

## Managing barriers to empathy in the clinical encounter:

a qualitative interview study with GPs

### Abstract

#### Background

Current daily general practice has become increasingly technical and somatically oriented (where attention to patients' feelings is decreased) due to an increase in protocol-based guidelines. Priorities in GP-patient communication have shifted from a focus on listening and empathy to task-oriented communication.

#### Aim

To explore what barriers GPs experience when applying empathy in daily practice, and how these barriers are managed.

#### Design and setting

Thirty Dutch GPs with sufficient heterogeneity in sex, age, type of practice, and rural or urban setting were interviewed.

#### Method

The consolidated criteria for reporting qualitative research (COREQ) were applied. The verbatim transcripts were then analysed.

#### Results

According to participating GPs, the current emphasis on protocol-driven care can be a significant barrier to genuineness in communication. Other potential barriers mentioned were time pressures and constraints, and dealing with patients displaying 'unruly behaviour' or those with personality disorders. GPs indicated that it can be difficult to balance emotional involvement and professional distance. Longer consulting times, smaller practice populations, and efficient practice organisation were described as practical solutions. In order to focus on a patient-as-person approach, GPs strongly suggested that deviating from guidelines should be possible when necessary as an element of good-quality care. Joining intercollegiate counselling groups was also discussed.

#### Conclusion

In addition to practical solutions for barriers to behaving empathically, GPs indicated that they needed more freedom to balance working with protocols and guidelines, as well as a patient-as-person and patient-as-partner approach. This balance is necessary to remain connected with patients and to deliver care that is truly personal.

#### Keywords

empathic behaviour; empathy; patient-centred care; primary health care; protocol-driven care; shared responsibility.

### INTRODUCTION

Caring for the 'whole person' in a holistic manner is at the foundation of primary care and is regarded as a basic expertise for GPs.<sup>1</sup> 'Whole-person care' means '... *integrating a biomedical, psychological, social, cultural and holistic knowledge of the patient and community and applying this understanding to practical care planning through person-centred approaches ...*'<sup>2</sup> However, this person-centred approach is under pressure nowadays. Over the past decades, priorities in doctor-patient communication in everyday practice have shifted, from focusing on listening and empathy to task-oriented communication.<sup>3</sup> As a result of protocol-based guidelines, daily practice has become increasingly technical and somatically oriented.<sup>4</sup> A biomedical mainstream of care may be life-saving and health-promoting but it risks neglecting the patient's experiences of illness; understanding this is essential to ensure shared decision making based on the individual patient's perspective, preferences, and needs,<sup>5-9</sup> and contributes to effective health care.<sup>10</sup>

The emphasis in general practice on evidence-based and protocol-driven care, and the observed reduction in viewing the patient as an individual, has caused an ideological debate.<sup>6,11,12</sup> To achieve insight into different factors playing a role in GP-patient communication, models of the

medical consultation were constructed.<sup>9,13</sup> In these models, empathy was regarded as an important tool to establish a person-centred approach. By empathy the authors mean that a physician:<sup>14,15</sup>

- understands the patient's situation, perspective, and feelings;
- communicates that understanding and checks its accuracy; and
- acts on that understanding in a helpful, therapeutic way.

Empathy implies a morally valuable aspect, namely the recognition of the other as the centre of their own experience.<sup>16</sup>

The effectiveness of empathy on specific clinical outcomes for patients has been widely proven<sup>17</sup> and GPs view empathy as an important element during consultations.<sup>18</sup> However, so far there have been no thorough studies into what barriers GPs experience in applying empathy in daily practice and how they manage these barriers, especially in the light of the aforementioned changes in communication in the medical consultation. Therefore, this study aims to examine barriers to GPs expressing empathy and how they manage these barriers.

