

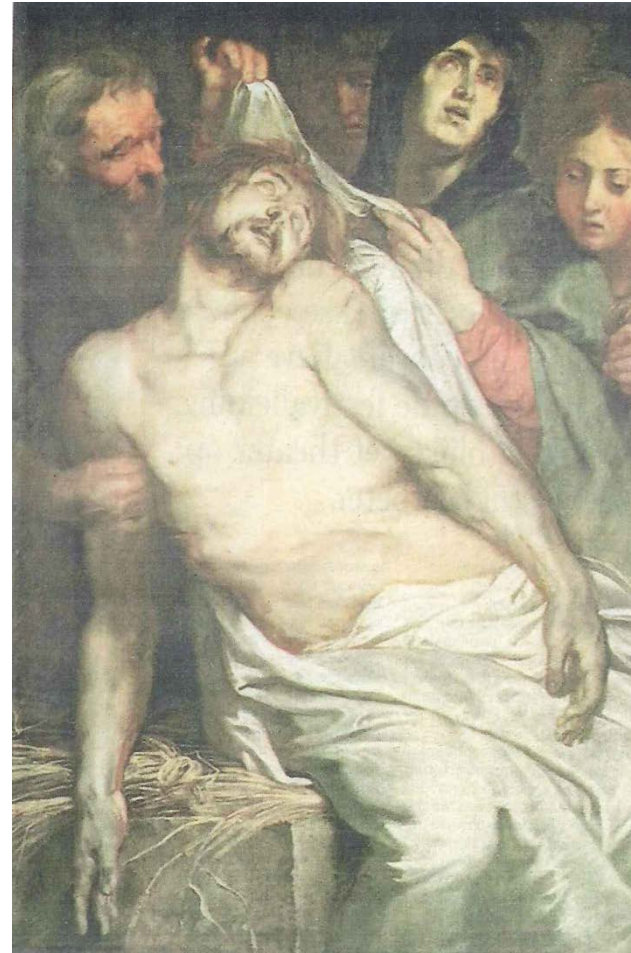
'My body knows'

An explorative study of experiences of healthcare providers as simulated care receivers in a 'care-ethical lab'

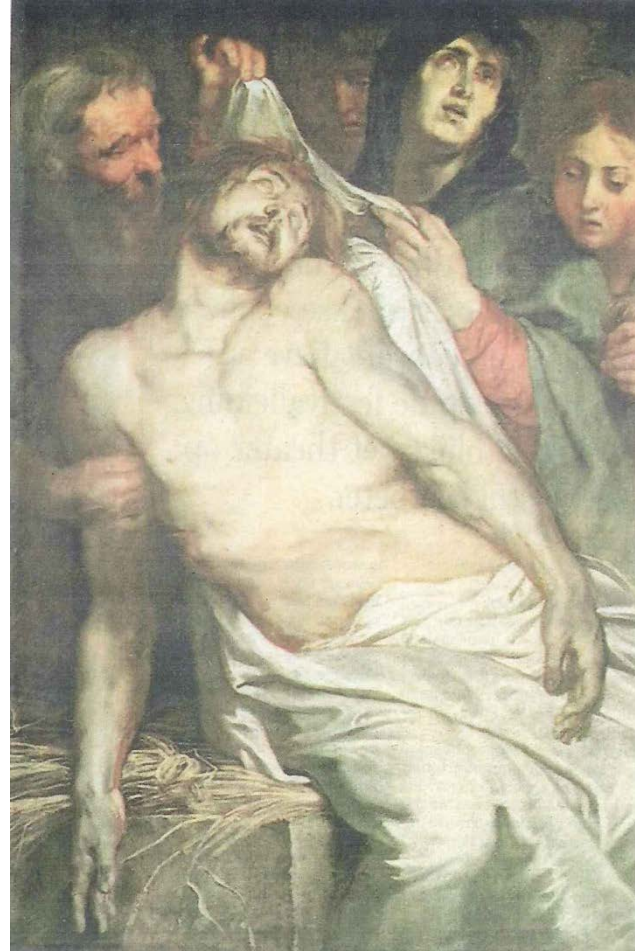
Linus Vanlaere

A large, light pink, stylized hand graphic is positioned in the background, centered behind the text. The hand is open with fingers slightly spread, and it has a soft, glowing appearance.

