"THIS WILL ONLY HURT A BIT" EVALUATING THE USAGE OF PATIENT FOCUSED EMPATHY AMONGST GENERAL SURGERY RESIDENTS

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APPROVED: _____
Monica Indart, Psy.D

_____
Elisa Shernoff, Ph.D

DEAN: _____
Francine Conway, Ph.D

Abstract

Within the medical setting, surgery has the potential to have traumatic implications on the psychological functioning of patients. One way to combat these traumatic effects is to improve the training doctors receive on how to provide empathic care. Unfortunately, research has shown an observable decline of empathy amongst physicians in training, as well as missed opportunities for demonstrating empathy among practicing physicians (Plant, Barone, Serwint, & Butani, 2015). The purpose of this study was to obtain a measurement of current levels of empathy amidst General Surgery Residents at Robert Wood Johnson University Hospital, utilizing the Jefferson Scale of Empathy. This study also sought to acquire an understanding of prior empathy training by assessing the frequency in which empathy was being modeled, as well as how effective residents found the training to be. This data was then used to inform the development of a curriculum aimed at enhancing the usage of patient-focused empathy amongst the residents. Data analysis included scoring the Jefferson Scale of Empathy according to its manual. This revealed all but two residents fell in the average range of empathy for their sample. Further data analysis included utilizing descriptive statistics to identify the frequency in which empathy was modeled, and for assessing the effectiveness of prior training. Residents rated the frequency in which they observed physicians demonstrating empathy as either sometimes (12 respondents) or often (13 respondents). In regards to previous trainings, a majority of the residents felt like prior trainings were only “slightly” helpful. Following the data analysis, a period of integration occurred in which the data collected was fused with a common factors approach

that emphasized hope, empathy, language, loyalty, permission, partnership, and planning to develop a training curriculum. The focus of the proposed training curriculum is to create an opportunity to teach patient focused empathy and to ultimately improve patient care. Along with the proposed curriculum, suggestions for future research included here call for evaluating the impact of the training through pre- and post-test evaluations. Limitations to this current study include the lower than anticipated sample size, the Jefferson Scale of Empathy's lack of standardized scoring guidelines, and a limited amount of qualitative data obtained.

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Chapter I: Introduction

Purpose of Study

Within the medical setting, surgery has the potential to have long term traumatic implications on the psychological functioning of patients. One possible way to combat the traumatic effects surgery can have on patients, is to better train doctors on how to provide empathic care in medical situations requiring surgery. Dr. Helen Riess of Harvard Medical School, defines empathy in the medical setting as "the physician's ability to understand patients' emotions, which can facilitate more accurate diagnoses and more caring treatments." (Killam, 2015). The biggest factor in delivering empathy in the medical setting is realizing that it is dependent on the patient's perception of how his or her feelings are being understood and accepted by the physician (Kim, Sung, Kaplowitz, & Johnston, 2004). Unfortunately as of the early 2000s, there has been an observable decline of empathy amongst physicians in training (Hojat, Vergare, Maxwell, Brainard, Herrine, Isenberg, & Gonnella, 2009) as well as missed opportunities for demonstrating empathy among practicing physicians (Plant, Barone, Serwint, & Butani, 2015). When taken together, evidence is now suggesting that the very culture of medicine and of medical training may be such that empathy is under-valued and under-taught (Mercer & Reynolds, 2002).

The purpose of this study was to obtain a measurement of current levels of empathy amongst General Surgery Residents, as well as to acquire a better understanding of how effective prior trainings were. This data was then used to inform the development of a curriculum aimed at enhancing the usage of patient-focused empathy

amongst the residents. Utilizing the Jefferson Scale of Empathy, this study provides an operational measure of empathy for the General Surgery Residents at Robert Wood Johnson University Hospital. The Jefferson Scale of Empathy was ideal for this research as its purpose is to assess empathy in a medical setting. Through administration of a Empathy Training Survey created by the author, this study also assessed for the frequency in which the residents observed physicians demonstrating empathy and the observable effects empathy had on patients. The Empathy Training Survey also included an opportunity for the residents to give feedback regarding the effectiveness of the empathy training they have received thus far and how they felt they learned best. Data analysis in this study included scoring the Jefferson Scale according to its designated guidelines and utilizing descriptive statistics to identify the frequency in which empathy was modeled. Data analysis also consisted of utilizing descriptive statistic to demonstrate the effectiveness of prior trainings. Following the data analysis, a period of integration occurred in which the data collected was fused with a common factors approach that emphasizes hope, empathy, language, loyalty, permission, partnership, and planning (HELP) to develop a training curriculum. The focus of the training curriculum proposed is to integrate a best practice model, with the feedback from the General Surgery residents to create an opportunity to teach patient focused empathy and to ultimately improve patient care. The proposed training initiative would be delivered during didactic training sessions and provide an opportunity for confidential in-vivo feedback for the residents.

Background

Research has demonstrated that the quality of the interaction between the patient and doctor has an impact on the patient's health outcomes. In fact, deficits in the psychosocial quality of care can result in increased stress susceptibility, lower compliance rates, and higher complication rates for a patient (Steinhausen, Ommen, Thüm, Lefering, Koehler, Neugebauer, & Pfaff, 2014). Furthermore, surgery has been demonstrated to be associated with higher levels of patient reported anxiety, psychological distress, and memory disturbance (O'Hara, Ghoneim, Hinrichs, Mehta,& Wright,1989). As such, providing adequate empathic care during these instances is a crucial component of working towards patient recovery and health. These increased psychological factors can also be applied to children undergoing surgical procedures. Research has also demonstrated that hospitalization and surgery can be an emotionally threatening and psychologically traumatizing experience for children especially (Lerwick, 2013). In fact, child development experts report that painful procedures, such as those related to general surgeries, produce high levels of emotional discomfort in children specifically. As a result many children become anxious as a means of self-protection. It is estimated that approximately 25% of children demonstrate negative psychological and behavioral responses within the first year of post discharge. These negative responses include instances of hallucinations, delusional memories, increased medical fears, anxiety, changes in friendships, Post-Traumatic Stress Disorder, and major depression. Child development experts believe that these negative outcomes associated with surgery can be reduced based on how the child's feelings are addressed in the hospital (Lerwick, 2013).

Patient focused empathy can be conceptualized as containing both a cognitive and affective component. The cognitive aspect relates to the physician's ability to accurately take their patient's point of view and effectively communicate it back to the patients. The affective aspect of physician empathy relates to the physician's ability to respond to and improve his or her patient's emotional state (Kim et al., 2004). Research has demonstrated that patients cared for by humanistic clinicians (i.e. those who demonstrate empathy) have better medical outcomes, increased satisfaction, and improved adherence to an agreed upon plan of care (Plant, Barone, Serwint, & Butani, 2015).

The current purpose of this study is to assess for the empathy levels currently present amongst General Surgery Residents at Robert Wood Johnson University hospital, located in New Brunswick, New Jersey. Empathy levels amongst this population are of interest because studies are showing the current climate in this field may not be fostering the development and enhancement of patient focused empathy. In fact, while the importance of empathic medical providers has been documented and researched, there is a decline in this service actually being provided. It has been hypothesized that within the medical settings, residents often have two options. They can join the crowd and restrain any empathic behavior or become the 'odd man out' by demonstrating empathy in their practice (Kramer, Ber & Moore, 1989). More often than not, residents withhold empathic services because clinical mentors can view it as a waste of time in a hospital setting (Kramer, Ber & Moore, 1989). Additionally, physicians in training are finding that working with clients with a psychiatric component (involving additional empathy and attention) to be unappealing, citing that it causes increased levels of stress. Professional literature continues to document the decline in empathy in these students capacity for

empathy over the course of their training. This phenomenon has been referred to as the "hardening of the heart" (Cutler, Harding, Mozian, Wright, Pica, Masters, & Graham, 2009).

Research has found that on average only 1% of the dialog between a surgeon and patient demonstrated empathy (Levinson & Chaumeton, 1999). However, it also important to note that in an understaffed hospital setting where the workload is high, there are several barriers preventing empathy from being delivered (Reynolds & Scott, 1999). Some additional factors to consider include the possibility of a violation of the clinician's empathy if he or she is unable to dissociate their personal lives from work. This can ultimately lead to the physicians neglecting their personal lives, because they are in a sense "bringing their work home." Research illustrates that this can heighten the risk of physician burn out, especially in medical fields considered "high touch" disciplines, such as General Surgery (Dehning, Reiß, Krause, Gasperi, Meyer, Dargel, & Siebeck, 2014).

The ability to demonstrate empathy can be viewed as a mode of the surgeons' professionalism, which is defined as "those attitudes and behaviors that serve to maintain patient interest above physician self interest" (Nwomeh & Caniano, 2011). The AAP Committee on Bioethics has specified that empathy be considered one of the eight components of professionalism (Nwomeh & Caniano, 2011). Because empathy is an important aspect of professionalism and a possible link to preventing the traumatic effects of surgery, one purpose of the current study is to measure the actual levels of empathy present. This information will then be used to create a curriculum for medical residents to refine their skills regarding delivering empathic services to patients. Improving the

delivery of empathy to surgery patients has the potential to reduce the negative psychological outcomes associated with having surgical procedures, as well as help doctors abide by their ethical oath to professionalism. Public health and social welfare may also be positively impacted by doctors' improving their empathy skills as research has linked empathic doctors to having improved patient outcomes. Ultimately the health of these patients could potentially improve because empathically delivered instructions have the potential to enhance the likelihood that patients will follow their doctor's recommendations for post-operative care. As noted in Kim et al., (Kim et. al, 2004) hospitals that have more empathic physicians have an advantage over hospitals that have fewer empathic physicians because they are more satisfying to patients.

Chapter II: Literature Review

The purpose of this chapter is to provide an understanding of how empathy is conceptualized. This chapter should also provide insight into the discussion regarding understanding empathy as a unique character trait versus a professional skill that can be taught. This chapter will then go on to highlight the crucial role of empathy within the medical profession and current methods of teaching empathy to medical clinicians.

Empathy

The word empathy originally comes from Greek word 'empatheia' meaning a strong feeling or passion (Maatta, 2006). As the word empathy began to be used more widely it became simultaneous with the ability to suffer with other sentient beings (Maatta, 2006). Empathy can be defined as "an observer's reacting emotionally because he perceives that another is experiencing or is about to experience an emotion" (Davis, 1994). It is important to distinguish empathy from sympathy, pity, or identification, as the terms are often used interchangeably, but have different meanings (Davis, 1990). Empathy can be conceptualized as having cognitive and affective components: cognitive role taking or affective reactivity to others (Davis, 1994). In order to provide empathic service, the provider must understand and relate to the experiences, perceptions and emotions, while actively conveying this understanding through verbal and non-verbal behavior (Davis, 2009).

Empathy, an Innate Characteristic or a Trait That Can Be Taught?

Thus far, empathy has been conceptualized by practitioners as either a human trait

(one that cannot be taught) or a professional state, one that allows for continuous training (Davis, 2009). As such, within the specialty of emotional intelligence, there has been a disagreement on how empathy is acquired. Some clinicians believe empathy may be an innate characteristic and people either have it or they do not. Other clinicians believe empathy is a character skill that can be taught and with training consistently improved. German philosopher Edith Stein and psychologist Carol Davis represent a body of literature that posits empathy cannot be taught, but that the process of empathy can be facilitated by developing other attitudes and behaviors that relate to achieving good quality heath care (Davis, 1990). Carol Davis contends that the most that can be done is help facilitate the process related to empathy development. This includes offering experiences that encourage self-awareness, listening skills, awareness of commonalities, and respect and tolerance for differences (Davis, 1990). Carol Davis believes that teaching humanistic interviewing skills, helping people identify their prejudices and fears, and developing individual confidence levels, empathy will be fostered and developed in an indirect manner (Davis, 1990). Awareness of deficits in these skills creates an opportunity to address them as they can potentially prevent empathy. From this view point, while empathy cannot be taught, steps can be made to improve a more therapeutic presence through professional socialization experiences. Again, while this point of view does not believe that empathy can be taught directly, it lends to the idea that a possible alternative to this is encouraging physicians who lack this trait to take a more humanistic approach to patients. (Maatta, 2006).

Alternatively, the early work of Carl Rogers describes the acquisition of empathy as a skill that can be taught (Davis, 1994). Carl Rogers defined empathy as “to perceive

the internal frame of reference of another with accuracy and with emotional components and means which pertain thereto as if one were the person but without ever losing the 'as if' condition" (Maatta, 1990). A key aspect of Rogers' works that lends to the idea that empathy can be taught is the intentional component of utilizing empathy which allows for the idea that empathetic behavior can be learned (Maatta, 2006). After the work of Carl Rogers, Robert Carkuff developed an elaborate theory and process of training that identified empathy as a skill (Davis, 1994). As such, affective and cognitive empathy can be conceptualized as ~~an~~ emotional and intellectual understanding. Situational empathy speaks to the ability or skill of the empathizer to perceive and react to the other's person's feelings in a situation (Maatta, 2006). These ideologies support the notion that empathy can be taught.

Those who perceive empathy as a skill that can be taught and improved can conceptualize empathy as an objective ability because it requires an individual to be able to understand the difference between self and other (Adams, 2012). As Carl Rogers has conceptualized this skill, it is the ability to understand a person's reality and feelings without taking them as your own (Adams, 2012).

The Role of Empathy in the Medical Field

There is an ongoing debate in regards to empathy and its role in the medical field. Health care providers face the daily challenge of tending to patients' biomedical and psychosocial needs (Davis, 2009). Some practitioners may take the view that there is no place for empathy in the medical field as its utilization interrupts the physician's ability to remain objective in medical service. In contrast however, there is evidence to support

physicians delivering empathic services. A physician's ability to emphasize with the patient is a crucial prerequisite to a successful and therapeutic physician-patient relationship (Neumann, M., Scheffer, C., Tauschel, D., Lutz, G., Wirtz, M., & Edelhäuser, F., 2012). This evidence suggests that empathic approaches result in improved patient treatment outcomes (Adams, 2012). Survey data has also demonstrated that patients are expecting both accurate medical service, as well as a caring and empathetic medical experience (Davis, 2009). As with most things there is a balance that comes with the utilization of empathy in the medical field. For example, Dr. Lawrence Kolb explains that it is important for a medical provider to be mindful of over-identification as it can be harmful for the physician's emotional well being (Adams, 2012). Here Dr. Kolb is implying that there is a crucial balance between a physician understanding a patient's emotions so that it helps them to deliver the most appropriate medical services possible and alternatively, over-identifying with a patient in a way that may impede appropriate medical services. The knowledge on how to achieving this balance is contingent on physicians receiving adequate patient focused training.

There is a strong body of evidence that demonstrates the effectiveness of empathic services over several years. In 1963, medical trainers Rene Fox and Howard Lief described training medical students on delivering a method of empathy known as "detached concern." Essentially this refers to the notion that it is optimal for medical providers to able to listen empathically without becoming emotionally involved (Decety, 2012). Research supports clinical empathy as it has been linked to patient empowerment and ability to cope with illness (Davis, 2009). An appropriate use of empathy demonstrates a crucial aspect in the patient-physician role and that is trust (Decety,

2012). Once trust is established in a physician, patients are most likely to adhere to treatment recommendations, which is ultimately one of the biggest obstacles. Furthermore, empathy is linked to patients reporting more on their symptoms or concerns, increased diagnostic accuracy, patient's receipt of more illness-specific information, increased patient participation and education ,reduced depression, and increased quality of life (Neumann, M., Scheffer, C., Tauschel, D., Lutz, G., Wirtz, M., & Edelhäuser, F., 2012).

Current Methods for Teaching Empathy During Residency

Regardless of one's stance on empathy being a character trait or an attribute or skill that can be taught, what is undeniable is the medical field is in need of more patient-focused and empathic clinicians. In the Institute of Medicine's 2001 report entitled, "Crossing the Quality Chasm: A New Health System for the 21st Century" a new interest in patient-centered care was emphasized and a need for change highlighted (Ananth, 2013). Since then the president of The American Association of Medical Colleagues, Dr. Darrell Kirch was quoted saying "Being a good doctor is about more than scientific knowledge. It also requires an understanding of people" (Anath, 2013). As of 2015, these revelations have ultimately resulted in a section on the Medical College Admissions Test (MCAT) devoted to assessing an applicant's understanding of the psychological, social, and cultural factors related to health outcomes (Anath, 2013).

As emotional intelligence becomes a more apparent issue for those within the medical field, integrating this skill into the education of medical students is an ongoing challenge. One apparent issue that arises from reviews of how empathy is taught, is that it

is taught inconsistently. Students receive empathy training, but it lacks consistency in terms of frequency and comprehensiveness (Bayne, 2011). In regards to the debate regarding empathy being a personality trait versus a skill that can be taught, educators have opted to teach empathy as a cognitive and behavioral skill, as these appear to be ~~a~~ more plausible skills to teach (in comparison to moral and emotive empathy). This approach can sometimes be referred to as "communication skills" training (Bayne 2011). There ~~is~~ are also a smaller number of programs that chose to teach empathy through narratives or film. Finally, there are also programs that decide empathy should be taught via observation of senior physicians and ultimately do not decide to dedicate official training to the subject (Bayne, 2011).

One way that medical educators have attempted to teach new practitioners empathy is by embedding communication skills training within their medical training. One avenue that is sometimes taken is hiring professional actors to come in and act out scenarios for training medical clinicians to react to. In these instances, the student's reactions are observed and structured feedback is given by a professor. This type of training typically occurs during the first and second years of medical school and the topic is not revisited again (Levinson, Lesser & Epstein, 2010). This training approach is an issue because patient contact does not occur until the third year of medical school, which creates a disconnect between the communication classes and utilization of the strategies (Levinson, Lesser, & Epstein, 2010). In other places, additional training opportunities may be available outside of the required class trainings to help improve communication skills. For example at Kaiser Permanente, America's leading integrated health care organization, an initiative on teaching clinicians communication skills has been taken

(Kaiser Permanente, 2017). The training entitled the "Clinician Patient Communication" workshop works with clinicians to offer a professional development opportunity to continue to learn how to improve communication between physicians and patients. The structure of this workshop entails having role plays where clinicians can give each other feedback on their performance. Also, the scenarios utilized are considered standardized as they represent common occurrences in the medical field such as breaking bad news, disclosing medical errors, and discussing end-of-life issues (Levinson, Lesser & Epstein, 2010).

As mentioned before, some medical programs have opted to teach empathy through narratives. This is often referred to as narrative medicine. The ultimate goal of this approach is to have physicians listen to the narratives of their patients, while grasping and honoring their meanings. Professors can sometimes reiterate this point by saying "listen to your patients: he or she is telling you the diagnosis" (Greenhalgh & Hurwitz,1999). Dr. Charon describes this competence as a physician being able to absorb, interpret, and respond to these stories. This ability allows for physicians to practice medicine with empathy, reflection, professionalism, and trustworthiness. The goal of understanding a patient's narrative is not only for a physician to relay the facts and objective information pertaining to an illness, but to then consider what the illness' consequences or potential meanings are for the patient. Narrative focused training focused on the patient and understanding "who is telling this story" "how is it told", and "who is hearing this story." Narrative training not only examines how the patient communicates with the physician, but also how the physician communicates with his or herself, as well as how the physician communicates with colleagues and society (Charon,

2001). This ongoing dialogue of narratives creates a foundation for physicians to reflect on the needs of their patients, themselves, colleagues, and society. Narrative based medicine seeks to understand the process of getting ill, being ill, getting better (or worse), and coping (or not) will an illness through an analysis of the patient's story (or narrative) of their lives (Greenhalgh & Hurwitz, 1999). This approach provides support for taking a more holistic, bio-psycho-social approach to the medical field. It can help set new agendas, encourage reflection, and promotes understanding between physician and patient. For example, taking this type of training may focus on how a physician can become more aware of the patient's tone of voice. Being cognizant of any sense of immediacy, rushed, fear etc, that may be present in the patient's voice is often not recorded on medical documentation, but can hold great meaning (Greenhalgh & Hurwitz, 1999). Training on how to tease apart what players are present in this narrative is also crucial. There may be a dismissive partner, or judgmental previous physician that may influence how the patients shares their illness or had elements overlooked and only a clinician's guided attention to meaning can uncover this (Swenson & Sims, 2000). Being aware of these patient qualities can help to prevent a patient feeling unheard, which can ultimately result in a lack of relevant information. This type of training also encourages the use of narratives that may not relate directly to the medical field. As such, narratives surrounding life experiences, such as having a family or children, or a learning situation is often encouraged to be used in this training (Swenson & Sims., 2000). In some cases actual patients are invited to the trainings to tell their stories for training purposes. Regardless of the narrative utilized the focus is still the same. We are asking medical personnel to put themselves in their patients' situations and reflect on

what it means for them. Currently, there is work to put together a database entitled, “The Database of Individual Patient Experience” to collate the patient experience and have these real life patient narratives serve as learning objectives for others (Greenhalgh & Hurwitz, 1999). Research on this approach to teaching more empathic communication styles has revealed that students perceive that they were able to develop and improve specific communication skills which allowed them to enhance their capacity to collaborate, empathize, and deliver more patient-centered services. Students also found that this type of instruction allowed them to develop personally and professionally through reflection (Arntfield, Slesar, Dickson & Charon, 2013). Additional studies on the effectiveness of taking the narrative approach to enhancing patient communication and empathy have revealed that student participants have felt like they’ve reached additional competencies in their training that entailed the students understanding the patients beyond their pathology. Student participants report that that these trainings equipped them with the ability to explore the patients’ lives in a way that allowed them to establish more empathic relationships. This approach ultimately allowed the student participants to better deal with the complexity of patient illness and take a genuine individualized approach (Cruz, Caeiro & Pereira, 2014). Additional feedback indicates that this approach allows students to shift their focuses from the pathology to the patient, from the clinician to the patient, and from a biomedical perspective to a biopsychosocial model (Cruz, Caeiro & Pereira, 2014). These results are the ideal for incorporating more patient focused empathy into the daily interactions of clinicians.

Research demonstrates that as students remain in the medical field for longer periods of time, the usage of empathy declines (Neumann, Edelh€auser, Tauschel,

Fischer, Wirtz, Woopen, Haramati & Scheffer, 2011). The challenge then becomes for medical educators to create a way to continue ~~to~~ teaching empathy during residency years. In a study entitled "Residents' Engagement and Empathy Associated With Their Perception of Faculty's Teaching Performance" it was found that resident empathy and academic performance were positively associated with faculty's teaching performance (Lases, Arah, Pierik, Heineman& Lombarts, 2014). Teaching performance was characterized by learning climate, attitude towards residents, communication of goals, evaluation of residents, and feedback. The implications of this study demonstrate that having faculty members whose teaching performance is reviewed positively by the residents help improve the resident's empathy scores. This study revealed that one aspect of teaching empathy in residents is dependent on the teaching quality of the faculty members mentoring them.

Additional emerging research suggests group work can be an effective way of promoting empathy (Bayne, 2011). This approach differs significantly from more traditional lecture style of medical education, but has the potential to foster interpersonal skills and the development of humanistic skills in this population. This format has been demonstrated to increase empathic ability in medical students as well as improve their abilities to identify their own emotions, motivations, and reactions to patients.

While these studies demonstrate various strategies that may help point to a more effective way of teaching empathy to medical residents, the fact remains that "medical education still seems unsurprisingly ineffective in helping students walk a mile in their patients shoes" (Sulzer, Feinstein & Wendland, 2016). Hence, this demonstrates a need

for the re-evaluation of how training is currently being delivered and room for improved methods on delivering patient focused empathy trainings. This study seeks to take these previous methods and enhance them based on the feedback provided by the medical residents who have endured them.

