

Abstract

Empathy is an important way for doctors to demonstrate their understanding of patients' subjective experiences. This research considers the role of empathy in 37 doctor-patient palliative or end-of-life care consultations recorded in a hospice. Specifically, it focuses on four contexts where there is a disparity between the patient's displayed experience of their illness and the doctor's biomedical, expertise-driven perspective on their illness. These include cases where the patient is sceptical of the medical perspective, cases where the patient's expectations exceed what can realistically be provided, and cases where patients have an overly pessimistic view of their condition. The analysis shows how doctors can use empathic statements to display that they are attentive to the patient's subjective experience even when the task at hand is, ostensibly, an expertise-driven, biomedical one. It thus demonstrates that empathy is of importance throughout palliative care consultations, even in those phases which might seem biomedical or task-driven.

Key words: empathy, palliative care, end-of-life care, hospice, conversation analysis, healthcare communication

What do displays of empathy do in palliative care consultations?

It is well established that a doctor's biomedical expertise about a patient's condition can be incongruent with a patient's own displayed emotional experience of that condition. Mishler (1984), for example, famously portrays medicine as a dialectic between the doctor's 'voice of medicine' and the patient's 'voice of the lifeworld'. More recently, Raymond (2014) distinguishes between 'doctor's side' and 'patient's side' knowledge, with the former relating to doctors' "scientific training and understanding of how diseases operate" and the latter to patients' "own personal, biographical experience of living with the illness" (p. 426). Peräkylä (1989), also, outlines the four 'frames of death' in a hospital, the first two of which (the practical and the medical) see the patient as an "Object", the second two of which (the lay and the psychological) see the patient as a "Feeling and experiencing subject" (p. 119). Relatedly, Heritage (2013) suggests a distinction between an 'epistemics of expertise' and an 'epistemics of experience' (see also Heritage, 2011), a distinction taken up at length in a medical context by Lindström and Weatherall (2015).

In this article, we will focus on these two different perspectives in palliative care. Palliative care is, of course, an environment where patients are likely to deal with particularly distressing experiences of their illnesses. Our focus will be on moments when it becomes clear interactionally that patients' experiential and doctors' expertise-based perspectives are at odds. Using conversation analysis (CA), we will show how, at such moments, doctors can display empathy (that is, an understanding of the patient's emotional experience) to bridge the gap between their perspective and the patient's perspective.

We will begin by outlining our approach to empathy, before going on to analyse four interactional contexts where incongruence between these two perspectives becomes apparent.

An interactional approach to empathy in medicine

Perhaps the most common way of empirically researching empathy in clinical settings is to use questionnaires and other post-hoc measures to determine how empathic a doctor is or was perceived to be. Popular measures of this type, according to reviews by Hemmerdinger et al. (2007) and Pedersen (2009), include the Interpersonal Reactivity Index (Davis, 1983) and the Jefferson Scale of Physician Empathy (Hojat et al., 2001). As useful as such measures might be, though, we will not use them in this research.

Instead, we will approach empathy "as [a] sequential [process] in talk-in-interaction" (Ruusuvuori, 2005, p. 206). One popular framework in this interactional tradition has been that of 'empathic opportunities', defined by Suchman et al. (1997) as moments "in which a patient directly [expresses] an emotion and [creates] the opportunity for an empathic response, in which the physician explicitly [acknowledges] that emotion" (p. 679). Coding systems such as the Empathic Communication Coding System (Bylund and Makoul, 2002) study such opportunities more systematically, including in palliative care (Pollak, Arnold, Jeffreys et al., 2007). Other researchers, however, have approached empathy from a conversation analytic (hereafter CA) perspective. This has included research on empathy in non-institutional, everyday contexts (Heritage, 2011; Kupetz, 2014) and research on empathy in non-medical institutions such as helplines (Pudlinski, 2005; Hepburn & Potter, 2007; Moore, 2009) and earthquake volunteer response (Kuroshima & Iwata, 2016).

