Chapter 6
A Definition and Key Features of Empathy in Patient Care

Clinical study amounts to the study of one person by another, and dialogue and relationship are its indispensable tools.

—(George L. Engel, 1990, p. 15)

Abstract

- Empathy in patient care is addressed in this chapter with regard to the World Health Organization's (WHO) definition of health, consistent with the notion of a biopsychosocial paradigm of illness.
- Empathy in the context of patient care is defined as a predominantly cognitive attribute that involves an understanding of the patient's experiences, concerns, and perspectives, combined with a capacity to communicate this understanding and an intention to help. The importance of the four key features (cognition, understanding, communication, and an intention to help) used in the definition of empathy is elaborated and suggestion is made to make a distinction between cognition and emotion, between understanding and feeling, and between empathy and sympathy because of their different consequences in patient outcomes.
- Because of its cognitive nature, an abundance of cognitively defined empathic engagement is always beneficial in the context of patient care, whereas excessive sympathetic involvement (akin to emotional empathy), because of its affective nature, can be detrimental to both the clinician and the patient, leading to exhaustion and burnout.
- In the context of patient care, empathy bonds the patient and the health care provider together, whereas sympathy blinds them to objectivity and reason. Thus, efforts should be made to maximize empathy and regulate sympathy for optimal patient outcomes.
- To achieve optimal patient outcomes, communication of understanding in empathic engagement between physician and patient must be reciprocal, confirming the patient's significant role in the outcome of patient care.

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DOI 10.1007/978-3-319-27625-0_6

Introduction

We cannot scientifically study empathy in patient care unless an agreement exists concerning its definition and unless a psychometrically sound instrument is available to measure the defined concept. The descriptions of empathy presented in Chap. 1 provide a framework for the definition and conceptualization of empathy in the context of health professions education and patient care. I begin in this chapter by describing the definition of health proposed by the WHO and briefly describe the biopsychosocial paradigm of health and illness. Then I offer a definition of empathy in patient care and elaborate on the definition's key features and their implications for patient outcomes.

The World Health Organization's Definition of Health and a Biopsychosocial Paradigm

The constitution of the WHO (1948, p. 1) defines health as "a state of complete physical, mental, and social well-being, and not merely an absence of disease or infirmity." This definition is consistent with the biopsychosocial paradigm of illness in medicine (Engel, 1977, 1990; Hojat, Samuel, & Thompson, 1995). Generally, human infirmity can be viewed from two different perspectives: biomedical and biopsychosocial.

The *biomedical* paradigm of disease, postulated by the German physician Robert Koch and the French scholar Louis Pasteur, although still valid for some diseases, presents an incomplete picture of infirmity suffered by humankind. This "microbe hunting" model of disease (DeKruif, 1926) has a more limited scope than the triangular *biopsychosocial* paradigm of illness (Engel, 1977, 1990; Hojat et al., 1995; Ray, 2004). In the biopsychosocial paradigm, the targeted treatment of an affected organ is replaced by curing the whole patient, who is viewed as a system of being, always in relation to the biological, psychological, and social elements interacting closely with one another (see Chap. 14 for a discussion of the systems theory). Because of its limited scope, the biomedical model can neither describe the underlying interpersonal reasons for the victories in overcoming human illnesses (Frenk, 1998; McKinlay & McKinlay, 1981) nor explain the health-promoting effects of human connections, including empathic physician–patient engagement in health and illness.

In addition to the importance of pathophysiological determinants of infirmity, in the biopsychosocial paradigm of health and illness, psychological, social, and interpersonal factors are taken into consideration as well (Engel, 1977, 1990). This paradigm of health and illness attests that curing occurs when the science of medicine (the biomedical and pathophysiological aspects of disease) and the art of medicine (the psychological, social, and interpersonal aspects of illness) merge into one unified holistic approach to patient care. Empathy is a key element in the holistic care system.

The art of medicine, according to Blumgart (1964), consists of skillfully applying the science of medicine in the context of human relationships to maintain health and ameliorate illness. The unit of observation in the art of medicine is the individual person in relation to social and cultural factors, whereas the unit of observation in the science of medicine is the affected organ or the pathophysiology of disease. Empirical evidence is available to support the art and science of medicine dichotomy (Hojat, Paskin et al., 2007).