Chapter III: Methodology

This study sets out to explore the following research questions: Are the General Surgery Residents utilizing patient focused empathy currently and if so, in what ways? Are the General Surgery residents observing other physicians utilizing empathy in the hospital? If so, what effects have been observed? How effective were prior trainings on preparing the residents to use patient focused empathy? What could make the trainings more helpful? The Jefferson Scale of Empathy, a standardized instrument specifically developed for use with medical professionals, provides an operational measure of empathy based upon the responses from the General Surgery Residents at Robert Wood Johnson Hospital. This research also included a brief Empathy Training Survey to assist in identifying additional empathy training residents believed would be helpful for them. It was hypothesized that there will be a lack of empathy practice amongst the residents demonstrated by the Jefferson Scale Scoring guidelines. It was hypothesized that the residents would indicate low frequencies of physicians utilizing empathy in the hospital. It was also hypothesized that the residents will provide feedback that will identify deficits in the usage of empathy in the hospital, as well as deficits in the empathy related trainings they have received thus far.

The data collected will be used to inform a curriculum to be used to help refine the skills necessary to deliver patient-focused care and empathy. Empathy scores, along with the Empathy Training Survey feedback will indicate how empathy is currently being used both by the residents and by other physicians, the effectiveness of previous empathy training, and how the residents feel they learn the best. Having data unique to this group

will allow for a curriculum to be specialized to meet their needs and allow for the residents to feel heard by incorporating their feedback.

Participants

The participants of this study were General Surgery Residents at Robert Wood Johnson University Hospital. This specialty area was chosen after the Principal Investigator spent a year working on the Trauma Unit alongside the General Surgery Residents. The supervisors of the General Surgery Residents expressed an interest in assessing current levels of patient focused interactions to inform future training opportunities. Recruitment procedures for this research sample consisted of identifying an opportunity for the Principal Investigator to speak to the General Surgery residents. After consulting with supervisors, it was identified that the residents attend weekly, regularly scheduled didactic learning sessions and it would be permissible for the Principal Investigator to attend. During these didactic sessions the Principal Investigator explained the study and consent procedures, making clear that participation was voluntary and results were anonymous. The Jefferson Scale of Empathy and Empathy Training Survey were then handed out to those General Surgery Residents who wished to participate. It was estimated that the sample size would be between 30 and 50 research subjects. Subjects were excluded from this study if they were not completing their residency in general surgery.

Of the total number of participants recruited, 61% of respondents identified as female and 39% identified as male. 17% of the sample were between ages 25 and 27, 50% were between the ages of 28 and 30, 17% was between ages 31 and 33, 8% between ages 34 and 36, and 8% above the age of 36. Additional demographic data collected

indicates 46% of respondents identified as Caucasian, 5% as Hispanic/Latino, 9% as African American, and 40% as Asian/Pacific Islander.

Jefferson Scale of Empathy. The Jefferson Scale of Empathy was utilized in this study because it provided an assessment of empathy specific to the medical setting and could be administered anonymously. The scale consists of 20 items focused on assessing for empathy in the medical setting. A major strength of this scale is its relevancy to the medical field and overall patient care. The questions on the Jefferson Scale allow for participants to answer based on a 7-point Likert-Scale. (Hojat, M., Mangione, S., Nasca, T. J., Cohen, M. J., Gonnella, J. S., Erdmann, J. B., ... & Magee, M., 2001). A 7-Point Likert-Scale is utilized on this measure instead of a dichotomous yes or no answering system. This allows for more variation in responses in addition to more discriminatory power. Answers range from 1, indicating that the respondent strongly disagrees with the given statement, to 7 indicating that the respondent strongly agree with a given statement. Selected questions are reversed scored, allowing for respondents to disagree with specified statements, in with which disagreements indicate empathy.

The original Jefferson Scale of Empathy was a 45-item measure. A confirmatory factor analysis and an exploratory factor analysis were conducted to reduce the length of the instrument. After these analyses were conducted, 20 of the 45 questions were kept. These items had the highest factor structure coefficients (>.40). In regards to the construct validity for the Jefferson Scale of Empathy, the new 20-item version of the scale was subjected to another factor analysis. Four factors emerged with an eigenvalue greater than one. The factors were: “physicians view from patient’s perspective,”

"understanding patient's experiences/feelings/clues," ignoring emotions in patient care," and "thinking like a patient." This value (equal or greater than one) meets the Kaiser's criterion, which was used to retain the most important factors. The four extracted factors accounted for 56% of the total variance. A look at criterion related validity revealed that the Jefferson Scale of Empathy was significantly correlated with the Interpersonal Reactivity Scale and The NEO Personality Inventory Personality Facets. When assessed for reliability, medical residents attained an alpha of .87 (Jefferson Scale Users Manual). In regards to interpreting the Jefferson Scale of Empathy, the user's manual indicates that higher empathy scores denote a higher presence of empathy amongst a sample. Low and high empathy scores are determined by the sample's mean. Low empathy scores are characterized by being two standard deviations below the sample's mean and high empathy scores are characterized by scores that are two standard deviations above the mean (Hojat, 2017).

Empathy Training Survey. The Empathy Training Survey was developed for this research project, and had the major goal of identifying how empathy was taught to those being trained in the medical field. The Empathy Training Survey, created by the Principal investigator, was given to the General Surgery Residents to gain a better understanding of how frequently empathy is modeled to them, how much they utilize empathy, and their training experiences surrounding patient focused empathy. This was done through the utilization of both multiple choice and open-ended questions. The Empathy Training Survey administered assessed the following areas:

- The frequency in which empathy is being modeled to the General Surgery Residents. This aspect is evaluated by giving the residents choices of Never,

Sometimes, Often, and Always to describe how often empathy is demonstrated to them.

- When have the residents seen empathy demonstrated and how do they demonstrate empathy themselves.
- What positive or negative outcomes do the residents associate with demonstrating empathy.
- What previous training they have received on patient focused empathy and how helpful were they.
- What aspects of empathy training would the residents like to see improved and how.
- How do the residents feel they learn best.

Procedures

Data collection began in September 2016. The study was explained to the subjects by the Principal Investigator during their weekly scheduled didactic learning sessions. The consent forms were then read, and confidentiality explained. The Principal Investigator then answered any questions the subjects may have had. Those electing to participate signed two consent forms (one for the Principal Investigator and one for their personal records). Participants agreeing to take part in the study were assigned a random code number that was used on each Jefferson Scale and Empathy Training Survey. To ensure we did not have students taking the assessment more than once, the resident's name appeared only on a list of subjects who signed the consent forms. These names were not linked to the code number assigned to them. After residents completed the

Jefferson Scale and-Empathy Training Survey, their consent forms and assessments were collected and stored separately, to ensure confidentiality.

Data Collection and Analysis

After data collection ended in October of 2016, data for the Jefferson Empathy Scale was entered into an Excel spreadsheet. A frequency table was created for responses, with ratings of 2 and 3 combined, and ratings of 5 and 6 combined due to similarities in frequency for total counts. Total empathy scores were also identified.

For Empathy Training Survey analysis, responses given numerical scores were also turned into frequency charts. Open ended responses were then categorized as a positive response, (indicating that empathy was being utilized/modeled), a negative response, (indicating that empathy was not being utilized/modeled), or neutral (indicating that neither a positive or negative conclusion could be drawn from the statement). Finally, a list of all the suggestions for improving empathy training was compiled and frequency counts conducted to assess for each suggestion.

The analysis for this research study consisted of presenting the overall range of empathy scores and examining if they were within an acceptable range, as identified through previous research studies using this instrument. Item analyses for specific questions on the Jefferson Scale were also conducted to demonstrate the percentage of General Surgery residents who accurately or inaccurately utilized empathy in the situations presented. An analysis of the Empathy Training Survey data consisted of identifying major themes based on open-ended responses that highlighted areas of

improvement. These areas are then reported and will be used to inform future areas of training.

Proposed Curriculum

Based on the ratings that emerged from the Jefferson Scale of Empathy and the results of the Empathy Training Survey, the Principal Investigator will then work on creating a pilot curriculum to be used in training the General Surgery Residents on how to deliver patient focused empathy. The data collected will be integrated with research literature and best practices to formulate a personalized curriculum for these residents. The focus of the training curriculum proposed is to integrate a best practice model, with the feedback from the General Surgery residents to create an opportunity to teach patient focused empathy and to ultimately improve patient care. The proposed training initiative would be delivered during didactic training sessions and provide an opportunity for confidential in-vivo feedback for the residents.

Chapter IV: Results

While there are currently approximately 50 General Surgery residents working at Robert Wood Johnson University Hospital, a total of 25 participated in this study. This may be due to only being able to collect data during non-mandated didactic sessions. This affected the sampling procedure as a large proportion of General Surgery residents can opt to not attend these didactic sessions. The implications of this are discussed further in the limitations section. As noted in Table 1, 61% of respondents identified as female and 39% identified as male. As noted in Table 2, 17% of the sample were between ages 25 and 27, 50% were between the ages of 28 and 30, 17% was between ages 31 and 33, 8% between ages 34 and 36, and 8% above the age of 36. Table 3 represents additional demographic data collected which indicates 46% of respondents identified as Caucasian, 5% as Hispanic/Latino, 9% as African American, and 40% as Asian/Pacific Islander.

Table 1

Gender

Gender	**Number/Percentage of Respondents**
Female	15/61%
Male	10/39%

Table 2

Age

Age Range	**Number/ Percentage of Respondents**
25-27	4/17%
28-30	13/50%
31-33	4/17%
34-36	2/8%
>36	2/8%

Table 3

Race

Race	**Number/Percentage of Respondents**
Caucasian	12/46%
Hispanic/Latino	1/5%
African American	2/9%
Asian/Pacific Islander	10/40%

Jefferson Scale of Empathy

Empathy scores on the Jefferson Scale of Empathy ranged from 85 to 131, as seen in Table 4. The Jefferson Scale Users Manual indicates that higher empathy scores

denote a higher presence of empathy amongst a sample. Low and high empathy scores are determined by the sample's mean. Low empathy scores are characterized by being two standard deviations below the sample's mean and high empathy scores are characterized by scores that are two standard deviations above the mean (Hojat, 2017). Table 5 notes the descriptive statistics associated with the sample. Following the two standard deviation rule, one participant's score (85) can be characterized as a low empathy score and one participant's score can be closely considered as a high empathy score (131).

Table 4

Jefferson Scale of Empathy Scores Frequency Table

Score	**Frequency**
85	1
96	1
97	1
98	2
99	1
100	1
102	1
105	1
106	1
107	2
111	1
112	1
113	1
116	2
117	1
118	1
119	1
121	1
122	1
124	1
126	1
131	1

Table 5

Jefferson Scale of Empathy Descriptive Statistics

Empathy	Minimum	Maximum	Mean	Standard Deviation	Total Number of Scores
	85	131	109.84	11.06	25

An item analysis of selected questions provided some additional context to consider when determining the usage of empathy in the residents' daily clinical activities. Table 6 includes each question on the Jefferson Scale and the number and percentage of respondents per answer choice. Please note questions 1, 3, 6, 7, 8, 11, 12, 14, 18, and 19 are reversed scored and are represented in Table 7.

Table 6

Jefferson Scale of Empathy Question and Answer Break Down, Number and Percentage

Question	Strongly Disagree	Moderately Disagree/Disagree	Neutral	Moderately Agree/Agree	Strongly Agree
2. Patients feel better when their physicians understand their feelings	0/0%	0/0%	0/0%	10/40%	15/60%
4. Understanding body language is as important as verbal communication in physician-patient relationships.	0/0%	0/0%	2/8%	11/44%	12/48%
5. A physician's sense of humor contributes to a better clinical outcome.	2/8%	4/16%	8/32%	10/40%	1/4%
9. Physician's should try to stand in their patients' shoes when providing care to them.	0/0%	4/16%	2/8%	13/52%	6/24%
10. Patients value a physician's understanding of their feelings, which is therapeutic in its own right.	0/0%	2/8%	4/16%	15/60%	4/16%

Table 6 – Continued

Question	Strongly Disagree	Moderately Disagree/Disagree	Neutral	Moderately Agree/Agree	Strongly Agree
13. Physicians should try to understand what is going on in their patients' minds by paying attention to their non-verbal cues and body language	0/0%	0/0%	2/8%	15/60%	8/32%
15. Empathy is a therapeutic skill without which the physician's success is limited.	0/0%	2/8%	2/8%	16/64%	5/20%
16. Physicians' understanding of the emotional status of their patients, as well as that of their families is one important component of the physician-patient relationship.	0/0%	0/0%	1/4%	14/56%	10/40%
17. Physicians should try to think like their patients in order to render better care.	1/4%	5/20%	9/36%	9/36%	1/4%
20. I believe that empathy is an important therapeutic factor in medical treatment.	0/0%	0/0%	2/8%	10/40%	13/52%

Table 7

Jefferson Scale of Empathy Reverse Scored Question and Answer Break Down, Number and Percentage

Question	Strongly Agree	Moderately Agree/Agree	Neutral	Moderately Disagree/Disagree	Strongly Disagree
1. Physicians' Understanding of their patients' feelings and the feelings of their patients' families does not influence medical or surgical treatment.	1/4%	3/12%	1/4%	13/52%	7/28%
3. It is difficult for a physician to view things from patients' perspectives	0/0%	4/16%	20%	13/52%	3/12%
6. Because people are different, it is difficult to see things from patients' perspectives.	1/4%	4/16%	3/12%	12/48%	5/20%
7. Attention to patients' emotions is not important in history taking	0/0%	0/0%	2/8%	12/48%	11/44%
8. Attentiveness to patients' personal experiences does not influence treatment outcomes.	1/4%	1/4%	2/8%	13/52%	8/32%
11. Patients' illnesses can be cured only by medical or surgical treatment; therefore physicians' emotional ties with their patients do not have a significant influence in medical or surgical treatment.	0/0%	2/8%	1/4%	11/44%	11/44%

Table 7 – Continued

12. Asking patients about what is happening in their personal lives is not helpful in understanding their physical complaints.	1/4%	0/0%	2/8%	19/76%	3/12%
14. I believe that emotion has no place in the treatment of medical illness.	0/0%	0/0%	1/4%	8/32%	16/64%
18. Physicians should not allow themselves to be influences by strong personal bonds between their patients and their family members.	2/8%	11/44%	3/12%	9/36%	0/0%
19. I do not enjoy reading non-medical literature or the arts.	0/0%	5/20%	2/8%	6/24%	12/48%

A majority of the results of the Jefferson Scale of Empathy were in the Average range, indicating that overall the General Surgery Residents did not lack empathy according to this scale. However, when looked at individually a few response patterns allowed for some thought provoking conclusions. For example, statement 9 poses the statement: "physician's should try to stand in their patients' shoes when providing care to them." 16% of our sample indicated that they either moderately disagreed or disagreed with this statement. When thinking about providing patient centered care, this aspect is crucial as it allows for physicians to align with a patient given their understanding of the patient's circumstance. Statement 17 of the survey posits, "Physicians should try to think like their patients in order to render better care." 20% of the sample indicated that they again either moderately disagreed or disagreed with this statement. This is concerning as a patient's cognitive abilities and conceptualization of their illness is important in understanding how to formulate a treatment plan that they will not only adhere to, but also understand. Statements 3 and 6 communicate the idea that it is too difficult for physicians to gain a patient's perspective. In both instances 16% of respondents either Moderately Agreed or Agreed. Finally, statement 18 says "Physicians should not allow themselves to be influences by strong personal bonds between their patients and their family members," and 44% of respondents either Moderately Agreed or Agreed with this statement. Taken together these individual questions indicate that there is a sense of difficulty physicians experience when trying to understand patient's perspective. This again, may indicate a gap in previous training opportunities. Also, the idea that physicians should not allow themselves to have strong personal bonds provides further

evidence, that a major barrier in facilitating patient-focused empathy is the preconceived notion that these bonds make it more difficult for physicians to remain objective. These responses revealed aspects such as perspective taking and appropriate empathic care to be explored in the proposed curriculum.

General Surgery Empathy Training Empathy Training Survey

Along with the Jefferson Scale of Empathy, an Empathy Training Survey was administered to the residents. Please note that the Empathy Training Survey represents a lower response rate when compared to the Jefferson Scale of Empathy responses. As time is a huge factor in the medical field, it is hypothesized that the open-ended questions were more challenging for residents to take the time to complete.

This Empathy Training Survey has seven questions. Question 1 of the Empathy Training Survey quantitatively assesses for how often empathy is being modeled to the general surgery residents. It asks, "in your medical training, how frequently do you observe physicians demonstrating empathy?" Respondents had the answer options of: never, sometimes, often, and always. Twelve General Surgery Residents responded to this question by indicating that they "sometimes" observe empathy and thirteen general surgery residents said that they "often" observe empathy. This question had a 100% response rate.

Table 8

General Surgery Empathy Empathy Training Survey Question 1

In your medical training, how frequently do you observe physicians demonstrating empathy? 25/25 (100%) response rate	
Never	0
Sometimes	12
Often	13
Always	0

Question 2 of the Empathy Training Survey asks "please describe the effect of an empathic approach with patients that you observed, including any positive or negative aspects of the patient's response." This was an opened ended question and held a response rate of 60% (15/25 respondents). The responses can be found below in Table 9.

Table 9

General Surgery Empathy Empathy Training Survey Question 2

Please describe the effect of an empathic approach with patients that you observed, including any positive or negative aspects of the patient's response Response Rate: 60% (15/25 respondents)
I sometimes see good examples of empathic approaches. It allows the patient to feel more comfortable with the discussion and decisions.
It makes patient's feel more comfortable about sharing their concerns.
13 year old trauma patient. Had to tell family that we could not offer any surgery to save him, he had un-survivable injury. offered apology and held family meeting with multiple docs - family appreciative
You can tell if an attending does a good job if after they leave the room the patient doesn't ask you to stop and explain things. Lack of time is a huge barrier
The relationship is deepened, patients can trust physicians and be more open
Patients feel thankful, less stressed; less worried
Patient often expresses gratitude to the physician
Patient and family more receptive to treatment plan
Better patient rapport
Patients are willing to be more open regarding their experiences which influence their medical decision making process
Increased patient compliance and likelihood of follow up
I have found that by using verbal/nonverbal language to show understanding of a patient's emotion has helped build trust btw our relationship
Patients are more appreciative
Patient becomes willing to strict adhering to medication and treatment plan w/ the empathic approach
The patient had more respect and trust for the physician

Question 3 of the Empathy Training Survey asks "please describe a specific instance where you demonstrated an empathic approach with a patient. How did the patient respond to your empathic approach (please include any details about positive or negative

responses from the patient, as applicable)." This was an opened ended question and held a response rate of 56% (14/25 respondents). The responses can be found below in Table 10.

Table 10

General Surgery Empathy Empathy Training Survey Question 3

Please describe a specific instance where you demonstrated an empathic approach with a patient. How did the patient respond to your empathic approach (please include any details about positive or negative responses from the patient, as applicable. Response rate: 56% (14/25 respondents)
I was asked about what I would do for the patient if it was my family member. I response with a personal experience. the patient was grateful for my honest response
Family above was very understanding although upset
Patients will share more information with you frequently as an afterthought
They are very thankful
Patient and family appreciated the interaction and time spent with them
Patient responded better to empathic approach. agreed more with plan
Empathy by describing a similar family experience and how it was difficult. helped establish a better more positive relationship with patient
patient combative initially but I sat by patient and relayed personal story and he relaxed and was more receptive
Patient had chronic pain that the rest of the team avoided - i tried to understand her point of view and listen to her concerns. She was more compliant and honest with me.
I had a patient who presented w/ and pain awaiting possible colonoscopy to evaluate his condition. although I did not think that this procedure was necessary to be done right away I could tell that knowing information from procedure would greatly improve his anxiety, patient and daily very appreciative that I tried to facilitate colonoscopy to be done sooner.
I'm always empathic. Patient responses very from gratitude to further frustration. for example, "if you're so sorry then DO something" more often gratitude and good relationships
With warmth
As above, patient was agreeing to take medications and adhere to treatment
The patient showed appreciation for my time and appeared to cope with the news of their progress better

Question 4 of the Empathy Training Survey is a quantitative question and asks "how helpful were the trainings you received on delivering empathy to your patients?" Two respondents felt the trainings were very helpful, 8 respondents felt they were moderately

helpful, ten respondents felt they were slightly helpful and 5 respondents felt the trainings were not at all helpful. This question had a 100% response rate (25/25). These rates can be found below in Table 11.

Table 11

General Surgery Empathy Empathy Training Survey Question 4

How helpful were the trainings you received on delivering empathy to your patients? Response Rate: 100% (25/25)	
Extremely	0
Very	2
Moderately	8
Slightly	10
Not at all	5

Question 5 of the Empathy Training Survey asks, "please describe how these trainings were specifically helpful or unhelpful. " This was an opened ended question and held a response rate of 64% (16/25 respondents). The responses can be found below in Table 12.

Table 12

General Surgery Empathy Empathy Training Survey Question 5

Please describe how these trainings were specifically helpful or unhelpful. Response rate: 64% (16/25 respondents)
I've received very little training- usually its minimally helpful
They were not very helpful because...? real patient encounters is more helpful.
Went to med school here. We had patient centered medicine with a lot of role play. helpful to practice but awkward
Most trainings overlook the practical issues with having enough time to address
They force you to deal with questions/situations that can be uncomfortable
These things are hard to learn from a medical training program. It's more of a personal character
Session brought to light the lack of attention given to empathetic conversation
I think it's hard to teach empathy. part is innate to the person
Its a hard thing to teach
Set a stage for future communications
Not useful in terms of how to but more so as an exercise/repetition allowing one to become more comfortable
A lot of theory. empathy is developed by living experiences

?? information on how to relation to patients

Table 12 - Continued

Good to hear other doctors' techniques to apply them to my patients
We did have some talks about empathetic interacting (?)
Lecturing doesn't translate into practice or change

Question 6 of the Empathy Training Survey asks, "What elements or aspects were missing from your previous training on empathy?" This was an open-ended question and held a response rate of 48% (12/25 respondents). These responses can be found below in Table 13.

Table 13

General Surgery Empathy Training Survey Question 6

What elements or aspects were missing from your previous training on empathy?
Response rate: 48% (12/25 respondents)

Better focused trainings for surgical residents/ attending's
Seeing attending's have a conversation with a patient
I think its most helpful to observe real patient/physician interactions and learn from both good and bad
The case studies are frequently too black and white
None
Not enough role playing and a good role model
It takes time/experience with people. not just training
Who to contact when you need help
Non formal formal
Too much to write
Specific examples
We did not really deal w/ difficult patients or circumstances during medical school

Question 7 of the Empathy Training Survey asks, "how do you think you can best learn empathic medical service delivery (i.e. role plays, classroom training, workshops etc.)" This was an open-ended question and held a response rate of 76% (19/25 respondents). These responses can be found below in Table 14.