'The descent from the cross'



'The descent from the cross'



'The descent from the cross'

- Characteristic for the christian faith: God who suffers as humans do → Gods empathy for the suffering humankind
- Characteristic for heroism: a hero as human who is as vulnerable like all humans (but who also can do something extraordinary within the same vulnerability) → 'No balls, no glory'

'The descent from the cross'

- It is difficult to empathize with another person if we do not deal (for at least a bit) into the same vulnerability.



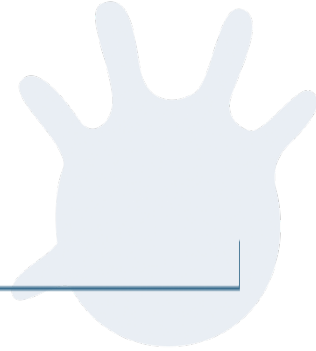
- °Concept of 'sTimul: care ethics lab'

Aim



- To present a qualitative pilotstudy about an ethics education program to illustrate the contribution of empirical research to ethics
- More specific, this pilotstudy gives more insight in how empathy can be generated and in the role of 'ethical intuitions' in this context

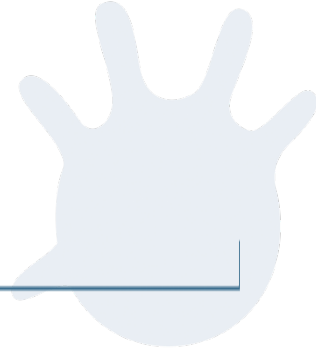
Overview



- Introduction:
 - Care ethics and the renewed ethical interest in ‘empathy’
 - Design of sTimul: care-ethics lab
- Background:
 - Empathy and nursing education: recent insights and research



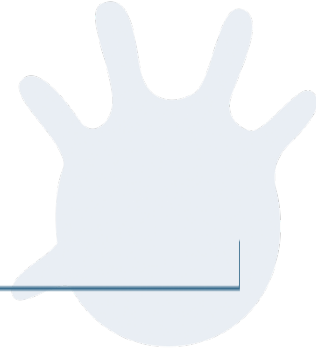
Overview



- Research objective and method
- Results
- Discussion of the results
- Conclusion



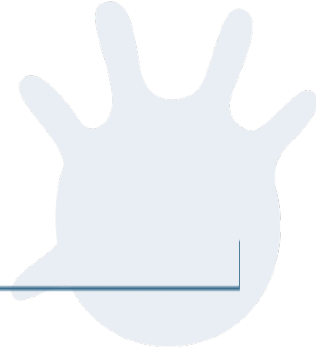
Introduction



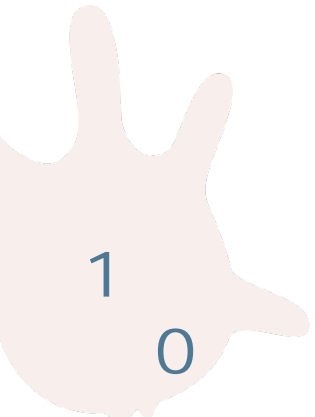
- Care ethics as a 'recent' development in the field of ethics
 - Differs from initial stances in bio-ethics by not trying to improve the ethical quality of care practices only on the basis of an external framework to be applied to these practices.
 - Care ethics is an ethical approach that offers an overall analysis of moral behaviour. This behaviour is approached in the context of specific care relationships.



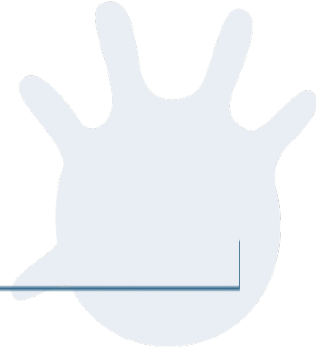
Introduction



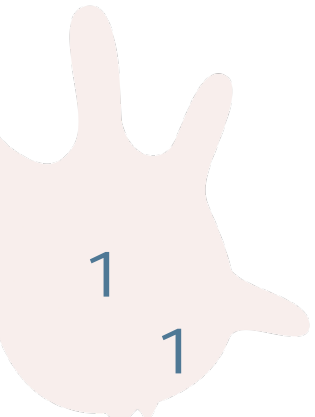
- The ‘contextual and relational focus’ of care ethics
 - Care ethics remains closely related to real care practices and examines at the way(s) in which care responsibility takes shape: the contextual elements, the way people feel involved, the way emotions are involved.