The science of medicine in the treatment of diseases and the art of medicine in the curing of illnesses are not independent entities; they supplement one another (Peabody, 1984). As Peabody (1984, p. 814) pointed out, "Treatment of disease may be entirely impersonal, but the care of the patient must be completely personal." Considering that the physician–patient relationship is an indispensable tool in clinical situations to achieve better patient outcomes (Engel, 1990), health care professionals should pay attention not only to the biomedical aspects of disease but to the psychosocial factors of illness as well (Spiro, 1992). Treating a pathophysiological disease may not require as much empathy as is required in curing the patient's illness (Novack, 1987; Novack, Epstein, and Paulsen 1999).

Definition and Key Features of Empathy in Patient Care

Empathy in patient care has been characterized as arising "out of a natural desire to care about others" (Baron-Cohen, 2003, p. 2). Gianakos (1996, p. 135) referred to empathy in patient care as "the ability of physicians to imagine that they are the patient who has come to them for help." Greenson (1967, p. 367) described empathy in patient care as follows: "I have to let a part of me become the patient, and I have to go through her experience *as if* I were the patient." (Remember the "as if" condition in Rogers's definition of empathy described in Chap. 1.)

The notion of an empathic relationship with the patient was elegantly described in a statement attributed to Sir William Osler (1932): "It is as important to know what kind of man [sic] has the disease, as it is to know what kind of disease has the man." This quotation is often attributed to Osler, as cited in White, 1991, p. 74; it also is attributed to Hippocrates, as cited by Ray, 2004, p. 30.) In any case, this statement best describes the biopsychosocial paradigm in which science and the art of medicine are complementary. To Larson and Yao (2005, p. 1105) empathy is the royal road to treatment and "a symbol of the health care profession." Engaging in empathic relationships makes physicians more effective healers and makes their careers more satisfying. Freud (1958a) suggested that empathy is not only a factor in enhancing the clinician–patient relationship; it also provides a condition for correct interpretation of the patient's problems. Therefore, empathy is valuable both in making accurate diagnoses and in achieving more desirable treatment outcomes. Both the patient and the physician benefit from empathic engagement. This topic will be discussed in more detail in Chap. 8.

Definitions of the key concepts in research serve as a common language to understand the nature of the concepts under study. Although not all experts may agree on all aspects of any definition, at least some agreement should exist on the key features of a definition; otherwise, research based on a vague concept obviously will prove to be fruitless. By considering the various descriptions and features of empathy that were described in Chap. 1 and by taking into account the specific nature of empathy in the context of patient care and its implications for positive patient outcomes, our research team proposed the following definition of empathy in the context of patient care (Hojat et al., 2001b, 2002b, 2009a, 2009b; Hojat, Erdmann, & Gonnella, 2014; Hojat, Spandorfer, Louis, & Gonnella, 2011):

> Empathy is a predominantly *cognitive* (rather than an affective or emotional) attribute that involves an *understanding* (rather than feeling) of experiences, concerns and perspectives of the patient, combined with a capacity to *communicate* this understanding, and an *intention to help*.

The four key terms in this definition are printed in italics to underscore their significance in the construct of empathy in the context of patient care. We developed this definition after a comprehensive review of the literature (Hojat et al., 2001b, 2002c) and a careful consideration of the factors that contribute to positive patient outcomes. Our original intention was to present a working definition that would clarify the key ingredients we believed were conceptually relevant to empathy in the health professions education and in patient care to provide a framework for quantifying the defined concept by developing an instrument with which to measure empathy in the context of the health professions education and patient care (the instrument will be described in detail in the next chapter). Also, in our definition we intended to make a distinction between empathy and sympathy in the context of patient care. Our deliberate choice of the four key ingredients in the definition of empathy—*cognition*, *understanding*, *communication,* and *intention to help*—needs some elaboration.

Cognition

Our research team viewed empathy as a predominantly cognitive (rather than an emotional) attribute based on a belief that in patient care situations, empathy emerges as a result of mental activities described in Chap. 1 as facets of cognitive information processing. Such facets include reasoning and appraisal, which are the basis of clinical judgment. Although cognitive mental processing (a key feature of empathy) can lead to positive patient outcomes, overwhelming emotion (a key feature of sympathy, see Chap. 1) can impede the optimal outcomes by obscuring objectivity in clinical judgments.

