

The Empathy Quandary in Postgraduate Medical Training

Abstract

Background: Empathy stands as a cornerstone of humanistic qualities and is essential in healthcare for understanding and alleviating emotional suffering. Despite its necessity, formal empathy training remains elusive in postgraduate medical education across the globe, contributing to decline of humanistic practice among trainees. This study aims to assess and establish the need for empathy training by evaluating the perspectives of postgraduate trainees and faculty. **Materials and Methods:** The study was conducted in a medical college of western India in 2023. Three online validated questionnaires were used to assess empathy-related perceptions among faculty and postgraduate trainees across various specialties. The questionnaires focused on demographic data, importance of empathy in patient care, empathy training, perceived levels of empathy, reasons for shortfalls in empathetic behavior and recommendations for nurturing empathy. Data were analyzed quantitatively and thematically. **Results:** A total of 150 and 127 responses were gathered and analyzed from faculty and trainees, respectively. Excessive workload, lack of formal training, and technology-dependent fast paced lifestyle were attributed for lack of empathy in clinical care. All the faculty agreed that empathy training is essential and majority (67%) believed that lack of empathetic behavior led to dissatisfaction among patients and caregivers. **Conclusion:** Empathetic communication and behaviors are fundamental competencies for health-care professionals. There is need for a structured training for empathy in postgraduate medical curriculum.

Keywords: Empathy, hidden curriculum, humanities, postgraduate trainee

Introduction

Empathy is considered as one of the core tenets of humanistic qualities. The concept of empathy is well summarized in layman terms by Alfred Adler as “seeing with the eyes of another, listening with the ears of another and feeling with the heart of another.”^[1] Empathy can be divided into either emotional or cognitive and spontaneous or deliberate. Dohrenwend defined cognitive empathy as a conscious, strenuous, and mental effort to clarify a patient’s expression of their experiences using a soft interpretation of their stories.^[2] Daniel Goleman has popularized the term “emotional intelligence” and shown why and how empathy is a core element of the emotional quotient.^[3] Goleman has identified three components of empathy: cognitive, emotional, and compassionate. Empathy is a sense of similarity between feelings of self and the other with clear distinction between the two.^[3] Riess have described empathy as a cultivable attribute

and not just an inherent skill. Empathy plays a critical role in forming a bridge between two individuals for sharing of emotions, experiences, needs, and desires.^[4]

Although used interchangeably in daily communications, “empathy” “compassion” and “sympathy” have different meanings and value. Sympathy is more of a feeling of pity for another. Empathy is our ability to understand how someone feels while sympathy is our relief in not having the same problems. Similarly, “empathy” and “compassion” are also not the same.

While empathy is our feeling of awareness toward other people’s emotions and an attempt to understand how they feel, compassion is an emotional empathy along with a desire to alleviate the suffering. While the former is called general empathy, clinical empathy is a sense of connection between the health professional and the patient through perspective taking, expressed through behavior and genuine concern, and combined with a capability to communicate this understanding to the patient.^[5,6]

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Among other humanistic virtues, empathy is very relevant in health care as it involves health-care professionals to understand and alleviate distress of patients. Unfortunately, lack of formal training in humanities is one of the reasons for declining humanistic values and empathy among trainees.^[7,8] It is also critical for the professional development and identity formation of trainees. Humanities and its role in education has remained a part of the hidden curriculum. A formal structured empathy training for postgraduates is not routinely practiced in India. The present day postgraduate curriculum is designed to be much more objective, filled with scientific and technical content.^[5] Humanities and soft-skills such as communication and empathy have taken a backseat. Lack of role models, excessive cognitive load, time pressure, busy workload, patient, and environmental factors and digitalization for patient care have also been attributed to regression of empathy.^[6,9-11] Lack of compassion and humanistic care from trainees result in dissatisfied patients who are unlikely to adhere with treatment recommendations, increase medical errors, poorer health outcomes, and mistrust in patient–physician relationships. Although literature states that empathy can be nurtured by educational interventions,^[12-15] no formal needs assessments have been done for empathy training in postgraduate medical education. This study was conducted to assess the need for training in empathy in the postgraduate education.

