IMPROVING INPATIENT EXPERIENCE UTILIZING AN EMPATHY ENHANCEMENT PROGRAM

A DOCTOR OF NURSING PRACTICE PROJECT SUBMITTED TO THE OFFICE OF GRADUATE EDUCATION OF THE UNIVERSITY OF HAWAI‘I AT MĀNOA IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF NURSING PRACTICE

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By

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Keywords:

Empathy, education, program, burnout
Dedication

To my family.
Acknowledgement

I would like to take this opportunity to thank my committee, Dr. Scott Ziehm, Laura Westphal and Dr. Debra Mark. Deepest thanks for directing my learning, expanding my view of the world, and for keeping me on track.

I would also like to thank the staff at Castle Medical Center in Hawaii for embracing this project with thoughtfulness, enthusiasm, and heart.

Finally, my husband and children, whose support is immense. We are a great team!
ABSTRACT

Low empathy amongst health care providers can affect patient outcomes and the patient experience. This is both a quality and financial concern. The Center for Medicare and Medicaid (CMS) reimburses hospitals under pay-for-performance rules for high quality care and high patient experience as measured by the Hospital Consumer Assessment Healthcare Provider and System (HCAHPS) survey results.

A literature search indicated that implementing several interventions that involve experiential exercises and engagement in self-reflection could increase empathy. The interventions selected for this project included a workshop, video development, and an ongoing Empathy Enhancement Program. These interventions were implemented at Castle Medical Center (CMC) using the Iowa model as a conceptual guide for implementing evidence-based practice changes.

The objectives for implementing this project at CMC were to improve empathy in healthcare workers, improve employee engagement, and improve inpatient experience results. The program was evaluated by pre and post intervention staff empathy assessments, HCAHPS survey results, patient complaints, patient readmission rate, Gallup employee engagement survey results, and rate of employee turnover. All employees at CMC were included in the program.

Results show improvement in each of the outcome measures except employee turnover. During the program implementation there were other concurrent synergistic projects that may also have impacted these outcomes. Recommendations to sustain the program include ongoing empathy refresher activities, review of barriers to empathy such
as workflow processes, establishment of a staff resiliency/burnout prevention program, and the reframing of the Empathy Enhancement Program to encompass these elements.
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CHAPTER 1. EXECUTIVE SUMMARY

Evidence suggests that improved clinician empathy levels positively impact the patient experience and healthcare outcomes as well as reduce error and malpractice claims (Lewin, Skea, Entwistle, Zwarenstein, & Dick, 2001; Hardee, 2003; Hojat, Louis, Markham, Wender, Rabinowitz, & Gonnella, 2011). When clinicians are attuned with patients, they are more likely to meet their needs and address their concerns (Koloroutis & Trout, 2012).

Although empathy is known to have a positive impact on care, evidence shows that healthcare professionals do not necessarily demonstrate empathic behaviors. The consequence of failing to understand the needs of the patient may result in inadequate sharing of information, inadequate emotional support, and contribute to poor health outcomes (Dempsey & Wojciechowski, 2014; Reynolds & Scott, 2000).

This is both a quality and financial concern. The Center for Medicare and Medicaid (CMS) reimburses hospitals under pay-for-performance rules for high quality care and high patient experience as measured by the Hospital Consumer Assessment Healthcare Provider and System (HCAHPS) survey results.

The inherent nature and intensity of the work in the hospital environment may contribute to a decline in clinician’s levels of empathy over time and lead to burnout (Rosen, Gimotty, Shea, & Bellini, 2006). Emotional exhaustion, low levels of empathy, and dehumanization are features of burnout (Shanafelt, West, Zhao, Novotny, Kolars, Habermann, & Sloan, 2005). It is thought that the use of empathy may protect clinicians from burnout; by being emotionally attuned to the patient, the clinician is more effective and in turn feels greater satisfaction and fulfillment (Halpern, 2003).
A literature search indicated that implementing several interventions that focus on self-awareness, reflection, discussion, simulation, role-playing and experiential methods of instruction could increase empathy. The interventions selected for this project included a workshop, video development, and an ongoing Empathy Enhancement Program. These interventions were implemented at Castle Medical Center (CMC) using the Iowa model as a conceptual guide for implementing evidence-based practice changes.

The objectives for implementing this project at CMC were to improve empathy in healthcare workers, improve employee engagement and improve inpatient experience results. By recognizing that each staff member has an impact on the patient throughout their hospital stay, and on each other as colleagues in their work, the purpose of the program was to encourage staff to connect with the patient and each other through authentic behaviors.

The program was evaluated by pre and post intervention staff empathy assessments, HCAHPS survey results, amount of patient complaints, patient readmission rate, Gallup employee engagement survey results, and rate of employee turnover. All employees at Castle Medical Center were included in the Empathy Enhancement Program entitled, “In Their Shoes”. Exclusion criteria for employees included those that were on an extended leave of absence. The patient population included for outcome measurement included all inpatient adults except those admitted to the Behavioral Health Unit.

The workshop was well received by staff and attended by over 90% of all employees. In workshop evaluations, participants discussed particular concepts they appreciated and practice changes they intended to make. Participants also expressed
gratitude for the opportunity to spend time connecting with their personal mission. Many shared that they felt inspired and rejuvenated and that they enjoyed the interdepartmental learning setting.

The video was developed in the style of a documentary with frontline staff participation and followed the organization’s journey to explore empathy. It has been viewed by all staff and is now included in the orientation program for new employees. Ongoing activities have been instituted to sustain the program including an implementation toolkit for other Adventist Health facilities to use for replication.

Results of the program implementation show improvement in each of the outcome measures listed earlier except employee turnover and overall complaints. Patient complaints related to staff attitudes and behaviors decreased from 1.4 to 1.0 per 1000 patient days but total complaints increased from 2.3 to 2.9 complaints per 1000 days. This increase may be due to a new reporting software that was implemented. Overall rating of HCAHPS improved by 5 percentile ranking points. All Cause 30-day Readmissions decreased by 19.5%. Employee engagement improved from the 51st to 78th percentile ranking. Post workshop empathy assessment scores compared with pre-workshop scores improved by 0.74% for clinicians and 0.53% for non-clinicians. Total employee turnover increased from 19.6% to 21.3% which may be attributed in part to increased accountability throughout the organization, difficulty with talent selection and first year new hire onboarding. Other concurrent synergistic projects implemented may also have impacted these outcomes.

Staff identified barriers to use of empathy include burnout and workflow inefficiencies. The support of clinicians’ emotional well-being and health is crucial in
aiding them to provide care that is empathetic. Recommendations to sustain the success of this program include support of ongoing empathy refresher activities; regular review of barriers to empathy such as workflow processes; establishment of a staff resiliency/burnout prevention program; and the reframing of the Empathy Enhancement Program to encompass these elements.
CHAPTER 2. PROBLEM

Introduction

High emphasis is being placed in hospitals on raising the quality of care being delivered. This project addresses the role of empathy and empathic behaviors on inpatient experience and employee satisfaction. The scope of the issue, the triggers prompting action, and the conceptual model used to determine and apply evidence-based practice are described in this chapter. A description of the literature search with literature synthesis is outlined with evidence-based strategies for implementation selected.

Background

Nationwide, the patient experience, measured by Hospital Consumer Assessment of Healthcare Provider and System (HCAHPS) survey results (see Appendix A), is one of the ways that hospitals are reimbursed by the Centers for Medicare & Medicaid Services (CMS) for patient care (CMS, 2014). In addition, there is evidence that patient experience correlates positively with clinical effectiveness and safety (Doyle, Lennox, & Bell, 2013). HCAHPS results are published on the CMS Hospital Compare website. The availability of this data will impact consumer choices in healthcare decisions in the future if it does not already. Clearly, improvements in patient experience are a top priority for hospitals.

Evidence suggests that improved clinician empathy levels also positively impact the patient experience and healthcare outcomes as well as reduce error and malpractice claims (Lewin, Skea, Entwistle, Zwarenstein, & Dick, 2001; Hardee, 2003; Hojat, Louis, Markham, Wender, Rabinowitz, & Gonnella, 2011). When clinicians are attuned with
patients, they are more likely to meet their needs and address their concerns (Koloroutis & Trout, 2012).

Over time, studies show that clinician’s levels of empathy diminish (Chen, Lew, Hershman & Orlander, 2007). Additionally, some healthcare providers suffer from burnout (Rosen, Gimotty, Shea, & Bellini, 2006). Burnout can be categorized in part as dehumanization and an attitude of depersonalization (Shanafelt, West, Zhao, Novotny, Kolars, Habermann, & Sloan, 2005). Continuous change and reorganization with reduced resources increases demands and responsibilities of healthcare workers. Combined with high principles and expectations, this makes staff question their worth and abilities. This sense of inadequacy, pessimism and powerlessness leads to burnout (Glasberg, Norberg, & Soderberg, 2007). Additionally, high exposure to intense emotional situations and high workloads causes some healthcare providers to suffer from burnout (Rosen, Gimotty, Shea, & Bellini, 2006). This decline in empathy indicates a need to review its causes and implement evidence based interventions that improve it (Riess, Kelley, Bailey, Dunn, & Phillips, 2012).

**Triggers at DNP Site**

**Patient Experience.** One of the biggest challenges found by hospitals is sustaining momentum and continued commitment to the patient experience. Initial strategies at Castle Medical Center (CMC) focused on inpatient nursing and included implementation of hourly rounding, bedside shift report; partnering with the Studer Group on improving nurse communication, and customer service training. Patient Experience survey score increases were seen, and by 2014 were in the 75th percentile
ranking hospital wide (see Figure 1). This nationwide ranking signals that CMC was in good standing however, the goal was and is to reach the 90th percentile ranking.

Figure 1.

Inpatient Overall Patient Experience Results at CMC (HCAHPS)

Patient complaints. The number of patient complaints per 1000 patient days is another way of measuring patient satisfaction. Figure 2 illustrates CMC’s ongoing work over the prior 4 years to improve the patient experience. As benchmarks for patient complaints are not available, this was not a primary trigger, but it was expected that an increase in empathic interactions between staff and patients would reduce complaints. Our goal was to reduce these by 5%.
**Figure 2.**

Number of Patient Complaints per 1000 Patient Days at Castle Medical Center

![Bar chart showing Total Number of Complaints Per 1000 Patient Days, with a significant decrease from 2012 to 2013, indicating Good ↓]

**Readmissions.** Penalties have been increased to 3% by CMS for all cause readmissions within 30 days for select diagnosis. Although CMC had a rate that was below expected, there was still opportunity for improvement in order to avoid these large penalties (see Figure 3). Reducing readmissions was a key initiative for 2015. Although not the primary trigger for this program, there was synergy, as empathic discussions by health professionals are important in understanding discharge needs and avoiding readmissions (Dempsey & Wojciechowski, 2014).
**Figure 3.**

All Cause 30-day Readmissions at Castle Medical Center.

![Castle Medical Center 30 Day Readmissions - All Causes](image)

**Strategic Plan.** To attain and sustain the goal of top performance, the engagement of all staff (not just in clinical areas but throughout the organization) was and is considered crucial. The Adventist Health Patient Experience Planner (2013) references material from the patient experience website BeyondPhilosphy.com and discusses the need to include all staff in the patient experience:

The patient experience is a result of the interaction between an organization and a patient as perceived through the **patients’ conscious and subconscious mind.** It is a blend of an organization’s rational performance, the senses stimulated and emotions evoked and intuitively measured against patient expectations across **all moments of contact.** As such, the patient experience must embrace:

1. The whole organization delivering, (not just front line staff or individual people, back office and management too)
2. The rational as well as the emotional experience (not just about what you do but also how you do it)

3. Dealing with the intuitive perceptions (i.e., gut feelings) of patients (reality is in your patients’ mind) (Beyondphilosophy.com as cited in Adventist Health Patient Experience Planner, 2013, p. 12).

**Employee engagement.** The Gallup survey was used for the first time in 2014 to measure employee engagement. It consists of 12 questions that measure growth, teamwork, individual contribution and basic needs to complete their work (see Appendix B). Participation of all CMC employees in the survey was 90% and CMC scored high for first time users, with engagement at the 94th percentile ranking in the Gallup First Administration Company Level Database. This was the top score of all 20 Adventist Health hospitals in our system. There was still opportunity to improve however, as CMC’s overall score was at the 51st percentile ranking in Gallup’s Hospital Level National Database.

**Employee turnover.** Turnover rate is another indicator of employee engagement. CMC had an increase in overall turnover in 2013-14 (see Figure 4). This trend continued in 2014, with overall turnover up to 19.6%. Registered Nurse turnover was 14.6%. In part this trend was related to an increase in accountability throughout the organization. According to Nursing Solutions, Inc. (2014), the national average turnover rate for hospitals is 16.5%. The average cost of turnover for a bedside RN ranges from $44,380 to $63,400, which put employee engagement and reduction in turnover as a top priority for the organization. It is suggested in the literature that when empathic behavior is engaged upon, healthcare professionals note improved job satisfaction and a sense of fulfillment, which in turn prevents burnout (Lagro-Janssen, 2013; Riess et al, 2012).
Castle Medical Center, recognizes that each staff member has an impact on the patient and/or significant other(s) throughout the patient stay, and determined that it would invest in promoting and sustaining both staff empathy and engagement. An Empathy Enhancement Program that included every person and department in the facility was initiated. The purpose of this program was to encourage staff to connect with the patient through authentic empathic behaviors. This parallels closely the mission of the organization: “Caring for our community, sharing God’s love”. As a result of this program it was anticipated that staff would feel more engaged with patients, their work and that the patient experience would be enhanced.
Conceptual Model

The conceptual model used to guide this project was the Iowa Model of Evidenced-Based Practice to Promote Quality Care developed by Titler et al. (2001). This model begins with identifying a problem and/or knowledge based trigger(s) and determining the importance and priority of the topic to the organization. This is key to the success of any Evidence-Based Practice (EBP) project. Every organization has many priorities and although a topic may be important, internal and external influences, such as available economic resources or political climate may not support an investment of scare resources into the project.

After determining support, a team is formed that assembles relevant research and literature. This team critiques, synthesizes and evaluates the research. Outcomes are selected, baseline data collected, and EBP guideline designed. A pilot of the change is conducted, processes and outcomes evaluated, and the practice guidelines modified if needed. As well as quality of care and processes, the effects on patients, family, staff, and finances are evaluated and disseminated. Ongoing development of new knowledge ensures that an EBP project is never really finished.

If there is not enough research and literature on a topic, other types of evidence may be critiqued and evaluated for relevance such as case reports, expert opinion, scientific principles, and theory. The lack of evidence may indicate the necessity for research to be conducted before the rest of the model can be followed.

The reason the Iowa model was selected is because it has a logical framework that made sense with the project that was being implemented and also because it is has been used by staff at Castle Medical Center for EBP projects as part of the Nurse Residency
Program. Some staffs that have participated in the Hawaii State Center for Nursing EBP program that teaches the Iowa Model were selected for the project team. This prior knowledge of the model helped the team be more effective and efficient in our team meetings, which was an advantage to the project implementation.

**Iowa Model of Evidenced-Based Practice (EBP) to Promote Quality Care** developed by Titler et al. (2001).

1. Identify a problem and/or knowledge based trigger(s).
2. Determine importance and priority of the topic to the organization.
3. Form a team
4. Assemble relevant research and literature
5. Critique, synthesize and evaluate the research
6. Select outcomes, collect baseline data and design EBP guideline
7. Pilot change, evaluate processes, and outcomes.
8. Modify the guideline as needed.

**Form a Team**

As outlined below in Table 1 the project team was composed of a variety of disciplines and strengths with participation of ad hoc members as agenda items and consulting needs emerged. The project was strategically open to all throughout the organization. The project team needed to connect with the full range of hospital employees, clinical and nonclinical. The multidisciplinary composition, inclusion of stakeholders, and selection of members for high influence and high performance assisted in promoting this project formally and informally and mitigating resistance. Because this innovation required diffuse communication and the quantity of work required to implement was substantial requiring all departments’ engagement, three sub-teams were created that reported to the Project Team. These teams consisted of a
Marketing/Communication team, a Logistics team and a Curriculum development team.

Members for each are outlined in Tables 1 and 2.

Table 1

*Empathy Enhancement Project Team Members*

<table>
<thead>
<tr>
<th>Team Member</th>
<th>Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive</td>
<td>Mentor and executive sponsor. High influence, early adopter.</td>
</tr>
<tr>
<td>Therese Courtenay, Director Inpatient Nursing Services</td>
<td>Team leader – experienced in leading change.</td>
</tr>
<tr>
<td>Staff RN</td>
<td>Early adopter, high influence in nursing.</td>
</tr>
<tr>
<td>Director</td>
<td>Non-clinical influence, late adopter for this project.</td>
</tr>
<tr>
<td>Quality Dept.</td>
<td>Early adopter, high influence.</td>
</tr>
<tr>
<td>Director</td>
<td>High influence, opinion leader.</td>
</tr>
<tr>
<td>Quality Dept.</td>
<td>Excellent facilitator, change agent, early adopter.</td>
</tr>
<tr>
<td>Director</td>
<td>Innovator.</td>
</tr>
<tr>
<td>Director</td>
<td>Innovator.</td>
</tr>
</tbody>
</table>
Table 2

*Project Sub Teams and Members*

<table>
<thead>
<tr>
<th>Marketing/Communication Team Member</th>
<th>Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director</td>
<td>High influence, strength in marketing and communication, early adopter.</td>
</tr>
<tr>
<td>Manager</td>
<td>High influence, strength in graphic design.</td>
</tr>
<tr>
<td>Marketing Associate</td>
<td>Communications expert.</td>
</tr>
<tr>
<td>Marketing Associate</td>
<td>Communications expert.</td>
</tr>
<tr>
<td>Marketing Associate</td>
<td>Videographer, early adopter.</td>
</tr>
<tr>
<td>Director</td>
<td>High influence, opinion leader.</td>
</tr>
<tr>
<td>Staff RN</td>
<td>Opinion leader, high influence hospital wide.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Logistics Team Member</th>
<th>Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td>Highly organized, late adopter.</td>
</tr>
<tr>
<td>Business Associate</td>
<td>Organized, HealthStream administrator</td>
</tr>
<tr>
<td>Director</td>
<td>High influence, early adopter.</td>
</tr>
<tr>
<td>Director</td>
<td>High influence, late adopter.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Curriculum Team Member</th>
<th>Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therese Courtenay, Director</td>
<td>Project lead, completed literature review.</td>
</tr>
<tr>
<td>Unit Secretary</td>
<td>High influence, frontline stakeholder.</td>
</tr>
<tr>
<td>Director</td>
<td>Well-organized, high performer, early adopter.</td>
</tr>
<tr>
<td>Nurse Manager</td>
<td>High influence, opinion leader, early adopter.</td>
</tr>
<tr>
<td>Director</td>
<td>High interest in topic, non-clinical perspective.</td>
</tr>
<tr>
<td>Staff RN</td>
<td>High influence, opinion leader, early adopter.</td>
</tr>
<tr>
<td>Staff RN</td>
<td>High influence, frontline stakeholder.</td>
</tr>
<tr>
<td>RN Manager</td>
<td>Innovator.</td>
</tr>
<tr>
<td>Director</td>
<td>Experience with topic. Late adopter.</td>
</tr>
</tbody>
</table>
Assemble Relevant Research and Related Literature

The quantity of literature relating to empathy is extensive. Many articles are literature reviews discussing the impact and need for improved empathy in healthcare and the relationship between empathy, the patient experience, and patient outcomes. Expert opinion and descriptive studies are next in frequency in evidence type, which include barriers to demonstrating empathic behavior. A smaller group of experimental and quasi-experimental studies show some success in teaching clinicians to demonstrate empathy.

The electronic literature search strategy started broad and included the key words “empathy”, “emotional intelligence”, “caring”, “compassion”, “clinicians”, “nursing”, “physicians”, “patient experience”, “patient satisfaction”, “patient centered care”, “quality”, “improving”, “promoting”, “outcomes”, “training”, and “education”. Reviewing articles from this broad perspective was helpful in understanding the historical perspective and relationships between topics related to empathy. Over time the searches were refined and many relevant articles to this project were found using key words “empathy”, “patient experience”, “outcomes”, “training” and “burnout”. The databases of CINAHL, PubMed, and Cochrane were searched as well as Google Scholar. Searches were limited to adults, human, English language, and the years 1995 - 2014.

Critique and Synthesize Research for Use in Practice

A total of 51 articles were examined and used for this review. This writer critiqued all articles (see Appendix C); members of the project team were able to review three of the articles and provided verbal critique.

The level of evidence and internal validity of each piece of literature was graded using Mosby’s Quality of Evidence as seen in Figure 5 (Melnyk, 2004). This hierarchy
allows assignation of each piece of literature into one of eight levels using Mosby’s Research Critique Form (2004). The “Other” category presented at the base of the pyramid includes review of the literature (Mark, 2014).

*Figure 5.*

Mosby’s Level of Evidence (Mosby, 2004)

In Figure 6 it is seen that nineteen of the fifty-one articles reviewed are classified as “other” according to Mosby’s level of evidence, and considered the lowest level of evidence, as they are literature reviews. These literature reviews form a large body of evidence that consistently indicates that empathy is a key behavioral characteristic to display in the healthcare professional-patient relationship. In regards to the highest level of evidence in Mosby’s tool, there is no meta-analysis reviewed. There are seven randomized controlled trials seen in this review, which fall into the category of Level II evidence. The systematic literature reviews reference higher levels of evidence including randomized controlled trials and cohort studies (Doyle, Lennox, & Bell, 2014; Lelorain,
Seven descriptive studies were reviewed and fall into Level VI of Mosby’s categorization tool. As a body, the articles have three main sub concepts: Empathy and the patient, empathy and the clinician, and enhancing empathy.

**Figure 6.**
Number of Literature Articles Reviewed and Critiqued

<table>
<thead>
<tr>
<th>Literature Review</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
<th>V</th>
<th>VI</th>
<th>VII</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of articles</td>
<td>0</td>
<td>7</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

**Empathy and the patient.** Researchers are divergent in opinion regarding exactly how to define empathy (Price & Archbold, 1997; Reynolds, Scott & Austin, 2000; Kunyk & Olsen, 2001). It is described as being cognitive in nature featuring the understanding of the experiences of others, or an emotional state that features the sharing of feelings. At other times empathy is described as being a combination of both cognitive and emotional attributes (Hojat, 2007). Nursing scholar, Theresa Wiseman describes the attributes of empathy as being the ability to see the world as others see it, understand
another’s current feelings, be non-judgmental, and have the ability to communicate that understanding back (1996). Carl Rogers explains the effects of empathy on the patient when the other person is hurting, confused, troubled, anxious, alienated, and terrified; or when he or she is doubtful of self-worth, uncertain as to identity, then understanding is called for. The gentle and sensitive companionship of an empathic stance . . . provides illumination and healing. In such situations deep understanding is, I believe, the most precious gift one can give to another (Rogers, 1980, p. 160).

The human need for understanding, connection and sharing of emotions and thoughts is verified by studies that indicate that family members and friends play an important role in the prevention of disease (Hojat, 2007). A resounding theme in the body of literature reviewed is that empathy plays a key part in establishing an effective healthcare professional-patient relationship.

Knowing and understanding the patient accurately are emphasized as fundamental to meeting patients’ needs, and improving outcomes (Brunero, Lamont, & Coates, 2009; Cutcliffe & Cassedy, 1999; Davis, 2009; Hardee, 2003; Hojat et al., 2011; Lewin et al., 2001; Lelorain, Brédart, Dolbeault, & Sultan, 2012; Norfolk, Birdi, & Walsh, 2007; Price & Archbold, 1997; Reynolds & Scott, 1999; Reynolds et al., 2000; Riess, Kelley, Bailey, Dunn, & Phillips, 2012; Stickley, 2011; Ward, Cody, Schaal & Hojat, 2012; Ogle, Bushnell, & Caputi, 2013).

Specific health outcome improvement is measured by an improvement in readmission rate (Dempsey & Wojciechowski, 2014), acceptance of care, (Doherty & Thompson, 2014) and clinical indicators (Hojat et al., 2011).
The patient experience is positively impacted by use of empathic behaviors (Bramley & Matiti, 2014; Dempsey & Wojciechowski, 2014). In addition, a review summarizing evidence from 55 studies (Doyle et al., 2013, Systematic review) indicates a consistent positive correlation between patient experience, patient safety, and clinical effectiveness for a range of disease areas.

**Empathy and the clinician.** Accurate use of empathy is expressed as involving more than the ability to understand the patient but also the capacity of the health care provider to communicate this understanding to the patient in a way that is comprehended (Reynolds et al., 2000; Riess et al., 2012; Ogle et al., 2013).