An even closer antecedent for the present study is CA work on empathy in medicine. Conversation analysts in this area have, like researchers in the empathic opportunities tradition, largely focused

on empathy as a doctor's response. Muntigl et al. (2014), for example, analyse how psychotherapy clients describe events while displaying some affective stance towards those events, creating an opportunity for the therapist to respond empathically. Wynn and Wynn (2006), also, outline the different types of empathy found in psychotherapy, and emphasise the importance of the patient's response to being empathised with. Weiste and Peräkylä (2014), meanwhile, analyse therapists' prosody when formulating patients' talk, seeing it as an indicator of the trajectory (either validating or challenging patients' emotions) these formulations are initiating.

To summarise, much interactional research on empathy in medicine has focused on how it is precipitated by the patient and the design of the doctor's turns when responding to such precipitating turns. This view on empathy is summarised by Frankel (2009) as a 'three-part sequence:

- "(1) a patient initiated empathic opportunity"
- "(2) an empathic response on the part of the physician"
- "(3) the patient's response to receiving empathy" (p.1-2).

A number of conversation analytic researchers have gone beyond this framework, however, to show how empathy can be used not simply in *responding* to patient-generated opportunities but in accomplishing clinical goals. This is the approach taken by Ruusuvuori (2007), who highlights a case in which a patient's response to the doctor's 'proposal of affiliation' was used by the doctor to support a treatment decision. A similar 'integration' of empathy "into the institutional problem-solving task" (Ruusuvuori, 2007, p. 617) was also observed by Voutilainen (2010) in psychotherapy, where a therapist's affiliative turn performed an empathic function while simultaneously "[serving] the therapeutic problem-solving" (p. 29) (see also Voutilainen, Peräkylä and Ruusuvuori (2010) and Voutilainen and Peräkylä (2016) on the functions of empathy and affiliation in this context). In a non-medical context, meanwhile, Hepburn and Potter (2007) showed how call-takers on a child-protection helpline empathically responded to callers' upset. They showed how these responses displayed understanding of the caller's plight while simultaneously avoiding, as mandated, "any commitment to the factuality of the caller's account" (p. 108). They also showed how these responses helped to move the call back to the topic at hand.

The present research will build upon that of Hepburn and Potter (2007), Voutilainen (2010), and, particularly, Ruusuvuori (2007) by considering the *function* of empathic turns (beyond simply, and somewhat tautologically, 'being empathic') in the institutional context in which they are done, and the benefits that this can have for the ongoing interaction. Whereas Ruusuvuori (2007) focused on how empathy could be used in supporting treatment decisions, here we will focus on how doctors can use empathic displays to bridge the gap between their expertise and the patient's experience when it becomes clear within the interaction that there is a disparity between the two.

Data

The data for this research were collected as part of the Video-based communication research and training in decision-making, empathy and pain management in supportive and palliative care (VERDIS) research project¹. The researchers made a total of 37 audio and video recordings of doctor-patient consultations in a UK hospice over six months.

¹ <http://www.nottingham.ac.uk/research/groups/srcc/projects/video-research.aspx>

In total, approximately² 100 overt empathic moments were found in the data. The six cases (with four doctors) featured in this chapter come from a smaller subset of these cases in which empathy was integrated into a clinical task. Both inpatients and outpatients were recruited, and both are represented in this research, as are family members and friends who accompanied them. All participants gave verbal consent prior to being recorded, before giving written consent after the fact.

Analysis

We will now consider four interactional contexts in which a disparity can arise between the doctor's expertise-driven, and the patient's experiential, perspective. Our focus will, as above, be on how the doctor's empathic displays address such disparities by bridging the gap between the two perspectives. For our analysis, 'empathic displays' are defined as statements in which the doctor shows his or her understanding of the patient's emotional experience³.

The patient is sceptical of the medical perspective

This section will focus on cases where the patient is sceptical of the treatment or advice offered, even if they are, from a medical perspective, sound. Faced with such a situation, the doctor must acknowledge the patient's scepticism while still conveying the medical perspective.

