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Empathy in graduate medical education milestones

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Abstract

Introduction
Competencies in both empathy and cross-cultural health care are considered essential skills for physicians. A bedside learning activity was developed and piloted to define and teach empathy for residents, in order to improve clinical skills in cross-cultural patient care.

Methods
This activity was done on an inpatient medicine teaching service at Bellevue Hospital Center and New York University School of Medicine in New York City. Twenty-nine residents in internal medicine and thirteen faculty participated in one bedside session each. The objective of this exercise was to help the learner utilize empathy to: 1) gauge a patient's identity and culture; 2) assess health literacy; and 3) change clinical management. Patients with communication barriers were interviewed with the BATHE technique (Stuart, Lieberman, 2008). All participants received anonymous surveys.

Results
76% of participating residents agreed this activity improved their ability to provide cross-cultural care, 87% agreed it assessed their patient's health literacy, and 87% agreed it changed their clinical management.

Conclusions
Empathy offers a promising bedside exercise in which to gauge health literacy and to demonstrate effective cross-cultural patient care. Based on this experience, an instructor's guide was written for faculty, for use in training residents in empathy and cross-cultural patient care.

Practice Points

1. Competencies in empathy and cross-cultural patient care are essential skills for physicians.
2. The BATHE empathy technique improves cross-cultural communication, changes clinical management, and improves patient outcomes.
3. Based on this pilot experience, an instructor's guide was written for faculty to facilitate their own bedside teaching sessions on empathy.

Keywords: Empathy, cultural competency, communication skills (patient-doctor), instructional design, and graduate medical education.

Article

Introduction

Competencies in both empathy and cross-cultural health care are considered essential skills for physicians (Riess 2012, Bonvicini 2013, Napier 2014). Empathy is increasingly recognized as a skill linked to improved adherence (Vermeire 2001), patient satisfaction (Zachariae 2003), continuity (Hojat 2011), and trust in health care providers and systems (Levinson 1997). Empathy is an essential component of patient-doctor communication (Kalet 2004). Both bedside teaching (Janick 2003, Elder 2013) and patient-centered training (Bombeke 2012) are effective ways to model and teach communication skills.

Demand for bedside training in cross-cultural sensitivity and communication skills is increasing (Francis 2012). US Accreditation Council for Graduate Medical Education (ACGME) internal medicine milestones include the expectation that all graduating residents (physicians-in-training) demonstrate competency in cross-cultural health care (ACGME 2014). The current project hypothesized that clinical empathy is a clinical skill that can demonstrate this cultural competency. To that end, a bedside learning activity was developed and piloted, with three aims: 1) to define and apply empathy as a clinical skill that can demonstrate cultural competence; 2) to explore connections between empathy and assessment of patient's health literacy; and 3) to improve cross-cultural communication at the bedside between patients and providers.

Setting

This bedside activity was done at Bellevue Hospital Center (BHC), a teaching site for the ACGME internal medicine postgraduate residency training program at New York University (NYU) School of Medicine. As an 828-bed central municipal referral center in New York City (NYC), BHC serves an exceptionally culturally diverse patient population. According to the 2012 United States Census, 37% of 8.3 million total residents of NYC were born outside of the US, from dozens of countries in all continents. 49% of the foreign-born and 6% of the native-born NYC population speak a language other than English at home (City of New York, 2013).

Participants

While rotating on an inpatient bedside teaching service, individual sessions were held with 10 different teams of 2 interns (first-year residents), 1 second-year resident and 1-2 faculty on each team. 19 interns, 10 residents and 7 faculty participated in one session each. In addition, faculty with expertise in empathy, cross-cultural health care, and bedside teaching were identified to facilitate these sessions.

Methods

By the end of this bedside session, this activity aimed to measure whether residents could do the following: 1) describe how empathy can allow clinicians to gauge a patient-centered understanding of identity and culture; 2) apply the BATHE technique (Stuart 2008) as a clinical tool to assess patient levels of understanding and concerns about health status and needs; and 3) identify elements of empathy that change clinical management and improve patient outcomes.

