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# Conditions for Empathy in Medicine: A Grounded Theory Study

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CONDITIONS FOR EMPATHY IN MEDICINE:

A GROUNDED THEORY STUDY

by

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August 2011

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## **ABSTRACT**

### **CONDITIONS FOR EMPATHY IN MEDICINE: A GROUNDED THEORY STUDY**

Hannah Barnhill Bayne  
Old Dominion University, 2011  
Chair: Dr. Ed Neukrug

Previous research in the medical setting has credited empathy with improving treatment outcomes and patient satisfaction, though operational definitions of the concept are widely varied and indicate inconsistencies in conceptualization and subsequent assessment. The purpose of this grounded theory study was to examine the role of empathy in the medical setting. A model of conditions for empathy in medicine was developed through in-depth interviews with 21 healthcare professionals, utilizing their professional experiences and perspectives to structure the multi-level model. The seven levels of the model indicate the layers of complexity inherent in facilitating optimal empathy in medicine and add to the conceptualization empathic practice and development.

For my husband – my constant support, biggest fan, and best friend.

## ACKNOWLEDGEMENTS

This dissertation process has been long and tedious, but also fascinating and satisfying. I have learned many lessons over the past year of how to survive within the extremes – learning to work in isolation while also utilizing mentors and participants; growing to dread the hours of writing, but simultaneously gaining excitement from each word that was written; wanting it all to be over, yet fearing the end of this, my most significant project. In a life of extremes it is the people around you who act as a balance, and I would like to thank these people here.

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To my husband, Chris – your support has been unending, and your belief in my research has pulled me through many moments of doubt. Your hours of help transcribing and listening to me mull over my data has made you my muse. Thank you for inspiring me to enter the world of your profession. May you always allow your own natural empathy to enhance your treatment of patients.

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energy to help me. Your enthusiasm for this project, and excitement over the data, also energized me and was incredibly valuable in helping me move forward.

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## CHAPTER ONE

### INTRODUCTION

#### Overview of the Research Problem

For over a century, empathy has been considered a core condition for a strong therapeutic relationship (Hojat, 2007). Indeed, within the mental health professions empathy is viewed as an essential facilitative aspect of the therapeutic process (Clark, 2010). The concept has also been applied to the medical field in the past few decades, with many studies demonstrating desirable outcomes as the result of empathic physician and patient interactions, such as higher patient satisfaction, increased adherence to treatment procedures, and more accurate diagnosis (du Pre, 2001; Nicolai, Demmel, & Hagen, 2007; Romm, 2007; Shapiro, Morrison, & Boker, 2004; Stepien & Baernstein, 2007).

Despite empathy's long history as a descriptor of therapeutic relatedness, there has been enough variance in definitions and inconsistencies in measurement to support the need for further investigation into its primary attributes and to distinguish it from related constructs (Hojat, 2007; Pederson, 2009). This need to clearly define empathy is particularly apparent within the medical professions. Though empathy has been identified as a goal of medical training, there remains a lack of consensus as to what this training may involve and, more importantly, what role empathy may play in the medical setting. In a field devoted to efficient diagnosis and treatment of physical ailments, biopsychosocial concerns are frequently seen as secondary (Levasseur & Vance, 1993; Shapiro, 2008). Therefore, though research has illuminated the valuable benefits of using empathy within the medical setting, there is little known about what this might look like

and how it might differ from the more commonly understood view of empathy within mental health settings. This study thus explored the concept of empathy within the medical setting, utilizing grounded theory methods to provide a theoretical framework regarding the scope and application of empathy in medicine.

### **Brief Summary of Relevant Literature**

#### **Definitions of Empathy**

Empathy is a broad concept that has eluded a firm operational definition, so much so that Pigman (1995) once suggested empathy has come to mean so much it no longer means anything at all. Early definitions conceptualized empathy as an internalization of another's emotions, whether by observation or self-projection (Hojat, 2007). These definitions were later adopted by social and behavioral scientists to explain the psychotherapeutic relationship, thus molding the term into its more modern day meaning. However, a firm operational definition of empathy has remained elusive, thus leaving much up to interpretation regarding its implementation and measurement (Greenberg, Elliot, Watson, & Bohart, 2001; Marks & Tolsma, 1986; Norfolk, Birdi, & Walsh, 2007).

Within the mental health profession, empathy has primarily been defined as a clinical skill that is essential in the formation of a strong therapeutic relationship (Clark, 2010). Carl Rogers, a leader in the fields of counseling and psychology, stressed empathy as a core condition for effective therapy and defined it as the ability to "sense the client's anger, fear, or confusion as if it were your own, yet without your own anger, fear, or confusion getting bound up in it" (Rogers, 1957, p.99). Rogers' definition is undoubtedly one of the most cited explanations of empathy within the field of mental health (Clark, 2010).

Truax and Carkhuff (1967), however, believed that Rogers' definition was an insufficient description of the phenomenon and expanded upon it by stating:

Accurate empathy involves more than just the ability of the therapist to sense the client or patient's private world as if it were his own. It also involves more than just his ability to know what the patient means. Accurate empathy involves both the therapist's sensitivity to current feelings and his verbal facility to communicate this understanding in a language attuned to the client's current feelings. It is not necessary – indeed, it would seem undesirable – for the therapist to share the client's feelings in any sense that would require him to feel the same emotions. It is instead an appreciation and sensitive awareness of those feelings (p. 46).

This continual reinterpretation of the term demonstrates that even mental health professions have difficulty reaching consensus on what empathy means and how it is to be applied in a professional setting. One difficulty in defining empathy within the mental health field is that the construct is so intertwined with other facilitative conditions that it can be almost impossible to view it as a separate and measurable construct. Rogers, for example, included components of empathy within his other facilitative conditions of genuineness and unconditional positive regard. Carkhuff (1969; 2000) developed a model for effective helping that has frequently been characterized as a model of empathic communication. However, Carkhuff's model also includes additional elements of helping, such as nonverbals and goal-setting (Carkhuff, 2000). Thus, in many models of counseling empathy neither stands alone as an independent construct, nor is it always clear where empathy ends and a related therapeutic condition begins. Since empathy is

nearly inextricable from the psychotherapeutic process, at least in theory, a full understanding of the phenomenon may remain elusive. The task of understanding empathy as a distinct process is thus challenging. Other professions, however, have continued to explore how empathy can be defined and targeted in training and practice. The medical field has been active in this research, and has furthered the study of empathy in some important ways.

Within the medical literature, definitions of empathy separate the concept into multiple components, thus allowing researchers to specify which subset of empathy they hope to study (Barkham & Shapiro, 1986; Marks & Tolsma, 1986; Nicolai et al., 2007; Norfolk et al., 2007; Stepien & Baernstein, 2007). Stepien and Baernstein (2007) defined empathy as having emotive, moral, cognitive, and behavioral components. Within these definitions, emotive empathy reflects the *ability to experience and identify* emotions, moral empathy reflects a *motivation* to accurately understand and empathize, cognitive empathy refers to the *ability to identify and understand* a patient's experience, and behavioral empathy consists of the *ability to convey this understanding* to the patient (Greenberg, Elliott, Watson, & Bohart, 2001; Mercer & Reynolds, 2002; Stepien & Baernstein, 2007). The majority of the medical literature focuses on cognitive and behavioral components, measuring physician understanding and the ability to communicate this understanding to the patient (Mercer & Reynolds, 2002; Nicolai et al., 2007). Cognitive and behavioral components of empathy have also been identified as the easiest elements to teach, with moral and emotive empathy seen as more of a personal trait that lies beyond the scope of short-term training (Norfolk et al., 2007; Stepien & Baernstein, 2007; Yu & Kirk, 2008).

The medical literature also frequently uses other terms seemingly interchangeably with empathy. Communication skills, interpersonal communication, emotional intelligence, and relationship-building skills are mentioned throughout the literature in empathy-related studies. The interchangeable nature of these terms lends additional support to the idea that empathy is inconsistently identified and defined within the medical profession, leading to further confusion about the meaning of the construct.

### **Empathy in Medicine**

Though the medical field has made an effort to further define and assess for empathy, it is still unclear how much of a role empathy should play within medical settings. The primary task of a physician is to treat medical complaints, and physicians are thus trained almost exclusively in an understanding of the physical body. However, empathy can play an important role in establishing a relationship of trust, as well as broadening the perspective of factors that have an impact on illness (Glick, 1993; Yu & Kirk, 2008). Though often seen as an additive component of a medical interview, empathy can have profound effects on the experiences of both the patient and the physician, leading to greater satisfaction and better treatment outcomes (Shapiro et al., 2004; Stepien & Baernstein, 2007).

Unfortunately, despite the potential benefits of empathic ability, empathy levels tend to decline in medical students throughout their training (Chen, Lew, Hershman, & Orlander, 2007; Hojat et al., 2004; Shapiro, 2008; Shapiro et al., 2004; Thomas et al., 2007). Whereas first year students are said to be idealistic and patient-oriented, by the third year many students have begun to counter-identify with their patients, preferring emotional detachment and clinical neutrality (Chen et al., 2007; Hojat et al., 2004;

Shapiro, 2008, Thomas et al., 2007). Much of this decline may be explained by the culture and intent of medical education. Medical students are necessarily trained to treat illness, interpret x-rays, and diagnose physical conditions. They must wrestle with an overwhelming amount of knowledge and be able to apply it to the treatment of the body. As a result, students are sometimes implicitly taught that understanding the personhood of the patient has little to do with their ability to identify and treat physical complaints (Levasseur & Vance, 1993; Shapiro, 2008). The push towards diagnosis, often driven by time constraints, restricts the physician's ability to connect empathically with a patient, and also results in incomplete assessments of contributing factors (du Pre, 2001).

In response to some of these constraints and challenges, many medical programs have developed training modalities to enhance empathy in students (Shapiro, Lancee, & Richards-Bently, 2009; Stepien & Baernstein, 2006). The majority of these training approaches focus upon the more observable and measurable categories of cognitive and behavioral empathy, although some may target emotional and moral empathic development (Nicolai et al., 2007). Although many programs incorporate training to some degree, there is a lack of literature demonstrating a standard practice or curriculum for effective instruction.

One challenge in the design and implementation of empathy training within medicine is that many medical programs have adopted definitions of empathy and training techniques from the mental health field, without fully investigating how empathy is different in medicine. Physicians have a qualitatively different role than a counselor or other mental health professional in that they necessarily must provide brief treatment for primarily physical concerns. It would therefore not be advisable for the physician to take



on the role of a therapist or to screen for all possible mental health concerns (Bylund & Makoul, 2005). However, ignoring biopsychosocial domains may greatly impact the ability to successfully treat physical symptoms, make appropriate referrals, or ensure that patients comply with treatment goals (Hojat, 2007). This balance of information gathering and treatment does not seem to have any certain framework, and the opportunities and limitations for including empathy within this process have yet to be fully determined (Bylund & Makoul, 2005; Mercer & Reynolds, 2002).

### **Conceptual Framework**

Previous literature thus indicates that empathy may be a multidimensional construct, consisting primarily of the ability to relate to another individual as he or she experiences the world (Rogers, 1957; Stepien & Baernstein, 2007). Within this relational focus, empathy may involve emotional connection, suspension of self, moral intent, unconscious processes, or observable communicative skills (Clark, 2010; Hojat, 2007; Spiro et al., 1993). In addition, some suggest that empathy is dependent upon whether the individual receiving an empathic statement understands it, while others believe it may be valid regardless of the receiver's understanding (Pederson, 2009; Truax & Carkhuff, 1967). Finally, empathy could be a quality attributable to personality or genetics, or it could be a trainable skill that can be applied intentionally for better outcomes (Hojat, 2007). The core component among current definitions of the term seems to be the ability to connect to the lived experience of another person and to utilize this understanding in a practical way.

These various existing conceptualizations of empathy served as a framework for the formation of the research questions and initial data collection procedures for this

study. However, this study also further defined empathy within medicine, utilizing grounded theory methods to explore the various dimensions and practical limitations of empathic communication within the medical setting. Grounded theory acknowledges that contextual variables can influence the generalizability of the data, yet asserts that approximations of truth can be revealed by following prescribed methods and allowing theory to emerge from a variety of data sources (Corbin & Strauss, 2008). Therefore, it was important for this study to not adhere too strongly to existing conceptual frameworks of empathy, but rather to use them as a starting point and point of comparison with emergent themes. Openness to data that broadens understanding of empathy, particularly as it is applied in the medical setting, resulted in a new conceptual framework to inform future research.

### **Rationale for the Study**

A great majority of studies have attempted to examine empathy exclusively through quantitative methods. In fact, a review of the past several years of research on empathy in medicine reveals that 171 out of the 206 empathy-related studies employed a quantitative methodology (Pederson, 2009). This research has served to illustrate where further training may be needed, and it has also been pivotal in making a case for the inclusion of empathy in physician training and practice. However, one key weakness in utilizing quantitative research to study empathy is that, given the confusing and varied definitions of empathy, the researcher must determine how to operationalize the concept, which also has an impact on his or her selection of instruments, variables, and interventions (Yu & Kirk, 2008). Pederson (2009) found that many quantitative studies on empathy in medicine did not even provide this definition. Furthermore, construct

validity among instruments claiming to measure the same or similar constructs is weak, suggesting that identified components of empathy may not be valid (Hemmerdinger, Stoddart, & Lilford, 2007; Marks & Tolsma, 1986; Yu & Kirk, 2008). As a result, it is sometimes unclear what exactly is being measured and whether empathy is being correctly assessed.

As a result of these limitations, many quantitative studies conclude with an acknowledgement that qualitative methods may be needed to further develop and interpret the results (Bylund & Makoul, 2005; Pederson, 2009). The rich descriptive data that characterizes qualitative research can be used to develop theory or explain inconsistencies resulting from quantitative methodology (Charmaz, 2006). This study therefore explored the concept of how empathy is applied in the medical setting using grounded theory, a qualitative model that allows themes to emerge through continuous data collection and interpretation. The resulting theory can then be further developed, tested, and applied through future research, thus adding to the understanding of the phenomenon and revealing potential constructs otherwise unidentified in current literature.

### **Research Question**

Based on the current conceptual framework of empathy and the intent to add qualitative data to the study of empathy in medicine, the primary research question for this study is: “How do physicians conceptualize the practice of empathy in the medical interview?” Sub-questions include: “What influences empathic communication in the medical setting?” and “How does the conceptualization of empathy influence medical training?”

### **Definition of Terms**

Though grounded theory attempts to create some distance between preexisting frameworks and the phenomenon under study, several important terms need definition in order to form the general conceptual framework of the study, as well as to provide some structure for data collection procedures (Corbin & Strauss, 2008).

#### **Biopsychosocial**

Whereas the *biomedical* paradigm of disease views the physical body as the primary unit of treatment, the *biopsychosocial* model stresses a holistic view of a patient in which biological, psychological, and social elements are intertwined (Hojat, 2007). Thus, successful treatment must assess the patient as a system of interplaying forces, only one of which is physical in nature. This biopsychosocial paradigm asserts that:

Curing occurs when the science of medicine (biomedical and pathophysiological aspects of disease) and the art of medicine (psychological, social, and interpersonal aspects of illness) merge into one unified holistic approach to patient care (Hojat, 2007, p. 78).

#### **Empathy**

As the primary focus of this study, the concept of empathy remained loosely defined prior to data collection. A consolidation of current definitions reduced the concept to its core components – namely, that empathy represents a relational connection between two people in which the ability to understand the experience of the other person achieves some practical goal. The practical goal could consist of strengthening a relationship, performing a professional task, or acquiring a personal benefit as a result of the connection. Empathy is most frequently used to describe a professional process to

ensure comprehensive treatment, though it is also used to describe nonprofessional relationships. This study focused on the professional utility of empathy.

### **Medical Interview**

The medical interview refers to the primary point of contact between physicians and patients. This interview could be a brief screening, a yearly physical, a pre-surgical conversation, or any number of clinical interactions. The defining component, for the purpose of this study, is that the medical interview has certain expectations for diagnosis and suggestion of treatment options. Both the physician and the patient must be physically present in order for the communication to qualify as a medical interview.

### **Medical Setting**

The medical setting can consist of a hospital, private practice, free clinic, or a home visit. Medical schools and training facilities may also be considered as medical settings. The qualification of the setting includes the presence of a medical professional and a focus on medical procedures. The medical setting was thus considered a place where medicine is practiced or taught.

### **Mental Health Issues**

Mental health refers to conditions that may impact the biopsychosocial functioning of an individual and that can be treated by mental health professionals. These conditions include, but are not limited to, depression, anxiety, somatoform disorders, substance abuse, physical abuse, and post-traumatic stress disorder. Within this study, mental health issues served as the broad term to describe issues that cannot be fully addressed through medical care, and that therefore require counseling or psychiatric attention.

**Mental Health Professional**

Mental health professionals include licensed counselors, psychologists, and social workers working within or outside of the medical setting. For the purpose of this study, psychiatrists were considered medical professionals due to their training and focus within the medical setting.

**Patient**

A patient is any individual presenting to a physician with a concern, whether that concern is primarily physical or the result of other biopsychosocial concerns.

**Physician**

A physician in this study is anyone with a medical degree who is currently working within a medical setting, whether in a clinical or teaching role. Physicians will likely vary in specialty area, years of experience, and practice settings. Medical students will not be included within this description of physicians due to their status as physicians-in-training.

**Relationship**

For the purpose of this study the concept of the relationship denotes a therapeutic or professional relationship, rather than one of a more personal nature. In this context, a relationship will be the joining factor between a professional and a person seeking help. Relationships can vary in perceptions of closeness or distance, but will serve as the vehicle through which a professional service is carried out. Therefore, quality of the relationship can be described and assessed, with the assumption that quality will have some impact on the ability to fully apply the professional service.

**Sympathy**

Sympathy and empathy are often used interchangeably, though they each represent distinct constructs. Sympathy involves a degree of emotional attachment through the feeling or expression of concern or compassion (Clark, 2010). Empathy, in contrast, consists of emotional detachment and objective understanding of an individual's situation, feelings, or values (Clark, 2010; Rogers 1957). Thus, for the purpose of this study sympathy is defined as “feeling for” a patient, involving emotional responses from the professional.

## **Overview of Methodology**

### **Grounded Theory**

The aim of this study was to address a gap in current literature by developing a conceptual model of how empathy and other facilitative conditions are implemented and valued within the medical interview. Through a deeper understanding of how empathy is employed within medicine, a clearer conceptualization of the construct was developed, thus potentially influencing both the assessment and successive training of medical professionals. This goal required a method that could examine the constructed realities of medical professionals and patients, without imposing potentially faulty concepts from previous literature. Therefore, a qualitative methodology was determined to be the best fit for establishing a theoretical framework that could later be tested through quantitative methods. The chosen method for this study, grounded theory, is a means of generating theory based upon inductive and deductive examination of data on processes or issues of importance (Corbin & Strauss, 2008; Creswell, 2008; Ghezeljeh & Emami, 2009).

Grounded theory is a method in which a researcher “derives a general, abstract theory of a process, action, or interaction grounded in the views of the participants”

(Creswell, 2008, p. 13). This method of theory development requires constant comparison of data, which results in a circular process of gathering and interpreting data in search of commonalities and divergent themes. Initial data collection begins the process of inductive analysis, from which hypotheses emerge and are tested by subsequent theoretically sampled data (McGhee, Marland, & Atkinson, 2007). The goal of the inquiry is to create a robust theory of a social phenomenon that accounts for all of the thematic variations within the data set (McGhee et al., 2007).

### **Role of the Researcher**

The researcher is a key instrument within qualitative studies, actively engaged in collecting and evaluating data for common themes (Creswell, 2009). To assume the perspective of participants, researchers must understand their impact upon the interpretation of the data. Researchers can reach an understanding of their impact upon the interpretation of data through the practice of reflexivity, in which they identify and document their influence on the research process (McGhee et al., 2007). In other words, researchers must try, as best they can, to create interpretations of data while asking themselves “am I correctly representing what the data says, or am I applying my own biases to this interpretation?”

### **Memo Writing**

One core component of grounded theory research is the use of memoing to track significant themes and interpretations (Corbin & Strauss, 2008; Ghezeljeh & Emami, 2009). Although memos are primarily used to reflect on findings and make new connections among data, they can also be used to examine researcher bias. By incorporating a reflection on personal interpretation and reactions through memoing,



researchers are able to monitor their involvement in naming and categorizing major themes. Throughout this study, I engaged in memo writing as new thoughts and interpretations arose. Memos documented personal reactions and insights, along with hypotheses of new connections and categories during analysis.

### **Member Checking**

Member checking involves actively including participants in the confirmation of the researchers' interpretations. By sending coded transcripts and summaries of major themes back to participants, researchers allow for correction or expansion upon their primary interpretations, thus ensuring a more accurate view of the data. In this study, participants had the option of confirming, denying, or expanding upon data at two separate points in the process.

### **Triangulation of Data**

An additional means of ensuring sensitivity to the data is to utilize several research assistants to help with the coding of transcripts and selection of major themes. Multiple perspectives dilute the influence of the primary researcher's biases and assist in creating a more objective review of the data. For the purpose of this study, two additional researchers made up the research team. To ensure a multidisciplinary examination of the data, the research team consisted of a counseling doctoral student and a medical student.

### **Sampling Procedures**

Corbin and Strauss (2008) recommend theoretical sampling as the sampling procedure of choice in grounded theory studies. This method originates with an initial sample, based upon the research question, and then allows the researcher to "follow the data" by investigating new concepts as they arise. Therefore, in this study physicians

were initially selected based upon theoretical criteria of moral, emotive, cognitive, and behavioral empathy. Physicians who strongly purported empathy in their practice or teaching (moral), those who had a reputation of emotional connection to patients or students (emotive), and those who had demonstrated understanding and sensitivity to patient's medical and nonmedical concerns (cognitive and behavioral) were viewed as appropriate for the first round of interviews. Physicians were thus selected based on reputation, receipt of awards, expressed dedication to empathy in medicine, or recommendation by peers. Because this study aimed to ultimately achieve maximum variation of participants, initial participation was not restricted to a specific specialty area or level of practice. Theoretical and snowball sampling guided subsequent selection of participants until saturation of data was reached. Saturation was achieved when new data did not reveal any new themes or categories (Corbin & Strauss, 2008).

### **Data Analysis**

In grounded theory, data analysis is woven throughout a study. This cyclical process of data collection and analysis is conducted until the analysis reaches saturation, with no new concepts emerging (Wasserman, Clair, & Wilson, 2009). The purpose of data analysis in qualitative research is to make sense of the various concepts gathered through data collection by piecing them together in search of a larger meaning (Creswell, 2009). In this study, data were analyzed by following grounded theory reduction procedures (Corbin & Strauss, 2008) of open, axial, and selective coding. These coding procedures guide the process of breaking down large amounts of data into meaningful categories and, eventually, into major themes. Organizational procedures further assist with this process through the identification of conditions, actions and interactions, and

consequences within the data (Corbin & Strauss, 1990; 1998). Creswell (2009) describes the entire process as “generating categories of information (open coding), selecting one of the categories and positioning it within a theoretical model (axial coding), and then explicating a story from the interconnectedness of these categories (selective coding)” (p. 184). Analysis also included the use of data displays to map out potential relationships among concepts.

### **Trustworthiness**

Trustworthiness reflects the degree to which the study is logical, clearly organized, and presented in a way that allows readers to interpret the applicability of its results (Corbin & Strauss, 2008). Among the criteria to establish trustworthiness of a qualitative study are credibility, transferability, dependability, and conformability. This study attempted to establish credibility by carefully following grounded theory methods of triangulation and member checking, and thoroughly documenting each stage of the process. Transferability was addressed through sampling procedures aimed at capturing maximum variation of individuals and concepts within the medical setting, in hopes that a diverse sample might enhance the utility of the results. Dependability consisted of comparing codes and memos with other research team members to determine the degree of consistency among interpretations. Finally, confirmability was addressed through member checking by allowing participants the opportunity to view their interview transcripts. If participants felt they had been misquoted, misunderstood, or if they wanted to expand upon certain points they felt had been de-emphasized, they could do so at any point throughout the study.

### **Summary**

Empathy has been identified as an important component of success within the medical setting, with research demonstrating positive outcomes as the result of strong physician-patient relationships, and medical programs including empathy enhancement as a goal of training. However, despite the recent interest in empathy's application within the medical setting, little is known about how physicians should utilize empathy for an optimal balance between medical treatment and exploration of psychosocial concerns. This study attempted to address this gap in understanding through grounded theory methods, aiming for the development of a conceptual framework that acknowledged both the nature of empathy in medicine as well as the limitations of expressing empathy in the medical setting. The applicability and verification of results were enhanced through close adherence to qualitative procedures of trustworthiness and data analysis.

## **CHAPTER TWO**

### **REVIEW OF THE LITERATURE**

#### **Introduction**

Current literature asserts that the quality of the doctor-patient relationship has a significant impact on both doctor and patient satisfaction, proper diagnosis, and adherence to treatment (du Pre, 2001; Nicolai, Demmel, & Hagen, 2007; Romm, 2007; Shapiro, Morrison, & Boker, 2004; Stepien & Baernstein, 2007). One component of this relationship, empathy, has been identified as a determining factor of relationship strength and satisfaction (Mercer & Reynolds, 2002; Norfolk, Birdi, & Walsh, 2007). The benefits of empathic connection between doctors and patients have been so well documented in the literature that the American Association of Medical Colleges (AAMC) has identified empathy enhancement as a main goal of instruction (Shapiro, 2008; Stepien & Baernstein, 2007). However, despite promising research and AAMC's endorsement, levels of empathy tend to decrease as students progress through medical school, reaching their lowest points during residency (Chen, Lew, Hershman, & Orlander, 2007; Hojat et al., 2004; Shapiro, 2008; Stepien & Baernstein, 2007).

This chapter discusses the historical development of definitions of empathy, and examines how such definitions have been adjusted and applied to the medical setting. This review also covers the identified barriers to empathic behavior, as well as a discussion of how empathy has traditionally been measured and taught in the medical setting. Finally, gaps in the existing literature are summarized and a case is made for the current study.

#### **Empathy Defined**

Empathy is a broad concept that has eluded a firm operational definition; so much so that Pigman (1995) once stated empathy has come to mean so much it no longer means anything at all. From its origin as the Greek *empathia*, meaning *affection* and *passion*, to its German inception of *Einfühlung*, a term meaning *feeling into* that originally described the emotional reaction one has to a work of art, empathy has been defined and redefined based upon the orientation of a researcher or the needs of a profession (Hojat, 2007; Peitchinis, 1990; Spiro, Curnen, Peschel, & St. James, 1993). Early definitions conceptualize empathy as an internalization of another's emotions, whether by observation or self-projection (Hojat, 2007). These definitions were later adopted by social and behavioral scientists to explain the psychotherapeutic relationship, thus molding the term into its more modern day meaning. However, a firm operational definition of empathy has remained elusive, as the scope of the definition and subsequent evaluation of behavior varies according to the theoretical orientation and goals of the researcher (Greenberg, Elliot, Watson, & Bohart, 2001; Marks & Tolsma, 1986; Norfolk et al., 2007).

### **Empathy as Trait or State**

One factor complicating the acceptance of any one definition of empathy is the debate over whether it should be viewed as a natural trait or as a specific skill that can be increased through training and practice (Goldstein & Michaels, 1985; Hojat, 2007). The stance taken on this issue likely has implications for both the selection and training of helping professionals. If empathy is a natural response that serves an evolutionary purpose, then empathic enhancement may involve nothing more than nurturing this natural ability inherent in all individuals. If, however, empathy is a trait possessed by

some but deficient in others, training may prove ineffective. An understanding of the various hypotheses regarding this concept is therefore necessary, as each philosophy has implications for the way in which empathy is approached.

**Evolutionary and neurological empathy.** Empathy has been considered by many to be an evolutionary adaptation necessary for the maintenance of interpersonal exchanges. The human need for connection and community as a mechanism for survival makes empathy a valuable trait. Previous research has linked the existence of social support, whether through family or friends, as a protective factor against disease and death (Hojat, 2007). Indeed, medical studies have shown that individuals in secure and supportive relationships with others are less prone to contracting diseases, recover faster, and live longer than individuals who do not have such relationships. Conversely, individuals who are disconnected from others experience an increased susceptibility to disease, a quicker progression of illness, and an overall greater deterioration of health (Hojat, 2007). In addition, the ability to recognize and respond to verbal and nonverbal cues from others provides a means of assessing safety or danger, thus enhancing survival (Brothers, 1989). Empathy, then, is seen as an adaptive skill to ensure closer connection among people, as well as the ability to identify friend from foe.

Other studies have employed science and technology to examine the hypothesis that empathy could be an automatic and nondeliberate response to stimuli. This theory operates under the assumption that empathy is a quality inherent in all people, and that empathic responses lie beyond the awareness and intentionality of human control. Researchers have measured this physiological response by connecting participants to functional magnetic resonance imaging (fMRI) machines and recording their neural

activity to various stimuli (Hojat, 2007). When shown pictures of human hands or feet in painful positions, the brain regions associated with cognitive and affective responses were activated. However, these observations did not trigger activity in the regions of the brain that respond to actual experienced pain (Campbell-Yeo, Latimer, & Johnston, 2008; Hojat, 2007). The implications of these studies suggest individuals naturally have an affective reaction towards one another that lies outside of directly shared experience. In other words, one does not need to directly experience pain in order to respond at a cognitive and affective level to another individual experiencing pain.

Research on “mirror neurons” adds to the study of the physiological components of empathy by noting mirrored neural responses to observed actions. Though not affective in nature, these more tactile and sensory responses suggest a connection to the experiences of others. For example, observing an individual grasp an object or express disgust at a foul odor triggers a neural reaction in the observer (Hojat, 2007). The observer’s brain thus responds as if the observer is experiencing the same sensations. These reactions point to an innate understanding of another’s experience, at least at a neurological level. Whether the connection extends beyond sensory experiences into true understanding is beyond the scope of these studies, but the idea of natural and unconscious connections to indirect experiences does illuminate the study of empathy as a physiological phenomenon.

Within psychotherapy, studies of synchronous responses have lent further support for the physical manifestation of empathic connection. In studies of therapists and clients, heart rate and perspiration levels at times would converge during a session, suggesting that the connection between the two individuals naturally reached synchronicity (Ickes,



1997). Much of this research has since been criticized for methodological errors, but at the time it sparked interest in the potential for better understanding of empathy and its unconscious manifestations.

**Genetics and development.** An additional theory regarding a person's capacity for empathy involves the combination of genetic predisposition and optimal development (Campbell-Yeo et al., 2007). This theory states that although genetics determines the range of an individual's potential empathic abilities, the quality and quantity of early interactions with parents or other caregivers ultimately determines how these abilities are expressed. Strong maternal and/or paternal attachments are essential in the development of empathy through the provision of emotional support, tolerance, and acknowledgement of emotions (Hojat, 2007). These early interactions can form the basis for an individual's worldview, which subsequently determines his or her desire to connect and form meaningful relationships with others. In fact, a study of medical students showed that reported strong attachments in the past predicted the selection of specialty areas involving more patient contact (Ciechanowski, Russo, Katon, & Walker, 2004).

This theory of empathy implies that those individuals in their adult years who are deficit in their ability to connect empathically with others may not be able to overcome these biological and early childhood influences. This deterministic view has implications for the selection of individuals in the helping professions. If empathy is a desired trait of a physician, then perhaps empathy should be assessed prior to admittance to programs. Otherwise, the insecure attachments and genetic deficits of the individual will prevent major gains in empathic ability. Programs adhering to this view would therefore not

invest much energy in the training and development of empathy in students, but would rather select individuals already scoring high in empathy-related constructs.

**Learning.** To complete the discussion on various philosophies of empathy development, many adhere to the antideterministic view that empathy is not a fixed trait and can thus be taught and enhanced in individuals. Though some individuals may be predisposed in some way, empathy is still seen as a trainable attitude or skill set. Genetic traits and early experiences may make empathy enhancement more or less challenging, but proponents of this view claim that change is still possible (Hojat, 2007). In other words, this view posits that certain individuals may indeed be limited in their available range of empathic understanding, but that through training or social learning individuals can move towards higher levels of their natural range (Goldstein & Michaels, 1985).

There are several theories regarding how empathy might be taught, or enhanced, in individuals. One such theory states that empathy develops through social learning and socialization, as individuals learn to interact based on the observation of socially desired behaviors (Goldstein & Michaels, 1985). Empathic ability is thus identified as a desirable quality, and empathic interactions are rewarded by reinforcement from others in one's social group. Through this theory, empathy training need not be highly structured or prescriptive. Instead, empathic ability could increase merely by interacting with highly empathic others. Carl Rogers, for example, believed that empathy was more of an attitude than an observable skill, and stated that individuals can learn to be empathic merely by being exposed to the climate created by other empathic persons (Gazda & Evans, 1990).

Other theories describe empathic development as a process of learning, similar to the development of knowledge. Gazda, in his Human Relations Training (HRT) model, discussed empathy as a skill comparable to learning grammatical rules:

Individuals can learn effective components of interpersonal communication/human relations in a fashion similar to the ways they learn the rules of grammar and speaking. If we take into account the person's developmental level and readiness to learn, the concepts of the model can then be taught with increasing degrees of complexity to children, adolescents, and adults (Gazda et al., 1987, pp. 177-178).

In other words, Gazda acknowledges that there may be certain developmental and motivational limitations on learning, but that given the right conditions a person can approach higher levels of empathic ability. Gazda's model of empathy training thus focuses on skills deemed appropriate for various developmental levels, and encourages growth through recognition of what others need, development of attending behaviors, and the ability to give empathic responses (Gazda & Evans, 1990). Related training programs aim for the enhancement of empathy through role playing, role modeling, instruction on skills such as verbal and nonverbal attending, active listening, paraphrasing, and summary statements (Hojat, 2007).

Another approach is the use of personal stories, or lived experiences, to teach individuals how to relate to the realities of others. These techniques are aimed at facilitating an emotional connection and an awareness of other perspectives and experiences (DasGupta & Charon, 2004; Parkin & Stein, 2001; Shapiro, Morrison & Boxer, 2004). For example, movies and novels may be used to elicit emotional

connection with the protagonist and his or her situation. Though an individual may not have the same experience, the ability to feel the protagonist's struggle is facilitated by the literary portrayal (Shapiro & Rucker, 2003). In the context of training, a discussion of personal reactions to a movie or novel may further awareness of empathic connections and how to pursue such connections with nonfictional others (Shapiro et al., 2004; Shapiro & Rucker, 2004).

Another related approach is to allow an individual to directly experience an event to assist with empathic understanding. This may include instructing students to run errands in a wheelchair, such as going to the grocery store or ordering lunch at a restaurant, in order to better identify with the experience of disability or illness (Parkin & Stein, 2001). Another example would be asking a beginning counselor to attend a personal counseling session in order to identify with client reactions of first-session stress or insecurity. The assumption, then, is that the act of experiencing some part of the world of another person can assist in the formation of empathic understanding (Parkin & Stein, 2001; Stepien & Baernstein, 2006). These experiences provide a point of reference from which to begin the empathic connection. However, though these techniques have been used for a variety of training purposes, they do not, in and of themselves, ensure a person's ability to communicate understanding, nor do they teach how to connect empathically beyond a shared experience.

The debate over whether empathy is a trait or a state thus has many implications for how the helping professions approach the concept. Depending upon the position taken, educating for empathy may be considered either highly valuable or a waste of time

and resources. Further research is needed to understand the scope of empathy's role in personality, physiological responses, and the efficacy of learned communication.

### **Definitions from Mental Health**

The mental health profession has primarily conceptualized empathy as a clinical skill that is essential in the formation of a strong therapeutic relationship (Clark, 2010). However, despite the profession's reliance on empathy as a core condition, it remains a somewhat nebulous concept both in definition and implementation (Marks & Tolsma, 1986; Mercer & Reynolds, 2002). Carl Rogers, a leader in the field of psychology, stressed empathy as a core condition for effective therapy and defined it as the ability to "sense the client's anger, fear, or confusion as if it were your own, yet without your own anger, fear, or confusion getting bound up in it" (Rogers, 1957, p.99). Rogers' opinion, then, was that professionals should be able to share their understanding of a patient's experience without sharing the emotionality of that experience. Rogers' definition is undoubtedly one of the most cited explanations of empathy within the field of mental health (Clark, 2010).

Truax and Carkhuff (1967) believed that Rogers' definition was an insufficient description of the phenomenon and expanded upon it by stating:

Accurate empathy involves more than just the ability of the therapist to sense the client or patient's private world as if it were his own. It also involves more than just his ability to know what the patient means. Accurate empathy involves both the therapist's sensitivity to current feelings and his verbal facility to communicate this understanding in a language attuned to the client's current feelings. It is not necessary – indeed, it would seem undesirable – for the therapist

to share the client's feelings in any sense that would require him to feel the same emotions. It is instead an appreciation and sensitive awareness of those feelings (Truax & Carkhuff, 1967, p. 46).

Later still, Keefe (1976) tried to further clarify empathy by delineating it into three distinct phases. In the first stage, the helper notices overt clues in the behavior and language of the other. The second stage consists of the helper's generation of cognitive and affective responses to the expressed messages of the other, while withholding personal biases and judgments. In the third stage, the helper must sort out which of his or her feelings is in line with the client's experience and must then accurately communicate these reactions to the client. In order for true empathic connection to occur, all of these processes must be optimized (Goldstein & Michaels, 1985).

The description of empathy and its identifying processes thus has been subject to revision over the years. One difficulty in defining empathy within the mental health field is that the construct is so intertwined with other facilitative conditions that it can be almost impossible to view it as a separate and measureable construct. Rogers, for example, included components of empathy within his other facilitative conditions of genuineness, congruence, and unconditional positive regard. Carkhuff (1969; 2000) developed a model for effective helping that has frequently been characterized as a model of empathic communication. However, Carkhuff's model also includes additional elements of helping, such as nonverbals and goal-setting. Though empathy is acknowledged as an essential ingredient within each stage of Carkhuff's model, the levels of responses are dependent upon additional tasks of the therapist (Carkhuff, 2000). Carkhuff also made an effort to distinguish the discrimination of empathic responses

from actual empathic communication. He stated that it is much easier to train individuals to determine the empathic level of an observed response, but much more difficult to formulate such a response (Carkhuff, 1969). Thus, in many models of counseling empathy neither stands alone as an independent construct, nor is it always clear where empathy ends and a related therapeutic condition begins.

Clark (2010) attempted to clarify the conceptualization of empathy within counseling by reinvestigating Roger's original definitions. Most modern definitions of empathy in counseling target the interpersonal nature of the counselor and client relationship. This interpersonal connection involves the act of perceiving an individual's internal frame of reference and then conveying this understanding back to the client. However, Clark calls attention to two additional forms of empathy, first acknowledged by Rogers. Though Rogers himself stressed interpersonal empathy above the other constructs, he identified subjective and objective empathy as additional ways of knowing that, when joined with interpersonal empathy, could enhance a therapist's overall understanding. Subjective empathy, then, involves the counselor's attunement to his or her personal reactions in response to the client's experience. This process occurs whenever a counselor identifies, imagines, or uses intuition to hypothesize about how a client might be feeling. Though not included in many definitions of empathy, Clark argues that this process exists when relating to others, whether a counselor uses it intentionally or not. Objective empathy, in contrast, involves applying external information, such as theory, diagnosis, or other conceptual material to the client's experience as a way of understanding the client's reality (Clark, 2010).

The implication of Clark's proposed integration of Roger's three elements of empathy would suggest a redefinition of what empathy looks like in the counseling relationship. Primarily restricted to interpersonal understanding, empathy could now have a much broader focus. Subjective and objective empathy may allow for a more intentional use of empathy, requiring a strategic blend of approaches to understand client experiences.

Many professionals within mental health and social sciences have a "felt sense" of what empathy entails, yet there is enough variance in its operational conceptualizations that any objective understanding of the construct remains unclear. Since empathy is nearly inextricable from the psychotherapeutic process, at least in theory, a full understanding of the phenomenon may remain elusive. The task of understanding empathy as a distinct process is thus challenging, as the mental health field has taken little notice of variations in the term since Roger's 1957 definition and Carkhuff's model of discrimination (1969). Other professions, however, have continued to explore how empathy can be defined and targeted in training and practice. The medical field has been active in this research, and has furthered the study of empathy in some important ways.

### **Definitions from Medicine**

Within the medical literature, definitions of empathy break the concept down into multiple components, thus allowing researchers to specify which subset of empathy they hope to study (Barkham & Shapiro, 1986; Marks & Tolsma, 1986; Nicolai et al., 2007; Norfolk et al., 2007; Stepien & Baernstein, 2007). Stepien and Baernstein (2007) defined empathy as having emotive, moral, cognitive, and behavioral components. Within these definitions, emotive empathy reflects the *ability to experience and identify* emotions,



moral empathy reflects a *motivation* to accurately understand and empathize, cognitive empathy refers to the *ability to identify and understand* a patient's experience, and behavioral empathy consists of the *ability to convey this understanding* to the patient (Greenberg et al., 2001; Mercer & Reynolds, 2002; Stepien & Baernstein, 2007). The majority of the medical literature focuses on cognitive and behavioral components, measuring physician understanding and the ability to communicate this understanding to the patient (Mercer & Reynolds, 2002; Nicolai et al., 2007). Cognitive and behavioral components of empathy have also been identified as the easiest elements to teach, with moral and emotive empathy seen as more of a personal trait that lies beyond the scope of short-term training (Norfolk et al., 2007; Stepien & Baernstein, 2007; Yu & Kirk, 2008).

Definitions focused primarily upon the understanding, motivation, and communications of the physician do not always take into account the felt, or received, empathy experienced by the patient. Received empathy can indicate whether communicated empathy is effective, rather than merely whether the physician's response is judged, by self or an objective other, to be empathic (Bachelor, 1988; Greenberg et al., 2001; Norfolk et al., 2007). Research emphasizing patient perceptions shows that empathy in the doctor-patient relationship may be a complex interaction of physician skill and intentionality and patient understanding and acceptance of communicated messages (Bachelor, 1988; Greenberg et al., 2001).

The medical literature also frequently uses other terms, seemingly interchangeably with empathy. Communication skills, interpersonal communication, emotional intelligence, and relationship-building skills are mentioned throughout the literature in empathy-related studies. The interchangeable nature of these terms lends

additional support to the idea that empathy is inconsistently identified and defined within the medical profession, leading to further confusion about the meaning of the construct.

### **Empathy in Medicine**

The variety of definitions, conceptualizations, and implications of empathy on training and practice demonstrate some confusion in terminology. In the mental health field, empathy can blend easily with other therapeutic practices and there is therefore less of a need to extract it as a unique concept. Instead, counselors can be trained in all of the core conditions, of which empathy is a part. However, in professions such as medicine, where empathic communication is seen as separate and distinct from the goals of the medical interview, the need to understand the distinct qualities of empathy is more apparent (Shapiro, 2008; Yu & Kirk, 2008). Additionally, there is a need to understand the various barriers to empathy's application in medicine, as these barriers influence the efficacy of training programs and the realistic integration of these elements within the medical interview.

Statistics show that 25-30% of patients presenting with a physician complaint have additional concerns such as depression, anxiety, alcohol abuse, or other somatoform disorders (Gunn & Blount, 2009). These mental health issues often include co-occurring physical symptoms that, if treated without attention to other biopsychosocial concerns, result in incomplete treatment and thus continued health issues (Enochs, Young, & Choate, 2006; Gunn & Blount, 2009; Spiro et al, 1993). Therefore, in order to provide more complete and effective care, including appropriate referrals for non-medical issues, physicians must be able to explore the various components of disease or dysfunction.

Empathy can be seen as one way in which to establish a relationship of trust, as well as to broaden the perspective of factors impacting the illness (Glick, 1993; Yu & Kirk, 2008).

Though often seen as an additive component of a medical interview, empathy can have profound effects on the experiences of both the patient and the physician, leading to greater satisfaction and better treatment outcomes (Shapiro et al., 2004; Stepien & Baernstein, 2007). Furthermore, Levasseur and Vance (1993) stated that lack of attention to empathy, or acknowledgement of the personhood of the patient, can in fact be hurtful if physicians restrict their view to only the physical ailments:

They [physicians] sometimes cause suffering by seeing a person as divided into a mind, on the one hand, and a body, on the other, and then concluding that the object of their professional concern is only the body... True empathy focuses on the impact that disease and its treatment have on a patient's ability to lead a meaningful life. (Levasseur & Vance, 1993, p. 82).

Medical students are trained to treat illness, interpret x-rays, and diagnose physical conditions. They must wrestle with an overwhelming amount of knowledge and be able to apply it to the treatment of the body. With the inclusion of advances in technology, such as electronic records, advanced imaging, and accessibility of databases for accurate diagnosis, students are sometimes implicitly taught that understanding the personhood of the patient has little to do with their ability to identify and treat physical complaints (Levasseur & Vance, 1993; Shapiro, 2008). This view takes the patient out of the equation and ignores the fact that often patients know more about the specific circumstances and details of their illness than the physicians (Spiro, 1993). Unfortunately, physicians typically interrupt patients an average of 18 seconds after they

start speaking, suggesting that the physician's search for answers many times overweighs a thorough examination of the patient's concerns (Levasseur & Vance, 1993; Morton, Worthley, Testerman, & Mahoney, 2006). This push towards diagnosis, often driven by time constraints, restricts the physician's ability to connect empathically with a patient, and also results in incomplete assessments of contributing factors (duPre, 2001).

It should be stated, however, that physicians have a qualitatively different role than a counselor or other mental health professional. Physicians necessarily must provide brief treatment, and patients present primarily for physical concerns. It would therefore not be advisable for the physician to take on the role of therapist, or to screen for all possible mental health concerns (Bylund & Makoul, 2005). However, neither should they ignore the biopsychosocial domains that may impact their ability to successfully treat physical symptoms, make appropriate referrals, or ensure that patients comply with treatment goals. This balance of information gathering and treatment does not seem to have any certain framework, and the opportunities and limitations for including empathy within this process have yet to be fully determined (Bylund & Makoul, 2005; Mercer & Reynolds, 2002).

One model for incorporating the various tasks of the medical interview without excluding humanistic concerns has been developed by Glick (1993) to provide a paradigm for future training and practice. In this model, compassion for the patient provides the necessary foundation from which all other tasks must follow. This concept is contradictory to many current views of medicine that conceptualize empathy and compassion as ancillary and additive components of the interview (Shapiro, 2008). However, Glick is quick to state that compassion is not enough for one to be an effective

physician. Compassion must be followed by a standard of care, and physicians must allow themselves to be scientists, exploring hypotheses and utilizing all available data to reach their conclusions. Glick proposed that the biopsychosocial model is the “only model that can satisfactorily meet, not just the demands imposed by compassion, but those required by the exactitude of science” (p. 91). He stated that ignoring social or psychological factors results in a scientific error by not acknowledging all of the available data impacting the disease and its treatment. Glick noted that training in therapeutic skills, namely empathy, is necessary in medical education and cannot be accomplished merely by observation of other physicians (Glick, 1993; Shapiro, 2008)

Unfortunately, despite the endorsement of empathy throughout the helping professions, as well as within the American Association of Medical Colleges (AAMC), statistics point to a decline in empathy of medical students throughout their training (Chen et al., 2007; Hojat et al., 2004; Shapiro, 2008; Shapiro et al., 2004; Thomas et al., 2007). Whereas first year students are said to be idealistic and patient-oriented, by the third year many students have begun to counter-identify with their patients, preferring emotional detachment and clinical neutrality (Chen et al., 2007; Hojat et al., 2004; Shapiro, 2008, Thomas et al., 2007). Rieser (1993) highlighted this change through his own research on first- and third-year medical students:

First-year medical students often elicited the true purposes for which the appointment was sought and gained a comprehensive picture of the factors influencing patient symptoms, behaviors, needs, and requests...Clinical understanding was the preserve of the third-year students whom we recorded.

Their histories were filled with knowledge of pathology. But often they were not

as good as first-year students in gaining an accurate and comprehensive view of what bothered the patient, or what living with the illness was like...The disparate behavior of first- and third-year medical students was the result of education. First-year students listened to the story of illness. Third-year medical students strove to write a story of disease (Rieser, 1993, pp. 128-129)

Some research has hypothesized that the medical culture itself leads to such a decrease in empathy, with its focus on modern medicine, the scientific paradigm, and emotional distancing, rather than a holistic approach that includes the non-medical experiences and realities of the patient (DasGupta & Charon, 2004; Shapiro, 2008, Thomas et al., 2007). These issues will be discussed in the following section to further illuminate the challenges of utilizing empathy within a medical setting.

### **Barriers to Empathy in Medicine**

There are several constraints on the development of empathy among medical students and professionals. First, in pursuing an empathic connection a student may be unable to separate him- or herself from the emotionality of the patient's experience. Such a connection can be emotionally draining, and thus most students are encouraged to practice some form of professional distancing (Hojat et al., 2004; Shapiro & Rucker, 2004). This distancing reflects a confusion of sympathy, which is defined as the experiencing of another's emotions, for empathy, which is an act of understanding another's subjective reality without directly experiencing it (Hemmerdinger, Stoddard, & Lilford, 2007; Stepien & Baernstein, 2006). Confusion of this terminology may result in the erroneous rejection of empathic practices, whereas proper understanding and

empathic training could instruct students in techniques that promote objectivity and enable emotional distance.

Second, students are taught to honor the objectivity of scientific rationality and professionalism by adopting a depersonalized language and treatment style that views patients through medical terminology and diagnoses, rather than through a humanistic lens (DasGupta & Charon, 2004; Hojat et al., 2004; Shapiro, 2008). Third, throughout training and also within professional settings, the issue of time becomes a salient factor. Pressure placed upon students and physicians for brief but efficient clinical visits often makes empathy an ancillary consideration (du Pre, 2001; Hojat et al., 2004). In contrast, one case study suggests that empathy can be included as a core component of treatment within brief visits and that such attention during the first appointment can result in quicker and less frequent visits later on (du Pre, 2001).

Finally, quality of life of medical students may also play a role in empathy at all levels, whether emotive, moral, cognitive, or behavioral (Thomas et al., 2007). As students gain contact with patients during third and fourth year clerkships and throughout residency, long work hours and both physical and emotional fatigue may numb students to empathic communication (Chen et al., 2007; Thomas et al., 2007). Students and physicians who are burnt-out, anxious, depressed, or under great distress may provide lower quality care to patients (Thomas et al., 2007).

### **Empathy Training**

Despite these constraints and challenges, empathy training remains a goal of many medical programs, as well as a necessary endeavor for promoting humanistic and patient-centered care. Multiple training modalities have been developed to enhance

empathy in students. The majority of these training approaches focus upon the more observable and measurable categories of cognitive and behavioral empathy, although some may target emotional and moral empathic development (Nicolai, Demmel, & Hagen, 2007). The type of training correlates with the desired outcome of empathic behavior, reflecting a preferred definition of empathy among different institutions. Most institutions seek to develop empathy in students through “communication skills” training, reflecting a preference for the behavioral definition of empathy (Shapiro, Lancee, & Richards-Bently, 2009; Stepien & Baernstein, 2006). Other programs elect to use narrative, film, or experiential components to target both emotive and moral components of empathy (DasGupta & Charon, 2004; Parkin & Stein, 2001; Shapiro et al., 2004; Shapiro & Rucker, 2004). Other programs do not include structured opportunities for empathy training, believing that empathy will be developed over time by observing senior physicians in their interactions with patients (Pence, 1983; Shapiro, 2008). This view seems not to account for physician burnout and decreasing empathy levels among residents and practitioners.

A meta-analysis by Stepien and Baernstein (2006) reveals that communication skills training accounts for almost half of programs studied. Training focuses on increasing the observed aspects of behavioral empathy and typically includes a demonstration of effective communication skills by a faculty member or facilitator, followed by an opportunity for students to practice skills in small groups or with a standardized patient (Shapiro et al., 2009; Stepien & Baernstein, 2006). Techniques include the development of verbal skills (e.g., open-ended questions, reflecting patient statements, clarifying, summarizing) as well as nonverbal skills (e.g., warmth, active



listening, use of silence) (Norfolk et al., 2007). Although many programs incorporate communication training to some degree, there is a lack of literature demonstrating a standard practice or curriculum for effective instruction.