Carl Rogers (1961) described empathy as a non-judgmental communication of understanding of the feelings and personal meanings of the client, while staying aware of the distinction of one’s own identity. Perspective taking by the clinician is used to accurately attune oneself to the patient’s feelings and understand their situation; self-regulation is necessary to prevent emotional over-involvement and exhaustion (Riess, 2015). According to Singer and Klimecki (2014) empathy makes it possible to resonate with other’s feelings while allowing us to appreciate that this is the emotion of another and is distinct from ourselves. If the distinction of self and other is not made this can lead to a response of distress to empathic feelings. A response of distress to empathic feelings can lead to a desire to protect oneself from those feelings, withdrawal and burnout. In contrast, a response to empathy of compassion leads to motivation to help and positive feelings of fulfillment.

Although effective communication skills are required to express empathy (Davis, 2009) and key words can be employed in skill building, such as those in the Heart-Head-
Heart communication model (Leebov, 2012). Empathy cannot be scripted as a customer service tactic. Resonance emotions must be part of understanding and attuning to the patient and active listening requires a conscious effort to appreciate the patient’s position (Halpern, 2003). The genuineness of the clinician is also expressed through nonverbal mannerisms, such as expressions and proxemics during speech and it is this attention that promotes an authentic connection (Davis, 2009).

Although empathy is known to have a positive impact on care, evidence shows that healthcare professionals do not necessarily demonstrate empathic behaviors. The consequence of failing to understand the needs of the patient may result in inadequate sharing of information, inadequate emotional support, and contribute to poor health outcomes (Dempsey & Wojciechowski, 2014; Reynolds & Scott, 2000). A study of 115 internal medicine residents found that 76% met the criteria for burnout and this was strongly associated with self-reported suboptimal patient care practices that occurred one or more times a month. The most common of these were “I found myself discharging patients to make the service ‘manageable’ because the team was so busy” and another “I felt guilty about how I treated a patient from a humanitarian standpoint” (Shanafelt, Bradley, Wipf, & Back, 2002).

Over time empathy diminishes in health care professionals and students (Chen, Lew, Hershman & Orlander, 2007; Hardee, 2003; Hojat et al., 2011; Ogle et al., 2013; Ward et al., 2012). Work related challenges, including long work hours and sleep deprivation are thought to contribute to medical resident decline in empathy (Chen et al., 2007). Participants in a longitudinal study of empathy in 214 undergraduate nursing students were found to have a significant decline in empathy over the course of the study.
The decline was higher in the group of 94 students with more clinical experience, compared with the group who spent most of the year in the learning lab (Ward et al., 2012). Higher empathy scores have been found in nurses who are young, new in the job, and more educated (Watson, Garfinkel, Gallop, Steven, & Steiner, 2000).

Variables that may affect professionals’ ability to offer empathy are suggested as being lack of time and privacy, lack of organizational support, the fear of risk taking when the patient’s emotional distress is severe, lack of support from unsympathetic colleagues, and patients exhibiting different values to that of the health care professional (Davis, 2009; Dempsey & Wojciechowski, 2014; Reynolds et al., 2000; Ward et al., 2012). Personality traits of the professional, such as being overly charismatic or narcissistic are also suggested to hinder the provider’s ability to cultivate empathy (Davis, 2009). Issues such as horizontal/vertical violence affect the entire workplace, traumatizing and influencing the victim’s ability to in turn be empathic, the team’s ability to work together and finally impacting patient safety (Becher & Bisovsky, 2012). The need for empathic behavior between employees and a policy of zero tolerance for horizontal/vertical violence is essential to contribute to a workplace culture of safety (Christie & Jones, 2014).

Burnout is also a hindrance to offering empathy. Emotional exhaustion, dehumanization and dissatisfaction are characteristics of burnout (Maslach & Jackson, 1981; Shanafelt, West, Zhao, Novotny, Kolars, Habermann, & Sloan, 2005). High exposure to intense emotional situations and high workloads causes some healthcare providers to suffer from burnout. In a study of 47 interns in an internal medicine resident program 4.3% reported a high level of burnout initially compared with 55.3% at year-end
(Rosen, Gimotty, Shea, & Bellini, 2006). Exaggerated by high ideals and expectations, staff can feel inadequate, powerless and pessimistic (Glasberg, Norberg, & Soderberg, 2007).

Empathy-related brain activity has been noted in MRI studies to be less in those who have self-rated themselves with high levels of burnout (Tei, Becker, Kawada, Fujino, Jankowski, Sugihara, Murai, & Takahashi, 2014). It is thought that empathy may protect healthcare providers from burnout; being empathic presumes an awareness of the negative emotions and necessitates the clinician to be self-aware of this as a skill to prevent burnout (Sultan, 2012). Additionally, by being emotionally attuned to the patient, the clinician is more effective which in turn gives them greater satisfaction and fulfillment (Halpern, 2003). In a study of communication patterns of 127 physicians it was found that those with a highly engaged communication pattern had the lowest rate of burnout (Roter, Stewart, Putnam, Lipkin, Stiles, & Inui, 1997). By involving and engaging the healthcare team and giving them control over responsibilities and how goals are achieved, it is suggested that burnout can be relieved and prevented (Felton, 1998). Burnout, dissatisfaction and staff turnover may be improved by addressing communication, workflow and initiating quality improvement projects that target staff concerns (Linzer, et al., 2015). Proper support of clinicians’ well-being is essential to enable them to provide empathy in their care and healthcare organizations are ethically obliged to provide the environment and training to support the health of both patients and clinicians (Riess, 2015).

**Empathy enhancement.** Driven by the premise that the patient is in need of empathic health care providers, several articles indicated that health care professionals
should be educated in and demonstrate empathic behavior as an essential practice competency (Hardee, 2003; Hojat et al., 2011; Reynolds & Scott, 2000; Reynolds et al., 2000; Riess et al., 2012; Ogle et al., 2013). Two articles discuss the positive impact that empathy has upon the clinician-patient relationship resulting in satisfaction and fulfillment for the clinician and reducing compassion fatigue and burnout (Lagro-Janssen, 2013; Riess et al., 2012).

Several articles discussed methods to teach, enhance, and validate empathy that include a focus on self-awareness, reflection, discussion, simulation, role-playing and experiential methods of instruction. Length of instruction varies from 90 minutes to several weeks (Brunero et al., 2009; Cutcliffe & Cassedy, 1999; Lagro-Janssen, 2013; Moore, Rivera Mercado, Grez Artigues, & Lawrie, 2013; Norfolk et al., 2007; Ogle et al., 2013, Level V; Price & Archbold, 1997; Reynolds et al., 2000; Williams, Brown, & McKenna, 2013). There is very limited evidence on the long-term effects of any of the interventions. Sustaining effects may depend on addressing barriers, periodic peer and administrative review and self-reflection to remain aware and maintain professionalism.

Patricia Benner (1984) describes the journey of novice nurse to expert “Practices grow through experiential learning and through transmitting that learning in practical settings. Practices cannot be completely objectified or formalized because they must ever be worked out anew in particular relationships and in real time” (p.vi). This reinforces the need for practical experience and ongoing activities to sustain empathy.

Reviewing vignettes of real life situations from the patient perspective to engage staff in collaborative learning is suggested to offer opportunities for reflection and valuable learning (Bramley & Matiti, 2014). Institutional promotion of relationship-
centered care through role modeling and interprofessional education and collaboration are also recommended (Crandall & Marion, 2009). Empathy oriented DVD simulations with discussion within a 90 minute workshop showed a statistically significant difference between empathy scores before and after for a variety of health professional students in an Australian study (Williams, Brown, & McKenna, 2013).

One randomized controlled trial study with good validity incorporated physician training in the neurobiology of empathy, and significantly improved empathy rating by patients (Riess et al., 2012). Studying and understanding the response of the brain in empathic situations is useful in promoting empathy amongst those who identify with the objective science of empathy.

The Cleveland Clinic (2013) produced videos aimed to improve health care professional’s empathy. These have been viewed over a million times on the internet video sharing site YouTube, and are a useful tool to prompt thought on how empathy can impact practice (Riess, Pallotta, & Hayward, 2014). They also tell the story of the patient’s situation and connect viewers to the emotional side of empathy, provoking a desire to understand the perspective of others. It was determined by the project team that showing the patient story at the start of the workshop via video would assist in creating motivation for enhancing skills.

Guiding staff through a journey of discovery regarding their own empathy is crucial for engagement in enhancing their empathy. A purely didactic approach has limited behavioral effect. The General Electric Change Acceleration Program (GE CAP) tools have a proven track record for successfully facilitating change management through a series of exercises that staff participates in to engage and be part of the change.
Incorporating these into the program was determined as a method to heighten participation and achieve acceptance and alignment.

Debate exists regarding the effectiveness of methods and tools for assessing empathy with self-assessment being common, but less accurate than patient assessment (Ogle et al., 2013; Riess et al., 2012). Bias may occur with self-reporting and behavior is not assessed with self-assessment tools. Tools that rely on a trained judge based on participant performance are more objective, but rely on accuracy of interpretation of behavior by the judge. Scales that involve patient ratings evaluate clinicians’ empathic behavior, but do not provide insight into the patient’s perspectives. Some aspects of empathy are better self-assessed (cognitive, emotive, and moral components) while the recipient of empathy better assesses behavior. To address both types of assessment, multiple measures are needed (Yu & Kirk, 2009). The challenge of using multiple measures is that assessment becomes complex and resource intensive to administer.

**Weaknesses, limitations and gaps.** Some limitations in the body of knowledge involve clinicians’ evaluations of their own empathy, which are not necessarily the same as the patients’ reports. Gaps between the two perspectives may exist with clinicians subscribing to the view that if a person does not feel genuine empathy it can be feigned. Self-rated empathy is not associated with clinical competence (Ogle et al., 2013). Clinicians’ evaluations of patients’ perspectives need to be compared with patients’ reports to address both patient and clinician perspectives (Lelorain et al., 2012). A systematic review of 12 different empathy measurement tools used in nursing research found that many tools do not cover all the relevant domains of empathy and have not all been tested with appropriate populations in applicable settings (Yu & Kirk, 2009).
Small sample sizes, and or samples from one small geographic area or institution do not permit generalization (Riess et al., 2012; Reynolds et al., 2000). The exclusion of very sick patients and those with dementia, as well as lack of cultural diversity limits the transferability of the findings (Bramley & Matiti, 2014). The sample of clinicians that participated in the studies was not truly randomized and those that participated may have had a bias towards improving their empathy that affected training outcomes (Norfolk et al., 2007; Ogle et al., 2013).

Gaps in the body of knowledge include an agreed upon definition of empathy, the known amount of empathy needed to have maximum impact on patient satisfaction and outcomes, definitive tools and methods to enhance and communicate empathy, best practices in organizational support of empathy, and return on investment for an investment in an Empathy Enhancement Program. These weaknesses and gaps as well as the evidence referenced above were taken into account as a clinical practice guideline was developed.

In summary, the literature consistently indicates with acceptable quality and quantity that empathy is necessary in the provider-patient relationship to improve outcomes, patient experience, and safety (Ogle et al., 2013; Riess et al., 2014). Although not always seen, it is becoming an expectation that providers demonstrate competence in demonstrating empathic behaviors (Hojat et al., 2005), however, there are many organizational and psychosocial barriers (Reynolds et al., 2000).

Neurobiology is providing new insights into how to enhance empathy, although further research is required to understand its inclusion into skills development (Riess et al., 2012). Empathy can be taught; the most effective methods thus far include self-
awareness, simulation, and targeted experiential methods (Brunero et al., 2009).
Healthcare professionals note improved job satisfaction and sense of fulfillment when
empathic behaviors are engaged upon with the patient (Hardee, 2003). Sustaining
empathy through operational and organizational identification of barriers and granting
ownership over redefinition of workflows can help protect against and relieve burnout
(Felton, 1998).

**Innovation/Objectives**

The objective of this project was to implement and evaluate an Empathy
Enhancement Program at Castle Medical Center. The goal was to improve the patient
experience and the experience of health care workers by enhancing empathy and
empathic behaviors in the inpatient venue. Incorporating empathy awareness strategies to
improve empathic behavior long-term into the culture of Castle Medical Center was
expected to improve the quality of care that is delivered.

Engagement of all levels of staff was a key objective of this project with
involvement from executive leaders to frontline clinical and non-clinical staff in the
evolution of the program essential to its development, team ownership and ultimate
sustainability. Three core sub-teams were encouraged to develop the program with
guidance from the team lead. Interprofessional and interdepartmental teamwork,
participation and collaboration were promoted using engagement tools from the General
Electric Change Acceleration Program. The incorporation of a simple communication
tool that could be used daily in practice at all levels was initiated as a method to trigger
and sustain empathic behavior. Identification of barriers to the use of empathy was
important in strategizing their resolution and the reinforcement of the significance of self-
care in professions where serving others was identified as key to resiliency. A program that was fun, inspirational, and provided a solid understanding of the meaningful impact each individual has collegially as well as clinically was also a crucial objective.

Based on the literature review, site triggers, and the available organizational resources three evidence-based strategies were selected: (1) Workshop, (2) Video development, and (3) Ongoing Empathy Enhancement Program. These strategies were and will be continually adjusted based on the organizational needs/resources and any updates in the literature. The Adventist Health Innovations Council funded a $48,000 grant for the cost of the workshop and video development.

**Workshop.** A 90 minute workshop (see Appendix D) for all employees was developed that focused on self-awareness and experiential exercises to promote understanding of the patient/family experience (Brunero, Lamont, & Coates, 2009). Rather than demanding that staff be more empathetic, the goal was to assist staff in connecting to their own personal mission in providing care and help them understand the value for themselves as well as the patient in connecting at a relationship level with the patient (Dempsey & Wojciechowski, 2014).

**Interprofessional learning.** The World Health Organization (2010) promotes interprofessional education as a method to foster innovation and collaboration between disciplines to improve health outcomes. Enrollment in the workshop was strategically open to all staff to encourage mixed participation from all departments of the organization. Once in attendance, participants were positioned in small groups of mixed disciplines to encourage collaboration.
**Storytelling.** The workshop begins with storytelling through the use of a video produced by the Cleveland Clinic that shows the viewer the untold story of strangers in a hospital setting. This introduces the topic effectively, sets the tone immediately with participants, and engages their emotions by looking through the eyes of another. Storytelling contributes to the development of empathy (Fairbairn, 2002; Manney, 2008).

**Definitions.** Empathy is a complex concept and often used interchangeably with other similar concepts such as compassion, sympathy and caring (Williams & Stickley, 2010; Davis, 2009). Small group participation in a definitions matching cards game serves as an icebreaker, engagement exercise as well as clarifying definitions (Williams et al. 2014). The Sympathy versus Empathy video by Brene Brown [https://www.youtube.com/watch?v=1Evwgu369Jw](https://www.youtube.com/watch?v=1Evwgu369Jw) was also shown to differentiate and further highlight the effectiveness of empathy (Royal Society for the Encouragement of Arts, Manufactures and Commerce, 2013). Carl Rogers’ (1961) definition including the “As if” perspective was emphasized as being important in healthcare to both establishing authentic connections and preventing clinician distress. The concept of “leaning in” enough to connect meaningfully, yet not “leaning in” so far that the individual becomes emotionally distressed or conversely “leaning out” disconnected. Attuning with both patients and colleagues to meet each other’s needs was emphasized.

**Neurobiology and empathy.** Mirror neurons are a type of brain cell that respond equally when we perform an action and when we witness someone else perform an action. This may help explain why we feel empathy and be the basis of caring (Kelley, Lepo, & Frinzi, 2011). An exercise from Shawn Achor (2014) to demonstrate this was utilized. Paired up, participants looked at each other’s eyes for 10 seconds. One partner
was instructed to smile and the other to not smile. The reaction to this exercise served as an icebreaker, to encourage engagement and to demonstrate the effect we have on each other. It also served as a basis for participants to understand that we are somewhat hardwired to be empathetic and that with training, this can be enhanced (Kelley et al., 2011).

**Role playing.** Simulation exercises can lead to a richer understanding of the patient experience (Kelley, et al., 2011). The discussion that empathy may protect health providers from burnout (Halpern, 2003) and that it feels good to show empathy was stimulated by the roleplaying of scenarios between pairs in which participants first demonstrated no empathy when acting the scenario and then compared and contrasted that with a re-take roleplay using empathy. Use of the GE CAP tools to elicit participants thoughts on behaviors that inhibit or interfere with empathy (such as speaking before listening or trying to fix the problem) and those that enhance empathy (such as being curious) (Reiss, 2013) encouraged sharing.

**Heart-Head-Heart.** The inclusion of a communication tool to practice in the workshop and proceed with use in the workplace was suggested by curriculum development team members. The heart-head-heart tool was selected (Leebov, 2012). This tool promotes the use of language to address both caring and information. This is perhaps helpful as a strategy when considering the neurological fMRI study that shows that our brains are constrained from being both empathetic and analytic at the same time (Jack, Dawson, Begany, Leckie, Barry, Ciccia, & Snyder, 2013).

**Self-reflection.** Interventions to facilitate self-awareness are recommended to develop empathy (Williams & Stickley 2010). Towards the end of the workshop
participants were asked to pause and reflect upon which communication skill they felt they needed to keep working on. This was written down and kept with the student for future reference.

**Barriers.** Although empathy is known to have a positive impact on care, healthcare professionals do not necessarily demonstrate empathic behaviors (Dempsey & Wojciechowski, 2014; Reynolds & Scott, 2000). Health system issues in an increasingly complex environment may exacerbate this (Davis, 2009). Burnout severity is correlated with reduced empathy (Tei, et al., 2014). Empowering staff to redesign workflows may help to alleviate burnout (Felton, 1998). An exercise using the GE CAP tools that engaged staff in discussing their perceptions of barriers to using empathy was designed to provide staff with time for self-reflection on their behavior, identification of burnout and determine opportunities for organizational improvements.

**Self-care.** Healthcare professionals are at risk for burnout (Felton, 1998). High mental well-being is associated with enhanced empathy (Shanafelt, et al., 2005). A self-care discussion included the use of perspective taking, self-regulation and breathing to promote mindful stress relief (Riess, 2015) and incorporated a “Stop, Breath, Listen, and Respond” exercise to practice throughout the day. A relaxation exercise at the end of the workshop served to heighten awareness of the need to replenish in order to prevent burnout.

A pre-assessment and post assessment of empathy (see Appendices E & F) was selected to assist in measuring the initial effectiveness of the workshop (Ward et al., 2012; Williams et al., 2013). A post workshop evaluation (see Appendix G) was also developed to allow participants to rate the value of the topic, the delivery and to provide
immediate feedback to presenters. This feedback was important to allow immediate continual fine-tuning of the program.

**Video development.** A video to promote empathy was selected as an intervention to be developed by staff and the marketing department for the purpose of reinforcing and sustaining empathetic behaviors in all areas of the hospital. It is also used as a tool for enculturation of new staff into the organization during their hospital orientation. Inspiring this intervention was a video produced by the Cleveland Clinic (2013) that had positive impact on viewers prompting discussion, heightening awareness and attention to this topic (Riess et al., 2014). The filming of the video engaged staff in a meaningful way as they were asked to respond to the question “What is empathy?” Although the creation of a video is an innovation that is not evidence based for empathy training, it evolved from the literature that suggests story-telling and self-reflection can enhance empathy (Brunero, et al., 2009).

**Ongoing empathy enhancement program.** It is recognized that over time empathy diminishes (Chen et al., 2007), but with reflection and training, empathy can be enhanced as seen by self-assessment and patient rating of empathy using standardized tools (Riess et al., 2012). Ongoing activities in staff meetings, at staff huddles, and an emphasis on providing support organizationally for staff to demonstrate empathic behaviors (Dempsey & Wojciechowski, 2014) is necessary to sustain behavior change. The Empathy Enhancement Team which consists of approximately 30 frontline and management staff members throughout various departments of the organization meets regularly to develop and deploy these activities throughout the facility. This encourages engagement, ownership and the sustainment of the program. Organizational support
includes analysis and rework of some workflows and processes that present barriers and challenges to demonstrating empathy (Dempsey & Wojciechowski, 2014; Reynolds et al., 2000).

Summary

A low level of empathy in health care providers negatively affects patient outcomes and the patient experience. This is both a quality and financial concern as hospitals are reimbursed under pay-for-performance rules for providing both high quality patient care and high patient experience.

The synthesized literature consistently indicates that when empathy is utilized there is a positive impact on patient outcomes, patient experience, and employee engagement. The purpose of this project was to improve each of these areas. Although the literature shows that empathy may diminish with time, the literature also indicates that training, including self-awareness, simulation and experiential exercises, can improve empathy and aide in preventing burnout (Riess, 2015).

In order to sustain improvements, an empathy promotion video was developed, designed to help with the enculturation of new hire employees and reinforce empathy to present employees. An ongoing empathy enhancement program focuses on improving operational systems to support staff organizationally as well as exercises to keep empathic behaviors top of mind.

Pre and post empathy assessment measure staff response to the workshop, while HCAHPS and Gallup surveys measure patient experience and employee engagement, respectively. Key to the success of this project and culture change was the inclusion of staff members from a broad array of departments, encouraging input and high
participation. The General Electric Change Acceleration Program (GE CAP) tools were utilized to facilitate this engagement.
CHAPTER 3. METHODS

Introduction

Value-based purchasing demands that hospitals achieve both high quality clinical outcomes and high patient satisfaction with their experience in the hospital. Hospitals are incentivized to put both quality and patient experience as a top priority with this reimbursement model.

Evidence suggests that clinicians who demonstrate empathic behaviors positively impact healthcare outcomes and experience (Hardee, 2003; Lewin, Skea, Entwistle, Zwarenstein, & Dick, 2001; Moore, Wilkinson, & Mercado, 2004). In a correlational study design of 891 diabetic patients treated by 29 family physicians, the hypothesis of a positive relationship between physicians’ empathy and patients’ clinical outcomes was confirmed with patients with high empathy physicians significantly more likely to have good control of hemoglobin A1c (56% than were patients of physicians with low empathy scores (40%) (Hojat et al., 2011). It is also noted that healthcare professionals have improved job satisfaction and sense of fulfillment when empathic behaviors are engaged upon with the patient (Hardee, 2003).

Although empathy is known to have a positive impact on care, healthcare professionals do not necessarily demonstrate empathic behaviors. The consequence of failing to understand the needs of the patient may result in inadequate sharing of information and emotional support and contribute to poor health outcomes (Dempsey & Wojciechowski, 2014; Reynolds & Scott, 2000).

The purpose of this evidence-based practice project was to improve the patient experience and the experience of health care workers by enhancing empathy and
empathic behaviors in the adult inpatient venue. Incorporating empathy awareness strategies to improve empathic behavior long-term into the culture of Castle Medical Center (CMC) through an Empathy Enhancement Program is expected to improve the quality of care that is delivered. By increasing empathy, we will increase staff engagement in our mission and drive innovation to improve the patient experience.

The objective of this project was to implement and evaluate an Empathy Enhancement Program at Castle Medical Center. The Iowa Model of Evidenced-Based Practice to Promote Quality Care developed by Marita Titler (2001) was used as the conceptual model to form the organizing framework for implementing the steps of this project. This chapter will describe the interventions of the innovation; the characteristics, the sampling plan and data collection procedures as well as the program evaluation plan.

**Population, Intervention, Comparison, Outcomes (PICO) Statement.**

- Population - Adult inpatients and employees at Castle Medical Center
- Intervention - Empathy Enhancement Program
- Comparison - Current practice
- Outcomes -
  - Improved patient experience as measured by:
    - Increase in Hospital Consumer Assessment Healthcare Providers and Systems (HCAHPS) survey results to 80\textsuperscript{Th} percentile ranking.
    - 5\% decline in patient complaints.
    - 5\% decrease in 30-day readmissions.
  - Improved employee engagement as measured by:
    - 5\% increase in employee engagement via Gallup survey results.
- 3% decrease in employee turnover in 2015 compared with 2014.
  - 5% increase in employee empathy as measured by pre and post intervention empathy scales.

Table 3

Summary of Empathy Enhancement Program Outcome Measuring Tools, Pre-measures and Goals

<table>
<thead>
<tr>
<th>Outcome Measure / Tool</th>
<th>Premeasure 2014</th>
<th>Outcome goal for 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCAHPS overall rating</td>
<td>75th percentile ranking</td>
<td>80th percentile ranking</td>
</tr>
<tr>
<td>Patient complaints</td>
<td>2.3 per 1000 patient days</td>
<td>5% decrease</td>
</tr>
<tr>
<td>All cause 30-day readmissions</td>
<td>8.9 %</td>
<td>5% decrease</td>
</tr>
<tr>
<td>Gallup employee engagement survey</td>
<td>51st percentile ranking</td>
<td>5% increase</td>
</tr>
<tr>
<td>Employee turnover</td>
<td>19.6% overall</td>
<td>3% decrease</td>
</tr>
<tr>
<td>Post workshop empathy</td>
<td>Pre workshop empathy</td>
<td>5% increase</td>
</tr>
</tbody>
</table>

Design. This evidence-based practice project used a quality improvement design to evaluate the effectiveness of an Empathy Enhancement Program on patient experience, employee empathy, and employee engagement. A pre and post intervention assessment was administered using the Toronto Empathy Questionnaire for non-clinicians and the Jefferson Scale of Empathy – Health Profession version for clinicians.

