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# Novel approach to teaching empathic leadership using heuristics

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## ABSTRACT

**Introduction** National Health Service (NHS) failures at Mid-Staffordshire, Shrewsbury and Telford, and East Kent reached the same conclusion: leaders who fail to listen and understand put patients at risk. The NHS response has been to promote compassionate leadership. Yet, compassion often entails emotional merging, which can blur boundaries and lead to fatigue. By contrast, empathic leadership and curiosity-driven perspective-taking, rather than emotional merging, offers a promising new way forward. Yet no practical method exists to teach empathic leadership. To fill this gap, we aimed to develop heuristics ('rules of thumb') for empathic leadership and create a course to teach them.

**Methods** 21 healthcare leaders attended a structured workshop. Using established heuristic development and curriculum design methods, participants generated, refined and prioritised heuristics for empathic leadership, then co-designed a training course to teach them.

**Results** The group produced 35 heuristics and prioritised 12, including 'Listen first, speak last', 'Say sorry', and 'Walk the shop floor'. A one-day interprofessional empathic leadership course was then co-designed, featuring experiential learning, role play and implementation planning.

**Conclusion** We identified and prioritized heuristics for empathic leadership and produced a course to teach them. The short course may support healthcare leaders to strengthen empathic leadership in practice.

## INTRODUCTION

### The problem with lack of empathic leadership

When healthcare leaders fail to listen, patients suffer.<sup>1</sup> Reports into tragedies at the Mid-Staffordshire,<sup>2</sup> Shrewsbury and Telford,<sup>3</sup> and East Kent National Health Service (NHS) Trusts<sup>4</sup> all found that lack of empathy—including failures of empathic leadership—contributed to avoidable mortality.

In parallel, evidence for the potential benefits of empathic leadership is growing.<sup>5–7</sup> Empathic leadership has been shown to improve patient safety and quality of care<sup>1</sup> and enhance team performance.<sup>8</sup> Within healthcare, empathic leaders can be role models for practitioners whose enhanced empathy can subsequently improve patient outcomes ranging

## WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Empathic leadership can improve staff and patient outcomes yet is lacking in many healthcare settings.

## WHAT THIS STUDY ADDS

⇒ First systematic development of heuristics (short rules of thumb) for empathic leadership generated through structured collaboration of healthcare leaders.

## HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Provides teachable, practical tools for increasing empathic leadership (and downstream: patient outcomes), though impact requires empirical validation.

from reduced pain,<sup>3</sup> increased satisfaction with care<sup>9</sup> as well as lower mortality.<sup>10</sup> Empathy is also associated with lower staff burnout and turnover.<sup>11</sup> Empathy has even been linked to better financial performance. Satya Nadella from Microsoft demonstrated that a focus on empathic leadership can drive substantial financial success—an insight with implications for economically pressured healthcare systems.<sup>12</sup>

Despite its promise, there is little research on empathic leadership in healthcare. Healthcare leadership differs from leadership in other sectors because: it involves life and death consequences<sup>1</sup>; there is a complex stakeholder landscape with patient and professional voices sometimes competing<sup>13</sup>; there are tensions between different professions such as nurses and doctors<sup>13</sup>; the professions are driven by values that play a central role in decision-making; the sector is highly regulated which constrains the ability to make decisions; and medical science changes rapidly.

## Distinguishing empathic from compassionate leadership

The NHS has long promoted compassionate leadership, which includes empathy.<sup>14</sup> Compassion has clear value and has made an important contribution to humanising healthcare leadership. However, it



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also has limitations.<sup>14</sup> Many models of compassionate leadership include emotional merging (feeling the same thing as another person),<sup>14</sup> which can lead to ‘compassion fatigue’. Compassionate leadership can also be conceptually confusing, overlapping with servant, benevolent and transformational leadership,<sup>15</sup> which dilutes its clarity in training. These problems may partly explain why, despite 15 years of compassionate leadership training, compassion-related failures in the NHS seem to have increased.<sup>3</sup>

