



Clinical education

Use of healthcare consumer voices to increase empathy in nursing students



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ABSTRACT

Nurses need to be well prepared to address the needs of a diverse population and facilitate positive experiences in an equitable and inclusive approach to care. The aim of the study was to determine whether the integration of consumer lived experience interviews into the content of a first-year course influenced empathy in nursing students. A one group pre-test, post-test design was used. A convenience sample of first-year undergraduate nursing students ($N = 32$) from a regional Australian university was recruited for the study. The pre and post tests were conducted using the Kiersma Chen Empathy Scale and t-tests performed to analyse the data. Results showed overall that nursing students demonstrated moderate levels of empathy; pre-test score of ($M = 75.53$; $SD = 5.76$). After the intervention the post-test results showed that there was a statistically significant increase in students' empathy towards vulnerable, disadvantaged and stigmatised population groups. The healthcare consumer voice has the potential to strengthen current teaching practices that promote caring behaviours in nursing students.

1. Introduction

Healthcare professionals need to be well prepared to address the needs of a diverse population to facilitate positive experiences in an equitable and inclusive approach to care. Negative staff attitudes lead to lower levels of satisfaction in care for people from diverse population groups such as those who are vulnerable, disadvantaged and stigmatised, leading to poorer health outcomes and reluctance to seek health care in the future. Engaging in therapeutic nurse-patient relationships is fundamental to quality nursing care. Empathy, trust and respect are seen as critical components of this relationship, and are incorporated into professional standards and competencies for the nursing profession (Nursing and Midwifery Board of Australia [NMBA], 2016; Nursing and Midwifery Council, 2015). However, empathy, trust and respect are diminishing, according to various reports.

Ward et al. (2012) and Nunes et al. (2011), found empathy declined over a one-year period in student nurses. Also, Evans et al. (1998), maintains that learned empathy is not carried on into the post registration experience. These, and other authors (Chen et al., 2015), recommend that nurse educators need to look at innovative ways of teaching empathy and supporting empathic ability into their professional lives. Zaki and Ochsner (2012) define empathy as the ability and tendency to share and understand others' internal states. Empathic nurse-patient interactions that involve considerations of another person's perspective, together with the ability to communicate this understanding, leads to improved patient outcomes, satisfaction, and

compliance with health information (Hojat, 2007; Reynolds et al., 2000). However, students and new graduates may have difficulties understanding and empathising with people from vulnerable, disadvantaged and stigmatised population groups, especially if they have not experienced any of the challenges associated with disability or stigma, for example. The involvement of healthcare consumers, sometimes known as service users, is one strategy being used in undergraduate education of students in both social work (Brown and Young, 2008; Duffy et al., 2013; Warren, 2007) and mental health (Blackhall et al., 2012; Happell et al., 2014); and, to a much lesser extent, in nursing. The aim of this paper is to report on an educational innovation that incorporated the voices and perspectives of health care consumers and its effect on student empathy in an Australian nursing undergraduate program.

2. Literature review

2.1. Empathy in nursing

In the nursing literature, empathy is widely seen as a vital component of quality nursing care and is part of the ethical and philosophical foundation for caring (Allgood, 1992; Maatta, 2006; Williams and Stickley, 2010). Empathic patient interactions lead to better patient outcomes, increased satisfaction and compliance (Hojat et al., 2011; Ward et al., 2012), as well as improvements in pain control, pulse and respiratory rates, and client self-report of worry and distress (Reynolds

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and Scott, 2000). In a therapeutic world, empathy implicates more than transmission of information; it also includes conveying feelings, acknowledging these feelings and informing the patient that their feelings have been recognised (McCabe, 2004). Nurses are expected to engage in therapeutic and professional relationships, and in this are guided by the three 'Codes' in Australia: 'Registered nurse standards for practice', 'Code of Ethics for nurses in Australia' and 'Code of professional conduct for nurses in Australia'. The three 'Codes' ask that nurses communicate in a manner that is "respectful of a person's dignity, culture, [ethnicity], values, beliefs and rights" (NMBA, 2008a, p.1; NMBA, 2016, p.3), and "value the diversity of people" (NMBA, 2008b, p.1). Although these "Codes" are embedded into nurse curricula, evidence suggests there is still much work to be done for nurse educators.

Despite recognising its significant value in nurse-patient interaction by theorists, physicians and researchers (Peplau, 1997; Rogers, 1975), it is frequently found that there is an insufficient or lack of empathic communication between nurses and patients (McCabe, 2004; Ward et al., 2012; Williams et al., 2016). Neto et al. (2006), suggest that for student nurses, this could be due to the short period of exposure to the patients in clinical placement, where students may be more focussed on developing their theoretical and procedural knowledge than learning a new social skill to develop and enhance their communication with patients. As the core of therapeutic nurse-patient relationships, empathy is essential in understanding the health care needs of people, particularly those who belong to vulnerable, disadvantaged and stigmatised population groups (Porr et al., 2012), which are the groups central to this study. In light of this discussion, our situation demands a more holistic view of empathetic relations by wanting to develop a socially inclusive awareness in students when caring for the diverse patient group inherent in our course.

