Open Research Online

The Open University's repository of research publications
and other research outputs

Fostering empathy in clinical teaching and learning environments: A unified approach

Journal Item

For guidance on citations see FAQs.

oro.open.ac.uk

Fostering Empathy in Clinical Teaching and Learning Environments: A Unified Approach

Rajvinder Samra
The Open University

Emma Jones
The Open University

Fostering Empathy in Clinical Teaching and Learning Environments: A Unified Approach

Rajvinder Samra∗∗ and Emma Jones∗∗

∗∗ The Open University.

Abstract

This paper draws together broad insights into the notion of empathy, with specific lessons learned from current approaches to empathy within both law and medicine. The role of empathy is becoming more central to modern professionalism in both fields as they demonstrate a movement towards partnership-building, with an emphasis on patient-centred decision-making in medicine and more holistic, personalised client care within law. The paper aims to identify fundamental principles to inform the development of a unified approach to the inclusion of empathy within clinical teaching and learning environments. These principles can then be used as a basis to highlight and share best practice and consider common challenges and opportunities, as well as being drawn upon by those working within interdisciplinary clinical partnerships. Identifying and exploring fundamental principles will assist in ensuring that empathy is acknowledged and utilised in a psychologically and emotionally healthy and appropriate manner to benefit the students, clients, patients and other stakeholders involved.

I INTRODUCTION

Within contemporary Western society, the understanding and use of empathy is often portrayed as both vitally important and an unmitigated good. In academic circles, Hoffman has characterised it as '...the spark of human concern for others, the glue that makes social life possible' (Hoffman, 2000, p.3). More generally, there is a plethora of self-help style titles available promoting its importance and development[1], and it has received high-level endorsement from public figures such as Barack Obama (Northwestern Now, 2006). Even those who have sought to critique the heavy emphasis on the virtues of empathy have acknowledged its vast influence and power (Bloom 2016; Prinz, 2011), for example, Kwon (2017) refers to current US President Donald Trump's manipulation of people's empathic responses to victims of terrorist attacks to gain support for anti-immigration policies.

Within the specific fields of both medicine and law, there has been an increasing interest in, and discussion of, empathy (concerning medicine see, for example, Ekman and Krasner, 2017, for law see Westaby and Jones, 2017). Mirroring the broader societal view, this has mostly framed empathy as a positive, even necessary, component of clinical work, forming a part of the required competencies for practise (General Medical Council, 2017; Legal Education and Training Review, 2013, Table 4.3). This acknowledgment and inclusion of empathy has a range of potential benefits and provides a number of opportunities in relation to approaches and standards of patient and client care. In medical settings, these benefits include greater trust and more information sharing by patients which facilitates more successful shared decision making (Parkin, de Looy, & Farrand, 2014). There is some evidence that empathic encounters are therapeutic in their own right to patients (Bertakis, Roter, & Putnam, 1991) and increase patients' adherence to treatment recommendations (Kim et al., 2004). From the clinician's perspective, greater empathy is argued to lead to better clinical decision-making and is facilitative of diagnosis (Levinson, Gorawara-Bhat, & Lamb, 2000). Doctors who report high empathy scores also report higher personal wellbeing (Shanafelt et al., 2005), although the direction of this relationship is unknown (Samra, 2018). In legal settings, the relationship between wellbeing and empathy remains mostly unexplored. However, there is a body of literature arguing that its use enhances client care, develops trust, facilitates effective representation and potentially improves interactions and negotiations with other parties and their representatives (Gallacher, 2012; Gerada Brown, 2012; Gerdy, 2008; Barkai & Fine, 1983). There have also been suggestions that empathy may have a role in developing a greater appreciation of the way in which the law works, its relationship with society and its interplay with social justice and ethics through the insight it provides into the experiences of others, as well as in challenging potentially damaging forms of adversarialism by promoting more collaborative ways of working (Deigh, 2011; Margulies, 1999, Rosenberg, 2002).

However, alongside these benefits and opportunities, the increasing focus on empathy raises a variety of challenges, particularly for those operating within clinical teaching and learning environments. Although the underlying pedagogies and objectives of such environments are varied, and encompass multiple discourses (Hodges, 2006; Walkden-Brown & Stevenson-Graf, 2018), the experiential learning process they employ commonly (whether explicitly or implicitly) involves socialisation into professional behaviour and norms and the modelling of best practice around these (Hodges, 2006; Wizner, 1991 This leads to questions, common to both disciplines, around the way in which the notion of empathy is defined, how it can best be taught and how it interacts with notions and standards of professionalism within the disciplines.

This paper seeks to address a number of these challenges by drawing together comprehensive research on empathy, and literature on its use within medicine and law, to identify fundamental principles to form a strong, evidence-informed foundation for the acknowledgment and use of empathy within clinical teaching and learning environments. While the application of these principles may diverge significantly within individual disciplines, identifying a unified approach enables an understanding and sharing of best practice and the construction of new, multi-disciplinary discourses to further clinical approaches. This will be of particular value for those

---

1. Bloom (2016) refers to 1,500 titles with "empathy" in the title available on Amazon.com

clinicians working within interdisciplinary environments but also facilitates further insights in discipline-specific clinical settings. Such a unified approach reflects the broader interplay between medicine and law, which the more extensive health and justice movement is promoting internationally (see, for example, Curran, 2017).

II PRINCIPLE 1: EMPATHY SHOULD BE DEFINED AS A MULTI-FACETED CONCEPT INCLUDING BOTH COGNITIVE AND AFFECTIVE ELEMENTS

In the UK, the importance of communication skills in medical education and training is outlined in the 1993 *Tomorrow's Doctors* report from the General Medical Council (GMC) on its recommendations for undergraduate medical education (GMC, 1993). However, there was no specific reference to empathy in this policy document, nor the following two versions of Tomorrow's *Doctors* (GMC, 2003; 2009).

Since 1993, the UK medical education curriculum around clinical communication skills training has dramatically developed, such that communication skills form a core part of the curriculum (Brown, 2008). The inclusion of empathy specifically as a skill occurred more recently; the establishment of a UK Council of Clinical Communication Skills Teaching in Undergraduate Medical Education in 2005 led to the development of a consensus statement on the content of undergraduate medical curricula in 2008 which included 'empathic reflection' (Fragstein, et al., 2008, p.1103). At a similar time, the GMC outlined that, in order to progress to professional registration, junior doctors should demonstrate "empathy and the ability to form constructive therapeutic relationships with patients" (GMC, 2007, p.86). Presently, demonstrating empathy now appears in the General Medical Council's Generic Professional Capabilities for all doctors across the 66 medical specialties (General Medical Council, 2017), as well as the Council's standards for medical schools and training programmes (General Medical Council, 2016).

In the United States of America (USA), the role of empathy in medical training was outlined as a learning objective in the Association of American Medical Colleges' Guidelines for Medical Schools in 1998 which stated that "Physicians must be compassionate and empathetic in caring for patients" (Anderson et al., 1998). Further detailing this approach to care, the Guidelines expanded:

> In all of their interactions with patients, they must seek to understand the meaning of the patients' stories in the context of the patients' beliefs and family and cultural values. They must avoid being judgmental when the patients' beliefs and values conflict with their own. (p.4).

The role of clinical empathy has been increasingly formalised within the educational and training curriculums in medical systems beyond the USA (Tuning Project (Medicine) Steering Group and Task Force, 2008; Warmington, 2012). In teaching empathy in medicine, early definitions positioned empathy in cognitive terms as 'the act of correctly acknowledging the emotional state of another without experiencing that state oneself' (Markakis, Frankel, Beckman, & Suchman, 1999). Halpern (2003) describes this definition of empathy as 'an intellectual rather than emotional form of knowing' (p.670). Halpern (2001) was critical of this perspective of empathy, citing it as 'detached concern' rather than empathy. She noted that medical educators were using the norm of detachment in order to reformulate this 'clinical empathy' into a reliable professional skill that could be taught (Halpern, 2003). However, detached concern could not be expected to fulfil patient and doctors' needs for genuine empathy in medical care (Halpern, 2003). In recent years, the affective aspect of empathy has become a growing focus in medical education, but cognitive empathy is still favoured in these settings (Preusche, & Lamm, 2016). Halpern (2001) details the history of empathy in medicine and outlines Hippocratic writings which indicate that, long ago, physicians considered being affected emotionally by patients as part of the healing process. However, these emotions were more akin to developing sympathy and compassion towards patients (Halpern, 2001).