Empathic leadership offers an alternate, yet related, approach that carries lower risk of emotional merging and is conceptually coherent (formal definitions of empathy and empathic leadership are provided below).<sup>16</sup> It centres on curiosity and perspective-taking: understanding others’ experiences without being overwhelmed by them.<sup>17</sup> This is not to say that empathic leadership is entirely cognitive or that it excludes affective components. In fact, we believe that trying to label empathy as having inseparable cognitive or affective components is naive.<sup>16 18</sup> For instance, it would be difficult to watch someone walk a tightrope across the Grand Canyon without feeling a little bit of anxiety or vertigo.<sup>18</sup> However, rather than feeling *the same* emotions as somebody, empathic leadership involves feeling *something* (eg, concern) in response to understanding another person’s perspective.<sup>16 17</sup> These distinctions are important. Not only does empathic leadership sustain leaders’ resilience by avoiding compassion fatigue, but also encourages problem-solving and learning. In practice, an empathic leader may ask, “What matters most to you right now?” rather than focusing on feeling with the person in front of them.

### The gap: no courses on empathic leadership

Despite their potential value, a systematic review did not identify any courses to teach empathic leadership in the healthcare setting.<sup>13</sup>

### Heuristics (versus slogans) for busy healthcare leaders

In other fields, heuristics—short, memorable rules of thumb—help leaders make better decisions under pressure.<sup>19 20</sup> Taught correctly, heuristics generate deep learning which is what makes them effective. Unlike slogans, heuristics ‘must be felt and owned and acted on by those using them; they must be embodied through long experience’.<sup>19</sup> By contrast, slogans are superficial and often oversimplify complex issues. Slogans can lead to cognitive biases and ineffective decision-making.<sup>19</sup>

### Aims

1. Generate a set of heuristics for empathic leadership in healthcare.
2. Co-design a course to teach empathic leadership heuristics to future leaders.

## METHODS

### Definitions

*Empathy*: a systematic review of empathy definitions found that they had more in common than they had differences. Therapeutic empathy (empathy in the healthcare setting) can be summarised as follows: listening, seeking to understand someone’s situation and feelings, caring and helping, all while respecting professional boundaries.<sup>16</sup> According to this view, empathy involves both cognitive and affective components.<sup>16</sup>

*Empathic leadership*: an evidence-based model of empathic leadership has been proposed that mirrors the definition of therapeutic empathy.<sup>12</sup> Following this model, empathic leadership

requires perspective-taking, gaining shared understanding and cooperative action which together generate high performing teams.

*Leadership in healthcare*: there are different definitions of leadership in healthcare. For example, the NHS Leadership Academy describes leadership as including compassion, curiosity and collaborative action.<sup>21</sup> The Institute of Medicine defines leadership in healthcare as ‘the ability to guide individuals, teams and organisations to achieve goals that improve health outcomes, ensure patient safety and enhance system performance’.<sup>22</sup> While there are differences between these and other definitions, they share the idea that leadership involves motivating others toward the achievement of a common goal.

*Heuristics*: rules of life or mental shortcuts that help us make complex decisions efficiently. For example, ‘listen twice as much as you speak.’ Derived from the Ancient Greek ‘to find’, (as in Archimedes’ cry *Eureka* on discovering how to measure the volume of irregularly shaped objects), heuristics have been used by Tversky and Kahneman to show how heuristics influence our thinking. Consider the anchoring heuristic. If a seller begins with a high price it anchors the negotiation upwards making overpaying seem reasonable.<sup>23</sup> More recently, heuristics have been applied to management and leadership, and shown to improve project success.<sup>19</sup> Flyvbjerg has identified five key characteristics of effective project management heuristics:

1. Limited in number, usually a handful or two.
2. Personal, tailored to the person and organisation using them.
3. Specific, based on deep domain experience.
4. Intuitive, unreflected (unless teased out).
5. Clear, offering concrete guidance once teased out.

