# Empathy in Action

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How can pediatric clinicians best display empathy and support parents who are confronting the death of a child? Over the past 2 decades, as pediatric palliative care has become established as an essential element in the care of children with serious life-threatening illness,[1] this question has moved out from the shadows and into high-quality mainstream clinical practice.

This large question can be broken down into 2 issues: first, determining what accurate or effective answers are, and then how to teach these answers. What we know on these fronts is worth surveying briefly. The broader area of empathy or compassion training for medical trainees and physicians has found that these individuals can learn specific behaviors (such as sitting down when talking to patients or offering supportive verbal statements) that improve ratings of their degree of empathy or compassion.[2] More narrowly, regarding how to talk with patients with serious illness, the VitalTalk curriculum, typically delivered as a multisession program, has been shown to enhance the communication skills and increase the frequency of empathetic behaviors of participants.[3,4] And even more specifically, regarding how a clinician should communicate and behave when providing care to a dying child, educators have developed an interdisciplinary simulation for trainees and clinical staff to learn ways to appropriately and compassionately manage such situations.[5] However, in terms of improving how patients or parents perceive clinicians' intentions and behaviors, doubt exists as to whether these educational efforts actually work because studies are either lacking, limited, or negative.[2,6]

Not only is the literature insufficient to know what works, we clinicians also need to be wary of assuming that our self-assessment of how well we express empathy correlates with how patients (or parents) perceive us, because it does not correlate.[7] And the notion that if we employ the skill of "perspective taking" and take someone else's perspective we will be able to figure out what they want is also not backed up by evidence; it is far better to ask what someone wants than to try to guess.[8]

Enter the simulation study by Lizotte et al,[9] published in this issue of the journal. Let me highlight key elements of the study's methods and findings. The study put 31 active participants, including residents, fellows, neonatologists, advance practice nurses, and neonatal transport staff, in the proverbial hot seat of having to manage the simulation situation, specifically, per the specifications of the simulation, preparing for and running the resuscitation of a newborn infant who dies. Everything the active participants did during the simulation was recorded, analyzed, and evaluated by 21 evaluator participants, which again included doctors and nurses but also a social worker, psychologist, respiratory therapist, and 6 bereaved parents (4 mothers and 2 fathers).

On the basis of the evaluators' ratings of and comments about how the active participant managed the situation, the research team identified specific behaviors that were highly esteemed, and participants who enacted more of these behaviors were more likely to be

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rated as top-notch communicators who were honest, compassionate, and empathetic. I might divide the behaviors into 2 groups. Taking some liberty in how I describe them, the first set of behaviors I would label as "Calm Kind Politeness," which included acknowledging the presence of the parents in the room, introducing themselves, sitting down, asking about and then using the infant's name, permitting silence, and remaining calm.

The second group of behaviors I might term "Skillful Situational Leadership," which included preparing the parents for the resuscitation activities, providing verbal milestone markers as the resuscitation went on that prepared the parents for the unsuccessful fatal outcome, stopping the resuscitation without asking the parents for permission, speaking plainly and avoiding euphemisms when telling the parents that the infant has died, providing the parents with physical closeness to both their infant and the doctor, making clear declarative statements that the parents were in no way to blame for the infant's death, and providing knowledgeable guidance about what will happen next now that the infant had died.

Importantly, the parent evaluators essentially singled out the same behaviors as the other evaluators did as being critical components in the repertoire of an outstanding clinical communicator. Equally important, they did not rate highly certain formulaic expressions, such as "allowing natural death," that have been recommended. This finding emphasizes the importance of performing controlled experiments to determine what behavior and language works.

Overall, this study, in terms of design and methodologic rigor, is a great advance toward answering our key question: how to best support parents in such circumstances. Similar studies will need to be done in other settings to determine broadly generalizable findings, and the resulting findings will need to be taught or trained in a way that durably improves clinicians' behavior and overall performance. In this regard, the highest-rated communicators in this study gave us a major clue about how to proceed when they said that they "just did what they usually do." Habits are paramount. Picking up on a metaphor offered by the authors of the study, training and repetitive drills on these specific behaviors cannot be emphasized enough because they are not only the skeleton of excellent communication; they are likely also the muscles, the heart, and even the soul.

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