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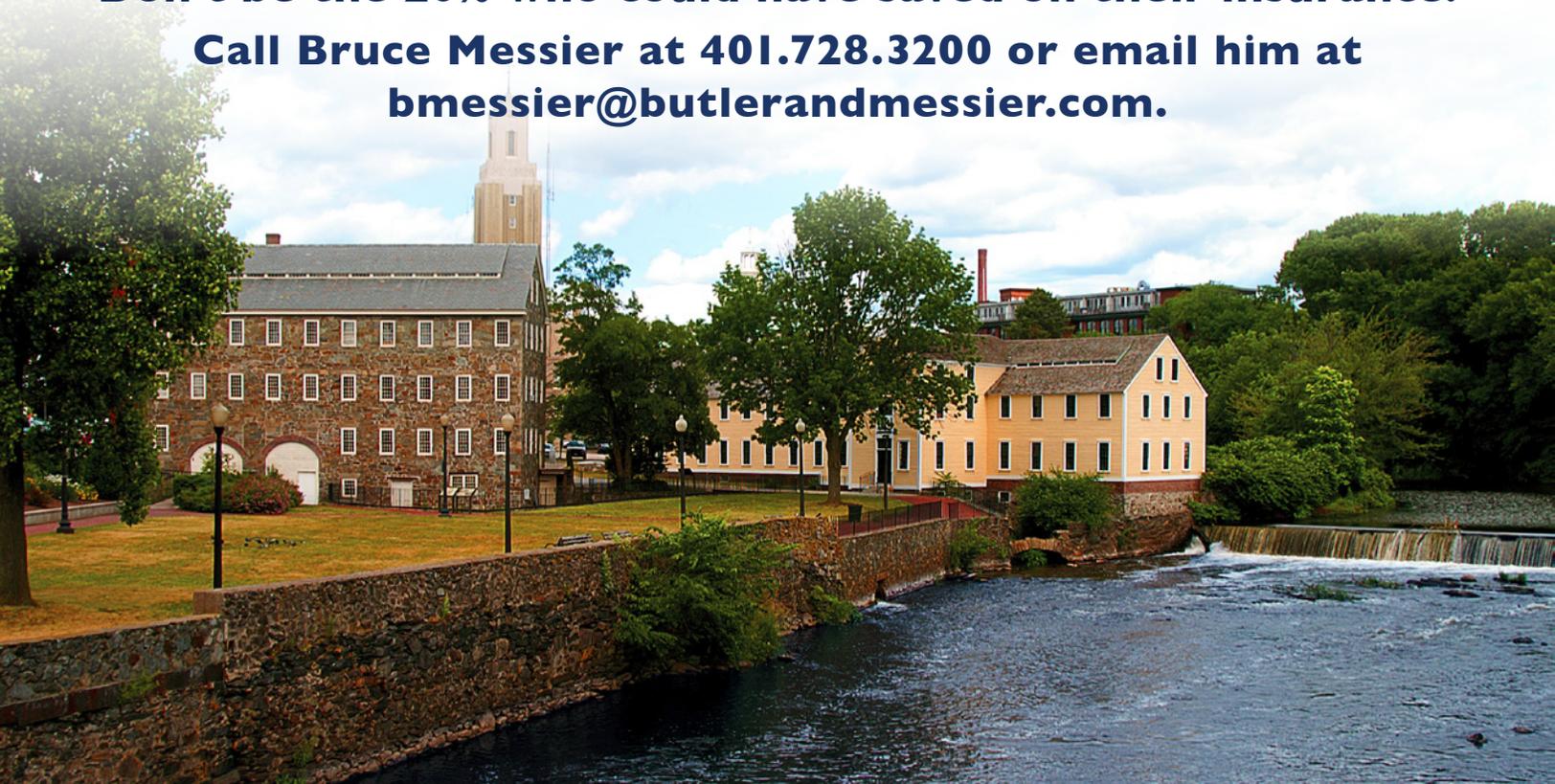
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## Can Empathy Be Taught? Reflections from a Medical Student Active-Listening Workshop

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[Author: *Lianna Karp is a fourth year medical student at Warren Alpert Medical School of Brown University (AMS). She was instrumental in introducing active-listening skills as a crucial part of the first year medical school curriculum. In this article, she shares her thoughts about the workshop based program she developed under the guidance of Sarita Warriar, MD, and the results of the follow up survey of those who participated. Lianna has served on the AMS Student Health Council (SHC) for the past three years. The SHC is modeled after the Rhode Island Medical Society's Physician Health Program and supported by the RIMS Foundation. The RIMS' Physician Health Program's director and Committee Chairperson serve in an advisory and consultative capacity to the SHC.*]

### ABSTRACT

Medical students deserve training in active listening and counseling before they encounter patients in distress. At the Alpert Medical School of Brown University we created and evaluated a workshop that trains first-year medical students to assess patients' emotional states and express empathy in an efficient and effective manner. Using second-year students as near-peer facilitators, we integrated the workshop into the existing preclinical first-year curriculum. We found that students' self-reported comfort in counseling a patient experiencing an emotionally challenging situation increased from 27% to 79% after the 90-minute workshop.