An example can be seen in extract 1, which begins after the (female) doctor has physically examined the (male) patient. The doctor is remarking upon the patient's improved condition which, just prior to the start of the extract, she has attributed to his tablets.

Extract 1 [VERDIS DOCTORS P36/F: 25.18 – 25.38]⁴

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1          Doc: And I'd sAY ye-
2          Pat: M(h) : [m: .
3          Doc:          [I'd say your br↑eathing's probably better than
when I saw
4          you: .
5          Pat: >(D')you think sO.<
6          Doc: I dO: .=(It) might not [be as g]ood as you want
i (h) (h) : t: . =
7          Pat:          [(Yeah.) ]
8          Doc: =[.hhh N(h)o eheh .hh I guess what' [s: ]
9          Pat: [Nō: :. Nō: :.          [Mm:] : hh[h.
10         Doc:          [what's
frustrating
11         IS: .hh (0.3) i:s (.) we mAYbe cā:n't geddit as good
you'd
12         Pat: M(h)m(h)m pt.
13         Doc: li:ke it [to be. ]
14         Pat:          [ Nō: :.] =And p' raps it's cuzza took me
nebuliser first
15         thing .hh this morning.

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At lines 3-4, the doctor positively assesses the patient's condition, suggesting that there has been improvement ("I'd say your br↑eathing's probably better than when I saw you:."). The patient's

² This number is approximate because it includes borderline cases that, while not used in the analysis itself, were not removed from the collection.

³ This is congruent with, for example, classic work on empathy in psychotherapy (e.g. Rogers, 1980).

⁴ [VERDIS DOCTORS Patient label/Doctor label: Start time in recording – End time in recording]

response at line 5, though, treats this claim (about something to which he can claim primary access – his breathing) as unexpected assessment requiring confirmation: “>(D’)you think so.<”. There is, then, an incongruence here: the doctor’s *expertise* does not chime with the patient’s *experience* (Heritage, 2013).

To see how the doctor addresses this incongruence, consider line 6, where she first reiterates her own perspective (“I do:.”) before conceding that the patient’s own experience of his illness differs from this at line 6: “(It) might not be as good as you want i(h)(h):t.”. Note her emphasis on “you”, which indexes particularly strongly the contrast between the medical and the experiential perspective.

The doctor expands her claims at lines 8, 10-11 and 13: “I guess what’s:... what’s frustrAting IS: .hh (0.3) i:s (.) we mAYbe ca:n’t geddit as good you’d... li:ke it to be.”⁵ In response, at lines 14-15, the patient confirms the doctor’s understanding (“No:.”) and offers a possible reason for her findings on examination (“And p’raps it’s cuzza took me nebuliser⁶ first thing .hh this morning.”). He thus reinforces his experiential perspective while still displaying scepticism.

This extract shows the doctor empathically acknowledging the patient’s scepticism about his medication while simultaneously conveying the medical perspective: that it is nonetheless having a positive effect. Empathy thus ensures, in Peräkylä’s (1989) terms, that the patient is being addressed as “Feeling and experiencing subject” rather than just an “Object” to be treated (p. 119).

A second example of a patient conveying scepticism about the medical perspective can be seen in extract 2. The patient here has started the consultation by complaining about a doctor who, on a recent trip to the hospital, advised her to ‘go exercising’. She found this advice offensive because of the implied assumption that she was well enough to do so and thus must be exaggerating her illness. In other words, she saw the doctor at the hospital as challenging the ‘legitimacy’ (see Stivers et al., 2003; Heritage & Robinson, 2006; Heritage, 2009) of her illness.

It is well established that giving advice can be problematic, fraught with underlying implications. Heritage and Sefi (1992), for example, show how a mother may treat advice from a health visitor as calling into question the competence of the care she is giving to her baby, while Hepburn and Shaw (2013) show how recipients of advice can be put into morally-comprising positions. Furthermore, the patient here is complaining about advice which was presumably medically sound, whatever problems she may have had with how it was conveyed. It remains for the hospice doctor, then, to reiterate it without the offensive connotations. Extract 2 comes shortly after the patient has expanded upon her complaint.

