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# Needs Analysis of Empathic Communication Enhancing Program for Health-Science EFL Students

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**ABSTRACT**

This research explores the needs of health science EFL students in empathic communication when interacting with foreign patients from various backgrounds. As English proficiency alone is not sufficient in the healthcare context, empathic communication in English is an essential ability that enhances patient satisfaction and has a positive impact on patient outcomes. The study comprised two phases: a curriculum analysis and a needs analysis survey. Data from 40 accredited Thai medical curricula and 300 completed needs survey questionnaires, provided by individuals in the field, including students, healthcare practitioners, and university lecturers, were analyzed. Conceptual content analysis, descriptive statistics, and the Wilcoxon Signed Rank Test were used to analyze the data. The findings revealed that current

Thai medical curricula lack empathic communication practice in English-speaking contexts. The needs survey revealed that participants' expectations regarding healthcare practitioners' ability in empathic communication and its sub-components exceeded their perceptions of the practitioners' current abilities (p-value <.001). The sum rank value for empathic expression was greater than empathic perception. The largest gap was observed in Clear Articulation. The preferred learning platform was an onsite classroom with supplementary videos. The study discusses the selection of empathic communication training contents for Thai EFL. Finally, an experiment testing the suggested program elements is recommended for further research and communication course design.

**Keywords:** empathic communication, needs analysis, course development, English language teaching, Health-science students

## Introduction

In Thai higher education, English language teaching is significant in preparing students for future academic and professional endeavors. There is a strong emphasis on English language proficiency as a means of improving the country's competitiveness in the global market (It-ngam et al., 2023). However, it is known that having high language proficiency alone does not guarantee successful communication, particularly in intercultural or interpersonal contexts (Marzuki et al., 2013; Ward & Masgoret, 2006). Several other essential abilities are also important in intercultural communication, such as communicative competence, effective intercultural interaction skills, social adaptability, cultural competence, empathy, active listening, non-verbal communication, and more (Deardorff, 2011; Ward & Masgoret, 2006).

Empathic communication is one of the fundamental human abilities that is intrinsically intertwined with linguistic expressions (Krystallidou et al., 2020). It facilitates the achievement of communication goals, maintains good relationships, and creates satisfaction for the interlocutors (Goleman, 1998; Hojat et al., 2003; Chen et al., 2007; Hojat et al., 2009; Lim, Moriarty & Huthwaite, 2011). It is difficult to identify the specific dialogue that individuals with empathic communication would use because empathic communication itself is a combination of verbal and nonverbal expressions, conveying honest messages with an appropriate method that suits each individual. For example, when dealing with a patient who has no background in proper wound care in a doctor's office, a doctor asking, 'Do you know how to clean the wound?' could be considered an empathic message, whereas

posing the same question to another person would be inappropriate. However, it seems easier to identify individuals who lack empathic communication, as they often express their opposition to society through language and aggressive behavior (Miller & Eisenberg, 1988), leading to the inability to achieve desired communication goals and prevent conflicts.

Empathic communication is vital, especially in healthcare services, and is closely linked to patients' outcomes and satisfaction. Developing empathic communication in students can be challenging, particularly when their primary focus is on the content of their chosen profession. It is revealed that medical students encounter challenges in advancing their empathic communication skills when immersed in medical coursework or exposed to technological distractions (Notably, Crisp & Turner, 2011; Jacoby, 2015a). Therefore, it is imperative to implement focused and explicit training programs. Furthermore, while learning to establish empathic communication in one's native language is considered a fundamental skill, expressing empathy in a foreign language can present additional challenges and requires specific training.

To encourage empathic communication among students in the context of English as a Foreign Language (EFL), this study conducted a curriculum analysis to determine if such an experience is currently included in Thai health science curricula. Moreover, a needs survey was conducted to identify relevant experiences, content, learning methods, and essential elements that align with the needs and preferences of Thai health science students. The results of this survey would be beneficial for curriculum designers and health science educators in creating courses for health science students or current practitioners.

## Literature Review

### Definition and concept of empathic communication

Empathic communication refers to a communication ability that has been variously defined, primarily meaning the ability to understand the interrogator's feelings or state of mind and effectively, sincerely, and respectfully express that understanding to the interrogator emphasizing on conveying meaning rather than adhering to strict linguistic form (Pohontsch et al., 2018; Cameron et al., 2019). While being proficient in empathic communication in one's native language does not always equate to the same level of proficiency in a foreign language (Booncherd & Rimkeeratikul, 2017), multiple factors come into play. These factors encompass the cultural background of the individuals involved, the depth of their language

comprehension, language proficiency, and various other influential elements as language often takes a backseat and is usually tied to one's native tongue.