Before the exercise, background reading on empathy and clinical outcomes was assigned. The exercise began by identifying a patient with a communication barrier related to his or her current clinical care. After receiving the patient's permission, the team visited the bedside together, where the resident interviewed the patient with the BATHE technique. The BATHE technique is a guideline for communication that assists providers in connecting meaningfully with patients and their feelings, which was chosen as a brief, validated clinical tool for patient-doctor empathy that has been in use since 1986. It is a checklist of 4 specific questions about the patient's background, affect, troubles, and handling of a current situation, followed by an empathic response. After the patient interview, the team debriefed together with faculty about the case in a quiet room. Topics for discussion varied, ranging from cultural competency theory, self-awareness exercises, and videos, to clinical cases that illustrated cross-cultural communication such as adherence, health literacy, traditional healing beliefs, and refugee health. Finally, how to incorporate empathy skills into routine clinical practice was discussed.

Upon completion of this pilot, all 29 participating residents received anonymous electronic surveys. All participating residents consented to participate in curriculum evaluation through an approved Institutional Review Board registry at NYU.

Results

Overall survey response rate was 58% (68% for first-year and 40% for second-year residents). Residents were asked to respond to 11 statements about the impact of this bedside learning activity, all with 5-point Likert scales from Strongly Agree to Strongly Disagree (Table 1). Responses between first-year and second-year residents were similar and reported together.

Most (85-93%) residents who responded agreed or strongly agreed that this empathy activity made them reflect on their own attitudes about their patient's identity and culture, improved their ability to provide cross-cultural care, improved patient satisfaction, introduced them to something new, changed their clinical management, and allowed them to assess and respond to their patient's level of health literacy, as defined as their patient's understanding and concerns about his or her health. All agreed that this activity addressed a communication barrier. When empathy was discussed without speaking with a patient, residents indicated that they had difficulty understanding the relevance of clinical empathy to patient care. Almost half agreed that they will use the BATHE method again with patients. When used over time, two-thirds of residents agreed that this exercise would help them meet the ACGME milestone, which measures whether residents respond appropriately to each patient's unique characteristics and needs, including culture.

Additionally, residents were asked to rate the effectiveness of each components this activity, on 5-point Likert scales from very effective to very ineffective. The bedside component was considered the most effective (81% respondents). Finally, participants were asked to add additional comments about their experiences with this exercise, which recognized both an eager desire among residents to learn empathy skills, while also expressing concern over time limitations to discuss both patient's feelings and their understanding of health and illness.

Discussion

According to these residents' experiences, empathy offers a promising clinical measure in which to gauge health literacy and to demonstrate effective cross-cultural patient care, within the ACGME milestone context. The bedside component with a patient was found to be essential for the exercise.

The overall survey response rate of 58% from residents was another limitation for this study. Group size was also an issue; this activity worked best in small teams, and larger groups made it more difficult for patients to share their feelings.

During many exercises, the connection between empathy and cultural competence was often challenged, and many clinicians felt that these separate topics should not be combined in the same activity. However, because both empathy and cultural competence require one's understanding of another's feelings and perspectives, it was possible to explore and learn about both topics during this activity. Two-thirds of residents agreed that empathy helped them meet the milestone on cultural competence.

When selecting a patient with a communication barrier, this exercise was found to work well when a patient with limited health literacy was selected. In these cases, residents would share that they were surprised to learn that they significantly misunderstood their patient's understanding of their illness, which impacted patient agenda, patient satisfaction, informed consent, and adherence. This information gathered during the bedside exercise changed the patient's management in each case, thus indicating this exercise to be a useful component for effective patient care.

