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Linus Vanlaere, Madeleine Timmermann, Marleen Stevens and Chris Gastmans

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What is This?

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

Linus Vanlaere
sTimul: care-ethics lab, Belgium
Catholic University of Leuven, Belgium

Madeleine Timmermann
sTimul: care-ethics lab, Belgium

Marleen Stevens
sTimul: care-ethics lab, Belgium

Chris Gastmans
Catholic University of Leuven, Belgium

Abstract

In recent approaches to ethics, the personal involvement of health care providers and their empathy are perceived as important elements of an overall ethical ability. Experiential working methods are used in ethics education to foster, inter alia, empathy. In 2008, the care-ethics lab 'sTimul' was founded in Flanders, Belgium, to provide training that focuses on improving care providers' ethical abilities through experiential working simulations. The curriculum of sTimul focuses on empathy sessions, aimed at care providers' empathic skills. The present study provides better insight into how experiential learning specifically targets the empathic abilities of care providers. Providing contrasting experiences that affect the care providers' self-reflection seems a crucial element in this study. Further research is needed to provide more insight into how empathy leads to long-term changes in behaviour.

Introduction

Bioethics has undergone spectacular growth over the last few decades.[1,2] The scope of bioethics has broadened from being a strictly medical field to including the entire healthcare sector, including nursing.[3] This evolution of scope has proceeded in parallel with some substantive methodological changes. Recent examples of how ethics is applied to the healthcare sector differ from initial approaches in bioethics, as they

Corresponding author: Linus Vanlaere, sTimul: care-ethics lab, Sint-Maartensplein 13, 8560 Moorsele, Belgium
Email: Linus.Vanlaere@med.kuleuven.be

are now more firmly rooted in the practice of care itself.[4] Care ethics is an example of such a recent development in the field of ethics. Instead of trying to improve the ethical quality of care practices on the basis of an external framework of normative values and principles to be applied to these practices, care ethics focuses on unearthing the value-based vision underlying all of these care practices. The perspective of 'good care' thus shown in specific situations is not provided solely on the basis of moral theories, but is also the result of analysing the context in which the situation presents itself and the beliefs and experiences of the persons involved.[4] Care ethics departs from the idea that care providers rely on their 'moral intuition' to guide their actions, i.e. a pre-reflexive concept of what is good, which underlies and is shaped by their care practices.[5] By entering into a dialogue with care providers, care providers become exposed to these value-based concepts, which are then linked to moral theory.

In recent approaches to ethics, it is no longer only the ethicist who creates processes to improve the ethical quality of care practices.[4] For example, what is considered to be 'good care' from a care ethical point of view is the outcome of a reflection process, which takes place as a result of and through a dialogue with all actors involved.[6] The ethicist's task is to initiate and foster this process; for example, by adding theoretical insights into the process of reflection.[4] Care providers are expected to be able to reflect on the ethical aspects of their own practices, which means that they need to be able to determine what is morally relevant in a given situation, to phrase their own perspective on what is 'good', and to converse with others about this issue.[6] From a care ethical perspective, exploring the personal involvement and motivation of the care provider is also considered to be an important element of good care, which, consequently, is included in the ethical reflections and dialogue.[7] Involvement also always requires empathy.[8] Thus, care providers must, for example, be able to change their perspectives and ask themselves: How does the patient view the world?

When care providers' ethical reflection and ability to integrate their personal involvement and empathy into their overall ethical ability happen, their education on ethics needs to include more than just moral theory. According to recent approaches to bioethics, it is better to link ethical learning processes to the specific experiences of care providers.[4] For example, care ethicists believe that care providers learn ethical reflection 'by doing', not only by acquiring theoretical knowledge. Ethical reflection is a contextual and experiential learning process. Also when considering empathy as part of ethical ability, experiential working methods are used in ethics education to foster, inter alia, the moral power of imagination of care providers.

In 2008, the care-ethics lab sTimul was founded in Flanders, Belgium, to provide training that focuses on improving care providers' ethical abilities through experiential working simulations. The curriculum of sTimul focuses on empathy sessions, aimed at care providers' empathic skills. An empathy session consists of a two-day and one-night session in which eight care providers receive simulated care as patients.[9] They take on the profile of an elderly patient in need of care, and they receive care from undergraduate nurses who act as care providers during the empathy session (bathing, feeding, caring, recreation, etc.). The afternoon of the second day is dedicated to discussing and reflecting on what the care providers, in their capacity as elderly patients, and their simulated care providers experienced during the empathy session.

