

## Debate & Analysis

# Clarifying empathy:

the first step to more humane clinical care

### THE DEHUMANISING OF CLINICAL CARE: AN EMPATHY DEFICIT

Currently, empathy and the 'humanisation' of medical care are of particular concern in the wake of high-profile reports. These include the Mid Staffordshire NHS Foundation Trust public inquiry; *Dying Without Dignity*, a report by the Health Service Ombudsman into end-of-life-care; and the Leadership Alliance for the Care of Dying People report, *One Chance to Get it Right*.<sup>1-3</sup> These reports all pointed to an empathy deficit in clinical care. A disheartening aspect of the current situation is that empathy deficit is not a new phenomenon.

In 1927, in a seminal study Peabody wrote:

*'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.'*<sup>4</sup>

Twenty years ago, Weatherall argued that many of the ills of the medical profession reflect a lack of 'whole person understanding'.<sup>5</sup> More recently, Spiro observed that doctors who used to listen to patients now looked at a screen. He wrote:

*'Empathy has always been and will always be among the physician's most essential tools of practice.'*<sup>6</sup>

Spiro argues that physicians must have the time to listen to patients.<sup>7</sup>

However, medicine's positivist view prioritises technical progress, evidence-based medicine, targets, and efficiency, so risking a view of patients solely as objects of intellectual interest.<sup>8</sup> Mattingly suggests that, because the medical culture does not consistently support the practice of empathy, it becomes easy for doctors to see empathy as 'nice' but not an essential part of practice.<sup>9</sup>

### CLARIFYING EMPATHY

Doctors have always struggled to achieve a balance in their relationship with patients between connection and distance. Doctors can choose between a narrow technical approach based on their competence, or a broader humanistic approach that is more ambiguous and less reductionist.<sup>10</sup> The way in which doctors define appropriate empathy can influence their approach to patients and their concepts of professionalism, so there is

*" [The] tension between detached concern and emotional connection lies at the heart of humanising medical care."*

a need to clarify empathy.

Lipps used the term *Einfühlung* (feeling into) to explain how people become aware of each other's mental states.<sup>11</sup> Edward Titchener used the Greek word *empathia* to translate *Einfühlung* and, in 1909, coined the term 'empathy'.<sup>12</sup> A simple view of empathy is the ability to understand and share another person's feelings and perspectives, and using that understanding and emotion to guide future action.<sup>13</sup> Empathy, sympathy, and compassion are terms that refer to emotions that people experience in response to the suffering of others.<sup>14</sup>

Sympathy may overlap with emotional aspects of empathy but it is not concerned with understanding the other person's affective state or point of view. Sympathy can be felt towards people whether they are known or not and even to fictional characters.<sup>14</sup> Sympathy takes a 'self-oriented' perspective, that is, 'How would I feel if this was happening to me?' Compassion and empathy are often used interchangeably in the literature and the close link between them is reflected in Maxwell's term 'compassionate empathy'.<sup>15</sup> Compassion means 'to suffer with' and is usually accompanied by a desire to relieve the other's suffering. Compassion, like sympathy, is shown when some misfortune occurs to another person but it is triggered by more serious concerns. One might have sympathy for someone missing a train but not compassion. Empathy is a deeper construct than compassion because one can feel compassionate concern for another without making any attempt to understand their feelings and point of view.

### EMPATHY: DETACHMENT (NARROW VIEW) OR CONNECTION (BROAD VIEW)?

There is a division in the literature between those who take a broad view of empathy and those adopting a narrow view. This division has major implications for clinical practice and for psychosocial aspects of care in particular. For those adopting a narrow definition, empathy is considered as intellectual understanding of the patient's affective state, a form of

'detached concern'. This type of empathy has been described as cognitive empathy.<sup>16</sup> However, I argue it is more appropriate to take a broad view, in which empathy involves a sharing of emotional feeling and connecting with the patient at an emotional level. This is described as affective or emotional empathy.<sup>10</sup> This tension between detached concern and emotional connection lies at the heart of humanising medical care.