Other medical training in empathy has taken the form of narrative and reflective activities meant to develop moral and emotive empathy skills. These interventions utilize film, literature, and reflective writing to illicit a personal and emotional connection to the patient's experience (DasGupta et al., 2004; Shapiro et al., 2004; Shapiro & Rucker, 2004; Stepien & Baernstein, 2006). Students are asked to reflect on their own experiences with illness or attempt to view clinical issues through the patient's perspective (DasGupta et al., 2004). Some approaches include an experiential component where students accompany patients through a series of medical visits (Parkin & Stein, 2001; Stepien & Baernstein, 2006). However, although these methods have been shown to increase the student's understanding of the patient's perspective, most of these programs have been unable to achieve significant results in empathy improvement (Shapiro et al., 2004).

One explanation for these mixed results is that medical programs have adopted definitions of empathy and training techniques from the mental health field without fully investigating how empathy is different in medicine. Goals for student improvement are also varied. In some studies, students are expected to improve only in their appreciation of empathy and its utility in patient communication. This goal does not ensure that students are actually able to communicate empathically with patients. Additionally, programs are typically offered as brief workshops or elective courses and thus participants may not be representative of all medical students. These issues in training

reflect the larger conceptual uncertainties surrounding the nature of empathy in the medical field.

### **Measuring Empathy**

Empathy has traditionally been measured through three particular lenses, depending upon a study's definition of empathy and the aim of the researcher (Marks & Tolsma, 1986). One common measure is a first-person assessment of skill and efficacy, achieved through self-rating or self-report (Hemmerdinger et al., 2007). Numerous rating scales have been developed to assess an individual's felt competence in empathic expression. However, follow-up testing has shown that most self-report scales show declines in reliability between 4 to 12 months after training (Hemmerdinger et al., 2007). Results also indicate that student self-ratings do not always correlate with actual empathic behavior (Stepien & Baernstein, 2006; Yu & Kirk, 2008). These findings may indicate that self-report alone is insufficient in empathy testing.

A second form of measurement is that of third-person observer ratings (Hemmerdinger et al., 2007). These ratings are typically provided by individuals who are considered experts, or who have undergone some training to identify empathic skills within interpersonal communication. However, observer ratings are limited in their ability to measure non-observable experiences or interpretations of the physician or the patient (Pederson, 2009). For example, an external observer can comment only on behavioral exchanges, which excludes the assessment of emotive, moral, or cognitive processes. It is also unclear as to whether a correctly formed empathic response is interpreted as empathic by the patient. If the patient does not feel the benefit of the response, it is questionable whether the response was effective, even if it was measured

as highly empathic by an observer. Patient or client ratings can thus provide a third method of empathy assessment, centered on their personal experiences and interpretations of the relationship (Hemmerdinger et. al, 2007).

Empathy scales and measures are diverse, ranging from standardized self-report to video observation and rating scales (Marks & Tolsma, 1986). One historically popular measure is the Carkuff and Truax Accurate Empathy Scale (1965), which uses observer ratings to indicate which level of empathic communication has been achieved. The Barrett-Lennard model adds to the measure of empathy by including received empathy (from the patient's perspective) as a necessary condition (Bachelor, 1988). Self-report measures include the Empathy Construct Rating Scale (ECRS), the Balanced Emotional Empathy Scale, and the Jefferson Scale of physician empathy (JSPE), among many others (Hojat et al., 2004; Stepien & Baernstein, 2006). In fact, in the study of medicine 38 different measures of empathy have been used, many of which measure different elements of the construct (Pederson, 2009). These instruments have been met with some criticism, mainly in the lack of consistency in defining empathy, the inclusion of very general items that seem questionable for measuring empathy, and an apparent lack of consideration for the realistic expectations of the physician's role (Hemmerdinger et al., 2007; Pederson, 2009).

Empathy assessments, then, reflect the confusion surrounding conceptual definitions of empathy, as well as how empathic communication might vary across various professions. The existence of several instruments targeted specifically towards empathy in medicine suggests that the nature of empathy may be qualitatively different in such a setting. There may indeed be differences in how empathy is utilized, how it is

experienced, and what the results of an empathic connection might look like. If this is true, then other more general forms of empathy assessment may overlook important empathic processes within the medical interview, thus resulting in scores that suggest empathic deficiency. A clearer understanding of whether empathy is subject to situational variance is needed. Additionally, more clarification is needed regarding which constructs are related to empathy versus which are aspects of related but distinct therapeutic constructs.

### **Need for Qualitative Research**

As the variety of empathy measures indicates, a great majority of studies have attempted to examine empathy exclusively through quantitative methods. In fact, a review of the past several years of research on empathy in medicine reveals that 171 out of the 206 empathy-related studies employed a quantitative methodology (Pederson, 2009). Although quantitative methods are advantageous in many ways, the absence of qualitative research has likely resulted in an incomplete understanding of the phenomenon.

It is easy to see the benefit of quantitative methods, particularly when studying empathy in the medical field. Quantitative research grows out of the positivist philosophical view that objective truth exists and can be discovered through approximate measures (Creswell, 2009). Previous studies have used quantitative research to measure improvement or decline in empathy levels, determine correlations between empathy and other factors such as age, gender, education, medical specialty, and emotional intelligence, and place empathic levels on a continuum of observable skills. This research has served to illustrate where further training may be needed, and it has also been pivotal

in making a case for the inclusion of empathy in physician training and practice. Studies have shown decreasing levels of empathy as students progress through medical school (Chen et al., 2007; Hojat et al., 2004; Shapiro, 2008; Shapiro et al., 2004; Thomas et al., 2007), and other studies have attributed empathy with higher patient satisfaction and outcomes (Nicolai et al., 2007; Romm, 2007; Shapiro et al., 2004; Stepien & Baernstein, 2007). Quantitative methods, then, have played an important role in bringing empathy to light and identifying its relation to medical practice.

Given the confusing and varied definitions of empathy, one key weakness in utilizing quantitative research to study empathy is that the researcher must determine how to operationalize the concept, which also impacts his or her selection of instruments, variables, and interventions (Yu & Kirk, 2008). Pederson (2009) found that many quantitative studies on empathy in medicine did not even provide this definition. Furthermore, construct validity among instruments claiming to measure the same or similar constructs is weak, suggesting that identified components of empathy may not be valid (Hemmerdinger et al., 2007; Marks & Tolsma, 1986; Yu & Kirk, 2008). As a result, it is sometimes unclear what exactly is being measured and whether empathy is being correctly assessed.

Beyond the issue of properly defining and identifying constructs, quantitative research on empathy is also frequently far removed from the doctor-patient relationship. Self-report or observational assessments are conducted outside of normal practice, and patient perspectives are rarely sought (Yu & Kirk, 2008). This restricts the ability of the researcher to generalize results and it also ignores an essential component of empathic communication – namely, whether the patient felt heard.

As a result of these limitations, many quantitative studies conclude with an acknowledgement that qualitative methods may be needed to further develop and interpret the results (Bylund & Makoul, 2005; Pederson, 2009). Of the few qualitative studies in medicine, some contain empathy as a theme among many other constructs, but very few exclusively study the phenomenon (Pederson, 2009). Qualitative methods allow researchers to read between the numbers, fleshing out quantitative data with the nuances of personal experience and opinions (Charmaz, 2006; Patton, 2002; Pederson, 2009). The rich descriptive data that characterize qualitative research can be used to develop theory or explain inconsistencies resulting from quantitative methodology (Charmaz, 2006). The qualitative researcher can also be open to new definitions, rather than trapped by poorly defined and operationalized constructs.

Both quantitative and qualitative methods have advantages and disadvantages in the study of empathy, but the lack of qualitative research is worrisome and suggests that gaps in understanding left by quantitative approaches may go unaddressed. Previous research has indeed been dominated by quantitative studies, to the exclusion of a deeper and more nuanced view of the phenomenon that may be achieved through qualitative methods.

### **Summary**

In summary, the concept of empathy is subject to much variability and debate. Conceptualizations range from believing that empathy is an innate or unconscious response, to seeing it as an emotive, moral, cognitive and behavioral process. Though the terminology varies, the one consistent judgment is that empathy involves a connection with another person that leads to some benefit, whether it is evolutionary, therapeutic, or

increased satisfaction and compliance with medical care. These and other related benefits have recently been identified by medical training programs as desired educational outcomes. Unfortunately, empathy levels tend to decrease as students move throughout their medical programs and residencies. This decrease can be attributed to various barriers, such as time constraints, stress, lack of sleep, lack of professional role models, and emphasis on aspects of disease rather than biopsychosocial issues.

Various training programs have been designed to help mitigate this decrease in student empathy, as well as to enhance empathic communication skills. Most programs have met with mixed results, and few longitudinal studies exist to demonstrate training gains over time. Assessments to measure empathy are also subject to criticism due to inconsistent definitions of constructs, limitations of perspectives through which the phenomenon is viewed, and lack of criterion validity among instruments. These challenges within current research have resulted in a sense that perhaps empathy is not fully understood as a general construct, much less understood as a specific component of the medical interview.

A further critique of the existing literature is the notable absence of qualitative studies in the study of empathy. Qualitative methodologies can assist with clarifying the dimensions of a phenomenon under study, particularly when a deeper understanding of the phenomenon and its related constructs is lacking. Empathy has remained a broad concept and has been subject to many reinterpretations over the years. Current definitions, training, and assessment models do not seem to acknowledge the nuances of empathic communication, nor do they delineate whether empathy consists of certain essential components, or whether it has a variety of representations depending upon the

goals of the professional relationship. In other words, it is unclear whether empathy is the same process in therapy as it is in medicine, or whether these settings employ empathy in different ways. Because medicine has borrowed definitions of empathy from the social sciences without fully exploring how empathy manifests itself in the medical relationship, current models and training procedures may be missing the mark. This study aimed to help close this gap in understanding by using qualitative methods to define and conceptualize empathy within a medical framework.



## CHAPTER THREE

### METHODOLOGY

#### Introduction

Current literature demonstrates that the quality of the doctor-patient relationship has a significant impact on both physician and patient satisfaction, proper diagnosis, and adherence to treatment (du Pre, 2001; Nicolai, Demmel, & Hagen, 2007; Romm, 2007; Shapiro, Morrison, & Boker, 2004; Stepien & Baernstein, 2007). Empathy has been identified as a determining factor of relationship strength, and thus assessment of empathy has necessarily become an important component of current research (Mercer & Reynolds, 2002; Norfolk, Birdi, & Walsh, 2007). The benefits of empathic connection between doctors and patients have been well documented in the literature. As a result, the American Association of Medical Colleges (AAMC) has identified empathy enhancement as a main goal of instruction (Shapiro, 2008; Stepien & Baernstein, 2007).

Despite the current focus on empathy in training, levels of empathy tend to decrease as students progress through medical school, reaching their lowest points during residency (Chen, Lew, Hershman, & Orlander, 2007; Hojat et al., 2004; Shapiro, 2008; Stepien & Baernstein, 2007). Current barriers in the assessment and instruction of empathic behavior in medicine include the lack of clear definitions of empathy (Marks & Tolsma, 1986; Mercer & Reynolds, 2002), the de-emphasis on humanistic methods in medical education (DasGupta & Charon, 2004; Hojat et al., 2004; Shapiro, 2008), inconsistent empathy training curricula (Nicolai, Demmel, & Hagen, 2007; Shapiro, Lancee, & Richards-Bently, 2009; Stepien & Baernstein, 2006), and insufficient

assessment tools (Bachelor, 1988; Barkham & Shapiro, 1986; Stepien & Baernstein, 2006; Yu & Kirk, 2008).

This chapter proposes a methodological foundation for exploring the conceptualization of empathy within the medical interview. First, a description and rationale for the selection of qualitative methodology will be presented, including a discussion on the suitability of grounded theory for this topic. Next, a description of the research problem and specific research questions will be provided. The intended role of the researcher and methods of data collection will be discussed, as well as procedures for analysis and generation of theoretical codes. Finally, verification procedures will be addressed in order to enhance trustworthiness of the study. Implications of this research may impact training and assessment, as well as clarify current issues surrounding the *definition of empathic communication*.

### **Rationale for Qualitative Methodology**

Quantitative and qualitative methodologies have frequently been described as dichotomous, when in actuality these approaches exist along more of a continuum of inquiry (Creswell, 2009). The key differences between quantitative and qualitative methods lie in the goals of the study and the philosophical assumptions of the researcher (Corbin & Strauss, 2008; Creswell, 2009). Whereas quantitative researchers are interested in testing theories and relationships among variables, qualitative researchers are more concerned with exploring meaning or creating theories through the study of human experience (Creswell, 2009). Qualitative methods allow a researcher to “get at the inner experience of participants, to determine how meanings are formed through and in culture, and to discover rather than test variables” (Corbin & Strauss, 2008, p. 12).

Qualitative inquiry is most frequently used when a researcher seeks to investigate a phenomenon that is not easily operationalized, or create new understanding in an area where previous research is lacking (Corbin & Strauss, 2008; Creswell, 2009). The research question itself will frequently dictate the appropriate method of inquiry, as most qualitative questions do not lend themselves to statistical analysis but rather rely on systematic processes of interpretation (Corbin & Strauss, 2008).

As a process of discovery, qualitative inquiry must employ rigorous methods to ensure that results are viewed as high-quality and the researcher is seen as credible (Patton, 2002). Qualitative methods have been criticized for a lack of standard procedures to ensure the quality of results. However, researchers who intentionally follow a rigorous design and control for or directly acknowledge researcher bias can create meaningful results subject to empirical support (Patton, 2002).

The aim of this study was to address a gap in current literature by developing a conceptual model of how empathy and other facilitative conditions are implemented and valued within the medical interview. Through a deeper understanding of how empathy is employed within medicine, a clearer conceptualization of the construct can be developed, thus potentially influencing both the assessment and successive training of medical professionals. This goal required a method that could examine the constructed realities of medical professionals without imposing potentially faulty concepts from previous literature. Therefore, a qualitative methodology appeared to be the best fit for establishing a theoretical framework that could later be tested through quantitative methods. Qualitative methodologies are varied and offer many options for focusing the goals of research. The chosen method for this study, grounded theory, is means of generating

theory based upon inductive and deductive examination of data on processes or issues of importance (Corbin & Strauss, 2008; Ghezeljeh & Emami, 2009).

Grounded theory was developed by Glaser and Straus (1967) and later expanded upon by Strauss and Corbin (1990, 1998, 2008). It is a method in which a researcher “derives a general, abstract theory of a process, action, or interaction grounded in the views of the participants” (Creswell, 2008, p. 13). This method of theory development requires constant comparison of data, which results in a circular process of gathering and interpreting data in search of commonalities and divergent themes. Initial data collection begins the process of inductive analysis, from which hypotheses emerge and are tested by subsequent theoretically sampled data (McGhee, Marland, & Atkinson, 2007). The goal of the inquiry is to create a robust theory of a social phenomenon that accounts for all of the thematic variations within the data set (McGhee et al., 2007).

The paradigm through which grounded theory is viewed has been a subject of debate, which leaves the method open to critique due to conflicting methods and philosophical underpinnings (Chen & Boore, 2009; Corbin & Strauss, 2008; Ghezeljeh & Emami, 2009). Grounded theory was originally developed through a positivist epistemology, which assumes that an objective, external reality exists and can be discovered through neutral observation (Ghezeljeh & Emami, 2009). Corbin and Strauss (2008) later took a post positivist stance, acknowledging that while reality exists, it can only be approximated through inquiry and thus never fully known (Creswell, 2009; Ghezeljeh & Emami, 2009). Later still, Charmaz (2006) proposed a constructivist framework for guiding grounded theory, acknowledging that meaning and *truth* is

socially constructed and therefore subjective in interpretation (Creswell, 2009; Ghezjeljeh & Emami, 2009).

Clearly, the paradigm a researcher chooses to use with grounded theory influences not only the process of inquiry but also the interpretation of results. Corbin and Strauss (2008) later agreed with the constructivist notion of created and shared realities, but also argued that conceptual language and creation of knowledge is essential for knowledge-based practice. In other words, while constructivism may be a new direction for grounded theory research, rigorous procedures should be still be applied to ensure that resulting theories can be accepted as applicable and not just resigned to a limited and changing context (Corbin & Strauss, 2008). As Corbin states, “though readers of research construct their own interpretations of findings, the fact that these are constructions and reconstructions does not negate the relevance of findings nor the insights that can be gained from them” (p. 12). Corbin draws upon pragmatist, integrationist, and feminist paradigms to explain her own approach to grounded theory (Corbin & Strauss, 2008).

With the conflicting approaches to selecting a structuring paradigm for grounded theory research, the researcher must be intentional about not only the question to be examined, but also his or her intent for the findings. Because of the need for a framework of empathy and facilitative conditions, as they relate to medicine, that can be of practical and empirical use for future study and program implementation, a constructivist paradigm may be too contextual to be viewed as valuable within the medical profession. A post-positivist approach offers a compromise between positivism and constructivism, in that it employs the ontological view that truth is contextual and approximated, but argues that findings can approach truth and be refined through further examination (Creswell, 2009).

This allows for generated theories to be subject to further investigation, whether qualitative or quantitative, which can confirm or expand upon findings to create meaningful results for individual or group practices. Applied to the study of empathy, then, this approach would suggest that structured investigation of empathy and its related constructs could at least approximate a practical theory that can then be placed under further empirical scrutiny.

Epistemologically, post-positivism allows knowledge to be shaped indirectly through observation, and attempts to objectively make claims and connections among data (Creswell, 2009; McGhee et al., 2007). In investigating empathy, one can assume that both direct contact with participants through interviews and indirect contact through observation can yield information on the phenomenon. Researchers attempt to be objective by responding to the data rather than imposing meaning upon it, yet acknowledge that remaining completely value-free is unlikely (Patton, 2002). This axiology of researcher influence requires that preconceptions and personal reactions be closely documented and controlled throughout the study. Acknowledgement of previously held views of empathy, previous study of literature related to empathy, and personal biases should all be documented and assessed throughout all stages of the investigation. Structured methods ensure the rigor of the study and credibility of the findings, establishing *truth value* through careful attention to processes and thorough documentation of outcomes (Patton, 2002). Within this study, thorough documentation and adherence to grounded theory methods were essential to ensure the trustworthiness of findings.

The identification of grounded theory methods and post-positivistic philosophies helped guide the procedures of the study and, ultimately, the interpretation of results. Attention to structure, researcher awareness, and the search for at least an approximation of the *truth* created a foundation for exploring the concept of empathy in medicine.

### **Researchable Problem**

According to Corbin and Strauss (2008), researchable problems can be identified through several sources, such as problems that are suggested by others, problems derived from literature, problems derived from experience, and problems that emerge from the research. True grounded theory espouses the view that researchers should not review literature prior to the study, but rather consult the literature only after major themes have emerged (Creswell, 2009; McGhee et al., 2007). However, some argue (Corbin & Strauss, 2008; McGhee et al., 2007) that literature can provide a justification for the study by identifying a need for the research. Literature on the topic can also help direct theoretical sampling and can be used as secondary data to offer a comparison point for emergent themes (McGhee et al., 2007).

For this study, the researchable problem was identified through both an initial review of the literature and the personal experience of the researcher. Gaps in current literature supported the need for a theoretical foundation of empathy in medicine, and helped determine that grounded theory was the ideal method of investigation. Personal experience in conducting a quantitative pilot study on empathy training for medical students also identified a need for further research. Additionally, it was expected that the researchable problem may evolve throughout the study, as grounded theory encourages a

process of letting new data guide and revise previous foundations (Corbin & Strauss, 2008; McGhee et al., 2007; Wasserman, Clair, & Wilson, 2009).

### **Research Question**

The research question in qualitative research is designed to give the researcher flexibility to deeply explore a problem or phenomenon, as well as identify the key people, groups, or issues to be investigated (Corbin & Strauss, 2008). As such, questions should be broad enough to allow for thorough exploration of emergent themes, but not too broad as to make a study meaningless.

With these guidelines in mind, the primary research question for this study was: “How do physicians conceptualize the practice of empathy in the medical interview?” Sub-questions included: “What influences empathic communication in the medical setting?” and “How does the conceptualization of empathy influence medical training?”

### **Role of the Researcher**

The researcher is a key instrument within qualitative studies, actively engaged in collecting and evaluating data for common themes (Creswell, 2009). As such, researchers can never be fully removed from the study, nor can they be seen as fully objective, as post-positivism acknowledges (Patton, 2002). Corbin and Strauss (2008) stated that researchers bring “perspectives, training, knowledge, and biases” that “then become woven into all aspects of the research process” (p. 32). Grounded theory thus employs the method of sensitivity, as opposed to objectivity, whereby researchers take on the perspectives of participants and become sensitive to relevant insights within the data (Corbin & Strauss, 2008). To assume the perspective of participants, researchers must understand their impact upon the interpretation of the data. Researchers can reach an



understanding of their impact upon the interpretation of data through the practice of reflexivity, in which they identify and document their influence on the research process (McGhee et al., 2007). Previous information and personal experience need not restrict the process but, when appropriately acknowledged, can lead to greater sensitivity that allows connections in the data to emerge (Corbin & Strauss, 2008).

### **Researcher Biases**

**My biases.** As a counselor, I have a vested interest in empathy as a core condition to facilitate positive therapeutic relationships. The fact that the medical field has recently drawn from decades-old research on empathy sparked my interest in the modern and multi-disciplinary implications of this construct. Also, I am married to a medical resident, and through our conversations I began to notice a difference in how people and their problems are both conceptualized and explored in the medical and counseling professions. When he described patients being treated for psychiatric issues, I had questions about social, cultural, and personal factors, whereas he focused almost exclusively on whether patients were taking medications and how those medications were influencing behaviors. We both had a valuable perspective that could shed light on the patient's situation, yet we both also missed important factors likely contributing to the patient's recovery. I began to wonder whether using empathy could assist medical professionals to identify psychosocial elements impacting disease, thus leading to more comprehensive treatment and referrals.

I realized that empathy training and development could be an entry point for the integration of counseling professionals in health care settings, as counseling has more formalized methods for empathy training and conceptualization. I developed a training

program for third year medical students through consultation with counselors and physicians, and implemented it through a pilot study at a local medical school. As I was conducting the training and hearing feedback from the students, I began to realize that counselor-initiated definitions of empathy might not be directly transferrable to a medical setting. I started wondering whether empathy in medicine was qualitatively different than empathy within counseling settings, and realized the implications this would have for future training of medical professionals. If empathy is indeed different in medicine it may explain why empathy scores, determined by assessments based on current definitions of empathy, decrease throughout medical school and residency. A discipline-specific definition would have implication for training, and would further multi-disciplinary understanding of empathy.

I also have some preliminary data in the form of student comments recorded during the pilot study workshops that may predispose me to certain themes. Among these data is the issue of time as it impacts students' ability to respond empathically. Students in the pilot study believed that empathic communication was not always relevant or advisable due to time constraints of the session. They feared an empathic response would launch a patient into a diatribe that would override the primary reason for the visit. Students also perceived a need to protect themselves from becoming exhausted by connecting emotionally with patients' stories. This fear seemed to reflect a confusion of empathy with sympathy. My belief that empathy and sympathy are frequently confused constructs represents an additional bias that might impact my interpretation of the data. I also have a list of concepts students generated to describe *good* and *bad* physician

encounters (see Appendix A), which may predispose me toward identifying certain themes.

My experiences and training as a counselor also influence the way I perceive empathy and its importance. I operate clinically from a humanistic perspective, valuing empathy as the key condition to establishing a therapeutic relationship. I use empathic statements frequently with clients, and have observed the utility of these statements in establishing a relationship. My training in empathy has also given me a perspective through which to view empathic development (e.g., use of roleplays, providing didactic support of concepts). I have observed how lack of empathy can restrict the development of a trusting and supportive relationship, thus restricting the depth of information a client or patient is willing to share. I attribute my own negative experiences with physicians to a lack of expressed empathy, namely through “not being heard” and feeling like “just another case.”

My interest in this topic was therefore supported in large part by what I would have liked to find, and also the implications findings may have on opportunities for counselor collaboration. My experience with the pilot study, as well as my own use of empathy within counseling, also may have impacted my ability to view results objectively. Negative experiences with physicians might have caused me to overemphasize the importance of empathy in the medical setting. Therefore, it was important to not only acknowledge these biases up front, but to also monitor them through the process of the study to ensure they would not pre-determine the results.

**Research team biases.** Prior to research team training and transcript coding I met with both team members to discuss their potential biases. One team member, a doctoral

student in counseling, had previous work experience at a health center and had interacted with medical professionals. She noted the pressure that physicians and nurses were often under, and remarked that empathy was frequently an afterthought in the busy medical environment. She did state that she was personally biased regarding the importance of empathy in the medical setting. As a counselor, she often saw how valuable the use of empathy could be with a patient, as well as how damaging it could be if physicians neglected this component.

The other research team member, a medical student, had similar biases about empathy in medicine. She also saw it as an important component of medical care, as well as a skill that was difficult to maintain in a busy and high-pressure setting. She additionally stated that she was biased in terms of which specialty areas required empathy. For example, she associated family medicine with empathy more than orthopedic surgery. She remarked that it seemed certain personalities were drawn towards different specialty areas, with empathic ability also influencing specialty choice.

### **Researcher Sensitivity**

As briefly discussed earlier in the chapter, researcher sensitivity involves “having insight, being tuned in to, and being able to pick up on relevant issues, events, and happenings in data” (Corbin & Strauss, 2008, p.32). Sensitivity acknowledges that a researcher does not approach data as a blank slate. Researcher characteristics, such as background, knowledge, and experience inform the research and enable a researcher to identify themes and make connections amongst varied concepts (Corbin & Strauss, 2008). The importance of sensitivity for grounded theory research lies in remaining continually aware of what the data is saying versus what the researcher is seeing within it.

Researcher perspectives are important for identifying the significant patterns within data, but the focus should never stray far from the pure data source (Corbin & Strauss, 2008). In other words, researchers must try, as best they can, to create interpretations of data while asking themselves “am I correctly representing what the data says, or am I applying my own biases to this interpretation?” Several methods can be employed to enhance researcher sensitivity throughout the process.

**Memo writing.** One core component of grounded theory research is the use of memoing to track significant themes and interpretations (Corbin & Strauss, 2008; Ghezjeljeh & Emami, 2009). Although memos are primarily used to reflect on findings and make new connections among data, they can also be used to examine researcher bias. By incorporating a reflection on personal interpretation and reactions through memoing, researchers are able to monitor their involvement in naming and categorizing major themes. Throughout this study, the primary researcher engaged in memo writing as new thoughts and interpretations arose. Memos were used to describe personal reactions and insights, as well as to document hypotheses regarding new connections and categories during analysis. Memos were created to brainstorm alternatives, map out concepts, or consider new directions (see Appendix H). All memos were saved with a keyword or phrase and catalogued so that they could be easily retrieved later in the research process.

These documents served a valuable purpose in tracking personal reflections on biases and assumptions, as well as documenting the inductive and deductive processes of theory formation. Research team members also turned in memos with each version of their codebook. Their preliminary memos after coding the first five transcripts were used in consensus coding. Final memos submitted after coding another five transcripts were

used to further clarify categories and form the final model. Team members used memos to reflect on their personal reactions to various statements or themes, as well as to comment on larger categories they saw emerging from the data. Research team memos are included in Appendix H.

**Member checking.** Member checking involves actively including participants in the confirmation of the researchers' interpretations. By sending coded transcripts and summaries of major themes back to participants, researchers allow for correction or expansion upon their primary interpretations, thus ensuring a more accurate view of the data. This process also allows the researcher to ask follow-up questions, or to clarify statements that seem confusing or incongruent. In this study, participants had the option of confirming, denying, or expanding upon data at two separate points in the process. The first member checking procedure occurred upon completion of the transcripts. Participants who consented to be contacted via email received the transcribed version of their interview and were given an opportunity to clarify points, provide alternate examples, or present additional information. After the first categories and themes were identified, participants received a copy of the tentative model and were encouraged to provide suggestions, point out missing elements, or offer reasons for exclusion of an existing theme.

**Triangulation of data.** An additional means of ensuring sensitivity to the data is to utilize several research assistants to help with the coding of transcripts and selection of major themes. Multiple perspectives dilute the influence of the primary researcher's biases and assist in creating a more objective review of the data. Each additional researcher should explore his or her biases and assumptions prior to working with the

data, and members of the research team should continually examine whether any biases are impacting individual or group interpretations. For the purpose of this study, the research team consisted of two additional team members. To encourage a multi-disciplinary examination of the data, the team included a medical student and a counseling doctoral student. The primary researcher provided research team members with a general training in grounded theory methods and coding options.

Before the research team coded the first interviews the team met to discuss possible biases and current understanding of empathy, particularly as it relates to the medical interview (see Research Team Biases). Team members were then asked to complete memos throughout the process to monitor biases and examine connections among the data. Due to the amount of interviews required for grounded theory research, as will be discussed in the following section, research team members assisted in coding the first five interviews before meeting with the primary researcher to reach consensus on codes and recommend future data sources. The primary researcher then randomly assigned additional interviews to each team member for coding. In the final stage of the study team members were given input into the categories and definitions that ultimately formed the final model.

### **Research Plan**

Following the approval of the proposed study by the dissertation committee, a proposal was submitted to the Human Subjects Committee of the Institutional Review Board at Old Dominion University. The study design was approved with no changes, and therefore the proposed study was carried out using grounded theory methods and procedures.

## **Sampling Procedures**

Corbin and Strauss (2008) recommended theoretical sampling as the sampling procedure of choice in grounded theory studies. This method originates with an initial sample, based on the research question, and then allows the researcher to “follow the data” by investigating new concepts as they arise. In this way, the full sample is not predetermined and thus a greater variation of data is likely (Corbin & Strauss, 2008). Since grounded theory research is a continual process of data collection and analysis, researchers may wish to explore previously unconsidered sources to expand upon divergent themes. This method reinforces grounded theory’s belief that a study should be driven by the data, rather than by the preconceived notions of the researcher.

To begin the study, physicians were selected based upon theoretical criteria. Previous research has separated the components of empathy in medicine into categories of moral, emotive, cognitive, and behavioral empathy. Although cognitive and behavioral empathy have been targeted in training, no distinction has been made as to which of these components of empathy are more important than the others. Therefore, it could be assumed that physicians demonstrating high levels of empathy in any of these categories could be considered “experts” on empathy in medicine and thus qualify as potential participants. Thus, physicians who demonstrated at least one of the following criteria were considered appropriate for initial interviews:

1. Strongly purport empathy in their practice or teaching (moral) as evidenced by commitment to research on empathy or patient-centered care, mission statement on personal websites, or current involvement in empathy development;



2. Have a reputation of empathic connection to patients or students (emotive) as evidenced by reviews, ratings, or reputation among colleagues; or
3. Have demonstrated understanding and sensitivity to patient's medical and nonmedical concerns (cognitive and behavioral) as evidenced by interview protocol, stated goals of an office visit, receipt of awards for humanistic or patient-centered care, or patient/student feedback.

Physicians were thus selected based on reputation, receipt of awards, expressed dedication to empathy in medicine, recommendations by peers, or other related criteria mentioned above. The first eight participants were selected using survey results from patient satisfaction ratings at a large teaching hospital (criteria 2). The hospital provided a list of 12 physicians who consistently receive high patient satisfaction ratings, and of these physicians eight consented to participate in the study. Because the researcher hoped to ultimately achieve diverse perspectives, initial participation was not restricted to a specific specialty area or level of practice. Theoretical and snowball sampling guided subsequent selection of participants until saturation of data was reached. Snowball sampling relied on referrals by participants to medical professionals they identified as highly empathic, or to individuals they believed could provide some additional insight into empathy in medicine. Towards the end of the study a list of top-ranking physicians, provided by a community-wide survey, was used to identify physicians in psychiatry and pediatric specialties since these specialties were not represented in the initial or subsequent samples. Saturation was achieved when new data did not reveal any new themes or categories (Corbin & Strauss, 2008).

Using theoretical sampling provides the benefit of establishing deliberate selection procedures. However, as with any selection method it can also restrict access to divergent perspectives or preclude the discovery of broader insights. By trying to identify empathic physicians, the opinions of unempathic physicians were consequently not obtained. Because this study aimed to examine the nature of empathy this restriction was necessary, though future research could add to current data by examining perspectives of physicians who choose not to utilize empathy in their work with patients.

Ideally, theoretical and snowball sampling of physicians will result in diverse perspectives within data that reflects common variables, as well as divergent themes. Corbin and Strauss (2008) acknowledge the importance of this method, stating that a variation in data “will maximize the opportunity to discover new properties and dimensions about a concept” (p. 150). A more complete theory should emerge as a result of actively searching for new connections based on existing data.

Though grounded theory research aims for saturation of data before a study can be considered complete, guidelines do exist for the recommended number of participant interviews. Creswell (1998) states that 20-30 participants are sufficient, whereas Morse (1994) suggests 30-50. In an analysis of dissertation-level grounded theory studies, the average number of participants equaled 32 (Mason, 2010). Aiming for 20-30 interviews does not in itself ensure saturation; it can, however, guard against concluding a study prematurely by assuming saturation too early and neglecting the search for variation in perspectives. The general view on the issue of study participants is that the use of anywhere from 20 to 60 participants can shed a favorable light on the credibility of the results (Mason, 2010). Saturation of data can indeed occur before this number is reached,

but even so additional cases could only further confirm the findings. This study will therefore aim for between 20 and 30 cases, primarily consisting of individual interviews.

### **Gaining Entry**

I had contacts within a mid-size medical school in Southeast Virginia through previous research and my husband's status as a medical student. The school contains students, residents, faculty, physicians, nurses, physician assistants, psychologists, counselors, social workers, and staff covering the full range of medical specialty areas. The school is particularly well known for its pediatric and family medicine specialties, as well as its clinics for diabetes and infertility. Opportunities to achieve diverse perspectives were certainly available within this institution. Primary interview participants were identified using results from a patient satisfaction survey maintained by the hospital. The survey results were based on recent as well as archival data to identify top performing physicians. Because this survey is conducted and maintained by the hospital, I was unable to review or influence the specific content of the survey questions. As the data drove subsequent data collections the study expanded only slightly beyond this institution to include some professionals from private practice and other settings.

### **Confidentiality**

To ensure participant confidentiality, the primary researcher had sole responsibility for contacting and interviewing participants. Transcripts were coded with numerical identifiers the primary researcher maintained only for the purposes of member checking. Any identifying information provided within the interview was deleted from the transcripts before being passed along to research assistants for coding. Participants signed an informed consent detailing the extent of confidentiality and granting

permission to be contacted at a future date to provide member checking of transcripts and interpretations. None of the participants declined the option of future correspondence.

### **Data Collection**

In order to allow for triangulation of data sources, multiple data collection procedures were utilized. Data included individual interviews, patient questionnaires, and memos.

#### **Individual Interview**

Participants selected through theoretical sampling were contacted by the primary researcher for an audio recorded in-person interview. Semi-structured interviews lasted between 30 and 60 minutes, providing structure but allowing participants to guide the direction of the interview based on their perspectives and experiences. After interviews were transcribed and coded participants received a copy of their interview and were invited to add to or clarify the information they provided.

#### **Interview Questions**

Primary interview questions were constructed based upon the literature review and research questions. However, as is common for grounded theory research, questions were later revised as the study progressed in order to explore new concepts more fully. This method allowed for the emergence of new themes driven by the data, rather than restricted by the researcher. Interviews were semi-structured to allow for elaboration and new directions, with an interview protocol consisting of the following questions:

1. Could you describe your practice? What is a typical day like?
2. Can you give me a sense of the types of patients you typically see?
3. What are usually your goals when you sit down with a patient?

4. What do you feel are the components of “good practice” in medicine?
5. What do you think patients expect from their doctors?
6. How, if at all, do you facilitate a relationship with your patients?
7. What do you do, if anything, to understand your patient’s frame of reference?
8. When you hear the term “empathy,” what comes to mind?
9. How would you define empathy as it relates to medicine?
10. What part of what you consider empathy is important to your success with a patient?
11. What parts of what you do are not related to empathy?
12. What barriers exist in using empathy in medicine?
13. How, if at all, did you learn to be empathic in medicine?
14. How, if at all, do you think medical students should learn about empathy?
15. Is there anything else you would like to add?

### **Participant Questionnaire**

Participants who consented to participate in the study were asked to complete a questionnaire containing demographic information and information specific to their specialty area (see Appendix E). Questions included information such as age, gender, years in practice, specialty area, and details about patient populations and typical workload.

### **Memos**

Corbin and Strauss (2008) list memo writing as a significant piece of grounded theory research, and one that is not to be avoided or done half-heartedly. Memos begin at the start of the study and are regularly completed throughout the analytic process. Patton

(2002) states, “recording and tracking analytical insights that occur during data collection are part of fieldwork and the beginning of qualitative analysis” (p. 436). Therefore, memos must be kept regularly and used to organize concepts, reveal new connections among data, reflect on interviews and observations, and track the progression of emergent themes. Memos can thus be their own part of data collection, as they mark the researcher’s experience of working with data and searching for connections. In this study, memos were used to document observations of interviews as well as possible interpretations of the data.

### **Data Analysis**

In grounded theory, data analysis is woven throughout a study. Analysis of the first pieces of data influences the way subsequent data are collected and analyzed. This cyclical process of data collection and analysis is conducted until the analysis reaches saturation, with no new concepts emerging (Wasserman et al., 2009). There are several techniques for analyzing and sorting data, all of which can occur at different times throughout a study. Memoing helps to facilitate and record these analysis procedures, and therefore should not be seen as a separate process (Corbin & Strauss, 2008). The purpose of data analysis in qualitative research is to make sense of the various concepts gathered through data collection by piecing them together in search of a larger meaning (Creswell, 2009).

### **Reduction**

Data can be reduced into more manageable units through coding procedures that pull significant concepts from interviews and observations (Corbin & Strauss, 2008). As a grounded theory study evolves, researchers must break new data into manageable

sections and compare emerging concepts with current themes. In this way, new concepts can result in the revision of existing interpretations, and current themes can offer a framework for coding new data. This process, known in grounded theory research as “constant comparison,” offers a model for ongoing analysis and data reduction without minimizing the importance of subsequent data collection (Wasserman et al., 2009). Data are thus reduced continually through a variety of coding procedures outlined in the following section.

### **Coding Procedures**

Although grounded theory research does not follow a strictly linear coding procedure, there are several different types of coding that all contribute to data interpretation and can be used throughout the study (Giske & Artinian, 2007). The first of these methods is open coding, which involves breaking down data, frequently line-by-line, and identifying primary concepts (Wasserman et al., 2007). Memos are written to capture the full range of concepts within a given section of data (Giske & Artinian, 2007). During this process it is important for researchers to code using the words or concepts of the participants, rather than employing a priori codes from the research (Corbin & Strauss, 2008). In this study, the primary researcher conducted open coding of interviews in sets of five, with the first five interviews coded before subsequent interviews were conducted and transcribed. This allowed for analysis of early data and the opportunity to adjust interview protocol or explore new directions with subsequent interviews. Research team members also coded the first five interviews using open coding procedures, then were randomly assigned five additional interviews to code later in the process.

The next procedure for reducing data is known as axial coding. Though originally delineated as a separate process, Corbin and Strauss (2008) have more recently identified it as occurring almost simultaneously with open coding. Axial coding involves relating concepts or categories as they emerge from the data by answering the questions of “where, when, why, who, how, and what with consequences” (Strauss & Corbin, 1998, p. 125). This is a process of making connections, and it is often automatic as a researcher examines new data. As open codes are generated, patterns may emerge and causal relationships may be identified, leading to larger categories that contain similar concepts. This process should be closely monitored through memoing.

To assist with clarifying the axial coding process, Corbin and Strauss (1990, 1998) identify procedures that can illuminate links between categories. These organizational procedures include the identification of conditions, actions and interactions, and consequences. Conditions refer to elements of the data that identify the structure of the phenomenon. Applied to this study, conditions would include any circumstances or situations that participants identify as fostering or restricting empathy, as well as any descriptions of how empathy is conceptualized. Actions and interactions answer the question of “whom” and “how” by identifying issues, events, and problems that participants frequently associate with the phenomenon under study. Consequences address the outcomes of the identified actions/interactions (Charmaz, 2006; Strauss & Corbin, 1990, 1998). These concepts can be useful to employ when dealing with large amounts of data as a way to structure the coding process. However, if researchers are comfortable with ambiguity and prefer to identify categories as they emerge from the data, axial coding procedures may not be necessary (Charmaz, 2006). Corbin and Strauss



(2008) also warn that these procedures are guidelines but should not be used to force data into categories that may not be appropriate. Researchers should ultimately allow the data to guide the analysis, using the principles of axial coding to add structure but not dictate the process.

The next stage of the coding process, selective or focused coding, is used to further reduce data into larger categories (Ghezeljeh & Emami, 2009). Creswell (2009) describes the entire process as “generating categories of information (open coding), selecting one of the categories and positioning it within a theoretical model (axial coding), and then explicating a story from the interconnectedness of these categories (selective coding)” (p. 184). Selective coding, therefore, allows the larger theory to emerge. It involves synthesizing larger segments of the data into broader categories, allowing the researcher to look across interviews and participants to compare and contrast more general themes (Charmaz, 2006). However, it is easy to see how the coding process becomes cyclical, as contradictory themes emerging from new data would require a shift in theoretical assumptions.

In this study, the primary researcher used axial and focused coding to organize concepts into a codebook and later into a theoretical model. Axial coding indeed seemed to flow easily as open codes were generated and categories between codes began to emerge. The primary researcher wrote brief memos to document as new concepts or connections were identified, and research team members were also encouraged to memo about their thought processes (see Appendix H). These memos assisted in forming initial codebooks as well as structuring the final model. Research team members submitted their

memos at the first consensus coding meeting, as well as with their final codebooks at the end of the study.

### **Data Display**

Corbin and Strauss (2008) recommend that researchers should regularly create diagrams to map out potential relationships among concepts. Diagrams provide organization and allow researchers to explore relationships without getting bogged down in pages of text (Corbin & Strauss, 2008). Through diagrams, data can be reduced to its essence, which both helps the researcher find connections and also helps others to understand the findings. Conceptual mapping can also assist in this process (Giske & Artinian, (2007). Other methods, such as fractal concept analysis (Wasserman et al., 2009) and reflective coding matrices (Scott & Howell, 2008), can further clarify and organize concepts. In this study, the primary researcher utilized data displays to accompany memos and illuminate emerging hypotheses regarding the links between categories of data.

### **Verification Procedures**

Qualitative research differs from quantitative in that the quality of the study is determined not by tests of reliability and validity, but by credibility of the researcher and trustworthiness of the implemented procedures (Corbin & Strauss, 2008; Creswell, 2009). In qualitative research, trustworthiness reflects the degree to which the study is logical, clearly organized, and presented in a way that allows readers to interpret the applicability of its results (Corbin & Strauss, 2008). Research that has clarity of purpose, that follows established procedures with little variation, and that acknowledges the influence of the researcher will be viewed as more trustworthy than a study that does not employ these

methods (Corbin & Strauss, 2008). Criteria for trustworthiness in qualitative research have been developed in response to quantitative emphasis on validity, reliability, neutrality, and generalizability. Though the methods and goals of qualitative research are inherently different, criteria offer a standard for scholarly research that, if followed, can add credibility to the findings. Among the criteria to establish trustworthiness of a qualitative study are credibility, transferability, dependability, and conformability. Each criterion will be discussed, along with the assumptions of trustworthiness each method addresses.

### **Credibility**

Credibility entails the overall face value of the study. In other words, the degree of credibility determines the believability of results. To ensure that a study is viewed as credible, a researcher should be transparent about the methods used and the process of analysis (Corbin & Strauss, 2008). There should be detailed accounts of sampling procedures, coding methods and formation of major categories and themes, acknowledgement of outliers and divergent themes, descriptions of how the final theory was determined, and evidence that results are both meaningful and applicable (Corbin & Strauss, 2008). This study sought to establish credibility by carefully following grounded theory methods and thoroughly documenting each stage of the process. The use of other research team members to triangulate data interpretation and guard against the effects of researcher bias also contributed to the credibility of the study. Member checking of primary interpretations can also enhance credibility by ensuring that participant voices are being preserved as data are reduced.

### **Transferability**

The transferability of qualitative results determines how well findings can be applied outside of the immediate research setting. Although qualitative studies are non-generalizable by their nature, readers of qualitative reports can make inferences as to the degree of applicability. If the researcher has thoroughly described the setting, participants, and process of inquiry, a reader may be able to make some judgment as to how findings could fit within a similar setting. Since the intent of this study was to formulate a theory on the rather broad concept of empathy within the medical interview, transferability of the results was a key concern. Therefore, sampling procedures attempted to capture maximum variation of individuals and concepts within the chosen setting, in hopes that a diverse sample would enhance the utility of the results in other settings.

### **Dependability**

Dependability addresses consistency of data collection and analysis amongst researchers to establish a sense of reliability within the study. As the primary researcher, I was responsible for most data collection. However, research team members assisted me with coding interviews and memoing about potential associations in the data. These codes were compared to determine the degree of consistency among interpretations. The research team met twice to discuss codebooks and larger themes. In the first consensus coding meeting, team members each submitted a codebook based on the first five participant interviews. During the meeting the research team compared codebooks, exploring commonalities and differences to agree upon a new codebook based on consensus between all members. The team also discussed codes that seemed to be related, or that illuminated an important theme. In the second team meeting, team members

submitted updated codebooks as well as several memos of themes they felt would be relevant for a final model. These team meetings to discuss emerging themes were an important part of monitoring the degree of similarity amongst coders and ensuring dependability.

### **Confirmability**

Grounded theory methods aim to ensure that data drives analysis, rather than allowing the researcher to guide data in a predetermined direction. Part of this process is to enhance the confirmability of the results. Confirmability addresses how well participant voices are maintained throughout the study and the final analysis. As a procedure, it guards against the threat of the researcher's interpretations overshadowing the original intent of the participants. This study employed strategies of triangulation to address confirmability by using a research team to provide consensus coding, as well as by allowing participants the opportunity to view their interview transcripts. If participants felt they had been misquoted, misunderstood, or if they wanted to expand upon certain points they felt had been de-emphasized, they could do so at any point throughout the study. This method of member checking held the researcher accountable in preserving the intent of each participant, accurately portraying his or her point of view within the data and thus adding to the confirmability of the results. The use of a research team also enhanced confirmability by offering multiple interpretations of the data and encouraging an examination of researcher biases.

### **Summary**

This chapter presented the methodology for exploring the concept of how empathy is conceptualized within the medical interview. A justification for qualitative

methodology was provided, along with support for the selection of grounded theory. Support was also provided for adopting a post-positivist paradigm to establish the assumptions of the inquiry. The chapter presented the research question, discussed the role of the researcher, outlined a detailed research plan, and described methods for data collection and analysis within grounded theory research. Finally, verification procedures were addressed to enhance the trustworthiness of the study.

## **CHAPTER FOUR**

### **FINDINGS AND INTERPRETATIONS**

#### **Introduction**

Following grounded theory methods and guided by the research questions, this study examined the characteristics of empathy in medicine and resulted in the development of a theoretical model. This chapter presents the model developed from data obtained through individual interviews, research team collaboration, and memo writing. Each element of the model will be addressed, utilizing participant quotes and presenting emergent theoretical concepts. It is important to note that, due to the post-positivistic paradigm of this study, the model will be presented as a solid theory that can be subject to future testing. The model represents consistent themes that emerged from over 20 individual interviews and is presented as factual according to these participants. Implications for the universality of these themes should be the subject of future testing and investigation.

#### **Brief Review of Data Collection and Analysis Procedures**

Data collection consisted of 21 individual participant interviews, member checking procedures, research team interpretations, and memos to document emerging themes. Interviews averaged 59 minutes in duration, ranging from 35 to 79 minutes, and consisted of a semi-structured interview protocol that utilized pre-established questions but offered the flexibility to explore tangents or alternate interpretations of the subject matter. Interview questions were adjusted throughout the study as new information emerged and holes in the data were identified (see Appendix F).

Initial participants were identified through a list of physicians receiving high patient satisfaction ratings at a local teaching hospital, and subsequent participants were obtained via snowball sampling by the recommendation of each interviewee. The patient satisfaction survey used to identify initial participants was maintained by the hospital, and a list of top-scoring physicians was provided to the primary researcher. Interviews were audio-recorded, transcribed in full, and coded line-by-line in sets of five. Interviews were also analyzed and entered into the main codebook in sets of five, allowing a circular process of data collection and analysis throughout the study. Memos were written throughout the process as new connections were found in the data (see Appendix H). The primary researcher and research team members utilized memoing as an important step in seeing “beyond” the descriptive data. The primary researcher wrote memos throughout the study as new thoughts emerged, and research team members were encouraged to submit their own memos at the initial consensus coding meeting as well as when they submitted their final codebooks. Furthermore, all consenting participants were sent a copy of their individual interview and invited to provide additional comments or corrections. Though none of the participants provided additional clarification, many acknowledged the receipt of their interview and expressed an interest in knowing the final results.

The research team met twice throughout the process and corresponded via email at various stages. During the primary meeting, team members received a brief training on qualitative research and grounded theory methodology. This meeting also included a chance to discuss potential biases and assumptions regarding the topic. The research team consisted of a first-year doctoral counseling student and a fourth-year medical student. The



counseling doctoral student had prior training in qualitative research but the medical student had not received any formal instruction in conducting qualitative research. This proved to be an advantage during the research process, as the medical student demonstrated a coding method that focused more on overarching themes and meanings, whereas both research team members in counseling remained more attentive to descriptive data in the form of participant quotes. During the research team meetings these styles were complimentary in extending the multiple quotations and subthemes into more specific overarching categories, thus clarifying major themes and furthering the theoretical reach of the study.

Both research team members were also encouraged to memo about their reactions to the data and to comment on themes that seemed to carry extra weight in the study. They submitted memos at the first consensus coding meeting, as well as with their final codebooks. These memos were pivotal in both confirming the strength of categories and in illuminating connections between data. Each research team member coded the first five participant interviews before meeting for the first consensus meeting. During the meeting the research team compared codebooks and discussed potential themes and categories, resulting in a new consolidated codebook based on a synthesis of team member perspectives. Following this meeting a revised codebook was distributed to team members and they were each provided with five additional interviews to code and place within the codebook. Each research team member wrote final memos on areas they felt were important to the final data analysis. Though formal research teams are not a prescribed protocol for grounded theory methodology, the input from this team was invaluable to the study and resulting theoretical model.

The primary researcher, in addition to maintaining the main codebook and memoing throughout the study, also created data displays at various points in the process to visually represent interactions among data and connections between broader themes (see Appendix I). These data displays assisted with determining the strength of theoretical categories, and also helped identify unrelated or ancillary data that was overextending and weakening the model. Data displays created early on in the study as a result of initial interviews and the literature review also helped to form the structure of the codebooks.

Coding procedures utilized line-by-line coding for each individual interview and incorporated these codes within the larger codebook. Due to the strength of the categories that emerged from early data displays, axial coding was not formally employed in the coding process. Corbin and Straus (1990; 1998) described axial coding procedures as occurring almost automatically as a natural result of synthesizing meaning among open codes, and this seemed to occur within this study. As a result, the formal axial coding methods of identifying conditions, actions and interactions, and consequences were employed only loosely in categorizing data within the larger codebook so as not to limit the emerging organizational structure. Even so, the final model does reflect the intent of axial coding procedures in that it contains conditions, actions/interactions, and consequences within its levels.

