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Teaching Empathy Through Qualitative Research in Dental & Medical Health Promotion Education: A Snapshot

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Abstract

Through this article, I endeavour to reflect on decades of experience as an applied philosophical hermeneutic qualitative researcher, engaging participants' perspectives about living with chronic pain, osteoporosis, cancer as well as communicative approaches to medical/dental education. Having spent over a decade as an educator on the topics of professionalism empathy and ethical behaviours for dentistry students. As a co-instructor for Dental Public Health, where whole person care and empathy become invaluable concepts to help develop these characteristics in our students. This observation of the curriculum reveals that these sometimes are referred to as "soft skills" are interspersed within the curriculum rather than interwoven throughout both classroom teaching and clinical experiences. Whereas the scientific/professional skills dentists need to demonstrate dominate the student's experiences as they move through the curriculum. The question may become, can the two modes of professional dental/medical education co-exist in ways where both are valued and meaningfully integrated together? If so, perhaps how we teach as well as what we teach needs to find an empathic harmony. This article was written with the intention to open-up conversations among educators and students about how to teach empathy through qualitative research.

Keywords

Medical/Dental Education, Soft Skills

1. Introduction

I have chosen hermeneutics, a philosophically based research and educational approach, which offers diverse ways to help explore and interconnect a topic like empathy into this conversation that spans a myriad of different levels of accessibility for the purpose of engaging a wider audience of readers. Potential readers include other researchers, clinicians, students, and indeed the people who live with the health conditions researched, explained, and interpreted. This article is intended to act as an introduction to how to engage qualitative research with empathy into enhanced education and ethical clinical practice. The hope is that readers may take up a deeper, more profound interest about the utility of qualitative research and the need to teach empathy through the students' curriculum before it becomes misplaced during their clinical experiences and culture of credits. The term "*snapshots*" in the context of this article uses its definition of creating an impression or view of something succinctly within the limitations of this reflective article. Metaphorically, a snapshot of something that is captured at a moment in time, such that the reader is not confronted by daunting quantities of text but serves as an introduction to complex topics of potential interest. An interest that might encourage further future thought, discussion, and exploration.

2. Respectful Beginnings

I was inspired, provoked, and challenged by the following quote about living with trauma while choosing to engage in my own research about others who suffer; I frequently return to these words from Sophie Tamas (Tamas, 2009) whose writings help me understand my role as a qualitative researcher and to remind me that the promise of empathy surrounds us. Tamas wrote,

> "*If we are sitting in the gore and confusion of our own suffering, my sane, readable account of loss may reinforce the expectation that our trauma ought to make sense, and if it doesn't, we must be somehow inadequate or failing. It implies that the order of the universe is, in fact, intact, and the traumatized who have lost faith in reason, language, and human decency are mistaken. I do not think realizing that we are utterly lost and broken necessarily causes despair. What breaks us is the impression that everyone else isn't. Clean and reasonable scholarship about messy, unreasonable experiences is an exercise in alienation* (*p. 5*)."

My responsibility as a researcher is not to diminish or numb the experiences of trauma, pain, or suffering but to find a balance between retaining its narrative authenticity while making it accessible to others who could benefit from reading about such experiences. This inclusionary invitation to read about the trauma and suffering of others has clinical implications through creating empathic awareness that has clinical educational value by providing insight into the lived experience of a condition or life context that may not be our own…*yet*. The conundrum for the researcher of trauma (Hovey, Pavate, & Vigouroux, 2022) is knowing the limitations and depth of interpretation that may engage new readers rather than losing their attention due to the bluntness of the sufferer's narrative. This can happen because the words are written in a way that sit as outliers of their encultured way of learning and understanding. The following is a brief exploration of how hermeneutic research metaphorically is "*walking the tight rope*" between writing philosophically which offers a substantial depth of available understanding about a topic for the reader while considering the specific journal and accessibility of the writing to engage a wider audience.