### METHOD

#### Study design

This study was carried out in the Netherlands where primary care is

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### How this fits in

Priorities in GP-patient communication have shifted from focusing on listening and empathy to task-oriented communication and protocol-driven care. The effectiveness of empathy on specific clinical outcomes for patients has been widely proven and GPs appreciate empathy as an important element during consultations. There are limited data concerning what barriers GPs experience in applying empathy in daily practice and how they manage these barriers. This study indicates that GPs use different ways to manage barriers in order to preserve the role of empathy in GP-patient communication. For example, GPs may deviate from the recommendations described in the guidelines, to deliver high-quality person-centred care and to show genuine interest in their patients. More work is needed to resolve the barriers experienced by GPs.

delivered by a GP and where patients are registered on their practice list. Most GPs cooperate in first-line health centres where they often help out with other GPs and health professionals such as specialised practice nurses, with practice assistants. After medical school and internships, GP residents follow 3 years of postgraduate vocational training. Since 1989 the Dutch College of GPs has published more than 100 standardised protocols on different diseases prevalent in primary care.<sup>19</sup>

For this study GPs were interviewed between June 2012 and January 2013. In-depth interviews were performed because they enable experiences in daily practice and the meanings interviewees attribute to them to be explored. Furthermore, they clarify participants' opinions about their own priorities.<sup>20,21</sup> The consolidated criteria for reporting qualitative research (COREQ) were applied.<sup>22</sup>

### Preparation and participants

Thirty-one interviews were conducted. To establish the appropriateness of the questions, four test interviews were performed by three authors before the interviews; these were audiotaped and discussed by the first author within the research group.

Participants were recruited using a step-by-step procedure. To avoid the possibility of interviews taking place between people who knew each other, a statistical employee performed a systematic random sampling from the NIVEL (Netherlands Institute for

Health Services Research) GP register (which includes all practising Dutch GPs). To produce a maximum variation sample, characteristics such as age (<45, 45–55, >55 years), sex, practice type (solo, being one GP in a practice and duo being two, or a group practice), and grade of urbanisation were taken into account. A total number of 147 GPs were selected and approached by letter, explaining the subject of the study and the duration of the interview. Some weeks after this letter was sent, the GPs were contacted by telephone. After 100 telephone calls, 31 GPs with sufficient variety in the aforementioned characteristics had consented to take part and signed an informed consent form. The 47 GPs who were not telephoned were placed on a reserve list (Figure 1). Appointments were made with the 31 GPs; anonymity and confidentiality were guaranteed.

### Data collection

The interviews were held face to face at the GPs' own practices and lasted between 45 and 70 minutes. All fieldwork was conducted by one author with a background in general practice who was an experienced interviewer.

The interviews were based on an interview guide formulated by the lead author and based on literature and expert opinions (Appendix 1). No repeat interviews were carried out. At the end of each interview the interviewee was given a short summary and was asked if they agreed with it. All interviews were recorded on audiotape and transcribed verbatim (in Dutch). After the first eight interviews, the interviewing style was analysed. After this, more open-ended questions were introduced to achieve more probing interviews and more room for reflection.

After 20 interviews it became clear that no new issues were arising. Although the first 20 interviews approached various aspects of empathy, the issue of barriers to empathy and how to manage these turned out to be the topic that came up the most. Therefore, the final 10 interviews were used to focus even more on the barriers GPs experienced in applying empathy during consultations and the way they managed these barriers.

### Data analysis

To analyse the data, iterative content analysis was employed.<sup>23</sup> The systematic examination of transcripts was undertaken by the interviewer and two doctoral medical students trained in qualitative analysis. This team of researchers was formed to minimise the influence of personal characteristics on

