Doctor of diseases or doctor of people - Empathy in clinical practice: Let's practice!

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Model of Clinical Care

Biomedical Model

- Find it
- Fix it

Communication model

(The Four Habits of Highly Effective Clinicians)

- Invest in the Beginning
- Elicit the Patient’s Perspective
- Demonstrate Empathy
- Invest in the End

Model of Complete Clinical Care

Opening

Communication Task
- Engage
- Empathy
- Educate
- Enlist

Biomedical Task
- Find it
- Fix it

Closing
1. Introduction

The patient-physician relationship is the center of medicine. As described in the patient-physician covenant, it should be “a moral enterprise grounded in a covenant of trust.” This trust is threatened by the lack of empathy and compassion that often accompany an uncritical reliance on technology and by pressing economic considerations.

2. How Does the Presence or Absence of Empathy Affect Medical Care?

On May 1st, I went to the emergency room because of a persistent cough. After taking a chest x-ray, Dr. X told me I had a mass in my right lung. I asked the doctor what I should do. His reply to me was “If I were you I would go home, make out a will, and a living will.” I then asked if this meant it was cancer. His response was “there is a 75% chance if it is a small cell form of cancer, you won’t be around for next Christmas.” This absolutely devastated me!!

On my way home I contemplated driving my car into a tree so I would not have to live through this and put my family through it. It took approximately six weeks to determine that it was in fact small cell lung cancer. I have lived since with his words on my mind.

Looking back on these happenings and talking to other doctors, nurses, etc., I cannot believe this doctor’s insensitivity. I cannot tell you the mental state of mind I have been in because of these words.

Letter of complaint to a large Midwestern HMO, 1994.

3. What is empathy?

Empathy is a response that demonstrates an accurate understanding and acceptance of the patient’s feelings or concerns.

Wells, et al. 1985
4. A Model of Empathy in the Medical Encounter

POTENTIAL EMPATHIC OPPORTUNITY

Patient: [discussing a relative’s illness] The doc said it was touch and go, touch... PEO
Physician: Yeah.
Patient: ...and go.

PEO TERMINATOR

Patient: I’m in the process of retiring... PEO
Physician: You are?
Patient: Yeah. I’ll be sixty-six in February
Physician: Do you have Medicare? PEO TERMINATOR
EMPATHIC OPPORTUNITY

Dr: ...How do you feel about the cancer—about the possibility of it coming back?  EO
Pt: Well, it bothers me sometimes but I don’t dwell on it. But I’m not as cheerful about it as I was when I first had it. I just had very good feelings that everything was going to be all right, you know. But now I dread another operation.
Dr: You seem a little upset; you seem a little teary-eyed talking about it.

MISSED EMPATHIC OPPORTUNITY

Physician: Does anybody in your family have breast cancer?
Patient: No.
Physician: No?
Patient: Now I just start (unintelligible) after I had my hysterectomy. I was taking estrogen, right?
Physician: Yeah?
Patient: You know how your breast get real hard and everything? You know how you get sorta scared?
Physician: How long were you on the estrogen?
Patient: Oh, maybe about six months.

Suchman et al, JAMA 1997,
A Model of Empathy in the Medical Encounter

Potential Empathic Opportunity Continuer

Potential Empathic Opportunity  ➔  Empathic Opportunity  ➔  Patient Feels Understood

Potential Empathic Opportunity Terminator

Empathic Opportunity Terminator

Suchman et al., JAMA 1997; 227:8
Please write below after watching the video vignette

1. What are the patient’s feelings or emotions?

2. How does the patient make you feel?

3. What would you like to say at a gut level, if there would not be any social boundaries or if you can get away with it?