Through the review, it was found that empathic communication is generally defined in the context of the first language or an unidentified context. Therefore, the researcher had to redefine empathic communication to make it more explicit in the context of EFL. The former definitions of empathic communication (Pohontsch et al., 2018; Cameron et al., 2019) and oral communication—an ability to both receive and convey meaningful messages through vocabulary, structure, tone of voice, fluency, pragmatic and communicative strategies (Newton & Nation, 2021)—were synthesized, redefined, validated by experts related to the fields, and revised to have a comprehensive version and its components. In this recent study, empathic communication is defined as the ability to engage in interactions by understanding and expressing emotions, thoughts, and circumstances using careful word choice, sentence construction, modulation of voice and fluency, adept use of pragmatic skills, application of communication strategies, and proficient utilization of body language. This ability can be dissected into two primary components:

(1) Empathic Perception - an ability to listen, observe, and use strategic strategies to gather information which contains direct and implied meaning of feelings, thoughts, and situations of the interrogator. This component composes of three subcomponents:

> (1.1) Thorough Understanding - Proficiently grasping both essential message components and nuanced details, encompassing thoughts and emotions, by analyzing word choice, tone of voice, speed, and intonation.
>
> (1.2) Effective Information Acquisition - Employing suitable strategies to gather accurate and ample information.
>
> (1.3) Reflective Alignment - Reassessing gathered and interpreted information while considering the interlocutor's psychological state from a personal standpoint and ensuring mutual understanding for effective communication.

(2) Empathic Expression - an ability to speak, express and use strategic strategies in a manner that genuinely conveys care, respect, and reflects a personal, shared perspective on the emotions, thoughts, and situations of the interlocutor. This component consists of three subcomponents:

> (2.1) Clear Articulation - Skillfully articulate words, gestures, and utilize appropriate vocabulary, tone of voice, and pacing to convey the message in a manner that minimizes the possibility of misunderstanding by the interlocutor.

(2.2) Effective Persuasion - Employ techniques such as logical reasoning, strategic use of information, and persuasive strategies to facilitate a smooth and engaging conversation.

(2.3) Comforting Assurance - Employ content, tone of voice, speed, and gestures that foster a sense of security and warmth, creating an atmosphere in which the interlocutor feels at ease.

The goal of empathic communication is to establish a safe and comfortable environment for conversation partner, leading to successful communication and better relationships between interlocutors. Incorporating the context of English as a Foreign Language (EFL) into the definition and its components can help narrow down and provide a clearer picture of situations where English is used in diverse settings by a variety of users, considering various factors that may affect communicators' understanding of each other.

## Training Empathic Communication

Empathic communication is a skill that can be developed through training, distinct from empathy. It requires explicit and dedicated instruction (Hojat et al., 2009; Taggart, 2011; Lim, Moriarty, & Huthwaite, 2011; Jacoby, 2015b; Pohontsch et al., 2018; Plotkin & Shochet, 2018). Medical students face challenges in advancing their empathic communication skills within their coursework, amid technological distractions and stress. Therefore, it is difficult to have students adopt an ability like empathic communication, which can be challenging to observe.

To teach empathic communication, moral instruction and reflective learning were usually included and various approaches have been applied such as Wellness Programs, drama techniques, literature engagement, virtual patient interactions, patient shadowing, drama-based learning, self-care techniques, service learning, and more. Plotkin and Shochet (2018) summarized these approaches into three key components:

(1) Providing Knowledge: Delivering essential content, including empathic communication's definition, delivery methods, communication characteristics, and encounter strategies, equips students to evaluate and manage their learning.

(2) Providing Experience: Immersing students in empathic and non-empathic message exchanges through role-playing exercises, especially in patient roles, helps develop communication skills, perspective adjustments, and problem-solving capabilities in real-world scenarios.

(3) Providing Stress Management: Recognizing stress as a barrier to empathic communication, equipping students with stress management

techniques ensures the sustainability and effectiveness of their empathic communication.

Training students in empathic communication in a foreign language should not rely solely on innate empathy, as there is debate on whether empathy can be cultivated. Some people consider empathy as an affective ability, some as cognitive, and some as behavioral. Instead, the focus should shift towards nurturing distinctive attributes in students' foreign language communication to ensure genuine and empathetic interactions.

## The Context of Health Science Education in Thailand

In Thailand, health sciences have gained popularity due to a shortage of healthcare professionals and the emergence of new roles driven by health technology. This includes positions like radio technicians, operational instrument technicians, and medical technologists.

Historically, medical education primarily focused on only the deceases and their treatments over patients and their points of view. Moreover, in Thai society, healthcare professionals occupied a special place and were widely respected as benefactors. People held them in high regard for their kindness, care, and their role in saving lives, especially in life-threatening cases. Consequently, they typically played a dominant role in their interactions with patients. While, Western culture wherein medical professionals provide services, and patients are seen as customers whose satisfaction should be ensured, has influenced Thai culture. This change has led to a misplaced role and has strained healthcare practitioner-patient relationships (Phra Brahmagunabhorn, 1997).

Therefore, in Thai health science curricula, a patient-centered approach has emerged. However, the instructional methods remain similar to those of the past, with content knowledge being transmitted from senior to later generations, which still places seniors in a dominant role. Healthcare students, both in Thailand and abroad, often face high stress levels, sleep deprivation, and declining empathy during clinical training due to various pressures such as sleep less than seven hours, lack confidence in leading healthy lives (Hojat et al., 2020), exam pressure, parental expectations, dissatisfaction with instructional methods, and students' readiness (Phanpanich et al., 2021). Understanding precisely what students should be equipped with and in what situations can enhance their ability to handle various scenarios, particularly emphasizing interactions with patients. This approach helps novices become aware of their appropriate position and learn how to approach patients more patiently.

