

health systems

An Overview of Empathy

Abstract

Empathy is a powerful communication skill that is often misunderstood and underused. Initially, empathy was referred to as “bedside manner”; now, however, authors and educators consider empathetic communication a teachable, learnable skill that has tangible benefits for both clinician and patient: Effective empathetic communication enhances the therapeutic effectiveness of the clinician-patient relationship. Appropriate use of empathy as a communication tool facilitates the clinical interview, increases the efficiency of gathering information, and honors the patient.

Introduction

That the medical care experience is enhanced by effective communication between clinicians and their patients is a well established fact. Byproducts of this enhanced communication include improved health outcomes,¹ better patient compliance,² reduction in medical-legal risk,^{3,5} and improved satisfaction of clinicians and patients.^{6,7} Of all the elements involved in effective communication, empathy seems to be the component that is most powerful yet is easily overlooked—and some commentators have asserted that in medical practice the importance of empathy cannot be over-emphasized.⁸

What is Empathy?

The origin of the word *empathy* dates back to the 1880s, when German psychologist Theodore Lipps coined the term “*einfühlung*” (literally, “in-feeling”) to describe the emotional appreciation of another’s feelings. Empathy has further been described as the process of understanding a person’s subjective experience by vicariously sharing that experience while maintaining an observant stance.⁹ Empathy is a balanced curiosity leading to a deeper understanding of another human being; stated another way, empathy is the capacity to understand another person’s experience from within that person’s frame of reference.¹⁰

Even more simply stated, empathy is the ability to “put oneself in another’s shoes.” In an essay entitled “Some Thoughts on Empathy,” Columbia University psychiatrist Alberta Szalita stated, “I view empathy as one of the important mechanisms through which we bridge the gap between experience and thought.” A

few sentences earlier in her essay, she had emphasized that ... “[empathy is] consideration of another person’s feelings and readiness to respond to his [or her] needs ... without making his [or her] burden one’s own.”^{11,p151}

Can Empathy Be Taught?

Unfortunately, many physicians were trained in the world of “Find it and Fix it” medicine, a world where empathetic communication was only an afterthought—if this behavior was considered at all. Empathy was known as “bedside manner,” a quality considered innate and impossible to acquire—either you were born with it or you weren’t. More recently, greater emphasis has been placed on empathy as a communication tool of substantial importance in the medical interview, and many experts now agree that empathy and empathetic communication are teachable, learnable skills.^{12,13} As we might therefore expect, empathy is the cornerstone of several communication models, including “The Four Habits” model (Invest in the Beginning, Elicit the Patient’s Perspective, Demonstrate Empathy, Invest in the End) developed by The Permanente Medical Group’s Terry Stein with Richard Frankel,¹⁴ “The 4 E’s” (Engage, Empathize, Educate, and Enlist) model used by the Bayer Institute for Health Care Communication,¹⁵ the “PEARLS” (Partnership, Empathy, Apology, Respect, Legitimization, Support) framework adopted by the American Academy on Physician and Patient,¹⁶ and other models.^{17,18}

Many medical schools have developed curricula with a strong focus on physician-patient communication and

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empathy. Delivery of these curricula begins early in the students' training. At the University of Colorado Health Sciences Center, this curriculum is known as the "Foundations of Doctoring" program, a curriculum whose teaching staff includes several physicians and trainers from the Colorado Permanente Medical Group (CPMG). CPMG has also developed an eight-hour clinician-patient communication course based on The Four Habits model which is offered to all newly hired physicians in the Kaiser Permanente (KP) Colorado Region. In this course, plenty of time is set aside to explore empathy and to practice empathetic communication with patients selected according to standard criteria.

Practical Empathetic Communication

Making practical use of an otherwise esoteric concept such as empathy requires division of the concept into its simplest elements. As outlined by Frederic Platt,¹⁹ key steps to effective empathy include:

1. recognizing presence of strong feeling in the clinical setting (ie, fear, anger, grief, disappointment);
2. pausing to imagine how the patient might be feeling;
3. stating our perception of the patient's feeling (ie, "I can imagine that must be ..." or "It sounds like you're upset about ...");
4. legitimizing that feeling;
5. respecting the patient's effort to cope with the predicament; and
6. offering support and partnership (ie, "I'm committed to work with you to ..." or "Let's see what we can do together to ...").

