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Emotion and the Physician–Patient Relationship

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This paper develops a framework of the role of empathy in patient care and explicitly links the framework to important outcomes. Following a definition of empathy and clinical examples, evidence is reviewed on the relevance of empathy to increasing patient satisfaction, increasing adherence with physician recommendations, and decreasing the frequency of medical malpractice suits.

> The essence of the practice of medicine is that it is an intensely personal matter . . . the treatment of a disease may be entirely impersonal, the care of the patient must be entirely personal. The significance of the intimate personal relationship between physician and patient cannot be too strongly emphasized, for in an extraordinarily large number of cases both diagnosis and treatment are directly dependent on it . . . one of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient. (F. W. Peabody, 1927)

The qualities of caring, compassion, and concern have characterized the doctor–patient relationship throughout history. It is only recently that the skills associated with these qualities have been operationalized and related to outcomes of care (Cohen-Cole, 1991; Inui & Carter, 1985; Squier, 1990). This paper focuses on affect and the development of therapeutic relations in the medical encounter, and explores the use of a family of caring skills including empathy, support, and legitimation.

Lazare (1989) described four key tasks in developing therapeutic relations: (1) facilitating patients' willingness to provide diagnostic information, (2) relief of physical and psychological distress, (3) satisfaction of physician and patient, and (4) willingness to accept and adhere to a treat-

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ment plan. He goes on to identify the skills necessary to accomplish these tasks. These include (1) defining the nature of the relationship; (2) allowing the patient to tell his or her story; (3) hearing, bearing, and tolerating expressions of painful feelings; (4) showing appropriate and genuine interest, empathy, support, and cognitive understanding; (5) attending to concerns over shame and humiliation; and (6) eliciting the patient's perspective. In communication terms, the skills necessary to develop therapeutic relations are active listening, empathy, and support.

Although the topic of therapeutic relations is a good deal more complex than space permits here [see, for example, Novack's (1987) excellent review], empathy and support are the most studied and have consistently been shown in the literature to relate to desired outcomes of care. I will focus on the relationship of empathy and support to outcomes of satisfaction, adherence to the treatment plan, and medical malpractice.

WHAT IS EMPATHY?

According to Rogers (1975) empathy is one of the most potent therapeutic interventions. It allows the clinician to join with the patient in constructing a shared understanding of the patient's lived experience of illness. Cohen-Cole and Bird (1986) provided a more specific definition, stating that empathy and related responses such as support, legitimation, and partnership are means by which physicians can reduce negative emotions such as anger, depression, and anxiety which are common reactions to illness. And Wells, Benson, and Hoff (1985) defined empathy as " . . . a response that demonstrates an accurate understanding and acceptance of the patient's feelings or concerns." To summarize, empathy and the related skills of support, legitimation, and partnership involve first the recognition of a negative feeling or concern on the part of the patient, and second a response to the feeling that acknowledges it or gives it a name.

It is important to distinguish empathy from sympathy. While empathy involves recognition and reflection of the patient's feelings, sympathy is a more directly parallel response to emotion. If a patient begins to weep, for example, an empathic response might be to say "You look teary eyed," while a sympathetic response would be for the physician to begin crying along with the patient. Sympathetic responses are both more directly involving of the physician's own experience and are more powerful. Although sympathetic responses are less open to conscious control, it is possible to modify them if recognized early. As a patient begins to weep over the recent loss of a spouse and the clinician begins to recognize that it parallels

her or his own experience of a recent loss, it is frequently possible to convert or blend sympathetic responses to or with empathetic responses.

Combining the concepts of empathy and sympathy gives the physician a broad range of legitimate responses to patients' expressions of negative and painful feelings and these responses carry with them varying degrees of personal involvement. In my own experience as a teacher I have found that trainees often experience a reduction in anxiety over losing emotional control once they realize that a range of caring responses from sympathy to empathy is available.

EMPATHY: A CLINICAL EXAMPLE

Mrs. Dottie Keller is a 65-year-old woman who is a clinic patient at a large Midwestern university outpatient internal medicine practice, partially staffed by residents. Although she was not new to the practice, she was being seen for the first time by Gary Powers, an intern in our training program (all names have been changed to protect anonymity). As part of the communication skills curriculum this encounter was videotaped. Approximately 3-min into a visit for a routine pap smear the patient revealed that she had had a mastectomy. At this point the following dialogue ensued:

Dr.: You just had your 6-month check up?

Pt.: Yes, but I'm wondering about something because he [the surgical oncologist] instructed me to come back after 4 months and that's unusual.