## Methodology

This research aims to explore the requirements for a program designed to enhance empathic communication in healthcare services for foreign patients, thereby preparing students for their future careers. The study consists of two phases: (1) documentary research of accredited Thai medical curricula employing conceptual analysis to identify deficiencies, and (2) a needs analysis survey to investigate the needs of healthcare practitioners in empathic communication when providing healthcare services to foreigners. The documentary research aims to check if any English language courses provide empathic communication, while the needs analysis seeks to identify what aspects should be emphasized more than others. The survey was conducted to collect quantitative data, including participants' perceptions of the current empathic communication skills of healthcare practitioners, their expectations, and their preferred forms of learning.

### Participants and sample selection

For Phase 1, documentary research explores all accredited medical curricula in Thailand as of August 2023. These curricula comprised 36 regular Thai programs, 2 international programs, 1 English program, and 1 joint program. The study specifically focused on English courses within the General Education category.

For Phase 2, a needs analysis questionnaire which created by the researcher asking for demographic information, participants' expectation, and their reflection on the current ability of current healthcare practitioners was administered to three hundred stakeholders who were selected through a non-probability quota sampling method. The sample size was calculated using G*power, applying Cohen's (1988) conventional effect size of 0.3. The suggested total sample size was 154. The actual sample consisted of 300 participants, including healthcare practitioner students, healthcare practitioners, and health science university lecturers.

### Data Collection

During the curriculum analysis phase, all accredited medical curricula in Thailand were thoroughly reviewed, focusing on theme-level analysis of course descriptions for the compulsory English courses within the General Education category, utilizing conceptual analysis. The process involved 40 curricula and aimed to identify deficiencies in empathic communication training. After the review, the themes of the courses were identified, and the courses were categorized accordingly. The number of courses was manually

double-categorized and counted. This examination aimed to determine whether any aspect of empathic communication was provided to health-science university students and what aspects were still lacking.

In the needs analysis questionnaire, three sections were presented in the Thai language to ensure that all respondents could understand the questionnaire and answer the questions. Each item in this questionnaire underwent content validation by five experts in the field using the item-objective congruence index, with a score threshold of over 0.7. The Cronbach's alpha coefficient of the scale was 0.95. The first section comprised nine items aimed at collecting demographic information to provide an overview of the participants. The second section consisted of 15 dual-response Likert scale items designed to assess the 6 essential elements of empathic communication in the English language within the context of healthcare provision. These items aimed to explore and compare the respondents' perspectives on the present healthcare providers' abilities with their ideal expectations. Through this section, the gap between their expectations and their current experiences could be revealed, and the results could guide the focus areas for improvement. The third section featured five multiple-choice items inquiring about content scope and preferred learning methods, with participants allowed to select more than one choice. The results could aid in scoping and sequencing the scenarios and content. A total of 450 hard copies of the self-administered questionnaire were distributed among three stakeholder groups: healthcare practitioner students, healthcare practitioners, and health-science university lecturers. Data from 300 completed questionnaires were collected, resulting in a response rate of 66.67%.

## Data Analysis

Theme-level conceptual content analysis was employed to quantify English course descriptions in Thai medical curricula. Descriptive statistics, including mean, standard deviation, and frequency, along with theme-level conceptual content analysis, were utilized to analyze the number of courses, credit hours, and the quantified data.

The responses from the needs analysis were collected and analyzed using statistical software. Descriptive statistics were employed to analyze the quantitative data. Raw scores obtained from the 15 Likert scale items for each component were calculated and transformed into standard scores, using the full score of 5 as the reference - the interpretation criteria are presented in Table 1 below. Descriptive statistics and the Wilcoxon Signed Rank Test were applied to compare the responses of dual-response questions, assessing the gaps between participants' perceptions of healthcare practitioners' current

empathic communication abilities and their ideals. The data were analyzed to address program requirements, assist in scoping and sequencing the program, and provide valuable insights.

**Table 1**

*The Interpretation Criteria for Mean Scores of 5-Point Likert Scale*

| Likert | Interval | Different | Description |
|---|---|---|---|
| 1 | 1.00 – 1.79 | 0.79 | the lowest |
| 2 | 1.80 – 2.59 | 0.79 | low |
| 3 | 2.60 – 3.39 | 0.79 | moderate |
| 4 | 3.40 – 4.19 | 0.79 | high |
| 5 | 4.20 – 5.00 | 0.79 | the highest |

## Results

### English Courses in Thai Medical Curricula

To provide an overview of the English courses in Thai medical curricula, 40 currently activated curricula accredited by the Institute for Medical Education Accreditation (IMEAc) valid from 2012 to 2029 were examined including 2 international programs, 1 English program, and 1 joint program. Table 2 shows that the program credits spanned from 166 to 324 credits. All mandatory language courses were categorized in the Language Section under the General Education category. In the Language Courses category, credit hours varied from 4 to 20, with 9 credit hours being the most common, observed in 12 curricula. On average, medical schools provided 10.95 credit-hour language courses. Specifically, when considering English courses, most of the language courses were in English with an average of 8.55 credit hours and ranging from 4 to 16 credits, with 9 credits being the most frequently observed, present in thirty out of forty curricula.