4. What would you actually say to the patient to get a grasp of situation or to get patient’s confidence?
EMPATHY AND OUTCOMES OF CARE

The Four Habits Approach to Effective Clinical Communication

<table>
<thead>
<tr>
<th>Habit 3</th>
<th>Skills</th>
<th>Techniques and Examples</th>
<th>Payoff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrate Empathy</td>
<td>Be open to the patient’s emotions</td>
<td>Assess changes in body language and voice tone</td>
<td>Adds depth and meaning to the visit</td>
</tr>
<tr>
<td></td>
<td>Make at least one empathic statement</td>
<td>Look for opportunities to use brief empathic comments or gestures</td>
<td>Builds trust, leading to better diagnostic information, adherence, and outcomes</td>
</tr>
<tr>
<td></td>
<td>Convey empathy nonverbally</td>
<td>Name a likely emotion: “That sounds really upsetting.”</td>
<td>Makes limit-setting or saying “no” easier</td>
</tr>
<tr>
<td></td>
<td>Be aware of your own reactions</td>
<td>Compliment the patient on efforts to address own problem</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use a pause, touch, or a facial expression</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use your emotional response as a clue to what the patient might be feeling</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Take a brief time-out if necessary</td>
<td></td>
</tr>
</tbody>
</table>

Frankel, Stein and Knippen 2003
The Effect of Emotional Support During Pediatric Encounters

Table 1. Frequency of Clinician Support (No. of episodes per visit)

<table>
<thead>
<tr>
<th>Support Categories</th>
<th>Mean ± SD</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encouragement</td>
<td>7.8 ± 4.0</td>
<td>7</td>
<td>0 - 17</td>
</tr>
<tr>
<td>Reassurance</td>
<td>16.6 ± 11.6</td>
<td>15</td>
<td>0 - 27</td>
</tr>
<tr>
<td>Empathy</td>
<td>3.1 ± 2.9</td>
<td>2</td>
<td>0 - 12</td>
</tr>
<tr>
<td>TOTAL SUPPORT</td>
<td>27.5 ± 14.7</td>
<td>27</td>
<td>4 - 83</td>
</tr>
</tbody>
</table>

Wasserman et al. 1984

Table 2. Maternal Visit Outcomes by Exposure to Different Levels of Empathy*

<table>
<thead>
<tr>
<th></th>
<th>High-Level Empathy†</th>
<th>Low-Level Empathy‡</th>
<th>P Value§</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfaction with visit</td>
<td>80.6 ± 4.9</td>
<td>75.1 ± 7.1</td>
<td>.03</td>
</tr>
<tr>
<td>Change in perception of infant</td>
<td>6.6 ± 4.0</td>
<td>5.8 ± 3.2</td>
<td>.57</td>
</tr>
<tr>
<td>Change in self-confidence</td>
<td>3.3 ± 1.4</td>
<td>2.9 ± 0.7</td>
<td>.47</td>
</tr>
<tr>
<td>Change in opinion of clinician</td>
<td>3.0 ± 1.1</td>
<td>2.8 ± 0.4</td>
<td>.51</td>
</tr>
<tr>
<td>Reduction in concern</td>
<td>8.1 ± 3.6</td>
<td>5.6 ± 1.9</td>
<td>&lt;.05</td>
</tr>
</tbody>
</table>

*Values are means ± SD
†High-level empathy: more than three episodes per visit
‡Low-level empathy: less than two episodes per visit
§Two-tailed test

Wasserman et al. 1984
The Effect of Continuous Emotional Support During Labor

Study Design: Randomized controlled trial in U.S. hospital, 600 nulliparous women.
1) Support group received continuous emotional support during labor by *doula*,
2) Observed group, 3) Control group.

<table>
<thead>
<tr>
<th></th>
<th>Supported Group</th>
<th>Observed Group</th>
<th>Control Group</th>
<th>Support vs. Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>C-section rates</td>
<td>8%</td>
<td>13%</td>
<td>18%</td>
<td>↓ 56%</td>
</tr>
<tr>
<td>Epidural anesthesia</td>
<td>8%</td>
<td>23%</td>
<td>55%</td>
<td>↓ 85%</td>
</tr>
<tr>
<td>Forceps delivery</td>
<td>8%</td>
<td>21%</td>
<td>26%</td>
<td>↓ 70%</td>
</tr>
<tr>
<td>Oxytocin</td>
<td>17%</td>
<td>23%</td>
<td>44%</td>
<td>↓ 61%</td>
</tr>
<tr>
<td>Duration of Labor</td>
<td>7.4 hrs.</td>
<td>8.4 hrs.</td>
<td>9.4 hrs</td>
<td>↓ 25%</td>
</tr>
<tr>
<td>Neonate hospitalization (&gt;48 hrs.)</td>
<td>10%</td>
<td>17%</td>
<td>24%</td>
<td>↓ 58%</td>
</tr>
</tbody>
</table>