Cognition and emotion, although seemingly related, have different qualities independent of their joint appearance (Lazarus, 1982). Experienced therapists tend

to respond to patients' distress with cognitive rather than emotional feedback. For example, an analysis of the interpersonal responses between Carl Rogers and his patients showed that approximately two-thirds of his responses were referred to as cognitive as opposed to emotional reactions (Tausch, 1988).

The distinction between cognition and emotion (and correspondingly, between empathy and sympathy) may not seem as important in situations where patient care is not a primary consideration. In the context of patient care, however, such a distinction must be made because of the different implications and consequences in patient outcomes. Physicians should feel their patients' feelings only to the extent necessary to improve their understanding of the patients without impeding their professional judgment (Starcevic & Piontek, 1997). It is not essential for physicians to experience their patients' feelings, pain, and suffering to an overwhelming degree. Emotional overinvolvement is a feature of sympathy, not empathy (Olinick, 1984). However, for the purpose of more accurate diagnoses, it is essential for physicians to understand, as much as possible, their patients' feelings and concerns.

The notions of "detached concern," "compassionate detachment," "affective distance," "exhaustion," and "professional burnout" have been mistakenly used to describe the limits of empathic engagement in clinician–patient relationships (Blumgart, 1964; Halpern, 2001; Jensen, 1994; Lief et al., 1963). However, I strongly believe that linking those notions to empathy is a grave mistake. They are indeed most relevant to sympathetic involvement (not empathic engagement) in patient care, based on the definitions of empathy and sympathy (see Chap. 1).

Ayra (1993) suggested that physicians' dissociation from patients' emotions can help them to retain their mental balance. Farber, Novack, and O'Brien (1997) reported that although medicine is a profession characterized by caring and empathy, it has also been characterized throughout history as aspiring to "objective detachment." This is possible when emotional involvement in clinician–patient encounters is restrained. However, *complete* emotional detachment has its own perils in the context of patient care (Friedman, 1990). As I described in Chap. 1, emotion is acceptable to some extent, and sometimes it is difficult to distinguish when emotion ends and cognition begins in the context of patient care. The controversy about "detached concern" in clinician–patient encounters arises from confusion about the nature and meaning of empathy and sympathy. Maintaining an affective distance to avoid emotional overinvolvement (a feature of sympathy) makes the physician's clinical judgment more objective, but cognitive overindulgence (a feature of empathy) can always lead to a more accurate judgment. Objectivity when making clinical decisions can be better achieved by avoiding emotional overinvolvement, which clouds medical judgment (Koenig, 2002).

It is difficult to be highly emotional and objective at the same time (Wispe, 1986) because excessive emotion in patient care can interfere with the principle of objectivity when making diagnostic decisions and choosing treatments (Blumgart, 1964; Gladstein, 1977; Spiro, 1992). Perhaps one reason why physicians are advised not to treat close family members who have serious health problems is the notion that excessively sympathetic feelings toward close family members can impede clinical objectivity (Aring, 1958). Indeed, the professional guidelines on the treatment of

immediate family members in the American Medical Association's Code of Ethics (Section E-8.19) state that "Professional objectivity may be compromised when an immediate family member of the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered."

Borgenicht (1984) suggested that in performing certain procedures, physicians must maintain a certain degree of emotional distance from the patient because overwhelming emotional involvement may prevent them from making objective decisions at times of crisis. Too much affect impedes effective communication between physician and patient, whereas an abundance of understanding facilitates it. Brody (1997) suggested that the real danger to the physician's effectiveness lies in sympathetic overengagement with the patient. Issues such as dependency, exhaustion, burnout, compassion fatigue, and vicarious traumatization (Figley, 1995; Linley & Joseph, 2007) which are often mistakenly attributed to empathic engagement in patient care are indeed the results of sympathetic overengagement which is overwhelming to the health care providers and their patients. This speculation was confirmed in a large-scale study of board-certified practicing physicians in Argentina (Gleichgerrcht & Decety, 2013) in which it was found that compassion fatigue, burnout, and secondary traumatic job-related stress were closely associated with personal distress (which is a feature of emotional empathy which is analogous to sympathy).

