Empathic communication skills in CALD medical student interviews

ELMA AVDI, PETRINA BARSON and ILANA RISCHIN – Holmesglen Institute and The University of Melbourne

ABSTRACT

The study outlined in this paper tested the application of the Model of Empathic Communication (MEC) (Suchman et al 1997) to medical interviews of culturally and linguistically diverse (CALD) medical students at an Australian university. It examined the extent to which this model accounts for CALD medical student behaviour and considered the potential role of the model in teaching empathic communication skills. Using the model, the study involved a descriptive, qualitative analysis of the examination performances of 21 first-year CALD medical students. Consistent with the model, the CALD students missed opportunities to demonstrate empathic skills by using terminators, which directed the interviews away from any stated emotions. The patients, who were played by actors, responded to these missed empathic opportunities by escalating their attempts to convey their emotional messages. The MEC appears to be a useful tool for mapping and understanding where CALD medical students miss opportunities to recognise, explore and acknowledge direct and indirect expressions of feelings. The model has the potential to be used in medical education curriculums as a teaching tool to raise awareness of the behavioural and verbal skills required in patient–clinician empathic interactions and to facilitate the teaching of these skills.

Introduction

The essence of empathic communication is ‘the accurate understanding of the patient’s feelings by the clinician and the effective communication of that understanding back to the patient so that the patient feels understood’ (Suchman et al 1997: 678). The expression of empathy is regarded as an important component of medical interviewing, as a growing body of research suggests a relationship between the quality of a doctor’s communication skills, including empathy and patient treatment (Levinson et al 1997; Larson and Yao 2005), and doctor job satisfaction and work stress (Ramirez et al 1996). Given these multiple areas of impact, a major goal of medical education should be improving the empathic communication of medical students.

The MEC traces the emotional content of medical interviews in terms of empathic opportunities presented by the patient and labels the clinician’s responses according to whether he or she takes up or misses opportunities to demonstrate empathy. This research study extends the MEC to medical student interviews for the first time. By examining how the MEC accounts for CALD medical student behaviour in medical interviews, the study also considers the potential role of the model in teaching empathic communication skills to these students.

Previous studies have isolated the skill of empathy. One qualitative study examined how patients present clues rather than verbalise their emotions and how physicians respond to these clues (Levinson, Gorawara-Bhat and Lamb 2000). This study found physicians frequently missed opportunities to respond to patient emotions and to strengthen the patient–physician relationship, as did Suchman et al (1997). It is also worth noting that our understanding of empathy in doctor–patient communication is limited to studies of doctors in Western countries, where the cultural backgrounds of the doctors have not been considered.

The study of empathy in medical students has centred mostly on finding a reliable measurement tool (Chur-Hansen and Winefield 2000; Hojat et al 2001; Mangione et al 2002), which, although interesting, does not directly relate to the question of how the expression of empathy can best be taught. Other areas of debate have been the extent to which empathy is teachable, the stability of empathic skills over time, the effect of gender (with females scoring higher on empathy scales than males), and the possible
correlation of empathy with clinical competence but not with objective exam results (Spiro 1992; Holm

However, there has been relatively little research on empathic behaviour in communication between
medical students in the early years of training and patients, and fewer still of CALD students.
A longitudinal study of medical students, who were taught medical interviewing skills in their first year
of training, showed their interviewing skills decreased as they learned more about medical problem-
solving (Craig 1992). In a study of the relationship between English-language proficiency and medical
communication skills, unsatisfactory spoken language proficiency was associated with poor medical
communication skills under exam conditions (Chur-Hansen, Vernon-Roberts and Clark 1997). Another
study of preclinical students interviewing volunteer non-English-speaking clients found that, although
students gained confidence in interviewing people from different cultures, their empathic communication
skills did not improve (Farnill et al 1997). In contrast, another study of third-year students, undertaking
their first year of clinical training, found that giving students a consulting skills course resulted in
significant improvement in their empathic behaviour (Evans, Stanley and Burrows 1993). Four other
studies of medical students in later years of training have highlighted the importance of empathic skills
and point to potential teaching and learning implications (Rosenfield and Jones 2000; Roberts and
Sarangi 2001; Maynard and Heritage 2005).

The MEC was chosen for this research study because it describes behaviours and patterns of interaction
related to empathic communication, which can be readily applied to medical student interviews
with patients. Analyses of recorded interviews, based on the model, could then be used to improve
communication skills and the relationship between future clinicians and their patients. A descriptive,
qualitative analysis of the transcripts and videotapes of the examination performances of 21 first-year,
CALD medical students, utilising the MEC, is presented here.

