.
- 29 Bajwa H, Neuking E, Haas D et al. A comprehensive model for optimizing empathy in person-centred care. *Patient Educ Coun* 2013; 93: 209–15.
- 30 Barrett-Lennard GE. The empathy cycle: Refinement of a nuclear concept. *J Couns Psychol* 1981; 28: 91.
- 31 Svanessu F. The relationship between empathy and sympathy in good health care. *Med Health Care and Philos* 2011; 18: 267–77.
- 32 Suchman AL, Mankix K, Beckman HD et al. A model of empathic communication in the medical interview. *JAMA* 1997; 277: 678–82.
- 33 Håkansson J, Montgomery H. Empathy as an interpersonal phenomenon. *J Soc Pers Relat* 2003; 20: 267–84.
- 34 Teasak S, Dennick R, Teasak M. Medical students' understanding of empathy: a phenomenological study. *Med Educ* 2012; 46: 306–16.
- 35 Brody A. *Intoxicated By My Illness: And Other Writings On Life And Death*. New York: Rowell Columbine; 1992.
- 36 Rogers C. *A Way of Being*. New York: Houghton Mifflin Harcourt; 1956.
- 37 Norfolk T, Bird K, Welsh D. The role of empathy in establishing rapport in the consultation: a new model. *Med Educ* 2007; 41: 690–7.
- 38 Charlton R. *Compassion, Continuity and Caring in the NHS*. London: Royal College of General Practitioners; 2016.
- 39 Kzmaric R. *Empathy: A Handbook for Revolution*. London: Random House; 2014.
- 40 Brown B. *Daring Greatly: How The Courage to be Vulnerable Transforms the Way We Live, Love, Parent, and Lead*. London: Penguin; 2012.
- 41 Doherty J, Ickes W. *The Social Neuroscience of Empathy*. London: MIT Press; 2011.
- 42 Marshall CRT, Hooker C. Empathy and affect: what can empathic bodies do? *Med Humanit* 2016; 42: 128–34.
- 43 Heyhoe J, Birka Y, Harbison R et al. The role of emotion in patient safety: Are we brave enough to scratch beneath the surface? *J R Soc Med* 2016; 109: 52–8.
- 44 Kearney MK, Weininger RB, Vachon ML et al. Self-care of physicians caring for patients at the end of life: 'being connected...a key to survival'. *JAMA* 2009; 301: 1155–64.
- 45 Zeman T, Boujut E, Werner A et al. Burnout and empathy in primary care: three hypotheses. *Br J Gen Pract* 2012; 62: 346–7.
- 46 Larson E, Yao X. Clinical empathy as emotional labor in the patient-physician relationship. *JAMA* 2005; 293: 1100–6.
- 47 Macnaughton J. The dangerous practice of empathy. *Lancet* 2009; 373: 1940–1.
- 48 Tate T. Ideas, concerns and expectations. *Medicine* 2005; 33: 26–7.
- 49 Rogers C. A theory of therapy, personality and interpersonal relationships as developed in the client-centered framework. In: Kock SE, editor. *Psychology: A Study of Science: Formulations of the person and the social context*. 3. New York: McGraw-Hill; 1969.
- 50 Bond L. On the relational dynamics of caring: a psychotherapeutic approach to emotional and power dimensions of women's care work. *Gender, Place and Culture* 2008; 15: 249–65.
- 51 Bond L. Empathy and identification: Conceptual resources for feminist fieldwork. *ACME* 2003; 2: 64–76.
- 52 Jamison L. *The Empathy Exams*. London: Granta; 2014.
- 53 Balint M. *The Doctor, His Patient and the Illness*. London: Pitman Medical Publishing; 1957.
- 54 Bond L. Understanding feelings: Engaging with unconscious communication and embodied knowledge. *Emotion, Space and Society* 2014; 10: 44–54.
- 55 Svanessu F. Empathy as a necessary condition of praxis: a line of thought for medical ethics. *Med Health Care Philos* 2014; 17: 293–9.
- 56 Noddings N. *Caring: A Feminine Approach to Ethics and Moral Education*. Berkeley, CA: University of California Press; 1984.
- 57 Chochinov H. Dignity and the essence of medicine: the A, B, C, and D of dignity conserving care. *BMJ* 2007; 335: 184–7.
- 58 Gelhaus P. The drained moral attitude of the physician(s) care. *Med Health Care Philos* 2013; 10: 125–39.
- 59 Gordon R. Expanding clinical empathy: an activist perspective. *J Gen Intern Med* 2009; 24: 122–5.
- 60 MacIntyre A. *After Virtue*. 2nd ed. London: Duckworth; 1985.
- 61 Shapiro J. The Paradox of Teaching Empathy in Medical Students. - In: Decety J, editor. *In Empathy: From Bench to Bedside*. New York: MIT Press; 2012.
- 62 Jeffrey D. *Medical Mentoring: Supporting Students, Doctors in Training and General Practitioners*. London: Royal College of General Practitioners; 2014.
- 63 Pedersen R. Empathy development in medical education – a critical review. *Med Teach* 2010; 32: 593–600.
- 64 Jeffrey D, Downie R. Empathy – can it be taught? *J R Coll Physicians Edinb* 2016; 46: 107–12.
- 65 Howie JD, Heaney DJ, Maxwell M et al. Quality of general practice consultations: cross sectional survey. *BMJ* 1999; 319: 738–43.

A meta-ethnography of interview-based qualitative research studies on medical students' views and experiences of empathy

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ABSTRACT

Background: Quantitative research suggests that medical students' empathy declines during their training. This meta-ethnography asks: What new understanding may be gained by a synthesis of interview-based qualitative research on medical students' views and experiences of empathy? How can such a synthesis be undertaken?

Methodology: A meta-ethnography synthesizes individual qualitative studies to generate knowledge increasing understanding and informing debate. A literature search yielded eight qualitative studies which met the inclusion criteria. These were analyzed from a phenomenological and interpretative perspective.

Results: The meta-ethnography revealed a conceptual confusion around empathy and a tension in medical education between distancing and connecting with patients. Barriers to empathy included a lack of patient contact and a strong emphasis on the biomedical over the psycho-social aspects of the curriculum. A number of influences discussed in the paper lead students to adopt less overt ways of showing their empathy.

Conclusion: These insights deepen our understanding of the apparent decline in empathy in medical students. The lessons from these studies suggest that future curriculum development should include earlier patient contact, more emphasis on psycho-social aspects of care and address the barriers to empathy to ensure that tomorrow's doctors are empathetic as well as competent.

Introduction

Empathy is defined in many different ways in the literature which creates difficulties in researching the construct (Coplan & Goldie 2011). Rather than adopting a reductive definition of this complex nuanced construct empathy is conceptualized in this study as having four dimensions: affective, feeling with the patient; cognitive, other-orientated perspective taking; behavioral, pro-social behavior; and moral, the motivation to care (Morse et al. 1992; Mercer & Reynolds 2002). Empathy is generally accepted as a fundamental part of the doctor–patient relationship (Pedersen 2009). In the wake of the Francis Report which described gross deficiencies in patient care, there is a need for improved psychosocial care and there were calls for healthcare professionals to be more empathetic (Francis 2013). One way of responding to this need is to explore empathy development in medical undergraduates since they are tomorrow's doctors.



Quantitative research using self-reported questionnaires suggests that medical students' empathy declines during their undergraduate training (Hojat et al. 2004; Chen et al. 2007; Pedersen 2009; Neumann et al. 2011). However, this view has been challenged by other studies which failed to demonstrate any decline or questioned their methods (Colliver et al. 2010; Quince et al. 2011). Quantitative studies do not reveal the reasons for any change in students' empathy, so the authors call for further qualitative research to deepen our understanding of what happens to medical students' empathy during their training (Pedersen 2009; Neumann et al. 2011; Batt-Rawden 2013).


Practice points

- Empathy is conceptualized in many ways.
- There is a tension between detachment and connection with patients.
- A lack of patient contact may hamper the development of empathy.
- A strong emphasis on the biomedical over psycho-social elements of care may create a barrier to empathy.

This meta-ethnography asks two questions: What new understanding may be gained by a synthesis of one-to-one interview qualitative studies on medical students' views and experiences of empathy during their undergraduate training? How can such a synthesis be undertaken?

The relatively few qualitative studies of medical students' empathy tend to adopt differing conceptualizations of empathy, they use a cross-sectional approach in study differing contexts, have varied theoretical backgrounds, and use different methods of data collection (Pedersen 2009; Batt-Rawden 2013). The challenge for a meta-ethnography is how can these individual studies be compared and synthesized? A common criticism leveled at individual qualitative studies has been the small number of participants and a lack of generalizability (Ring et al. 2011; Tavakol & Sandars 2014).

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 Supplemental data for this article can be accessed [here](#).

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Traditionally evidence-based medicine (EBM) uses the combined findings of quantitative studies through meta-analysis and systematic review. However, there are a number of difficulties in applying this standard approach when reviewing the qualitative research literature on empathy (Campbell et al. 2003). Where quantitative meta-analysis is concerned with aggregating data from randomized controlled trials to have a statistical power to detect causes and effect relationships between a treatment and an outcome, qualitative synthesis involves conceptual innovation (Campbell et al. 2003). The purpose of this qualitative synthesis is to achieve a greater understanding of empathy and its influences beyond that achieved in any individual study. It is not simply an aggregation of findings, a meta-ethnography derives new concepts which perhaps were not identified in the original studies. Thus, a meta-ethnography increases the potential of any individual study to stimulate debate and to gain understanding (Ring et al. 2011). Such understanding and debate may inform future research and curriculum development.

Methodology

Meta-ethnography, an evolving research discipline, is the leading method for synthesizing qualitative health research (Ring et al. 2011). It is a creative process and the researcher's interpretive phenomenological "lens" affects the collection, interpretation, and understanding of the data (Ring et al. 2011). Meta-ethnography provides an interpretive approach for synthesizing qualitative studies and was originally developed by Noblit and Hare (1988). It involves seven steps which, by bringing together findings from individual interpretative accounts produces a new interpretation (Noblit & Hare 1988). It is interpretivist in that the researcher seeks an explanation for social or cultural events based on the perspectives of the medical students being studied, grounded in their everyday lives. The interpretivist and phenomenological approach of this research does not seek to develop a scientific theory but rather to gain understanding of the students' world in relation to empathy and its influences.

The process of a meta-ethnography reduces the account while preserving its "sense" and context. The "senses" of the different accounts are then translated into one another. Meta-ethnography often involves only a small number of studies. Data for synthesis are the interpretations and explanations in the original papers rather than the data collected at interview.

Critics of the interpretivist paradigm often argue against its relativism. It is not a matter of "anything goes" but rather an acknowledgment that different groups perceive differently and act differently. The range of perception is always determined by context and socialization, a fundamental tenet of social constructivism (Smith et al. 2009).

Meta-ethnography: Seven step method (Noblit & Hare)

Step 1. Defining the meta-ethnography question

What new understanding may be gained by a synthesis of interview-based qualitative research on medical students' views and experiences of empathy during their undergraduate training?

Step 2. Identifying and listing keywords

Using simple broad-based terms can be as effective as more complex search strategies for identifying relevant qualitative research reports (Flemming & Briggs 2007). The keywords were: empathy, compassion, sympathy, medical student, undergraduate, qualitative, interview, and meta-ethnography.

Step 3. Deciding the scope of the search

Inclusion criteria The inclusion criteria are influenced by my phenomenological interpretivist stance. The synthesis included studies related to interviews of medical students and adopted an iterative approach to literature searching and screening. Since the terms empathy, compassion, and sympathy are sometimes used interchangeably in the literature, studies using these terms were included as were studies exploring the experiences, perceptions, attitudes, and influences of the students in regard to empathy. Qualitative research papers including Phenomenology, Grounded Theory, Interpretivist, Narrative studies, Ethnography, and one-to-one interview studies. Papers published in English and articles from all countries were included. Papers published after 1980 were also included.

Exclusion criteria Other healthcare staff: nursing, Allied Health Professionals, and qualified doctors were excluded from the study. This synthesis excluded any papers which did not have a primary focus on exploring empathy, since the construct of empathy overlaps with other forms of pro-social behaviors such as compassion, kindness, and patient-centered care. Quantitative research, questionnaire-based studies, audio diaries, focus groups, and reflective narrative writing are qualitative research methods which can increase understanding on empathy. However, each of these methods bring new challenges and limitations, to simplify this complex area, this synthesis excludes studies which did not use one-to-one interviews. Papers published in other languages than English and papers published before 1980 were also excluded.

Step 4. Searching the databases

Search strategy Searching for qualitative studies is more complex and difficult than searching for quantitative studies (Ring et al. 2011). Qualitative research papers can be difficult to identify using electronic indexing systems. Standard indexing terms do not exist in the same way as they do for quantitative reports. There may also be a lack of good descriptions of research methods in the titles and abstracts of the papers. The process of searching for qualitative reports can be messy there are "eureka" moments which are difficult to record or retrospectively retrace (Finfgeld-Connett & Johnson 2013). These authors also observe that maintaining a search strategy log can be creatively stifling if not virtually impossible (Finfgeld-Connett & Johnson 2013).

There is uncertainty around the best methods of searching the literature (Booth 2010). The literature review is iterative and multiple searches are carried out in the databases using the alternative terms. The iterative approach is expansive and does not aim to be exhaustive as in a standard review of scientific quantitative data where usually

"more is better" (Yoshii et al. 2009). A "berry picking" approach was also used to generate contextually consistent and relevant research papers. This often involved the serendipitous finding of a relevant article which led to a patch of rich articles in the same way as one finds when black-berrying (Barroso et al. 2003; Finfgeld-Connett & Johnson 2013).

Databases searched: Medline, Scopus, Web of Science, Embase, CINAHL, and Psych Info. Manual searching of frequently cited authors, and references in review articles have been followed up.

Step 5. Selecting an article for inclusion

A first read of the title might lead to rejection online, while retaining potentially relevant titles. Abstracts of the potentially useful articles were read online and relevant papers retained. All relevant papers were printed out and read in full. The eight papers selected for the meta-ethnography were coded for themes, categories, and finally lines-of-argument in the manner described below.