Extract 2 [VERDIS DOCTORS P35/F: 15.59 – 17.05]

1 Doc: What we (0.3) do kno:w (0.4) .hh (.) i::s that
try::i::ng to:
2 (0.3) h:elp you <m:a:nage> the breathlessne::ss: (0.4)
so
3 that (0.6) y:ou can be as active >as you °chan.°<=Now

⁵ Notice the doctor’s use of the epistemic markers “I guess” and “mAYbe” here, which recognise her encroachment on the patient’s experiential rights (see Ford, 2018; Hepburn & Potter, 2007). Notice, also, how the patient mirrors this in his response at lines 14-15 by epistemically downgrading his speculation about the reason for his improved condition (something that falls into the doctor’s expertise-based domain) using “p’raps.”

⁶ A device for administering drugs in the form of an inhaled mist.

lines 21-22 and 24, showing that she understands that the episodes of breathlessness are “frightening” for the patient and recognising that she feels that it is “important to go to hospital” in response to them. This display is prefaced by “although”, however, and the doctor, at lines 26-27, 30 and 32, draws upon the patient’s experience at the hospital to highlight the medical inefficacy of going there. The patient agrees with this at line 31 (“>No it didn’t.<”) and 34 (“Yeah.”).

The doctor’s empathic displays are especially relevant in this extract because the patient has complained about the *lack* of understanding shown by the other doctor. By showing that she understands that remaining active could be “hard”, and by showing her understanding of why the patient would feel that it is “important to go to hospital” (the medical inefficacy of doing so notwithstanding), the doctor addresses her concerns about the treatment she received at the hospital while still conveying the thrust of the recommendation that the doctor there had made. This has echoes of Heritage and Stivers’s (1999) findings about what they call ‘online commentary’, where doctors’ remarks during physical examination flag up that a ‘no problem diagnosis’ is forthcoming while still recognising patients’ reasons for seeking treatment (reflected particularly strongly here at lines 21-22 and 24). Like in extract 1, therefore, the doctor here has acknowledged the patient’s scepticism about medical advice while simultaneously conveying the medical perspective.

The patient has unrealistic expectations about treatment

Another context in which doctors can use empathic displays to bridge the gap is when patients have overly optimistic expectations of the care that can be provided. Consider, for example, extract 3, which begins during a discussion about the patient’s preference for where he would be at the end of his life. He is talking about how he would rather go to hospital than be at home.

Extract 3 [VERDIS DOCTORS P31/D: 32.44 – 33.34]

1 Pat: I’d rather< (.) they treat me and then if I die I die.
2 Doc: pt. [Right.
3 Pat: [.hhh I either (want to) go in (the) hospital
o:::r where
4 they (would look) after mhe.
5 Doc: Mm.=Would you come he:re r- (ehh) as opposed to
hospital?=Or
6 would you want to go to hospital.=
7 Pat: =.hh (That’s) one thing I’m n(h)ot s(h)ure o(h)f.
8 Doc: No.
9 Pat: .hhh (No. I’d ra-) I mean I don’t mind here (y’know
and) hhh
10 (I [heard] it’s being looked after well) but (0.3)
.hh[hh]hh=
11 Doc: [Mm.]
[Mm.]
12 Pat: =I think (coming/I’m down he::re) it’s like (1.0) pt.
hh .hh
13 (0.4) the dead end.
14 (.)
15 Pat: .[h h h] h hAafter here there’s nowhere e(h)lse.
[.hhh=
16 Doc: [Mm-hm.] [Mm-
hm.
17 Pat: =(°Yhou knho::whh.°)=
18 Doc: =°Mm.°=
19 Pat: =So I’m a bit scAREd. hh
20 (.)