Dr.: Mmh hmh.

Pt.: I think he might have noticed something, I don't know. It was the exact date 5 years ago that I had the operation. I must have looked worried because he said, "Don't worry about a thing; enjoy your holiday. These are things I have to do to keep check on you." But it was alright. I mean I'm okay [laughing].

Dr.: You look fine. How do you feel about ... the cancer and the possibility of it coming back?

Pt.: Well, it bothers me sometimes but I don't dwell on it .... Here of late though, I don't know what it is, but I'm not as cheerful about it as I was when I first had it. I just had very good feelings that everything was going to be alright you know. But now I dread another operation.

Dr.: You seem a little upset, you seem a little teary eyed talking about it.

Pt.: Yeah, well, it gets to you, you know sometimes . . . you . . . ahh . . . . This is the first time I've had a little session like this where you really talk to someone about it. I think I'm blessed, because I had a very dear friend who passed . . . but she waited too long to have chemotherapy. I guess that's why I'm crying . . . I don't know.

Dr.: Well it's frightening.

Pt.: It is, because you hear so much about it . . . but I always say that if I don't have to endure so much pain . . . I mean—I imagine when the time comes for the pain, you know, to endure that you can go through that too.

Dr.: What's your greatest fear for the rest of your life? Do you have any fears?

Pt.: Yes, the fear of the, you know, therapy if I have to go through any and the pain involved. I think about all that but I don't dwell on that too much either. I read a lot, I look at TV, I try to take little trips and things like that. And then my mother encourages me, you know, she's great.

The physician's empathic response to the patient begins where he says, "You look fine. How do you feel about the cancer . . . and the possibility of it coming back?" In a recent paper Branch and Malik (1993) characterize such statements as "windows of opportunity." In this case the contrast between the patient's concern over being brought back 2 months early by her surgical oncologist, followed immediately by her statement that it was really okay, provides a window of opportunity for further exploration. More generally, any patient expression of moderate to strong negative affect creates the potential for empathic response (Markakis, Suchman, Beckman, & Frankel, 1993). The patient's response to the intern's initial appraisal confirms the presence of strong affect both verbally and nonverbally. Recognizing this, the intern attempts to identify the emotions he observes by saying, "You seem a little upset, you seem a little teary eyed talking about it." Again, there is strong acknowledgment from the patient about the accuracy of the intern's observation and she goes on to describe an additional component of her fear, the loss of a dear friend. At this juncture the intern uses another empathic statement that both names and legitimizes fear as the emotion the patient is grappling with. The patient acknowledges the accuracy of the intern's reflection and adds, for the second time, an additional fear about pain. Following the patient's lead, the intern probes about the patient's greatest fears. After restating her concern about pain, the patient shifts the topic away from fear and begins to discuss her coping strategies.

This entire sequence took less than 2 min to complete. It provided the clinician with important clinical information as well as insight into the patient's illness experience. More importantly, the intern's sensitive use of empathy and reflection allowed the patient to experience deeply felt emotion in a safe, supportive context. Such is the power and potential for empathy.

EMPATHY AND PATIENT SATISFACTION

Among the most frequently cited findings in the literature on doctor–patient communication is the linkage between empathy and support, and patient satisfaction. Despite differences in definitions, methods, and study populations, the finding that empathy leads to higher levels of patient satisfaction has been consistent. For example, Stiles, Putnam, Wolfe, and James (1979) found that patients' satisfaction with their practitioners was related to being facilitated in clarifying problems and formulating solutions more acceptable to themselves. Physicians who acknowledge the importance of facilitating patient insight through empathic understanding were found to elicit greater trust and gain greater involvement in the consultation process. Similarly, DiMatteo, Taranto, Friedman, and Prince (1980) found that patients' satisfaction with their care related to independent measures of the clinicians' general sensitivity to emotions and ability to express feelings. And Wasserman, Inui, Barriatua, Carter, and Lippincott (1984) found a positive relationship between practitioner empathy and support (defined as an appreciation of the mother's point of view) and both satisfaction and reduction in concerns for pediatric visits. Women health professionals including doctors and nurses were rated as conveying the most empathy while male health professionals were rated as conveying the least. In a related vein, Hall and Dornan (1988) found that younger and less experienced physicians were more empathic in their relations with patients than older and more experienced clinicians.

