J R Coll Physicians Edinb 2017; 47: 266–70 | doi: 10.4997/JRCPE.2017.312 **PAPER**

Communicating with a human voice: developing a relational model of empathy

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Abstract

The medical profession has adopted a cognitive model of empathy, or detached concern, in its professionalism and practice. As a consequence there is now an empathy gap which has been demonstrated by lapses in patient care in the UK. There may also be an empathy gap developing in medical students during their training. This paper argues for the adoption of a relational view of empathy which embraces emotional and moral dimensions of the concept, acknowledges the importance of the clinical context and prioritises the relationship between the doctor and patient. A relational model extends to encompass the patient's family and all members of the healthcare team. By exploring the process of empathising in clinical practice I develop a relational model that is more appropriate for modern patterns of patient care and medical education than detached concern. Adoption of a relational model of empathy in training and practice can help bridge the empathy gap.

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Keywords: doctor–patient relationship, empathy, medical education, professionalism

Declaration of interests: No conflict of interests declared

Introduction

> We are two beings, and we have come together in infinity... for the last time in the world. Abandon your tone and take a human one! At least for once in your life speak in a human voice. Not for my sake, but for your own.
>
> *Demons*, Fyodor Dostoevsky

In the wake of high-profile public reports in the UK identifying an empathy gap in clinical care, there have been calls for more empathy in healthcare.[1–3] Conflicting evidence of a decline in medical students' empathy during their training potentially widens the empathy gap.[4–8]

Medicine's positivist philosophy, prioritising technical progress, fosters a cognitive form of empathy: 'detached concern'.[9,10] Detached concern is now widely adopted as an appropriate form of empathy in medical professionalism, practice and training.[10–15] I argue that a relational view of empathising, embracing emotional and moral dimensions and acknowledging the importance of placing the doctor–patient relationship at its core, including the family and healthcare team, is more appropriate for medical education and practice.[16–20] I hope to stimulate debate and to suggest ways of bridging the empathy gap in practice and medical education, and so enhance patient care.[13,21,22]

Empathy

Differing definitions of empathy highlight its varied dimensions; some focusing on understanding the patient's view (cognitive), others on sharing feelings (affective).[13,23,24] The complexity of empathy is described elsewhere; here I argue for a broader approach which embraces empathy's cognitive, affective, behavioural and moral aspects.[18,19,25–28] Empathy may also be seen as a personal attribute or as a relational concept, depending on the context for its expression.[19,21,23] Empathy may occur at superficial or deep levels according to the clinical context.[29] For instance, during an OSCE examination with a simulated patient, a superficial level of empathy may suffice, but in planning end of life care with a patient and their family, a deeper level is required. When explaining the technicalities of an operation to a patient, the cognitive dimension of empathy predominates, but when responding to a euthanasia request, affective and moral dimensions dominate the dialogue.

Practising empathy

The 'empathy cycle' is a dynamic process in which both patient and doctor learn more about each other over time in an iterative deepening of their relationship.[30] Although the focus of this paper is empathy in the doctor–patient relationship, empathy extends to involve all relationships between the patient, family and healthcare team. Empathising comprises a series of steps which interact, according to the context of the relationship, in a subtle psychological dance involving connection and detachment. Interrogating this process may help us to understand the empathy gap and to develop more humane clinical teaching and care. The first step is showing concern for the patient.

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Concern

Empathy begins with an individual's willingness to empathise.[31,32] This initial concern or 'empathic resonation' between a doctor and patient ensures that empathy is an interpersonal phenomenon from the outset.[30,33] Suchman describes this moment as 'empathic opportunity'.[32] Emotional resonance is automatic and may involve mirror neurones.[22]

Students and doctors want to empathise with patients and feel frustrated when prevented from doing so;[34] patients want their doctors to demonstrate empathy.[26] Broyard, describing his experience as a patient, said of his doctor:

'I just wish he would give me his whole mind just once, be bonded with me for a brief space, survey my soul as well as my flesh, to get at my illness, for each man is ill in his own way'.[35]

The empathetic doctor is trying to see the world through the patient's eyes using imagination, curiosity and listening skills. Letting go of our assumptions forms part of our willingness to empathise. The doctor may adopt Carl Roger's therapeutic stance of 'unconditional positive regard' for the patient, giving the patient their full attention.[36]

Attention

A deep level of empathy requires face to face contact with the other person. Patient contact is an important way of bridging the empathy gap.[37] Empathy can be enhanced by simply being present, by giving the other person the focus of one's full attention. Empathy cannot occur while the doctor is gazing at a computer screen.

Norfolk et al. describe a relational model for developing rapport in the consultation in which empathy is construed as a skill.[37] Their model highlights the importance of innate interest or curiosity and being inclined to care for others.[37] Empathic motivation, attention, listening skills and understanding combine to increase rapport.[37] Empathy as a relational concept deepens with continuity of care,[21] which is difficult to achieve in the UK; many patients feel they cannot relate to 'their' general practitioner.[38]

Attention involves active listening as a doctor seeks the underlying hidden agenda each patient brings, listening to their story and allowing time to pass. Time is necessary to establish deep empathy which takes account of the patient's context. When time is short there is a risk that the doctor distances themselves from the patient and empathy then becomes superficial rather than deep.