Materials and Methods

This questionnaire-based study was conducted in a medical college of western India in 2023. The project was approved by our institutional ethics committee. Three questionnaires – for trainee self-assessment of empathy and knowledge about empathy and faculty perception about empathy training in postgraduate medical education – were developed [Annexures a-c] using validated open access preexisting questionnaires from literature.^[16-24] The questionnaires were modified after face and content validation done by internal and external experts.

The faculty questionnaire with consent was distributed through institutional social media groups. Links to the questionnaire were also sent individually to all clinical and nonclinical departmental faculty. This questionnaire included demographic and experiential data, views regarding the value of empathy in health care, need of empathy training, perceived levels of empathy among postgraduate trainees, reasons for lack of empathetic behavior, and recommendations to enhance empathy.

The faculty gathered the consenting postgraduate trainees at a mutually convenient time and shared the links with them. The trainees were asked to complete and submit the questionnaires in the presence of the faculty. Through the questionnaires, apart from demographic details, their general empathy and clinical empathy was assessed; opinions regarding important attributes for an empathetic patient–doctor relationship and their perceived reasons

for decline in empathy during medical training were gathered; and their knowledge about empathy was analyzed.

All responses were entered into Microsoft Excel sheet. Standard statistical analysis using *t*-test and ANOVA test was performed along with significance calculation where applicable. For analysis of general empathy scores, the item responses were scored as: Never =0; Rarely =1; Sometimes =2; Often =3; and Always =4 for positively worded items and reverse scored for the negative items. Similarly, for analysis of clinical empathy scores, the item responses were scored as: Strongly disagree =1, Disagree =2, Agree =3, and Strongly agree =4 and reverse scored for the negative items. Item scores were summed to derive total score for each student. All qualitative data were analyzed and segregated according to codes and themes.

Results

Needs assessment of faculty

One hundred and fifty faculty responded to the survey from 23 departments of the medical college and hospital. The distribution of the specialties is shown in Figure 1 wherein surgical specialties include general surgery (N 5), ophthalmology (N 68), orthopedics (N 1), neurosurgery (N 2), ear, nose, throat (N 2), urology (N 1), burns and plastic surgery (N 1); medical specialties include general medicine (N 3), emergency medicine (N 3), respiratory medicine (N 1), obstetrics and gynecology (N 2), psychiatry (N 3), pediatrics (N 4), immunohematology and blood transfusion (N 3), dermatology (N 2), anesthesia, (N 9) radiology (N 2); laboratory and diagnostic specialties include pathology (N 5), microbiology (N 4), biochemistry (N 2); basic sciences include anatomy (N 11), pharmacology (N 8), physiology (N 5), and public health includes community medicine (N 3).

Among them 40 were professors, 49 were associate professors, 49 were assistant professors and 12 were tutors.

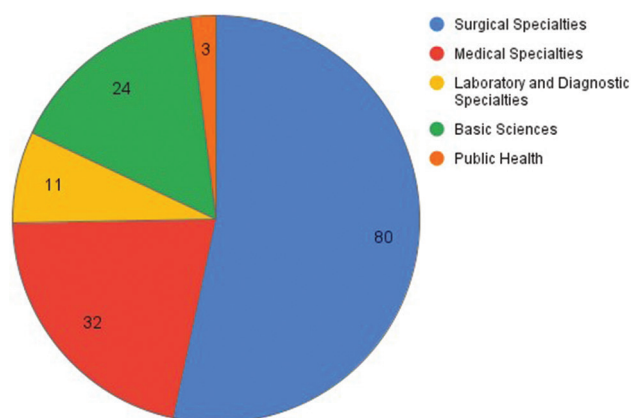


Figure 1: Distribution of faculty specialties

Their teaching experience ranged from <5 years to more than 15 years, with majority faculty (N 96) having more than 15 years' experience. The responses of faculty for statements related to empathy are shown in Table 1.