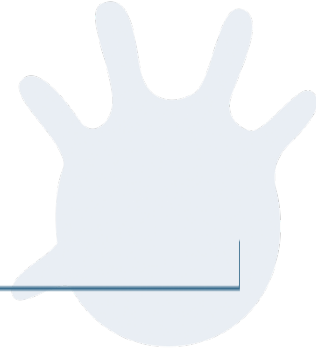
Introduction



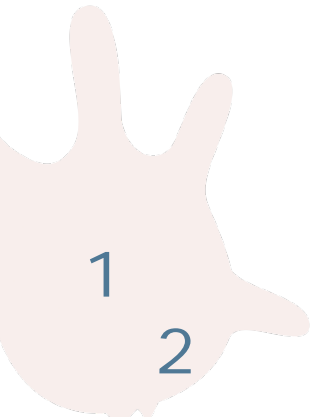
- Care ethics & empathy
 - Empathy – as the ability of health care providers to take into account the situation of the care receivers and how they experience the situation – is crucial into the process of ethical reflection.
 - Ethical reflection is a contextual and experiential learning process. Also when considering empathy as part of this reflection, experiential methods are used.



Introduction



- The care ethics lab 'sTimul'
 - Founded to provide training focusing on care providers's ethical abilities through experiential working forms
 - Empathy sessions →
 - Aim: to generate empathy + to foster reflection
 - Care providers take on the profile of a care receiver - Student nurses take on the role of care provider (for one day $\frac{1}{2}$ + night)
 - Guided reflection in the afternoon of the 2nd day (retake some weeks later for $\frac{1}{2}$ day)

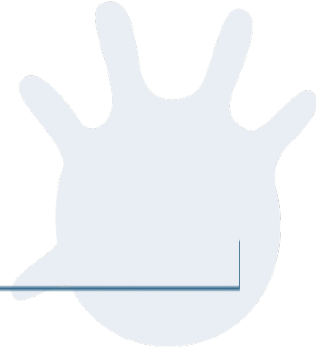








Background



- Empathy in nursing literature
 - Empathy = an interactive and dynamic process in which nurses develop a **feeling** for and generate **insight** into what is at stake for the patient, which is then reflected in their **actions**.

(J. Williams & T. Stickley. Empathy and Nurse Education. *Nursing Education Today*. 2010: 30 (8): 752-5.



Background



- Empathy in nursing literature
 - 3 ‘phases’ of empathy
 - **Affective**: being affectively moved and internally motivated
 - **Cognitive**: gaining insight into the patient’s perspective and being able to suspend one’s own perspective
 - **Behavioural**: communicating back to the patient

(J. Williams & T. Stickley. Empathy and Nurse Education. *Nursing Education Today*. 2010: 30 (8): 752-5.

Background



- Empathy in nursing education
 - 17 empathy programmes for postgraduate and undergraduate nurses
 - Research to the effect on the empathic ability of the participants
 - Most studies apply a quantitative research method (using various ‘empathy scales’)
 - Different length of programmes (from 6 to 100 hrs)
 - Most programmes include a form of experiential learning (role play, simulation, re-enacting cases)
 - 11 studies show a significant increase in the empathic ability of nurses

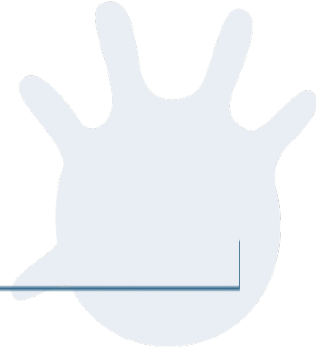


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S. Brunero, S. Lamont & M. Coates. A Review of Empathy Education in Nursing. *Nursing Inquiry* 2010: 17; 1; 65-74.

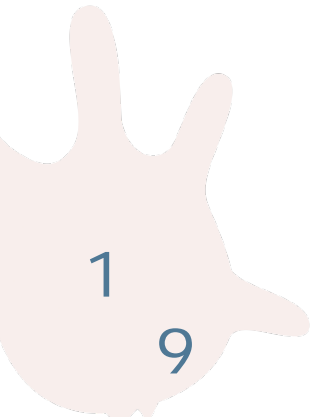
Background



- Benchmarking of the programmes is difficult, as different measurement instruments are used
- Different types of training; which aspects of empathy are focused and for which aspects ‘results’ are achieved?