Lief and Fox (1963) introduced the concept of "detached concern" in the medical education literature to prevent emotional overengagement (certainly different from empathic engagement) between physicians and patients. In contrast, no one has ever expressed concern about excess in understanding (or empathic understanding). An "affective distance" between physician and patient is desirable not only to avoid an intense emotional involvement, which can jeopardize the principle of clinical neutrality, but also to maintain the physician's personal durability (Jensen, 1994). Empirical evidence suggests that physicians who had difficulty to regulate their emotions were likely to experience more exhaustion and lower sense of accomplishments (Gleichgerrcht & Decety, 2013). Because excessive emotions (different from cognition and understanding) can obscure the physician's judgment concerning the patient's predicament, Freud (1958b) proposed that to achieve better therapeutic outcomes, clinicians must put aside all of their human sympathies! (not empathies).

For practical reasons, a distinction between cognition (a major ingredient of empathy) and emotion (a major ingredient of sympathy) is important because of its implications with regard to determining the contents of the items in instruments intended to measure empathy in the context of patient care (see Chap. 7), developing educational programs to regulate sympathy, maximize empathy, and assess their consequences in clinical outcomes. The amenability to change will vary for cognitive and emotional behaviors. Cognitive attributes (e.g., empathy) are more prone to change as a result of educational programs than are emotional responses (e.g., sympathy).

Understanding

Understanding others' feelings and behaviors is central to human survival (Keysers & Perrett, 2004). Understanding is also a key ingredient of empathic engagement in the clinician–patient relationship (Levinson, 1994). Patients' perception of being understood, according to Suchman, Markakis, Beckman, and Frankel (1997), is intrinsically therapeutic because it helps to restore a sense of connectedness and support. Empathy in patient care is built on the central notion of connection and understanding (Hudson, 1993; Sutherland, 1993). Because being understood is a basic human need, the physician's understanding of the patient's physical, mental, and social needs, in itself, can fulfill that need. Accordingly, we proposed elsewhere that "when an empathic relationship is established, a basic human need is fulfilled" (Hojat, Gonnella, Mangione, Nasca, & Magee, 2003, p. 27).

According to Schneiderman (2002, p. 627), "the better we understand them [the patients], the closer we come to discovering the true state of affairs, and the more likely we will be able to diagnose and treat correctly." Understanding of the patient's perspective was considered as an essential element of physician–patient communication by a group of medical education experts in the Kalamazoo, Michigan, conference held in 1999 (Makoul, 2001). A specific feature of understanding in the physician–patient relationship is the ability to stand in a patient's shoes (knowing that the shoes belong to someone else), and to view the world from the patient's perspective without losing sight of one's own personal role and professional responsibilities. With this background in mind, we decided to consider "understanding" (rather than "feeling") as a keyword in the definition of empathy in the context of patient care.

Accuracy of understanding is another topic of discussion in empathy research. As Rogers (1975, p. 4) advised clinicians, "perhaps if we wish to become a better therapist, we should let our clients tell us whether we are understanding them accurately." In general, the accuracy of understanding depends on the strength of the empathic relationship and the feedback mechanisms. Because the accuracy of understanding is an issue that may be a subject of debate, physicians should occasionally verify the degree to which their understanding is accurate by *communicating* with the patent—another essential ingredient of empathy in patient care that will be discussed in the following section.

Communication of Understanding

Communication of understanding is indeed a behavioral aspect of empathic engagement in patient care. According to Carkhuff (1969) and Chessick (1992), the central curative aspect of clinician–patient relationships rests not only on the clinician's ability to understand the patient but also on his or her ability to communicate this understanding back to the patient. Reynolds (2000), and Diseker and Michielutte (1981) included communication of understanding as a feature of empathy in clinician–patient relationships. Carkhuff (1969, p. 315) indicated that "[empathy is] the

ability to recognize, sense, and understand the feelings that another person has associated with his (her) behavioral and verbal expressions and to accurately communicate this understanding to him or her." Similarly, Reynolds (2000, p. 13) defined empathy as "an accurate perception of the client's world and an ability to communicate this understanding to the client."

Communication of understanding also is a key feature in LaMonica's description of empathy: "Empathy … involves accurate perception of the client's world by the helper, communicating this understanding to the client, and the client's perception of the helper's understanding" (LaMonica, 1981, p. 398). Truax and Carkhuff (1967, p. 40) described empathy as involving the ability to sense the client's "private world" and to communicate this understanding in "a language attuned to the client's current feelings." A physician who has an empathic understanding of the patient but does not communicate such an understanding would not be perceived as an empathic physician (Bylund & Makoul, 2005). According to Branch and Malik (1993), there are windows of opportunities in clinical encounters for expressing mutual understanding when patients describe emotional, personal, and family concerns. Physicians must capture these moments of "potential empathic opportunities" (Suchman et al., 1997) to express their understanding of patients' concerns.

