Empathy and Patient–Physician Conflicts

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Physicians associate empathy with benevolent emotions and with developing a shared understanding with patients. While there have been many articles on managing "difficult" patients, little attention has been paid to the challenges physicians face during conflicts with patients, especially when both parties are angry and yet empathy is still needed. This topic is especially important in light of recent studies showing that practicing medicine increasingly requires physicians to manage their own feelings of anger and frustration. This article seeks to describe how physicians can learn to empathize with patients even when they are both subject to emotions that lead to interpersonal distancing. Empathy is defined as engaged curiosity about another's particular emotional perspective. Five specific ways for physicians to foster empathy during conflict are described: recognizing one's own emotions, attending to negative emotions over time, attuning to patients' verbal and nonverbal emotional messages, and becoming receptive to negative feedback. Importantly, physicians who learn to empathize with patients during emotionally charged interactions can reduce anger and frustration and also increase their therapeutic impact.

KEY WORDS: doctor-patient relationships; communications skills; professionalism; patient-centered care; empathy.
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INTRODUCTION

A 58-year-old athletic businessman, suddenly paralyzed from the neck down with (potentially reversible) Guillan–Barre syndrome, is refusing necessary care because he sees the doctors and nurses as "incompetent." The whole intensive care team is fed up with him and his wife and daughters are panicked.

A 19-year-old is blocking the door to his dying mother's room and threatening to shoot the oncology nurses if they give his mother more sedating pain medication. He can't stand the idea of losing contact with her. The entire team is terrified of him and furious.

Clinical accounts of patient–physician conflicts often focus on managing difficult patients.[1–4] Articles on conflict that do explore physicians' negative emotions[5,6] or take a conflict-resolution approach[7–10] recommend that physicians empathize with patients or family members. However, there is virtually no literature in medicine about *how* physicians can empathize with their patients during conflicts that evoke their own anger or other negative emotions.[11] This article seeks to bring together theoretical work, research findings from the social sciences, clinical studies, and observations by a psychiatrist from consultation-liaison work (JH) to suggest some basic skills that physicians can develop to maintain empathy when they are involved in overt conflict or otherwise experiencing negative feelings towards patients.

Outside of medicine, the term "empathy" commonly refers to a complex affective–cognitive activity involving emotional attunement and imagining how another person feels[12–14] but, in medicine, traditionally refers to a purely cognitive understanding of patients' emotions—a special professional "detached concern."[15,16] Detachment has been viewed as necessary for objectivity, for avoiding burnout,[17,18] and especially for avoiding negative emotions during doctor–patient conflicts.

Today, however, the ideal of detached concern is being replaced by the goal of emotional attunement, and thus of complex affective–cognitive empathy.[18–23] There is increasing evidence that emotionally engaged physicians have greater therapeutic efficacy.[24–30] Engagement generates more trust, leading directly to improved patient adherence to treatment.[24,31–34] Emotionally engaged physicians communicate more effectively, decreasing patient anxiety and improving patients' coping, leading to better outcomes.[35–38] Patients disclose more to emotionally attuned physicians,[19,39,40] who are more sensitive to individual differences and able to recognize atypical problems that might otherwise be missed.[15,41–45] Conversely, a lack of empathy increases patient dissatisfaction and the risk of malpractice suits.[33,46]

However, despite the shift toward emotional empathy,[47–49] detachment remains the norm in doctor–patient conflicts.[1,50–52] I use the term "conflict" here to identify not only overt disagreements, but also a broad range of situations in which physicians face role conflicts due to feeling negatively towards patients. Physicians especially need to be able to recognize submerged tensions. Some patients are reluctant to openly disagree with or question their physicians, fearing that decreased care might result.[7,53,54] Irritation with such patients may be the only clue of conflict.

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How can physicians empathize when feeling negatively towards their patients?[55–59] General sympathy or concern does not appear to be enough, as highly charged situations—where patients refuse medically necessary care or have needs that are difficult to meet—appear to pose a particular challenge for sympathetic physicians.[1,50–52,56,60] Sympathy primarily involves feeling rather than cognition, and simply resonating emotionally with the patient is problematic when the main emotions are anger and frustration, which are among the most contagious affects.[61] Absent some clear skills to manage such feelings, physicians, like other human beings, readily become defensive and engage in counterproductive arguments,[1,2,50–52,62–64] ultimately escalating the conflict.[65]