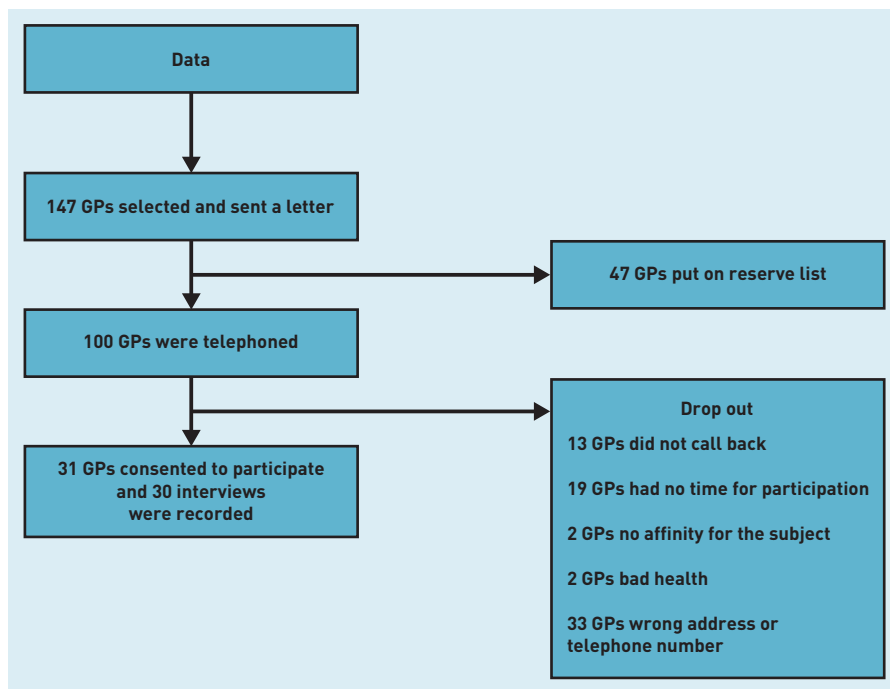


Figure 1. Participants flowchart.

the analysis and thus the possibility of bias. Atlas.ti (version 7) was used to assist with registering, searching, and coding the data. The researchers, independently of one another, read and re-read the transcripts, and met regularly to discuss the subjects and interpretations. In addition, after the third, twelfth, and thirtieth interview, the coding process was discussed with one author acting as supervisor. By using axial

Table 1. Characteristics of the participating GPs

Characteristics of the 31 <sup>a</sup> participating GPs	N(%)
<b>Sex</b>	
Male	14 (45)
Female	17 (55)
<b>Age, years</b>	
<45	13 (42)
45–55	10 (32)
>55	8 (26)
<b>Practice type</b>	
Sole	8 (26)
Two partners (duo)	14 (45)
Group	9 (29)
<b>Urbanisation</b>	
Rural area	12 (39)
Urban area	19 (61)
Mean experience as GP, years (range)	16 [2–33]

<sup>a</sup>Thirty-one GPs participated but, because one recording failed, the study was based on 30 interviews.

and selective coding, codes and super codes were attributed to text segments. Codes referring to the same phenomenon were grouped in categories and significant themes were made explicit. These themes formed the structure of the final result; quotations were used to explicate the themes. The original quotations were in Dutch and were translated into English with the help of a native speaker.

## RESULTS

### Overview of the results

Thirty-one GPs participated but, because one recording failed, the study was based on 30 interviews. The demographics of the participants show variability concerning sex, age, degree of urbanisation, and practice type (Table 1). An algorithm showing the procedure by which participants were recruited and information about those GPs not willing to participate is presented in Figure 1.

GPs indicated that they encounter barriers when they apply empathic behaviour in daily practice. However, because they consider empathy in the clinical encounter to be very important, they emphasised ways to manage these barriers. Four main barriers were distinguished:

- a conflict between protocol-driven care and showing genuine interest;
- a tension between professional distance and emotional involvement;
- patients' behaviour threatening connectedness within the GP–patient communication; and
- a conflict between time pressures and constraints and the GPs' need for personal space, peace, and need to regroup after each encounter.

These barriers and the ways that GPs manage them so that they can continue to show empathy are described below.

### Protocol-driven care versus showing genuine interest

GPs considered empathy to be an important prerequisite for humane care. However, they found that guideline-driven care results in a disease-centred emphasis rather than a person-centred way of thinking and working. The increased number of guidelines and bureaucratic requirements were seen as significant barriers to behaving empathically during the consultation.

Six GPs also mentioned that therapeutic regimens and 'programmed asking' (a list of standard questions) from evidence-based guidelines and protocols hamper

genuine reactions, interest, and creativity, thereby reducing the effectiveness of their empathic behaviour. This programmed way of working in the current medical system was identified as an external barrier to providing empathic care:

*'... that we're working in an extremely protocolised way, in fact being the doormat of the health insurance companies, that when I witness a resident doing a cardiovascular risk protocol, reading out 30 questions to the patient and looking at the computer screen all the time, and I tell them they were doing that, they will hate it as much as I do, but that is the danger of working with protocols ... and it causes you to completely miss out on contact with the patient, and empathy suffers enormously, I think.'* (GP 12, male, age 40 years)

*'In my experience, the more you're doing your own thing, like I want this and I need that, the more you're doing that, the less you really listen. That way you run the risk of missing things in a patient and later you think, if I had just kept quiet for a moment and listened, if I had just taken a little bit more time, I would have picked up on things that would have changed the situation and the patient would have been more satisfied.'* (GP 3, male, age 58 years)