Because the participants to the empathy session are students or experienced care providers, the session is two-dimensional. First, the experienced care providers have the opportunity to play the part of an older resident according to a specific resident profile in a simulation exercise. These care providers are all working in residential care settings for older people. They are registered nurses or allied with health and social work professionals. Second, a group of nursing students are given full autonomy in planning and carrying out the care process for the simulation residents. These groups are always students from the same school and the same degree course. For both groups, students and care providers, participation in the empathy session is not obligatory, but is voluntary. Participation to the empathy session is the result of a meeting in the respective school or care institution where the objectives of the care-ethics lab, the course and the goals of the empathy session are explained. Participants are selected at random from the persons who say 'yes' to the question 'Who wants to participate in an empathy session?'.

The care providers who take part in the empathy session as a simulated patient have the opportunity to adjust their 'care profile' as simulated patient at least two weeks before the two-day empathy session. This adjustment concerns their own limits and preferences. They decide which care actions are to be applied: hygienic care, general daily support, use of incontinence pads, possible application of physical restraint, meal provision and support, entertainment, administration of medication and so on. By having the opportunity to adjust their profile, the simulated patients themselves determine to what extent they wish to engage in the simulation exercise. They regulate themselves on 'how far to go'; they are actually bathed or treated as incontinent only if they want to experience this. This 'respect for autonomy' guarantees that the simulation exercise will not break into anyone's intimate privacy.

In present research, we focused on the following question: What does experiential learning about ethics bring about in care providers who take on the role of elderly patients? More specifically, what impact does participation in the empathy session in a care-ethics lab have on the empathic ability of the simulated patients?

Background

In a recent overview article, Williams and Stickley demonstrated that much confusion and debate exist about the concept of 'empathy' in nursing.[10] Empathy in nursing is generally considered to be an interactive and dynamic process in which care providers develop feeling for and generate insight into what is at stake for the patient, which is then reflected in their actions. In this way, empathy includes an affective dimension: the care provider is affectively moved by what is going on with the patient and is internally motivated to understand the patient. However, empathy is also about gaining insight into the patient's perspective and his frame of reference. This implies that a nurse suspends his or her own perspective; this is called the cognitive dimension. Empathy also includes a behavioural dimension: the care provider uses skills to communicate to the patient that he is being understood. This should not be limited to only behavioural skills – such as listening and verbal skills. According to Carl Rogers, the literature often speaks of an 'attitude' that the nurse adopts within the care relationship.[10] Empathy is thus seen as a fundamental part of the nurse's care relationship.

In nursing literature, there is a consensus, therefore, about the importance of focusing on empathic ability during training. There is also discussion about how best to do this. For example, empathy training is often taught as part of listening and answering skills. However, this approach is rejected in other training programmes, as the focus on skills is deemed to be too restrictive, hampering the integrity of empathy. Recently, a growing trend is emerging in the literature that associates empathy with emotional intelligence with respect to training nurses. Although this type of intelligence may be innate, it can be stimulated by events and experiences. Consequently, training programmes focusing on empathy include experiential methods.

A recent article by Brunero et al. provides an overview of 17 training programmes in which research measured the effectiveness of empathy levels in postgraduate and or undergraduate nurses.[11] Research designs were either qualitative or quantitative. The length of the programmes differed. Two programmes for undergraduate nurses lasted throughout the entire nurse-training programme. The programmes for postgraduate nurses were usually short; the longest educational programme in this category lasted slightly more than 100 hours, whereas the shortest lasted six hours (i.e. a six-hour writing assignment). Almost all training programmes included a form of experiential learning, often involving role play, simulation exercises, re-enacting specific cases, or mixed exercises. Only three programmes did not use an experiential method. Short-running training programmes focusing on empathy appeared to achieve the most significant results. In total, 11 studies examining the effect of training programmes showed that the empathic ability of undergraduate and postgraduate nurses significantly increased. Thus, the overview article concluded that it is possible for the empathic skills of both undergraduate and postgraduate nurses to increase. However, benchmarking these effects is very difficult, as different measurement instruments were used. Also, different

types of training were implemented. Moreover, it was not always clear which aspects of empathy were focused on and for which aspects 'results' were achieved. It was also not clear which skills were specifically linked to 'empathic ability' and how training programmes taught these skills. Thus, current research should endeavour to provide better insight into empathy and how training programmes should focus on nurses' empathic abilities.