21 Pat: But if I have to I hhave to. .h[hhh] hhhh [I don't]
mind.
22 Doc: [Mm.] [pt. .hh]
23 (0.4)
24 Doc: >It's difficult isn't it.<='Cos I: (.) I hear what
you're
25 sa:ying,=it's (im-) (.) it's helpful to have hope and
treatment
26 might wo::rk, (0.3) .hhh Someti:mes: you come to a
point whe::re
27 people know treatment won't work,
28 Pat: Yeah [I know.]
29 Com: [(M:::):m.)
30 (0.3)
31 Pat: [°Yeah.°]
32 Doc: [And th]en:: (0.7) it- (.) it fee:ls is it helpful
then to:
33 (0.5) to go to the hospital where it's busy: and
noisy:

At lines 1 and 3-4, the patient expresses his wish to go to the hospital where he hopes they will “treat” him. At lines 5-6, the doctor’s question proposes the hospice as an alternative to the hospital, using a format that ‘prefers’ agreement (“Would you come he:re r- (ehh) as opposed to hospital?”). He quickly latches an addition (“Or would you want to go to hospital.”) that reverses the preference, making it easier for the patient to decline hospice.

This patient responds to the initial question, accounting for his preference for the hospital by indexing his fear that the hospice would mean that he would no longer be receiving *life-extending* treatment (“it’s like (1.0) pt. hh .hh (0.4) the dead end.”, lines 12-13; “hA_hfter here there’s nowhere e(h)lse.”, line 15)⁷. From the patient’s perspective, the hospital and the hospice are not equivalent because the former can provide life-extending treatment and the latter cannot. The patient concludes with two statements of resignation at line 21.

The outcome of this part of the consultation has potentially wide-reaching consequences. The patient could, after all, make an important decision (where he will be at the end of his life) based on an overly optimistic judgement – that the hospital can ‘treat’ him in a way that the hospice cannot. The doctor’s project here, therefore, is seemingly to counter this by informing the patient that his expectations of what can be provided at the hospital are misplaced.

The doctor starts this project at lines 24 with an empathic assessment of the decision that the patient must make: “It’s difficult isn’t it.”⁸. Latched onto this, from lines 24-26, is the doctor’s more extended empathic display, which articulates the emotions driving the patient’s expectations: “‘Cos I: (.) I hear what you’re sa:ying,=it’s (im-) (.) it’s helpful to have hope and treatment might wo::rk,”. He then goes on, however, to contrastively suggest that it is possible to “come to a point whe::re people know treatment won’t work,” – meaning, of course, that the patient’s wish for life-extending treatment would be futile.

⁷ Later in the consultation, the patient makes this concern even more explicit: “I don’t mind being here [in the hospice]... (My only thought), if I go to the hospital, they might treat me.” The doctor also addresses this much more explicitly, telling the patient that the hospital “won’t have a great treatment to keep you alive”.

⁸ Note the doctor’s tag question (“isn’t it”). Hepburn and Potter (2007) show how such questions are used when a call-taker is offering advice that goes against a caller’s preferences, acknowledging their primary rights to their own perspective while offering a counter to it. That appears to be the case here, as well.

The patient shows his understanding of what the doctor has said at line 28: “Yeah I know.” The doctor then, at line 32, suggests why going to the hospital (“where it’s busy: and noisy:”) might not be the best option. In data not shown here, the patient concurs and agrees that, if there was no more hope for life-extending treatment, he would like to die “somewhere peaceful” like the hospice.

In summary, the doctor here has managed the patient’s expectations (something crucially important in palliative care practice – see Land et al., 2018) by informing him that his hopes for treatment at the hospital are unrealistic. In the process of doing so, though, he has shown his understanding of how “difficult” this situation is for the patient and the “hope” for a life-extending treatment which underlies his expectations. The doctor’s empathy ensures here, then, that his suggestion about coming to the hospice is being made in full recognition of, rather than opposition to, the patient’s misgivings.

The doctor and the patient have just discussed a distressing topic

This section will show how the incongruence between expertise and experience can emerge at moments when the medically-relevant topics being discussed could be distressing for the patient. Consider extract 4, which comes amidst a discussion about what the (male) patient would like to happen should he take a sudden bad turn. The patient has just said that he would like to receive treatment if there was a possibility of him returning to his current state.