Connection (affective)

Doctors have always struggled to balance emotional connection (affective empathy) and detached professional concern (cognitive empathy) in their relationships with patients.[5,10,14] A close empathetic relationship with a patient encourages trust and allows patients to confide their deepest fears. Empathy involves feeling with the patient to gain an understanding of their suffering.[31] It inevitably exposes the doctor's vulnerability and involves sharing part of oneself with the other person.[39] If we are to bridge the empathy gap we need to develop a medical culture which acknowledges the doctor's vulnerability.[40]

Empathic concern results in a sharing of emotion, the doctor feels the pain of a patient while remaining aware of the self–other boundary.[41] This appropriate empathic concern can be distinguished from personal distress. Stress may result from taking a self-orientated perspective ('how would I feel in this situation?') which can lead to identification and becoming overwhelmed. Reducing stress, by providing support, may diminish the empathy gap by allowing students and doctors to be open to emotions and so to enhancing their empathy.[42] Giving time to students and doctors to discuss difficult emotional situations with a mentor or in a group setting may be one way of providing such support.

Doctors may fear emotional connection because they are concerned their clinical judgement may be less 'objective' or that they will become overwhelmed and burn out. These concerns may lead them to distance themselves from patients, mistakenly feeling that detachment is part of being professional. Personal experience of suffering may inform the doctor's empathy but care is needed to avoid making assumptions that the patient necessarily shares the same feelings. A crucial aspect of affective (emotional) empathy is to share feelings rather than merely labelling an emotional state.

Detachment is not necessary for reliable clinical judgement since emotional insights can inform clinical decision-making.[10,43] Moreover, it has been suggested that empathetic doctors have more job satisfaction and less burnout than detached colleagues.[44,45] Even if doctors try to suppress their feelings by distancing themselves, they cannot avoid having emotional attitudes towards patients.[46]

Understanding (cognitive)

While I argue for adopting emotional-based reasoning instead of detached concern, the cognitive area is a core dimension of empathy.[22] Imagination, or perspective taking, is integral to empathising. The doctor adopts an other-orientated perspective where they are trying to see the world from the patient's point of view. In the detached concern form of empathising, understanding occurs within the doctor. In a relational model, understanding is an interpersonal activity depending on the doctor and the patient who also gains an understanding of the doctor's world.

Some authors have pointed out that it not possible to fully understand what another person is thinking or feeling.[47] Doctors need the humility to accept that empathy cannot achieve a complete understanding of the other person's world view, but in making the effort to reach out and connect with

the other and taking account of differences in perspectives, empathy can still be of great value.[13]

Communication skill (behavioural)

Non-verbal communication skills include eye contact, touch, facial expression and other body language communicating concern.[19] Reflecting the patient's feeling is an important verbal tool in conveying empathy along with the sensitive use of language and self-disclosure.[19] These behaviours, however, are only part of the art of practising empathy which is a nuanced process requiring authenticity.

Authenticity

The acronym 'ICE', designed to explore patient's Ideas, Concerns and Expectations, acts as a reminder to cover these areas of the consultation.[48] There is a risk students may perceive ICE as something to be tacked on the end of history-taking to gain a few marks in an exam. This behaviour can lead to a form of pseudo-empathy where the doctor or student exhibits behaviours which appear to convey empathy but do not engage with the patient. This pseudo-empathy has been compared to surface acting, in which empathic expressions are adopted without any change in the doctor's emotions or understanding of the patient.[46] Patients can easily detect the 'have a nice day' approach of pseudo-empathy.

Self–other boundary

Self–other differentiation implies that although empathy should involve a deep engagement with the patient, this does not mean the doctor loses sight of where the self ends and the other begins. Carl Rogers emphasised that empathy involved entering the perceived world of the other person 'as if' one were the other person, but without ever losing the 'as if' condition.[49] Rogers' account conceptualises empathy as an experience which paradoxically combines closeness and distance, similarity and difference.[50] Empathy creates a space which enables the doctor and patient to convey respect and recognition.[51] In empathy, the doctor is emotionally engaged with the patient and at same time is able to reflect on these emotions, knowing that they originate in the other person.[10] In retaining a sense of the self–other boundary, empathy differs from identification which can result in personal distress and burnout.[41] Empathy requires effort, is often emotionally draining and empathic failures are likely to occur.[50,52] To maintain this delicate psychological balance between detachment and connection, the doctor needs to be self-aware, to reflect on their work and to have access to support. A self-aware doctor understands that their own feelings and the part they play in counter-transference are an integral part of their empathy.[53,54]

Responding (moral)