Method and model

First-year medical students at an Australian university in this study undertake a subject entitled Introduction
to clinical medicine for two hours a week. This course introduces the skill of interviewing patients by
focusing on patient social histories. As part of the course assessment in Week 10, each medical student
is videotaped in a nine-minute interview with an actor playing the role of a patient. Actors as patients
are used widely in medical education to allow medical students to practise and have their clinical
communication skills assessed before they meet real patients. Students are instructed to take social histories
but no medical knowledge is needed for the interviews. The aim is to test student communication skills,
with specific marks being awarded for showing empathic responses, as well as for developing rapport and
general communication skills. The cases for these simulated patient interviews are outlined in Figure 1.

Figure 1: Two communication skills exam scenarios

<table>
<thead>
<tr>
<th>Case 1</th>
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<td>A single woman in her late 30s comes to the doctor to discuss the feasibility, both practically and in terms of her fertility, of becoming a single mother.</td>
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<tr>
<th>Case 2</th>
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<td>A 35-year-old married father of two comes to the doctor because his wife wants him to have a vasectomy.</td>
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These cases were devised for actors simulating patients from Anglo-Celtic backgrounds. Due to the
difficult content of these cases, the simulated patients were instructed to be direct about their emotional
concerns. For the medical students, the skill of showing empathy in these scenarios consists of eliciting
the patient’s story and emotional concerns, and demonstrating that he or she has heard the story and the
contents. There is no requirement to give advice or have any knowledge of the medical options.

After this assessment was completed, all the students were invited to submit their videotapes for the
research project, to enable possible comparison of CALD and non-CALD students at a later stage. Of the 31 videotapes submitted, 21 were from CALD students and formed the data for the analysis presented in this paper. This group was chosen because our work involves providing linguistic and cultural support to CALD students, and greater understanding of CALD student performances would lead to more informed teaching. Ten of the 21 students were international students and had mostly arrived in Australia only three months prior to commencing their studies. The main country of origin was Malaysia, but there were also students from Iran, China and Singapore. The remaining 11 students were born overseas but had mostly completed some secondary study in Australia. The main country of origin for this group was China, followed by Malaysia, India and Taiwan.

The data were analysed using the MEC, outlined in Figure 2. This model tracks the emotional content of an interview in terms of empathic opportunities presented by the patient, and labels the clinician’s response according to whether he or she takes up or misses those opportunities to demonstrate empathy.

Figure 2: Flowchart of MEC

In Figure 2, an interactional sequence pertaining to patient expressions of affect and physician responses is shown. The horizontal line shows the patient process of feeling is understood if the doctor provides a potential empathic opportunity continuer and then an empathic response.

The distinction between process (how doctors communicate) and perceptual skills (thoughts, feelings and attitudes) is highlighted in the breakdown of what is involved in the skill of empathy. There are two aspects to empathic communication:

1. the cognitive aspect, or the doctor’s accurate understanding of the patient’s feelings
2. the behavioural aspect, when the doctor’s understanding is communicated back to the patient, so that the patient feels understood.
Figure 3 outlines a descriptive classification of terms (Suchman et al 1997: 679) used in the analysis.

### Figure 3: Definitions of terms describing patient expressions of affect and clinician responses

<table>
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<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td>Empathic opportunity</td>
<td>A direct and explicit description of an emotion by a patient</td>
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<tr>
<td>Empathic response</td>
<td>A clinician’s explicitly expressed recognition of a patient’s expressed emotion</td>
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<tr>
<td>Empathic opportunity terminator</td>
<td>A clinician’s statement that immediately follows an empathic opportunity and directs the interview away from the stated emotion</td>
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<tr>
<td>Missed empathic opportunity</td>
<td>An empathic opportunity that is not followed by an empathic response</td>
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<tr>
<td>Potential empathic opportunity</td>
<td>A patient statement from which a clinician might infer an underlying emotion that has not been explicitly expressed</td>
</tr>
<tr>
<td>Potential empathic opportunity continuer</td>
<td>A clinician’s statement following a potential empathic opportunity that facilitates further exploration and direct expression of an implied emotion</td>
</tr>
<tr>
<td>Potential empathic opportunity terminator</td>
<td>A clinician’s statement that immediately follows a potential empathic opportunity and directs the interview away from the implied emotion</td>
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Three researchers individually reviewed the transcripts and videotapes of the medical student interviews with patients and coded the interactions using the model. They then compared and discussed these codings in order to reach consensus on the application of the model.