*'People with diabetes, for instance, they have to record about 73 items in a list ... and I thoroughly dislike that, because you're spending most of your time looking at the computer screen instead of at the patient, so, yes, the increase in administrative tasks does influence my communication ...'* (GP 2, male, age 40 years)

To maintain their humane, empathic behaviour, GPs suggested that it is more effective and natural to combine the recommendations in the guidelines with questions about the patient's personal situation. GPs indicated that they considered patients as equal human beings, and that they wanted to treat them with respect and to show genuine interest, for example, by telephoning patients proactively in case of hospital admissions or life events, or by reflecting on previous situations. Furthermore, according to GPs, it helps to mutually value each other's expertise: the GP with regard to medical knowledge and the patient with regard to their specific situation and illness experiences. This patient-as-person approach contributed, in their view, to an innately humane form of contact, enhancing mutual understanding,

shared responsibility, and commitment, and it helped to develop a trusting relationship:

*'Empathy also means asking further questions: how are the kids, or if you know the husband is recovering from an illness, how is your husband doing? When the woman is visiting you to have her blood pressure checked, it is interesting to let go of protocol for a minute and ask after her husband, thereby showing interest in her context and broadening the picture; I can see that it's greatly appreciated, and it also gives me a lot of information about how she's doing.'* (GP 13, male, age 37 years)

*'Empathy also involves a certain disposition, an outlook on how you want to deal with a person ... I believe that patients can put forward their own expertise, to which I add mine, and together we can then explore the problem and get to work ... it's like building a foundation for cooperation with the patient.'* (GP 23, female, age 55 years)

### **Professional distance versus emotional involvement**

The risks of getting too close to and emotionally involved with patients emerged during the interviews, with GPs concluding that such relationships may interfere with their objective judgement with regard to diagnosis and treatment. At the same time, GPs stated that they needed a certain level of involvement in order to behave empathically. Furthermore, according to GPs, when involvement becomes too intense, they risk developing burnout:

*'That sometimes you start to cry when something is really tough, that has happened to me a few times. It makes me think less clearly and that is not good, so for me that's a boundary I don't want to cross. I think it's fine to be sympathetic with someone, but I shouldn't start blubbing along, that's not what I'm there for and I don't want to go there, and I think I can be more empathetic when I'm not eaten up by it.'* (GP 9, female, age 55 years)

GPs mentioned ways to protect their professionalism, for example, by setting clear boundaries and creating distance in their doctor-patient contact by behaving in a business-like way.

Furthermore, they were convinced that intercollegiate counselling groups offer an excellent opportunity to discuss this issue in depth:

*'Of course, there are moments when*

*there is a lot of pressure, for example during palliative care ... when a different connection with someone develops, you must try to remain professional, which is quite difficult and I try not to show that to my patient. When necessary I can show my emotions to my partner at home or during counselling with colleagues.* (GP 17, female, age 36 years)

*'There is a boundary and I can work with that. I think it's OK to have emotions, as a GP it's OK to show you have feelings and you're not a business-like person, you can express your feelings, but there is a boundary and that is your professionalism.'* (GP 18, female, age 34 years)

### **Patients' behaviour threatening connectedness within GP-patient communication**

GPs indicated that certain patients' characteristics can hamper GP-patient contact and complicate spontaneous and honest empathic communication. GPs specifically mentioned problems with the 'unruly behaviour' of some patients, such as those who argue aggressively with the reception staff, patients who keep an emotional distance, those with personality disorders, or patients who cross moral boundaries such as actively engaging in sexual abuse or drug dealing:

*'They sometimes fend it off, they build up a wall, like "What is it, what do they want." That occurs pretty regularly here, with older men of the rough-diamond type, they don't say much but do come, and I think that can be tough, but if you approach them more quietly, you do sometimes get through to them, but I do find it tough sometimes.'* (GP 17, female, age 36 years)

*'When I get the feeling ... it does happen that you have to deal with someone and you just don't click. "You can't please them all." So there are people you just don't get along with, but that usually filters itself out, people switch to another GP and so they should.'* (GP 5, male, age 65 years)