Table 14

General Surgery Empathy Empathy Training Survey Question 7

How do you think you can best learn empathic medical service delivery (i.e. role plays, classroom training, workshops etc.)
Response rate: 76% (19/25 respondents)

Workshops
Role play
Debriefs after real time family meetings/interactions
Observation of good role models. ??
Roleplay
Roleplaying
Less workload (seriously). We are required to see so many patients in a limited time. its hard to keep empathy after patients problems are not that significant problems when we are super busy.
Most physicians appear to me empathetic. the real issue is time, people generally want to culture an robust and empathetic relationship with patients but this is unrealistic when you have 30 other people to see that day.
Workshops
Workshops ; observing real life scenarios is practice
Role play and real world scenarios
Role plays
Living
Workshops
Experience with patients and working with other doctors
Workshops
Role plays - no chance, classroom training - maybe, workshops - no time. Be a human being.
Role models in the clinical setting.
Demonstrations/ workshops

The Empathy Training Survey was a crucial part of the data collection process as its results were used to directly inform the curriculum these residents are to receive. Question 1 asks respondents to indicate how often they observe physicians demonstrating empathy. The residents appeared to be split on their experiences, despite going through the same rotations and working with the same supervising physicians. 12 of residents

indicated that they sometimes observed physicians demonstrating empathy and 13 residents indicated that they often observe this. In addition to having differing experiencing, these results also create some concerns regarding the patient focused empathy supervising physicians are demonstrating to their residents. A lack of this modeling may also indicates that the culture of this department and the training the supervising physicians have received should also be considered when formulating the curriculum. These results may indicate that having opportunities for the supervising physicians to get involved in this additional training can both help shift the culture to be more accepting of patient focused empathy, as well as serve as refreshers for ways to use these skills in their daily patient interactions.

Question 2 of the Empathy Training Survey asks residents to indicate the effects they have observed from empathic interactions. Many residents indicated that they have noticed positive effects such as patient adherence, trust, and communication improve when empathy is conveyed. This feedback demonstrates that the residents are aware of the positive impacts empathic interactions can potentially yield. When thinking about the curriculum this line of thinking may dictate how much psychoeducation is necessary for achieving buy in, because as is the residents seem to grasp the importance of this concept. Question 3 consisted of residents providing examples of them demonstrating empathy. It is important to note here that while not every resident responded, those who did respond described solely possible effects of empathic approaches, rather than explaining what they did that was empathic. Again, this may lend to training objectives in providing explicit skills to utilize in these situations.

Question 4 of the Empathy Training Survey begins the questions regarding prior training experiences. Overall a majority of the residents (10 residents) found the prior trainings to be "slightly" helpful. In addition to that, 5 residents found prior trainings to be "not at all" helpful. These results further demonstrate a need for more improved training initiatives as a majority of respondents do not feel that they have benefitted from the trainings they have received thus far. This gap in training translating into practice is further demonstrated by responses to this question specifically. Questions 5 and 6 then goes on to ask what elements were helpful/unhelpful about their trainings and what aspects did they feel were missing. A look at these responses reveal that prior trainings lacked practicality, did not address the time constraints the residents are placed under, made residents uncomfortable, and consisted of only lecture format. Again, this qualitative data is crucial in the Principal Investigator's quest of formulating a curriculum. By addressing these concerns and providing skills that align with the residents' needs, it may increase compliance. Finally, question 7 allowed for the residents to provide suggestions for the teaching modalities they feel like they learn best from. Overarching themes of the responses provided revealed that modeling, role-playing, and work shops would be idea. Again, this information can be integrated into the Principal Investigator's curriculum as a common elements approach allows for multiple data sources to be incorporated when creating a new approach to programming, which in this case involves a curriculum for patient focused empathy.

Results Summary

Twenty-five General Surgery Residents at Robert Wood Johnson University Hospital were administered the Jefferson Scale of Empathy along with an Empathy

Training Survey assessing for empathy preparation. This is 50% of the anticipated 50 resident sample pool. It is hypothesized that the reduction in the sample size is due to a limitation placed on the sampling procedure regarding attendance being optional during didactic sessions. A review of the scores on the Jefferson Scale of Empathy revealed two outlier scores. The-score of 85, is two standard deviations below the sample's mean, and constitutes a low empathy score. The score of 131, which is close to two standard deviations above the mean, constitutes a relatively high empathy score. The remaining scores can be interpreted as in the Average range. A look at the individual question responses on the survey indicate that the residents may struggle with patient perspective taking and finding an appropriate balance that allows them to be professionally competent while demonstrating empathy. This feedback will be used to inform the curriculum as skills and suggestions for becoming adequate in these areas will be addressed. The Empathy Training Survey had a total of 7 questions. Responses rates decreased for the open-ended questions on the Empathy Training Survey. It is hypothesized that this occurred due to a lack of time in the medical setting for the residents to elaborate on their thoughts and opinions. The results of the portion indicate that the residents are split in regards to their opinions on how often they observe other physicians demonstrating empathy. This identifies a future direction that aims to integrate their supervising physicians in the proposed curriculum. Other major themes that emerged from this survey indicate that prior trainings were not perceived as helpful and that the residents are looking for additional training that teaches skills practically, with their time constraints in mind, and does not comprise of solely lecture style. This concrete feedback is helpful and in designing the curriculum will be integrated explicitly.

The data gathered here, along with the literature review, and the principal investigator's observations will be used to inform an empathy-based curriculum for the general surgery residents.

Chapter V: Program Proposal

Course Design

The following program has been developed after integrating the empirically supported strategies for teaching medical empathy in an educational environment, the resident Empathy Training Survey feedback which identified the skills residents are seeking, and the Primary Investigator's observations of this hospital setting. The content of the program reflects an adaptation of a Common Factors approach used for providing appropriate communication with patients in primary care settings (Foy, 2010). This approach is based on educating medical personnel on family centered techniques surrounding hope, empathy, language, loyalty, permission, partnership, and planning, summarized as the acronym HELP, to effectively communicate with patients and their families while utilizing empathy. This approach can be used with patients of all ages. In adult patients, research has demonstrated that this common factor approach is linked to improved patient outcomes without increasing lengths of visits. In pediatric settings, this approach is linked to reducing parental distress and increasing children's functioning across a range of mental health areas (Foy, 2010). This approach to training is ~~also~~ favorable because there is considerable evidence that indicates this common factor skill set can be readily taught and maintained over long periods of time (Finset, Ekeberg, Eide, Aspergren, 2003). This approach is also ideal because research has found that these core sets of skills can be taught with a minimal time commitment, which is ideal for this resident population (Wissow, Anthony, Brown, DosReis, Gadomski, Ginsburg, & Riddle, 2008).

The purpose of this programming is to work towards integrating a more patient focused and empathy driven perspective into daily clinical interactions. There are 6 modules included here and they are to be implemented once a month at a designated didactic session for half of the time (1 hour). This timeline can be flexible to accommodate other scheduled didactic sessions. Attendance to these program sessions should be required.

A guide for each of the 6 sessions can be found below. The following information will be included for each session outline: session objective, estimated duration, learning/training modality being utilized, materials needed, session activity, and key points.

Table 14

Overview of Sessions

Session 1	Rationale for training. How to cultivate hope in patients.
Session 2	Empathy: How to demonstrate patient focused empathy.
Session 3	Language & Loyalty: How to understand and show support for patients.
Session 4	Permission & Partnership: Strategies on aligning with patients and their needs.
Session 5	Plan: Using patient relationships to inform follow up medical plans.
Session 6	Field Observation w/ Confidential feedback

Objectives and Goals

The objective of "This Will Only Hurt A Bit – Facilitating Patient Focused Empathy" is to offer training opportunities for residents to refine their skills delivering patient focused services and empathy. This training model will provide residents with the skills and strategies for communicating effectively and empathically with their patients.

By the end of this training, participants should be able to:

- Understand the difference between empathy and sympathy in the medical setting.
- Understand how patient focused empathy differs from physician centered care.
- Work to adapt a more patient focused perspective, utilizing the HELP common factors approach.
- Utilize strategies to demonstrate empathic services towards patients.
- Trouble shoot ~~on~~ how to deliver empathic services in the medical setting.
- Work in groups to share personal patient experiences and gather feedback on how to improve empathy driven services.

Expected Outcomes of This Training

Participants will be demonstrate competence in delivering patient-focused empathy. These competencies can be determined by utilizing an empathy specific assessment tool, such as the Jefferson Scale of Empathy. These assessments can be delivered at either the 3 or 6 months time points to assess retention of the skills being presented. Patient-focused empathy skill retention can also be assessed by an in-vivo observation opportunity at the end of the training modules. A multi-rater assessment can be utilized in this assessment by including feedback on skill retention from the perspective of supervisors.

The above training objectives will:

- Improve the ability of clinicians to deliver patient focused empathy.

- Provide realistic strategies to utilize in their current fast paced work environments.
- Work to ensure patients are receiving the best care possible.

Session Content

Session 1

Intro: Rationale for training. "H" in HELP is for Hope.

Facilitator's Notes: This session should have an emphasis on attaining buy in from the group. Identify how trainings have been conducted in the past and how this one will be different. Highlight that this training is reflective of best practices occurring nationwide along with their feedback on how they could learn best. This can be accomplished by utilizing the motivational interviewing principles outlined in the power point.

Session Objective: Objectives here include identifying group goals and attaining buy in for this training module. Additional objectives include providing some psychoeducation on why this empathy training is important. Finally, begin to have residents learn how to deliver the "Hope" element of the curriculum.

Estimated Duration: 1 hour

Materials Needed: Session 1 powerpoint slides with supporting information (see below).

Session Activity: First**,** participants will break into groups. Each member in the group will identify a challenging case in which hope was difficult to cultivate. The group participants will then work together to identify a dialogue that could have been utilized with the given case to illustrate the "hope" aspect of the HELP acronym.

Competencies: Participants will acquire the skills necessary to covey "hope" to a client.

Learning methodology: Lecture and Group Activity

Key points: Key points here include learning how to illustrate hope in clinical cases

Session 2

Review Hope. "E" in HELP is for Empathy.

Facilitator's Notes: It is important to begin to link session strategies together. In this session you should begin by reviewing ways that clinicians can illustrate hope. As you begin to explain how to demonstrate empathy, use examples that integrate hope as well.

Session Objective: Provide strategies and opportunities for clinicians to practice demonstrating empathy with patients.

Estimated Duration: 1 hour.

Materials Needed: Session 2 powerpoint. Volunteer faculty member.

Session Activity: Have faculty member describe a challenging case in which they struggled with demonstrating empathy. After patient and situation has been described, residents will write a narrative as if they were the patient. The resident should identify any thoughts and emotions that they hypothesize the patient may have felt in that given situation. In pairs, the residents will then act our their narratives with their partners. Each resident will take a turn role-playing how a clinician would empathically respond to the "patient" narrative.

Competencies: Participants will acquire an attitude that encompasses willingness to try to understand what their patients are thinking, feeling, and experiencing.

Learning methodology: Learning methodology here includes lecture, patient narrative, and role-play.

Key points: Key points here include attaining empathy strategies to be utilized with patients.

Session 3

Review H & E. "L" is for Language and Loyalty in HELP

Facilitator's Notes: During this session a focus should be placed on building each skill interdependently. The facilitator should illustrate ways to demonstrate the skills simultaneously and emphasize that one skill is no more important than another.

Session Objective: Demonstrate strategies for clinicians to use to implement the "language" aspect of the HELP acronym, which focuses on understanding the perspective of the patient. Also, provide strategies on how clinicians can demonstrate loyalty to the family via support and commitment to help.

Estimated Duration: 1 hour

Materials Needed: Session 3 powerpoint.

Session Activity: Have a nurse come in and act as a difficult patient. Have group work to illustrate HEL strategies, and find ways to align with the patient in this manner. Please note: having a patient example that demonstrates a potential language barrier would be ideal in this module.

Activity 2: In pairs have participants identify how they demonstrate loyalty, support, and commitment to a loved one. The residents should then review their lists as a group to identify common elements.

Competencies: Participants will demonstrate skills for utilizing appropriate patient centered language in the clinical setting, as well as how to navigate potential cultural barriers, during their daily patient interactions. Participants will support their patients and remain committed to helping them through the medical process.

Learning methodology: Learning methodology for this module includes lecture, group exercise, and partner exercise.

Key points: Attaining conversational language that is patient focused. Learning how to demonstrate loyalty. Trouble shooting how to align with a patient or family member when the patient is perceived as "difficult."

Session 4

Review HEL. "P" Permission & "P" Partnership

Facilitator's Notes: Reflect again on the interdependent nature of the acronym. Emphasize that this session is crucial for learning how to facilitate patient buy in because it gives the patient some power over their medical experience.

Session Objective: This session objective is to provide strategies on how clinicians can gain a patient/family buy in so that they can appropriately ask more in-depth questions, and make suggestions that patients will see as plausible and realistic for them as individuals. Clinician's will also learn strategies for aligning with patient to promote collaboration in care.

Estimated Duration: 1 hour.

Materials Needed: Session 4 powerpoint.

Session Activity: Clinicians will first break into groups. A non-resident volunteer will present as a family and/or patient whom which the clinician's goal is to gain buy in and form a partnership. Each clinician will have an opportunity to attempt to gain permission and partnership with the family being utilized. The clinicians will "tap" other clinicians in when they are ready to pass the conversation to another team mate. Each clinician should have an opportunity to be tapped in.

Competencies: Participants will gain buy in from their patients.

Learning methodology: Learning methodology for this module includes lecture and a group activity.

Key points: Participants will learn how to question patients in a patient focused manner, taking into consideration their pace and comfort.

Session 5

Review HELP. "P" Plan.

Facilitator's Notes: It is important to stress collaboration and flexibility in this module. A plan of action is contingent on both parties buying in to it.

Session Objective: Provide clinicians with strategies on how they can present an incremental plan, with an agreed upon goal at the end of it.

Estimated Duration: 1 hour.

Materials Needed: Session 5 power point.

Session Activity: Clinicians will break into pairs. Activity 1: Clinicians will first identify personal goals they would like to accomplish and set out stepping stones in terms of short, medium, and long-term goals. Partners will verify goals are specific, measureable, attainable, results oriented, and times (SMART objectives) . Activity 2: clinicians will then be given a vignette. In their pairs they will develop a goal setting plan. -Components will be shared as a class and the suggested steps can be compared.

Competencies: Clinicians will set goals according to the SMART objectives and work incrementally to plan the steps to accomplish the set goal.

Learning methodology: Learning methodology in this module consists of lecture and a group Activity.

Key points: Key points in this module include collaboration, goal setting, and incremental planning.

Session 6 - Invivo opportunity for feedback.

Facilitator's Notes: This "session" is to occur outside of didactic time. Facilitator will make arrangements to observe the clinician's interactions with a designated patient.

Session Objective: The evaluator will have an opportunity to observe the clinician in real time and provide confidential feedback on their utilization of the HELP model.

Estimated Duration: Feedback session should be no more that 10 minutes.

Materials Needed: HELP feedback form.

Session Activity: N/A

Competencies: Clinician should demonstrate competent utilization of the HELP model in vivo with a patient.

Learning methodology: Fieldwork

Key points: Mastery of the HELP model

Chapter VI: Discussion

The medical setting has the capacity to have long term effects on the psychological functioning of its patients. While in the immediate moment medical care is the priority, taking a patient focused approach can have long lasting implications as well. The purpose of this current study was to intensively focus on the effects surgery can have on patients and to acknowledge that the steps both leading up to procedures and post-operative care can potentially be traumatic for patients. While patient focused empathy has been a priority for medical practitioners during recent decades, the data as well as observations, have indicated that this focus has not translated into practice during the past ten to fifteen years. There is also a level of disconnect between when patient focused empathy is emphasized (i.e. early on in medical school), and how often the topic is revisited for reinforcement. This all demonstrates a decline in the level of importance placed on empathy training throughout a physicians' training.

The structure of this study sought to assess the residents' current usage of patient centered empathy by utilizing the Jefferson Scale of Empathy and an Empathy Training Survey. This Jefferson Scale of Empathy was used because it is specific to assessing empathy in a medical setting. This study also sought to obtain feedback from the General Surgery residents by administering a semi structured Empathy Training Survey that allowed them to both quantitatively and qualitatively share their experiences learning and observing empathy in their current placements. These measures were collected anonymously in hopes of having the General Surgery residents speak freely about ~~and~~ their experiences.

Research question 1 asked if the General Surgery Residents are utilizing Patient Focused Empathy. The results of the data indicated that all but two scores fell in the average range of Empathy based on the Jefferson Scale. In regards to the two outliers, one fell in the "low" empathy range and the other fell in the "high" empathy range. Overall this indicates that there is not an overarching lack of empathy amongst the General Surgery Residents, as originally hypothesized. In fact, the results of the Jefferson Scale of Empathy demonstrate that the General Surgery Residents are sufficient in their practice of demonstrating patient focused empathy. Research question 2 assessed the effectiveness of prior empathy trainings. The results of the Empathy Training Survey indicated that there were mixed feelings about how often empathy was observed and personally demonstrated. These results also indicate that there was no consensus on the effectiveness of the trainings previously offered. These results demonstrate that while the General Surgery Residents are enrolled in the same program for training, they are having different experiences. As such, these results demonstrate that there is a number of residents who are not observing empathy and who feel ill equipped to demonstrate empathy themselves. The Empathy Training Survey also allowed for the residents to give feedback regarding what learning strategies were most effective for them. This element of the survey was crucial for creating a learning curriculum. The General Surgery Residents filling out this survey, would be the same residents who would receive this training. Understanding what modalities of learning they are open to is crucial for creating a curriculum that would foster buy in from this sample.

When taken together, the data collected from the Jefferson Scale of Empathy and the Empathy Training Survey have several important implications. The first being that

the residents perceived there to be a lack of empathy being demonstrated amongst the staff. This implies that patients and families are not receiving the patient focused care that is crucial to positive long-term outcomes. When this data is understood in the context of research literature, the potential for a lack of patient follow up by way of not attending follow up appointments, not adhering to medical advice, not seeking the expertise of other specialist, etc. becomes a reality. Also, this research literature surrounding data like this outlines the potential psychological impacts this lack of empathy is correlated with including diagnoses like depression, PTSD, and anxiety. The data collected also revealed a sense of inadequacy towards the trainings the residents have received thus far on patient focused empathy. This is important to recognize because it illustrates that while we expect residents to be competent in their abilities to demonstrate empathy, they feel unprepared because they have not been trained adequately. This demonstrates a need for more improved empathy training opportunities because ultimately we cannot expect residents to exceed in a skill they have not been taught masterfully. This lack of effective training can be considered as a disservice to the patients and families because they are not receiving the patient focused care and empathy they deserve. However, there is potential for improve the trainings medical personnel such as General Surgery Residents, are receiving. As the medical field is moving towards a more integrated, multidisciplinary approach to health care, this may mean that the psychologists working with the medical personnel can supplement the trainings they have received and offer plausible ways for physicians to demonstrate empathy.

Using the Jefferson Scale scores and the Empathy Training Survey data collected in conjunction with how patient focused empathy was being taught nationally, a six

session curriculum was proposed to teach the residents strategies for implementing patient focused empathy in their clinical work. This curriculum included ~~encompassed~~ the explicit feedback acquired on the Empathy Training Surveys that outlined what the residents felt worked and did not work for them in the past. The curriculum is also based upon the empirically supported HELP model utilized in teaching these skills to medical practitioners. This model was appropriate because prior research indicates it can be taught over time with sessions being brief in nature without losing its validity. These factors made this model ideal for this population and the parameters surrounding delivering the material. This model also takes a common factors approach, which allows it to be flexible and adaptable to those clinicians utilizing it. Furthermore, the curriculum suggested here is unique in that it offers an opportunity for the residents to be observed utilizing the skills during an in-vivo field opportunity. The feedback from this observation opportunity would be kept confidential and can be used to offer individualized feedback on how residents can continue to improve their patient focused care. The confidentiality is crucial when working to refine these skills, as the nature of the residents' training is very results oriented. The priority here is to improve skills and that focus should be separated from the traditional performance-based evaluations done during residency. The goal of this type of programming is to give the residents some realistic strategies to utilize in the field. Based on the completed Empathy Training Surveys there were concerns about the applicability of what they've been taught, in addition to a need for straight forward "how to's." Another goal of this curriculum was to have residents get exposure practicing these strategies outside of the traditional

"lecture" format. All of these competencies lead to the final goal: to provide the highest quality comprehensive care to patients.

Limitations

There were a few limitations that became apparent throughout this study. While research has demonstrated that there has been an overall decline in patient focused empathy across various medical domains, the principal investigator in this research study had access only to residents being trained in General Surgery for this data collection opportunity. In order to expand this training opportunity to other residential domains, having an opportunity to Empathy Training Survey and assess the empathy levels in other resident programs at this hospital could be helpful. While it was anticipated that about 50 General Surgery residents would have the opportunity to take this assessment, it became apparent that the structure of the didactic session would not allow for this. The didactic sessions utilized for data collection were posited to the General Surgery residents as "optional," therefore about 50% of the anticipated residents were not present to be given the opportunity to participate in the study. It is also important to note, that this may also have the potential to skew the empathy scores on the higher end, as those residents who chose to attend the didactic session may have a pre-existing interest in this topic. Ultimately, this may indicate the sample may not be representative of the population. A point to note here as well is evaluative nature of the medical field. Residents are constantly being evaluated on their performance and thoughts and this may have prevented residents from answering questions honestly even given the confidentiality assurance. Another limitation in this study relates to the Jefferson Empathy Scale. Currently, evaluations are considered based on the average score the study sample yields.

The creators of this scale are working relentlessly to establish global norms to serve as cut off points. Future studies that can be conducted with these established cut off will be more statistically sound for inter-hospital comparisons. A final limitation to note here is the limited amount of qualitative data collected from the Empathy Training Surveys administered. While the residents who did participate in the study answered the quantitative ratings on empathy in the Empathy Training Survey, most opted to not elaborate on their experiences. It is hypothesized that this may be due to the time limited nature of their jobs preventing them from elaborating on their experiences.

Future directions

Future studies may choose to look at the effects the proposed curriculum may have on the competency of the residents in delivering patient focused care. This can be done in a few ways. The first way may include the collection of pre and post data regarding the levels of empathy present among the residents. The Jefferson Scale of Empathy would be ideal for this as it is specific to the medical setting and there are no time stipulations regarding re-assessment. Pre and post data opportunities could also incorporate feedback from supervising physicians on any growth they observe throughout the duration of the training opportunities. This would allow for a multi-rater, multi-disciplinary element to the ongoing assessment.

Future studies may also incorporate a process level evaluation to continuously gather data on how the residents perceive the training to be going. One thing that the literature and the data here revealed is that retrospectively residents find the trainings to be ineffective. This is information that is ideal to gather while there are opportunities to enhance what is left of the training and to inform future trainings. The process evaluation

can take place in an array of modalities including anonymous surveying, focus groups, interviews, etc. The modality chosen can also be a source of ongoing assessing as one modality may be more informative than another.

Furthermore, additional studies may seek to establish a feedback form that patients can fill out. This data can be used to assess the effectiveness of the patient focused approach from the perspective of the patient. It would be ideal if the patient feedback form could correlate with the in-vivo evaluation opportunity, citing the different domains of the HELP model. Having the feedback form include elements of perspective taking and treatment adherence would collect valuable data that relates to the current field of literature on this topic.

Appendix A
IRB Approved Consent Form/Description of Study

Attachment 4
CONSENT FORM
FOR ANONYMOUS DATA COLLECTION

You are invited to participate in a research study that is being conducted by Ramona Ross, who is a Doctoral Student *at* the Rutgers, Graduate School of Applied and Professional Psychology. The proposed research will provide an operational measure of empathy currently present amongst the General Surgery Residents at Robert Wood Medical School and will survey for additional empathy training the Residents would like to have.