### Results

#### Empathic opportunity terminators

The major finding of the study is that CALD students, like the qualified physicians in the study by Suchman et al (1997), often miss opportunities to express empathy. Analysis of the videotaped interviews shows that, consistent with the MEC, CALD students miss opportunities to demonstrate empathy by using terminators, which direct the interview away from any stated emotion. This is generally done by changing to a factual or biomedical topic, either abruptly or with a tenuous connection to what the patient has been talking about. For example, in the following excerpt, when the patient expresses his fears about the permanency and possible sexual side-effects of a vasectomy, the student responds with an abrupt terminator.

**Example 1: Case 2**

The patient (Graham) has explained that his wife wants him to have a vasectomy.

Graham:  … How is it going to affect me? How is it going to affect my sex life? Is it permanent? Can I reverse it? All that stuff, that is what I really want to know. [empathic opportunity]

Student C:  So, can I ask you about your hobbies? [empathic opportunity terminator]

The patient has directly expressed fears that are not addressed by the student. Instead, the student’s terminator – the inappropriate question about the patient’s hobbies – threatens rapport, as it seems to ignore what the patient has said.

In other examples the terminators are less abrupt because they are superficially related to the topic at hand, but miss or do not respond to the emotional content. In Example 2 there is a tenuous link between the patient’s talk about not being able to have more children and the student’s request for more information about his two existing children. However, the issues of most concern to the patient, his desire
for a larger family and his fears about the effects of a vasectomy on his relationship, are only superficially acknowledged with *Yeah, that seems a reasonable*.

**Example 2: Case 2**

Graham: … I want to find out from the doctor what is going on, what can I do? What effect there is going to be on me personally, on my wife? Whether, you know, she goes off the pill? Is her blood pressure going to go up? Can we have any more children? [empathic opportunity]

Student D: [PAUSE]Yeah, that seems a reasonable [PAUSE], yeah, I mean, that is a good reason why you came to the doctor today, Graham. So can you tell me more about your two children? [empathic opportunity terminator]

Graham: Yeah, I have got one that is ten and one is six, both at primary school.

**Limited empathic responses**

While the negative and positive ways of dealing with patient emotions are described by the model as terminators and empathic responses respectively, the students in our study demonstrated an intermediate category of response, which we have termed *limited empathic response*. This category best describes the ways in which the CALD medical students in our study unsuccessfully responded to patient emotions. In adding this category, we have drawn on discourse analysis, an approach to language grounded in the turns speakers take and how these turns affect the communication from moment to moment. While the model is based on the existence or non-existence of certain responses from doctors, accounting for the wider range of student responses requires a finer-grained linguistic analysis. Considering what the patient says after a student response helps determine how that response is categorised. CALD students in our study displayed four types of limited empathic responses.

1. **Stock phrases**: stock or general comments are defined as lacking an explicit recognition of patient emotion, for example *that must be stressful*. When employed as standalone responses, these phrases are limited. In Example 2: Case 2, the student response is a typical example – *Yeah, that seems a reasonable … a good reason why you came to the doctor today*.

2. **Problem-solving**: another common type of limited response is a problem-solving orientation. This is when the student does not respond explicitly to the patient's emotion but, rather, asks a question, for example *Have you talked to anyone about your problem?/Have you considered X?* At times, this method of responding to patient emotion is particularly inappropriate. For example, in one interaction with Graham about the vasectomy, the student asked if he had talked to his young children about his feelings about the operation.

   While there is a place for both stock phrases and problem-solving responses within the interview, the timing of such responses immediately after empathic opportunities prevents the patients from expressing feelings more fully.

3. **Misdirected empathy**: misdirected empathy refers to instances when a student responds to a part of the patient's talk, but not to the core emotional content. Typically, students tend to respond to positive aspects of a patient's talk and ignore the negative. In the following excerpt, the patient's ambivalence about her casual relationship with Peter and about being a single mother is ignored by the student. The student's positive statements do not match the patient's ambivalent feelings, so the empathy is misdirected.

   **Example 3: Case 1**

   Student: … may I ask about your relationship at the moment?

   Patient: Yep, yeah, well, I have a sort of casual relationship with, his name is Peter [wringing hands] and it is about 12 months now and he is a really good man and I think he is sort of happy to help me out and father a baby if it could happen, but, yeah, it is just a casual relationship. He will be supportive but … [empathic opportunity]
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4 Poorly phrased empathic responses: poorly phrased empathic responses range from statements that result in awkward communication and miscommunication to statements that may appear judgmental or patronising. These responses often elicit correction or a defensive response from patients. In the following excerpt, the student’s poor phrasing elicits a defensive response from the patient (Virginia).

Example 4: Case 1

Virginia: … I don’t think it’s going to happen [a deeper relationship], we are too different. In the back of my mind I would like that to happen.

Student: All right.