Extract 4 [VERDIS DOCTORS P38/G: 9.06 – 9.31]

1 Doc: You feel ha:ppy (.)
 2 Pat: Y:e:[s.]
 3 Doc: [To-] to go in⁹ if w- if we thou:ght it would
 reverse
 4 things.= [If it was a rever:sible cause.=
 5 Pat: [Ye::s. Just-] =s’ long as
 it
 6 got me back to square one °shorta thhing.°
 7 Doc: Okay.=
 8 Pat: =Ye:[s.]
 9 Doc: [>Okay.<] =That’s really helpful.=Thank you [for
 t]alking=
 10 Pat: [Yeah.]
 11 Doc: =that through.
 12 (.)
 13 Doc: **I know it’s not always the easiest thi:ng [to uh]**
 14 Pat: [pt. No.]
 15 [No.]
 16 Doc: [to] **chat about.=**
 17 Pat: =No.

At lines 1 and 3-4, the (female) doctor is clarifying that the patient would like to go into hospital and receive treatment “if it was a rever:sible cause.”. The patient confirms this at lines 5-6, and the planning sequence draws to a close, with the doctor showing her appreciation at lines 9 and 11: “That’s really helpful. Thank you for talking that through.” Then, as an extension of this appreciation, she displays her understanding of the patient’s difficulties at lines 13 and 16: “I know it’s not always the easiest thi:ng to uh to chat about”. The patient agrees at line 17 (“No.”).

The future can, of course, be a sensitive topic (or, to use Peräkylä’s (1995) term, a ‘dreaded issue’) in palliative care, which patients might not be ready to discuss. As such, previous research has outlined

⁹ To the hospital.

some of the techniques that doctors can use to broach it in a way that recognises its sensitivity (Parry, Land & Seymour, 2014). Although the doctor here is not *broaching* the topic of the future, we can still see in her turn at lines 13 and 16 an after-the-fact recognition that this topic could well have *been* difficult for the patient, even as she notes that it is “helpful” to have discussed it.

The patient has an overly negative view of their condition

Earlier, we saw how a disparity could arise when the patient had an optimistic idea of the treatment that was available. This led the doctor to empathically convey the medical perspective, which was more pessimistic. This section will focus on cases where it is the *patient* who has a negative perspective on their condition and the doctor who opts to reassure them by conveying the more positive medical perspective. Reassurance is different from the tasks in the previous sections in that it is, seemingly, in line with what the patient would want to hear. Reassurance can present a problem, however, because simply telling patients that their symptoms are not serious from a medical perspective does nothing to address the impact that these symptoms have on their lives (Tannen & Wallat, 1986; Roter & Hall, 2006; Drew, 2013).

With this in mind, consider extract 5, which comes after the (male) patient has admitted to fearing that he might die during one of his episodes of breathlessness. Clinically speaking, breathlessness episodes do not in fact culminate in death, though they can precipitate fainting. How then can the (female) doctor convey her expertise about the patient’s condition without diminishing the patient’s experience of feeling that he will die?

Extract 5 begins after the patient has described an episode of breathlessness which caused him to black out.

Extract 5 [VERDIS DOCTORS P23/F: 20.30 – 21.14]

1 Doc: U:m that- that sort of .hh what- what blacking out (.)
 2 does is it allo:ws your body to res:et itself.
 3 Pat: (°°Yeahhh.°°)
 4 Doc: Really. pt. .h[h]
 5 Pat: [°Ye]ah.°=
 6 Doc: =And that’s f::ar more likely to happen than you are
 7 (0.3) °to ddrop dhead rheally.°
 8 Pat: (°°Yheah.°°)
 9 Doc: Okay? **So it feels really frightening,**
 10 Pat: Yeah.
 11 (0.4)
 12 Doc: U::m .hh what’s- (.) what’s **really hard when you can’t**
get
 13 **your brea:th (.) is that you can’t help but (0.9)**
 14 **panic a bi:t,**
 15 Pat: Yeah.
 16 Doc: **And that when you panic a bit, (.) you don’t (0.7)**
brea:the as
 17 **eff#ectively,# (.) And it kind of s:pira:ls (0.7)**
 18 **rhoun[d and] round. .hh [Um]**
 19 Pat: [(Yeah.)] [pt.] °Yheahhh.°
 ((Doctor goes explain the biological mechanisms underlying the patient’s sense of fear))