Preoperative Suggestions and Postoperative Recovery

Study Design: 40 GI surgery patients randomized to treatment (5-min specific suggestion for early return of bowel function) or controls (5-min reassurance and nonspecific instructions).

<table>
<thead>
<tr>
<th>Postoperative Outcomes</th>
<th>Specific Suggestion Intervention</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Return of Intestinal Motility</td>
<td>2.6 days</td>
<td>4.1 days*</td>
</tr>
<tr>
<td>Length of Hospital Stay</td>
<td>6.5 days</td>
<td>8.1 days</td>
</tr>
</tbody>
</table>

*p<0.5
Projected savings: $1,200 per patient

Harvard Community Health Plan
Ambulatory Care Claims: Principal Loss
Prevention Issues by Specialty

Risk Management Foundation of the Harvard Medical Institutions* Based on 312 Claims from January, 1985 - March, 1992

The following are the most frequently identified loss prevention issues, by physician specialty, as recorded in CRICO claims occurring in the ambulatory setting. Multiple issues may be identified in a single claim.

**Internal Medicine**
- Appropriate and timely referrals
- Patient’s failure to follow up
- Patient/clinician communication
- Clinician’s failure to follow up

**Orthopedic Surgery**
- Failure to fully assess patient injuries
- X-rays misread
- Lack of failure of call-back system
- Patient/clinician communication

**General Surgery**
- Failure to fully assess
- Patient/clinician communication
- Patient/clinician communication
- Timely referral to specialist

**Radiology**
- Equipment maintenance and safety
- Patient/clinician communication
- Inattention to patient’s medical history
- Incomplete radiographic study

**Ob/Gyn**
- Clinician’s failure to follow up
- Patient/clinician communication
- Technical errors
- Failure to treat partner for STD

**Psychiatry**
- Consent for medication/treatment
- Monitoring of drug therapy
- Confidentiality of patient information
- Sexual misconduct

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**Categories and Frequency of Relationship Issues Identified in 45 Depositions**

<table>
<thead>
<tr>
<th>Issues</th>
<th>No.</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not understanding the patient and/or family perspective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failure to solicit patient and/or family opinion</td>
<td>1</td>
<td>(2.6)</td>
</tr>
<tr>
<td>Inattention to patient’s discomfort</td>
<td>3</td>
<td>(7.9)</td>
</tr>
<tr>
<td>Failure to recognize the psychosocial impact</td>
<td>1</td>
<td>(2.6)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>5</td>
<td>(13.1)</td>
</tr>
</tbody>
</table>
### Categories and Frequency of Relationship Issues Identified in 45 Depositions

<table>
<thead>
<tr>
<th>Issues</th>
<th>No.</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dysfunctional delivery of information</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failure to provide an explanation</td>
<td>4</td>
<td>(10.5)</td>
</tr>
<tr>
<td>Failure to keep a patient and/or family up-to-date</td>
<td>2</td>
<td>(5.3 )</td>
</tr>
<tr>
<td>Blaming a patient and/or family for bad outcome</td>
<td>2</td>
<td>(5.3 )</td>
</tr>
<tr>
<td>Insensitivity informing a patient and/or family</td>
<td>2</td>
<td>(5.3 )</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>10</td>
<td>(26.4)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Issues</th>
<th>No.</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Devaluing patient and/or family views</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discounting a patient and/or family opinion</td>
<td>2</td>
<td>(5.3 )</td>
</tr>
<tr>
<td>Discounting a patient’s illness and/or suffering</td>
<td>4</td>
<td>(10.5)</td>
</tr>
<tr>
<td>Not listening</td>
<td>3</td>
<td>(7.9 )</td>
</tr>
<tr>
<td>Discounting a family’s attempt to advocate</td>
<td>2</td>
<td>(5.3 )</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>11</td>
<td>(28.9)</td>
</tr>
</tbody>
</table>
### Categories and Frequency of Relationship Issues Identified in 45 Depositions