Need for qualitative research to gain more insight into empathy and how training programmes should focus on nurses’ empathic abilities



Research objective and method

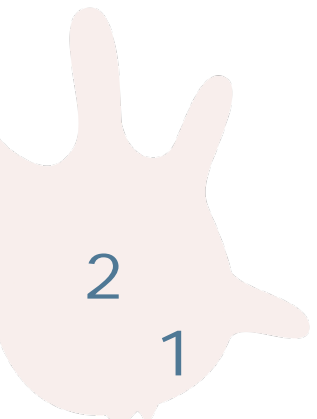
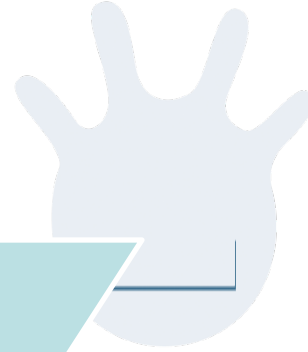
- Research question: what is the impact of the empathy session in a care-ethics lab on the simulated patients' empathic ability?
- Qualitative design
- Interview with 15 care providers between 1 January 2009 and 1 August 2009 (Mrs. Leen Stevens)
- 2nd interview three to six months later with 7 of the 15 respondents
- Analysis of the data (Dr. Madeleine Timmermann)

Results

All respondents went through at least one experience that really affected them.

Many respondents were encouraged to reflect on their own views on care.

Some respondents provides examples of what they actually started doing differently.



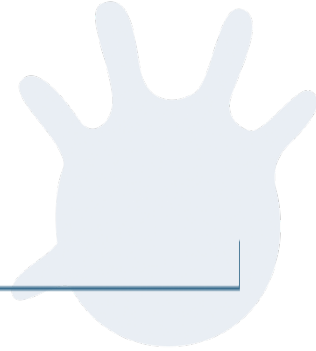
Results



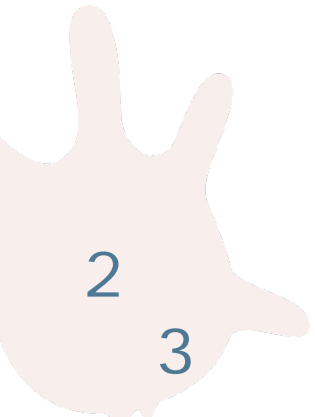
- What affected them?
 - Many of the relevant experiences related to feeling pain and cold (lit. and fig.)
 - Physically feeling pain, e.g. by being forced to sit in an uncomfortable position
 - Experienced physically coldness, e.g. while dressing, washing and after a bath

I spent all morning in a wheelchair, whose seat was reclined. I constantly had to push back and at one stage I just could not take the pain in my tail bone anymore.

Results



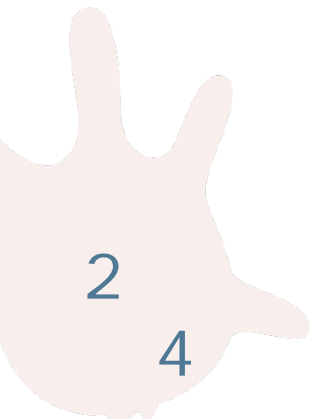
- What affected them?
 - “Pain” as a result of losing independence (being dependent on others for daily tasks such as washing, going to the toilet, eating and drinking)
 - Some resp. found it difficult to expose themselves to and allow themselves to be washed by strangers
 - Washing was perceived by 1 resp. as an nasty experience, because the soap was not rinsed of properly.



Results



- What affected them?
 - Various resp's mention that it is painful not to be able to go to the toilet by yourself when you feel you need it.
 - The inability to feed oneself is experienced by the respondents as a painful loss of independence (food is too hot, spoonful is too big, pace is too quick). One feels powerless and insecure.



During the night I got thirsty and could not reach my drink. You cannot fathom what it means to be dependent on others for everyting, to not be able to reach it yourself, to lie there thinking: "when is someone going to show up? Or should I call?"

Results



- What affected them?
 - A number of resp's feel left out in the cold in a figurative way because they are not heard or considered as a person who still matters (e.g. they felt an object to be washed, treated childish, ignored, not given any attention).
 - A lot of respondents felt ignored and humiliated by not being heard.