Empathy has a moral dimension, since appropriate understanding of the patient is necessary before being in a position to apply ethical professional principles in practice.[13] Pedersen does not imply that 'appropriate' means perfect or complete understanding but rather it is sufficient for the participants. The doctor and patient participate in a dialogue and reflect on their understanding.[13] Empathy is a source of moral knowledge and an essential component of practical wisdom (phronesis) and of care ethics.[55–57] Care implies both a moral attitude and activity.[58] A relational model incorporates empathy as an integral part of medical understanding and as a motivating concern to care.[31] Empathy includes action and a shared sense of fraternity.[10,59] A shared humanity creates a sense of security in situations of great uncertainty. Empathy has also been conceptualised as a virtue, i.e. a desirable character trait.[11,28,60]

Support

Doctors and medical students need support in enhancing their empathetic skills, and this may involve addressing some of the barriers blocking their innate empathy.[4,61] Doctors need to develop the self-awareness to recognise the difference between empathic concern, which is an essential part of professionalism, and personal distress, which can be self-destructive. However, it is not good enough to provide doctors with training or exhortations to be more empathetic and then expect them to work in an environment that does not support empathy. Support and mentoring needs to be available for all doctors and medical students, not just reserved for those perceived to be struggling.[62]

Teaching empathy

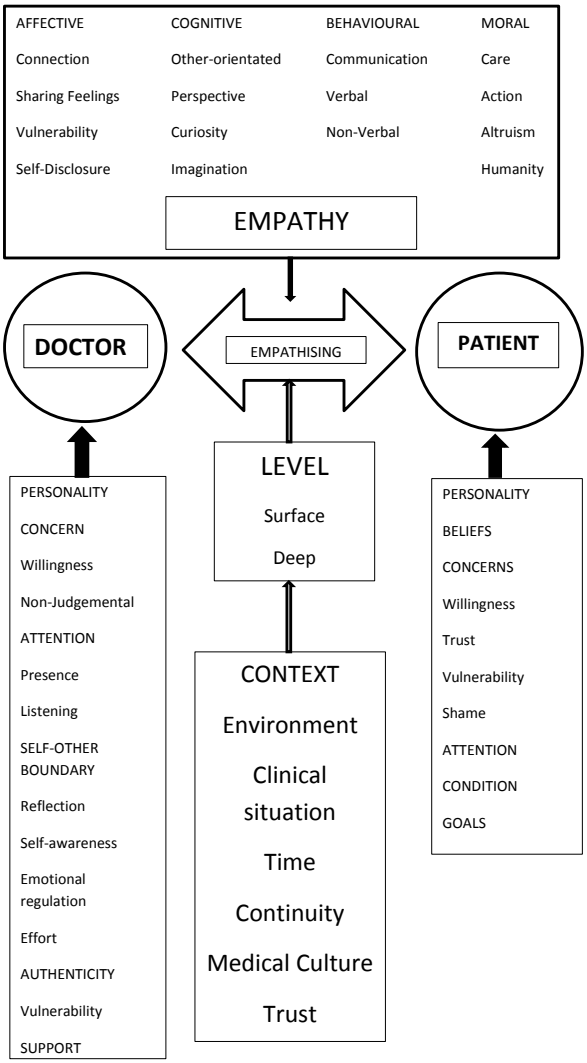
It is beyond the scope of this paper to review the many initiatives which have been used to enhance empathy in students and doctors[4,63,64] Role modelling, mentoring and the use of the medical humanities are all considered to be helpful in enhancing empathy.[4]

Conclusions

Fifteen years ago, Jodi Halpern, in her seminal work *From Detached Concern to Empathy: Humanizing Medical Practice*, suggested that doctors should adopt a model of empathy which included affective dimensions instead of detached concern.[10] I echo her plea and argue that by analysing the process of empathising, a broad model of empathy emerges which moves beyond detached concern to a more dynamic relational model. In this model, empathising is a creative process which changes and develops with experience. The relational model extends to the doctor's relationships with the patient's family and to other members of the healthcare team. As empathy develops, practice becomes more patient-centred. If doctors are to establish close therapeutic relationships with patients they need to be given time to establish empathy, to acknowledge the individuality of the patient and to properly address their concerns.[65] Time, presence, feelings, curiosity and imagination combine in empathy to recognise the person, and not simply their illness (Figure 1).

Doctors need courage to enter the interpersonal world and to practise their empathetic skills. Empathy is not

Figure 1 A relational model of empathising in the doctor-patient relationship



something that just happens to us, it is a choice we make to pay attention, to extend ourselves and it requires effort.[52] A willingness to feel and convey empathy may result in a culture shift in medicine from detached concern to a broader relational view of empathy as the way of seeing the world from the patient's point of view.

I argue that appropriate empathy in modern clinical care is neither detachment from patients nor being overwhelmed by emotions. It is an iterative process of emotional resonance and curiosity about the meaning of a clinical situation for the patient.[10,61] This broad form of empathy involves the capacity to participate deeply in the patient's experience while not losing sight of the fact it is not one's own experience but that of another person.[44] 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.[10] Perhaps every doctor, clinical teacher and medical student needs to ask themselves 'Do I speak with a human voice?'

Acknowledgements

My thanks to my PhD supervisors, Dr Marilyn Kendall, Professor Marie Fallon and Dr Michael Ross for their support. I am also grateful to the reviewers of this paper for their helpful insights.

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