Determine Practice Change

Setting. This project took place at Castle Medical Center (CMC) in Kailua, Hawaii. CMC was founded over 50 years ago through efforts of residents, physicians,
benefactors and the Seventh-day Adventist Church. It is a 160-bed facility that provides a full range of services including 24-hour emergency services, acute inpatient care, outpatient and home care, chemotherapy clinic, surgical weight loss institute, wellness and lifestyle medicine, joint care center, birth center, and cardiovascular surgical service line. CMC has a workforce of over 1000 employees and is recognized as a key provider of health care on Windward O’ahu. Caring for the community, and sharing God’s love is CMC’s mission and the feel of family and Aloha spirit is expressed by patients, staff and community. Since its foundation, CMC has been part of Adventist Health (AH) a not-for-profit health system based in Roseville, California and operated by the Seventh-day Adventist Church. AH is a regional system that operates in California, Hawai’i, Oregon, and Washington. It includes 20 hospitals, 220 rural health clinics and outpatient centers, 14 home care agencies, seven hospice agencies and four retirement agencies. AH has a workforce of 28,600 (CMC, 2014).

Social systems. The organization is made up of employees that have diversity in culture, education, religion, and exposure to clinical care and innovation. Each of these has an impact on the complexity. Promoting adoption at various levels and meeting many levels of literacy was required in the implementation of this project and was accounted for in the development of the workshop. The organization has a history of adopting change rapidly and successfully over the last 10 years. CMC also has well-established models for change implementation such as the Plan, Do, Check, Act, process improvement model.

There is a high degree of interconnectedness at CMC. It is large enough, with moderate centrality and enough organizational slack to encourage and provide adequate
resources for innovation. It is also small enough to be able to involve stakeholders quickly and effectively. Each employee was reached by 3-6 different methods of communication regarding the project. The mission of “Caring for our community and sharing God's love” provides another level of interconnectedness. This mission provides a spiritual underpinning that provides a backdrop to promoting empathy. Many staff are from our Windward community and utilize the medical center for their own and their family needs. The level of connectedness is increased when staff know that they are both a giver and receiver (at some point) of the care delivered.

This program was designed to meet organizational goals of improving the patient experience and quality of care. This matching has made it possible to receive an Innovations grant from the Innovations Council of Adventist Health. The centralization of CMC within the Adventist Health Corporation has allowed this innovation to emerge.

Sample. All 1054 employees at Castle Medical Center were included in the Empathy Enhancement Program entitled, “In Their Shoes”. Exclusion criteria for employees included those that were on an extended leave of absence. The patient population included for outcome measurement included all adults that are admitted as an inpatient to the facility with the exception of the Behavioral Health Unit patients that are not included in the HCAHPS patient experience survey.

Users of Innovation. Although CMC has a reputation for being a very warm organization, there is an opportunity for all employees to enhance their empathic behavior in the workplace. From information obtained in sensing sessions at multiple staff meetings in multiple departments, there appeared to be a large early majority group and a smaller late majority group. This population attended the workshop with some
initial reservations but enjoyed it and saw relevancy quickly as reflected in the workshop evaluations. Many of the early majority were opinion leaders and perhaps influenced the late majority.

Over 30 innovators and early adopters were involved with the planning of the project and the development of the workshop as part of the three planning sub-teams that were formed. This group were easy to convey the vision to and became involved quickly contributing ideas and developing ownership. They then communicated the vision to others through word-of-mouth and departmental specific internal communication methods.

The late adopters may have believed that the project did not apply to them. As the workshop was mandatory for all staff, there were a few staff that were late signing up or arrived to it with negative preconceived ideas of its relevancy. Through repeated communication via multiple sources these ideas were somewhat dispelled. As the workshop consists of many exercises that are specifically designed to encourage engagement and self-awareness, much of this negativity was reduced as staff found themselves relaxing, having fun and were exposed to the relevancy of empathy in everyday life as well as their workplace. Those late adopters that I was aware of, I met with ahead of time to give them time to discuss with me their concerns. Their peers who attended the workshop ahead of them imparted an opinion that may have influenced the late adopter also. I also included a late adopter who is an opinion leader in the workshop development team. This person provided critique, but also some good ideas that helped with development.
**Interventions.** The program included an initial intervention of a workshop (see Appendix D). This was followed by the creation of a video to promote and reinforce concepts learned in the workshop and to also be used in enculturation of new employees. The program will continue with the development of interventions to promote sustained empathic behaviors, such as empathy promotion exercises conducted at staff meetings quarterly (see Table 4). A toolkit consisting of the workshop curriculum, props, activities, and video has been developed and packaged for dissemination to other Adventist Health facilities for use.
**Table 4**  
*Summary of Empathy Enhancement Program Interventions at Castle Medical Center*

<table>
<thead>
<tr>
<th>What</th>
<th>Who</th>
<th>When</th>
<th>How</th>
</tr>
</thead>
<tbody>
<tr>
<td>90-minute empathy enhancement workshop</td>
<td>All employees &amp; new hires</td>
<td>Initial March – June 2015 &amp; ongoing</td>
<td>Taught by trained “Empathy Champions”</td>
</tr>
<tr>
<td>Empathy video</td>
<td>All employees including new hires</td>
<td>June -Nov 2015</td>
<td>Developed by staff and Marketing department</td>
</tr>
<tr>
<td>Toolkit for program dissemination</td>
<td>Adventist Health West</td>
<td>July – Dec 2015</td>
<td>Project team developed for dissemination at corporate health system level</td>
</tr>
<tr>
<td>Sustained empathy enhancement exercises</td>
<td>All employees at CMC</td>
<td>July 2015 - ongoing</td>
<td>Developed by the project team for use at staff meetings</td>
</tr>
<tr>
<td>Examination of operational barriers to empathy with recommendations</td>
<td>All employees at CMC</td>
<td>March 2015 – ongoing</td>
<td>Feedback was gathered in workshops, collated and next phase recommendations made to leadership</td>
</tr>
</tbody>
</table>

Finally, in order to address operational barriers to empathy, examination of employee feedback and recommendations for workflow analysis were made to leadership to support changes that allow promotion of empathy in areas of impact. The implementation of these will depend on future available organizational resources.

**Characteristics of the Innovation.** Rate of adoption of an innovation is different for users and the characteristics of an innovation affect it. Rogers (2003) describes these as being compatibility, relative advantage, complexity, observability and trialability.
Compatibility. This innovation is compatible with health system goals as evidenced by Adventist Health’s allocation of grant money to this project from its Innovation Seed Money Grant program. The Adventist Health corporate strategic plan includes the theme of Care Transformation and Population Health, specifically in alignment with the Patient Experience Redesign initiative. Reimbursement for health care is dependent on quality outcomes and the patient experience. An increase in empathy of staff is expected to increase our ability to deliver these outcomes and is therefore compatible with the strategic plan and needs of the adopters.

Encouraging staff to connect with the patient and each other through authentic empathic behaviors is compatible with Castle Medical Center’s mission of “Caring for our Community and Sharing God’s Love”. The project is seen as an innovative way of promoting care and God’s love.

Relative advantage. Empathy can be taught; the most effective methods thus far include self-awareness and targeted experiential methods (Brunero et al., 2009). A 90-minute workshop for all 1100 CMC employees was conducted that focused on self-awareness and experiential exercises to promote understanding of the patient/family experience (Brunero, Lamont, & Coates, 2009). The relative advantage of this workshop is that it assists in connecting staff to their own personal mission in providing care and understanding the value for themselves as well as the patient in connecting at a relationship level with the patient (Dempsey & Wojciechowski, 2014). Also, healthcare professionals note improved job satisfaction and sense of fulfillment when empathic behaviors are engaged upon with the patient (Hardee, 2003).
The workshop is entitled, “In Their Shoes”. A logo and slogan developed with the marketing department for all communications adds observability to the program. To align with cultural mores regarding shoes in Hawaii, a slipper (flip-flop) was used in the logo. The “In Their Shoes” theme was embedded further into the workshop with staging of the classroom with poster sized shoe-shaped word clouds on the walls and “In Their Shoes” role-playing exercises.

The workshop consisted of small groups (< 20 people) and contained a mix of clinical and non-clinical employees from across multiple departments. This interdisciplinary composition provided participants with an opportunity to build relationships and learn from each other (Crandall & Marion, 2009). The advantages of demonstrating empathy with patients, their family members, and colleagues became apparent to participants as discussion surrounding positive outcomes ensued within the workshop.

In addition to the goal of individual awareness and enhanced empathy, another objective for the workshop was for staff to come away with a simple tool that they could put into practice immediately. This may be as simple as taking time to sit down when engaging in conversation with the patient and employing the Stop, Breath, Listen, Respond mindfulness technique for preparing to cultivate an empathic environment. The Heart-Head-Heart communication model is another tool that was introduced in the workshop. These tools were seen as a relative advantage as staff had expressed the preference for a tangible tool to employ after the workshop.

*Complexity.* Empathy can be difficult to define and demonstrated empathic behaviors difficult to impact without long-term efforts. Combined with the large volume
of staff we involved, this adds a level of complexity to this project innovation.

Continuing the learning completed in the workshop is essential to address this and sustain change. Quarterly empathy enhancing activities to be conducted at staff meetings are being developed on an on-going basis, and will keep the subject top-of-mind and a high priority throughout the organization.

The topic of compassion burnout emerged as a barrier to empathy and added complexity to this project also. Although the literature addresses burnout in the context of improved job satisfaction with focus on demonstrating empathic behaviors, it is a topic that workshop facilitators needed to be sensitive to. Referral to the Employee Assistance Program for access to resources to address this may be appropriate in some instances. Early intervention to address burnout should be addressed from an organizational standpoint in terms of promoting staff resiliency and resolving workflow inefficiencies.

**Observability.** A video that captures the value of and promotes empathy was developed internally with the marketing department and reinforces empathetic behaviors in all areas of the hospital. The video is used to orient new staff to the expectations and culture of Castle Medical Center. A video made by the Cleveland Clinic (2013) has had a positive impact on viewers (Riess et al., 2014) prompting discussion, heightened awareness, and attention to this topic. This video will increase the observability of the innovation and help to ensure sustained change.

**Trialability.** The workshop was trialed with a pilot group initially to gain input from a variety of staff. Ongoing feedback was received via the evaluation form and through informal discussions. The workshop can be modified very easily as feedback is
received from participants and the order of activities was manipulated as part of this fine-tuning process.

**Sustainability.** It is recognized that over time empathy diminishes (Chen et al., 2007), but that with reflection and training, empathy can be enhanced (Riess et al., 2012), thus ensuring sustainability. Ongoing activities in staff meetings, at staff huddles, and an emphasis on providing support organizationally for staff to demonstrate empathic behaviors (Dempsey & Wojciechowski, 2014) is necessary to sustain behavior change. The Empathy Enhancement project team continues to meet on an ongoing basis as a sub-committee of the Patient Experience Council. This team generates activities and diffusion of these will occur through Leadership and Empathy Champions. Ongoing 90-minute workshops monthly for new staff were approved by CMC leadership to enculturate new employees and sustain the initiative.

Organizational support of sustained enhancement of empathy may require an analysis of some workflows and processes that present barriers and challenges to demonstrating empathy (Dempsey & Wojciechowski, 2014; Reynolds et al., 2000). Feedback on barriers was obtained from staff during the workshop, in a “Barriers to Empathy” exercise. From this exercise, recommendations for future innovations were developed with the themes of employee resiliency and workflow improvement as future opportunities.

All interventions in the Empathy Enhancement Program have not only relative advantage for staff, but also enhance sustainability by giving them time away from their regular work to reflect, have fun, and reconnect to their personal mission and vision. The activities are presented in a way that encourages staff participation, are experiential, and
gives the participant time to reflect on and share their own experiences and stories. This connection to meaning and making a difference in their work may aide in rejuvenating staff and renewing passion for their work.

Pilot Practice Change

The program was piloted in three ways:

1. Prior to the workshop, brief priming exercises using the General Electric Change Acceleration Program (GE CAP) tools were conducted at targeted staff meetings to measure support and garner input regarding teaching strategies.

2. The workshop curriculum was trialed on a group of staff members from various departments and altered based on their feedback.

3. The Empathy Marketing team shared video ideas with the Project team, for feedback regarding the videos effectiveness at promoting empathy and conveying the cultural expectations of its use at Castle Medical Center.

Institute Practice Change

The practice change of increasing use of empathy in interactions with patients, family members, and colleagues was instituted primarily through the workshop. Pre-interventions to prime participants for the workshop included use of the General Electric Change Acceleration Program tools in obtaining input into what participants would like to see in the workshop and how they believe empathy can be enhanced. The pre-work also included activities to stimulate thinking about what empathy is, and how it feels to both the giver and the recipient of empathy. The goal of this pre-work was to stimulate thinking so that workshop participants were not starting the workshop entirely cold to the
subject. Given that the workshop is only 90 minutes, it may have been of benefit for participants to arrive with some understanding of the subject in order to gain the most benefit from the activities.

**Conceptual definition.**

*Empathy.* Carl Rogers (1961) described empathy as the non-judgmental communication of understanding of the feelings and personal meanings of the client, while staying aware of the distinction of his own identity, the “as if” way of thinking. The attributes of empathy are summarized by Wiseman (1996) in her concept analysis, as being the ability to see the world as others see it, be nonjudgmental, understand another person’s feelings, and communicate that understanding.

**Operational definitions:**

*Empathy.* The definition of empathy used in this program is the self-rating of employees’ empathy pre and post “In Their Shoes” empathy enhancement workshop as measured by the Toronto Empathy Questionnaire (non-clinicians) and the Jefferson Scale of Empathy for Health Providers (clinicians).

*Patient experience.* The definition of patient experience used in this program is the rating by patients of their experience in the hospital using HCAHPS, which gives an overall rating of the hospital as well as rating elements of care including communication with nurses and doctors, staff responsiveness, pain management, communication about medicines, cleanliness and quietness of hospital environment, discharge education, and care transitions.

*Patient readmission.* The definition of patient readmissions used in this program is the all cause readmission of patients within 30 days of discharge for those initially
admitted with an acute diagnosis of Chronic Obstructive Pulmonary Disease, total hip or knee arthroplasty, acute myocardial infarction, pneumonia or congestive heart failure.

**Patient complaints.** The definition of patient complaints used in this program is the complaints of patients that are not resolved at point of care and are escalated to the risk management department for aid with resolution.

**Employee engagement.** The definition of employee engagement used in this program is rating of employee’s own engagement as measured by the Gallup Q12 employee engagement survey, which asks the following questions:

- I know what is expected of me at work
- I have the materials and equipment I need to do my work right
- At work, I have the opportunity to do what I do best every day
- In the last seven days, I have received recognition or praise for doing good work.
- My supervisor, or someone at work, seems to care about me as a person.
- There is someone at work who encourages my development.
- At work, my opinions seem to count
- The mission or purpose of my organization makes me feel my job is important.
- My fellow employees are committed to doing quality work.
- I have a best friend at work
- In the last 6 months, someone at work has talked to me about my progress
- This last year, I have had opportunities at work to learn and grow.

**Employee turnover.** The definition of employee turnover used in this program is the amount of employees that voluntarily or involuntarily leave CMC within the year 2015.
**Recruiting/marketing plan.** Buy in from stakeholders throughout the hospital was required in order to achieve maximum attendance at the workshop. In addition to the input received from departments via the pre-workshop primer, three sub-teams (Curriculum, Communication/Marketing, & Logistics) were developed to encourage stakeholder involvement in the project. Involvement and input encouraged ownership. The Communication/Marketing sub-team developed communication that was disseminated through usual mass media hospital communication routes as outlined in Table 5.
Table 5.

*Communication and Marketing Plan*

<table>
<thead>
<tr>
<th>Communication Method</th>
<th>Frequency &amp; Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ulupono magazine</td>
<td>Magazine produced monthly for all employees.</td>
</tr>
<tr>
<td>Kathy’s Aloha Friday Report</td>
<td>Weekly message emailed from the CEO to all employees.</td>
</tr>
<tr>
<td>Leadership Meeting</td>
<td>CEO/VP monthly meeting with Directors and Managers.</td>
</tr>
<tr>
<td>Castle MD</td>
<td>Quarterly magazine for physicians.</td>
</tr>
<tr>
<td>Staff meetings</td>
<td>“In Their Shoes” agenda item on monthly meeting in most departments.</td>
</tr>
<tr>
<td>Castle Leadership Institute</td>
<td>Quarterly gathering of all leadership including supporting leaders such as Charge Nurses.</td>
</tr>
<tr>
<td>Weekly Huddle</td>
<td>Weekly for all staff in huddles.</td>
</tr>
<tr>
<td>Workshop flyers</td>
<td>A series, posted weekly on departmental notice boards and in elevator poster holders.</td>
</tr>
<tr>
<td>Newsletter</td>
<td>Weekly, departmental specific.</td>
</tr>
<tr>
<td>Pre-workshop primer</td>
<td>At departmental staff meetings.</td>
</tr>
<tr>
<td>Email invitation from CEO</td>
<td>To CMC All email group</td>
</tr>
</tbody>
</table>

An interpersonal method of communication and marketing of the program occurred through 20-minute engagement exercises at multiple different department staff meetings. These exercises were conducted with various staff to obtain input regarding development of the workshop. A train-the-trainer method was used to implement the workshops. This is another interpersonal method of communication. The trainers are opinion leaders in the organization and come from various departments, both clinical and
non-clinical. By involving these trainers in the teaching of the workshop, continuity of the program will be ensured and ownership by informal leaders will occur.

**Resources.** A grant from Adventist Health for $48,000 was received for implementation of an Empathy Enhancement Program at Castle Medical Center. This grant was used as outlined in Table 6. Quarterly reports to the Adventist Health Innovations Seed Money Committee on project implementation were completed.

Resources to develop curriculum for the workshop and video and any other costs came out of existing department budgets.

Table 6

*Resources and Budget for Implementation of Empathy Enhancement Program*

<table>
<thead>
<tr>
<th>Step</th>
<th>Cost</th>
<th>Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Education via Workshop</td>
<td>90 min class x 1000 employees. ($30/hour) = $45,000</td>
<td>Innovations grant</td>
</tr>
<tr>
<td>Curriculum development &amp; workshop logistics</td>
<td>160 hours</td>
<td>Individual department budgets</td>
</tr>
<tr>
<td>Marketing of project &amp; workshop</td>
<td>$1000 + time of staff</td>
<td>Marketing department budget</td>
</tr>
<tr>
<td>Video production</td>
<td>$3000</td>
<td>Innovations grant for production by CMC Marketing department</td>
</tr>
</tbody>
</table>

**Milestones and Timeline.** As the resources for this project primarily came from a grant, there were some time constraints for implementation. Completion of the workshop and costs for the video parts of the Empathy Enhancement Program needed to be complete by June 30, 2015. The timeline is outlined in Table 7.
<table>
<thead>
<tr>
<th>Milestone</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formation of 3 stakeholder sub-teams (Communication/Marketing, Logistics, Curriculum)</td>
<td>December 2014</td>
</tr>
<tr>
<td>Mobilize commitment through marketing strategy</td>
<td>December 2014</td>
</tr>
<tr>
<td>Determine exact dates/times/location of Workshops</td>
<td>December 2014</td>
</tr>
<tr>
<td>Develop video ideas</td>
<td>January 2015</td>
</tr>
<tr>
<td>Communication of workshop via marketing strategy</td>
<td>February 2015</td>
</tr>
<tr>
<td>Workshop Sign up online in HealthStream</td>
<td>February 2015</td>
</tr>
<tr>
<td>Complete workshop curriculum</td>
<td>February 2015</td>
</tr>
<tr>
<td>Pre-workshop primer exercise/input at staff meetings</td>
<td>February 2015</td>
</tr>
<tr>
<td>Complete workshop pilot</td>
<td>February 2015</td>
</tr>
<tr>
<td>Pre-workshop empathy assessment</td>
<td>February 2015</td>
</tr>
<tr>
<td>Obtain baseline employee engagement survey data, staff turnover data, patient readmission data, patient complaint data, and inpatient HCAHPS data</td>
<td>February 2015</td>
</tr>
<tr>
<td>Pilot workshop, obtain participant feedback, modify curriculum as needed</td>
<td>March 2015</td>
</tr>
<tr>
<td>Complete workshop and post-workshop empathy assessment</td>
<td>June 2015</td>
</tr>
<tr>
<td>Video filming</td>
<td>June 2015</td>
</tr>
<tr>
<td>Collate feedback from workshop evaluation</td>
<td>July 2015</td>
</tr>
<tr>
<td>Develop empathy enhancing activities for quarterly activities</td>
<td>July 2015</td>
</tr>
<tr>
<td>Develop toolkit for Adventist Health dissemination</td>
<td>July 2015</td>
</tr>
<tr>
<td>Complete Innovations grant report back to Adventist Health</td>
<td>July 2015</td>
</tr>
<tr>
<td>Show video to all staff and include in new hire orientation</td>
<td>November 2015</td>
</tr>
</tbody>
</table>
Table 7. (Continued) *Detailed Timeline for Empathy Enhancement Project*

*Implementation*

<table>
<thead>
<tr>
<th>Activity</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Package toolkit for Adventist Health dissemination</td>
<td>November 2015</td>
</tr>
<tr>
<td>Monitor post workshop Inpatient HCAHPS data collection (lag time at least 1 month)</td>
<td>July – Dec 2015</td>
</tr>
<tr>
<td>Complete 2015 employee engagement survey</td>
<td>September 2015</td>
</tr>
<tr>
<td>Collate post intervention evaluation data: employee engagement survey data, staff turnover data, patient readmission data, patient complaint data, and inpatient HCAHPS data</td>
<td>Jan – March 2016</td>
</tr>
</tbody>
</table>

*Monitor & Analyze Structure, Process, & Outcome Data*

Empathy is not easy to teach or assess due to its nebulous properties (Williams & Edlington, 2014). The application of assessment tools pre and post workshop provides an indication of impact, but does not indicate behavior change. Behavior will perhaps change in subtle ways that are difficult to measure, such as kindness given as an employee walks a lost visitor to their destination, or an intentionally listening ear to a patient as they voice anxiety. Impact therefore must be measured through measureable outcomes that indicate attunement to patients and engagement between staff. There are many other initiatives in the hospital that have been implemented during the same timeframe that may have impacted the same metrics. The faith based culture and feeling of family that exists at CMC provide a catalyst for this program and shape the individual actions of staff also. These variables cannot all be accounted for and are a limitation of the evaluation of this program. However, based on suggestions from the literature, the evaluation of the Empathy Enhancement Program consists of the following quantitative and qualitative measures (see Table 8).
**Program evaluation plan: Employee related measures.** An increase in empathy is suggested to improve employee engagement. These measures are outlined as follows:

*Workshop evaluation.* 90% of staff attended the workshop and all attendees completed an evaluation form (see Appendix G). Results were reviewed daily to provide feedback to workshop facilitators for potential program modification.

*Empathy assessment tool.* Several tools were examined for use with this project. The tools chosen are The Jefferson Scale of Empathy – Health Profession version, for administration with clinicians (see Appendix E); and the Toronto Empathy Questionnaire, for administration with non-clinicians (see Appendix F). These tools were to be administered pre-workshop and within one to three months after the workshop. These tools are self-rating assessments and administered via HealthStream, an online education and competency tool. Results were to be reviewed in aggregate; individual results not reviewed.

The Toronto Empathy Questionnaire consists of 16 items measuring the emotional and behavioral aspects of empathy in the general population. It is considered to have good internal consistency with Cronbach’s alpha of .85, high test-retest reliability and “is a brief, reliable, and valid instrument for the assessment of empathy” (Spreng, McKinnon, Mar, & Levine, 2009, p.62).

The Jefferson Scale of Physician Empathy is an instrument that was developed by researchers at Jefferson Medical College for use in the context of medical education and patient care. The Health Profession version was later introduced for use more broadly amongst other health professionals and includes 20 items answered on a 7-point scale.
This scale is widely referred to in the literature pertaining to empathy in health care and is considered to have good validity, consistency, and high test-retest reliability (Hojat et al., 2009). The Cronbach’s alpha is 0.87 with residents and 0.89 with medical students (Yu & Kirk, 2009).

**Gallup Q12 survey.** Employee engagement is currently measured by the Gallup Q12 survey (see Appendix B). This survey is administered yearly and asks 12 simple questions that are rated on a 1 to 5 scale and highlights strengths and opportunities. CMC took this survey for the first time in October 2014. These results are utilized as the baseline.