For these reasons, traditional thinking has been that when negative emotions are involved, one can, at best, strive for a detached, intellectual understanding of another person's perspective.[66] However, psychology research shows that conflict also makes it more difficult to cognitively take another's perspective and that, ironically, an attitude of concern for another increases the difficulty of seeing things from their point of view during conflict.[67–70] Thus, during conflict, the concerned physician finds it difficult both to feel the right feelings and even to be able to see, intellectually, the patient's perspective. It is especially difficult to imagine how another feels when the other person is subject to negative emotions, such as anger or shame.[66] All of this suggests that physicians encounter difficult emotional and cognitive demands when trying to empathize during conflict. Yet these difficulties are worth addressing because full-blown empathy, both feeling with and cognitively imagining another person's perspective, is extremely valuable for conflict *resolution* because it encourages helping behavior and reduces anger.[71]

We can better address the challenge of empathizing during conflicts by widening our view of empathy to include not only spontaneous emotional attunement, which may not occur initially, but also a conscious process of cultivating curiosity about another's distinct perspective. While empathy is akin to sympathy in involving actual emotional receptivity, empathy is more complex, guided by cognitive as well as affective interest in another.[15,72] For sympathy, it is sufficient to resonate with another's general mood without becoming curious to learn more about another's particular point of view, whereas such curiosity is central to empathy. This distinction is crucial because empathy pushes one to appreciate that another sees things differently, whereas sympathy may blur such differences.[15]

Clinical empathy, in particular, aims for a more accurate view of what, precisely, is troubling the patient. Yet physicians, like other individuals, vary in their ability to imagine another person's thoughts and feelings, and some patients may be easier to "read" than others.[73,74] However, research has shown that empathic accuracy[75] is a trainable skill, which is improved by direct feedback and by an established relationship or desire for a future relationship with another.[73,74,76] Most importantly, combining curiosity with emotional engagement, more so than a detached intellectual grasp of another's situation, appears to correlate with improved empathic accuracy.[77]

This paper describes five skills for cultivating engaged curiosity about negative feelings, one's own and the patient's. Insofar as shutting down negative emotions also constricts the ability to remain engaged emotionally, the skills described below seek to avoid such shutdown. Instead, physicians are encouraged to stay fully emotionally engaged during conflicts, in part by recognizing how even their negative feelings can be put to good therapeutic use.[1,50–52]

RECOGNIZING ONE'S EMOTIONS IN REAL TIME

A crucial first step is for physicians to recognize their own feelings accurately. In contrast to many nurses and psychotherapists, physicians rarely learn to attune to their negative feelings.[16,78,79] Yet, evidence suggests that taking a few moments for self-awareness can reduce errors, improve decision-making, and resolve conflict.[78–80] Basic psychology research shows that once people recognize their negative emotions, they readily correct their negative appraisals and actively seek more information about their situation.[81,82]

REFLECTING ON NEGATIVE EMOTIONS OVER TIME

The second step is for physicians to become curious about the meaning of negative feelings in themselves and their patients. Physicians are socialized against self-reflection,[79,83,84] yet preliminary research suggests that physicians can learn to examine of their own negative feelings and, in so doing, improve their clinical care and professional satisfaction.[83,84] Still, self-reflection does not automatically lead to curiosity about another's views, especially when that person causes distress. Psychotherapists bridge the two by becoming curious about what clues their own feelings provide about patients' feelings.[85,86] Recognizing and skillfully using this "countertransference" is considered key to psychiatric clinical competence,[85,86] and could become an identified core skill for other physicians as well.[87,88] In the example of the young man who was threatening to shoot the nurses, once the team learned that he had no gun nor any history of violence, psychiatric consultation helped the staff members recognize that some of their terror was based on their own personal fears of loss and their identification with this 19-year-old's intense grief.

ATTUNING TO EMOTIONAL MESSAGES IN A PATIENT'S STORY

However, reflecting on what one's own feelings may reveal about another person is not yet empathy. A distinct step is to deliberately listen for the patient's distinct emotional concerns, which may be embedded in, yet hidden by, concrete clinical demands.[63,64,72] Observational research shows that physicians miss most opportunities for empathy by restricting attention to facts rather than to the emotional meanings of patients' words.[39,89,90] For example, when an 18-year-old athlete with severe bowel disease was refusing life-saving surgery because he could no longer be "active" in sports, most of his physicians became frustrated or furious and withdrew emotionally. One resident, sensing that this young man found it excruciating to discuss his fears with healthy, male doctors, arranged to have the patient meet with a female nurse who had a colostomy. In this meeting, the patient was able to disclose his fear that the surgery would prevent him from having an "active" sex life. The nurse was able to reassure him, and he decided to have the operation.

