

Empathy and quality of care

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SUMMARY

Empathy is a complex, multi-dimensional concept that has moral, cognitive, emotive and behavioural components. Clinical empathy involves an ability to: (a) understand the patient's situation, perspective, and feelings (and their attached meanings); (b) to communicate that understanding and check its accuracy; and (c) to act on that understanding with the patient in a helpful (therapeutic) way. Research on the effect of empathy on health outcomes in primary care is lacking, but studies in mental health and in nursing suggest it plays a key role.

Empathy can be improved and successfully taught at medical school, especially if it is embedded in the student's actual experiences with patients. A variety of assessment and feedback techniques have also been used in general medicine, psychiatry, and nursing. Further work is required to determine if clinical empathy needs to be, and can be, improved in the primary care setting.

Keywords: empathy; consultation; quality of care.

Introduction

THE clinical encounter between a patient and a healthcare professional is the core activity of medical care. As such, the clinical encounter has rightly attracted attention, particularly in the primary care setting where the vast majority of NHS consultations take place. Increasingly, attention is being paid to patients' views on care and to developing a more patient-centred approach.¹⁻⁴

Empathy is considered a basic component of all helpful relationships.^{5,6} Empathy is often cited as a core aspect of effective, therapeutic consultations in general, yet there is a dearth of rigorous research on empathy, particularly in the primary care setting.⁷ What evidence there is suggests that empathy is often lacking in modern medicine⁸ and this may include primary care.⁹

Quality of care is a complex subject with no simple, single solution. The present paper aims to highlight the possible importance of empathy in quality of primary care, mainly by focusing on its role in the clinical encounter. It is not intended to be a comprehensive or systematic review of the subject matter but, rather, a discussion paper designed to provoke thought, reflection, and debate.

Empathy and quality of care

In terms of patients' own definitions of quality of care, empathy emerges as a key factor in primary care.^{10,11} However, there is a general lack of research on the role of empathy in terms of clinical outcomes in primary care.⁷ Empathy has been demonstrated to enhance the doctor-patient relationship and to improve both patient¹²⁻¹⁴ and doctor satisfaction.¹⁵ The use of

empathy can also enhance diagnostic accuracy.¹⁶ A link between the patient's perception of the doctor's empathy and the outcome of patient enablement at the end of the consultation has recently been demonstrated¹⁷ and further work has confirmed this link between empathy and enablement in other settings, including general practice (S Mercer, unpublished data, 2002). Further studies are ongoing in this area.

Empathy and the therapeutic relationship

Empathy is regarded as being crucial to the development of the therapeutic relationship^{1,18,19} and several studies in psychiatry have linked empathy and the therapeutic relationship to improved outcomes from both psychological and pharmacological interventions.^{20,21} An empathetic relationship appears to be more important to the clinical outcome of psychotherapy than the type of therapy itself.²² Even in cognitive behavioural therapy — a highly technical and brief form of psychotherapy — the importance of therapist empathy in recovery from depression has been demonstrated.^{23,24}

In recent times, evidence has steadily accumulated in support of the utility of empathy in clinical nursing.⁶ For example, a study of the effect of nurses' empathy on anxiety, depression, hostility, and satisfaction of patients with cancer showed significant reductions in anxiety, depression, and hostility in patients being cared for by nurses exhibiting high levels of empathy.²⁵

The importance of empathy in the therapeutic relationship is related to the aims of such relationships. Irrespective of the context of the therapeutic relationship, there appears to be a core set of common aims or purposes. These include:

1. initiating supportive, interpersonal communication in order to understand the perceptions and needs of the patient;
2. empowering the patient to learn, or cope more effectively with his or her environment; and,
3. reduction or resolution of the patient's problems.

In relation to these aims, several studies⁶ have suggested that empathy can help create an interpersonal climate that is free of defensiveness and that enables individuals to talk about their perceptions of need.