The Gallup Q12 survey is based on more than 30 years of quantitative and qualitative research. Its reliability and validity have been extensively studied and its Cronbach’s alpha is 0.91. The survey has two categories: the first category measures attitudinal outcomes such as satisfaction, loyalty, pride, customer service intent, and intent to stay with the company. The second category measures actionable issues that drive outcomes (Harter, Schmidt, Killham, & Asplund, 2006).

**Employee turnover.** The rate of employee turnover is a determination of employee satisfaction and engagement. The Human Resource department at CMC tracks this currently, reviewing length of employment before termination, voluntary versus involuntary termination, reason for termination and role in organization. In 2014, CMC had a turnover rate of 19.6%. Registered Nurse turnover was 14.6%. The national average turnover rate for hospitals is 16.5% and the “average cost of turnover for a bedside RN ranges from $44,380 to $63,400” (Nursing Solutions, Inc. 2014, p.1).
**Program evaluation plan: Patient related measures.** An increase in empathy is suggested to improve patient experience and health outcomes. The following metrics will be utilized to help evaluate program effectiveness.

**Hospital Consumer Assessment of Healthcare Provider Systems survey (HCAHPS).** This is a national standardized survey tool consisting of 27 questions used since 2006 to measure patients’ perspectives of hospital care (see Appendix A). It enables valid comparisons across all hospitals and supports consumer choice with care options. The survey asks random discharged adult patients, questions about seven domains of care: nurse communication, nursing services, doctor communication, physical environment, pain control, communication about medicines, and discharge information. It also assesses overall rating of the hospital, and whether or not the patient would recommend the hospital to family and friends. The seven composites had a median internal consistency reliability of 0.69 and a median hospital-level reliability of 0.74 in the pilot study completed (Agency for Healthcare Research & Quality, 2003). The reliability target for the HCAHPS items is 0.8 or higher. Based on this target, hospitals must obtain at least 300 completed surveys over the 12-month reporting period (CMS, 2014). CMC HCAHPS results from 2014 are utilized as baseline data and moving forward, quarterly results will be reviewed and compiled for evaluation of this project.

**Patient complaints.** The Risk Manager collects the number of patient complaints monthly. Results from 2014 are used as a baseline. The literature suggests that with increased empathy and compassionate behavior, patient needs are met more consistently and complaints may be reduced (Bramley & Matiti, 2014). The introduction of a new
patient complaint software system in March of 2015 may have affected reporting of complaints and influence use as a metric for this project.

**Readmissions.** As with patient complaints, if there is an increase in empathy, clinicians may be more attuned to patient needs, and prevent unnecessary readmissions within 30 days to the hospital. This data is currently collected by our Quality Department. Results from 2014 are utilized as the baseline. Hospital Compare reports 30-day readmissions for patients with acute myocardial infarction, heart failure, pneumonia, hip/knee replacement, stroke, chronic obstructive pulmonary disease, and overall rate of unplanned readmission after discharge. This is risk-adjusted data to make true comparison of hospital performance possible (CMS, 2014).
Table 8

*Data Collection Procedures for Evaluation of Empathy Enhancement Program*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Instrument</th>
<th>Data collection point</th>
<th>Data analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Measures</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empathy pre workshop</td>
<td>Jefferson empathy scale health provider version (clinicians).</td>
<td>Within 1 day of workshop</td>
<td>Descriptive statistics</td>
</tr>
<tr>
<td>intervention</td>
<td>Toronto empathy questionnaire (non-clinicians).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empathy post workshop</td>
<td>Jefferson empathy scale health provider version (clinicians).</td>
<td>Within 1 month of workshop</td>
<td>Descriptive statistics</td>
</tr>
<tr>
<td>intervention</td>
<td>Toronto empathy questionnaire (non-clinicians).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workshop attendance</td>
<td>HealthStream database</td>
<td>Daily at each workshop</td>
<td>Descriptive statistics</td>
</tr>
<tr>
<td>Workshop evaluation</td>
<td>Evaluation form</td>
<td>Daily at each workshop</td>
<td>Identify themes for modification</td>
</tr>
<tr>
<td>Barriers to</td>
<td>Workshop exercise</td>
<td>Daily at each workshop</td>
<td>Identify themes for resource allocation</td>
</tr>
<tr>
<td>implementation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outcome Measures</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient experience</td>
<td>HCAHPS survey tool</td>
<td>Quarterly</td>
<td>Descriptive statistics and trend analysis</td>
</tr>
<tr>
<td>Patient complaints</td>
<td>Risk management records</td>
<td>Quarterly</td>
<td>Descriptive statistics and trend analysis</td>
</tr>
<tr>
<td>Patient readmissions</td>
<td>Patient records</td>
<td>Quarterly</td>
<td>Descriptive statistics and trend analysis</td>
</tr>
<tr>
<td>within 30 days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee engagement</td>
<td>Gallup Q12 survey tool</td>
<td>Yearly</td>
<td>Descriptive statistics and trend analysis</td>
</tr>
<tr>
<td>Employee turnover</td>
<td>Employee records</td>
<td>Quarterly</td>
<td>Descriptive statistics and trend analysis</td>
</tr>
</tbody>
</table>

**Human subjects considerations.** The Empathy Enhancement Program has been designed to protect the rights of all human subjects. As a quality improvement initiative,
participants freely choose their level of engagement in the workshop, viewing of the video, and participation in ongoing activities. These are considered standard, evidence-based interventions.

As all employees are participating in the program, they are being treated fairly and there are no plans to randomize participants to different interventions or treatments. The program does not increase risk to participants compared with current practice. The workshop evaluation serves as a method to receive feedback for modification as participants make suggestions. The benefit of the project implementation for employees and patients lies in the improved ability to identify the context, meaning, and feelings of another and communicate those feelings to the other person. Person-identifiable information is not collected.

A committee consisting of faculty, CMC leadership and clinical experts reviewed this project to ensure that there is sufficient human subjects’ protection. This author has completed the Collaborative Institutional Training Initiative program in human subjects’ research protection. As a quality improvement initiative, this project was not designed as a systematic investigation or intended to generate generalizable new knowledge.

**Limitations.** High-level evidence that provides exact methodologies for impacting empathy long term is limited, however, most courses are longer than a 90-minute workshop. Sustained activities are important as follow up to the initial intervention. Various empathy champions facilitated the workshop, and the quality of their delivery may have limited impact on participants. Co-facilitation by the curriculum team may have helped to standardize delivery. Behavior change of participants cannot be assumed even if the pre and post workshop assessment of empathy showed improvement.
The impact of interventions to outcomes are difficult to quantify, as there are many initiatives throughout the hospital that may have impacted the same patient and employee metrics.

**Summary**

This chapter discusses the intervention of an Empathy Enhancement Program; it’s method of implementation and the plan to evaluate results. The purpose of this DNP project is to improve the empathy of employees at Castle Medical Center. In turn, it is expected that employees will be more attuned to and better able to meet the needs of patients, families, and colleagues. This program was expected to result in improved patient experiences, better patient outcomes, and higher staff fulfillment and engagement.
CHAPTER 4. RESULTS

Introduction

There is evidence in the literature that the use of empathy in the healthcare environment can improve patient outcomes, improve the patient experience, and improve employee engagement. The implementation of an Empathy Enhancement Program at Castle Medical Center encompassed the development and completion of a 90 minute workshop for employees, the development of an empathy enhancement video for use in new hire orientation, the creation of an empathy enhancement toolkit for other Adventist Health facilities to use, and a plan for ongoing quarterly empathy enhancement activities to sustain the initiative. Following the Iowa Model of Evidence Based Practice (EBP) change, the workshop was piloted with a core group of attendees from various clinical and non-clinical departments and modified based on their feedback. Over the next three months the workshop was completed and during the following six months the program was fully implemented. Goals were set based on 2014 pre-measures and monitoring and analysis of metrics during 2015 included employee and patient outcomes, workshop attendance, post workshop evaluations, and use of financial resources.

Description of the Sample

Employee sample. 983 of 1054 employees at Castle Medical Center were included in the Empathy Enhancement Program entitled, “In Their Shoes”. Exclusion criteria for employees included those that were on an extended leave of absence. Clinical and non-clinical staff were included, with the program mandated for all staff. Employees who did not attend were those on a leave of absence during the implementation time frame. This consisted of 7% of total staff.
**Patient sample.** The patient population included for outcome measurement included all adults that were admitted as an inpatient to the facility Jan through December of 2015, excluding the Behavioral Health Unit. The Behavioral Health unit is not included in readmissions data or the HCAHPS survey.

**Trend Analysis for Process and Outcome Variables**

The objectives for implementing this project at CMC were to improve empathy in healthcare workers, improve employee engagement, and improve inpatient experience results. The program was evaluated by attendance at the empathy enhancement workshop, attendee evaluation of the workshop, pre and post intervention staff empathy assessments, HCAHPS survey results, number of patient complaints, patient readmission rate, Gallup employee engagement survey results, and rate of employee turnover.

**Workshop attendance.** The workshop was offered at many different times of the day and evening and attendance was supported and encouraged by leaders. Both clinical and non-clinical staff attended from 72 different departments with 93% participation.

**Workshop attendee evaluation.** Attendees completed a 5-point Likert scale evaluation on paper at the end of the workshop and scored the training an average of 18.69 out of a possible 20 points (see Appendix G). In free text comments participants discussed particular concepts in the workshop that they appreciated and practice changes they intended to make. Participants also expressed gratitude for the opportunity to spend time on this topic and feedback that completing the workshop reminded them of why they were working in healthcare. Many shared that they felt inspired and rejuvenated and that they enjoyed spending time with new people from different departments. Others shared that the content of the workshop was also useful for everyday life. Although there were
no responses selected that were negative (disagree or strongly disagree) on the Likert scale, 4% of responders answered neutral to the question regarding applicability of the workshop to their professional practice. These responders were mostly non-clinicians.

**Pre and post workshop empathy assessment.** Attendees completed the empathy assessment within one month pre and three months post the workshop. Clinicians completed the Jefferson Scale of Empathy for Health Professionals (see Appendix E) and non-clinicians completed the Toronto Empathy Questionnaire (see Appendix F). Results were aggregated organizationally.

**Clinical pre and post assessment based on Jefferson Scale of Empathy.** The Jefferson scale of empathy has 20 items for the respondent to answer. Ten items are directly scored using a Likert scale from 1-7, from Strongly Disagree (1) to Strongly Agree (7). There are 10 items that are reverse scored from Strongly Disagree (7) to Strongly Agree (1) (see Table 9). The higher the score the more empathic the inclination. The total pre-score was 116.78 and total post-score was 117.64 (see Figure 7). The maximum possible total score is 140. The overall score of empathy for clinical staff increased by 0.74% after the workshop.
There was an improvement in many scores to individual questions as expected. For example when asked “Patients value a healthcare provider's understanding of their feelings, which is therapeutic in its own right”, there was 17% increase in those who “strongly agreed” and 7.2% decrease in those who “strongly disagreed”.

However, there appeared to be some uncertainty from the respondents regarding some questions as evidenced in the following results. When asked about “Empathy is a therapeutic skill without which a healthcare providers' success is limited”, as expected, there was 28.9% increase in those who “strongly agreed”, however, there was a 48.5% increase in those who “strongly disagreed”. Additionally, there were some unexpected answers, for example when asked about “A healthcare provider's sense of humor
contributes to a better clinical outcome”, there was 32.6% increase in those who
“strongly disagreed” and only 4.3% increase in those who “strongly agreed”.

Table 9

*Difference (%) in Pre and Post Assessment Scores for Clinical Staff Based on Jefferson Scale of Empathy at Castle Medical Center*

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Question</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Not Sure</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Healthcare providers' understanding of their patients' feelings and the feelings of their patients' families does not influence treatment outcomes</td>
<td>+6.5</td>
<td>-9.9</td>
<td>-43</td>
<td>+19.4</td>
<td>-7.2</td>
<td>+21.9</td>
<td>-2</td>
</tr>
<tr>
<td>2</td>
<td>Patients feel better when their healthcare providers understand their feelings</td>
<td>+0.6</td>
<td>0</td>
<td>0</td>
<td>+179</td>
<td>-26</td>
<td>-2.1</td>
<td>+0.5</td>
</tr>
<tr>
<td>3</td>
<td>It is difficult for a healthcare provider to view things from patients' perspectives</td>
<td>+11</td>
<td>+2.3</td>
<td>-18</td>
<td>+45.9</td>
<td>+1.5</td>
<td>-4.5</td>
<td>-26</td>
</tr>
<tr>
<td>4</td>
<td>Understanding body language is as important as verbal communication in healthcare provider-patient relationships</td>
<td>+6.1</td>
<td>-54</td>
<td>-7.2</td>
<td>+179</td>
<td>-30</td>
<td>+3.1</td>
<td>-1.5</td>
</tr>
<tr>
<td>5</td>
<td>A healthcare provider's sense of humor contributes to a better clinical outcome</td>
<td>+32.6</td>
<td>-59</td>
<td>+85.7</td>
<td>-35</td>
<td>-9.9</td>
<td>+14.8</td>
<td>+4.3</td>
</tr>
<tr>
<td>6</td>
<td>Because people are different, it is difficult to see things from patients' perspectives</td>
<td>+17.6</td>
<td>-2.8</td>
<td>+1.1</td>
<td>+11.4</td>
<td>-13</td>
<td>-29.1</td>
<td>-41</td>
</tr>
<tr>
<td>7</td>
<td>Attention to patients' emotions is not important in patient interviews</td>
<td>+0.9</td>
<td>-1.5</td>
<td>+1.3</td>
<td>+48.5</td>
<td>-54</td>
<td>+104</td>
<td>-69</td>
</tr>
</tbody>
</table>
Table 9 (Continued) *Difference (%) in Pre and Post Assessment Scores for Clinical Staff Based on Jefferson Scale of Empathy at Castle Medical Center*

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Question</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Not Sure</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Attentiveness of patients' personal experiences does not influence treatment outcomes</td>
<td>+8.9</td>
<td>-9.4</td>
<td>-3.1</td>
<td>-33</td>
<td>+225</td>
<td>+85.7</td>
<td>+85.7</td>
</tr>
<tr>
<td>9</td>
<td>Healthcare providers should try to stand in their patients' shoes when providing care to them</td>
<td>+225</td>
<td>-77</td>
<td>-77</td>
<td>+44.4</td>
<td>-39</td>
<td>-6.5</td>
<td>+17</td>
</tr>
<tr>
<td>10</td>
<td>Patients value a healthcare provider's understanding of their feelings, which is therapeutic in its own right</td>
<td>-7.2</td>
<td>+85.7</td>
<td>0</td>
<td>-15</td>
<td>+15.1</td>
<td>-18</td>
<td>+17</td>
</tr>
<tr>
<td>11</td>
<td>Patients' illnesses can be cured only by targeted treatment; therefore, healthcare providers' emotional ties with their patients do not have a significant influence in treatment outcomes</td>
<td>+7.1</td>
<td>-6.6</td>
<td>-23</td>
<td>+28.5</td>
<td>+30</td>
<td>+45.9</td>
<td>+23.8</td>
</tr>
<tr>
<td>12</td>
<td>Asking patients about what is happening in their personal lives is not helpful in understanding their physical complaints</td>
<td>+5.1</td>
<td>+1.3</td>
<td>-29</td>
<td>-7.2</td>
<td>+59.2</td>
<td>+32.6</td>
<td>-20</td>
</tr>
<tr>
<td>13</td>
<td>Healthcare providers should try to understand what is going on in their patients' minds by paying attention to their non-verbal cues and body language</td>
<td>-26</td>
<td>-54</td>
<td>-7.2</td>
<td>-43</td>
<td>-12</td>
<td>-2.1</td>
<td>+9.7</td>
</tr>
</tbody>
</table>
Table 9. (Continued) *Difference (%) in Pre and Post Assessment Scores for Clinical Staff Based on Jefferson Scale of Empathy at Castle Medical Center*

<p>| | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>I believe that emotion has no place in the treatment of medical illness</td>
<td>-4.2</td>
<td>+0.8</td>
<td>+16.1</td>
<td>+23.8</td>
<td>+23.8</td>
<td>+271</td>
</tr>
<tr>
<td>15</td>
<td>Empathy is a therapeutic skill without which a healthcare providers’ success is limited</td>
<td>+48.5</td>
<td>-13</td>
<td>+0.6</td>
<td>-32</td>
<td>-8.9</td>
<td>-10</td>
</tr>
<tr>
<td>16</td>
<td>Healthcare providers’ understanding of the emotional status of their patients, as well as that of their families, is one important component of the healthcare provider-patient relationship</td>
<td>+179</td>
<td>0</td>
<td>0</td>
<td>-23</td>
<td>+17.3</td>
<td>-4.9</td>
</tr>
<tr>
<td>17</td>
<td>Healthcare providers should try to think like their patients in order to render better care</td>
<td>-7.2</td>
<td>-42</td>
<td>-44</td>
<td>+14.7</td>
<td>-13</td>
<td>+18.2</td>
</tr>
<tr>
<td>18</td>
<td>Healthcare providers should not allow themselves to be influenced by strong personal bonds between patients and their family members</td>
<td>+50.6</td>
<td>+7.95</td>
<td>-24</td>
<td>-18</td>
<td>+1.82</td>
<td>+0.8</td>
</tr>
<tr>
<td>19</td>
<td>I do not enjoy reading non-medical literature or the arts</td>
<td>-2.8</td>
<td>-6.6</td>
<td>+17.3</td>
<td>+10.2</td>
<td>-7.2</td>
<td>+12.7</td>
</tr>
<tr>
<td>20</td>
<td>I believe that empathy is an important factor in patients’ treatment</td>
<td>-44</td>
<td>0</td>
<td>-7.2</td>
<td>-7.2</td>
<td>+12.4</td>
<td>-4.1</td>
</tr>
</tbody>
</table>

Note: + indicates % increase; - indicates % decrease; Shaded items are reverse scored items (i.e., Strongly Agree=1…Strongly Disagree=7).
Non-Clinical pre and post assessment based on the Toronto Empathy Questionnaire. The Toronto Empathy Questionnaire has 16 items for the respondent to answer, rating how frequently they feel or act in the manner described (see Appendix F). Eight items are directly scored using a Likert scale from 0-4, from Never (0) to Always (4). There are 8 items that are negatively worded and reverse scored from Never (4) to Always (0). The higher the score, the more empathic the behavior inclination. The total pre-score was 48.89 and total post-score was 49.15. The maximum possible total score is 64. Overall, there was 0.53% increase in the empathy scores among the non-clinical staff (see Table 10).
Figure 8.
Overall Pre and Post Assessment Score and Difference (%) for Non-Clinical Staff Based on Toronto Empathy Questionnaire

The results show that there was an expected increase in the percentage of the non-clinical staff who selected “Always” and decrease in the percentage of those who selected “Rarely” or “Never” when asked many of the directly scored questions, for example when asked “I enjoy making other people feel better” there was an 0.6% increase and 100% decrease. However, there was an equal increase in “Always” responses and “Never” or “Rarely” responses to the item “I can tell when others are sad even when they do not say anything” (9.2% increase and 9.2% decrease). There was an unexpected decrease in some of the reverse scored questions, for example “When I see someone being treated unfairly, I do not feel very much pity for them” (13% decrease of Never, 36.5% increase of Sometimes and 6.4% decrease of “Often”).

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Although these empathy assessment tools are used frequently in the literature, feedback from the respondents in regards to both the Jefferson Scale of Empathy and the Toronto Empathy Questionnaire indicates that some people found the negatively worded questions that are reversed scored difficult to understand, perhaps leading to confusion in answering the assessment, and an increase in the “Not Sure” or “Sometimes” responses or an erroneous selection of the less empathic answer.
Table 10

*Difference (%) in Pre and Post Assessment Scores for Non-Clinical Staff Based on Toronto Empathy Questionnaire at Castle Medical Center*

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Question</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>When someone else is feeling excited, I tend to get excited too.</td>
<td>0</td>
<td>-1.5</td>
<td>-11</td>
<td>+8.3</td>
<td>+16.6</td>
</tr>
<tr>
<td>2</td>
<td>Other people's misfortunes do not disturb me a great deal</td>
<td>+19.4</td>
<td>+25.3</td>
<td>-21</td>
<td>-2.3</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>It upsets me to see someone being treated disrespectfully</td>
<td>0</td>
<td>-69</td>
<td>+0.8</td>
<td>+17.9</td>
<td>-4.5</td>
</tr>
<tr>
<td>4</td>
<td>I remain unaffected when someone close to me is happy</td>
<td>+1.5</td>
<td>+4.5</td>
<td>-9.2</td>
<td>-36</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>I enjoy making other people feel better</td>
<td>0</td>
<td>-100</td>
<td>-39</td>
<td>+7.9</td>
<td>+0.6</td>
</tr>
<tr>
<td>6</td>
<td>I have tender, concerned feelings for people less fortunate than me</td>
<td>0</td>
<td>-69</td>
<td>+3.9</td>
<td>+8.2</td>
<td>-6.9</td>
</tr>
<tr>
<td>7</td>
<td>When a friend starts to talk about his/her problems, I try to steer the conversation towards something else</td>
<td>+8.6</td>
<td>-5.4</td>
<td>+1.2</td>
<td>-2.2</td>
<td>0</td>
</tr>
<tr>
<td>8</td>
<td>I can tell when others are sad even when they do not say anything</td>
<td>0</td>
<td>+9.2</td>
<td>+1.8</td>
<td>-1.9</td>
<td>+9.2</td>
</tr>
<tr>
<td>9</td>
<td>I find that I am &quot;in tune&quot; with other people's moods</td>
<td>0</td>
<td>-12</td>
<td>+4.1</td>
<td>-4.7</td>
<td>+3.3</td>
</tr>
<tr>
<td>10</td>
<td>I do not feel sympathy for people who cause their own serious illnesses</td>
<td>+6</td>
<td>+2.4</td>
<td>+4.7</td>
<td>-34</td>
<td>0</td>
</tr>
<tr>
<td>11</td>
<td>I become irritated when someone cries</td>
<td>+7.8</td>
<td>-8.5</td>
<td>+7</td>
<td>-44</td>
<td>0</td>
</tr>
<tr>
<td>12</td>
<td>I am not really interested in how other people feel</td>
<td>+6.2</td>
<td>-5.8</td>
<td>-12</td>
<td>-26</td>
<td>0</td>
</tr>
<tr>
<td>13</td>
<td>I get a strong urge to help when I see someone who is upset</td>
<td>0</td>
<td>-63</td>
<td>+4.2</td>
<td>+2.5</td>
<td>-4.2</td>
</tr>
<tr>
<td>14</td>
<td>When I see someone being treated unfairly, I do not feel very much pity for them</td>
<td>-13</td>
<td>+16.1</td>
<td>+36.5</td>
<td>-6.4</td>
<td>0</td>
</tr>
<tr>
<td>15</td>
<td>I find it silly for people to cry out of happiness</td>
<td>-2.5</td>
<td>+2.3</td>
<td>+8.3</td>
<td>+5.3</td>
<td>0</td>
</tr>
<tr>
<td>16</td>
<td>When I see someone being taken advantage of, I feel kind of protective towards him/her</td>
<td>0</td>
<td>-6.4</td>
<td>-0.1</td>
<td>+1.5</td>
<td>+1.2</td>
</tr>
</tbody>
</table>

Note: + indicates % increase; - indicates % decrease. Shaded items are reverse scored (Never=4; Rarely=3; Sometimes=2; Often=1; Always=0).

**Patient Experience.** Inpatient experience as measured by HCAHPS showed an increase in overall satisfaction from 80th percentile ranking in 2014 to 85th percentile
ranking year-to-date in 2015 (see Figure 9). Results for 2015 are not yet complete as there is a 1-3 month delay due to the survey turn-around process. Of the ten components of HCAHPS, only two areas did not improve post workshop. These are the categories of Cleanliness/quietness and Pain Management (see Figure 10). Specific HCAHPS questions that relate to Nurse Communication showed an improvement during the time the workshop was being deployed to all staff (March through May 2015) and decreased back to baseline in the three months after the workshop (see Figure 11).

Figure 9.

Inpatient Overall Patient Experience results at CMC (HCAHPS YTD).
Figure 10.

Inpatient experience components percentile rankings at CMC (HCAHPS)

![Inpatient Experience Percentile Rankings 2015]

Figure 11.

Pre, Intra and Post Empathy Workshop Nurse Communication Patient Experience results at CMC (HCAHPS)

![Nurse Communication HCAHPS Questions]
**Patient complaints.** The number of patient complaints per 1000 patient days is another way of measuring patient satisfaction. As benchmarks are not available at this time, this was not a primary trigger, but it was expected that an increase in empathic interactions between staff and patients would reduce complaints. The goal was to decrease complaints by 5% overall.

