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ACADEMIC INTERNAL MEDICINE INSIGHT

By the Numbers

62%

Sentinel events caused by poor communication among staff, physicians, and patients

Page 14

53%

Residents who reported no formal training on hospital follow-up visits

Page 11

10

Best practices for attendings to promote resident autonomy on the wards

Page 9

Also in This Issue

Got Empathy? Using Improv and a Theater-Based Workshop to Enhance Communication and Teach Empathy to Residents and Fellows

Background

Empathy is an essential skill for medical professionals to learn and build during training. Increased empathy has been shown to improve the effectiveness of patient care and the well-being of physicians (1-8). However, in the medical community there continues to be much debate about what behaviors constitute empathy in the clinical environment (9). Theater techniques are promising methods for teaching empathic communication skills to clinicians. Theater combines features from each of the following methods, which have been shown in the literature to successfully teach empathy: 1) interpreting of narrative, 2) simulation, and 3) emotion recognition (10-14). Because developing empathy skills during training is imperative, we implemented a theater-based empathy training workshop in internal medicine and its subspecialties. We studied the effectiveness of this intervention in equipping trainees with new empathic behaviors.

Methods

We conducted a six-hour workshop for all clinical staff in the Department of Medicine. All members of the department were required to attend a workshop. Each workshop session included up to 20 participants of varying roles and disciplines. The workshop began with a brief didactic segment, which covered the definition of empathy, communication mnemonics SPIKES (Setting, Patient's perspective, Invitation, Knowledge, Exploring/Empathy, Strategy/Summary) and NURSE (Naming, Understanding, Respecting, Supporting, Exploring), the meaning of empathy, and a demonstration of skills using a breaking "bad news" situation (15, 16). It was followed by an overview of a few principles of improvisational theater—such as "yes, and"—and a few improv games in the large group. These games focused on collaborative meaning making and mirroring. The "yes, and" principle framed the communication interaction as one of agreement and contribution. The participants were asked to agree with and build on what the other person said.

The group of 20 was then divided into smaller groups of five, who worked for the next four hours with a trained facilitator. Each participant spent 25 minutes with an actor within the small group, building empathic communication skills in the context of a case. Each session began with the learner articulating one to three goals on which he or she wanted to focus during the session. The sessions with the actor included facilitator- or participant-initiated timeouts, during which the entire group engaged in reflective dialogue to support the participant in achieving his or her goals. At the conclusion of each session, the participant articulated a take-home point. For example, a participant could say that she wanted to work on naming emotion and found anger particularly challenging. In this case, the actor was asked to heighten the character's anger, and the facilitator would find a moment within the case to concentrate on that skill. This moment could be rewound several times until the participant and the facilitator felt a successful strategy was uncovered, which would likely then be the participant's take-home point.

We defined empathy using deWaal's model of cognitive and embodied empathy and Davis's four domains of empathy: 1) perspective-taking, 2) empathic concern, 3) fantasy, and 4) personal distress (17-18) **(Figure 1)**.

We used items from the CARE (Consultation and Relational Empathy) Measure to assess perceptions of behavior prior to the workshop, immediately following it, and six weeks afterward (19). The pre- and post-surveys were completed using pen and paper at the training sessions. The post-six-weeks survey was sent by email. The questions we used focused on caring, understanding, listening, planning, and explaining. We also added one item on the pre- and post-survey to assess whether the participants felt they could change their communication plan in real time if things were not going well. This last item arose from the observations of many previous trainees who felt powerless to deviate from their communication

FIGURE 1. Davis's Four Domains of Empathy Within deWaal's Cognitive and Embodied Framework

Embodied Empathy	Cognitive Empathy
Empathic Concern and	Perspective Taking and
Personal Distress	Fantasy

plans once they were in a patient's room. Because empathy is necessarily an individual act—not something that can be codified and applied precisely the same way in every instance—this is an essential skill.

We conducted 26 workshops from October 14, 2013, to August 11, 2014. Along with faculty, we trained fellows from allergy and immunology, cardiology, endocrinology, gastroenterology, geriatrics, hematology/oncology, infectious disease, nephrology, rheumatology, and pulmonary/critical care as well as internal medicine residents in their second year of training. A total of 451 learners, 63 of them trainees, attended workshops during the study period of November 1, 2013, to August 4, 2014. Results were compared using paired samples *t*-tests.