The TV is on and is playing behind me. I cannot watch, because nobody turns me around to face the TV. So I listen, until the news starts. It is 7PM, I have to go to bed! I ask whether I can first listen to the news, but "no, otherwise we can't finish our work"...

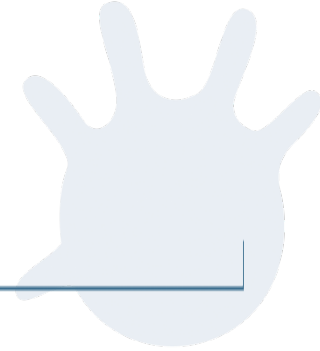
Results



- What did they learn?
 - For many respondents, the physical and mental misery lead to new insights in their view on care.

What has changed is that I now think about this more as their last journey and I want it to be as pleasant as possible. I hope people will be patient with me later, that I will be allowed to go to the toilet whenever I need to.

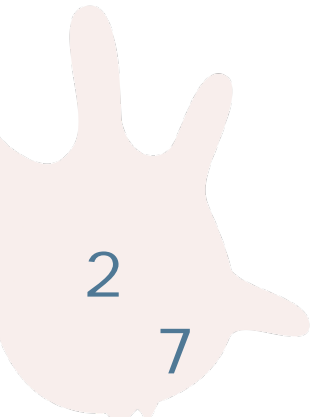
Results



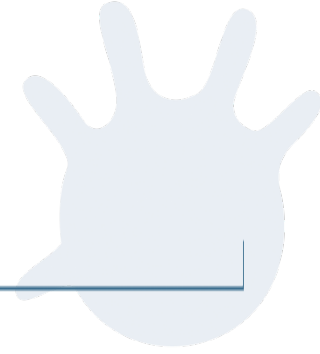
- What did they learn?
 - Respondents apply their own experience to the situation of the residents in their own ward.

I thought: do we threat our people like this as well? It should be different! It is all done with the best of intentions, but it is a confronting experience. It has to change!

I always have at the back of my head what it has done to me. The negative experiences are also reflected on our residents, I will be extra careful when covering them during washing times. I will use a towel to cover them. (...) It feels cold lying there...

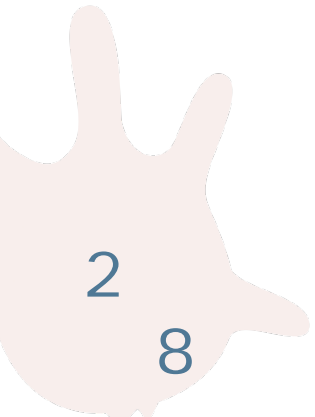


Results



- What did they learn?
 - On the basis of their own experiences, some resp's believe that they know better what their patients need and they formulate intentions to focus more on these needs.

When people sitting in a wheelchair tell me that they are uncomfortable I will listen to them more from now and try to change their posture. I myself experienced that sitting still in a wheelchair for a long time is very hard, you start feeling pain. (...) I am glad I experienced it for myself, because people who are growing demented cannot say everything they want to anymore. I am now more aware of this and try to change their seating positions.



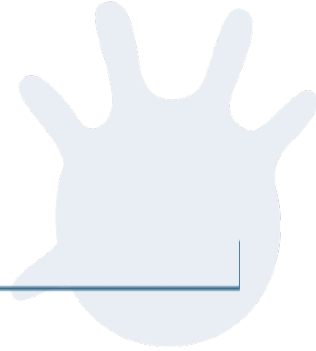
Results



- What did they learn?
 - Due to their experiences, some resp's reflect on their own practices (walking off during washing, ignoring mute persons, lacking the personal touch...).
 - Some resp's stress that their experiences do not always tell the truth about their residents.

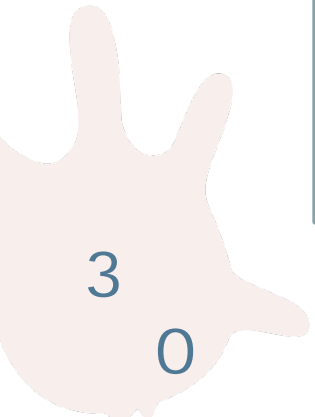
You cannot always know what it really feels like for someone else, for example in a situation that we felt to be impossible, the resident in question, to my surprise, pushed back her own boundaries again. (...)