The fundamental underpinning principle is ‘Keep It Simple’. To be effective, heuristics must be easily remembered and applied. This is so decision-makers can avoid the distracting noise inherent in complex systems. Research consistently shows simpler models often outperform complex ones in accuracy, testability and improvement potential.<sup>20</sup> For example, in the 1990s, doctors at a hospital in Ann Arbor, Michigan, faced a problem. About 90% of patients with chest pain were sent to the coronary care unit, yet only 25% had myocardial infarction. The unit became overwhelmed and ended up in financial trouble. The (over-)diagnosis was caused by a complex statistical method involving logistic regression (the Heart Disease Predictive Instrument, HDPI). It required a calculator and yielded a chart with about 50 probabilities. To use the HDPI, a doctor had to review seven symptoms, plug their probabilities into a calculator and interpret the results. It established a way to assess heart attack risk. But busy doctors found this method too complicated to be practical, and quickly reverted to their defensive strategy of referring patients to the coronary care unit.<sup>24</sup>

To solve this, Green and Mehr developed a three-step ‘Fast and Frugal Tree’ for triage.<sup>25</sup> It involved three simple yes/no questions and did not require a calculator. The approach drastically improved outcomes—it reduced unnecessary coronary care admissions by about 40% and decreased missed heart attacks by roughly 50% compared with the more complex method. The triage tool became a landmark demonstration of how a well-designed, simple heuristic can outperform more complex statistical approaches in a high-stakes medical setting. Flyvbjerg has shown that applying similarly simple heuristics improves the success of project management and leadership.

**Table 1** Steps for generating heuristics for empathic leadership

	Description	Origin
Step 0	Gather group of experts	Flyvbjerg 2024 <sup>19</sup>
Step 1	Explain what heuristics are	Flyvbjerg 2024 <sup>19</sup>
Step 2	Provide examples of other leaders' heuristics	Flyvbjerg 2024 <sup>19</sup>
Step 3	Ask participants to identify heuristics that resonate and why	Flyvbjerg 2024 <sup>19</sup>
Step 4	Have participants reflect on their work (or the work of empathic leaders they know) then articulate heuristics that help them be empathic leaders	Flyvbjerg 2024 <sup>19</sup>
Step 5	Ask participants to share their heuristics with the cohort, explain their choices and give concrete examples	Flyvbjerg 2024 <sup>19</sup>
Step 6	Use the nominal group technique to identify up to 12 favourite heuristics	Howick 2024 <sup>33</sup>

### Part I: generating heuristics for empathic leadership

We followed the model described by Flyvbjerg for developing heuristics to improve project management (see [table 1](#)).<sup>19</sup> We supplemented this with the nominal group technique for selecting the top 12 heuristics for empathic leadership.<sup>26</sup>

26 healthcare leaders were invited to participate in a 1-day workshop (between 20 and 40 experts have been involved in previous workshops successfully).<sup>19</sup> The first half of the workshop focused on generating heuristics for empathic leadership. The second half involved co-designing a course to teach these heuristics. Experts were identified through peer nomination and professional networks, with inclusion criteria of holding senior clinical or managerial roles and being recognised by peers for empathic leadership. Invitees were contacted by email.

For step 1, we described heuristics, and for step 2, we provided a list of example heuristics. As no workshops for developing heuristics for empathic leadership in healthcare had been developed, one author (JH) conducted a scoping search to identify potential heuristics for empathic leadership in healthcare (these are the first six heuristics in [table 2](#)). These heuristics were named and each illustrated with healthcare-specific examples. For instance, we explained that 'Walk the Shop Floor' comes from research at the Mayo Clinic, showing that leaders who spend time walking around the wards have happier, healthier and less burned-out staff.<sup>24</sup>

For step 3, we invited participants to reflect on the example heuristics and record which ones resonated with them most closely. We reiterated Flyvbjerg's admonition that participants must embody the heuristic at an emotional rather than intellectual level. Participants were asked to share their top choice of heuristic with the group.

Step 4 was crucial. In small groups of four to five, we asked participants to focus on what their own heuristics are and to write them down on sticky notes. The expression of the heuristic had to be short and pithy, to make them easy to remember, act upon, and disseminate. Participants were allowed to be inspired by the ones listed, but were not allowed to use the same language unless it truly resonated with them at a deep level. The group was then tasked with choosing their top three heuristics.