Four conceptual themes of the English courses were identified: basic communication, general academic English, health science academic English, and healthcare-related English. The majority of courses (n = 35) were grouped into the basic communication category, focusing on teaching foundational knowledge and skills to develop students' English language literacy. Seventeen programs provided courses in the general academic English and health-science academic English categories. In these two categories, the course objectives aimed to enhance English skills relevant to general university-level teaching and learning or, more specifically, in the health science field. Only two programs provided students with the

opportunity to develop patient-encountering knowledge and skills. However, the focus of these two courses was not on patient-encountering experiences but rather on lexical knowledge, and the credit hours were limited to 2.

The results showed that none of the medical curricula provided explicit training in empathic communication and professional communication experiences when encountering foreign patients, despite allocating most credit hours in the language section to English courses. Therefore, students might lack the opportunity to learn content related to patient encounters and explore efficient experiences to develop their empathic communication skills.

**Table 2**

*Descriptive Statistics of Thai Medical Curricula and Types of English Language Courses*

| Category | Number of Program | Mode | Min | Max | $\bar{x}$ | S.D. |
|---|---|---|---|---|---|---|
| English Courses | 40 | 9 | 4 | 16 | 8.55 | 2.80 |
| ● basic communication | 35 | 6 | 0 | 12 | 6.06 | 3.23 |
| ● general academic English | 17 | 6 | 0 | 9 | 1.75 | 2.57 |
| ● health science academic English | 17 | 0 | 0 | 9 | 1.4 | 2.10 |
| ● healthcare-related English | 2 | 0 | 0 | 2 | 0.1 | 0.44 |

## Needs of English Language Courses for Thai Health-Science Students

There were 300 completed questionnaire responses received. Part 1 asked the demographics of the participants. Part 2 examined the necessary elements of empathic communication to be included in training by assessing participants' perceptions of healthcare practitioners' current empathic communication, their ideal expectations, and comparing the two to identify gaps that needed to be addressed. Part 3 focused on participants' preferred learning methods. The results are reported below.

### *Demographics of the Needs-Analysis Participants*

The participants were 148 students, 132 healthcare practitioners, and 20 health science university lecturers. As shown in Table 13, the majority were male (71.3%), and their educational backgrounds were primarily at the bachelor's degree level or lower.

**Table 3**

*Demographics of the needs-analysis participants*

| Profession | Number of Participants | Percentage of participants |
|---|---|---|
| Student | 148 | 49.3 % |
| Doctor | 19 | 6.3 % |
| Nurse | 46 | 15.3 % |
| Other Healthcare Practitioner | 67 | 22.3 % |
| Healthcare Teacher | 20 | 6.7 % |

Most of the participants self-reflected that they could communicate in English, with a variety of proficiencies, as shown in Table 4. About half of participants were basic user (52.4%) and independent user (43.7%) of English language. Yet, as shown in Table 5, they were "fair" (60.7%) in empathic communication. Only 30.6% were able to communicate empathically at "good" or "excellent" level.

**Table 4**

*Participants' Self-rated English Proficiency Levels*

| English Proficiency | | Number of Participants | Percentage of participants |
|---|---|---|---|
| below A1 | | 4 | 1.3 |
| basic | A1 | 74 | 24.7 |
| | A2 | 83 | 27.7 |
| independent | B1 | 110 | 36.7 |
| | B2 | 21 | 7.0 |
| proficient | C1 | 6 | 2.0 |
| | C2 | 2 | .7 |

**Table 5**

*Participants' Self-rated Empathic Communication Levels*

| Empathic Communication | Number of Participants | Percentage of participants |
|---|---|---|
| poor | 26 | 8.7 |
| fair | 182 | 60.7 |

| Empathic Communication | Number of Participants | Percentage of participants |
|---|---|---|
| good | 82 | 27.3 |
| excellent | 10 | 3.3 |

### *Participants' Perceptions of Healthcare Practitioners' Empathic Communication*

Table 6 shows the results of Part 2 of the needs analysis questionnaire which revealed the mean scores for both the current and expected sub-component scores in empathic communication appeared similar within the groups but notably different between the groups. Participants' perceptions of current healthcare practitioners' empathic communication mean scores were at a moderate level (ranged from 2.86 – 3.15), while their expectations for what a proficient practitioner should achieve were set at a high level (ranged from 3.81 – 3.95).