Being a psychiatrist or mental health expert is not necessary for using empathetic communication; the only requirement is an awareness of opportunities for empathy as they arise during the interview with a patient. This type of opportunity arises from a patient's emotion (either directly expressed or implied): This emotion creates the opportunity for an empathetic response by the physician. In a study by Wendy Levinson et al,²⁰ 116 office visits to primary care and surgical physicians were audiotaped and transcribed to look at the frequency of empathy opportunities or "clues." More than half of visits in each setting included one or more clues. In more than half of cases, patients presented these clues not overtly but in more subtle ways. Unfortunately, physicians responded to those clues in only 38% of surgical cases and in only 21% of primary care cases and frequently missed opportunities to adequately acknowledge a patient's feelings.²⁰ Clues are often hidden in the fab-

ric of discussion about medical problems and thus may be easily missed by physicians who are busy attending to biomedical details of diagnosis and management. In fact, when opportunities for empathy are missed by physicians, patients tend to offer them again, sometimes repeatedly. This phenomenon can lead to longer, more frustrating interviews, return visits, and "doctor shopping" by patients who feel dismissed or alienated.

After an opportunity for empathy has been presented, the clinician should consider offering a gesture or statement of empathy. Statements that facilitate empathy have been categorized as queries, clarifications, and responses.²¹ Examples of each are as follows:

- Queries

"Can you tell me more about that?"

"What has this been like for you?"

"How has all of this made you feel?"

- Clarifications

"Let me see if I've gotten this right ..."

"Tell me more about ..."

"I want to make sure I understand what you've said ..."

- Responses

"Sounds like you are ..."

"I imagine that must be ..."

"I can understand that must make you feel ..."

Ideally, after perceiving the clinician's statement of empathy, the patient expresses agreement or confirmation ("You got it, Doc!" or "Yeah, that's exactly how I feel"). When we have not understood the patient's experience exactly, we must allow the patient to correct our perception. Use of the Hypothesis-Test-Feedback Loop allows the patient to clarify his or her experience and thus allow the physician to restate an empathetic statement that originally missed its mark. The following exchange is an example of this Hypothesis-Test-Feedback Loop used in the doctor-patient encounter:

Patient: I am sick and tired of living with these headaches. No one has been able to help me, and none of the medications are working.

Doctor (stating the hypothesis): I can see that you are frustrated by the lack of improvement in your symptoms.

Patient (giving feedback): Yeah, but I'm really more worried that we're missing something serious. I've got a wife and kids who are depending on me.

Doctor (correcting the hypothesis): So, it sounds like you're really more concerned that something

serious could be going on that is causing these headaches.

Patient (closing the empathy loop): Yes, exactly.

In this example, the physician makes an empathetic statement (hypothesis) about what he or she surmises is the chief aspect of the patient's experience: frustration about an unrelenting headache. When the hypothesis is tested, the patient clarifies that although frustrated, he is mainly experiencing worry about the situation. Armed with this feedback, the physician restates the hypothesis back to the patient, who lets the physician know that he or she "got it exactly right."

Barriers to Giving Empathy

Because empathy is such a powerful communication skill, we might suppose that clinicians would scramble to learn about and use it at every available opportunity. However, this is not necessarily the case. Clinicians have many reasons for not offering empathy to patients. An informal survey of practicing clinicians participating in a recent clinician-patient communication course revealed misgivings (and misconceptions) about empathetic communication. Concerns mentioned included:

- "There is not enough time during the visit to give empathy."
- "It is not relevant, and I'm too busy focusing on the acute medical problem."
- "Giving empathy is emotionally exhausting for me."
- "I don't want to open that Pandora's box."
- "I haven't had enough training in empathetic communication."
- "I'm concerned that if I use up all my empathy at work I won't have anything left for my family."

In our experience, empathy facilitates the clinical interview, increases efficiency of gathering information, and honors the patient. Empathy need not be awkward nor emotionally exhausting; unlike sympathy, empathy does not require emotional effort on the part of the clinician. An appropriate statement or gesture of empathy takes only a moment and can go a long way to enhance rapport, build positive relationships, and even improve difficult ones. Studies have shown that when opportunities for empathy were repeatedly missed, visits tended to be longer and more frustrating for both physician and patient.^{18,20} Conversely, empathy may save time and expense and often is a cost-effective method of facilitating early diagnosis and proper treatment.¹⁰

Empathy Versus Sympathy (and Versus Pity)

Despite some divergent opinion on the matter, we may propose a subtle but important distinction between empathy and sympathy.

Whereas empathy is used by skilled clinicians to enhance communication and delivery of care, sympathy can be burdensome and emotionally exhausting and can lead to burnout. Sympathy implies feeling shared with the sufferer as if the pain belonged to both persons: We sympathize with other human beings when we share and suffer with them. It would stand to reason, therefore, that completely shared suffering can never exist between physician and patient; otherwise, the physician would share the patient's plight and would therefore be unable to help.

Empathy is concerned with a much higher order of human relationship and understanding: engaged detachment. In empathy, we "borrow" another's feelings to observe, feel, and understand them—but not to take them onto ourselves. By being a participant-observer, we come to understand how the other person feels. An empathetic observer enters into the equation and then is removed.