Focused coding relied on the data displays, diagrams, and memos to consolidate codes based on the research questions. As new interviews were conducted, memos written, and the codebook expanded, the coding process indeed took on a cyclical

function of comparison of new data with larger constructs, and subsequent revision of larger categories to accommodate new connections.

### **Participant Profiles**

Due to initial sampling and snowball selection procedures the majority of participants were employed within the same medical school/teaching hospital, though some worked in community or private practice settings (see Table 1). Participants represented a wide range of specialties and included a selection of physicians, nurses, a medical student, and a counselor. Though initial data collection was focused on obtaining a sample of physicians, several participants recommended other healthcare professionals as experts on empathy in medicine. Thus, the study extended slightly beyond physicians to include some other perspectives, though interviews still centered on the role of empathy in the medical setting.

Most participants reported treating a diverse patient population in terms of ethnicity, socioeconomic status, and age. Participants were primarily male with an mean age of 50 and an average of 21.5 years in practice. Though a variety of specialty areas were represented, family medicine was the most common area of practice, employing five of the 21 participants. Patient visit time and patients seen per day varied according to specialty and setting, with an average reported visit time of 25 minutes and an average of 18.8 patients seen per day (see Table 1).

**Table 1**  
**Participant Group Profile**

Participants	Gender	Age	Race <sup>a</sup>	Years in practice	Specialty <sup>b</sup>	Avg. Visit Time (min)	Avg. # patients /day	Avg. patient race <sup>a</sup>	Avg. patient age	Avg. patient income <sup>c</sup>	Avg. # of visits	Setting <sup>d</sup>
P01	F	59	C	29.5	FM	20	10	½ AA	50	MC/MD/ SP	--	MS
P02	M	61	C	35	ID	--	20	--	--	UI	--	MS
P03	F	56	C	30	MM	10	40	½ AA	varies	MC/SP	10-12	MS
P04	F	45	C	10	OB	30-60	30-40	varies	10-79	varies	monthly	MS
P05	M	73	--	38	PS	10-20	5-35	varies	varies	varies	--	MS
P06	M	25	C	0	MS	30-60	6-9	AA	varies	UI	1-3 mo.	MS
P07	M	46	C	15	ID	30-60	12	C/AA	40	varies	3 mo.	MS
P08	M	59	A	30	FM	15-20	11	AA/C	--	--	--	MS
P09	F	53	C	20	MM	15-60	28-38	varies	varies	MD	2 wks	MS
P10	M	44	C	16	FM	20-30	14	C/AA	1-100	I/MC	--	PP
P11	F	61	C	39	GC	60	1-7	varies	varies	varies	varies	PP
P12	F	61	C	38	NP	30	12	AA/C	19-69	varies	3 mo.	CL
P13	F	34	C	3	NP	30	25	varies	varies	>avg	--	MS
P14	M	40	C	9	GS	5-30	15-20	varies	varies	varies	--	MS
P15	M	55	C	26	FM	20	11-12	varies	varies	varies	--	MS
P16	F	54	C	23	PN	--	35-50	--	--	--	--	MS
P17	M	35	C	5	NE	30	15-20	varies	18+	varies	varies	MS
P18	M	67	C	37	FM	15-30	25	C/AA/L	35-40	30-35/yr	25 yr.	PP
P19	M	63	C	31	PD	15	22	varies	0-24	varies	varies	PP
P20	M	33	C	2	PSY	30	10-20	varies	varies	varies	varies	MS
P21	F	38	FA	14	GE	10-60	5-10	varies	>65	varies	2-10	MS
AVG:	M	50.6	C	21.5	FM	25	18.8	varied	varied	varied	varied	MS

<sup>a</sup> Abbreviations: C, Caucasian; AA, African American; A, Asian American; FA, Filipino American

<sup>b</sup> Abbreviations: FM, Family Medicine; ID, Infectious Disease; MM, Maternal Fetal Medicine; OB, OBGYN; PS, Plastic Surgery; MS, Medical Student; GC, Grief Counselor; NP, Nurse Practitioner; GS, General Surgery; PN, Pathology/Neuropathology; NE, Nephrology; PD, Pediatrics; PSY, Psychiatry; GE, Geriatrics

<sup>c</sup> Abbreviations: MC, Medicare; MD, Medicaid; SP, Self-pay; UI, Uninsured; I, Insured

<sup>d</sup> Abbreviations: MS, Medical School; PP, Private Practice/Outpatient Office; CL, Clinic

## Results of Interviews

Interview coding and memoing procedures led to the development of a theoretical model to explain the conditions for empathy in the medical setting. As major categories and common themes emerged from the data, memos were used to record possible connections among participant statements. The resulting model, discussed below, is a synthesis of the main themes present in the data. This model reflects the opinions and experiences of the participants interviewed, as well as links made by researchers to establish connections among data points. It is displayed as a linear process, as each level builds upon the next. The assumption, based on participant data and theoretical memos, is that if one of the primary levels of the model is not facilitative of empathy, the final level will likely also not be facilitative.

In its current form, any bidirectional interactions within the model can only be assumed, as participant data did not illuminate many firm bidirectional influences among levels. However, it seems likely that internal and external barriers could be interrelated. For example, it is likely that time pressures and volume of patients (external barriers) could lead to burnout and the need for emotional distancing (internal barriers). Thus, internal and external barriers could demonstrate a bidirectional relationship and both should be subject to future study and clarification. Further research should also include patient and administrative perspectives to examine potential bidirectional influences.

Each of the stages in the model is identified by its place in the overall diagram, and each contains several subcategories that are supported by direct participant quotations. It is unclear at this point in the model's development how many subcategories must be achieved at each level in order to reach a facilitative empathic relationship. The

model does, however, identify what the conditions of empathy may be, and how they might interact with one another to achieve desired results.

### A Model of Conditions for Empathy in the Medical Setting

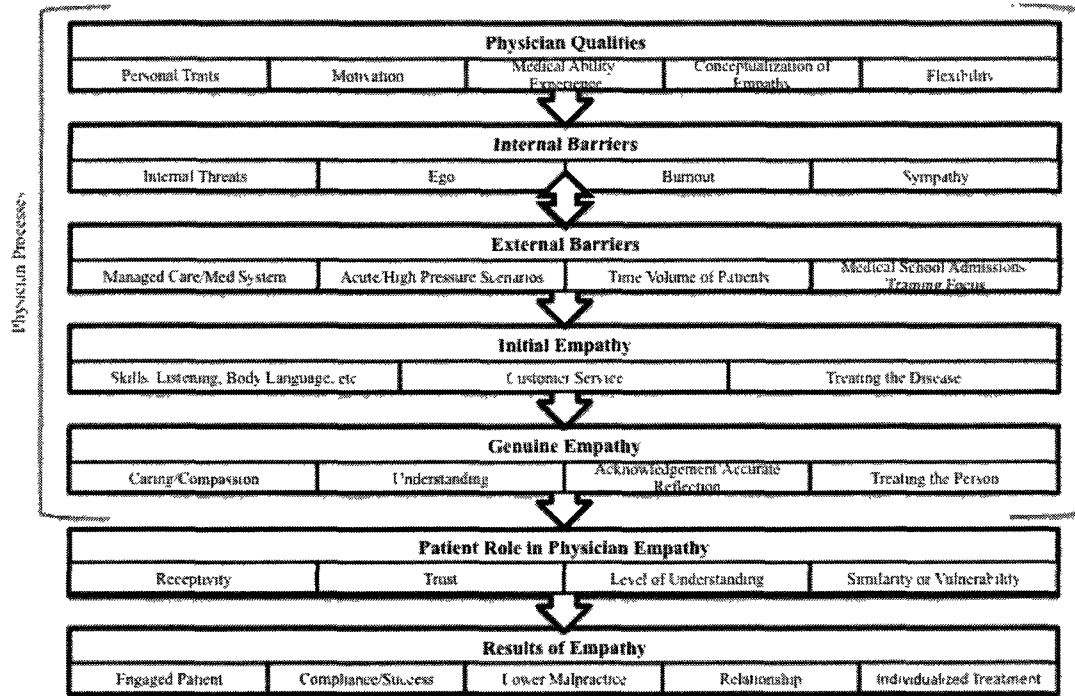


Fig. 1. Conditions for Empathy in the Medical Setting

### Physician

<b>Physician Qualities</b>				
Personal Traits	Motivation	Medical Ability Experience	Conceptualization of Empathy	Flexibility

Fig. 1A. Part One – Physician Qualities

The first important element in establishing optimal empathy within the medical setting consists of qualities and characteristics of the physician. A physician who possesses all or most of these characteristics would, according to participants, have more of a capacity for empathy than a physician who possesses few or none of them. The components of physician empathy addressed in the following section include personal traits, motivation for empathy, medical ability and experience, the physician's conceptualization of empathy, and the ability to be flexible when working with patients.

**Personal traits.** One of the key elements mentioned by nearly all of the participants as either contributing to or subtracting from a physician's empathy is the physician's intrinsic qualities of compassion or perceived empathic ability. Nearly all participants viewed these traits as either inherent from birth or developed in early childhood through observations of parents or other significant role models:

I suspect that it's just probably an innate quality that was just fostered with how you were raised. You know, if you have caring parents or grandparents or family members, it seems as though that probably just allows that inheritance to be manifest. Participant 7 (P07), line 207

But I think you have to have some role model and some key critical windows of opportunity in your life... and I think if somebody hasn't had that, you know, they're not even gonna be um, before you in class wanting to learn it. P01, 385

I think its just part of my personality, really. Just trying to see your patient's perspective and listening to it. P13, 100

Individuals with natural empathic ability were described as having a way about them that could put others at ease, independent of any particular actions or words to achieve this effect. In other words, the physician's demeanor or way of being can be sensed by the patient and is an important element in the physician's empathy:

I think it's something that's innate in people. Some people are ...can get connected with a patient like that (snaps fingers). For some people, it's a little bit different. P21, 346

Now, the others care and love the patients, and the patients love them cause they know ...they're just like us. They walk in a room and look around, they know who cares about them and who doesn't. P05, 495

They know if you care or not, the patient can tell right away if you're just talking. And um, we've all seen physicians who you know right away that they don't give a hoot. P09, 423

**Motivation.** Another key element of physician empathy is the motivation or desire to connect with patients. A physician could have all of the intrinsic qualities for an empathic interaction, but in the absence of motivation a true empathic connection would not be realized:

So, yes, there are things that are technical, like how you ask things. But a lot of it, I think, is the desire to develop that relationship. P04, 197

Yeah. I think there might just be a difference between being naturally empathic and willing to open yourself to somebody. P11, 354

Motivation also includes a physician's motivation for entering the medical field. Physicians who are primarily interested in the patient's well being are likely to be more empathic than those who are motivated by salary or prestige:

I think it's the person. I think the person who goes into medicine wanting really to help other people, not for the prestige, not for the title. Those are the people who are going to be more naturally empathic. P11, 469

It has nothing to do with how much money you're going to make, how much time you're gonna have with your family, all those are like benefits that may come with the job, but if you don't feel it in your heart and your gut, you won't make a good doctor, because you need to do it for the right reason. P09, 586

**Medical ability/experience.** Participants also suggested that empathy might develop over time, particularly once a physician is more confident in his/her medical abilities. Though still requiring some intrinsic qualities, empathy can potentially be



enhanced through practice, observation, maturity, and greater competency. Medical students, for example, may have some natural empathic ability but be unable to fully demonstrate this trait during their training. The sheer volume of medical knowledge to digest, the pressure to appease or impress superiors, and the interest in medical procedures may overshadow their ability to show empathy to a patient. However, upon entering a professional role, observing empathic colleagues, and mastering medical concepts and procedures, a physician may gradually have a greater ability to turn his/her attention back to the patient. Physicians may also, over years of practice, develop sensitivity to patients and become better able to empathize:

So I think it's more something that's within you, and then you know, over the course of 30, 40 year career you learn to try to shape it a little bit. P08, 338

So they may need to learn a little bit about themselves and mature in their field in order to continue to develop and be able to have that rapport with their patients. P12, 232

Some of that's maybe just getting older, but I think that concept—I think over the first few years, I think, really through experience—I sort of became better at employing effectively. P15, 169

So I think a lot of people have that side to them, that somewhere inside of them, but when they really see it in action and they see it through other people is when they really are like ...they turn it on. P06, 414

I think so much of the way you learn medicine is by watching other people do it. You're like little kids going by modeling, following what other people do. Same thing with medicine, and you kind of learn it. You know, 'Hey, this guy interacts with patients and does well and has good rapport,' then you kind of do that. You see some other people, and you think, 'That guy, he does not do well with his method,' and you sort of learn things to avoid. P14, 406

Another way participants conceptualized medical ability and empathy was to describe the incorporation of empathy within the medical interview as an art, which stood in contrast to the science of medical procedures. The art of medicine, according to

participants, seems to be the ability to simultaneously balance medical knowledge and skill with a thoughtfulness and sensitivity to the patient. Whether it is honing in on something a patient says that goes beyond medical symptoms, knowing more personal details about a patient, expecting certain reactions to bad news based on responses of other patients before them, or seeing that patients are much more than a collection of symptoms, somehow this "art" emerges and allows physicians to blend roles in the same way an artist might blend colors or paint strokes. It is a process of "becoming" that occurs with time and can be thwarted by many barriers and challenges (see Internal Barriers and External Barriers). Therefore, as physicians mature and gain familiarity with the "science" of medicine, the "art" is able to develop.

The art of medicine is where the empathy comes in, I think. P09, 235

But everything comes from that, and the problem is, you take that patient who has a whole different perspective on a whole different number of things, and then you have to try and, again, how do you manage the message for the patient. P10, 432

Again, the technique can be taught. But how you apply it, I think, is part technique and part art. P04, 241

**Conceptualization of empathy.** Another element influencing the role of empathy in the medical setting involves how physicians conceptualize empathy and its role in patient care. Participants in this study provided many definitions when asked to describe empathy, and likewise their conceptualizations of how to employ empathy with patients also varied as a result. It could be assumed, then, that variations in an understanding of what empathy is and how it relates to medical treatment will have an impact on how physicians treat patients when they are choosing to act empathically. One common definition of empathy, for example, describes empathy as being primarily about caring or compassion that is felt towards the patient. These same participants who view empathy in

this way are also very aware of the need for establishing emotional boundaries (see Internal Barriers) and regulating the degree of compassion they feel for each patient so as not to become enmeshed.

I guess, you know, the number one most important thing I can think of is caring... That's ... To me, that's the most important thing: You have to care because if you don't care, than nothing else really falls into place. P07, 15-17

Well when I think of empathy I think of a genuine caring for the other individual, as well as a caring about their outcome, their health outcomes. P12, 155

Empathy can sometimes get a little bit out of control. You know, if you're... if you're someone who is altruistic, like I was coming out, if you sometimes really took it to heart, if you had someone who was really hurting bad, you were hurting as bad as they were, and sometimes it took you away from the business at hand, you know you took your work home with you very often, and I know I did for the first couple of years, until you really know how to control it. P18, 141

Another very common definition among participants describes empathy as being primarily about understanding the patient. Variations of this definition include being able to take on the patient's perspective, putting oneself "in the shoes" of the patient, sensing how a patient is feeling, or relating to a patient's condition through first hand experience. Participants who provided these conceptualizations of empathy also often discussed how cultural barriers or lack of common experiences could interfere with their ability to be empathic.

But, um, there's a technical definition (of empathy) that John Coulahan uses ... "empathy is understanding exactly." (P01, 188)

Then you gotta stop and put yourself in their position and say, you know, their husband is out of work, the poor guy is getting unemployment, you know they can't afford their medicine, what would I feel like? What would I be like in that position? And you have to kind of understand their situation to be able to go forward and treat them. P18, 207

I think empathy has probably many definitions, but I'd say it's the ability to get into the mind and the spirit and the psychology of another person. P05, 35

I think it's just the ability to put yourself in that person's shoes. Or imagine yourself in that position. Um ... I guess the ability to relate to somebody's pain and suffering, or whatever challenges they are facing. So, can you truly imagine being in that position and feeling for them? P07, 106-109

Within their definitions of empathy, many participants indicated that being empathic was difficult or draining:

And your heart goes out to them. I use that expression purposefully because I think it's really a part of yourself that you're extending to them, and you're giving them something: You're giving them your trust. You're giving them your energy. You know, there's only so much energy that every person has. And I think the process of empathizing takes energy. P20, 364

And um, you know, you give a lot of yourself and a lot of your heart sometimes, and the more you give the more it hurts you, the more things don't work out right, or when a relationship doesn't work out right. P05, 12

Hmm.... it's more exhausting. It's easier to go through life without letting your emotions get in the way. Very easy to just exist. It's much more exhausting to put yourself in their place to start thinking about "how would I feel if I had this?" P09, 439

Some participants stated that this sacrifice of personal energy or emotion was part of the job and worthwhile in the establishment of a relationship. Others, however, seemed wary of engaging fully in empathy with a patient in fear that they would become too invested or affected and thus lose their objectivity and quickly reach burnout (see Internal Barriers):

And to be able to connect with the patients on that level I think is, it makes your experience as a physician that much richer, in my view anyway. P09, 473

There are numerous patients who work their way into you. And, um ... That's okay. That's okay. And, um ... As you follow through their diseases, and perhaps even, then, you talk to their families afterward, and it's not ... It's not necessarily easy, but it's also, um, enlightening I think ... I think it makes you feel as if you are actually doing something. P10, 335

You know, if I couldn't have that sense of empathy I wouldn't be here, I wouldn't do it, cause first of all in two ways. It wouldn't serve my patients the way I hoped,

and in all honesty and all fairness in a selfish way, it serves me, you know? P18, 90

There are certain boundaries you can't let be crossed because otherwise you make yourself useless if you become too enmeshed. You need to be involved, but ... it's kind of like a relationship with a teacher, right? A teacher and their student. There's this unspoken boundary, and you have to always respect that. P21, 255

Because I have other patients. So, there's that risk, too. You don't want it to be a poor-functioning relationship. I'm still the provider. I'm still helping you with whatever thing is going on. I understand that you think I'm your friend. I'm not your friend. I am friendly, and I understand, but there still has to be that line, and that's the big risk. P13, 293

This conceptualization of empathy as difficult or draining seemed to impact the willingness of physicians to engage in empathy with their patients. Participants who associated empathy with caring or compassion also seemed more likely to have reached the conclusion that empathy was a balancing act that required attention to boundaries with patients.

**Flexibility.** Finally, many participants said that being empathic allowed them a degree of flexibility to respond to the individual needs of patients, tailoring medical treatment to incorporate biopsychosocial factors. According to participants, empathic physicians are observant, noticing body language and listening to non-medical asides with interest. They can step back and view the patient as complex, thus enabling them to explore treatment options and directives with more attention to whether they fit within the patient's lifestyle (also see Empathy – Genuine). This idea of flexibility also alludes to the concept of the art of medicine, as many participants described the ability to make adjustments and the sensitivity to individual needs as an artistic quality in their work.

Yeah, you know, you can tell based on body posture. And, uh ... You know, just their shift—you know that shift when you're talking? You can sense that they're either happy with the way that things are going or they're anxious about something. And then you can tailor your interview accordingly. P17, 37

That you, in a way, put yourself in their shoes because what you are prescribing for one patient may not work at all for another one—being because of religious concerns, because of ethical issues, because of working hours. Um ... They want you to tailor care to their needs. That's a big one. And we do ...our treatments are very involved, and many patients cannot do it, so they need you to adapt things to what they need. P04, 6

You know, you're taught early on in medical school that it's Mrs. Jones in Room Two. It's not ... It's not a heart attack in Room Two because Mrs. Jones who is ninety and having a heart attack is totally different than Mrs. Jones who is forty-eight and having a heart attack. You know? You've gotta do different things; you've gotta think differently because it's always the disease in the context of the patient. P10, 397

There are times when, you know, you change your volume, and you approach a patient differently. Does that mean you are throwing empathy out the window? Or are you ... Because you understand what is going on and that it requires a different technique and approach. P15, 327

### Internal Barriers

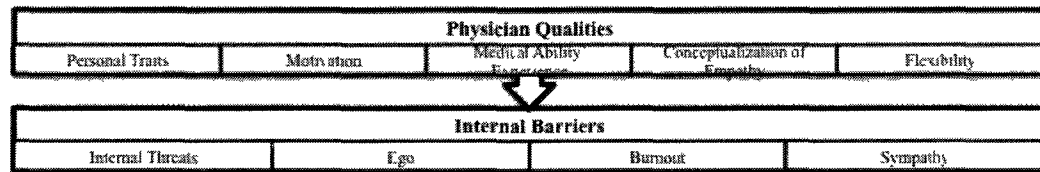


Fig. 1B. Part Two – Internal Barriers

Assuming that physicians have met at least some of the qualities identified as facilitative of empathic treatment, given the right conditions it is likely that they will provide empathic care to their patients. However, participants in this study identified many barriers that may restrict or prevent such a connection from occurring, even in spite of optimal physician characteristics. This section of the model describes internal barriers,

occurring primarily within the physician, which can impede an empathic connection. These internal barriers come in the form of setting boundaries or emotional distancing, physician ego, burnout, and a confusion of sympathy for empathy.

**Internal threats.** As mentioned previously in discussing physician conceptualizations of empathy, many participants indicated that clear boundaries were oftentimes necessary in order to manage the professional relationship with patients. Empathy was viewed as a connection that, while valuable, ran the risk of making the relationship too personal and possibly resulting in enmeshment:

And I remember the doctor told me at the time “it’s not a bad thing to have this kind of empathy, you’re gonna have to learn how to control it cause otherwise you’re gonna forget about the other 25-30 people you have to see, or the people you’re gonna operate on, the people who are gonna need you.” You know, and I remember that, and it was something that really took awhile to try to put that screen up at a certain point, and you can only go so far with empathy. P18, 166

It’s just exhausting and tiring to be the empathetic physician, to be able to leave your office at the end of the day and not take some of the sadness with you, along with the happiness, of course. It’s hard, it’s hard to close the door of your office and leave for the day. As a physician it’s a 24/7 job. You may not be seeing patients that night, but I’m thinking about people. I’m like, you know, thinking about a case, what am I gonna tell them tomorrow when I’m seeing them and I gotta tell them that things are really not good. P09, 447

As a result, participants described a constant monitoring of the boundaries of the relationship, and indicated that this need for professional distancing was often stressed during their training as well. Depending on the perceived threat of the impact of the relationship, physicians either permitted an empathic connection or prevented it. Boundaries and emotional distancing appear fairly easy to maintain within the medical context, as physicians who feel the need for such boundaries can focus exclusively on the medical problem to the exclusion of an interpersonal connection:

I think what has been difficult is when I first came out of training you know we were always taught this idea that you're supposed to kind of build a barrier, this so called objectivity, not subjectivity. And you dealt with a patient or illness but don't get too close to them. Um, if I had to do that with what I'm doing in medicine I would have quit a long time ago. P18, 49

Um, it's very exhausting to be able to have that connection. It especially depends on the news you're delivering, the clinical situation. It's easier to be detached, it's easier to go through life just delivering information without emotions that it comes with. P09, 444

And I suppose sometimes that's what physicians do, you know, just come in and say you have cancer and walk out and you don't have to deal with your own emotions. And so it may not be ...that they're not empathetic, they just don't want to be too vulnerable. You know, cause as soon as you open yourself up you start...becoming too involved with the patients. P08, 364

The perceived need for emotional distancing stemmed from what many participants described as the “burden of suffering,” meaning that such distancing may be a necessary form of self-protection in a setting filled with death, fatal diagnoses, pain, and lawsuits. Many physicians in this study described the need to detach themselves emotionally from the patient in order to get through the day. Thus, empathy was seen as an intervention that must be used with care, or abandoned if physicians felt particularly susceptible to the burden of suffering.

Many of them have told me that they can't get close to their patients, they can't...they have to have that wall, because if they did it would be too stressful and they couldn't handle it. P11, 201

Empathy can sometimes get a little bit out of control. You know, if you're...if you're someone who is altruistic, like I was coming out, if you sometimes really took it to heart, if you had someone who was really hurting bad, you were hurting as bad as they were, and sometimes it took you away from the business at hand, you know you took your work home with you very often, and I know I did for the first couple of years, until you really know how to control it. P18, 141

**Physician ego.** Another barrier that may prevent a physician from establishing an empathic connection with a patient is the degree to which the physician stresses his/her



authority. Physicians who view themselves as “above” a patient in some way are less likely to be motivated towards empathic care. This perception of authority can result in the physician dominating the medical interview, dismissal of patient questions or potential diagnoses, or a failure to see the patient as anything more than a collection of symptoms. According to participants, physicians who are not as invested in their own ego or role as an authority figure often take deliberate actions to come “to the level” of the patient. This may involve seeking patient opinions, sitting down next to the patient, and communicating in layman’s terms.

I think it’s partly the authority level, maybe. They don’t want to establish maybe that connection with the patient. They still think that they’re the doctor and all that. P06, 487

You have to read your patient to be able to interact with them at their level, at their appropriate level and not sound, um, judgmental, not sound too paternalistic or materialistic. Really you have to come to their level. P09, 266

In addition, physicians may have their sense of competency threatened by poor patient outcomes, a sense of failure, or malpractice claims. Thus physicians, particularly those in high-risk medical settings or specialties, may establish firmer barriers towards patients in order to protect their egos from setbacks or failures.

They get tied up in the job. And in succeeding. And maybe some of them have an ego that needs to be stroked everyday by positive outcomes. P11, 216

And so it’s a self-defense mechanism. And you have to be pretty tough in ego to withstand failure in surgery, cause it’s not what we go into medicine for. And yet some specialties lend themselves to that. P05, 131

No, they are afraid. They are just as afraid of death, they are afraid of their own failure – maybe it was something I should have seen and didn’t see. So they’re retreating to their own little hole to deal with it. P11, 209

**Burnout.** Regardless of physician characteristics or motivations towards empathic treatment of patients, elements of burnout can deplete physician energy and

reduce the goal of the medical interview to information gathering and treatment planning. Burnout can be temporary, such as in the case of physician illness, fatigue, distraction, or pressure to move on to other patients. Medical students and residents may be particularly prone to this form of burnout, as long hours and little ownership of patient care result in exhaustion and frustration. During periods of burnout physicians are much more likely to focus exclusively on the medical problem, often resorting to checklists and closed-ended questions to speed along the visit:

Fatigue and, uh one of the reasons that we're moving towards shorter duty hours is that there's very good evidence that if you're exhausted, if you're sleep deprived, you're less likely to be empathic. In fact, you're more likely to be irritable and snappish with your colleagues and so forth. P01, 308

And I tend to think its burnout. I tend to think it's the system that pushes them and pushes them until, honestly, it's not Mrs. Jones in room two. It's another patient with diagnosis X in room two, so then you've lost the empathy at that point. P10, 212

But yeah, empathy is absolutely the glue that holds it all together, and it is directly related—directly related—to the burnout of the physicians. P10, 286

... A lot of it has to do with timing. When are people coming in? Is it the right time of the day? Is it the right time of the week? How many people have I seen before them? How tired am I? How is my life going outside of work? How focused am I on work at this time? P20, 229

However, burnout can also develop slowly throughout a physician's career and become a more permanent barrier in patient care. Physicians may, for example, become cynical about the medical system itself, resentful of long hours and steep loans from medical school, or become hurt by patient lawsuits or criticisms. If gone unchecked, physician burnout can result in treatment void of empathy or any other interpersonal connection in an effort to "go through the motions" until retirement.

Um, but it's really the system, which is setup in a way that really tends to create burnout. And that's something there is not enough discussion on. Now, they've

cut back resident hours, but that's just because residents were killing people, its not because residents were unhappy. Residents are miserable people, and again the question is: 'Why?' And there are lots of studies that show that what you do in residency then is kind of a prelude for what you're going to do the rest of your life. So, if you're miserable in residency, guess what: You're going to be miserable the rest of your life in medicine, and that's because you learned to work too many hours and you feel like you deserve to have an income of \$500,000 a year, and the only way you're going to do that is to do all these different things, and it ends up being overwhelming and miserable, and you become totally burned out, and you don't have any empathy. P10, 507

Part of it, I think, is as I've spent more time in this profession, I think you become a little more jaded and cynical. Um ...and so a lot of times it's almost people have to earn my empathy. P20, 350

There's a certain empathy level where people tend to go down with age and time, where people get hardened and bitter with what they're doing, or bored with medicine, or bored with people, or tired of phone calls, or tired encountering patients. P05, 537

So, then, what is that all about? How can we continue to beat them and say, 'You have to see more and more patients,' but at the same time say, 'You have to give better and better and better care?' Um ...you know, finally, they just say, 'This is stupid,' and they come to work to collect a paycheck. P10, 264

**Sympathy.** As previously discussed in this model, sympathy can be a useful tool to inspire physician motivation to connect with a patient. However, sympathy can also result in enmeshment and an emotional investment that can be potentially harmful in providing treatment. The fear and discomfort of such an emotional connection often results in boundary setting and attempts at emotional distancing, as described above. Throughout the interviews for this study there often seemed to be a confusion of sympathy for empathy, with many participants describing empathy as an ability to experience the same emotions as the patient. If this indeed is empathy, then the importance of establishing protective barriers is both understandable and advisable. However, some participants disagreed with the notion that empathy involved an

emotional connection. Instead, they identified sympathy as an emotional process while distinguishing empathy as a process of understanding and observing.

It's hard to define. But I just feel like empathy is the reflection of the feeling you have whereas sympathy is a shared connection, rather than just a reflection. P17, 78

That would be more empathy whereas sympathy is more an emotional form of communication. For example—this is an extreme. If you're crying, and I'm crying—I can cry to your cry—that's sympathy, I think. Empathy: I can say, 'I see you're crying. You seem sad. I can see that you're sad.' That's more empathy to me. Sympathy would be you cry, then I cry because I'm sad about what you're sad about. P17, 90

Participants also indicated that sympathy, or any form of strong emotional connection to a patient, could act as a barrier in limiting physician objectivity and sound clinical judgment. Becoming too invested in a patient could prevent a physician from making difficult decisions during medical treatment and could also impact a physician's clarity of thought during complex or risky procedures. Many participants stated that it was unwise to personally treat a spouse or family member for this very reason. Patients who remind physicians of close family or friends, or who otherwise trigger some sort of protective or personal reaction, may cloud the physician's judgment.

If someone comes to me, I don't think I can do as good a job if all I provide is sympathy because if you provide sympathy, you may overlook things that are medically important because you're so involved in a sympathetic way. P17, 75

I, I started realizing putting myself in the position like her husband, and what he was going through and feeling, and I found myself going home everyday almost in tears, thinking about if that were my wife, how would I feel? And I remember it was almost distracting to the point I almost couldn't function. You know I would go back and look at my baby who was in the crib and my wife and the amount of pain that I felt, as a husband. P18, 162

It just makes it much harder to come up with tougher decisions and everything. You're more part of the family. P19, 174

## **External Barriers**

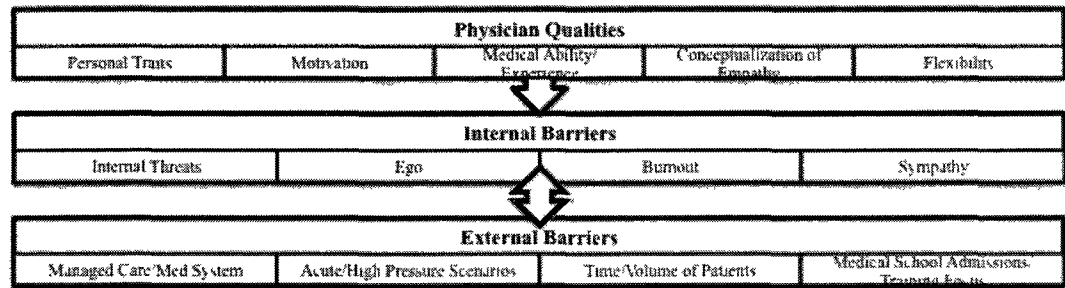


Fig. 1C. Part Three– External Barriers

Just as internal barriers can prevent empathy from developing between a physician and his/her patient, certain external barriers also restrict both the quality of the relationship and the extent to which empathy is employed. This next section of the model addresses barriers that are systemic or situational and that can impact a physician's ability to demonstrate optimal empathy. Again, even if the physician and internal barriers are facilitative of empathy, the process can be weakened or impeded due to external barriers. The barriers discussed in this section include limitations due to managed care, pressures of the medical system, the stress of acute or high pressure situations, the volume of patients and time restrictions, and medical school admissions and the focus of training.

**Managed care/medical system.** Many participants referred to managed care and insurance companies as significant factors limiting empathy within the medical interview. Reimbursement guidelines, copious amounts of paperwork, restrictions on prescription coverage, and a focus on standardization of treatment all reportedly deemphasize the

physician/patient relationship and leave little room for adapting treatment to meet the biopsychosocial needs of patients.

I'm not sure what's the better option here, if you're a student coming out now where you don't know any better and you have to deal with this mish mosh, or coming out in my generation when we really had what we considered the best years in medicine because you were able to develop relationships and care for people, you know, be empathetic and compassionate at the same time, and not have to worry about looking at the clock. You know, how many people am I seeing today? And I can't order this or can't order that, or, you know, I need to upgrade it so I can get more money coming in. P18, 72

Technically speaking—and I haven't had anyone have this happen yet—but technically speaking the insurance company can look and say, 'Nah, you didn't need to talk about this; you didn't need to talk about that. So, we're not paying for it.' My problem is, every minute I spend with a patient, even if we're talking about fishing or their children or whatever ...it is a connection with a patient that then lowers their guard so that then I can do the other things I need to do. P10, 450

And I think unfortunately what medicine's turned to nowadays is it's less about what the patient's feeling and more about what is the insurance company telling me I have to do, what I gotta give, and how I'm getting out of here by such and such an hour. P18, 95

Beyond insurance and managed care, many participants pointed a finger at the medical system as failing to emphasize empathy as an integral part of patient care. There seemed to be a feeling of regret, particularly among older physicians who were nearing retirement, that changes in modern medicine are deemphasizing relationships and putting perhaps too much emphasis on procedures. A theme that was nearly universal among participants was the idea that the “human” side of medicine is being lost, and that it is being replaced with patient quotas and checklists. Even younger members of the profession seemed to share in this sentiment. Pressure to meet a business model dependent on reimbursements thus encourages physicians to focus on quantity over quality of care:

So if you get someone whose motivation is really that they just want to make money, within the ranks of medicine you could certainly do that. And you could just churn out a bunch of patients and basically provide them the standard of care. You know, ‘standard of care.’ Because that’s really what a lawsuit is about—that you’ve violated the standard of care. Not that you didn’t provide the best medical care that was possible. And so ...you know ...if you’re in that kind of system where people are just really seeing a high volume of patients in order to bill for more money, then all they are doing is providing adequate care. P20, 266

Right now we are paid to run people through like cattle, to treat them like crap, and to not care, and to do procedures. That’s what we ‘re paid to do. It’s assumed we’re going to be wonderful, humanistic human beings to our patients ...and empathetic ... that’s assumed. But that assumption is wrong because we don’t get paid to do that. P10, 548

And I, I don’t want it to be lost, you know? I don’t want medicine to become like a car factory. Because we are people. P16, 348

**Acute/high pressure scenarios.** Within high pressure scenarios empathy quickly falls to other priorities such as fast and objective decision-making, life-saving procedures, and pain management. Indeed, many patients in these situations are likely to be unconscious or in significant pain, rendering empathy rather useless until their condition has improved. Though this barrier seems self-explanatory, it stands as an important caveat to the goal of empathy in medicine. Within such fast-paced and urgent settings empathy may take on the form of optimizing patient comfort, taking effort to minimize pain, or shifting attention to worried family members. What is important, however, is to note that empathy does change in these settings, and in many cases it can be an irrelevant tool among others at a physician’s disposal.

The ability to be forceful, make decisions quickly, and so forth, eliminating the patient, because if the patient is horizontal basically the patient’s cognitive process is eliminated. Um, so, that’s what you’re trained to do. P01, 362

Yeah, it may not be so much that there’s a lack of empathy, but there’s a certain sense of urgency. And, you know, if you come in and you’re bleeding to death and you’re doing to die, I would love to sit down and have a cup of tea and

discuss with you the various options we have to keep you from dying. I don't have that luxury. P14, 127

But no matter at that point how much you empathize, you still have to get the body back to some sort of livable, physiological state. You can't have someone with a very, very low blood pressure and emphasize. You have to treat them medically, too. So I think empathy maybe takes a back seat—it's not as important to my job when they have such an acute illness that's not compatible with life. P17, 206

So my amount of empathy is probably pretty small because, you know, I'm bringing medicine at the end of a spear. P14, 442

**Time/volume of patients.** As mentioned above in the managed care/medical system section, many physicians feel pressured to shorten patient visits and see a large number of patients each day. The number of patients seen per day, which can run as high as 30-40 in some settings, necessarily reduces each visit to just a few minutes.

Participants stated that these brief visits still have the same demands in terms of identifying and treating the medical problem. Therefore, a comprehensive assessment – to include empathy and consideration of psychosocial factors – is traded for an analysis of symptoms and more standardized treatment:

So, there are barriers of time; barriers of the volume of patients you are supposed to see where they are narrowing it ... Especially for primary care, where they are narrowing it down to 15 and 20 minute visits, and you have to do ... I mean, there are actual problems, their med lists, and their preventive care ... And what, you are going to do this all in fifteen minutes, and you're going to be caring? P02, 360

Fifteen minutes to see a patient. I go in there, and I'm supposed to do all that stuff. And I picked up, maybe, that this person was depressed. So I go into my depression questions. Then I hear a (makes knocking sound) on the door, and the resident says, 'Alright, are you done?' I hadn't even done an exam or anything—I was still on depression! So I can see how that stuff kind of gets moved to the back because people have an agenda to finish. P17, 503

I think a lot of what medicine is these days is you need to get a certain amount of patients and you have a schedule of, ok this patient is 9-9:30, the next patient is 9:30-10. And so forth, and I think people just have a constant sense of time, that they think "I'm going to interview this patient, and there are certain things that I



have to get done in this 30 minutes. And if I don't I'm screwed and the whole appointment just goes down the drain." So I think the sense of time and the pressure to keep up the daily patients, that's why when the patient comes in for most people they'll say "ok, I saw your lab work from last time, it was so and so, blah, blah, blah." They want to get that stuff done so they can move on. P06, 459

**Medical school admissions/training focus.** Perhaps as a result of potential changes in the philosophy of the medical system, as some participants suggested, many participants indicated that medical training and criteria for admissions now favor intellect over attributes such as compassion or passion for patient care. According to participants, admissions committees put an emphasis on standardized test scores, high GPAs, and involvement in extracurricular activities. Students who score below the top percentage but who are exceptionally caring and empathic persons may not be accepted into medical school.

But admissions committees are too concerned with grades and research and all that stuff, which doesn't mean anything because those are going to be the doctors that sit down and have monotone voice and don't really listen to patients. P06, 231

You know, we select these very driven, self-oriented people, and then their practice should be the opposite. P02, 28

And I think, very unfortunately, we select a group of people who are very, very good at science, very bright, and in fact, in my opinion is, not the best candidates to be doctors. It's totally driven by scores, and I think essentially irrelevant to the practice of medicine. I mean, the facts you have to know ... it's not rocket science. I mean, it's not a lot of facts. You have to be smart. And you have to pull these people to the humanistic, patient-centered pole because they are way over here on the science-driven pole. P02, 30

Once admitted, medical training puts heavy emphasis on knowledge of disease and treatment. Students are tested primarily on their knowledge base, and secondarily on patient interviewing. Though patient interviewing does include elements of empathic communication it also provides a lengthy checklist of questions and quick tests that must

be done in a short time frame. The implied message is that medical knowledge and clinical finesse are the core components of patient care, with empathy as a nicety that can be developed later on in one's career (see Medical Ability/Expertise):

In medical school, I don't think—at least personally, for me—I spent as much time commitment and learning about empathy because you're not really graded on it. You're so focused on passing your anatomy test and knowing histology and what people on rounds are going to ask you. You study those things because on rounds someone is going to say, 'So what medication would you give?' No one is going to say, 'So how did you communicate your feelings to her ...' No one is going to ask you that. There is so much information to learn that you have to survive, so you go to where the money is, which is what you're going to get asked on. That's why you pick it up, I guess, when no one is questioning you as much. Then you're like, 'Oh, I guess I should listen more to what people are saying.' P17, 487

When you look at the training, there are just so many different requirements for things. Um ...and the requirement for communication skills ... I mean, it's kind of, sort of there. I mean it's a competency skill. It's interpersonal skills in communication, so I think that's encompassed there. But it's not ... I just feel like it's not ... emphasized. Because there's so much—there's so much people need to know how to do now in medicine...and it's a time crunch. Even now with residents. They have work-duty hours. They're very restricted. So they're trying to get in as much medicine as they can. So the technical aspect is what people are really concentrating on. P21, 374

### Initial Empathy

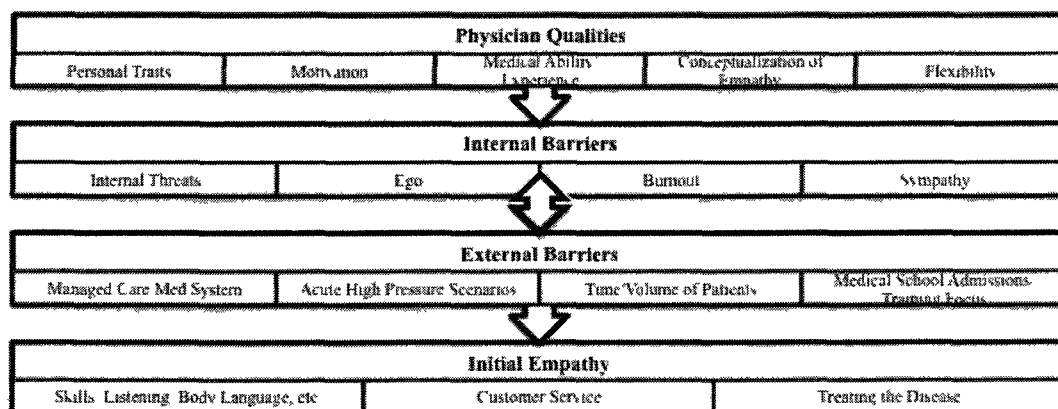


Fig. 1D. Part Four – Initial Empathy

One category that emerged rather early in the study and that was strengthened by subsequent interviews was the idea that empathy existed along a continuum that ranged from superficial technique to genuine compassion. This idea of a continuum is not new – in fact, counseling models of empathy have similar scales that measure the affective accuracy of an empathic response (Carkhuff, 2000). In this model, however, the continuum hinges on the degree of physician motivation and genuineness rather than accuracy of technique. The next two stages of the model have thus been divided to represent this difference and describe what empathic treatment might look like in either stage. The first step, initial empathy, could arguably be an appropriate facilitative level in most medical settings. This stage includes many of the microskills of empathy and interpersonal communication, principles of good customer service, and treatment of the disease. It is important to note that this stage is also a foundation for genuine empathy, as many of the components in this level are necessary skills or considerations for providing empathic treatment.

**Skills: listening, body language, etc.** Skills of interpersonal communication are included in this level since they are minimally facilitative and can be utilized without a deeper desire to connect with a patient. Techniques such as letting a patient begin the medical interview, pausing or not interrupting a patient, sitting down at the same level as the patient, or maintaining eye contact are all things that can be easily learned and implemented even in a brief visit. Frequently participants referred to these techniques as standards of good practice, and several participants quoted specific models or studies that

addressed the need for such techniques in patient care. Though these techniques do not ensure an empathic connection, they are respectful and patient-centered and thus can contribute to patient satisfaction.

(Medical students) have to talk, and the more they sit and the more they become used to it...and they've come to me and they've said, "you know, I've sat with that cancer patient the other day, and I tried what you said and we just sort of sat there, and the whole visit was 15 minutes and I don't think I said two sentences, but when I got up to leave that patient grabbed my hand and said thank you. And I said I didn't do anything, and they said 'yes you did.' And they came back to me and they're like "it worked." I say "yeah, it does work, you have to believe in the process. But it works." P11, 344

Spending the time to sit there and make eye contact with them. P14, 70

It's a lot of stuff we have to learn, but it really does work, you know, the open ended questions, rather than saying "what would you like to talk about?" You know "tell me more about a, b, and c." So let the patient tell the story as much as possible. P08, 103

And studies have shown that we physicians maybe give only 15, 20 seconds to patients to tell us. And 15 seconds is a long time, so sometimes I have to, you know, bite my tongue to not interrupt a patient to, you know, to address it. P08, 101

**Customer service.** Within the initial level of empathy the physician's goal is less about fully understanding the patient and more about ensuring patient comfort and demonstrating comprehensive care. Providing a standard of care is seen as respectful of the patient as well as the profession. Participants referred to this concept as providing good "customer service" in order to satisfy patients and maintain a successful practice. Such behaviors could include sitting down with a patient, adjusting the temperature if the patient appears cold, ensuring accessibility by providing a phone or pager number, recording personal details about patients in a chart for later reference, or staying on schedule so patients do not have to wait long. Several participants also mentioned that they frequently utilize the placebo effect in their treatment of patients in order to

maximize the benefits of a treatment plan. Telling a patient that a medication is highly effective, for example, could generate a placebo effect in which the patient's belief in the medication achieves just as much, or possibly more, of an effect than the medication itself. Thus, knowing how to achieve a placebo effect with a patient adds to eventual treatment outcomes and is therefore utilized in the context of providing good customer service.

If you look at the environment and the patient is sitting there shivering or cold, if you're not observing proper modesty and if they feel exposed or vulnerable, then they're not as likely to be experiencing empathy. P01, 318

Because there are actually studies. I did this long before any of the studies because I sensed that if I sat down then the patient realized that I wasn't just passing them through as a regular ... I mean this was twenty-five years ago I started doing this. And then there are more recent studies that say if you sit down, patients feel that you are spending more time with them even though you're spending exactly the same amount of time as somebody who doesn't sit down. P03, 352

I tell them how they can contact me, how they can... I give them telephone numbers and everything so that they know that they can contact me at other times, other than just this clinic visit P12, 117

Well, the placebo effect is very, very real. I mean, it can get you thirty- to fifty-percent better outcomes than not. So, if I'm going to prescribe something, I'm going to say, 'This is what I'd give to my mother. This stuff is great. This stuff ...' Even if I don't necessarily believe it, I'm going to hype it because then I add the placebo effect to what I'm doing. P02, 415

I think you can certainly teach behaviors that can emulate it. It may not be pure empathy, but you can ... Behaviors are things that are taught that people can do. You can teach people to go in, sit down, and look them in the eyes. You can teach people to speak, um ...to speak plainly in laymen's language and not use medicalese. P21, 348

**Treating the disease.** Frequently physicians who are working within the initial level of empathy primarily hope to alleviate or eradicate the disease. Since this is also often the primary goal of most patients, treatment at this level can still be highly

satisfactory. Healing or achieving progress in the treatment of the disease thus brings both the patient and the physician a sense of success and satisfaction. If the physician is especially skilled, or the patient is especially ill, empathy may indeed be seen as unimportant in light of treatment outcomes. The content of patient and physician dialogue in this level is centered on symptoms, exceptions to symptoms, family medical history, and explaining diagnoses or test results. Questioning is more directed, closed-ended, and goal-oriented.

And I think if you're the world's most technically sound neurosurgeon who can operate, you know, really sound, some people will say "ok, you know, I don't give a darn what his bedside manner is." P08, 314

Sure. If my job is to do heart surgery and to fix your heart, I don't care if you don't like me. I just fixed your heart, so you should love me. Do you know what I mean? If that was my job, and I did it. It doesn't matter if you like me or not—and that's true: It really doesn't matter. P13, 343

But, not forget that they are coming here because they have a particular issue also. You know, again, even though we are very, very collegial and friendly, I want to make sure that when they leave the office that they have whatever it is that they want addressed. P08, 144

Um, you know when you do...when you help someone and you can see measurable improvement and positive outcomes, that's extremely rewarding, extremely rewarding. P12, 176

### **Genuine Empathy**

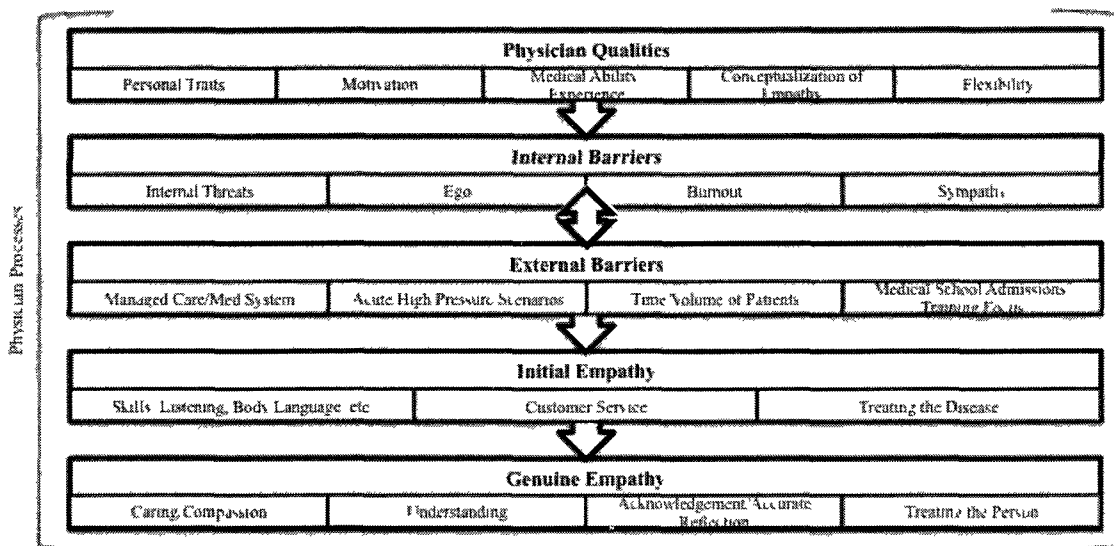


Fig. 1E. Part Five – Genuine Empathy

Genuine empathy builds on the skills from the previous section of the model, but goes beyond the use of skill or technique to result in a compassionate connection between a physician and his or her patient. The results of reaching this level of empathy will be discussed in the final section of the model. To achieve this level of empathy, all other elements of the model must in some way facilitate the process. When referring to concepts within this level, participants indicated that this form of empathy is not only ideal for the patient but also for the physician. Genuine empathy adds interpersonal components that are not fully present in a superficially empathic relationship. Participants suggested that patients can sense whether their doctor is just “going through the motions,” or whether his/her empathy is genuine.

I honestly do not know if you can teach empathy because (patients) will know immediately if you are faking it—if it is something forced. You can start an

interview with open-ended questions and end up with nothing—just a list of answers. And you never developed a relationship. P04, 193

As stated previously, an initial level of empathy may be perfectly sufficient for most patients and physicians within the medical setting; however, this deeper level of empathy demonstrates what many participants identified as an “ideal” doctor/patient relationship. Genuine empathy, as described by participants, includes compassion, accurate understanding, acknowledgement of patient experiences, and treating the person rather than the disease.

**Caring/compassion.** Perhaps the most common words used by participants in describing empathy in medicine is that empathic physicians are caring and compassionate individuals. This sense of compassion seems to be related to a physician’s motivation to connect (see Physician), and may touch on previously discussed elements of sympathy. Even though many participants later described the need to set boundaries to avoid becoming overly connected to a patient (see Internal Barriers), most acknowledged that a level of compassion towards patients was a necessary component of providing empathic care. The fact that caring and compassion are at the heart of empathy in medicine further exposes the complexity most physicians face in understanding how to be both compassionate and professional. In other words, if physicians simultaneously feel that compassion is essential but also dangerous then they are left to navigate a precarious balance of approach and avoidance with each patient. Many who hold firm to the principle that compassion is key end up sacrificing personal time, money, or prestige in order to invest more in each patient relationship. However, most participants who self-identified as compassionate individuals stated that the ability to care and invest in their patients was deeply fulfilling and thus worthy of extra effort or personal sacrifice.