**KEYWORDS:** Empathy, medical students, active listening

Empathy is a critical skill to develop as a physician-in-training. Empathetic care leads to better adherence to treatment and fewer major medical errors,<sup>1</sup> greater health benefits for patients with diabetes<sup>2</sup> and common cold<sup>3</sup> and fewer malpractice lawsuits.<sup>3</sup> Despite the importance of empathy, counseling training and active-listening skill-building are not a required part of medical education. Other organizations, such as volunteer-based suicide prevention hotlines, require up to 60 hours of counseling training prior to allowing volunteers to answer calls. Why is it that medical schools do not require active-listening training?

There are several reasons why this might be the case. There is very limited time in the preclinical curriculum, meaning that time dedicated to building medical knowledge would be sacrificed. Additionally, it has never been a traditional



part of medical education so there are no readily adoptable training models. However, the reason that may be most detrimental to the advancement of humanistic medical education is the notion that empathy is an unteachable skill.

Our goal for an empathy workshop was to help people better express empathy, rather than to generate empathy from scratch. It is important to distinguish our objective from the

idea that it is possible to teach a person to feel emotions if they have inherent deficits in socio-emotional functioning. The aim of the workshop was to enhance the comfort level of students so that they would be more likely to offer patients opportunities to open up. Additionally, it was meant to provide structure for students' initial responses when patients divulged information distressing to the student.

The workshop was performed for 122 students in a small group format with two faculty members (MD faculty and Social Behavioral Sciences faculty) and one second-year medical student facilitator for each group of eight first-year medical students.

We began the workshop with a written reflection exercise, asking the students to contemplate the difference between empathy and pity, to think about obstacles to empathy, and to articulate a personal opinion about the definition of empathy. We then had the students share their answers with each other and discuss the statistics cited above about the health benefits of having an empathetic provider.

The first skill-based portion of the workshop focused on nonverbal skills such as body language, eye contact, matching tone, and the power of silence. The second skill-based portion focused on verbal skills, first by discussing general guidelines of active listening such as steering away from problem solving and personal information sharing. We encouraged discussion about how problem solving is an inherent part of medical practice and yet it is in direct conflict with the principles of non-directive active listening. We asked students to think about times when it might be more important to listen first before problem solving – when collecting the details of a patient's story prior to making

diagnoses, when elucidating patient-derived goals of care, or when building rapport with a patient in order to create sufficient trust for a patient to follow physician advice.

### BATHE technique

The second verbal skill that we introduced was the BATHE technique, a physician-created evidence-based checklist for helping doctors provide brief supportive psychotherapy. The BATHE technique has been shown to improve patient satisfaction<sup>5</sup> without increasing visit length.<sup>6</sup> It consists of five questions: Background (What is going on in your life?); Affect (How has this been affecting you?); Troubling (What is most troubling to you about this?); Handling (How are you handling this?); and Empathetic statement (That sounds very challenging, distressing, or difficult). The BATHE checklist was introduced to the students as something very different than the Review of Systems checklist or CAGE questionnaire – the importance of flexibility in administration was stressed. Each group discussed how the BATHE technique may not apply to all scenarios and that students should feel empowered to select only the questions that they feel comfortable asking.

The final phase of the workshop consisted of role-playing exercises asking the students to practice the skills that had been discussed. They were given patient scenarios, and had time for both individual and group feedback to determine what worked well and what could be changed about their interactions.

Students completed a post-workshop survey using a Likert scale, with 5 representing “strongly agree.” After the workshop, 90% of students agreed or strongly agreed that they felt comfortable using the BATHE technique (average 4.23). Seventy-nine percent of students agreed or strongly agreed that they felt comfortable counseling a patient experiencing an emotionally challenging situation after the workshop, compared to 27% of students who agreed or strongly agreed when describing pre-workshop attitudes. Preliminary qualitative analysis of responses to open-ended questions about the workshop’s strengths identified the following themes: using second-year students as facilitators, interactive discussion, role-plays, and incorporation of BATHE’s structured technique. The major change that students encouraged was a video demonstration prior to the workshop. Limitations include lack of a validated empathy measure pre- and post-workshop.

This transferable 90-minute workshop improved first-year medical students’ comfort with counseling and expressions of empathy. Active-listening training should be an integral part of medical education. By using interactive exercises facilitated by second-year students we were able to provide first-year students with valuable skills that they will draw upon as they enter their clinical sites and meet their first patients.

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