This research is **anonymous**. Anonymous means that I will record no information about you that could identify you. There will be no linkage between your identity and your response in the research. This means that I will not record your name, address, phone number, date of birth, etc. If you agree to take part in the study, you will be assigned a random code number that will be used on each test and the questionnaire. Your name will appear only on a list of subjects, and will not be linked to the code number that is assigned to you. There will be no way to link your responses back to you. Therefore, data collection is anonymous.

The research team and the Institutional Review Board at Rutgers University are the only parties that will be allowed to see the data, except as may be required by law. If a report of this study is published, or the results are presented at a professional conference, only group results will be stated. All study data will be kept for three years in a locked cabinet located in a secured office.

There are no foreseeable risks to participation in this study. In addition, you may receive no direct benefit from taking part in this study, other than being provided resources on research based methods deliver more empathy based services.

Participation in this study is voluntary. You may choose not to participate, and you may withdraw at any time during the study procedures without any penalty to you. In addition, you may choose not to answer any questions with which you are not comfortable. It is estimated that it will take between 15 to 20 minutes to complete the study materials.

If you have any questions about the study or study procedures, you may contact me at 152 Frelingysen Road, Piscataway, NJ, 08854, by phone at 908-531-2693, or by e-mail at ramross26@gmail.com

You can also contact my faculty advisor Dr. Monica Indart by mail at 152 Frelingysen Road, Piscatway, NJ, 08854, by phone at 973.762.6878 : or by e-mail at: monica.indart@rutgers.edu

If you have any questions about your rights as a research subject, please contact an IRB Administrator at the Rutgers University, Arts and Sciences IRB:

Institutional Review Board
Rutgers University, the State University of New Jersey
Liberty Plaza / Suite 3200
335 George Street, 3rd Floor
New Brunswick, NJ 08901
Phone: 732-235-9806
Email: humansubjects@orsp.rutgers.edu

For IRB Use Only. This Section Must be Included on the Consent Form and Cannot Be Altered Except For Updates to the Version Date.

IRB Stamp Box
APPROVED
AUG 01 2016
Approved by the Rutgers IRB

IRB Stamp Box

Version Date: v1.0
Page 1

Appendix B
Jefferson Scale of Empathy

Jefferson Scale of Empathy

Medical Student version (S - version)

Use a ball-point pen. Mark one response for each item below.
For *ID Code*, write numerals completely inside the boxes, one numeral to a box.
Leave *Optional* fields blank unless otherwise instructed.

Name _____ **ID Code .....** | | | | | | | | | |

Date ___/___/_____

Age:

☐ < 22 ☐ 22-24 ☐ 25-27 ☐ 28-30 ☐ 31-33 ☐ 34-36 ☐ > 36

Gender:

☐ Male ☐ Female

Year of Medical School:

☐ 1st year ☐ 2nd year ☐ 3rd year ☐ 4th year ☐ > 4th year

Which specialty do you plan to pursue? [Please choose only one]

☐ Anesthesiology	☐ Dermatology	☐ Emergency Medicine
☐ Family Med./General Prac.	☐ Internal Med. (see below)	☐ Neurology
☐ Neurosurgery	☐ Obstetrics/Gynecology	☐ Ophthalmology
☐ Otolaryngology	☐ Orthopaedic Surgery	☐ Pathology
☐ Pediatrics	☐ Physical Med./Rehabilitation	☐ Plastic Surgery
☐ Preventive Medicine	☐ Psychiatry	☐ Public Health
☐ Radiology	☐ Surgery (see below)	☐ Urology
☐ Other _____	☐ Undecided	

Medical Sub-specialty: [Please choose one if your primary specialty interest is Internal Medicine]

☐ Cardiology	☐ Critical Care/Pulmonary	☐ Endocrinology
☐ General Internal Medicine	☐ Gastroenterology	☐ Hematology/Oncology
☐ Infectious Disease	☐ Nephrology	☐ Rheumatology
☐ Other _____	☐ Undecided	

Surgical Sub-specialty: [Please choose one if your primary specialty interest is Surgery]

☐ Cardiothoracic	☐ Colorectal	☐ General Surgery
☐ Transplant	☐ Trauma/Critical Care	☐ Vascular
☐ Other _____	☐ Undecided	

Optional field #1 .... | | | | |

Optional field #2 .... | | | | |

Please continue on the back --- Do not write below this line

B60 Page 1

Jefferson Scale of Empathy

Medical Student version (S - version)

Instructions: Using a ball-point pen, please indicate the extent of your agreement or disagreement with *each* of the following statements by marking the appropriate circle to the right of each statement.

Please use the following 7-point scale (*a higher number on the scale indicates more agreement):*
Mark one and only one response for each statement.

1-------2-------3-------4-------5-------6-------7
Strongly Disagree ***Strongly Agree***

	1	2	3	4	5	6	7
1. Physicians' understanding of their patients' feelings and the feelings of their patients' families does not influence medical or surgical treatment.	○	○	○	○	○	○	○
2. Patients feel better when their physicians understand their feelings.	○	○	○	○	○	○	○
3. It is difficult for a physician to view things from patients' perspectives.	○	○	○	○	○	○	○
4. Understanding body language is as important as verbal communication in physician-patient relationships.	○	○	○	○	○	○	○
5. A physician's sense of humor contributes to a better clinical outcome.	○	○	○	○	○	○	○
6. Because people are different, it is difficult to see things from patients' perspectives.	○	○	○	○	○	○	○
7. Attention to patients' emotions is not important in history taking.	○	○	○	○	○	○	○
8. Attentiveness to patients' personal experiences does not influence treatment outcomes.	○	○	○	○	○	○	○
9. Physicians should try to stand in their patients' shoes when providing care to them.	○	○	○	○	○	○	○
10. Patients value a physician's understanding of their feelings which is therapeutic in its own right.	○	○	○	○	○	○	○
11. Patients' illnesses can be cured only by medical or surgical treatment; therefore, physicians' emotional ties with their patients do not have a significant influence in medical or surgical treatment.	○	○	○	○	○	○	○
12. Asking patients about what is happening in their personal lives is not helpful in understanding their physical complaints.	○	○	○	○	○	○	○
13. Physicians should try to understand what is going on in their patients' minds by paying attention to their non-verbal cues and body language.	○	○	○	○	○	○	○
14. I believe that emotion has no place in the treatment of medical illness.	○	○	○	○	○	○	○
15. Empathy is a therapeutic skill without which the physician's success is limited.	○	○	○	○	○	○	○
16. Physicians' understanding of the emotional status of their patients, as well as that of their families is one important component of the physician-patient relationship.	○	○	○	○	○	○	○
17. Physicians should try to think like their patients in order to render better care.	○	○	○	○	○	○	○
18. Physicians should not allow themselves to be influenced by strong personal bonds between their patients and their family members.	○	○	○	○	○	○	○
19. I do not enjoy reading non-medical literature or the arts.	○	○	○	○	○	○	○
20. I believe that empathy is an important therapeutic factor in medical treatment.	○	○	○	○	○	○	○

Appendix C
Empathy Training Survey

Demographics

Ethnicity (please circle):
White Hispanic or Latino Black or African American
Native American or American Indian Asian / Pacific Islander
Other (please specify) _____

1. **Empathy**

In your medical training, how frequently do you observe physicians demonstrating empathy with patients?

Never Sometimes Often Always

2. Please describe the effect of an empathic approach with patients that you observed, including any positive or negative aspects of the patient's response.

_____
_____
_____

3. Please describe a specific instance where you demonstrated an empathic approach with a patient. How did the patient respond to your empathic approach (please include any details about positive or negative responses from the patient, as applicable)

_____
_____
_____

Training

4. How helpful were the trainings you received on delivering empathy to your patients (circle one)?

Extremely Helpful Very Helpful Moderately Helpful
Slightly Helpful Not at all Helpful

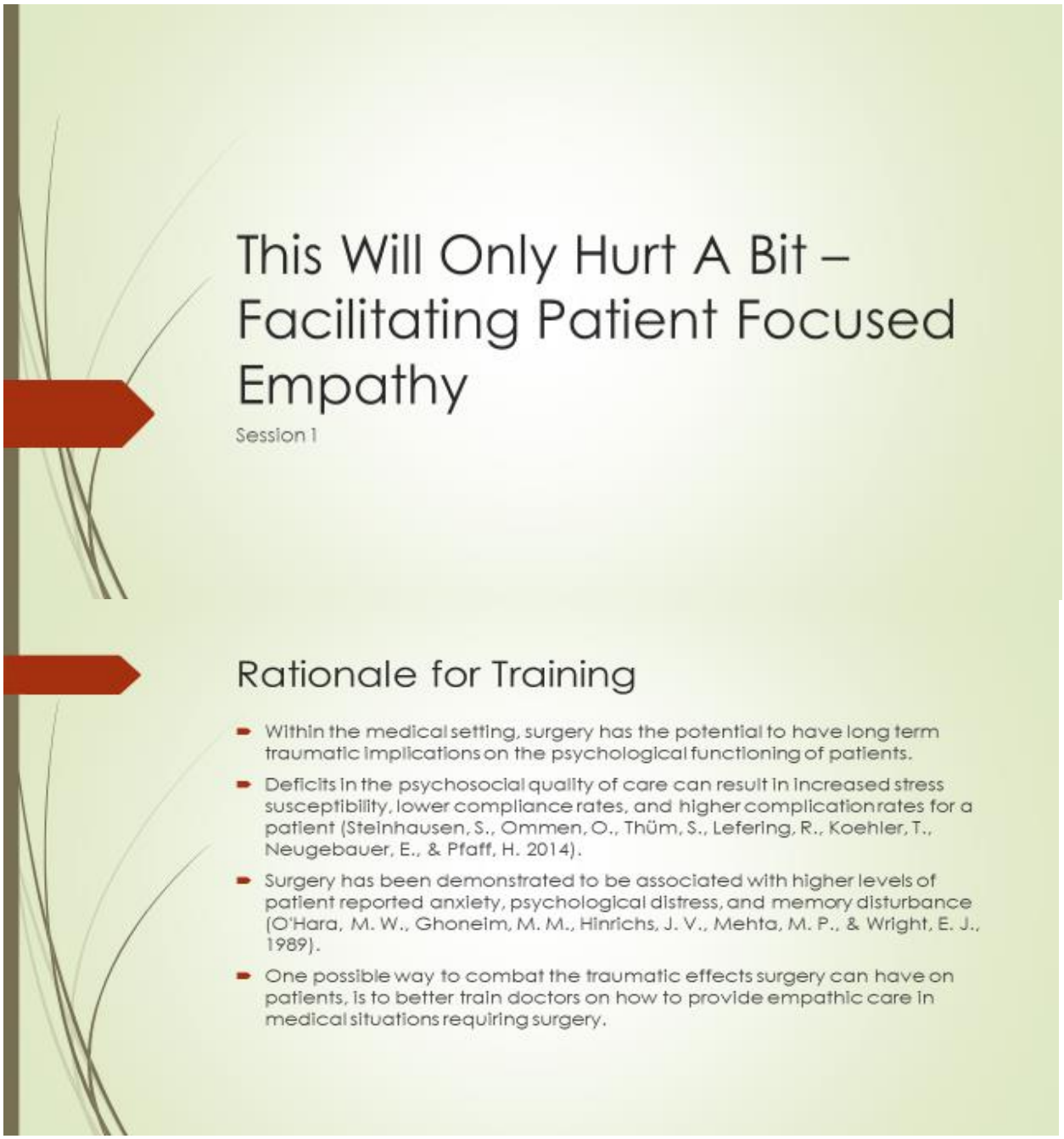
5. Please describe how these trainings were specifically helpful or unhelpful.
   _____
   _____
   _____

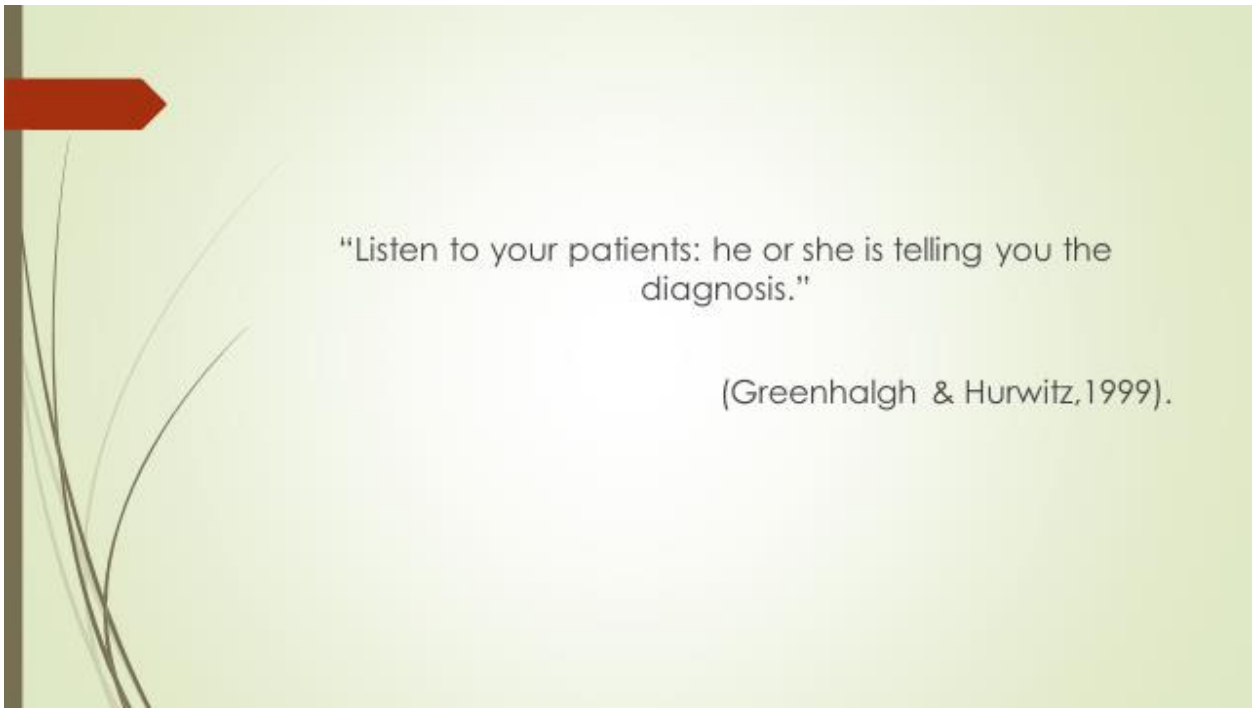
6. What elements or aspects were missing from your previous training on empathy?

_____
_____
_____

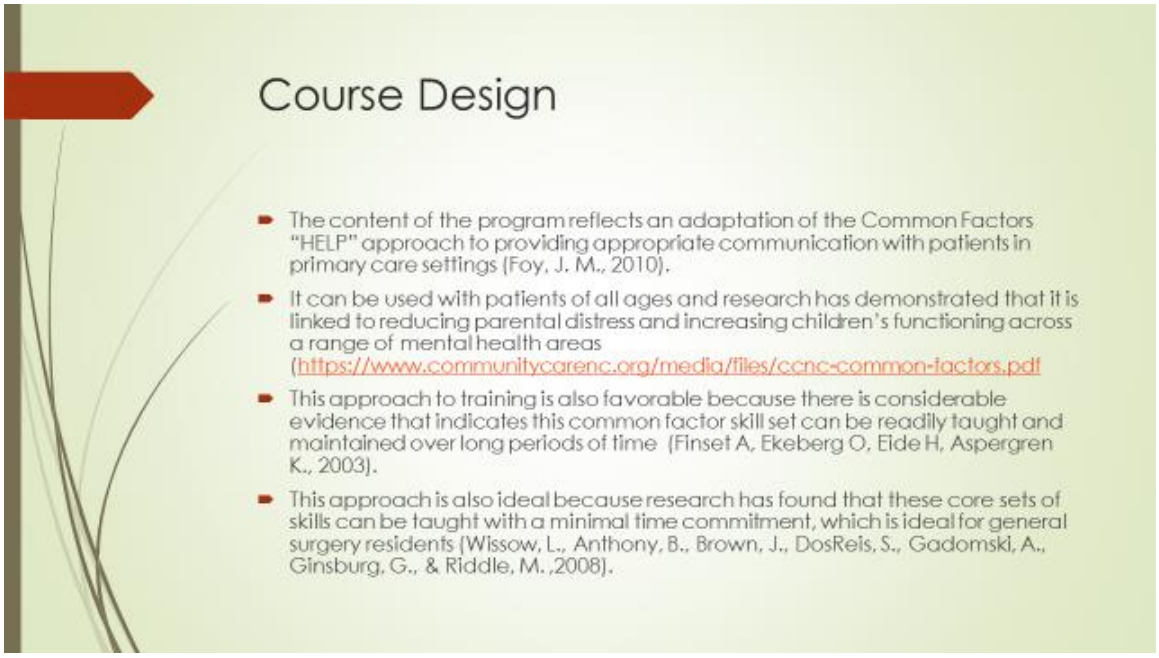
7. How do you think you can best learn empathic medical service delivery (i.e. role plays, classroom training, workshops etc.)
   _____
   _____
   _____

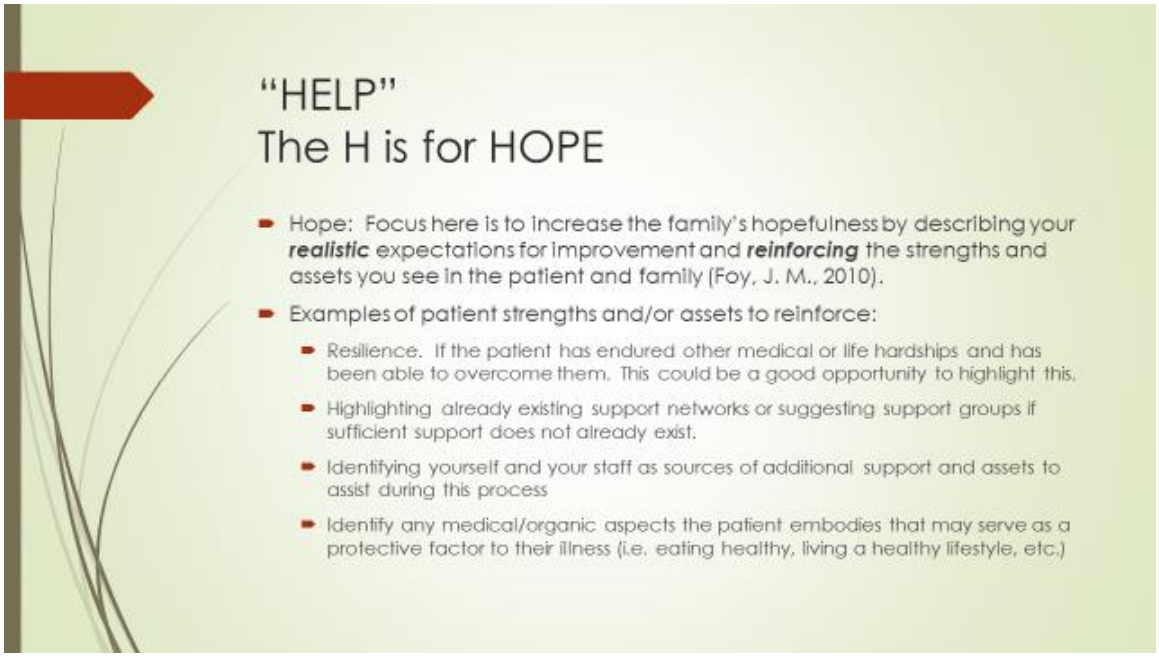
Appendix D
Curriculum Powerpoints

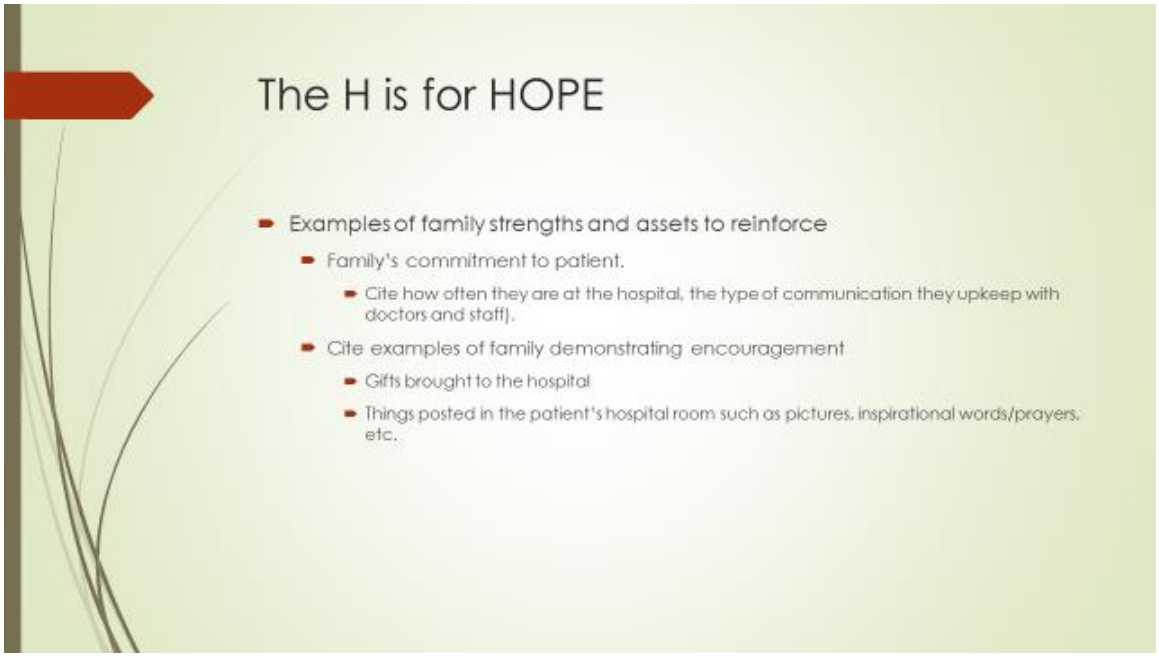


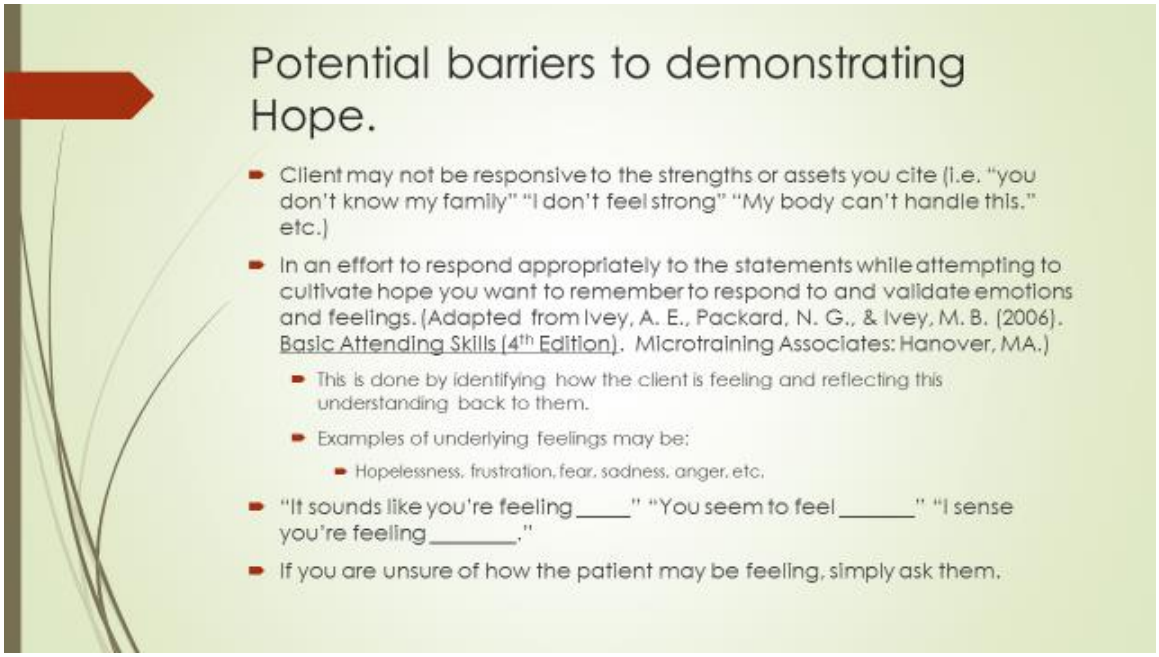

"Listen to your patients: he or she is telling you the diagnosis."
(Greenhalgh & Hurwitz,1999).