Despite a seminal paper in the context of the USA by Henderson arguing for the inclusion of empathy within legal discourse in 1987, the recognition of its role within legal training has been slower to develop than within medical education. The American Bar Association's Model Rules of

Professional Conduct (2016) make no explicit reference to it. In Australia, there also appears to be little explicit reference to empathy within educational and regulatory frameworks, although Spivak et al. (2014) note the implicit inclusion of such broader skills in the Bachelor of Laws Learning and Teaching Academic Standards Statement. In England and Wales, the recent Legal Education and Training Review (2013) did identify empathy as a key component of legal competency, but of the new competency frameworks to develop from this, only the Bar Standards Board's Statement of Competence for Barristers (2016) explicitly refers to it.

Within the broader academic discussions on empathy's role within law and legal education, a similar focus on the cognitive aspects of empathy to that of medicine can be discerned. In particular, it has often been conceptualised as an 'active listening' strategy within client interviews (Binder et al., 2004). Margulies (1999) argues that this approach focuses on preserving the practitioner's neutrality at the expense of genuine engagement with the client. It has also been suggested that a lack of engagement with affective (emotional) aspects can lead to a poor understanding and relationship with clients, potentially leading to a less effective form of representation (Gerarda Brown, 2012).

The question of whether empathy is cognitive or affective or both has been one of the broader debates surrounding the concept as a whole (Kim et al., 2004). The prevailing view is that empathy includes cognitive and affective components (Schweller, Costa, Antônio, Amaral & de Carvalho-Filho, 2014). Cognitive empathy involves 'entering into' a patient or client's perspective or mental state (Mercer & Reynolds, 2002). It focuses on identifying and recognising another's beliefs or experiences and can include communicating this viewpoint back to the patient or client. Affective empathy pertains to the ability of an individual to identify and respond to the emotional state of another and can include feeling similar emotions (Decety & Jackson, 2006).

Experiencing affective empathy in clinical practice raises the question of whether feeling another's emotional experiences blurs the professional boundaries or invites over-identification with patients and clients (Mercer & Reynolds, 2002). However, despite such concerns, empathy in medicine and modern notions of clinical empathy now typically involve both an emotional/affective component and cognitive component (Jeffrey, 2016a). Within law, the focus remains mainly on the cognitive, but there are valid arguments to suggest that an affective element is also necessary, as part of a wider acceptance and acknowledgment of the inter-relation of legal education and practice with the affective domain (Jones, 2018; James, 2005). Indeed, to ignore the affective element of empathy is arguably potentially damaging to those students within clinical teaching and learning environments who have relatively high levels of affective response to their patients or clients. Without giving students the tools to understand and regulate such responses effectively, they are ill-equipped to deal with the emotional labour, which can result (Westaby, 2014; Westaby, 2010). It could also impoverish the experiential learning, which is at the heart of the mission of clinical teaching and learning environments:

> Because experience contains both cognitive and affective content, exploring an experience requires exploring not just its cognitive but also its affective dimensions. Feelings often provide windows to thought, and analyzing the causes and consequences of particular affective reactions often is a valuable step toward comprehending experience. (Goldfarb, 1990, p.1669)

Mercer and Reynolds (2002) consider empathy to have emotive, moral, cognitive and behavioural underpinnings. They define clinical empathy as the ability to:

(i)   to understand the patient's situation, perspective and feelings (and their attached meanings),

(ii) to communicate that understanding and check its accuracy and

(iii) to act on that understanding with the patient in a helpful (therapeutic) way [S11].

Mercer and Reynolds' definition of empathy has been widely adopted in the medical research literature and used as a basis for a systematic review of studies on empathy decline in medical students and medical residents (Neumann et al., 2011). This approach to empathy reflects Henderson's discussion of its conceptualisation within law (which is the most nuanced to be found

within the legal literature). She identifies three 'psychological phenomena' captured by the term, including:

> (1) feeling the emotion of another; (2) understanding the experience or situation of another, both affectively and cognitively, often achieved by imagining oneself to be in the position of the other; and (3) action brought about by experiencing the distress of another (Henderson, 1987, p.1579)

The key commonality between the definitions of both Mercer and Reynolds and Henderson is their acknowledgment that empathy is a complex and multi-faceted (or multidimensional) concept formed of several components, including both cognitive and affective elements.

How the concept of empathy is defined has significant implications for its use within clinical learning and teaching environments. Failing to acknowledge its cognitive and affective elements, or focusing on one at the expense of the other, leads to an incomplete and potentially flawed understanding of its role. Therefore, the first principle to inform the use of empathy within clinical learning and teaching environments is that its definition must follow the example of Mercer and Reynolds (2002) and Henderson (1987) in identifying and, where appropriate, emphasising that it contains both cognitive and affective elements in interactions with patients, clients and others. Such an acknowledgment of the multi-faceted character of empathy enables a fuller, more productive discussion of the topic and moves it away from becoming applied as a form of 'active listening' device or technique.

III PRINCIPLE 2: EMPATHY SHOULD BE VIEWED AS AN INTEGRAL PART OF PROFESSIONALISM

Mercer and Reynolds' (2002) and Henderson's (1987) definitions of empathy as both affective and cognitive also lead towards the identification of a crucial second principle to underpin the acknowledgment and use of empathy in clinical teaching and learning environments. In particular, they consider clinical empathy to represent 'a form of professional interaction (a set of skills or competencies), rather than a subjective emotional experience, or a personality trait that you either have or do not have' (Mercer & Reynolds, 2002, S10). Indeed, within medicine, empathy has become integral to individuals' modern notions of professionalism (Tweedie, Hordern, & Dacre, 2018). A 2018 report on Advancing Medical Professionalism cites empathy as one of ten key attributes most valued in doctors by patient representatives and professionals (Tweedie et al., 2018). Employing focus group methodology, Tweedie et al. (2018) asked junior doctors and lawyers about the characteristics they deemed essential to 'professionalism', and empathy was listed alongside other attributes including honesty, transparency, accountability and advocacy.

Within medicine, two systematic reviews have independently concluded that doctors' empathy is positively related to improved patient outcomes and patient satisfaction (Derksen, Bensing, & Lagro-Janssen, 2013; Howick et al., 2018). Howick et al. (2018) systematically reviewed 28 randomized trials of empathy and positive communication interventions in medicine. Results from seven interventions found statistically significant differences relating to improved pain and anxiety from patients in empathic consultations. Using meta-analyses, Howick et al., (2018) found that these differences were only of a small effect size (standardized mean difference -0.18). Eighteen of 22 studies reported improved psychological outcomes for patients receiving positive and supportive communication by practitioners and found a modest effect (standardized mean difference -.043). Eleven of these 22 studies also explored physical outcomes (such as length of hospital stay) and reported a positive benefit of a small effect size (standardized mean difference -0.18). These reviews demonstrate that empathic encounters are linked to improved clinical outcomes as well as patient experience and satisfaction, although the effects may be small.

Despite Tweedie et al.'s (2018) findings, such a portrayal of empathy as a professional interaction is seemingly more contentious in law, because any suggestion of the inclusion of an affective element has traditionally been viewed as antithetical to the neutrality and objectivity prized within legal practice:

> Legal education devotes insufficient attention to developing the attendant skills, and mechanisms lawyers need to negotiate the emotional demands of the profession successfully. Lawyers and

academics frequently discount the emotional aspects of professional work as a "distraction" or "irrelevant" to the tasks of lawyering. By labelling attention to these issues as "soft" or "touchy-feely," the profession does a disservice to its students, its practitioners and its clients. (Fletcher & Weinstein, 2002, p.144)

However, given the emerging acknowledgment of empathy as a core component of legal competence, Mercer and Reynolds' (2002) and Henderson's (1987) definitions reinforce the notion that empathy has a vital role to play as a professional tool for enhancing client care. At the same time, recognition of this role validates the forms of emotional engagement that legal practice may generate (even despite an individual's best efforts to the contrary).[2] The inclusion of empathy as a practitioner skill and part of modern medical professionalism means that teaching or training for empathy is a common aspect of medical education (General Medical Council, 2016). Previous conceptualisations of medical professionalism hinged on limited, careful communication with patients and paternalism (Halpern, 2003), but they now encompass empathy, emotional connection, open dialogue, and patient-centeredness (Borgstrom, Cohn, & Barclay, 2010). A similar acceptance and affirmation of the role of empathy within legal professionalism is a fundamental part of fully acknowledging and utilizing its value in law.

A recent example of how this role can be acknowledged in clinical teaching and learning settings is given in Parker et al. (2018) where they discuss the use of a simulated Board of Pharmacy hearing in which students role-played Board members. The scenario required them to not only demonstrate their knowledge of addiction and the relevant administrative law but also to reflect on the role of empathy and professionalism in this setting. Of a cohort of 141 students, 138 (97%) subsequently completed an online assessment with a reflective section. Using a Likert scale, 134 out of the 138 students agreed or strongly agreed with the statement "I feel I could empathize with someone who is called before the Board of Pharmacy due to a violation" Parker et al., 2018, p.1514). This suggests that this form of experiential learning had fostered the notion of empathy as a positive part of professionalism. Such simulations are widely used in both medicine and law and explicitly incorporating a role for, and discussion of, empathy within these could provide a simple route to obtaining students' recognition of its professional importance.