The searches yielded the following numbers of papers, many of which were duplicated. Medline 44; Scopus 37; Web of Science 40; Embase 36; CINAHL 23; and Psych Info 23.

Final total from all searches after excluding duplicates = 47 papers

Excluded reviews and descriptive articles not primary research (14) = 33 papers

Excluded studies on reflective writing (7) = 26 papers

Excluded data collection from audio diaries and focus groups (8) = 18 papers

Excluded papers with focus not including empathy (10) = eight papers for meta-ethnography comprising the data set.

Step 6. Analyzing the articles and synthesis

Meta-ethnography involves selecting the eight relevant empirical studies to be synthesized, becoming familiar with them and coding key concepts manually (first-order constructs). Noblit and Hare suggest synthesis is achieved by examining the key concepts in relation to others in the study and in other studies (second-order constructs) (Noblit & Hare 1988). The aim is to derive concepts that encompass more than one of the studies being synthesized. These derived or synthesized concepts may not have been explicitly identified in any of the original empirical studies and are in fact third order constructs (Campbell et al. 2003).

Data collection

In a qualitative research, there is a debate as to what constitutes high quality and how or if it should be measured. Measures used for quantitative research such as reliability, validity, and generalizability are not applicable to qualitative research (Pope et al. 2000). Instead the key points to consider in this qualitative research are rigor, credibility, and relevance. A simple quality measure has been used here the critical appraisal programme (CASP) 10 questions (CASP 2010). Only those papers with a CASP score of 7 or above were included in the synthesis. There is a risk of

excluding a perhaps less well-conducted study purely on the grounds of quality, which might in fact have provided valuable insights into empathy.

Step 7. Report of the meta-ethnography

Reporting the results involved reflecting on the themes and then constructing lines-of-argument (third-order constructs) which set the work in a broader context and raise further questions. What can we say about the whole (e.g. influences on empathy) based on selective studies of the parts? The interpretation and comparison of key concepts aims to derive concepts that cover more than one of the studies being synthesized (Campbell et al. 2003). These derived or synthesized concepts may not have been explicitly identified in the original empirical studies and can be described as third-order constructs.

The data set comprises eight papers for the meta-ethnography which met the inclusion criteria and all had a CASP score above 7 (Table 1, available online as Supplemental Material). Two studies were in the UK and the whole range covered every year of the undergraduate curriculum. Although each individual study had small numbers of students, the meta-ethnography considers the views of the 185 students in all the studies.

Table 2 (available online as Supplemental Material) shows the manual coding for each paper, the first-order constructs derived from the results sections of the papers, the second-order categories from the discussion and conclusions.

Results

Concepts in the synthesis

Paper 1. Lempp H, Seale C (Lempp & Seale 2004). This study looked at medical student's views about the quality of teaching they received. They carried out semi-structured individual interviews with 36 students across all years of one medical school. Personal encouragement, which included positive role models, was a positive factor which motivated students. Negative influences included: haphazard teaching where staff disregarded the timetable, made unscheduled changes, exhibited poor teaching skills, and showed a low level of commitment. Hierarchy, teaching through humiliation, professional rivalry, and disrespect from nurses. Competition manifested by a need to impress senior staff. The authors recommended that attention be given to the hidden curriculum.

Paper 2. Ratanawongsa N, et al. (Ratanawongsa et al. 2005). This study looked at third year medical students' experiences with death and dying patients. They conducted 32 open-ended interviews using a grounded theory approach. The themes identified included: relationship with patients: attachment, empathy identification emotions, and advocacy. Emotional and personal background: prior education, personal experiences coping strategies. Interaction with teams: acknowledgement, person not a disease, emotions shared, closure, time pressure, lack of opportunities to mourn, role-modeling, participation, and hierarchy. Development of professional identity: relationship in team, patients, struggle to balance objectivity with tendency to identify with patient, and emotional reactions to death.

Transitions: would capacity for caring diminish? Detachment as a form of self-preservation.

Paper 3. Nogueira-Martins MCF et al. (Nogueira-Martins et al. 2006) described 16 fifth year student perceptions of the doctor–patient relationship. Their concepts included: preclinical experiences: the gap between theory and practice, the desire for patient contact and the wish to be socially recognized, no time for socializing and competition. Clinical experiences: teachers' lack of interest in psychosocial care, role models positive and negative empathy and trust in doctor–patient relationship, delusions of omnipotence, clinical situations which inhibited empathy, difficult patients.

Their other key concept area was future fears: handling psychological problems, complaints, lack of empathy loss of idealism emotional neutralization, and a change in ethical integrity.

Paper 4. Griswold K et al. (Griswold et al. 2007). A qualitative study of 27 first and second year medical students which looked at cultural awareness in the context of caring for refugees. The themes identified were awareness of interpretation services, cross-cultural communication, humility, cultural background, and empathy.

Paper 5. Cutler JL et al. (Cutler et al. 2009) addressed stigma and enhancing empathy in medical students. Using a Grounded Theory approach, they studied 47 fourth year students who expressed an interest in psychiatry. The themes identified included stigma, stereotypes, stressful emotions, willingness to care, emotions and capacity for empathy.

Paper 6. Michalec B (Michalec 2011). This qualitative study with 10 first year and 10 second year students looked at the effects of the pre-clinical curriculum on their empathy. Themes identified were: the need to absorb facts and regurgitate information and concerns over what the faculty wanted them to know, examinations reflected what was important to the medical school, the absence of formal testing of psychosocial care, empathy and psychosocial care were not propagated in the culture of medicine and a lack of training or assessment in empathy.

Paper 7. Tavakol S et al. (Tavakol et al. 2012). A phenomenological study of 10 medical students in years 4 and 5. The themes identified were: the meaning of empathy, willingness to empathize, innate empathetic ability, barriers to empathy, empathy decline or detachment, and empathy education.

Paper 8. Eikland H-L et al. (Eikland et al. 2014) explored 11 third year students' views on influences on their empathy. Themes identified included: becoming a professional, how to balance distance and empathy, vulnerability, emotional blunting, emotional control, biomedical emphasis, the effects of the hidden curriculum, medical socialization and cynicism.

The third-order "lines of argument" synthesis is discussed in detail after the main themes across the papers are described.

Main themes from the studies

Conceptual confusion

Medical students thought of empathy in different ways. Some felt that it was predominantly cognitive, i.e.

concerned with understanding thoughts and feelings but not experiencing or sharing feelings with patient (Eikland et al. 2014). On the other hand, many students felt that empathy involved an affective core, i.e. connecting emotionally with the patient and so sharing feelings (Ratanawongsa et al. 2005). The way in which appropriate empathy is conceptualized has important implications for medical practice. If one adopts a narrow cognitive view then an appropriate professional stance may be one of detached concern (Halpern 2001). If on the other hand, a broad view of empathy is adopted then professionalism would include both academic cognitive skills and a willingness to explore and share the patient's emotions (Cutler et al. 2009). Students generally felt that patients wanted effective treatment with empathy and that understanding emotions would help them to be more effective doctors (Nogueira-Martins et al. 2006). Students expressed a strong desire to help patients and to be empathic. They also talked about empathy, as a broad concept, as being a fundamental part of care (Tavakol 2012). Students felt that a conception of empathy which encompassed emotions and feelings resulted in better communication and improved patient outcomes (Ratanawongsa et al. 2005). They said that understanding emotions helps doctor be more effective because far from impairing decision making, emotions are an important source of information. They also found that sharing emotions acted as a trigger for reflection.

Some students defined empathy by contrasting it with sympathy where they took a self-orientated perspective of the emotional suffering, i.e. how would I feel in this situation? (Tavakol 2012). Empathy differs from sympathy because it involves an other-oriented view, i.e. how does the patient feel? Others felt that empathy was an innate capacity, a personality trait, rather than a situation specific state (Tavakol 2012). Some students talked about empathy as a virtue, and the necessity for humility and kindness in medical care (Ratanawongsa et al. 2005; Eikland et al. 2014).

Distancing vs. connection

Distancing

Students talked about negative role models who are doctors who appeared insensitive, and lacked an interest in psychosocial issues (Lempp & Seale 2004; Ratanawongsa et al. 2005; Nogueira-Martins et al. 2006). Occasionally, these insensitive team members had an effect of teaching the student how not to interact with patients. Students commented about the stressful effect of humiliation and bullying (Lempp & Seale 2004). They noticed a gap between theory and practice in relation to the medical school's attitude to psychosocial care (Nogueira-Martins et al. 2006).

Teaching on empathy was lacking, some students described their communication skills training as a box-ticking exercise (Tavakol 2012). But perhaps the strongest message coming from these studies is the students' perception of a lack of hands-on patient contact, especially in the early years (Tavakol 2012). They found this frustrating since they had a strong desire for patient contact (Ratanawongsa et al. 2005; Nogueira-Martins et al. 2006). Students felt that

empathy was best learned in working with patients and that OSCEs and lectures were unhelpful in teaching them empathic skills (Tavakol 2012).

Students found that empathizing with difficult patients, conflict with patients, chaotic family situations, mental health patients, and critical patients was more challenging (Nogueira-Martins et al. 2006; Cutler et al. 2009; Tavakol 2012; Eikeland et al. 2014). There were issues of stigma and stereotyping when working with patients from different cultures or patients with mental illness (Cutler et al. 2009; Tavakol 2012). Some felt it was difficult to display empathy in team situations (Tavakol 2012). Students felt that one of the challenges in empathizing was their own lack of life experience (Ratanawongsa et al. 2005; Eikeland et al. 2014).

Connection

A number of broad themes were identified by students in these studies as facilitating empathy and emotional connection with patients. Positive caring role models were cited as powerful ways of learning to empathize with patients (Lempp & Seale 2004; Nogueira-Martins et al. 2006; Cutler et al. 2009). Young people need encouragement and need to be socially recognized and made to feel part of the team (Lempp & Seale 2004). Students particularly valued opportunities for patient contact and had a strong desire to be helpful (Ratanawongsa et al. 2005). They wanted to display their emotions and be humane but felt that they were constrained to do so (Eikeland et al. 2014).

Students found their own experience of illness was helpful in establishing empathy (Ratanawongsa et al. 2005; Eikeland et al. 2014). Contact with dying patients was a powerful means of experiencing empathy and was felt as a privilege (Ratanawongsa et al. 2005). Students appreciated having more time with patients and felt this established trust and empathy (Ratanawongsa et al. 2005; Cutler et al. 2009). In the context of end of life care, they learned their own limitations, biases and accepted vulnerability (Ratanawongsa et al. 2005). They recognized a need to maintain permeability and understanding for empathy to occur (Nogueira-Martins et al. 2006). They felt humility was related to empathy and found acting as a patient's advocate was helpful (Griswold et al. 2007; Eikeland et al. 2014). Storytelling was described by some students as an effective way to learn about empathy (Griswold et al. 2007).

The balance between detachment and connection

Students struggle to balance objectivity with empathy (Ratanawongsa et al. 2005). When assimilating the biomedical curriculum, they risk a cognitive overload when trying to do both (Eikeland et al. 2014). But many students wanted to be both academically sound and empathic, but were uncertain where to draw the line (Eikeland et al. 2014). They could appreciate that some distance may be appropriate but too much could lead to indifference (Ratanawongsa et al. 2005; Eikeland et al. 2014). Detachment meant that they did not engage in genuine dialogue with the patient (Eikeland et al. 2014). This synthesis shows that rather than any decline in empathy, students

cope by making a less overt demonstration of their empathy. They learn to hide their feelings (Tavakol 2012).

Since they retain their wish to empathize students are fearful of how they will be when they graduate as doctors (Eikeland et al. 2014). Would their capacity for caring diminish? How would they cope with the pressure of time? (Ratanawongsa et al. 2005; Nogueira-Martins et al. 2006) They still feared academic evaluation and the risk of appearing wanting (Ratanawongsa et al. 2005). They feared losing their empathy and lacked confidence in their ability to handle psychosocial problems. They also had worries around litigation and patients' complaints, further evidence of a lack of confidence. They hoped that they would not lose their idealism and suffer emotional blunting (Nogueira-Martins et al. 2006).

Biomedical model vs. psycho-social care

There were many references to the fact that the biomedical model and technical aspects of care were given a higher priority in medical school than psychosocial elements of care (Michalec 2011). Academic skills were prioritized over humanistic ones (Eikeland et al. 2014). The students talked about the emphasis on the need to be objective and this ideal of objectivity driving the need to be detached (Ratanawongsa et al. 2005; Eikeland et al. 2014). Emotions were seen as a threat to rationality (Eikeland et al. 2014). Some students consequently expressed negative feelings about seeking the patients' views in case emotions arose (Ratanawongsa et al. 2005). The students remarked that the first two years of the course were largely biomedical (Michalec 2011).

There was some feeling that emotions distract from clear thinking (Eikeland et al. 2014). However, when discussions with patients occurred without emotions the students described feelings of isolation and frustration (Ratanawongsa et al. 2005). They remarked on the strong emphasis on Evidence Based Medicine and their need to absorb facts (Michalec 2011; Eikeland et al. 2014). This strong emphasis on facts may alienate students from own feelings and experiences and undermine opportunities for reflection (Eikeland et al. 2014).

Some students were concerned about "What do faculty want me to know?" (Michalec 2011). Exams were seen as reflecting what the medical school valued (Michalec 2011). As there was no testing of their empathic or psychosocial skills students felt these were of lesser importance than biomedical aspects. Students said that they were not required to practice or to demonstrate empathy (Michalec 2011).

Hidden curriculum

Turning from their formal and informal curriculum students talked about the influences sometimes described as the hidden curriculum. Lempp defines this as "the set of influences that function at the level of organizational structure and culture including, for example, the implicit rules to survive the institution such as customs, rituals and taken for granted aspects" (Lempp & Seale 2004).

Students felt in a low position in the hierarchical atmosphere of the medical school (Lempp & Seale 2004; Ratanawongsa et al. 2005). They felt a pressure to compete and a need to impress their seniors (Lempp & Seale 2004).