For example, when asked about his current situation, one undomiciled patient informed the team how concerned he was about his uncontrolled diabetes, and that it was very difficult for him to keep his insulin and supplies in his shelter. During debrief, the team shared that they had mistakenly assumed that his poor

glycemic control was a result of him not being well informed or concerned about his health, when in fact this empathy activity informed the team that he had logistic barriers instead to adhere properly to his insulin regimen. Another patient, who was identified by the clinical team as uncooperative and non-adherent, shared during this activity how isolated he felt in New York City, after moving from another state completely disrupted the social and support structure in his life. He specifically stated that the BATHE technique made him feel that the team was genuinely concerned with his thoughts and opinions, and reiterated "I *need* and *want* medical and mental assistance." During the debrief discussion, the team shared that these feelings were an unexpected surprise. After this empathic connection, the team reported having improving discussions about informed consent and adherence to recommended procedures during his hospital stay.

Conclusion

Overall, the project was feasible and well-received. Feedback from both residents and faculty to continue this activity at BHC and NYU was positive. Future offerings should include a faculty assessment tool that measures resident skills in these areas. Based on this pilot experience, an instructor's guide was written for faculty to facilitate their own bedside teaching sessions on empathy, for use in training residents in cross-cultural patient care (Appendix 1).

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3) Prior presentations: An abstract entitled "Designing and piloting a curriculum in clinical empathy for internal medicine residents, in order to improve clinical skills in cross-cultural patient care" was presented by poster at the Society of General Internal Medicine 2014 San Diego meeting, which reported an earlier stage of this project, prior to the BATHE technique bedside activity reported here.

Declaration of Interest

All authors report no declarations of interest.

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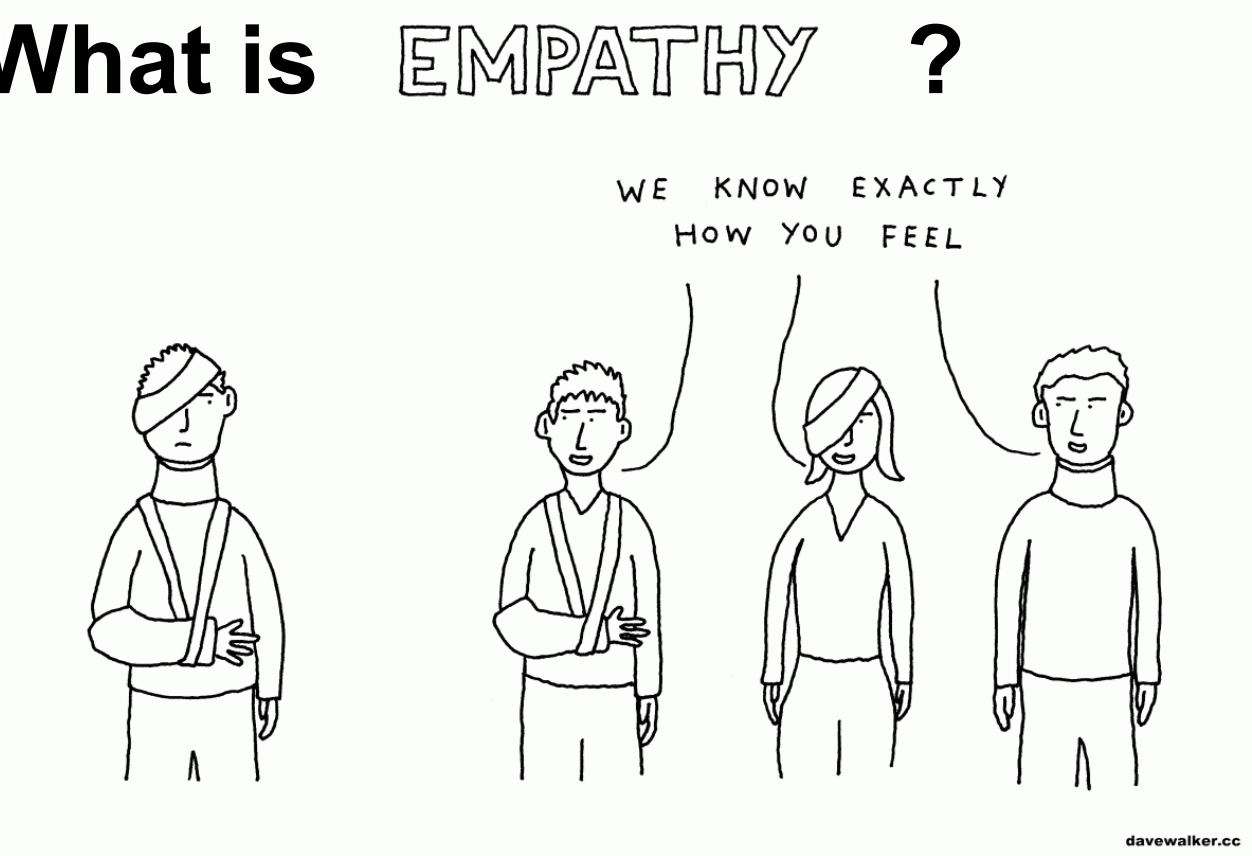
Table 1: Evaluation of the BATHE empathy technique by residents