IV PRINCIPLE 3: EMPATHY SHOULD BE CONTEXTUALIZED THROUGH A CONSIDERATION OF ITS ETHICAL AND MORAL DIMENSIONS

The above sections have identified two key principles to be applied within clinical teaching and learning environments, namely, the conceptualisation of empathy as both cognitive and affective and the affirmation of its role as a part of (rather than external, or even opposed to) professionalism. However, moving on from this initial conceptualisation, it is essential to consider how empathy should be contextualised specifically within clinical teaching and learning environments. In other words, empathy cannot be solely acknowledged and utilised as a 'stand-alone' concept. There is a need to address its inter-relationship with professional ethics and morality.

To begin with, there are tensions within the requirement for being a modern empathic professional itself (Samra, 2018), including how professionals manage boundaries and resolve moral and ethical issues. For example, in medicine, the patients' wishes may conflict with best practice or best interests (Borgstrom et al., 2010). A patient might refuse information or state their wishes not to be informed, which conflict with the clinicians' need to share information to allow patients to make an informed decision. Similar moral and ethical issues can also arise in law, with Fletcher et al. (2002, p142) referring to a lawyer's need to identify with their client, to obtain their trust and understand their perspective, but also avoid over-identifying in a way which detracts from their judgement as a professional. Within a setting such as a law clinic, it is easy to imagine a law student dealing with a disadvantaged client who struggles to advise them that legally their claim is flawed when morally they appear to have a strong case.

---

[2] For first-hand accounts of the experience of empathy, see, for example, O'Carroll (2006) and Genty (2000).

When considering such ethical and moral dilemmas, the starting point must be that there is a clear link between ethical and moral reasoning and empathy (Decety & Cowell, 2014; Gleichgerrcht & Young, 2013; Yoder & Decety, 2018). Neuroscientific findings demonstrate that the brain regions activated by moral thinking also share resources with decision-making and emotional processing. The ventromedial prefrontal cortex is involved in empathic concern as well as moral cognition (Decety & Cowell, 2014). Studies have shown that there is a link between morality and empathy by demonstrating that individuals who have a low empathic response to witnessing harm to others (empathic concern) are more likely to endorse utilitarian judgements than those with greater empathic concern (Gleichgerrcht & Young, 2013). In other words, an individuals' empathic concern for others will impact on the outcomes of reasoning in ethical and moral dilemmas (Yoder & Decety, 2018).

This, in part, ties into a broader debate over whether empathy is intrinsically a force for good, or whether it can equally be misleading, manipulated and even dangerous.[3] There is some debate in medicine about the lack of clarity around the concept and role of empathy relating to providing compassionate, patient-centred care in practice settings and the need for conceptual clarity for medical education (Jeffrey, 2016b). Within law, although commentators such as Hoffman (2000) portray it as facilitating prosocial behaviour, it has also been suggested that empathy is ethically and morally neutral. As Nussbaum points out 'a good sadist or torturer has to be highly empathetic, to understand what would cause his or her victim maximal pain' (2006, p.321). The broader literature on empathy provides evidence that an empathetic response can induce people into making altruistic decisions which conflict with broader notions of justice and are, therefore, 'a source of immoral injustice' (Batson et al., 1995, p.1043). As a result, when acknowledging and utilising empathy, it is essential to ensure that students understand it can impact on their approach to ethical and moral dilemmas in both potentially positive, but also possibly negative, ways. Emphasising this point is, in itself, a critical step in student learning, as it encourages students to understand and appreciate the need for self-awareness within clinical settings. As Rosenberg explains 'Basically, the more we are aware of our feelings and thoughts, the more able we are to make conscious decisions about our actions' (2002, p.641). Thus a third principle in the development of a unified framework is that empathy should be contextualised through an acknowledgment of its potential role and influence within professional ethics and morality, particularly those dilemmas that arise within clinical settings.

In line with this third principle, educators can expect that ethical and moral dilemmas and subsequent debates, will arise in student-teacher explorations of the role of empathy in clinical settings. Experiential learning, such as simulated clinical work or reflections on practice, can open up avenues for students and teachers to explore perceptions around the positive and negative consequences of providing empathy in clinical work. A systematic review of 27 studies in medical education found that empathy-based experiential learning resulted in statistically significant attitude change scores of medical students' and doctors' attitudes towards working with under-served and disadvantaged patients (Samra et al., 2013). In contrast, interventions that were knowledge-building only, with no empathy-building experiential learning, showed no statistical difference in attitude change scores towards this patient group (Samra et al., 2013). This review highlights the transformative power of experiential and empathy-based learning, which is often not being fully utilized in our current clinical and training environments. This work fits with recent movements to incorporate empathy into design thinking to create services that meet user's actual needs rather than their perceived or assumed needs (McDonagh & Thomas, 2010).

Learning exercises that explore the consequences of empathy to the professional, the client/patient and the quality of the work can also allow students and teachers to reflect on ways to minimize or mitigate negative aspects to empathy. For example, students may reflect on case studies, such as an example of a doctor who forms a close empathic relationship with a patient who dies, which some consider the 'cost of caring' (Costa & Moss, 2018). An equivalent in law

---

[3] See, for example, Johnson et al. (2016, p.574) discussing the use of empathy within capital trials in the USA where, they argue, the prosecutor will seek to dehumanise the defendant, whereas the defence will emphasise their human characteristics to invoke empathy and discourage the application of the death penalty.

could be a case study of a client with what their lawyer perceives to be a strong ethical/moral case, but one which is not supported by the current law on an issue, meaning that they will be unable to obtain legal assistance (Brooks, 2006). By signalling and identifying the potential for empathic practice to have potentially adverse consequences to the professional, students can begin imagining and problem-solving around how best to deal with or mitigate the stress or negative emotions that they might experience should this happen in their professional work.

V PRINCIPLE 4: THE RELATIONSHIP BETWEEN GENDER AND EMPATHY SHOULD BE EXPLICITLY ACKNOWLEDGED AND DISCUSSED

Another way in which empathy should be contextualised within clinical settings is through an appreciation of the issue of gender and empathy and how this manifests in individuals and their professional behaviours. Empathy is gendered in that it is more socially acceptable for females to display empathy than males (Strauss, 2004). Psychological research indicates that women show higher empathic concern for others at an earlier age which has been postulated to relate to care-orientation which might stem from evolutionary factors and social learning (Hojat et al., 2002). The link between gender and empathy is controversial and has been debated despite some support from neuroscientific studies (Cheng et al., 2008; Christov-Moore et al., 2014). Gender differences in clinician-patient encounters in medicine have also been demonstrated in empirical studies in which female doctors have more emotion-focused talk and talk more about psychological and social issues (Hojat et al., 2002).

Recent neuroscientific evidence supports the proposition that biological and sex effects of experiencing empathy may be minor, with differences showing small effect sizes, and varying according to the choice of assessment measure (Baez et al., 2017). In a population-based study on sex differences in empathy for pain, Baez et al., (2017) analyzed results from 10,802 individuals who were asked to watch different animated scenarios of accidental or deliberate harm where pain was inflicted on someone as well as a neutral (control) scenario where no harm was inflicted. A second task asked participants to answer moral dilemmas to determine whether they reported utilitarian or non-utilitarian decision-making. Results showed minimal differences between men and women in empathy measures. Although differences between men and women on empathy ratings were statistically significant, they did not reach even a small effect size.

Similarly, the authors concluded that there were minimal differences between men and women for moral judgements. The authors concluded that neither sex nor moral judgements appear to be predictors of empathy. The authors conducted a second study which involved self-reported empathy in 334 individuals using questionnaire methods. Women showed statistically significantly higher self-reported empathy with a medium effect size. The authors concluded that sex differences in empathy emerge depending on the conditions of assessment. This study indicated that, under experimental conditions, women and men show small differences in empathy for pain, but under conditions which allowed for personal judgement about oneself, the role of gender role stereotypes may have underpinned larger differences in empathy scores. Specifically, women considered themselves more empathic in self-report measures which support the idea that differences between men and women in empathy may be based on assuming gender role stereotypes.

Within the context of clinical education and training, the implications of these findings include the need to acknowledge that there are likely to be gender-based role assumptions about empathy which may affect the students' perceptions of themselves as well as clients' expectations and perceptions of them. Within medicine, a recent systematic review and meta-analyses of patient ratings of practitioner empathy indicated that, using data pooled from 12 studies, studies with predominantly female practitioners were significantly more likely to have higher levels of expressed empathy scores, scoring 16% higher than studies with predominantly male practitioners (Howick et al., 2017). As a limitation, this review found that there was great variability across the studies regarding the way that practitioner gender data is reported, which required the authors to use a crude measurement of categorizing data across studies. The authors concluded that the results might underestimate the effects of gender on empathy ratings. Therefore, there

exists an opportunity to explore more conclusively the gender differences in practitioners' expressed empathy, according to patient ratings.