From lines 1-2, the doctor describes “blacking out” as a mechanism for the body to “res:et itself.”, an outcome that she suggests, at lines 6-7, is “f::ar more likely” than the patient dying. Given that, as noted above, the patient has previously said that he *is* scared of dying at such moments, the doctor

is informing him here that his fear is, from a purely medical standpoint, unwarranted.

She immediately follows this up, however, with an empathic display at line 9. It is here that she demonstrates that, the medical facts notwithstanding, she understands the patient's reactions in these moments: "So it feels really frightening". Note her contrastive emphasis on "feels", which, like the doctor's emphasis on "you" in extract 1, succinctly encapsulates the dual task that she is performing. Following the patient's show of understanding at line 10 ("Yeah."), the doctor expands upon her understanding between lines 12-14 and 16-18. She also at this point makes stronger claims about the patient's experience, which can perhaps be attributed to the routine, biological nature of that experience (meaning, of course, that it falls more strongly into her domain).

We can, then, see how an empathic display has helped the doctor to reassure the patient that his symptoms are not of lethal potential while recognising why he would feel *in the moment* that they might be so. This has echoes of a case in Heath (1992) where a doctor diagnoses that a child does not have a throat infection but, in the process of doing so, shows an understanding of why the child's mother felt that it was worth seeking medical help. It also, again, has echoes of Heritage and Stivers (1999), who suggest that "it is desirable that patients be firmly informed that their presenting problem is mild or insignificant, while also being reassured that it was reasonable to consult their physician" (p. 1516).

To bolster this point about the function of empathy in reassurance, it is worth considering extract 6. As in extract 5, the matter of concern here is the (female) patient's breathlessness.

Extract 6 [VERDIS DOCTORS P43/F: 42.37 - 42.56]

1 Doc: `Cos what I know,
2 Pat: M::m.
3 Doc: is that if we're gonna try and keep you goi:ng (0.9)
4 keeping you (0.3)
5 Pat: M::[m.]
6 Doc: [g]ently a[c t]iff[:,:]
7 Pat: [Mm.] [M]:m.
8 (0.6)
9 Doc: is wh[at we need.]
10 Pat: [Yes:.] Yes:.
11 Doc: `Cos getting OUT of brea:th: (0.8) in itself,
12 Pat: (°That's ri[ght.°])
13 Doc: [is]n't harm- (0.3) (is/it's) not
harmful
14 (°actu[ally°])
15 Pat: [>No it's not harmful< but it's
16 frighten[i:ng at the ti:::me.
17 Doc: [It's frIGHTening. [(Yes yes.)
18 Com: [(Yes it is.)=
19 Pat: =Y[es: : : :.]
20 Doc: [And we need to help you] manage that.

Between lines 1 and 8, the (female) doctor emphasises the importance of "keeping [the patient]... gently acti:ff:", which is interspersed with response tokens from the patient herself. The doctor then, at lines 11 and 13-14, emphasises for the patient what we previously saw emphasised in extract 5: that "getting OUT of brea:th:, (0.8) in itself,... isn't harm- (is/it's) not harmful (°actually°)". The doctor seems to be continuing her turn after this and, based on the previous example, we can speculate that she would have gone on to do an empathic display. Regardless, her turn is cut off

because the patient *herself* comes in in overlap at line 15 to emphasise that, while she understands that breathlessness is “>not harmful<”, it is nonetheless “frighteni:ng at the ti::me.”. The doctor, coming in in overlap, strongly affirms this in overlap at line 17 (“It’s frIGHTening.””) before going on, in data not shown here, to outline some of the practical ways it can be dealt with.