Halpern identifies, and then dismisses, three arguments in the literature that attempt to justify avoiding affective (or emotional) empathy and adopting 'detached concern'.<sup>10</sup> These arguments are that: emotions interfere with the clinical assessment of the patient and the doctor's objectivity; they threaten the ability to provide effective care during difficult circumstances; and that emotions will increase the risk of burnout.<sup>10</sup>

Detachment is not necessary for reliable clinical judgement because emotional insights can inform clinical decision making. Moreover, it has been suggested that empathic doctors have more job satisfaction and less burnout than detached colleagues.<sup>17</sup> In a recent editorial Zenasni and colleagues explored the complex relationship between burnout and empathy.<sup>18</sup> Even if doctors try to suppress their feelings by distancing themselves, they cannot avoid having emotional attitudes towards patients.<sup>19</sup>

Some doctors who adopt 'detached concern' define empathy as strictly cognitive empathy. For instance, the US Society of General Internal Medicine defines empathy as:

*'... the act of correctly acknowledging the emotional state of another without experiencing that state oneself.'*<sup>20</sup>

It appears that professionalism for some doctors means keeping suitably detached from emotional situations.

However, it seems that patients want their doctors to demonstrate concern.<sup>21</sup> People recovering from psychological trauma describe how an emotionally neutral listener

makes them feel insignificant or even unreal.<sup>10</sup> A crucial aspect of affective (emotional) empathy is to share feelings rather than merely labelling an emotional state.

Maxwell helpfully suggests that the contrast between affective and cognitive empathy should not define rival conceptions of empathy but rather point out which dimension of empathy is appropriate in any clinical situation.<sup>15</sup>

### APPROPRIATE EMPATHY: A BROAD VIEW THAT CAN HUMANISE CLINICAL CARE

In developing a broad view of empathy there is a need to examine behavioural, cognitive, emotional, and moral facets of empathy that combine in different ways in different clinical situations.<sup>22</sup> From a broad perspective, empathy becomes a unique kind of understanding through which we experience what it is like to be another person:

*Empathy is a complex imaginative process in which an observer simulates another person's situated psychological state (both cognitive and affective) while maintaining a clear self-other differentiation.*<sup>23</sup>

Decety extends the definition of empathy by including a commitment to action:

*... a process which may involve three steps; perceiving the individual in need, understanding and feeling the patient's unique experience and caring about this enough to engage in helping the patient.*<sup>24</sup>

From a broad view, empathy is a process that is dependent on the clinical context and occurs in a reciprocal relationship with a patient. From a review of the theoretical and empirical literature on empathy the following model of empathy emerges.

### A MODEL OF EMPATHY

At empathy's core lies **Connection**, which involves engaging emotionally with the patient's perspective and feeling the distress of the patient, while maintaining an **other-oriented perspective**. The doctor tries to imagine what it is like to be the patient and to see the world from the patient's perspective. This perspective protects the doctor from the personal distress that may result from taking a self-oriented (sympathetic) perspective.<sup>23</sup> **Self-other differentiation** implies that, although empathy should involve a deep engagement with the patient, this does not mean that the doctor loses sight of where the self ends and the other begins. In empathy the doctor is emotionally engaged with the patient and at the same time they are able to

reflect on these emotions, knowing that they originate in the other person.<sup>10</sup>

**Cognition** involves attempting to understand the perspective and experience of the other person. This depends on having **Curiosity**, to gain understanding into the patient's concerns, feelings, and distress. **Curiosity** requires suspending judgement and allowing uncertainty. It prevents the doctor from having an initial naive sympathetic response, taking their initial resonance at face value and then projecting their concerns onto the patient.<sup>25</sup>

