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Patient Empathy & Effects on Health Outcomes

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Alternative Plan Paper

Master of Science – Community Health Education

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Patient Empathy & Effects on Health Outcomes

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Chapter One: Introduction

There is a system of needs in human beings for social affiliation—for bonding and attachment, for forming a social network and for feeling understood (Hojat, 2007). The grand principle is the same whether the individual is an infant, a child, an adolescent, an adult, male or female, healthy or ill, being connected is beneficial to the human body and mind. This bond can be formed through empathy.

Empathy has many definitions depending on the context. When used in a general sense, and outside the profession of medicine, it is the ability to understand another's experience, to communicate and confirm that understanding with the other person and to then act in a helpful manner (Buckman, Tulsy, & Rodin, 2011). Regarding the use of empathy in the healthcare setting, the Society for General Internal Medicine defines empathy as “the act of correctly acknowledging the emotional state of another without experiencing that state oneself” (Halpern, 2003, p. 670).

Background of the Problem

In healthcare today, it appears that the trait of empathy is not widely practiced. There is a history of pressure in the healthcare provider's role, from medical school, residency and then once practicing to seeing a certain number of patients and performing a certain number of treatments or surgeries. Most medical students begin their medical practice with much empathy and genuine love—a real desire to help other people (Spiro, 1992). In medical school, however, they learn to mask their feelings, or worse, to deny them. Medical students are taught science first and detachment second (Spiro, 1992). Providers strive for detachment to unfailingly

care for all patients regardless of their personal feelings. In contrast, patients want genuine empathy from their providers (Halpern, 2003).

In a healthcare setting, empathy has been shown to enhance the doctor-patient relationship in several ways: it can improve both doctor and patient satisfaction, it can enhance diagnostic accuracy, and it can increase patient enablement (Canale et al, 2012). According to patients' own definitions of quality care, physician empathy is a central concern (Blane & Mercer, 2011).

Statement of the Problem

If empathy can have a positive effect on a patient's satisfaction and treatment, then is it safe for one to assume that a lack of empathy should have a negative effect on patient satisfaction and treatment. In a recent study in which oncologists were video-recorded speaking with their patients, it was found they responded to only 22% of the 200 moments thought to be an empathic opportunities (Pollak, Arnold, Jeffreys, Alexander, Olsen, Abernethy,... Tulskey, 2007). A similar study of oncologists and lung cancer patients showed the physicians responding to only 11% of empathic opportunities (Morse, Edwardsen, & Gordon, 2008). It can be argued that if empathy can decline then it should also be possible to increase empathy by targeted educational programs. It is clear that there are numerous empathetic opportunities presented to physicians, it is just a matter of determining why physicians are not utilizing this trait.

Significance of the Problem

“Illness cannot be understood without understanding the patient, and healing begins, not when medicine is administered, but how it is administered” (Hojat, 2007, p. 145). Understanding a patient and his or her health issues can be done in two ways: the “curing” model, which the emphasis is placed on identifying the disease with the aim of treating the symptoms or the “caring” model, which the emphasis is placed on the patient as a whole. The “caring” model focuses on the treatment of illness, not just on the removal of the symptoms of disease (Hojat, 2007). The “caring” model thrives on empathy and there are many reasons that empathy is central to this model.

Empathy is a valuable communication tool to possess, especially when communicating health information. In a study completed with 144 patients, the relationship between understanding the information and health literacy is stronger and more positive among patients who perceived that their physicians was empathetic toward them. The relationship is usually weak but still positive among patients who believed their physician showed some empathy but believed they could have shown more. However, the relationship became more negative among the population of those who believed they received little to no empathy from their physician (Chu & Tseng, 2013).

Many patients have very low health literacy (Chu & Tseng, 2013). The consequences of low health literacy include difficulties navigating the health care system, receiving fewer preventive services, providing inaccurate or incomplete histories, missing appointments, failing to follow medication instructions, not

providing informed consent, suffering worse health outcomes and experiencing overall anxiety and nervousness (Chu & Tseng, 2013). Much literature and research recommends that patient-centered approaches generally are associated with stronger feelings of understanding (Chu & Tseng, 2013). Of all the components involved in effective patient-centered communication and overall healthcare, empathy seems to be the element most influential, yet also easily ignored (Chu & Tseng, 2013).