For the following statements, please rate how much you agree or disagree **The BATHE empathy technique helped to:**							
	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	**Responses who agree or strongly agree / Total responses**	**Percentage who agree or strongly agree**
Inform me about my patient's feelings.	3	9	0	1	0	12/13	**92%**
Respond to my patient's level of understanding and concerns about his or her health.	3	9	0	1	0	12/13	**92%**
Change my clinical management of my patient.	3	9	0	1	0	12/13	**92%**
Improve my patient's satisfaction with my care.	3	9	0	2	0	12/14	**85%**
Assess my patient's level of understanding and concerns about his or her health.	4	9	0	1	0	13/14	**92%**
Identify and address a communication barrier with my patient.	3	11	0	1	0	15/16	**93%**
Improve my ability to provide cross-cultural patient care for my patient.	3	6	0	1	0	9/10	**90%**
Make me reflect on my own attitudes about my patient's identity and culture.	5	7	0	1	0	12/13	**92%**
Introduce me to something new.	4	9	0	1	0	13/14	**92%**
ACGME milestone #18 measures whether residents can, in an unsupervised setting, "respond to each patient's unique characteristics and needs, based upon culture, ethnicity, gender, religion	1	10	4	1	0	11/16	**68%**

and personal preference." When used over time, the BATHE empathy technique could help me to meet this milestone.							
I will use the BATHE empathy technique with my patients in the future.	2	6	8	1	0	8/17	**47%**

EMPATHY AND CROSS-CULTURAL PATIENT CARE
APPENDIX 1: BEDSIDE INSTRUCTOR'S GUIDE

What is EMPATHY ?



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PURPOSE

This Instructor's Guide is designed to define and teach clinical empathy in one hour (or less) at the bedside, as a health literacy tool to improve cross-cultural patient care.

Bonvicini reminds us that being a student of empathy is a privilege and a source of endless fascination, while we aim to ensure patients feel the "care" in clinical care.[i]

GOALS

By using this Instructor's Guide, this exercise aims to:

1. Define and teach empathy as a clinical skill that can demonstrate cultural competence.
2. Explore connections between empathy and assessing a patient's health literacy.
3. Improve cross-cultural communication at the bedside between patients and providers.

OBJECTIVES

By the end of this exercise, the learner will be able:

1. To describe how the BATHE[ii] technique can allow clinicians to gauge a patient-centered understanding of identity and culture, at the bedside with team.
2. To apply empathy as a clinical tool to assess patient levels of understanding and concerns about health status and needs.
3. To identify elements of empathy that change clinical management and improve patient outcomes.

DESIGN OF SESSION

This skills-building session can take from 20 to 60 minutes. It has two components: bedside and discussion. To begin, the clinical team identifies a patient with a communication barrier related to health literacy, and goes to the bedside.