Empathy is dynamic, requires effort, and involves **Action**, which is shown in **Concern** and **Care** for the patient, giving them a sense that they matter and that they will not be abandoned.<sup>26</sup> **Care** is the activity generated by the understanding gained by empathy. Empathy has an ethical dimension as a fundamental element of care. Empathy needs action and feedback by checking with the patient whether the doctor's understanding of their concerns is accurate.<sup>10,27</sup> **Reciprocity** implies that empathy is a two-way relationship with the patient. Empathy also enables patients to imagine what it might be like for the doctor.<sup>23</sup> **Humility** is an essential virtue and is a part of empathy that acknowledges limits. It is not possible to fully understand another person's thoughts, beliefs, and feelings, so humility counters the paternalistic phrase 'I know how you feel.'<sup>28</sup>

So it seems that, rather than attempting to capture the elusive concept of empathy in a reductive definition, it is more helpful to conceptualise empathy by describing the various facets that may be involved. The balance of particular elements of the construct will vary in differing clinical contexts, giving rise to multiple forms of empathy. For instance, the empathy involved when resuscitating a patient in the emergency department will be different from that involved when breaking news to a mother that her child is dying.

### CULTURE CHANGE: A MORE HUMANE PRACTICE

Francis called for a culture change in the NHS to include more compassionate care.<sup>1</sup> By fostering a broad view of empathy and incorporating this into daily practice, empathy can become a routine way in which a doctor works. Halpern maintains that empathy elevates a doctor's work from just a job to a profession in which they contribute to the meaningfulness of people's lives.<sup>10</sup> A broad view of empathy integrates emotional and cognitive elements of empathy. As Jamison writes, *we care because the feelings of others matter.*<sup>29</sup> Doctors need courage to enter the

### ADDRESS FOR CORRESPONDENCE

David Jeffrey

University of Edinburgh, Department of Primary Palliative Care, the Medical School, Teviot Place, Edinburgh EH8 9AG, UK.

E-mail: [d.i.jeffrey@sms.ed.ac.uk](mailto:d.i.jeffrey@sms.ed.ac.uk)

interpersonal world and to practise their empathic skills. Empathy is not something that just happens to us; it is a choice we make to pay attention, to extend ourselves, and it requires effort.<sup>29</sup> Empathy is not just necessary for effective medical practice but it is almost inconceivable for a skilled doctor to lack empathy.<sup>15</sup> A willingness to feel and convey empathy may result in a culture shift in medicine from detached concern to a broad view of empathy as the way of seeing the world from the patient's point of view.

### CONCLUSION

The aim of this article is to stimulate debate about empathy in clinical practice. I have argued that appropriate empathy in modern clinical care is neither detachment from patients nor being overwhelmed by emotions. It is rather an iterative process of emotional resonance and curiosity about the meaning of a clinical situation for the patient.<sup>8</sup> This broad form of empathy involves the capacity to participate deeply in the patient's experience while not losing sight of the fact that it is not one's own experience but that of another person. If doctors are to respect the patient's dignity they need empathy and self-awareness. Without self-awareness doctors can lose the 'other-perspective' and then become overwhelmed. Self-aware physicians can then experience empathy as a naturally healing connection with their patients.<sup>17</sup>

David Jeffrey,

Honorary Lecturer in Palliative Medicine, University of Edinburgh, Department of Primary Palliative Care, Edinburgh.

**Provenance**

Freely submitted; externally peer reviewed.

**Competing interests**

The author has declared no competing interests.

**Acknowledgements**

I would like to thank the Royal College of Physicians of Edinburgh for a Myre Sim Bursary for my PhD research. I am also grateful to my supervisors, Dr Marilyn Kendall, Professor Marie Fallon, and Dr Michael Ross, for their advice.

©British Journal of General Practice

This is the full-length article (published online 29 Jan 2016) of an abridged version published in print. Cite this article as: **Br J Gen Pract 2015; DOI: 10.3399/bjgp16X683761**