Some talked of an illusion of omnipotence generated by this culture (Nogueira-Martins et al. 2006). Students were socialized to learn that empathy was not as important as biomedical learning and the technical aspects of treatment (Michalec 2011; Tavakol 2012; Eikeland et al. 2014). Lack of time was commonly cited as a challenge for empathy (Ratanawongsa et al. 2005; Tavakol 2012; Eikeland et al. 2014). If time is short then students drop what is not a top priority. Empathy was not propagated as a top priority by their teachers (Eikeland et al. 2014).

Some students felt that this culture did not reduce their empathy but made them less overt in their demonstration of empathy (Tavakol 2012). This was reflected in comments stating that empathy was harder to show in a team situation (Tavakol 2012). However, others felt that emotional blunting was inevitable (Eikeland et al. 2014). Students described situations where showing feelings was not permitted by senior doctors, so they became afraid to show emotions, e.g. not allowed to cry, or to hold a patient's hand (Eikeland et al. 2014). In consequence, they learned to hide their emotions when with a patient. Some commented that they were discouraged from exploring the patient's true feelings (Eikeland et al. 2014). Students were aware of the need to be professional and linked their concept of professionalism to detachment (Tavakol 2012). The context of their clinical work also affected their ability to be empathic, i.e. when they were very busy or where there was little privacy (Tavakol 2012).

Coping strategies

Detachment or distancing was widely used as a coping strategy to avoid being overwhelmed by the emotions involved in connecting with patients (Cutler et al. 2009). Distancing was then seen as a form of self-preservation (Eikeland et al. 2014). Some students differentiated between empathizing and identifying with patients, especially younger patients (Cutler et al. 2009). Simply sympathizing may cause distress which results in the student distancing herself to avoid suffering (Michalec 2011; Eikeland et al. 2014). Some reported becoming accustomed to distress and even to indifference (Eikeland et al. 2014). Another extreme distancing tactic described was cynicism, which in some cases was an accepted means of dealing with stress rather than a cause for concern (Eikeland et al. 2014). Students may struggle with empathizing because they do not know how to regulate emotions (Eikeland et al. 2014).

Limitations of the meta-ethnography

Meta-ethnography like much qualitative research is interpretative and creative. Searching for qualitative studies is more complex and difficult than searching for quantitative studies (Ring et al. 2011). Not only do definitions of empathy vary in the literature but the contexts of the research are often very different. Qualitative studies of empathy in medical students using one-to-one interviews are rare. Inclusion and exclusion criteria are critical for a meta-ethnography to achieve a specific a field of study. Data could have included focus groups, audio diaries, observational ethnographies, and written reflections but these were excluded to focus on the one-to-one interview

studies since these were a consistent method of data collection common to the eight papers. Most of the studies were cross-sectional in structure making it difficult to draw conclusions about changes in empathy. The generation of themes from the papers was the work of a single researcher, but the paper and conclusions were read by colleagues.

Discussion

Line of argument: third-order constructs

An over-arching theme across the synthesis appears to be whether empathy in a medical context should involve a sharing of emotions and feelings with the patient. This was expressed in many ways: the cognitive vs. affective conceptualization of empathy, the tension between distancing or connection, the emphasis on the biomedical rather than psycho-social dimensions of care, the hidden curriculum, and the fear of burnout or stress.

At a theoretical level, it is manifest in the differing conceptualizations of empathy, some emphasizing cognitive aspects and so favoring detached concern while others see empathy as both affective and cognitive and so involving a necessary sharing of emotions. The tensions are evident in the biomedical emphasis of the formal curriculum which is favored over psycho-social elements of care. The hidden curriculum may lead students to perceive emotions as threatening, perhaps leading to burnout, and so detachment may be adopted as a coping strategy.

This qualitative synthesis provides rich data which deepens understanding about the empathy decline claimed in quantitative research on empathy. The picture is much more complex, the synthesis reveals an underlying dichotomy in medical education and practice. The often quoted empathy decline in students may be rather that they have learned less overt ways of demonstrating empathy and feel that detachment is the appropriate stance of the medical professional.

Students may gain the impression that the medical school conducts examinations on the subjects it values most. A lack of teaching or assessment of empathy risks confirming to students that while empathy may be "nice", it is not essential.

Is detachment or connection (empathy) to be an integral part of the sort of professionalism which we wish our future doctors to develop? If we want to develop caring empathic doctors this meta-ethnography has some important lessons for medical education. A clear broad definition of empathy would include the affective as well as cognitive elements of the construct and so encourage connection with patients. The psycho-social elements of the curriculum need to be given a higher profile and students need to be tested to demonstrate their proficiency in these areas as well as their biomedical skills. Students fear that they may be overwhelmed, or that their clinical judgment may be clouded, by emotional connection with patients. They may respond to this uncertainty by either detaching from patients or concealing their empathy. They are unclear how to regulate empathy and need training to enable them to connect with patients without being overwhelmed. They need time to develop trusting relationships with patients and opportunities to experience continuity of care.

They also have fears that their empathy may be eroded in the future once they have qualified as doctors.

Students need to have more direct patient contact both earlier in the course and during the later stages since this seems to be the time when empathy can be best enhanced. Clinical teachers need to encourage students to share their feelings and to reflect on their care of the patient as a person rather than an intellectual problem. The often quoted empathy decline in students may be illusory and rather reflect that they have learned less overt ways of demonstrating empathy. If medical students are encouraged to share and to discuss their emotions and feelings then they will feel confident in adopting a broad concept of empathy as a core part of their developing professionalism.

Glossary

Phenomenology: Phenomenological research is the study of the lived experience and the life world with the aim of achieving a deeper understanding of the nature or meaning of one's everyday experiences (Van Manen M. 2015. *Researching lived experience: human science for an action sensitive pedagogy*. Left Coast Press).

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Notes on contributor

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References

- Barroso J, Gollap C, Sandelowski M, Meynell J, Pearce PF, Collins LJ. 2003. The challenges of searching for and retrieving qualitative studies. *West J Nurs Res*. 25:153-178.
- Batt-Rawden SA. 2013. Teaching empathy to medical students: an updated, systematic review. *Acad Med*. 88:1171-1177.
- Booth A. 2010. How much searching is enough? Comprehensive versus optimal retrieval for technology assessments. *Int J Technol Assess Health Care*. 26:431-435.
- Campbell R, Pound P, Pope C, Britten N, Pill R, Morgan M, Donovan J. 2003. Evaluating meta-ethnography: a synthesis of qualitative research on lay experiences of diabetes and diabetes care. *Soc Sci Med*. 56:671-684.
- CASP. 2010. Critical appraisal skills programme: making sense of evidence about clinical effectiveness: 10 questions to help you make sense of qualitative research. Oxford; [cited 2015 Jul 8]. Available from: http://media.wix.com/ugd/dded87_29c5b002d99342f788c6a-c670e49f274.pdf.
- Chen D, Lew R, Hershman W, Orlander J. 2007. A cross-sectional measurement of medical student empathy. *J Gen Intern Med*. 22:1434-1438.
- Colliver JA, Conlee MJ, Verhulst SJ, Dorsey JK. 2010. Reports of the decline of empathy during medical education are greatly exaggerated: a reexamination of the research. *Acad Med*. 85:588-593.
- Coplan A, Goldie P, editors. 2011. *Empathy philosophical and psychological perspectives*. Oxford: Oxford University Press.
- Cutler JL, Harding KJ, Mozian SA, Wright LL, Pica AG, Masters SR, Graham MJ. 2009. Discrediting the notion "working with 'crazies' will make you 'crazy'": addressing stigma and enhancing empathy in medical student education. *Adv Health Sci Educ*. 14:487-502.
- Eikeland HL, Omes K, Firsat A, Pedersen R. 2014. The physician's role and empathy – a qualitative study of third year medical students. *BMC Med Educ*. 14:165.
- Fingfeld-Connett D, Johnson ED. 2013. Literature search strategies for conducting knowledge-building and theory-generating qualitative systematic reviews. *J Adv Nurs*. 69:194-204.
- Flemming K, Briggs M. 2007. Electronic searching to locate qualitative research: evaluation of three strategies. *J Adv Nurs*. 57:95-100.
- Francis R. 2013. Report of the Mid Staffordshire NHS foundation trust public inquiry: executive summary. Vol. 947. London: The Stationery Office.
- Griswold K, Zayas LE, Kernan JB, Wagner CM. 2007. Cultural awareness through medical student and refugee patient encounters. *J Immigr Minor Health*. 9:55-60.
- Halpern J. 2001. *From detached concern to empathy: humanizing medical practice*. New York: Oxford University Press.
- Hojat M, Mangione S, Nasca TJ, Rattner S, Erdmann JB, Gonnella JS, Magee M. 2004. An empirical study of decline in empathy in medical school. *Med Educ*. 38:934-941.
- Lempp H, Seale C. 2004. The hidden curriculum in undergraduate medical education: qualitative study of medical students' perceptions of teaching. *BMJ*. 329:770-773.
- Mercer SW, Reynolds WJ. 2002. Empathy and quality of care. *Br J Gen Pract*. 52:59-512.
- Michalec B. 2011. Learning to cure, but learning to care? *Adv Health Sci Educ Theory Pract*. 16:109-130.
- Morse JM, Anderson G, Bottoff JL, Yonge O, O'Brien B, Solberg SM, McIlveen KH. 1992. Exploring empathy: a conceptual fit for nursing practice? *Image J Nurs Sch*. 24:273-280.
- Neumann M, Edelhaeuser F, Tauschel D, Fischer MR, Wirtz M, Woopen C, Haramati A, Scheffer C. 2011. Empathy decline and its reasons: a systematic review of studies with medical students and residents. *Acad Med*. 86:996-1009.
- Noblit GW, Hare RD. 1988. *Meta-ethnography: synthesizing qualitative studies*. Vol. 11. London: Sage.
- Nogueira-Martins MCF, Nogueira-Martins LA, Turato ER. 2006. Medical students' perceptions of their learning about the doctor-patient relationship: a qualitative study. *Med Educ*. 40:322-328.
- Pedersen R. 2009. Empirical research on empathy in medicine – a critical review. *Pat Educ Counsel*. 76:307-322.
- Pope C, Ziebland S, Mays N. 2000. Qualitative research in health care. *Analysing qualitative data*. *BMJ*. 320:114-116.
- Quince TA, Parker RA, Wood DF, Benson JA. 2011. Stability of empathy among undergraduate medical students: a longitudinal study at one UK medical school. *BMC Med Educ*. 11:90.
- Ratanawongsa N, Teherani A, Hauer KE. 2005. Third-year medical students' experiences with dying patients during the internal medicine clerkship: a qualitative study of the informal curriculum. *Acad Med*. 80:641-647.
- Ring N, Jepson R, Ritchie K. 2011. Methods of synthesizing qualitative research studies for health technology assessment. *Int J Technol Assess Health Care*. 27:384-390.
- Smith JA, Flowers P, Larkin M. 2009. *Interpretative phenomenological analysis: theory, method and research*. London: Sage.
- Tavakol M, Sandars J. 2014. Quantitative and qualitative methods in medical education research: AMEE Guide No. 90: Part I. *Med Teach*. 36:746-756.
- Tavakol M, Sandars J. 2014. Quantitative and qualitative methods in medical education research: AMEE Guide No. 90: Part II. *Med Teach*. 36:838-848.
- Tavakol S, Dennick R, Tavakol M. 2012. Medical students' understanding of empathy: a phenomenological study. *Med Educ*. 46:306-316.
- Tavakol S. 2012. Medical students' understanding of empathy: a phenomenological study (vol 46, pg 306, 2012). *Med Educ*. 46:306-723.
- Yoshii A, Plaut D, McGraw K, Anderson MJ, Wellik K. 2009. Analysis of the reporting of search strategies in Cochrane systematic review. *J Med Libr Assoc*. 97:21.

Debate & Analysis

Clarifying empathy:

the first step to more humane clinical care

THE DEHUMANISING OF CLINICAL CARE: AN EMPATHY DEFICIT

Currently, empathy and the 'humanisation' of medical care are of particular concern in the wake of high-profile reports. These include the Mid Staffordshire NHS Foundation Trust public inquiry; *Dying Without Dignity*, a report by the Health Service Ombudsman into end-of-life-care; and the Leadership Alliance for the Care of Dying People report, *One Chance to Get it Right*.¹⁻³ These reports all pointed to an empathy deficit in clinical care. A disheartening aspect of the current situation is that empathy deficit is not a new phenomenon.

In 1927, in a seminal study Peabody wrote:

*'One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient.'*⁴

Twenty years ago, Weatherall argued that many of the ills of the medical profession reflect a lack of 'whole person understanding'.⁵ More recently, Spiro observed that doctors who used to listen to patients now looked at a screen. He wrote:

*'Empathy has always been and will always be among the physician's most essential tools of practice.'*⁶

Spiro argues that physicians must have the time to listen to patients.⁷

However, medicine's positivist view prioritises technical progress, evidence-based medicine, targets, and efficiency, so risking a view of patients solely as objects of intellectual interest.⁸ Mattingly suggests that, because the medical culture does not consistently support the practice of empathy, it becomes easy for doctors to see empathy as 'nice' but not an essential part of practice.⁹

CLARIFYING EMPATHY

Doctors have always struggled to achieve a balance in their relationship with patients between connection and distance. Doctors can choose between a narrow technical approach based on their competence, or a broader humanistic approach that is more ambiguous and less reductionist.¹⁰ The way in which doctors define appropriate empathy can influence their approach to patients and their concepts of professionalism, so there is

" [The] tension between detached concern and emotional connection lies at the heart of humanising medical care."

a need to clarify empathy.