Healthcare practitioners' responses to the questionnaire items, reflecting their current behavioral frequency, mostly fell into moderate level, whereas their expectations regarding what should be done were mostly in the high level which is one level higher. The question with the lowest mean score, indicating their present ability, pertained to whether practitioners speak and express facial expressions and body language to communicate with international patients empathetically, with a mean score of 2.77 (S.D. = 0.93). Conversely, the highest score was observed in the question related to whether practitioners demonstrate appropriate body language (mean = 3.41, S.D. = 0.96). In terms of their expectations, the item assessing whether practitioners gather information related to their treatment or duties accurately received the highest mean score (mean = 4.01, S.D. = 0.73). Conversely, two items received the lowest scores. One pertained to "Empathic Perception," assessing whether practitioners understand the content of the message sent by the conversational partner correctly (mean = 3.73, S.D. = 0.96). The other pertained to "Empathic Expression," assessing whether practitioners speak to demonstrate an understanding of the thoughts and feelings of the conversation partner (mean = 3.73, S.D. = 0.96).

**Table 6**

*Descriptive Statistics of Participants' Perceptions of Healthcare Practitioners' Current and Expected Empathic Communication Sub-Components*

| Component/Questions | Current Ability | | | Expected Ability | | |
|---|---|---|---|---|---|---|
| | $\bar{X}$ | S.D. | Level | $\bar{X}$ | S.D. | Level |
| **Empathic Communication** | **3.00** | **0.76** | **moderate** | **3.88** | **0.85** | **high** |
| **(1) Empathic Perception** | **3.00** | **0.80** | **moderate** | **3.91** | **0.88** | **high** |
| **(1.1) Thorough Understanding** | **3.00** | **0.75** | **moderate** | **3.89** | **0.86** | **high** |
| Q1) Listen and observe the facial expressions and body language of international patients quickly to understand their feelings. | 2.82 | 0.87 | moderate | 3.80 | 0.91 | high |
| Q2) Understand the content of the message sent by the conversational partner correctly. | 2.93 | 0.93 | moderate | 3.73 | 0.96 | high |
| Q3) Understand the emotions of the conversational partner correctly. | 3.25 | 0.96 | moderate | 3.90 | 0.99 | high |
| **(1.2) Information Acquisition** | **3.01** | **0.88** | **moderate** | **3.95** | **0.94** | **high** |
| Q1) inquiry or the use of methods to gather information from the conversation partner, such as asking about their feelings and perspectives | 3.02 | 0.98 | moderate | 3.86 | 1.02 | high |
| Q2) Gather information related to their treatment or duties accurately. | 3.07 | 0.97 | moderate | 4.01 | 0.73 | high |
| Q3) Gather information related to their treatment or duties comprehensively. | 2.95 | 1.03 | moderate | 3.98 | 1.03 | high |
| **(1.3) Reflective Alignment** | **2.98** | **1.03** | **moderate** | **3.90** | **0.99** | **high** |
| Q1) Verify one's own understanding with the conversation partner. | 2.98 | 1.03 | moderate | 3.90 | 1.00 | high |
| **(2) Empathic Expression** | **3.01** | **0.76** | **moderate** | **3.86** | **0.86** | **high** |
| **(2.1) Clear Articulation** | **2.86** | **0.81** | **moderate** | **3.81** | **0.86** | **high** |
| Q1) Speak and express facial expressions and body language to communicate with international patients empathetically. | 2.77 | 0.93 | moderate | 3.80 | 0.94 | high |
| Q2) Respond/answer questions from international patients understanding the content. | 2.86 | 0.90 | moderate | 3.89 | 0.95 | high |

| Component/Questions | Current Ability | | | Expected Ability | | |
|---|---|---|---|---|---|---|
| | $\bar{\chi}$ | S.D. | Level | $\bar{\chi}$ | S.D. | Level |
| Q3) Respond to international patients understanding their emotions. | 2.89 | 0.89 | moderate | 3.82 | 0.96 | high |
| Q4) Speak to demonstrate an understanding of the thoughts and feelings of the conversation partner. | 2.92 | 0.95 | moderate | 3.73 | 0.96 | high |
| **(2.2) Effective Persuasion** | **3.02** | **0.87** | **moderate** | **3.87** | **0.94** | **high** |
| Q1) Present information, reasons, and appropriate supporting materials in a way that persuades the conversation partner to accept negotiation | 3.02 | 0.98 | moderate | 3.90 | 1.02 | high |
| Q2) Establish communication methods appropriately. | 3.02 | 0.93 | moderate | 3.84 | 1.01 | high |
| **(2.3) Comforting Assurance** | **3.15** | **0.87** | **moderate** | **3.89** | **0.91** | **high** |
| Q1) Demonstrate appropriate body language. | 3.41 | 0.96 | high | 4.00 | 0.93 | high |
| Q2) Use suitable words, tone, speed, and intonation to make international patients feel safe. | 2.90 | 0.98 | moderate | 3.78 | 1.03 | high |