Complaints are defined as those that are not resolved immediately but are escalated to the risk management department for aid with resolution. The trend of total complaints over the last five years is illustrated in Figure 12. In 2015 there was an increase from 2.3 to 2.9 complaints per 1000 patient days. This increase may have been in part due to the implementation of a new software system to report complaints. Complaints related to staff attitudes and behaviors decreased pre and post workshop from 1.4 to 1.0 per 1000 patient days (see Figure 13).

*Figure 12.*

Total Number of Patient Complaints per 1000 Patient Days at Castle Medical Center
Figure 13.
Complaints Regarding Staff Attitudes and Behaviors per 1000 Patient Days Pre and Post Workshop

<table>
<thead>
<tr>
<th>Complaints Regarding Staff Attitudes &amp; Behaviors / 1000 Patient Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline: 10/1/2014 - 3/31/15</td>
</tr>
<tr>
<td>Post Workshop: 7/1/15 - 12/31/15</td>
</tr>
</tbody>
</table>

Readmissions. The Center for Medicare and Medicaid (CMS) penalizes hospitals for all cause readmissions within 30 days for select diagnoses. Reducing readmissions was a key initiative at CMC during 2015. Although not the primary trigger for this program, there is synergy, as empathic discussions by health professionals are important to understanding discharge needs and avoid readmissions (Dempsey & Wojciechowski, 2014). At CMC the percent of observed versus the percent of expected All Cause 30-day Readmissions decreased by 19.5%, from 8.34% in 2014 to 7.17% in 2015 (see figures 14 & 15).
**Figure 14.**

Observed/Expected All Cause 30-day Readmissions at Castle Medical Center.

**Figure 15.**

Percent Observed/Percent Expected All Cause 30-day Readmissions at Castle Medical Center.
**Employee engagement.** As described earlier, the Gallup survey was used for the first time in 2014 to measure employee engagement. It consists of 12 questions that measure growth, teamwork, individual contribution, and basic needs to complete their work (see Appendix B). The overall score was at the 51st percentile ranking in Gallup’s Hospital Level Database in 2014, which allowed an opportunity to improve. In September 2015, CMC employees again completed the survey, had 94% employee participation, and increased engagement dramatically to the 78th percentile ranking in Gallup’s Hospital Level Database.

**Employee turnover.** Turnover rate is another indicator of employee engagement. In 2015 CMC had an increase in total turnover of all staff from 19.6% to 21.3%. Of full time and part time staff there was an increase from 13.9% to 15.7%. Full time and part time Registered Nurse turnover went from 15.7% to 19.5%. In part these trends were related to an increase in accountability throughout the organization which resulted in some involuntary turnover. According to Nursing Solutions, Inc. (2014), the national average turnover rate for hospitals is 16.5%. The average cost of turnover for a bedside RN ranges from $44,380 to $63,400, which puts employee engagement and reduction in turnover as a top priority for the organization. It is suggested in the literature that when empathic behavior is engaged upon, healthcare professionals note improved job satisfaction and a sense of fulfillment (Lagro-Janssen, 2013; Riess et al, 2012).
Figure 16.

Overall full time/part time turnover rate compared to engagement at Castle Medical Center
Table 11

*Summary of Empathy Enhancement Program Outcome Measuring Tools, Pre-measures, Goals and Outcomes*

<table>
<thead>
<tr>
<th>Outcome Measure/Tool</th>
<th>Premeasure 2014</th>
<th>Goal for 2015</th>
<th>Outcome in 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCAHPS overall rating</td>
<td>75th percentile ranking (PR)</td>
<td>80th PR</td>
<td>85th PR (YTD)</td>
</tr>
<tr>
<td>Total Patient complaints</td>
<td>2.3 per 1000 patient days</td>
<td>5% decrease</td>
<td>Increase to 2.9 per 1000 patient days</td>
</tr>
<tr>
<td>Complaints re: staff attitudes/behaviors</td>
<td>1.4</td>
<td>5% decrease</td>
<td>Decrease of 28% to 1.0 per 1000 patient days</td>
</tr>
<tr>
<td>All cause 30-day readmissions (observed/expected)</td>
<td>8.9 %</td>
<td>5% decrease</td>
<td>Decreased to 7.17%</td>
</tr>
<tr>
<td>Gallup employee engagement survey</td>
<td>51st PR</td>
<td>5% increase</td>
<td>Increased to 78th PR</td>
</tr>
<tr>
<td>Employee turnover</td>
<td>19.6% overall</td>
<td>3% decrease</td>
<td>Increased to 21.3%</td>
</tr>
<tr>
<td>Post workshop empathy</td>
<td>Pre workshop empathy</td>
<td>5% increase</td>
<td>Increase: Clinical = 0.74% &amp; Non-clinical = 0.53%</td>
</tr>
</tbody>
</table>
Evolution of Project

Expected Versus Actual Outcomes.

**Process outcomes.** The goal of this project was to initiate an Empathy Enhancement Program. The program was initiated as designed following the Iowa model of EPB Practice to Promote quality Care (Titler et al., 2001). A team of stakeholders that included frontline staff as well as management from various clinical and non-clinical departments reviewed literature and designed a 90-minute workshop curriculum based on the evidence to enhance empathy. A second team developed marketing tools to promote and communicate the project to staff and a third team worked on the logistics of arranging the workshop. These three teams formed the Project Team. The teams were comfortable with adopting new projects and had a history of success with change and adoption. As expected, they achieved their process goals according to the timeline. One outcome that was unanticipated was the enthusiasm that this project was met with from members of the project team as well as participants in the workshop. An attitude of good will, innovation, connection to the organization’s mission and heartfelt gratitude for the opportunity to be part of the project was present at meetings, in discussions, and in each workshop.

An Empathy Champion class was taught to 20 Champions and included a variety of staff from Finance to Security to the Emergency Department, with the goal of achieving Champion competency in teaching/co-teaching the curriculum. The workshop itself was taught March through May 2015, by Champions and members of the Project Team. Champions followed the “See one, Do one, Teach one” model of experimental learning with guidance from the Project Lead. Small multidisciplinary groups of
participants consisted of a mix of clinicians and non-clinicians alike from various departments.

The workshop evaluations completed at the end of each class were invaluable for obtaining immediate feedback and giving the opportunity to adapt the class; themes from these evaluations emerged. The interprofessional collaboration during the workshop allowed new relationships between staff to develop and the role playing exercises created new understandings of colleague’s roles and work demands as well as the needs of patients and their support members. The small class size, staging of the workshop, use of the General Electric Change Acceleration Program tools to encourage participation, and the informal atmosphere promoted an appraisal of self and sharing of barriers to use of empathy. Busyness, competing priorities, and the topics of compassion fatigue and burnout were prevalent as part of this discussion, consistent with the literature (Reynolds, Scott & Austin, 2000; Felton, 1998). This prompted modification of the workshop to include a creative visualization relaxation exercise and a discussion surrounding the need to monitor one’s self for burnout and be proactive in preventing it. Despite CMC’s robust employee wellness program and culture of spirituality, an opportunity is evident from these discussions to address burnout and compassion fatigue.

On a few occasions, a workshop participant questioned the ability of a clinician to deliver empathy in their practice under certain circumstances. The example of a patient that was behaving in a disruptive, aggressive manner or was “drug seeking” was suggested as being a time when empathy was not possible to give. In each of these situations, the other members of the class were able to provide support and suggestions to their colleague, rather than the workshop leader addressing this. For instance, ideas
generated from other participants opened dialogue acknowledging the judgments clinicians can easily make and how, although the staff member does not have to agree with the choices a patient has made, their judgment is not helpful in understanding the life circumstances of the individual, attuning to their needs, and not helpful in assisting the individual through this time in their life. This discussion between participants helped direct peers towards maintaining an empathic professional support role for patients. This level of engagement with the topic by participants was unanticipated and provided learning for the group as a whole, including the workshop facilitator.

Inefficient workflow processes leading to lack of time were also prevalent as a cause for frustration in the workday and expressed as sometimes leading to a lack of empathy towards patients and colleagues. Staff was encouraged to work with their leaders to develop solutions to workflow issues. However, the organization may benefit from a more structured process for workflow analysis and rework to streamline. Although there is not yet a formal shared governance model at CMC, the opportunity to participate in like committees is present.

Overall the positive feedback from the workshop participation and evaluations built momentum for the team to implement the second phase of the project, the development of an empathy video. The project team had many ideas for this video, some to replicate other videos such as those created by the Cleveland Clinic. The goals for the video creation were to sustain the work achieved in the class and enculturate new staff to CMC during their orientation. It was unexpectedly difficult to develop ideas that each of the team members were comfortable with and development progressed slower than expected. Eventually the idea of a 5-7 minute documentary asking the question, “What is
Empathy?” featuring employees and a patient was arrived upon. The video was filmed and edited by our in-house Marketing department and has since been shown to CMC employees, the CMC and Adventist Health Governing Boards and is now included as part of our new hire orientation (Castle Medical Center, 2015).

**Patient Outcomes.** The majority of the workshops were completed during the months of March through May 2015. Improvements in patient outcome metrics of patient experience, readmissions, and patient complaints related to staff attitudes and behaviors were seen in 2015. However, other projects and work throughout the organization continued during this time frame that had synergy with the Empathy Enhancement Program and likely also had impact on the same metrics. For example, the implementation of physician/nurse rounding in the room with the patient/family may have contributed to improving components of HCAHPS such as Communication, Medication, and Discharge Education. The use of empathy in this rounding may have improved its effectiveness, further demonstrating the synergy between these two activities. Conversely, challenges, such as the Emergency Room renovation that reduced beds, space, and patient flow may have negatively impacted these same metrics. The evaluation limitations of this project include the lack of control over these types of variables that may have had impact on these metrics.

**Employee Outcomes.** Employee engagement has improved at CMC since 2014 from 51st to 78th percentile ranking in Gallup’s Hospital Level National Database as of September 2015. The use of empathy is associated with improved job satisfaction in the literature, however in combination with this project, each department has also being actively working on improving engagement during the same time frame that the Empathy
Enhancement Program was initiated. Staff turnover has increased slightly from 19.6% to 21.3% and is thought to be attributed to both adherence to accountability policies as well as some possible challenges in talent selection and first year onboarding.

Efforts to sustain empathy. Ongoing change is dependent on continuous emphasis on use of empathy every day. As a result of the Empathy Enhancement Project, the Human Resource department included a Behavioral Criteria statement of “shows empathy to all” in the employee performance evaluation tool (Appendix H). This helps to promote the concept that use of empathy is a standard of behavior and part of how we practice at CMC. To help onboard new hires to this expected behavior, the Administration approved attendance of all new hire employees to the empathy enhancement workshop within their first three months of employment. In order to disseminate ongoing empathy enhancement activities, time has been dedicated at the last two quarterly leadership institutes for empathy enhancement activities, such as the “Talking Walls” exercises to be experienced by leaders in readiness for deployment at staff meetings (see Appendix I). This allows the opportunity for continued staff engagement with this topic. In addition, a house-wide “Show Your Heart-Share Your Heart Challenge” competition was held in February 2016 with 42 departments involved in creating a display for their department empathy heart (see Appendix J). These ongoing activities are well received and keep a heightened awareness of empathy sustaining the initial kick-off that the workshop provided.

Cost outcomes. The cost of the workshop and video development was as anticipated. Ongoing costs for the new hire workshop will be absorbed by individual departmental education budgets. Estimated labor cost per year is $13,500. As the
materials and workshop are already developed, cost for maintenance and modification are expected to be minimal.

**Facilitators.** The project aligns well with CMC’s mission “Caring for the community, sharing God’s love” as well as the Adventist Health strategic plan. This provided the CMC Administrative team a basis to support the initiative from a resource, strategic, and mission perspective. The Administrative team participated in the workshop as did the Chief of Staff (see Appendix K). The Project Team and many individuals around the organization have connected with the spirit of this project and worked hard to ensure it moved forward smoothly. The Marketing team in particular facilitated communication and promotion of the project and development of the video. The Education department facilitated the logistics of the workshop such as location, class times, and sign ups. Managers and Directors ensured that their staff attended the workshop and provided time for attendance of frontline staff at project development meetings and to star in the empathy video. Frontline project team members spoke informally to their colleagues about the project and were highly influential in ensuring workshop attendance.

**Barriers.** The resource of time was a barrier to the implementation of this project. Competing priorities within the organization led to this. For example, the organization was heavily involved in completing an application for the Malcolm Baldrige Quality award and preparing for a Baldrige site visit at the national level. Many of the same individuals were involved in both initiatives. Continual readjustment of priorities can lead to a dilution of effort and the team experienced loss of momentum during some weeks.
Summary

The Empathy Enhancement Project was successfully implemented using the Iowa model of Evidence-Based Practice to Promote Quality Care (Titler et al., 2001) due in part to a team of high performers and a culture that is both receptive and responsive to its mission of caring and love. Attendance at the workshop was high, the video was developed using frontline staff, and post workshop empathy assessment scores showed improvement compared with pre-assessments. Behavior change, to include empathy in practice, may be determined by employee and patient outcomes although, due to synergy with other projects, this is inconclusive. Improvements were seen in the patient outcome metrics of HCAHPS, All Cause 30-day Readmissions, and the reduction in amount of patient complaints regarding staff attitudes and behaviors received. Although employee turnover increased overall slightly, employee engagement improved greatly as seen by Gallup scores.
CHAPTER 5. DISCUSSION

Introduction

Value-based purchasing demands that hospitals achieve both high quality clinical outcomes and high patient satisfaction with their experience in the hospital. Hospitals are incentivized to put both quality and patient experience as a top priority with this reimbursement model. In order to achieve these results, staff must be fully engaged in their role within the organization, supporting both patients and each other in their shared mission to achieve these collective outcomes. The use of empathy by health care professionals with patients can improve patient outcomes such as readmission rates (Dempsey & Wojciechowski, 2014), acceptance of care (Doherty & Thompson, 2014), and clinical indicators (Hojat et al., 2011).

The patient experience is also positively impacted by use of empathic behaviors (Bramley & Matiti, 2014; Dempsey & Wojciechowski, 2014). In addition, the use of empathy may also enhance job satisfaction. When emotionally attuned to the patient, the clinician is more effective which in turn gives them greater satisfaction and fulfillment (Halpern, 2003). It may also protect against burnout (Lagro-Janssen, 2013; Riess et al., 2012). After the Empathy Enhancement Program was implemented at Castle Medical Center (CMC), improvements in both patient and employee outcome measures were seen, although other projects with synergy implemented in a similar timeframe may have also contributed to these results.

Interpretation of Findings

The smooth and enthusiastic implementation of the Empathy Enhancement Program at CMC demonstrates that the organization is receptive to emphasis on a culture
of caring. A contributing factor may be the inherent faith based culture of the organization. The understanding that empathy is both valuable as a tool and can be taught is seen in the literature, supported by the participant workshop evaluations, and evidenced by improvement in pre and post workshop empathy assessment scores. These results are similar to those of other empathy training programs that focused on communication skills and self-reflection (Ancel, 2006; Brunero et al., 2009; Riess, et al., 2012; Williams et al., 2014).

Short-term behavior change reflecting enhanced empathy can be determined by the resulting improvements in employee and patient outcomes. Improvements were seen in the patient outcome metrics of HCAHPS, All Cause 30-day Readmissions and the reduction in the number of patient complaints related to staff attitudes and behavior received. These results too are aligned with other studies of the impact of empathy on patient outcomes such as an improvement in readmission rate (Dempsey & Wojciechowski, 2014), acceptance of care, (Doherty & Thompson, 2014) and clinical indicators (Hojat et al., 2011).

Although employee turnover increased slightly overall, employee engagement improved greatly as seen by Gallup scores. Due to synergy with other hospital projects, such as the Physician/Nurse/Patient team rounding initiative and other specific employee engagement actions, the outcomes cannot be attributed solely to the Empathy Enhancement Program implementation.

That said, the value of the program has been consistently reinforced by employee comments and general enthusiasm in participation in ongoing empathy enhancement activities and the spawning of other activities by individuals around the organization that
are not at the initiation of the Project Team, such as an invitation to present empathy to
the Physician Office Staff luncheon (see Appendix L) and a lunch-time activity designed
by Nutritional Services staff in the cafeteria for staff to participate in (see Appendix M).
Barriers to the use of empathy that were consistently communicated from staff to
workshop facilitators are burnout and workflow frustrations. It is important to note that
empathy is part of a relationship that is authentic, genuine and characterized by
“unconditional positive regard” (Williams & Stickley, 2010). To support the clinician in
this relationship and in long-term behavior change, the issue of burnout may need to be
addressed from an organizational standpoint in terms of promoting staff resiliency,
continued empathy and communication skills training, resolving workflow inefficiencies
and improving work-life conditions (Ancel, 2006; Linzer et al., 2015).

Implications/Recommendations for the Doctorate of Nursing Practice Essentials

The American Association of Colleges of Nursing Doctorate of Nursing Practice
(DNP) Essentials are the competencies determined to be essential of all graduates of a
DNP program (AACN, 2006). The DNP Task Force states, “practice-focused graduates
are prepared to generate new knowledge through innovation of practice change, the
translation of evidence, and the implementation of quality improvement processes in
specific practice settings, systems, or with specific populations to improve health or
health outcomes” (AACN, 2015, p. 2). The Empathy Enhancement Program
implemented at Castle Medical Center is an innovative application of the evidence,
focused on staff behavior change that will impact healthcare outcomes directly and
indirectly. The program is evaluated via both patient and employee outcomes comprising
patient experience survey scores, readmission rates, patient complaints, employee engagement, and turnover.

Modification of the program is ongoing based on new evidence. Sustainment of this program is through ongoing refresher activities, incorporation of the video and workshop into new employee orientation, and includes a plan to reframe the program to include workflow evaluation and burnout prevention. The knowledge gained through this practice innovation implementation is transferable and will be disseminated to other Adventist Health facilities through standard communication avenues and an implementation toolkit.

**Essential I: Scientific Underpinnings for Practice.** In order to address issues in healthcare, the advanced practice nurse must be able to integrate scientific evidence into the complex world of practice (AACN, 2006). The incorporation of empathy into practice can make positive life changing differences in the functioning of patients by the attunement of the nurse to the patient’s needs. Empathy promotes accurate recognition of needs and supports caring actions. A core principal of nursing is caring (Watson, 2008). The profession of nursing recognizes that health is multifaceted and that a person is more than their physical health alone. The incorporation of empathy into nursing practice allows the patient to share anxiety, concerns, and circumstances that may be contributing to their health status. When the nurse practices empathy, job satisfaction is achieved. Empathy is an essential skill for nurses to be competent in (Hardee, 2003; Hojat et al., 2011; Reynolds & Scott, 2000; Reynolds et al., 2000; Riess et al., 2012; Ogle et al., 2013) and this project enhanced empathy not only in the nursing staff, but all employees at CMC.
Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking. In order for improvements in practice to be sustainable, the organization’s support from a systems perspective must be obtained. This DNP competency ensures that professional, cultural, financial, and policy support is met to strategically meet the needs of the population (AACN, 2006).

The facility-wide Empathy Enhancement Program at CMC, supported by a $48,000 Adventist Health Innovations grant for a workshop, creation of a video, and creation of a toolkit for dissemination has been a useful kick-start to highlight and introduce the topic into practice across all areas of the organization.

Creating and sustaining a culture that encourages the use of empathy long-term will require a continued investment by the organization. CMC has demonstrated a willingness to continue this by incorporating the workshop into new hire orientation each month with an annual cost of $13,500 and by supporting resource allocation to continue empathy enhancement activities each quarter.

Barriers to the use of empathy of burnout and workflow inefficiencies exist. Reframing the Empathy Enhancement Program and addressing these critical areas by reflecting on the insights of staff would be a meaningful next step for the Project Team and Leadership. Efficiency gains could be realized by extending the success of this innovation program towards workflow analysis by front line staff in each department, moving to a shared governance model and developing a staff resilience program as part of the employee wellness program.

This project has significant implications for strategic and operational efforts to improve the patient experience and employee engagement across all types of health care
services. While the program was implemented in the inpatient arena, it could be replicated in other types of settings. The same results could occur with similar leadership commitment, program design, communication and engagement from stakeholders in other facilities.

**Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice.** Applying knowledge from diverse sources across disciplines to improve health outcomes and evaluating the application and outcomes generates evidence to guide improvements in care (AACN, 2006).

The critical appraisal of the literature on empathy, the synthesis of this, and application of the findings into a program of evidence based interventions expands the realm of knowledge surrounding the method of implementation and the impact an Empathy Enhancement Program can have on patient and employee outcomes. This knowledge can be used across disciplines and form a foundation for connecting staff to mission, understanding their own value, and engaging them in problem-solving to achieve patient experience and quality goals. Although somewhat difficult to measure exact impact of this program when other synergistic interventions were in progress, this quality improvement project with its system-wide focus on enhancement of empathy, has integrated knowledge, been implemented across disciplines, and forms a foundation to guide similar work across other facilities. It has also prompted discussion and knowledge surrounding topics for future work to promote and sustain the use of empathy in the inpatient setting.

**Essential IV: Information Systems/Technology and patient Care Technology for the Improvement and Transformation of Health Care.** The use of information
systems including the electronic medical record to measure clinical outcomes such as patient readmissions is significant in monitoring outcomes related to this project. Databases that capture patient complaints, HCAHPS, employee turnover, and engagement are all essential in aggregating useful data and supporting decisions. In support of sustaining and furthering this initiative, these databases will continue to be used and, as other metrics are developed that may offer new insights into empathy, information systems technology will continue to be essential.

**Essential V: Health Care Policy for Advocacy in Health Care.** The creation of policy that provides a framework in which healthcare is facilitated rather than impeded is essential in addressing patient needs (AACN, 2006). The Empathy Enhancement program can stimulate participant insight into their own behavior. As a standard of care, patient perceptions of received empathy can be measured through the patient experience HCAHPS survey. Empathy should be included in standards of behavior in relevant policies and competency evaluated as part of employee performance. Since the advent of the Empathy Enhancement Program at CMC, showing empathy is a behavioral criteria included in the CMC Associate Assessment of Performance, the program is included in new employee orientation and Adventist Health West is considering implementing the program throughout the system.

**Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes.** Effective interprofessional collaborative teams are necessary to meet healthcare needs and facilitation of this is a DNP essential competency (AACN, 2006).
The Empathy Enhancement Program at CMC involved and engaged staff from the executive suite to frontline clinician and non-clinician roles. Three core sub-teams comprised of various roles and departments developed, organized, and implemented the program. These teams now form the Empathy Enhancement Committee that develops ongoing sustainment activities. The empathy video that CMC created is a good example of the range and depth of involvement of staff, with employees from the Chief Financial Officer, to Emergency Room Nurse, Nutritional Services Aide, and Unit Secretary filmed speaking of their understanding of empathy and its impact.

As per the World Health Organization recommendations for interprofessional education, all employees were included in the Empathy Enhancement program and participated in random mixed interprofessional workshops. The goal of this was to enhance staffs understanding of each other’s roles, realize alignment of goals, and develop relationships between individuals. The premise behind this collaboration is that there will be spillover into the work arena, where trusting relationships are linked to a culture of safety and improved patient outcomes. The outcome metric for this was employee engagement, which improved significantly per the 2015 Gallup survey.

**Essential VII: Clinical Prevention and Population Health for Improving the Nation’s Health.** The use of empathy to attune oneself to another’s condition and needs can impact the health status of that person. Implementation of an Empathy Enhancement Program for hospital staff can lead to improvements in clinical outcomes, patient experience, and employee engagement. If this program is sustained and enculturated into the organization when utilized as a foundation for the care delivery model, strategies will
be selected that relate to the needs of the community in a meaningful way and will ensure improvement of the health status of that population.

**Essential VIII: Advanced Nursing Practice.** Although marked by increasing specialization, nursing in all domains share the foundation of caring. The nurse expert uses their specialty skills while attending to the needs of the whole person. The inclusion of the practice of empathy in patient care, as well as in nursing leadership, encourages attunement to the needs of others. Leadership is obliged to facilitate workflow effectiveness and training and to create an environment that supports a culture of empathy in which clinicians can deliver empathetic care. Evaluating the systems and culture that exist for opportunities to improve and implementing organizational changes will help prevent disengagement, burnout, turnover, and negative patient outcomes.

**Plans for Dissemination**

The project was celebrated internally at CMC with a lunch for champions and members of the project team and the premier screening of the “In Their Shoes - Empathy in Action” video. Adventist Health (AH) is a regional health system that operates in California, Hawai’i, Oregon, and Washington. It includes 20 hospitals, 220 rural health clinics and outpatient centers, 14 home care agencies, seven hospice agencies and four retirement agencies. AH has a workforce of 28,600 (CMC, 2014). Approaches to disseminate this project throughout AH have been received well by local and corporate leadership and it appears that opportunities will develop for replication of program within the system. An article on the project was published in the AH system February, 2016 issue of the IMPACT eNewsletter (Adventist Health, 2016), and a second article is planned as an update to the first. The “Empathy in Action” toolkit (see Appendix N),
which includes workshop materials and a “How To” manual with marketing/communication materials, is in the process of being disseminated to the Chief Nursing Officers of the AH system, with a video conference call promoting replication of the program by other facilities and planned as they desire. A presentation to local community physician office staff at their quarterly luncheon outlined the program and highlighted the video with good reception (Courtenay, 2016).