Lipps used the term *Einfühlung* (feeling into) to explain how people become aware of each other's mental states.¹¹ Edward Titchener used the Greek word *empathia* to translate *Einfühlung* and, in 1909, coined the term 'empathy'.¹² A simple view of empathy is the ability to understand and share another person's feelings and perspectives, and using that understanding and emotion to guide future action.¹³ Empathy, sympathy, and compassion are terms that refer to emotions that people experience in response to the suffering of others.¹⁴

Sympathy may overlap with emotional aspects of empathy but it is not concerned with understanding the other person's affective state or point of view. Sympathy can be felt towards people whether they are known or not and even to fictional characters.¹⁴ Sympathy takes a 'self-oriented' perspective, that is, 'How would I feel if this was happening to me?' Compassion and empathy are often used interchangeably in the literature and the close link between them is reflected in Maxwell's term 'compassionate empathy'.¹⁵ Compassion means 'to suffer with' and is usually accompanied by a desire to relieve the other's suffering. Compassion, like sympathy, is shown when some misfortune occurs to another person but it is triggered by more serious concerns. One might have sympathy for someone missing a train but not compassion. Empathy is a deeper construct than compassion because one can feel compassionate concern for another without making any attempt to understand their feelings and point of view.

EMPATHY: DETACHMENT (NARROW VIEW) OR CONNECTION (BROAD VIEW)?

There is a division in the literature between those who take a broad view of empathy and those adopting a narrow view. This division has major implications for clinical practice and for psychosocial aspects of care in particular. For those adopting a narrow definition, empathy is considered as intellectual understanding of the patient's affective state, a form of

'detached concern'. This type of empathy has been described as cognitive empathy.¹⁶ However, I argue it is more appropriate to take a broad view, in which empathy involves a sharing of emotional feeling and connecting with the patient at an emotional level. This is described as affective or emotional empathy.¹⁶ This tension between detached concern and emotional connection lies at the heart of humanising medical care.

Halpern identifies, and then dismisses, three arguments in the literature that attempt to justify avoiding affective (or emotional) empathy and adopting 'detached concern'.¹⁷ These arguments are that: emotions interfere with the clinical assessment of the patient and the doctor's objectivity; they threaten the ability to provide effective care during difficult circumstances; and that emotions will increase the risk of burnout.¹⁸

Detachment is not necessary for reliable clinical judgement because emotional insights can inform clinical decision making. Moreover, it has been suggested that empathic doctors have more job satisfaction and less burnout than detached colleagues.¹⁷ In a recent editorial Zenasni and colleagues explored the complex relationship between burnout and empathy.¹⁹ Even if doctors try to suppress their feelings by distancing themselves, they cannot avoid having emotional attitudes towards patients.¹⁹

Some doctors who adopt 'detached concern' define empathy as strictly cognitive empathy. For instance, the US Society of General Internal Medicine defines empathy as:

*... the act of correctly acknowledging the emotional state of another without experiencing that state oneself.*²⁰

It appears that professionalism for some doctors means keeping suitably detached from emotional situations.

However, it seems that patients want their doctors to demonstrate concern.²¹ People recovering from psychological trauma describe how an emotionally neutral listener

makes them feel insignificant or even unreal.¹⁰ A crucial aspect of affective (emotional) empathy is to share feelings rather than merely labelling an emotional state.

Maxwell helpfully suggests that the contrast between affective and cognitive empathy should not define rival conceptions of empathy but rather point out which dimension of empathy is appropriate in any clinical situation.¹⁵

APPROPRIATE EMPATHY: A BROAD VIEW THAT CAN HUMANISE CLINICAL CARE

In developing a broad view of empathy there is a need to examine behavioural, cognitive, emotional, and moral facets of empathy that combine in different ways in different clinical situations.²² From a broad perspective, empathy becomes a unique kind of understanding through which we experience what it is like to be another person:

Empathy is a complex imaginative process in which an observer simulates another person's situated psychological state (both cognitive and affective) while maintaining a clear self-other differentiation.²³

Decety extends the definition of empathy by including a commitment to action:

... a process which may involve three steps; perceiving the individual in need, understanding and feeling the patient's unique experience and caring about this enough to engage in helping the patient.²⁴

From a broad view, empathy is a process that is dependent on the clinical context and occurs in a reciprocal relationship with a patient. From a review of the theoretical and empirical literature on empathy the following model of empathy emerges.

A MODEL OF EMPATHY

At empathy's core lies **Connection**, which involves engaging emotionally with the patient's perspective and feeling the distress of the patient, while maintaining an **other-oriented perspective**. The doctor tries to imagine what it is like to be the patient and to see the world from the patient's perspective. This perspective protects the doctor from the personal distress that may result from taking a self-oriented (sympathetic) perspective.²⁵ **Self-other differentiation** implies that, although empathy should involve a deep engagement with the patient, this does not mean that the doctor loses sight of where the self ends and the other begins. In empathy the doctor is emotionally engaged with the patient and at the same time they are able to

reflect on these emotions, knowing that they originate in the other person.¹⁰

Cognition involves attempting to understand the perspective and experience of the other person. This depends on having **Curiosity**, to gain understanding into the patient's concerns, feelings, and distress.

Curiosity requires suspending judgement and allowing uncertainty. It prevents the doctor from having an initial naive sympathetic response, taking their initial resonance at face value and then projecting their concerns onto the patient.²⁶

Empathy is dynamic, requires effort, and involves **Action**, which is shown in **Concern** and **Care** for the patient, giving them a sense that they matter and that they will not be abandoned.²⁶ **Care** is the activity generated by the understanding gained by empathy. Empathy has an ethical dimension as a fundamental element of care. Empathy needs action and feedback by checking with the patient whether the doctor's understanding of their concerns is accurate.^{10,27} **Reciprocity** implies that empathy is a two-way relationship with the patient. Empathy also enables patients to imagine what it might be like for the doctor.²⁸ **Humility** is an essential virtue and is a part of empathy that acknowledges limits. It is not possible to fully understand another person's thoughts, beliefs, and feelings, so humility counters the paternalistic phrase 'I know how you feel.'²⁸

So it seems that, rather than attempting to capture the elusive concept of empathy in a reductive definition, it is more helpful to conceptualise empathy by describing the various facets that may be involved. The balance of particular elements of the construct will vary in differing clinical contexts, giving rise to multiple forms of empathy. For instance, the empathy involved when resuscitating a patient in the emergency department will be different from that involved when breaking news to a mother that her child is dying.

CULTURE CHANGE: A MORE HUMANE PRACTICE

Francis called for a culture change in the NHS to include more compassionate care.¹ By fostering a broad view of empathy and incorporating this into daily practice, empathy can become a routine way in which a doctor works. Halpern maintains that empathy elevates a doctor's work from just a job to a profession in which they contribute to the meaningfulness of people's lives.¹⁰ A broad view of empathy integrates emotional and cognitive elements of empathy. As Jamison writes, *we care because the feelings of others matter.*²⁹ Doctors need courage to enter the

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interpersonal world and to practise their empathic skills. Empathy is not something that just happens to us; it is a choice we make to pay attention, to extend ourselves, and it requires effort.²⁹ Empathy is not just necessary for effective medical practice but it is almost inconceivable for a skilled doctor to lack empathy.¹⁵ A willingness to feel and convey empathy may result in a culture shift in medicine from detached concern to a broad view of empathy as the way of seeing the world from the patient's point of view.

CONCLUSION

The aim of this article is to stimulate debate about empathy in clinical practice. I have argued that appropriate empathy in modern clinical care is neither detachment from patients nor being overwhelmed by emotions. It is rather an iterative process of emotional resonance and curiosity about the meaning of a clinical situation for the patient.⁸ This broad form of empathy involves the capacity to participate deeply in the patient's experience while not losing sight of the fact that it is not one's own experience but that of another person. If doctors are to respect the patient's dignity they need empathy and self-awareness. Without self-awareness doctors can lose the 'other-perspective' and then become overwhelmed. Self-aware physicians can then experience empathy as a naturally healing connection with their patients.¹⁷

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A duty of kindness

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The problem

'When I can think of nothing positive to write about in a reference for a junior doctor, I say she is kind,' commented a colleague. Kindness has now been relegated to an attribute of losers rather than being an integral part of a doctor's duty to a patient. Because our medical culture does not consistently support the practice of kindness, doctors may view kindness as 'nice' but not an essential part of their practice. The Francis Report contained harrowing examples of unkindness to patients and failings in basic patient care.¹ Medicine's positivist view, prioritising technical progress, evidence-based medicine and targets, risks viewing a patient solely as an object of intellectual interest.² Respecting a patient's dignity now involves pathways, guidelines and risk assessments. The technical and scientific elements of medicine outweigh psycho-social care which is sometimes thought of as part of an outdated 'nostalgic professionalism'.³

Professionalism has a dark side and unkindness is often hard to challenge in a medical hierarchy. Some doctors can humiliate students and junior doctors by embarrassing them in the presence of patients and their peers. Unkindness may extend to bullying and harassment which often goes unchecked and even becomes an accepted part of a macho culture. Institutional unkindness may occur in prolonged investigations of complaints which may subject doctors to unbearable stress.

Unkindness to patients is often more subtle; by using distancing tactics such as appearing busy, concentrating on scans and the results of tests, and ignoring patients' anxieties, doctors can leave patients feeling isolated. In a management culture which measures success in numbers, league tables and throughput, time spent with the patient addressing their concerns is not valued so is not seen as an essential part of a doctor's duty. Medicine is not a competitive sport yet sadly some doctors take a lifetime to learn this. Competition is instilled in students from their school days. When they achieve a place in medical school they are aware from their first day that their future posts as Foundation Year doctors

depends upon their grading throughout their medical undergraduate training. Is this the way to foster cooperation and kindness and inspire young people to learn the craft of medicine?

It is paradoxical that we have developed the most sophisticated methods of communication but at a personal level these seem to have isolated us from others. We find it difficult to find another human being to speak to face-to-face, to touch, to listen, to share our thoughts, to connect. Independence and self-reliance are now our ethical aspirations. We have come to deny our dependency on others. Rather than embracing dependence and vulnerability, we scorn them as though they are incompatible with autonomy. Kindness inevitably exposes our vulnerability and acknowledges our dependence on others. Kindness can have negative associations with patronising behaviour, pity or paternalism. It may also be regarded with suspicion as either a self-serving behaviour or a form of weakness.

Kindness

Kindness is an elusive concept which is easy to recognise but difficult to define. Kindness can be conceptualised as a virtue with links to other forms of pro-social behaviour such as compassion in its concern to benefit others.⁴ A virtue is part of the moral character of a doctor while a duty implies an obligation to others, a rule of conduct.⁵ Kindness is derived from kinship or concern for fellow human beings and acts as a connection between the self and the other. Ballatt and Campling⁶ argues that kindness is no soft option but inspires people to build relationships with patients and to treat them well. An experienced and humane American physician describes how he was reprimanded after giving a patient a small amount of money from his own pocket to buy medication which he could not afford.⁷ This small act of human kindness was regarded by some other doctors as unprofessional. They cling to a detached professionalism which discourages doctors from caring for and about their patients.⁷ Students and doctors always remember acts of kindness by their teachers

and trainers. I remember an inspiring consultant whose kindness and support for his junior staff extended through our careers.⁸

Patients often appreciate acts of kindness more than the technical expertise of doctors. I remember the cardiologist who sat in his busy clinic and asked me 'What's it like to have atrial fibrillation?' He took time to listen as I described how the arrhythmia had affected my life and work. After a successful laser ablation operation I will always be grateful for his technical skill, but it is his humanity and kindness that I most remember. Kindness may be expressed by giving time and sharing our humanity. Appropriate humour, self-disclosure and empathy may be ways in which we share in our human predicament and be perceived by the patient as kindness.

How did we get here?

Philips and Taylor⁹ ask why does our society perceive kindness as a threat? The authors trace the history of kindness in medicine and society to seek an answer to their question.⁹

Over 2000 years ago, Plato (428–347 BC) described two types of doctors. 'For doctors, as I may remind you, some have a gentler, others a ruder method of cure. The slave doctors run about and cure the slaves... practitioners of this sort never talk to their patients individually, or let them talk about their individual complaints. But the other doctor who is a freeman, attends and practices upon freemen; and he carries his enquiries far back, and goes into the nature of the disorder; he enters into discourse with the patient and with his friends, and is at once getting information from the sick man.'¹⁰

Plato's different doctors are recognisable in our hospitals and communities today. Even Stoics who were notoriously resilient had a communal sense of the self. They described the attachment of the self to others as circles of *Oikesiosis* (connection) gradually radiating outwards like the ripples on a pond to eventually include all humanity.⁹

Hume, in the Enlightenment, thought that anyone foolish enough to deny the existence of kindness 'has forgotten the movements of his heart'.^{9,11} Hume's notion of kindness was linked with sympathy but probably corresponds with modern notions of empathy.

In the 19th century, kindness was seen as a bridge between the self and the other. However, later in the century, Philips and Taylor⁹ describes how kindness was feminised and selfishness became institutionalised in our society. In the *Descent of Man*, Darwin argues that we are a profoundly social and caring species. He concluded that evolution was not simply

a matter of survival of the strongest but the survival of the best adapted, a cohesive group being better adapted to survive.¹² Nowadays in our enterprise culture, practising medicine is often a life of overwork, anxiety and isolation, a competitive society breeds unkindness.

The notion that doctors should be detached from patients was endorsed by the famous physician Sir William Osler. 'This neutrality in witnessing human suffering gives him (the doctor) a special glimpse into the "inner life" of patients.'¹³ An opposing view was presented in 1927, in a seminal paper, Peabody said 'One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient'.¹⁴ Twenty years ago, Weatherall¹⁵ argued that many of the ills of the medical profession reflect a lack of 'whole person understanding'. More recently, Spiro expressed concern that doctors who used to listen to patients now looked at a screen.¹⁶

How can this change?

Philips and Taylor⁹ remark that while kindness connects us to the other person, it also makes us aware of our own and others' vulnerabilities. If doctors are to be kind in their practice they need to embrace vulnerability rather than pretending that they are omnipotent. We are all vulnerable at every stage of our lives, we are born dependent on others and die dependent on others. In clinical care, bearing another person's vulnerability means connecting with them and sharing their suffering without necessarily relieving it. Desmond Tutu expands the concept of kindness in describing *Ubuntu*. 'A person with ubuntu is welcoming, hospitable, warm and generous, willing to share. Such people are open and available to others willing to be vulnerable, affirming of others, do not feel threatened that they are able and good, for they have a proper self assurance that comes from knowing that they belong in a greater whole.'¹⁷

Can kindness be restored into medical care? Chochinov's ABCD model of dignity care teaches us to understand that our approach and behaviour can affect a patient's sense of self-worth.¹⁸ One way of improving care could be by teaching students to value kindness, tolerance and an open approach to others. The challenge we face in the West is how do we institutionalise kindness as a duty, extend our kindness to family and friends and spread it to meet the needs of strangers?⁹ Kindness is an integral part what makes us fully human. We depend on each other not just for survival but for human flourishing, a fulfilling of our potential, described by Aristotle as *eudaimonia*.¹⁹ Modern medical education and clinical

practice resists this truth in valuing independence and competition. We need now to establish kindness as one of the doctor's duties to a patient.