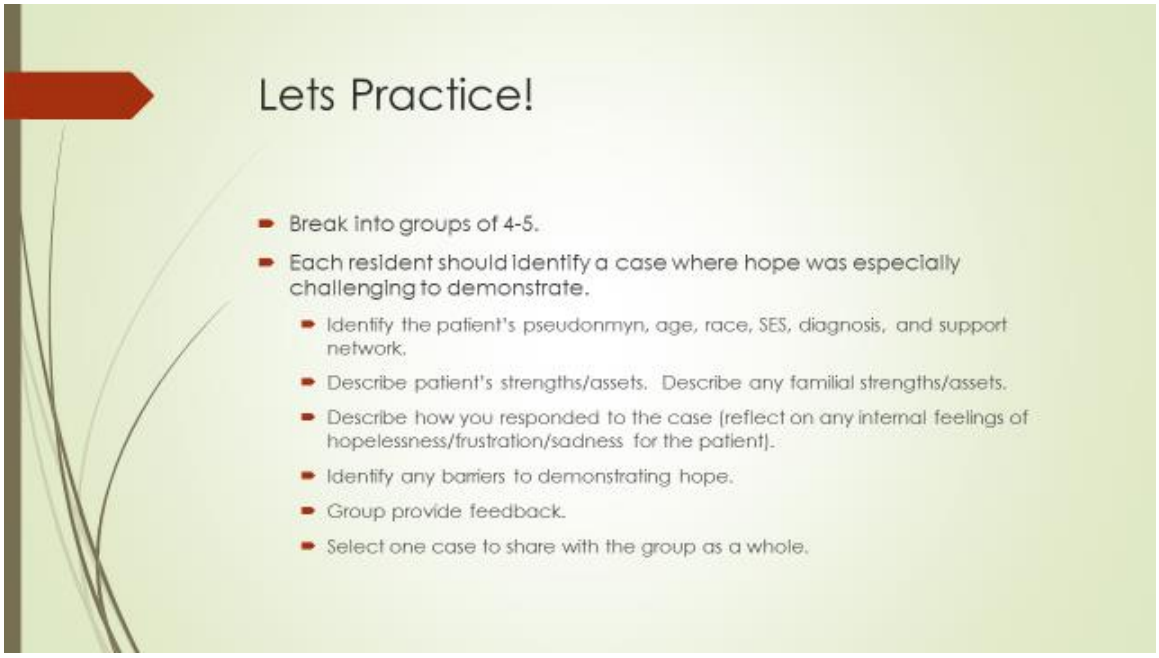

Workshop Goals
The objective of this workshop is to offer training opportunities for residents to refine their skills delivering patient focused empathy. This training model will provide residents with the skills and strategies for communicating effectively and empathically with their patients.
By the end of this training, participants should be able to:
Understand the difference between empathy and sympathy in the medical setting.
Understand how patient focused empathy differs from physician centered care.
Work to adapt a more patient focused perspective, utilizing the HELP common factors approach.
Utilize strategies to demonstrate empathic services towards patients.
Trouble shoot on how to deliver empathic services in the medical setting.
Work in groups to share personal patient experiences and gather feedback on how to improve empathy driven services.


Course Design
The content of the program reflects an adaptation of the Common Factors "HELP" approach to providing appropriate communication with patients in primary care settings (Foy, J. M., 2010).
It can be used with patients of all ages and research has demonstrated that it is linked to reducing parental distress and increasing children's functioning across a range of mental health areas (https://www.communitycarenc.org/media/files/ccnc-common-factors.pdf
This approach to training is also favorable because there is considerable evidence that indicates this common factor skill set can be readily taught and maintained over long periods of time (Finset A, Ekeberg O, Eide H, Aspergren K., 2003).
This approach is also ideal because research has found that these core sets of skills can be taught with a minimal time commitment, which is ideal for general surgery residents (Wissow, L., Anthony, B., Brown, J., DosReis, S., Gadomski, A., Ginsburg, G., & Riddle, M. ,2008).


"HELP"
The H is for HOPE
Hope: Focus here is to increase the family's hopefulness by describing your realistic expectations for improvement and reinforcing the strengths and assets you see in the patient and family (Foy, J. M., 2010).
Examples of patient strengths and/or assets to reinforce:
Resilience. If the patient has endured other medical or life hardships and has been able to overcome them. This could be a good opportunity to highlight this.
Highlighting already existing support networks or suggesting support groups if sufficient support does not already exist.
Identifying yourself and your staff as sources of additional support and assets to assist during this process
Identify any medical/organic aspects the patient embodies that may serve as a protective factor to their illness (i.e. eating healthy, living a healthy lifestyle, etc.)


The H is for HOPE
Examples of family strengths and assets to reinforce
Family's commitment to patient.
Cite how often they are at the hospital, the type of communication they upkeep with doctors and staff).
Cite examples of family demonstrating encouragement
Gifts brought to the hospital
Things posted in the patient's hospital room such as pictures, inspirational words/prayers, etc.


Potential barriers to demonstrating Hope.
Client may not be responsive to the strengths or assets you cite (i.e. "you don't know my family" "I don't feel strong" "My body can't handle this." etc.)
In an effort to respond appropriately to the statements while attempting to cultivate hope you want to remember to respond to and validate emotions and feelings. (Adapted from Ivey, A. E., Packard, N. G., & Ivey, M. B. (2006). Basic Attending Skills (4th Edition). Microtraining Associates: Hanover, MA.)
This is done by identifying how the client is feeling and reflecting this understanding back to them.
Examples of underlying feelings may be:
Hopelessness, frustration, fear, sadness, anger, etc.
"It sounds like you're feeling ____" "You seem to feel _____" "I sense you're feeling _____."
If you are unsure of how the patient may be feeling, simply ask them.


Lets Practice!
Break into groups of 4-5.
Each resident should identify a case where hope was especially challenging to demonstrate.
Identify the patient's pseudonmyn, age, race, SES, diagnosis, and support network.
Describe patient's strengths/assets. Describe any familial strengths/assets.
Describe how you responded to the case (reflect on any internal feelings of hopelessness/frustration/sadness for the patient).
Identify any barriers to demonstrating hope.
Group provide feedback.
Select one case to share with the group as a whole.


References
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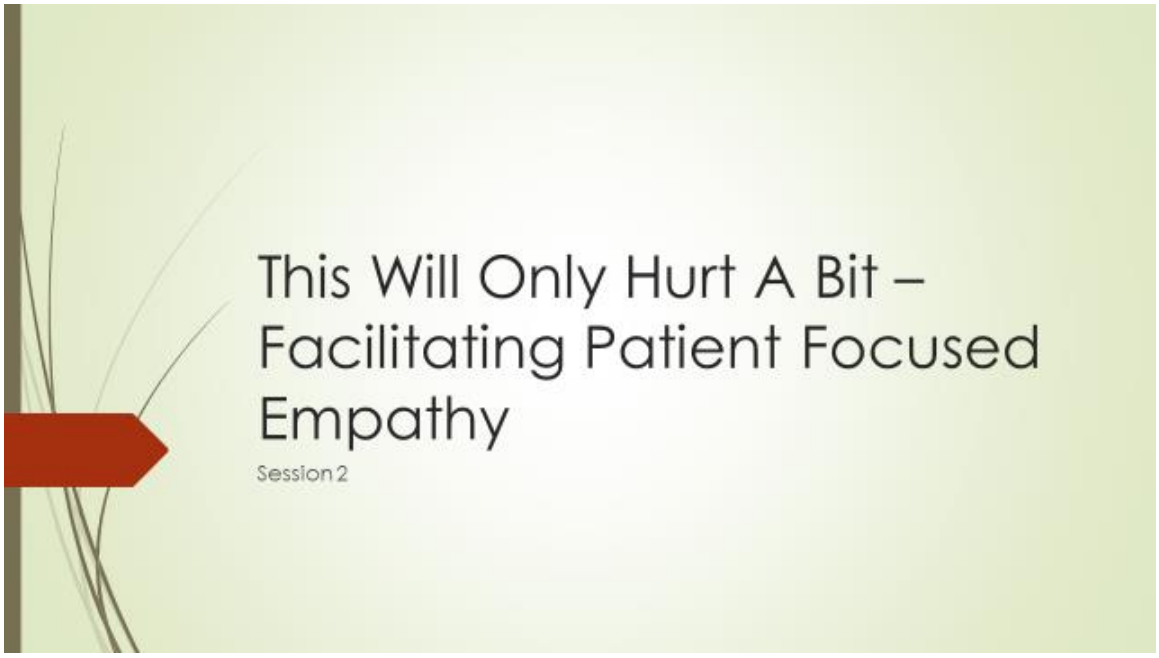
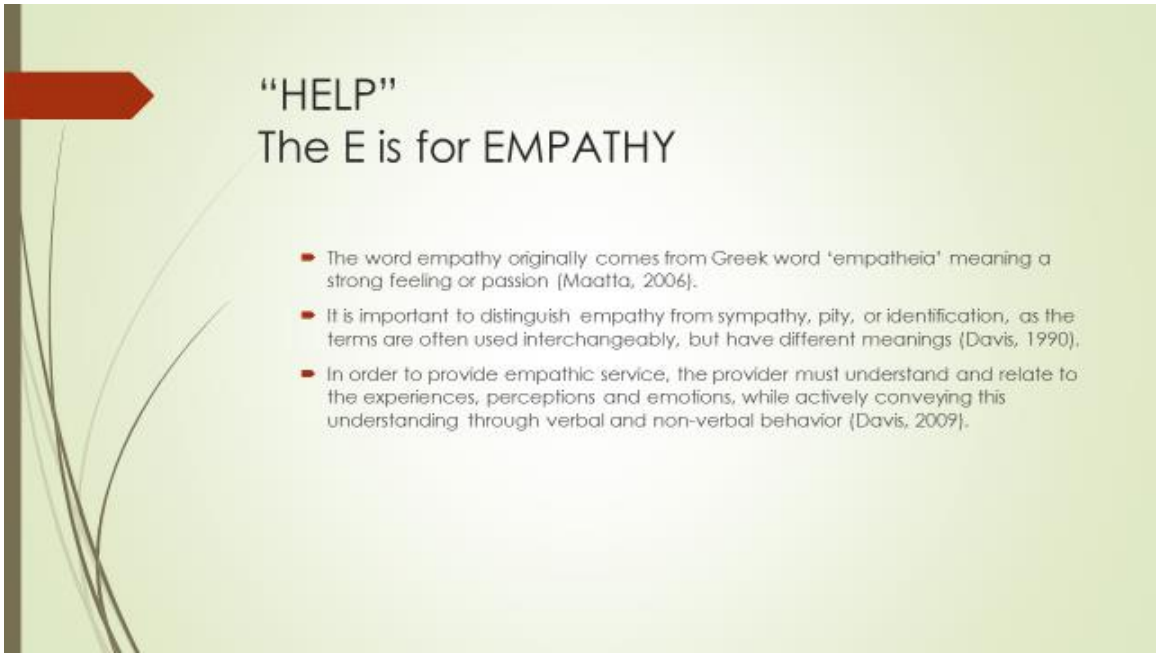
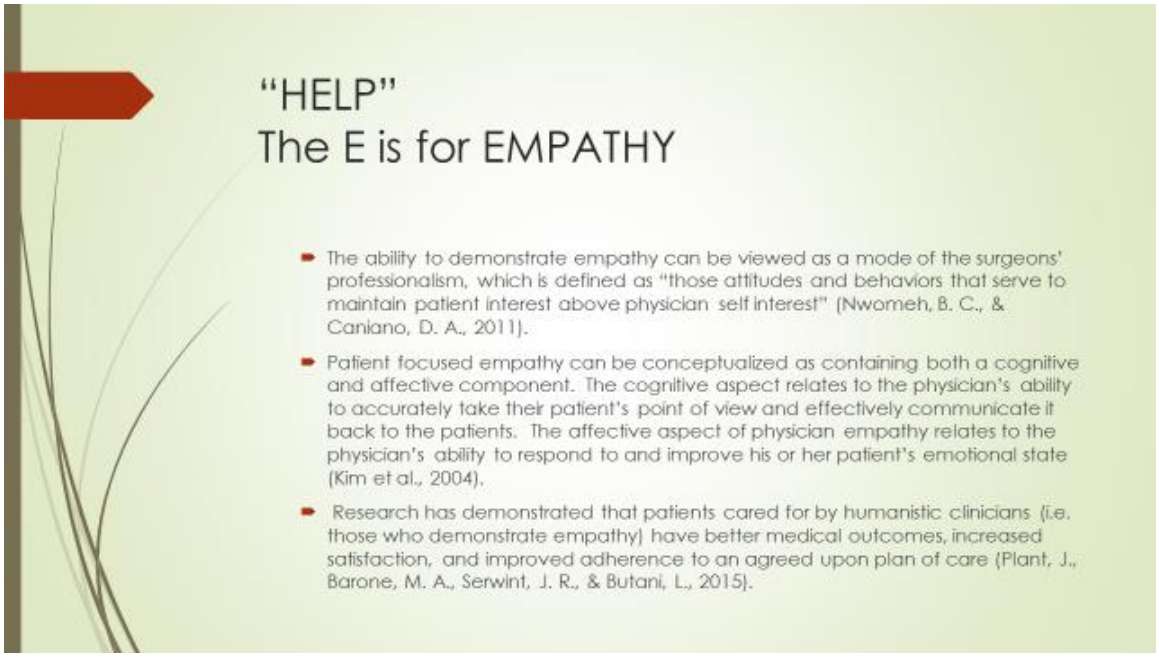
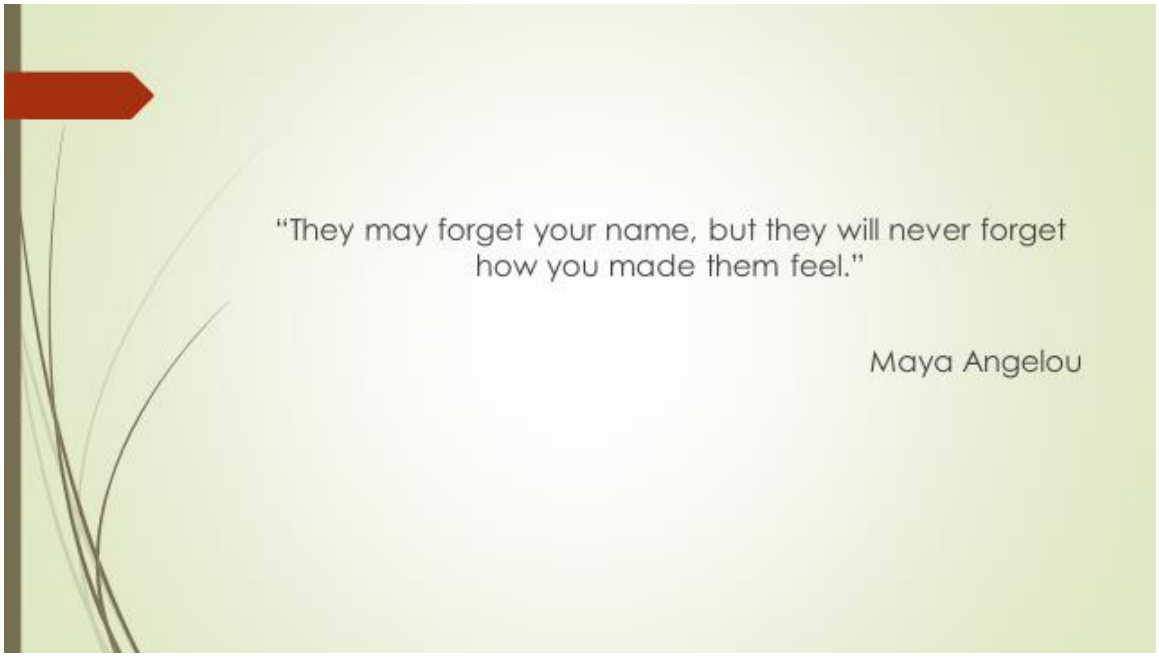
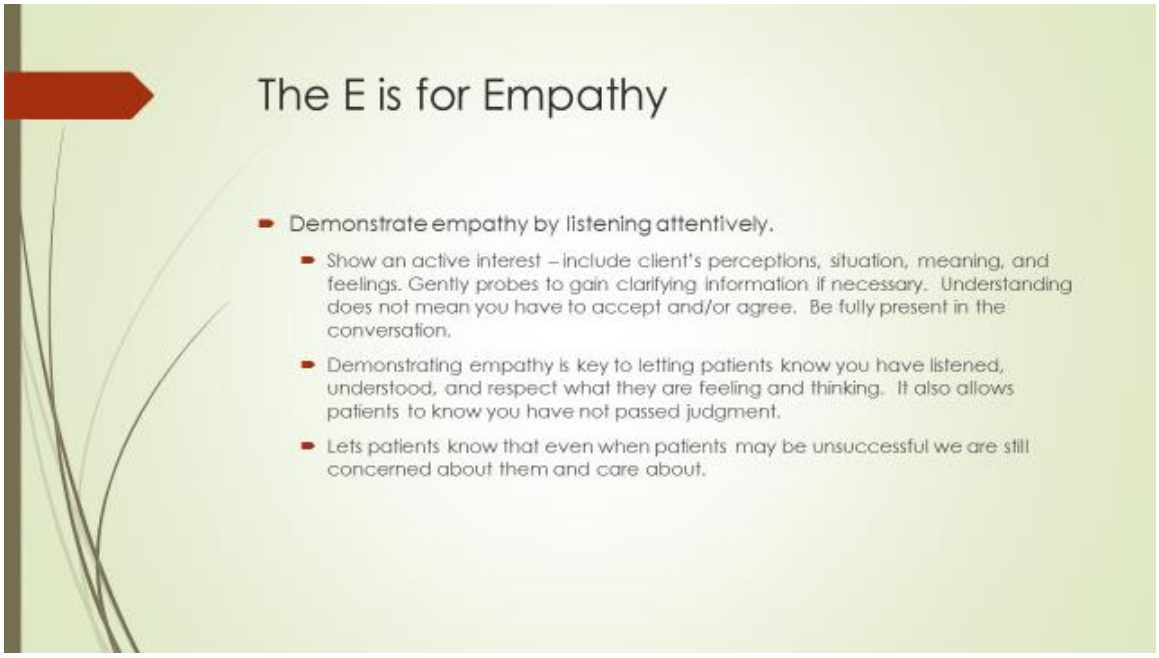
Foy, J. M., 2010.
Ivey, A. E., Packard, N. G., & Ivey, M. B. (2006). Basic Attending Skills (4th Edition). Microtraining Associates: Hanover, MA.
O'Hara, M. W., Ghoneim, M. M., Hinrichs, J. V., Mehta, M. P., & Wright, E. J., 1989.
Steinhausen, S., Ommen, O., Thüm, S., Lefering, R., Koehler, T., Neugebauer, E., & Pfaff, H. 2014.
Wissow, L., Anthony, B., Brown, J., DosReis, S., Gadomski, A., Ginsburg, G., & Riddle, M. ,2008.

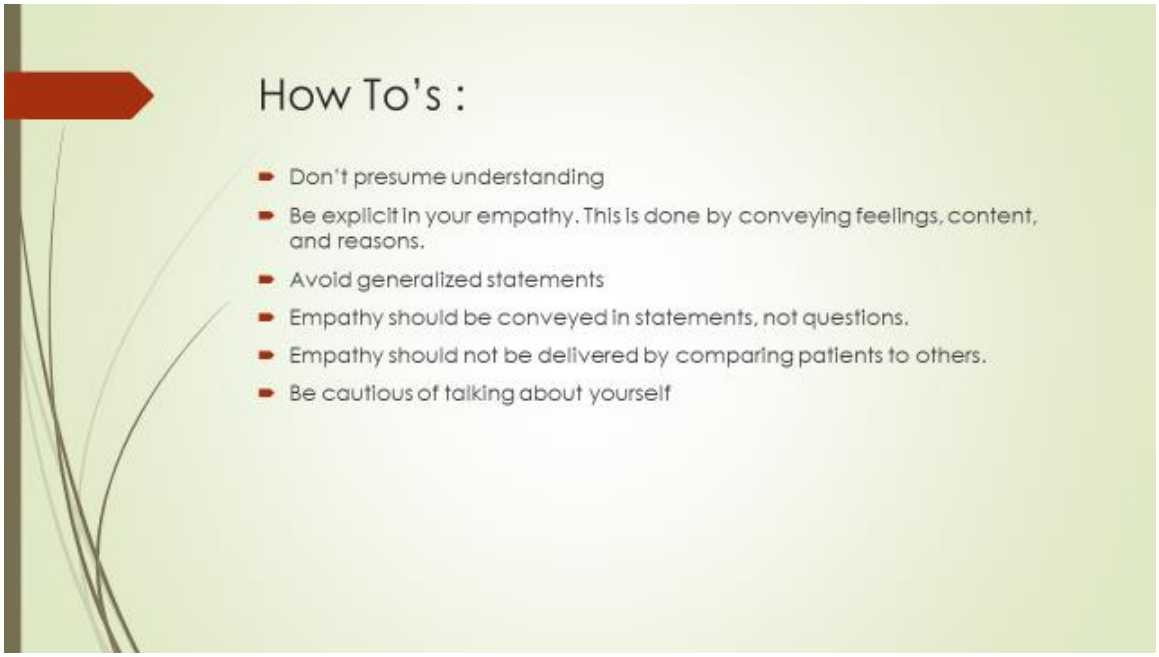

This Will Only Hurt A Bit – Facilitating Patient Focused Empathy
Session 2

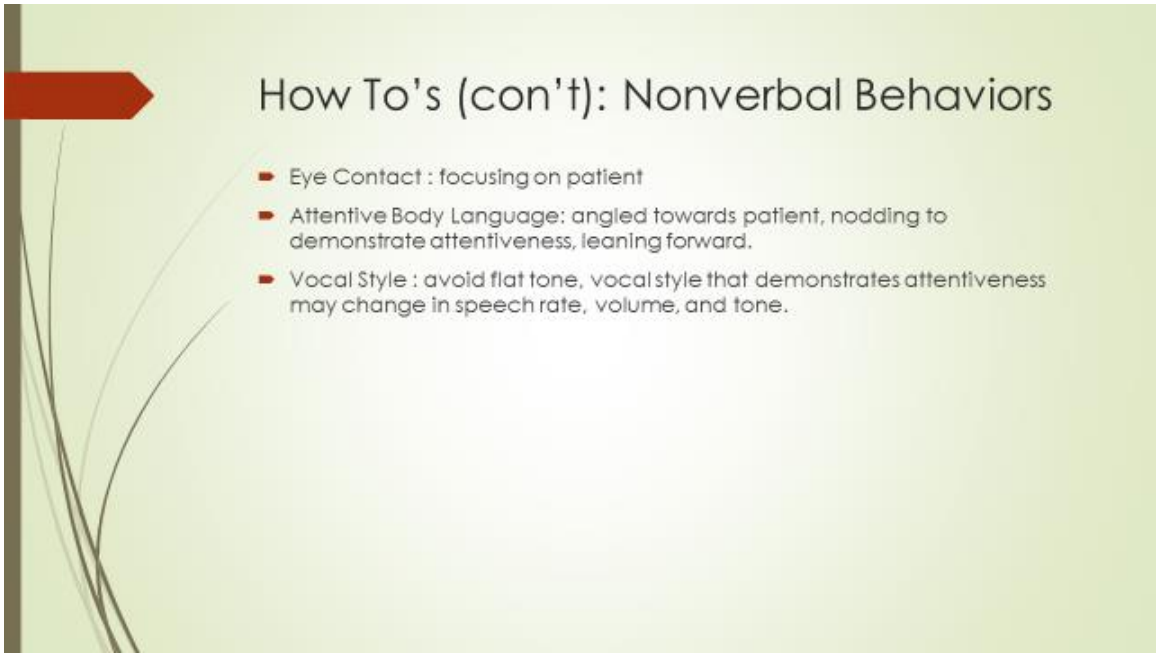

"HELP"
The E is for EMPATHY
The word empathy originally comes from Greek word 'empatheia' meaning a strong feeling or passion (Maatta, 2006).
It is important to distinguish empathy from sympathy, pity, or identification, as the terms are often used interchangeably, but have different meanings (Davis, 1990).
In order to provide empathic service, the provider must understand and relate to the experiences, perceptions and emotions, while actively conveying this understanding through verbal and non-verbal behavior (Davis, 2009).