Australian Indigenous people, people with varying degrees of disabilities and mental illness, people who are homeless, and people from different racial and ethnic backgrounds where English is their second language are considered as vulnerable, disadvantaged and stigmatised population groups (AIHW, 2015; Queensland Council of Social Services (QCOSS), 2011). Poor communication between health service providers and patients lead to ineffective health care service for ethnic minorities (Fleming et al., 2015). Such health care service disparities for racial and ethnic minorities resulted in less involvement in decision making for their health needs and dissatisfaction with the provision of care (Smedley et al., 2009). Others affected by negative staff attitudes are illicit drug users (Young et al., 2005); people who are homeless (Moore et al., 2011); people with intellectual disability (Hemsley et al., 2012; Iacono et al., 2014); people from Culturally and Linguistically Diverse (CALD) communities (Komaric et al., 2012); and Indigenous Australians (Best and Fredericks, 2014). The prejudiced, stereotyping and discriminatory behaviour of health care providers intensify these disadvantaged patients' feelings of fear, misery, and vulnerability, and discourage them from accessing health care services (Emul et al., 2011; Goreczny et al., 2011). We posit that empathy is not just about the ability to understand a patient's experience and communicate in a manner that conveys recognition of patient concerns and perspectives (Ward et al., 2012). Our situation demands a more holistic view of empathetic relations by wanting to develop a lasting and socially inclusive awareness in students when caring for the types of patients described in our course. However, in a course that is offered by distance education delivery, we were posed with the problem of how to teach empathy.

2.2. Empathy in nurse education

Some researchers believe it is possible to prepare students for the empathetic process with the help of education (Chen et al., 2015). Bhana (2014), suggests that interpersonal skills are practical skills and therefore active participation in learning activities should be adopted as a teaching strategy. A report on empathy education in nursing (Brunero

et al., 2010) found models of empathy education that were most effective were experiential styles of learning. A variety of experiential teaching strategies has been tested with positive results. Some studies with targeted educational strategies that aimed to develop empathy in nurse students have been conducted in the UK and USA (Ansel, 2006; Charlton et al., 2008; Chen et al., 2015). In the study by Chen et al. (2015), students engaged in a three-hour laboratory simulation game, playing the role of an older adult, which helped them gain an awareness of feelings and experiences related to ageing. Another study by Everson et al. (2015) consisted of an immersive 3D simulation experience whereby students played the role of an acutely unwell patient in a developing country to help them understand CALD patients' perspectives, with positive results. Other studies (Edwards et al., 2006; Krautscheid et al., 2008), adopted case study-experiential learning approaches using realistic content and events to create scenarios that allowed students to trial a range of clinical judgments with minimum risk. Other teaching strategies have included debates, role-playing, storytelling, journaling, web page links to audio and video clips, and simulation to develop interpersonal skills in students, adopting a deconstructive approach, and leading to learners becoming more engaged in their practices (Bhana, 2014). The use of health care consumers has also been explored as a learning approach in nurse education.

2.3. Integration of consumer lived experience

It is a challenge for educators to teach empathy about a particular population group without the lived experience of the people central to the interaction. Without the understanding of what it is like to be vision impaired, or homeless, or be a migrant from another country, it is difficult for a teacher to legitimise such situations in transforming knowledge. Exposing students to the various population groups they may ultimately be caring for, and allowing them to hear the stories and lived experiences of people, has the power to transform students to adopt an empathic stance as defined above. Engaging service users in health care provision and education is a directive of UK policy makers (Turnbull and Weeley, 2013). The use of consumers' lived experience as a pedagogical approach to learning and teaching has been explored in a variety of ways (Tremayne et al., 2014), although the studies were predominantly in the disciplines of social work and mental health (O'Donnell and Gormley, 2013; Stickley et al., 2009). Real-life vignettes featuring an Aboriginal elder were successfully used in social work education to transform student cognitive understanding of empathy and non-judgmental relationships (Gair, 2013). In nursing, such pedagogy has been successful in impacting on student attitudes in mental health (Blackhall et al., 2012; Happell et al., 2014; Simons et al., 2007), and intellectual disability nursing in the UK (Bollard et al., 2012). The use of first person memoirs in teaching mental health students about empathy, hope and guidance for people with eating disorders was found to be an empowering tool for both face-to-face and online learning (McAllister et al., 2014). However, there is a paucity of research on the use of health care consumer voices in pre-recorded interviews embedded into a course offered by distance education delivery mode to first-year nursing students.

2.4. Educational innovation

We redesigned a course on inclusive practice for nursing to include the voices and perspectives of a range of health care consumers who were representative of the diverse population groups in our course (Table 1). Consumers were purposefully recruited, interviewed, and after consenting (by way of signing a talent release consent form), to their image being released for education purposes, their conversation was video recorded. Quality checks, such as editing the digital recordings were carried out to maximise student engagement with the final media product. Consumers were asked to relate their stories, including good and bad experiences, and encouraged to tell students how

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