Although the mean scores for empathic communication and all the sub-components indicated some deficiencies in achieving participants' expectations, a Wilcoxon Signed Rank Test was applied to confirm that these deficiencies were statistically significant. Table 7 displays the results of both overall empathic communication and the sub-components' expectation scores, which were statistically significantly higher than participants' perceptions of the empathic communication abilities of current practitioners. The test results showed that 72% of participants indicated significantly higher expectations for empathic communication ($Z = -12.02$, p-value $< .001$), aligning with their self-reflection in Part 1. This suggests that current practitioners may still lack a certain level of empathic communication. All sub-components need to be included in a training program. When comparing participants' responses on current ability and expectations, the largest gap between current ability and expectation was observed in the case of "Clear Articulation" (Positive rank = 202, sum rank = 25261.50). "Reflective Alignment" had the lowest sum rank (Positive rank = 159, sum rank = 15553.50), while the second lowest was "Effective Persuasion" (Positive rank = 186, sum rank = 20423.00). The sum ranks for the remaining sub-competencies were relatively similar, around twenty-three thousand.

**Table 7**

*Comparison of Participants' Perceptions of Current Healthcare Practitioners' Empathic Communication And Their Perceived Ideal*

| Component | Type of Rank | n | Mean Rank | Sum Rank | Z | P |
|---|---|---|---|---|---|---|
| **Overall Score of Empathic Communication** | positive | 216 | 148.08 | 31984.5 | -12.02 | <.001 |
| | negative | 46 | 53.66 | 24.68.5 | | |
| | ties | 38 | | | | |
| **(1) Empathic Perception** | positive | 211 | 133.51 | 28171.50 | -11.81 | <.001 |
| | negative | 34 | 57.75 | 1963.50 | | |
| | ties | 55 | | | | |
| (1.1) Thorough Understanding | positive | 198 | 119.05 | 23571.50 | -11.52 | <.001 |
| | negative | 25 | 56.18 | 1404.50 | | |
| | ties | 77 | | | | |
| (1.2) Information Acquisition | positive | 201 | 116.81 | 23478.00 | -11.62 | <.001 |
| | negative | 21 | 60.71 | 1275.00 | | |
| | ties | 78 | | | | |
| (1.3) Reflective Alignment | positive | 159 | 97.82 | 15553.50 | -10.13 | <.001 |
| | negative | 24 | 53.44 | 1282.50 | | |
| | ties | 117 | | | | |
| **(2) Empathic Expression** | positive | 213 | 136.37 | 29046.00 | -11.86 | <.001 |
| | negative | 36 | 57.75 | 2079.00 | | |
| | ties | 51 | | | | |
| (2.1) Clear Articulation | positive | 202 | 125.06 | 25261.50 | -11.68 | <.001 |
| | negative | 29 | 52.91 | 1534.50 | | |
| | ties | 69 | | | | |
| (2.2) Effective Persuasion | positive | 186 | 109.80 | 20423.00 | -11.26 | <.001 |
| | negative | 21 | 52.62 | 1105.00 | | |
| | ties | 93 | | | | |
| (2.3) Comforting Assurance | positive | 198 | 117.60 | 23284.00 | -10.54 | <.001 |
| | negative | 29 | 89.45 | 2594.00 | | |
| | ties | 73 | | | | |

### *Participants' Preferred Forms of Learning*

Part 3 of the questionnaire assessed participants' opinions regarding training situations, contents, and platforms for training delivery. Five

questions were asked, and participants could choose more than one option provided. The results are presented in Tables 8, 9, and 10.

Question 1 inquired about the main group of patients with whom practitioners need to communicate in English. According to the responses, practitioners need to interact more with Asian patients (n=179), followed by European (n=117), American (n=64), and Chinese (n=47) patients, in that order.

Question 2 asked participants to identify situations in which healthcare practitioners often encounter difficulties in empathetic English language communication and what experiences should be provided to students. Table 8 shows that the most challenging situation that should be included in training was the patient-diagnosis interview (n=161, 27.15%). The situations perceived as least difficult were discharge instructions (n=30, 5.06%) and treatment negotiation (n=31, 5.23%).

Question 3 aimed to cross-check the responses from Question 2 by asking participants to identify situations that were most crucial for empathetic English communication. As seen in Table 8, the results showed that the most important situation was the patient-diagnosis interview (n=112, 23.14%), which aligned with the responses to Question 2. The least significant situation was communication among healthcare practitioners. Additionally, discharge instructions (n=32, 6.61%) and treatment negotiation (n=32, 6.61%) received the second-lowest scores, aligning with their status as the least challenging situations when encountering patients.

Moreover, when comparing the frequencies reflecting participants' perspectives on the difficulty encountered and the perceived importance of 8 situations, it was observed that half of them seemed difficult rather than important – patient registration (77, 42), treatment (83, 67), patient diagnosis interview (161, 112), and team communication (50, 22), while the other half was the vice versa, bad news delivery (75, 90), result delivery (86, 87), treatment negotiation (31, 32), and discharge (30, 32).