In step 5, the groups shared their top three heuristics with the rest of the group. The facilitators managed this process to ensure that the heuristics were short and sweet. If not, participants were asked to rephrase their heuristic into a five-to-eight-word expression. In step 6, we used a modified nominal group technique<sup>26</sup> to prioritise heuristics. To achieve this, heuristics were first written on sticky notes, then participants voted on which ones they thought were more relevant and effective.<sup>27</sup>

### Part II: co-design of a one-day course on empathic leadership

In the second half of the workshop, participants co-designed a 1-day training course. Using Thomas' six-step approach to

curriculum development,<sup>28</sup> participants specified: the problems to be solved through the course; the general and targeted need for the course; goals and learning objectives; educational strategies; implementation requirements and evaluation measures.

The problem identification and needs assessment were addressed earlier in the workshop, by highlighting the problems associated with the lack of empathic leadership in healthcare and the need for a course to address this. We therefore started by asking participants to develop three learning objectives that aligned with its overarching goal: to teach healthcare leaders how to use heuristics for empathic leadership. Each learning objective was written on a sticky note and participants voted on their top three.<sup>26</sup> Those with the most votes became the course learning objectives.

To determine educational strategies, participants designed teaching plans. Based on previous empathy training courses in healthcare,<sup>27</sup> we asked participants to develop four learning experiences, framed by an introduction and a course debrief, considering possible underpinning theories. Plans were presented, voted on<sup>26</sup> and the top four learning experiences sequenced into the final course plan. Participants then made recommendations for how to implement the course.<sup>28</sup> They considered factors such as optimal participant numbers, facilitator preparation, resources and scalability. Each group shared and developed their ideas through facilitated discussion. Finally, participants considered how to evaluate the course. Groups identified at least three desired evaluation measures and then each participant voted on their top three.<sup>26</sup>

## RESULTS

26 participants were invited to participate and five declined due to diary conflicts. 21 participants attended the workshop (13 male, 8 female). Thirteen had clinical training in medicine, nursing or midwifery.

### Heuristics for empathic leadership

Participants endorsed the six prespecified heuristics and added 29 new suggestions, creating a pool of 35 (see online supplemental file 1). Participants drew extensively on their personal experience. For example, several participants resonated with the heuristic 'Be vulnerable', recalling their own experiences of expressing uncertainty about decision-making within their teams. Using the nominal group technique, 12 heuristics were prioritised (see [table 2](#)). These clustered into four domains:

- ▶ *Listening and curiosity*: listen first, speak last; check in, not just on.
- ▶ *Visibility and accessibility*: walk the shop floor; be prepared to muck in.
- ▶ *Humility and openness*: say sorry; be vulnerable.