Within law, the gendered aspects of empathy (and emotion more generally) are arguably less well-explored. However, Henderson (1987, p.1582) suggests that feminist legal epistemologies have often sought to portray empathy as a female characteristic. She argues that this arises from a conflation of empathy with the notion of an ethic of care (Gilligan, 1993). This assumption that empathy leads to compassion (Hoffman, 2000) has been discussed above, and it has been suggested that it is flawed. Another way the gendered aspects of empathy has been highlighted in relation to law are through suggestions that certain, female-dominated areas of legal practice require a more exceptional ability to both provide emotional support and also to deal with the emotional demands involved. For example, Melville and Laing identify that family law work 'is often seen within the legal profession as a natural extension of women's supposedly innate nurturing traits' (2007, p.291). This perpetuates the notion of a skill such as empathy as being a form of innate, feminine trait. More generally, in relation to the legal profession, Sommerlad has emphasised its gendered nature with a 'hyper-masculine', increasingly corporatized culture which positions women as the expected providers of emotional labour at a time when client demands and an emphasis on client care increasingly challenges previous boundaries, shaping a new and often toxic form of professionalism (2016, p.61). This once again implies that empathy is being characterised as a gendered trait in a way which needs to be acknowledged and challenged to avoid the perpetuation of an unhealthy culture based on gender stereotypes.

Given the problematic relationship between empathy and gender, the fourth principle in the development of a unified framework is that empathy must be contextualised in clinical teaching and learning environments through an explicit acknowledgment and discussion of this problematic inter-connection. This form of debate will also feed into the conceptualisation of professionalism mentioned above. It is vital not to inadvertently provide students with a gendered notion of professionalism which perpetuates existing, damaging norms of the type emphasised by Sommerlad (2016). Instead, it is crucial to raise awareness and understanding of the broader social and cultural factors which influence when, how, and by whom empathy is displayed. Although proposing the inclusion of the principle may seem somewhat theoretical and abstract for the clinical setting, in fact, the on-going impact it can have on professional practice makes it an essential part of the clinical curriculum.

A valuable starting point for teaching about gendered notions of empathy in clinical environments is student, practitioner and faculty awareness and self-reflection. For example, faculty and teaching staff should be encouraged to examine their gender-related assumptions about empathy and its link to professional competence (Samra, 2019). Clinical educators should examine their teaching materials to check for unwarranted assumptions that contribute to the hidden curriculum around gendered notions of empathy and professionalism (Babaria, Abedin, Berg & Nunez-Smith, 2012). Those in clinical training environments can also examine gendered notions within the hierarchy of their disciplines in which technical work which is not people-centred (such as surgery in medicine) is considered at the top of the prestige hierarchy. In contrast, people-focused work (such as general and family medicine) languish at the bottom of the prestige hierarchy in medicine (Samra, 2019). For law, this could mean exploring the delineation of "feminine" and "masculine" fields of practice and the broader characterisation of legal culture as embodying a form of toxic masculinity (Sommerlad, 2016).

VI PRINCIPLE 5: CLINICAL TEACHING AND LEARNING ENVIRONMENTS SHOULD INCLUDE SPECIFIC TEACHING AND LEARNING STRATEGIES TO DEVELOP EMPATHY

The above sections have identified four fundamental principles around the conceptualisation and contextualisation of empathy. These, in turn, feed into the way in which empathy can and should be implemented within clinical settings. If empathy is positioned as a part of professional competence, rather than as an innate personality trait which is difficult to influence, it follows that levels of empathy displayed by students in clinical teaching and learning environments can be influenced, consciously or unconsciously, by their experience.

Within medical education, there has been much debate about whether clinical exposure influences or changes students' empathy levels. Studies have demonstrated that empathy declines during medical school with one of the hypotheses being that students move from idealism to realism (Nunes, Williams, Sa, & Stevenson, 2011). Another explanation supported by neuroscientific studies (Decety, Smith, Norman, & Halpern, 2014; Gleichgerrcht & Decety, 2013) is that students' (and medical practitioners') empathic reactions become downregulated in order to cope with repeated and excessive arousal. Michalec (2010) suggests that medical students 'shed' empathy as an adaptive response to dealing with excessive stressors. Elsewhere, Newton, Barber, Clardy, Cleveland, and O'Sullivan (2008) posit that students become increasingly cynical as they progress through medical school. Nunes et al. (2011) specifically suggest that clinical curriculums need to incorporate adaptations that better support the emotional learning of students and encourage the maintenance and development of empathy. Nunes et al. (2011) suggest inter-professional learning and the development of teamwork ethics may be incorporated into the redesigned curriculum which more realistically caters for applied learning rather than merely fact-based learning, and that this applied approach needs to be reinforced throughout training.

In relation to law, the literature is somewhat sparser. Discussing legal education generally (in the USA context), Gallacher has argued that it is designed to "eliminate that directive ethical and empathetic intelligence and replace it with an ethical, but entirely logical, intelligence that prohibits human understanding" (2012, p.33). In terms of empirical evidence, Williams et al. (2016), arguing for the importance of measuring empathy amongst law students, conducted a survey of 275 law students at Monash University in Australia applying an adapted version of the standard measure (the Jefferson Scale of Empathy – Law Students). Although the main focus of the study was on the reliability of this measure, they did note that the participants "yielded lower empathy scores than what is typically seen among health students", although they acknowledged it might be that the definition of empathy for law students is "slightly different" to that of health students (Williams et al., 2016, p.178). It should be noted that the validity of this measure has since been questioned (Spivak et al, 2018); however, the study's conclusion on levels of empathy is supported by an earlier study by Wilson et al. (2012) which compared levels of empathy amongst nursing, pharmacy and law students, measuring the levels of both first and third-year students at the University of Central Lancashire, England by applying the Jefferson Scale of Empathy – Students. This study found that "students in both of the health-related professions obtained significantly higher empathy scores than did the law students" (2012). Interestingly, it found there was "no significant difference in empathy" between first- and third-year law students. This study reported small sample sizes and included only 63 law students. Further work is needed to explore empathy decline in law with larger sample sizes to provide more robust evidence. This study could, however, suggest there is a lesser risk of empathy decline amongst law than medical students, but given the sparsity of empirical evidence, it is difficult to speculate on this.

Overall, it is important for educators within clinical teaching and learning environments to understand that, if levels of empathy can be increased, they can also be decreased. Empathy decline throughout clinical education represents a plausible and immediate risk to medical students (Nunes et al., 2011). This empathy decline is postulated to occur when students embark on clinical practice and the distress caused by this (Neumann et al., 2011). This suggests that the possibility for empathy decline in legal education and training settings might arise after the law degree and once legal students and trainees begin client-facing legal work, or earlier if students are working in clinical teaching and learning environments. Therefore, the fifth principle within the unified framework being proposed is that clinical settings must not only acknowledge the importance of empathy but also seek to develop specific teaching and learning strategies to proactively develop (and prevent the decline of) empathy as students' progress through their clinical experience. Sharing lessons of good practice and successful interventions between clinical professions, such as medicine and law, may facilitate more rapid interdisciplinary learning in relation to such shared clinical issues.

This principle may sound almost self-evident, given the discussions above. However, in fact, it raises a number of challenges. One of these is the limited specificity within both medicine and

law regarding the causes of the lack of empathy that educators are being encouraged to address. Pedersen (2009) identifies a range of factors that may cause or account for the 'lack of empathic behaviour', such as the clinician not perceiving empathy to be relevant to the encounter and thus not identifying or addressing emotional cues. Alternatively, this lack may instead stem from a failure of emotionally understanding the patient/client in the first instance, or it might be a failure to communicate empathic understanding, and/or demonstrate empathic behaviour. Unpicking where and how empathy decline may be triggered and identifying where and how it can be fostered might pose challenging. This may be further complicated by the fact that the majority of research evidence is based on self-report, in which individuals report their perceptions of their own abilities regarding empathy. This means that those who are most in need of empathy training because they lack self-awareness of their empathy skills may be overlooked (Pedersen, 2009). Therefore, empathy training and educational research and practice should incorporate observer-judgements as well as self-assessments regarding personal skills levels (Batt-Rawden et al., 2013). In particular, for clinicians, it may be wise to begin training medical students or law students/trainees to seek the feedback and evaluations of their patients, clients, peers or educators more often to inform themselves of others' perceptions of their empathic understanding, communication and behaviours.