Empathy is also crucial in the healing process. Patients respond better to a provider who is empathic and understanding, than one who is not (Canale et al., 2012). Human beings are designed by evolution to form meaningful interpersonal relationships through verbal and nonverbal communication (Hojat, 2007). There is significant evidence suggesting that empathy directly enhances healing efficacy (Canale et al., 2012). Engaged communication has been linked to decreasing patient anxiety and stress and, for a variety of illnesses; decreasing these feelings have been linked to beneficial physiologic effects and improved outcomes. An expert panel on how physicians and providers deliver bad news concluded that patients cope better in the long term if their doctors are empathic (Halpern, 2013).

Research Questions

1. How is empathy defined in healthcare settings?
2. How do physicians' empathy skills impact health outcomes of patients?
3. How can empathy be better incorporated into the healthcare setting?

Limitations

1. There is limited published research on this topic.
2. Literature review as a research method could only provide an overview on the topic of patient empathy.

Delimitations

1. Research reviewed is limited to publications dated 1992 to 2016
2. Internet resources, including journals, are used as a primary source. Some of research may have been published in other forms

Assumptions

1. Lack of empathy is of concern for physicians and patients
2. Empathy can be measured
3. The literature reviewed is valid and accurate

Definitions

Empathy - the ability to understand and share the feelings of another; “standing in the patient’s shoes” in the experience of the illness (Hojat, 2007).

Health literacy – the degree to which individuals have the capacity to obtain, process and understand basic health information needed to make appropriate health decisions and services to prevent and treat illness (Chu & Tseng, 2013).

Sympathy – feelings of pity and sorrow for someone else's misfortune (Canale et al., 2012); developing feelings for the patient’s sufferings (Hojat, 2007).

Chapter Two: Review of Related Literature

The purpose of this study is to examine the relationship between physician empathy and health care outcomes for patients. The first section of the literature review will define empathy specifically in clinical settings. The second part will focus on the effects empathy has on health and healing of patients, particularly the empathetic relationship between the physicians and patients. The third and final section will focus on how to improve use of empathy in the clinical setting and potential training options.

Definition of Empathy

Empathy can be defined, simply, as the ability to understand and share the feelings of another. Empathy has to do with, in some sense, sharing or “feeling in tune” with another person’s affective state (Smith, 2014). Empathy can also be defined as the act of correctly acknowledging the emotional state of another without experiencing that state oneself (Halpern, 2003).

The construct of empathy has two components: cognitive and affective. The cognitive aspect of physician empathy is defined as the physician’s ability to accurately apprehend the mental state of his or her patients (the ability to take another person’s point of view) and to effectively communicate this perspective to patients. The affective aspect of physician empathy is defined as the physician’s ability to respond to and improve his or her patients’ emotional states (Kim, Kaplowitz, & Johnston, 2004). Halpern (2003) argues that the cognitive component forms the basis of empathy and involves “imagining how it feels to be in another

person's situation." The affective component is termed as "resonance" or "emotional attunement" (p 671).

Many professionals argue that the affective part of empathy is not necessarily an important component of patient empathy, as it is too closely associated with sympathy, which is not always welcomed in a healthcare setting because sympathy may interfere with treatment decisions (Hojat et al., 2002). The key feature of empathy is understanding, rather than affective involvement with patients' experiences. It is important to distinguish the difference between empathy and sympathy. The affective domain is a key component of sympathy, but not empathy (Hojat et al., 2002). Sympathy is feelings of pity and sorrow for someone else's misfortune and sympathetic physicians risk over-identifying with patients and all emotional responses are seen as threats to objectivity when it comes to medical treatment for patients (Halpern, 2003). Sympathy involves compassion but not passion (Spiro, 1992). Empathy is associated more with cognitive response and understanding, whereas sympathy is associated more with emotions (Hojat, 2007). Although, physicians cannot fully experience the suffering of each patient, a patient's observation of physician empathy is that his or her feelings are being understood and accepted by the physician; generally patients do not need or expect the physician to become emotionally involved (Kim et al., 2004). The professional skill of clinical empathy is distinguished by the use of subjective, experiential input for specific, cognitive aims. Empathy has as its goal to visualize how it feels to be in another person's situation. Empathy does not merely label emotional states but

recognizes what it feels like to experience something (Halpern, 2003). The goal of empathy is to focus attention on the patient.