Planned also is a presentation to the CMC Administration that will include the barriers to the use of empathy as identified by staff and suggested reframing of the Empathy Enhancement Program in light of the current strategic plan that places both employee engagement and patient experience as two of its top initiatives planned for the next five years. The incorporation of patient needs, staff engagement, innovation, and barriers to the use of empathy is outlined in the diagram below as contributing ideas to an ongoing collaborative Empathy Enhancement Program.

**Summary**

To attain and sustain top performance in quality care and patient experience, the engagement of all staff (not just in clinical areas but throughout the organization) is crucial. The whole organization must deliver the tasks as well as the emotional experience to ensure that the patients’ needs are met. Although the organization has many other initiatives to improve quality and the patient experience, the “In Their Shoes” Empathy Enhancement Program has heightened awareness that each of us have a role in ensuring this happens. Improvements have been seen in both patient and employee related outcome measures. However, a one-time initiative is not enough to sustain this response. To continue the movement, ongoing activities must occur.
Staff identified barriers to the use of empathy that include burnout and workflow inefficiencies. Reframing the Empathy Enhancement Program to embrace engagement of frontline staff in addressing these critical areas could extend the success of this innovation, improve efficiency, and improve staff resilience further supporting the ongoing use of empathy to improve outcomes.

This project has significant implications for strategic and operational efforts to improve the patient experience and employee engagement across all types of health care services. While the program was implemented in the inpatient arena, it could be replicated in other types of settings. Similar results could occur with comparable leadership commitment, program design, communication, and engagement from stakeholders in other facilities.
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Appendices

Appendix A. Hospital Consumer Assessment of Heath Provider Systems Survey

HCAHPS Survey
SURVEY INSTRUCTIONS
You should only fill out this survey if you were the patient during the hospital stay named in the cover letter. Do not fill out this survey if you were not the patient. Answer all the questions by checking the box to the left of your answer. You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:
☐ Yes
☐ No →If No, Go to Question 1
You may notice a number on the survey. This number is used to let us know if you returned your survey so we don't have to send you reminders. Please note: Questions 1-25 in this survey are part of a national initiative to measure the quality of care in hospitals. OMB #0938-0981. Please answer the questions in this survey about your stay at the hospital named on the cover letter. Do not include any other hospital stays in your answers.

YOUR CARE FROM NURSES
1. During this hospital stay, how often did nurses treat you with courtesy and respect?
   1. □Never
   2. □Sometimes
   3. □Usually
   4. □Always

2. During this hospital stay, how often did nurses listen carefully to you?
   1. □Never
   2. □Sometimes
   3. □Usually
   4. □Always

3. During this hospital stay, how often did nurses explain things in a way you could understand?
   1. □Never
   2. □Sometimes
   3. □Usually
   4. □Always

4. During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?
   1. □Never
   2. □Sometimes
   3. □Usually
   4. □Always
   5. □I never pressed the call button

YOUR CARE FROM DOCTORS
5. During this hospital stay, how often did doctors treat you with courtesy and respect?
   1. □Never
   2. □Sometimes
   3. □Usually
   4. □Always

6. During this hospital stay, how often did doctors listen carefully to you?
   1. □Never
   2. □Sometimes
   3. □Usually
   4. □Always

7. During this hospital stay, how often did doctors explain things in a way you could understand?
   1. □Never
   2. □Sometimes
   3. □Usually
   4. □Always

THE HOSPITAL ENVIRONMENT
8. During this hospital stay, how often were your room and bathroom kept clean?
   1. □Never
   2. □Sometimes
   3. □Usually
This hospital stay, how often was the area around your room quiet at night?
1. ☐ Never
2. ☐ Sometimes
3. ☐ Usually
4. ☐ Always

YOUR EXPERIENCES IN THIS HOSPITAL
10. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan?
   1. ☐ Yes
   2. ☐ No → If No, Go to Question 12

11. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?
   1. ☐ Never
   2. ☐ Sometimes
   3. ☐ Usually
   4. ☐ Always

12. During this hospital stay, did you need medicine for pain?
   1. ☐ Yes
   2. ☐ No → If No, Go to Question 15

13. During this hospital stay, how often was your pain well controlled?
   1. ☐ Never
   2. ☐ Sometimes
   3. ☐ Usually
   4. ☐ Always

14. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?
   1. ☐ Never
   2. ☐ Sometimes
   3. ☐ Usually
   4. ☐ Always

15. During this hospital stay, were you given any medicine that you had not taken before?
   1. ☐ Yes
   2. ☐ No → If No, Go to Question 18

16. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?
   1. ☐ Never
   2. ☐ Sometimes

17. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?
   1. ☐ Never
   2. ☐ Sometimes
   3. ☐ Usually
   4. ☐ Always

WHEN YOU LEFT THE HOSPITAL
18. After you left the hospital, did you go directly to your own home, to someone else’s home, or to another health facility?
   1. ☐ Own home
   2. ☐ Someone else’s home
   3. ☐ Another health facility → If Another, Go to Question 21

19. During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
   1. ☐ Yes
   2. ☐ No

20. During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?
   1. ☐ Yes
   2. ☐ No

OVERALL RATING OF HOSPITAL
Please answer the following questions about your stay at the hospital named on the cover letter. Do not include any other hospital stays in your answers.

21. Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?
   0 ☐ Worst hospital possible
   1 ☐  6 ☐
   2 ☐  7 ☐
   3 ☐  8 ☐
   4 ☐  9 ☐
   5 ☐  10 ☐
22. Would you recommend this hospital to your friends and family?
1 ☐ Definitely no
2 ☐ Probably no
3 ☐ Probably yes
4 ☐ Definitely yes

UNDERSTANDING YOUR CARE WHEN YOU LEFT THE HOSPITAL
23. During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.
1 ☐ Strongly disagree
2 ☐ Disagree
3 ☐ Agree
4 ☐ Strongly agree

24. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
1 ☐ Strongly disagree
2 ☐ Disagree
3 ☐ Agree
4 ☐ Strongly agree

25. When I left the hospital, I clearly understood the purpose for taking each of my medications.
1 ☐ Strongly disagree
2 ☐ Disagree
3 ☐ Agree
4 ☐ Strongly agree
5 ☐ I was not given any medication when I left the hospital

ABOUT YOU
There are only a few remaining items left.
26. During this hospital stay, were you admitted to this hospital through the Emergency Room?
1 ☐ Yes
2 ☐ No

27. In general, how would you rate your overall health?
1 ☐ Excellent
2 ☐ Very good
3 ☐ Good
4 ☐ Fair
5 ☐ Poor

28. In general, how would you rate your overall mental or emotional health?
1 ☐ Excellent
2 ☐ Very good
3 ☐ Good
4 ☐ Fair
5 ☐ Poor

29. What is the highest grade or level of school that you have completed?
1 ☐ 8th grade or less
2 ☐ Some high school, but did not graduate
3 ☐ High school graduate or GED
4 ☐ Some college or 2-year degree
5 ☐ 4-year college graduate
6 ☐ More than 4-year college degree

30. Are you of Spanish, Hispanic or Latino origin or descent?
1 ☐ No, not Spanish/Hispanic/Latino
2 ☐ Yes, Puerto Rican
3 ☐ Yes, Mexican, Mexican American, Chicano
4 ☐ Yes, Cuban
5 ☐ Yes, other Spanish/Hispanic/Latino

31. What is your race? Please choose one or more.
1 ☐ White
2 ☐ Black or African American
3 ☐ Asian
4 ☐ Native Hawaiian or other Pacific Islander
5 ☐ American Indian or Alaska Native

32. What language do you mainly speak at home?
1 ☐ English
2 ☐ Spanish
3 ☐ Chinese
4 ☐ Russian
5 ☐ Vietnamese
6 ☐ Portuguese
9 ☐ Some other language (please print):________________________
Appendix B. Gallup Q12 Survey

**Ranking by Results Category**

Q12. This last year, I have had opportunities at work to learn and grow.
Q11. In the last 6 months, someone at work has talked to me about my progress.

Q10. I have a best friend at work.
Q09. My fellow employees are committed to doing quality work.
Q08. The mission or purpose of my organization makes me feel my job is important.
Q07. At work, my opinions seem to count.

Q06. There is someone at work who encourages my development.
Q05. My supervisor, or someone at work, seems to care about me as a person.
Q04. In the last seven days, I have received recognition or praise for doing good work.
Q03. At work, I have the opportunity to do what I do best every day.

Q02. I have the materials and equipment I need to do my work right.
Q01. I know what is expected of me at work.
### Appendix C. Literature Matrix

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Journal</th>
<th>Title</th>
<th>Aim/Question</th>
<th>Study Design</th>
<th>Sample</th>
<th>Data Collection</th>
<th>Findings</th>
<th>Mosby’s Level of Evidence</th>
<th>Limitations</th>
<th>Conclusion</th>
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<tr>
<td>Ogle, J. &amp; Bushnell, A., Caputi, P.</td>
<td>2013</td>
<td>2013 John Wiley &amp; Sons Ltd. MEDICAL EDUCATION N 2013, 47: 824-831</td>
<td>Empathy is related to clinical competence in medical care</td>
<td>The purpose of this study was to investigate the relationship of both internal empathy and the behaviour-oral expression of empathy (i.e. observed empathy) to clinical competence in medical students.</td>
<td>Correlation Study: Fifty-seven medical students participated in the study. Clinical competence was assessed in an objective-structured clinical examination (OSCE). Empathy was rated by an independent observer of the clinical interaction in OSCE stations. In addition, empathy was self-rated using the Jefferson Scale of Physician Empathy–Student Version.</td>
<td>All Year 3 students (n = 77) in a regional and rural Australian graduate school of medicine (GSM) were informed of and invited to take part in the project. The response rate was 74% (males, n = 22; females, n = 55).</td>
<td>Observer-rated empathy was measured using the Rating Scales for the Assessment of Empathic Communication in Medical Interviews (REME). Self-rated empathy was measured using the Jefferson Scale of Physician Empathy–Student Version (JSP–S), which comprises 20 items.</td>
<td>Observed behaviour indicative of empathy, as rated objectively by an independent observer, was strongly associated with clinical competence. Self-rated empathy, however, was not associated with clinical competence. Significant differences in mean total competence scores were noted between students low in observed empathy and students high in observed empathy.</td>
<td>V</td>
<td>The measures (focusing on a single score) may not do justice to the complex nature of empathy. 9-minute OSCE stations may not provide a true test for assessing a meaningful relationship in which empathy plays a real role; the extent of training of the independent observer to assess the behavioural expression of empathy may not be adequate; the validity of patient ratings of student competence may be insufficient, and lack of variation in the criterion measures (ratings were all high) may reflect a ceiling effect.</td>
<td>The results of this study indicate that empathy may be an enabling factor in clinical competence and that clinicians should make the most of opportunities to express their understanding and validation of their patients’ concerns.</td>
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<tr>
<td>Reeves, H., Kelley, J. M., Bailey, R. W., Dunn, E. J., Phillips, M.</td>
<td>2012</td>
<td>Journal of General Internal Medicine, 2012, May, 27(10), 1280-1286</td>
<td>Empathy Training for Resident Physicians: A Randomized Controlled Trial of a Neurosciences-Informed Curriculum</td>
<td>Whether an innovative empathy training protocol grounded in neuroscience could improve physician empathy as rated by patients.</td>
<td>Randomized controlled trial: Randomly assigned residents and fellows from surgery, medicine, anesthesiology, psychiatry, ophthalmology, and orthopedics (N=99, 52% female, mean age 30.6±3.6) to receive standard post-graduate medical education or education augmented with three 60-minute empathy training modules.</td>
<td>Patient ratings of physician empathy were assessed within one-month pre-training and between 1-2 months post-training with the use of the Consultation and Relational Empathy (CARE) measure. Each physician was rated by multiple patients (pre-mean=4.6±3.1, post-mean=4.9±2.5), who were blinded to physician anonymity. The primary outcome was change score on the patient-rated CARE.</td>
<td>The empathy training group showed greater changes in patient-rated CARE scores than the control (difference 2.2, P=0.04). Trained physicians also showed greater changes in knowledge of the neurobiology of empathy (difference 1.8, P=0.001) and in ability to decode facial expressions of emotion (difference 1.9, P&lt;0.001).</td>
<td>I</td>
<td>The sample size was relatively small, and the training was delivered by a single physician who may have been a particularly effective teacher. Residents volunteered to participate, and therefore the sample may have been biased toward participants who were more receptive to the training. Different patients were used pre- and post-intervention, and the patient cohorts could have differed in their ratings of empathy which may have introduced bias.</td>
<td>A brief intervention grounded in the neurobiology of empathy significantly improved physician empathy as rated by patients, suggesting that the quality of care in medicine could be improved by integrating the neuroscience of empathy into medical education.</td>
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<tr>
<td>Reynolds, W. Scott, P.A. &amp; Austin, W.</td>
<td>2000</td>
<td>Journal of Advanced Nursing, 2000, 32(1), 235-242</td>
<td>Nursing, empathy and perception of the moral</td>
<td>Aims of study: (1) the development and evaluation of the empathy scale; (2) the investigation of variables that may affect nurses’ ability to offer empathy, and (3) the evaluation of the empathy course.</td>
<td>Quasi-experimental and descriptive. Scores from empathy testing pre, during and post education with control group collected. Interviews conducted regarding barriers to empathy use.</td>
<td>20 nurses completed empathy education and interviews.</td>
<td>3 empathy scores for each nurse who completed the study, and nurses’ responses during semi-structured interviews and a questionnaire probing the context of care.</td>
<td>Nurses gains in empathy after a course in empathy persisted for some time (3-6 months).</td>
<td>VI</td>
<td>Small sample size of 37 nurses. Not sure of moral prior to study.</td>
<td>Although empathy scores increased after training, challenges in clinical areas prevented barriers to use of empathy.</td>
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<td>Author</td>
<td>Year</td>
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<td>Title</td>
<td>Aim/Question</td>
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<td>Doyle, C., Lennox, L., Bell, D.</td>
<td>2005</td>
<td>BMJ Open</td>
<td>To explore evidence on the links between patient experience and clinical safety and effectiveness</td>
<td>A systematic review of evidence on the links between patient experience and clinical safety and effectiveness outcomes.</td>
<td>Systematic review</td>
<td>Wide range of settings within primary and secondary care including hospitals and primary care centers. A wide range of demographic groups and age groups.</td>
<td>Included studies that measured associations between patient experience and safety or effectiveness outcomes at a patient level or at an organization level.</td>
<td>This study, summarising evidence from 55 studies, indicates consistent positive associations between patient experience, patient safety and clinical effectiveness for a wide range of disease areas.</td>
<td>Literature review</td>
<td>Literature review Time limited review.</td>
<td>Patient experience is positively associated with clinical effectiveness and patient safety.</td>
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<tr>
<td>Reynolds, W. J. and Scott, B.</td>
<td>1999</td>
<td>Journal of Psychiatric and Mental Health Nursing</td>
<td>Empathy: a crucial component of the helping relationship</td>
<td>To substantiate the view that empathy is crucial to all forms of helping relationships.</td>
<td>Literature review</td>
<td>Broad review of literature including other authors literature reviews.</td>
<td>Broad review</td>
<td>Definition of empathy as it relates to nursing.</td>
<td>Literature review</td>
<td>literature review</td>
<td>Conclusions drawn from the literature reviewed in this paper are that: (a) empathy is crucial to a nondefensive relationship; (b) empathy can facilitate satisfactory and productive outcomes for clients and other recipients of helping relationships.</td>
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<td>Author</td>
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<td>Lelorain, S., Bredart, A., Dolbeault, S., Sultan, S.</td>
<td>2012</td>
<td>Psycho-Oncology</td>
<td>A systematic review of the associations between empathy measures and patient outcomes in cancer care</td>
<td>Despite a call for empathy in medical settings, little is known about the effects of the empathy of healthcare professionals on patient outcomes. This review investigates the links between physicians' or nurses' empathy and patient outcomes in oncology.</td>
<td>With the use of multiple databases, a systematic search was performed using a combination of terms and subject headings of empathy or perspective taking or clinician-patient communication, oncology or end-of-life setting and physicians or nurses.</td>
<td>Among the 394 hits returned, 39 studies met the inclusion criteria of a quantitative measure of empathy or empathy-related constructs linked to patient outcomes.</td>
<td>Systematic review</td>
<td>Empathy was mainly evaluated using patient self-reports and verbal interaction coding. Investigated outcomes were mainly proximal patient satisfaction and psychological adjustment. Clinicians' empathy was related to higher patient satisfaction and lower distress in retrospective studies and when the measure was patient-reported. Coding systems yielded divergent conclusions. Empathy was not related to patient empowerment (e.g., medical knowledge, coping).</td>
<td>Literature review</td>
<td>Clinicians' evaluations of patients' perspectives should be studied and compared with patients' reports so that problematic gaps between the two perspectives can be addressed.</td>
<td>Clinicians' empathy has beneficial effects according to patient perceptions. Future research should apply different empathy assessment approaches simultaneously, including a perspective-taking task on patients' expectations and needs at precise moments. Indeed, clinicians' understanding of patients' perspectives is the core component of medical empathy, but it is often assessed only from the patient's point of view.</td>
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<tr>
<td>Dempsey, C., Wojcieszowski, S.</td>
<td>2014</td>
<td>JONA</td>
<td>Reducing patient suffering through compassion connected care</td>
<td>Connecting with patients in compassionate ways to alleviate inherent patient suffering and prevent avoidable suffering is key to improving the patient experience. The Compassionate Connected Care framework identifies strategies for meeting the challenges of connecting with patients and reducing suffering</td>
<td>Review of C3 (Compassionate Connected Care) framework and effect on patient experience, nurses ability to deliver compassionate care</td>
<td>NA</td>
<td>NA</td>
<td>Decrease patient suffering through application of C 3.</td>
<td>VII</td>
<td>Opinion piece, review of literature</td>
<td>Bringing people who care for patients back to the heart of compassion, connection, and care by applying C 3 framework to daily operations.</td>
</tr>
<tr>
<td>Doberty, M., Thompson, H.</td>
<td>2014</td>
<td>British Journal of Community Nursing</td>
<td>Enhancing person-centered care through the development of a therapeutic relationship</td>
<td>This case study reflects on the assessment process used by a district nursing student in clinical practice and demonstrates how a therapeutic relationship is developed, thereby supporting person-centeredness</td>
<td>Case study</td>
<td>One case study</td>
<td>NA</td>
<td>Therapeutic relationship supports person centeredness.</td>
<td>Literature review</td>
<td>One case study in home health setting in Ireland</td>
<td>Tailoring of therapeutic skills required to be successful in person-centered care.</td>
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<td>Norfolk, T.</td>
<td>2007</td>
<td>Medical Education</td>
<td>The role of empathy in establishing rapport in the consultation of a new model</td>
<td>Establish a clear understanding of the patient’s perspective on his or her problem, and to allow this understanding to inform both the explanation and planning stages of the consultation. The quality of this understanding is largely determined by the empathic accuracy achieved by the doctor; the primary benefit is a therapeutic rapport between doctor and patient.</td>
<td>To highlight the role of empathy and communication skills in establishing rapport, we initially developed a model which seeks to draw the various motivational and skill elements identified in separate research papers into a comprehensive model of the journey towards shared understanding between doctor and patient. We then conducted an initial validation of the model via qualitative analysis involving general practitioners (GPs) and clinical psychologists.</td>
<td>Twelve experienced practitioners, identified through opportunity sampling, took part in the study. 6 GPs (with an average of 16 years in practice) and 6 clinical psychologists (with an average of 19 years in practice).</td>
<td>Each practitioner first took part in a 90-minute semi-structured interview based on the critical incident technique; in which he or she was initially asked to recall and describe separate specific patient sessions in which the development of rapport had: 1 gone well, and 2 proved difficult. Practitioners were then asked to define and describe the concept of ‘rapport’, and the relationship between empathy and rapport. Finally, they were asked for their professional opinions on the validity of the model. An average of 4 patient sessions were discussed with each participant, resulting in a total of 48 analysed sessions, which were transcribed.</td>
<td>The validation offered encouraging support for the principal elements of the model. Specific suggestions for clarification and extension were then incorporated in a revised model.</td>
<td>VI</td>
<td>Small sample size. Patients not included in validity of physician education. Physicians included in study already had awareness of model. Future research might focus on experimental validation of the model in the training environment and analysis of its impact on patient outcomes.</td>
<td>The model appears to capture the dynamic process of establishing a therapeutic relationship (rapport) between doctor and patient, defined by the quality of the doctor’s understanding of the patient’s perspective on his or her problem. Arguably, the most important contribution of the model is to highlight the fact that ‘rapport’ and consequent ‘rapport’ are not mystical or exclusive concepts but rather, involve the use of specific skills accessible at some level by all.</td>
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| Bramley, L., Matiti, M. | 2014 | Journal of Clinical Nursing: Volume 23, Issue 19-20, pages 2790-2799, October 2014 | How does it really feel to be in my shoes? Patients’ experiences of compassion in nursing care and their perceptions of developing compassionate nurses | A qualitative exploratory descriptive approach | 10 patients | In-depth, semi-structured interviews were conducted with a purposive sample of 10 patients in a large teaching hospital in the United Kingdom. Interviews were digitally recorded and transcribed verbatim. Thematic networks were used in analysis. | Three overarching themes emerged from the data: (1) what is compassion: knowing me and giving me your time; (2) understanding the impact of compassion: how it feels in my shoes and (3) being more compassionate: communication and the essence of nursing. | The small sample size, exclusion of very sick patients and those with dementia, is limiting to the transferability of the findings. It is also worth noting that all participants described their empathy as white British, and compassionate care may be perceived differently in a more culturally representative sample. | VI                                                                 | Compassion from nursing staff is broadly aligned with actions of care, which can often take time. For some, this time needs only be fleeting to establish a compassionate connection. Despite recent calls for the increased focus on compassion at all levels in nurse education and training, patient opinion was divided on whether it can be taught or remains a moral virtue. Gaining understanding of the impact of uncompassionate actions presents an opportunity to change both individual and cultural behaviours. |
Models of education that focus on cultivating clinical empathy. A review of the literature on empathy in nursing students. The aims of this paper are to discuss the role of empathy in clinical practice.

Hojat, M., Schaal, M., Cody, J., Coates, M., Brunero, S., Cummings, J., McGrath, J., Profetto-McClintock, K., Bulmer, J., Cutcliffe, J., and Davis, M. The impact of a counseling course on student nurses’ empathy levels. A pilot study to measure the development of empathy in students on a 6-week counseling course.

Quasi-experimental Design

38 students

Participants were measured on the Jefferson Scale of Empathy. The results indicate that changes in empathy levels of student nurses occurred in all but one of the students with a wide variation in the degree of change.

Findings

Null hypothesis was rejected. The study showed a significant increase in empathy levels among students.

Limitations

Small sample size.

Conclusion

Effective communication is an essential tool in expressing empathy in a clinical setting.


Literature review

39 articles reviewed

Theoretical = 21, empirical = 9. A broad search of computerized databases focusing on articles published in English during 1995-2007 was completed. Extensive screening sought to determine current literature themes and empirical research related to empathy in nursing focused specifically on emotional intelligence.

Findings

The literature focuses on EI and nursing education, EI and counseling, EI and nursing practice, EI and clinical decision-making, and EI and emotional intelligence.

Limitations

English language only.

Conclusion

This literature reveals widespread support for EI concepts in nursing. EI needs to be explicit within nursing education as EI might impact the quality of empathic decision-making, critical thinking, evidence-based practice, and leadership. Emotionally intelligent leaders influence employee retention, quality of patient care, and patient outcomes.


Literature review

A review of 44 articles published in English during 1995-2007. The approach used was a critical analysis of the literature using a critical appraisal tool.

Findings

The results indicated that the literature focuses on EI and nursing education, EI and nursing practice, EI and clinical decision-making, and EI and emotional intelligence.

Limitations

English language only.

Conclusion

Models of education that show promise are those that use experiential learning. The studies reviewed demonstrated that it is possible to increase nurses’ empathy ability.


Longitudinal Design

214 undergraduate nursing students

Jefferson Scale of Empathy and Survey containing questions on demographics, academic background, future career goals at beginning of academic year and at the end of the academic year (2006-2007).

Findings

Decline in empathy in the total sample, which was statistically significant.

Limitations

Decline in empathy noted in nursing students. Further research is needed to identify the extent of this decline.