Um, empathy is...if you don't care about the individual that you're having to...that you're administering care, if you don't care about what is happening to them, then I don't see how you can be effective. P16, 169

When he sees me he sits down, and he doesn't do this just for me, this is all of his patients. He sits down and he asks how things are at work, he asks how my family is doing, what kind of stressors I have...he cares, he's not just asking me that to make a note in the chart. He wants to know what I'm going through and what's happening to me, in addition to the physical symptoms cause he knows he'll get a clue. And I can tell he cares. P11, 61

'To care and not know is dangerous. To know and not care is even worse. Caring and knowing must be combined to succeed in medicine.' P02, 155

But you're taking the emotions with it. You're signing up for being sad, and being happy, and incredibly rewarding situations, where you deliver someone after they've had 10 miscarriages, and you finally hand them a baby, and you see those tears of joy. P09, 474

You have to care, because if you don't care you don't listen. And if you don't listen you don't know. You know, you have to listen to the patient who is trying to tell you the diagnosis. P16, 172

**Understanding.** The ability to understand the patient's experience is a core element of physician empathy. Understanding may require open-ended questions, seeking clarification, or asking patients to begin the medical interview with their reasons for coming in. Suspending clinical problem-solving until a broader picture of the patient's condition has developed requires listening and taking on a patient's perspective. Participants frequently described empathic understanding as an awareness or sensitivity to how other elements of a patient's life impacted their condition. In other words, physicians who are genuinely empathic have an interest in "knowing" a patient fully, giving great weight to nonmedical issues. Interestingly, these physicians also acknowledge how difficult it is to truly walk "in the shoes" of another person, and are thus aware of limitations to their own understanding. This awareness of patient complexity and the desire to understand a patient's perspective leads physicians to

constantly assess their own level of understanding, as well as the patient's level of comprehension.

There was a person on that ship (Star Trek) called the Counselor who was an Empath. She was a Beta from this planet Beta, and everybody there had an ability to know what everyone was thinking and feeling. They could not only read minds but they could feel emotions, and that's sort of what I feel like I am. I feel like I'm an Empath. I feel like I'm ...I can listen to somebody and put myself in them. P11, 319

None of us could ever walk in someone's shoes, but the attempt of empathy is to put yourself in that person's shoes as best you can, to really understand what they're going through. P18, 130

The same way when I'm a physician, if I'm just, if I'm focused on a model or something like that and I can't relate to the patient, um, then I just might ... you know, I go from asking them why they're here today to, and then asking what illnesses run in your family, and then the patient doesn't know why I've done that, and it's confusing and so forth. You know, but if I say, I summarize and say it sounds like you've had this, this, and this, and it's been bothering you, this is what you're concerned about, have I got it right? Let me just ask you some questions about your family so I can understand this better. You know, I've enhanced the empathy by doing that. P01, 298

But I think you gotta stop there and put yourself in their position and say "if I were that patient, where am I? What's happening to me, what's going on?" I think you find a whole different picture, you realize that oftentimes when people aren't doing what you ask them to do or can't comply, cause they're struggling, they're struggling emotionally, physically, financially. P18, 214

**Acknowledgement/accurate reflection.** If a physician is able to understand a patient's experience in the context of the medical problem he or she must then be able to communicate this understanding back to the patient. This communication can come in the form of verbal acknowledgement of a patient's feelings or concerns, or it can be a reflection of patient statements in order to invite confirmation or clarification.

Acknowledgement of patient emotions or concerns can diffuse defensiveness and create a more trusting relationship. Accurate reflection of patient statements also results in greater trust and confidence, as patients are assured that the physician is engaged and has heard

their concerns. Participants in this study mentioned that many patients will arrive for a visit worried about potential diagnoses, or prepared to request a specific form of treatment. Empathic physicians realize that these patients are worried, and also that they want to be involved in their care. Even if patient questions or fears seem highly improbable, taking the time to explore these issues can put patients at ease as well as communicate respect and understanding.

Right off the bat, just telling them that, that you acknowledge, that you recognize that what you're asking them to do, pricking their finger 7 times a day, eating a regular diet, you know, keeping track of everything they put in their mouth, their blood sugar, is huge. Acknowledging that you're asking them to really overcome a huge barrier already is half the battle, because the patient can already put down her... "ok, my doctor understands, she may not have diabetes herself, but at least she gets it." P09, 178

You need to be able to read the situation and figure out how it is that you're going to be able to share that knowledge with your patient. Um and if you can't then you're gonna be perceived as a bad doctor. P09, 299

I can, um... empathy, the importance of acknowledging, you know, emotions. An emotional cue... might be an expression of emotion, "I feel sad, I feel angry." What do I feel? "I feel discouraged," and so forth. Well, it's important for me to acknowledge that. (P01, 223)

Putting it out in the open that I know they have worries about maybe starting dialysis. A lot of times they have family members on dialysis, and these things run in families, and their doctor says, 'You know, I need you to see the kidney doctor. You may need dialysis.' And then they come in all anxious and worried, and I know, obviously, that the big elephant in the room is, 'Do I need dialysis?' So I acknowledge that: 'Yes, that is a concern. And I understand that is a concern.' Because I don't want them to come in here and think, okay, I'm seeing them, blah, blah, blah, and I'm going to do labs, and leave. I want them to know that I know what they're afraid of. P17, 106

**Treating the person.** Physicians who achieve a genuine level of empathy tend to view their patients as individuals with complex issues, only some of which might be addressed through medical treatment. These physicians are certainly still concerned with providing quality clinical services, but their awareness of patient needs extends beyond

their medical training. In fact, several participants described a “human” element of medicine that seemed to run parallel to treatment but that can be accessed by those physicians who are aware of it. Instead of focusing exclusively on disease, physicians understand cultural, social, economic, and psychological factors. Participants alluded to the fact that physicians are capable of healing in therapeutic ways, apart from prescriptions and medical treatment. This level of care results in the consideration and treatment of the whole person, rather than just the disease.

Um, and so, it's something about the way we're built as humans, that having another person, whom we respect, have some relationship with, expressing empathy is helpful to our health. It's healing. P01, 232

At the end of the day we didn't do too much, you know changing what the medication this person's on, but it's the interaction and things like that they value. You know, and myself as a physician they call it, it...itself is a therapeutic intervention. You know, it's not the medicine, it's just us as physicians. P08, 148

So, what are we treating there? Are we treating the diabetes, in which case, look: We've got it under control, what's the problem? Are we treating the patient? In which case we're going, 'Yeah, we're killing you sooner by treating your diabetes aggressively. P10, 391

So I think what has happened is you get the ability to relate to these people in more than the disease entity, but rather as people, as patients, as friends, and not as customers. P18, 60

But the problem is most patients are really complex, and what you find is that many patients—and it's just mind-bogglingly simple, but at the same time, it makes total sense—and that is that people who have multiple diseases have dysfunction in multiple areas of their life —it's not just, 'Oh, I've got diabetes.' It's, 'I got diabetes because I'm not eating right, or I'm not exercising.' It's, 'It's I'm not eating right, I'm not exercising, and oh, by the way, my financial situation is a total mess, I can't hold a job ...' I mean, they just have total dysfunction. P10, 403

### **Patient Role in Physician Empathy**

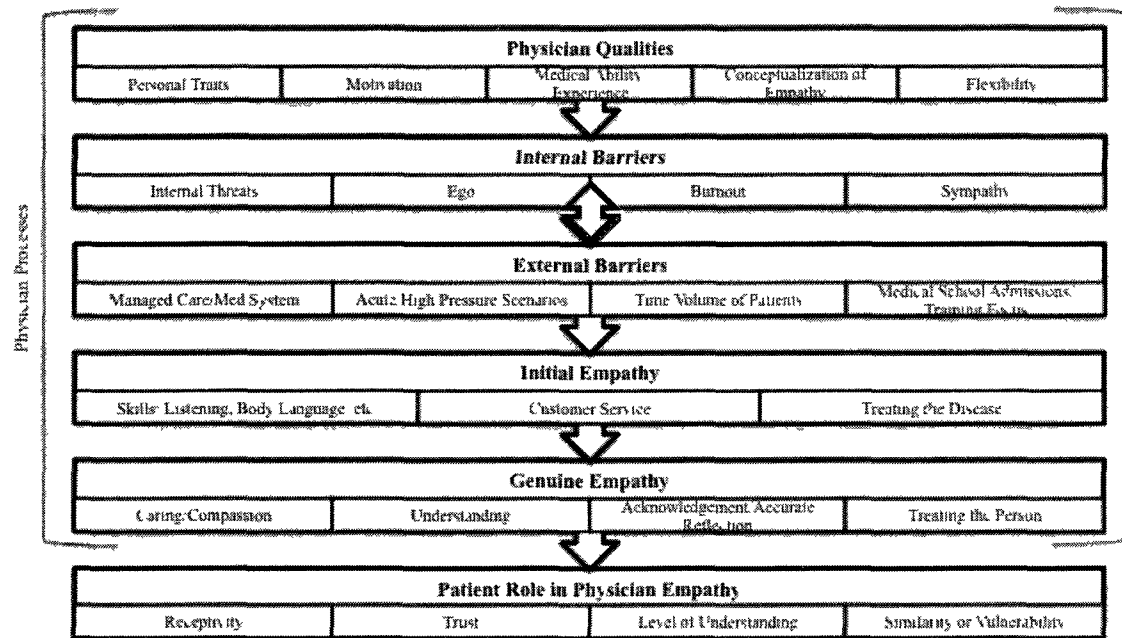


Fig. 1F. Part Six – Patient Factors

Though this model has focused on physician empathy up to this point, some mention must be made of how patients contribute to or detract from the ability to form an empathic connection. Assuming that the physician has met at least some of the necessary qualities for empathy, the barriers have been minimal, and the physician has been able to achieve genuine empathy, the task of establishing optimal empathy is then transferred to the patient. The patient him/herself is an integral part of whether an empathic connection is made. There are certain characteristics or conditions within the patient that may determine the strength of the empathic connection, or that can prevent such a connection from forming. This section of the model addresses the patient's role in establishing

empathy, including patient receptivity, trust, level of understanding, and the ability to incite sympathy through vulnerability or similarity to the physician.

**Receptivity.** Patients must be receptive to physician attempts at empathy in order for the empathic connection to develop. Receptivity may include increased self-disclosure, acknowledgement of empathy (verbal or nonverbal), and a dedication to the relationship with the physician. In addition, receptive patients follow through with treatment goals and remain dedicated to their own progress.

Some of them (patients) don't want it. They don't want...they've got a stone wall up and they don't want anything going in. P05, 265

Well, because you know the empathy part is not a one-way street, it's a two-way street. P09, 265

Um, but sometimes you can't. Some times you think you're connecting, and they walk out and go, 'Well, I don't know; he just kind of rambled on about stuff.' P10, 445

When they really start to open up and talk about things beyond the medical realm, is when you can start to tell that you're being empathic. P06, 332

I think when people don't make any effort to help themselves. Um ... And you tend to lose your empathy—I do, to a degree—for people who wait until the last minute. I mean the 'I got this five days ago.' And I've been following them for fifteen years, and I know that that shouldn't happen, and they call Friday at 5 or whatever. It's kind of hard to feel sorry for that person, you know? I think when there is no effort put forth on the part of the patient to help themselves, and their expectations are unrealistic—like I can't do everything for them. P07, 173-179

**Trust.** Following with the condition of receptivity, participants frequently stressed the importance of trust in the establishment of empathy with a patient. Physicians in this study listed trust as a core ingredient in the facilitation of a relationship and in the patient's own willingness to respond to physician empathy. Trust in the physician results in patient disclosure, adherence to treatment, engagement in a relationship, and willingness to return for future visits. Lack of trust, on the other hand, limits the

relationship, makes it difficult to gather necessary personal information for diagnosis, and often results in a patient looking elsewhere for medical treatment.

Um, you know, so I think you first have to earn their confidence. That's the most important thing. And that's just a lot of hard work. P07, 63-65

It's not getting their ... It's not delaying their fears, so at that point things start to break down because the patient says, 'Well, he doesn't really care about me anyway, why am I even coming here?' P10, 220

I hope I have developed enough rapport with the patient that they trust me, and they, to some extent, follow my recommendations—assuming those recommendations are made with their interests in mind. P20, 93

And I think the more you can connect with the patient, the better they do because then they have confidence in when you're saying, and it just works a whole lot better. P02, 123

I think the worse thing you can tell someone is, 'Hey, you know what, it's going to be okay. You're going to be alright. This isn't going to hurt you; you'll be fine.' Then you do all these things to them that hurt, they're uncomfortable, and they're thinking, 'Dude, you are lying to me.' But I think you can tell someone, 'this is going to hurt. This is what we need to do.' We're going to try to do everything to make it the best we can.' The person will be like, 'Okay, I'm cool with that. Nothing I can do. Nothing you can do. We're thrust into this situation. We're going to make the best of it.' P14, 192

**Levels of understanding.** Also impacting the patient's ability to participate in an empathic connection with his or her physician is the level of understanding the patient has about the condition, treatment options, and physician communications. Levels of literacy, cultural differences, and unfamiliarity with medical terminology can all impact patient understanding, which acts to distance patients from their physicians and thus decrease empathic connection.

I share that knowledge with them, and I try to share it with them on their level of understanding. So I'm very, um, I try to be very aware of different levels of health literacy. P12, 133

And the next step that we usually take is, 'What's your understanding of what's happening to you?' It's very eye opening to hear what their thoughts are and what

their reality is because there is so much information that's thrown at them in the hospital. Number one: They're sick. If you're in the hospital, you're pretty sick, so you've got that on your mind. You've got the stress of that. And a lot of this medical stuff, it's another language, and some physicians don't speak English; they speak in 'medicalese,' which patients will just say, 'Okay. Yup. Mm hmm. I understand,' and really not. I mean, if you look at the medical ... Or health care literacy ... Maybe folks understand ten, twenty percent of what's discussed with them. So how do you know what's going on if you're only getting ten percent of the conversation? 'So what are you understanding?,' and after that, trying to help them understand what's happening. P21, 101

You know, um, sometimes you just don't realize your cultural barriers that just don't allow you to get through to that person, that empathy can't get to that person and you can't read that person, that creates a barrier, you know, between what you're trying to communicate to the patient. P09, 281

**Similarity or vulnerability.** Finally, patients may possess certain characteristics that engage physician sympathy more easily and thus can result in greater effort towards empathy and thorough treatment. Though sympathy is different from empathy and can be a barrier (see Internal Barriers), some form of sympathy towards a patient seems to elicit extra care from the physician and a greater desire to be empathic. One such characteristic is the degree to which the patient is similar to the physician. Physicians who have personally experienced a similar medical condition, or whose patients remind them of loved ones, may feel a stronger positive connection and desire to help the patient than a physician who cannot relate. This is not to say that physicians provide inadequate care to patients who are different from themselves, but an ability to relate to patients can ensure that they will "go the extra mile" in providing treatment.

Um ... I think people who have had experiences where they have actually ... You know, I guess, uh ... For me, if I see somebody who has a herniated disk or low back pain. Well, I had that when I was an intern. And it was miserable, you know? And so, you know, I know what they feel like. I get migraine headaches, so if someone says they have a migraine, 'Ah, gosh, I know ...' so, it tends to make you, uh, more determined, I think, to help them to the best of their ability. Um ...or, gives you better insight into, 'What can I possibly do to help you out in this situation?' P07, 111-117



Like “you know I totally know where you’re coming from, I know. I feel it in my bones. You know, let’s get that out of the way, I get it. Alright let’s move forward.” So most people who are good empathetic doctors who can communicate with their patients, they have a story to tell and they have roots that brought them, ties, something that brought them to be where they’re at and to help them be the doctors that they are. P09, 573

Certainly I think it’s easier to put yourself—to empathize with someone—that is in some way perceived to be more similar to you. P20, 204

Because, you know, I think probably subconsciously, there is probably a certain selfishness to this. When they see someone that they identify with, I think in some way it’s almost like they’re treating themselves. And if it’s somebody they can really identify with, I think it’s easier to empathize with them, and you say, ‘Wow. This could be me.’ P20, 243

And if this were to happen to me, I would want somebody to do this to try and help me, whereas I think that when people don’t identify with people, it makes it more difficult to empathize with them. And I think there is a higher likelihood that that person is going to get a more superficial level of care. P20, 250

In addition to perceived similarity, patients who seem vulnerable in some way may also trigger physician sympathy, which can lead to an increased interest in helping and understanding the patient. Vulnerability can include age (infants or older adults) or condition (particularly those with terminal diagnoses).

When I was in the special care nursery, all of a sudden I had this draw to the parents whose babies were dying. And I was comfortable holding their babies as they died if they weren’t there, talking to them afterward, getting them prepared before. I don’t know where that evolution happened, I honestly don’t. But I did a 180 since then, and...I feel like this is where I’ve been put. P11, 246

Yeah. Some people just aren’t very nice. You know? Some people who come in, they’re kind of endearing. A little old person falls and breaks something, and they’re very sweet and nice. And some people are just horribly mean. And they were mean to start with, and now you put them in a bad situation—they just become downright brutal. And there are just some people you don’t want to go and deal with, and your interactions are just very, very short because you don’t feel like taking their abuse. P14, 333

But just the whole dynamic of how these people survive with their children, with their lack of income, with their HIV, and with their... I mean, it's just endlessly fascinating. P02, 350

## Results of Empathy

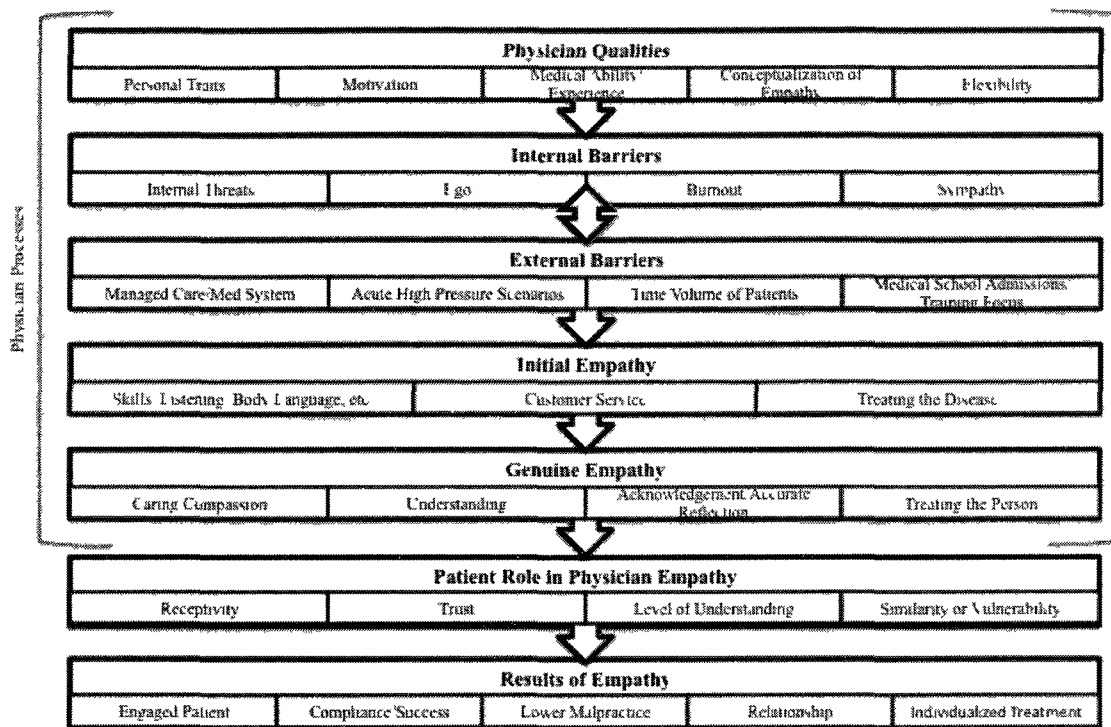


Fig. 1G. Part Seven – Results of Empathy

If all other levels of the model facilitate the development of an empathic connection between the physician and his or her patient, medical treatment can be enhanced. This final section of the model describes some of the potential outcomes of a genuine empathic connection in the medical setting. Superficial empathy may approach some of these outcomes, but it is likely that the outcomes will themselves be superficial or short-lived in proportion to the level of empathy. Among the potential outcomes of

empathic medical treatment are an engaged patient, increased compliance with treatment, lower malpractice claims, a stronger relationship, and a focus on individualized treatment. Participants frequently cited research in support of these outcomes, and stated that such outcomes should motivate increased attention to empathy in medicine. The results of empathy can add to the experience of the patient, but physicians also gain greater personal and professional satisfaction from facilitating empathic treatment and experiencing the outcomes. Despite the fact that empathy in medicine is not solely focused on the medical problem, the results of empathy add significantly to the success of the medical goal, as described below.

**Engaged patient.** Genuine empathy encourages an engaged patient by placing the patient at the center of treatment. Patients are encouraged to ask questions, attention is paid to their level of comprehension, and their statements are viewed as both relevant and important. Patients who leave a visit feeling heard and understood become encouraged and active in their treatment. Empathic statements can also serve to engage a patient and lower personal barriers that then leads to a closer relationship. Often physicians can see nonverbal indications that a patient has transitioned from a passive receiver of care to an engaged collaborator in treatment.

This young woman that I saw today for the first time, when she first came in there was very little eye contact and her body language was her legs were crossed and her arms were folded. And um, and she was sitting almost on the edge of the chair. And she had her coat close by and her purse right there, like touching her. And as the, I'll call it the "interview" or the visit progressed, the coat got thrown over the back of the chair, she was kind of leaning into the conversation, she was smiling, we had eye contact, her, uh, actually her blood pressure was kind of elevated when she first go there, and at the end of the visit I took her blood pressure again, her blood pressure had come down. So I had some physical measures. P13, 294

Ok, in this patient-centered interviewing, what I'm talking about, that active listening, open ended questions and active listening, its ... empathy encourages an activated patient. And that's the best we can do. If you have a ... a consistently nonjudgmental physician, who's oriented towards patient-centered medicine, and you have a patient that's activated, they are interested in their health, they're informed, they're willing to contribute, and they feel power in the relationship, that's the best we can do. P01, 212

You'd be shocked at how acknowledging a patient's little success gives them a sense of self worth and makes them empowered, where they say "I can do this, I can actually do this." P09, 347

**Compliance/success.** An engaged patient is also more likely to follow through with treatment goals than a patient who leaves feeling misunderstood or discouraged. In the absence of empathy a physician could miss important nuances that impact compliance with treatment such as social, economic, or cultural influences. Patients who feel a connection with their physician tend to follow through with treatment, show up for appointments, and discuss potential issues with meeting treatment goals. As a result, physicians can design appropriate interventions to help patients achieve successful outcomes.

I think people learn that the more empathy they have in the clinic the more they'll establish patient rapport and the patients will come back more and the compliance will be better. P06, 401

We may write a lot of prescriptions, but what really counts is how do patients feel about things? What's going to get them better? And I think a lot of what goes [toward that] is empathy in [helping] build relationships and trust, and I'm sure it improves compliance with therapy. P15, 206

Maybe you know this better than I do. Maybe there are some studies that show that if the person trusts the physician, or has that opened, relaxed relationship, they probably will take their medications—I'm assuming—better. Probably show up to their appointments on time. P17, 182

Undoubtedly the more empathy you can show to somebody, the more likelihood that your care is going to be more helpful to them. P20, 221

**Lower malpractice.** Not only can empathic care increase treatment success but it can also reduce malpractice lawsuits when mistakes are made. Many participants stated that malpractice claims are frustrating in terms of loss of time and money, and that they are also indicative of a poor quality relationship. Physicians who achieve genuine empathy with patients also seem to receive some empathy and understanding from patients when outcomes fall short of perfection. Patients who have a positive relationship with their physician make allowances for mistakes and believe that despite outcomes their physician was acting in their best interest.

But, then if there are problems—if there are complications—the one that had the better relationship with the patient will have the better outcome than the one that was maybe technically perfect. P04, 227

And I think that can actually play an impact in the legal side of things where, ‘Well, that doctor was mean, and he doesn’t care about me, and he this bad thing happened, so I’m going to sue him.’ Versus, ‘This terrible thing happened, she called me in the hospital, she’s so sad, too, it wasn’t really their fault.’ I think it can have small, everyday flow of office impact. But I think it can have a huge, overall impact, as well. P13, 148

Doctors that get sued, usually, are not the ones who are negligent. Everyone makes medical mistakes, but the ones who get sued are the ones who the patients actually have a problem with. Maybe it’s personality—they don’t connect. And your lovable family doctor that may not be up to date on everything will never get sued because he talks, empathizes, does everything right. P17, 314

**Relationship.** As discussed previously, empathy often results in developing a closer, somewhat therapeutic relationship between a physician and his or her patient. Though some participants warned that boundaries must be established to prevent relationships with patients from becoming true friendships, the value of having a relationship of mutual acceptance, trust, and dedication to one another facilitates treatment outcomes and adds significantly to patient and physician satisfaction.

I mean, the reality is I can see a hundred patients a day, probably, if it was just a matter of diagnosing and throwing a prescription at them. I mean, that's simple—that's nothing. But it would also be a relatively meaningless, in my mind, way of being a doctor because the relationship is so important. P10, 435

Some of my patients I've had for 13 years, so I know a lot about them, but I share with them certain things about myself too, when it's appropriate. I have little pictures in my office of my family and my pets and things like that. And I like to put a little bit of that personal touch in it, because when I'm asking intimate questions and asking them things about behaviors or trying to encourage, you know, change in behavior, I think it's important that you have to find a way to connect to people. P12, 94

Uh, cause my intention from the beginning was the relationship...it was nice to be you know, talking about the science side of it, it's exciting and interesting, but to me the real grab was the relationship issues. You know, how to have a personal relationship with each individual patient or families. That to me was a real joy. P18, 43

I mean, I think that's one thing that makes the job rewarding: To have those relationships. To understand—you'll never understand what someone is going through—but to have some insight into what their thoughts are, what their feelings are doing usually a very difficult time in their life. P21, 362

**Individualized treatment.** As mentioned earlier in the model, the ability to have some flexibility in treating patients and a sensitivity to nonmedical factors can be an important part of successful treatment. This flexibility can be achieved through an empathic relationship between the physician and the patient. Attempting to fully understand a patient, genuinely care about him/her, and value the patient as an individual can lead to a more accurate diagnosis and treatment plan. Participants stressed that individualized treatment is especially important in an era of managed care and standardized procedures. According to participants, the medical and insurance system value prescriptive treatments to assist in shorter visit times and easier reimbursements. Many participants expressed concern that this new medical culture was in danger of stripping the humanity from individual patients, as well as from physicians themselves.

Patients who are understood only in terms of their diagnosis may receive incomplete treatment, and physicians who are charged with applying standardized procedures lose their ability to be creative and artistic in their practice. Genuine empathy, however, results in a motivation to treat the whole person and to adjust treatment despite systemic limitations. This again leads to greater patient and physician satisfaction.

Yeah. I mean, that's the problem with, for example, health care. Everyone wants this cookie-cutter thing with this... One size fits all. That's for you. That's for you. But patients aren't like that, you know? You have to be able to take those nuances with different things that make people special, or individual ... That's why people are special and they're individual because they aren't like a certain kind of person that you can just fit into a protocol and say, 'If this, then that.' Like I said, if that were the case, you wouldn't need us. P21, 180

That as our knowledge base grows as far as genetics and hard sciences, perhaps there is a tendency of people to over focus on objective measures of what's going on with somebody. And unfortunately, I think a lot of 'common sense' is lost. So patients tend ... I think when people become overly reliant on labs and, perhaps, neuropsychological testing, or what are felt to be objective measures, that a lot of the 'humanness' of the patient becomes lost. They just become the guy in room 13 who is psychotic. The guy in room 25 with the appendix. P20, 52

Some of the things that are shaping in medicine with, you know, these strict care guides and everything, it really sounds good and you can make a good sound bite for the fact that "you've got to use medicine that works," but yet none of us like to be a key in the slot, and what works for almost everybody else doesn't work for us, well gee that's a shame. We all like to think that we're individuals, so we go and listen to what *we* have to say, and consider *us* when we decide what we're gonna do and what course we're gonna take. P19, 49

I mean, if that were the case, you wouldn't need doctors. You just say, 'Okay, here are the protocols, you have this, you get this, this, and that.' And then you ... What do you need a physician for? You just pop it all in to a computer, and the computer tells you what ... I mean, there are lots of guidelines. It's trying to marry that—the medicine piece—with the whole person. Again, that's someone's mother, brother, sister, cousin, whatever. That's someone who has had a career. Raised kids. These are all different things that you can't put in, factor into a computer. And being able to synthesize all of that, how does the person feel about what's going on? And, you know, their feelings are often based on what their life experiences were. So it's incredibly intertwined with medicine. You have to have ... I mean, unless you're just doing something very technical. But, I mean, if you're taking care of the whole patient you have to have the ability to understand

where the patient is coming from in order to take care of them as a person. P21, 165

### **Conclusion Drawing and Verification Procedures**

This model provides a comprehensive look at various elements that can either facilitate empathy in the medical setting or prevent its development. Healthcare professionals may find it useful to assess themselves across the various components of the model in order to achieve optimal empathy and the resulting benefits of empathic treatment. The model can potentially be used to identify internal and external barriers that can be removed or addressed in order to better facilitate empathic relationships with patients. The model also expands upon conceptualizations of empathy as solely interpersonal exchanges to include optimal characteristics of physicians and patients, as well as situational conditions within the setting or larger medical system. The fact that the model is multifaceted demonstrates the complexity of achieving optimal empathy within the medical setting. Participants in this study were all aware of the many layers and processes that impacted their ability to be empathic with patients, and they were unified in demonstrating a difficulty at reducing empathy in medicine to a singular definition.

Various coding procedures, described early in this chapter, were pivotal in identifying major themes and categories amongst the large amount of interview data. The model that emerged is therefore based solely on participant data and theoretical connections made between major themes. The aim of grounded theory research is to extend beyond descriptive data in order to produce an integrative whole, in which related data is linked to explain complex processes (Charmaz, 2006). Therefore, I utilized descriptive interview data to identify categories and used subsequent interviews and theoretical memos to connect categories into a cohesive model. During this process



several verification procedures were used to protect against researcher bias and add support to the final model.

### **Peer Reviews**

Research team members were each provided with a copy of the model and asked comment on the content and flow of the model. Since team members had been memoing and coding interviews throughout the process, their perspectives were pivotal in approving the final model and challenging potential researcher biases. Both research team members approved the overall content of the model and made suggestions for specific content within each section.

### **Member Checks**

All participants of the study were provided with copies of their transcript in order to provide further clarification or corrections. Only one out of the 21 participants responded with any specific changes. Participants were also provided with a copy of the model and asked if they could provide specific feedback or general comments. None of the participants responded with any changes or specific feedback, though two indicated their support of the model.

### **Rival Explanations**

Rival explanations for emerging themes were sought throughout the data collection process. Memos were used to map out possible connections and ask questions about themes and categories. New interview questions were also developed to explore different explanations, particularly for strong themes that were emerging. Participants in the latter half of the study were frequently asked questions regarding patterns that had emerged in coding other interviews, or asked to elaborate on areas that seemed confusing

or irrelevant to the study. As a result, a clearer picture of connections among data developed and the overall model benefitted from deeper analysis.

The verification procedures added to the credibility and trustworthiness of the final model by establishing a means to guard against drawing premature conclusions or overlooking important subtle elements in the data. Following these verification and grounded theory procedures resulted in a theoretical model based on participant accounts of empathy in the medical setting.

### **Summary**

This chapter described data collection and coding procedures, provided a description of participant profiles, and presented an integrated theoretical model that resulted from grounded theory procedures. The complete model contains seven levels, or conditions, to achieve optimal empathy within the medical setting. These levels include physician characteristics, internal and external barriers to empathy, initial and genuine levels of empathy, and the potential impact of empathy on treatment outcomes. Each level of the model contains subcategories that can either facilitate or impede empathy from developing. Each level was explained and supported with participant quotations. Finally, verification procedures were employed in order to confirm findings and protect against researcher bias in the formation of this theory.

## **CHAPTER FIVE**

### **DISCUSSION**

#### **Introduction**

This chapter will revisit the purpose of the study, provide an overview of the selected methodology, and address the findings as they relate to the initial research questions. The model will then be compared with other conceptualizations of empathy in the existing literature. Finally, implications and limitations of the model will be addressed.

#### **Purpose of the Study and Review of Methodology**

The purpose of this study was to develop a grounded theory to conceptualize how empathy is applied in the medical setting. The rationale for such a model was justified by the largely inconsistent and inconclusive existing accounts of the nature of empathy in medicine, as well as the need for more qualitative research as cited by recent studies (Bylund & Makoul, 2005; Norfolk, Birdi, & Walsh, 2007; Pederson, 2009). Grounded theory was selected as the proposed methodology due to its methodological structure and goal of theory creation, allowing the study to extend beyond descriptive data to form an integrated model subject to further testing and analysis (Charmaz, 2006; Patton, 2002). The study aimed to utilize rich description from participant interviews to gain a broader understanding of the phenomenon of empathy in medicine, while also potentially revealing elements not currently present in the literature.

Following grounded theory methods, 21 semi-structured interviews were conducted, transcribed, and coded. The first round of participants was identified through high patient satisfaction ratings and other criteria based on current literature. From there,

participants identified colleagues whom they considered to be highly empathic, thus utilizing snowball sampling. In several cases physicians recommended other healthcare professionals as potential interview participants. As a result, additional interviews were conducted with a medical student, a counselor, and two nurses. Though these interviews with non-physicians did not greatly impact the final model, they did serve to confirm some larger themes as well as to add alternate perspectives that in some cases clarified nuances in the data. For example, one physician recommended a fourth-year medical student as someone who demonstrated a high level of empathy during his training. In his interview, the medical student confirmed many of the same themes present in interviews of more experienced physicians. Interviews with nurses added to an understanding of training differences between nursing and medicine, as well as barriers unique to the role of the physician. The counselor, also recommended by a physician, had a unique perspective of both barriers to empathy as well as the emotional impact on patients when physicians neglected empathy. These perspectives thus contributed some outlier data to the final results.

Each participant interview was coded line-by-line through open coding, then further collapsed into categories and themes using axial and focused coding. Two additional research team members also coded interviews and met with the primary researcher to compare codebooks for consensus coding. Research team members also recorded memos, which were integrated into the memos of the primary researcher and later used to structure the final model. Upon completing a draft of the model, research team members provided feedback and indicated their consensus with the final levels and

subcategories. Copies of the model, including quotes and descriptions, were also sent to participants for input on the model's content.

### Summary of Findings

The coded interview transcripts created a vast amount of descriptive data and presented some confusion for the research team as to how to select the themes most relevant to the study's purpose. By referring back to the research questions, a more focused and structured model was able to emerge. The final model thus addresses each research question, but also extends beyond the questions to portray an interconnected process. A brief summary of the final model will be provided, followed by an analysis of how the model answers each research question.

### Model Summary

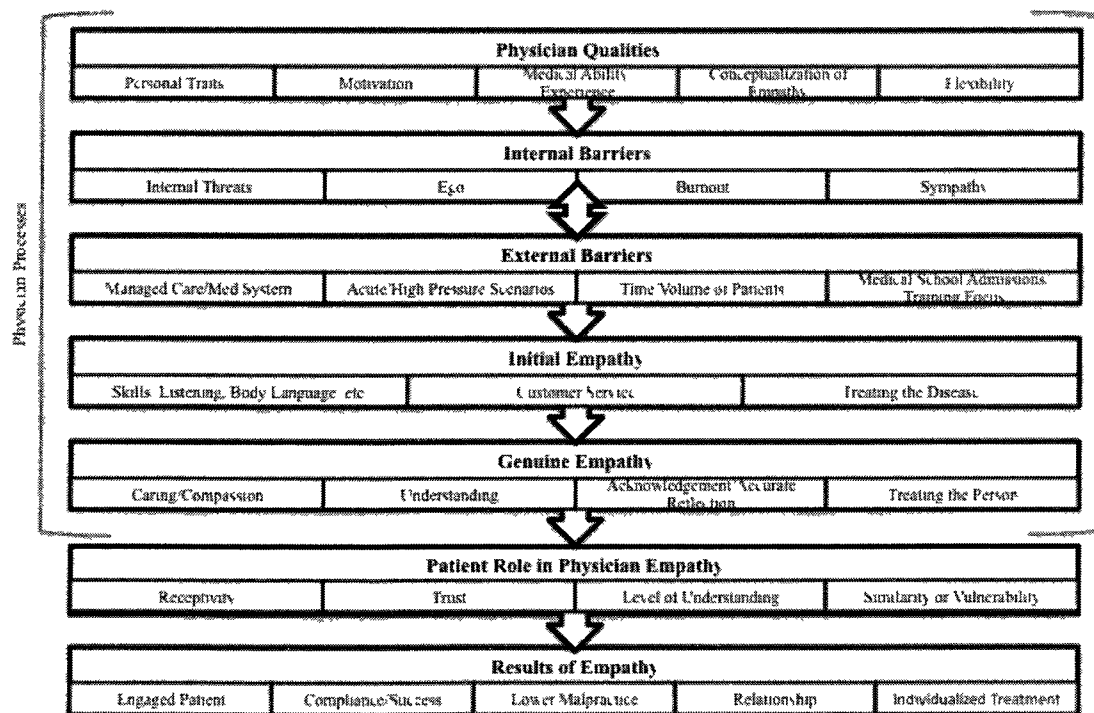


Fig. 1. Conditions for Empathy in the Medical Setting

Participant interviews revealed that empathy in medicine is a complex and multi-level process, requiring that several independent factors be at least minimally facilitative of empathy in order for it to occur in this setting. Barriers to empathy, included within the model, should also be absent or minimized in order to facilitate the empathic process. The model is thus presented as a linear process in that each level adds to the next and the final stage results in empathic treatment and outcomes. Some degree of bidirectional influence likely exists between levels and subcategories, though data from this study did not identify strong bidirectional relationships and thus they can only be assumed until future research confirms such interactions. Since this study was limited exclusively to the perspective of the healthcare professional, the model is likewise centered on the professional's role in facilitating empathic care. The patient is considered in one of the final levels, but even then it is through the lens of how patients might impact a physician's ability to provide empathic treatment.

**Physician qualities.** The first level to consider concerns the characteristics of the physician that can potentially impact empathic care. Physicians may have inherent personal qualities, such as compassion or interpersonal ease, which makes them by nature more likely to include empathy in their practice. A motivation to connect with patients, or a feeling of investment in the person of the patient, also adds to the likelihood of an empathic physician. Likewise, physicians who are not generally compassionate or feel a lack of motivation towards providing empathic care may not pursue an empathic connection.

In addition, as physicians reach levels of competency and expertise in their area of medicine they are more likely to have the time and mental energy to devote to improving empathy and other communication skills with patients. Medical students, residents, and new physicians may be primarily focused on improving knowledge and medical techniques to the exclusion of an awareness or desire to practice empathic care.

The way a physician conceptualizes empathy and its role in medicine also may impact how he or she utilizes it when interacting with patients. Varied participant definitions reflect the difficulty of describing such a complex and vague process, and also indicate diversity in the way empathy might be used in the medical setting. If a physician believes that empathy is primarily a sense of caring or compassion for a patient, he or she may also attempt to limit empathic connections so as not to become emotionally exhausted due to the volume of patients seen each day and the severity of patient issues. Physicians who view empathy as more of an act of understanding the patient's perspective may not feel this need for emotional distancing and will likely be more concerned with cognitive processes and accurate reflections.

Finally, physicians who can demonstrate flexibility in assessment and treatment of patients based on individual and situational factors are more likely to be empathic. The use of empathy, according to participants, allows physicians to pick up on subtle cues from patients, or to recognize biopsychosocial factors that require unique treatment plans for each patient. Thus, this perceptiveness and ability to adjust can result in more empathic treatment.

**Internal barriers.** Physicians may possess some or all of the personal qualities that can contribute to empathy in the medical setting, but the presence of internal barriers

can impede even the most empathic physician from providing empathic treatment. One such barrier occurs when physicians impose professional boundaries or emotionally distance themselves from patients due to perceptions of internal threats. Physicians may over identify with a patient or may be afraid of an enmeshment that could prevent difficult decisions from being made regarding patient care. As a result, these boundaries can interfere with the ability to connect with the patient. Additionally, physicians may view themselves as authority figures or as more of an expert on patient symptoms than the patient him/herself. This perspective can result in not listening to the patient or eliciting patient perspectives regarding their condition. Physicians who have made an error in judgment or who fear criticism of their work may also be unwilling to demonstrate empathy towards a patient.

Physician burnout is another situational internal barrier that can impact the ability to provide empathic care. Physicians who are sick, exhausted, or discouraged by the medical system may not be able to demonstrate empathy. Burnout can also occur if physicians confuse empathy with sympathy, attempting to form strong emotional connections with patients and thus becoming overburdened with feelings of responsibility or sadness that can become immobilizing in the medical setting. Some participants clarified that empathy does not always involve such an intense emotional connection and does not necessitate that physicians directly experience patient emotions. Physicians who are not aware of a distinction between sympathy and empathy may inadvertently render themselves ineffective in their efforts to connect with their patients.

**External barriers.** Just as internal barriers can operate within the physician to impede empathy external barriers can prevent even empathic physicians from achieving



optimal empathy with their patients. Participants identified managed care and the business focus of the medical system as being significant barriers to providing empathic care. Restrictions on reimbursements and prescriptions, paperwork requirements, and standardized treatment serve to deemphasize the physician/patient relationship. High-pressure scenarios and life threatening conditions also serve to move empathy to the back burner as physicians attend to more immediate needs. Furthermore, a high volume of patients and short patient visits leave little time for anything beyond checklists and quick goal-setting. Additionally, many participants indicated that current medical students are ill prepared to provide empathic treatment due to medical school admissions emphasizing measures of intelligence over compassion and curriculum favoring clinical knowledge over patient communication skills.

**Initial empathy.** Provided that the physician possesses some or all of the personal characteristics identified as facilitating empathy, and internal or external barriers do not limit his/her ability to be empathic, a primary level of empathy may be achieved. This level, referred to by participants as “fake” or “learned,” contains elements of empathy in medicine that, though not optimal, can still achieve some positive outcomes. Various skills, such as active listening and open-ended questions, are included in this level. These skills, also referred to as microskills or communication skills, can be taught to most people and can be employed without a genuine desire to connect empathically with a patient. In other words, participants identified skills in this level as components that could be taught to enhance physician/patient communication, but that could still come across as mechanical or disingenuous if not accompanied by more genuine attributes of the

physician. Participants mentioned many of these skills when referring to teachable components of empathy, rather than intrinsic and static characteristics.

The initial level of empathy also includes actions taken towards patients that are motivated more by providing quality customer service than a desire to connect empathically with the patient. Attention to the patient's level of comfort, practicing timeliness with visits, or sitting down with patients rather than standing are all examples of good practice and common courtesy. These actions are likely well received by patients and may be sufficient for patient satisfaction, even in the absence of genuine empathy. Despite this attention to customer service, the primary focus of the initial level of empathy remains on treating the disease. There may be a genuine concern for the patient's health and wellbeing contained in this stage, but it is approached exclusively through a focus on symptoms and treatment standards.

**Genuine empathy.** The genuine level of empathy does not exclude the components of initial empathy. Indeed, most of the elements of initial empathy should exist to some extent at this level as well. The genuine level of empathy is an extension of the previous level in that it utilizes microskills while also involving a compassionate connection between physician and patient. Physicians at this level care for their patients as individuals and are concerned with understanding the patient's perspective. They are aware of nonmedical factors and sensitive to how these factors might impact treatment. In addition to understanding the patient, physicians at this level are able to communicate their understanding back to patients through accurate reflections of patient statements and acknowledgement of emotions. Additionally, in this stage physicians are concerned with treating the whole person, rather than just the disease. Several participants remarked that

the empathic connection itself can be healing for patients and expressed a desire to provide more for patients than a diagnosis or medical treatment plan.

**Patient role in physician empathy.** Although this model focuses on the physician's perspective of empathy in medicine, certain qualities of patients can influence whether physicians are able to provide empathic treatment. For one, patients must be receptive to the physician's attempts at empathic communication. Patients who are angry or who have other intentions, such as drug seeking or malingering behaviors, will likely act as a barrier to forming an empathic connection. According to participants, trust is also a key component in that patients must have faith that the physician is acting in their best interest in order to respond to physician empathy and follow through with treatment goals.

Patients should also be able to understand their physicians in order to successfully follow treatment plans. Patients who are illiterate or who are unfamiliar with medical terminology may lack full understanding and thus limit what physicians can accomplish. If physicians are not sensitive to barriers in patient comprehension, or if patients do not disclose lack of understanding, both empathy and successful treatment will likely be compromised.

Finally, certain patients may be easier to connect with than others, thus influencing the extent of physician motivation and ability to respond empathically. Patients who are similar to physicians, or to significant others in a physician's life, are more likely to elicit a sympathetic reaction. This potentially increases a physician's perceived understanding of the patient as well as the motivation to provide thorough and empathic care. Patients who are vulnerable, whether by terminal condition, age, or

disability, also may trigger sympathetic responses that result in more comprehensive or sensitive care.

**Results of empathy.** Provided that empathy has been at least minimally facilitated in each preceding level, it is likely that physicians and their patients will experience some of the outcomes of empathic treatment. These outcomes, identified by participants as unique to empathic care, enhance medical treatment in several key ways. One result of empathy reported by several participants is that patients become more engaged in their own care and in the medical process. Patients who feel as though their physician understands and cares for them will likely provide more information, ask for clarification to ensure understanding, and feel like collaborators in their treatment. This can lead to the second outcome of empathy in medicine, which is higher compliance with treatment goals and thus greater long-term success. According to participants, patients are more likely to follow through with taking medication, appearing for follow-up appointments, and making lifestyle changes as a result of an empathic relationship with their physician. Patients are also less likely to sue their physician for medical malpractice if an empathic bond exists.

In addition to enhanced medical care, participants reported that the quality of the physician/patient relationship also improves as a result of empathic treatment. This relationship is reportedly important both for the patient's satisfaction as well as the physician's. Many participants mentioned that their relationships with patients made their jobs more personally fulfilling. Finally, empathy in medicine can also enhance the quality of care that physicians provide for each patient by encouraging individualized treatment

that attends to the spectrum of unique needs of each patient. This in turn also leads to greater patient and physician satisfaction and adds to the strength of the relationship.

### **Research Question One**

The first research question to guide this study and the subsequent analysis was: how do physicians conceptualize the practice of empathy in the medical interview? Although the final model extended beyond this question, participant data did provide several variations of physician conceptualizations of empathy in the medical interview. As discussed in the model, most participants described empathy as pertaining either to a sense of compassion towards patients, or to an effort and ability to understand the patient's perspective. Nearly all participants identified empathy as an intrinsic quality, though they did believe certain communication skills could be taught to physicians to help them at least appear empathic. Many participants also spoke about the "art" of medicine as an additive skill in medical practice that involved empathy at its core. This "art" involved sensitivity to patient emotions, interpersonal dynamics, and individual differences when determining treatment.

Additionally, as the model describes, participants spoke of various actions that can occur during the medical interview that are indicative of empathy. Sitting down with patients was seen as an important action to assure patients that their physician was attentive. Asking open-ended questions was attributed to a more comprehensive assessment, and checking in with patients to ensure their understanding was recommended to help patients feel more comfortable with expressing doubts. However, several participants warned that these actions could seem disingenuous if the physician was not intrinsically empathic, thus suggesting that an initial and a genuine level of

empathy may exist. The initial level, as described by participants, seems more grounded in specific actions, whereas the genuine level of empathy resides primarily in the person of the physician.

Finally, although some common themes were identified across participant interviews, as mentioned above, there did seem to be a variety of conceptualizations of empathy and a general confusion regarding how to define the term as it related to medical practice. Some participants attributed empathy to feeling an emotional connection with the patient's experiences, whereas other participants distinguished this emotional response as sympathy and characterized empathy as more of a cognitive process. Others were unable to describe any specific skills of empathy and instead spoke of close relationships with their patients as indicative of an empathic physician. The variety of definitions and conflicting components of empathy as reported by participants thus indicates that physicians may indeed have some confusion as to the nature of empathy and how to employ it in their practice. Nearly all participants identified empathy in medicine as essential, yet many had difficulty describing what it is. Therefore, in answer to research question one, there may be multiple and sometimes conflicting conceptualizations of empathy in medicine. How physicians choose to define the concept may reflect more of their personal orientation towards patient relationships than a universal definition of empathy.

### **Research Question Two**

This research question ultimately structured the final model of conditions for empathy in medicine. Participant responses to interview questions designed to examine this research question identified the seven major levels and subcategories of the model.

The second research question asked: what influences empathic communication in the medical setting? In answer to this question, the model outlines seven core levels and demonstrates that empathy in medicine is a complex process with many interfering factors. Physician and patient attributes, along with internal and external barriers, all influence the degree to which empathy can be optimized in medicine. Beyond these factors, separate levels of initial and genuine empathy demonstrate that if empathy is achieved it can still lie along a continuum. The impact of empathy on treatment outcomes can potentially be varied depending on how all of the other levels of the model interact. Therefore, participant data reveals that there are a variety of influences on empathy in medicine, whether they are personal, interpersonal, or situational.

### **Research Question Three**

The third research question asked: how does the conceptualization of empathy influence medical training? Though the model does not fully address the answer to this question, participant data did provide some tentative answers as to how physician training might be impacted. Several participants stated that medical school admissions requirements were favoring intellect above passion for medicine or compassion for patients. Many of the participants saw compassion and intelligence as two separate and competing constructs that should ideally be balanced to achieve optimal patient care. Therefore, since many participants felt as though admissions committees were focusing almost exclusively on grades and test scores, they worried that incoming students would be less intrinsically empathic, thus resulting in less empathic physicians. As a result, participants stated that more emphasis should be made throughout medical training to facilitate empathy in students.

Although nearly all of the participants identified empathy as an intrinsic quality, many believed that training could at least minimally facilitate an increase in empathic behaviors. According to participants, such training should include learning how to interact with patients by utilizing open-ended questions, letting patients speak without interrupting, and maintaining eye contact while sitting down with patients. In addition, allowing students to spend more time interacting with patients and observing other empathic physicians may also facilitate greater empathic behavior throughout training and future employment. However, several participants stressed that this skill training would still be largely ineffective if students lacked the motivation to connect empathically with patients. In other words, students might utilize empathic skills during training but choose not to continue with these skills once they graduated.

Another frequent concept espoused by participants regarding medical training was the idea that certain personalities were better suited for certain specialty areas, dependent upon the amount of patient contact involved and the interest in long-term versus acute medical problems. Medical students who are low in intrinsic empathy, for example, should be mentored into specialties such as trauma surgery or pathology where the quality of the physician/patient relationship is not as important. Students who show great interest in interacting with patients and who demonstrate compassion would similarly be led into specialties such as family medicine, pediatrics, or gerontology. Participants who worked as faculty at a teaching hospital were particularly aware of the importance of helping students find their match, especially as it related to patient communication and interaction.

### **Comparison to Existing Literature**



This study adds to the current research on empathy in medicine by presenting an integrated theoretical model that identifies seven core levels and subcategories to explain the complexity of the empathic process in medical practice. Interview data also revealed many concepts that can confirm or expand upon themes currently in both the medical and counseling literature, thus adding to the credibility of these claims and continuing the dialog regarding the nature of empathy in the medical setting. In this section, related literature will be revisited in order to determine what this study might have added to the current understanding of empathy in medicine, as well as various concepts that have been confirmed through participant data.

### **Empathy in Medicine**

Previous research on empathy in medicine has consisted primarily of quantitative data, anecdotal models, or theories of empathy adapted from other fields of study (Bylund & Makoul, 2005; Mercer & Reynolds, 2002; Pederson, 2009; Spiro, Curnen, Peschel, & St. James, 1993). Data gathered through this study revealed many themes consistent with current literature and also added new elements of consideration for future research.