3. Subsections Relevant to the Topic

Hermeneutics is, "the classical discipline concerned with the art of understanding text" (Gadamer, 1989), spoken or written is an interpretation (researcher) of an interpretation (research participant), which offers the possibility of gaining insight into another person's experiences. These can span from the mundane to the profound within the same narrative. The conundrum becomes if we write these suffering narratives in a way that is too restrictive or foreign for a specific audience, it risks failing the research participant's narrative authenticity. "We belong to our suffering; it humanizes all worldly activities through a common 'rough-ground' from which we can become more compassionate, generous, and open to the experiences of others (Hovey & Amir, 2013: p. 1)." A committed engagement among clinicians and the people who suffer, their patients, together becoming experienced about the many faces of suffering, deconstructing its complexity, and thus co-creating a deeper understanding how to communicate, respond, share language, and learn from each other. However, plunging deeper hermeneutically in language and philosophy also risks losing readers' interest because it is unfamiliar to their encultured ways of knowing, understanding, and writing. The essence of writing about traumas is to offer an education for the unexperienced about a condition they themselves do not possess, adding to their overall understanding of its complexity. This is the role of interpretive accessibility because our role as researchers is to inform clinicians and policy makers and to validate people living with a specific health condition.

Given this delicate balance, we try to achieve a middle-ground where it becomes an invitation for others who will read our research, and perhaps gain a new perspective on living with specific health conditions. From my experiences, this addresses the need for a balance between the availability of hermeneutic writing such that it is not only available but also accessible to other readers from other disciplines who are unfamiliar with hermeneutics. If we do not attend to this matter, this divide can be problematic if hermeneutics is only read by people who understand philosophical hermeneutics, therefore limiting its possibility for understanding their perception of research for others who would benefit from this work. I have heard colleagues tell me that they had to read and re-read passages over and over before they understood what was written. This was considered a detriment by some as they were accustomed to getting it through a single read. Therefore, my research writing depends on the envisioned audience that exists on a continuum of depth of hermeneutic interpretation, sometimes deep in the hermeneutic tradition, while others are written to be more accessible to invite others to read this type of research and writing. In this case, this was written for, clinicians, people living with chronic pain, and other researchers who may use this writing to inform their next research project (Hovey, Vigouroux, Noushi, Pavate, & Amja, 2022).

4. A Window into Whole Person (Patient)-Centered Care

The World Health Organization (WHO), at its 2009 World Health Assembly, declared for the first-time person-centered care as a pivotal health-care strategy. This remains a central strategic principle, along with integrative and universally accessible care, in the WHO's 2014-2019 Work Program (Mezzich, Appleyard, & Ghebrehiwet, 2014). People/patient-centered care is concerned and philosophically orientated toward people with their health experience, perspectives, culture, circumstances, and values rather than exclusively their diagnosis. This predicates a shift from labeling a patient as "fibromyalgic", for example, to a person who lives with fibromyalgia. Gadamer (Gadamer, 1996), explains that there are two kinds of treatment of the patient, the first is biomedical and the second is the treatment of the whole person as patient to which the medical treatment is applied.

The interpretation of one sentence from Tamas invites illumination of something deeper than just the words spoken. They become an invitation to understand how to negotiate this powerful expression with personal or clinical implications. "*I do not think realizing that we are utterly lost and broken necessarily causes despair. What breaks us is the impression that everyone else isn't* (Tamas, 2009: paragraph 18)." This invitation could be one to begin to understand the role of empathy in clinical practice. "Empathy explicitly can be interpreted as a moral emotion, and as a form of attachment seen to be necessary for living responsibility together, and it is this emphasis on what empathy brings to our sense of togetherness which is why the promise of empathy comes to the forefront for our discussions (Todd, 2003)." Apathy appears in both sympathy and empathy as a root word that signifies a type of behaviour, one of showing or demonstrating no interest or energy and is unwilling to act, especially over something important. What might be important is not only the medical condition presented but the suffering, which is connected to it, as emotional pain. An online etymology dictionary (Online Etymology Dictionary, 2022) deconstructs the word apathy to mean, the "*a*" in "*apath*" meaning without something or absence and "*pathy*" from a "*pathy*", or *pathos* meaning emotions, feelings, or suffering. This could be what is meant by *objectivity* in healthcare, a distancing from the patient other than their health condition. A freedom or safety from another person's suffering, to avoid the feeling or sensation of their suffering. Perhaps even an encultured sense of indifference to the plight of others to help protect oneself from being too engaged with each patient's concerns beyond their, "chief complaint". This brief description of apathy leads us into a discussion about the role of sympathy and empathy in healthcare. In a healthcare context, empathy can be understood as a cognitive attribute that involves an ability to understand experiences of patients relating to their discomfort and suffering