Results

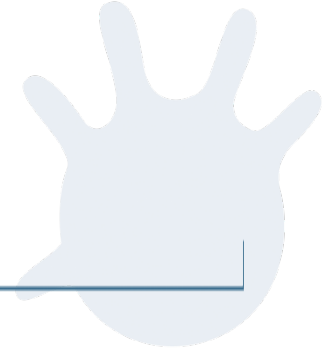


- What moves them?
 - Some resp's give examples about how they introduced minor changes in their own practice due to their experiences (e.g. not mixing the ingredients of food together, taking care of a noiseless mealtime,...)

(...) During mealtimes we want it to be quieter. For example, we have agreed to leave the meal cart outside the dinging hall. We first remove the lids and then roll it in, so we don't have to listend to the noise of lids being removed in the dining hall anymore. And (...)



Results



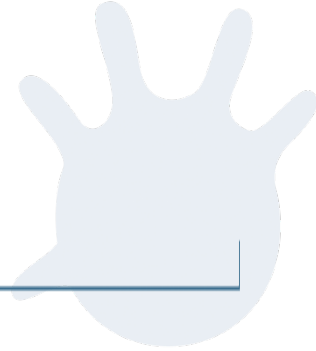
- What moves them?
 - Some resp's express that they see more, understand more and try to solve more problems. They also stress the importance of keeping alive the experience.
 - Factors that limit improving one's own care practice emerge as well: working pressure, the role of the head nurse,...

Some days I can do it, but if I'm honest, I don't really think about it on other days. Then I just cannot stop to think about it. When the working pressure is high, it seems as though a link is missing. Then it's all about 'rush rush rush' and you are not so focussed on your job.

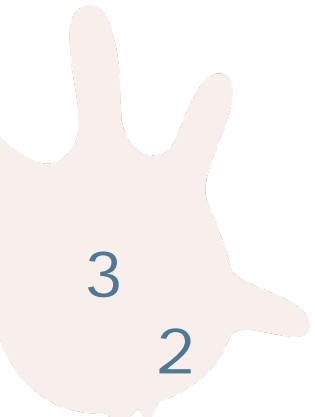
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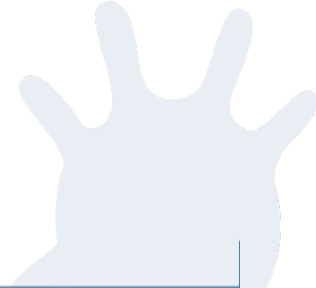
Discussion



- Strengths and weaknesses
 - The qualitative design allows us to acquire in-depth insight into the experiences of respondents and into the processes affecting care provider's empathic abilities.
 - The number of respondents (15) is very limited ⇒ 'pilot research'



Discussion



Affective
phase of
empathy

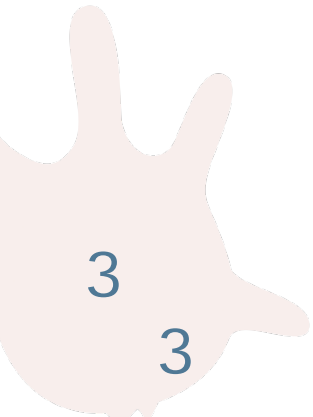


Resp's feelings of shame, outrage, humiliation, fear,... bring them closer to their patients' daily lives and provide them with an affective insight into the world of their patients

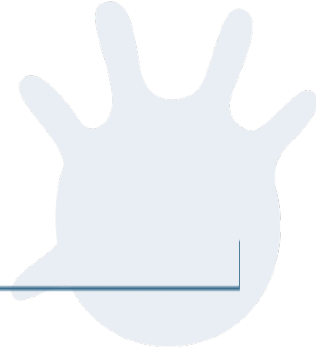
All respondents went through at least one experience that really affected them.

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Discussion

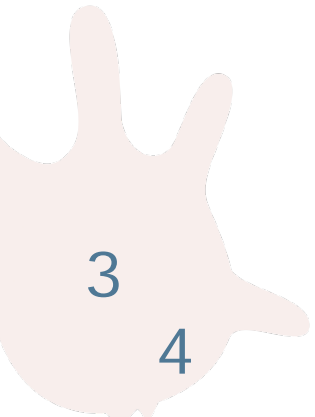


- A large part of the impressions were **physical** in nature

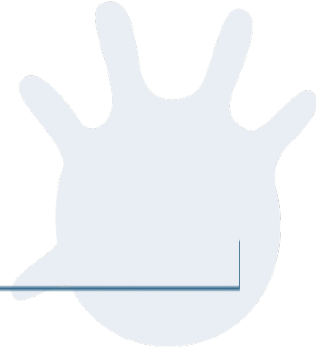
More than half of the respondents indicate that their feelings were a result of very physical experiences (feeling nasty, sitting uncomfortable, bad tasting,...)