Reasons for lack of empathy for patient care among postgraduate trainees were identified and could be grouped as those related to students, teachers, curriculum, administration, and patients. The most common reasons were excessive workload (N 64), lack of formal training (N 41), and technology dependent lifestyle (N 26) while the others were patient attitude, stress, lifestyle with excessive digitalization, lack of role modeling, absence of soft skills assessment, assessment-oriented education, workplace environment, and a lack of "empathetic culture [Table 2]." Recommendations to enhance empathetic skills among the trainees were shared among which the most common was to provide training for the same (N 86). The others were more effective work management, faculty role modeling, continuous student encouragement, inclusion of soft skills training in curriculum with reinforcement sessions and creating a more conducive and empathetic working environment [Table 3].

Trainee self-assessment of empathy

Demographic distribution of the 192 responses of postgraduate trainees according to their year of study, gender, relationship status, and their native residence is shown in Table 4. The general and clinical empathy scores of trainees and their self-rating for empathetic behavior are shown in Table 5. Although there was a difference in raw values, no statistically significant difference was observed gender-wise or according to year of postgraduation as per unpaired *t*-test and ANOVA test, respectively with $P < 0.05$.

Trainee's knowledge assessment

The knowledge test scores ranged from 5.5 to 16 with a median of 11.04 out of a possible score of 20. The most common attributes for a trustworthy patient–doctor relationship as perceived by the trainees were grouped as – understanding patients well (N 52) and effective communication skills (N 44) followed by respectful and kind behavior (N 17). Knowledge and professional skills were listed as necessary attributes by only 5 trainees. The reasons for decline in empathy during medical training were ranked on a scale of 1–7, in order of their influence, where 1= maximal influence and 7= least influence [Figure 2]. These reasons were found to be like those

identified by faculty, with over work being the chief reason among trainees followed by lack of formal training.

Discussion

Empathy in a physician has benefits for wellbeing. Conducive clinical environment and management, compliance and optimum outcomes may be achieved by training postgraduate residents not only with the clinical acumen and procedural skills but also by inculcating humanistic behavior in their approach towards patients. Empathetic attitude can humanize the experiences, wants, and wishes of patients. Several studies support our finding that empathy declines throughout medical training, with the primary reasons being overwork, inadequate training and isolation from family and friends.^[6-11,21,25] Lack of empathy runs the risk of unsatisfied patients with nonadherence to treatment resulting in poor outcomes and increased financial burden on patient and health-care system.^[4]

Table 1: Agreement responses of faculty regarding empathy-related statements

Statement	Number of faculty in agreement (n=150) (%)
A holistic perspective is extremely relevant for patient care	142 (94.66)
Empathy during patient care is a core clinical skill	150 (100)
Teaching empathy will improve patient–doctor relationship	150 (100)
Empathetic doctor–patient relationship can improve health outcomes	145 (96.66)
Lack of understanding of patient perspectives affects patient management	146 (97.33)
Teaching empathy should be mandatory even if not taught explicitly in the curriculum	145 (96.66)
Teaching humanities is easy	43 (28.66)
Faculty have time to teach humanistic skills	100 (66.66)
Only few trainees demonstrate empathy under routine working conditions	125 (83.33)
There is an increase in complaints of patient dissatisfaction due to lack of empathetic behavior of postgraduate trainees	100 (67)
Being empathetic can increase work satisfaction and self-compassion and decrease stress among trainees	150 (100)
An empathy training module would be helpful for trainees	100 (67)

Table 2: Factors affecting empathetic patient care as derived from thematic analysis

Student related	Teacher related	Curriculum related	Administration related	Patients related	Others
Workload	Lack of training	Lack of training	Workload	Attitude	Excessive digitalisation
Attitude	Lack of role modeling	Absence of soft skills assessment	Workplace environment		
Stress		Assessment oriented education	Lack of "empathetic culture"		
Lifestyle					

Horton has highlighted the technical and theoretical nature of medical curricula across the world.^[26] Such data indicate a significant gap in medical education that may be addressed by including humanities training into medical education. This can help physicians to be empathetic along with excellent clinical decision-making skills. Participants trained in empathy can improve their capacity for perspective-taking, active nonjudgmental listening, emotional control, and rapport building. It can assist in identifying and overcoming prejudices, preconceptions, and assumptions that could impact meaningful engagement with patients. Several studies on empathy education have assessed the impact of empathy

Table 3: Suggestions to improve empathetic behavior among postgraduate trainees as derived from thematic analysis