**Table 2** List of heuristics for empathic leadership\*

Heuristic	Description	Healthcare-specific example
Listen first, speak last	Prioritise listening deeply before offering opinions or solutions.	During a debrief after a stressful Intensive Care Unit (ICU) shift, a nurse manager allows all staff to express concerns before offering guidance, making everyone feel valued. <sup>34</sup>
Walk the shop floor	Leaders should maintain physical visibility and accessibility.	Cleveland Clinic Chief Executive Officer (CEO) Dr Mihaljevic maintains weekly clinical rounds where he joins frontline teams. During one round, he identified a communication bottleneck between departments that was frustrating staff and implemented an immediate solution that would have taken months to reach his attention through formal channels. <sup>24</sup>
Say sorry	To err is human; successful leaders are not afraid to apologise when wrong, then <i>take concrete action</i> to reduce the chances of the error repeating itself.	After Tylenol bottles were tampered with in California, a nationwide recall of Tylenol products was issued on 5 October 1982; an estimated 31 million bottles were in circulation, with a retail value of over US\$100 million (equivalent to US\$326 million in 2024). The apology and recall built trust and after an initial setback, profits increased. <sup>35</sup>
Assume positive intent	In emotionally charged moments, believe colleagues or patients mean well.	A doctor receives pushback from a nurse on a care plan. Instead of becoming frustrated, they assume it is coming from concern for the patient's safety. The positive interpretation helps avert a potential conflict. <sup>36</sup>
Check in, not just on	Regularly connect on an emotional level, not just about performance.	A medical director routinely asks physicians, "How are you holding up with the patient load?" not just, "Are you on schedule?" <sup>31</sup> Seeking to understand allows the leader to find ways to overcome challenges that would otherwise be invisible.
Be vulnerable	Appropriate disclosure of challenges and uncertainties.	At the height of the COVID-19 surge, one CEO began a staff meeting with: "I don't have all the answers... and I'm worried too. Let's solve this together." That vulnerability unlocked creative solutions frontline staff had been holding back. <sup>30</sup>
Value every person, value every role	Recognise and acknowledge the unique importance and worth of staff and their roles, as well as how their contribution fits in with the bigger picture.	An experienced consultant surgeon gathered all theatre staff to offer insights. A junior healthcare assistant (HCA) suggested rearranging the theatre to optimise access and pre-packaging equipment. By accepting the suggestion of a less experienced staff member who might otherwise have been ignored, surgery times were halved and innovations of the HCA praised. <sup>37</sup>
Use words and humour intentionally	Use deliberate language and humour to facilitate communication, creativity and uplift. Avoid the opposite (negative language) which can bring people down.	The NHS launched the 'call my name right' campaign in February 2024. Using the correct pronunciation of names improves the working lives of staff and prevents confusion between colleagues and even potentially reduces mistakes and errors. <sup>38</sup>
Connect and give a damn	Take the time to really listen, notice and try to care for team members. True connection happens when care is genuine.	During a hectic night shift, two resident (junior) doctors were called to an Emergency Department to help resuscitate a child. The child died, and the loss was heavy for everyone involved. A thoughtful medical registrar bought food for the team and created a safe space to grieve. This approach humanised the loss and demonstrated care beyond rote duty. <sup>39</sup>
Look for undisclosed brilliance in people	Not all strengths are obvious. Look deeper for hidden strengths—not just those needed for the job—and create space for people to reach their potential.	Nottinghamshire Healthcare NHS Trust senior leaders paired with Black, Asian, and Minority Ethnic (BAME) staff in long-term learning partnerships. These relationships highlighted individuals' unique strengths and experiences. Staff gained confidence and career progression, while leaders developed deeper understanding of workplace inequities. The programme improved inclusion, morale and positively influenced patient care. <sup>40</sup>
Personalised thanks improve performance	Specific and personal appreciation motivates people to go further.	After busy ward rounds, a consultant general surgeon buys drinks for her resident doctors as a token of gratitude throughout their 4-month placement. Inspired, one doctor began buying beignets for the team. The team felt appreciated and their well-being remained high. <sup>41</sup>
Be prepared to muck in	Commit fully without holding back.	Hospital wards were short staffed during strike action. Hierarchy flattened and multi-disciplinary staff divided responsibilities regardless of seniority: charge nurses took patient observations and consultants wrote discharge summaries. Staff gave their all to maintain morale and patient safety. This synergistic approach demonstrated no task is below an empathetic leader.

\* The first six heuristics were provided as examples, and subsequently approved in the prioritisation exercise.

► *Recognition and inclusion*: value every person, value every role; personalised thanks improve performance; use words and humour intentionally; connect and give a damn; look for undisclosed brilliance in people

Vignettes provided context for these heuristics (see [table 2](#) for examples). For instance, a CEO during the COVID-19 Personal Protective Equipment (PPE) shortage openly admitted uncertainty and asked staff for solutions, leading to improved

results ('Be vulnerable'). Another leader within an ICU takes time to listen to all team member concerns despite the time pressured environment, exemplifying, 'Listen first, speak last', thus ensuring that all team members feel valued and heard.

### Leicester empathic leadership course

Participants developed and voted for four learning objectives for the course:

1. Define empathic leadership and describe how this differs from other leadership styles.
2. Describe and apply heuristics for empathic leadership to real-life scenarios.
3. Develop a personalised implementation plan for empathic leadership heuristics.
4. Analyse the organisational and environmental influences on empathic leadership within their local context.

Participants suggested a cap of 25 inter-professional participants for teaching heuristics. This was to re-create the depth of discussion achieved in the workshop they took part in. Two experienced facilitators were recommended, and there was strong support for conducting the course off-site and in person to foster creative and open discussion.