Cf. Williams & Stickley:
Discovering empathy is often a physical experience. Empathy is a physical sensation: the body is aware of something.



Discussion

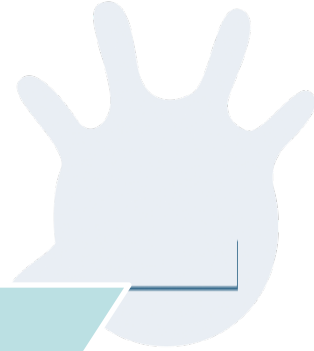


- A number of experiences appear to take the form of **'negative contrast experiences'** (E. Schillebeeckx)
 - = Experiences of irritation or annoyance that makes people suddenly say *'This should not and must not go on'*. It implies an awareness of values that are veiled. These values are revealed in a negative manner.

The experiences of a lot of resp's illustrate their insights as a result of a negative experience is related to a 'sensation' of what good care is (not) about.



Discussion



All respondents went through at least one experience that really affected them.

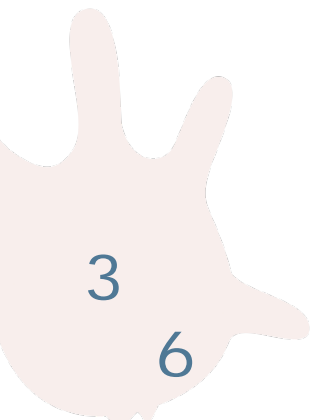
Many respondents were encouraged to reflect on their own views on care.

Cognitive phase of empathy



Some respondents provides examples of what they actually started doing differently.

A number of respondents demonstrate the type of reflection that is a result of a contrast experience: they come to some insights.



Discussion



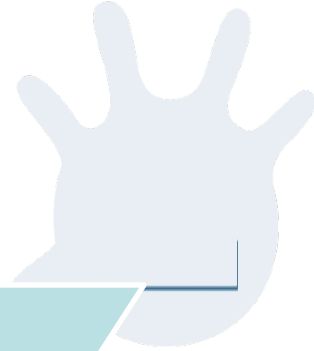
- Due to their contrast experiences...
 - some resp's come to **insights** about their care
 - They realise what is going on in one's own moral awareness → type of reflection, crucial for the moral development of care providers
 - a few resp's come to the **reprieve** of their own perspective



They realise that it is impossible to feel what the other person is experiencing. This insight may lead to suspend or distancing oneself from the frames of reference one holds.

These insights and reflections are crucial to empathy
(cf. **cognitive phase**)

Discussion

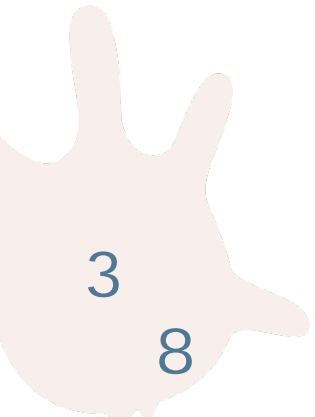


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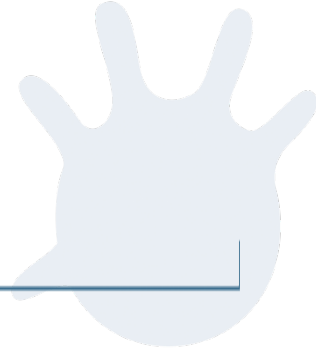
Many respondents were encouraged to reflect on their own views on care.

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Behavioral phase of empathy



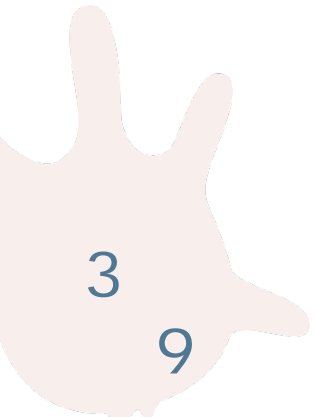
Discussion



- A few resp's who were interviewed a second time, indicate that the insights that folowed out of their experiences changed their behaviour in practice.