For the first 10-30 minutes, the learner (i.e. resident) applies the BATHE technique during a patient interview. For the next 10-30 minutes, the clinical team goes to a quiet area for facilitated discussion, covering 1) empathy, 2) ways that empathy can be applied to health literacy and/or cross-cultural patient care, and 3) discussion of clinical pearls and best practices that change our management.

Within patient care, among many clinical outcomes, building empathy can change one's clinical management. Regarding assessment, because empathy offers a tool to recognize and respond to a patient's health literacy needs, empathy is one way to measure a resident's cross-cultural patient care within the ACGME milestone context (see ACGME Milestone #18 below).

ASSIGNED READINGS

Primary reading

1. Stuart MR, Lieberman JA. The fifteen minute hour: Therapeutic talk in primary care. Radcliffe Publ., 2008. (*resident to use **BATHE technique** during bedside activity*)

Background readings

2. Bonvicini K, Andrews B. "Can empathy be learned? lessons from ninjas and neuroscience." Communication Matters, November 2013.
3. Hojat M, etal. "Physicians' empathy and clinical outcomes for diabetic patients." Acad Med. 2011;86:359-364.

PRIOR TO ENCOUNTER (first step of teaching session)

For this encounter, as outlined in the Lieberman paper, the resident initiates the interview with the first question from BATHE, proceeds with each question and responds empathetically:

Background: "What is going on in your life?"
Affect: "How do you feel about that?"
Trouble: What troubles you the most about this?"
Handling: "How are you handling that?"
Empathy: "That must be very difficult for you."

Stuart, Lieberman, 2008

To provide a starting point to use the BATHE technique, a communication barrier can be identified for a specific patient, for whom a better understanding of the patient's own perspective would likely change management—a call for the clinical team to express empathy. This patient-centered perspective can include knowledge and attitudes about their own health and illness, diagnostic and therapeutic measures, inpatient or outpatient care plan, roles of everyone they see each day, etc.

Before going to the bedside, the facilitator (i.e. faculty) huddles briefly with the team to review the BATHE technique and context. The initial goal is to ensure the learners feel sufficiently prepared to utilize BATHE at the bedside, while in-depth discussion may be saved for after the encounter. To illustrate that empathy improves clinical outcomes, the Hojat reading may be referenced, which demonstrated that physicians with more empathy had patients with better controlled diabetes and dyslipidemia.

To maintain participation for the whole team, facilitators can assign active roles to each team member. For example, one intern can take notes of important history provided by the patient. Another intern can note clinical management that could be influenced by this encounter. Another task can be to take note on the patient's agenda, and yet another can be to follow how this agenda may or may not change throughout the encounter.

DURING ENCOUNTER

While the resident applies BATHE during the interview, it is essential for practice-based learning that the learners lead the exercise. In addition to the resident initiating the interview, other team members can take notes according to their assigned roles. Facilitators can take note of verbal and non-verbal strategies applied by the resident, and model and reinforce with their own clinical approach as appropriate. Ideally, while facilitating faculty should wait until after the resident finishes BATHE, of course the faculty can step in earlier, if needed. In particular, faculty can pay close attention to attitudes of all participants, to address during the debrief discussion.

Always mindful of time, the facilitator can look for a natural pause in the interview, ask if anyone has any further questions (especially the patient), thank the patient, and close the encounter. An important clarification: while the BATHE technique is designed to be a brief, 2-minute clinical tool, empathy must remain a central part of every clinical encounter of any duration. Therefore, while the initial BATHE questions can be done quickly to frame the interview, the interview can extend as long as necessary, as the clinical encounter allows.