As a prerequisite for empathic behaviour in these situations, GPs emphasised that they need to be able to communicate in a free and honest way. They stated that their residency training in communication styles and intervision courses (Balint groups or coaching groups) help them to stay on speaking terms with these patients, preserving a trusting doctor-patient relationship:

*'Really wishing the other person to have a good consultation, even if they enter all grumpy. It can be pretty tough in a situation like that to find out what is bothering them.'* (GP 23, female, age 55 years)

*'What I want to say is that it doesn't simply happen by "switching on", so yes, I'm all for supervision and intervision for GPs. In my opinion it is very important to experience personal growth, you could say that "growing and pruning" is my motto.'* (GP 8, female, age 37 years)

### **Everyday time pressures and constraints versus GPs' personal space and peace**

GPs indicated that it is more difficult to pay empathic attention to the patient when the consultation schedule is overloaded. Overcrowded waiting rooms and large numbers of patients get in the way of empathy. Disturbance to the consultation itself, for example, because of incoming telephone calls, has a negative influence on GPs' attention and communication. Furthermore, GPs indicated that personal factors also play an important role in hindering empathic attention. For example, reduced physical fitness, personal difficulties, or a recent night shift can result in a decrease in a GP's ability to show empathy:

*'Well, it is affected by how you feel, how well you've slept ... you do have an off-day sometimes, and if you're doing consultations with a splitting headache, you know, it can be difficult to be really empathic; so yes, it does have to do with the condition you're in yourself.'* (GP 29, female, age 64 years)

*'Being distracted, someone entering ... when you're distracted it's hard to focus on a conversation, whether it be from being tired, or busy, or having all sorts of thoughts running through your head, there are phone calls and messages all the time. I think all those things can interfere.'* (GP 9, female, age 45 years)

To manage these barriers, GPs stated that they try to plan longer consultation times for specific patients. In addition, they indicated that having a thoughtful and committed practice assistant who predicts patients' required consultation times helps them apply empathy. Furthermore, optimising the organisation of the consultation hours by structured deliberations between GPs and practice assistants was regarded by some as useful. Others saw a reduction in the number of registered patients as an opportunity to create extra time:



*'Wouldn't it be an idea to switch to smaller practices and to spend 15 minutes on each patient, while keeping your income ... that way you'd actually facilitate empathy by keeping incomes at the same level ... I think there's certainly a case for setting a 15-minute consultation time for many complaints.'* (GP 12, male, age 40 years)

*'So that is an important prerequisite, you know, having peace of mind, things running smoothly in the practice. Your staff need to understand when they can interrupt you and when they cannot, and that some questions are worth an interruption and others are not; that's a matter of fine-tuning things.'* (GP 16, male, age 45 years)

## DISCUSSION

### Summary

This study describes the barriers GPs encounter when applying empathy in daily practice and how they manage these barriers. GPs perceive the current emphasis on protocol-driven care with guidelines, bureaucratic requirements, pay-for-performance, and quality-of-care indicators to be an important barrier to remaining genuinely patient-oriented during the consultation. Although the government is not driving these changes, health insurance organisations use, for example, blood levels (an HbA1c value from the diabetes protocol) as quality-of-care indicators.

To manage these barriers GPs try to combine a patient-as-person approach with the recommendations given in the guidelines. GPs mentioned overcrowded office hours and disturbances in consultations as factors hampering empathic behaviour. Longer consulting times, smaller practice populations, and efficient practice organisation were described as practical solutions. Furthermore, GPs argued that approaching patients as partners with mutual expertise can result in shared responsibility. Conversely, they described how having to deal with transgressive behaviour in patients, those exhibiting unruly behaviour, those with personality disorders, and those keeping an emotional distance presented a barrier to displaying empathy in a spontaneous way. GPs also discussed their own internal difficulties in balancing emotional involvement and professional distance.

### Strengths and limitations

GPs' experiences with barriers to empathetic behaviour and the ways they manage these barriers during consultations are, to the best of the authors' knowledge,

hitherto under-researched aspects of GPs' everyday practice. Previous studies have explored the views of GP trainees, medical educators, and hospital specialists, or have approached the subject theoretically.<sup>9,24</sup>

Being interviewed by a colleague has possibly affected the data collection.<sup>25</sup> Negatively, it could result in a lack of objectivity and possible bias, and, with respect to the participants, the possibility of them providing 'desirable' answers. Positively, being interviewed by a trustworthy colleague may have led GPs to give more personally detailed information.