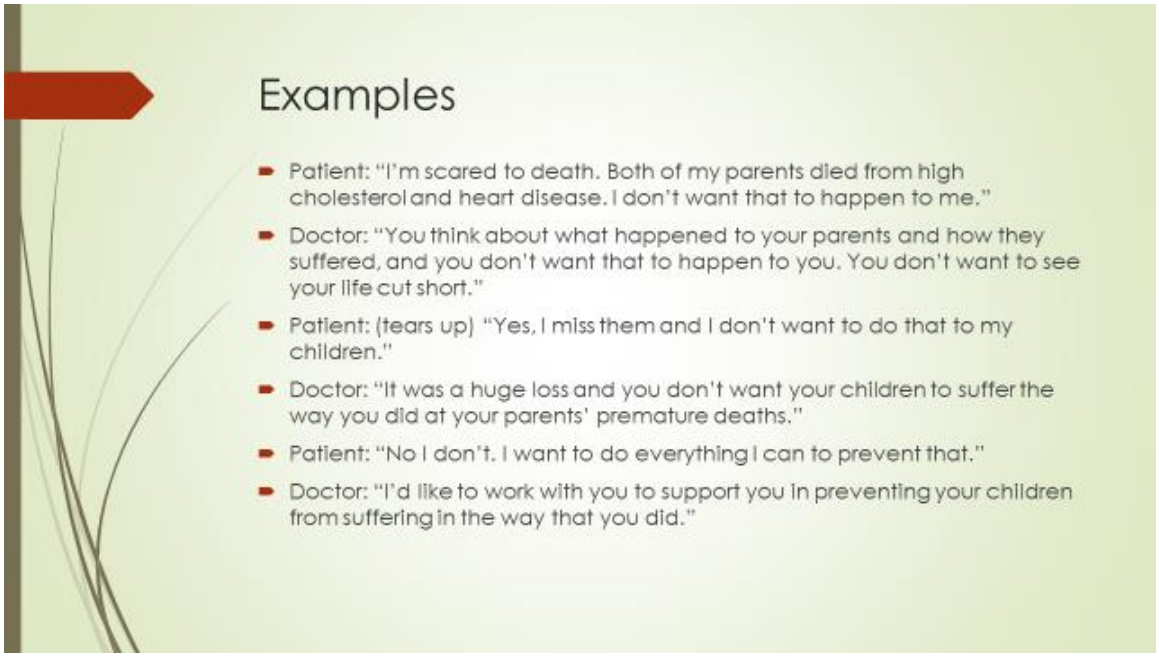

"HELP"
The E is for EMPATHY
The ability to demonstrate empathy can be viewed as a mode of the surgeons' professionalism, which is defined as "those attitudes and behaviors that serve to maintain patient interest above physician self interest" (Nwomeh, B. C., & Caniano, D. A., 2011).
Patient focused empathy can be conceptualized as containing both a cognitive and affective component. The cognitive aspect relates to the physician's ability to accurately take their patient's point of view and effectively communicate it back to the patients. The affective aspect of physician empathy relates to the physician's ability to respond to and improve his or her patient's emotional state (Kim et al., 2004).
Research has demonstrated that patients cared for by humanistic clinicians (i.e. those who demonstrate empathy) have better medical outcomes, increased satisfaction, and improved adherence to an agreed upon plan of care (Plant, J., Barone, M. A., Serwint, J. R., & Butani, L., 2015).

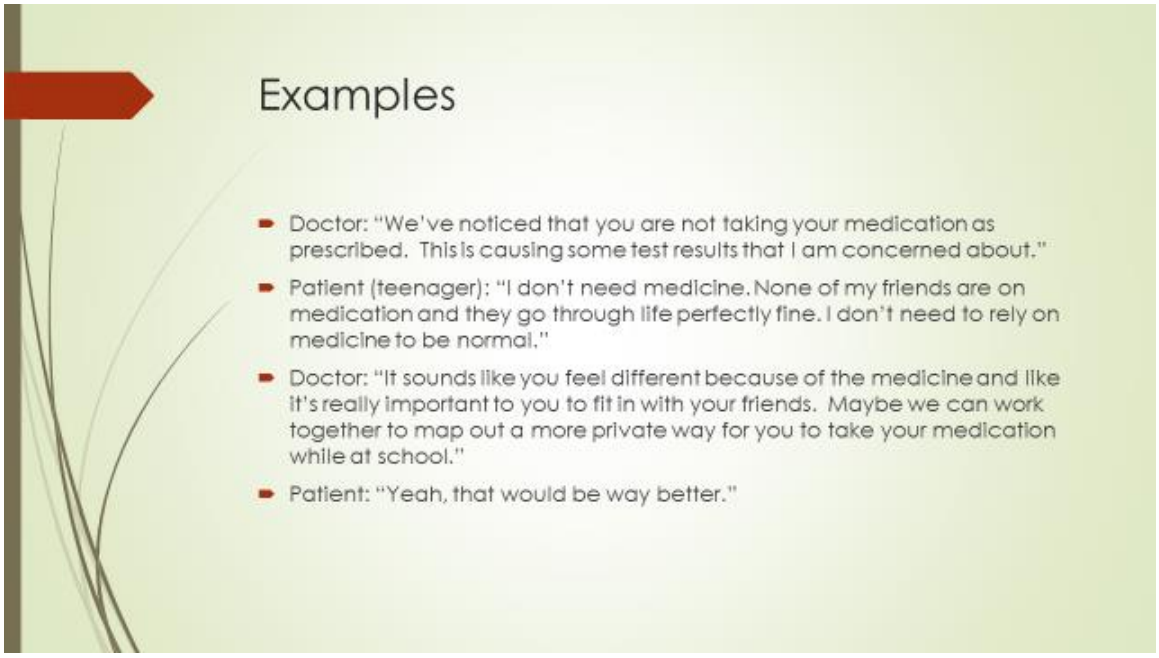

"They may forget your name, but they will never forget how you made them feel."
Maya Angelou

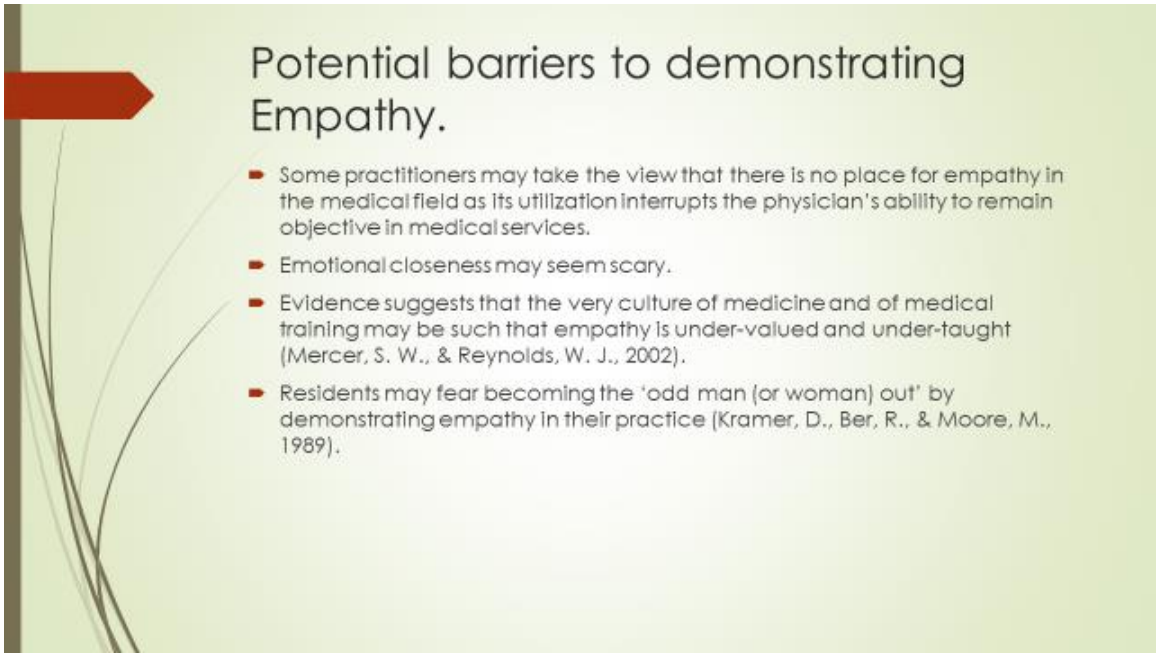

The E is for Empathy
Demonstrate empathy by listening attentively.
Show an active interest – include client's perceptions, situation, meaning, and feelings. Gently probes to gain clarifying information if necessary. Understanding does not mean you have to accept and/or agree. Be fully present in the conversation.
Demonstrating empathy is key to letting patients know you have listened, understood, and respect what they are feeling and thinking. It also allows patients to know you have not passed judgment.
Lets patients know that even when patients may be unsuccessful we are still concerned about them and care about.

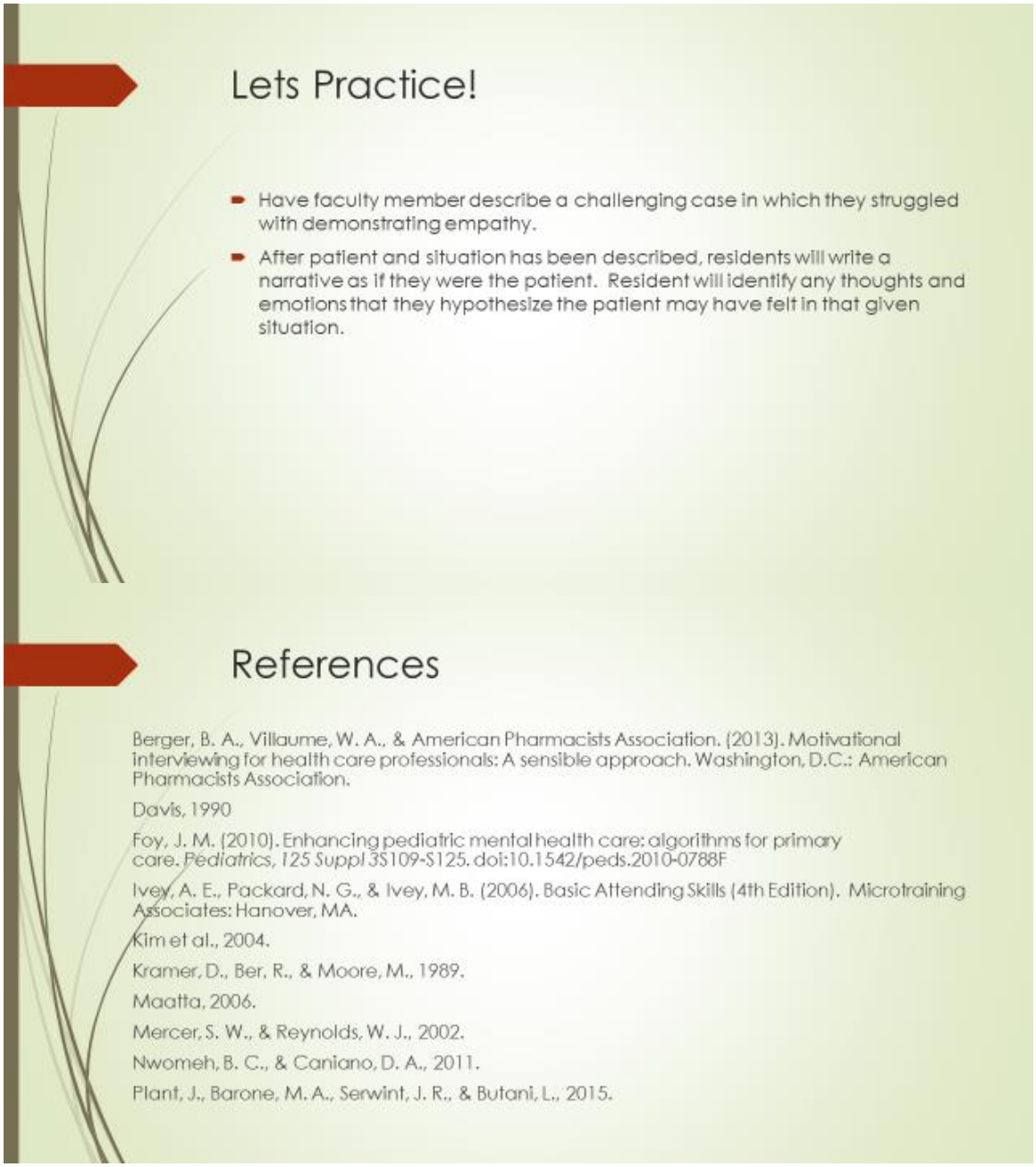

How To's :
Don't presume understanding
Be explicit in your empathy. This is done by conveying feelings, content, and reasons.
Avoid generalized statements
Empathy should be conveyed in statements, not questions.
Empathy should not be delivered by comparing patients to others.
Be cautious of talking about yourself


How To's (con't): Nonverbal Behaviors
Eye Contact : focusing on patient
Attentive Body Language: angled towards patient, nodding to demonstrate attentiveness, leaning forward.
Vocal Style : avoid flat tone, vocal style that demonstrates attentiveness may change in speech rate, volume, and tone.


Examples
Patient: "I'm scared to death. Both of my parents died from high cholesterol and heart disease. I don't want that to happen to me."
Doctor: "You think about what happened to your parents and how they suffered, and you don't want that to happen to you. You don't want to see your life cut short."
Patient: (tears up) "Yes, I miss them and I don't want to do that to my children."
Doctor: "It was a huge loss and you don't want your children to suffer the way you did at your parents' premature deaths."
Patient: "No I don't. I want to do everything I can to prevent that."
Doctor: "I'd like to work with you to support you in preventing your children from suffering in the way that you did."


Examples
Doctor: "We've noticed that you are not taking your medication as prescribed. This is causing some test results that I am concerned about."
Patient (teenager): "I don't need medicine. None of my friends are on medication and they go through life perfectly fine. I don't need to rely on medicine to be normal."
Doctor: "It sounds like you feel different because of the medicine and like it's really important to you to fit in with your friends. Maybe we can work together to map out a more private way for you to take your medication while at school."
Patient: "Yeah, that would be way better."


Potential barriers to demonstrating Empathy.
Some practitioners may take the view that there is no place for empathy in the medical field as its utilization interrupts the physician's ability to remain objective in medical services.
Emotional closeness may seem scary.
Evidence suggests that the very culture of medicine and of medical training may be such that empathy is under-valued and under-taught (Mercer, S. W., & Reynolds, W. J., 2002).
Residents may fear becoming the 'odd man (or woman) out' by demonstrating empathy in their practice (Kramer, D., Ber, R., & Moore, M., 1989).