DEBRIEF AFTER ENCOUNTER

As during the encounter, it is essential that the learners lead the debrief discussion, while the facilitator maintains focus and flow. Again, there are many ways to define and apply empathy. Of course, facilitators are welcome to draw from their own experience and expertise. Here are various questions that can help frame the team's discussion:

Empathy-based discussion questions	**Cultural-based discussion questions**
1. How did the BATHE exercise go? 2. What did we learn? 3. What went well? 4. What could be better? 5. What is clinical empathy? 6. Can empathy be learned? 7. Can empathy save lives? 8. Do doctors care for sick people, or keep people well? 9. Did this exercise change our clinical management for this patient? 10. Did this exercise influence the patient's satisfaction with our care?	1. What did we learn, if any, about this patient's culture? 2. How did this exercise change, if any, our own cultural attitudes? 3. How can someone learn about another's culture? 4. How does the iceberg concept help us understand another's culture? 5. How does empathy relate to a patient's traditional beliefs ? 6. How does empathy explain the difference between "cultural competency" and "cultural sensitivity"? 7. Did this exercise improve our ability to provide cross-cultural patient care?

Take home points:

- **Empathy improves clinical outcomes**
- **Empathy is a tool to gauge and respond to health literacy needs**
- **Because all people are culturally unique, all communication is cross-cultural**
- **Empathy belongs in every clinical encounter, inpatient or outpatient, every day**
- **Empathy saves lives!**

Take home challenge:

- **Use these empathy skills at the bedside, again and again!**

ORIENTATION TO EXERCISE (ahead of time)

Empathy

There are many ways to define, demonstrate, teach and assess empathy. Simply put, empathy is "the ability to understand and share the feelings of another." It is increasingly recognized as a clinical skill linked to improved patient satisfaction, adherence, continuity, informed consent, end of life care, and trust in health care providers and systems. To begin preparing to facilitate this exercise, one may ask oneself, "What do I already know about empathy? How would I explain these skills to others, and how would others express these skills to me?"

According to US Department of Health and Human Services, health literacy is defined as the "capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions." It is essential for patients to find and interpret health information, adopt healthy behaviors, and act on important public health alerts and other needs. In order to gauge an individual's level of health literacy, a clinician must know their patients' understanding of themselves and how they understand their own sickness and health. Therefore, empathy is a valuable tool to promote health literacy.

The Bonvicini reading asks the question, "Can empathy be taught, or does someone need to be born with it (or not)?" Many people believe empathy *cannot* be taught, because of the difficulty to teach a standard *emotional* response to a patient's feelings (i.e. "Do I feel connected to this patient?"). However, for clinicians to *understand* their patients requires a *cognitive* response ("Do I understand this patient?"); a clinician can still "share the feelings of another" by *understanding* the feelings of one's patient. *Cognitive* empathy captures this dimension of clinicians understanding their patients' feelings, without which no clinical history is complete.

Consider for a moment looking at a tightrope walker, hundreds of feet above the ground, dangling without any harness or safety net. Many of us will instantly feel uncomfortable or anxious, although our own safety is not actually threatened in any way. While *emotional* responses are likely to be variable (which is ok!), *cognitive* responses for clinicians can be (and should be) defined, taught, and assessed, if we were to gather a clinical, *cognitive* understanding of what the tightrope walker is feeling. In other words, as clinicians we do not all need to feel the same way to care for our patients, but we should all know how are patients are feeling in order to provide appropriate and accurate care.

When discussing empathy, many colleagues in our group asked for a checklist to help structure a clinical discussion on the topic. The BATHE technique is a checklist of 4 questions followed by an empathetic response. Designed as a brief tool that can be used in as few as two minutes, BATHE can help "connect meaningfully with patients, screen for mental health problems, and empower patients to handle many aspects of their life in a more constructive way."