Harry Wilmer²² summarizes these three emotions—Empathy, Sympathy, and Pity—as follows:

- Pity describes a relationship which separates physician and patient. Pity is often condescending and may entail feelings of contempt and rejection.
- Sympathy is when the physician experiences feelings as if he or she were the sufferer. Sympathy is thus shared suffering.
- Empathy is the feeling relationship in which the physician understands the patient's plight as if the physician were the patient. The physician identifies with the patient and at the same time maintains a distance. Empathetic communication enhances the therapeutic effectiveness of the clinician-patient relationship.

Conclusion

Empathy is a powerful, efficient communication tool when used appropriately during a medical interview. Empathy extends understanding of the patient beyond the history and symptoms to include values, ideas, and feelings. Benefits of improved empathetic communication are tangible for both physician and patient. ❖

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References

1. Stewart MA. Effective physician-patient communication and health outcomes: a review. *CMAJ* 1995 May 1;152(9):1423-33.

2. Stewart MA. What is a successful doctor-patient interview? A study of interactions and outcomes. *Soc Sci Med* 1984;19(2):167-75.
3. Moore PJ, Adler NE, Robertson PA. Medical malpractice: the effect of doctor-patient relations on medical patient perceptions and malpractice intentions. *West J Med* 2000 Oct;173(4):244-50.
4. Levinson W, Roter DL, Mullooly JP, Dull VT, Frankel RM. Physician-patient communication. The relationship with malpractice claims among primary care physicians and surgeons. *JAMA* 1997 Feb 19;277(7):553-9.
5. Beckman HB, Markakis KM, Suchman AL, Frankel RM. The doctor-patient relationship and malpractice. Lessons from plaintiff depositions. *Arch Intern Med* 1994 Jun 27;154(12):1365-70.
6. Suchman AL, Roter D, Green M, Lipkin M Jr. Physician satisfaction with primary care office visits. Collaborative Study Group of the American Academy on Physician and Patient. *Med Care* 1993 Dec;31(12):1083-92.
7. Brody DS, Miller SM, Lerman CE, Smith DG, Lazaro CG, Blum MJ. The relationship between patients' satisfaction with their physicians and perceptions about interventions they desired and received. *Med Care* 1989 Nov;27(11):1027-35.
8. Aring CD. Sympathy and empathy. *JAMA* 1958 May 24;167(4):448-52.
9. Zinn W. The empathic physician. *Arch Intern Med* 1993 Feb 8;153(3):306-12.
10. Bellet PS, Maloney MJ. The importance of empathy as an interviewing skill in medicine. *JAMA* 1991 Oct 2;266(13):1831-2.
11. Szalita AB. Some thoughts on empathy. The Eighteenth Annual Frieda Fromm-Reichmann Memorial Lecture. *Psychiatry* 1976 May;39(2):142-52.
12. Platt FW, Keller VF. Empathic communication: a teachable and learnable skill. *J Gen Intern Med* 1994 Apr;9(4):222-6.
13. Spiro H. What is empathy and can it be taught? *Ann Intern Med* 1992 May 15;116(10):843-6.
14. Frankel RM, Stein T. Getting the most out of the clinical encounter: the four habits model. *Perm J* 1999 Fall;3(3):79-88.
15. Keller VF, Carroll JG. A new model for physician-patient communication. *Patient Educ Couns* 1994;23:131-40.
16. Barrier PA, Li JT, Jensen NM. Two words to improve physician-patient communication: what else? *Mayo Clin Proc* 2003 Feb;78(2):211-4.
17. Makoul G. Essential elements of communication in medical encounters: the Kalamazoo consensus statement. *Acad Med* 2001 Apr;76(4):390-3.
18. Suchman AL, Markakis K, Beckman HB, Frankel R. A model of empathic communication in the medical interview. *JAMA* 1997 Feb 26;277(8):678-82.
19. Platt FW. Empathy: can it be taught? *Ann Intern Med* 1992 Oct 15;117(8):700; author reply 701.
20. Levinson W, Gorawara-Bhat R, Lamb J. A study of patient clues and physician responses in primary care and surgical settings. *JAMA* 2000 Aug 23-30;284(8):1021-7.
21. Coulehan JL, Platt FW, Enger B, et al. "Let me see if I have this right ...": words that help build empathy. *Ann Intern Med* 2001 Aug 7;135(3):221-7.
22. Wilmer HA. The doctor-patient relationship and issues of pity, sympathy and empathy. *Br J Med Psychol* 1968 Sep;41(3):243-8.

Two Things Stand

Life is mostly froth and bubble,

Two things stand like stone,

Kindness in another's trouble,

Courage in your own.

Adam Lindsay Gordon, 1833-1870, poet