Research objective and method

The present study was set up to gain insight into the impact of empathy sessions on the empathic abilities of care providers who underwent an empathy session in the sTimul care-ethics lab as simulated patients. The present research focused not only on postgraduate nurses but also on a broad spectrum of healthcare providers active in elderly care (residential or acute).

Design

To present a rich and in-depth view of the impact of sTimul empathy sessions on the empathic abilities of caregivers, we chose a descriptive qualitative research design based on a constant comparison approach.

Procedure and sampling

Empathy sessions took place between 1 January 2009 and 1 August 2009. During this period of time, 80 care providers participated in the empathy sessions. At the end of every empathy session, we informed all participating care providers about our research objectives and invited them to participate in the present study. Out of these groups of volunteers, the selection was made after every empathy session. For the selection of the research sample, the following inclusion criteria were used: (a) being Dutch-speaking; (b) having experienced an empathy session as a simulated patient; and (c) willing to participate in an interview about their experience. Fifteen care providers were at random selected for interview out of the groups of volunteers, with the aim of obtaining a sample with diverse personal characteristics and experiences. The sample included 14 women and one man, with an age range spanning 42 years. Seven participants had a Registered Nurse degree, four worked as cleaning or logistics assistants, three were healthcare assistants, and one had a bachelor degree in kinesistherapy. Twelve participants were from nursing homes, three were from an educational institution.

Data collection

Data were collected in two phases. In the first phase (January–May 2009), 15 one-on-one semi-structured interviews were conducted with each participant. The interviews lasted between 45 and 90 minutes. The participants determined the place, date, and time for the interview. Seven interviews took place in the care-ethics lab itself, immediately after the empathy session. The other interviews took place one to six days after the empathy session.

In the second phase, seven of the 15 participants were re-interviewed 13 to 29 weeks after the initial interview. The goal of this phase was to enlarge and refine the results obtained from the first phase. More specifically, we wanted to get a better view of the impact of time and external context on the participants' experiences.

The data were collected systematically via semi-structured, narrative interviews by one researcher (LS) (see Table 1). During the interview, the participants were invited to speak freely about their experiences as a simulated patient. By asking further questions, the researcher tried to get a reliable impression of the exact circumstances of the participant's experiences. The interviews were audio taped and transcribed verbatim.

Table 1. Procedure of data collection

- Individual interview.
- Interview within one week after the empathy session.
- Interview is audio taped and transcribed verbatim.
- Respondent is asked for his first and spontaneous reaction on the empathy session and is invited to tell about impressing specific experiences during the session.
- By further questioning, the researcher tries to discover the experiences of the respondent and to find out the specific meaning of these experiences.

Data analysis

A second researcher (MT) analysed the data systematically using thematic analysis. Interviews were reread several times for verification of the substantive reflections. In addition, already-formulated reflections were tested and refined continuously in light of the newly collected data. Through systematic reading, examination, and re-examination of the interview transcripts, the researcher identified themes and patterns in the stories of the participants. The themes were compared and checked for similarities, differences, and connections.

To gain a clear idea of the analytical process, we coded the transcripts manually by using 'cut and paste' techniques and coloured pens to categorize the data. Data analysis was characterized by an interactive team process in which all authors discussed the preliminary results.

After explorative analysis, we found that the data could be considered in terms of responses to three main questions: (a) What exactly has affected them deeply? (b) What did they learn? (c) What has motivated them to act differently? The main analysis of the data was conducted using these three questions.

The first question was intended to map the experiences that affected the participants the most. After making an inventory of the experiences, we found that we could categorize the experiences by using an instrument for mapping relational matching in nursing homes for people with dementia (see Table 2).[12] On the basis of this instrument, we mapped the experiences of the participants into three categories: pain ('Ouch!' category), coldness ('Brr!' category), and helpless ('Help!' category). Each category can be considered both literally and metaphorically.