These studies support the conclusion that empathy in the practitioner–patient relationship increases patient satisfaction with medical care. There is emerging evidence that the lack of empathy and support in the relationship is associated with patient dissatisfaction (Goleman, 1992). The following letter to a large Midwestern health maintenance organization (HMO) illustrates this point in graphic detail. It came from a study of patient dissatisfaction that is currently underway to identify communication dimensions of patient dissatisfaction. (Note: Names have been changed to protect anonymity.)

> About noon Wednesday, Dr. Jones called me to tell me my F.T.A. test was negative. I asked her why then was I told the Health Department was going to call me? Dr. Jones said I must have gotten syphilis in the past six months! When I protested that the timing was impossible, Dr. Jones told me that I had to take care of the emotional aspect myself and that was all there was to do as far as she was concerned. She told me I was lucky I didn't have AIDS, herpes, or warts, but something treatable and curable. Dr. Jones insisted I had syphilis and to take my medicine and be done with the situation.

As is clear from the letter, the patient's experience of care was both confrontational and adversarial, and from the patient's point of view, lacking in empathy and support. It also turned out that the test result was incorrect and the patient did not have syphilis. In reviewing over 400 letters to the HMO over a 4-year period, we have found almost 70% of the issues raised by patients dealt with relationship issues. These included failed expectations for the physician's role (32%), physician insensitivity (12.7%), antagonistic comments from the physician (12.9%), and poor staff communication (11.8%). Such findings suggest that the perceived absence of empathy in care is a strong motivation for patients to express their dissatisfaction through letters of complaint. More research needs to be done in the area of patient dissatisfaction and its relationship to the presence or absence of empathy. However, results to date suggest that, where empathy is absent in the relationship, significant risks for dissatisfaction, including nonadherence to treatment plans and malpractice suits, may result.

EMPATHY AND ADHERENCE

Like the evidence linking empathy with satisfaction, there have been a number of studies that have investigated the relationship between empathy and adherence. A number of major reviews of this literature have been conducted (Becker & Maiman, 1975; Becker & Rosenstock, 1984; Garrity, 1981; Haynes, 1976). All of these studies have concluded that there are significant relationships between empathy and adherence to treatment advice. Though the relationship is not perfect, the presence of empathic understanding in the relationship consistently relates most strongly to adherence. Also, like the literature on satisfaction, most of this research has focused on the positive relationship between empathy and adherence. Little research has focused on documenting the potentially negative consequences on adherence where empathy is absent.

The following clinical example comes from a qualitative study of the relationship between doctor–patient communication and nonadherence to treatment plan (Frankel and Beckman, 1989). The patient is a 47-year-old

black woman with a history of hypertension, diabetes, and obesity. Participants in the study were videotaped and then given an open-ended opportunity to review the videotapes, commenting on aspects of the care process that they found satisfying, challenging, etc. Commentaries were audiotaped and then mapped onto the exact locations where the tape was stopped during the independent video reviews. This segment began with the physician inquiring about the patient's adherence to her diet. An asterisk indicates the points at which the tape was stopped and a comment was made. The comment appears below the stopping point.

Dr.: Did you fill your diet sheets in?
Pt.: I've been putting something down and basically this is the way I've been eating.
Dr.: You haven't done very well have you?
Pt.: Pardon?
Dr.: You haven't done very well.
Pt.: I don't know
Dr.: [Interrupting] You put on half a pound this time.
Pt.: I'm not feeling very successful in doing anything with the diet. I may be eating a little bit too much but I don't eat any salt and I don't eat any* fried foods.

*Reviewer A: [Patient] I sit and talk with the medical doctor but I really don't talk my problems to her. She's looking at me from another viewpoint. All she cares about is my weight and blood pressure . . . . You know I have four boys; one of them is 28, one is 19, one is 17, and one's 15. Not being from a middle class family there are some things I just can't afford to purchase and it's a problem to cook food that's nourishing for the boys and buy the things I really need. And that's my problem, the reason I haven't been successful.

It is evident from the patient's comments that her difficulties in adherence are directly related to the physician's lack of identification with her economic situation. Looking at the discourse itself, it is clear that the physician was frustrated with the patient's attempts to lose weight. This is expressed through her negative judgments "You haven't done very well" and "You put on half a pound this time," and her failure to explore the meaning of the patient's illness through empathy and support. Again, while the literature suggests a positive association between empathy and adherence to treatment plans, less is known about the negative effects on patient behavior where empathy is absent.

As a footnote to the case presented, both patient and physician had the opportunity to view the tape with each other's comments before their next scheduled visit. The effects were dramatic. Once the physician discovered the patient's economic difficulties, she was able, in the subsequent visit, to offer a less expensive alternative to the diet she had prescribed.