<table>
<thead>
<tr>
<th>Issues</th>
<th>No.</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desertion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perceived as unavailable</td>
<td>2</td>
<td>(5.3)</td>
</tr>
<tr>
<td>Abandoned</td>
<td>7</td>
<td>(18.1)</td>
</tr>
<tr>
<td>Physician too important</td>
<td>2</td>
<td>(5.3)</td>
</tr>
<tr>
<td>Sending a surrogate</td>
<td>1</td>
<td>(2.6)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>12</td>
<td>(31.6)</td>
</tr>
</tbody>
</table>

### Bibliography


Dealing with Patient Emotions

Dealing with a patients’ anger or any such strong emotion could be a challenging task during the medical consultation/interviewing. The strong emotion could affect the interview process in many ways including the ability for the physician to obtain necessary information during the interview, to negotiate a plan of care with patient and to have a long-term relationship for continued partnership in care.

It is important to address and diffuse the emotions otherwise it will create barrier to effective and efficient communication during the encounter.

Following is a suggested algorithm providing strategies for dealing with difficult emotions. (Mnemonic: **NURS** the emotion)

1. **Name** – name the emotion
   a. I can see that you are frustrated…”
   b. If you’re not sure of the emotion or you “guess” wrong… the patient will correct you….”I’m not frustrated, I’m angry”
   c. Move forward and name the correct emotion, “I can see that you are angry…”

2. **Understand** – show the understanding of the reason for the emotion
   a. “I can understand how you would be angry if you had to wait as long as you did…”
   B. Or ask the patient the reason for his emotion

3. **Respect** – Provide recognition for the helpful behaviors the patient is exhibiting
   a. “I appreciate the fact that you choose to wait to see me even if you were upset about…..”
   b. Respect their reason with out judgmental comments.

4. **Support** – Provide a statement of ongoing support and partnership
   a. “I’d like to know that I am going to do my best to help you with the time we have today..”

**Angry Patient**

Anger in patients is usually obvious, but sometimes anger is expressed in more subtle ways such as discordant message between the verbal expressions and the nonverbal communication.

Physicians frequently avoid addressing anger, most commonly by ignoring it or by changing topic. The two most common reasons given for failure to address anger are for fear of unleashing more anger, or fear of time involvement. This practice may escalate
the anger. Responding to patient anger with anger may further escalate the tension, prolong the encounter and visit may be non productive.

Patients’ anger is usually a defense mechanism for dealing with a fear of their own:
- fear of loss of control
- fear of dependence
- fear of rejection
- fear of meaning of illness
- fear of inadequacy
- fear of dying

Following are some of physicians’ responses:
- fear
- Vulnerability
- Confusion
- Reduced empathy
- Resentment
- Sense of being manipulated
- Exhaustion
- Impatience
- Frustration
- Desire to punish
- Anger

**Strategies:**
1. **Active Listening** – Paralanguage skills, position, posture, eye contact, facilitative responses, silence
   *Try talking as little as possible during this time. Listen and paraphrase what you’ve heard.*
2. **Framing** – “Sounds like what you are telling me…”
   “Let’s see if I have this right…”
3. **Reflecting Content** – Factual as well as nature and intensity
4. **Identifying and Calibrating the Anger** – Sometimes content is evident, but nature of anger is unclear
   “That situation really got to you, didn’t it?”
   “I can imagine how angry I’d feel if that happened to me”
5. **Requesting and Accepting the Correction** – “Did I get that right...?”
6. **Empathy** – Three implications
   - Cognitive – enter patients’ perspective but don’t loose your own
   - Affective – put yourself in patient’s place
   - Action – verify emotion so patient can correct and/or feel listened to.