**Table 8**

*Frequency of Difficulty Encountered and Perceived Importance of Situations*

| Task | Difficulty Encountered | | Perceived Importance | |
|---|---|---|---|---|
| | Frequency | Percent | Frequency | Percent |
| Patient Registration | 77 | 12.98 | 42 | 8.68 |
| Patient Diagnosis Interview | 161 | 27.15 | 112 | 23.14 |
| Result Delivery | 86 | 14.50 | 87 | 17.98 |
| Treatment | 83 | 14.00 | 67 | 13.84 |

| | | | | |
|---|---|---|---|---|
| Treatment Negotiation | 31 | 5.23 | 32 | 6.61 |
| Bad News Delivery | 75 | 12.65 | 90 | 18.60 |
| Discharge | 30 | 5.06 | 32 | 6.61 |
| Team Communication | 50 | 8.43 | 22 | 4.55 |
| Total Response | 593 | | 484 | |

In response to Question 4, participants were asked to select their preferred teaching platform. Table 9 reveals that onsite classroom with video support (n=138, 43.13%) was the most selected platform, followed by onsite classroom (n=83, 25.94%). The virtual online classroom (n=36, 11.25%) received the lowest frequency of selection.

**Table 9**

*Frequency of Selected Teaching Platform*

| Teaching Platform | Difficulty Encountered | |
|---|---|---|
| | Frequency | Percent |
| Onsite | 83 | 25.94 |
| Virtual online classroom | 36 | 11.25 |
| On-demand video | 63 | 19.69 |
| Onsite classroom with video support | 138 | 43.13 |

Question 5 aimed to evaluate the self-learning methods of the participants. Table 10 exhibits that the majority of participants preferred watching videos (n=178, 44.28%), followed by listening to podcasts (n=95, 23.63%). The least popular choice was using learning kits, with only (n=53, 13.18%)) participants selecting this option.

**Table 10**

*Frequency of Preferred Self-Learning Methods*

| Self-Learning Methods | Difficulty Encountered | |
|---|---|---|
| | Frequency | Percent |
| Listening to podcasts | 95 | 23.63 |
| Watching videos | 178 | 44.28 |
| Reading documents | 76 | 18.91 |
| Using learning kits | 53 | 13.18 |

## Discussion and Implications

To design an empathic communication course for EFL students, a needs analysis was conducted. The results showed that participants' English proficiency varied, but the majority considered themselves poor in empathic communication. Their expectations for each empathic communication sub-component were significantly higher than what they observed current practitioners could perform. Clear articulation appeared to be the most problematic ability, as indicated by the highest sum rank, and this aligned with the lowest mean score in the separated question within this sub-component category. On the other hand, the most expected ability was not related to expression but rather empathic perception, specifically the gathering of accurate and ample information. Therefore, the training should encompass all six sub-components as enabling objectives to achieve the expected level of empathic communication. The course should focus on both empathic expression and perception, with a slightly greater emphasis on empathic expression.

Interestingly, it was also found that there were two essential components that received unexpected scores. Firstly, Reflective Alignment gained the lowest sum among the six components, and its score was significantly lower than the others. Reflective Alignment, the ability to reflect on comprehension and reassurance, is considered an essential component and a vital step in expressing empathy (Hojat et al., 2009; Lim, Moriarty, & Huthwaite, 2011; Lee et al., 2016). Secondly, a question asking if present practitioners could demonstrate appropriate body language under the Comforting Assurance sub-component earned the highest mean score. This might indicate a true lack of understanding of empathic communication, as Plotkin & Shochet (2018) mentioned that patients prioritize non-verbal communication while novice practitioners tend to concentrate on verbal communication. Both Reflective Alignment and the demonstration of appropriate body language could be the area requiring further attention and practice.

To identify suitable training methods, in Part 3 of the questionnaire, five questions were utilized. The first question aimed to identify the context in which English language would be used. Surprisingly, the results showed that, in participants' perception, the majority of users of English in healthcare contexts were not considered "native speakers" but rather individuals from Asian and European countries. Therefore, the focus of the training should not be on perfect form-focused English but rather on meaning-focused English as a lingua franca. Additionally, contents related to the situation, such as cultural awareness, people's background diversity, and social norms, both ours and theirs, should be integrated. Raising awareness of English usage

among international people could help students empathize more easily with a variety of people and foster deeper understanding of empathic communication.

To select the targeted training situations, the results from cross-referencing between questions 2 and 3 revealed that, from the participants' perspective, they paid more attention to patient-practitioner communication than to communication among healthcare teams. The most essential and problematic situation identified was the patient-diagnosis interview, which is the primary task of healthcare consultation. However, it was quite surprising to see that situations like discharge instructions and treatment negotiation appeared to be overlooked. These are complex situations that are usually difficult to deal with and involve decision-making, which can significantly impact a patient's quality of life and their outcomes (Chandra et al., 2011).

