Commentary

Who cares for empathy?

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Empathy is seen by some researchers as a cognitive attribute (i.e. ‘understanding’ another person’s concerns) and by others as an affective attribute (i.e. ‘feeling’ another person’s suffering) or both. We propose that clinical empathy should be viewed as a continuum of three obligatory sequential stages: ‘comprehension’ of the patient’s predicament (a cognitive process based on listening); followed by ‘compassion’ (an emotional or affective process) and then, ‘commitment’ to do the best for this patient (a practical stage of obtaining and applying the best patient-suited evidence and providing ongoing support). Thus, for empathy to be effective, the physician’s compassion needs to be not only felt by the patient but also followed by action.

Clinical empathy is universally lauded. This interpersonal skill is an acknowledged essential component of professional competence.1 Patients desire it.2 Physicians who are empathic are more satisfied and have less burnout.3 Sincere empathy is recognized as a major constituent in the practice styles of excellent ‘healing’ clinicians.4 However, despite all these attributes, empathy in medicine may be hard to find.

While patients’ anecdotal experiences lamenting heartless ‘technical’ medical practice may not be objective, and many additional reasons are cited by patients for the escalating popularity of ‘complementary and alternative medicine’ providers,5 research reveals a similar pattern. In a well-known study, physicians were found to cut short and redirect their patients’ narratives after approximately 20 seconds.6 Observations of patient–physician encounters in varied settings show that patients often offer clues instead of verbalizing emotions and concerns directly. However, the great majority of clues and expressions of affect (four out of five) were allowed to pass unacknowledged by physicians.7 Empathic opportunities abound, but physicians disregard most of them and when they do respond, they are extremely brief and quickly shift to biomedical issues.8 Patient-centered interviewing was developed and widely accepted as a means of bringing physicians closer to their patients, but in ‘real life’ it is seldom employed.9

These data are disturbing, since empathy goes way beyond just making the patient feel better. An empathic, patient-centered attitude (as opposed to a purely ‘clinician-centered’ or ‘disease-focused’ approach) is associated with remarkable benefits to both the patient and physician. A patient–physician encounter that is devoid of empathy not only deprives the patient of crucial support and of his or her basic right to be treated humanely as well as competently, but may also lead to actual patient harm through the loss of a myriad of significant benefits. First, emotional problems such as depression, anxiety or stress are common and following significant illness their incidence considerably increases. They profoundly affect both patients’ quality of life and patient survival, partly due to associated high-risk behavior and poor compliance with medical advice.10 Timely recognition and treatment may improve survival. An open-ended, empathic communication allows the physician to become cognizant of these problems, identify them correctly and react appropriately to alleviate the patient’s distress (offering counsel, support, test,
referral or drug). This aspect is especially important since many visits in primary care are motivated primarily by psychosocial problems. Second, a patient-centered and empathic interviewing is much more likely to elicit the full exact spectrum of the patient’s symptoms and risk factors, including more ‘sensitive’ contents enabling the physician to have all the essential information. Third, patients cite ‘humaneness’ as a very highly rated aspect of care expressing strong preferences for good communication, partnership and autonomy. Patient-centered care and physician’s empathy are strongly associated with patient satisfaction and trust. Compliance and adherence with medications and recommendations increase, translating into improved risk factors and ‘hard’ outcomes for many acute and chronic conditions. In addition, better coping, decreased symptom burden, and less referrals and lesser use of resources have been reported. Thus, physicians’ behavior in the encounter is closely linked to health outcomes. Finally, physicians’ gains were no less impressive. Empathic physicians had higher job satisfaction, less stress, less burnout, fewer errors and less suing. Empathic skills can even help physicians deal with difficult patients by attuning to their negative feelings, transforming them into empathy and overcoming the conflict.

How can the gap between the remarkable benefits of clinical empathy and its meagre actual display be explained? Many ‘barriers’ to the feeling of empathy in clinical encounters have been identified and unfortunately, they seem to be increasing. Empathic barriers may be classified as related to the encounter such as time constraints; barriers related to deficiencies in medical education and training such as the ‘hidden curriculum’ focusing on scientific achievement and technology; barriers associated with the alienation between doctors and patients due to the emergence of opposing interests; and barriers related to the current ‘culture of medicine’.

Diverse, potent and prevalent as the barriers to empathy are, the good news is that empathy can still be acquired and this remains true not only for medical students but also for residents, primary physicians and faculty alike. Indeed, training for empathy is one of the major challenges facing medical education today. Three essential principles can be identified. First, to be effective, interventions had better be multifactorial. Several types of interventions are more likely to be helpful than one and supplementing personal training programs by organizational efforts will also facilitate change. A second principle is to start at an early stage in medical education and go on indefinitely. The best interventions lose efficacy over time unless strengthened by ‘adjuvant’ reminder activities. Thirdly, interventions must be based on foundations of solid research data. With these strategies in mind, how can empathy be promoted from its current often-low position? A review of the literature analyzed 13 studies of teaching empathy to medical students. All reveal that empathy can be enhanced and identify several effective strategies including interpersonal skills workshops; communication skills workshops; literature and medicine courses; reflective writing seminars; and even student hospitalization experience. Short interventions were sufficient to achieve statistically significant changes in empathy scores, although relatively few studies were based on objective observations or tested durability of the improvement. Empathic expression can be enhanced even when physicians with ‘established’ clinical habits are targeted. These physicians show significantly improved well-being with less burnout. These encouraging results are so far limited to research. Currently, students emerge out of medical school significantly less empathic than they came in. Attitudes of 1170 medical students studied recently show three types of experiences that had the greatest effect on their development of humanism: experiences of great intensity (e.g. being involved in a case where the patient dies); participatory learning experiences (e.g. volunteer work, international clinic rotations); and participatory positive role models. In contrast, stressful conditions, such as massive workloads or being tired, inhibited their humanism. These findings can be used to enhance specific areas in the curriculum to promote humanism, reversing the current ‘hardening of the heart’ developing in many third-year medical students.

One particular approach deserves special mention. Physicians who listen to the patient in order to ‘elicit’ the history also listen to a story unfold. The ability to understand the text and subtext and imagine the situation of the teller in the context of the patient’s family, culture, profession and life can be termed ‘Narrative medicine’. Such ‘narrative competence’ (very much like the one we use when reading a story) is essential to the effective practice of medicine, and empathic-humanistic medicine in particular. It can be promoted by reflective writing exercises or the study of literary texts. One outstanding piece of advice comes from a survey of 293 medical students and interns who rated listening as the top factor (out of 160) affecting empathy. Even before other educational changes are implemented, the technique of the interview needs to be improved. Generally, the more patient-centered interviewing is employed, the more empathic the encounter is likely to be.
Patient-centered care is quality medical care that is not technological-centered, doctor-centered, hospital-centered or disease-centered. Thus, it is inevitably relationship-centered and likely to be empathic, adding an integral dimension to professional care. A personal adoption of a few simple attitudes summarized by the ‘CAPTURES*’ mnemonic (Box 1)\textsuperscript{2,3} is recommended. Its sincere adoption as a routine reflexive component of the encounter may improve doctors’ attention to the humanistic aspects of patient care.

In conclusion, expressing an honest, personal, sensitive, caring attitude in every patient-physician encounter, despite objective difficulties such as time constraints, is an essential part of medical care and healing. As a result, both patients and physicians gain immensely and the quality of care and ‘hard’ health outcomes improve. Thus, empathic medical practice adds an absolutely essential domain to the current sophisticated, technological and scientific medicine, therefore existing deficiencies in the empathic aspects of care need urgent attention.

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References