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References

- Francis R. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary*. London: The Stationery Office, 2013.
- Shapiro J. The paradox of teaching empathy in medical students. In: Decety J (ed.) *In Empathy: From Bench to Bedside*. New York: MIT Press, 2012.
- Erde EL. Professionalism's facets: ambiguity, ambivalence, and nostalgia. *J Med Philos* 2008; 33: 6–26.
- Batson CD and Shaw LL. Evidence for altruism: toward a pluralism of prosocial motives. *Psychol Inq* 1991; 2: 107–122.
- Hursthouse R. *On Virtue Ethics*. Oxford: Oxford University Press, 1999.
- Ballatt J and Campling P. *Intelligent Kindness*. London: RCPsych Publications, 2011.
- Schiff G. Crossing boundaries – violation or obligation? *JAMA* 2013; 310: 1233–1234.
- Jeffrey D. *Medical Mentoring: Supporting Students, Doctors in Training and General Practitioners*. London: Royal College of General Practitioners, 2014.
- Philips A and Taylor B. *On Kindness*. London: Hamish Hamilton, 2009.
- Plato. *Laws Book IV*. Jowett B, ed., New York: Dover Publications, 2006.
- Hume D. *A Treatise of Human Nature*. Nidditch PH, ed. Oxford: Oxford University Press, 1739/1978.
- Darwin C. *The Descent of Man*. London: Wordsworth Editions, 2013.
- Osler W. *Aequanimitas*. New York: Norton, 1963.
- Peabody F. The care of the patient. *JAMA* 1927; 88: 876–882.
- Weatherall D. The inhumanity of medicine. *BMJ* 1994; 309: 1671.
- Spiro H. Commentary: the practice of empathy. *Acad Med* 2009; 84: 1177–1179.
- Tutu D. *No future without forgiveness*. London/Johannesburg: Rider Books, 1999.
- Chochinov H. Dignity and the essence of medicine: the A, B, C, and D of dignity conserving care. *BMJ* 2007; 335: 184–187.
- Aristotle. *The Nichomachean Ethics*. Tredennick H, ed. London: Penguin Books, 2004.

Empathy, sympathy and compassion in healthcare: Is there a problem? Is there a difference? Does it matter?

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Introduction

Empathy, sympathy and compassion are defined and conceptualised in many different ways in the literature and the terms are used interchangeably in research reports and in everyday speech.¹ This conceptual and semantic confusion has practical implications for clinical practice, research and medical education. Empathy, sympathy and compassion also share elements with other forms of pro-social behaviour such as generosity, kindness and patient-centredness.² There is a need for conceptual clarity if doctors are to respond to the calls to provide more 'compassionate care'.³ This paper argues that there is currently a problem in the balance between scientific-technical and psychosocial elements of patient care. A broad model of empathy is suggested which could replace the vaguer concepts of sympathy and compassion and so enable improvements in patient care, psycho-social research and medical education.

Is there a problem?

Since the Francis Report which revealed severe failings in patient care in the Mid Staffordshire NHS Foundation Trust, there has been a resurgence of interest in the humanisation of medical care.³ Francis called for a culture change in the NHS to include more compassionate care and this was echoed by the Chief Nursing Officer's recommendation to nurses.^{3–5} The essence of dehumanisation is the denial of another person's mental life and dignity.⁶

The question arises as to why people in caring professions cease to show care?⁶ Among the contributory factors identified in the Francis report were: compassion fatigue, overwork, excess demand, lack of continuity and a failure to see the patient as a fellow human being.^{3,6} Medicine's positivist view prioritises technical progress, evidence-based medicine, targets and efficiency, so risking a view of patients solely as objects of intellectual interest.⁷ Healthcare

professionals may distance themselves from patients, avoiding emotions and focusing on biomedical facts: a process described as 'existential neglect'.^{8,9} The blame culture prevalent in the NHS leads to a punitive climate where a lack of tolerance leads to a loss of learning and the generation of fear.⁹ In such a social environment, the dynamics of power conformity may influence good people to act thoughtlessly.⁹ Mechanistic organisational healthcare systems create a risk of dehumanisation, with a loss of empathy, which can alienate clinicians from patients.^{5,9–11} Commercialisation of healthcare leaves people vulnerable to being treated instrumentally, not as ends in themselves in a culture which fosters competition rather than collaboration.⁹ Zulueta¹⁰ identifies the overemphasis of the biomedical model in medicine as another factor threatening the delivery of good psycho-social care.¹⁰

Although the lapses in care reported by Francis and others are not entirely due to a 'compassion deficit', the general consensus is that there is a problem in the provision of psycho-social care in all settings and an urgent need to address the balance between scientific and psycho-social care.¹⁰ Concern about a deficit of empathy in clinical practice is mirrored in medical undergraduate education, where there is conflicting evidence of a decline in empathy as students move through their training.^{12–15}

Is there a difference?

Words that describe human social relationships and subjective emotions may be difficult to define. Empathy, sympathy and compassion are often confused with each other and with a number of other processes involving sharing in another person's feelings especially of distress or suffering.^{10,16} Compassion and empathy are often used interchangeably and the close link between them is reflected in Maxwell's term 'compassionate empathy' which represents his attempt to clarify the confusion by adopting the broadest term.¹⁶

Empathy

Empathy is a complex, multifaceted, dynamic concept which has been described in the literature in many different ways. So it appears that empathy means different things to different people. The conceptualisation of empathy has evolved in different ways relating to differing disciplines such as medicine, nursing, philosophy, psychology and counselling. This evolution can be best illustrated by addressing four dimensions of empathy: affective, cognitive, behavioural and moral. However, in practice, these four dimensions interact and overlap to differing extents in differing contexts in different clinical situations.

Affective (emotional) empathy

Theodor Lipps (1851–1914) used the term *Einführung* (feeling into) to explain how people become aware of each other's mental states.¹⁷ *Einführung* was a process of inner resonance with the other, an 'emotional contagion', a state in which the observer takes on the emotion of the other person.¹⁷ Affective empathy is the ability to subjectively experience and share in another's psychological state or feelings.¹⁸ Sharing the emotion (affective matching) may lead to empathic distress or concern which precedes and contributes to helping behaviour.¹⁹ In affective matching, the doctor experiences the same type of emotion as the patient; this process also involves cognitive evaluation and imagination.²⁰ Our emotional lives inevitably are linked to our actions so there cannot be a rigid distinction between action and attitude. As perception is context-specific, empathy can be conceptualised as a form of perception where people can literally feel the emotional states of others as their own.²¹

Cognitive empathy

Cognitive empathy is the ability to identify and understand another person's feelings and perspective from an objective stance.¹⁸ This cognitive requirement differentiates empathy from sympathy and compassion. Cognitive empathy has been described as 'detached concern' or the ability of one individual to understand the experiences of another without evoking a personal emotional response.²² Cognitive empathy has been conceptualised as an active skill that is acquired and is amenable to nurturing.^{23–26}

Edward Tichener used the Greek word *empathia* to translate *Einführung* and was first, in 1909, to coin the term 'empathy'.²⁷ Stein emphasised the intersubjective and relational aspect of empathy and claimed that empathy enabled us to understand others and

also to understand ourselves as others experience us. This relational component was another important development of the construct of empathy.²⁸

Carl Rogers, the founder of humanistic psychology, placed empathy at the heart of his patient-centred psychotherapy.²⁹ For Rogers, when we empathise, we enter the world of the other and become at home in it, regarding empathy, like Stein, as a relational process. Rogers felt that there was a risk of over-identifying with the patient which then may distort understanding and threaten the therapeutic process.²⁹

It is necessary here to distinguish between self- and other-orientated perspective taking. In self-orientated perspective taking, I imagine what it is like for me to be in your situation, a form of identification.³⁰ This assumption of similarity leads people to conclude that others will think and feel as they do. So we do not just fail to understand the patient's experience, we assume we do and this can lead to a new set of problems: mistakes in prediction, false assumptions and personal distress in the observer.²⁰ This self-orientated perspective, exemplified in sympathy rather than empathy is shown by the doctor who says 'I know how you feel'. Another of the many problems with a self-orientated perspective is that the doctor focuses on his/her own distress and this may result in them distancing themselves from the patient as a way of relieving their distress.²⁰ Doctors who take a self-orientated perspective are at risk not only of personal distress but eventually burnout.³¹

In contrast, an other-orientated perspective avoids the false assumptions, prediction errors and the personal distress experienced by those taking a self-orientated perspective.²⁰ Empathy starts with curiosity and imagination.³² I imagine being the patient undergoing the patient's experience rather than imagining being myself undergoing the patient's experience. This more sophisticated approach requires mental flexibility, an ability to regulate one's emotions and to suppress one's own perspective in the patient's interests. To adopt the patient's perspective, one has to have some background knowledge of the patient and the context in which she suffers. Halpern describes the need to 'decentre' rather than detach, stepping aside from one's own emotional perspective and imaginatively viewing the situation from the patient's position while not submerging in identification with the patient by retaining a sense of the self-other boundary.³²

Behavioural empathy

Irving's three-dimensional model of empathy proposes that the doctor has to understand the patient's

world (cognitive), feel with the patient (affective) and communicate this understanding with the patient (behavioural)³³ Derksen et al.³⁴ conceptualise the three-dimensional model of empathy as comprising attitude (affective), competency (cognitive) and skill (behaviour). Coplan defines empathy as: 'Empathy is a complex imaginative process in which an observer simulates another person's situated psychological state (both cognitive and affective) while maintaining a clear self-other differentiation'. For Coplan, empathy involves the following steps: affective matching, other-orientated rather than self-orientated perspective taking and self-other differentiation.²⁰ Decety extends the definition of empathy to include helping the patient.³⁵ Mercer's definition also includes action; empathy in a clinical situation includes an ability to: (a) understand the patient's situation, perspective and feelings (and their attached meanings); (b) to communicate that understanding and check its accuracy; and (c) to act on that understanding with the patient in a helpful (therapeutic) way.³⁶ Halpern also claims that empathy needs action, 'empathy without action is not empathy'.³² Bondi³⁷ emphasises the maintenance of the self-other boundary: Empathy is a process in which one person imaginatively enters the experiential world of another without losing an awareness of its difference from one's own.

Moral empathy

Morse identifies a moral component as a fourth dimension of empathy; an internal motivation of concern for the other and a desire to act to relieve their suffering by caring and driving acts of altruism.³⁸ There is evidence to support the claim that empathy increases motivation to perform pro-social and altruistic acts so overlapping with notions of compassion.^{38,39}

Feminist care ethics maintains that moral thought and action require both reasons and emotions as well as attention to the needs of particular others⁴⁰⁻⁴² From a care ethics perspective, the practice of caring is integral to the moral life and empathy is an important element of caring. Noddings thought that empathy was an essential tool for developing our understanding of others and enabling us to decide what is the best course of action in practice.⁴¹ For Noddings, care closely relates to empathy since caring depends upon attending to the specific needs of particular patients and attempting to understand the situation from the patient's point of view.⁴¹ Slote adds that empathy maintains the motivation to care.⁴³ A moral issue of authenticity also arises in connection with empathy. In everyday experience, we instantly recognise the 'have a nice day' approach

of fake empathy. It is not sufficient to mimic the patterns of speech or behaviours which appear empathic, there must also be authentic concern.^{44,45}

Maxwell³⁶ proposes that empathy can be conceived as a competence or disposition which plays a role in enabling moral judgement and so is basic to moral functioning. Hilfiker argues that a fundamental goal of teaching ethics in medicine should be to foster a sense of empathy.⁴⁶

Sympathy

Sympathy is the broadest of these terms, signifying a general fellow feeling, no matter of what kind. Sympathy is an emotion caused by the realisation that something bad has happened to another person.¹ The triggers of sympathy can be mild discomfort to serious suffering. In defining empathy, some authors contrast the concept with sympathy, which has been defined as experiencing another's emotions, as opposed to imagining those emotions.⁴⁷ It has also been described as concern for the welfare of others.⁴⁸ Some authors feel sympathy is a wholly distinct concept from empathy, while others maintain that sympathy overlaps with the emotional component of empathy.^{32,36,49} Sympathy may slide into a feeling of pity or feeling sorry for the other person.⁵⁰ Sympathy takes a 'self-orientated' perspective which may arise from an egoistic motivation to help the other person in order to relieve one's own distress. In taking such a self-orientated perspective, the doctor risks being distressed or overwhelmed.⁵¹

Compassion

Compassion, a word derived from the Latin meaning 'to suffer with' has, like empathy, varied and confusing definitions in the literature. Chochinov's definition describes compassion as a deep awareness of the suffering of another coupled with the wish to relieve it.⁵² Charlton, reflecting the conceptual confusion surrounding compassion concludes that it is almost indefinable.⁵³

Compassion, like sympathy, is evoked when something bad happens to another person, but compassion is generated by more serious states. It implies a desire to help but does not necessarily result in a helping action.¹ Compassion highlights engagement and commitment to relieve suffering reflecting our need for social relationships.⁵⁴ Tronto⁵⁵ emphasises the two-way relationship involved as the healthcare professional has needs as well as the patient. Compassion in its drive to alleviate suffering also shares elements of altruism. However, one can feel compassionate concern for another without making any attempt to

understand their feelings and point of view. Nussbaum⁵⁶ argues that compassion is more intense and involves a greater degree of suffering in the patient and the doctor than empathy.

