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Communication Study

Residents' and standardized patients' perspectives on empathy: Issues of agreement

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ABSTRACT

Objective: We investigated correlations between residents' scores on the Jefferson Scale of Empathy (JSE), residents' perceptions of their empathy during standardized-patient encounters, and the perceptions of standardized patients.
Methods: Participants were 214 first-year residents in internal medicine or family medicine from 13 residency programs taking standardized patient-based clinical skills assessment in 2011. We analyzed correlations between residents' JSE scores; standardized patients' perspectives on residents' empathy during OSCE encounters, using the Jefferson Scale of Patient Perceptions of Physician Empathy; and residents' perspectives on their own empathy, using a modified version of this scale.
Results: Residents' JSE scores correlated with their perceptions of their own empathy during encounters but correlated poorly with patients' assessments of resident empathy.
Conclusion: The poor correlation between residents' and standardized patients' assessments of residents' empathy raises questions about residents' abilities to gauge the effectiveness of their empathic communications. The study also points to a lack of congruence between the assessment of empathy by standardized patients and residents as receivers and conveyors of empathy, respectively.
Practice implications: This study adds to the literature on empathy as a teachable skill set and raises questions about use of OSCEs to assess trainee empathy.

1. Introduction

Empathy is fundamental to the development and sustainability of constructive physician–patient relationships [1–4] and is an essential component of physician professionalism [5–7]. Studies have shown that physicians' empathy contributes to patients' and physicians' satisfaction [8–10], increases patient adherence to treatment [11], and leads to better health outcomes [12–14]. The Medical School Objectives Project of the Association of American Medical Colleges [15] states that medical graduates should be empathic, and medical schools and residency programs teach the skills of empathic communication [4,16,17]. Moreover, trainees' interpersonal skills, including communication of empathy, are assessed in standardized-patient examinations and in clinical skills assessments for licensure [18–20].

However, there is no consensus in the literature about the definition of empathy in medical care. Hojat and colleagues [21] define empathy in the context of patient care as a predominantly cognitive attribute that involves an understanding of patients' inner experiences, concerns, and perspectives combined with the capability to communicate this understanding and intention to help. Others have expanded this definition to include further

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dimensions: emotive (the ability to imagine patients' emotions and perspectives); motivational (the physician's internal motivation to empathize); cognitive (the intellectual ability to identify and understand patients' emotions and perspectives); and behavioral (the ability to convey understanding of those emotions and perspectives back to the patient) [4]. Mercer and Reynolds [22] define physician empathy as the ability to understand the patient's situation, perspective, and feelings (and their attached meanings); to communicate that understanding and check its accuracy; and to act on that understanding with the patient in a helpful (therapeutic) way. In their discussion of empathy, Coulehan et al. [23] also assert that the clinician must check back with the patient to ensure that the empathic communication has been accurate and has been received. Halpern [24,25] has made a convincing case that empathy also involves emotional "attunement" and "resonance" throughout an encounter, concepts supported by Rogers [26] in his early discussions of the importance of empathy in therapeutic relationships. Still others have emphasized the importance of emotional intelligence, emotional regulation, and self-awareness as being critical to empathic expressions by clinicians [27,28].

Because conceptions of the definition and nature of empathy vary, there is likewise little consensus in the literature on the ideal ways to assess empathy in medical trainees and in practicing physicians. In a critical review of over 200 empirical studies on empathy in medicine, Pedersen [29] found that many studies had conceptual and methodological flaws, often separating empathy from other aspects of encounters, including clinical perception, judgment, and communication.

In a review of 36 instruments to assess empathy in medical students and doctors, only eight had sufficient evidence of validity, reliability, and internal consistency. The Jefferson Scale of Empathy (JSE), developed specifically to measure empathy in medical students, physicians, and health professionals [21–23], was among them [30].

Empathy scores in medical students measured using the JSE are associated with likelihood to be nominated by peers for citations in clinical and humanistic excellence [31]; with faculty ratings of clinical competence [32]; and with residency program directors' evaluation of trainees' empathic behaviors 3 years after trainees' self-assessments using this scale [33].