(Hooker, 2015). Empathy is a process in which one person may imaginatively enter the experiential world of another without losing an awareness of its difference from one's own. Empathy completes the patient clinician relationship because empathy is about understanding the totality of the person who-is-patient who is being treated medically as well as a person treated as a whole person. Through the term "whole person care", we propose the application of McGill University's definition which describes it as an "approach that involves the total care of patients through not only the control of symptoms but also attention to the experiential and spiritual concerns that result from illness" (Programs in Whole Person Care, 2023).

Empathy differs from other emotional connections not as one affective response among many, but it is seen to have ethical legitimization in a way other emotions, such as pity and guilt, do not have (Todd, 2003: p. 43). However, at this juncture of this discussion, there exists a need to understand the difference between sympathy and empathy. However, these are very different terms which relate to engagement with others and although they are in a colloquial sense used as being similar. They are distinctly different. Sympathy and empathy are both modes of feeling, but with sympathy, you feel for the person; it implies distance, where one might avert their gaze to avoid contact or feel such a strong emotional sensation that it becomes overwhelming and perhaps unhealthy for the healthcare provider. You might feel sorry for them or pity them, but you don't specifically understand *what* they are feeling. Empathy means to engage the person in need, or at risk specifically from your health professional perspective with one metaphorical foot planted firmly in your professional stance. Empathy then becomes a mode of clinical engagement that is working to understand the situation of the patient while keeping oneself safe, maximizing the care one may provide. Halpern (Halpern, 2001) describes the need to "decentre" rather than detach, stepping aside from one's own emotional perspective and imaginatively viewing the situation from the patient's position while not submerging in identification with the patient by retaining a sense of the self and other boundaries. Metaphorically, one can imagine the difference between *drowning* in another person suffering, which can overwhelm and be detrimental to the patient-clinician relationship. Whereas imaging empathy as a "washing over" one's body, where lived and felt experience of the another within the clinical encounter becomes where one can gain a deeper understanding of the meaning of the other person's suffering, with a metaphoric "drying off" to help preserve one's sense of personal and professional self. In this scenario, the clinician can learn from their patient while being objective but without the distance that alienates the patient.

Sometimes, empathy and/or sympathy is equated to walking in someone else's shoes. However, as well-meaning as this sentiment is, it defies reality. How can a younger person be engaging with a much older person about multiple health conditions as well as the reality of confronting their imminent death? When the "shoe-gap" is too great, the young healthcare provider can gain insight by preparing for their clinical encounter by reading qualitative research about such life situations with an empathic intention beyond the biomedical facts of the situation. The idea of simply walking in someone else's shoes or moving with their wheelchair to understand the other can be diminishing and impossible. However, it may help in introducing the healthcare provider to insight empathically about the lives of others as an invitation to empathy. I recall a reflection from a friend while learning to become a physiotherapist, who was suggested to spend a morning or afternoon in a wheelchair to experience the challenges of navigating a world, which was not particularly wheelchair friendly. Although this was a powerful "eye-opening" experience for her, at the end of her time in a wheelchair, she could simply stand up and walk away. In this case, the imagination of what being in a wheelchair was like was given a practical application. However, there is something missing when your reality does not include the permanence of a life situation. These kinds of experiences as well are purposefully provided during simulated patient encounters with actors who help the student prepare for real-life clinical encounters. These provide a safe bridge between the pretend or simulated and the actual encounters. These, along with the experience of clinical instructors and perhaps the inclusion of qualitative health research, offer the possibility for discussion about the role of empathy and its role of healing for both the patient and the clinician. The following is a snapshot of research about empathy in both medical education and clinical practice. In brief, the following section outlines that empathy can be lost, but it can also be taught, recovered, sustained. If dentists and dentistry students lose empathy because of burnout, unhappiness, and a loss of a sense of control over their work, then alleviating these conditions may directly or indirectly enhance one's sense of empathy for a patient centered approach to dentistry.