Lets Practice!
Have faculty member describe a challenging case in which they struggled with demonstrating empathy.
After patient and situation has been described, residents will write a narrative as if they were the patient. Resident will identify any thoughts and emotions that they hypothesize the patient may have felt in that given situation.
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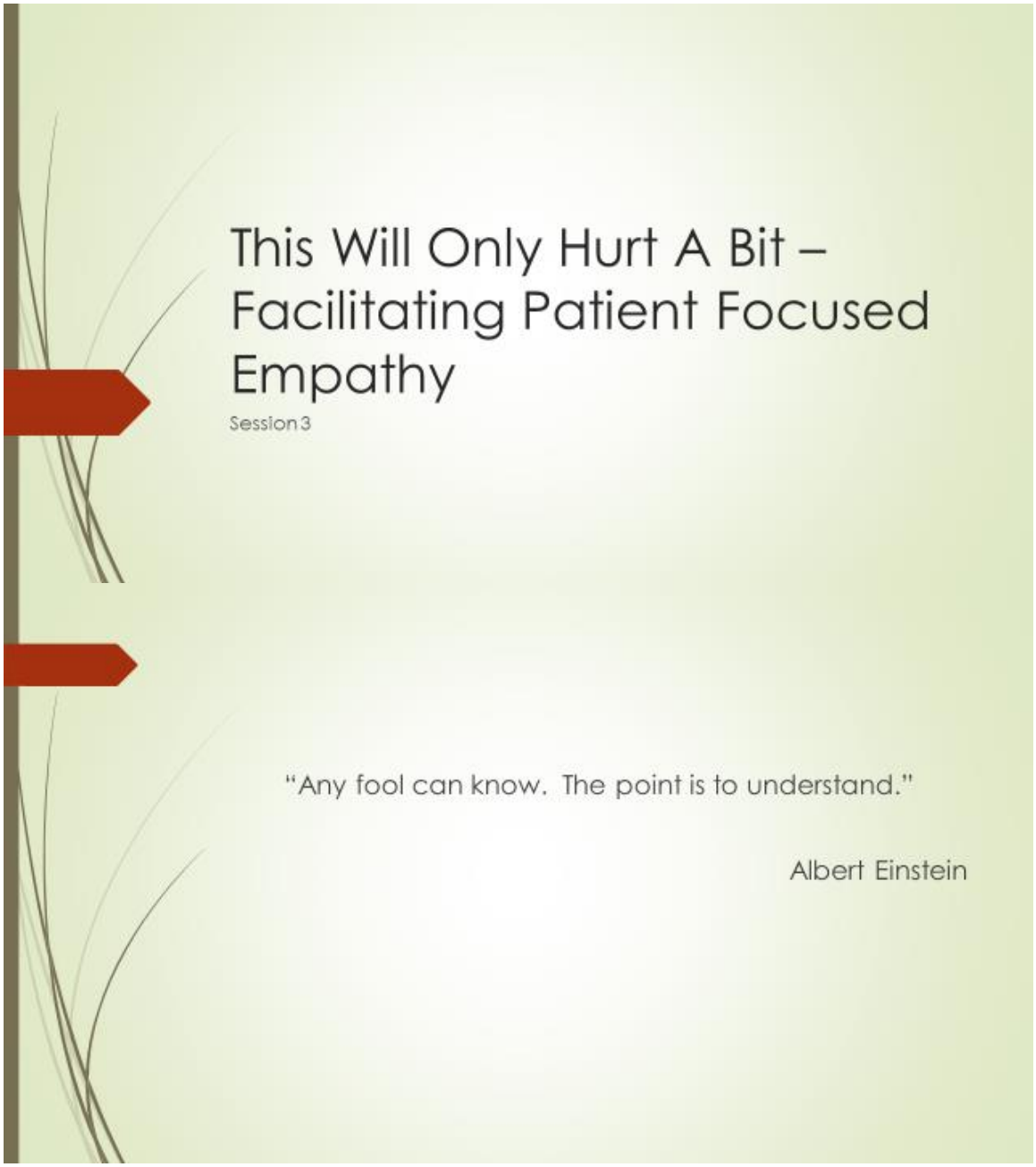
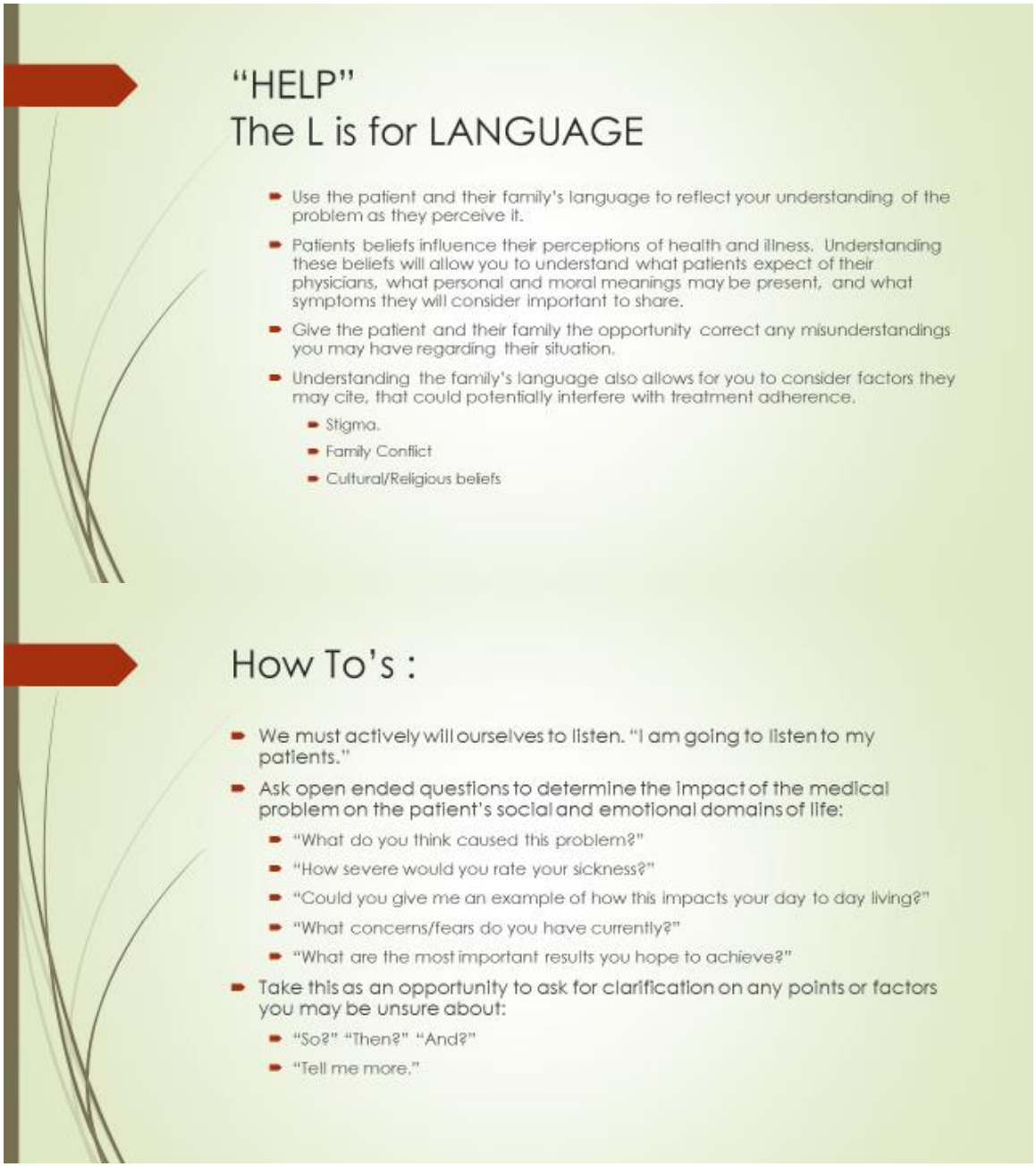
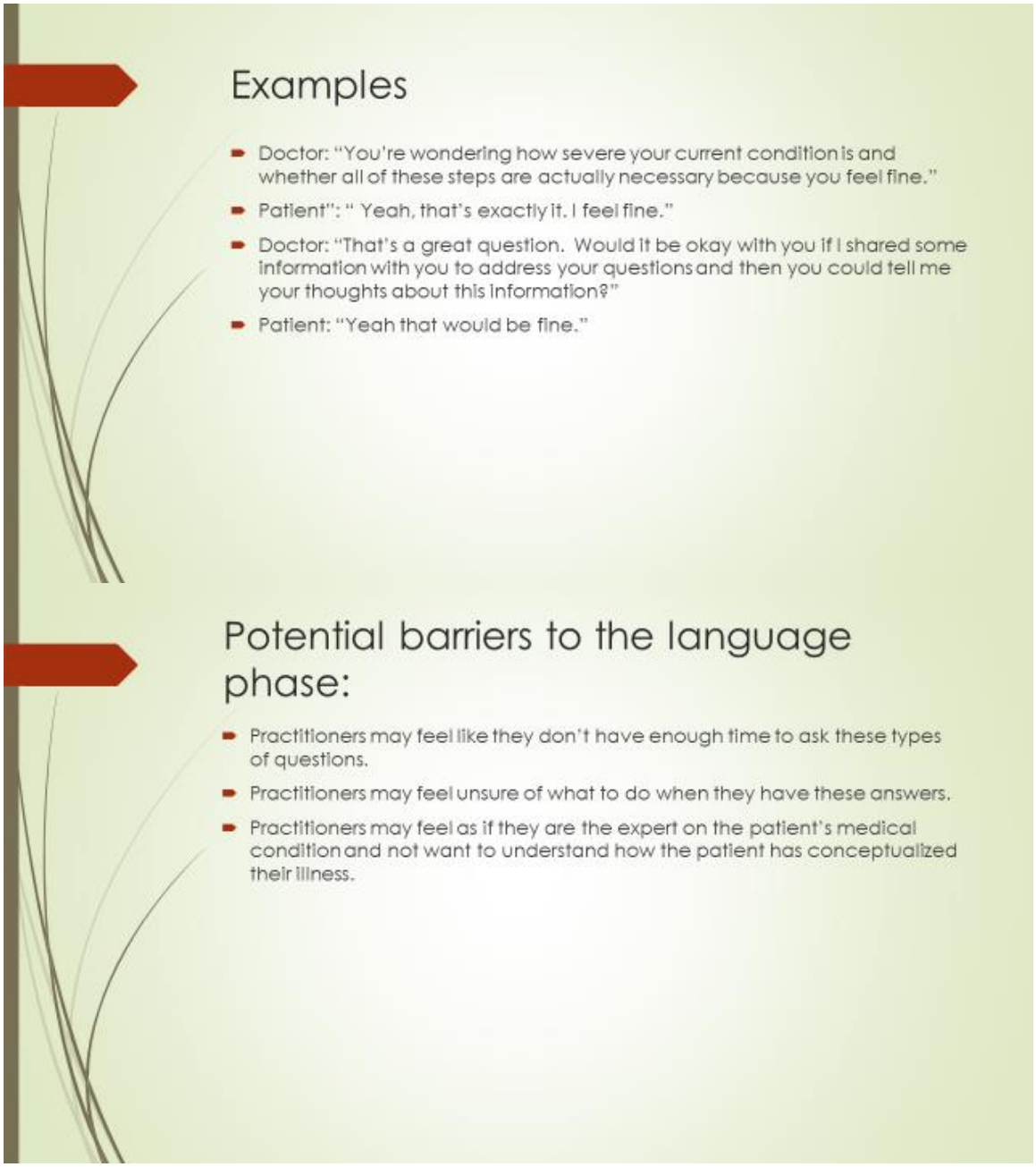
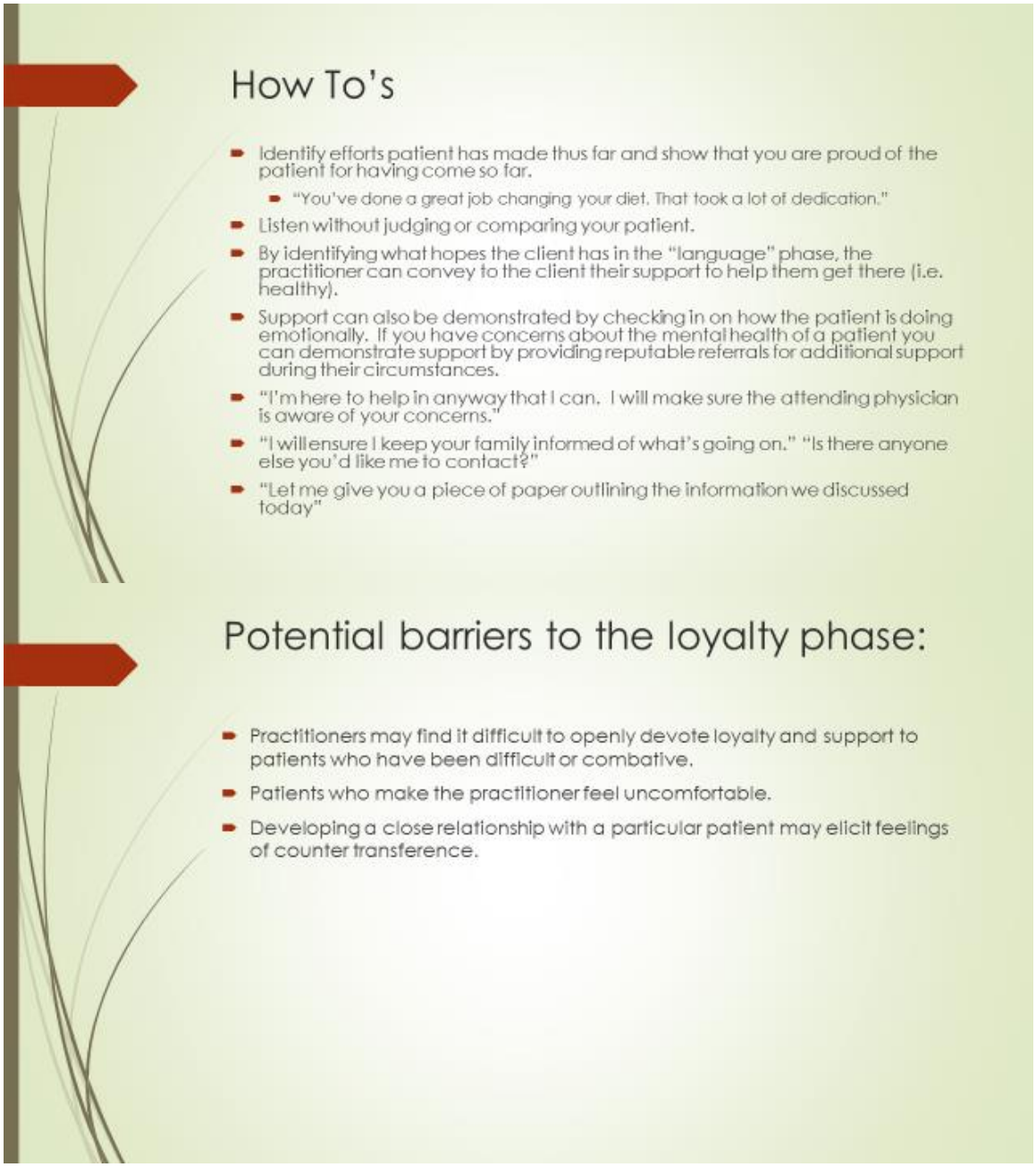
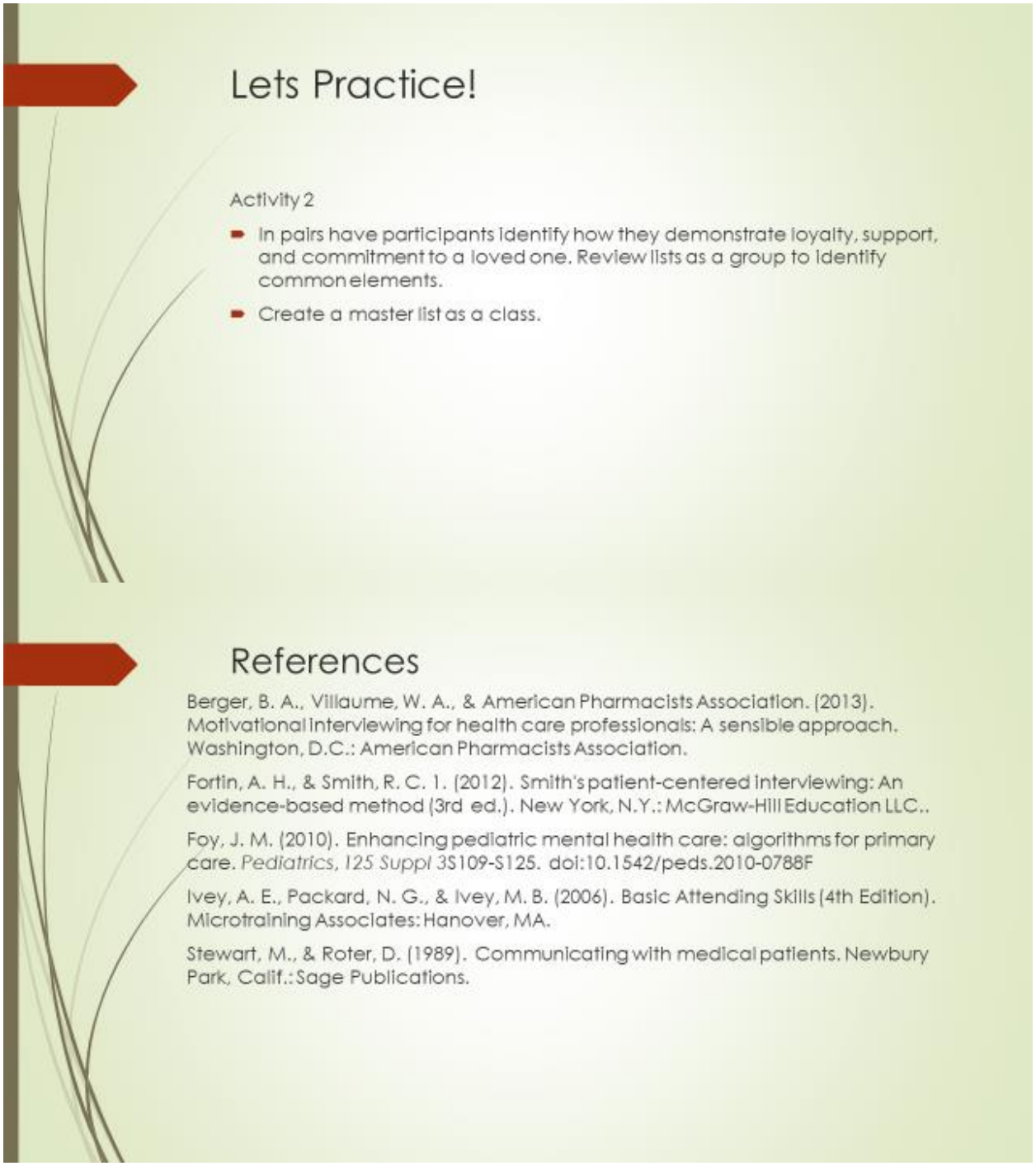

This Will Only Hurt A Bit – Facilitating Patient Focused Empathy
Session 3
"Any fool can know. The point is to understand."
Albert Einstein


"HELP"
The L is for LANGUAGE
Use the patient and their family's language to reflect your understanding of the problem as they perceive it.
Patients beliefs influence their perceptions of health and illness. Understanding these beliefs will allow you to understand what patients expect of their physicians, what personal and moral meanings may be present, and what symptoms they will consider important to share.
Give the patient and their family the opportunity correct any misunderstandings you may have regarding their situation.
Understanding the family's language also allows for you to consider factors they may cite, that could potentially interfere with treatment adherence.
Stigma.
Family Conflict
Cultural/Religious beliefs
How To's :
We must actively will ourselves to listen. "I am going to listen to my patients."
Ask open ended questions to determine the impact of the medical problem on the patient's social and emotional domains of life:
"What do you think caused this problem?"
"How severe would you rate your sickness?"
"Could you give me an example of how this impacts your day to day living?"
"What concerns/fears do you have currently?"
"What are the most important results you hope to achieve?"
Take this as an opportunity to ask for clarification on any points or factors you may be unsure about:
"So?" "Then?" "And?"
"Tell me more."


Examples
Doctor: "You're wondering how severe your current condition is and whether all of these steps are actually necessary because you feel fine."
Patient": " Yeah, that's exactly it. I feel fine."
Doctor: "That's a great question. Would it be okay with you if I shared some information with you to address your questions and then you could tell me your thoughts about this information?"
Patient: "Yeah that would be fine."
Potential barriers to the language phase:
Practitioners may feel like they don't have enough time to ask these types of questions.
Practitioners may feel unsure of what to do when they have these answers.
Practitioners may feel as if they are the expert on the patient's medical condition and not want to understand how the patient has conceptualized their illness.


Lets Practice!
Guest star!
In groups, brainstorm a possible dialogue to enact with this "patient."
Each group will interact with the "patient" utilizing the dialogue the group has prepared.
"HELP"
The L is *also* for Loyalty
Practitioner should also communicate loyalty to the patient by expressing support and commitment to helping
The goal here is to allow the patient to feel like they have been heard and understood.
This support ensures that the doctor does not become "just another face" they've interacted with in the hospital. This can cause patients to feel disconnected and unheard.


How To's
Identify efforts patient has made thus far and show that you are proud of the patient for having come so far.
"You've done a great job changing your diet. That took a lot of dedication."
Listen without judging or comparing your patient.
By identifying what hopes the client has in the "language" phase, the practitioner can convey to the client their support to help them get there (i.e. healthy).
Support can also be demonstrated by checking in on how the patient is doing emotionally. If you have concerns about the mental health of a patient you can demonstrate support by providing reputable referrals for additional support during their circumstances.
"I'm here to help in anyway that I can. I will make sure the attending physician is aware of your concerns."
"I will ensure I keep your family informed of what's going on." "Is there anyone else you'd like me to contact?"
"Let me give you a piece of paper outlining the information we discussed today"
Potential barriers to the loyalty phase:
Practitioners may find it difficult to openly devote loyalty and support to patients who have been difficult or combative.
Patients who make the practitioner feel uncomfortable.
Developing a close relationship with a particular patient may elicit feelings of counter transference.


Lets Practice!
Activity 2
In pairs have participants identify how they demonstrate loyalty, support, and commitment to a loved one. Review lists as a group to identify common elements.
Create a master list as a class.
References
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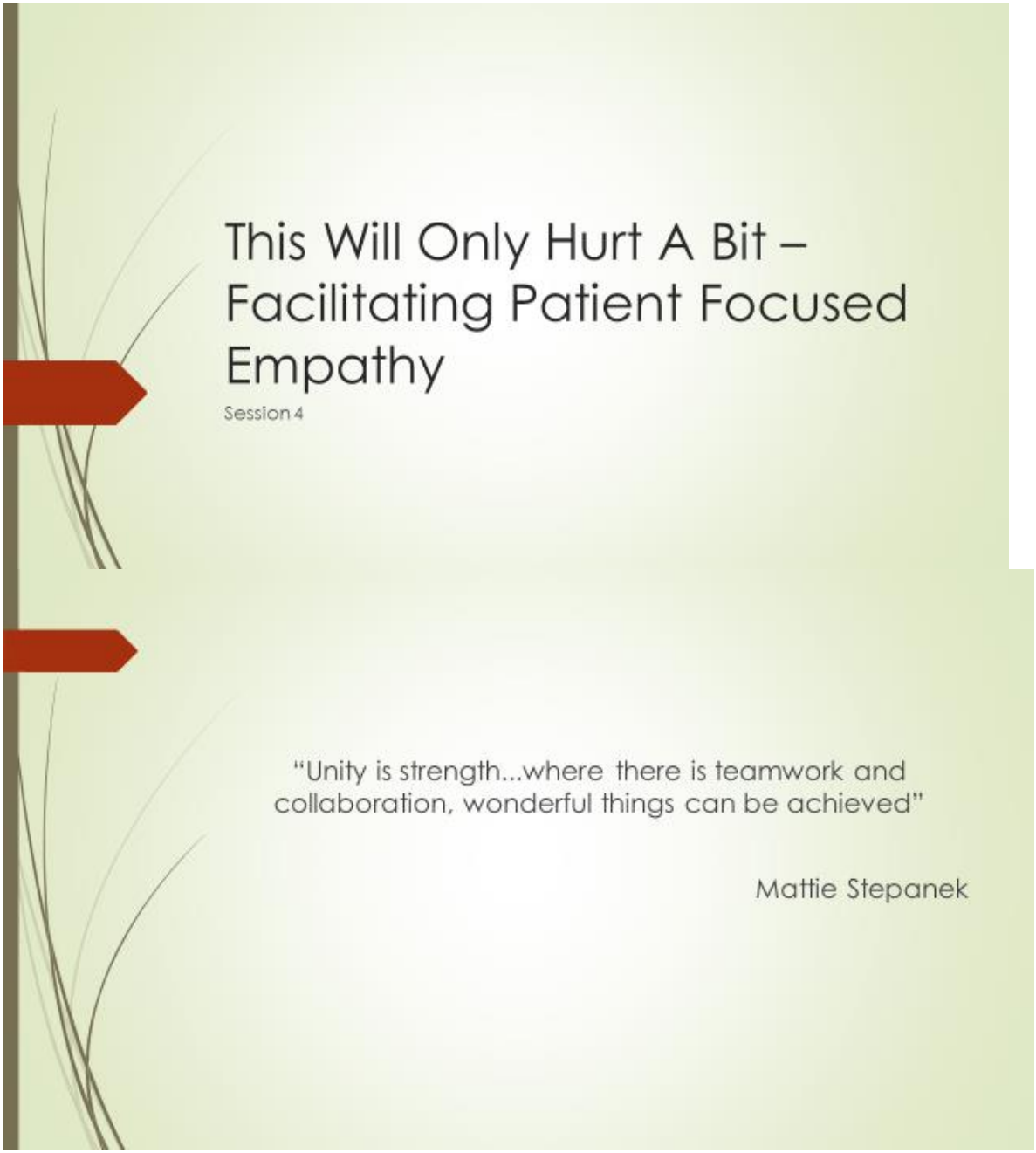
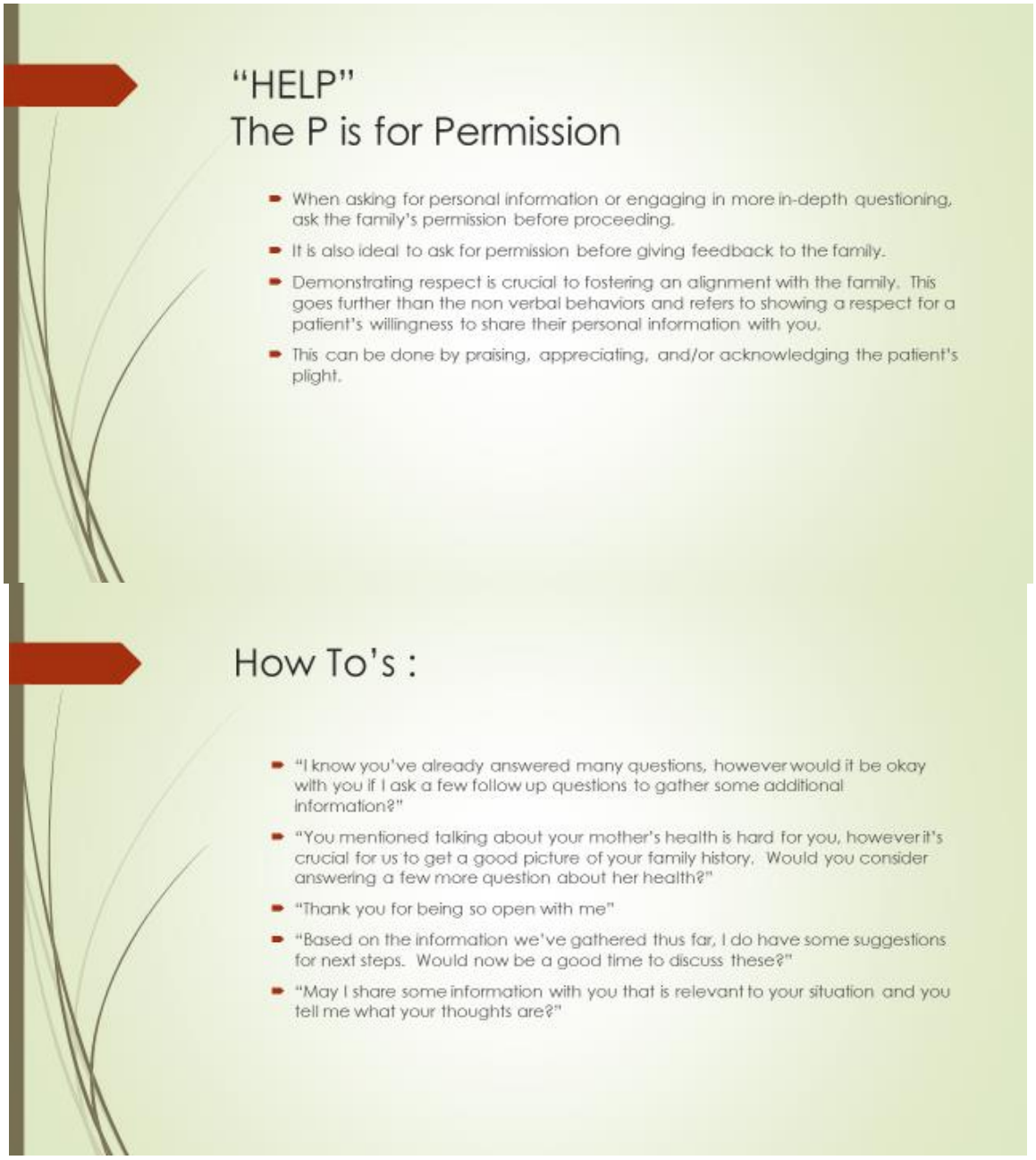
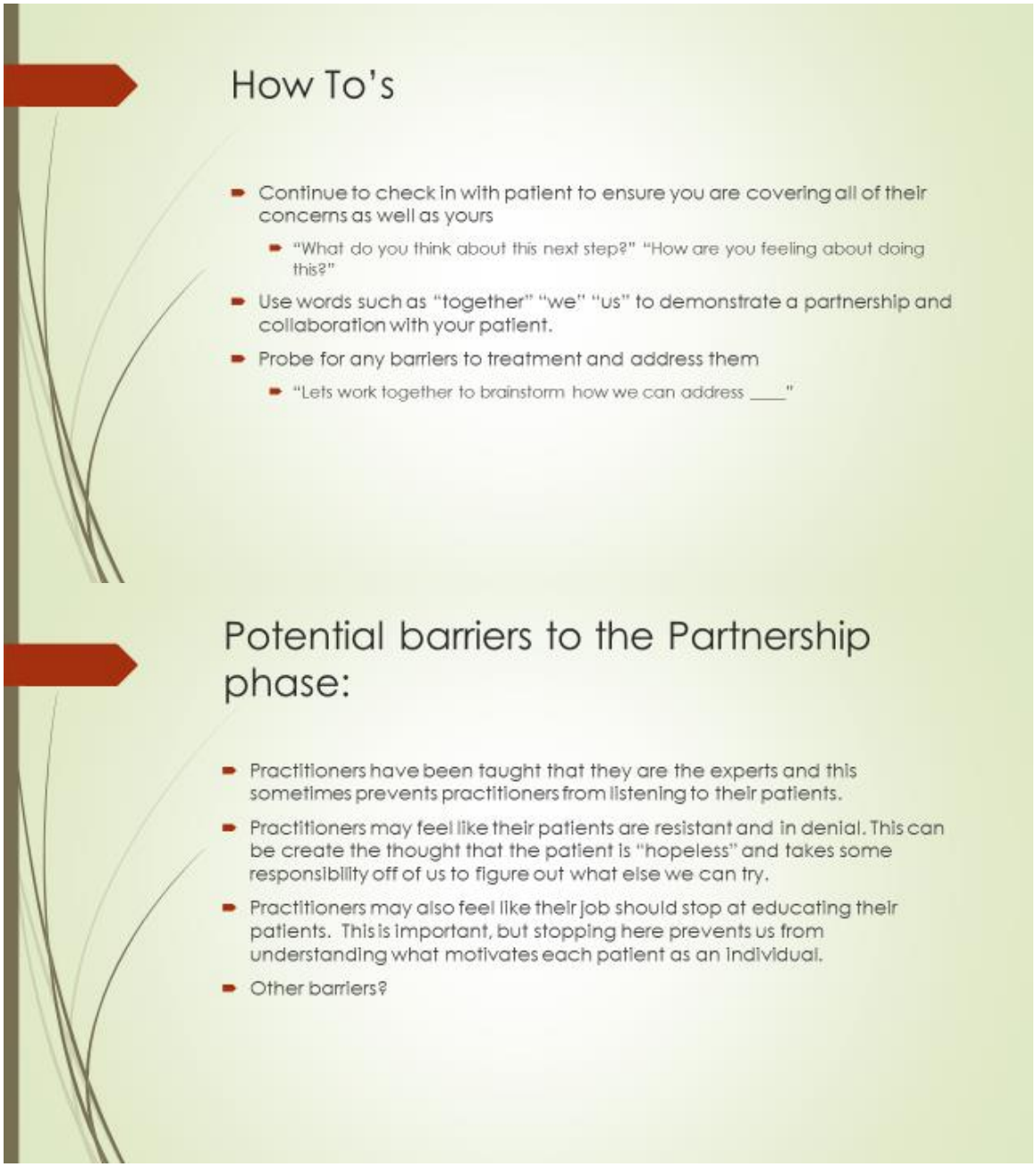