An important aspect of communication in patient care is the notion of "reciprocity" or "mutuality" (Makoul, 1998; Miller, 2002; Raudonis, 1993). Although the idea that empathy involves mutual understanding is not widely discussed in empathy research (Bennett, 2001), it must be regarded as an essential ingredient of empathic engagement in patient care. Mutual understanding generates a dynamic feedback loop that is helpful not only in strengthening empathic engagement but also in making a more accurate diagnosis and thus providing better treatment. It is important to note that mutual understanding and reciprocal feedback during verbal and nonverbal exchanges indicate that both clinician and patient must play an active role to enhance empathic engagement. Without such features, empathic engagement cannot fully develop.

Physicians should let their patients know that their health problems and their psychosocial concerns are fully understood. It is also desirable for a patient to confirm the physician's understanding. By using a coding system (Empathic Communication Coding System), Bylund and Makoul (2005) reported that most patients do provide physicians with potential empathic opportunities. In their coding system, physicians' reactions to these potential opportunities were recorded on a 7-point scale (0 = physician ignores the empathic opportunity, 6 = physician makes an explicit statement to express understanding of the patient's concerns). They found that more than 80 % of physicians could detect the opportunities and reacted either by confirmation, acknowledgment, or pursuing or elaborating the issues of concern. The patient's belief concerning the physician's understanding reinforces the empathic engagement between the two. The following statements represent some simple approaches to the communication of empathic understanding: "I understand your feelings. You have gone through a lot of difficulties"; "I can see how being in a cast would make you helpless" (the expression of empathic understanding approach); "I can understand why this problem is so difficult for you" (the validation approach); "I understand your problem very well because I went through a similar situation" (the self-disclosure

approach); "I want to make sure that I understand your concern. Let me rephrase it this way …" (the rephrasing approach); "It is saddening to have that kind of feeling" (sympathy); or "This reminds me of the story of …" (the metaphorical approach) (Matthews, Suchman & Branch, 1993; Mayerson, 1976).

Mutuality generates a belief in the patient that not only enhances the empathic relationship but also has a mysterious beneficial effect on clinical outcomes (Hudson, 1993). Although the mechanism of the positive effect of mutuality in understanding is not well understood, one could speculate that the beneficial outcomes are attributable to greater satisfaction with the health care provider, to better compliance with treatment, or to such psychological factors as reduced anxiety, enhanced optimism, and perceptions of social support, which are activated in mutually understood interpersonal relationships. The reciprocal communication can help to remove the constraints of physician–patient relationships because, as a golden rule in interpersonal relationships, when constraints diminish, people begin to reveal their secrets.

Intention to Help

Intention to help is another specific feature of empathic engagement in patient care. Decety and Jackson (2006) described empathy as the capacity to understand and respond to the needs of others. Understanding in itself does not necessarily imply that the individual is compelled to help. However, readiness to respond to another person's call for help is indeed synonymous to the intention to help. Such intention in patient care often derives from altruistic motivation, making it different from the empathy of, for example, a sales agent, whose understanding of potential consumers often rests on egoistic motivation for personal gain. This feature of empathic engagement in patient care is consistent with the golden ethical principle of medical practice that the best interest of the patient must be of primary consideration.

Empathy Versus Sympathy in Patient Care

A large number of empathy researchers have failed to make a distinction between empathy and sympathy, and used the terms interchangeably. A clear distinction between these two terms, as I indicated before, is utterly important in patient care. The conceptual confusion and interchangeable use of "empathy" and "sympathy" may not cause a serious problem in social psychology, but separating the two in the context of patient care is important. In social psychology, both empathy and sympathy can lead to a similar outcome (e.g., prosocial behavior), albeit for different behavioral motivations. A prosocial behavior induced by empathic understanding is more likely to be elicited by a sense of altruism (Hojat, Spandorfer et al., 2011). A prosocial behavior prompted by sympathetic feelings, however, is more likely to be triggered by a self-serving egoistic motivation to reduce the observer's personal

distress. In patient care, the two constructs must be distinguished because, in that context, they lead to different outcomes. For example, Nightingale, Yarnold, and Greenberg (1991) have shown that in simulated conditions empathic physicians, compared with their sympathetic counterparts, used resources appropriately by ordering fewer laboratory tests, had less preference for unwarranted patient intubation, and did not perform cardiopulmonary resuscitation for an excessively long time. In an empirical study we showed that it is possible to differentiate empathic and sympathetic responses to patient care and test the validity of such responses (Hojat, Spandorfer et al., 2011).

