**Empathy: Vital in patient care, but are we looking at it close enough?- An intern’s perspective**

Authors:

1. Dr. Gokul Gopi

Intern

All India Institute of Medical Sciences, Bhubaneswar

Sijua, Patrapada

Bhubaneswar, Khorda Dist., ODISHA, INDIA -751019

Email:- [gokulgopi2@gmail.com](mailto:gokulgopi2@gmail.com)

Mob: +91-7749995659

1. Dr. Manish Taywade

Assistant Professor

Department of Community Medicine & Family Medicine

All India Institute of Medical Sciences, Bhubaneswar

Sijua, Patrapada

Bhubaneswar, Khorda Dist., ODISHA, INDIA -751019

Mobile No. +91-9970840967 / 9438884017

email:-  [drmanishtaywade@gmail.com](mailto:drmanishtaywade@gmail.com)

1. Dr. Sonu H Subba

Professor

Department of Community Medicine & Family Medicine

All India Institute of Medical Sciences, Bhubaneswar

Sijua, Patrapada

Bhubaneswar, Khorda Dist., ODISHA, INDIA -751019

Mob: +91-9438884025

Email:- [sonuhsubba2016@gmail.com](mailto:sonuhsubba2016@gmail.com)

Acknowledgement: Joel George Sunny

All India Institute of Medical Sciences, Bhubaneswar

Sijua, Patrapada

Bhubaneswar, Khorda Dist., ODISHA, INDIA -751019

Email:- [joelgsunny@gmail.com](mailto:joelgsunny@gmail.com)

Mob: +91-7978584773

Details of sponsorship or relevant competing interests, financial or otherwise: Nil

**ABSTRACT**

Empathy is imperative in patient care. Besides enhancing patients’ satisfaction, comfort, and trust, which in turn may facilitate better diagnosis, shared decision making, and therapy adherence, empathetic doctors experience less burnout, greater job satisfaction and better overall psychological well-being. In this article we try to bring into focus on empathy needed in modern medicine. The meaning of empathy is briefly explained along with the concept of detached concern. The need of empathy in patient care is undebatable, but physician burnout, emotional drainage and overburden are some of the reasons why physicians tend to drift away from it. Empathy, without adequately communicating the same to the patient is unproductive. Current medical curriculum should acknowledge and give due emphasis on empathy and effective patient communication as important elements in building the professional identity of future physicians.

**Background**

There exists a long-standing dilemma faced by almost anyone who plays the role of a physician: on one hand lies the concept of detached physician, whereby the doctor strives for detachment to reliably care for his/her patients regardless of his/her personal feelings, while on the other hand lies the need for genuine empathy expected from the doctor by his/her patients. This statement was most explicit to me when I found myself in the paediatric oncology ward facing a six-year-old with terminal stage acute myeloid leukaemia. Each time I entered the ward, the sorrow and hopelessness of the family were emotionally overwhelming; yet I could not give in to my emotions if I was to be useful to them as a doctor. As I was struggling with the dilemma, I realised that this is an out of syllabus life/clinical question. We are not taught about empathy in medical school. Nobody discusses the distress one feels, the nuances of how to conduct oneself amidst emotional onslaught. Hence, I thought of embarking on this journey to understand what empathy is; how it is different from sympathy and how to be empathetic, along with the benefit and the dilemma we encounter in being empathetic.

**What is Empathy?**

Empathy, sympathy, and compassion are portrayed in many ways in literature and are used interchangeably in everyday speech and research papers. Even though empathy doesn’t have a clear-cut definition, it encompasses several elements of pro-social behaviours like kindness, generosity and patient centeredness.

Empathy is an emotional connection between an observer and a subject in which the observer, based on visual and auditory cues, identifies and transiently experiences the subject’s emotional state (1). It is a complex, intricate and dynamic concept. The concept of empathy can be best understood if we analyse the four dimensions of it: affective, cognitive, moral and behavioural. Affective or emotional empathy is the ability to subjectively experience and share the psychological state or feelings of another person. It is a process of inner resonance whereby the observer takes on the emotions of the other person. Cognitive empathy is the ability to identify and understand another person’s feelings and perspective from an objective stance (2). It is also described as a detached concern. This component of cognitive requirement differentiates empathy from sympathy and compassion. Behavioural empathy is based on the fact that empathy needs action and communication of the understanding with the other person. “Empathy without action is not empathy”(3). The fourth dimension of empathy is the moral component. It can be explained as the internal urge of concern for the other and a desire to relieve their anguish by caring and driving acts of humanity (2).