Empathy can be considered a 'container' concept. Some interviewees merged it with aspects of general communication or patient-centredness. Qualitative studies are limited in their generalisability. However, compared with quantitative studies, they can provide richer insights. By using a cyclical and iterative way of collecting and analysing data, 'progressive focusing' on the barriers that GPs encounter and on the way these barriers are managed was realised. The GPs who participated did so as volunteers. Accepting a time-consuming interview may imply that GPs had some sympathy with the subject and may have under-exposed negative thoughts. Therefore, caution should be taken in generalising conclusions beyond this study.

Although the qualitative method is appropriate to explore and clarify GPs' opinions, it does not provide insight into the GPs' actual behaviour. However, tape-recording the interviews, multiple coding during analysis, and member checks added to the rigour of the study.

### Comparison with existing literature

Previous research has pointed out that communication styles of GPs have changed from focusing on listening and empathy towards task-oriented communication.<sup>26</sup> It can be assumed that this task-oriented communication originates from the ever-expanding numbers of standardised protocols and guidelines. Recently, health insurance companies have focused on the GP guidelines — which were not intended to be used in this way<sup>27</sup> — in order to define quality-of-care indicators for primary care. These indicators are mostly somatically oriented. Van Os and colleagues pointed out that merely following guidelines is not enough to deliver good-quality care.<sup>28</sup> The best outcome will be gained when doctors follow the professional guidelines and are able to build a trustful and personal doctor-patient relationship with their patients as well. Therefore, evaluating the quality of

health care simply by measuring adherence to the guidelines is not appropriate at all.<sup>10,29</sup> This explains the tension GPs face when they try to deliver good-quality health care. It is also in line with what patients expect: they count on a humane and personal approach from their GP, who shows an affective attitude and who is aware of the latest evidence available, and who takes the needs and consequences of their illness into account.<sup>10,30,31</sup> In this regard patients have previously identified certain types of non-verbal behaviour of GPs, such as being occupied by the computer screen, as negative.<sup>31</sup>

Furthermore, this study highlights that empathy helps GPs to consider patients as so-called cooperating experts, an approach with shared responsibility and expertise, enabling tailor-made solutions. Previous research has defined the mutual-expert approach as partnership-building, a working alliance, or as achieving collaboration.<sup>9,32,33</sup>

To choose the best course of action for the individual patient, Greenhalgh and colleagues argue that evidence-based medicine should reintroduce its founding principles, that is, a strong interpersonal, humanistic, and professional relationship, empathetic listening, and a collaboration between an expert physician and an expert patient.<sup>34</sup> GPs expressed exactly the same opinion in this study.

Preserving a more emotionally involved GP-patient relationship does have consequences. GPs in this study experienced tension between behaving empathically and remaining professional. They described how engaging empathy brings with it a need to create a balance between involvement and preserving some distance. The authors are not aware of recent general-practice-oriented studies analysing GPs' experiences regarding these aspects. Ethicists such as Gelhaus point to the depth of emotional participation of GPs in enabling adequate empathic understanding.<sup>35</sup> Previous theoretically oriented studies describe similar ideas about working on the boundary of self-other awareness. It is stated that mental flexibility, self-critical analysis, and self-knowledge help in maintaining a clear self-other separation. Self-knowledge allows one to have a controlled, balanced, and efficient regulatory process of empathy-related responding.<sup>35-37</sup>

#### **Implications for research and practice**

Given the results of this study, there is a

need to get quantitative insight into the prevalence and relevance of barriers to empathic behaviour in daily practice. The consequences of overly biomedical protocol-driven care especially should be studied in depth, as well as the influence of the role of health insurance companies on patient-centred care.<sup>38</sup> The urgency of resolving the barriers experienced by GPs should also be determined. Further research in this area may be helpful to convince policymakers and health insurance companies to take action and to stimulate positive conditions for empathic behaviour in GPs. Because patients are considered important judges on healthcare issues,<sup>39,40</sup> and research into patient outcomes has been performed,<sup>41</sup> the authors advocate more detailed research into patients' experiences and opinions with regard to GPs' empathetic behaviour. Insight into patients' points of view gives physicians the opportunity to act on them.<sup>42</sup>

According to GPs, empathy is a requisite for high-quality person-centred care, GP education should then focus on this to show students and residents the added value of empathetic behaviour. Teaching and practising this behaviour should be embedded explicitly in the current teaching models on GP-patient communication. A focus on personal development and the introduction of humanities within GP education and residency may preserve and strengthen empathy as a humanising communication skill in general practice.<sup>43</sup> Furthermore, continuous medical education and organising intercollegiate counselling groups may help GPs in preserving an effective GP-patient relationship and in managing involvement with patients, while at the same time maintaining professional objectivity.