Defining empathy

Empathy appears to have its origin in the German word 'Einführung'²⁶ which literally means 'feeling within'. Titchener²⁷ coined the term 'empathy' from two Greek roots, *em* and *pathos* (feeling into). Since that time there has been much con-

fusion and debate around the precise meaning of empathy, particularly in the clinical context.⁶ Empathy has been variously conceptualised as a behaviour, a personality dimension, or as an experienced emotion. Much of this confusion can be seen as arising from the fact that empathy is both a complex process (i.e. a multi-dimensional, multi-phase construct that has several components⁶) and a concept whose meaning continues to evolve.²⁸

An extensive review of the literature on empathy by Morse²⁹ summarises the components of empathy under four key areas (Table 1). Many people seem to consider only the emotive aspect of empathy, and are often concerned about the dangers of 'getting too involved with patients'. However, empathy is distinct from sympathy³⁰ and Morse's model helps to widen out this common unitary view. From this stance, clinical empathy can be seen as a form of professional interaction (a set of skills or competencies), rather than a subjective emotional experience, or a personality trait that you either have or don't have.

In the clinical encounter, cognitive and behavioural aspects of empathy have received most attention,⁶ although the importance of a moral stance in the overall philosophy of medicine (engendering altruism and ethical behaviour) should not be dismissed. The cognitive focus of empathy entails an intellectual 'entering into' of the patient's perspective, beliefs, and experiences but does not call for a need to 'feel the other's suffering' on an emotional level. There has been less investigation into the importance of the emotive component of empathy and some commentators have dismissed this as 'over-identification' and a blurring of professional boundaries.³¹ However, Halpern argues eloquently for the concept of emotional reasoning as the core of clinical empathy, which is dependent on an emotional resonance between patient and helper²⁸ — an identification and connection on a 'gut' level with the patient and what he or she is feeling. The term 'emotional intelligence' has been used to describe this type of empathetic understanding.³²

However, none of these aspects of empathy are effective without a behavioural or action component, i.e. without demonstrating unequivocally that we do indeed grasp what the patient is experiencing, and are able to act accurately on the basis of this understanding. This of course requires a feedback loop — checking back with the patient that you have understood correctly.

Barret-Lennard³³ has developed a multi-dimensional model of empathy, referred to as the 'empathy cycle', consisting of three phases. Phase 1 is the inner process of empathetic listening to another who is personally expressive in some way, reasoning, and understanding; phase 2 is the attempt to convey empathetic understanding of the other person's experience, and phase 3 is the client's actual reception or awareness of this communication.

Others have categorised empathy under two headings, 'empathetic understanding' and 'empathetic action' to emphasise the importance of the cognitive/emotive aspects on the one hand and the behavioural/action component on the other.¹

As to an exact definition of empathy, it is unlikely that any one definition is adequate to cover all components and all clinical encounters and situations. Coulehan *et al* (2001),²⁷ referring to clinical empathy generally in the medical profession,

Table 1. Morse's components of empathy.

| Component | Definition |
|-------------|---|
| Emotive | The ability to subjectively experience and share in another's psychological state or intrinsic feelings |
| Moral | An internal altruistic force that motivates the practice of empathy |
| Cognitive | The helper's intellectual ability to identify and understand another person's feelings and perspective from an objective stance |
| Behavioural | Communicative response to convey understanding of another's perspective |

puts it succinctly when he defines empathy as 'the ability to understand the patient's situation, perspective and feelings, and to communicate that understanding to the patient'.

Measuring empathy

The measures that have been developed to assess empathy have principally been designed for a psychiatric or nursing setting, rather than general practice. Many have their origins in the work of Rogers in the 1950s on client-centred therapy.³⁴ However, there is concern that the items included in these scales have generally been determined by professionals and 'experts', and may therefore fail to actually reflect patients' own views.⁶ Although we are not suggesting that the views of professionals are unimportant, the construction of many existing measures of empathy seems somewhat one-sided. If patients are able to perceive the amount of empathy existing in a helping relationship, they are also in a position to advise professionals about how to offer empathy. This is supported by the substantial literature demonstrating that it is the patient's perception of the helping relationship that determines the effectiveness of empathy. Such a collaborative process with patients enabled Reynolds⁶ to develop a measure of empathy for use in nursing training that reflects patients' views of the helping relationship. This is now being widely used in nursing teaching in several countries.