Results

The trainee group consisted of 32 internal medicine PG2 residents and 31 fellows. Of the 63 trainees, 59 (94%) completed the pre-test and immediate post-test. Thirty-one (49%) trainees also responded to the survey given after six weeks. We found that after six hours spent in the theater-based training program, participants reported better ability to engage in empathic behaviors. Participants rated their empathic communication skills significantly higher in all seven areas after completing the course (N = 59) and in all areas at six weeks post (N = 31). Results are displayed in **Figures 2 and 3.**

We also ran independent samples *t*-tests to explore possible differences between males and females, MDs and RNs, or different medical specialties (that is, cardiology v. endocrinology). We found no significant differences in the overall change scores between these groups nor on any individual measure. The intervention was able to address the learning needs of a diverse group of trainees.

Discussion

One goal of simulation training is to approximate real-life situations and environments to teach transferable skills. While some have shown that attention to high-fidelity reenactments facilitates knowledge and skill transfer to the clinical environment, we intentionally took a different approach. In our training, we acknowledged the disconnect between real-life and theater-based training in order to encourage trainees to try new strategies. The use of improvisational and participatory theater techniques enabled us to move trainees from a space of comfort with their current level of skill into a learning space, a liminal space, in which to explore new skills. These skills addressed the cognitive and the embodied nature of empathy equally, something not often done in medical education.

Our results illustrate that a six-hour workshop has the capacity to improve trainees' self-report of empathic communication skills. Moreover, based on short-term follow-up (six weeks), this study suggests that as trainees reentered their real-world practice, they continued to work on these skills and to improve. They were able to translate the fictional situation from the workshop to clinical encounters in their everyday work. Interestingly, at

FIGURE 2. Assessment of Empathic Behavior Before and Immediately After Workshop

During patient encounter, how good are you at:	Pre	Post	Difference	p-value
Explaining things clearly	3.32	3.56	0.24	<0.05
Allowing patients to tell their story	3.31	3.93	0.62	<0.0001
Understanding patients concerns	3.25	3.83	0.58	<0.0001
Making a plan of action with a patient	3.36	3.64	0.28	<0.05
Showing care and compassion	3.59	3.86	0.27	<0.05
Changing the communication plan in real time	2.88	3.50	0.62	<0.0001

Poor = 1, Fair = 2, Good = 3, Very Good = 4, Excellent = 5

FIGURE 3. Assessment of Empathic Behavior Before and Six Weeks After Workshop

During patient encounter, how good are you at:	Pre	Post	Difference	p-value
Explaining things clearly	3.26	4.00	0.74	<0.0001
Allowing patients to tell their story	3.19	4.06	0.87	<0.0001
Understanding patients concerns	3.13	3.84	0.71	<0.0001
Making a plan of action with a patient	3.42	4.03	0.61	<0.001
Showing care and compassion	3.61	4.10	0.49	<0.01
Changing the communication plan in real time	2.87	3.48	0.61	<0.001

Poor = 1, Fair = 2, Good = 3, Very Good = 4, Excellent = 5

The strengths of this study include the participation of clinicians from different disciplines, as well as residents and fellows, suggesting that these methods are useful in education across the continuum.

baseline, the group rated themselves the lowest in the area of "reflection in action" or being able to change course during a conversation. The improvement in these scores suggests that the workshop heightened their ability to flexibly react in the moment. Again, since empathy requires that we treat each person as an individual, it is impossible to script a conversation perfectly before it happens. Therefore, the clinician must know how to reflect in the moment and adjust appropriately.

The strengths of this study include the participation of clinicians from different disciplines, as well as residents and fellows, suggesting that these methods are useful in education across the continuum. Limitations include the use of self-report to evaluate the effectiveness of the workshop and the use of a single center. Further work should focus on gaining observational data of trainee skills before and after the program, as well as studying the impact of this intervention at additional institutions.