Sympathy is a broad term that signifies a fellow feeling. It is a result of realisation that something has happened to another person (4). The way it is different from empathy has been argued much in literature and a clear-cut demarcation is never possible. Some authors describe sympathy as imagining another person’s emotions whereas empathy is experiencing it. It may also slide into pity or a feeling of sorry for the other person (5).

Compassion is derived from the Latin word ‘compati’ meaning to “suffer with”. Chochinov defined compassion as a deep awareness of the suffering of another person with a wish to relieve it (6). Both compassion and sympathy are evoked in the observer when the subject experiences an unfortunate event, but compassion is evoked by more serious circumstances. Although it involves a sense of need to alleviate a person’s suffering, it may not necessarily result in any helping actions.

**Concept of Empathy as Detached Concern**

Cognitive empathy or detached concern is the ability of one to understand and acknowledge the experiences of the other person without evoking a personal emotional response. It is an active skill that is acquired and pliable to nurturing (7-9). It is a frequently used terminology in medicine and means “not being moved or influenced emotionally by the patient”. The patient doesn’t need to be showered with love. He/she needs to feel that the doctor has listened enough to grasp the problem, rather than immediately putting the patient in a category, or jumping to conclusions.

Certainly, some detachment is needed. When I think of my experience in the paediatric oncology ward, it was very uncomfortable as many of the patients were terminally ill and the family members of these patients were in a perpetual state of despair. The girl in question was at the terminal stage and there was little we could have done for her. The disease had also produced an extremely painful complication for the girl, and she was in constant pain. The parents of the child were at her bedside praying incessantly for their child. The sorrow they felt was huge and every time when I entered the room to check up on the girl it hung like a shadow covering the entire room in gloom. As a doctor, if I were to have given in to my emotions, I would never have been able to function. During these situations, what the patient needs is a doctor who can give support and mental strength to the caregivers rather than a sobbing mess. Hence, empathy as a detached concern becomes a pragmatic approach.

**The benefit of being empathetic and ways to show empathy**

The cornerstone of successful patient care is the doctor-patient relationship with empathy. There is evidence that patients value concern and understanding as much if not more than technical competence when choosing their physician (10). The quality of information obtained from the patient is more important than the quantity. A patient who has confidence and trust in a physician tends to give more detailed and accurate information, and the non-medical aspects of his/her illness. Sharing one’s own story has been found to be therapeutic (11) and decreases the anxiety level of the patient (12). Everyone wants to be treated as a person and not as a disease. They expect acknowledgement of the magnitude of their suffering and discomfort and reassurance from the physician that he will do his best to help the patient not only to be cured of the disease but also to restore a good quality of life in terms of health.

Understanding the patients concern is not enough and the same has to be conveyed to the patient by means of verbal and non-verbal cues. Hence communication skills play a crucial role in expressing empathy and the chances for misinterpretation is high if the physician cannot visibly and verbally express concern to the patient. For example, a foreign doctor not well versed with the local language may understand the concern and difficulties of the patient but fails to reciprocate and acknowledge the same due to the language constraint. This could easily be misinterpreted by the patient as a lack of interest leading to a lack of confidence and questionable follow-up and compliance. This is not uncommon in our own setting. India is a widely diverse country with different parts of the country having a totally different language and culture, and students coming from another part of the country may not be able to express themselves clearly. Despite adequate feelings of empathy, in such situations inability to communicate effectively with the patients and their relatives may be a deterrent in patient satisfaction and clinical outcome.

The concept of a good doctor includes “good listener’ as one of the essential qualities. Being empathetic not only needs expression, but also the ability to decipher and discern cues from the patients and what they are trying to communicate or are feeling. Without the ability to read or pick up such cues, the response of the physician may neither be correct nor adequate. This is an important part of communication which needs to be learnt and honed. Again, communication is not something that is taught in Indian medical schools adequately. When one considers the concept of detached insight, this part of communication may be overlooked as detachment might entail not seeing or ignoring the visible cues and concentrating only on the verbal expression of the patients, which would not be adequate. Communication and empathy, therefore, go hand in hand and are inter-dependent. Communication has a vital role to play in the way physicians read the patients and express empathy. Both need to be adequately covered in the medical curriculum.