A requirement for empathy to be proactively fostered also raises questions over the role faculty has in the development of such skills. Within both medical and legal clinical settings, despite the increasing acceptance of the role of empathy within professionalism, students may learn about being a patient-centred and empathic practitioner from faculty members who were taught with different notions of professionalism which do not extend to empathic understanding (Borgstrom et al., 2010). For example, law students may find their faculty are modelling forms of 'thinking like a lawyer' which exclude any acknowledgment of the role of empathy (James, 2005; Jeurgens, 2005). Indeed, it has been argued that legal education as currently framed encourages students away from experiential thinking and towards a form of rational thinking which excludes the affective domain (Towness O'Brien et al., 2011). The forms of implicit messages and learning generated by the attitudes of individual faculty members become part of what has been referred to as the 'hidden curriculum' which is taught along with the explicit curriculum and demonstrates a powerful influence on students' professional norms and culture (Borgstrom et al., 2010). Therefore, to fully embrace the principles referred to within this paper, those faculty members providing clinical education will need to examine their understanding and perceptions of empathy, to ensure they are modelling an appropriate form of empathy conceptualisation and general professionalism (Bandini et al., 2017; Juergens, 2005).

The possibility of empathy decline with more considerable clinical experience also reinforces the need to allow students and trainee practitioners to be able to discuss stress, mental ill-health, the hidden curriculum and the influence of negative role models as well as how to respond and adjust to the loss of idealism (Batt-Rawden et al., 2013). It is relevant to note the reciprocal nature of training for empathy: 'perhaps students need to receive more empathy from faculty, other physicians, and even their patients before they can truly understand how to establish empathic connections.' (Bayne, 2011). It is likely that in order to teach relationship-centred practice, faculty and clinician educators will have to develop their understanding of the relationship they have with, and its impact upon, students and trainees.

Research on the development of other professional skills in clinicians can provide useful evidence and future directions for the field of empathy training, including the role of faculty and ways to combat the limitations of self-report mechanisms. Krasner et al. (2009) tested an educational program in mindful communication through an 8-week intensive course followed by a 10-month maintenance phase in 70 primary care doctors and found statistically significant post-intervention improvements in empathy towards patients, as well as improved personal wellbeing, self-awareness, mood and reduced symptoms of burnout. The standardized mean difference of empathy scores were 0.45 indicating a small to medium effect size. This study indicated that personal and professional skills training needs to be practised over an extended period (e.g. one year) for effective change and may benefit from professional accreditation. This course (Krasner

et al., 2009) was part of the doctors participants' Continuing Medication Education (CME) which is akin to Continuing Professional Development (CPD) in law and the other professional groups. It should be noted that offering CME/CPD points may have affected the results of the study and the lack of a control/comparison group also served as a limitation of the study. Regarding the mindful communication course, the content included self-awareness exercises, which explored narratives about meaningful clinical encounters, traditional didactic methods, discussion and, crucially, it involved appreciative interviews. Appreciative interview methods focus on discovering the causes of success and factors that make success possible in any particular behaviour or outcome. Translated to empathy training, appreciative interview methods would be about encouraging individuals to reflect and discuss causes and conditions for successful empathic encounters that they have had with patients or clients in the past to inform their future practice. Such approaches build on positive examples and are not deficit-focused. The authors considered appreciative inquiry to be a vital element of the success of the intervention (Krasner et al., 2009).

Interestingly, allowing time to reflect and master new behaviours has been described as successful in cross-cultural settings. A Brazilian study of medical students indicated that under normal teaching conditions, the pace of learning and education in medical school is fast and does not necessarily allow for time for reflection and feedback required to develop excellent professional communication and empathy skills (Schweller et al., 2014). In a study by Schweller et al. (2014), 4th year (n= 124) and 6th year students (n=123) underwent simulated consultations with 'standardized patients' (Ainsworth et al., 1991) who are people trained to portray patients through having learnt a real-life clinical case. Students were filmed in their consultations and encouraged to watch and reflect on their performance as well as that of their peers and think about what they might do differently. These simulation activities were led by reflective practitioners. Schweller et al. (2014) found that students were relieved to find that their challenges were similar to those experienced by their peers. The authors note that it is important that the facilitators guiding the session have experience of the realistic and day-to-day challenges of providing patient-centred care and empathy so that students feel comfortable that these sessions are not detached from real-life practice. Schweller et al. (2014) demonstrated statistically significant empathy score increases ($p<.001$) after the simulation exercises, and found medium effect sizes in both the 4th year students (effect size 0.61) and the 6th year students (effect size 0.64). The authors also reported an unexpected finding which they believe to be an important factor in intervention success. The post-simulation debriefing sessions became a discussion forum on aspects typically not discussed between students and practitioners, including negative role models and the hidden curriculum in medical school. Therefore supervised practice with relevant clinicians can allow time and space in the curriculum to discuss the informal or hidden curriculum and its effect on professional norms and culture.

The importance of reflection in fostering empathy has also been highlighted specifically in relation to legal clinical settings, with Gerdy (2008, p.44) referring to the need for students to reflect on both their own experiences and those of others whom they come into contact with, to develop a more empathic response. For example, it is suggested that students could be encouraged to consider what clients may want, need or expect from an encounter with a lawyer and compare this with their own perceptions of the qualities that are desirable in a lawyer. When reading case law, students could also be asked to consider the people involved in the case and reflect upon their feelings and needs (Gerdy, 2008, p.57). Overall, Gerdy's suggestions within the legal literature tend to focus on repositioning the client's story as central to the lawyer's role and understanding, as opposed to the traditional focus on the written law. Perhaps Massaro encapsulates this approach most clearly when she argues that 'Empathy, human stories, and different voices should be woven into the tapestry of legal scholarship, legal training, law formulation, legal counselling and advocacy, and law application and enforcement' (1989, p.2101). As with the study of Schweller et al. (2014), the linking of empathy to clients, client care and case law emphasises its real-life role and impact within practice.

Training for empathy skills can also be informed by the wider literature on the facilitators of skills training in higher education students. To date, the research literature on skills training in the

general student group has focused on mental health promotion and prevention programs as this area is a growing worldwide concern (Castillo & Schwartz, 2013; Saleh, Camart, & Romo, 2017). A recent meta-analysis of 103 intervention studies testing mental health prevention programs on higher education (college, graduate and professional) students identified some key elements that were associated with significant improvements and effective change (Conley, Durlak, & Kirsch, 2015). Specifically, skills training which included supervised practice was significantly more effective than skills training without supervised practice and that which was predominantly psychoeducational in nature (informational). Supervised practice occurred where a practitioner or professional was able to monitor or evaluate students' abilities to develop the target behaviours or skills. Conley et al. (2015) concluded that supervised practice is crucial to acquiring new skills because it allows time and space for the rehearsal of the behaviours, as well as feedback and support about how best to develop and master these new behaviours and skills. These interactions with supervisors are also expected to be motivational for students after they leave the supervised sessions as they have received personalised, informative feedback and support. Concerning clinical legal education, the recent paper by Gascón-Cuenca et al. (2018) has also emphasised the importance of supervision within law clinics, providing practical examples of exercises supervisors can undertake with students to proactively foster the development of empathy. These include a self-awareness activity, incorporating the discussion of 'common bias' against particular groups and a form of role-play where students are required to assume personas and effectively put themselves in that person's shoes. Incorporating the findings around skills training in higher education generally with focused suggestions for empathy training, such as the above exercises, indicates the potential for supervised empathy training to transform students' abilities to develop and master skills relevant to communicating and interacting with clients or patients with appropriate empathy.

VII CONCLUSION

'Even if clinicians endorsed the mastery of lawyering arts as their pedagogical objective, law students could not attain such mastery during the brief span of a clinical program. Students do inevitably learn some lawyering skills in the course of a clinical program, but more importantly, they learn the foundational skills for learning further skills in the future.' (Goldfarb, 1990, p.1652)

Clinical teaching and learning environments, even within one discipline, vary significantly. For example, legal clinical settings may encompass anything from a brief exposure to a handful of cases during a single course to a fully integrated part of the overall law school experience. However, as the quotation from Goldfarb (1990) indicates, there is a commonality in the way in which all these clinical settings provide their students with such 'foundational skills' which they will then take with them into their future lives and careers. The overarching theme of this paper is that empathy can and should be a part of this foundation through its acknowledgment and incorporation as an important component of professionalism and its proactive development and fostering.