This extract thus shows a patient emphasising her experiential perspective in direct response to the doctor’s expertise, pre-empting the doctor doing so. It is thus an appropriate final extract for the analysis as a whole, giving a particularly strong interactional illustration of the dialectic between expertise and experience (Heritage, 2013), doctor’s side and patient’s side knowledge (Raymond, 2014), or ‘the voice of medicine’ and ‘the voice of the lifeworld’ (Mishler, 1984).

Discussion

The aim here was to analyse how palliative care doctors’ empathic statements can bridge the gap when it becomes interactionally clear that their perspective is incongruent with the patient’s. We have seen four biomedical contexts in which this can occur, the first involving patients’ scepticism of the medical perspective, the second involving patients’ overly optimistic views of treatment, the third involving the discussion of difficult topics, and the fourth involving patients’ overly negative views of their condition. In all of these contexts, we saw how doctors could ‘build in’ empathic statements which showed an understanding of the patient’s emotional experiences of their illness even when these feelings were at odds with a strictly medical perspective.

In developing this analysis, we have treated empathy as the explicit invocation of patients’ experiences and emotional states and noted the utility of doing so in acknowledging contrasting perspectives. Ruusuvuori (2007) suggests that seeing empathy as something that doctor’s ‘use’ like this could be seen as coercive and thus “not... entirely unproblematic in health care environments” (p. 617). Certainly, this kind of concern is justified, given that empathy has traditionally been regarded as something that doctor’s do for its own sake rather than for other purposes.

However, the doctors that we have seen are not being manipulative in their ‘use’ of empathy to resolve an interactional difficulty. On the contrary, the integration of empathy has made clinical tasks (advice-giving, reassurance etc.) that could easily have been done in a purely rationalistic way affiliative. In Mishler’s (1984) terms, then, it is not that the doctors in these examples have paid superficial heed to the ‘voice of the lifeworld’ to better promote ‘the voice of medicine’ but, rather, that they have ensured that the latter is consistently taking into account the former. This is in line with other research on how the two ‘voices’ can be integrated with each other (Leanza, Boivin & Rosenberg, 2013), as well as Bensing’s (2000) work on bridging the gap between evidence-based and patient-centred medicine.

This chapter has shown the integration of empathy into multiple tasks. Future research could explore other tasks into which it can be integrated, and if the integration itself could be done in other ways (for example, non-verbally). It could also explore whether this integration is present in other clinical (and, indeed, non-clinical) environments.

This latter point raises the question of whether these findings can be generalised to other contexts. The doctors’ practices in this paper are, after all, grounded in this field’s holistic approach (Clark, 1999; Saunders, Baines & Dunlop, 1995), and the terminal conditions with which they deal are also particularly concentrated within palliative care contexts. As noted, however, Hepburn and Potter (2007), Ruusuvuori (2007) and Voutilainen (2010) all observed empathy being integrated into

institutional tasks. This integration was, in both cases, limited by the remits of the institutions studied (helpline calls, general practice and homeopathic consultations, and psychotherapy, respectively). Nevertheless, they found that empathy was, as we too found, managing, offsetting, and softening the socially problematic implications of something that the professionals were doing, saying, or proposing. While it may be true that palliative care contexts are *particularly* amenable to the integration of empathy into institutional tasks, it seems this integration is a more general phenomenon in both clinical and non-clinical contexts.

Acknowledgements

We would like to thank the patients and doctors who participated in the study. We would also like to thank Christina Faull, Marco Pino and Charles Antaki for their comments on this paper, and LOROS hospice.

Funding

The data used in this research was collected by the 'VERDIS' programme of research and training funded by the Health Foundation Insight Award RU33. Joseph Ford was funded by a PhD studentship from Loughborough University. Some of Ruth Parry's time working on this project was funded by a National Institute for Health Research Career Development Fellowship CDF-2014-07-046.

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