It is important to note that there are ways to measure empathy in both patients and physicians. One of the most common ways to measure physician empathy is The Jefferson Scale of Physician Empathy (JSE). The JSE was designed to evaluate physicians and other practicing health care professionals, medical students and other health professions students. It was constructed based on extensive review of literature. The tool uses 20 Likert-type items to be answered on a seven-point scale. There are several different versions of the scale. One version was developed for administration to physicians and other practicing health professionals (Physician/HP-Version). The other versions are for administration to medical students (S-version) and other health professions students (HPS version). All are similar in content with minor modifications in wording of some items to maintain face and content validity for the target populations (Sidney Kimmel Medical College, 2015).

While the Jefferson Scale of Physician Empathy is the most common way to measure empathy, there are numerous other ways to. The Toronto Empathy Questionnaire has 16 questions that encompass a wide range of attributes associated with the theoretical facets of empathy (Spreng, McKinnon, Mar, & Levin, 2009). Another empathy scale, the Interpersonal Reactivity Index (IRI) consists of 28-items answered on a 5-point Likert scale. It has 4 subscales, each made up of 7 different items. These subscales are Perspective Taking, Fantasy, Empathic Concern and Personal Distress. Another tool, Hogan's Empathy Scale, was one of the first

empathy scales. It contains 64-item scale composed of 31 items selected from the Minnesota Multiphasic Personality Inventory, 25 items selected from the California Psychological Inventory and 8 items created by Hogan and colleagues (Fitzer Institute, 2016). Similarly, the Questionnaire Measure of Emotional Empathy (QMEE) contains seven subscales that together show high split-half reliability, indicating the presence of a single underlying factor thought to reflect affective or emotional empathy (Spreng, McKinnon, Mar, & Levin, 2009). Finally the Balanced Emotional Empathy Scale (BEES) is a fairly new scale. This questionnaire has 30 items using a 9-point agreement-disagreement scale Spreng, McKinnon, Mar, & Levin, 2009). A few other scales worth noting are the Scale of Ethnocultural Empathy, Nursing Empathy Scale, Japanese Adolescent Empathy Scale and the Measure of Emotional Intelligence Spreng, McKinnon, Mar, & Levin, 2009).

Relationship between Empathy and Healing

Empathy and patients' treatment have been proven to have a very strong relationship. As stated before, empathy is about physicians understanding their patients' situations. This understanding allows the patient to feel respected and validated. Empathy promotes patient and physician satisfaction, contributes to patient enabling and participation, and may improve patient outcomes.

Furthermore, empathy improves the quality and sometimes quantity of data obtained from the patient, which helps to improve physicians' diagnostic ability, and decreases the rate of miscommunication and lawsuits (Chen, Lew, Hershman, & Orlander, 2007).

A major component of effective communication in healthcare is health literacy. According to the most recent national literacy study, 29% Americans have basic to below basic literacy skills. An additional 5% are non-literate in English. About half of the U.S. adult population has difficulty using text to accomplish everyday tasks and the ability of the average American to use numbers is even lower at about 33% having basic quantitative skills (The Joint Commission, 2007). When literacy collides with health care, that is when the real issue of health literacy begins. About 44% of Americans fall into the “intermediate” level of literacy (The Joint Commission, 2007). That is, they can apply information from moderately dense information and make simple inferences. Yet, health care information – such as insurance forms, consent forms, and medication instructions – is often very complex and seemingly dense (The Joint Commission, 2007). Its also easy for a patient to believe they understand something while in a healthcare setting, but almost immediately after talking to their physician, patients are able to recall 50% or less of important information just given to them (Williams, Davis, Parker, & Weiss, 2002). Patients with inadequate literacy skills, particularly those with a poor understanding of common medical terms and written health materials, probably account for a substantial portion of these patients. Patients with poor health literacy have a complex array of communication difficulties, which may affect health outcomes (Williams, Davis, Parker, & Weiss, 2002).