Conclusion

Decline in empathy noted in nursing students. Further research is needed to identify the extent of this decline.

Author | Year | Journal | Title | Aim/Question | Study Design | Sample | Data Collection | Findings | Mosby's Level of Evidence | Limitations | Conclusion
---|---|---|---|---|---|---|---|---|---|---|---
Stickleby, T. | 2011 | Nurse Education in Practice | How compassion and empathy might be taught in nursing using empathic skills for non-verbal communication in a less mechanistic way than seen with the use of SOLER. | Review of literature and introduction of new model | N/A | N/A | Limitations with SOLER expressed | VII | Expert opinion

Laggs, M., Mogil, J., Bushnell, C. 2007 0044-3990/$34.00 © 2007 International Association for the Study of Pain. Published by Elsevier B.V. All rights reserved. doi:10.1016/j.pain.2007.07.007

Author | Year | Journal | Title | Aim/Question | Study Design | Sample | Data Collection | Findings | Mosby's Level of Evidence | Limitations | Conclusion
---|---|---|---|---|---|---|---|---|---|---|---
Laggs, M., Mogil, J., Bushnell, C. | 2007 | International Association for the Study of Pain. Published by Elsevier B.V. All rights reserved. doi:10.1016/j.pain.2007.07.007 | Empathy hurts: Compassion for another increases both sensory and affective components of pain perception | Randomized controlled trial | 24 men and 24 women, from 18 to 31 years old, after inducing in half of our subjects a state of high empathy for an actor and in the other half a state of low empathy towards him, we measured the sensitivity to heat stimuli of various intensities in healthy participants while they watched the actor being exposed to similar stimuli. Participants in the “high empathy” group rated painful (but not non-painful) stimuli applied to themselves as more intense and unpleasant than those in the “low-empathy” group. | Randomized controlled trial | N/A | N/A | During the observation of the neutral video (baseline), the average ratings of 42 and 44 °C were below pain threshold (p < 0.01), and the ratings of 46.5 and 48 °C were above pain threshold (p < 0.05 and p < 0.001, respectively). The AEPs and AFE - groups did not differ in their ratings of pain intensity or unpleasantness during this baseline testing period preceding the empathy manipulation (Group * Temperature interaction not significant. F(3, 138) < 1.14, p’s > 0.05). | N/A | Sample size


Author | Year | Journal | Title | Aim/Question | Study Design | Sample | Data Collection | Findings | Mosby's Level of Evidence | Limitations | Conclusion
---|---|---|---|---|---|---|---|---|---|---|---
Price, V., Archbold, J. | 1997 | Nurse Education Today | What's it all about, empathy? | N/A | This paper investigates the concept of empathy, a core element of all helping relationships. A discussion of its importance, prevalence in the nursing literature is traced, before a discussion ensues as to whether it is a naturally acquired ability which develops with maturity, or whether it is a skill that can be taught and learnt. | N/A | N/A | It is concluded that empathy remains a poorly defined, multidimensional concept which still remains not fully identified. | VII | Opinion piece, review of literature

Laapro-James, A. 2013 The British Journal of General Practice, 63(608), e76-e84. doi:10.3399/bjgp13X60860 814

Author | Year | Journal | Title | Aim/Question | Study Design | Sample | Data Collection | Findings | Mosby's Level of Evidence | Limitations | Conclusion
---|---|---|---|---|---|---|---|---|---|---|---
Laapro-James, A. | 2013 | The British Journal of General Practice | Evaluation of the effectiveness of the model SURETY in nursing using empathic communication and includes touch. | Systematic literature search | After screening the literature using specified selection criteria, 964 original studies were selected. Seven were included in this review after applying quality assessment. | Systematic literature search | N/A | N/A | There is a good correlation between physician empathy and patient satisfaction and a direct positive relationship with strengthening patient engagement. The effects of empathy on patients’ anxiety and distress and delivers significantly better clinical outcomes. | N/A | Literature review

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<th>Author</th>
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<tr>
<td>Kunyk, D., Olson, J.</td>
<td>2001</td>
<td>Journal of Advanced Nursing, 2001; 35(3):317-325</td>
<td>Clarification of conceptualizations of empathy</td>
<td>The purpose of our analysis was to describe empathy as presented in the nursing literature between 1992 and 2000.</td>
<td>A concept clarification methodology of concept analysis was used because of the many definitions, the rich descriptions, and the application of empathy as a research variable in the reviewed literature.</td>
<td>Nursing literature between 1992 and 2000.</td>
<td>Between 1992 and 2000.</td>
<td>Five conceptualizations of empathy were revealed: empathy as human trait, empathy as a professional state, empathy as a communication process, empathy as caring, and empathy as a special relationship.</td>
<td>Literature Review</td>
<td>Description of empathy as presented in the literature.</td>
<td>The literature reviewed contained evidence that the concept is developing more depth and breadth. Nurse authors are approaching empathy from a variety of perspectives, time frames, measurements, and outcomes. While all are important to the development of the concept, further enrichment of the conceptual work on empathy is needed before a fully mature concept emerges that is fully useful in nursing practice, research, and education.</td>
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<tr>
<td>Hojat, M., Louis, D., Markman, F., Wender, R., Rubinstein, C., and Gonnella, J.</td>
<td>2011</td>
<td>Acad Med. 2011; 86(6):359-364. doi: 10.1097/ACM.0b013e3182066631</td>
<td>Physicians’ Empathy and Clinical Outcomes for Diabetic Patients</td>
<td>To test the hypothesis that physicians’ empathy is associated with positive clinical outcomes for diabetic patients.</td>
<td>A correlational study design was used in a university-affiliated outpatient setting. Results of the most recent hemoglobin A1c and LDL-C tests were extracted from the patients’ electronic records. The results of hemoglobin A1c tests were categorized into good control (&lt;7.0%) and poor control (≥7.0%). Similarly, the results of the LDL-C tests were grouped into good control (&lt;100) and poor control (≥130). The physician, who completed the Jefferson Scale of Empathy in 2009, were grouped into high, moderate, and low empathy scorers. Associations between physicians’ level of empathy scores and patient outcomes were examined.</td>
<td>Participants were 891 diabetic patients treated between July 2006 and June 2009, by 29 family physicians.</td>
<td>Medical record review, physician empathy measured via the Jefferson scale of Empathy.</td>
<td>Patients of physicians with high empathy scores were significantly more likely to have good control of hemoglobin A1c (56%) than were patients of physicians with low empathy scores (40%; P &lt; .001). Similarly, the proportion of patients with good LDL-C control was significantly higher for physicians with high empathy scores (59%) than physicians with low scores (44%; P &lt; .001). Logistic regression analyses indicated that physicians’ empathy had a unique contribution to the prediction of optimal clinical outcomes after controlling for physicians’ and patients’ gender and age, and patients’ health insurance.</td>
<td>V</td>
<td>Inability to control for all variables including patients, physicians, culture, race, ethnicity, severity of disease, environment of care, and regulations. Single institution in academic setting.</td>
<td>The hypothesis of a positive relationship between physicians’ empathy and patients’ clinical outcomes was confirmed, suggesting that physicians’ empathy is an important factor associated with clinical competence and patient outcomes.</td>
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<td>Author</td>
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<tr>
<td>Hardee, J.</td>
<td>2003</td>
<td>The Permanente Journal</td>
<td>An overview of empathy: A focus on patient centered care and office proactive management.</td>
<td>Overview of empathy: A focus on patient centered care and office proactive management.</td>
<td>Literature review</td>
<td>N/A</td>
<td>N/A</td>
<td>Empathy is a powerful, efficient communication tool. Benefits are tangible for both physician and patient.</td>
<td>N/A</td>
<td>Literature review</td>
<td>Empathy is a powerful, efficient communication tool. It extends beyond the understanding of the patient history and symptoms to include values, ideas and feelings. Benefits of improved empathetic communication are tangible for both physician and patient.</td>
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<tr>
<td>Lewin S., Skea Z., Entwistle V., Zwarenstein M., Dick J.</td>
<td>2001</td>
<td>Cochrane Database Syst Rev</td>
<td>Interventions for providers to promote patient-centred approach in clinical consultations.</td>
<td>To assess the effects of interventions for health care providers that aim to promote patient-centred approaches in clinical consultations.</td>
<td>Literature review of Randomized controlled trials, controlled clinical trials, controlled before and after studies, and interrupted time series</td>
<td>We searched Medline Randomized controlled trials, controlled clinical trials, controlled before and after studies, and interrupted time series.</td>
<td>Two reviewers independently extracted data onto a standard form and assessed study quality for each study. We extracted all outcomes other than health care providers' knowledge, attitudes and intentions.</td>
<td>There is fairly strong evidence to suggest that some interventions to promote patient-centred care in clinical consultations may lead to significant increases in the patient-centredness of consultation processes. 12 of the 14 studies that assessed consultation processes showed improvements in some of these outcomes. There is also some evidence that training health care providers in patient-centred approaches may impact positively on patient satisfaction with care. Of the eleven studies that assessed patient satisfaction, six demonstrated significant differences in favour of the intervention group on one or more measures.</td>
<td>Literature review</td>
<td>There is limited and mixed evidence on the effects of such interventions on patient health care behaviours or health status, or on whether these interventions might be applicable to providers other than physicians. Further research is needed in these areas.</td>
<td>Interventions to promote patient-centred care within clinical consultations may significantly increase the patient-centredness of care.</td>
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<td>Moore P., Rivera Mercedo, S., Grez Antigues, M., Lawrie T.</td>
<td>2013</td>
<td>Cochrane Database</td>
<td>Spet Res. 2013 Mar 28:CD00357 51. doi: 10.1002/1465134856.00013.d03</td>
<td>Communicating skills training for healthcare professionals working with patients who have cancer.</td>
<td>Literature review of RCTs limited to evaluating Communication Skills Training (CST)</td>
<td>The original review was a narrative review that included randomised controlled trials (RCTs) and controlled before-and-after studies. In this updated version, we limited our criteria to RCTs evaluating CST compared with no CST or other CST in HCPs working in cancer care. Primary outcomes were changes in HCP communication skills measured in interactions with real and/or simulated patients with cancer, using objective scales.</td>
<td>Two review authors independently assessed trials and extracted data to a pre-designed data collection form. We pooled data using the random-effects model and, for continuous data, used standardised mean differences (SMDs).</td>
<td>Some communication skills training improves skills. Patients with reduced anxiety scores.</td>
<td>Evidence level V</td>
<td>Literature review</td>
<td>Various CST courses appear to be effective in improving some types of HCP communication skills related to information gathering and supportive skills. We were unable to determine whether the effects of CST are sustained over time, whether consolidation sessions are necessary, and which types of CST programs are most likely to work. We found no evidence to support a beneficial effect of CST on HCP ‘burnout’, patients’ mental or physical health, and patient satisfaction.</td>
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<tr>
<td>Chen, D., Lewis, R., Hershman, W., Stolander J.</td>
<td>2007</td>
<td>J Gen Intern Med. 2007 Oct;22(10):1464–8.</td>
<td>Epub 2007 Jul 26.</td>
<td>A cross-sectional measurement of medical student empathy</td>
<td>Cross-sectional study</td>
<td>A cross-sectional study of students at Boston University School of Medicine in 2006. Incoming students plus each class near the end of the academic year were surveyed. 658 students.</td>
<td>The Jefferson Scale of Physician Empathy-Student Version (JSPE-S), a validated 20-item self-administered questionnaire with a total score ranging from 20 to 140. JSPE-S scores were controlled for potential confounders such as gender, age, anticipated financial debt upon graduation, and future career interest.</td>
<td>The first-year medical student class had the highest empathy scores (115.6), whereas the fourth-year class had the lowest empathy scores (106.6).</td>
<td>Literature review</td>
<td>Evidence level IV</td>
<td>Some communication skills training improves skills. Patients with reduced anxiety scores.</td>
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Empathy scores of students in the preclinical years were higher than in the clinical years. Efforts are needed to determine whether differences in empathy scores among the classes are cohort effects or represent changes occurring in the content of medical education. Future research is needed to confirm whether clinical training impacts empathy negatively and, if so, whether interventions can be designed to mitigate this impact.
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<td>Tsai, S., Becker, C., Kawada, R., Fujino, J., Jankowski, K., Sugihara, K., Murai, S., Takahashi, T., Takehoshi, H.</td>
<td>2014</td>
<td><em>Translation of Psychiatry</em>, 4, e393, doi:10.1036/tp.2014.34</td>
<td>Can we predict burnout severity from empathy-related brain activity?</td>
<td>We studied the relationship between self-reported burnout severity scores and psychological measures of empathetic disposition, emotional dissonance and alexithymia in medical professionals to test two contradictory hypotheses: Burnout is explained by (1) 'compassion fatigue'; that is, individuals become emotionally over-involved, and (2) 'emotional dissonance'; that is, a gap between felt and expressed emotion, together with reduced emotional regulation. Then, we tested whether increased or decreased empathy-related brain activity measured by fMRI was associated with burnout severity scores and psychological measures.</td>
<td>Participants were 25 nurses in active service with less than 11 years of experience (20 females, aged 22–34, mean=26.0, s.d.=3.14). All participants had worked in nursing for at least 1 year. Participants were right-handed, according to the Edinburgh handedness inventory.</td>
<td>Burnout severity was assessed by the Maslach Burnout Inventory (MBI). Empathetic disposition was assessed by the IRI. Emotional dissonance was assessed by the Emotion Work Requirements Scale (EWR). Video clips showing a hand in painful (pain) or nonpainful (no-pain) situations were presented to participants during the fMRI scanning. Participants were asked to passively look at the stimuli. After the scanning session, participants were asked to rate each of the video clips on the following: (1) intensity of distress (how much distress they felt from a first-person perspective); and (2) intensity of pain (objective rating of pain form a third-person perspective). Distress and pain were each rated on a 0–9-point Likert scale, ranging from no distress/pain to the most extremely imaginable distress/pain.</td>
<td>Correlation between high burn-out and reduced empathy-related brain activity.</td>
<td>III</td>
<td>The observed relationship between burnout severity and empathy-related brain activity might only apply to inexperienced nurses because burnout can be triggered by various factors besides altered emotional regulation. This reduced brain activity was also associated with greater difficulty in recognizing one’s own emotional state, as well as with greater self-reported empathic disposition. Our results support findings from previous behavioral studies, arguing that burnout is related to weakened emotional regulation.</td>
<td>In conclusion, burnout in medical professionals might be explained by reduced empathy-related brain activity. This reduced brain activity was also associated with greater difficulty in recognizing one’s own emotional state, as well as with greater self-reported empathic disposition. Our results support findings from previous behavioral studies, arguing that burnout is related to weakened emotional regulation.</td>
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<td>Rosen I., Gimotty P., Shea J., Bellini L</td>
<td>2006</td>
<td>Academic Medicine, 81, (1)</td>
<td>Evolution of sleep quantity, sleep deprivation, mood disturbances, empathy, and burnout among interns.</td>
<td>To explore the relationships between sleep deprivation and the evolution of mood disturbances, empathy, and burnout among interns.</td>
<td>Quasi-experimental</td>
<td>Residents completed the following instruments at baseline and at year end: Sleep Quantity, Sleep Deprivation, Mood Disturbances, Empathy, and Burnout Survey. The prevalences of acute and chronic sleep deprivation, subjective sleepiness, burnout, empathy, and depression at the beginning of the year were compared to prevalences at the end of internship. Associated sleep deprivation and mood, empathy, or burnout were explored.</td>
<td>The prevalence of chronic sleep deprivation, depression, burnout, and empathy increased from baseline to year end. There was an association between becoming chronically sleep deprived and becoming depressed.</td>
<td>III</td>
<td>First, a single-institution study of a single residency program limits generalizability. Second, global estimates of sleep duration are usually less reliable than daily diaries or the combination of daily diary and actigraphy. Third, testing participants immediately before the start of internship may have actually produced different results than if they had been sampled a few weeks prior. Lastly, the prevalence of depression was not high enough in the beginning of the year to data to assess the effects of sleep deprivation on those who already had established depression.</td>
<td>Given the association between chronic sleep deprivation and mood disturbances during internship, outcome assessment is warranted to see if duty-hour reform will translate into more hours slept or fewer hours worked, coincident with improved mood.</td>
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<td>Maslach, C. &amp; Jackson, S. E.</td>
<td>1981</td>
<td>Journal of Organizational Behavior, 2(2), 99-113</td>
<td>The measurement of experienced burnout.</td>
<td>To postulate a specific syndrome of burnout and devise an instrument to assess it.</td>
<td>A preliminary form of the MBI, which consisted of 47 items with a two-scale format, was administered to a sample of 165.</td>
<td>Three subscales emerged from the data analysis: emotional exhaustion, depersonalization, and personal accomplishment. Various psychometric analyses showed that the scale has both high reliability and validity as a measure of burnout.</td>
<td>II</td>
<td>The development of the MBI was based on the need for an instrument to assess experienced burnout in a wide range of human service workers. Its inclusion in future research studies will allow us to achieve a better understanding of the personal, social, and institutional variables that either promote or reduce the occurrence of burnout.</td>
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<tr>
<td>Glasberg, A., Norberg, A., Soderberg, A.</td>
<td>2007</td>
<td>Journal of Advance Nursing</td>
<td>Sources of burnout among healthcare employees as perceived by managers</td>
<td>This paper is a report of a study to investigate healthcare managers’ perspectives on factors contributing to the increase of healthcare employees on sick leave due to burnout symptoms. The data were collected in Sweden in 2003 and analyzed using thematic qualitative content analysis.</td>
<td>Interviews were carried out with 30 healthcare managers, with different occupational backgrounds and from different units. The data were collected in Sweden in 2003 and analyzed using thematic qualitative content analysis.</td>
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<td>According to the healthcare managers, continuous reorganization and downsizing of healthcare services has reduced resources and increased demands and responsibilities. These problems are compounded by high ideals and expectations, making staff question their own abilities and worth as well as making them feel less confirmed and less valued as people. The main finding indicates that healthcare employees are thrown into a spiraling sense of inadequacy and an emerging sense of pessimism and powerlessness.</td>
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<td>VI</td>
<td>To understand and influence people’s actions, one has to understand their perceptions and thoughts - their explanatory models. This study shows the complexity and interconnection between sources of burnout as perceived by healthcare managers, and highlights the encouragement of realism without the destruction of enthusiasm as an important factor in management and healthcare practice.</td>
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<td>Felton, J.</td>
<td>1998</td>
<td>Occupation and Medicine</td>
<td>Burnout as a clinical entity—its importance in health care workers.</td>
<td>To review the impact and effects of burnout in health care workers.</td>
<td>Literature review</td>
<td>-</td>
<td>-</td>
<td>Burnout is a professional occupational disease manifest in the many specialties of health care.</td>
<td>Literature review</td>
<td>-</td>
<td>Burnout will be a disorder as long as human values and worth are disregarded by inept policy makers and managers of human resources. In the ultimate, the elimination of burnout will mean better care for clients and patients.</td>
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<tr>
<td>Bellini LM, Baime M, Shea JA.</td>
<td>2002</td>
<td>The Journal of the American Medical Association</td>
<td>Variation of mood and empathy during internship</td>
<td>To examine mood patterns and changes in empathy among internal medicine residents over the course of the internship year.</td>
<td>Cohort study of interns involving completion of survey instruments at 4 points: time 1 (June 2000, Profile of Mood States [POMS] and Interpersonal Reactivity Index [IRI]), times 2 and 3 (November 2000 and February 2001, POMS), and time 4 (June 2001, POMS and IRI).</td>
<td>Sixty-one interns.</td>
<td>Baseline scores of mood states and empathy trends in mood states and empathy over the internship year.</td>
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<td>IV</td>
<td>We found that, in this sample, enthusiasm at the beginning of internship soon gave way to depression, anger, fatigue, and confusion and have even more vigor than general adult and college student populations. Results of the IRI showed better baseline scores for perspective taking and empathic concern and lower scores for personal distress among interns compared with normals. Five months into internship, however, POMS scores revealed significant increases in the depression-dejection, anger-hostility, and fatigue-inertia scales, as well as an increase in IRI personal distress level.</td>
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<td>Sonia J. Crandall, PhD, MS,</td>
<td>2009</td>
<td>Academic Medicine;</td>
<td>Commentary: Identifying Attitudes Towards Empathy: An Essential Feature of Professionalism</td>
<td>Literature review and Commentary</td>
<td>Review of 3 articles that assess empathy in health care using the Jefferson Scale of Physician Empathy</td>
<td>The authors agree with the distinctions made in the three studies between empathy (described as a cognitive attribute) and sympathy (described as an emotional attribute) and believe that empathy as a cognitive skill can be role modeled, taught, and assessed. Barriers can be remedied in medical education through interprofessional education and practice and institutional promotion of relationship-centered care, which maintains the centrality of the patient–clinician relationship while recognizing the importance of relationships with self and others.</td>
<td>Literature review</td>
<td>Opinion</td>
<td>Barriers can be remedied in medical education through interprofessional education and practice and institutional promotion of relationship-centered care, which maintains the centrality of the patient–clinician relationship while recognizing the importance of relationships with self and others.</td>
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<td>and Gail S. Marion, PA-C, PhD</td>
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<td>200984:117 4–1176.</td>
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<td>Williams, B., Brown, T.,</td>
<td>2013</td>
<td>Medical Education,</td>
<td>DVD empathy simulations: an intervention study</td>
<td>Pre and post intervention testing of empathy.</td>
<td>In total, 293 participants completed follow-up results at 6 weeks with ID matched pre-workshop questionnaires</td>
<td>In total, 31 workshops (90 minutes each) were delivered over a 4-week period during August and September 2012 at four Australian universities. These workshops were attended by 321 students from all year levels (first to fifth year) and included participants from over 10 different health care professions (medicine, paramedics, nursing, radiography, physiotherapy, medical imaging, podiatry, biomedical science, occupational therapy, nutrition and dietetics, occupational therapy, physiotherapy and social work).</td>
<td>Using a paired t-test, there was a statistically significant difference between empathy scores before and at 6 weeks (114.34 versus 120.32; p &lt; 0.0001) with a moderate effect size (d = 4.7). Qualitative findings also suggested greater understanding of their personal perceptions of empathy, patient centered- ness and workshop impact relating to practice-based education.</td>
<td>III</td>
<td>The results from this study suggest that the workshops have played a positive role in improving students’ self-reported empathy levels. Further research is needed to explore if these results can be replicated to achieve better empathetic behaviors leading to improved therapeutic relationships and positive health outcomes.</td>
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<td>Watson, J. W.,</td>
<td>2000</td>
<td>Nursing Research, 49, 191-200</td>
<td>The impact of nurses' empathic responses on pain management in acute</td>
<td>To examine the relationship between nurses' empathic responses and their</td>
<td>Logitudinal study</td>
<td>Two hundred twenty-five</td>
<td>Data Collection</td>
<td>Nurses were moderately empathic, and their responses did not significantly</td>
<td>IV</td>
<td>Future studies on long-term effects of training needed.</td>
<td>Compassion training promotes prosocial behavior and augments positive affect and resilience, fostering better coping with stressful situations. Opens up opportunities for targeted development of adaptive social, emotional and motivation.</td>
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<td>Garlitzel, P.,</td>
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<td>care.</td>
<td>patients' pain intensity and analgesic administration after surgery.</td>
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<td>patients from four</td>
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<td>influence their patients' pain intensity or analgesia administered.</td>
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<td>Glorop, R.,</td>
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<td>cardiovascular units in</td>
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<td>Patients reported moderate severity in pain but received only 47% of</td>
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<td>Stevin, B., &amp;</td>
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<td>three university-affiliated</td>
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<td>their prescribed analgesia. Patients' perceptions of their nurse's</td>
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<td>Steiner, D.</td>
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<td>Steiner, D.</td>
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<td>and misbeliefs about pain management were evident for nurses</td>
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<td>independent of empathy, and knowledge explained 7% of variance in</td>
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<td>Singer, T.,</td>
<td>2014</td>
<td>Current Biology, 24 (18), 875-</td>
<td>Empathy and compassion.</td>
<td>Discussion of the plasticity of the socio-emotional brain.</td>
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<td>Exposure to distress and suffering of others can lead to 2 different</td>
<td>VII</td>
<td>Future studies on long-term effects of training needed.</td>
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<td>emotional reactions: Empathic distress results in negative feelings and</td>
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<td>positive, other-oriented feelings and the activation of prosocial</td>
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<td>motivation and behavior.</td>
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<td>Riess, Helen</td>
<td>2015</td>
<td>AOUB Neurosciences</td>
<td>The impact of clinical empathy on patients and clinicians understand</td>
<td>To understand clinical empathy and emotional labor.</td>
<td>Literature review</td>
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<td>Increased support of clinicians' well-being is vitally needed to enable</td>
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<td>decline. Physicians are finding current medical environments a poor fit</td>
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<td>for careers they were once passionate about, and interventions that</td>
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<td>improve communication, workflow solutions, and group supports that</td>
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<td>address clinician concerns are all needed. Providing &quot;resilience rounds&quot;</td>
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<td>for providers could enable them to be more empathic when making patient</td>
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<td>rounds in hospitals.</td>
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128

**Aim/Question**: What is clinical empathy?

**Findings**: Patients seek empathy from their physicians. Medical educators increasingly recognize this need. Yet in seeking to make empathy a reliable professional skill, doctors change the meaning of the term. Outside the field of medicine, empathy is a mode of understanding that specifically involves emotional resonance. In contrast, leading physician educators define empathy as a form of detached cognition. In contrast, this article argues that physicians' emotional attunement greatly serves the cognitive goal of understanding patients' emotions. This has important implications for teaching empathy.