Empathy is always...

- feeling
- insight
- acting




Discussion



- A few resp's who were interviewed a second time, indicate that the insights that folowed out of their experiences changed their behaviour in practice.

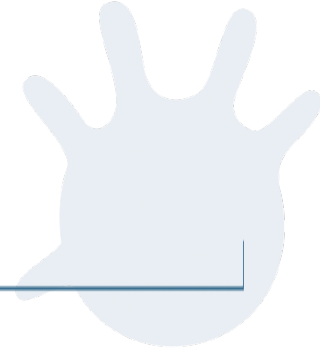
Empathy is always...

- feeling
- insight
- acting



*Can empathy be considered as a **virtue**?*
Virtues always bring together emotions and insight, motivations and practices

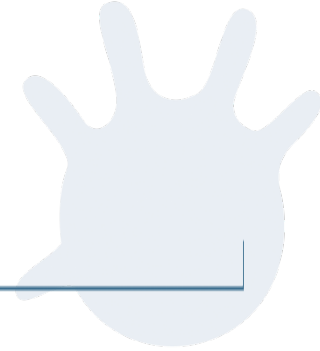
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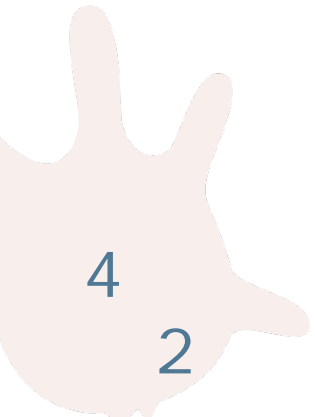
- From the virtue ethics perspective, the empathy sessions may be seen as an **‘educational context’** which allows for empathy to be practiced and taught.
 - Characteristic for this context: experiences gain impact on the affective level and may reverberate through the cognitive level and may cause people to change their behaviour.
 - Also the work floor itself must be an ‘educational context’. If this is not the case (cf. external factors such as working pressure and lack of ongoing incentives), acting in an emphatic way is in danger.



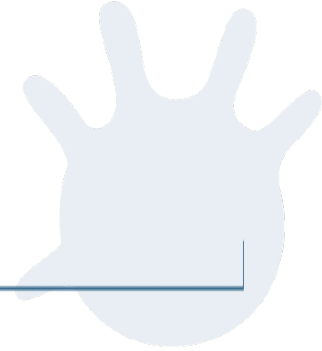
Conclusion



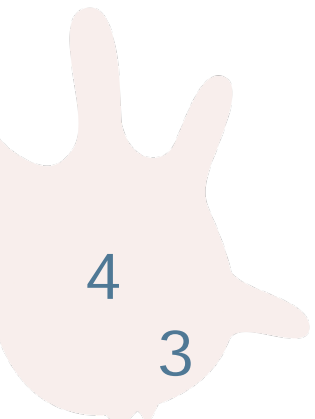
- This qualitative study provides a better insight into how experiential learning specifically targets the empathic abilities of care providers.
 - This pilotstudy reveals that the providing of contrasting experiences that inherently impact the cognitive level is a crucial element.



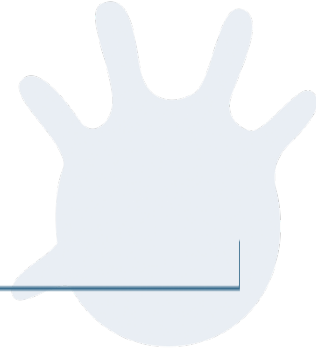
Conclusion



- Further research is needed to provide more insight into how empathy leads to long-term changes in behaviour.
 - This requires research into the exact role of ethical reflection on experiences.



Conclusion



- Further research is also needed into the meaning and the role of the ‘work floor’ as an educational context for developing empathy.
 - How should this educational context be created?
 - Who takes up a facilitating role and how is the facilitation of empathy to occur exactly?
 - How can care providers be motivated in a lasting manner to practice their empathic abilities?
 - What is the place of ethical reflection in this context?



L. Vanlaere, M. Timmermann, L. Stevens, C. Gastmans, *'My body knows'. An explorative study of experiences of healthcare providers posing as simulated care receivers in a 'care-ethical' lab*, in *Nursing Ethics* 2012 (19): 68-79.