The differences

For some, empathy is a part of compassion, while others feel compassion is a result of empathy.^{9,53} Some authors view compassion as having cognitive components which makes the differentiation from empathy even more unclear.^{9,10,57} Smajdor⁵⁰ conflates compassion with emotional empathy and links it with distress and burnout. Contemporary social psychology admits a distinction between empathy, sympathy and compassion but then treats them as variations of the broad affective phenomena they wish to consider.⁵⁸ This constellation of constructs are often then collectively referred to as empathy.⁵⁸ Maxwell¹⁶ summarises this confusing situation: "When it comes to "empathy" the waters of terminological confusion run deep indeed" I argue, however, that despite this complexity, empathy is the preferable term to replace 'sympathy' or 'compassion' in clinical care.²

Empathy does include elements of sympathy and compassion, but it also carries pertinent connotations that both sympathy and compassion lack.¹⁶ Empathy clearly involves imaginative involvement and although it is possible for both sympathy and compassion to be mediated by imaginative involvement, these terms typically refer to reactive and unreflective responses whose features require no great psychological acumen to appreciate. Empathy seems to suggest a response to situations whose features are more subtle, imperceptible and complex which require both affective and cognitive skills to perceive, share, understand and put into action.

Empathy is a skilled response, while sympathy and compassion are reactive responses, which is why developing the skill of empathy is a more realistic goal for medical education, whereas teaching compassion seems counterintuitive.¹⁶ For Maxwell,¹⁶ empathy involves capacities of moral sensitivity, both opening oneself to the other's subjective experience and getting judgements about the others' subjective experience right (empathic accuracy). Maxwell proposes the term 'compassionate empathy' to resolve this conceptual confusion but I argue that a less confusing solution is to develop a broad conceptualisation of empathy which is of particular relevance in a medical setting. Here, we are concerned with empathy in the sense of feeling distress in solidarity with a suffering person so that we might respond appropriately in order to help.^{2,16} Empathy

is the preferred term because empathy, more than sympathy and compassion, connotes not just reactive distress at another's suffering but considered, justified and hence rational distress.¹⁶ The empathiser is able to resonate with the patient's emotions yet remain aware of what is distinct in that patient's experience. Empathy is a form of engagement that seeks both cognitively and affectively to make sense of another's experience while preserving and respecting difference. This is in contrast to compassion which does not necessarily involve cognitive understanding of the others' views.

However, the current use of the term empathy in healthcare is at risk of being equated with empathy in the narrower cognitive sense.^{59,60} The 'detached concern', cognitive model of empathy, has characterised a narrow conceptualisation of empathy in medicine. This makes little of the affective component of empathy, whereas the word compassion puts the emotional affective element of empathy at its core. However, compassion then crucially lacks the cognitive elements of empathy.³² Motivation in compassion may be misguided, unlike the case in empathy which requires understanding of the other's view and so forms a part of prudence or practical wisdom. Some authors argue that a motivation to help creates a distinction between compassion and empathy, but this paper argues that a motivation to help others is integral to empathy.¹⁰

The empirical nature of compassion is not well understood, it involves the presence of suffering and a desire to relieve it in a dynamic relationship which may change over time. There is a debate as to whether it can be nurtured or is simply an innate quality of the person. There is an inherent tension in linking the intangible nature of compassion to concrete institutional initiatives mandating compassion as a right.^{3,4} Research into compassion and its influences in medical is less developed than that into empathy providing a pragmatic reason for preferring empathy as the construct of choice.¹³

A broad model of empathy with clear components encourages researchers and medical educators to study and teach the construct, whereas the vaguer notions of compassion are much more difficult to research or to teach.¹⁶

Does it matter?

Empathy is generally regarded an essential component of the doctor—patient relationship but doctors have always struggled to achieve a balance between empathy and clinical distance.^{16,20,32} Doctors can choose between a narrow technical approach based on their competence or a broader more humanistic

approach which is more ambiguous and less reductionist.³² The central question seems to be how to empathise without becoming overwhelmed and burning out? However, it appears that detachment is not necessary for sound medical judgement because emotional insights can and should inform clinical decision-making.^{32,61} Empathy is critical for diagnosis and for effective treatment, doctors need empathy to learn more of the patient's situation. So empathy supplements objective knowledge and technology. By allowing the patient to participate more fully in decision-making, empathy supports patient's autonomy.

There is some evidence that doctors with high empathy scores have more job satisfaction and less burnout.^{62,63} Despite the literature in support of empathy in medical training and practice, this has not been translated into effective actions and attitudes.³⁵ Empathy has been linked to improved patient satisfaction,³⁴ better concordance with medical advice,⁶⁴ decrease of anxiety and distress,⁶⁵ improved diagnosis⁶⁶ and clinical outcomes.^{34,67} Perhaps the best understood pathway by which empathy improves health outcomes is in the generation of trust between the patient and doctor.⁶⁸⁻⁷⁰

Empathy is a way of seeing the world from a patient's point of view. Empathy is involved in perspective-taking capabilities which enable students and doctors to gain insight into the ethical aspects of clinical problems.¹⁶ Empathy is person-focused not condition-focused, i.e. it relates to a particular person in a particular condition. The other-regarding of empathy involves empathic distress or a healthy concern for others who are suffering. Empathic distress motivates the action to help and must be differentiated from the personal distress arising from a self-orientated perspective of sympathy which can result in burnout.^{71,72}

Conclusion

This paper argues that a broad concept of empathy, being more complex and nuanced than compassion, is a more relevant and useful construct for clinical practice, medical research and education.⁷³ A review of the literature reveals a broad concept of empathy, which is appropriate in the medical setting, which combines affective, cognitive, behavioural and moral dimensions.² These dimensions vary in expression according to the individual patient, healthcare professional and to their clinical situation.⁷⁴ Empathy is a dynamic process which is dependent on the clinical context and occurs in a reciprocal relationship with a patient. It comprises the following features:²

- Connection: involving emotional sharing with the patient in a two-way relationship.

- Clinical curiosity: to gain insight into the patient's concerns, feelings and distress, giving patients a sense that they matter.
- Another-orientated perspective: the doctor tries to imagine what it is like to be the patient and to see the world from the patient's perspective.
- Self-other differentiation: this respects the patient as an individual with dignity.
- Care: acting appropriately on the understanding gained to help the patient.

A benefit of this model of empathy is that it focuses on developing skills, attitudes and moral concern rather than just urging medical students and doctors to be more compassionate.³² By accepting rather than resisting their own emotions, doctors can stay involved in care without despair.³² Caring involves some degree of identification of a person as a human being with the same needs and deserving the same respect as oneself this is part of the moral force of empathy.⁷⁵ Empathy, unlike compassion or sympathy, is not something that just happens to us, it is a choice to make to pay attention to extend ourselves. It requires an effort.⁴⁴

Declarations

Competing Interests: None declared.

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Ethics approval: No research on human subjects so approval was not needed.

Guarantor: DJ

Contributorship: Sole authorship

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Provenance: Not commissioned; peer-reviewed by Hazel Thornton.

References

1. Gladkova A. Sympathy, compassion and empathy in English and Russian: a linguistic and cultural analysis. *Culture Psychol* 2010; 16: 267-285.
2. Jeffrey D. Clarifying empathy: the first step to more humane clinical care. *Br J Gen Pract* 2016; 66: 101-2.
3. Francis R. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary*. London: The Stationery Office, 2013.
4. Cummins J and Bennett V. *Compassion in Practice: Nursing, Midwifery and Care Staff, our Vision and Strategy*. Leeds: NHS Commissioning Board, 2012.
5. Borgstrom E and Walter T. Choice and compassion at the end of life: a critical analysis of recent English policy discourse. *Soc Sci Med* 2015; 136: 99-105.

6. Haslam D. More than kindness. *J Compassion Health Care* 2015; 2: 1.
7. Shapiro J. The paradox of teaching empathy in medical students. In: Decety J (ed.) *In Empathy: From Bench to Bedside*. New York: MIT Press, 2012, pp.275–290.
8. Agladahl KM, Gulbrandsen P, Førde R and Wifstad Å. Courteous but not curious: how doctors' politeness masks their existential neglect. A qualitative study of video-recorded patient consultations. *J Med Ethics* 2011; 37: 650–654.
9. de Zulueta P. Compassion in 21st century medicine: is it sustainable? *Clin Ethics* 2013; 8: 119–128.
10. de Zulueta P. Compassion in healthcare. *Clin Ethics* 2013; 8: 87–90.
11. Zigmund D. Five executive follies. How commodification imperils compassion in person healthcare. *J Holist Health* 2011; 9: 7–10.
12. Neumann M, Edelhauser F, Tauschel D, Fischer MR, Wirtz M, Woopen C, et al. Empathy decline and its reasons: a systematic review of studies with medical students and residents. *Acad Med* 2011; 86: 996–1009.
13. Pedersen R. Empirical research on empathy in medicine – a critical review. *Patient Edu Counsel* 2009; 76: 307–322.
14. Batt-Rawden SA. Teaching empathy to medical students: an updated, systematic review. *Acad Med* 2013; 88: 1171–1177.
15. Colliver JA, Conlee MJ, Verhulst SJ and Dorsey JK. Reports of the decline of empathy during medical education are greatly exaggerated: a reexamination of the research. *Acad Med* 2010; 85: 588–593.
16. Maxwell B. *Professional Ethics Education Studies in Compassionate Empathy*. New York: Springer, 2008.
17. Lipps T. *Ästhetik*. Leipzig, Germany: Leopold Voss Verlag, 1903.
18. Morse JM, Anderson G, Bottorff JL, Yonge O, O'Brien B, Solberg SM, et al. Exploring empathy: a conceptual fit for nursing practice? *Image* 1992; 24: 273–280.
19. Eisenberg N. Emotion, regulation, and moral development. *Ann Rev Psychol* 2000; 51: 665–697.
20. Coplan A and Goldie P (eds) *Empathy Philosophical and Psychological Perspectives*. Oxford: Oxford University Press, 2011.
21. Wisniewski JJ. Perceiving sympathetically: moral perception, embodiment, and medical ethics. *J Med Human* 2015; 36: 309–319.
22. Neumann M, Scheffer C, Tauschel D, Lutz G, Wirtz M and Edelhäuser F. Physician empathy: definition, outcome-relevance and its measurement in patient care and medical education. *GMS Zeitschrift für Medizinische Ausbildung* 2012; 29: 1–11.
23. Baron-Cohen S. *Zero Degrees of Empathy*. London: Allen Lane, 2011.
24. Batt-Rawden SA, Chisolm MS, Anton B and Flickinger TE. Teaching empathy to medical students: an updated, systematic review. *Acad Med* 2013; 88: 1171–1177.
25. Neumann M, Scheffer C, Tauschel D, Lutz G, Wirtz M and Edelhäuser F. Physician empathy: definition, outcome-relevance and its measurement in patient care and medical education. *GMS Z Med Ausbild* 2012; 29: Doc11.
26. Hojat M, Gonnella JS, Nasca TJ, Mangione S, Veloksi JJ and Magee M. The Jefferson scale of physician empathy: further psychometric data and differences by gender and specialty at item level. *Acad Med* 2002; 77(10 Suppl): S58–S60.
27. Tichner E. *Lectures on the Experimental Psychology of the Thought Processes*. New York: Macmillan, 1909.
28. Stein E. transl. W Stein. *On the Problem of Empathy: The Collected Works of Edith Stein, Vol. 3*. Washington, DC: ICS Publishers, 1989.
29. Rogers CR. *On Becoming a Person*. London: Constable, 1961.
30. Bondi L. Understanding feelings: engaging with unconscious communication and embodied knowledge. *Emotion Space Society* 2014; 10: 44–54.
31. Kearney MKWR, Vachon MLS, Harrison RL and Mount BM. Self-care of physicians caring for patients at the end of life “Being Connected....A Key to Survival”. *JAMA* 2009; 301: 1155–1164.
32. Halpern J. *From Detached Concern to Empathy: Humanizing Medical Practice*. New York: Oxford University Press, 2001.
33. Irving P and Dickson D. Empathy: towards a conceptual framework for health professionals. *Int J Health Care Qual Assur* 2004; 17: 212–220.
34. Derksen F, Bensing J and Lagro-Janssen A. Effectiveness of empathy in general practice: a systematic review. *Br J Gen Pract* 2013; 63: 76–84.
35. Decety J. Introduction. In: Decety JHS (ed.) *Empathy: from bench to bedside*. Cambridge, MA: MIT Press, 2011, pp.vi–ix.
36. Mercer SW and Reynolds WJ. Empathy and quality of care. *Br J Gen Pract* 2002; 52: S9–S12.
37. Bondi L. Empathy and identification: conceptual resources for feminist fieldwork. *ACME* 2003; 2: 64–76.
38. Eisenberg N. *Empathy and its Development*. Cambridge: CUP Archive, 1990.
39. Batson C. *The Altruism Question: Toward a Social-Psychological Answer Hillsdale*. Mahwah, NJ: Lawrence Erlbaum Associates, 1991.
40. Gilligan C. *In a Different Voice: Psychological Theory and Womens' Development*. Cambridge, MA: Harvard University Press, 1982.
41. Noddings N. *Caring: A Feminine Approach to Ethics and Moral Education*. Berkeley, CA: University of California Press, 1984.
42. Slote M. *The Ethics of Care and Empathy*. London: Routledge, 2007.
43. Slote M. *Moral Sentimentalism*. Oxford: Oxford University Press, 2010.
44. Jamison L. *The Empathy Exams*. London: Granta, 2014.
45. Roper L, Foster K, Garlan K and Jorm C. The challenge of authenticity for medical students. *Clin Teach* 2016; 13: 130–133.
46. Hilfiker D. From the victim's point of view. *J Med Human* 2001; 22: 255–263.