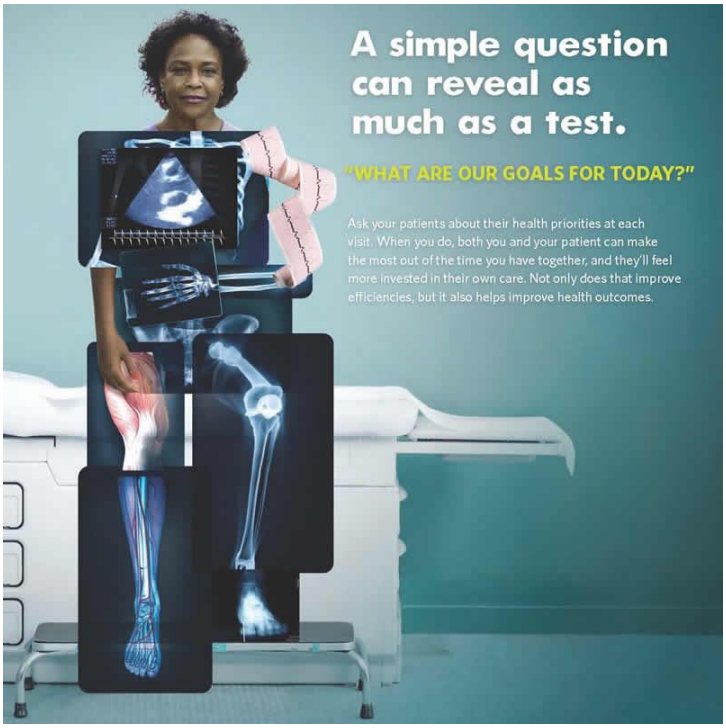
> **B**ackground: "What is going on in your life?"
> **A**ffect: "How do you feel about that?"
> **T**rouble: What troubles you the most about this?"
> **H**andling: "How are you handling that?"
> **E**mpathy: "That must be very difficult for you."
>
> *Stuart, Lieberman, 2008*

In order to convey empathy in our response to our patient's BATHE answers, strategies from the Bonvicini reading include:

Non-verbal strategies	**Verbal strategies**
Voice tone	Inviting input
Facial expression	Open-ended questions
Pausing	Reflective listening
Eye contact	Not interrupting
Touch	Checking for understanding
Posture	Asking permission

While most people will recognize the intrinsic value of achieving clinical empathy, there is growing evidence that empathy translates into better clinical outcomes. For example, the Hojat paper demonstrates significantly better hemoglobin A1c and LDL levels among patients of physicians with higher empathy scores than those with lower scores.[iii]

In summary, cognitive empathy offers the clinician an understanding of how patients feel about their health, which in turn, helps us identify and respond to their health literacy needs. As AHRQ reminds us, a simple question may in fact be all we need to reveal how a patient is feeling.



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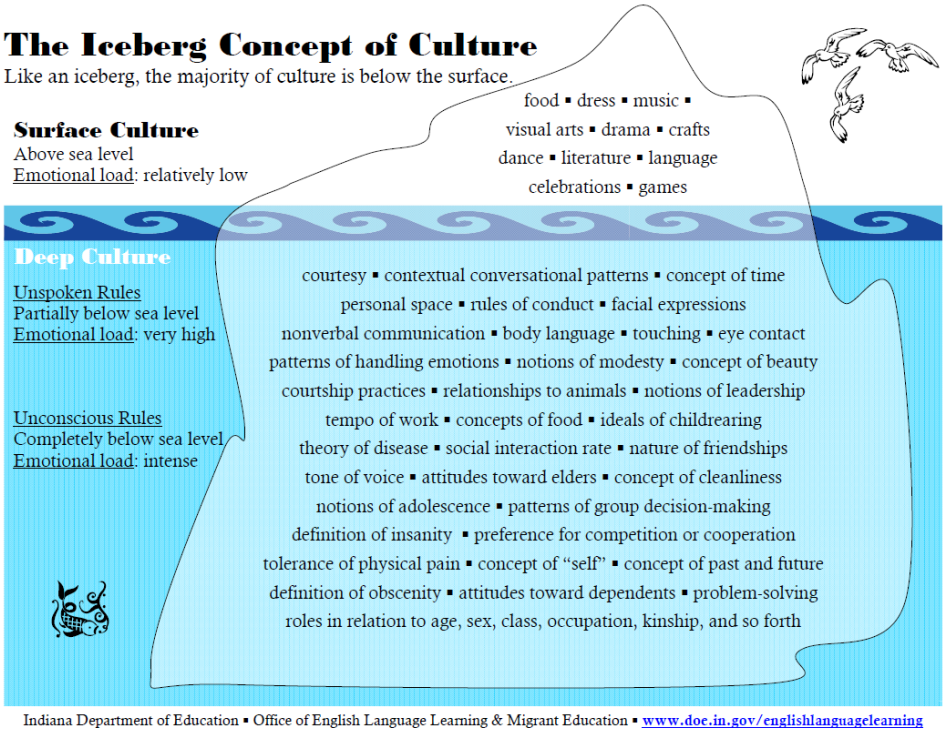
Competence in cross-cultural patient care