Virginia: But I don’t think I am going to find anybody now. [empathic opportunity]

Student: Okay, it sounds to me that a little bit desperate. [poorly phrased empathic response]

Virginia: [short laugh, sharp intake of breath] A little bit desperate? [patient is defensive]

Student: Sorry, that was the wrong word. Sorry, I just feel that because, it seems to me that your relationship with your partner. And, by the way, what is your partner’s name?

In Example 5: Case 2, the student summarises the patient’s fears for his masculinity and sexuality and his fear of being sterile and not being able to have more children by saying, so you are basically worried about not being able to have children and all that. The final phrase – and all that – is a very poorly phrased response to such deep-seated and explicitly stated fears.

Example 5: Case 2

Graham: … so that means I lose my masculinity and become sterile, so what do I do then? [empathic opportunity]

[Series of short exchanges including limited empathic response, continuers and empathic opportunity]

Graham: … Up top, I don’t know anything about what is going to happen. [escalating empathic opportunity]

Student: What do you mean by that? … [empathic opportunity continuer]

Graham: Like, what is going to happen to my masculinity, I am going to be sterile, I can’t have any more children or what goes on. [escalating empathic opportunity – patient repeats earlier concern about masculinity]

Student: Yeah, yeah, that would … so you are basically worried about not being able to have children and all that. [limited empathic response – misdirected empathy – summary is partial, omitting escalating fears about sexuality; and all that – poorly phrased empathic response]

Graham: Not being able to perform any more. [escalating empathic opportunity – more explicit reference to fear of sexual side-effect]

Student: Right, right, that must be stressful. [limited empathic response – stock phrase rather than explicit recognition of fear of sexual side-effect]

Graham: Very much so for me. [potential empathic opportunity]

Student: And what does your wife think about this? [limited empathic response: problem-solving]

Graham: Well, she has arranged for me to go and see the doctor. [acceptance that the topic is closed]

Another sub-type of a poorly phrased response is termed the escalator effect in the original model. When patients feel that their emotional issues are not being addressed, they may repeat them, often with increasing intensity. While the model describes this effect happening as a result of doctors closing
off patient emotions with terminators, the same effect can be observed in our data when students offer limited empathic responses. In this study, the actors frequently provided emotional opportunities and repeated these opportunities, sometimes with greater intensity (the escalator effect) because student empathic responses were often limited. In Example 5: Case 2, the student’s limited empathic responses lead to the patient repeatedly expressing his fear of the sexual side-effects of a vasectomy.

Discussion

While the frequent use of terminators aligns with the model derived from the study of doctor–patient interviews, the reasons for this phenomenon may well be different for doctors and medical students. The authors of the model assert that the prioritising of objective data throughout medical training, and the ‘quest for control over subjective experience’ (Suchman et al 1997: 682), is possibly a major reason for the lack of empathic responses in doctors. The argument is that doctors are so concerned about their diagnostic agenda that they neglect patient emotions. Our data consists of CALD students at the very beginning of their medical course, taking a social history, with no training in diagnostic interviewing and no pressure to arrive at a diagnosis. Nonetheless, there appears to be a similar pattern of preference for biomedical or purely factual content. The similarity in behaviour between medical students and doctors may be related to the fact that medical students achieve high academic results in science subjects, which predisposes them to focus on the biomedical or factual content of the interview, rather than the emotional.

Furthermore, our teaching experience suggests that, regardless of cultural or linguistic background, students are often uncomfortable about asking patients for personal information, particularly of an emotional and/or sexual nature. Differences between medical students and simulated patients in age, gender, cultural background and life experiences may lie behind the use of terminators and limited empathic responses on the part of the students. Further research interviewing students after their exams with actor/patients would be needed to test this hypothesis.

The researchers added the category limited empathic response to the model to describe the ways in which CALD medical students unsuccessfully attempt to show empathy. This category may be related to linguistic or cultural influences. Although all students, when placed under pressure in exam conditions, have the potential to resort to limited empathic responses, our teaching experience suggests that CALD students may offer limited empathic responses because they are processing patient information more slowly, translating in their heads, searching for the right phrasing and/or encountering culturally challenging ideas from patients. Examples of culturally challenging ideas were the notion of a woman deliberately choosing to be a single mother and not anticipating marriage (Case 1) and the idea that the husband, not the wife, was seeking more children and gaining fulfilment from his family rather than work (Case 2).

Further research is needed to understand if limited empathic responses are, in fact, more characteristic of CALD students and, if so, whether this is due to cultural and/or linguistic factors. If further research comparing the performance of CALD and local students shows that CALD students have a particular style of responding to patient emotions, and if this style is due to cultural and/or linguistic factors, then targeted cross-cultural training would be recommended.

References