This Will Only Hurt A Bit – Facilitating Patient Focused Empathy
Session 4
"Unity is strength...where there is teamwork and collaboration, wonderful things can be achieved"
Mattie Stepanek


"HELP"
The P is for Permission
When asking for personal information or engaging in more in-depth questioning, ask the family's permission before proceeding.
It is also ideal to ask for permission before giving feedback to the family.
Demonstrating respect is crucial to fostering an alignment with the family. This goes further than the non verbal behaviors and refers to showing a respect for a patient's willingness to share their personal information with you.
This can be done by praising, appreciating, and/or acknowledging the patient's plight.
How To's :
"I know you've already answered many questions, however would it be okay with you if I ask a few follow up questions to gather some additional information?"
"You mentioned talking about your mother's health is hard for you, however it's crucial for us to get a good picture of your family history. Would you consider answering a few more question about her health?"
"Thank you for being so open with me"
"Based on the information we've gathered thus far, I do have some suggestions for next steps. Would now be a good time to discuss these?"
"May I share some information with you that is relevant to your situation and you tell me what your thoughts are?"


Potential barriers to the permission phase:
Practitioners may feel like they have the right to know all of the answers to the questions they are asking as they are providing critical medical care.
Practitioners may fear they lose power in the relationship, by giving the patient more control and direction over their conversations.
Patients may use this line of questioning as an opportunity to view crucial medical questions as optional.
In this case, you can emphasize the importance of the question and your support/dedication to the patient.
Any other barriers?
"HELP"
The P is also for Partnership
It is important for practitioners to partner with the patient and their family to identify any barriers or resistance. This will allow the practitioners to:
address the problem
Find strategies for overcoming the problem and/or barriers
Come to an agreement on achievable steps that are aligned with the patient and family's motivation.
Make clear that you are working together throughout this process.
The practitioners job is to be a resource and share with the patient options for managing their health. The patient's needs should be negotiated not dictated.


How To's
Continue to check in with patient to ensure you are covering all of their concerns as well as yours
"What do you think about this next step?" "How are you feeling about doing this?"
Use words such as "together" "we" "us" to demonstrate a partnership and collaboration with your patient.
Probe for any barriers to treatment and address them
"Lets work together to brainstorm how we can address ____"
Potential barriers to the Partnership phase:
Practitioners have been taught that they are the experts and this sometimes prevents practitioners from listening to their patients.
Practitioners may feel like their patients are resistant and in denial. This can be create the thought that the patient is "hopeless" and takes some responsiblity off of us to figure out what else we can try.
Practitioners may also feel like their job should stop at educating their patients. This is important, but stopping here prevents us from understanding what motivates each patient as an individual.
Other barriers?


Lets Practice!
Clinicians will break into groups. A "non resident" volunteer will present as a family and/or patient whom which the clinician's goal is to gain buy in and form a partnership. Each clinician will have an opportunity to attempt to gain permission and partnership with the family being utilized. The clinicians will "tap" other clinicians in when they are ready to pass the conversation to another team mate. Each clinician should have an opportunity to be tapped in.
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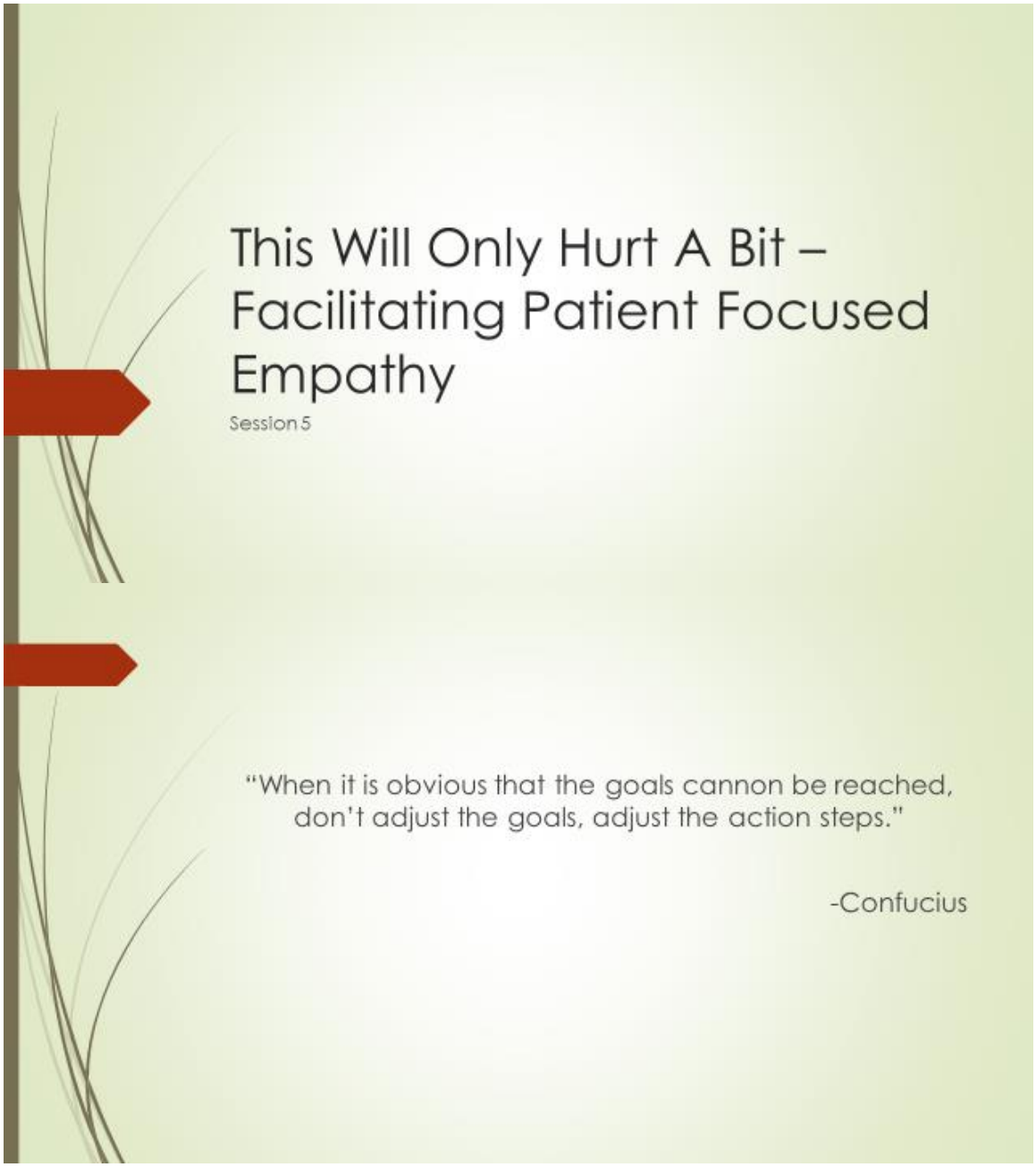
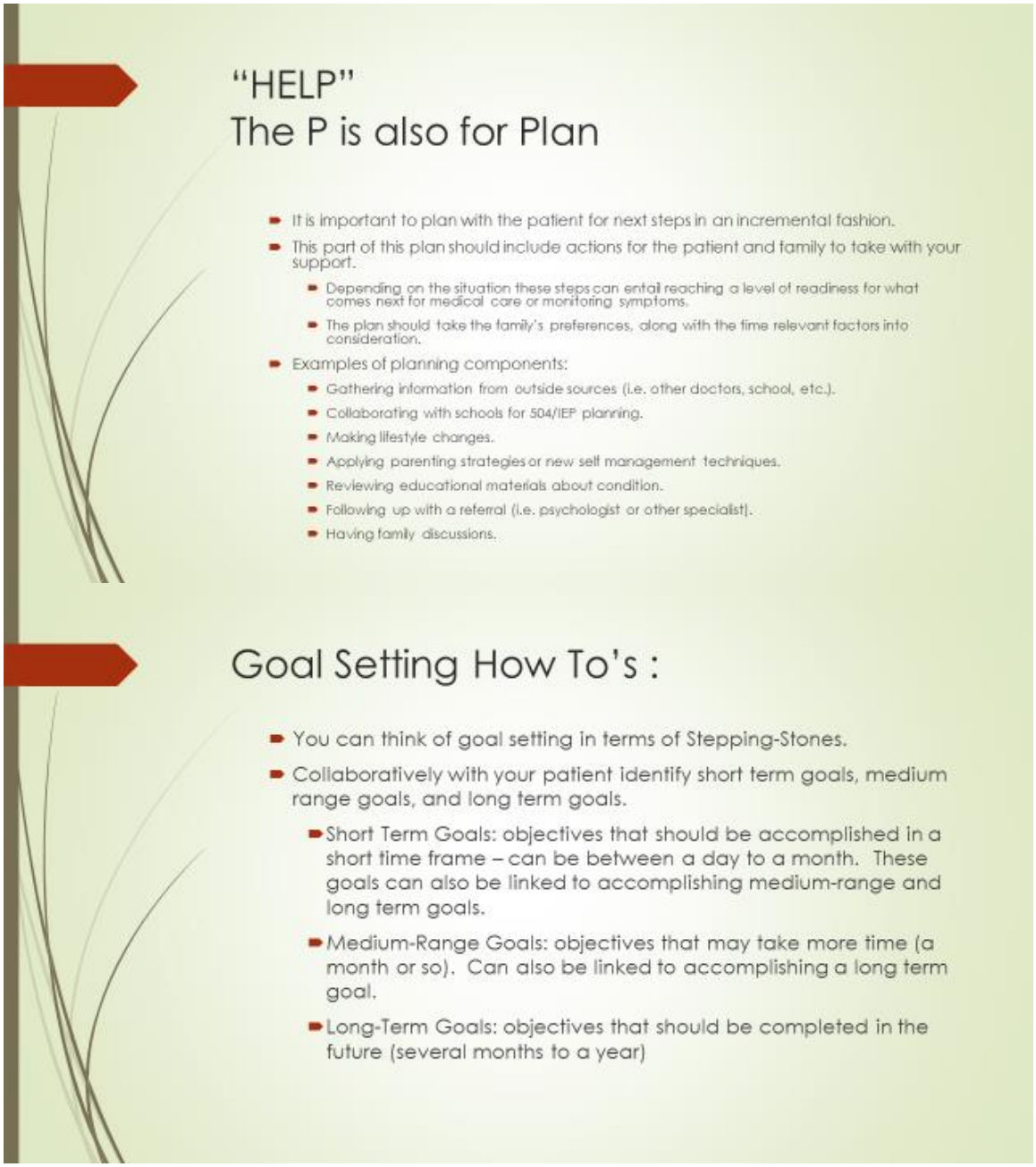
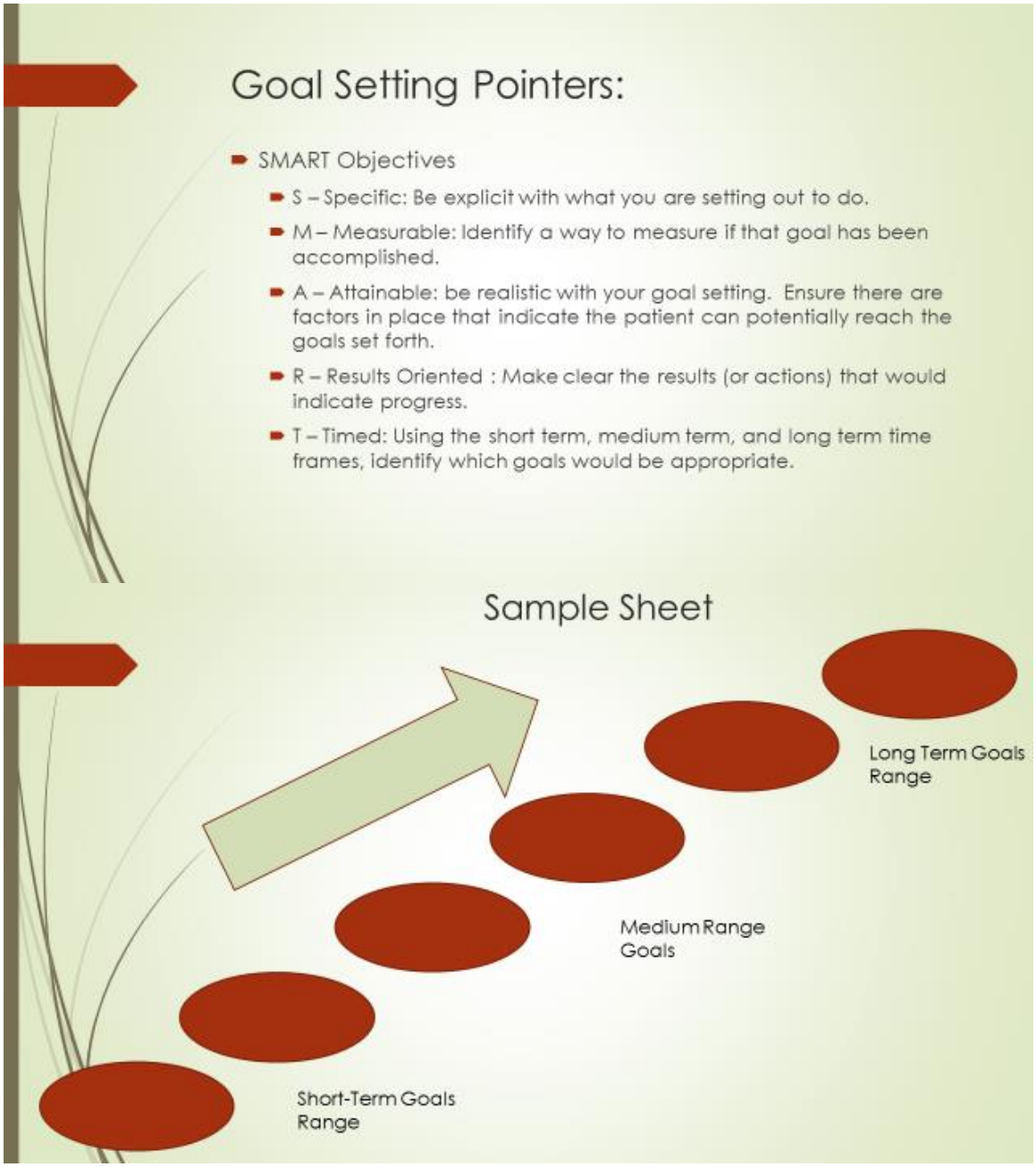
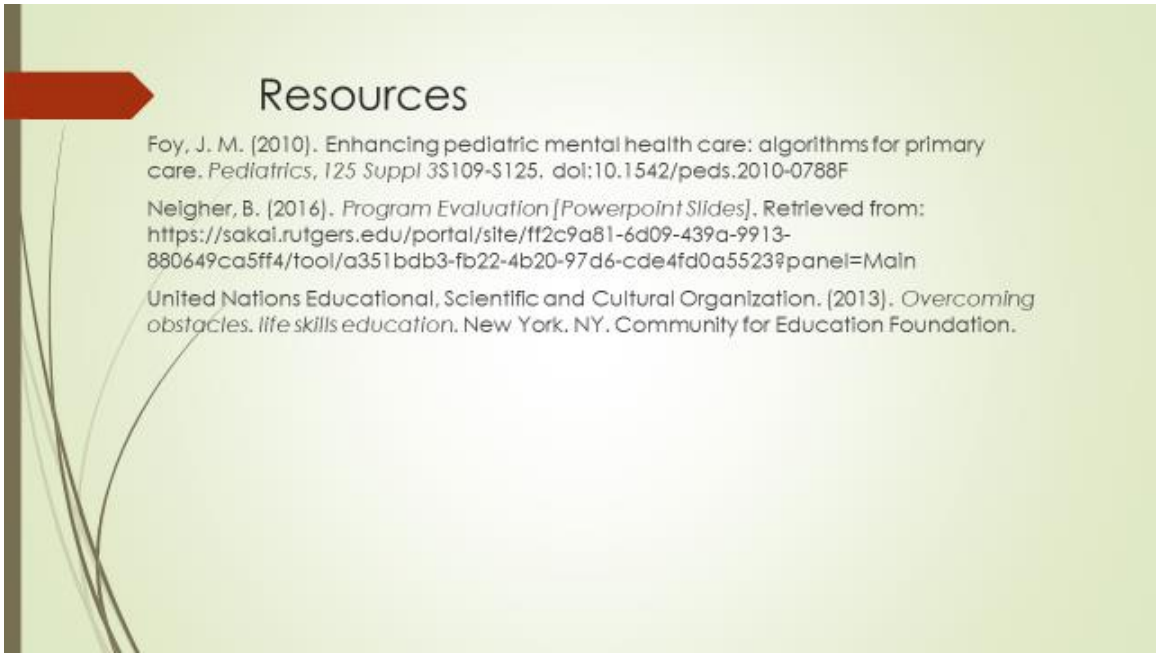

This Will Only Hurt A Bit – Facilitating Patient Focused Empathy
Session 5
"When it is obvious that the goals cannon be reached, don't adjust the goals, adjust the action steps."
-Confucius


"HELP"
The P is also for Plan
It is important to plan with the patient for next steps in an incremental fashion.
This part of this plan should include actions for the patient and family to take with your support.
Depending on the situation these steps can entail reaching a level of readiness for what comes next for medical care or monitoring symptoms.
The plan should take the family's preferences, along with the time relevant factors into consideration.
Examples of planning components:
Gathering information from outside sources (i.e. other doctors, school, etc.).
Collaborating with schools for 504/IEP planning.
Making lifestyle changes.
Applying parenting strategies or new self management techniques.
Reviewing educational materials about condition.
Following up with a referral (i.e. psychologist or other specialist).
Having family discussions.
Goal Setting How To's :
You can think of goal setting in terms of Stepping-Stones.
Collaboratively with your patient identify short term goals, medium range goals, and long term goals.
Short Term Goals: objectives that should be accomplished in a short time frame – can be between a day to a month. These goals can also be linked to accomplishing medium-range and long term goals.
Medium-Range Goals: objectives that may take more time (a month or so). Can also be linked to accomplishing a long term goal.
Long-Term Goals: objectives that should be completed in the future (several months to a year)


Goal Setting Pointers:
SMART Objectives
S – Specific: Be explicit with what you are setting out to do.
M – Measurable: Identify a way to measure if that goal has been accomplished.
A – Attainable: be realistic with your goal setting. Ensure there are factors in place that indicate the patient can potentially reach the goals set forth.
R – Results Oriented : Make clear the results (or actions) that would indicate progress.
T – Timed: Using the short term, medium term, and long term time frames, identify which goals would be appropriate.
Sample Sheet
Long Term Goals Range
Medium Range Goals
Short-Term Goals Range


Potential barriers to the planning phase:
Time
Cooperative Patient
Feeling unsure of next steps
Several steps may feel overwhelming to both you and the patient.
Relying on patient follow through to demonstrate progression.
Any other barriers?
Lets Practice!
Clinicians will break into pairs. Clinicians will first identify personal goals they'd like to accomplish and set out stepping stones in terms of short, medium, and long term goals. Partners will verify SMART objectives are met.
Clinicians will then be given a vignette. In their pairs they will work out a goal setting plan. Then components will be shared as a class and the steps suggested can be compared.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HELP Model Feedback

Resident Name:
Evaluator:
Date:

Competencies Evaluated

Hope: Encouraging hope in patient and families.
Observed Not Observed
Strategy Utilized:

Empathy: Physician's ability to accurately take their patient's point of view, effectively communicate it back to the patient, and respond appropriately.
Observed Not Observed
Strategy Utilized:

Language: Uses the patient and their family's language to reflect understanding of the problem as they perceive it.
Observed Not Observed
Strategy Utilized:

Loyalty: Practitioner communicates loyalty to the patient by expressing support and commitment to help.
Observed Not Observed
Strategy Utilized:

Permission: Practitioner asks for permission for more in-depth/personal questions. Practitioner demonstrates respect with the medical process.
Observed Not Observed
Strategy Utilized:

Partnership: Practitioners partner with the patient and family to identify any barriers or resistance.
Observed Not Observed
Strategy Utilized:

Plan: Practitioner plans next steps with patient in an incremental fashion.
Observed Not Observed
Strategy Utilized:

Overall Feedback:

Evaluator Signature: _____

Resident Signature: _____

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