*If you’d like to show empathy without saying “I’m sorry” which might imply responsibility for the situation, consider using a statement with the words” I wish”, for example, “I wish you didn’t have to wait as long as you did.”
* Empathy is not the same as agreeing with patient. Empathizing is expressing understanding of how the patient feels.

7. **Sorry** - I you made a mistake that lead to anger, admit it and apologize. Do not try to excuse, explain or discuss specifics at first… the patient will need to have his or her feelings validated first before they are willing to listen if they are angry. Trying to excuse the problem may lead him or her to feel as if their feeling is not valid and lead to more anger.

8. **Consider Motivation** – Secondary gain? Hidden agenda
9. **Recognizing Physician Limitations.**

### Notes
**Case Studies**
Courtesy of American Academy on Patients & Physicians (AAPP)

**QUESTION # 1**
Last year you found that your patient, an active 56yo carpenter who also serves in city government, had diabetes. He dieted and walked more and lost 15 pounds, reducing his Hgb A1C from 8.5 to 6.0. This year, his weight slowly increased and his A1C is 8.5. His wife reveals his liking for Girl Scout cookies. Patient complains of worsening hip pain, which you previously successfully treated with NSAIDS. After discussion, you advise him to lose 15 pounds again, and he says, "Oh doctor, with my hips, I just can't walk enough!" His wife again interrupted and complained about his sweet tooth.

Which of these POSSIBLE RESPONSES do you prefer?
A. Perhaps stopping cookies will get the weight off.
B. I think I can ease your hip pain.
C. You lost weight before; can you do it again?
D. You may have to start a diabetes medication.
E. You want to manage the diabetes, but are concerned you can't lose weight because of your hip pain and your wife is worried about your eating habits.

**QUESTION # 2**
You are doing an initial complete history & physical examination on a new patient who is a 42-year-old construction worker. Two days prior to the visit his spouse called you and made you aware of the fact that she is very worried about his heavy drinking and that she wanted you to be sure to address it in the context of the visit, but not to divulge the fact that she called.

During the history taking the patient reveals that he has 3-4 beers "on the way home with the boys" then usually another three or four each evening. He made it clear that he sees this as a modest intake as it is "only beer." He denied having his drinking ever interfere with his interactions at home, his work situation or his driving, although he reveals he had one "close call" for a DWI.

Which one of these POSSIBLE COMMENTS regarding this patient's drinking do you prefer?
A. Your alcohol intake is clearly excessive and will likely get you into medical trouble down the line.
B. I understand from your wife that your drinking has been a problem at home.
C. You are drinking the equivalent of six or eight shots of liquor each evening.
D. I am concerned about your drinking.
E. It is only a matter of time until you get caught for a DWI.
Answers:

**QUESTION # 1**
Our PREFERRED RESPONSE is E:
Research shows that engagement and commitment are enhanced when doctors paraphrase patient's thoughts, particularly when the patient's initial response is qualified or negative. This strategy is called *reflective listening*. It demonstrates your attention and gives the patient freedom to suggest a plan, to ask a question, or to name additional concerns. Letting him have the lead (as well as his wife) will boost your efficiency at finding successful solutions.
Giving orders (C) or simple fixes (A, B) to complex lifestyle problems often fails. People will succeed only when they make a considered decision. Threats (D) leave him hanging and stifle dialog, as would emphasis on his admitted transgression (A).

**QUESTION # 2**
OUR PREFERRED RESPONSE is D:
Personal ("I") statements reflecting sincere concern on the part of an empathic physician are very powerful tools in building a relationship and gaining trust. In a patient who is still in denial, accusatory statements such as A or E often only result in further alienation from the clinician. An educational statement such as C, to help with the reality check can be helpful, but perhaps not as an initial offering. Certainly statement B, which betrays trust in three directions will only serve to make the patient suspicious and likely not return.