**Definitions of empathy.** Previous conceptualizations of empathy in medicine have suggested that empathy can consist of emotive, moral, cognitive, and behavioral components (Greenberg, Elliott, Watson, & Bohart, 2001; Mercer & Reynolds, 2002; Stepien & Baernstein, 2007). Participants in this study primarily mentioned compassion (possibly emotive or moral) and understanding (cognitive or behavioral) when asked to define empathy based on their experience. Though participants did not seem to be familiar with the existing four-part definition of empathy, many of their responses hit on

these four constructs. When discussing empathy as it related to compassion, participants mentioned the ability to “feel with” a patient or to identify patient emotions and respond in a caring manner. This response seems indicative of the emotive level of empathy, as described by Stepien and Baernstein (2007). Furthermore, an additional component of the compassionate view of empathy, as described by participants, included a genuine desire to care for patients and to connect with them. This definition may be similar to the concept of moral empathy, as discussed in the literature (Stepien & Baernstein, 2007).

Participants also identified empathy as a process of understanding the patient’s reality and utilizing this understanding to assist with proper diagnosis and treatment. The ability to understand the patient’s frame of reference, as identified in this study, appears similar to the cognitive dimension of empathy espoused by previous research.

Additionally, participant data may have also touched on the behavioral component of empathy by noting the importance of conveying understanding back to the patient and using communications the patient can easily understand (Stepien & Baernstein, 2007). Therefore, though this study only identified two clear qualities of empathy in medicine, components of each definition seem to touch on additional definitions in the literature. This overlap may not be enough to add definitive support to existing definitions, but it does suggest a similarity across conceptualizations of empathy that could be strengthened with further research.

**Training in empathy.** Similar to existing research, participants in this study mentioned a variety of elements that could be included in training programs to develop empathy in medical students. Most participants mentioned some form of microskills training, which resonates with the popularity of behavioral training interventions cited in

previous research (Shapiro, Lancee, & Richards-Bently, 2009; Stepien & Baernstein, 2006). Participants also stressed the importance of allowing students to be exposed to patient encounters early on and to have empathic behaviors modeled by more senior clinicians. These responses were consistent with training program goals cited in the literature that require hands-on practice and observation for empathy development (Pence, 1983; Shapiro, 2008; Shapiro, Morrison, & Boker, 2004).

Although participants were able to identify potential methods to facilitate empathy development in students, many prefaced their comments by warning that such training could only go so far. Training methods, they warned, would be limited by a student's personal characteristics and motivation to be empathic towards patients. One participant stated that he could teach students all of the ways to appear empathic, but that he could never "make them care" (P07, 238). Thus, these "tools" would have limited success based on the nature of the student. In addition, many participants stated that patients would be able to sense when an effort to be empathic was genuine versus when it was done out of a sense of obligation. These findings could explain some of the inconsistencies in outcomes of previous research on empathy training programs. Though many training programs have shown some success, the longitudinal impact of training has been discouraging and training outcomes have not always achieved statistical significance (Shapiro et al., 2004). Thus, interfering factors such as student motivation and intrinsic ability may limit the success of such programs.

**Nature vs. nurture.** One issue currently under debate in the literature is whether empathic ability is a case of nature or nurture (Campbell-Yao, Latimer, & Johnston, 2007; Goldstein & Michaels, 1985; Hojat, 2007). Participants in this study

overwhelmingly identified empathy as an intrinsic trait that could be subject to some degree of molding but that was more or less fixed in an individual. However, when asked how their own empathy developed, nearly every participant attributed their empathic ability to learning and observation from childhood or throughout their training. Most participants stated that one or both of their parents provided the modeling that led to their current empathy. According to the participants of this study, then, empathy may be both an intrinsic trait and a result of early childhood. Indeed, most participants stated that empathy was “set” in an individual after childhood, thus making it nearly impossible to facilitate optimal empathy in an individual once they reached adulthood. Participants stated that training could help enhance natural born traits, but may be ineffective on students who lacked the required traits and upbringing.

**Barriers to empathy.** Previous research has identified many potential barriers to empathy that were confirmed by participant accounts in this study. Fatigue, pressure, frustration, and a high volume of patients provide ample distraction for physicians and detract from their ability to be empathic (du Pre, 2001; Hojat et al., 2004). Participants identified these same barriers, with time pressures and volume of patients the most frequent barriers mentioned in participant interviews. Participants also echoed the concerns expressed in recent medical literature that humanistic qualities of medicine are being lost due to an increased emphasis on managed care and clinical expertise (DasGupta & Charon, 2004; Hojat et al., 2004; Shapiro, 2008). Many participants voiced a fear that empathy in medicine may be a thing of the past if the medical system continues to stress efficiency over quality of treatment.

Additional barriers, less frequently discussed in the literature, were also introduced in participant interviews. The need to set some sort of professional distance and thus regulate empathy was a common theme, as were patient characteristics that reduce a physician's motivation to connect empathically. In addition, participants acknowledged that some specialty areas or medical scenarios were more facilitative of empathy than others. High-risk settings required skills other than empathy, and in some instances patients were unconscious or experiencing a level of pain that rendered empathy useless. Therefore, the setting itself could restrict empathic communication, and in some situations empathy could be seen as relatively superfluous. This distinction, though somewhat intuitive, adds to the literature by suggesting that empathy may not be valid in all aspects of medicine. Further research on specialty areas and how empathy might manifest in different medical scenarios may add more clarification to this finding.

**Benefits of empathy on treatment.** Participants in this study also identified many benefits of empathy that were similar to those cited in previous research. In fact, several participants cited specific statistics or facts from related studies, indicating that they had exposure to some of the recent research on empathy in medicine. Among the benefits identified by participants were lower malpractice claims, increased compliance with treatment, and greater patient and physician satisfaction (du Pre, 2001; Nicolai et al., 2007; Romm, 2007; Shapiro et al., 2004; Stepien & Baernstein, 2007). Aside from the statistics published in previous studies, however, participants in this study were able to discuss in detail their own experiences with seeing how empathy impacted their treatment outcomes with patients. Many participants could recount successful patient relationships, and several expressed a high degree of satisfaction from being able to connect deeply

with their patients beyond a strictly professional relationship. In addition, most participants also told stories of circumstances where a physician was not empathic, and noted the damaging impact this had on the patient and the goals of treatment. Therefore, this study confirmed many of the previously reported benefits of empathy in medicine but also added richly detailed personal accounts of why these benefits may occur.

Participants also provided details regarding how showing empathy towards patients could be personally rewarding, and many indicated that the ability to connect with patients was the primary reason they were still in practice.

### **Other Models of Empathy**

In addition to the medical literature, empathy has been studied across other disciplines, particularly within the mental health professions. Perhaps the most well known conceptualizations of empathy are attributed to Carl Rogers (1957) and Truax and Carkhuff (1967). The model of empathy developed within this study touches on some of the main premises included in the work of Rogers, Truax, and Carkhuff, but also adds some new considerations that may be applicable in understanding empathy beyond the medical setting.

Participants who clarified the difference between empathy and sympathy touched on an important component of Carl Rogers' definition that defined empathy as imagining another person's experience "as if" you were that person, without losing sight of the fact that your experiences were indeed separate (Rogers, 1957). Some participants echoed this distinction by stating that it was not necessary to directly experience the emotions of the patient in order to be empathic. Rather, a physician's empathy involved perspective taking and imagining the patient's experience as separate and unique from their own. In

addition, participants universally identified empathy as an essential component of patient care, much as Rogers labeled empathy a core condition for effective therapy (Clark, 2010; Rogers, 1957).

The results of this study also show some similarity to the Truax and Carkhuff model of effective helping (Truax & Carkhuff, 1967). Though their model did not exclusively focus on empathy, it did include a scale to measure empathic responses. Counselor responses fell along a continuum of either subtracting noticeably from the meaning or feeling expressed by clients, to communicating client meaning at a level beyond that which the client was able to express. Although the Truax and Carkhuff model is much more detailed regarding what characterizes unempathic and empathic responses, the model produced by this study contains a similar notion that empathy lies along a continuum. Labeled here as initial or genuine empathy, this model presents various behaviors or characteristics that can determine whether empathy is being practiced at a minimally or fully facilitative level. Just as Truax and Carkhuff identified the third level of their model as minimally facilitative and thus the goal of counselor training, so does this model identify initial empathy as both trainable and necessary for minimal effects of empathy in patient care to occur (Carkhuff, 2000).

Another key component of the Truax and Carkhuff definition of empathy was supported by participants in this study. Empathy, according to Truax and Carkhuff (1967), includes the ability of the therapist to communicate his/her understanding of patient communications in a way that the patient can understand. Participants in this study also stressed the importance of this communication process, stating that patient literacy, understanding of medical terms, and degree of comprehension were essential in

establishing an empathic relationship. Many participants reported being constantly aware of how to “package” a message for each individual patient, knowing that different patients would have different reactions or levels of understanding. These findings also support Keefe’s (1976) model of empathy, which includes the ability to communicate understanding back to the client.

One clear addition of this model to other existing models of empathy is that it extends beyond interpersonal communication to include situational or environmental factors that can influence the level of empathy achieved in a professional setting. In other words, this model does not so much identify *what* constitutes empathy as it describes *how* empathy might be either facilitated or limited at different levels. Accuracy of the empathic response is not measured as much as the genuine intent and mitigation of various barriers. Therefore, this model may add to existing research by suggesting additional components of empathy that extend beyond behavioral or cognitive skills.

## **Implications**

### **Implications for Medicine**

Although this model has not yet been examined through additional research, tentative findings suggest several implications for medical practice and training. First, the model contains seven levels, all of which could be assessed to determine whether optimal conditions for empathy exist. Furthermore, the model could be utilized in future research or clinical practice to determine how certain interventions could facilitate empathy at each level or subcategory. The internal and external barriers in particular may be important to consider, as removing or alleviating barriers might be more time-effective than interventions at other levels of the model. For example, the intrinsic qualities of a



physician are unlikely to change drastically in a short amount of time. However, the model would suggest that an empathic physician can provide more optimally empathic treatment if barriers can be reduced. Hospitals or practitioners who wish to facilitate more empathic patient care could thus refer to this model in order to assess current strengths in providing empathy, as well as identify areas for improvement.

The model also has implications for physician training in empathy development. First, the overwhelming consensus among participants that empathy is intrinsic and difficult to enhance without some sort of previous disposition, whether genetic or learned, suggests that medical schools seeking to train highly empathic physicians should assess for these qualities in admissions criteria. Several participants stated that admissions were focusing too heavily on academics and less on individuals who had higher levels of empathy. This model did not fully capture all of the required criteria to measure empathy levels in an individual, but such assessments could be instrumental in selecting students based on empathic ability. Otherwise, as participants in this study suggest, students with low empathic ability may be admitted to programs and remain unable or unwilling to further develop empathic skills throughout training.

Regarding training, this model suggests that teaching communication skills and techniques to relate to patients may indeed facilitate a minimal level of empathy. Though genuine empathy may be difficult for some individuals to achieve, based on personality or situational barriers, at minimum a level of initial empathy could enhance patient and physician satisfaction. Therefore training programs should continue their efforts at providing students with the “tools” of empathy, as well as facilitating opportunities for students to interact with patients and observe empathic physicians. However, this model

does indicate that much of this training, while helpful, cannot fully develop the conditions necessary for genuine empathy to occur. Training programs should thus keep in mind the goals of training and develop assessments of student progress accordingly.

On a systemic level, themes from participant interviews revealed a need for renewed focus on empathy and patient-centered care in medicine. Participants expressed concern over the limitations imposed by managed care, and the business model espoused by the medical field. In an effort to streamline practice for better efficiency and cost-effectiveness, the more humanistic side of medicine is reportedly being lost. Participants seemed to view the situation as a trend that was both unfortunate and largely irreversible, unless a restructuring of the current medical system occurred. Participants discussed various options, such as billing physicians based on patient satisfaction rather than diagnosis, or allowing physicians more freedom in professional decision-making. This concern regarding the loss of a system supportive of empathy suggests the need for future research on how to blend empathic treatment within a system structured by competing values.

### **Implications for Other Helping Professions**

Because this model was developed exclusively for application within the medical field, any implications for other related professions can only be speculated and addressed through further research. However, it may be worthwhile to examine how this model might fit within other professions. The specific subcategories in each level might vary depending on professional roles, but the seven levels could add further insight regarding how to optimize empathy in other settings. In counseling, for example, the goal of treatment focuses more on deep, therapeutic connections and achieving behavioral,

cognitive, or emotional changes. Therefore, the requirements for counselor attributes, client characteristics, and both superficial and genuine empathy would likely be different. It could also be assumed that internal and external barriers would vary, as would the ultimate results of empathy on treatment. However, this model could be used as a starting point to examine each of the seven levels to identify applicable subcategories, thus broadening professional understanding of the empathic process in other settings.

An additional component to consider from this model is the idea that, at least for physicians, achieving a minimal level of empathy can still be sufficient to enhance treatment goals and increase patient satisfaction. Although genuine empathy is still optimal even in the medical setting, the initial level of empathy may be satisfactory. This could raise the question in related professions of what minimally facilitative empathy might look like. In counseling this level is identified by Carkhuff and Truax (1967, 2000) as consisting of statements that accurately capture the meaning and feeling of what a client has expressed. However, other elements of empathy may be discovered, as they were in this study, to add to the understanding of minimally facilitative empathy beyond accurate reflections. Additionally, different professions may have significantly different levels of empathy required to achieve desired treatment effects. Mental health professionals, for example, may find that initial empathy is insufficient in establishing therapeutic connections. Future research could investigate and clarify what is needed in different professional roles, thus likely resulting in implications for selection and training of other professional groups.

### **Proposed Interventions**

Participant data was primarily descriptive and provided little in the way of proposing interventions to facilitate empathy at different stages of the model. However, professionals wishing to utilize the model in a clinical setting would likely benefit from suggestions on how to best enhance empathic communication at each level. The following proposed interventions can provide a starting point for facilitating empathy based on the model. Professionals should also brainstorm interventions that are appropriate for their specific settings and available resources.

**Survey physicians.** Through the process of conducting interviews with physicians across a range of specialties, the common thread was that physicians recognized their limitations and had a sense of what needed to change in order for them to be more empathic with patients. Regularly surveying physicians can accomplish several things within this model. First, surveys can assess for levels of physician burnout or cynicism, as well as physician perspectives on empathy and the need for emotional distancing. Results of such surveys could indicate whether further intervention may be needed in the form of counseling or continuing education for medical staff. Surveys could also indicate whether physicians felt overly pressured by volume of patients, time constraints, or managed care requirements. Though some of these barriers may be difficult to remove, they could perhaps be somewhat lessened or physicians could be trained on how to manage these challenges when providing patient care. Survey results could also be used in lobbying or legislative efforts to advocate for changes that may enhance the quality of healthcare and managed care policies.

**Utilize counselors.** As mentioned in many of the internal barriers of this model, physicians are constantly faced with stressful and demanding circumstances, many of

which can result in burnout and career dissatisfaction. The effects of burnout can then greatly diminish a physician's ability to form an empathic connection with a patient. Conversely, physicians who are able to connect empathically with their patients can experience greater satisfaction and increased motivation to provide this level of treatment. Several participants mentioned the potential benefit of making counseling available to physicians in danger of burnout, or to those struggling with personal issues that could impact their level of care. The participants who mentioned counseling as a potential intervention suggested that the referral to counseling should come from a colleague or administrator who had concerns for the impaired physician.

The medical culture may not initially be open to utilizing counseling as a viable intervention for physicians. For one, time is valuable and physicians who are experiencing burnout are likely already mindful of time pressures. Setting aside time to meet with a counselor may therefore seem prohibitive. In addition, physicians are trained to sacrifice attention to self in order to provide care. They work long hours, often without time to eat or sleep, and may therefore be frequently unaware of their own needs. Therefore, counseling offered to physicians may be most helpful if it is time-limited and prescribed by respected colleagues or administrators. The likelihood of physicians voluntarily seeking counseling for burnout or other personal matters is slim and should therefore be incorporated within the particular work setting.

**Assess physician qualities in medical school.** One common suggestion provided by participants regarding physician training was to assess for empathic qualities during the medical admissions process. Most of the physician characteristics highlighted in the first level of the model consist of personal traits, many of which participants viewed as

fixed qualities that could be minimally enhanced through further training. Therefore, participants believed that students admitted to medical programs without the necessary characteristics would be unable to fully develop them throughout training, thus resulting in unempathic doctors. This concept is not new, but it would have a significant impact on admissions procedures and training goals. Indeed, assessing for personal traits beyond test scores, academic records, and successful interviews is a current issue facing many medical programs. It is unclear what these assessments might look like, or how heavily they should weigh against other criteria. However, the first level of this model could be used to choose additional assessments, limiting the selection to those focused on motivation, personal traits, or conceptualization of empathy.

There is also a need for continued assessment of these desired traits throughout medical school. Perhaps students with initially low scores on related assessments could improve significantly through enhanced training. Conversely, the participants of this study could be correct in their hypothesis that these traits are largely fixed and resistant to further training. Since the answer to this question may indeed impact future admissions procedures and training goals more intensive and longitudinal research is needed.

**Enhance training.** Several participants also commented on how current empathy training was either lacking or inefficient in ensuring empathic development of medical students. This study additionally found that many physicians and students might confuse sympathy with empathy, thus impacting their conceptualization of empathic practice. The model also demonstrates that basic empathy may be sufficient in ensuring patient satisfaction and quality of care, thus establishing some basic skills that could be stressed during training. For example, trainings could be structured to focus on skills of empathy

as well as principles of effective customer service. Medical students could be taught that this form of empathy is a minimal level in providing empathic care. Elements from the genuine level of empathy can also be presented to students in order to demonstrate the continuum along which they could choose to practice. Students could be provided with scenarios and asked to select whether genuine or initial empathy was used, thus ideally increasing their ability to see the difference in their own interactions with patients. They can also be educated on the difference between empathy and sympathy in providing care.

**Use the model as a checklist.** As mentioned previously, the model can be used as a checklist to identify barriers that may be limiting empathy in the medical setting.

Physicians can use the model to self-assess and identify areas they may need to address to enhance empathic treatment of their patients. Similarly, administrators and supervisors can regularly use the model to identify barriers impacting physicians within their specific settings. Utilizing the model in this way could help medical professionals take a proactive approach to empathic care through early detection of barriers and enhanced training goals.

**Reward empathic treatment.** One common statement by participants in this study was that empathy was not rewarded in the medical setting and thus motivation to be empathic had to be a personal value maintained by the physician. While this intrinsic motivation is a core element of physician empathy and important for empathic care, hospitals and medical schools could develop initiatives to promote the practice of empathy during patient visits. Rewarding empathic physicians, screening patient charts to inclusion of biopsychosocial information, surveying patients on empathy experienced during recent visits, and stressing the importance of empathy during rounds could serve

as important reminders of empathy's importance. One participant suggested that instead of reimbursing physicians for the number of patients seen, physicians should be reimbursed based on quality of care and level of patient satisfaction. While this may not be reasonable for most settings, it does echo the importance of having a system that is structured to value empathy as a part of quality treatment.

**Assess the patient prior to the visit.** The role of the patient in empathic treatment was not a focus of this current model, but participants did reveal that certain patient characteristics can enhance or limit empathy. Many of these characteristics had to do with patient understanding and receptivity to empathy. Patients who have limited health literacy, language difficulties, or other conditions impacting their ability to understand or follow treatment goals will make it difficult for the benefits of empathy to be realized. If time is limited and the number of medical problems are substantial there may be very little opportunity to assess patients for understanding or biopsychosocial constraints. One suggestion for assisting with this process would be to include questionnaires with patient paperwork to be completed prior to the visit. These questionnaires could assess for illiteracy or language difficulties, as well as contain items to assess lifestyle and biopsychosocial problems. Physicians could then review the questionnaire prior to meeting the patient and thus have some initial understanding of additional elements impacting patient care. This would of course not replace the need for physician empathy but it could help focus the direction of patient and physician communication, particularly regarding understanding and ability to comply with treatment goals.

### **Limitations and Delimitations**



Certain limitations and delimitations inherent both in the nature of qualitative research as well as the specific details of this study warrant discussion and should be considered when applying results beyond the context of this research. Although every attempt was made to ensure that the results of this study accurately portrayed the opinions and experiences of participants, the limitations discussed below may impact the degree of universality of the model. Therefore, future research should examine the model and claims made by this research to add credibility and applicability to participant accounts and theoretical interpretations.

### **Researcher Bias**

One potential limitation of this study concerns any biases held by the researcher that may have impacted the process of gathering data as well as the interpretation of data. Researcher bias is frequently cited as an unavoidable limitation of qualitative research, as research design and data analysis require researchers to make connections and assumptions that may inadvertently involve drawing upon previous thoughts (Corbin & Strauss, 2008; Creswell, 2007). However, attempts at controlling researcher bias can at least minimize this effect and serve to hold researchers accountable for efforts to maintain objectivity. In this study a research team was formed primarily to provide alternate interpretations of data, ensure through consensus coding that the primary researcher was not manipulating data away from the intent of participant accounts, and review the final model for fit and accuracy. The model was also sent to participants for review in an attempt to highlight potential misinterpretations or inaccuracies.

One researcher bias in particular that guided the study and the formation of the model was the assumption that empathy is important in medical care. Some degree of

control over this limitation was attempted by including questions in interview protocol that presented opportunities for participants to discuss empathy's limitations or disown it as an applicable strategy. The final model thus captures some instances when empathy may not be essential in medicine and also acknowledges that a more superficial level of empathy could be sufficient in most settings. When in doubt as to whether personal biases were clouding the interpretation of the data the primary researcher returned to participant interviews and codebooks to ensure that the final model was true to participant statements.

### **Researcher Inexperience**

Research inexperience is another limitation of this study. The primary researcher had previous experience as a team member or primary investigator for three qualitative studies, as well as assisting with a course on qualitative research. However, this was the first study of this scope and also the first time utilizing grounded theory methods. Research team members also had limited to no experience with qualitative methods. Although training was provided, there was still some variation in the coding and interpretative practices among team members. As a result, the primary researcher utilized texts on grounded theory and consulted with research mentors during the process. In addition, differences in coding styles were seen as opportunities to view data in different ways.

### **Methodology and Data Collection**

Grounded theory was selected for this study due to the lack of qualitative research on empathy in medicine, the intent to form a theory for subsequent testing and revision, and the ability to uncover new interpretations of a phenomenon through in-depth

interviews (Charmaz, 20006; Corbin & Strauss, 2008; Pederson, 2009). Qualitative methods thus sacrifice some degree of generalizability in favor of rich descriptions and deeper understanding of phenomena where there is a lack of research or consensus. The generalizability of these results to other settings or medical professionals can only be determined by further assessment or application of the model. However, it does provide some new areas for consideration, and presents at least one option for conceptualizing empathy as a process in the medical setting.

An additional limitation common to qualitative research is the issue of participant selection. Participants were initially chosen based on the criteria outlined at the beginning of the study:

1. Strongly purport empathy in their practice or teaching as evidenced by commitment to research on empathy or patient-centered care, mission statement on personal websites, or current involvement in empathy development
2. Have a reputation of empathic connection to patients or students as evidenced by reviews, ratings, or reputation among colleagues
3. Have demonstrated understanding and sensitivity to patient's medical and nonmedical concerns as evidenced by interview protocol, stated goals of an office visit, receipt of awards for humanistic or patient-centered care, or patient/student feedback

The majority of initial participants were identified through a list of top-scoring physicians within the hospital system at a local medical school. Later in the research process lists of top rated physicians in the community were utilized to identify

participants in specialty areas, such as pediatrics and psychiatry, which were underrepresented in the sample. Participants themselves were asked to provide suggestions for additional individuals to interview, operating under the assumption that physicians who possessed some level of empathy would also be able to recognize this trait in others. As a result, participants consisted mostly of professionals within the medical school/teaching hospital setting, although some participants in other settings were identified by their colleagues which somewhat expanded the scope of the study. These selection procedures were utilized to identify participants from a variety of specialty areas while still remaining feasible in scope. It is unclear how participants of this study might compare to professionals in unexamined settings or communities. Therefore, though efforts were made to find a variety of perspectives, participants of this study may be significantly different from professionals in other settings, and any application of the model developed as a result of this study should take this limitation into account.

In addition, although interview questions were carefully chosen to allow alternative interpretations and to cover a wide range of topics, they were still based upon predetermined categories from the research and also in line with the research questions of this study. Interviews were semi-structured in that participants could introduce new directions in the conversation throughout the interview, but interview protocol necessarily focused the interview on the major points of discussion. It is feasible to think that different questions may have produced different results, or may have added further clarification to the model. As the study progressed, the primary researcher did adjust the

interview protocol in order to explore new concepts, or to clarify points made in previous interviews that did not seem to fit within the emerging structure.

### **Complexity of the Model**

Though this model adds several elements to current literature on empathy in medicine it may lack some complexity that should be addressed in future research. The model has been structured as a linear process, in which each layer builds upon the next. The model was structured in this way to reflect the data generated from participant interviews that portrayed the empathic process as a series of steps, some of which could facilitate empathy and others that could impede the process. The model also functions as a sort of equation, indicating that successful navigation of each level in turn can lead to empathic treatment. Displaying each level as a sequence of events leading to optimal empathic treatment therefore allows anyone wishing to employ this model to assess at each level, to identify and remove barriers, and to thus enhance the final goal.

What is not addressed within the model, however, is whether there are bidirectional influences, aside from the interaction between internal and external barriers, which could alter the linear nature of the progression. An analysis of subcategories would likely illicit several hypotheses for how later levels in the model might impact earlier levels. This model focuses primarily upon the final product, that is, the level and quality of empathy. Therefore, a linear process is appropriate to demonstrate how each level can add or subtract from the quality of empathic behavior. The model does not address, however, whether each level could have a permanent effect on qualities of a preceding level, rather than just impacting the final product. For example, one might assume that perhaps time constraints or volume of patients (external barriers) could impact physician

characteristics of motivation or flexibility. However, for the purpose of this model physician characteristics are seen as more permanent traits that are relatively consistent. In other words, physician motivation is less tied to situational influences and more a value and overall intent of the person of the physician. External barriers could weaken this motivation, but such an effect is still consistent with the linear progression of the model in that the product of empathic behavior is the focus. It would require a different study to determine, for example, whether external barriers have a more permanent effect on physician motivation in expressing empathy. There is therefore not enough known about the nuances within the model to draw many bidirectional inferences. Future research could do more to clarify potential interactions.

In addition, it is unknown how many subcategories may need to be achieved in each level in order for empathy to occur. It could be that some subcategories are more important than others, or that all subcategories in each level are needed in order for empathic communication to occur. Currently the model is structured to portray each level as a rubric of sorts. If physician characteristics are strong then the potential for empathy is high within the first level. It can then be strengthened or weakened by subsequent levels. However, the weight of the various components within each level are unknown and, though each subcategory has been identified as important, it is impossible at this point to assign particular value to each item. Future research could examine each element in the model to determine whether certain components are more essential than others, or whether the importance of each item varies due to situational influences.

### **Concluding Remarks**

The intent of this study was to examine the nature of empathy in the medical setting, using grounded theory methods to synthesize findings within a theoretical model. The model that emerged through analysis of participant interviews demonstrates the complexity and various levels impacting the utilization of empathy in medicine. It presents an organized method of identifying barriers, designing interventions, and understanding the many factors that can influence empathy in the context of the physician/patient relationship. This model, as with any new theory, must be subject to future testing in order to establish its degree of generalizability and utility. However, the findings of this study do share commonalities with existing research and will potentially add new considerations for future analysis and conceptualizations of empathy in the medical setting.

**CHAPTER SIX****MANUSCRIPT**

Facilitating Empathy in Medicine:

A Model for Optimizing Empathy in Patient-Centered Care

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Empathy has been identified throughout current literature as a facilitative component of the physician/patient relationship, contributing to optimal outcomes and higher satisfaction with treatment. However, research on empathy is often inconsistent or vague, and a model of how to conceptualize empathy within the medical setting appears to be lacking. After an overview of current perspectives of empathy in medicine and a description of the study, the authors present a new model outlining the conditions for achieving optimal levels of empathy in medicine. The model is based on in-depth interviews with participants from a variety of specialty areas, thus capturing practical considerations in empathic care. Implications and limitations of the model are also discussed.

The quality of the relationship among physicians and patients can significantly impact treatment outcomes through increased compliance, lower malpractice claims, more accurate diagnosis, and higher patient satisfaction.<sup>1, 2, 3, 4, 5</sup> One component of this relationship, empathy, has been identified as a determining factor of relationship strength and satisfaction.<sup>6, 7</sup> These findings have led to a renewed focus on how to facilitate empathy in medical training and have resulted in the establishment of empathy as an essential component of instruction by the American Association of Medical Colleges (AAMC).<sup>8, 5</sup>

Though empathy has been identified as a goal of medical training, there remains a lack of consensus as to what this training may involve and, more importantly, what role empathy may play in the medical setting. In a field devoted to efficient diagnosis and treatment of physical ailments, biopsychosocial concerns are often seen as secondary.<sup>9, 8</sup> Therefore, though research has illuminated the valuable benefits of using empathy within the medical setting, there is little known about what this might look like and how it might be facilitated in practice and training.

### **Background**

Empathy can play an important role in establishing a relationship of trust as well as identifying the various factors that have an impact on illness.<sup>10, 11</sup> Though often seen as an additive component of a medical interview, empathy can have profound effects on the experiences of both the patient and the physician, leading to greater satisfaction and better treatment outcomes.<sup>4, 5</sup> Furthermore, Levasseur and Vance<sup>9</sup> state that lack of attention to empathy, or acknowledgement of the personhood of the patient, can in fact be hurtful if physicians restrict their view to only the physical ailments:

They [physicians] sometimes cause suffering by seeing a person as divided into a mind, on the one hand, and a body, on the other, and then concluding that the object of their professional concern is only the body... True empathy focuses on the impact that disease and its treatment have on a patient's ability to lead a meaningful life. (Levasseur & Vance, 1993, p. 82)

Stepien and Baernstein<sup>5</sup> define empathy as having emotive, moral, cognitive, and behavioral components. Within these definitions, emotive empathy reflects the *ability to experience and identify* emotions, moral empathy reflects a *motivation* to accurately understand and empathize, cognitive empathy refers to the *ability to identify and understand* a patient's experience, and behavioral empathy consists of the *ability to convey this understanding* to the patient.<sup>12,6,5</sup> Most of the recent literature focuses on cognitive and behavioral components, measuring physician understanding and the ability to communicate this understanding to the patient.<sup>6,2</sup> Cognitive and behavioral components of empathy have also been identified as the easiest elements to teach, with moral and emotive empathy seen as more of a personal trait that lies beyond the scope of short-term training.<sup>7,5,11</sup> Although many programs incorporate training to some degree, there is a lack of literature demonstrating a standard practice or curriculum for effective instruction.

Other terms are also used seemingly interchangeably with empathy in the literature. Communication skills, interpersonal communication, emotional intelligence, and relationship-building skills are mentioned throughout empathy-related studies. The interchangeable nature of these terms lends additional support to the idea that empathy is

inconsistently identified and defined, leading to further confusion about the meaning of the construct.

Additionally, a great majority of studies have attempted to examine empathy exclusively through quantitative methods. In fact, a review of the past several years of research on empathy in medicine reveals that 171 out of the 206 empathy-related studies employed a quantitative methodology.<sup>13</sup> This research has served to illustrate where further training may be needed, and it has also been pivotal in making a case for the inclusion of empathy in physician training and practice. However, one key weakness in utilizing quantitative research to study empathy is that, given the confusing and varied definitions of empathy, the researcher must determine how to operationalize the concept. Various operational definitions can then impact the selection of instruments, variables, and interventions.<sup>11</sup> Pederson<sup>13</sup> found that many quantitative studies on empathy in medicine did not even provide an operational definition. Furthermore, construct validity among instruments claiming to measure the same or similar constructs is weak, suggesting that identified components of empathy may not be valid.<sup>14,15,11</sup> As a result, it is sometimes unclear what exactly is being measured, and whether empathy is being correctly assessed.

As a result of these limitations, many quantitative studies conclude with an acknowledgement that qualitative methods may be needed to further develop and interpret the results.<sup>16,13</sup> The rich descriptive data that characterizes qualitative research can be used to develop theory or explain inconsistencies resulting from quantitative methodology.<sup>17</sup> We therefore chose grounded theory, a qualitative model that allows themes to emerge through continuous data collection and interpretation, to explore the

concept of how empathy is applied in the medical setting using. The resulting theory will hopefully be subject to further development, testing, and application through future research, thus adding to the understanding of the phenomenon and revealing potential constructs otherwise unidentified in current literature.

### **Study Design and Implementation**

Our purpose for this study was to develop, through grounded theory methods, a theory to conceptualize how empathy is applied in the medical setting. We selected grounded theory as our methodology due to its methodological structure and goal of theory creation, allowing the study to extend beyond descriptive data to form an integrated model subject to further testing and analysis.<sup>17,18</sup> We aimed to utilize rich description from participant interviews to gain a broader understanding of the phenomenon of empathy in medicine, while also potentially revealing elements not currently present in the literature.

Following grounded theory methods, we conducted, transcribed, and coded a total of 21 semi-structured interviews of physicians and other healthcare professionals. We identified the first round of participants through high patient satisfaction ratings on a hospital-wide survey. This selection process was informed by current literature identifying empathy as a pivotal component of patient satisfaction.<sup>4,5</sup> Thus, it was assumed that high satisfaction ratings could identify empathic physicians. From there, participants identified colleagues whom they considered to be highly empathic. Participants represented a wide range of specialties and included a selection of physicians, nurses, a medical student, and a counselor. Most participants reported treating a diverse patient population in terms of ethnicity, socioeconomic status, and age. Patient

visit time and patients seen per day varied according to specialty and setting, with an average reported visit time of 25 minutes and an average of 18.8 patients seen per day.

The following table displays participant profile information.

Table 4  
Participant Group Profile

Participants	Gender	Age	Race	Years in practice	Specialty	Avg. Visit Time (min)	Avg. # patients/day	Avg. patient race	Avg. patient age	Avg. patient income	Avg. # of visits	Setting*
P01	F	59	C	29.5	IM	20	10	AA	50	MC, MD, SP		MS
P02	M	61	C	15	ID		70			UI		MS
P03	F	57	C	30	MM	10	40	AA	varies	MC, SP	10-12	MS
P04	F	45	C	10	OB	30-60	30-40		10-79	varies	monthly	MS
P05	M	73		38	PS	10-70	5-25	varies	varies	varies		MS
P06	M	25	C	0	MS	30-60	6-9	AA	varies	UI	1-3 mo	MS
P07	M	46	C	15	ID	30-60	12	C, AA	40	varies	3 mo	MS
P08	M	59	A	30	FM	15-20	11	AA, C				MS
P09	F	53	C	20	MM	15-60	28-38	varies	varies	MD	2 wks	MS
P10	M	44	C	16	FM	20-30	14	C, AA	1-100	1 MC	--	PP
P11	F	61	C	39	GC	60	1-7	varies	varies	varies	varies	PP
P12	F	61	C	38	NP	30	17	AA, C	19-69	varies	3 mo	CI
P13	F	34	C	1	NP	30	25	varies	varies	avg		MS
P14	M	40	C	9	GS	5-30	15-20	varies	varies	varies		MS
P15	M	55	C	26	FM	20	11-12	varies	varies	varies		MS
P16	F	54	C	23	PN		35-50					MS
P17	M	35	C	5	NL	30	15-20	varies	181	varies	varies	MS
P18	M	67	C	27	IM	15-30	75	C, AA, L	35-40	30-35 yr	75 yr	PP
P19	M	63	C	31	PD	15	27	varies	0-24	varies	varies	PP
P20	M	32	C	2	PSY	30	10-70	varies	varies	varies	varies	MS
P21	F	38	FA	14	GF	10-60	5-10	varies	15	varies	? 10+	MS
AVG	M	50.6	C	21.5	FM	25	18.8	varies	varies	varies	varies	MS

\* Abbreviations: C: Caucasian, AA: African American, A: Asian American, FA: Filipino American

† Abbreviations: FM: Family Medicine, ID: Infectious Disease, MM: Maternal Fetal Medicine, OB: Obstetrics/Gynecology, PS: Plastic Surgery, MS: Medical Student, GC: Grief Counselor, NP: Nurse Practitioner, GS: General Surgery, PN: Pathology/Neuropathology, NE: Nephrology, PD: Pediatrics, PSY: Psychiatry, GE: Geriatrics

‡ Abbreviations: MC: Medicaid, MD: Medicaid, SP: Self-pay, UI: Uninsured, I: Insured

§ Abbreviations: MS: Medical School, PP: Private Practice, Outpatient Office, CI: Clinic

We coded each participant interview line-by-line through open coding, then further collapsed codes into categories and themes using axial and focused coding. Two additional group research team members, a medical student and a doctoral counseling student, coded interviews and met to compare codebooks for consensus coding. Research team members also recorded memos, which were integrated into other researcher memos and later used to structure the final model. Upon completing a draft of the model, research team members provided feedback and indicated their consensus with the final levels and subcategories. Copies of the model were also sent to several participants who were randomly selected to provide input on the model's content.

## A Model of Conditions for Empathy in the Medical Setting

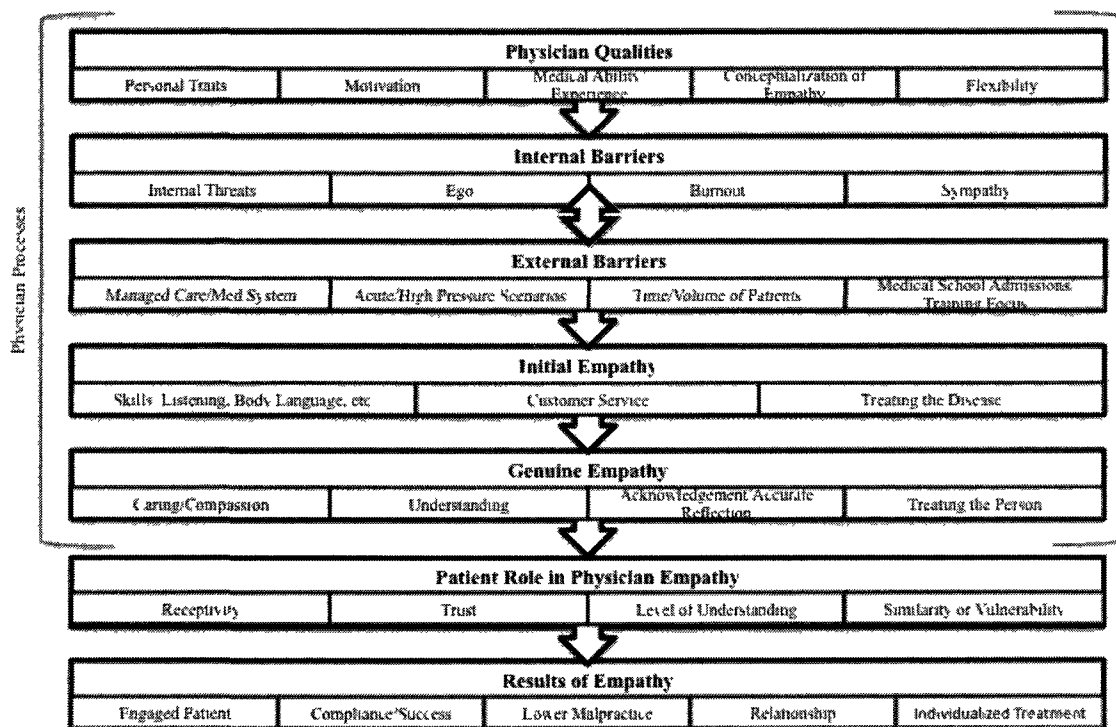


Fig. 11. Conditions for Empathy in the Medical Setting

Participant interviews revealed that empathy in medicine is a complex and multi-level process, requiring that several independent factors be at least minimally facilitative of empathy in order for it to occur in this setting. The model is presented as a linear process in that each level adds to the next and the final stage results in empathic treatment and outcomes. Since this study was limited exclusively to the perspective of the healthcare professional the model is likewise centered on the professional's role in facilitating empathic care. The patient is considered in one of the final levels, but even then it is through the lens of how patients might impact a physician's ability to provide empathic treatment.

**Physician qualities.** The first level of the model concerns the characteristics of the physician that can potentially impact empathic care. Physicians may have inherent personal qualities, such as compassion or interpersonal ease, which makes them by nature more likely to include empathy in their practice. A motivation to connect with patients, or a feeling of investment in the person of the patient, also adds to the likelihood of an empathic physician. Likewise, physicians who are not generally compassionate or feel a lack of motivation towards providing empathic care may not pursue an empathic connection.

I think it's something that's innate in people. Some people are ...can get connected with a patient like that (snaps fingers). For some people, it's a little bit different. P21, 346

In addition, as physicians reach levels of competency and expertise in their area of medicine they are more likely to have the time and mental energy to devote to improving empathy and other communication skills with patients. Medical students, residents, and new physicians may be primarily focused on improving knowledge and medical techniques to the exclusion of an awareness or desire to practice empathic care.

So they may need to learn a little bit about themselves and mature in their field in order to continue to develop and be able to have that rapport with their patients. P12, 232

So I think a lot of people have that side to them, that somewhere inside of them, but when they really see it in action and they see it through other people is when they really are like ...they turn it on. P06, 414

The way a physician conceptualizes empathy and its role in medicine also may impact how he or she utilizes it when interacting with patients. Varied participant definitions reflect the difficulty of describing such a complex and vague process, and also indicate diversity in the way empathy might be used in the medical setting. If a physician



believes that empathy is primarily a sense of caring or compassion for a patient, he or she may also attempt to limit empathic connections so as not to become emotionally exhausted due to the volume of patients seen each day and the severity of patient issues. Physicians who view empathy as more of an act of understanding the patient's perspective may not feel this need for emotional distancing and will likely be more concerned with cognitive processes and accurate reflections.

I think empathy has probably many definitions, but I'd say it's the ability to get into the mind and the spirit and the psychology of another person. P05, 35

Empathy can sometimes get a little bit out of control. You know, if you're...if you're someone who is altruistic, like I was coming out, if you sometimes really took it to heart, if you had someone who was really hurting bad, you were hurting as bad as they were, and sometimes it took you away from the business at hand, you know you took your work home with you very often, and I know I did for the first couple of years, until you really know how to control it. P18, 141

Hmm.... it's more exhausting. It's easier to go through life without letting your emotions get in the way. Very easy to just exist. It's much more exhausting to put yourself in their place to start thinking about "how would I feel if I had this?" P09, 439

Finally, physicians who can demonstrate flexibility in assessment and treatment of patients based on individual and situational factors are more likely to be empathic. The use of empathy, according to participants, allows physicians to pick up on subtle cues from patients, or to recognize biopsychosocial factors that require unique treatment plans for each patient. Thus, this perceptiveness and ability to adjust can result in more empathic treatment.

You know, you're taught early on in medical school that it's Mrs. Jones in Room Two. It's not ... It's not a heart attack in Room Two because Mrs. Jones who is ninety and having a heart attack is totally different than Mrs. Jones who is forty-eight and having a heart attack. You know? You've gotta do different things; you've gotta think differently because it's always the disease in the context of the patient. P10, 397

**Internal barriers.** Physicians may possess some or all of the personal qualities that can contribute to empathy in the medical setting, but the presence of internal barriers can impede even the most empathic physician from providing empathic treatment. One such barrier occurs when physicians impose professional boundaries or emotionally distance themselves from patients. Physicians may over identify with a patient, or may be afraid of an enmeshment that could prevent difficult decisions from being made regarding patient care. As a result, these boundaries can interfere with the ability to connect with the patient. Additionally, physicians may view themselves as authority figures or as more of an expert on patient symptoms than the patient him/herself. This perspective can result in not listening to the patient or eliciting patient perspectives regarding their condition. Physicians who have made an error in judgment or who fear criticism of their work may also be unwilling to demonstrate empathy towards a patient.

And I suppose sometimes that's what physicians do, you know, just come in and say you have cancer and walk out and you don't have to deal with your own emotions. And so it may not be ...that they're not empathetic, they just don't want to be too vulnerable. You know, cause as soon as you open yourself up you start...becoming too involved with the patients. P08, 364

I think it's partly the authority level, maybe. They don't want to establish maybe that connection with the patient. They still think that they're the doctor and all that. P06, 487

Physician burnout is another situational internal barrier that can impact the ability to provide empathic care. Physicians who are sick, exhausted, or discouraged by the medical system may not be able to demonstrate empathy. Burnout can also occur if physicians confuse empathy with sympathy, attempting to form strong emotional connections with patients and thus becoming overburdened with feelings of responsibility or sadness that can become immobilizing in the medical setting. Some participants

clarified that empathy does not always involve such an intense emotional connection, and does not necessitate that physicians directly experience patient emotions. Physicians who are not aware of a distinction between sympathy and empathy may inadvertently render themselves ineffective in their efforts to connect with their patients.

... A lot of it has to do with timing. When are people coming in? Is it the right time of the day? Is it the right time of the week? How many people have I seen before them? How tired am I? How is my life going outside of work? How focused am I on work at this time? P20, 229

There's a certain empathy level where people tend to go down with age and time, where people get hardened and bitter with what they're doing, or bored with medicine, or bored with people, or tired of phone calls, or tired encountering patients. P05, 537

It's hard to define. But I just feel like empathy is the reflection of the feeling you have whereas sympathy is a shared connection, rather than just a reflection. P17, 78

**External barriers.** Just as internal barriers can operate within the physician to impede empathy, so can external barriers prevent even empathic physicians from achieving optimal empathy with their patients. Participants identified managed care and the business focus of the medical system as being significant barriers to providing empathic care. Restrictions on reimbursements and prescriptions, paperwork requirements, and standardized treatment serve to deemphasize the physician/patient relationship. High-pressure scenarios and life threatening conditions also serve to move empathy to the back burner as physicians attend to more immediate needs. Furthermore, a high volume of patients and short patient visits leave little time for anything beyond checklists and quick goal-setting. Additionally, many participants indicated that current medical students are ill prepared to provide empathic treatment due to medical school

admissions emphasizing measures of intelligence over compassion, and curriculum favoring clinical knowledge over patient communication skills.

And I think unfortunately what medicine's turned to nowadays is it's less about what the patient's feeling and more about what is the insurance company telling me I have to do, what I gotta give, and how I'm getting out of here by such and such an hour. P18, 95

But no matter at that point how much you empathize, you still have to get the body back to some sort of livable, physiological state. You can't have someone with a very, very low blood pressure and emphasize. You have to treat them medically, too. So I think empathy maybe takes a back seat—it's not as important to my job when they have such an acute illness that's not compatible with life. P17, 206

Especially for primary care, where they are narrowing it down to 15 and 20 minute visits, and you have to do ... I mean, there are actual problems, their med lists, and their preventive care ... And what, you are going to do this all in fifteen minutes, and you're going to be caring? P02, 360

But admissions committees are too concerned with grades and research and all that stuff, which doesn't mean anything because those are going to be the doctors that sit down and have monotone voice and don't really listen to patients. P06, 231

**Initial empathy.** Provided that the physician possesses some or all of the personal characteristics identified as facilitating empathy, and internal or external barriers do not limit his/her ability to be empathic, a primary level of empathy may be achieved. This level, referred to by participants as “fake” or “learned,” contains elements of empathy in medicine that, though not optimal, can still achieve some positive outcomes. Various skills, such as active listening and open-ended questions, are included in this level. These skills, also referred to as microskills or communication skills, can be taught to most people and can be employed without a genuine desire to connect empathically with a patient. In other words, participants identified skills in this level as components that could be taught to enhance physician/patient communication, but that could still come across as

mechanical or disingenuous if not accompanied by more genuine attributes of the physician. Participants mentioned many of these skills when referring to teachable components of empathy, rather than intrinsic and static characteristics.

The initial level of empathy also includes actions taken towards patients that are motivated more by providing quality customer service than a desire to connect empathically with the patient. Attention to the patient's level of comfort, practicing timeliness with visits, or sitting down with patients rather than standing are all examples of good practice and common courtesy. These actions are likely well received by patients and may be sufficient for patient satisfaction, even in the absence of genuine empathy. Despite this attention to customer service, the primary focus of the initial level of empathy remains on treating the disease. There may be a genuine concern for the patient's health and wellbeing contained in this stage, but it is approached exclusively through a focus on symptoms and treatment standards.

Well, the placebo effect is very, very real. I mean, it can get you thirty- to fifty-percent better outcomes than not. So, if I'm going to prescribe something, I'm going to say, 'This is what I'd give to my mother. This stuff is great. This stuff ...' Even if I don't necessarily believe it, I'm going to hype it because then I add the placebo effect to what I'm doing. P02, 415

I think you can certainly teach behaviors that can emulate it. It may not be pure empathy, but you can ... Behaviors are things that are taught that people can do. You can teach people to go in, sit down, and look them in the eyes. You can teach people to speak, um ...to speak plainly in laymen's language and not use medicalese. P21, 348

Sure. If my job is to do heart surgery and to fix your heart, I don't care if you don't like me. I just fixed your heart, so you should love me. Do you know what I mean? If that was my job, and I did it. It doesn't matter if you like me or not—and that's true: It really doesn't matter. P13, 343

**Genuine empathy.** The genuine level of empathy does not exclude the components of initial empathy. Indeed, most if not all of the elements of initial empathy

should exist to some extent at this level as well. The genuine level of empathy is an extension of the previous level in that it utilizes microskills while also involving a compassionate connection between physician and patient. Physicians at this level care for their patients as individuals and are concerned with understanding the patient's perspective. They are aware of nonmedical factors and sensitive to how these factors might impact treatment. In addition to understanding the patient, physicians at this level are able to communicate their understanding back to patients through accurate reflections of patient statements and acknowledgement of emotions. Additionally, in this stage physicians are concerned with treating the whole person, rather than just the disease. Several participants remarked that the empathic connection itself can be healing for patients, and expressed a desire to provide more for patients than a diagnosis or medical treatment plan.

When he sees me he sits down, and he doesn't do this just for me, this is all of his patients. He sits down and he asks how things are at work, he asks how my family is doing, what kind of stressors I have...he cares, he's not just asking me that to make a note in the chart. He wants to know what I'm going through and what's happening to me, in addition to the physical symptoms cause he knows he'll get a clue. And I can tell he cares. P11, 61

But I think you gotta stop there and put yourself in their position and say "if I were that patient, where am I? What's happening to me, what's going on?" I think you find a whole different picture, you realize that oftentimes when people aren't doing what you ask them to do or can't comply, cause they're struggling, they're struggling emotionally, physically, financially. P18, 214

At the end of the day we didn't do too much, you know changing what the medication this person's on, but it's the interaction and things like that they value. You know, and myself as a physician they call it, it...itself is a therapeutic intervention. You know, it's not the medicine, it's just us as physicians. P08, 148

So I think what has happened is you get the ability to relate to these people in more than the disease entity, but rather as people, as patients, as friends, and not as customers. P18, 60

**Patient role in physician empathy.** Although this model focuses on the physician's perspective of empathy in medicine, certain qualities of patients can influence whether physicians are able to provide empathic treatment. For one, patients must be receptive to the physician's attempts at empathic communication. Patients who are angry or who have other intentions, such as drug seeking or malingering behaviors, will likely act as a barrier to forming an empathic connection. According to participants, trust is also a key component in that patients must have faith that the physician is acting in their best interest in order to respond to physician empathy and follow through with treatment goals.