While the link between empathy and cultural competency is not always obvious (or necessary), both require the clinician to understand the unique perspective of each patient. Therefore, they are both discussed here in this exercise, in order to explore the cross-cultural context of empathy.

Cultural competency can be defined as the ability to interact effectively with people of different cultures and socio-economic backgrounds. Awareness of one's own cultural worldview, attitude towards cultural differences, knowledge of different cultural practices and worldviews all impact this ability. Many consider the term "competency" a misnomer, and call these skills cultural sensitivity or cross-cultural communication. Conscious and unconscious cultural bias is widely prevalent; rather than attempting to eliminate it, recognizing one's biases is considered an essential step toward overcoming them and providing more effective care.

The iceberg concept of culture reminds us that most of an individual's cultural identity is below the surface. It is imperative to avoid assumptions or cultural stereotypes based on a perceived cultural identity—there are over 100 languages spoken at Bellevue, and every patient has a unique sum of all cultural factors that make up cultural identity. Instead, being asked open-ended, empathic questions allows an individual to define one's own culture for the interviewer. Nonetheless, in a culturally sensitive way, knowledge of cultural norms and patterns can be carefully utilized to build context and rapport.



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Therefore, the iceberg concept offers a way to connect both topics of empathy and cross-cultural communication during this exercise. For example, the ability for a clinician to empathize with a patient at a glance (i.e., with only the "tip of the iceberg" visible) will never be complete. Similarly, a clinician cannot (and should never!) understand a patient's culture with a glance. Instead, clinicians must ask the right questions (i.e. empathetic listening) in order for patients to teach clinicians about their own unique cultural identity—to define their own cultural identity that lies below the surface.

While there are many dimensions to cultural identity, traditional beliefs can sometimes be the most important factor for many patients to make decisions. However, they are frequently missed during a clinical encounter. Traditional beliefs are incredibly diverse, especially regarding neurological or psychiatric illness. For example, many patients worldwide believe in spiritual factors like curse or witchcraft as an explanation for illness and suffering. In a respectful way, faculty can draw on personal clinical experience to facilitate this discussion.

Finally, similar to empathy, cultural competency can be clearly defined, taught and assessed. ACGME milestones are competency-based, observable clinical skill measures that ask faculty whether each resident is ready for unsupervised practice for each given skill. While there are many communication-based milestones, internal medicine milestone #18 has a cultural focus, asking whether each resident appropriately "responds to each patient's unique characteristics and needs based upon culture, ethnicity, gender, religion and personal preference." When designing this exercise, faculty found that empathy was one (of many) ways to gauge a resident's ability to demonstrate competency in this culturally-related ACGME milestone.

In summary, just as Bonvicini reminds us about being students of empathy, studying culture and health is also a privilege and a source of endless fascination, in order for our patients to feel the "care" in clinical care. We trust that this Instructor's Guide can serve as a useful resource for facilitating your own discussion on empathy and cross-cultural patient care.

[i] Bonvicini K, Andrews B. "Can empathy be learned? lessons from ninjas and neuroscience." Communication Matters, November 2013.
[ii] Lieberman JA, Stuart MR. The BATHE Method: Incorporating Counseling and Psychotherapy Into the Everyday Management of Patients. Primary Care Companion J Clin Psychiatry 1:2, April 1999.
[iii] Hojat M, etal. "Physicians' empathy and clinical outcomes for diabetic patients." Acad Med. 2011;86:359-364