47. Stepien KA and Baemstein A. Educating for empathy – a review. *J Gen Int Med* 2006; 21: 524–530.
48. Decety J, Yang C-Y and Cheng Y. Physicians down-regulate their pain empathy response: an event-related brain potential study. *Neuroimage* 2010; 50: 1676–1682.
49. Hojat M, Mangione S, Nasca TJ, Cohen MJM, Gonnella JS, Erdmann JB, et al. The Jefferson scale of physician empathy: development and preliminary psychometric data. *Educ Psychol Measure* 2001; 61: 349–365.
50. Smajdor A, Stöckl A and Salter C. The limits of empathy: problems in medical education and practice. *J Med Ethics* 2011; 37: 380–383.
51. Hojat M, Vergare MJ, Maxwell K, Brainard G, Herrine SK, Isenberg GA, et al. The Devil is in the third year: a longitudinal study of erosion of empathy in medical school. *Acad Med* 2009; 84: 1182–1191.
52. Chochinov H. Dignity and the essence of medicine: the A, B, C, and D of dignity conserving care. *BMJ* 2007; 335: 184–187.
53. Charlton R. *Compassion, Continuity and Caring in the NHS*. London: RCGP, 2016.
54. Batson CD. *Altruism in Humans*. Oxford: Oxford University Press, 2011.
55. Tronto JC. *Moral Boundaries: A Political Argument for an Ethic of Care*. Oxford: Psychology Press, 1993.
56. Nussbaum MC. *Upheavals of Thought: The Intelligence of Emotions*. Cambridge: Cambridge University Press, 2003.
57. Batson CD, Early S and Salvarani G. Perspective taking: imagining how another feels versus imagining how you would feel. *Personal Soc Psychol Bull* 1997; 23: 751–758.
58. Batson CD, Turk CL, Shaw LL and Klein TR. Information function of empathic emotion: learning that we value the other's welfare. *J Personal Soc Psychol* 1995; 68: 300.
59. Wispe L. The distinction between sympathy and empathy: to call forth a concept, a word is needed. *J Personal Soc Psychol* 1986; 50: 314.
60. Kohut H. *How does Analysis Care?* Chicago: University of Chicago Press, 1984.
61. Mayer JD, Salovey P and Caruso DR. Emotional intelligence: new ability or eclectic traits? *Am Psychol* 2008; 63: 503.
62. Larson E and Yao X. Clinical empathy as emotional labor in the patient-physician relationship. *JAMA* 2005; 293: 1100–1106.
63. Thomas MR, Dyrbye LN, Huntington JL, Lawson KL, Novotny PJ, Sloan JA, et al. How do distress and well-being relate to medical student empathy? A multicenter study. *J Gen Int Med* 2007; 22: 177–183.
64. Hojat M, Mangione S, Gonnella JS, Nasca T, Veloski JJ and Kane G. Empathy in medical education and patient care. *Acad Med* 2001; 76: 669.
65. van Dalen J. In the news! An opinion feelings about students' emotions. *Educ Health* 2010; 23: 515.
66. Levinson W, Lesser CS and Epstein RM. Developing physician communication skills for patient-centered care. *Health Affairs* 2010; 29: 1310–1318.
67. Mercer SW, Neumann M, Wirtz M, Fitzpatrick B and Vojt G. General practitioner empathy, patient enablement, and patient-reported outcomes in primary care in an area of high socio-economic deprivation in Scotland – a pilot prospective study using structural equation modeling. *Patient Educ Counsel* 2008; 73: 240–245.
68. Halpern J. Gathering the patient's story and clinical empathy. *Permanente J* 2012; 16: 1.
69. Roter DL, Stewart M, Putnam SM, Lipkin M, Stiles W and Inui TS. Communication patterns of primary care physicians. *JAMA* 1997; 277: 350–356.
70. Roter DL, Hall JA, Menisca R, Nordstrom B, Cretin D and Svanstad B. Effectiveness of interventions to improve patient compliance: a meta-analysis. *Med Care* 1998; 36: 1138–1161.
71. Batson CD, Eklund JH, Chermok VL, Hoyt JL and Ortiz BG. An additional antecedent of empathic concern: valuing the welfare of the person in need. *J Personal Soc Psychol* 2007; 93: 65.
72. Hoffman M. *Empathy and Moral Development: Implications for Caring and Justice*. Cambridge: Cambridge University Press, 2000.
73. Jeffrey D and Downie R. Empathy – can it be taught? *J R Coll Physicians Edinb* 2016; 46: 107–112.
74. Halpern J. From idealized clinical empathy to empathic communication in medical care. *Med Health Care Philos* 2014; 17: 301–311.
75. Darley JM and Batson CD. "From Jerusalem to Jericho": a study of situational and dispositional variables in helping behavior. *J Personal Soc Psychol* 1973; 27: 100.

APPENDIX 2 Ethical approvals for the research

Letter of Approval from the Ethics Committee of the Centre for Population Health Sciences

CENTRE FOR POPULATION HEALTH SCIENCES

Ethics Review Group

Medical School

Teviot Place

Edinburgh EH8 9AG

Telephone 0131 650 3239

Fax 0131 650 6909

email: cphs.ethics@ed.ac.uk

17 October 2014

Dear Dr Jeffrey

Re: Influencing Empathy: A Qualitative Longitudinal Study of Medical Students' Views and Experiences

Thank you for resubmitting your documentation with the amendments that were requested by the CPHS ethics committee. The amendments have been judged satisfactory. I am therefore pleased to be able to inform you that the above study have been granted ethical approval.

Just one point picked up by the committee, normally there is an independent person named at the end of the information sheet that people can talk to rather than the researcher – you might want to consider asking one of your supervisors to be that person. If you do add this information can you please send me an updated copy of the information sheet for our records.

Please be aware that this ethical approval is in respect of the protocol and methods as described in the documents submitted to the committee (with amended documents superseding predecessors). If there is in the future *a change* to the study design/protocol/methods, you should check whether this means your level 2 application form needs to be revised, and submit to the committee (via me), any documents that have been revised (study materials/protocol/level 2 form), using tracked changes. You should make clear in your covering email whether:

- (i) you are requesting ethical review of a study amendment; or
- (ii) you are not sure whether such is needed and, in the first instance, would like the committee's opinion on whether a formal approval is needed of the amended design/methods.

Yours sincerely



E-Mail of Approval from the College of Medicine and Veterinary Medicine Students' Ethics Committee (MVMSEC)

Dear David,

I am pleased to confirm that your application has been approved by the committee.

Best Wishes

Karen

Karen Muir, Secretary to
Professor Jonathan Rees FMedSci
Grant Chair of Dermatology, University of Edinburgh
Dermatology, Rm 4.018. Lauriston Building
Lauriston Place, EDINBURGH, EH3 9HA
tel: 00 (0)131 536 2041

On 29 Sep 2014, at 11:02

E-Mails to confirm R&D and NHS ethics approval were not needed

Maitland, Karen <Karen.Maitland@nhslothian.scot.nhs.uk>

Tue 03/06/2014, 11:59Hi David,

I can confirm that this will not require R&D Approval.

Thanks

Karen

Quoting "Bailey, Alex" <Alex.Bailey@nhslothian.scot.nhs.uk> on Wed, 28 May 2014 09:34:50 +0100:

Dear David,

If the study involves NHS staff or medical students in relation to their profession only then there is no requirement (policy-wise or legally) for NHS ethical review unless the study involves any of the following:

NHS patients (i.e. people identified through their involvement with the NHS, including services provided under contract with the private or voluntary sectors)

their carers

their tissue

NHS patient-identifiable data [...]

Alex Bailey

Scientific Officer, South East Scotland Research Ethics Service

APPENDIX 3 Invitation letter to the student

Dear Colleague

Invitation

Research Study : Influencing Empathy: A Qualitative Longitudinal Study of Medical Students' Views and Experiences

Researcher David Jeffrey D.I.Jeffrey@sms.ed.ac.uk

I am a palliative care doctor, with experience in student support, carrying out a PhD. I would be most grateful if you would consider taking part in a research study looking at your views and experiences on the influences on empathy during your undergraduate medical training.

Some quantitative research suggests that there is a decline in empathy during medical students' training. There is a need for qualitative research to explore what medical students understand by empathy and what you feel may influence empathy during your course.

The research involves being interviewed, at a time to suit you, twice a year, for three years to listen to your views and experiences about empathy and any influences on your empathy during your training. The interviews are recorded and transcribed. All data is anonymised and kept securely in the terms of the Data Protection Act on a password protected university computer .

Participation in this research is entirely voluntary and has no impact on your undergraduate teaching. You can withdraw from the study at any time without giving any reason. Your participation is completely confidential.

To an extent the students involved in the research are co-researchers, so this experience of qualitative research may be a part of your learning portfolio. There may also be an opportunity to be involved in writing a paper for publication during the research if you were interested in doing this.

I am aware of how busy you are and fully understand if you do not wish to take part. The attached information sheet gives further details and I am happy to answer any queries you may have before you decide whether you wish to join this research. If you are interested in joining this study or have any queries please email D.I.Jeffrey@sms.ed.ac.uk

Thank you for considering my request.

Best wishes

David Jeffrey

APPENDIX 4 Student information sheet

Information Sheet for students considering joining the research project

Title: Influencing Empathy: A Qualitative Longitudinal Study of Medical Students' Views and Experiences.

Researcher : David Jeffrey, PhD Student, Centre for Population Health Sciences(CPHS) , University of Edinburgh, D.I.Jeffrey@sms.ed.ac.uk

Supervisors: Dr Marilyn Kendall, Professor Marie Fallon, and Dr Michael Ross

Background: This study seeks to explore medical students' views and experiences of how they view empathy and of any influences on their empathy, during their undergraduate training.

Aims of the Research:

- To explore and gain a deeper understanding of the influences on empathy of medical students as they progress through their undergraduate training
- To clarify the construct of empathy as conceptualised in the literature

Method: In this qualitative research two groups of medical students will be followed through their undergraduate training. One group, 8-10 students (Group A) will be followed from year 1 to 3 ,and another group, 8-10 students (Group B) from years "intercalated" to year 5 (ie intercalated year plus year 4 and year 5 of the medical curriculum).If participating students are not taking an intercalated degree they will be followed for year 4 and 5.

Interviews One to one interviews, will be held twice each year through the study (total six interviews in three years). The researcher will be listening to your views on empathy and what specific experiences you have had which have influenced your empathy. Interviews will be carried out on the medical school premises and are expected to last 60-90 minutes. You will be able to contact me at any time during the study by email if you wish to discuss any particular issue. D.I.Jeffrey@sms.ed.ac.uk

Confidentiality and Consent Participation is entirely confidential and voluntary, anyone can drop out at any time during the study without giving a reason. If you decide to withdraw all your data will be destroyed and not used in the research. All data from the interviews is anonymised by giving you an individual study number .If you wish to join the study you will be asked to sign a consent form and retain a copy .Data from the interviews is transcribed and held with any field notes securely on a password protected university computer in accordance with the Data Protection Act. Only the researcher will have the names of the participants ,the three named supervisors will have access to the raw anonymized data from the interviews and

focus group. The data will be stored securely for 10 years and then destroyed. Anyone who wishes to withdraw from the study will have the data deleted.

Data Analysis Interviews and the focus group will be recorded and transcribed verbatim alongside field notes. Transcripts will be analysed both manually and using computer software such as NVivo. Data analysis will continue throughout the study.

Ethical approval This educational study has ethical approval from the Students Ethics Committee MVMSEC and from CPHS ethics committee level 2 .

Results The results from the study will be submitted as a thesis for PhD at Edinburgh University. The data may also be published in scientific papers and presented at conferences. The study may also be published as a book. All data will be anonymous and no students or academic teachers will be identified by name. If students expresses a wish to be involved in publishing a paper of interim results of the study the researcher would be happy for their involvement.

Feedback All participating students will receive an abstract of the PhD thesis on completion. Each student may have a copy of their anonymized transcripts of their own interviews .They will not have access to other participants' identity nor transcripts.

Further information Please contact David Jeffrey by email D.I.Jeffrey@sms.ed.ac.uk or telephone 07807273297 if you have queries or require further clarification about any aspect of the study. Thank you for your interest in this research.

David Jeffrey

APPENDIX 5 Informed consent form

Title of Study: Influencing Empathy: A Qualitative Longitudinal Study of Medical Students' Views and Experiences

Name of Researcher: David Jeffrey, PhD Student

Please initial the box

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to ask questions.
2. I understand that my involvement will involve being interviewed at a time and place to suit me. I understand that the study will involve me participating in up to 2interviews over 12 months for up to three years and that these interviews will be audio-recorded and kept securely, at the University of Edinburgh, for 10 years.
3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason or affecting my legal rights.
4. I understand that any data or information used in any publications which arise from this study will be anonymous.
5. I understand that all data will be stored securely and is covered by the data protection act.
6. I agree to take part in the above study.

Name of Participant Date Signature

Name of Researcher Date Signature

If you wish to discuss any aspects of the study you may also contact Dr Marilyn Kendall at Marilyn.Kendall@ed.ac.uk

APPENDIX 6 Interview Topic Prompts

EMPATHY

How would you describe empathy?

How do students feel they communicate empathy?

Why is empathy important in medical professionalism and patient care?

INLUENCES

What do medical students feel influences their empathy ?

What are positive influences on empathy?

What are negative influences on empathy?

Have you noticed any examples of a change in your empathy?

Does contact with patients affect their empathy?

Does depression or anxiety affect empathy?

Can role models influence the student's empathy?

Do students feel clinical assessments such as OSCEs affect empathy?

What is the effect of the 'hidden curriculum 'on the development of empathy?

Do students feel that there are factors outside the curriculum which influence the development of their empathy?

What do students feel influences empathic accuracy?

Do students feel there are situations when it is easier to empathise with patients or colleagues?

Do students feel that there are situations when it is harder to empathise with patients or colleagues?

Do students feel that self-awareness /reflection affects their empathy?

DISTRESS & HARMS

What are students' views about whether there can be such a thing as "too much" empathy?

What are students' views about empathy affecting burnout and compassion fatigue?

Do students feel that empathy can be regulated to avoid distress?

Have you received any training on how to regulate empathy to counter personal distress?

Do students feel that empathy could be harmful, to themselves, doctors or patients?

CONNECTION v DETACHMENT

Is there is a tension between empathy and detached concern, (between emotional empathy and cognitive empathy)?

What sort of empathy should medical students be expected to provide for their patients?

TEACHING

What training have you had on developing empathy?

What training have you had on regulating empathy?