Patients must have an understanding of not only the illness, but also risks and benefits of various treatment options in order to make informed decisions about medical care. Clinicians also need to understand patients’ values, preferences, and

beliefs about health. However, achieving a shared understanding can be difficult because clinicians and patients often understand health and illness through different lenses. The terminology or “language” healthcare providers use to communicate with patients can present a barrier for many patients who cannot sufficiently comprehend health vocabulary (Street, Makoal, Arora, & Epstein, 2009). There are numerous consequences of low health literacy rates which include difficulties navigating the health care system, receiving fewer preventive services, providing inaccurate or incomplete histories, missing appointments, failing to follow medication instructions, not providing informed consent, and experiencing overall worse health outcomes. Because many patients lack this skill, they may often feel short of information, which can lead to vagueness, nervousness and anxiety (Chen, Lew, Hershman, & Orlander, 2007). The consequences of low health literacy can also lead to higher healthcare costs. A study of English- and Spanish-speaking Medicaid participants revealed that among those enrolled in Medicaid because of medical need or indigence, those reading at the lowest grade levels had average annual health care costs of \$12,974, compared with \$2,969 for the overall population studied (Williams, Davis, Parker, & Weiss, 2002).

Of all the factors involved in effective patient-centered communication, empathy seems to be the most influential component, yet it is the most overlooked and underused. Appropriate use of empathy as a communication tool has multiple benefits in the patient- physician relationship, including: 1) encouraging patients to better describe their symptoms and concerns; 2) enhancing the efficiency of collecting and understanding health information leading to a more accurate

diagnosis; 3) aiding patients in participating in their treatment and recovery; and 4) honoring and soothing patients in a therapeutically beneficial manner (Chu & Tseng, 2013). Empathy can also be helpful in nonverbal communication. Nonverbal communication in clinical settings can be taught by understanding nonverbal expressions of concern. Such nonverbal expressions include: changes in tone of voice, eye contact, gaze and aversion of gaze, silence, laughter, teary eyes, facial expressions, hand and body movements, trembling, touch, physical distance, leaning forward or backward, sighs, or other signs of distress (Hojat, 2009).

Using empathy as a communication tool can lead to more successful outcomes for patients. Communication is thought to improve and contribute to health outcomes in seven ways: 1) Improving access to care 2) Augmenting patient Knowledge and shared understanding 3) Enhancing the therapeutic alliance 4) Enhancing patients' ability to manage emotions 5) Improving family and social support 6) Enhancing patient empowerment and agency and 7) Enabling higher quality decisions (Street et al., 2009).

There are numerous studies reviewed that suggest empathy is associated with improved clinical outcomes for patients. A study was conducted in Italy on patients with diabetes that compared the number of patient's complications with their provider's level of empathy. The providers' empathy scores were determined using the Jefferson Scale of Empathy. Patients of providers with high empathy scores compared to the patients with providers with moderate and low scores and they had significantly lower rates of acute metabolic complications (Canale et al., 2012). Empathy is a crucial instrument of communication and communication can

be healing. Talk can be therapeutic in that a physician who validates the patient's perspective or expresses empathy may help a patient experience improved psychological well-being—fewer negative emotions and more positive ones. A patient-centered approach and effective communication generally are associated with better feelings of understanding and lower levels of anxiety and nervousness (Levit, Balogh, Lighter, Park, Burke, Nass, & Herdman, 2013).

Incorporating Empathy into Healthcare System

While empathy has proven to be an effective tool in the healthcare setting, physicians generally are not using it when treating a patient (Street et al., 2008). The problem is not just about the lack of usage, but also the fact that many physicians don't have effective communication skills. There is concern among educators that clinical training may have an adverse effect on medical residents' and students' empathy. Empathy is a skill that many physicians just don't have today as it has been proven, through many studies, to be lost over the course of medical school (Chen et al., 2007). In one study of internal medicine residents, empathy was measured to be highest at the beginning but decreased by the end of residency, and remained low through the end of residency. Work-related challenges, including long work hours and sleep deprivation, are reasons believed to contribute to this decline. Research of medical students have shown that empathy measured over the third year of one cohort of medical students declined, and that a single medical school class had higher measured empathy at the start compared to the end of medical school (Chen et al., 2007).

There are many other reasons for the decline and ultimately lack of empathy in physicians. Spiro (1992) believed that medical students start out with empathy and a real desire to help others but are purposefully taught detachment or to mask their feelings or deny them. Spiro believes this is so that the students don't become attached to their patients and that they are not swayed when making medical decisions. "Empathy overcomes narcissism and isolation" – these are traits a physician must have to believe in themselves and their decisions (Spiro, 1992, p. 844).