I think when people don't make any effort to help themselves. Um ... And you tend to lose your empathy—I do, to a degree—for people who wait until the last minute. I mean the 'I got this five days ago.' And I've been following them for fifteen years, and I know that that shouldn't happen, and they call Friday at 5 or whatever. It's kind of hard to feel sorry for that person, you know? I think when there is no effort put forth on the part of the patient to help themselves, and their expectations are unrealistic—like I can't do everything for them. P07, 173-179

Patients should also be able to understand their physicians in order to successfully follow treatment plans. Patients who are illiterate or who are unfamiliar with medical terminology may lack full understanding and thus limit what physicians can accomplish. If physicians are not sensitive to barriers in patient comprehension, or if patients do not disclose lack of understanding, both empathy and successful treatment will likely be compromised.

And the next step that we usually take is, 'What's your understanding of what's happening to you?' It's very eye opening to hear what their thoughts are and what their reality is because there is so much information that's thrown at them in the hospital. Number one: They're sick. If you're in the hospital, you're pretty sick, so you've got that on your mind. You've got the stress of that. And a lot of this medical stuff, it's another language, and some physicians don't speak English; they speak in 'medicalese,' which patients will just say, 'Okay. Yup. Mm hmm. I understand,' and really not. I mean, if you look at the medical ... Or health care

literacy ... Maybe folks understand ten, twenty percent of what's discussed with them. So how do you know what's going on if you're only getting ten percent of the conversation? 'So what are you understanding?,' and after that, trying to help them understand what's happening. P21, 101

Finally, certain patients may be easier to connect with than others, thus influencing the extent of physician motivation and ability to respond empathically. Patients who are similar to physicians or to significant others in a physician's life are more likely to elicit a sympathetic reaction, thus potentially increasing a physician's perceived understanding of the patient as well as the motivation to provide thorough and empathic care. Patients who are vulnerable, whether by terminal condition, age, or disability, also may trigger sympathetic responses that result in more comprehensive or sensitive care.

Because, you know, I think probably subconsciously, there is probably a certain selfishness to this. When they see someone that they identify with, I think in some way it's almost like they're treating themselves. And if it's somebody they can really identify with, I think it's easier to empathize with them, and you say, 'Wow. This could be me.' P20, 243

Yeah. Some people just aren't very nice. You know? Some people who come in, they're kind of endearing. A little old person falls and breaks something, and they're very sweet and nice. And some people are just horribly mean. And they were mean to start with, and now you put them in a bad situation—they just become downright brutal. And there are just some people you don't want to go and deal with, and your interactions are just very, very short because you don't feel like taking their abuse. P14, 333

**Results of empathy.** Provided that empathy has been at least minimally facilitated in each preceding level, it is likely that physicians and their patients will experience some of the outcomes of empathic treatment. These outcomes, identified by participants as unique to empathic care, enhance medical treatment in several key ways. One result of empathy reported by several participants is that patients become more engaged in their own care and in the medical process. Patients who feel as though their



physician understands and cares for them will likely provide more information, ask for clarification to ensure understanding, and feel like collaborators in their treatment. This can lead to the second outcome of empathy in medicine, which is higher compliance with treatment goals and thus greater long-term success. According to participants, patients are more likely to follow through with taking medication, appearing for follow-up appointments, and making lifestyle changes as a result of an empathic relationship with their physician. Patients are also less likely to sue their physician for medical malpractice if an empathic bond exists.

Ok, in this patient-centered interviewing, what I'm talking about, that active listening, open ended questions and active listening, its ... empathy encourages an activated patient. And that's the best we can do. If you have a ... a consistently nonjudgmental physician, who's oriented towards patient-centered medicine, and you have a patient that's activated, they are interested in their health, they're informed, they're willing to contribute, and they feel power in the relationship, that's the best we can do. P01, 212

We may write a lot of prescriptions, but what really counts is how do patients feel about things? What's going to get them better? And I think a lot of what goes [toward that] is empathy in [helping] build relationships and trust, and I'm sure it improves compliance with therapy. P15, 206

In addition to enhanced medical care, participants reported that the quality of the physician/patient relationship also improves as a result of empathic treatment. This relationship is reportedly important both for the patient's satisfaction as well as the physician's. Many participants mentioned that their relationships with patients made their jobs more personally fulfilling. Finally, empathy in medicine can also enhance the quality of care that physicians provide for each patient by encouraging individualized treatment that attends to the spectrum of unique needs of each patient. This in turn also leads to greater patient and physician satisfaction and adds to the strength of the relationship.

Uh, cause my intention from the beginning was the relationship...it was nice to be you know, talking about the science side of it, it's exciting and interesting, but to me the real grab was the relationship issues. You know, how to have a personal relationship with each individual patient or families. That to me was a real joy. P18, 43

I mean, I think that's one thing that makes the job rewarding: To have those relationships. To understand—you'll never understand what someone is going through—but to have some insight into what their thoughts are, what their feelings are doing usually a very difficult time in their life. P21, 362

### **Implications and Analysis**

Although this model has not yet been examined through additional research, tentative findings suggest several implications for medical practice and training. First, the model contains seven levels, all of which could be assessed to determine whether optimal conditions for empathy exist. Furthermore, the model could be utilized in future research or clinical practice to determine how certain interventions could facilitate empathy at each level or subcategory. The internal and external barriers in particular may be important to consider, as removing or alleviating barriers might be more time-effective than interventions at other levels of the model. For example, the intrinsic qualities of a physician are unlikely to change drastically in a short amount of time. However, the model would suggest that an empathic physician can provide more optimally empathic treatment if barriers can be reduced. Hospitals or practitioners who wish to facilitate more empathic patient care could thus refer to this model in order to assess current strengths in providing empathy as well as identify areas for improvement.

The model also has implications for physician training and empathy development. First, the overwhelming consensus among participants that empathy is intrinsic and difficult to enhance without some sort of previous disposition, whether genetic or learned, suggests that medical schools seeking to train highly empathic physicians should assess

for these qualities in admissions criteria. Several participants stated that admissions were focusing too heavily on academics and less on individuals who had higher levels of empathy. This model did not fully capture all of the required criteria to measure empathy levels in an individual, but such assessments could be instrumental in selecting students based on empathic ability. Otherwise, as participants in this study suggest, students with low empathic ability may be admitted to programs and remain unable or unwilling to further develop empathic skills throughout training.

Regarding training, this model suggests that teaching communication skills and techniques to relate to patients may indeed facilitate a minimal level of empathy. Though genuine empathy may be difficult for some individuals to achieve, based on personality or situational barriers, at minimum a level of initial empathy could enhance patient and physician satisfaction. Therefore training programs should continue their efforts at providing students with the “tools” of empathy, as well as facilitating opportunities for students to interact with patients and observe empathic physicians. However, this model does indicate that much of this training, while helpful, cannot fully develop the conditions necessary for genuine empathy to occur. Training programs should thus keep in mind the goals of training and develop assessments of student progress accordingly.

On a systemic level, themes from participant interviews revealed a need for renewed focus on empathy and patient-centered care in medicine. Participants expressed concern over the limitations imposed by managed care, and the business model espoused by the medical field. In an effort to streamline practice for better efficiency and cost-effectiveness, the more humanistic side of medicine is reportedly being lost. Participants seemed to view the situation as a trend that was both unfortunate and largely irreversible,

unless a restructuring of the current medical system occurred. Participants discussed various options, such as billing physicians based on patient satisfaction rather than diagnosis, or allowing physicians more freedom in professional decision-making. This concern regarding the loss of a system supportive of empathy suggests the need for future research on how to blend empathic treatment within a system structured by competing values.

### **Limitations and Future Directions**

Certain limitations and delimitations inherent both in the nature of qualitative research as well as the specific details of this study warrant discussion and should be considered when applying results beyond the context of this research. Although every attempt was made to ensure that the results of this study accurately portrayed the opinions and experiences of participants, the limitations discussed below may impact the degree of universality of the model. Therefore, future research should examine the model and claims made by this research to add credibility and applicability to participant accounts and theoretical interpretations.

#### **Researcher Bias**

One potential limitation of this study concerns any biases held by the researcher that may have impacted the process of gathering data as well as the interpretation of data. Researcher bias is frequently cited as an unavoidable limitation of qualitative research, as research design and data analysis require researchers to make connections and assumptions that may inadvertently involve drawing upon previous thoughts.<sup>19,20</sup> However, attempts at controlling researcher bias can at least minimize this effect and serve to hold researchers accountable for efforts to maintain objectivity. In this study a

research team was formed primarily to provide alternate interpretations of data, ensure through consensus coding that we were not manipulating data away from the intent of participant accounts, and review the final model for fit and accuracy. The model was also sent to several participants for review in an attempt to highlight potential misinterpretations or inaccuracies.

One researcher bias in particular that guided the study and the formation of the model was the assumption that empathy is important in medical care. Some degree of control over this limitation was attempted by including questions in interview protocol that presented opportunities for participants to discuss empathy's limitations or disown it as an applicable strategy. The final model thus captures some instances when empathy may not be essential in medicine and also acknowledges that a more superficial level of empathy could be sufficient in most settings. When in doubt as to whether personal biases were clouding the interpretation of the data, we returned to participant interviews and codebooks to ensure that the final model was true to participant statements.

### **Methodology and Data Collection**

Grounded theory was selected for this study due to the lack of qualitative research on empathy in medicine, the intent to form a theory for subsequent testing and revision, and the ability to uncover new interpretations of a phenomenon through in-depth interviews.<sup>17,19,13</sup> Qualitative methods thus sacrifice some degree of generalizability in favor of rich descriptions and deeper understanding of phenomena where there is a lack of research or consensus. The generalizability of these results to other settings or medical professionals can only be determined by further assessment or application of the model.

However, it does provide some new areas for consideration, and presents at least one option for conceptualizing empathy as a process in the medical setting.

An additional limitation common to qualitative research is the issue of participant selection. The majority of initial participants were identified through a list of top-scoring physicians within the hospital system at a local medical school. Later in the research process lists of top rated physicians in the community were utilized to identify participants in specialty areas, such as pediatrics and psychiatry, which were underrepresented in the sample. Participants themselves were asked to provide suggestions for additional individuals to interview, operating under the assumption that physicians who possessed some level of empathy would also be able to recognize this trait in others.

As a result, participants consisted mostly of professionals within the medical school/teaching hospital setting, although some participants in other settings were identified by their colleagues, which somewhat expanded the scope of the study. We used these selection procedures to identify participants from a variety of specialty areas while still remaining feasible in scope. It is unclear how participants of this study might compare to professionals in unexamined settings or communities. Therefore, though efforts were made to find a variety of perspectives, participants of this study may be significantly different from professionals in other settings, and any application of the model developed as a result of this study should take this limitation into account.

### **Conclusion**

Empathy can be an important tool to enhance the quality of treatment physicians provide to their patients. Previous research indicates empathy impacts treatment

outcomes as well as the quality of the physician/patient relationship. Though identified as an important construct, empathy has proven difficult to define and measure, resulting in inconsistent definitions and assessments. In this study we utilized qualitative methods to capture the nature of empathy through the experiences and perspectives of healthcare professionals. The resulting model is therefore both comprehensive and based on practical examples. Although we caution blind adaptation of this model without further testing or confirmation, we believe it can add substantially to current conceptualizations of empathy in the medical setting.

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**APPENDICES**

**APPENDIX A**

**DATA FROM PILOT STUDY**

### **Data from Pilot Study**

The following information was gathered informally during a quantitative pilot study on the impact of empathy training on medical student empathy. The primary researcher took notes during the discussion portions of the training, and the data is displayed below.

#### **Medical Student Definitions of a “Good” Doctor**

- Asks patients about home life, family, medical problems
- Reassuring to patients
- Ask patients about their expectations for the visit
- Honest and forthcoming
- Expresses humility and is able to deal with mistakes
- Accessible for patients
- Nice with a sense of humor
- Advocates for patients and lets them see referrals
- Straightforward delivery of bad news
- Expresses his/her “human” side (ex: crying with the patient)

#### **Medical Student Definitions of a “Bad” Doctor**

- Has preconceived notions about patients
- “Zips in” to the room
- Brutal honesty
- Follows a checklist and shows little concern for why the patient is there

- Does not understand the reality of the patient, or the barriers to treating the patient
- Blaming/critical of patients
- Use of medical terminology without speaking to patient in layman's terms
- Does not explain medical conditions or treatments correctly

#### **Additional Student Comments on Use of Empathy**

- “It takes longer to go from patient to doctor than doctor to patient.” The student who stated this clarified that a doctor can manage to understand a patient's frame of reference, but a patient has a much more difficult time entering into the mindset of the doctor. Therefore, doctors would need to find ways to understand the patient's reality.
- Use of empathy could make patients more comfortable and they would therefore expand their stories.
- There is a danger of patients being so comfortable that they “share too much” and take over.
- Patients would be more likely to come back if they feel understood.
- Physicians are more likely to discover the patient's actual concern through using empathy.
- Student realized that she had confused empathy with compassion

#### **Perceived Barriers to Use of Empathy in Medicine**

- Time limitations prevent many students and physicians from expanding beyond immediate concerns.

- Expressing empathy may be “awkward” because a student may not have had a similar experience (demonstrates a confusing of empathy and sympathy).
- Stating “I know how that feels” could come off as condescending.
- Some patients might “just want the facts” and be uninterested in empathy.
- Physicians don’t get paid by the hour and thus feel the need to get through larger numbers of patients.
- Physicians have obligations to other patients and can’t take too long with each one.
- It is a habit to “go in, get information, get out.”
- It is hard to show empathy to difficult patients (malingering, language difficulties, cultural issues) because they are “draining.”
- Patients forget that the “physician is a human” and has limits.
- Students are not shown empathy by patients or other doctors/residents.

**APPENDIX B**  
**HUMAN SUBJECT APPROVAL LETTER**



DARDEN COLLEGE OF EDUCATION  
 COLLEGE DEAN  
 NORFOLK, VIRGINIA 23529-0156  
 PHONE: (757) 683-7938  
 FAX: (757) 683-9883

December 21, 2010

Proposal Number 201001043

**Professor Neukrug:**

Your proposal submission titled, "**The Role of Empathy in Medicine: A Grounded Theory Study**" has been deemed EXEMPT from IRB review by the Human Subjects Review Committee of the Darden College of Education. If any changes occur, especially methodological, notify the Chair of the DCOE HSRC, and supply any required addenda requested of you by the Chair. You may begin your research.

We have approved your request to pursue this proposal indefinitely, provided no modifications occur. Also note that if you are funded externally for this project in the future, you will likely have to submit to the University IRB for their approval as well.

If you have not done so, **PRIOR TO THE START OF YOUR STUDY, you must send a signed and dated hardcopy of your exemption application submission to the address below.** Thank you.

Edwin Gómez, Ph.D.  
 Associate Professor  
 Human Subjects Review Committee, DCOE  
 Human Movement Studies Department  
 Old Dominion University  
 2021 Student Recreation Center  
 Norfolk, VA 23529-0196  
 757-683-6309 (ph)  
 757-683-4270 (fx)

**APPENDIX C**  
INFORMED CONSENT DOCUMENT



## Informed Consent Document

Project Title: *The Role of Empathy in Medicine: A Grounded Theory Study*

The purpose of this document is to provide you with information regarding the purpose of this research so that you can make an informed decision as to whether you agree to participate in this study. This document will also provide further information to those who choose to participate in this project. If you are interested in being a part of this research, the completion of this Informed Consent Document and the Research Participant Questionnaire will be your record of consent. This form may be kept for your records.

The responsible project investigator of this study is Ed Neukrug, EdD, NCC, a professor in the Department of Counseling and Human Services in the College of Education at Old Dominion University.

The aim of this study is to gain physician perspectives on the role of empathy in the medical setting. The researcher's intent is to present results that reflect the reality of the individuals who are interviewed, capturing their opinions and experiences and identifying common themes.

The collection of data and the analysis of collected data are projected to occur between January 2011 and July 2011. If you choose to participate, you will be asked to complete a Research Participant Questionnaire, which will take approximately 5-10 minutes to complete. This will be followed by an interview which will take approximately 45 minutes to 60 minutes to complete. All information will be collected during one session. The primary investigator will have no knowledge of your identity. Each participant will have a participant code so that no identifying information will be tied to any participant, either through the Research Participant Questionnaire or the interview.

Following the collection of data, the interviews will be transcribed by the primary researcher and the taped recordings will be destroyed following transcription. The transcriptions will contain no identifying data. The Research Participant Questionnaire does not ask for any identifying information. If you fear that any information provided will result in your identification please feel free to discuss it with the primary researcher or refrain from providing the information. Transcriptions will be stored on a password protected computer.

**Participation in this study is completely voluntary. You may choose to opt out of this study by informing the research assistant at any time if you do not want to**

**participate. You may decline at any point in the interview to answer a particular question.**

This project poses no foreseeable risks. All information obtained about you will be kept confidential unless law requires disclosure of information. This is not anticipated however. Any information gathered from the Research Participant Questionnaire and information will be identified only by the given participant code. The results from the data may be used in reports, presentations, and publications, but no identifying information will be used whatsoever.

As previously stated, your participation in this project should be completely voluntary. Do not participate if you do not want to, and please understand that if you choose to say NO to the project even after saying YES to participation previously, there will be no consequences for this decision to withdraw from the study. In the remote possibility of harm befalling you via this research project, neither the researchers nor Old Dominion University will be able to provide any money, insurance coverage, free medical care, or any other compensation whatsoever. In the event that you suffer harm from participation in this research study, please contact Dr. Ed Neukrug at 757-683-6497 or Mrs. Hannah Bayne at 757-646-7831, who will discuss your grievance with you.

By participating in the interview and by completing the Research Participant Questionnaire you have indicated that you have read this form and understood its contents. You are indicating you understand the research project and the risks and benefits associated with it. The research assistant, Hannah Bayne, should answer any inquiries regarding this study. If you have any questions at any point during or after this study, please contact the primary investigator at [eneukrug@odu.edu](mailto:eneukrug@odu.edu).

Hannah Bayne, M.Ed., NCC  
Doctoral Student, Old Dominion University  
Department of Counseling and Human Services  
[hbayne@odu.edu](mailto:hbayne@odu.edu)

**APPENDIX D**  
INTRODUCTION LETTER

Sample Participation Request:

Dear Dr. \_\_\_\_\_,

I am a doctoral student at Old Dominion University in the department of Counseling and Human Services and am conducting my dissertation research on empathy and its role in medicine. You have been identified by patient satisfaction ratings as someone who values patient-centered care and who may be able to provide some insight into the role of empathy in medicine. If you are interested, I would love the chance to discuss the topic with you.

I know that you likely have many demands for your time. The interview would ideally last approximately 45-60 minutes, though I can work with your schedule. I will also be more than happy to meet wherever is most convenient for you. I am available most Monday mornings, Thursdays, or Fridays before 4:00 pm. To participate you do not need to have any formal knowledge or research experience on the topic of empathy. I merely want to hear your thoughts from your own experience.

Please let me know if you are interested in participating and, if so, what might work best with your schedule. I appreciate your time and consideration.

Sincerely,

Hannah Bayne, M.Ed., NCC  
Doctoral Candidate  
Old Dominion University

Note: This research has been approved as exempt by the Old Dominion University IRB. Any information provided will be confidential and used only for the purposes of this study. Please see the attached informed consent document for more information.

**APPENDIX E**  
DEMOGRAPHIC INVENTORY

ID Number (to be completed by researcher): \_\_\_\_\_

Date: \_\_\_\_\_

**PARTICIPANT DEMOGRAPHIC SHEET**

Age: \_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_

Years in practice: \_\_\_\_\_

Specialty area: \_\_\_\_\_

Average office visit time: \_\_\_\_\_

Average number of patients seen each day: \_\_\_\_\_

Practice setting (academic hospital, private hospital, community hospital, clinic, etc.):

\_\_\_\_\_

Please briefly describe your typical patient population (race, age, income, average visits, etc.):

May I contact you for follow up? Circle one:      Yes      No

How do you want to be contacted? : Phone, Email, Other (Please specify)

Phone number: \_\_\_\_\_ Email: \_\_\_\_\_

Please provide any additional information you would like for me to know about you.

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Thank You!

**APPENDIX F**  
INTERVIEW PROTOCOL

## Individual Interview Protocol

1. Could you describe your practice? What is a typical day like?
2. Can you give me a sense of the types of patients you typically see?
3. What are usually your goals when you sit down with a patient?
4. What do you feel are the components of “good practice” in medicine?
5. What do you think patients expect from their doctors? (What kind of relationship do you want with your patients?)
6. How, if at all, do you facilitate a relationship with your patients?
7. What do you do, if anything, to understand your patient’s frame of reference?  
(Is this important?)
8. When you hear the term “empathy,” what comes to mind?
9. How would you define empathy as it relates to medicine?
10. How much do you think empathy contributes to your success with your patients?
11. When is empathy not involved in your work with patients?
12. What barriers exist in using empathy in medicine?
13. How, if at all, did you learn to be empathic in medicine?
14. How, if at all, do you think medical students should learn about empathy?
15. Is there anything else you would like to add?



## Revised Individual Interview Protocol

### Individual Interview Protocol

16. Could you describe your practice? What is a typical day like?
17. Can you give me a sense of the types of patients you typically see?
18. What are usually your goals when you sit down with a patient?
19. What do you feel are the components of “good practice” in medicine?
20. What do you think patients expect from their doctors? (What kind of relationship do you want with your patients?)
21. How, if at all, do you facilitate a relationship with your patients?
22. What do you do, if anything, to understand your patient’s frame of reference?  
(Is this important?)
23. When you hear the term “empathy,” what comes to mind?
24. How would you define empathy as it relates to medicine?
25. How much do you think empathy contributes to your success with your patients?
26. When is empathy not involved in your work with patients?
27. What barriers exist in using empathy in medicine?
28. How, if at all, did you learn to be empathic in medicine?
29. How, if at all, do you think medical students should learn about empathy?
30. Is there anything else you would like to add?

Additional questions:

1. What, in your opinion, is the difference between empathy and just good “customer service”?
2. How do you decide how much of a relationship you want to have with a patient?
3. Are there certain types of patients you feel need more empathy than others?
4. How, if at all, are YOU impacted by using empathy with your patients?

**APPENDIX G**

**FINAL CODEBOOK – SELECTED QUOTES**

### Nature of Empathy

Theme	Keyword	Supporting Quotes
Defining Empathy	Understanding	<p>But, um, there's a technical definition that John Coulahan uses, and "empathy is understanding exactly ." (P01, 188)</p> <p>Being able to relate to the patient P06, 313</p> <p>To, um...the relationship part includes, and the connection part includes empathy, understanding . Um, and so to provide empathic responses. (p01, 34)</p> <p>And, so until you can get into the patient's perspective about symptom, you really can't understand it . P02, 27</p> <p>So yeah, empathy is kind of understanding P08, 235</p> <p>I think comes into empathy in terms of understanding...try to understand what the patient might be going through P08, 262</p> <p>So, it's understanding, kindof, what they're going through . Um ... And trying to see if you can somehow make that better. And if you can't, it's just to understand that . P10, 300</p> <p>I think of somebody who can understand what the other person is experiencing , even if they don't have first-hand knowledge of it; they can understand and feel P03, 93</p> <p>I've never lost a baby, but I've listened to enough parents over the years to almost feel like I understand what they're feeling P11, 314</p>
	Sensing Meaning or Feeling	<p>But I can sense it without having gone through it, sortof thing . So .... I guess drawing upon an experience and, you know, listening to the person and understanding what it is they're P03, 97</p> <p>And knowing when somebody is not going to do well or is not doing well. Those things that you just kindof sense . I call it, 'ESPN P03, 202</p> <p>But empathy would be you recognize the feeling, buy you may not share the exact feeling . You know what I'm saying? P17, 78</p> <p>Empathy is being able to have a feeling for how patients are feeling, or how family is feeling, about the situation, and being able to recognize that . P21, 122</p>
	Caring	<p>if you could do some survey about 'Do you care about people?' ... and I think there would be a direct correlation between caring and empathy . P02, 70</p> <p>Um, I guess just caring and , I mean that's probably the main thing I think about, but also, um, being human P06, 312</p> <p>So, but I think caring is a huge thing. Just...stepping down a level and just talking one on one, with somebody, with the patient.P06316</p> <p>I guess, you know, the number one most important thing I can think of is caring . Um ... (inaudible) a physician or a physician extender who cares. That's ... To me, that's the most important thing: You have to care because if you don't care, than nothing else really falls into place. P07, 15-17</p> <p>But, I think if you care, you tend to be more competent because you go the extra mile, you know, do whatever research you need to do to help the patient out . Whereas if you don't care and you don't know, then you don't seem to put forth any extra effort. P07, 19-21</p> <p>: Empathy. Um, ....caring, compassionate P08, 218</p>

- . You don't have to hurt like they do, you just have to be able to make them feel, you know, give them something that will make them feel like you care . P11, 408
- Well when I think of empathy I think of a genuine caring for the other individual, as well as a caring about their outcome, their health outcomes P12, 155
- Cause you know people that genuinely care about another individual, they're gonna develop relationships P12, 216
- I hope they understand that I am truly concerned about what's going on with them medically P15, 77
- I think it's just the ability to put yourself in that person's shoes. Or imagine yourself in that position . Um ... I guess the ability to relate to somebody's pain and suffering, or whatever challenge their facing. So, can you truly imagine being in that position and feeling for them? P07, 106-109
- that you can still do that even if you haven't experienced whatever particular problems they're having: The ability to put yourself in their shoes, you know P07, 123-124
- Um ... And I haven't been in that position, but I guess just, when you see people, and you realize how fortunate you are . It kind of makes you a little more able to empathize with them, I guess? P07, 130-131
- and so I walk into a room and I already have, a lot of times, a patient who is rebellious, who hasn't taken care of her diabetes for years, who in fact hates the fact that she has diabetes, hates everyone around her who tells her she has to control her diabetes, wants to be able to have a normal pregnancy like all her girlfriends , and I set it right out on the table, "let's get everything straight, we both agree diabetes sucks. And we can't make it go away. I am acknowledging that what you have sucks ." P09, 173
- And your job, I think, as an empathetic physician, is to figure out what is going to help you break down that barrier so that you can communicate P09, 220
- And I... it's a little easier for me to put myself in their shoes and say if this happened to me this is how I would feel P11, 315
- So, then putting myself in the place of the patient P14, 6
- You know, and so that's where I think that empathy comes in, is being able to throw it back in a patient's court and say, "you know, this isn't my decision to make." P09, 154
- . I may not agree with how ridiculous they're being about something that's not that big of a deal, but obviously it's important to them. So, I think that is always paying attention to their perspective of things, even if I can't relate to it at all. P13, 103
- Empathy is different. With empathy, I don't consider myself emotionally attached, P17, 56
- Or I guess I could experience it personally, but I won't be emotionally drained . Let's say a new diagnosis comes. I don't be as emotionally drained as you could be because it's your diagnosis, but I can at least empathize because I know that that's the thing that you have. That's empathy. But sympathy would be like, 'Oh man, I feel so bad for you that you have that.' P17, 62
- Um ... I certainly try to do that. I wonder how successful I am sometimes because, quite frankly, a lot of my patients' circumstances are vastly different than anything I've had to deal with . P20, 196

Imagining  
Patient's  
Experience

Acknowledging  
separation of  
self and patient

Relating from  
Personal  
Experience

Um ... I think people who have had experiences where they have actually ... You know, I guess, uh ... For me, if I see somebody who has a herniated disk or low back pain. Well, I had that when I was an intern. And it was miserable, you know? And so, you know, I know what they feel like . I get migraine headaches, so if someone says they have a migraine, ‘Ah, gosh, I know ...’ So, it tends to make you, uh, more determined, I think, to help them to the best of their ability. Um ... Or, gives you better insight into, ‘What can I possibly do to help you out in this situation?’ P07, 111-117

I try not to say “I know what you’re going through” cause that’s the easiest thing to say, P08, 263

and uh also your own personal experience may allow you to have a certain level of empathy for certain things . P08, 467

Don’t you think they would make wonderful doctors when you’re trying to work with a patient who is so frustrated they they’re not getting pregnant, when they’ve been through it ? Yes, of course they will. They have a different understanding. It’s hard to know what someone is going through. P09, 568

like “you know I totally know where you’re coming from, I know. I feel it in my bones. You know, let’s get that out of the way, I get it. Alright let’s move forward .” So most people who are good empathetic doctors who can communicate with their patients, they have a story to tell and they have roots that brought them, ties, something that brought them to be where they’re at and to help them be the doctors that they are P09, 573

Empathy as  
Difficult/  
Draining

Um ... I wish I were hard-hearted at times. Life would be easier ! (laughs) But I’m not, you know P07, 136

But it’s tough, it’s not an easy job. You know? And I think the more you invest in being able to communicate with patients, the harder you make your job. P09, 231

And that is the hardest part. The rest is easy. Going to medical school, learning the facts you need to learn, piece of cake. It’s the other stuff that is the, uh, the hard part P09, 238

Hmm...it’s more exhausting. It’s easier to go through life without letting your emotions get in the way. Very easy to just exist . It’s much more exhausting to put yourself in their place to start thinking about “how would I feel if I had this?” P09, 439

Uh ... And that’s not easy—it takes a relationship. And, relationships are emotionally draining, by definition P10, 302

... Just because it’s emotionally difficult to have a relationship with the patients doesn’t mean it’s not worth while P10, 313

And um, you know, you give a lot of yourself and a lot of your heart sometimes, and the more you give the more it hurts you, the more things don’t work out right, or when a relationship doesn’t work out right P05, 12

Empathy can sometimes get a little bit out of control. You know, if you’re...if you’re someone who is altruistic, like I was coming out, if you sometimes really took it to heart, if you had someone who was really hurting bad, you were hurting as bad as they were, and sometimes it took you away from the business at hand, you know you took your work home with you very often, and I know I did for the first couple of years, until you really know how to control it. P18, 141

And your heart goes out to them. I use that expression purposefully because I think it's really a part of yourself that you're extending to them, and you're giving them something : You're giving them your trust. You're giving them your energy . You know, there's only so much energy that every person has. And I think the process of empathizing takes energy P20, 364

Different from Sympathy

It's not ... Sympathy is feeling for them . But this is just kindof feeling with them. P10, 299

I had this coloring book, and it had these three... it was about three kittens, the three little kittens, but they were all, they were doing different things throughout the book, and there was one picture I never colored. It was the three of them at an ice cream parlor and one had fallen and dropped his icecream cone. And I would try to feed that kitten beans and smashed up (inaudible) and stuff because I felt so sorry for him, you know? But that's sympathy, not empathy . But you know, P16, 261

You know empathy and sympathy were terms that going through medical school were really confusing for me . Uh ... I just felt like the way it was taught, or the way I was learning it at the time ... The way I categorized it initially was that sympathy is you feel more sorry for the person . And then, now that that's behind me and I've had some experience, the way I define the two and the way I focus on empathy more then sympathy ... To me, empathy would be ... Let's say you're the patient and I'm the physician: both of us would share the same feeling. So let's say you had someone who died in your family, and then you would be sad. I would be sad, either for you being sad or sad because someone died in your family. That's sympathy—you sympathize with someone. P17, 48

Empathy not an emotional connection

It's hard to define. But I just feel like empathy is the reflection of the feeling you have whereas sympathy is a shared connection, rather than just a reflection P17, 78

That would be more empathy whereas sympathy is more an emotional form of communication . For example—this is an extreme. If you're crying, and I'm crying—I can cry to your cry—that's sympathy, I think. Empathy: I can say, 'I see you're crying. You seem sad. I can see that you're sad.' That's more empathy to me. Sympathy would be you cry, then I cry because I'm sad about what you're sad about. P17, 90

Patient's Response to Empathy

Reaction

Verbal

And I know I've been able to accomplish that when the patient says "right, that's it. That's just how I feel ." P01, 191

Usually if I do it right, that's the answer I get. Because then the person says, 'Yes, and that's what I'm afraid of, and it's because I have to support my family, and I don't have money for dialysis" P17, 119

Body Language

And again I think it's a body language, and so what happens to people's faces, you know, there can be a softening, an opening up . You know, their eyes can go like this. It's uh, and usually the smile is, is part of it, unless a person is severely depressed. So that, "yeah, you're right ." (P01, 200)

I'm fluent in Spanish and you can see a patient's eyes just light up when I'm prepared to discuss what's going on with their baby in Spanish. And it has nothing to do...because the doctor can do that, not through a translator, where you lose a whole bunch of communication that happens just from mannerisms, it happens with eye contact, it happens with immediate reaction to what you say from a patient. P09, 269

Ok, in this patient-centered interviewing, what I'm talking about, that active listening, open ended questions and active listening, it's ... empathy encourages an activated patient . And that's the best we can do. If you have a ... a consistently nonjudgmental physician, who's oriented towards patient-centered medicine, and you have a patient that's activated, they are interested in their health, they're informed, they're willing to contribute, and they feel power in the relationship, that's the best we can do. P01, 212

You see very quickly how ... And they get involved, and they ask questions , and they get a pen and they draw on it, as well. P04, 36

Yeah, so you can tell when you're relating to someone, you know ? When you're getting them to open up, you're ... um, like I said they're laughing, or maybe getting to the point where they're crying because they're so sad , that's when you can tell that, um, you've reached that level. P06, 359

You know, as humans there are different ways that we erect ... that's an interesting way to look at that, we erect barriers all the time to avoid being hurt , and in empathic relationships we feel like it's safe , so we ... yeah, I like that. P01, 252

If you have a ... a consistently nonjudgmental physician, who's oriented towards patient-centered medicine, and you have a patient that's activated, they are interested in their health, they're informed, they're willing to contribute, and they feel power in the relationship, that's the best we can do . You know, that's the best cost effectiveness , I mean that's, that's what we strive for . Um, so, that part of the active listening phase, I develop the relationship and I'm more likely to get to gold (P01, 214)

But if, if I don't respond to it, then that's an error on my part . It's an empathic error on my part. You know, "I just don't know if I could take it anymore." "Well, have you been taking your medicines?" That's an empathic error and that's a cut off. It doesn't allow this ... to further the relationship (P01, 229)

And a lot of physicians tend to want to make decisions for patients, tend to want to tell you what to do. Guess what? That patient reacts. Just like any teenager whose parents tell them what to do , P09, 155

And I think that we need to be realistic when working with patients, we need to, you know, their expectations...our expectations need to be realistic, and if they are you're gonna go far in terms of that communication . And if they're not, the barrier goes right back up. And that empathy thing is gonna come down, because (inaudible). Because they know the next time they come you're just going to yell at them P09, 354

It's not getting their ... It's not delaying their fears, so at that point things start to break down because the patient says, 'Well, he doesn't really care about me anyway, why am I even coming here ?' P10, 220

Activated/  
Involved

Lack of  
Empathy as a  
Cut-Off



Positive Perception of the Visit	<p>Um, I have seen people who have had that hospital experience, they'll come to me because they don't know what to do. They leave the hospital and they feel empty. And with no purpose. They planned for all these months to be a mom and even if they have other children, you can't tell somebody, "well you can just get another one." That doesn't work, even though many people tell them that . P11, 131</p> <p>Absolutely, because if somebody else walks in and says, 'You're not controlling your blood sugar,' they take that as an affront. So, you really have to know your patients well and develop a relationship with them . P13, 95</p> <p>. And I think if you care about people, the whole visit is easier—no matter what the time is—and it makes the time ... the patients seem like the time is adequate if you transmit this: 'I care what happens to you; I really do .' Even if it's a ten minute visit, it's a good ten minutes P02, 366</p>
Feeling Understood	<p>Again, when they see that you accommodate without compromising care to their needs, they value that tremendously ... Tremendously. Um ... Patients feel very secure when you draw things to them P04, 26</p> <p>but what it turned out is all the patients that we asked, they don't care how long they wait as long as when they get in the physician will give them enough time . P06, 532</p> <p>I think the way a patient will describe their doctor as a good doctor is often weighed very very heavily on how a patient interacts with that person, and has nothing to do with their knowledge, their training, their level of experience, um. It's, it's fascinating to me, because I'll have patients tell me, you know, "oh that person is a phenomenal doctor." And I'm thinking to myself "I wouldn't let them touch my dog ." P09, 80</p> <p>But the patient has no clue about that, and what they see is an empathetic doctor who listens to them, who is willing to give them the time that they need, and from their perspective that's a good doctor P09, 87</p> <p>At least 90% of the patients fall in your lap, and they're judging you with your peers based on your ability to interact, your ability to talk to them, and how much time you spend with them, and what do you blow off their complaints, um, or you acknowledge their complaints and say, you know, that's a normal complaint, that's normal for pregnancy, I recognize it's bothering you. You know, the way you approach something is very important, they hear that. P09, 95</p> <p>Right off the bat, just telling them that, that you acknowledge, that you recognize that what you're asking them to do, pricking their finger 7 times a day, eating a regular diet, you know, keeping track of everything they put in their mouth, their blood sugar, is huge . Acknowledging that you're asking them to really overcome a huge barrier already is half the battle, because the patient can already put down her, "ok, my doctor understands, she may not have diabetes herself, but at least she gets it ." P09, 178</p>
Impact on Treatment	<p>Because it's, it's a long term process, and I think people really change their attitude towards their disease, um, when you acknowledge that what they have really isn't a fun thing to have . P09, 208</p> <p>Dedication to Treatment / Physician</p> <p>It's interesting: They want to succeed not only for themselves, but if they have a good relationship with you, they want you to be proud of them .P04, 93</p>

It's not just the successes because I have many patients who were not able to succeed, and still they want to come for their annual exam . When I told you I have [some] who are 79 years-old, they are coming only for their annual exams. And their daughters were my patients and are bringing their mothers. So, I still do a lot of regular gyn that is not at all related to infertility. I have patients that I had to remove the uterus and they could never get pregnant and they still come back for their annual exams. So, yes, the successes probably give it the biggest push to keep going, but in a way it's the relationship that you build up . P04, 178

And you see the difference. If they do not like the doctor, they leave the clinic . If they like the doctor, they contact you and say, 'I'm having a hard time paying this. Can you help me?' The same thing if there are things they feel are not working well. The front desk, the nurse, she's, you know, bringing them late to the room, or whatever ... If they like you, they let you know because they want you to improve . P04, 290

And then I think they really respect him, I think that's a key to coming back . P06, 87

with these patients coming back for the next visit is huge , cause I think a lot of ...compliance is a big issue. A lot of patients will decide they don't want to come in. They don't want to take their medications . One guy the other day said, you know, "people are very ignorant these days, and it's people like you that makes me want to come in for my next visit ." I swear, like "people like you that makes me want to come in for my next visit, to take my medications ," and things like that. P06, 187

Confiding/  
Providing More  
Information

Um, when they're laughing, when they're talking about stuff where it's almost personal, not uncomfortable, just personal where you feel like they are telling you things because they are confiding in you P06, 328  
When they really start to open up and talk about things beyond the medical realm , is when you can start to tell that you're being empathic P06, 332

Um, you know, so I think you first have to earn their confidence. That's the most important thing. And that's just a lot of hard work P07, 63-65

Recognizing  
Genuine vs.  
Fake Empathy

If you remain totally 'Just doing your job,' then they immediately know—they immediately know P04, 145

I honestly do not know if you can teach empathy to patients because they will know immediately if you are faking it—if it is something forced. You can start an interview with open-ended questions and end up with nothing—just a list of answers . And you never developed a relationship P04, 193

And it's natural , it's not ...you can tell when people are trying, you know what I mean ? I'm sure you know. Or you can tell when physicians are trying too hard to either be cool or to be, um, relatable with patients P06, 102

: You get a sense, I'm sure you know, you get a sense of whether it's sincere . You know? P06, 352

if you ask questions about patients that's a huge step, but like I said, you can see when a physician is asking it because they care about it, of if they're asking it just to, you know, say that they've been empathetic . P06, 367

I knew how much they cared about people, because all they had to do was start opening their mouth and talk, and I knew where their interests lay P05, 149

Now, the others care and love the patients, and the patients love them cause they know ...they're just like us. They walk in a room and look around, they know who cares about them and who doesn't. P05, 495  
They know if you care or not, the patient can tell right away if you're just talking . And um, we've all seen physicians who you know, you know right away that they don't give a hoot P09, 423

Skills of Empathy	<p>And um, one ... the way to get there is to continue to reflect back what the patient has said. You know, was it ... and then, you can even get closer, "was it this or this?" and then when the patient says "that's it !" (P01, 194)</p>
	<p>Um and there are models of empathic responses. You know, the simple ones are just reflection . "Do you feel tired?" Um, the patient says "I feel tired," "do you feel tired?" Um, and if I pause ... and this is just how we're brought up, people respond and elaborate more (P01, 220)</p> <p>Empathy you can start out pretty much by repeating and showing that you understand P17, 88</p>
Knowing What to Say	<p>You need to be able to read the situation and figure out how it is that you're going to be able to share that knowledge with your patient. Um and if you can't then you're gonna be perceived as a bad doctor P09, 299</p> <p>Can't tell you the number of people who have been, you know, turned off by a physician, who I see later, who are perfectly great doctors. I mean, excellent clinicians, but they chose the wrong words to use P09, 301</p>
	<p>But everything comes from that, and the problem is, you take that patient who has a whole different perspective on a whole different number of things, and then you have to try and, again, how do you manage the message for the patient P10, 432</p> <p>You need to be able to read the situation and figure out how it is that you're going to be able to share that knowledge with your patient. Um and if you can't then you're gonna be perceived as a bad doctor P09, 299</p>
Acknowledging Emotions	<p>I can, um....empathy, the importance of acknowledge, you know, emotions. So, you talk about identifying an emotional cue. An emotional cue, Forest Lange has written about this, emotional cue might be an expression of emotion, "I feel sad, I feel angry." What do I feel? "I feel discouraged," and so forth. Well, its important for me to acknowledge that (P01, 223)</p> <p>Let them know that you're hearing what they're saying, and confirm: Be affirmative of their feelings, their actions, their worries, their concerns—even if they're absolutely ridiculous P13, 71</p>
	<p>So I say that. I say, 'I know that you may be worried you need dialysis in the future, or maybe you need a kidney transplant ...' so I try to tell them, from what I've seen—what people usually in that situation are scared of. So I tell them, you know, I listen to their story and then I tell them, 'Is this what it is ?' That's how I use empathy P17, 100</p>

Asking Non-  
Medical  
Questions

Putting it out in the open that I know they have worries about maybe starting dialysis. A lot of times they have family members on dialysis, and these things run in families, and their doctor says, 'You know, I need you to see the kidney doctor. You may need dialysis.' And then they come in all anxious and worried, and I know, obviously, that they big elephant in the room is, 'Do I need dialysis?' So I acknowledge that: 'Yes, that is a concern. And I understand that is a concern.' Because I don't want them to come in here and think, okay, I'm seeing them, blah, blah, blah, and I'm going to do labs, and leave. I want them to know that I know what they're afraid of, P17, 106

The same way when I'm a physician, if I'm just, if I'm focused on a model or something like that and I can't relate to the patient, um, then I just might ... you know, I go from asking them why they're here today to, and then asking what illnesses run in your family, and then the patient doesn't know why I've done that, and it's confusing and so forth . You know, but if I say, I summarize and say it sounds like you've had this, this, and this, and it's been bothering you, this is what you're concerned about, have I got it right? Let me just ask you some questions about your family so I can understand this better. You know, I've enhanced the empathy by doing that P01, 298

Yeah, um, it seems that for the most part all the patients I've seen him interact with, that they have, even from the start, like when we walk into the room he'll usually spend like 5 to 10 minutes saying "how's your family doing?" or "how's your house, what happened to your car?"

And he'll joke around with them as if they're friends . P06, 76

And usually he starts off by getting into that part, like I've said. He'll walk in and bring up the stuff that they've been talking about, like the social stuff . "How've you been doing, how's your wife, or how's your girlfriend?" things like that. Then when that's all taken care of that's when he'll address the main issues P06, 160

there's a time and there's not a time to get into that aspect, but with these patients it's essential to talk about some of the other stuff that's bothering them P06, 173

And so when I, I do the history, I elicit the history from the patient , I'm not only finding what biologic parameters have occurred, what the nuts and bolts are, but also I'm finding out how they perceive it. And what their, you know, their support is in their environment. What their perspective is . All of those things have a lot to do with the outcome. (P01, 89)

Body Language

And I came into the room and it was kindof dark in the room, and there was this little light. And he was right at the patient's bedside, like this. Right, eye-to-eye, bent over, you know, this positive body language, you know, right with the patient. And I was kindof behind him, and I thought, 'Boy, you know, that's the way it ought to be done P02, 139

' So, it is very difficult. We ... Many times you see it in their faces that things are not working well. And they are scared to tell you . Some of them have had depression in the past, and it's very important to look at them ... Very quickly their faces will change . P04, 79

But, I believe very strongly in body language, nonverbal communication. They don't look them in the eye. They don't give them a hug. They don't just pat their hand or do something, touch them in some way P11, 185

So I'm very aware of body language, and I have arranged my office where I'm talking with them in such a way that there's not very many barriers between us. So I'm at my desk because I have to, you know, put stuff into the computer for the electronic record, but I have them sitting on the side of the desk so that I can, I can touch them if need be, so that our space is controlled. So I make sure that I am close to them. Now I'm kind of a touchy person (laughs) so you know, if they were angst I could, you know, lay on of hands P12, 109

Spending the time to sit there and make eye contact with them . P14, 70 , it's all about communication. Body language. The non-verbal types of cues that people give P21, 128

Open-Ended  
Questions/  
Letting the  
Patient Talk

You have to, um, ask open-ended questions and let them say what they're going to say. Don't cut them off P02, 213

Open-ended questions . 'How can I help you?' That's the way I start my interviews P04, 18

It's a lot of stuff we have to learn, but it really does work, you know, the open ended question, rather than saying "what would you like to talk about?" You know "tell me more about a,b,and c." So let the patient tell the story as much as possible P08, 103

The verbal—what they tell you. How does that make you feel? You have no choice but to know what they're feeling because they tell you. We don't try to be subtle; we want to know where they are with everything . P21, 129

Art vs. Science

Otherwise, it's just a ... It's not an art, anymore: it's a job P03, 189

Oh, I always think of it as an art, actually. I think it is art. P03

Yeah. You are treating the medical condition, but you are treating the person with the medical condition P04, 123

. In a way, it's like an art more than a science . P04, 202

Again, the technique can be taught. But how you apply it, I think, is part technique and part art . P04, 241

I mean that's where some of the things, some of the art of medicine comes in, you know . You just go down a checklist, that may close them down, you know? At least we learned kinda the first thing a patient tells you and sometimes towards the end, you know when they're finding just enough courage to say "ok, I think I am going to tell my doctor about my sexual dysfunction," or whatever it is . So you know, listen, and if you're not clear, just come out and be direct. P08, 75

The art of medicine is where the empathy comes in, I think . P09, 235

And you know the ones you have to have really strict, um, guidelines with , and that's part of the art of medicine, and that comes along with just knowing when you have to be more paternalist versus more, uh, collaborative in the care that you're giving. P10, 332

Like, Ok...what comes up in a relationship between a doctor and a patient? Ok, there's the objective scientific credential space...uhh...everything to do with the delivery of medical care...: And then there's the friendliness, the um...attractiveness of people to each other, because we all have natural magnetism or repulsion. P05, 22

"the art of medicine consist of amusing the patient while nature takes its course ." P19, 36

Trying to  
Understand  
Behavior /  
Constraints on  
Patients

Most of the time I tolerate it because most of the time there is a circumstance that precipitates that behavior P03, 264

' And I said, you know what, 'Don't worry. I'm just going to ignore you,' because this is a really difficult time, and I understand that, so don't worry about it P03, 275

Underneath everybody is the same . People have bad things going on in their life . I learned a lot of this as I went along P03, 382

You realize very quickly that they are scared of failure, and that they are coming up with excuses. P04, 89

. So, it's a financial burden. It's an emotional burden. It's a time constraint. It's demands from work. P04, 103

Again, you can dictate treatment for that particular medical problem, but if the person cannot comply with that particular treatment, you are not being empathic . I can prescribe a very expensive treatment for infertility, but if she doesn't have the means, you aren't being empathic, you're, in a way, slapping the person's face with something you know she cannot afford P04, 114

Yeah. Because I always think, you know there are reasons for being that way, they are angry at the world. Maybe their husband is abusing them or something . That's not my problem...bottom line is I need to get through to this patient P09, 325

Listening

Um ... Listening . Some do not want to talk and you have to help them start to talk. Some are so scared . Others need to talk, and they want to see that you listen, so just looking at them and providing, you know, feedback—you know, cues —that you are there listening to them P04, 20

Um, I think with the other...you want to be able to talk to a doctor that's listening , you know what I mean? I think the other times when it's just some guy that's memorized questions that he just wants to ask, that's reviewing lab work, um, you don't feel comfortable to tell them everything that's on your mind P06, 192

Being able to be a good listener to the patient , is part of being a good physician P09, 32

Part of talking to somebody is actually learning how to listen, because patients actually want to talk to you . They don't want to be talked to, half the time they want to just be able to vent, they want to be able to talk. And usually the physicians that have that communication barrier are the ones that want to talk, do the talking P09, 505

but so you've got to make sure you listen every time, make sure there's nothing subtle that we don't want to miss P08, 193

I know I keep saying this, but—listening to them P13, 69

You have to care, because if you don't care you don't listen. And if you don't listen you don't know. You know, you have to listen to the patient who is trying to tell you the diagnosis. P16, 172

And the more I thought about that when I came out, I remember like a lot of the guys that were going to the Harvards and the Standfords and what they were doing was, every time somebody was sick if we were dealing with them together as a group, the first thing was "I'll order this test, that test," it was all about tests. They didn't listen to the patient P18, 372

Assessing  
Patient

And I can walk into a room and I can see the patients there for facelifts, and for example, or breast surgery, or tummy tucks, and I look at them, I see their accessories, I see their clothes, I see their make-up, I see their (inaudible), I look at the way...listen to their articulation, I see what's on their fingers. You can characterize an individual just like a fortune teller. P05, 324

Because the computer's got it down right. Brains are faster than computers, well no, particularly with graphics and visualization because you can run through a whole movie in your mind in almost two seconds, but what I...to me it's kind of like "chic a chic a chic a chic a" (computing sound) and there's a screen that just dissolves into this picture and you know where it is. It's like it does ...it's almost instantly. P05, 339

and I watch their body language to see how they're sitting, if they're leaning forward, if they're connected, if they're stressed, if they're having any body language that's kind of talking to me as far as their, uh, activity P12, 121

Yeah, you know, you can tell based on body posture. And, uh ... You know, just their shift—you know that shift when you're talking?—you can sense that they're either happy with the way that things are going or they're anxious about something . And then you can tailor your interview accordingly . P17, 37

Yeah, I'm pretty good at detecting what's going on, even to the thing of they're done with me and this is not working. P19, 297

### Empathy and Treatment

Theme	Keyword	Description	Supporting Quotes
Using Empathy as Part of Treatment	Empathy as Core to Medicine		<p>It's tough, it's really tough, and if you don't get cross that line and connect with your patients, my feeling is you picked the wrong profession . You should have gone into something else, you know? Be an architect or something, you know what I mean? (laughs) No you know what I mean? I mean do something that doesn't involve human nature, because I think that's part of what makes medicine the cool profession that it is. P09, 453</p> <p>It's like "oh, I could never do that." Ok. Well that's what we all signed up for, you know? P09, 471</p> <p>And there are studies that show quality of care drops when the empathy drops . Because, again, at that point you start to not meet the needs of the patient. P10, 215</p> <p>I mean, the reality is I can see a hundred patients a day, probably, if it was just a matter of diagnosing and throwing a prescription at them. I mean, that's simple—that's nothing. But it would also be a relatively meaningless, in my mind, way of being a doctor because the relationship is so important. P10, 435</p> <p>... I think you have to make an emotional connection before anything else will register P10, 447</p>

So I think those two things (respect, value), if you kind of keep that on your radar and go with that in mind, then that sort of takes care of a lot of things, and lets you focus on the medical knowledge and clinical skills ...P15, 236

Just that I think it's very important, and I think it's a very important concept and skill in people—not only in health care but in everywhere P15, 394

Um, empathy is...if you don't care about the individual that you're having to...that you're administering care, if you don't care about what is happening to them, then I don't see how you can be effective P16, 169