Does the culture of the medical school support empathy?

ANY OTHER AREAS YOU WISH TO RAISE?

APPENDIX 7 An extract from the transcript of my first interview with Paula (Year 4 student) with coding highlighted

This is a sample of the transcript of part my first interview with Paula to illustrate the style of interviewing. The highlighted segments are coded and downloaded onto NVivo. There are no grammatical corrections of the transcript.

David – OK Paula if we could start about um for start what made you interested in joining the project or stumbling into as you said in your email.

Paula – good questions. Um yeah I came across the piece of paper that was explaining it and something resonated with me. I think this is quite an important issue in medical school and is it something I have talked about with friends in my course. Um actually quite recently I think it coincided finding this study I that was talking to someone about how to deal with um yeah speaking with a patient that you knew was going to die.

David – right

Paula – that was something we had talked about. And yeah in terms of being involved in that research interested me and it was worth looking into.

David – good. Ok. If we go back a wee first before you start, tell me a little bit about yourself. Maybe a little bit about your back ground and when you decided to be a doctor and what made you.

Paula – hh

David – I know that sort of corny interview question but I just been interested what sort you stage you felt and motivated you and so on.

Paula – um I didn't always know I wanted to do medicine. I think for a long time I didn't know what I wanted to do all. Um but midway through high school I liked science, I thought maybe I will do something with this and then of course medicine is the choice if you want to work with people and use science. So that was how I ended up looking into it. And the more I looked into it the more I thought this is the dream job. Like I would really enjoy that and thankfully since coming to med school that is more been the case as well. So the more I do it the more I can't imagine doing anything else. So it was a discovery process. I did look into other things at one point but um

David – do you come from a medical family?

Paula – not really. My mum is a health visitor but my dad is musician actually. So there is no doctors in the family.

David – ok do you have any sibling doing medicine at all?

Paula – nope my younger sister is doing art [laughing]

David – oh good.

Paula – yeah pretty varied and that is

David – here or

Paula – she is coming to Herriot Watt next year

David – so if we um move on to talk about the subject empathy. When I say it means a lot different things to different people. What does it sort of meant to you empathy. What does?

Paula – in terms, in terms of this context of medicine it is to do with the relating with people and patients and how much you can. It is is different to sympathy isn't? But how much you can relate with them in what they are going through I think that is how I would look at. How much you would feel for what they are feeling I think.

David – so is it, I just want for clarification. For you it's definitely about feelings? I mean I just try and tease that out. Is it that you are feeling what they feeling? Or what do you think about that

Paula – um

David – so if was really depressed would you if you were empathising with me would have feelings of sadness and things when you were talking to me. Or do you feel

Paula – that is true. I think feelings do come into it because I don't think you can be truly empathetic without personally affected the way someone is feeling. Um equally there is element you can't take on everything that the person is feeling. So you can be empathetic in being understanding toward them without necessarily feeling everything they feel. Um but I think there is a big point in trying to understand where they are coming from.

David – right. So it is also if I am right here it is not just feeling is also understanding what they are thinking a bit too. What they want and what their goals and things are

Paula - yep I think that comes into. Yep.

David – so it is an understanding of sort of cognitive as well as a feeling thing?

Paula – yeah I think it is both. Yeah. I don't think you can separate from that instance as well.

David – you were sort of hinting there a little bit you can't take on everything.

Paula – yeah.

David - I say why can't you do that? What would happen if you take on everything?

Paula – in medicine you see a lot and it's hugely overwhelming I guess if you take on all the, there are a lot of sad things and you took on all of that it would be very difficult to do your job I think. And that that is also interested in this study and seeing how this changes over time. I think coming into medical school you I thought you take every patient you are affect by what you see but the more that your clinical medicine the more you see that doctors have to be detached from that. Or maybe not have to be but they are. Um and that is something that interested me. Do we have to be detached or is there a way to be empathetic and not completely detached from them?.

David – what is your sort gut feeling on that without any sort what you should be? What is you're feeling about it yourself? What would you like to be?

Paula – morally I think I would like to be empathetic to each patient that I meet um but I feel that by being this career that may actually change. I think, because I think because I probably would find it very difficult to be um like you said taking on feeling of an another person if I did that with every patient I do think I would struggle to do my job with a clear head because you have a responsibility to do your job and it well

David – in a way are you suggesting that if you are empathetic or if you like almost too empathetic it might affect your judgment?

Paula – yeah that tis probably the perception that there is. Yeah I do think that. There is a risk and I know that is something that is felt among other students as well I think. Um

David – and how you deal with it yourself. Do you find that when you are seeing patients and having a contact with empathetic and you take that away with you and worry about it later? Or what do you feel.

Paula – um

David – or it affects you later

Paula – it have done in the past year that has been the case. Um even before I started medicine and did work experience I saw difficult things um in a GP practice near home and I still can't get images of some those patients out of my head.

David – can you then tell me about that at all?

Paula – yeah we saw a woman who had been abused by her neighbour. Um and well she was very distraught at what happened had hair pulled out by someone. Um I guess it was very shocking from never having seeing that kind of thing before and seeing this woman very distressed about the whole situation. Um yeah. It was hard to watch really.

David – it still distresses you now?

Paula – yeah. I find it upsetting to think about it. Um the other examples more recently there was um actually I can go back to work experience again. I did work experience in paediatrics this time and um there was a very poorly young boy and it upset me when I saw it and I didn't react terribly well. And think at that point I was like this isn't very helpful if I want to be a profession where I can help them I can't react to everything. So in that situation I felt very overwhelmed just about passed and had to leave. So I think that yeah personally I can resonate with dealing with what to do with these kind of feelings. Yeah. Not being completely overwhelmed by what I am seeing.

David – I can see you don't want to be overwhelmed. Is it ok to cry with patients do you think?

Paula – I think so yeah.

Paula – have you cried with a patient or after you seen a patient or anything like that.

Paula – no I haven't yet. That has not happen.

David – would it worry you if did. Say with that wee boy there just shed a tear would that have worried you do you think or not?

Paula – um no

David – be a bad thing

Paula – not actually I think as a person on work experience I would have felt embarrassed and like I should not have done that. But at the same time I feel like now maybe as if I were a doctor in that situation and I reacted with sadness with the family I think it would be ok because it is sad.

David – you were hinting at. If I am wrong just say look David that is not what I said [laughing] me nodding furiously when you saying things. But you were sort of hinting there that getting impression during work experience you had experienced very distressing experience where you reacted in way with patients and people and kind of hinting now maybe things are slightly different. Is there anything in the course that has taught or you have seen affected your empathy or ability to empathise with patients.

Paula – I am wondering if one the thing that does affect is more exposure so seeing more. I have seen, that was my very first experience of hospital and GP and now it is a lot more familiar um and I was I am in third year started clinical placement and I thought I was nervous about starting them because the first two years are sciency and I hadn't deal with it. Um and this year it become second nature to be on the ward and talk to patients and I have gained a lot more from it than I thought I would. I think I was very nervous about it and wasn't sure. I guess have learnt about more

about that interaction. I would say less so specifically teaching on the course but more so just experience having to go onto the wards. They send you.

David – the exposure of seeing people.

Paula – that is it

David – have there been example you have seen doctors or nurses or your colleague been empathetic with patients that have affected you that is maybe how like to be? Is there any sort informal teaching you have had like that rather than?

Paula – yeah that is it. I'm yeah I think you do

David – can you think of anything like that?

Paula – I try, I see if I can think of any specific example. But you are do remember the good examples you do see actually. Some of the junior doctors as well you pick up how they are interacting with patients.

David – is there anything you have seen a junior doctor or anyone else deal with a patient and thought that is a nice thing to do or is that is a good way to do it or not? It doesn't matter just difficult to plunge something. Just wonder if you saw anything that struck you.

Paula – there is one junior doctor who was he seemed very personable with patients. And sometime like take their hand and speak to them at their level. You know get down to the bed. It was helpful to see him doing that because sometimes the other context you are seeing doctors working is in ward round and everyone is standing around bed and that is not quite the same the doctor who gets down and speaks to the patient you know where they're are. If I think another specific I will say that

David – when you say personable what do you mean by personable. Can you tease that out? What is it about him that made him personable? What do you mean by that?

Paula – um good question. I felt like he knew the patient when he went to speak to them. Um so address them by their name, ask them how they were doing. Yeah it wasn't the way he did it actually wasn't exactly how you taught. You know go and introduce and asked date of birth. It was how are thing it wasn't going through a list of questions um and asking

David – being a bit open, sorry

Paula – yeah that is it and asking if they had any concerns. Um

David – how are you then taught to deal with that? What your feel for the teaching of medical school do you think they emphasise empathy in the teaching. They teach you how to be empathetic with patients or how to

Paula – we get occasional communication skills tutorials but general you are taught about taking the history thing. And within that it is more the checklist like you have to get through all these things. Communication skills there they would tell us they would empathise more on the side of how to deal with patient who is angry, giving bad news. Um so I can think of two tutorials I had chance to practice with that an actor who was

David – how did you feel about that? What was that like?

Paula – um it is helpful because I guess it highlight things I hadn't really thought about in term of oh what would I actually say if someone actually said. Um that comes into the exposure thing as well I guess you don't know how to deal with something unless you have may be seen it or some sort of exposure so having an actor is better than nothing. At the same time you know it is also slightly false situation. It is not entirely true life.

David – is it difficult to be empathetic with someone who you know is an actor.

Paula – yeah it can be. Especially we have the same pretending to be a different patient every time. But that almost makes it harder again because the last time I had this. But no I think it is good and worthwhile. Um

David – do you get enough exposure to patients do you think. Do you think you get enough time with patients in course and teaching with patients?

Paula – um. Good question [laughs] I think the thing about the clinical years is a lot of how much exposure you get is up to you. So it is quite self led so there is opportunities to do it in the most part but um you have to take it upon yourself to see a patient.

David – do you have to be quite assertive to do that? Or do you feel

Paula – um

David – would you find that quite easy thing to do if you wanted to go and see patient on the ward.

Paula – it would depends I think it depends of the ward and probably your personality. I don't find I it is not too hard because you can often ask nurses or junior doctors is there anyone I can chat to. Um as long as there fear always getting in the way so

David – but you need to be attached to that ward? I am just {in audible}

Paula – yeah

David – long long time since I was in this medical school.

Paula – yep you would generally use the one you are attached to.

David – you wouldn't drift up to award say I would like to see some cardiology patients today.

Paula – no. I guess you may be could

David – but you wouldn't do that

Paula – no and there are some wards it is not a good ward to go and ask to see patients. So there are certain wards that have reputations for being ok to go to and others don't. Um just because they know I think in the past they have had issues with too many medical students and things. Um so this rotation I have been on most recently I hadn't been able to go and do that so much. You had to be scheduled and that was that. Thankfully on all my other ones it was very open and I can go in whenever I want to really.

David – but there are some that are not

Paula – yeah. [laughing] yeah it is variable.

David – you talked about some of the good thing with empathy. I want to clarify this that you one of the ways you of if you like regulating your empathy is as you say is not to be overwhelmed is kind of exposure and familiarity with more and more patients you get slightly used to that. You were saying the informal thing. Has there been any teaching in the medical school how psychologically you would um approach that problem. Has anyone given you tactics to say?

Paula – as in how I would approach it?

David – yeah how anyone would approach that. How do you control distress from a patient as anyone said how to do that that?

Paula – not that I can think of.

David – no. discussed it even. It is not an easy topic

Paula – no

David – looked at it and said this is something else you need to address. Ok. That is fine

Paula – that is something we talk about amongst ourselves but not something I don't think been any teaching on.

David – before we come on to there is so much stuff here. But you talk amongst yourselves. Each year has it own if you like culture how would you describe the year you are in just now? Again it just is it a happy year, is it competitive or is it sort very cliquey? I mean how what sort of words to describe the year.

Paula – competitive is probably one that clicks but then I think any year in medicine is probably going to be like that.

David – do you feel competitive?

Paula – I feel, it is probably just a medic thing everyone talks about work. Like when you are interacting in with people your course it is often about studying or what you have been going to and yeah. Maybe that is competitive or maybe it is the nature of what we do you just talk about how you are getting on with it.

David – but do people talk about it. I am interested in that. How you are going on is it more to say aha I have done such and such or is it can I help you are obviously struggling with that are you managing alright. Is it supportive in that sense do you feel your colleague support you or concerned progress is ok.

Paula – I feel that we are it is more of we are all in the same boat there is a bit of complaining I haven't done this yet or oh I need to catch up on such and such. And sometimes that does result in do you want to work on that together because that has definitely happened to between us. Um so competitive is one word but definitely very open and friendly like its I do feel like you could talk to most people in your year. I like that we get mixed up into different groups because you meet them all. There has never been anyone who is anti-social you know. Everyone does club together

APPENDIX 8 An Example of a Coding Framework

Name	Sources	References
Research comments	1	2
EMPATHY		
Quotes	17	41
PROCESS		
Understanding	24	51
Relationship	14	32
Rapport	10	17
Listening	28	64
Feelings	30	294
Challenges	27	135
Boundaries	30	140
Behaviours	4	5
INFLUENCES		
Time	16	34
Teaching	33	300
team	2	6
specialities	9	24
professionalism	10	33
PBL	3	9
patient contact	14	53
Continuity	8	14
group	8	25
Ethics	4	10
Detachment	27	123
competence	2	4
support	29	174
Stress	27	133
Reflection	17	48

Name	Sources	References
Social media	11	50
Role modelling	23	60
peers discussion	1	4
culture of medical school	30	238
Biomedical v Psychosocial	11	35
Background	0	0
Work experience	2	6
Religion	7	24
Motivation	27	100
Gender	2	4
family	13	23
Culture	12	28
Age	3	8
CONCEPT		
What is empathy	23	79
resilience	3	5
levels	4	6
fake	9	21
importance	16	41
Attribute	11	17
CHANGES	25	75
transition	4	7
Future fears	13	24
decline	5	9

Note Sources refers to the number of student interview transcripts referring to the topic or code

References indicate number of times the topic was coded.

APPENDIX 9 Coding Frequency Chart for Paula (Interview 1 Year 4)