Studies have found that other factors such as gender or occupation within the healthcare system may also contribute to the lack of empathy. Physicians in patient-oriented specialties (internal medicine, family medicine, pediatrics, rehabilitation, and so further) tend to score higher on the Jefferson Scale of empathy than those in technology-oriented specialties (pathology, surgery, radiology, anesthesiology, and so further). Further, females almost always scored higher than males. Additionally, physicians in specialties such as psychiatry scored higher than anesthesiologists, orthopedists, neurosurgeons and radiologists (Hojat et al., 2002).

Research focused on the decline of empathy throughout medical school was conducted at Boston University School of Medicine in 2007. This study investigated empathy more closely across the entirety of medical school education while controlling for potential confounding effects of gender, age, anticipated financial debt upon graduation, and future career interests (Chen et al., 2007). The first-year medical student class had the highest empathy scores and appears to increase throughout the first-year class, whereas the fourth-year class had the lowest

empathy scores, showing that empathy decreases throughout the course of medical education (Chen et al., 2007).

The next step in dealing with physician empathy is to determine how to better integrate empathy into the healthcare setting. Empathy is established mainly in childhood, however it can be relearned but may take more time and effort. Much of relearning empathy depends on experience and conversations to share these experiences and feelings (Spiro, 1992). There have been suggestions to integrate clinical narrative or critical incident writing into medical school. A creative writing outlet like this could help to maintain or even increase empathy. Role-playing or simulated patient scenarios could have a similar effect. Since communication is such a key component of empathy, a patient-interviewing course offered at medical schools might help to improve these traits (Chen et al., 2007).

Dr. Anthony Back, from the University of Washington, presents another approach. He first created the idea of a “Wise Mind” (Back, 2014). Back discusses the development of a way of thinking to help physicians move into an empathic mind set and showed how it can improve patients’ outcomes. He views humans as having two minds—an emotional mind and a rational mind. The emotional mind is where feelings and intuitions originate, and it is involuntary. The rational mind is analytical and logical, and it works only when we exert effort. The idea of a “wise mind” describes an integration of the emotional mind and the rational mind. “Wise mind” is when we can grasp the bigger picture, and for patients facing difficult medical decisions, wise mind is the place where medical decisions that match values originate. The first step is “seeing the affect as a spotlight” (Back, 2014, p. 142).

Physicians need to learn to listen in a different way in order to listen for the emotional tone. They need to frame the patient's emotion as a spotlight. The physician illuminates something important to the patient rather than try to turn off the patient's emotional mind or ignore it to set up the possibility that it could be heard in a different way. The physician should consider the emotion to be a spotlight rather than a distraction. The second part is "using the patient's affect as a focus to connect" (Back, 2014, p. 142). The physician must notice the emotional cue, and respond in a way that acknowledges the patient's experience and seek to connect to, and engage with, the patient's emotional mind. The third component is "reading between the lines of affect to infer what's important" (Back, 2014, p. 142). This requires the skill of listening to patients and not looking for data points, but rather sifting through associations that the patient makes. This skill is labeled as "listening for inferences" (Back, 2014, p. 142) because there is an emphasis on having to work from incomplete evidence. The final part is "the action plan as a process of joint design" (Back, 2014, p. 143). This involves developing the patient's commitment to act. The hallmark of success is not the number of topics covered—success is moving patients toward constructive action (Back, 2014).

There have been many recommendations to mandate empathy training in medical education (Spiro, 1992). Empathy can be assessed, so the recommendation is to have an assessment of empathy as a requirement for medical school graduation since medicine is a public service profession and the professional behavior of physicians includes compassionate care and empathy. Empathy should be a criterion for selection of medical students and residents, or perhaps even for

employment of physicians (Hojat, 2007). Often empathy is associated with clinical competence; there is a proven link between empathy and how smart the doctor is. Empathy should play a more important role in medical school (Hojat et al., 2002).

Summary

Empathy can be interpreted in many ways and is often mistaken for sympathy, but that doesn't negate its contribution to the healing process for patients. Empathy is important to communication, health literacy and health outcomes of the patient. Many physicians, due to the demands of their profession, rarely practice empathy, but it is something that can be relearned if integrated into medical education.

A summary of the literature reviewed in Chapter Two is included below.