Um, I think it's the major ingredient P19, 277

Sympathy as  
Detracting  
from  
Care/Distrac  
ting

If someone comes to me, I don't think I can do as good a job if all I provide is sympathy because if you provide sympathy, you may overlook things that are medically important because you're so involved in a sympathetic way. P17, 75

... I feel like if you are emotionally attached to a person, you may overlook some of the risks that come with treatment because you want the person ... There is a therapy ... Let's say this is the thing. Let's say I really like this person. That's why you shouldn't take care of your spouse. You want to do everything for them. And if you have a lot of sympathy for them, in my mind, it may ... If you have emotions that you've invested—even if they're in the right place—they may cloud your judgment as far as the risks and benefits of treatments P17, 219

Then if I turn around and evaluate the donor—because of my sympathy with you—the donor may not be a good candidate for a kidney—maybe right in the gray zone, like if they have diabetes or high blood pressure, or kidney problems themselves—if I have empathy with you, I can still make a clear judgment. If I have sympathy with you, I'm like, 'Yeah, but she's so nice, let's get her the kidney.' You know? And I think that's where it clouds the judgment P17, 232

I, I started realizing putting myself in the position like her husband, and what he was going through and feeling, and I found myself going home everyday almost in tears, thinking about if that were my wife, how would I feel? And I remember it was almost distracting to the point I almost couldn't function. You know I would go back and look at my baby who was in the crib and my wife and the amount of pain that I felt, as a husband P18, 162

: It just makes it much harder to come up with tougher decisions and everything . You're more part of the family and everything.P19, 174

Identifying  
the Problem

I think it's the ability to ... The ability to recognize the problems the person is having ... It is not the medical problem. The medical problem you know and you diagnose it . P04, 112



Errors in  
Empathy/  
Malpractice

to identify their reasons they...about which they're concerned . Their presenting problem. (P01, 31)

Um, to, probably the first one is to connect with them , to develop the relationship and to identify their concerns (P01, 32)

Well, expectation, sometimes it's that they answer the question, answer the concern. You know some of that is, gee, what is... why am I having this rash P08, 45

Well I mean that's how you'll be able to gather the most information I think. P06, 319

Um, to prioritize the ones that are most important to them today, to triage the ones we can address later (P01, 33)

“well, for a surgeon I want someone who's technically good, they don't need to be touchy-feely . Well, no, they don't need to be touchy-feely, but they can also make empathic errors um, that uh, increases their risk for suit, for medical suit, malpractice suit, reduces their risk for the patient not returning, and so and so . P01, 243

But, then if there are problems—if there are complications—the one that had the better relationship with the patient will have the better outcome than the one that was maybe technically perfect P04, 227

And if you're fortunate and have a good relationship you knock-on-wood don't get sued P08, 204

If they felt that the physician cared, there would be no suit. Because the physician would sit down with them and go over the autopsy results, or say, you know, “we've done everything and we can't find why, but we're gonna watch you extra close next time, we'll make sure we do every test possible.” And, rather than “well, you know, this pregnancy was probably doomed from the beginning because you needed to do this, this and this. So come back in later we'll try it again. Next time you need to do this, this and this.” It's not a partnership. It's...they lay the blame on the mother .P11, 451

' And I think that can actually play an impact in the legal side of things where, ‘Well, that doctor was mean, and he doesn't care about me, and he this bad thing happened, so I'm going to sue him.’ Versus, ‘This terrible thing happened, she called me in the hospital, she's so sad, too, it wasn't really they're fault.’ I think it can have small, everyday flow of office impact. But I think it can have a huge, overall impact, as well. P13, 148

Patient  
Compliance/  
Successful  
Outcome

I think people learn that the more empathy they have in the clinic the more they'll establish patient rapport and the patients will come back more and the compliance will be better . P06, 401

So, I might not know when there is a connection with a patient, but hopefully—my hope—is that at some time the patient comes back and say, ‘Oh yeah, you told me to do this, so I did it, and now I feel so much better .’ P10, 478

I haven’t remembered anything, but I put it in my note, and it kindof cues up the next visit. And I think the more you can connect with the patient, the better they do because then they have confidence in when you’re saying , and it just works a whole lot better P02, 123

Because we know there is a direct correlation between empathy and quality outcomes P10, 263  
And using that information to help provide better care P15, 165  
... I think empathy is important as far as health outcomes P15, 205  
We may write a lot of prescriptions, but what really counts is how do patients feel about things ? What’s going to get them better? And I think a lot of what goes [toward that] is empathy in [helping] build relationships and trust, and I’m sure it improves compliance with therapy P15, 206  
In some cases, though, I probably am okay with assuming a more paternalistic stance where I hope I have developed enough rapport with the patient that they trust me, and they, to some extent, follow my recommendations—assuming those recommendations are made with their interests in mind P20, 93  
Um, and so, it’s something about the way we’re built as humans, that having another person, whom we respect, have some relationship with, expressing empathy is helpful to our health . It’s healing. P01, 232

Trust

Healing with  
More than  
Medicine

And if that’s accomplished, you know, I may not be able to offer them a solution for their cancer, or for their complaint, or for their frustration with their son’s behavior, but if I’ve done that then they are going to walk out feeling in general ... and maybe that’s part of empowerment too , you know “ok, I can keep going,” you know, its very powerful (P01, 238)  
And part of being healing , treated as a whole person is that part of it, too. It’s not just the incision. I mean you can get ... I say, ‘You could teach a monkey to do a delivery P03, 187  
... You know that the human contact ... Works in healing in other medical conditions, too . So ... P03, 233  
I haven’t remembered anything, but I put it in my note, and it kindof cues up the next visit. And I think the more you can connect with the patient, the better they do because then they have confidence in when you’re saying , and it just works a whole lot better P02, 123

Seeing people struggle with issues, and you being able to—maybe not fix the problem—but at least being there to help them think through ... I think it's a lot of wanting to P04, 193

But if I can't completely get rid of it, then at least ameliorate it and make it better, and understand, um, where they are coming from, what's the impact on them . P02, 20

Seeing people struggle with issues, and you being able to—maybe not fix the problem—but at least being there to help them think through ... I think it's a lot of wanting to P04, 193

It's no different in a doctor-patient relationship. And it's no different, you know, if you're doing social work or whatever else—it's still the same. There's gotta be a connection. There's gotta be a mutual understanding. Hopefully, somewhat, of a mutual trust. And ... Yeah ... And trying a direction together to try and make things better P10, 305

Some of my patients I've had for 13 years, so I know a lot about them, but I share with them certain things about myself too, when it's appropriate . I have little pictures in my office of my family and my pets and things like that. And I like to put a little bit of that personal touch in it, because when I'm asking intimate questions and asking them things about behaviors or trying to encourage, you know, change in behavior, I think it's important that you have to find a way to connect to people .P12, 94

“If you get home and you forget something that you wanted to ask, call. I'll call you back. You know? So I keep that door open, so that we can start that relationship .P12, 151

But, I think any patient, if you're willing to open up just a little bit—you don't have to completely expose yourself; you just have to open up a little bit—they feel more comfortable . P13, 272

Relationship

Balancing Empathy and Knowledge

But, that's the point: you can't just be some family practitioner who doesn't know squat but really is very caring . That's dangerous . P02, 159

: I think it goes to a certain level, too. I think that people take it overboard. Like, I think you can be empathetic but not be extremely like, corny empathetic . You know, again, just being natural I think it comes naturally. But don't go overboard. P06, 560

Faking It for  
Patient Gain

I think you can probably stretch it as much as you want, but I think at the end of the day they are still a patient and they still have medical needs . So you need to be sure to address all of those also. Like, if you spend too much time soliciting personal information, talking to them about their life and family and all the rest, then you get to the medical information, you're like, ok I know this is going to take awhile to get labs, and I know it's going to take awhile to talk about their hepatitis and their HIV, and this and that. And then they're like "shoot, we should probably schedule another appointment for next time ." So, having a well balanced side, because you're still a physician at the end of the day P06, 565 I think good practice combines adequate knowledge from the physician's standpoint, being able to implement that knowledge . P09, 31

Otherwise they get shoved into that group of doctors that people are gonna think are bad doctors. They may be smart as all get out, but they can't communicate with the patient, the patient will never know that P09, 544

No one wants to go to a clinical, cold person who just spouts information . Nobody wants that P11, 55

Right, it's not just a matter of having the knowledge, cause there are people who have all the knowledge in the world but they're not very good providers of care, you have to be a people person, but you have to be competent too P12, 39

You have to be able to fake it sometimes if somebody is really horrible, and you're going to take care of them anyway P03, 364

You can't pretend that you have it, no . I mean maybe some patients ...I mean maybe it would work for some patients P06, 128

I mean, if it didn't come naturally the only thing I could say is to ask people "how are you doing, how have you been?" Um, "what's going on in your life ?" Just give them a second to talk about things other than their appointment. Um, just to pretend...to get that feeling that you're on the same level, again to take away the authority, whatever . P06, 339

I mean it's, um, there's times I have to keep from tearing up because of my patient, and you don't want to be...but they look to you for strength, you know? And here you are boohooing P08, 350

Well, the placebo effect is very, very real . I mean, it can get you thirty- to fifty-percent better outcomes than not. So, if I'm going to prescribe something, I'm going to say, 'This is what I'd give to my mother. This stuff is great. This stuff ...' Even if I don't necessarily believe it, I'm going to hype it because then I add the placebo effect to what I'm doing P02, 415

Common  
Courtesy/  
Customer  
Service

Um the placebo effect, I believe, really is, um, happens when the patient comes out of the interaction feeling that they're, that their diagnosis has changed for the better . You know, if they feel like they are going to get better, they are going to get better . Um, and that might be language the doctor uses. It might be, it might be just their trust for the doctor . If I say "Ms. Jones I think this is going to work. I think it is going to help you feel better," she's going to feel better. And all of the studies over time that have been done and randomized , the most biologically and biomedically effective studies that have ever been done, in all of those on the average the placebo works 30% of the time. So there's a placebo effect, and uh, that's part of ... it's kind of how you deal with this language, but the placebo effect, you can say that's part of the doctor-patient relationship . That's part of what I do with patients.(P01, 96)

Um, you know coming in 20 minutes late to the consultation isn't the best way to start trust. (P01, 122)

we can be attentive to their comfort, you know "is it too cold in here for you?" you know, "how was your parking?" That sort of...just starting to relate as humans . (P01, 126)

If you look at the environment and the patient is sitting there shivering or cold, if you're not observing proper modesty and if they feel exposed or vulnerable, then they're not as likely to be experiencing empathy P01, 318

So they expect you to care. They expect you to follow up. Um ... You know, they expect return phone calls. They expect their messages to be returned. Um ... I think they just expect you to treat them well, to treat them as an individual, and to, yeah, to follow up on the things you say you're going to. To be responsive . P07, 29-32

I think it's such an important part of proper care of a patient. So, my goal as a provider is to provide excellent care, but also equally important is providing excellent customer service . And the hugest part of that is empathy P13, 318

Um, I think no person would ever say it's not important, but I think they would say the priority is providing good, excellent medicine. Like, my job is to make sure that the person—or the grandparent or the baby—is to provide excellent medicine to make sure that whatever skill that I need to provide to them, that they come out healthier, better, whatever ... To fix the problem, and that is my priority, which it should be—absolutely . Excellent care first, but my approach is excellent customer service, too. And if someone is completely focused on the medicine—which again, they should be—but there are other aspects to providing excellent care. P13, 336

- I invite the family to come to rounds. So, at eight in the morning, in front of room one, I have a patient, and they may be with it, or they might not be, but I have mom and dad here. And they sit here and they say, 'Hey, we have two docs, four residents, physical therapy, pharmacy, nutrition, occupational therapy here, and respiratory therapy here,' and we're like a little gang of like fifteen people kindof all around. And they sit there and they go, 'Hey, there's a lot of thought that goes into all of this. There are a lot of people looking after my family member here.' And I think they appreciate, one, being involved in the process . P14, 215
- Customer service is really, in my mind, yielding to the patient no matter what. Um ... Even if it's not medically indicated P21, 314
- ? I mean you can be the smartest physician but if you can't get ahold of your, you know, your next appointment is three months down the road that may not be that helpful to the patient P08, 27
- But I feel in order to truly meet the needs of our patients, we need to have more time with our patients P10, 177
- I tell them how they can contact me, how they can... I give them telephone numbers and everything so that they know that they can contact me at other times, other than just this clinic visit P12, 117
- Not only that, I'm on the same level as you are. I'm not talking down to you P02, 134
- It's super cool, cause P02 is like this big, powerful physician in the area. He's head of the division, he started the division here, but he'll walk in and make fun of a guy for losing his car , or, we see a lot of HIV indigent populations, people who are already in bad drug habits and all this stuff, so he'll like, joke with them about just the past and all this stuff P06, 79
- Um, and, um even though you're wearing the white coat and all that stuff, pretending like you're just another person talking to that patient, you know, without your white coat, without your stethoscope, and without all that other stuff P06, 314
- You have to read your patient to be able to interact with them at their level, at their appropriate level and not sound, um, judgmental, not sound too paternalistic or maternalistic. Really you have to come to their level. It could be as simple as being able to communicate in their language P09, 266
- And so, my relationship with my patients is—I would like to think that it's—collaborative .P10, 166 . And most people just want to be treated like people. I don't go in (dropping his voice, stiffening his posture) "I'm Dr. (name)," get my white jacket and back away . That's not my modis operandi. P05, 308

Accessibility

Removing  
the  
Authority

Accomplishing the Medical Goal

the ones that are newly out of school in the last 10-15 years have really engaged more with patients and patient education, and empathy. And they're ...it's no longer "do as I say because I'm the doctor, or I'm the provider." They're....you know they are listening to what their patients have to say P12, 240

But at the same time though, you have to make sure that you're able to convey what you need to and get what you need to get done , P14, 86

And sometimes you have to really see past that because people come in horrible ... They may be been an alcoholic and wrecked their car and maybe killed three people, and you're thinking, 'You know, you're about the lowest level of life crawling around this world.' But at the same time, you have to take good care of them and work on getting them better and see past that . P14, 307

I went to school in Italy and that was a real emphasis, um, we were always taught, I remember this vividly, is that if you sit at the bedside, and you really talk to the patient, make eye contact and talk to them, they said 80% of the time you'll have it diagnosed by the end of the day P18, 369

yeah, it's behind the scenes empathy. That's what it is. You know? I mean it's like it's 3 o'clock Friday afternoon you get a bronchial biopsy. You're tired, you got to be outta here by like, you've budgeted your time so that you could get out of here by 4, ok? You know, so what do you do? Do you make that patient wait till Monday? Or do you stop and you look, and you call the doctor and tell him what it is, or what it's not. You know, that's the kind of things...people don't realize. And that's ok, because you don't do everything that you do to get a thank you and a pat on the back. You do it cause it's right. P16, 236

Going the Extra Mile

You may come up with more creative solutions for how to help this person—or you would be willing to come up with more creative solutions because, you know, obviously we live in a system and society that does not have endless resources . P20, 222

It's a very strong motivator as far as, 'Okay. You know what, even though I'm tired, and I want to go home, and I want to be with my family ... I'm not getting paid any extra money for this. Can I go a little bit further for this person? Can I make one more phone call? Can I check one more halfway house to see if they have an opening? Can I give a little more reflection to this medication I'm giving to make sure it's really the best one that they can be on? Did I order all the labs that I really should? P20, 234

Now I think that when you empathize with people, that's something that encourages you to do something more than just what's adequate P20, 274

## Attention

## Patient-Centered

## Providing a Standard of Care

You can't say, well, this person is poor, indigent, or non-adherent, or whatever. You have to say there's only one standard, and you have to do it that way . P02, 95

They expect to be informed about everything that's going on . They expect your attention. Um ... They expect you to provide the top level of service available ... Make appropriate referrals ... And reassure them when they have concerns P02, 32  
And I try to make them comfortable and to know that they are being well taken care of ... That they are getting the top level of care. P03, 242

That you follow through ... Up with their treatment, with their results, with their tests . P04, 5

Again, it's making them feel that you are going to provide them the best care. P04, 28

But, not forget that they are coming here because they have a particular issue also. You know, again, even though we are very very collegial and friendly, I want to make sure that when they leave the office that they have whatever it is that they want addressed P08, 144

## Being Flexible for Differing Needs or Expectations of Patients

Some people want to get in and out; they don't want to dilly-dally, and they just want 'What's the bottom line ?' P02, 146

Um, I don't think people want friendship, but I think they want a knowledgeable physician who cares P02, 147

but there are some people that really need that ... More of a personal ... There are some people who want the best technician , you know ... So, you can have all of those things, but some people need more than other people do. P03, 231

That you, in a way, put yourself in their shoes because what you are prescribing for one patient may not work at all for another one—being because of religious concerns, because of ethical issues, because of working hours. Um ... They want you to tailor care to their needs. That's a big one. And we do ... Our treatments are very involved, and many patients cannot do it, so they need you to adapt things to what they need P04, 6

And that you respect their values . That you do not impose what you think is the right treatment, especially when it conflicts with that they believe P04, 12

Yeah, so self-management support is one of the 9 standards that , you know, it's very much an emphasis on preparing the patient to be able to better deal with their disease . So for the chronic care visits I need to, um, keep their therapy going. Whether it's encouraging healthy behaviors , or providing pharmacologic intervention , or other types of



intervention (P01, 63)

like an acute care visit it's "I'd like a diagnosis, I'm hurting. This symptom, I'd like it taken care of, I'd like pain relief. (P01, 45)

They expect ... That you listen to their concerns P04, 4

You know, cause sometimes they've read the latest Parade article and they really worry now that this headache is a brain tumor and they don't want to come out and say it, you know? And some of the expectation is "oh, just give me my antibiotic and I'm out of here." You know? And other people say "I want you to tell me what's wrong with this thing that no one can tell me. So it's nice to have kinda, you know, open expectations, very important. Cause this way you can go around and around and the patient walk out of here, and you spent 20-30 minutes with them, and they may not feel satisfied cause, you know, they didn't let us know what their expectation is, and we may have missed the signal, body language or otherwise, for why they're here P08, 61

Yeah I mean, well I think you've got to be yourself. I mean not everybody, the most affable person may not be the cup of tea for some folks who, they don't want a lot of touchy feeling...well, you know, I like a lot of touchy feely stuff, like that's just me though. Some people say "ehh, I don't like those things. I want the doctor to come in and tell me what's wrong with me. Do what's necessary and then I'm out of here." P08, 128

Yeah, and on the other had I do have patients that I know what they're like and all, and they just want answers. They just want to know a, b, and c. And I still have those patients. So it's not like kum-bi-yah with everybody that comes and sees me. There's some patients that, you know, that I adjust to the style, at least I think anyway, and they keep coming back, I think I'm ok with that and my read is correct. P08, 162

In their doctor they are looking for a mentor, for someone to give them advice, much as you would look towards your mom if you had a good relationship with your mom or your dad. And if you provide that for them, then you're their hero. Because they want you to help them, they want you to be there to give them advice, they want you to kind of guide them, not in a parental kind of way, but supportive. P09, 132

Tough decisions, and maybe for patient A a very different choice than for patient B P09, 470

You know, you're taught early on in medical school that it's Mrs. Jones in Room Two. It's not ... It's not a heart attack in Room Two because Mrs. Jones who is ninety and having a heart attack is totally different than Mrs. Jones who is forty-eight and having a heart attack. You know? You've gotta do different things; you've gotta think differently because it's always the disease in the context of the patient. P10, 397

"I don't want any guff, I don't want anything. I just want plastic surgery. I know exactly where I'm going, here's the list, boom, boom, boom, boom, boom. Don't even tell me how much it costs I just wanna go there." P05, 276

You don't do what you did with the last patient. Or with the next five patients, you know exactly where to go with this . P05, 312

Well, not everyone is capable of doing that. You know, everyone has different levels of health literacy, and there's certain individuals that, they believe that the healthcare provider should tell them what to do. And they are very uncomfortable with taking the reins, shall we say of making their self care decisions. Those individuals we have to move on the path gently to get them where they want to be. There's other individuals that want to um, that are very self directed, and they do a lot of independent research in regards to their illness and their condition. And we have to negotiate, you know, health measures with them. You know, you have to approach the individual as an individual, cause there's no one way to deal with health care, and everyone's unique. P12, 56

And, cause I like the uniqueness of how everyone's different. Everyone responds to their diagnosis, their illness, their health differently, and it makes my job very interesting . P12, 88

They're, they...again, the patients are very different. Some want a lot of knowledge, some want numbers written down, some want actual facts, some are chomping at the bit to start taking medications initially, so there's a lot of different factors. P12, 142  
So I have two different kinds of patient groups, and what you need between those patient groups is very different . The first group, you need to have a lot of time and explanation: 'Why you need this surgery, and how we're going to do it ...' The second group doesn't really get that luxury. A lot of times it's kindof after the fact: 'Hey, I'm the guy who took out your spleen yesterday. You don't remember any of that because you were intubated and asleep, but ...'  
So, what I think you need is a good understanding of your patients and a good understanding of the situation or what brings them to see you .P14, 45

There are times when, you know, you change your volume, and you approach a patient differently. Does that mean you are throwing empathy out the window? Or are you ... Because you understand what is going on and that it requires a different technique and approach P15, 327

I think everyone is different, you know? Some people right away want to know everything. Some people you kind of have to warm up and learn the facts little by little, but ... Everyone I think is a little different . P17, 25

There are two scenarios. One scenario is that you've gotten to know a patient for a long time, and again that goes back to you size someone up and you realize what kind of personality they have . Ideally, you educate them about dialysis so when the time comes, they may know more about dialysis than you do . And the second scenario is you meet someone in the emergency room, and they need dialysis right away. So again, I try to—when I'm breaking the news—and these are different scenarios P17, 129

Yeah, because I think when these patients come in, when they see a doctor, and the doctor sees the patients, if you ask them, 'What are your expectations,' I think there'll be two different things. You know? Doctors' expectations are to diagnose, treat, don't miss anything big, and don't do any more harm. You know? Those are his or her expectations. Well, the patient's expectations something totally different, you know P17, 471

Different patients have different agendas as to what they really want to accomplish being in the hospital P20, 97

and it takes hours and hours and hours of time for one patient for one drug. And so I've always made my decisions on: 'If that was my father, would I do that extra work .' And then all questions are very easy. Ethical questions are easy. When I come back into the hospital in the middle of the night, well, 'If that was my father, would I go back in?' No brainer . Go back in. You know, it makes it very, very easy. Doesn't always make it time efficient , but it certainly makes you decision process easy because it becomes obvious. Well, 'Yes,' so, get busy. P02, 87

Not a number. I hear that all the time: 'I don't want to be another number in your clinic P04, 15

But most, a lot of them just feel very comfortable with P02, really respect that he has a great knowledge about their issue , and he's there to listen to them both as people and as patients , you know what I mean? P06, 92

Valuing the  
Patient

But it's really, when he walks into the room you feel like there's actually a friendship there, as if they've been talking on the phone for the past month. You know? But really he keeps a tab of what's going on with each of these people, from visit to visit. So really that's the thing I think that got me, like the first 5 to 10 minutes he'll spend that time catching up, as if they were friends, you know? P06, 83

Um, he also, he definitely wants to get the job done, but I think other physicians sometimes...they're there, they sit down and they just want the facts. You know? Like "what have you been doing, how are you feeling?" It's as if they know nothing about their personal life. You know? And some people argue against this but I think it's huge, especially for these types of patients. P06, 135

But just the whole dynamic of how these people survive with their children, with their lack of income, with their HIV, and with their ... I mean, it's just endlessly fascinating P02, 350

And you're sitting there going, you know, you gotta always make sure that this is ok to talk about. Ask permission, always ask your patient's permission P09, 523

But the patient is the only one who knows about themselves, but they don't know the medicine. So, you kind of have to listen to the patient but also know when not to listen ... Or, then redirect it ... Or whatever P02, 240

I mean, the widow who's husband is sick, I know where they're going, I know what they've done 20 years ago, I know where their kids are. Cause you can boom, boom, boom (motioning with hands), you can involve yourself with each other's lives. P05, 66 And I think, because every patient is different, and when you look for all these characteristics, and then you begin to look at what they want. And where they're going with this, and the characteristics that each person's face...I've done 4 facelifts this week, they're all similar. And if I were a person who just ...didn't think about the other stuff, I would be bored out of my mind. P05, 350

When he sees me he sits down, and he doesn't do this just for me, this is all of his patients. He sits down and he asks how things are at work, he asks how my family is doing, what kind of stressors I have...he cares, he's not just asking me that to make a note in the chart. He wants to know what I'm going through and what's happening to me, in addition to the physical symptoms cause he knows he'll get a clue. And I can tell he cares. P11, 61

: Oh I love the man. He hugs me when he leaves, you know? Um, I know that he genuinely cares about me as a whole person P11, 70

You know, they just need to convey that they care. That you're not a number or a chart or some patient with a demise. They need to know that you genuinely are sad for them . P11, 407

And just, respect them. Respect them for who they are as individuals. You're not the disease, you know? P12, 199

And then the other thing is patients will tell you anything, and it's a real privilege to be part of a person's life ... Treat that with respect and dignity . I think that's a pretty big deal P15, 234

So I think it's important not to get frustrated by here comes another patient with this, this, and this. Instead it's here's what I can do to help them . If they don't have insurance, well I'm not going to go buy their prescriptions for them, but I gonna try and do a \$4 plan. If they're willing to take the energy to go to patient assistance programs, then I'm willing to do the paperwork for them. It's, you know, not hand-outs ...

What can I do to help you help yourself P15, 383

So I think what has happened is you get the ability to relate to these people in more than the disease entity, but rather as people, as patients, as friends, and not as customers . P18, 60

And I think that what that helped me to do I think was I sort of focused every time I saw a patient in my training, you wanted to make them feel like they were the only person in the room and that they really mattered . P18, 376

, some of the things that are shaping in medicine with, you know, these strict care guides and everything, it really sounds good and you can make a good sound bite for the fact that "you've got to use medicine that works," but yet none of us like to be a key in the slot, and what works for almost everybody else doesn't work for us, well gee that's a shame. We all like to think that we're individuals, so we go and listen to what *we* have to say, and consider *us* when we decide what we're gonna do and what course we're gonna take P19, 49

And for patients, it's not just ... Okay, they're a person there in the bed, there's not just that disease.

They're not just that person with cancer, or that person with congestive heart failure. P21, 163

I think the patient would be lost. Because then the patient then ... That's congestive heart failure, so give them an ACE inhibitor. Put them on a beta-blocker.

Next. Oh, that's the person for cancer. No treatment for that. Oh well. Next. I think that's what would be lost. You know what I mean? Like I said, if that's the case, break out the robots .P21, 400

I have some patients like that who are just wonderful—I know their families, or I know their wives, or I know their husbands. That's ... That's the best kind of relationship to have . P07, 55-56

But there are some folks who are um, that like everybody else, you have friends and you have good friends, and you have patients who are just patients, and you have patients who you have ties to and things like that P08, 117

And I guess through the years, after 30 some years of practice my patient pattern now are pretty set, you know, we come in, and some of them are pretty casual, but I always think back and say, you know, we could joke around, talk about what's going on in his or her life and become very familiar, you know, like a good neighbor P08, 140

I do more than most other doctors so that I can then do what I think is more important, and that's trying to connect with the patients. P10, 194

Because, you know, we're involved in this relationship and we always want to nurture each other in a relationship. And that's in our marriage, or with our children, or our grandchildren, whatever, we want to nurture them, but we always want to see them do better. And have better. And that's true of our friends and our patients P05, 38

You can meet a whole ...a wonderful array of different people, and I get to know a lot about them P11, 90

I want patients to come back because I want them to be engaged in their care, and I think it's important for them to know that you truly care about them P12, 217

So, this is just an ideal because you get to see your patients over and over, you get to see them again, and you get to know them really well P13, 56

And that makes them feel like they're a part of your life, and even if you only spend twenty minutes in a room with them, they feel closer to you . Um, so ... Do I tell them the details of my wedding and stuff like ... No. But it makes them see a little ... I'm a person, too, and I have a life, too P13, 64

Uh, cause my intention from the beginning was the relationship...it was nice to be you know, talking about the science side of it, it's exciting and interesting, but to me the real grab was the relationship issues . You know, how to have a personal relationship with each individual patient or families. That to me was a real joy P18, 43

And if somebody has multiple complaints, I'll say 'Alright, let's do this: we can't do them all today. What's number one for you? You tell me what's your number one .' And then they will focus on that P02, 218

That was a way ... Signaling 'this is our time, tell me what you need .' P03, 358

They may not even start with the medical problem when you start that way P04, 19

Letting the  
Patient Drive  
the Interview

Asking for details of what they tell you, and it may be totally irrelevant to what is going on with them, but what they are telling you is what is important to them . You will get later on to what you need to find out, but respecting to what they have to tell you P04, 23

Sometimes a patient comes in, they have a litany of concerns from A-Z, and for those folks you've got to channel a focus. You know, we gotta, we don't have 50 minutes, let's go ahead and you know address your top two or three. You know, what would you like to talk about ? So you can, so it's patient centered, right? Versus physician centered. P08, 90

the first part should be completely open-ended, and that hopefully prevents me from eliminating something that the patient wanted to talk about, but that I didn't ... I wasn't smart enough to ask And I see it some days when I am rushed—I am a lot shorter—but still I try to put that effort : Letting them, you know, come through; letting them put their little thing, you know, in the interview. Make them feel it's their time . P04, 198

But, it's uh ... more broadly open is “why did you come in today ?” And so, theoretically she could tell me, uh “my nephew has a sore throat and I think it's a sore throat and I'd like some penicillin.” Or she could tell me that, um, you know, she's um, run down and working too hard lately and stressed out and now she's got a sore throat . So, that tells me about her explanatory model. That tells me about what she thinks about it . So, asking questions that are open-ended that don't, uh, bias the patient's response by telegraphic what I think the answer should be , is the way I try to find out their views about their perspective, their culture, their dilemma. (P01, 170) But I think if you at least listen to the patient ...

You've still got to make the decision, but if you at least listen to them and get their input P02, 244

And then when I'm getting ready to start asking them questions, because there's so much data you have to collect, their history, past, meds, all of that. I ask them that when they came in for this appointment today, what questions did they have ? So I want to make them the focus of the visit, but also make sure that I give them the opportunity to ask their questions, or to express their concerns before we get bogged down into what we have to do . P12, 125

Digging deeper, yes. It doesn't have to be an hour, but a lot of times making sure you, you know, by trying to open questions up to a patient, by saying “tell me about it.” Not the doctor doing what I'm doing right now and getting on a soapbox, but “tell me about it” and directing the conversation . P18, 453

Ensuring Patient  
Understanding  
of Care

There are a lot of times where there are lots of different procedures and things that can be done to people. Our quest is really to try and figure out, 'What do you want to do? What types of things can we do for you?' Because often times you get into the hospital and you get on that train and you ... You know ... You feel as if you have no control. That's how people feel. So letting people know that at any time you can stop things, or be more aggressive with things P21, 33

You know, I mean, rather than say to a patient smoking's bad for you, and figure it out for yourself. Part of our job is when they're ready say this is what we'd like to see you do . So, that would be instructive to a patient, best way we know how. P08, 307

Being able to, um, interact with them on a level they can understand P09, 33

You have to read your patient to be able to interact with them at their level, at their appropriate level and not sound, um, judgmental, not sound too paternalistic or maternalistic. Really you have to come to their level. It could be as simple as being able to communicate in their language

], 'You know, I've got this mole over here that I'm a little concerned about, and you go, 'Yeah, make another appointment.' You know ... That is not meeting the needs of the patient. It's not answering their questions. P10, 217

'What it boils down to isn't the big stuff. It's the little things that you say over and over and over and over and over again until finally the patient says, 'Oh, you know what, maybe I should do this.' That's when change happens. And it's really kind of miraculous. It might not be the first time. It might not be the second time. But you have to just keep repeating the same thing over and over again when you see a patient P10, 473

They don't realize ... You know, you break the ice ... But you give them the reassurance that you do care that they understand what you wrote . So, they are very simple things, but all you are saying is: 'I want you to understand, not with medical words P04, 39  
Yeah, and I describe things step by step when I tell them, 'Did you understand this part?' Giving them the time to rethink . And the other important thing is when you do that—and I always give printed information—but it seems patients come back to what I drew or what I wrote, not the medical literature. I always tell them: 'Read it. Mark the things you don't understand, and when we get together again we can go over it—the things that are not clear P04, 45  
I share that knowledge with them, and I try to share it with them on their level of understanding . So I'm very, um, I try to be very aware of different levels of health literacy .P12, 133



Probably eighty to ninety percent of the time is focused on education: What foods to eat. What's dialysis about? What you need to do is get a kidney transplant. How's life on dialysis? And then ten-twenty percent is physical exam, reviewing labs, and writing new prescriptions, P17, 152

People have to feel like...I think everybody feels better if they feel like they've participated in their care, contributed to all their symptoms, had all their questions...if not answered than at least explained or why they can't be answered, and then move on P19, 140

Well certainly always ask questions so that you address everything they have on their minds, start a dialogue. P19, 230

And the next step that we usually take is, 'What's your understanding of what's happening to you?' It's very eye opening to hear what their thoughts are and what their reality is because there is so much information that's thrown at them in the hospital .

Number one: They're sick. If you're in the hospital, you're pretty sick, so you've got that on your mind.

You've got the stress of that. And a lot of this medical stuff, it's another language, and some physicians don't speak English; they speech in 'medicalese,'

which patients will just say, 'Okay. Yup. Mm hmm. I understand,' and really not. I mean, if you look at the medical ... Or health care literacy ... Maybe folks understand ten, twenty percent of what's discussed with them. So how do you know what's going on if you're only getting ten percent of the conversation? 'So what you're understanding,' and after that, trying to help them understand what's happening. P21, 101

And it's very tempting to fall into that hole and say "well, if it were me, I would do this." Because you're not them . You know, you have to say "well, that is a very difficult decision, I'm not sure if I can answer that because I'm not in that situation." P09, 142

You know, I might be ...very pro choice, or the opposite, very pro life, and I might have been, felt I was blessed if I brought a downs baby ...but you have to be able to detach your personal feelings and say "this is not my choice to make, you are making a decision that you need to live with." P09, 146

Well, you can trust me to tell you about all of the options; you can trust me to tell you the truth and what those risks are—and what the benefits are—but it's your decision and I'm going to trust you in whatever decision you make . P13, 31

We're not there to say, 'Yeah, you need this feeding tube, and you need this artificial heart valve. This artificial heart. This artificial whatever. This dialysis ...' Those are just all tools. We help them pick those tools. But before you can pick those tools, you have to know where they want to go, and oftentimes that's this part P21, 48

Refraining from  
advice-giving

### Physician Empathy

Theme	Keyword	Supporting Quotes
Trait vs. State		It's very important, and, um, and I would say the other major thing is being authentic . You know, I can train people to do body language that help to build, have been shown to build trust and that's openness, openness of posture, you know, proximity and not putting things between me and the patient, and so forth like that . But um, I have to be authentic about it as well . Some people can pull it off, convince somebody they're trustworthy when they're not, but um, I'm too transparent (P01, 133)
Trait	Being Authentic/ Genuine	I mean, I think there is fake empathy and then there is genuine empathy. P03, 341 So, at least being able to be genuine in your conversation with them —be it pursuing comfort care or being aggressive, is helpful P07, 159 and of course if you learn to be empathetic then, I don't know, I think you're kind of superficial, aren't you? P08, 334 Learned empathy is probably...you know, sooner or later the patient will call you on it. Um, so you have to be genuine about it, P08, 337 I mean, this is just the way you think, this is not an effort P05, 186
	Motivation (Moral)	So, yes, there are things that are technical, like how you ask things . But a lot of it, I think, is the desire to develop that relationship P04, 197 it has nothing to do with how much money you're going to make, how much time you're gonna have with your family, all those are like benefits that may come with the job , but if you don't feel it in your heart and your gut, you won't make a good doctor, because you need to do it for the right reason P09, 586 But uh, anyway, the same things that attracted me to medicine and psychology are the same things that attract me to people today. You know, a need to help people and do something worthwhile for people .P05, 90 Yeah. I think there might just be a difference between being naturally empathic and willing to open yourself to somebody.P11, 354 : I think it's the person. I think the person who goes into medicine wanting really to help other people, not for the prestige, not for the title. Those are the people who are going to be more naturally empathic P11, 469 Well I think elements of good practice is, as a provider, you have to be doing...you have to be in a role that you want to be . You know, a lot of people are in different roles of medicine but they're, they really don't want to be there P12, 31 again, I've been a nurse for a long time, and when nurses went into practice you went into nursing because you had...you cared about people, cared about their health . We didn't go into it for the money, we didn't go into it for the prestige because there certainly wasn't any. We went into it because we wanted to help other people. P12, 207

Modeling from  
Childhood

I think there's some aspect of modeling to develop skills ...um, do I think ... I think that there's, if you have a basic belief that um, you know the other person is ... is um...respect-worthy , then those might have more to do with the Erikson's stages, you know when you're two years old it's trust vs. mistrust. Uh, and you know if you haven't had a good experience when you're two you may never have believed that you could trust other people . And therefore you may not think that it's a goal for you to strive for. Um, you know I think it's got to be if you've had relationships that have modeled that when you're very young ... I really think that . P01, 375  
Now, it can be reinforced or extinguished , you know, when you're 6 or 16 or 26, but I really have to think that there's some basic, you know, childhood stuff. P01, 382  
but I think you have to have some role model and some key critical windows of opportunity in your life to ... and I think if somebody hasn't had that, you know, they're not even gonna be um, before you in class wanting to learn in . P01, 385  
And maybe some of it is fostered by how you were raised, P07, 138

I suspect that it's just probably an innate quality that was just fostered with how you were raised . You know, if you have caring parents or grandparents or family members, it seems as though that probably just allows that inheritance to be manifest P07, 207

Oh, I think you learn to be empathic when you're a little kid. I think that is something that's instilled at a very young age , um ... Or not instilled at a very young age. I think that's something your family teaches you . P14, 342

And if you go to more long-term issues, and why they're that way or not that way, that can be due to their personality . It could be to how they were raised. You know, what the culture was in their family. Um ... Environment P15, 272

But I think if you're...depends on, sometimes you're raised having empathy P16, 247

I learned it from my parents P18, 367

I think some of it was probably just upbringing. I think my parents try to be nice people and consider empathy to be a part of that package. Um ... And trying to instill that in me P20, 342

Intrinsic quality

And that's from how they were raised, or ... That's just something that you kindof grew up with, I think . P21, 355  
cause we can identify in a small group, we think we can identify the guys who are gonna end up surgeons, and the ones that are gonna be radiologists or anesthesiologists P01, 395  
. I mean, I think so much of it is personality driven . So the question is: 'How do you take someone who wasn't given it and then make them like that?' P02, 387

So, there is ... Well, there's intrinsic personalities. Some people are warmer or, um, you know, more tolerant, understanding than other people are P03, 361

I think you get in the field because you want to help people suffering P04, 188

But I do not know if it is a permanent attribute . When you are on your own, in your office, are you going to keep doing it or

not if it's not natural P04, 239

So, they would get us all together in the auditorium and give us questionnaires, and then divide us into groups—probably based on personality. But, you could see the ones that were pathologists, and ... Future pathologists and radiologists—they were all in one corner, and that were ... And they didn't know at that time . You know, now I am thinking back through those groups, and the family, pediatricians, and internal medicine were in one corner, and the surgeons and ob-gyns were in another corner. For some reason the trauma and sport people and orthopedics were ... So, you could detect traits very easily . And again, there was no teaching there—that happened in the first year. So, those are the things that come naturally that the patients pick up very quickly . P04, 258

And I think that either comes natural or you don't have it. P06, 114

Uh, like I said I think it's just something that comes naturally , I don't think you can try P06, 337

Yeah, it's a natural process...I think all of us have certain things inside of our body and brain that just lie dormant , and it takes something to kind of spark them to get them to work , you know what I mean? P06, 408

But some people, certain people I don't think it's intrinsic P06, 420

Still, maybe it's like a personality type? Maybe it's just a part of your personality P07, 112

I suspect those are just the inherited traits that people have. I don't know. P07, 137

If you don't have that quality at all, you know, then maybe you're just not capable of it ? P07, 213

but uh I think it's maybe a bit more being inherent than learned P08, 333

I think you're born with some of that, I don't think you can learn it all P09, 315

Because they don't even have the personality for it . And most of the time the people will realize it.P09, 529

: I think it's something you're just born with, I think it's genetics P05, 439

Yeah, I definitely think it can be taught . Don't, don't misunderstand me there. Um, I think that um, it just can't necessarily be taught to everyone P01, 401

State Trainable

You just ... It happens. Some people, actually, have more of a knack for it than other people, but it comes with time . P03, 203

But you certainly can learn, I think, those skills to some extent. You can fake it . You can learn it P03, 363

I think so. I think so. And I'm not saying it should not be taught . To the contrary because I enjoyed those classes where they ... And they show you different ways of dealing with people. And you know a lot can be taught because it's what the drug reps are taught, the sales reps are taught ... Certain things . P04, 247

. Of course, as a medical institution you have the obligation to teach because there are some that really were not exposed in life to dealing with people . So, they may not know, and they may be so shy that they don't know how to. P04, 271

And I definitely think that some of my classmates that started off medical school, and I was like "how is this guy gonna be a doctor ?" You know? But then now they are getting really great with patients, you know ? P06, 396

I think it's interesting observing students coming through and the changes you can evoke. You see people mature. You see people change P07, 342

You know, that's tough, it's not something, sometimes you can teach people that and sometimes you can't. P09, 304

certainly you can take someone and mold them to a certain degree in the process of their training, P09, 316

: I think that you have to legislate, uh...a...well rounded approach by the caregiver to the patient to include all aspects of their lives. In other words, force them to be if necessary P05, 459

You can give the tools. We, you know, when I went through medical school, they gave you ... In the basic courses—in Family Practice, in Internal Medicine—how you do an interview. But, with the same tools, I could see some classmates—you wonder how they are going to handle patients . And then when you see they are going into radiology or pathology, that's perfect. Because that was your fear—they have the same tools, but they can recite an interview and get nothing out of it .P04, 202

Not Trainable

Maybe facilitated a little bit, but one thing I've learned having dealt with students for fifteen years is there are certain things that can change and certain things that can't P07, 236

And I've always said, I can't make people care . And I don't think people can. When you're twenty-something years-old, or some of them are almost thirty-years-old. I can't make you care. I can make you show up on time and do what you're supposed to do, but I can't make you care. P07, 238

They're adult learners, and you think, 'I can't make you care, I can't make you be respectful, I can't make you have a good rapport with patients.' I can say, 'Oh, that's inappropriate.' But by and large, all of those personality traits are already well ingrained in that person—I don't think I stand a chance of changing them . P07, 344

You can try to enforce certain things—like dress codes, you know? Certain kinds of, like, professional issues . But it's just interesting—the outliers that just don't see to care, you know? P07, 348

You know, cause we can teach you the technical part. The other part, you've gotta figure out on your own, you know P09, 590

You know..I do think that it can be a learned process. And it can be learned through practice as well as through mentors . P12, 204

I think with some people it's just their personality . Some people just can't do it P17, 319

We had a physician that retired and he was one of those rare, very smart, and people loved him. And even now patients come in, and they still talk about him. 'How is he doing? We loved him.' It's sickening, almost, to a point. And I'm always trying to figure out, 'What was he saying to them? Why do they like him so much?' I don't know if you can teach all of that . P17, 383

No, no. There's some people that just don't have it . P19, 325  
 And I think, very unfortunately, we select a group of people who are very, very good at science, very bright , and in fact, in my opinion is, not the best candidates to be doctors . It's totally driven by scores, and I think essentially irrelevant to the practice of medicine . I mean, the facts you have to know ... it's not rocket science. I mean, it's not a lot of facts. You have to be smart. And you have to pull these people to the humanistic, patient-centered pole because they are way over here on the science-driven pole P02, 30

Balancing  
 Between Intellect  
 vs. Compassion

. Because, you know, when you get out on the far side of a bell curve, that's where are the weirdos are . They aren't empathetic, caring people necessarily, they're smart. And you can almost argue there is an inverse correlation . P02, 53  
 So, 'To care and not know is dangerous. To know and not care is even worse. Caring and knowing must be combined to succeed in medicine .' P02, 155

Yeah. Actually, I can think of someone who is very bright, not particularly, I think, compassionate—almost ... I don't want to say cold ... But doesn't really ... You never really hear them referring to anyone saying, 'Oh, I feel sorry for this person. How horrible this situation is .' Or 'blah, blah, blah.' I mean, very successful at practice based on volume, but their perceived kindof as business adventures P07, 281

And you can't be some hyper, brilliant neurosurgeon who knows everything and is very technically competent but doesn't care . You really have to have both: caring and knowledge P02, 163

No empathy, he could not deal with patients. So here was somebody who was AOA and the cream of the crop, and this is our future, and he got to the clinics and he was in danger of washing out. P19, 339

It should have been pretty obvious at the admission committee that he may be brilliant and he may make your academics look good but we're not gonna develop a clinician here . P19, 352  
 Be more the empathetic, looking for somebody who is gonna work hard and try to put the patients first, rather than be the one to tell me what pi out to 18 decimals points P19, 409

Training

Learning Body  
 Language

You know, I can train people to do body language that help to build, have been shown to build trust and that's openness, openness of posture, you know, proximity and not putting things between me and the patient, and so forth like that (P01, 131)  
 Well, I was talking about one: sit down when you go in P02, 376

- Well, although some people ... People have to be trained to do that. I've seen folks who kind of go in, they're standing over the bed. Maybe not making any eye contact. That can be taught also .P21, 341
- Requires  
Readiness
- There's got to be some readiness, um, and I can teach the techniques, even if folks aren't, you know, don't have it in their hearts P01, 402
- I think teaching empathy is very difficult. I think, maybe, you can make people understand how important it is, and open their eyes to the value P02, 65
- Yeah, the team approach. It's like "I do this and you do that, and together we take care of the whole patient." But they're teaching whole patient care at (school). They're just not listening P11, 49
- I've seen residents who came into the program as medical students totally evolved and have a comfort level by their fourth year. To be able to sit on a patient's bedside and let them cry without running away or saying "I'll call your nurse." But...you have to be willing to do that. P11, 359
- Teaching more  
than  
Communication
- But they don't teach it. They teach a communications class, interpersonal relations, and I don't know I wish I could be a fly on the wall in that class cause I don't think they get anything. They get, they go in and they learn how to talk as a physician to a patient, which is down .P11, 400
- We actually learn communication skills. I think physicians have a little different approach to their schooling. It's you learn every disease, you learn every disease process, you learn how to treat the disease, whereas the holistic approach from nursing is you learn to treat the person who has the disease . P13, 162
- Skills to Appear  
Empathic
- And then, maybe if they aren't naturally empathic, you can teach them some skills that will make their non-empathic personality at least appear to be more empathic P02, 66
- And get little tid bits about the person and put them in your note . And then you have to review your note before you do the next visit to figure out, you know, what problems you're working on, what you did the last time. And then you can very quickly pick up those little ... I mean, it takes you ten seconds. P02, 376
- if they know how to get people to relate to them and trust them and so forth, you know, like a car salesman , they don't have the patient's benefit at the center, and those people can be dangerous P01, 404
- You just make them ask the right questions and reinforce that you've done the right questions and this is going to help you take care of this patient P05, 475
- They can be more open, even if they don't have um....a warm heart, or anything more objective, they can be taught to ask the right questions and get more out of the interview, and add more to the treatment process, I think. P05, 519
- There are tools ..that's what I call them, is tools. When I talk to the residents this is what I tell them – "I've brought some tools today that you can put in your little box. That when you're in a situation like this maybe you can pull some things out that will give you a level of comfort, not just your patients P11, 367

- They can work on body language, they can work on just, uh, their verbal as well as their nonverbal communication skills in order to utilize that patient encounter .P12, 214
- At Hopkins we did, like, this mini-course on communication, and you think communication is how you communication to someone else, but the other part of that communication is listening to the person, and they may say, 'I don't feel good.' Is it physical? Is it emotional ? Um, I learned how to listen to that patient, too, and I practiced that. And I don't think physicians have an opportunity in school to do that .P13, 172
- I think you can certainly teach behaviors that can emulate it. It may not be pure empathy, but you can ... Behaviors are things that are taught that people can do. You can teach people to go in, sit down, and look them in the eyes. You can teach people to speak, um ... To speak plainly in laymen's language and not use medicalese P21, 348
- Increasing Sensitivity You can do the same with medicine. You can teach people to be more oriented, and teach people to have a sensitivity, even if it's in black and white . P05, 470
- So those people who aren't...who don't automatically feel other people's pain, or whatever...um..through practice can learn to open up themselves just a little bit, to connect . On anything other than a clinical level P11, 355
- , I do think you can teach it. I've taught some nursing students in the past, and I think you can teach them by creating awareness of how they are responding to individuals and how patients are responding to them, and the process of doing that it creates the awareness to know, you know, how they're projecting as well as how they're being received .P12, 211
- You know, in a medical student class I have authority, they have to get to a certain level. Whether they will then use it effectively, you know, for their good in later life, that's up to them . P01, 410
- Retention of skills Well, one is to learn by observation , of course, to see how people interact and what seems to work. I guess, you can also do that in simulation . Or you can have movies, or films , or something showing those relationships P03, 324
- Observing Also I think...um, you know with, when you rotate with people like P02, here we do a great job in doing it, but I think a lot of the clinicians here are great at that, they talk with patients and stuff . So I think the learning aspect of it comes naturally , P06, 398
- So I think a lot of people have that side to them, that somewhere inside of them, but when they really see it in action and they see it through other people is when they really are like ...they turn it on. P06, 414
- I've found, you know, with the medical students I work with sometimes I tell them, "look, you're just gonna come in with me and you're gonna be there, but don't say a word, and just listen. Listen how we're gonna give this person bad news ." P08, 241
- I had some excellent mentors. I watched some good people at work P09, 314
- You can't be trained to be empathic but you can ... (pause)...you can learn things from people who are naturally empathic P11, 328



Wow, that's tough. I think you can show them empathy , and I think you can ... I think so much of the way you learn medicine is by watching other people do it . You're like little kids going by modeling, following what other people do. Same thing with medicine, and you kindof learn it. You know, 'Hey, this guy interacts with patients and does well and has good rapport,' then you kindof do that. You see some other people, and you think, 'That guy, he does not do well with his method,' and you sortof learn things to avoid . P14, 406

So I think that is important, and I think the other thing is role modeling—working with students and residents and colleagues sortof demonstrating that, whether it's when you're precepting down in the family practice center or with a student in that regard, or with in the hospital when you're rounding. Again, sortof demonstrating that at the bedside I think is pretty important to do. P15, 228

You know ... And also those mentors and role models throughout training may have accentuated some skills or some tendencies and not others P15, 275

Learning by  
Doing / Maturity

Um, some of it you just have to learn by trial and error. P03, 327

Um, I think so . I think that the way this school does it, like I started with standardized patients, I think it shows, um, a big role of empathy. P06, 386

That's all being older, you know, maturity. Um, being more tolerant. P03, 339

so I think it's more something that's within you, and then you know, over the course of 30, 40 year career you learn to try to shape it a little bit P08, 338

So the more experience you have and the more scenarios you've been in, obviously makes you usually, hopefully, better equipped to handle it .P09, 310

But I don't know, some people are um, with experience and with knowledge and with practice get better P09, 527

So they may need to learn a little bit about themselves and mature in their field in order to continue to develop and be able to have that rapport with their patients . P12, 232

Empathy was something I had to learn along the way ... And sortof is you figure out how close or not close you get to people, and things like that, P15, 162

Some of that's maybe just getting older, but I think that concept—I think over the first few years, I think, really through experience—I sortof became better at employing effectively .P15, 169

But I think you have to do it for a few years, and then see what's happening . P17, 323