Student related	Teacher related	Curriculum related	Administration related
Work management	Provide training Role modeling Continuous encouragement	Inclusion of soft skills training in curriculum Reinforcement sessions	Work management Working environment

Table 4: Demographic data of postgraduate trainees

Parameter	Sub groups of the parameter	Number of postgraduate trainees (n=192) (%)
Year of postgraduate training	Year I	79 (41.14)
	Year II	49 (25.52)
	Year III	32 (16.66)
	Senior resident	32 (16.66)
Gender	Male	77 (40.10)
	Female	113 (58.15)
	Prefer not to disclose	2 (1.04)
Status of relationship	None	106 (55.20)
	In relationship	53 (27.60)
	Married	29 (15.10)
	Prefer not to disclose	4 (2.08)
Native residence	Metro city	99 (51.56)
	Nonmetro urban city	55 (28.64)
	Semi urban	25 (13.02)
	Rural	13 (6.77)

training on the professional and personal development of trainees but there are no studies formally demonstrating the need of this training in the postgraduate medical education.^[27-32] This study establishes the need for empathy training of faculty and postgraduate trainees. A study done in the field of nursing showed that there are high levels of empathy in the nursing fraternity but there is still need for enhancement of the same.^[33] Empathy education among nurses by Brunero *et al.* studied 17 researches and 11 out of these 17 studies established a strong need of empathy education among this fraternity and showed improvements in empathy after training.^[34] A systematic review estimated the levels of empathy among health-care workers (HCWs) in South American countries between 2000 and 2019 that included 18,532 papers showed lack of empathy among HCW and surgery residents to be less empathetic than pediatric and obstetrician–gynecologist professionals.^[35]

General empathy is regarded as understanding another person's feelings and thoughts, and feeling congruent emotions and states. In health care, clinical empathy is defined as understanding and feeling a patient's emotions and perspective and offering a response that reflects understanding and aims to help. Theoretically, lower clinical empathy scores suggest diminished understanding of patient perspectives while higher scores indicate a better understanding which in turn reflect on meeting the patient needs and yielding more patient-centered care plans, better patient experiences, greater patient adherence and ultimately better patient, physician, and organizational outcomes. Thus, a good clinical empathic engagement remains an essential element of the overall professional competence of health care professionals. We did not find any significant difference in scores based on gender or according to year of postgraduation even though previous studies suggested that females and trainee in stable relationships have higher levels of empathy. According to the study done by Ravi and Mal, the cognitive empathy scores increased after humanities teaching module among 1st year medical trainees in Nepal. They also found that scores were significantly higher ($P < 0.001$) in females.^[13] Mestre *et al.* described a stronger empathic response in females than in males of the same age, differences growing with age.^[36] Similarly, Toussaint and Webb and Chen *et al.* also reported higher levels of empathy in females compared to male

Table 5: General and clinical empathy scores and self-rating for empathetic behavior of trainees

	General empathy score (maximum=52)	Clinical empathy score (maximum=29)	Trainee self-rating of empathetic behaviour on a scale of 0–10
Minimum	3	–3	2
Maximum	38	19	10
Mean	21.17	7.803	6.963
Mean for males	21.04	7.73	6.963
Mean for females	21.15	7.8	6.968
Mean for year I	21.173	7.803	6.968
Mean for year II	21.257	7.756	6.968
Mean for year III	21.416	8.035	6.978
Mean for senior residents	21.824	7.667	6.924