The second question tried to capture what the participants learned from their experiences. With this question, we tried to observe the precise link between the participants' experiences and their own care practices and views on care. The answers were classified as 'considerations' to act differently, as 'intentions' to act differently, or as 'other behaviour'. The latter category refers to what some participants verbalized as 'changed behaviour' in the second interview. The first two categories refer to how participants viewed, reframed/framed, or planned care practices differently after they took part in the empathy session.

The third question determined what motivated the participants to change their care practices. The interviews provided an overview of what the participants thought motivated them to change their care practices and what they thought hindered them from changing their practices.

Ethical considerations

Informed consent was carried out with care and concern. All participants received verbal and written information about the research. Participation was voluntary. The anonymity of the participants was carefully maintained, and we treated all data confidentially. Ethical approval was provided by an independent ad hoc ethics committee.

Trustworthiness

Trustworthiness was ensured by meticulous maintenance of an audit trail, comprising an overview of the research process and the decisions made (memos, reports of research team meetings, field notes such as

Table 2. Instrument for mapping relational matching in nursing homes for people with dementia (Timmermann, 2004)[12]

Code pain ('Ouch'-category)
Physical pain
– caused by certain physical moves or actions
– roughness of touching (also as a result of the use of rough material in the care)
– bluntness or unexpectedness of the move or action
Pain in a metaphorical sense
– loss of the familiar environment
– loss of a beloved one
– loss of independence
– being ignored as an autonomous subject
– left alone with pain that no one seems to notice
Code coldness ('Brr!'-category)
Physical coldness
– unpleasant sensation of coldness
– unexpectedness of the sensation of coldness
– being displeased with the removal of safe covering
Coldness of environment
– sense of shame and of slenderness by being uncovered
– literally not being heard
– complaints not taken seriously
Code helpless ('Help!'-category)
Being unable to move
– not knowing anymore what to do or how to do it
– preferring to be left alone for a while
– crying for help to be liberated of caregivers who are forced upon you
Desolation
– not knowing where you are, what happens with you and of what is expected from you
– not knowing that you exist (except when people are busy with you)

descriptions of persons and interview locations, analysis schemes, etc.). To the greatest extent possible, previous knowledge and researchers' assumptions were identified and bracketed. Data triangulation was obtained by striving for sample heterogeneity (personal characteristics of participants). Frequent meetings within the research team were held to compare and modify the results and to achieve similarity in wording and in definition of the categories and concepts. A peer debriefing took place in which a multidisciplinary team of independent experts read the raw data and assessed the analysis we had already performed.

Findings

The results of this study demonstrate that, during the empathy session, all participants underwent at least one experience that really affected them. Many participants were encouraged to reflect on their own views on care and their own care practice. A limited number of participants provided examples of what they actually started to do differently in their jobs as a result of their learning experience during the empathy session. They mentioned factors that fostered or hampered the conversion of experience into thought and action.

What affected them?

After analysing all of the interviews, we found that many of the relevant experiences were related to feeling pain and cold, that is, physically feeling pain and being uncomfortable due to feeling cold. This physical discomfort was an unpleasant sensation that affected their overall experience in the empathy session. The participants' physical pain usually resulted from being forced to sit in an uncomfortable position or in a certain position in a wheelchair for a long time.

Almost all participants suffered pain in a metaphorical sense as a result of losing their independence. Indeed, they depended on others for performing tasks that they used to perform. Pain also resulted when help was missing, lacking, or unpleasantly different from what they were accustomed. Experiences associated with daily nursing tasks such as bathing, going to the toilet, eating, and drinking left a great impression. Some participants found it difficult to expose themselves to and allow themselves to be bathed by strangers. Various participants mentioned that it was painful to be unable to go to the toilet by yourself when you feel the need. Participants were forced to ask for assistance and to wait to see whether it would be provided quickly. The inability to feed oneself was experienced as a painful loss of independence. Sometimes when one is fed by someone else, the food is too hot, the spoonfuls are too big, the pace is too fast. Participants felt as if people were staring at them, and they were embarrassed to sit waiting to receive their food with their mouths open. The pain they felt due to loss of independence may be associated with a feeling of powerlessness and insecurity, as phrased by one of the participants:

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

Not knowing what was going to happen next was a painful and sometimes fearful sensation when receiving care; for instance, having your wheelchair pulled back without knowing who is pulling on your chair and why. The participant quoted above also experienced fear when she was placed in a hoist: 'You cannot describe what you are going through.' A number of participants mentioned the desire for peace and quiet, for instance, during meals. Incidentally, many of the participants mentioned mealtimes as events that gave their days structure. There appears to be a great need for structure, as days in the nursing ward seemed to go on interminably, mainly consisting of waiting:

> You are constantly waiting; you're waiting around because you depend on others. You have to ask for everything. They tell you: 'We will pick you up later.' But when is 'later'? You spend your time listening out for someone to walk by in the corridor and then you think they'll be coming in and then they don't, again . . . Waiting . . . basically waiting all the time. You're constantly waiting.

Several participants felt left out in the cold in a metaphorical sense, because they were not heard or considered to be a person who still matters. When being bathed, one simulated patient recounted that the caregiver's small talk did not go beyond the standard chat: 'I felt let down as a person', this woman testifies, 'as though I wasn't a person but an object to be washed.' The examples also demonstrated that people felt patronized if they were talked down to or if they did not want to be addressed by their first names. This negative feeling was also experienced when the recreational activities were too childish. In their roles as mute residents, numerous participants felt ignored, not receiving any attention: 'It's as if you don't count anymore.' Some experienced the same feeling when they were put to bed without being consulted beforehand.

What did they learn?

It is particularly the experiences of physical and mental misery that made many participants stop and think. They called these experiences eye-openers, which led to new insights into their view on care. This awareness exposed certain self-evident beliefs.

Participants also related to their own care practice the insights they gained from their experiences during the empathy session. Their thoughts and beliefs regarding certain care actions changed. They applied their own experiences to the situation of the residents in their own wards:

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

As a result of the physical aspects of misery, the participants endeavoured, for example, to focus more on patients' posture to lessen their pain. They were also more careful to cover patients during baths to prevent them from becoming cold:

> I always have at the back of my head what has [been] done to me. The negative experiences are also reflected on our residents. I will be extra careful when covering them during washing times. I will use a towel to cover them . . . It feels so cold lying there. I only had to undergo it once, but imagine lying there every day . . .

Experiencing physical misery was apparently also a driving factor that motivated the participants to reflect on their own practices. One participant was surprised that the care provider left her during her bath, which she sometimes does when bathing her patients. Until this happened to her, she did not realize how being left alone in the middle of a bath can make a dependent person so miserable. After experiencing how mute people are often ignored, one participant furnished a different interpretation to something that occurred in her ward involving her opinion about the daughter of a mute woman. She considered the daughter to be a nuisance because she was demanding so much of the care providers' attention for her mother. After the empathy session, however, this participant reassessed her opinion of the daughter and she reacted in a more understanding way.

Consciously reflecting on one's own experiences may reinforce existing insights as well. After the empathy session, one participant realized that she did not sense 'a personal touch' from the care provided. In her own care practice, she always tried to share something from her own life with her patients, who appreciated it. The empathy session strengthened her belief in doing so further.

Careful reflection about their experiences also enabled some participants to put their experiences into perspective. Two participants stressed that their experiences did not always reveal the whole truth about the other residents. For example, although one of these participants felt embarrassed being undressed while being bathed, another stated that it's something one gets used to over time. The other participant, who empathized with a blind resident, realized that it must be different for the resident she was simulating, because through the years blind individuals develop more acute senses of hearing, taste, and smell:

> You cannot always know what it really feels like for someone else. For example, in a situation that we felt to be impossible, the resident in question, to my surprise, pushed back her own boundaries again. She said that she wanted to get through this. Apparently she had a reason to continue living.

What moves them?

A number of participants were interviewed again three or more months after the empathy session. Some described examples about how they introduced minor changes into their own practice because of their

experiences during the sessions. One participant was so disgusted by the indescribable gruel that she was fed that she is now extra careful not to mix the various foods of a meal together, so that residents can at least distinguish between meat and vegetables. Another example stemmed from the annoying racket heard during mealtime. Another participant noted that her own ward was very noisy during mealtimes:

> I am more mindful of things that annoyed me, which I notice now. A group of colleagues, who also attended sTimul, sat around the table to discuss things we had all experienced and we want to work on. During mealtimes we want it to be quieter. For example, we have agreed to leave the meal cart outside of the dining hall. We first remove the lids and then roll it in, so we don't have to listen to the noise of lids being removed in the dining hall anymore. It does not take extra time, although you do think that during the first days because you have to really focus: 'I have to stop here, I have to remove the lids.'