Conclusions

The broad application of an intensive empathic communication workshop is feasible and effective, and was broadly accepted by trainees. Participants significantly improved their skills in empathic communication, as evidenced by the self-assessment. We saw a sustained effect six weeks after the learners reintegrated into the clinical environment. This study suggests that adult learners can improve their abilities to engage in empathic behaviors in as little as six hours. More work needs to be done in order to learn how we can equip our trainees with skills that will better connect them with their patients.

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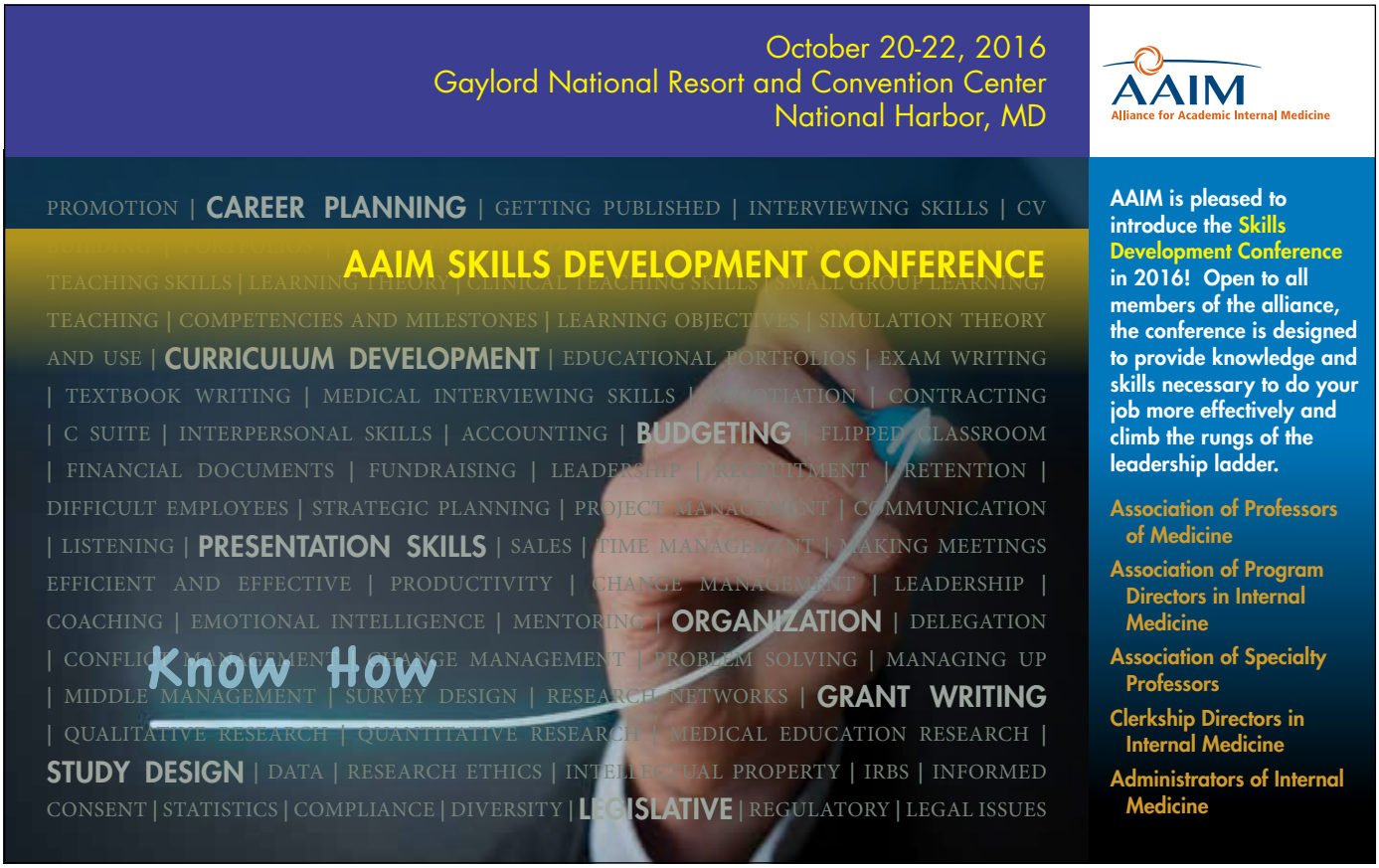

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