Discussing these results reminded me of Phra Brahmagunabhorn's (1997) review of Thai medical social norms. In Thai traditional culture, practitioners typically assume a dominant role over patients. Despite the lack of a comprehensive summary that the tradition persists to this day, the results, indicating ignorance of the importance of negotiating treatment choices and patient self-care action plans after treatment, could suggest a genuine lack of empathic communication. While discussing these results, Phra Brahmagunabhorn's (1997) review of Thai medical social norms came to mind. In Thai traditional culture, practitioners typically assume a dominant role over patients, as Thais traditionally prioritize gratitude above other qualities, and providing healthcare treatment or life-saving actions are situations where gratitude is highly emphasized. This deeply ingrained cultural trait normalizes doctor-dominant conversations. Despite the shortage in summarizing that this tradition persists to this day, the results, which indicate ignorance of the importance of negotiating treatment choices and patient self-care action plans after treatment, could suggest a genuine lack of empathic communication.

To build awareness of empathic communication through situations which people lack awareness due to their social norm such as the situation of treatment choices and discharge instruction in Thailand, the specific essential content and experience should be well selected and provided. As mentioned in Chandra, Cutler, and Song (2011), there are three main influential factors that could affect patients' choices and should be obligately included in the training without awareness of these factors, patients might simply follow the action plan or practitioner's suggestions. Firstly, financial reasons and tastes could cause variation in purchasing decisions. It includes treatment price, patients' income, their insurance, and their preference therapeutic choices which people's concern levels are vary. Secondly, trustworthy on professionals, institutions, and supply readiness are reasonable causes which

could vary the patients' response and also practitioners' encountering. Thirdly, situational factors such as lengthy wait, prior experiences of an individual, or other random contextual or behavioral influences could affect the communication as well. At this point, the selected contents, including all patient-practitioner encountering situations, seem to cover every step of hospitalization, from diagnosis and treatment to discharge. Following this chronological order appears to make sense to support students' understanding and imagination when role-play in the setting of the situations.

The results of the questions 4 and 5 revealed that the most suitable learning platform is an onsite classroom with online multimedia supplementary resources. The most desirable support comes in the form of video, followed by online audio clips and reading materials. According to the findings and the discussion above, the suggested pedagogical principles mentioned in Plotkin and Shochet (2018), consisting of knowledge, efficient experience, and stress management, seem beneficial and consistent with the selected objectives and contents. To provide a proper amount of well-selected and meaningful content and experiences, Drama-Based Learning (DBL) appears to be a good fit here. This approach could help students practice their lacking skills many times with enjoyment, place students in the targeted situations where they need to be, provide hands-on experience allowing them to create their individual knowledge that matches their identity, and also allow them to reduce their stress maintaining their creativity and their sense of security, as drama is an enjoyable task. The use of DBL could be in many levels, as a principle of the whole program, as a principle of teaching, as a teaching method, or as a teaching activity. In case of using DBL, to facilitate students' early exposure to patient-care experiences, materials such as role cards, props, situation explanation cards, protocol checklists, patient records, patient applications, self-reflection guidance, scoring rubrics, and other supplementary resources could assist in comprehending the desired outcomes and enhancing their imaginative engagement during role-play, rather than memorizing the scene, character, information.

However, some students might not feel safe participating in such extroverted learning involving collaboration with a group of people (Galante, 2018), and some teachers may not feel comfortable getting so involved in student activities as required when applying DBL. If educators wish to employ this approach, it becomes essential to address these issues beforehand, ensuring that they do not create new difficulties for students or teachers themselves. Individual preparation before working in pairs is a suggested method, as healthcare encounters usually involve pairs of practitioners and customers. Psychological methods for dealing with difficult communication are recommended to be integrated into training. Choosing methods that can help reduce stress is crucial. This integration can create a

better understanding, a sense of security, and improved relationships among students and between students and teachers. It is well-known that lower stress levels enhance empathic communication.

## Conclusion and Implications

A comprehensive analysis of health science EFL students' curriculum and needs were conducted to identify the elements of empathic communication training for EFL. The study identifies significant gaps within English courses designed for healthcare services, despite its crucial impact on patient outcomes. The curriculum analysis highlights the necessity for reevaluation, proposing a shift towards balancing basic language skills with other elements that enhance communication effectiveness, such as empathic communication training, given that there is currently no course addressing this aspect explicitly in healthcare education. The needs analysis reveals a consensus on their inadequacy in empathic communication among students with a variety of English proficiency. Both empathic expression and perception should be emphasized in training, addressing deficiencies in Reflective Alignment and body language comprehension. Interestingly, a cultural norm in Thailand where doctors traditionally hold dominant roles, impacting patient-practitioner interactions should be in educator's and course designers' consideration.

To bridge these gaps, the study advocates for a focus on meaning-focused English as a lingua franca, integrating cultural awareness and context of specific content. The proposed pedagogical approach, Drama-Based Learning (DBL) is suggested to enhance students' skills, though concerns about student and teacher comfort levels necessitate careful consideration. The study underscores the importance of reducing stress and fostering understanding within student interactions, ultimately emphasizing the crucial role of empathic communication in healthcare contexts. Moreover, merging or implying a psychological approach or treatment could help support students in managing their stress to participate in scenarios and be in a state that does not hinder them from creating empathic conversations. These results could serve as the foundation for designing an English language course for healthcare practitioner students or current practitioners. They also contribute to identifying gaps in health science curricula, especially in English language, foreign language, or communication courses, within Thailand and similar settings.

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