GPs described different kinds of barriers to their empathetic behaviour. They pointed out different ways to manage these barriers to preserve the role of empathy in GP-patient communication. In a healthcare system in which protocol-driven care and quality indicators have become increasingly important, GPs consider empathy as a fundamental tool in their patient-as-person and patient-as-partner approach. GPs in this study also stated that it is sometimes necessary to deviate from the recommendations described in the guidelines, in order to deliver high-quality person-centred care and to show a genuine interest in their patients.

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#### **Ethical approval**

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#### **Provenance**

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#### **Competing interests**

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## Appendix 1. Interview guidelines

### Introduction

My name is Frans Derksen and I am a retired GP. I conduct scientific research on empathy in GP–patient communication. As I mentioned in my letter of introduction, I am interested in the personal opinions, experiences, and perceptions of both GPs and patients on the role of empathy during consultations. This part of my research focuses on GPs; in a later phase the opinions of patients will be investigated. I have chosen face-to-face interviews as the method to collect the data for this research. Names and addresses of GPs to approach were obtained through taking a sample from the NIVEL GP file. You were in that sample and you have shown yourself willing to get involved with this research. Thank you for that. In the interview I would like to talk to you about the following topics: background information about your practice, your views on general practice, your views on empathy in communication with the patient, and, finally, the conditions you believe play a role when working with empathy. I would like to stress that in this interview there will be plenty of space for your thoughts. My aim is to let the interview take up to about 1 hour (15 minutes per topic). As we have agreed, I will audiotape the entire interview and I will make some notes and check my list of questions. Everything you say is strictly confidential; the research findings will be anonymised.

### Do you have any questions at this point?

Some questions to gain background information on your practice: Do you work in an urban or a rural area? When did you start working as a GP? Do you train GP students? Could you tell me something about your practice organisation (sole, two partners, group) and about your patient population?

### A. First your own general views on general practice:

1. At some point in your life you chose to become a GP. How did you come to that choice?
2. What aspects would you describe as the core of your job?
3. What important developments have you noticed during the time you have been a GP?
4. What do you think of these developments?
5. How do you feel now about your choice to become a GP, taking into **account** the developments that you just outlined?

### B. Now I would like to talk to you about empathy:

1. What does the concept of empathy mean to you as a GP?
2. Can you specify the way you use it? How do you use it? What do you find difficult or easy? Do you feel capable of providing it and are you skilled at it? Can you give me any examples? How do you experience empathy yourself?
3. Does the special feature of the GP with its longstanding contact with the patient play a role in the implementation of empathy?
4. There is a lot of talk about sex differences in the use of empathy. Do you have any opinion on that?
5. How much importance do you attach to the use of empathy in your relationship with your patients? Can you indicate this on a scale of 1 to 10? What if you relate it specifically to evidence-based medicine and/or protocol-based medicine?
6. Can you give any examples of your personal experiences with empathy during the consultation? Were they positive or negative?
7. In general, GPs are highly esteemed by their patients; if they complain about anything it is a lack of communication skills and empathy in their GP. Do you recognise this? Can you tell me anything about that?
8. How do you think patients experience empathy?

### C. Preconditions and barriers to empathy:

1. Do you think there are preconditions and barriers to being empathic? If so, what are they?
2. Is it possible to facilitate its use? How? Can GP training play a role in this? What was it like during your own training?
3. Do health insurance companies and the government show enough interest in the role of empathy in your opinion?
4. Is there enough, or too much, attention being paid to empathy in medical literature, during refresher courses, and by professional associations? If so, how could this be improved?

### D Final question:

1. We have talked at length about your views on general practice and empathy. Would you like to add anything, anything that we have not covered, but that in your view is important in this context?

These were the questions I wanted to put to you. Thank you very much for replying and for your cooperation.