## REFERENCES

1. Francis R. *Report of the Mid Staffordshire NHS Foundation Trust public inquiry: executive summary*. 2013. <http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffpublicinquiry.com/report> (accessed 23 Nov 2015).
2. Parliamentary and Health Service Ombudsman. *Dying without dignity*. 2015. <http://www.ombudsman.org.uk/reports-and-consultations/reports/health/dying-without-dignity> (accessed 23 Nov 2015).
3. Leadership Alliance for the Care of Dying People. *One chance to get it right*. 2014. <https://www.gov.uk/government/publications/liverpool-care-pathway-review-response-to-recommendations> (accessed 23 Nov 2015).
4. Peabody F. The care of the patient. *JAMA* 1927; **88(12)**: 876–882.
5. Weatherall D. The inhumanity of medicine. *BMJ* 1994; **309(6970)**: 1671–1672.
6. Spiro H. Commentary: the practice of empathy. *Acad Med* 2009; **84(9)**: 1177–1179.
7. Spiro H. What is empathy and can it be taught? *Ann Intern Med* 1992; **116(10)**: 843–846.
8. Shapiro J. The paradox of teaching empathy in medical education. In: Decety J, ed. *Empathy: from bench to bedside*. Cambridge, MA: MIT Press, 2012: 275–290.
9. Mattingly C. Stories that are ready to break. In: Hyden L-C, Brockmeier J, eds. *Health, illness, and culture: broken narratives*. New York, NY: Routledge, 2008: 73–98.
10. Halpern J. *From detached concern to empathy: humanizing medical practice*. New York, NY: Oxford University Press, 2001.
11. Lipps T. *Ästhetik*. Leipzig: Leopold Voss Verlag, 1903.
12. Titchener E. *Lectures on the experimental psychology of the thought processes*. New York, NY: Macmillan, 1909.
13. Krznaric R. *Empathy: a handbook for revolution*. London: Random House, 2014.
14. Gladkova A. Sympathy, compassion and empathy in English and Russian: a linguistic and cultural analysis. *Cult Psychol* 2010; **16(2)**: 267–285.
15. Maxwell B. *Professional ethics education studies in compassionate empathy*. New York, NY: Springer, 2008.
16. Hojat M, Mangione S, Nasca TJ, et al. The Jefferson Scale of Physician Empathy: development and preliminary psychometric data. *Educ Psychol Meas* 2001; **61(2)**: 349–365.
17. Kearney MK, Weininger RB, Vachon ML, et al. Self-care of physicians caring for patients at the end of life: 'being connected ... a key to survival'. *JAMA* 2009; **301(11)**: 1155–1164.
18. Zenasni F, Boujut E, Woerner A, Sultan S. Burnout and empathy in primary care: three hypotheses. *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X652193.
19. Larson E, Yao X. Clinical empathy as emotional labor in the patient-physician relationship. *JAMA* 2005; **293(9)**: 1100–1106.
20. Markakis K, Frankel R, Beckman H, Suchman A. Teaching empathy: it can be done. Working paper. Annual Meeting of the Society of General Internal Medicine San Francisco, CA, 1999.
21. Mercer SW, Reynolds WJ. Empathy and quality of care. *Br J Gen Pract* 2002; **52(Suppl)**: S9–S12.
22. Morse JM, Anderson G, Bottorff JL, et al. Exploring empathy: a conceptual fit for nursing practice? *Image J Nurs Sch* 1992; **24(4)**: 273–280.
23. Coplan A, Goldie P, eds. *Empathy: philosophical and psychological perspectives*. Oxford: Oxford University Press, 2011.
24. Decety J, ed. *Empathy: from bench to bedside*. Cambridge, MA: MIT Press, 2012.
25. Halpern J. Clinical empathy in medical care. In: Decety J, ed. *Empathy: from bench to bedside*. Cambridge, MA: MIT Press, 2012: 229–244.
26. Chochinov HM. Dignity and the essence of medicine: the A, B, C, and D of dignity conserving care. *BMJ* 2007; **335(7612)**: 184–187.
27. Coulehan JL, Platt FW, Egener B, et al. 'Let me see if I have this right ...': words that help build empathy. *Ann Intern Med* 2001; **135(3)**: 221–227.
28. Macnaughton J. The dangerous practice of empathy. *Lancet* 2009; **373(9679)**: 1940–1941.
29. Jamison L. *The empathy exams*. London: Granta, 2014.