Empathy Bonds, Sympathy Blinds

Our definition of empathy in the context of patient care as a predominantly *cognitive* attribute implies that it involves understanding another person's concerns. Sympathy as an *emotional* reaction implies that it involves feeling another person's pain and suffering. Some researchers have described two types of empathy: "cognitive empathy" and "emotional empathy" (e.g., Davis, 1983). Davis (1994) used cognitive empathy as "attempts to entertain the perspective of others" (p. 17) and "the capacity for role taking" (p. 29). However; he used emotional empathy (synonymous to sympathy) as "a tendency to react emotionally to the observed experiences of others" (Davis, 1994, p.55). Others have also described emotional empathy in terms of vicarious empathy (Mehrabian & Epstein, 1972).

To understand the operational definition of a concept, researchers must not only describe specific features of the concept but also take into consideration the clinical relevance of the features (Morse & Mitcham, 1997). Our definition of empathy in the context of patient care is close to Davis's description of cognitive empathy, whereas our conceptualization of sympathy is somewhat similar to Davis's description of emotional empathy, and analogous to Mehrabian and Epstein's (1972) vicarious empathy. The distinction between cognitively defined empathy and affectively defined empathy (or sympathy) has important implications for both health professions education and health care research. As I discussed before, it can be speculated that, in the context of patient care, cognitively defined empathy almost always leads to positive clinical outcomes, whereas sympathy in excess, due to its emotional nature, can be detrimental to objectivity in clinical decision making. In addition, empathy can lead to professional growth, career satisfaction, and optimal clinical outcomes, whereas sympathy can lead to unhealthy patient-physician dependency, career burnout, compassion fatigue (Figley, 1995), exhaustion, and vicarious traumatization (Linley & Joseph, 2007). These speculations await empirical verifications.

If my assumptions (see Chap. 1) that (1) the relationship between empathy and positive clinical outcomes is linear (that is, the outcomes progressively become better as a function of an increase in empathic engagement), and (2) the relationship between sympathy and clinical outcomes resembles an inverted *U* shape (similar to that

between anxiety and performance) are confirmed, then the following outcomes would be expected. (1) Abundance of empathy is always beneficial in patient care; (2) sympathy—to a limited extent—is beneficial, but excessive sympathy is detrimental to patient outcomes. In other words, for more optimal patient outcomes, empathy must be maximized, but sympathy must be optimized or regulated for its best effect.

Soenens, Duriez, Vansteenkiste, and Goossens (2007) have confirmed that past studies generally ignored the distinction between empathy and sympathy. I agree, and take it as a justification for my repeated reminder of differences between empathy and sympathy throughout this book which may seem redundant. However, I have deliberately placed the emphasis on this distinction in several pertinent occasions, because I believe that such differentiation is extremely important in the context of patient care, but has been benignly neglected in that context. This failure is not certainly inconsequential in the empathy research outcomes in patient care (see Chaps. 1 and 3), and particularly on exploring the neurological underpinnings of empathy as a separate entity than sympathy (see Chap. 13).

In summary, the distinction made by Solomon (1976) between the wisdom of "understanding" against the treachery of "emotion" with regard to the differences between empathic and sympathetic engagements in clinician–patient relationships can be translated into the following statement that "*empathy bonds, sympathy blinds!*"

Recapitulation

The triangular biopsychosocial paradigm of health and illness, consistent with the definition of health in the WHO's constitution, suggests that empathic engagement in clinician–patient encounters should lead to improvement in physical, mental, and social well-being. The distinction between cognition and affect and their corresponding attributes of empathy and sympathy has important implications for the health professions education, effects on patient outcomes, and explorations of their neurological roots. Empathy, due to its cognitive nature, is always beneficial to patient outcomes; thus attempts must be made to maximize empathic engagement in patient care. However, sympathy in excess, because of its emotional nature, can be detrimental to the patient and health care provider; thus, it is desirable to regulate or optimize sympathy to prevent dependency, exhaustion, and career burnout.