Since the participants' negative experiences reflected those of the residents, these experiences may drive care providers to action: seeing more, understanding more, trying to solve more problems. Of the conditions imaginable to facilitate this process, participants mainly mentioned the importance of keeping the empathy session experience alive, for example, by having a debriefing with colleagues about the session. Sharing experiences helped to reinforce their experiences and helped them to develop and implement changes in their vision of care and practice.

During the interviews, factors that limited participants from improving their care practice also emerged. Specifically external factors, such as work-related pressures, were mentioned as threats that could erode the lessons gained from their experiences and subsequent intentions:

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

A number of participants also mentioned that the chief nurse plays a key role in keeping the lessons learned from the empathy sessions 'alive'. The participants felt that it is crucial for the chief nurse and other senior staff to attach a lot of importance to what happens during the empathy sessions and for them to integrate the purpose of these sessions into the ward's objectives. If this did not take place sufficiently, many participants found it difficult to integrate their experiences and insights from the empathy sessions into their actions in a lasting manner.

Discussion

Strengths and weaknesses

In the present study, we opted for a qualitative research design, because it allowed us to acquire in-depth insight into what care providers experience during empathy sessions. A weakness of the study was that the number of participants was limited to 15. Moreover, only seven of the 15 participants were re-interviewed at least three months after the sessions. Another weakness is that the interviews did not continue until saturation was reached; however, we are not sure if saturation could be reached anyway. New data may always offer new insights. Hence, this study should be considered as explorative research with a pragmatic approach.

The strength of this study is that two different researchers were used to collect and analyse data. One researcher (LS) conducted and transcribed the interviews, whereas a second, independent researcher (MT) performed the analysis. The other members of the research team (LV and CG) helped to ensure the reliability

of the results by regularly and closely monitoring the analyses and by discussing the research data. Another strength of this study is that it can improve healthcare practice and education.

Discussion of the findings

The overview of the literature presented earlier on the concept of empathy demonstrated that empathy always contains a component in which a person is affectively moved.[10] Empathic nurses are affectively moved by what is happening to another person.[10] The results of this study show that sTimul empathy sessions mainly touch upon this affective component of the empathic abilities of the care providers who took part in the sessions. Almost all participants stated that they were affectively moved by what they experienced. They described feelings of shame when being fed a meal, of outrage at being treated like children, of humiliation when they were ignored, of fear when they did not know what was happening, etc. It is exactly these feelings that brought them closer to their patients' daily lives, providing them with an affective – and therefore pre-reflexive – insight into what vulnerable patients go through.

A large part of the lasting impressions were physical in nature. More than half of the participants indicated that they experienced physical pain or misery. Williams and Stickley, who suggest that discovering empathy is a largely physical experience, confirm this finding.[10] Empathy is a physical sensation, which even precedes sensorial experiences; the body is aware of something even though one is not cognitively aware of what is being felt. Care providers who adopt the profile of patients are precisely affected in this physical sensitivity during the empathy session. By experiencing 'in the flesh' what it feels like to be at the receiving end of care and also by literally being touched, participants experience that an important component of empathy is stimulated during the empathy session.

A number of the participants' experiences were contrasting experiences. Theologian Edward Schillebeeckx described contrasting experiences as negative experiences that make the person who is befallen by them shout out: 'this has to end, because it cannot and must not go on like this'.[13] Typical for contrasting experiences is that people, as a result of what they experience, notice an extreme contrast 'in the flesh' between the unacceptable nature of what has befallen them and what would be acceptable under the circumstances.[14] This means that people undergoing a negative experience not only detect a lack of what should be there, but, consequently, also feel what would be right in that situation. As Schillebeeckx indicates, this is not a cognitive reflection about good or bad, but an insight gained at an affective level.[13] Some participants in this study demonstrated such insight as a result of an extreme contrast they experienced. For example, one respondent explained how she became convinced that care should be different from what she experienced. Another respondent more concretely stated how important personal involvement is to care, because she experienced what the lack of 'a personal touch' did to her. Yet another respondent indicated that she came to the realization of how unpleasant it is when care providers walk out on patients while they are being bathed. These examples illustrate that the participants' insight, which resulted from a negative experience, is related to a 'sensation' of what good care is about and not about.