I think ... It just comes with experience P17, 383

You just grow. I think it just happens the longer you're in. P18, 175

So I think that more classes have to be taught , more hands on have to be done by students with patients, more one on one conversations like we're having. P18, 410

You know, I think as you begin to encounter more and more people of different backgrounds, um ... It becomes easier to identify with them. So I think the identification part of it has

gotten even easier P20, 347

Difficult to Teach You know that's where it is hard to teach people that. It's hard to teach people how to interview a patient empathetically, or how to deliver bad news . P09, 240

So that's the part that I think is so hard to teach someone. How do you take 5 patients in the room, all from different backgrounds all with different levels of education, and say you had the same information that you needed to deliver to all those different patients. How are you going to decide how you are going to deliver that information to patient A, to patient B, to patient C, and get the same information across to them, so that when they walk out of your office they feel that you have been able to give them that information and so empathy . That what you do for A is not going to be what you do for B. It's not like you can watch a module that's gonna make you an empathic doctor .P09, 285

Because they acknowledge that it's no longer about the facts anymore they're gathering for their classes, it's about learning how to communicate with people, learning how to interview, learning how you know? So they figure it out pretty quick, but it's tough to teach someone whose starting from a bad place P09, 530

That'd be hard to do. That'd be hard to, like, you know, 'Open your book to chapter eleven on empathy. We're going to learn about empathy.' I don't know if you could do that because its not that cut and dry. It's a tough thing to learn . P14, 418

### Barriers to Empathy

Theme	Keyword	Supporting Quotes
Barriers	Difficult Patients	<p>Uh, you know if they're someone who is straightforward they want this fixed, uh versus the patient who may be angry who, you know, has had series of bad relationships with doctors or so forth , in which my enthusiasm for doing the procedure with the client declines precipitously P01, 282</p> <p>But I think that's a barrier because sometimes it puts a fence up that you're not going to go out ... You know, it's two o'clock in the morning and your screaming the F-bomb at me every other word P03, 266</p> <p>Or people who want to use the system. Yeah. You tend to lose a little bit of compassion there . P07, 184</p> <p>And sometimes you have to really see past that because people come in horrible ... They may be been an alcoholic and wrecked their car and maybe killed three people, and you're thinking, 'You know, you're about the lowest level of life crawling around this world.' But at the same time, you have to take good care of them and work on getting them better and see past that . P14, 307</p>

- I think if you've got a patient that's, you know, stepped across boundaries, either, you know, drug-seeking is always kind of a big button-pusher for a lot of folks, or um, has done something to one of the staff or those kinds of things. I think there's times like that ... There are times when I'm certainly less empathic, and I'm very direct. P15, 331
- And sometimes it does take work, cause sometimes you get patients who are a handful, you joke about it like you get a giant headache when you walk out, but until you've put yourselves in your shoes to understand why they are the way they are and what they're going through, I don't think you can treat them appropriately or fairly P18, 222
- Because they will naturally put up a barrier. And there's a huge barrier to communication when they know that you don't have their problem P09, 212
- Every patient that walks through your door has barriers around them. They feel like you don't really know what they're going through, you're not pregnant, you don't have diabetes, you don't have a baby with an anomaly P09, 218
- Patients, patient personalities. Some of them don't want it. They don't want, they've got a stone wall up and they don't want anything going in P05, 265
- ... and yet I walk into some exam rooms, and there's a glass shield right there, "I won't go there." I see it instantly (snaps fingers P05, 310
- I think, depending on what's going on in the patient's life where they feel comfortable completely exposing themselves to what's bothering them . If there is a social situation, that's very uncomfortable. Or, they just don't want to admit to something where, um, I think judgement on both sides is the biggest barrier: 'They're going to think this of me .' P13, 213
- So, and cultural background may be an influence. So sometimes you say "why are you wasting my time with this pain in your finger?" You know, I don't come until my bone is broken. Uh, so I don't know, sometimes a person's views, background, things like that may color out a person's level of empathy P08, 458
- Language barriers sometimes ... Sometimes cultural barriers . It's hard to broach in a way that you're used to doing things in a familiar way . Or, it may not be acceptable to that person ... Your style may not be acceptable to that person . Um ... To some extent I have a problem with people that are really angry and rude and nasty P03, 260
- You know, um, sometimes you just don't realize your cultural barriers that just don't allow you to get through to that person, that empathy can't get to that person and you can't read that person, that creates a barrier, you know, between what you're trying to communicate to the patient P09, 281
- You could have some cultural and ethnic barriers, um, that can be challenges as well as um..you know things that you have to work with so that you can achieve respect in that level also .P12, 191
- And I think a lot of doctors I've interacted with aren't really human , either their ego gets in the way , um stressed out, things like that. P06, 114

Patients Putting Up Barriers

Cultural Differences

Ego/ Authority

- I think it's partly the authority level, maybe. They don't want to establish maybe that connection with the patient . They still think that they're the doctor and all that. P06, 487
- Or, you're like an authority figure or whatever it is. And, um, people lose touch with being human , so. P06, 439
- I think there's a need for protection of the ego of the person who is the caregiver P05, 162
- They get tied up in the job. And in succeeding. And maybe some of them have an ego that needs to be stroked everyday by positive outcomes P11, 216
- fatigue and, uh one of the reasons that we're moving towards shorter duty hours is that there's very good evidence that if you're exhausted, if you're sleep deprived, you're less likely to be empathic . In fact, you're more likely to be irritable and snappish with your colleagues and so forth. P01, 308
- There were times I would brush people off or not be as tolerant as I should be, especially when you are tired or overworked to do that P03, 384
- But if it's somebody else coming in for a cold, you're just like, 'Oh, gosh, another cold.' You know? So, not giving the patient the empathy they really need P10, 205
- doctors that are burned out—and by the way, I'm using burned out and lack of empathy as kindof the same thing because I think it all leads together . P10, 207
- And I tend to think it's burnout. I tend to think it's the system that pushes them and pushes them until, honestly, it's not Mrs. Jones in room two. It's another patient with diagnosis X in room two, so then you've lost the empathy at that point P10, 212
- But yeah, empathy is absolutely the glue that holds it all together, and it is directly-related—directly-related—to the burnout of the physicians. P10, 286
- ...if there's a certain empathy level where people tend to go down with age and time, where people get hardened and bitter with what they're doing, or bored with medicine, or bored with people, or tired of phone calls, or tired encountering patients. Or like some plastic surgeons, tired of hearing patients who, some patients come in and say "see, see this right here ... see that right there. Give me a mirror I'll show you." I think that, is there ... if there is a possibility that that could be an issue with time I think there's circumstances that might permit that, P05, 537
- So I think it's that on top of the stress, just the OR when operating is very stressful , you know? You're operating on another person so that's very stressful.P06, 446
- When I have a headache and a sore throat and I'm really just miserable, cause I'm getting sick, I'm not as likely to be as empathic P01, 312
- Um, you know, emergency rooms, you can still, you know, if you're dedicated to being empathic with your patients you can still be that in an emergency room but it's harder. There are noises and distractions and so forth . P01, 314
- You know, you just had a fight with your spouse when you left the door and you know, as soon as your mind lets up just a little bit you're returning to that conversation and you miss something important that the patient said

- It may be they're going through a particularly difficult time, or they may have some other things going on . P15, 269
- ... A lot of it has to do with timing. When are people coming in? Is it the right time of the day? Is it the right time of the week? How many people have I seen before them? How tired am I? How is my life going outside of work? How focused am I on work at this time P20, 229
- The goal is not to follow this model. Um, and so you know if I'm, if I'm wedded to a checklist , of course when we start with medical students we usually give them checklists at the beginning, and they're thinking "where's this checklist ?" The goal is to understand the principle so well that you don't have to do it in any particular order and, um, you do have to have awareness, focus, um you know if you're distracted by other things ... it's so easy to be distracted by other things. P01, 332
- So he would just sit down, and it would be like he'd memorized a series of questions that he wanted to ask, whereas P02 will come in, will chat with the guy, and a lot of other people do this, but will chat and will gather the information through conversation P06, 181
- Um, but I've worked even in the past week with docs that will just go into the room, the patient will come in, and it's this like monotone voice , sitting on the chair like this, asking questions like "how are you feeling, how's your last ...like, when was your last sickness." Paying no attention to their ....P06, 170
- you know, when you're in your medicine and you're dealing with people with very difficult lives, you know, there's a burden of suffering that, you know, physicians who are empathic adopt , you know to a certain extent. And we could go through these same questions and keep talking and go into greater depth at each one, but the burden of suffering and the amount that the caretaker takes on themselves P01, 497
- Fear to deal with personal feelings . It is ... It is depressing , it is caring to see someone crying in front of you. And I think for ob-gyns , it is something we do day in and day out. We see pregnancies. We see miscarriages. And we deal with that on daily basis. We see fetal death all the time. So, I think we are more capable of dealing with that . But, for the majority, you don't want a sad person in front of you. You don't want an angry person in front of you P04, 129
- . I think some people just don't want to be that way , and I think it's, you know, I know tons of surgeons who think that it will give them, it will make them a little sensitive , you know what I mean? And surgeons don't want to be like that.P06, 477
- Um, it's very exhausting to be able to have that connection. It especially depends on the news you're delivering, the clinical situation . It's easier to be detached, it's easier to go through life just delivering information without emotions that it comes with P09, 444
- And you couldn't offer things to people, and you, if you got too involved in that you would just be literally crying with people all the time P05, 128
- We are focusing way too much, and I've been telling so many people this, way too much on grades, on scores , and we're losing the people that truly wanted to practice medicine for

Checklists/ Models

Burden of Suffering

Medical School  
Admissions/ Focus  
of Training

patients . It's disgusting, really. It's horrible P06, 213

And you'll see like their scores are just outrageous, like I think they are just becoming way too smart you know ? And you are, you're losing the people that um, really want to practice medicine for a reason P06, 217

But admissions committees are too concerned with grades and research and all that stuff, which doesn't mean anything because those are going to be the doctors that sit down and have monotone voice and don't really listen to patients . P06, 231

So...I understand that you have to have a cut off line , you know, but I think if you sit down and you interview somebody and you judge it based on the person that's on the edge of their chair, nearly in tears because they want to practice medicine so badly, there's gonna be very few of those, you know? So I think they need to consider that. But.. P06, 259

Yeah, like I said I think medicine's becoming a conveyor belt of just like incredibly intelligent people on that conveyor belt all wanting to do medicine. And you are losing the people on the conveyor belt that are like dancing and singing, they are so pumped to do it, you know what I mean ? And they are just like jumping with joy. P06, 638

You know, we select these very driven, self-oriented people, and then their practice should be the opposite . P02, 30  
it's more like a careerpathway now , which is fine, and many of them turn out to be great docs. But it's a career, it's financially rewarding and it's a career, uh has some prestige with it P05, 96  
So, there are barriers of time ; barriers of the volume of patients you are supposed to see where they are narrowing it ...

Time/ Volume of  
Patients

Especially for primary care, where they are narrowing it down to fifteen- and twenty-minute visits , and you have to do ... I mean, there are actual problems, their med lists, and their preventive care ... And what, you are going to do this all in fifteen minutes, and you're going to be caring ? P02, 360

So, a lot of it is time constraint when you have to go, 'Boom, boom, boom, boom, boom.' P04, 134

I think it's um, like I said it sucks, but I think a lot of what medicine is these days is you need to get a certain amount of patients and you have a schedule of, ok this patient is 9-9:30, the next patient is 9:30-10 . And so forth, and I think people just have a constant sense of time , that they think "I'm going to interview this patient, and there are certain things that I have to get done in this 30 minutes. And if I don't I'm screwed and the whole appointment just goes down the drain ." So I think the sense of time and the pressure to keep up the daily patients, that's why when the patient comes in for most people they'll say "ok, I saw your lab work from last time, it was so and so, blah, blah, blah ." They want to get that stuff done so they can move on P06, 459

And that requires you see more people in a less amount of time. So, that would be my number one reason, P07, 79

But my practice, I've cut the overhead pretty dramatically. Um, and that allows me to spend more time with the patients, and that then frees up two different things: One, it gives me the breathing room to continue to innovate—to continue to make things better. But it also, um, gives me the time so that I don't feel like I'm rushed all the time .P10, 179

Okay, so, at what point do you start to feel like you're having an empathy drain? Um ... And most patients said around twenty patients ... That's when they started to say, 'You know, I'm just not there. I'm not emotionally involved anymore—unless something dramatic happens. P10, 203

All this peripheral stuff that has nothing to do with the doctor-patient relationship starts to leak out when you're feeling rushed and behind. Um ... And so, yeah—that's the problem P10, 238  
That it's not just a job. And they just get so caught up in the day to day, I've got to see more patients every hour, you know ?  
And this patient who I just told her lost her baby, she's gonna require more than 15 minutes and I just don't have it to give. Or I need to run because there's a delivery going on . P11, 410  
, 'Medical schools, you need to do something because you're putting out doctors that are cold and callous.' And so, medical schools are told now, 'Let's try to find people who appear to be caring and altruistic and empathic and all of these wonderful characteristics. And then, even, we'll give them courses on empathy or on ethics or on something, where they can then, actually, work on it. And then we'll have really empathic doctors . It's a good theory; it's a total failure. Okay? And the reason it's a total failure is not because the medical schools are choosing all these cold, heartless people to become doctors, the system kills people—and I don't mean this as in patients. The system kills doctors' empathy, and it kills it because it is setup in a way to reward productivity, and productivity is a wonderful thing if you're building cars. If you are taking care of people, you have to be very careful, because once you take the human element out of it , then you're in trouble because then a computer like WebMD can do the same as me once you take the emotional element out of it . P10, 490

#### Medical System

Um, but it's really the system, which is setup in a way that really tends to create burnout . And that's something there is not enough discussion on. Now, they've cut back resident hours, but that's just because residents were killing people, its not because residents were unhappy . Residents are miserable people, and again the question is: 'Why?' And there's lots of studies that show that what you do in residency then is kindof a prelude for what you're going to do the rest of your life. So, if you're miserable in residency, guess what: You're going to be miserable the rest of your life in medicine, and that's because you learned to work too many hours and you feel like you deserve to have an income of \$500,000 a year, and the only way you're going to do that is to do all these different things, and it ends up being overwhelming and miserable, and you become totally burned out, and you don't have any empathyP10, 507

But, you know, what you need to do is we need to get paid to care for our patients—paid to really care. And we should get dinged if we don't because we're not being a physician—we're being a technician, maybe, but we're not being a physician. Um ... And that's the thing. Empathy is not about the medical students coming in. It's not about the medical schools failing. It's about the entire medical system failing, and that can be changed, and that should be changed because it's our patients and our country . P10, 573

Well, I think probably the biggest barriers is the complexities of trying to practice medicine in the environment. And by that I mean all the other things. I don't want to sound frustrated because I'm not, but paperwork ... I hate to say documentation ... But, you know, all the different things that are sortof—I hate to say distractions from what you're trying to accomplish—but, um ... Anything from having to fill out prior-authorization forms for several prescriptions, the paperwork, sortof wading through the administrative aspects of patient care. P15, 284  
And I, I don't want it to be lost, you know? I don't want medicine to become like a car factory. Because we are people . P16, 348

Managed  
Care/Insurance

Well it worries me a little bit. I mean, they are trying to make everything cookbook. You know, and you have to do this, this, this, and this . P16, 178

I'm not sure what's the better option here, if you're a student coming out now where you don't know any better and you have to deal with this mish mosh, or coming out in my generation when we really had what we considered the best years in medicine because you were able to develop relationships and care for people, you know, be empathetic and compassionate at the same time, and not have to worry about looking at the clock . You know, how many people am I seeing today? And I can't order this or can't order that, or, you know, I need to upgrade it so I can get more money coming in . We don't have to worry about that." P18, 72

And I think unfortunately what medicine's turned to nowadays is it's less about what the patient's feeling and more about what is the insurance company telling me I have to do, what I gotta give, and how I'm getting out of here by such and such an hour . P18, 95

But yeah I think that's really important and I don't think unfortunately we do enough of it nowadays, because unfortunately there's so much pressure about, you know, how many people do I gotta see today, what is the insurance company telling me I'm doing ? P18, 234

the biggest barriers are insurance companies. The, the reason I say that is the reimbursements are very low, which essentially says to the doctor I've got to see more people than I'd like to, so I can't be as empathetic and I can't take time for empathy cause I've got to crank out a lot of patients each day P18, 261



Limits of  
Empathy in  
MedicineGetting Too  
Involved

I mean, I think sometimes you can go overboard because you can get too involved and too wrapped up . So, you have to kindof compartmentalize it; you can't be ... Every time a patient dies, you go into depression. I mean, you have to feel something, but you can't be overwhelmed by it . You have to have a way to have closure. P02, 427

So, I think that the only way empathy can be bad is if it overwhelms the provider . If you just get burnout because you're feeling so intensely about everything P02, 431

I don't like to ... I don't want to be their friend. I don't want to be friends with them . P03, 38

But, you know, I want to be available to some extent—and emotionally available to some limited extent —because I think if you get too caught up in some of it ... You just ... You don't make good judgments P03, 47

So, I think the same time you have to care, you have to be a little bit separate. You care, but then it's over. You don't care, care, care . P02, 433

make sure you don't become too vulnerable, susceptible, because sometimes you can get too wrapped up, you know P08, 339

And I suppose sometimes that's what physicians do, you know, just come in and say you have cancer and walk out and you don't have to deal with your own emotions. And so it may not be ...that they're not empathetic, they just don't want to be too vulnerable. You know, cause as soon as you open yourself up you start...becoming too involved with the patients . P08, 364 : Yeah, I'll help you to the extent that I don't have to put anything out, personally P11, 467

You know, sometimes we...you know we all as individuals a lot of people have their own barriers, their personal barriers and their personal space. And they may have that fear of if they care about another individual um, that it's gonna invade their personal spac P12, 228

Patient has to be  
Willing/ Engaged in  
Care

But, um, you know, with patient there has to be some give and take, you know, for that to exist. P03, 316

I think when people don't make any effort to help themselves . Um ... And you tend to lose your empathy—I do, to a degree—for people who wait until the last minute. I mean the 'I got this five days ago.' And I've been following them for fifteen years, and I know that that shouldn't happen, and they call Friday at 5 or whatever. It's kindof hard to feel sorry for that person, you know? I think when there is no effort put forth on the part of the patient to help themselves, and they're expectations are unrealistic—like I can do everything for them P07, 173-179 “oh, Ms. Jones is here again” (sighs), and then I've just got to go in there knowing that most likely I'm not going to do much of anything . P08, 188

Well, because you know the empathy part is not a one way street, it's a two way street P09, 265

I have expectations for my kids, I expect certain courtesy, certain behavior, and I have expectations for the patients too. I'm putting out, so I expect that they are going to do their part .P09, 411

Patients Engaging In  
Harmful/ Self-  
Destructive  
Behaviors

Because I think most of us when we're working, we want someone to meet us halfway. You know? And certainly when a lot of our patients ... If they come up and they stay there for a significant amount of time and we keep proposing things to them, and we want them to become engaged in their treatment plan and what their plans are going to be upon discharge ... For instance, calling to halfway houses and finding a place to live. Um ... If they don't do that, and there isn't some reason as to why they aren't able to do that other than just laziness, um ... You know, we don't feel too much more an obligation toward that person P20, 326

... Or people who, you know, you, I'm sure, have encountered this or heard this: People who smoke, who drink P07, 192

I mean, you know ... I truly ... I just tell them: 'Are you going to do this? Or are you going to die?' And I ask them: 'Do you want to die? Because if you do, you have to tell us so we can respect that.' You know, and stop the nonsense. And most of them are like, 'No, no ...' Well, if you don't want to die, you need to do A, B, and C. You know, I can't do that for you. A lot of times that works. You know? Everyone has a different approach, I guess. You know? I'm kind of hard on them, but I think you have to be kind of realistic. You can't sugar-coat, candy-coat thing, and say, 'It's okay.' Because for a lot of them, it's not. They don't have tons of time to decide whether their going to mess around with it. P07, 325

And that's when all else has failed and we feel like we're banging our heads against the wall, and I've tried all of the positive reinforcement and I've tried the, you know, bring you back every other day, contact you every, you know, moment I can to get you to do the right thing. I'm walking against a wall at that point, then is when I say, "you know, I'm worried and I'm concerned. And I know you want to have a good baby, and I know it's a bad scenario that the baby could, you know, get into big trouble if your blood pressure isn't under control. How, what can I do to help you?" I always put it in there, "tell me what it is your barrier to being able to do it right." P09, 200  
When you're in a tough situation, like I was saying earlier, where you have to tell them something where, 'You need to get your stuff together,' at that point I don't think it matters anymore because your putting yourself at risk P13, 224  
So, for example, if I have a patient who comes in and hasn't been to an appointment in six visits, which is, you know, two-and-a-half months, and they have uncontrolled diabetes or hypertension, that's where I come in and am like, 'Where have you been.' 'Oh, well ...' Okay, and I say, 'My concern, if you want to take care of you that way, that's fine. That's your choice. But, at that point, I'm responsible for the baby. You haven't been here. You haven't ... You're putting your baby at risk, and that is where they sometimes need a lightbulb. I understand it's hard; I understand there are reason for why this is going on, but this is what you're doing, and I'm responsible for that P13, 227

Degree of Pain/  
Consciousness

So with the horizontal patient there's different levels of consciousness. You know, somebody's just, you know, they're brought in unconscious. Well, you know, empathy is way back at that point . P01, 264

. So, that's the main thing, so and again somebody who has a broken leg and they're hurting, that...that pain overwhelms much of their perception , I think about courtesy and respect and stuff like that. I think you can still be respectful, and there's still a way to express it , but it's pretty much inversely proportional to the patient's level of consciousness. P01, 271  
The ability to be forceful, make decisions quickly , and so forth, eliminating the patient, because if the patient is horizontal basically the patient's cognitive process is eliminated. Um, so, that's what you're trained to do . P01, 362

Empathy, um, usually is not involved in the acute hospital setting. Not so much the people that are in the room and feeling a little better, but more the ones who are really sick and have such severe derangements that are almost non-compatible with life in a physiological standpoint. You know, they may be in the ICU on a breathing machine. You know . You can try to empathize with them at that point, but it's more the family than anyone else P17, 201

High-Pressure  
Scenarios

And I know it goes down the whole left hemisphere, and I know whatever I do, may make or break her in this next 30 minutes or next hour. And I know that the world is watching me, I know that everybody's television sets are tuned to what I'm going to be doing to this woman. And I've got to be able to emerge from this, and I've got to be able to explain my actions, I've got to be able to do this, uh, I've got to be the hardest, slickest, most goal-directed, most pointed, strongest, deliberate, concentrated...and I've even got to look good on television. P05, 111

And so, you know, it tends to make you lean away from the subjective and more towards the objective . And you have to have sometimes a closed ego, or closed mind, to be able to survive in that . P05, 120

Yeah, it may not be so much that there's a lack of empathy, but there's a certain sense of urgency . And, you know, if you come in and you're bleeding to death and you're doing to die, I would love to sit down and have a cup of tea and discuss with you the various options we have to keep you from dying. I don't have that luxury P14, 127

Yeah, and then after that you can kindof sit back and try to assess what's going on and be a little bit nicer. But, otherwise, you don't always have that luxury. And it is a luxury; it's nice to be nice. But it doesn't always happen . P14, 135

Or it might be a little bit of empathy-delayed . After all this is done, we come back and say, 'Hey, you know what (inaudible). P14, 260

But no matter at that point how much you empathize, you still have to get the body back to some sort of livable, physiological state. You can't have someone with a very, very low blood pressure and emphasize. You have to treat them medically, too. So I think empathy maybe takes a back seat—it's not as important to my job when they have such an acute illness that's not compatible with life P17, 206

Dealing with  
Failure/  
Disappointment

And so it's a self-defense mechanism. And you have to be pretty tough in ego to withstand failure in surgery, cause it's not what we go into medicine for. And yet some specialties lend themselves to that P05, 131

HB: And the protection is ...in terms of not getting too close to the patient... P05: Well, just not constantly being disappointed, everyday with your work . P05, 165

No, they are afraid. They are just as afraid of death, they are afraid of their own failure – maybe it was something I should have seen and didn't see. So they're retreating to their own little hole to deal with it. P11, 209

And the problem is the doctor doesn't know why the baby died. Mom wants to know immediately what happened and he can't tell her so he doesn't feel comfortable. He's not comfortable sitting there saying "we really don't know yet. Hopefully we'll see when you deliver. We'll do some tests and try to figure this out together. But I don't know. But it wasn't anything you did, wasn't anything you didn't do." P11, 188

Well, you do the best you can and understand you can't fix it. You fix what you can, you offer resources, and rather than get frustrated that you can't fix it all or feel inadequate or impotent because you didn't fix it all, you understand that, you know, issues with the patient and/or the family that prevent that from happening—and some of them they should be able to fix; some of them, maybe they can't P15, 376

No, you don't get used to people dying, in fact, you know at the beginning when people died it probably had more to do with the fact that you felt like as a doctor you failed cause you didn't save them P18, 176

Yeah, to know that something like that happened? Well, you sort of put up your own defensive walls and stuff. I mean, "how could I possibly have known what's different between this patient and any other one? Is there anything that I missed that I should have been more cautious about?" P19, 82

**APPENDIX H**  
**SELECTED MEMOS**

### **Empathy vs. Compassion (HB)**

Empathy is technique. It can be taught. But caring and compassion is something else all together, and you either have it or you don't. Your personality and experiences earlier in life guide your compassion and caring. The two are probably somewhat related. If you care about a patient, you're going to practice empathy so that you can achieve better outcomes for your patients. But just because you care doesn't mean you are empathic. Maybe caring is necessary for empathy, but the two are not mutually exclusive. Could you be empathic and not care? Sure, but you would have to consciously renew your motivation in each patient setting. I suppose the only reason you would be empathic and not truly caring is to improve outcomes--not solely for your patients' sake--but to improve your own standing, statistics, or income. Medicine is entering a new era of pay for performance, where the physicians with the best patient statistics will receive incentives (or avoid penalties). If empathy can have up to 30% therapeutic effectiveness, I suppose physicians could practice empathy with patients for the sole purpose of incentives.

### **Empathy as Acceptance and Recognition (RTM)**

Empathy is not normalizing a patient's fears or emotions. It's acknowledging that those fears and emotions exist. It's showing, as a physician, that you accept those fears and emotions and want to help address them.

### **Empathy as Reflecting Back (RTM)**

Providing empathy to a patient is like providing a the patient their own reflection. Looking into the Lincoln reflecting pool. Not only does a patient clearly see that you understand the emotions they're expressing, but they also seem those emotions in a raw, more accurate way. Looking into the Lincoln reflecting pool, someone might realize their makeup is smudged or that their sunscreen isn't rubbed completely into their skin. If you can reflect a patient's emotions back to them, not only do you express your understanding of those emotions, but you provide the patient something they may not have previously recognized: a different way of viewing themselves in their emotional narrative

### **Self of the Physician (HB)**

One fairly consistent theme seems to be that there are various levels of barriers or issues that must be chipped through in order to get to an empathic relationship, and many of these are external factors. However, there is also the emerging idea that physicians may have difficulty knowing how to incorporate their "self" in their medical care. There is the medical side of treatment, which is what is studied in medical school and perfected in practice. There are also customer service/considerate actions that are based on best practices or simple common courtesy. These elements are focused around outcome, diagnosis, and keeping a business running.

The element that is not taught, but rather observed or already present as an intrinsic quality, is how physicians can integrate themselves within their work. Are they just a white coat, or can they risk a relationship with a patient? Will the patient hurt them,

whether indirectly through the burden of suffering, or directly through a lawsuit? Can they trust to disclose some of their own information, or get to know a patient on a deeper level, risking the fact that they patient may die, or not return for a future visit? All of this seems to be something the physician "feels out" along the way, since there is no model (other than modeling from other physicians) for how to navigate the process. Physicians seem to continuously be trying to determine their role beyond medicine in how to handle the person before them. Some make this process easier by focusing exclusively on the disease, or working in high-risk and intense specialties where the task at hand is the most urgent. Others try to figure out the balance, with warnings in the back of their heads of getting "too close" or losing some element of medical objectivity which could then limit their work. How, in serving their patients, does the physician allow his/her "self" to enter the picture?

### **Types of Patients that Need Empathy (HB)**

#### Strong Empathy

- Dying patients
- Patients you will see for many years
- Patients facing a life changing diagnosis or loss (cancer, HIV, neonatal death, etc)
- Patients making significant lifestyle changes

#### Less Empathy

- Routine care
- Procedures that are minimally invasive
- Difficult patients/ Patients with Self-Inflicted Health Problems

#### Little to No Empathy

- Very young children
- Unconscious
- Trauma
- Patients who have harmed others

### **Levels of Empathy (RTM)**

It appears that physicians and nurse practitioners experience a similar struggle with boundaries as counselors do. When the participant was discussing the risks associated with being empathic, she mentioned that patient can perceive empathy as friendship. There is a healthy line that exists between counselors and client and doctors/nurse practitioners and patients. However, sometimes it is difficult to define that line and stay true to it. Balancing the risk with the need of empathy also appears to be a challenge.

### **Human and Physician (RTM)**

The participant mentions being human throughout his interview as being related to empathy. It is as though there is a difference between showing one's humanity and acting as a physician. My assumption is that it is a rejection of the compassion one might feel for someone's predicament. Allowing oneself to not feel those human emotions creates

focus on something more benign - medicine. Another component of this might be perfection. Seeking perfection in medicine typically does not include joking and building relationships with patients.

The interviewee speaks to the struggle between the humanity of a physician (e.g. making connections with the patient, showing empathy, building a relationship, showing courtesy) and being in the profession (e.g. focused on the solution, driven to get the job done).

### **Person-Centered Medicine (HB)**

Another way to possibly view it, one that would include empathy, is to draw in the idea of person-centered medicine. This would translate Roger's person-centered counseling and apply it to a medical relationship (probably very similar to patient-centered care). However, unlike patient-centered care, Roger's person-centered model goes beyond showing interest in a patient and asking broader questions. It is more a way of being with a patient - a respect, a desire to "know" and to understand more deeply. It is applicable in even a brief, time limited encounter. I wonder if many of my participants are really referring to this element when discussing intrinsic qualities of empathy or, as in counseling programs, can a person-centered model be taught and incorporated into medicine?

### **“Working the Trenches” and Empathy (HB)**

Nurses and some physicians who started out in related professions mention the value of "working in the trenches" in their ability to be empathic with patients. Something about performing intimately personal tasks with patients, such as sponge baths, feeding, cleaning up, or even just being there consistently throughout the day to see a patient progress, adds something that can then be retrieved later on when the professional is in a different role. The protection of academia and memorized learning in this sense may act as a barrier to prevent understanding this closeness, or seeing how patients handle being most vulnerable. Without these experiences "in the trenches" physicians might not have insight into the patient's experience.

If this is true, then perhaps some experience of entering a private segment of a patient's life is required for empathy to take place. A glimpse behind the curtain of defenses and an openness to responding to vulnerability may be necessary. Otherwise it would likely be easy to respond to only the "problem" without seeing or knowing what to do with the experiences of the person.

### **Customer Service (HB)**

Previously I was thinking of "common courtesy" as a way to describe the polite consideration of patients that did not seem to quite capture empathy but that still was present in participant interviews. One participant, however, called this good "customer service," which I think fits well. This concept of customer service is about marketing ones services and advice in ways that will be followed. I wonder if this is where the placebo effect comes in - physicians know placebo helps create positive outcomes, and thus will utilize it as a tool of their practice. Ensuring patient comfort, sitting down in the



room, letting the patient begin the interview - all are techniques designed to, ideally, increase patient satisfaction and compliance. I'm still unsure how much of that involves empathy, or whether it is really just good practice to produce desired outcomes.

### **Empathy as Tolerating Diversity (HB)**

Many participants mention using empathy to read patients - body language, tone of voice, content of stories. Participants also discuss the diversity of their patients and many make the point that no patients are alike, even if they have similar conditions. Empathy, then, seems to allow the flexibility needed to treat individuals rather than applying universal treatments. By recognizing the depth and diversity of patient identities physicians are able to suspend the belief that there is an easy or ready-made treatment and view the patient as complex.

### **Shades of Empathy (HB)**

I keep getting caught up in counseling's definition of empathy and thinking that these physicians I'm talking to are missing the mark in their definitions. It could very well be that physicians are unclear on what empathy is, and it could also be that empathy actually doesn't have a place in medicine. Or, I'm wondering if perhaps empathy has different "shades" to it that accomplish different professional goals. Obviously the point of empathy in counseling is to create a therapeutic relationship based on deep and accurate understanding to the client and the client's condition. The advanced empathy is aimed at helping clients explore deep and personal meanings that they may never have examined before. This requires time and a deeply personal relationship with the therapist. Physicians neither have that time, nor is their purpose to explore these deeply seeded therapeutic meanings. Their "shade" of empathy, then, may be much more muted and thus also would probably achieve much more muted reactions from patients. In other words, clients who are receiving advanced empathy may have "aha" moments that can be life changing. Perhaps empathy in medicine triggers much smaller reactions from patients, but still reactions that result in beneficial growth for the patient (compliance, positive feelings towards the visit, etc.).

Perhaps the reason physicians are not "hitting the nail on the head" and describing empathy in its purest form is because they only really need to tap into a more limited form of empathy. In that sense things like "understanding" or "caring," though inadequate to describe genuine therapeutic empathy, may be an accurate depiction of empathy in medicine. There is the sense that extending compassion, taking time to suspend medical goals/checklists to listen to a patient, valuing patients as individuals and removing the distance of the authority figure, etc. can be empathic. The main question I have at this point is can we call this empathy? Is it not better labeled as caring, compassionate practice, mutual respect? If we do call it empathy, as the physicians in my study have done, what "shade" of empathy is it? How can I place it along a continuum or otherwise describe the process of empathy - results - consequences?

### **Empathy More About Patient Understanding (HB)**

Several participants mention how communicating so that the patient understands is a major role of empathy. The act of modifying messages based on either

observing/listening to the patient or anticipating patient literacy/understanding/reactions is clearly the end goal. This seems to mirror the Carkhuff and Truax definition of empathy in terms of the final stage, namely communicating understanding in a way the patient can understand. The Carkhuff/Truax definition makes this the end result of the empathic process, and it is of course pivotal. What I am not really getting from my interviews, though, is the process of getting to that point. In other words, I'm unable to fully discover the stages that are "owned" by the physician. In describing these stages, participants have mentioned all that can go wrong or impede the process (barriers and limitations). There is also a sense of struggling to maintain and monitor personal barriers so that they do not get "too close" in the process of "packaging" the message for patients. Empathy is, of course, ultimately about the patient, but I wonder if physicians are unsure of how THEY contain and manage that empathic process. The role of the physician seems to be blurred, blunted, and perhaps a bit uncomfortable to consider.

### **Empathy and Success with Patients (RTM)**

Most participants attribute empathy as contributing significantly to their success with patients. In explaining how it contributes they use words like "trust" or "relationship" or "confidence." There seems to be a sense, then, that empathy (whatever it is and regardless of description) facilitates a trust for the physician that then allows successful treatment to occur.

### **Maturation (HB)**

There is almost a sense, as I code these interviews, that empathy (or at least empathy as it is perceived by physicians) is something that comes with maturation, growth, settling into a role. I get a vision of new students as having passion (or perhaps just dreams of income) but being too quick to find the problem, or get down the checklist, or please a superior. And then there seems to be a maturation. Participants talk about learning through example, leveling out over time in their responses, or becoming more comfortable with the medical side that they are able to fully engage in the "art." The "art" of medicine seems to be the ability to simultaneously balance medical knowledge and skill with a thoughtfulness and sensitivity to the patient. Whether it is honing in on something a patient says that goes beyond medical symptoms, wanting to connect with more personal details, expecting certain reactions to bad news based on responses of other patients before them, or seeing that patients are much more than a collection of symptoms, somehow this "art" emerges and allows physicians to blend roles in the same way an artist might blend colors or paint strokes. It is a process of "becoming" that occurs with time and that can be thwarted by many barriers and challenges, both internal and external.

### **Patient vs. Physician Drive (HB)**

In describing interactions with patients, several interviewees distinguish that an interview can be either physician-driven or patient-driven. In a physician-driven interview it seems as though the physician does most of the talking, asks closed-ended questions, and is very direct. In the patient-driven interview the physician allows the patient to speak, asks open-ended questions, is mindful of interrupting the patient, and allows the patient to focus on his/her area of concern (whether it is the primary issue or not). In this

conceptualization, the physician still holds the power in the relationship, but makes a determined effort to continually cede some of that power to the patient.

### **Personal Experience with Illness/Specialty (HB)**

Some participants (P09, P11, P07, etc) describe personal experiences with something within their speciality area, either they themselves experienced or they saw someone close to them experience. This experience seems to have led to their career choice, as well as their awareness of what is "needed" by a patient during that experience. Perhaps a potential theme to draw from this trend is that some physicians who have a personal connection with the area of their expertise may also place more emphasis on the patient's experience than a physician without that personal knowledge.

### **Learning Empathy as Superficial/Not Genuine (HB)**

Though many participants seem to see empathy as something that can be learned, at least in terms of types of responses, they largely seem to believe that such empathy will be seen as disingenuous by the patient. In other words, learned empathy without any of the inherent skill may come off as forced, not genuine, or superficial. Patients, according to these participants, can easily see through forced empathy and are able to distinguish when a physician is being genuinely caring as opposed to implementing training.

### **Selecting Empathy in Specialty Choice (HB)**

There seems to be a sense of medical students either choosing their specialty based on the ability to be empathic (or have a relationship with patients), thus indicating a self-selection process, or that maybe students are gradually led to a speciality area based on their identification with others in that area. In other words, seeing who the "surgeons" are, versus being able to tell who the "family doctors" are. Specialities seem to have a "type" that students may be sorted into, or that they may deliberately choose based on their desired professional conduct.

### **Empathy as Physician-Serving (HB)**

In various ways throughout the interviews I've conducted so far, empathy and the examples provided for it seems to be used as a means to an end for the physician. In other words, empathy is not as much about the patient feeling heard, as it is about the physician gathering information, eliciting the placebo effect, regulating the degree of emotion in delivering bad news, etc. Empathy seems to be a medical tool, also described as an "art," that is still more focused on delivering medical care than the experience of the patient. It is unclear whether this is a good or bad thing, however other interviews seem to cast new generations of medical students in a negative light due to self-serving motivations and behaviors. Therefore, if empathy is conceptualized as something to help the physician would it still result in empathic treatment, or is a concern for the patient's experience necessary for true empathy to occur?

### **Empathy as Intrinsic (HB)**

All of my interviewees so far (5) have said that their personality is the source of their empathy, and that training/skill development only helps them with that. They don't consciously think much about it, but can recognize if others are deficient in the quality.

They also seem to have difficulty explaining what it is, other than an interest in connecting with others.

### **Interviewee Empathy: Caring, Professional Courtesy, Treatment (HB)**

It is difficult to nail down such a broad and vague topic, and I'm finding that to be true in these interviews as well. However, I'm also finding some differences between them:

- Caring: they seem to be motivated by helping and serving others, almost seeing others as family members or close friends. They value the relationship and recognize this relationship as critical to their work.
- Professional Courtesy: The "right thing to do" in the professional role. Common courtesy (sitting down, not looking at watch, etc.)
- Adjunct to treatment: they feel that helping a client feel at ease, asking open ended questions, and investigating areas of the life other than just the physical will help with patient compliance. Thus, they accomplish their goals and the patient is happy. There may be some concern and caring for the individual involved, but it is almost a sense of using the right tools to get the job done.

I'm not sure if I'm capturing it accurately with these descriptions, but they are the closest I can get this early on.

### **Interview Question Changes? (HB)**

Add the question:

**- How do you know when you are being empathic?**

It also seems like I am not quite getting to the heart of the matter. I hope my research team members can help me identify how to change questions to discover new material, or to get deeper into the definitions.

Maybe I could also ask:

**- How do you know when a patient feels heard/understood?**

I think I might be allowing myself and my interviews to veer more towards training element, which is important but not my primary focus.

### **Medical School Admissions (HB)**

So far at least two of the first three interviewees have expressed some concern over medical admissions processes, in that students are selected based on GPA and MCAT scores, but not selected based on their ability to be empathic or care about patients. There is also a sense that many students are self-selecting a career in medicine based on the potential salary or prestige, more so than a desire to help patients.

At this point I'm wondering:

- Are my interviewees simply more mature and farther along in their careers that they don't remember how they once were, or is this new group of students really

qualitatively different?

- I wonder if students would say similar things, or if this is just a generational perspective?
- How could/should medical admissions processes be changed to reflect this need?
- Is empathy in medicine becoming an extinct factor due to the personalities of the current students?

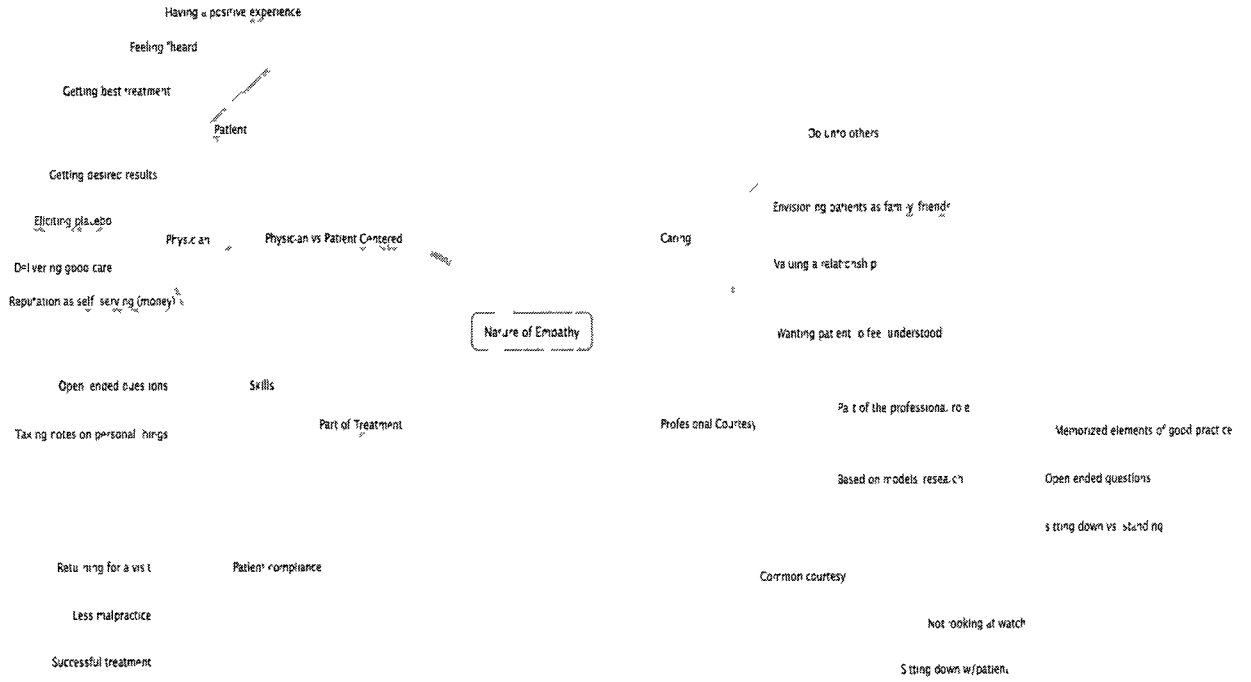
### **Empathy For Physicians (HB)**

One theme to emerge already, which is something I am also predisposed to due to my own musings, is the idea that physicians are rarely on the receiving end of empathy. They are expected to run as machines, without stopping or given a chance to stop and reflect on their experience. P01 stated that she tried several times to have an informal support group, in the tradition of Balint groups, and how rewarding that seemed to be.

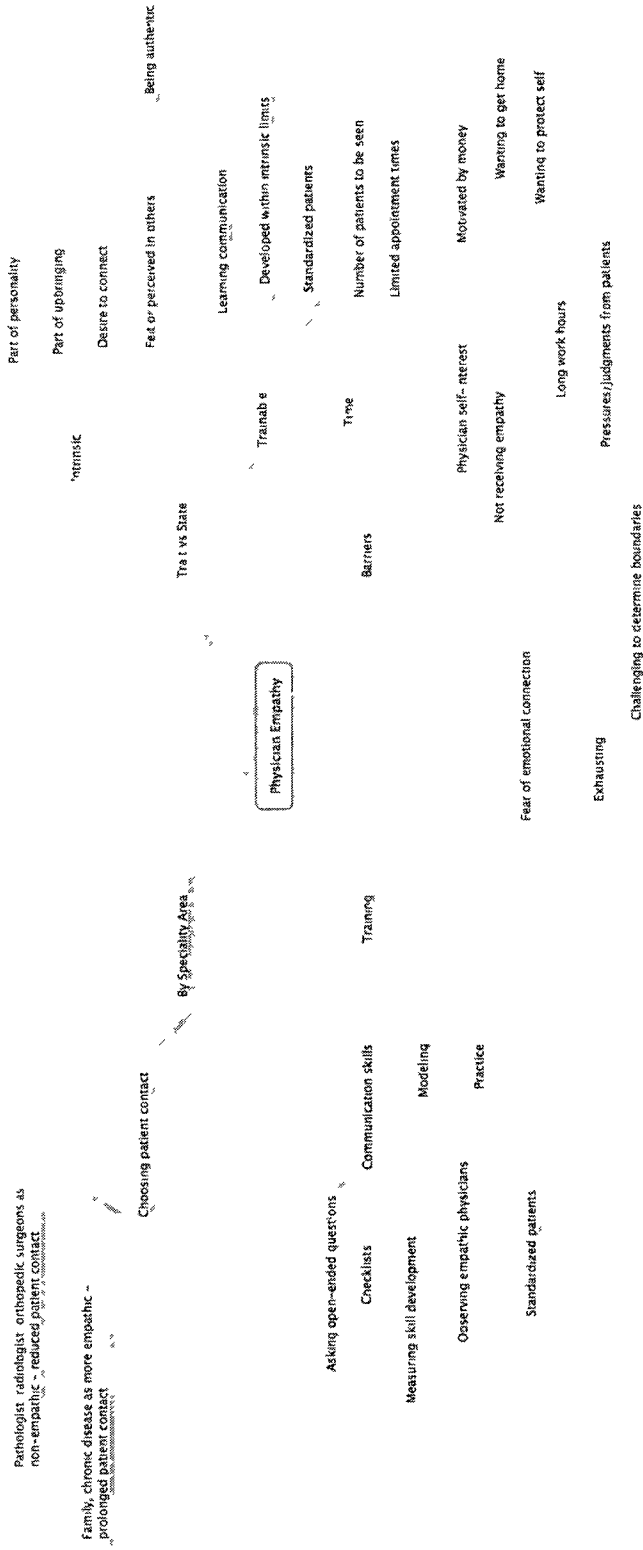
How can physicians be expected to be empathic when no one is empathic to them? How can long work hours and high pressure environments create doctors who even care about relating to patients? I wonder if the dehumanization within medicine is not really so much about the patient as it is about the physician, with patient care being the natural consequence of the physician's own state of being.

**APPENDIX I**  
**SELECTED DATA DISPLAYS**

# Nature of Empathy



# Physician Empathy



Pathologist, radiologist, orthopedic surgeons as non-empathic → reduced patient contact

Family, chronic disease as more empathic → prolonged patient contact

Choosing patient contact  
By Specialty Area

Asking open-ended questions

Checklists

Measuring skill development

Observing empathic physicians

Standardized patients

Communication skills

Modeling

Practice

Training

Time

Number of patients to be seen  
Limited appointment times

Physician self-interest  
Not receiving empathy

Motivated by money  
Wanting to get home  
Wanting to protect self

Long work hours

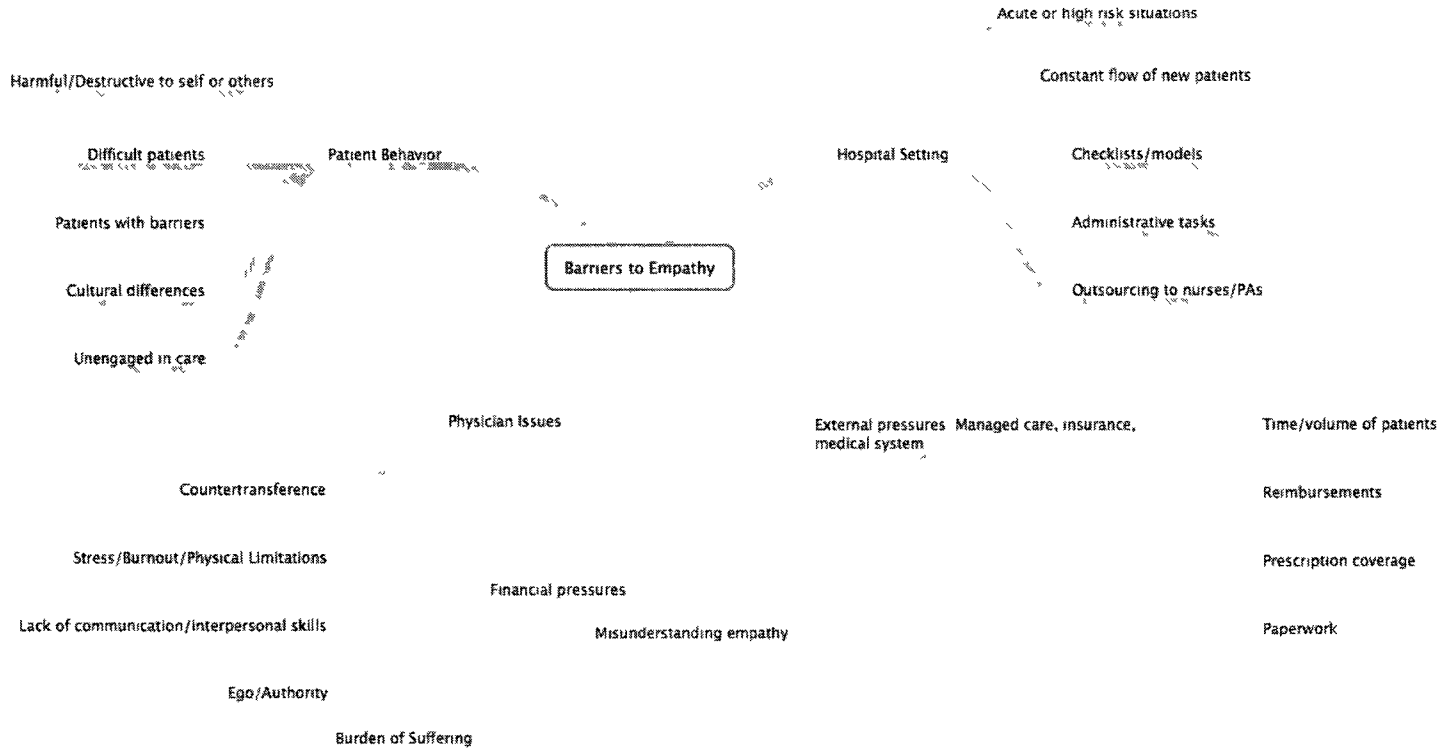
Pressures/judgments from patients

Challenging to determine boundaries

Exhausting

Fear of emotional connection





**VITA**

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Hannah has several years of counseling experience within the college counseling and community mental health settings. She has worked as the assistant coordinator for practicum and internship experiences in the counseling program at Old Dominion University, and was also employed as a graduate teaching assistant in the Human Services department. Hannah has taught at the undergraduate, master's, and doctoral level. She has also provided individual and group clinical supervision for master's level counseling students. She is currently employed as a counselor at Northern Virginia Community College in Annandale, Virginia.

In addition to clinical and teaching experience, Hannah has presented at international, national, and regional conferences. She has over 20 professional presentations, and has an article accepted for publication in 2011. She holds an executive council position in the American College Counseling Association, and is a member of several other national and state divisions.