ATTENDING TO NONVERBAL COMMUNICATION

Patients do not simply tell doctors what is most significant to them. Rather, they first give nonverbal hints that they have something important to say.[19,37,38,40,91] When physicians reciprocate at these critical moments, patients talk more fully about their concerns and give fuller histories.[19,39,40,47] A recent review of the literature concluded that both sensitivity to patients' nonverbal cues and appropriate nonverbal communication by physicians affect patient satisfaction and health outcomes.[91] Physicians demonstrate attentiveness by rapidly adjusting their own gestures, pauses, vocal tone, and interpersonal distance in coordination with the patient.[19,91] There has been little research on how the component behaviors of nonverbal communication can be taught.[91] However, one observational study suggests that these skills are mainly conveyed through role-modeling,[92] whereas another shows that training in communication skills improves students' abilities to establish rapport with patients.[93]

ACCEPTING NEGATIVE FEEDBACK

Finally, for physicians to experience and convey empathy during conflicts, it is essential to learn to accept patients' feedback, even when it is negative and blaming. This last step runs counter to many ingrained qualities of medical culture.[94–96] During conflicts, physicians often become more controlling and less open to negative feedback.[1,50–52]

Despite the prevailing culture, physicians and psychotherapists recount how accepting criticism without becoming defensive provides a gateway to empathy, enabling patients to share more difficult feelings lying underneath their anger.[62,97–99] For example, when I allowed the man with Guillan–Barre syndrome to complain, uninterrupted, about how "useless" his caregivers were (including me), he felt heard. He then talked about his own feeling of being trapped in a useless body and was able to cry and begin grieving.[100] While little research has examined links between empathy and negative feedback, studies have shown that accepting blame and offering an apology, when appropriate, can influence patient satisfaction and reduce anger, and may even prevent malpractice claims.[33,46,101,102]

DISCUSSION

Emotional conflicts offer special therapeutic opportunities. The same emotional resonance triggered during conflicts—when acknowledged—can become the basis for genuine empathy, through the act of taking the perspective of those in distress.[71] However, clinical empathy is not a panacea for resolving all conflicts. Some patients are outraged because of systems issues that are genuinely unjust, such as persistent racial disparities in health care.[103–105] Rarely, an enraged patient may be very disturbed or psychotic and need treatment.[1] Even so, an empathic medical team can likely provide more effective treatment.[24]

Physicians cannot will themselves to empathize during conflicts,[66] but they can cultivate an ongoing practice of engaged curiosity. Activities that help in this process include meditation, sharing stories with colleagues, writing about doctoring, reading books, and watching films conveying emotional complexity.[78,106,107] Empiric studies show that writing narratives from the patient's imagined perspective helps physicians develop lasting empathy skills.[72,108] Brief, problem-focused workshops that use role-playing can help health professionals identify negative emotions encountered in difficult communication tasks, then develop skills to clearly communicate during these highly conflictual situations. Follow-up evaluations show that participating individuals feel increased confidence in handling difficult emotions in their practices.[109]

The recommended strategies are likely to be efficient as well as effective. Despite expectations to the contrary, allowing patients to talk uninterrupted at the beginning of an interview or eliciting psychosocial information add very little time to history-taking.[110–112] However, missed emotional "clues" extend the length of medical visits.[39] Physicians who do not pay attention to their own emotions are likely to pathologize, ignore, transfer, or discharge "difficult" patients, leading to costs in personnel time, legal expenses, and patient transfers.[113] Finally, we have increasing evidence that physicians who engage emotionally enjoy their work more over time, which likely contributes to providing better care.[6,17,114]

Medical training absent explicit training in handling negative emotions can lead to the deterioration of empathy.[21–23,29,115,116] Even with an explicit commitment to empathy as a core feature of professionalism, the on-the-job experience of medical training tacitly promotes detachment, objectivity, and self-interest.[117,118] Yet, it is possible to equate professionalism with recognizing negative, as well as positive, emotions. In one study, highly empathetic staff members recognized and reported hostile emotional responses to client aggression *but* did not act on such feelings because of their sense of "professionalism."[119] During clinical rotations, it is especially important that attendings actually model the skills of accepting and managing negative emotions to help trainees learn to truly maintain empathy over time.

CONCLUSION

This article advocates cultivating engaged curiosity when conflict and negative emotions threaten to erode the patient–physician relationship. By learning to consciously accept and respond to negative emotions, we become more skilled individually and collectively at managing feelings that could otherwise be quite destructive.[78,120] When physicians develop the skill of transforming their own emotional reactions into empathy for patients' unspoken fears and suffering, they do much more than cure; they serve in the healing of their patients as persons.[15,51,98,121]

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