This paper has provided five fundamental principles to assist in the inclusion and integration of empathy in clinical teaching and learning environments. The first two of these are essentially definitional in character, emphasising, firstly, empathy as a concept with both cognitive and affective elements and, secondly, its role within professionalism as a critical skill or competence. The second two principles relate to its contextualisation, requiring that its inter-relationship with both ethics and gender be acknowledged and explored in a nuanced manner which avoids unthinkingly perpetuating assumptions around empathy as either an unmitigated good or as a feminine trait which are at best unproven and, at worst, erroneous. The final principle relates specifically to implementation and the need for empathy to be proactively fostered and maintained throughout the clinical experience. This may involve uncovering and challenging elements of the 'hidden curriculum' (Borgstrom et al., 2010), considering the models and norms being perpetuated by existing faculty and reflecting on the broader legal or medical culture, for example, the notion of 'thinking like a lawyer' (James, 2005). There are a range of examples within the broader

literature on higher education which provide helpful guidance on successful implementations which can be drawn on when seeking to challenge past, often implicit, norms and move on to accord empathy its appropriate status within professional socialisation. Each of the principles that have been identified are relatively broad in nature; however, it is hoped that this will allow individual clinicians and across various settings to use these as an evidence-based underpinning for their own practice, particularly those operating within an inter-disciplinary setting.

In terms of future directions, the authors of this article intend to publish a further paper focusing on the practical implementation of the five principles within clinical teaching and learning settings. Given the gaps in research that have been identified within this article (most notably with regard to legal education), it is also recommended that the practical incorporation of these principles be accompanied by a form of evaluation process. This will enable clinical programmes to continue to improve and develop their engagement with empathy and facilitate further sharing of best practice. The inclusion of empathy in such settings and programmes deserves continued acknowledgement and discussion both within, but most notably, between disciplines to ensure its value and importance is fully recognized.

REFERENCES

Ainsworth, M. A., Rogers, L. P., Markus, J. F., Dorsey, N. K., Blackwell, T. A., & Petrusa, E. R. (1991). Standardized patient encounters: a method for teaching and evaluation. *JAMA, 266*(10), 1390-1396. Doi: 10.1001/jama.1991.03470100082037.

American Bar Association (2016). Model Rules of Professional Conduct. Retrieved from: https://www.americanbar.org/groups/professional_responsibility/publications/model_rule s_of_professional_conduct/model_rules_of_professional_conduct_table_of_contents/.

Anderson, M., Cohen, J., Hallock, J., Kassebaum, D., Turnbull, J., & Whitcomb, M. (1998). Report I Learning objectives for medical student education: Guidelines for medical schools. Washington: Association of American Medical Colleges; 1998; Retrieved from: https://www.aamc.org/download/492708/data/learningobjectivesformedicalstudenteducat ion.pdf.

Babaria P, Abedin S, Berg D, & Nunez-Smith M. (2012) "I'm too used to it": a longitudinal qualitative study of third year female medical students' experiences of gendered encounters in medical education. *Social Science & Medicine 74*(7),1013–20.

Baez, S., Flichtentrei, D., Prats, M., Mastandueno, R., Garcia, A.M., Cetkovich, M. and Ibáñez, A., (2017). Men, women… who cares? A population-based study on sex differences and gender roles in empathy and moral cognition. *PloS one*, 12(6), p.e0179336.

Barkai, J. L. & Fine, V. O. (1983). Empathy training for lawyers and law students. *Southwestern University Law Review,* 13(2), 505.

Bar Standards Board. (2016). Professional Statement for Barristers. Retrieved from: https://www.barstandardsboard.org.uk/media/1787559/bsb_professional_statement_and _competences_2016.pdf.

Bandini, J., Mitchell, C., Epstein-Peterson, Z.D., Amobi, A., Cahill, J., Peteet, J., Balboni, T. and Balboni, M.J., 2017. Student and faculty reflections of the hidden curriculum: How does the hidden curriculum shape students' medical training and professionalization?. *American Journal of Hospice and Palliative Medicine, 34*(1), 57-63.

Batson, D. C., Klein, T. R., Highberger, L. and Shaw, L. L. (1995). Immorality from Empathy-Induced Altruism: When Compassion and Justice Conflict. *Journal of Personality & Social Psychology,* 68, 1042.

Batt-Rawden, S. A., Chisolm, M. S., Anton, B., & Flickinger, T. E. (2013). Teaching empathy to medical students: An updated, systematic review. *Academic Medicine, 88*(8), 1171-1177. Doi: 10.1097/ACM.0b013e318299f3e3.

Bayne, H. B. (2011). Training medical students in empathic communication. *The Journal for Specialists in Group Work, 36*(4), 316-329. Doi: 10.1080/01933922.2011.613899.

Bertakis, K. D., Roter, D., & Putnam, S. M. (1991). The relationship of physician medical interview style to patient satisfaction. *Journal of Family Practice, 32*(2), 175-182.

Binder, D. A., Bergman, P., Price, S. C. & Tremblay, P. R. (2004). *Lawyers as Counselors. A Client-Centered Approach*. 2nd ed. Thomson West.

Bloom, P. (2016) *Against Empathy.* Harper Collins.

Borgstrom, E., Cohn, S., & Barclay, S. (2010). Medical professionalism: Conflicting values for tomorrow's doctors. *Journal of General Internal Medicine, 25*(12), 1330-1336. Doi: 10.1007/s11606-010-1485-8.

Brooks, S. (2006). Using therapeutic jurisprudence to build effective relationships with students, clients and communities. *Clinical Law Review*, 13, 213-230.

Brown, J. (2008). How clinical communication has become a core part of medical education in the UK. *Medical Education, 42*(3), 271-278.

Bunn, W., & Terpstra, J. (2009). Cultivating empathy for the mentally ill using simulated auditory hallucinations. *Academic Psychiatry, 33*(6), 457-460. Doi: 10.1176/appi.ap.33.6.457.

Castillo, L. G., & Schwartz, S. J. (2013). Introduction to the special issue on college student mental health. *Journal of Clinical Psychology, 69*(4), 291-297. Doi: 10.1002/jclp.21972.

Cheng, Y., Lee, P. L., Yang, C. Y., Lin, C. P., Hung, D., & Decety, J. (2008). Gender Differences in the Mu Rhythm of the Human Mirror-Neuron System. *PloS one, 3*(5), e2113. Doi: 10.1371/journal.pone.0002113.

Christov-Moore, L., Simpson, E. A., Coudé, G., Grigaityte, K., Iacoboni, M., & Ferrari, P. F. (2014). Empathy: gender effects in brain and behavior. *Neuroscience & Biobehavioral Reviews,* 46(4), 604-627.

Conley, C. S., Durlak, J. A., & Kirsch, A. C. (2015). A meta-analysis of universal mental health prevention programs for higher education students. *Prevention Science, 16*(4), 487-507. Doi: 10.1007/s11121-015-0543-1.

Costa, D. K., & Moss, M. (2018). The cost of caring: emotion, burnout, and psychological distress in critical care clinicians. *Annals of the American Thoracic Society, 15*(7), 787-790.

Curran, L. (2017). Reflections on practice and recent research to enable future practitioners to learn about working collaboratively across disciplines to better help the community. *Journal of Commonwealth Law and Legal Education*, 12(1), 46-64.

Decety, J., & Cowell, J. M. (2014). The complex relation between morality and empathy. *Trends in cognitive sciences, 18*(7), 337-339.

Decety, J. and Jackson, P.L., 2006. A social-neuroscience perspective on empathy. *Current Directions in Psychological Science, 15*(2), 54-58.

Decety, J., Smith, K. E., Norman, G. J., & Halpern, J. (2014). A social neuroscience perspective on clinical empathy. *World Psychiatry, 13*(3), 233-237. Doi: 10.1002/wps.20146.

Deigh, J. (2011). Empathy, justice and jurisprudence. *The Southern Journal of Philosophy, 49*, 73.

Derksen, F., Bensing, J., & Lagro-Janssen, A. (2013). Effectiveness of empathy in general practice: a systematic review. *British Journal of General Practice 63*(606), e76-e84.

Ekman, E. and Krasner, M., 2017. Empathy in medicine: Neuroscience, education and challenges. *Medical Teacher*, 39(2), 164-173. Doi:10.1080/0142159X.2016.1248925.

Fernández-Olano, C., Montoya-Fernández, J., & Salinas-Sánchez, A. S. (2008). Impact of clinical interview training on the empathy level of medical students and medical residents. *Medical Teacher, 30*(3), 322-324. Doi: 10.1080/01421590701802299.

Fletcher, L. E. & Weinstein, H. E. (2002). When Students Lose Perspective: Clinical Supervision and the Management of Empathy. *Clinical Law Review*, 9(1), 135-156.

Gallacher, I. (2012). Thinking Like Non-Lawyers "Why Empathy is a Core Lawyering Skill and Why Legal Education Should Change to Reflect its Importance". Syracuse University SURFACE. Retrieved from: http://surface.syr.edu/cgi/viewcontent.cgi?article=1005&context=lawpub.

