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Reflection

Bed 18 and a Chair by the Bedside: Rethinking Empathy Beyond Scores

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Introduction

A Question Beyond Clinical Care

The ward was quite loud, following a hectic emergency call, one marked by clinical deterioration, urgent decisions, and conversations left incomplete.

"Bed 18," the resident began during rounds, scanning his notes. "Sixty-year-old male. Long-standing diabetes. Chronic kidney disease. Admitted with sepsis. Not improving." We approached the bedside. The patient lay frail and motionless, his breathing shallow. Beside him stood his son, his face marked by exhaustion and quiet anxiety. "Any change?" I asked. "Vitals unstable. Antibiotics escalated. Nephrology reviewed," the resident replied efficiently. It was a precise summary; everything clinically relevant had been said. We turned to move on. "Doctor…" The son's voice stopped us. "Is he in pain?" It was a simple question, yet it carried a depth that extended far beyond clinical parameters. I paused briefly and replied, "We are doing our best to keep him comfortable." He nodded, but his gaze lingered, searching for something more than reassurance. As we walked away, I felt a familiar unease. Not quite guilt, but an awareness that something essential had been missed. We had addressed the disease, but perhaps not the experience of illness

Teaching Empathy: The Workshop Experience

That same week, I stood in a seminar room facilitating an empathy training workshop for internal medicine residents, an essential component of my MHPE degree thesis. The setting contrasted sharply with the ward: structured, calm, and conducive to reflection. The residents completed the assessment before the session. Through role plays, patient narratives, and guided discussions, we explored empathy not merely as an emotion but as a clinical skill, one that involves understanding the patient's perspective and communicating that understanding effectively. The engagement was encouraging. Residents reflected openly on their experiences, acknowledging moments where communication had fallen short. There was a palpable shift in awareness. When the post-workshop scores were analysed, the results were promising. Empathy scores showed a significant increase. It felt, at least momentarily, like success.

When Scores Decline: A Harder Truth

Three months later, the follow-up data revealed a different narrative. Empathy scores had declined. The reduction was dramatic. The initial gains observed immediately after the workshop had not been sustained over time. This prompted an important question: Had the intervention failed, or had it exposed a deeper systemic issue? The answer became clearer when viewed through the lens of daily clinical practice.

The Reality of the Ward

In the busy environment of a public sector hospital, residents navigate an overwhelming workload. Patient volumes are high, time is limited, and clinical responsibilities are relentless. Empathy, though valued, often competes with efficiency. A resident who participated in the workshop articulated this tension candidly: "Ma'am, the session was very helpful. But in the ward, it's difficult. If I stop and talk to every patient, I fall behind." This statement reflects a critical reality: empathy is not merely an individual attribute. It is shaped by the

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environment in which clinicians work. In systems where speed and task completion are prioritized, empathetic engagement becomes challenging to sustain.

The Hidden Curriculum

Beyond formal teaching, the hidden curriculum plays a significant role in shaping professional behaviour. Residents learn by observing their seniors how they communicate, prioritize tasks, and respond to patients' emotional needs. If efficiency consistently outweighs engagement, and if emotional expression is subtly discouraged, empathy may gradually diminish, not due to lack of intent, but due to adaptation. In such contexts, a single workshop, no matter how well designed, cannot counterbalance the powerful influence of daily clinical practice.

A Moment of Change

This realization prompted me to reflect on my own practice. In the workshop, I had emphasized the importance of listening and presence. Yet in the ward, I often found myself constrained by the same pressures as my trainees. One day, during rounds, I encountered a patient on same bed with advanced liver disease. As the resident presented the case, I noticed the patient observing us closely. Instead of moving on immediately, I paused. "How are you feeling today?" I asked. "Thak gaya hoon," he replied softly, I am tired. I pulled a chair closer and sat down. For a few minutes, we spoke about his fatigue, his concerns, and his family. The interaction was brief, perhaps no more than a few minutes, yet it shifted the tone of the encounter. Later, a resident remarked, "When you sat down with the patient, it changed everything." This moment reinforced a simple yet powerful insight: empathy does not always require extensive time; it requires intention.

Empathy and the Limits of Measurement

Empathy is dynamic, context-dependent, and deeply relational. A high score may reflect awareness and attitudes, but it does not guarantee consistent application in complex clinical environments. The decline in empathy scores at three months highlights this gap between knowledge and practice. It suggests that empathy, when taught in isolation, may not endure in the absence of reinforcement.

A Missing Element in Postgraduate Training

One of the most striking observations from this experience is the absence of structured empathy training within postgraduate medical curricula. While clinical competence is rigorously taught and assessed, empathy often remains implicit, expected, but not explicitly developed. There are limited opportunities for residents to practice empathetic communication in a structured manner, receive feedback, or engage in reflective learning. As a result, empathy is vulnerable to erosion under the pressures of clinical training.

Towards Sustainable Empathy

The findings from this experience point towards the need for a more integrated approach. Empathy should not be confined to isolated workshops. Instead, it must be embedded within the curriculum and reinforced through clinical practice. This could include longitudinal training, incorporation into workplace-based assessments, and structured opportunities for reflection. Equally important is faculty development, as educators play a crucial role in modelling empathetic behaviour. Creating supportive clinical environments, where even brief moments of connection are valued, can help sustain empathy over time.

Conclusion: Beyond Scores

The patient in Bed 18 passed away a few days later. While the clinical outcome may not have changed, the encounter left a lasting impression. In an era increasingly defined by metrics, it is tempting to equate empathy with measurable outcomes. Yet, empathy resides in moments, in pauses, in listening, and in presence. Scores may rise and fall, as they did in this study. But the need for empathy remains constant. As clinicians and educators, our responsibility extends beyond teaching empathy as a concept. We must create systems and cultures where it can be practiced, sustained, and valued. Because ultimately, while medicine treats disease, it is empathy that shapes the experience of care.