Six interactive learning experiences were recommended (see online supplemental file 1), with suitable breaks and an introduction and close to the day. Designed to be adaptable to the contexts in which it is implemented, the course was designed to provide participants with activities that require collaboration and creativity to complete successfully. To evaluate the course, on-the-day participant satisfaction, perceived learning and stated intention to change behaviour was suggested, followed by a 3–6 months postcourse survey to assess actual changes in behaviour attributed to the course. This could be supplemented with data from the NHS Staff Survey. The overall course format, including underpinning theory,<sup>28</sup> is summarised in the supplementary table.

## DISCUSSION

### Summary of findings

We generated and prioritised 12 heuristics for empathic leadership in healthcare and co-designed a 1-day training course to teach them. This is the first structured attempt to make empathic leadership teachable in healthcare.

### Comparison with other literature

Our work builds on Flyvbjerg's framework for management heuristics,<sup>19</sup> extending it to healthcare leadership. The heuristics we identified resonate with the established leadership literature while offering healthcare-specific applications. 'Walk the shop floor' echoes management by walking around principles popularised by Peters and Waterman,<sup>29</sup> but our healthcare examples (such as Cleveland Clinic's CEO joining clinical rounds) demonstrate domain-specific implementation. Similarly, 'be vulnerable' aligns with Brené Brown's research<sup>30</sup> on courage and leadership vulnerability, while 'check in, not just on' reflects Amy Edmondson's work on psychological safety in healthcare teams.<sup>31</sup>

Our emphasis on empathic leadership addresses gaps in existing NHS compassionate leadership frameworks.<sup>32</sup> Compassionate leadership incorporates empathy, so our empathic leadership course could therefore complement rather as well as replace the teaching of compassionate leadership. However, our approach offers clearer definitional boundaries, avoids the emotional merging that can lead to compassion fatigue and emphasises pro-active curiosity to learn more about what people

are going through, for example by walking the shop floor. This distinction matters, given that compassion-related failures have persisted despite years of training.

### Strengths and limitations

Strengths of this study include the diversity of participants, the structured methodology<sup>19 28</sup> and theoretical grounding. The nominal group technique<sup>26</sup> enabled democratic prioritisation, and the workshop design fostered the emotional connection required to generate authentic heuristics that move beyond generic slogans.<sup>19</sup> Important limitations must also be noted. The heuristics as well as the course remain untested and require empirical validation to measure impact. Also, while several participants were not UK-based, the focus was on UK NHS contexts. Finally, it is also possible that participants' existing preferences biased the choice of heuristics: replication is therefore required.

### Implications for research and practice

Future research should prioritise the systematic implementation and evaluation of the course's effectiveness across diverse healthcare settings. Particular attention should be paid to sustained behavioural change, leadership impact and measurable improvements to organisational outcomes such as patient safety. Cross-cultural adaptation and contextualisation will be essential to ensure relevance and scalability across global healthcare systems. The implementation and evaluation should follow a structured approach, which is likely to include pilot testing followed by effectiveness testing using validated instruments capable of capturing both proximal (eg, participant satisfaction, intention to change) and distal (eg, behavioural change, organisational culture shift) outcomes. Cost-effectiveness analyses will also be critical to inform resource allocation decisions.

Integration with existing leadership development programmes, such as 360-degree feedback<sup>13</sup> and organisational initiatives, should be explored to enhance uptake and sustainability. Additionally, implementation science approaches may be employed to assess organisational readiness, identify barriers and facilitators and optimise course delivery within complex and evolving healthcare environments.

## CONCLUSION

For over 15 years, the NHS has trained leaders to be compassionate. Yet avoidable tragedies partly caused by compassion deficits show that compassion alone has not solved the problem. Empathic leadership—curiosity-driven, boundary-respecting and practical—offers a different path. We have provided the first systematic attempt to make empathic leadership teachable. By distilling tacit wisdom into 12 heuristics and embedding them in an experiential 1-day course, we offer leaders simple, actionable rules to protect patients, support staff and reshape organisational culture. The Leicester Empathic Leadership Course is a replicable model ready for testing. Its promise now depends on rigorous evaluation across contexts, with attention to long-term impact on safety, well-being and system resilience.

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