Gascón-Cuenca, A, Ghitti, C. & Malzani, F. (2018). Acknowledging the relevance of empathy in clinical legal education. Some proposals from the experience of the University of Brescia (IT) and Valencia (ESP). *International Journal of Clinical Legal Education*, 25(2) Retrieved from: file://userdata/documents2/ejj62/Downloads/727-2279-1-SM%20(3).pdf

General Medical Council (1993). *Tomorrow's Doctors: Recommendations on Undergraduate Medical Education*. London: GMC.

General Medical Council (2003). *Tomorrow's Doctors: Recommendations on Undergraduate Medical Education (2nd ed.)*. London: GMC. (2nd edition)

General Medical Council (2007). *The New Doctor*. London: GMC

General Medical Council. (2009). *Tomorrow's Doctors: Recommendations on Undergraduate Medical Education (3rd ed.)*. London: GMC.

General Medical Council. (2017). Generic Professional Capabilities Framework: GMC.

General Medical Council. (2016). Promoting excellence: standards for medical education and training: General Medical Council.

Gerarda Brown, J. (2012). Deeply Contacting the Inner World of Another: Practicing Empathy in Values-Based Negotiation Role Plays. *Washington University Journal of Law and Policy* 39, 189.

Genty, P. M. (2000). Clients don't take sabbaticals: The indispensable in-house clinic and the teaching of empathy. *Clinical Law Review*, 7(1), 273-286.

Gerdy, K. B. (2008). Clients, Empathy and Compassion: Introducing First-Year Students to the "Heart" of Lawyering. *Nebraska Law Review,* 87(1), 1.

Gleichgerrcht, E., & Decety, J. (2013). Empathy in clinical practice: how individual dispositions, gender, and experience moderate empathic concern, burnout, and emotional distress in physicians. *PloS one, 8*(4), e61526. Doi: 10.1371/journal.pone.0061526.

Gilligan, C. (1993). *In a Different Voice Psychological Theory and Women"s Development*. Cambridge, Massachusetts, Harvard University Press.

Gleichgerrcht, E., & Young L. (2013). Low Levels of Empathic Concern Predict Utilitarian Moral Judgment. *PloS one, 8*(4), e60418. Doi: 10.1371/journal.pone.0060418.

Goldfarb, P. (1990). A Theory-Practice Spiral: The Ethics of Feminism and Clinical Education. *Minnesota Law Review*, 75, 1599.

Halpern, J. (2001). *From Detached Concern to Empathy: Humanizing Medical Practice*. New York: Oxford University Press.

Halpern, J. (2003). What is clinical empathy? *Journal of General Internal Medicine, 18*(8), 670-674. Doi: 10.1046/j.1525-1497.2003.21017.x.

Henderson, L. N. (1987). Legality and Empathy. *Michigan Law Review,* 85(7), 1574.

Hodges, B., 2006. Medical education and the maintenance of incompetence. *Medical Teacher, 28*(8), 690-696.

Hoffman, M. L. (2000) *Empathy and Moral Development: Implications for Caring and Justice*, Cambridge, Cambridge University Press.

Hojat, M., Gonnella, J. S., Nasca, T. J., Mangione, S., Vergare, M., & Magee, M. (2002). Physician empathy: definition, components, measurement, and relationship to gender and specialty. American Journal of Psychiatry, 159(9), 1563-1569. *American Journal of Psychiatry, 159*(9), 1563-1569. Doi: 10.1176/appi.ajp.159.9.1563.

Howick, J., Moscrop, A., Mebius, A., Fanshawe, T.R., Lewith, G., Bishop, F.L., Mistiaen, P., Roberts, N.W., Dieninytė, E., Hu, X.Y. and Aveyard, P., 2018. Effects of empathic and positive communication in healthcare consultations: a systematic review and meta-analysis. *Journal of the Royal Society of Medicine, 111*(7), 240-252.

Howick, J., Steinkopf, L., Ulyte, A., Roberts, N. and Meissner, K., 2017. How empathic is your healthcare practitioner? A systematic review and meta-analysis of patient surveys. *BMC Medical Education, 17*(1), p.136.

James, C. (2005). Seeing Things as We Are. Emotional Intelligence and Clinical Legal Education. *Journal of Clinical Legal Education*, 8, 123-149.

Jeffrey, D. (2016a). Clarifying empathy: the first step to more humane clinical care. *British Journal General Practice, 66*(643), e143-e145.

Jeffrey, D., (2016b). Empathy, sympathy and compassion in healthcare: Is there a problem? Is there a difference? Does it matter? *Journal of the Royal Society of Medicine*, *109*(12), 446-452.

Johnson, S. L., Hritz, A. C., Royer, C. E. & Blume, J. H. (2016). When Empathy Bites Back: Cautionary Tales from Neuroscience for Capital Sentencing. *Fordham Law Review*, 85, 573-909.

Jones, E. (2018). Making Practice More Affective: Emotional Intelligence as a Legal Meta-Competency. European *Journal of Current Legal Issues,* 24(1). Retrieved from: http://webjcli.org/article/view/565/796.

Jeurgens, A. (2005). Practicing what we teach: The importance of emotion and community connection in law work and law teaching. *Clinical Law Review*, 11, 413-424.

Kim, S. S., Kaplowitz, S., & Johnston, M. V. (2004). The effects of physician empathy on patient satisfaction and compliance. *Evaluation & the health professions, 27*(3), 237-251. Doi: 10.1177/0163278704267037.

Kommalage, M. (2011). Using videos to introduce clinical material: Effects on empathy. *Medical Education, 45*(5), 514-515. Doi: 10.1111/j.1365-2923.2011.03951.x.

Krasner, M. S., Epstein, R. M., Beckman, H., Suchman, A. L., Chapman, B., Mooney, C. J., & Quill, T. E. (2009). Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. *JAMA, 302*(12), 1284-1293. Doi: 10.1001/jama.2009.1384.

Kwon, D. (2017). The limits of empathy. *The Psychologist,* 30, 28, https://thepsychologist.bps.org.uk/volume-30/january-2017/limits-empathy.

Legal Education and Training Review. (2013). Setting Standards: The future of legal services education and training regulation in England and Wales. Retrieved from: http://www.letr.org.uk/the-report/chapter-4/the-ingredients-of-legal-competence/index.html.

Levinson, W., Gorawara-Bhat, R., & Lamb, J. (2000). A study of patient clues and physician responses in primary care and surgical settings. *JAMA, 284*(8), 1021-1027. Doi: 10.1001/jama.284.8.1021.

Lim, B. T., Moriarty, H., & Huthwaite, M. (2011). "Being-in-role": A teaching innovation to enhance empathic communication skills in medical students. *Medical Teacher, 33*(12), e663-e669. Doi: 10.3109/0142159X.2011.611193.

McDonagh D, & Thomas J. (2010) Rethinking Design Thinking: Empathy Supporting Innovation. *Australasian Medical Journal, 3*(8), 458-464. Doi 10.4066/AMJ.2010.391

Margulies, P. (1999). Reframing Empathy in Clinical Legal Education. *Clinical Law Review, 5*(2), 605.

Markakis, K., Frankel, R., Beckman, H., & Suchman, A. (1999). *Teaching empathy: it can be done*. Working paper presented at the Annual Meeting of the Society of General Internal Medicine, San Francisco, Calif, April 29–May 1, 1999.

Massaro, T. M. (1989). Empathy, Legal Story Telling, and the Rule of Law: New words, old wounds? *Michigan Law Review*, 27, 2099-2127.

Melville, A. & Laing, K. (2007). 'I just drifted into it': constraints faced by publicly funded family lawyers. *International Journal of the Legal Profession*, 14(3), 281-300.

Mercer, S. W., & Reynolds, W. J. (2002). Empathy and quality of care. *British Journal of General Practice, 52*((Suppl)), S9-13.

Michalec, B. (2010). An assessment of medical school stressors on preclinical students' levels of clinical empathy. *Current Psychology, 29*(3), 210-221. Doi: 10.1007/s12144-010-9081-y.

Neumann, M., Edelhäuser, F., Tauschel, D., Fischer, M. R., Wirtz, M., Woopen, C., Scheffer, C. (2011). Empathy decline and its reasons: a systematic review of studies with medical students and residents. *Academic Medicine, 86*(8), 996-1009.

Newton, B. W., Barber, L., Clardy, J., Cleveland, E., & O'Sullivan, P. (2008). Is there hardening of the heart during medical school? *Academic Medicine, 83*(3), 244-249.

Norfolk, T., Birdi, K., & Walsh, D. (2007). The role of empathy in establishing rapport in the consultation: A new model. *Medical Education, 41*(7), 690-697. Doi: 10.1111/j.1365-2923.2007.02789.x.