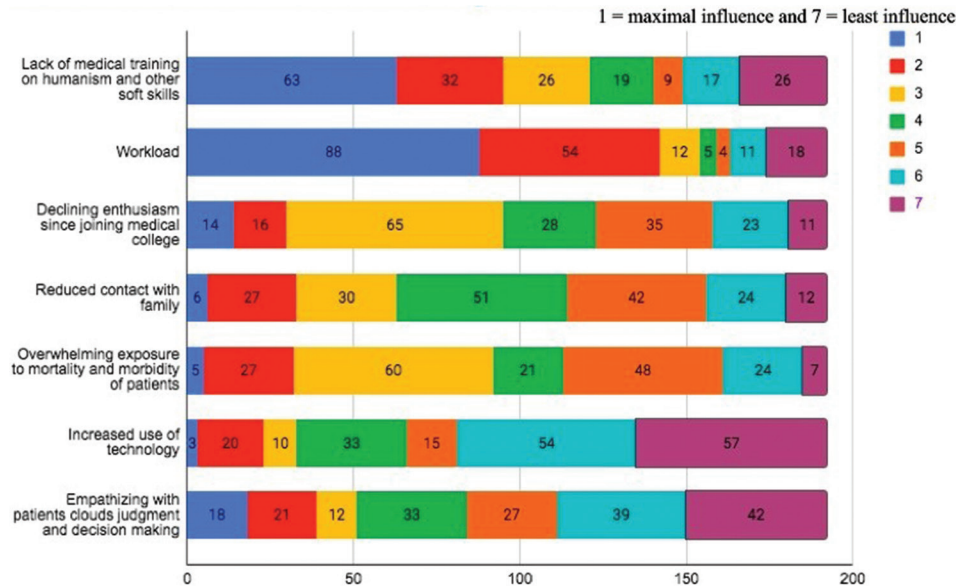


Figure 2: Reasons for decline in empathy during postgraduate training

trainees.^[37,38] Chen *et al.* found that 1st-year students had the highest empathy scores, whereas the 4th-year class had the lowest on the Jefferson empathy scale.^[38]

In our research, all faculty agreed on exhibiting empathy during patient care as a core clinical skill in fiduciary doctor-patient relationship. This can improve the patients' health outcomes and that even though empathy was not assessed, it was necessary to teach it. Faculty also agreed that empathy training would help the postgraduate trainees to respect patients' perspectives and improve doctor-patient relationships and enhance health outcomes. We identified the common barriers to exhibiting empathetic behavior, the key ones being heavy workload and lack of training. Identifying the barriers for exhibiting empathetic behavior can help to develop strategies to overcome them. A study done on general practitioner trainees of two Dutch universities noted that personal emotions and fewer empathy training opportunities were problems that required attention.^[5]

There are few limitations to our study. Our observations were limited to one medical school and the assessment is perception based and self-reported. It measures the trainees' orientation to empathy and is not correlated with behavior which can be best measured through patient feedback. The multidimensional and complex nature of empathy makes it difficult to measure with sufficient validity and objectivity. We also acknowledge that trainee participation and their responses could be influenced by the situation and emotional status during which the data was obtained. The precise response rate could not be determined due to faculty posting instability and trainee rotations and consequent lack of relevant accurate data. Nevertheless, such a study would motivate educators to focus on different dimensions of empathy and incorporate empathy in postgraduate training.

Recommendation

To enhance empathetic skills among medical trainees, it is recommended to address the common issues of excessive workload, lack of formal training and a technology-dependent lifestyle. Key strategies include providing dedicated empathy training, implementing more effective work management practices, and encouraging faculty to serve as role models. Continuous student encouragement, inclusion of empathy training in the curriculum, supported by reinforcement sessions; and fostering a more conducive and empathetic working environment can significantly improve trainees' ability to develop and practice empathy in their professional roles.

Conclusion

Empathetic communication and behaviors are crucial for physicians and patients. Most educators and clinicians concur that empathy and empathetic communication are fundamental competencies for health-care professionals. There is a need for formal training of postgraduate trainees for nurturing empathy. We could also identify local and systematic barriers against empathetic behavior. A need for a structured training program during the postgraduate education can help with compassion for long-lasting healthy patient-doctor relationships.

Annexures

- Empathy knowledge assessment of postgraduate trainees: <https://forms.gle/BzJDZUGR7x1wAb9h9>
- Empathy self - assessment of postgraduate trainees: <https://forms.gle/xAtc3NMNy6NzQvXg8>
- Faculty perception regarding empathy in postgraduate trainees: <https://forms.gle/uJD28EcQHqTDyRme9>

Ethical clearance

The study was approved by the Institutional Ethics Committee, B. J. Medical College & Civil Hospital, Ahmedabad. (EC/Approval/51/2023/17/8/2023 dated 17th August 2023).

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Nil.

Conflicts of interest

There are no conflicts of interest.

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