5. Discussion/Conclusion

A snapshot of selected research into the status of empathy from nine research studies ranging from 2004 to 2022 reveals the following main findings from their research (Chen, Kirshenbaum, Yan, Kirshenbaum, & Aseltine, 2012; Hojat, Vergare, Maxwell, Brainard, Herrine, Isenberg, Veloski, & Gonnella, 2009; Newton, Barber, Clardy Cleveland, & O'Sullivan, 2008; Costa-Drolon, Verneuil, Manolios, Revah-Levy, & Sibeoni, 2021; Mahoney, Sladek, & Neild, 2016; Haslam, 2007; Jeffrey, 2016; Hojat, Mangione, Nasca, Rattner, Erdmann, Gonnella, & Magee, 2004; Olsen & Gebremariam, 2022). The first finding uncovers that students' empathy declines during the final two years of medical education (Chen, Kirshenbaum, Yan, Kirshenbaum, & Aseltine, 2012; Hojat, Vergare, Maxwell, Brainard, Herrine, Isenberg, Veloski, & Gonnella, 2009; Newton, Barber, Clardy, Cleveland, & O'Sullivan, 2008). The reasons described touch on a variety of explanations such as confusion regarding the concept of empathy, prioritizing clinical facts over listening skills, a significant decrease in vicarious empathy even though it is essential for successful physician-patient relationships to form (Costa-Drolon, Verneuil, Manolios, Revah-Levy, & Sibeoni, 2021). A more sophisticated understanding of empathy in medical students is needed to help foster and promote empathy (Mahoney, Sladek, & Neild, 2016). Empathy is not only for the patient but also serves the physician as doctors who report higher levels of wellbeing and a greater sense of personal achievement also demonstrate higher levels of empathy (Haslam, 2007). Consequently, being aware and taking steps to preserve and nurture empathy is crucial as its erosion occurs during a time when the curriculum is shifting toward patient-care activities in third and fourth years. Medicine's and dentistry's positivist view prioritises technical progress, evidence-based medicine/dentistry, and targets efficiency, deferring attention from the whole person to seeing and emotionally distancing patients through viewing them solely as objects of intellectual interest (Jeffrey, 2016). Therefore, it is important to design and interweave educational programmes to help retain, reinforce, and cultivate empathy among medical students for improving clinical outcomes (Hojat, Mangione, Nasca, Rattner, Erdmann, Gonnella, & Magee, 2004). Additionally, students who majored in humanities or interpretive social sciences disciplines demonstrated higher empathy scores than their peers who majored in the positivistic social sciences and other disciplines such as science, technology, engineering, and mathematics (Olsen & Gebremariam, 2022).

Upon reflection on these research articles on empathy, it is clear that empathy is an essential attribute for most medical/dental healthcare providers in clinical situations. Empathy is a good practice for students, practicing physicians/dentists building on their future relationships. To achieve high levels of empathy throughout the trajectory of the medical/dental school experience, equal attention to both as necessary to produce graduates who are both competent in their medical/dental skills as well as proficient in their ability to retain and promote empathy for a lifetime of wellbeing for both patient and provider in their practice. Curriculum design and renewal need to make these distinctions, if we want to teach person-centered or whole person care (a philosophy of medical practice) then we need to engage the students differently. This takes into consideration not only what students need to learn (subject content), the epistemological, but as well how they need to learn, the contextual considerations which are ontologically located within the learning progression with specific attention to the type of person we wish to graduate.

We have different ways of offering medical services, however, empathy for and with patients is a common ground for patient care in dentistry, medicine, and nursing. Adopting a person/patient-centered or whole-person care approach suggests that treatments transcend the illness and into the whole person. Qualitative research and empathy are ways to ensure this happens. However, medical schools in general need to teach empathy as part of clinical education and practice, not as only a nice to have "soft-skill", but as core to all encounters, educational and clinical. Qualitative research offers insight into the whole person experience of living with a plethora of health conditions which could serve a vital role in the preparation of young health care professionals. Patients seeking healthcare and their care providers can only benefit from empathetic communication during and beyond medical treatments.

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Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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