The patient expressed great relief with this solution and in the weeks that followed her weight and blood sugar improved substantially.

EMPATHY AND MALPRACTICE

In the most recent line of inquiry about empathy, researchers have begun to note a relationship between perceived lack of caring and extreme forms of dissatisfaction, such as the decision to litigate for malpractice. There are many anecdotal accounts that illustrate this relationship (see for example Messenger, 1989). Nonetheless, insurance companies, hospital risk management personnel, and lawyers point to breakdowns and disruptions in caring as a key source of dissatisfaction. Some insurance companies are even offering reductions in malpractice premiums for physicians who either possess or agree to learn better communication skills. Other professional associations have responded similarly. In 1985, for example, the American Medical Association's action plan to address professional liability concluded, "It is increasingly apparent that one of our best protections against a professional liability law suit is the creation and maintenance of a good physician–patient relationship."

Three recent studies [Beckman, Markakis, Suchman, & Frankel (1994); Lester & Smith (1993); and Volk (1992)] have added some scientific validity to the assertion that lack of caring and malpractice are related. Lester and Smith, in an experimental manipulation, showed subjects videotapes of physicians using high- and low-empathic styles in situations in which errors and no errors occurred. The authors found that in the low-empathy/error condition subjects reported feeling more litigious than in the same condition with high empathy. Surprisingly, they also found that even where no error occurred low empathy was associated with increased litigiousness. Lester and Smith concluded from this study that failure to communicate caring and concern is a significant factor in the decision to bring a suit for malpractice.

In a qualitative study of 45 depositions of suits brought against a large hospital corporation in the Midwest, Beckman et al. (1994) found that, in addition to negligent adverse outcomes, 71% of the depositions studied contained evidence of relationship problems. Four themes emerged from a review of 3787 pages of transcript: (1) deserting the patient (32%), (2) devaluing patient/family views (29%), (3) delivering information poorly (26%) and (4) failing to understand the patient/family perspective (13%). Although failure to provide empathy and support was not specifically tracked in this study, it is certainly present in a majority of the relationship problems identified. Examples of utterances suggesting dissatisfaction with

empathy and support include the following " . . . He [the doctor] said he couldn't help me anymore, go find somebody else. And he didn't recommend any other doctor." "I [plaintiff/family member] said how do you [patient] feel and he said I feel sick I'm in pain, and the doctor told me there's nothing wrong with me."

Finally, in a study of 312 ambulatory claims to the Harvard Community Health Plan from 1985 to 1992, Volk (1992) found that five of six specialties in which suits occurred (psychiatry being the exception), breakdowns in patient–physician communication played a prominent role in bringing the malpractice action. For general surgery, OB/GYN, and radiology it was the second leading loss prevention issue. In internal medicine it was the third and in orthopaedic surgery the fourth leading loss prevention issue. Again, while the definition of communication in this study may include more than issues of empathy and support, the results are consistent with other more specific studies.

CONCLUSION

Empathy and its associated skills have been shown to have a strong positive influence on patient satisfaction and adherence to treatment plan. In addition the absence of empathy has been shown to increase dissatisfaction and the risk of medical malpractice. Empathic skills can be taught, learned and put into practice (Poole & Samson-Fisher, 1980; Samson-Fisher & Poole, 1978) without substantially adding to the length of visits (Stewart, Brown, & Weston, 1989).

Given the very convincing evidence that empathy skills make a difference in the process and outcomes of medical care, why does there seem to be so little emphasis on their use in medical education and practice? Spiro (1992), in a paper entitled "What is Empathy and Can it Be Taught?" suggests one answer to this question may be that medicine, at least in the modern era, has been driven by the image and value of clinical detachment and neutrality. It was Sir William Osler, Spiro reminds us, who advocated physician equanimity above all else. And it is Osler's legacy that continues to be the dominant view. Empathy, on the other hand, is based on passion and relationship, joy and sorrow, and the experience of being in the world. We could improve our own satisfaction and involvement in the delivery of care by learning and practicing empathic understanding with our patients and with ourselves, suggested Spiro. In this regard, it is no accident that Francis Peabody (1927), who 68 years ago urged his Harvard Medical School students to recognize that "the secret of the care of the patient is in caring for the patient," was himself under treatment for cancer that killed

him months later. Empathy and its related skills are perhaps the best approach for conducting satisfying and effective interviews. They may also be the best prescription for what currently ails the profession and practice of medicine.

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