However, there remains a need for a patient-assessed measure suitable for use in primary care. Such a measure has recently been developed by one of the authors (SM) in collaboration with colleagues in the Departments of General Practice in Edinburgh and Glasgow. Its aim is to capture the key competencies of holistic and empathetic consultations. Its development has been informed by patients' accounts of clinical encounters, as well as a theoretical consideration of the components and definitions of empathy.

The final version of this new measure is shown in Figure 1 (see *BJGP* website). Its face and content validity have been explored in 47 in-depth interviews with patients (14 in a holistic care setting characterised by healing and therapeutic consultations, 20 in general practice in an area of high deprivation in Glasgow, and 13 in general practice in a relatively affluent part of Glasgow). The wording reflects a desire to produce a measure that is meaningful to patients irrespective of social class. In this respect it may differ from current measures of patient-centredness, given the evidence that most patients generally prefer a directive style of consultation, particularly the

elderly and those of lower social class.³⁵

The new measure correlates highly with the Reynolds Empathy Measure ($r = 0.84$, $P < 0.001$, $n = 33$) and the Barrett-Lennard Empathy Scale ($r = 0.73$, $P < 0.001$, $n = 131$). It correlates significantly but less strongly with the patient enablement instrument ($r = 0.30$, $P < 0.001$, $n = 593$) supporting its divergent validity. It has a high internal reliability (Cronbach's $\alpha = 0.94$). These preliminary results support its initial validity and reliability and further work is underway to assess its ability to discriminate effectively between doctors, and to compare its performance with other interpersonal skills and patient-centredness measures currently being used to assess quality in primary care.

Enhancing empathy

In primary care a major constraint on the delivery of holistic consultations is workload. There is a growing demand (from general practitioners and patients alike) for more time to be available for each clinical encounter. Thus at present, the main limiting factor on clinical empathy in the consultation in primary care in the United Kingdom may be consultation length.

However, increasing empathy in primary care may require more than just longer consultations. The culture of medicine and of medical training may be such that empathy is undervalued and under-taught. Recent work with medical students has indicated that empathy skills can be significantly increased by a focus on empathy in teaching,^{36,37} particularly if this focus is embedded in students' experiences with patients.^{38,39}

In general medicine, feedback (in a relaxed, non-threatening environment) to physicians scoring low on interpersonal aspects of the consultation, has been shown to increase their scores significantly at follow-up six months later.⁴⁰ Similarly, in psychiatry, Burns and Auerbach²³ have outlined five techniques for improving empathy skills based around their empathy measure. In nursing, Reynolds has demonstrated significant and sustained improvements in empathy three to six months after a nine-week empathy training programme consisting of self-directed study, regular meetings with a supervisor, a two-day workshop, supervised clinical work, and the use of the Reynolds empathy measure.⁶

Conclusions

- Empathy is a complex, multi-dimensional concept. Empathy involves an ability to;
 - (a) understand the patient's situation, perspective and feelings (and their attached meanings);
 - (b) to communicate that understanding and check its accuracy; and,
 - (c) to act on that understanding with the patient in a helpful (therapeutic) way.
- Empathy in the consultation improves outcomes, and empathy can be improved by focused, experiential teaching methods.
- Several measures of empathy have been developed in psychiatry and in nursing over the past 40 years. A new empathy-based measure of holistic consultations in primary care has recently been developed.
- Empathetic consulting in primary care should be encouraged and the tradition of holism in general practice is a

strong foundation. Methods of assessment of quality of care in general practice should include the human dimension of the clinical encounter, of which empathy is a key part.

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