**The Dilemma**

Empathy in medicine is a topic that has long been studied and research has shown differing results. The questions that surface are- Does being empathic hamper with clinical decision making? By being too emotionally attached with the patient, do doctors run the risk losing objectivity or by detaching oneself risk failing to relate as a human being? Even though there is increasing evidence that empathy plays a crucial role in patient care (13,14), why does a large portion of the medical community fail to accept it? Does it make them uncomfortable? Do they feel that getting emotionally involved with the patients will make them lose the perspective to make right decisions for patient? On the other hand, how can one expect to be a good doctor without ‘feeling’ for the patients and ‘with’ the patient? Where does one draw the line?

The answers to these questions are not clear-cut and dry. Some experienced physicians can make precise clinical decisions despite being empathetic to the patient’s condition. There are cases where the physician has an indifferent outlook on patients but manages to treat the patients well based on scientific evidence and latest guidelines. One of the main reasons why a large portion of the medical community fails to accept empathy’s role in patient care is the fact that most if not all the medical courses are highly competitive. In the wake of such cut-throat competition, medical students take on a more objective view rather than a subjective one. Spending time studying a clear medical subject which can be measured objectively is valued over time spend with a topic like medical ethics that cannot be measured objectively.

**The Tightrope and Learning to Empathize**

It goes beyond saying that true empathy which encompasses experiencing the suffering of each patient can never be achieved fully by any physician. It has been shown that empathetic doctors tend to have more job satisfaction and less burnout (14), but being genuinely empathetic to all the patients take a huge emotional toll on physicians and leaves them emotionally drained. Compassion fatigue, high expectations, overwork, increased patient load and lack of continuity have been found to be some of the factors why physicians cease to show care (13,15). Thus healthcare professionals detach themselves from the patients, avoiding emotional attachment and focus on biomedical facts: a method called “existential neglect” (16,17,18). The key question appears to be- how to be empathetic without being overwhelmed and burning out? There are numerous studies that demonstrate the critical role emotions play in the process of diseases and in a physicians’ treatment decision (19). Emotions affect one’s motivation to pursue and follow the treatment as well as the ability to adjust with the necessary losses that pertain to chronic disease.

As discussed earlier, there is a need for verbal or non-verbal gesture so that the patient can know that the physician has adequately empathised. Here lies the key to the balance between empathy and detached concern. Often the physician may fail to empathise adequately with the patient, because he may never have experienced what the patient is going through. Even then, some intentional gestures and verbal statements made by the physician can help mask this deficiency. Some phrases like- “I’m sorry you have to go through all these difficulties”, “I can only imagine what you are going through”, “I will be with you throughout this endeavour” and some simple gestures like handing over a tissue, or a simple pause in speech allowing the patient to express his feelings, all these make a huge impact on the patient’s perception of empathy shown by the physician. The emotional response of a person to another person’s distress is usually an intricate mixture of empathy, sympathy, and compassion. Some argue that empathy is a part of compassion while for others compassion is the result of empathy(4,20,21). While sympathy and compassion are reactive responses, empathy is a skilled response and hence it is more practical to aim for the development of empathy as a clinical skill in medical education rather than teaching compassion (21).

Many researchers believe that empathy can be learned and taught (22,23). But what is the best way to do this? Since empathetic responses are a result of interaction between emotional and behavioural factors, improving either of these would lead to improved empathetic response. For example, improving the behavioural skills of a physician like using some gestures and phrases as described earlier would help the physician convey empathy to his patient and by improving the observational skills, one would be able to correctly identify the emotional cues that need empathy. These are skills that can be developed and improved over time with experience and may be aided by some exercises like reflective writing, whereby the physician becomes more aware of his own emotions, improving the ability to be empathetic towards another (23). It has been recently suggested that physicians who act empathetically are perceived to be genuinely empathetic by the patient (24). So even if the physician is not genuinely empathising enough, he/she can make the patient feel comfortable and relieve the doubts of patients through effective communication and appropriate gestures. It is also important that the physician does not project his/her personal feelings on to the patients. For example, a physician who recently experienced a bereavement/ had a fight are likely to express some of these feelings when dealing with his patients. So, another important aspect would be to train physicians and students to tolerate and learn from their own negative feelings much similar to the way psychiatrists are taught to pay attention to counter-transference (25,26).

**Conclusion**

“Humanisation” of medical care is a much-debated topic. The appropriate empathy in medical care should be an iterative process of emotional resonance and curiosity regarding the meaning of a clinical situation for the patient. Rather than distancing oneself from the patient, effort must be made to exercise the skill of objective reasoning to investigate empathetic intuitions. Moreover, effort must be taken to communicate the same with the patient. Empathy is an important aspect that must be emphasised both during medical education and the practice of medicine. The challenge faced by educators is to organise the teaching in a format that is relevant and engages the active participation of the students, thus making out of them not only skilled physicians but also empathetic communicators.