Northwestern Now. (2006). Obama to Graduates: Cultivate Empathy. Retrieved from: https://www.northwestern.edu/newscenter/stories/2006/06/barack.html

Nunes, P., Williams, S., Sa, B., & Stevenson, K. (2011). A study of empathy decline in students from five health disciplines during their first year of training. *International Journal of Medical Education 2,* 12-17 doi: 10.5116/ijme.4d47.ddb0.

Parker, K. W., Dipietro Mager, N. A., Aronson, B. D. and Hart, C. (2018). Using a mock board of pharmacy disciplinary hearing to teach concepts related to administrative law, addiction, empathy, and professionalism. *Currents in Pharmacy Teaching and Learning*, 10(11), 1512-1517

Parkin, T., de Looy, A. & Farrand, P. (2014). Greater professional empathy leads to higher agreement about decisions made in the consultation. *Patient Education & Counselling, 96*(2), 144-150. Doi: 10.1016/j.pec.2014.04.019.

Nussbaum, M. (2006). Reply to Amnon Reichman. *Journal of Legal Education*, 56(2), 320-329.

O'Carroll, S. (2006). Empathy, Courage and Diligence: Three Things I Wish I'd Learned in My Law School Ethics Course. *The Professional Lawyer*, 17(1) 24-29.

Pedersen, R. (2009). Empirical research on empathy in medicine—A critical review. *Patient Education and Counseling, 76*(3), 307-322. Doi: 10.1016/j.pec.2009.06.012.

Preusche, I. and Lamm, C., 2016. Reflections on empathy in medical education: What can we learn from social neurosciences? Advances in health sciences education, 21(1), 235-249. Doi: 10.1007/s10459-015-9581-5.

Prinz, J. (2011). Against Empathy. *The Southern Journal of Philosophy Spindel Supplement*, 49, 214-233.

Riess, H., Kelley, J. M., Bailey, R. W., Dunn, E. J., & Phillips, M. (2012). Empathy training for resident physicians: a randomized controlled trial of a neuroscience-informed curriculum. *Journal of General Internal Medicine, 27*(10), 1280-1286.

Rosenberg, J. D. (2002). Teaching Empathy in Law School. *University of San   Francisco Law Review*, 36, 621-657.

Rosenthal, S., Howard, B., Schlussel, Y. R., Herrigel, D., Gabriel Smolarz, B., Gable, B. Kaufman, M. (2011). Humanism at heart: Preserving empathy in third-year medical students. *Academic Medicine, 86*(3), 350-358. Doi: 10.1097/ACM.0b013e318209897f

Saleh, D., Camart, N., & Romo, L. (2017). Predictors of stress in college students. *Frontiers in Psychology, 8*(19). Doi: 10.3389/fpsyg.2017.00019

Samra, R. (2018). Empathy and Burnout in Medicine—Acknowledging Risks and Opportunities. *Journal of General Internal Medicine, 33*(991). Doi: 10.1007/s11606-018-4443-5

Samra, R. (2019). Gender-responsive education and training approaches to improving physician well-being. *Medical Education, 53*(3), 216-219.

Samra, R., Griffiths, A., Cox, T., Conroy, S., & Knight, A. (2013). Changes in medical student and doctor attitudes toward older adults after an intervention: a systematic review. *Journal of the American Geriatrics Society, 61*(7), 1188-1196. Doi: 10.1111/jgs.12312

Schweller, M., Costa, F. O., Antônio, M. Â. R., Amaral, E. M., & de Carvalho-Filho, M. A. (2014). The impact of simulated medical consultations on the empathy levels of students at one medical school. *Academic Medicine, 89*(4), 632-637. Doi: 10.1097/ACM.0000000000000175.

Shanafelt, T. D., West, C., Zhao, X., Novotny, P., Kolars, J., Habermann, T., & Sloan, J. (2005). Relationship between increased personal well-being and enhanced empathy among. *Journal of General Internal Medicine, 20*(7), 559-564. Doi: 10.1007/s11606-005-0102-8

Shapiro, J., Rucker, L., Boker, J., & Lie, D. (2006). Point-of-view writing: a method for increasing medical students' empathy, identification and expression of emotion, and insight. *Education for Health, 19*(1), 96-105. Doi: 10.1080/13576280500534776.

Shapiro, S. M., Lancee, W. J., & Richards-Bentley, C. M. (2009). Evaluation of a communication skills program for first-year medical students at the University of Toronto. *BMC Medical Education, 9*(1), 11. Doi: 10.1186/1472-6920-9-11.

Sommerlad, H. (2016). "A pit to put women in": professionalism, work intensification, sexualisation and work–life balance in the legal profession in England and Wales. *International Journal of the Legal Profession*, 23(1), 61-82.

Spivak, B., Batagol, B. Sifris, A. & Williams, B. (2018). Measuring empathy in undergraduate law students: Examining the factorial validity of the Jefferson Scale of Empathy – Law Students (JSE-LS). *International Journal of Law and Psychiatry*, 58, 143-149.

Strauss, C. (2004). Is empathy gendered and, if so, why? An approach from feminist psychological anthropology. *Ethos, 32*(4), 432-457. Doi: 10.1525/eth.2004.32.4.432

Tiuraniemi, J., Läärä, R., Kyrö, T., & Lindeman, S. (2011). Medical and psychology students' self-assessed communication skills: A pilot study. *Patient Education and Counseling, 83*(2), 152-157. Doi: 10.1016/j.pec.2010.05.013.

Towness O"Brien, M., Tang, S. and Hall, K. (2011). Changing our Thinking: Empirical Research on Law Student Wellbeing, Thinking Styles and the Law Curriculum. *Legal Education Review*, 21(1 & 2),149-182.

Tuning Project (Medicine) Steering Group and Task Force (2008). *Learning Outcomes/ Competences for Undergraduate Medical Education in Europe.* Edinburgh: Tuning Project (Medicine) Steering Group and Task Force.

Tweedie, J., Hordern, J., & Dacre, J. (2018). Advancing medical professionalism. London: Royal College of Physicians. Retrieved from: https://www.rcplondon.ac.uk/projects/outputs/advancing-medical-professionalism.

Van Winkle, L. J., Fjortoft, N., & Hojat, M. (2012). Impact of a workshop about aging on the empathy scores of pharmacy and medical students. *American Journal of Pharmaceutical Education, 76*(1), 9. Doi: 10.5688/ajpe7619

Varkey, P., Chutka, D. S., & Lesnick, T. G. (2006). The aging game: improving medical students' attitudes toward caring for the elderly. *Journal of the American Medical Directors Association, 7*(4), 224-229. Doi: 10.1016/j.jamda.2005.07.009.

Von Fragstein, M., Silverman, J., Cushing, A., Quilligan, S., Salisbury, H., Wiskin, C. and UK Council for Clinical Communication Skills Teaching in Undergraduate Medical Education, 2008. UK consensus statement on the content of communication curricula in undergraduate medical education. *Medical Education, 42*(11), pp.1100-1107.

Walkden-Brown, J. and Stevenson-Graf, L. (2018). Preparing for Practice: Clinical Legal Education Through the Lens of Legal Education Discourse. *Australian Journal of Clinical Education*, 3(1). Retrieved from: https://ajce.scholasticahq.com/article/6340-preparing-for-practice-clinical-legal-education-through-the-lens-of-legal-education-discourse

Warmington, S. (2012). Practising engagement: Infusing communication with empathy and compassion in medical students' clinical encounters. *Health, 16*(3), pp.327-342.

Westaby, C. & Jones, E. (2017). Empathy: an essential element of legal practice or 'never the twain shall meet'? *International Journal of the Legal Profession*, 25(1), 107-124.

Westaby, C. (2014). A Qualitative Study of the Impact of Law Clinics on Students' Perceptions of Emotional labour Expectations. *The Law Teacher*, 48(3), 248-280.

Westaby, C. (2010) "Feeling like a sponge": The emotional labour produced by solicitors in their interactions with clients seeking asylum. *International Journal of the Legal Profession*, 17(2), 153-174.

Williams, B., Sifris, A. and Lynch, M. (2016). A psychometric appraisal of the Jefferson Scale of Empathy using law students. Psy*chology Research and Behavior Management*, 9, 171-178.

Wilson, S. E., Prescott, J. & Becket, G. (2012). Empathy levels in first- and third-year students in health and non-health disciplines. *American Journal of Pharmaceutical Education*, 76(2). doi: 10.5688/ajpe76224.

Wizner, S. (2001). The Law School Clinic: Legal Education in the Interests of Justice. *Fordham Law Review,* 70, 1929-1937.

Yoder, K. J., & Decety, J. (2018). The neuroscience of morality and social decision-making. *Psychology, Crime & Law, 24*(3), 279-295.