**Limitations**: Literature review


**Aim/Question**: Communication patterns of primary care physicians

**Study Design**: Description of routine communication in primary care based on audiotape analysis and patient and physician exit questionnaires

**Sample**: The participants were 127 physicians and 537 patients coping with ongoing problems related to disease.

**Findings**: Cluster analysis revealed 5 distinct communication patterns: (1) "narrowly biomedical," characterized by closed-ended medical questions and biomedical talk occurring in 32% of visits; (2) "expanded biomedical," like the restricted pattern but with moderate levels of psychosocial discussion occurring in 33% of the visits; (3) "biopsychosocial," reflecting a balance of psychosocial and biomedical topics (20% of the visits); (4) "psychosocial," characterized by psychosocial exchange (8% of visits); and (5) "consumerist," characterized primarily by patient questions and physician information giving (8% of visits). Biomedically focused visits were used more often with more sick, older, and lower income patients by younger, male physicians.

**Conclusion**: Physician satisfaction was lowest in the narrowly biomedical pattern and highest in the consumerist pattern, while patient satisfaction was highest in the psychosocial pattern.


**Aim/Question**: Ethics, empathy and storytelling in professional development

**Findings**: Story forms a large part of the lives we lead. Consideration of some ways in which storytelling can be used to develop empathy and understanding in practitioners of the caring professions.

**Conclusion**: Authors view is that empathy is central to skilled and ethical caring and touch on some ethical issues, including the apparent seriousness with which the value of confidentiality is upheld within the caring professions.
<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Journal</th>
<th>Title</th>
<th>Aim/Question</th>
<th>Study Design</th>
<th>Sample</th>
<th>Data Collection</th>
<th>Findings</th>
<th>Mosby's Level of evidence</th>
<th>Limitations</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manney, PJ</td>
<td>2008</td>
<td>Journal of Evolution and Technology</td>
<td>Empathy in the time of technology: How storytelling is the key to empathy</td>
<td>Will the transhuman technologies that our accelerating future promises enable us to increase our empathy to others? Or will their use decrease our ability to understand &quot;the other&quot; that exists outside our own selves, families, communities and cultures?</td>
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<td>Practically, empathy is created through storytelling, which is not only the most successful remote means of creating social empathy, but has actually been the engine of social/cultural liberalization and change. I will demonstrate both the positive and negative affects on empathy through the increasing reliance we have on transhuman media technologies and how I believe storytelling is the key to empathy creation.</td>
<td>VII</td>
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<tr>
<td>Williams, J, Stickley, T.</td>
<td>2010</td>
<td>Nurse Education Today</td>
<td>Empathy and nurse education</td>
<td>Reviews the nursing and counseling literature related to empathy.</td>
<td>Literature review</td>
<td></td>
<td></td>
<td>Literature review</td>
<td></td>
<td></td>
<td>Educators might consider the use of educational interventions that explicitly facilitate emotional development and enable students to develop their own innate empathic capacity and self-awareness.</td>
</tr>
<tr>
<td>Jack, A., Dawson, A., Begany, K., Locke, R., Barry, K., Ciccia, H., Snyder, A.</td>
<td>2013</td>
<td>NeuroImage</td>
<td>fMRI reveals reciprocal inhibition between social and physical cognitive domains.</td>
<td>The goal of this investigation is to shed light on the cognitive significance of this tension between the TPN and DMN.</td>
<td>Experimental: Two-factor crossed design to examine the cortical regions recruited during social and mechanical reasoning tasks presented to neurologically normal participants during fMRI.</td>
<td>45 healthy college students</td>
<td>Data for each subject were entered into a general linear model in which baseline and linear trend were estimated alongside a single uniform assumed response associated with each condition</td>
<td>These results indicate the reciprocal inhibition is not attributable to constraints inherent in the tasks, but is neural in origin. Hence, there is a physiological constraint on our ability to simultaneously engage two distinct cognitive modes. Further work is needed to more precisely characterize these opposing cognitive domains.</td>
<td>II</td>
<td></td>
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<tr>
<td>Kelley, K., Lepo, A., Frini, C.</td>
<td>2011</td>
<td>International Journal for Human Caring</td>
<td>Empathy and nursing education: From mirror neurons to the experience of empathy: 21st century nursing education.</td>
<td>Review neurological basis for empathy and present empathy enhancing strategies.</td>
<td>In this article we briefly review our emerging understanding of the neurological basis for the human capacity for empathy and the various ways in which empathy has been conceptualized and defined. For nursing education, the transformative power of empathy is found only when a nurse can accurately communicate an empathetic connection to his/her patient. To that end, several empathy-enhancing strategies are presented designed to provide nurses with methods by which to foster greater empathy for patient experiences</td>
<td>Literature review</td>
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<td></td>
<td>Literature review</td>
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<tr>
<td>Author</td>
<td>Year</td>
<td>Journal</td>
<td>Title</td>
<td>Aim/Question</td>
<td>Study Design</td>
<td>Sample</td>
<td>Data Collection</td>
<td>Findings</td>
<td>Model’s Level of evidence</td>
<td>Limitations</td>
<td>Conclusion</td>
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<tr>
<td>Linzer, M., Poplau, S., Grossman, E., Yardley, A., Yaffe, S., Williams, E., Hicks, E., Brown, R., Wallock, J., Kolinhart, D., &amp; Barbouche, M.</td>
<td>2015</td>
<td>Journal of General Internal Medicine, 36(8),1105-1111, doi: 10.1007/s11606-015-3235</td>
<td>A cluster randomized trial of interventions to improve work conditions and clinician burnout in primary care: results from the healthy workplace (HWP) study</td>
<td>Aim to assess if improvements in work conditions improve clinician stress and burnout.</td>
<td>Cluster randomized controlled trial.</td>
<td>Primary care clinicians at 34 clinics.</td>
<td>Work conditions and clinician outcomes measured at baseline and at 12-18 months.</td>
<td>Multilevel regressions assessed impact of workplace data and interventions on clinician outcomes. Of 115 residents, 81.3% completed the study. More intervention clinicians showed improvements in burnout and satisfaction. Burnout was more likely to improve with workflow interventions and with targeted QI projects than in controls. Interventions in communication or workflow led to greater improvements in clinician satisfaction.</td>
<td>II</td>
<td>Heterogeneous intervention types and were uncertain how well interventions were instituted.</td>
<td>Organizations may be able to improve burnout, dissatisfaction and retention by addressing communication and workflow and initiating QI projects targeting clinician concerns.</td>
</tr>
<tr>
<td>Shanafelt, T., Bradley, K., Wipf, J., &amp; Back, A</td>
<td>2002</td>
<td>Annals of Internal Medicine, 136(5), 358-367</td>
<td>Burnout and self-reported patient care in an internal medicine residency program</td>
<td>To determine the prevalence of burnout in medical residents and explore its relationship to self-reported patient care practices.</td>
<td>Cross-sectional study.</td>
<td>115 internal medicine residents.</td>
<td>Burnout measured using the Maslach Burnout Inventory.</td>
<td>Of 115 residents 76% met the criteria for burnout. Compared with non-burned out residents, burned out residents were more likely to self-report providing at least one type of suboptimal patient care at least monthly.</td>
<td>II</td>
<td>Comparison to other tools.</td>
<td>The TEQ is a brief, reliable and valid instrument for the assessment of empathy.</td>
</tr>
<tr>
<td>Sprong, R., Mckinney, M., Mar, R., &amp; Lentine, B.</td>
<td>2009</td>
<td>Journal of Personality Assessment, 91(1), 62-71</td>
<td>The Toronto Empathy Questionnaire (TEQ): Scale development and initial validation of a factor-analytic solution to multiple empathy measures.</td>
<td>To formulate a tool to assess empathy.</td>
<td>Factor analysis on a combination of self-report measures to examine consensus and developed a brief self-report measure of this common factor.</td>
<td>115 residents</td>
<td>In 3 studies the TEQ demonstrated strong convergent validity, correlating positively with behavioral measures. Exhibited good internal consistency and high test-retest reliability.</td>
<td>II</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Yu, J., &amp; Kirk, M</td>
<td>2009</td>
<td>Journal of Advanced Nursing, 65(9), 1700-1806, doi: 10.1111/j.1365-2648.2009.0 5071.x</td>
<td>Evaluation of empathy measurement tools in nursing: systematic review.</td>
<td>Systematic review to identify, critique and synthesize nursing scales of the measurement of empathy in nursing research.</td>
<td>Systematic review</td>
<td>30 papers representing 29 studies included for review</td>
<td>20 scales used</td>
<td>Many different tools used and sometimes more than one tool used in a study. A range of settings were studied, but some neglected.</td>
<td>VI</td>
<td>No recommendation of a tool.</td>
<td>There appears to be no consistency in tools used suggesting the need to evaluate the rigor of empathy tools appropriately either to inform education or for application in clinical settings.</td>
</tr>
</tbody>
</table>
**Appendix D. Workshop Agenda**

### Workshop Agenda – March - May, 2015

<table>
<thead>
<tr>
<th>Minutes</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Cleveland clinic video</td>
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<tr>
<td>5</td>
<td>Welcome to the “In Their Shoes” program, Icebreaker – Matching cards exercise</td>
</tr>
<tr>
<td>5</td>
<td>Review objectives</td>
</tr>
<tr>
<td>5</td>
<td><a href="https://www.youtube.com/watch?v=1Evwqu369Jw">https://www.youtube.com/watch?v=1Evwqu369Jw</a> (Brene Brown Empathy vs Sympathy)</td>
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<tr>
<td>5</td>
<td>Positive effects of empathy</td>
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<tr>
<td>5</td>
<td>Habits that interfere with empathy</td>
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<tr>
<td>15</td>
<td>“In Their Shoes” - scenario role playing &amp; discussion</td>
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<tr>
<td>10</td>
<td>Enhancing empathy - Introduce the tool &quot;Heart-Head-Heart&quot; and role play</td>
</tr>
<tr>
<td>15</td>
<td>“In Their Shoes” - scenario role playing &amp; discussion</td>
</tr>
<tr>
<td>5</td>
<td>Self-reflection on use of empathy</td>
</tr>
<tr>
<td>10</td>
<td>Barriers to empathy / What happens to empathy over time? Brainstorm and discussion. Being mindful: Stop, Breath, Listen, Respond (SBLR)</td>
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<td>5</td>
<td>Taking care of yourself - Relaxation exercise</td>
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<tr>
<td>2</td>
<td>Next steps (post assessment on HealthStream)</td>
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<td>2</td>
<td>Evaluation of workshop</td>
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**Objectives**

1. Have fun, and come away feeling refreshed, rejuvenated, inspired and connected to your passion.
2. Understand what empathy is and what it’s not
3. Understand the Neurobiological component of empathy (mirror neurons).
4. Understand effects of empathy on:
   a. Your personal satisfaction and resiliency
   b. Employee relationships
   c. Patient outcomes
   d. Patient/Family experience at CMC
5. Discuss barriers to empathy
6. Learn a Tool to take away and use
7. Practice being empathic
Appendix E. Jefferson Scale of Empathy – Health Profession – Student version

Please indicate your level of agreement/disagreement with each statement about patient care below, by circling one option related to using the following scale (Adapted from Hojat et al 2001):

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<tbody>
<tr>
<td>A</td>
<td>Healthcare providers' understanding of their patients' feelings and the feelings of their patients' families does not influence treatment outcomes</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>6</td>
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<tr>
<td>B</td>
<td>Patients feel better when their healthcare providers understand their feelings</td>
<td>1</td>
<td>2</td>
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<td>6</td>
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<tr>
<td>C</td>
<td>It is difficult for a healthcare provider to view things from patients' perspectives</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
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<td>D</td>
<td>Understanding body language is as important as verbal communication in healthcare provider-patient relationships</td>
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<td>2</td>
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<td>4</td>
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<td>E</td>
<td>A healthcare provider's sense of humour contributes to a better clinical outcome</td>
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<td>F</td>
<td>Because people are different, it is difficult to see things from patients' perspectives</td>
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<td>5</td>
<td>6</td>
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<td>G</td>
<td>Attention to patients' emotions is not important in patient interview</td>
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<td>4</td>
<td>5</td>
<td>6</td>
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<tr>
<td>H</td>
<td>Attentiveness of patients' personal experiences does not influence treatment outcomes</td>
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<td>4</td>
<td>5</td>
<td>6</td>
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<td>I</td>
<td>Health care providers should try to stand in their patients' shoes when providing care to them</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>J</td>
<td>Patients value a healthcare provider's understanding of their feelings which is therapeutic in its own right</td>
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<td>K</td>
<td>Patients' illnesses can be cured only by targeted treatment; therefore, healthcare providers' emotional ties with their patients do not have a significant influence in treatment outcomes</td>
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<td>L</td>
<td>Asking patients about what is happening in their personal lives is not helpful in understanding their physical complaints</td>
<td>1 2 3 4 5 6 7</td>
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<td>M</td>
<td>Healthcare providers should try to understand what is going on in their patients’ minds by paying attention to their non-verbal cues and body language</td>
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<td>N</td>
<td>I believe that emotion has no place in the treatment of medical illness</td>
<td>1 2 3 4 5 6 7</td>
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<td>O</td>
<td>Empathy is a therapeutic skill without which a healthcare providers’ success is limited</td>
<td>1 2 3 4 5 6 7</td>
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<tr>
<td>P</td>
<td>Healthcare providers’ understanding of the emotional status of their patients, as well as that of their families is one important component of the healthcare provider – patient relationship</td>
<td>1 2 3 4 5 6 7</td>
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<tr>
<td>Q</td>
<td>Healthcare providers should try to think like their patients in order to render better care</td>
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<tr>
<td>R</td>
<td>Healthcare providers should not allow themselves to be influenced by strong personal bonds between patients and their family members</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
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<tr>
<td>S</td>
<td>I do not enjoy reading non-medical literature or the arts</td>
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<td>T</td>
<td>I believe that empathy is an important factor in patients’ treatment</td>
<td>1 2 3 4 5 6 7</td>
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Appendix F. Toronto Empathy Questionnaire

Below is a list of statements. Please read each statement carefully and rate how frequently you feel or act in the manner described. Circle your answer on the response form. There are no right or wrong answers or trick questions. Please answer each question as honestly as you can.

1. When someone else is feeling excited, I tend to get excited too
2. Other people’s misfortunes do not disturb me a great deal
3. It upsets me to see someone being treated disrespectfully
4. I remain unaffected when someone close to me is happy
5. I enjoy making other people feel better
6. I have tender, concerned feelings for people less fortunate than me
7. When a friend starts to talk about his/her problems, I try to steer the conversation towards something else
8. I can tell when others are sad even when they do not say anything
9. I find that I am “in tune” with other people’s moods
10. I do not feel sympathy for people who cause their own serious illnesses
11. I become irritated when someone cries
12. I am not really interested in how other people feel
13. I get a strong urge to help when I see someone who is upset
14. When I see someone being treated unfairly, I do not feel very much pity for them
15. I find it silly for people to cry out of happiness
16. When I see someone being taken advantage of, I feel kind of protective towards him/her

Scoring Item responses are scored according to the following scale for positively worded items 1, 3, 5, 6, 8, 9, 13, 16. Never = 0; Rarely = 1; Sometimes = 2; Often = 3; Always = 4. The following negatively worded items are reverse scored: 2, 4, 7, 10, 11, 12, 14, 15. Scores are summed to derive total for the Toronto Empathy Questionnaire.
Appendix G. Workshop Evaluation

Program Evaluation
2015 “In Their Shoes” Empathy Enhancement Workshop

Name: ___________________________ Date: ___________________

1. The overall purpose/goal for this activity was met. The purpose of this activity is to promote self-awareness of empathy, practice using it and enhance use in the workplace. (If you select “Disagree” or “Strongly Disagree”, please provide comment below)

   Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree

   Comments:

2. I found this activity worthwhile for my professional practice. (If you select “Disagree” or “Strongly Disagree”, please provide comment below)

   Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree

   Comments:

3. This activity will enhance my knowledge/skill. (If you select “Disagree” or “Strongly Disagree”, please provide comment below)

   Knowledge

   Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree

   Skill

   Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree

   Comments:

4. As a result of this activity, please share at least one action you will take to change your professional practice.

5. OTHER COMMENTS:
Appendix H. Associate Assessment of Performance

Assessment Template Preview:

Assessment Name: CMC - Associate Assessment of Performance
Assessment Description: The 2015 Castle Associate Assessment of Performance.
Assessment Instructions: 

Castle Medical Center’s goal is for associates to reach their full potential. The Associate Assessment of Performance is intended to assess achievement in relation to his/her job duties and Castle’s Standards of Service Excellence.

Assessment: If requested to complete a self-evaluation, please complete all sections of the self-evaluation as soon as possible. You must click Submit when you have finalized your ratings.

Please: If a manager requests you rate another associate, please complete the peer assessment as soon as possible. Complete only areas where you have experience with the employee. Responses will be anonymous and confidential. Click Submit when you have finalized your ratings.

Manager or Alternate Rater: Complete all sections of the evaluation. Confirm that the associate and peers (if applicable) have submitted their ratings and then click Submit to finalize all ratings. If no approvals are necessary, you can now review the assessment with the employee. If approvals are necessary, these must be completed by the applicable approvers before you review the assessment with the employee. After the employee review, please sign off on the assessment with the employee to close the assessment and complete your responsibilities. The assessment is not complete until it is closed.

Note: For certain overall evaluation or section ratings, you may be required to complete a performance improvement plan before sign-off.

Rating Scale: Performance (3-Level)
Rating Scale Description: Indicates employee's relative achievement against performance expectations. Useful for basic performance evaluations.

Always Behaviors + More: Our Always behaviors plus questions on Mission, Quality, Stewardship, and Integrity.
Scoring Description: Statement Scores are averaged to determine an overall section score.
Rating Scale Description: Indicates employee's relative achievement against performance expectations. Useful for basic performance evaluations.

CMC - Always Behaviors - Caring for Others:
Behavioral Criteria: Consistently demonstrates "Always Behaviors" of caring for each other

1. Welcome and mentor new associates.
2. Establish and maintain positive relationships with all team members.
3. Treat everyone with dignity and respect.
4. Address problems promptly and privately.
5. Practice the "3 Cs": caring, committing, and collaborating. Avoid the "3 B's": bickering, backbiting, and blaming.
6. Look for opportunities to support, recognize, and praise others. Celebrate teamwork.

CMC - Always Behaviors - Communication:
Behavioral Criteria: Adheres to the Always Behaviors of communicating with positive attitude

1. Seek first to understand, then to be understood. Avoid interrupting.
2. Project an "I can help you" attitude. Never imply that the patient/customer is an imposition.
3. Be flexible and open to change.
4. Check-in when swinging in, by leaving personal challenges at home.

CMC - Always Behaviors - Growing Professionally:
Behavioral Criteria: Adheres to the Always Behaviors of growing professionally.

1. Adhere to dress standards and view my appearance through the customer's eyes.
2. Keep my commitments: Under-promise and over-deliver.
3. Provide updates on unexpected delays.
4. Participate in professional development and follow best practices.
5. Protect patient privacy and confidentiality.

CMC - Always Behaviors - Caring for Patients / Families:
Behavioral Criteria: Adheres to the Always Behaviors of caring for our patients and their families

1. Care for patients the way I would like my loved ones to be cared for.
2. Practice the five fundamentals of service using ABET: Awareness, Introduction, Duration, Explanation, and Thank.
3. Call lights are for Pats, Jones. Always go into the room and ask the patient, "How may I help you?"
4. Escort visitors to their destination, rather than giving directions, whenever possible.
5. Always ACT on complaints: Apologize, Correct, and Thank. Never pass on a complaint to someone else without following up to make sure it was resolved.

Adheres to the Always Behaviors of maintaining a healing and safe environment.

1. Put safety first and report unsafe equipment or conditions.
2. Care for myself: physically, mentally, emotionally and spiritually (i.e. taking breaks, walking outside, praying or meditating).
3. Sanitize the patient’s room to make sure it is real and clean before leaving.
4. Pick up and dispose of any litter found throughout the facility or grounds.

CMC - SSE - Integrity:
Behavioral Criteria:
Absolute integrity in all relationships and dealings:
Being honest, moral, and ethical

Supports the hospital's mission by sharing God's love with those we serve:
Shows empathy to all

Excellence in clinical and service quality

Provides excellent customer service.

Understands and anticipates customer's needs.

Essential Job Functions: This section contains the essential functions for this job.
Scoring Description: Statement Scores are averaged to determine an overall Section Score.
Rating Scale: Performance (5-Level)
Rating Scale Description: Indicates the relative match between employee's actual performance and the expectations of the organization. Useful for robust performance evaluations.

CMC - SSE - Stewardship:
Behavioral Criteria:
Responsible resource management in serving our community

Manages up CMC to associates, patients, and families.

Uses materials, time, and skills efficiently, but never sacrificing on quality.

Attends department meetings in accordance with department standards.

The associate meets the essential functions of their role as outlined in the job description.
Appendix I. Talking Walls Exercise
Appendix J. Show Your Heart-Share Your Heart Competition

SHOW YOUR HEART—SHARE YOUR HEART CHALLENGE
Kick Off Nov 4 CLI: Due Wednesday, Feb. 10

What: Create a “Show Your Heart—Share Your Heart” display for your department/unit, using the enclosed heart.

Why: The display created will be proudly placed in your area to daily inspire your team to care with empathy.

How: CLI has allotted $30 per department to use for your display. Be Creative! Your display can take many formats. However, keep in mind that when the challenge is over, you need to display it for staff and visitors to enjoy.

Judging Criteria: Creativity; Uniqueness; Appeal; Best Use of Theme.

Theme
Heart: Use your heart for demonstrating empathy.
Head: Use your head for providing information, solving problems, etc.
Heart: Use your heart for reinforcing your caring.
Appendix K. Physician Chief of Staff Column in Castle MD Magazine

Message from the Chief of Staff

My Fellow Physicians,

Recently, there have been several occasions for us physicians to evaluate and review our perspectives on empathy. While we are all sympathetic to patients who might be suffering and in pain, Castle Medical Center recently held a series of seminars for its associates and medical staff intended to help us all improve our empathy. Some points that I recall from participating in the sessions are that it may appear to our patients that we are hurried in our interactions with them, at our minds rapidly consider a succession of questions about those very patients, questions that need to be answered immediately.

While we know that we are behaving as good physicians and considering many aspects of a differential diagnosis, we may forget that patients can sense within a moment of our entering their room whether we are “in the moment” with them or if we are just mentally hastening through a checklist in our minds. We should guard against this appearance in our daily interactions with our patients and try to sit down face to face with them rather than clicking on a keyboard, sometimes only partly facing them. When listening, we should listen to understand, not simply to get to a place where we offer solutions or advice.

The recent tragic accident of the U.S. military Osprey at Bellows Air Force Base brings up another topic close to our hearts and minds. Not only was one of Castle’s medical staff, neurologist, David Kaminskas, M.D., coincidentally present at the accident, his immediate actions at the scene were exemplary of what a good physician is and does. In addition, many of Castle’s staff all performed selflessly and professionally in what amounted to a real mass casualty situation.

Castle Medical Center truly is an outstanding place, with many outstanding staff members. We should also remind ourselves and never lose sight of the outstanding efforts, risks, and sacrifices made on our behalf by the members of the military in our community. We should keep them in our prayers and assist in activities to support them and their families whenever we can.

John T. McDonnell, M.D.
Chief of Staff, Castle Medical Center
Appendix L. Physician Office Staff Luncheon Invitation

Please join us!

MD Office Staff Luncheon
Monday, January 25

Medical Office Staff Luncheon
Monday, January 25, 2016
12:30 - 1:30 PM
Castle Medical Center Auditorium
(lunch provided)

Topics:
Empathy - How it impacts your practice
Hospital Updates - Latest news from Castle Medical Center

Wear red or pink to help us celebrate caring and kindness!

Kindly RSVP by January 15th
Colette Yamada, Physician Liaison
colotte.yamada@ah.org
253-5307
Appendix M. Nutritional Services empathy activity in the CMC cafeteria
Appendix N. Empathy in Action Toolkit