**References**

1. Buie DH. Empathy: Its nature and limitations. J Am Psychoanal Assoc 1981;29(2):281-307.

2. Morse JM, Anderson G, Bottorff JL, Yonge O, O’Brien B, Solberg SM, et al. Exploring Empathy: A Conceptual Fit for Nursing Practice? Image J Nurs Scholarsh. *Image* 1992; 24:273–80.

3. Halpern J. From Detached Concern to Empathy: Humanizing Medical Practice. From Detached Concern to Empathy: Humanizing Medical Practice. New York: Oxford University Press, 2001.

4. Gladkova A. Sympathy, compassion, and empathy in English and Russian: A linguistic and cultural analysis. Cult Psychol 2010;16:267–85.

5. Smajdor A, Stöckl A, Salter C. The limits of empathy: Problems in medical education and practice. J Med Ethics 2011;37:380–83.

6. Chochinov HM. Dignity and the essence of medicine: the A, B, C, and D of dignity conserving care. BMJ 2007;335:184–87.

7. Batt-Rawden SA. Teaching empathy to medical students: an updated, systematic review. Acad Med 2013;88:1171–77.

8. Neumann M, Scheffer C, Tauschel D, Lutz G, Wirtz M, Edelhäuser F. Physician empathy: definition, outcome-relevance and its measurement in patient care and medical education. GMS Z Med Ausbild 2012;29:1–11.

9. Hojat M, Gonnella JS, Nasca TJ, Mangione S, Veloksi JJ and Magee M. The Jefferson scale of physician empathy: further psychometric data and differences by gender and specialty at item level. Acad Med 2002;77(10 Suppl): S58–S60.

10. Zinn W. The empathic physician. Arch InternMed1993;153(3):306-312.

11. Adler HM. The history of the present illness as treatment: who’s listening, and why does it matter? J Am Board Fam Med 1997;10(1):28-35.

12. Halpern J. What is clinical empathy? J Gen Intern Med 2003;18(8):670-74.

13. Haslam D. “More than kindness.” J Compassionate Heal Care 2015;2:1.

14. Kelley JM, Kraft-Todd G, Schapira L, Kossowsky J, Riess H. The Influence of the Patient-Clinician Relationship on Healthcare Outcomes: A Systematic Review and Meta-Analysis of Randomized Controlled Trials. 2014 PLoS ONE 9(4): e94207. https://doi.org/10.1371/journal.pone.0094207

15. Anfossi M, Numico G. Empathy in the doctor-patient relationship. J Clin Oncol 2004 June 1;22(11):2258-9

16. Francis R. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary. London: The Stationery Office, 2013.

17. de Zulueta P. Compassion in 21st century medicine: Is it sustainable? Clin Ethics 2013; 8:119–128.

18. Agledahl KM, Gulbrandsen P, Førde R, Wifstad Å. Courteous but not curious: How doctors’ politeness masks their existential neglect. A qualitative study of video-recorded patient consultations. J Med Ethics 2011; 37: 650–54.

19. Kozlowski D, Hutchinson M, Hurley J, Rowley J, Sutherland J. The role of emotion in clinical decision making: an integrative literature review. *BMC Medical Education* 2017;17:255. doi:10.1186/s12909-017-1089-7.

20. Charlton R. Compassion, Continuity and Caring in the NHS. London: RCGP, 2016.

21. Maxwell B. Professional ethics education: Studies in compassionate empathy. Professional Ethics Education: Studies in Compassionate Empathy. New York: Springer, 2008.

22. Platt FW, Keller VF. Empathic communication: A teachable and learnable skill. Journal of General Internal Medicine 1994;9(4):222-26.

23. DasGupta S, Charon R. Personal Illness Narratives: Using Reflective Writing toTeach Empathy. Acad Med 2004;79(4):351-56.

24. Larson EB, Yao X. Clinical empathy as emotional labor in the patient-physician relationship. JAMA 2005 Mar 2;293(9):1100-06.

25. Vanderford ML, Stein T, Sheeler R, Skochelak S. Communication Challenges for Experienced Clinicians: Topics for an Advanced Communication Curriculum. Health Commun. 2001;13(3):261-84.

26. Dowling D. Hate in the counter-transference: Winnicott’s contribution to our understanding of hatred in our work as child psychotherapists. In: Winnicott’s Children. 2013:77–87.