Studies have examined the associations between students' or physicians' scores on the JSE and those of real or standardized patients. Glaser et al. [34] found a correlation ($r = .48$, $p < .05$) between scores on the JSE of residents in a family medicine program and their real patients' perceptions of their empathy, but the study conclusions were limited by a small sample size. During a multistation standardized-patient assessment, Berg et al. [35] found a significant but low correlation ($r = .19$, $p < .05$) between third-year medical students' scores on the JSE and standardized patients' perceptions' of the students' empathy. Recently, in a study linking observer-assessed empathy in a multistation standardized-patient examination to standardized patients' assessment of clinical competence, Ogle et al. [36] found no association between JSE scores and observer-assessed empathy.

These studies raise questions about the relationship between self-assessed empathic ability and physicians' empathic behaviors. Given the importance of empathy in clinical care, the ability to measure empathy in various ways, and the widespread use of standardized patient-based examinations to evaluate trainees' interpersonal skills for competency assessments and licensure, we wondered how trainees' self-reported empathy would relate to their self-assessment of their empathic communication in standardized-patient interactions, and how their self-assessed empathy would relate to standardized patients' assessments of this communication. We conducted this study to investigate the correlation between residents' scores on the JSE and both residents' perceptions of their own empathy during standardized-patient encounters and the perceptions of standardized patients.

2. Methods

2.1. Study design and participants

We conducted a cross-sectional study with 214 first-year residents in internal medicine or family medicine from 13 residency programs in the Delaware Valley who were taking 10-station, standardized patient–based clinical skills assessments between October and December 2011 at Drexel University College of Medicine. Although the clinical skills assessment has 10 stations, we selected five stations for the study because they provided more opportunities for empathic expressions. Therefore, five standardized patients were enrolled in the study. The cases included a middle-aged woman with poorly controlled diabetes without health insurance; a woman with recurrent headaches with depressive affect who is a victim of physical abuse; a woman whose mother is in the intensive care unit in a persistent vegetative state, with an advance directive that calls for terminating life support, to which the daughter objects on moral and religious grounds; the daughter of a woman who died of a ruptured aortic aneurysm, unrecognized on admission (the physician must admit his or her mistaken interpretation of the initial chest radiograph); and a 68-year-old man being discharged from the hospital after an acute myocardial infarction who needs to understand his medication regimen before discharge. Our standardized-patient trainer (TJD) selected standardized patients from a pool of experienced standardized patients and trained them to portray the case scenarios and assess residents on checklists. Faculty members familiar with the cases then validated the standardized patients' portrayals and assessments. Standardized patients familiar with the cases and checklists observed standardized-patient portrayals behind one-way mirrors to ensure quality of portrayals and accuracy of case checklist completion.

2.2. Instruments

Standardized patients completed the Jefferson Scale of Patient Perceptions of Physician Empathy [37] after each of the five encounters with the residents. This scale contains five items on the patient's perceptions regarding the physician's empathic engagement. For instance, the patient is asked whether or not this physician (in this case, resident) "can view things from my perspective." Each item is rated on a 7-point Likert scale from 1 (strongly disagree) to 7 (strongly agree).

Residents completed the JSE [38,39]. This scale is a self-report measure to measure empathy among medical students, physicians, and healthcare professionals 38-40. Because extensive data support its psychometrics, the Jefferson scale has been frequently used in medical education research [38–40] and has been translated into 42 languages and used in more than 63 countries [41]. We used the student's version (S-version) for residents because the residents who participated in the study were at the beginning of their residency training programs. The scale comprises 20 items assessing the respondent's self-reported attitudes toward empathy and asks them to rate statements on a 7-point Likert scale from 1 (strongly disagree) to 7 (strongly agree). Scores can range from 20 to 140, and persons with a more empathic orientation achieve higher scores [39,40]. After each encounter, we also administered to residents a version of the Scale of Resident Perception of Own Empathy, created by slightly modifying items on the Jefferson Scale of Patient Perceptions of

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