The literature describes these latter types of knowledge as a more hidden and intuitive form of 'knowledge'.[15-17] The term *tacit knowledge* is generally used as a generic reference to the type of knowledge that is present in the minds and hands of the care providers, but is difficult to make explicit or conceptualize. It is exactly this type of knowledge that Schillebeeckx links to contrasting experiences, dubbing it a precursor to ethical actions. Contemporary approaches to healthcare ethics also attach great importance to this type of experiential knowledge about ethical actions.[4] As this knowledge is also an embodied type of knowledge, the body plays an important role in acquiring that knowledge.

It is clear to Schillebeeckx that contrasting experiences only lead to ethical *actions* when they result in reflection. The contrasting experience itself is only the beginning to actual reflection. A number of participants in this study demonstrated the type of reflection that results from a contrasting experience. For

example, since her negative bathing experience in the empathy session, one participant became more conscientious about bathing patients, continuously reflecting on her own actions. Another participant testified about how experiencing what it is like to be ignored as a mute patient caused her to reassess an earlier event involving a mute patient. The reflection noted in these participants is in fact self-reflection, that is, acquiring insight into one's own moral awareness. For example, due to their experiences in the empathy session, these participants expressed doubts or displeasure of their earlier behaviour. Even though this is not a reflection about theoretical concepts, realizing what is going on in one's own moral awareness is a type of reflection that is crucial for the moral development of care providers.[18,19] Moreover, such reflection is necessary for developing empathy: A better understanding of what moves one as a care provider makes one better aware of other people in different situations from one's own, allowing one to suspend one's own judgment. For example, two participants mentioned specifically how their empathy session experience made them realize that it is impossible to feel what another person is experiencing and that, in the end, the care provider's empathy is subjective. Paradoxically, this realization is important in developing empathy, which brings us to what was previously called the 'cognitive phase' of empathy. The cognitive phase firstly involves critical self-awareness.[10] Care providers can only show empathy when they have sufficient insight into their own frames of reference and the limitations of those frames of reference. This insight may lead one to suspend or distance oneself from his or her frames of reference.

A number of participants who were re-interviewed three or more months after their empathy session indicated that their experience not only sparked new insights but also changed their behaviour in practice. For example, the negative experience of tasteless meals caused one respondent to assess her role during mealtimes and to adjust her actions accordingly by not serving foods that were jumbled together. This contrasting experience led not only to greater insight into the patient's emotional world but apparently also acted as a driver that adjusted her behaviour accordingly. This driver, together with the behavioural adjustment itself, is the third component of empathy, which relates to the development of skills that show patients that they are understood. Without this specific behavioural phase, true empathy is not possible. Empathy is always about feeling, insight (into one's own perspective and, as a result of a suspension thereof, also into another person's perspective), and acting according to that insight.

Implications for further research

The present qualitative study provides better insight into how experiential learning specifically targets the empathic abilities of care providers. The rather artificial way of providing contrasting experiences that inherently affect the cognitive level of care providers is a crucial element in this study. However, further research is needed to provide more insight into how empathy leads to long-term changes in behaviour. This requires research into the exact role of ethical reflection on experiences. This study falls short in bringing to light the role played by ethical reflection, which took place during the second afternoon of the empathy session and was repeated with the simulated patients about three months after the empathy session.

Almost all participants who were re-interviewed mentioned external factors, such as work-related pressure and lack of ongoing incentives, as obstacles to acting empathetically at work. We can infer from this that the work environment itself should evolve towards a more 'educational context' in which empathy can be practiced further. Further research is needed into the meaning and role of the actual care practice as an educational context for developing empathy. How should this educational context be created? Who takes up a facilitating role and how exactly is the facilitation of empathy to occur? How can care providers be motivated in a lasting manner to practice their empathic abilities? What is the place of ethical reflection in this context? These questions are important starting points for further research.

Conflict of interest statement

The authors declare that there is no conflict of interest.

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