Summary of Literature Reviewed

Study	Methodology	Population	Findings	General Comments
Buckman, R., Tulsky, J., & Rodin, G. (2011).	Descriptive, 398 clinic conversations between oncologists and patients with advanced cancer; oncologists also completed surveys	270 patients with advanced cancer	Oncologists encountered few empathic opportunities and responded with empathic statements infrequently. Empathic responses were more prevalent among younger oncologists and among those who were self- rated as socioemotional. To reduce patient anxiety and increase patient satisfaction and adherence, oncologists may need training to encourage patients to express emotions and to respond empathically to patients' emotions.	Pollak KI, Arnold RM, Jeffreys AS, et al. (2007). Oncologist communication about emotion during visits with patients with advanced cancer. Journal of Clinical Oncology; 25:5748- 52

<p>Canale, S., Louis, D., Maio, V., Wang, X., Rossi, G., & Hojat, M. (2012) .</p>	<p>Retrospective correlation study</p>	<p>20,961 patients with type I or II diabetes in Parma, Italy</p>	<p>Patients with physicians with high empathy scores, compared to physicians with moderate or low empathy scores, had significantly lower acute metabolic complications</p>	
<p>Chen, D., Lew, R., Hershman, W., & Orlander, J. (2007).</p>	<p>Cross sectional study</p>	<p>All medical students at Boston University School of Medicine during 2006</p>	<p>Difference in empathy among students in the different classes; empathy declines with increased clinical training</p>	
<p>Chu, C., & Tseng, C. A. (2013).</p>	<p>Survey done over a 2-month period; survey included the Chinese-edition Rapid Estimate of Adult Literacy in Medicine, the Barrett-Lennard Relationship inventory and the Preoperative Information Understanding Scale.</p>	<p>144 patients</p>	<p>Perceived empathy is a relevant factor when considering the relationship between health literacy and the understanding of information by patients</p>	

<p>Hojat, M., Gonnella, J., Nasca, T., Mangione, S., Veloksi, J., & Magee, M. (2002).</p>	<p>Comparison survey</p>	<p>704 physicians affiliated with Thomas Jefferson University Hospital and Jefferson Medical College</p>	<p>Significant difference in men and women; difference between “people-oriented” and “technology-oriented”</p>	<p>Utilized the Jefferson Scale of Physician Empathy; example of scale included in article</p>
<p>Hojat, M., Vergare, M., Maxwell, K., Brainard, G., Herrine, S., Isenberg, G., Veloski, J., & Gonnella, J. (2009)</p>	<p>Longitudinal Study</p>	<p>456 students entering Jefferson Medical College in 2002 (n=227) and 2004 (n=229); completed Jefferson Scale of Physicians Empathy at five different points (entry into medical school, orientation day and the end of each academic year)</p>	<p>Empathy scores did not significantly change during first two years of medical school but there was a significant decline in empathy scores at the end of the third year</p>	<p>Findings were similar for both men and women; study discusses ways to enhance and retain empathy during medical school</p>
<p>Kim, S. S., Kaplowitz, S., & Johnston, M. V. (2004).</p>	<p>Interviews</p>	<p>550 outpatients from a university hospital in Pusan, Korea in 1999</p>	<p>Patient perceived physician empathy significantly influences patient satisfaction and compliance via factors of information exchange, perceived expertise, interpersonal trust and partnership</p>	

Krupat, E., Bell, R., Kravitz, R., Thom, D., & Azari, R. (2001).	Assessments using a scale-system	45 physicians and 900 of their patients	Patient-centered beliefs were associated with being female, white, younger, more educated and having a higher income; patients whose beliefs were congruent with their physicians' beliefs were more likely to trust and endorse them	
Ogle, J., Bushnell, J. A., & Caputi, P. (2013).	Observation and examination – objective structural clinical examination (OSCE)	57 medical students	Observed behavior indicative of empathy was strongly associated with clinical competence	Observer-rated empathy measured using the Rating Scale for the Assessment of Empathetic Communication in Medical Interviews Self-rated empathy measured using the Jefferson Scale of Physician Empathy – Student Version

Chapter Three: Findings and Discussions

Research Question One: How is empathy defined in healthcare settings?

There is no universally accepted definition of empathy, so there is no single definition of empathy in a healthcare setting. The definition greatly depends on the healthcare setting and who is defining it.

When defined by medical students, empathy is an emotional experience between an observer and a subject in which the observer identifies and briefly experiences the subject's emotional state (Hirsch, 2007). In the context of medical education, empathy is defined as predominantly a cognitive attribute that involves understanding, as opposed to feeling, of patient's experiences, concerns and perspectives combined with capacity to communicate this understanding with the intention of helping by alleviating pain and suffering (Mudiyanse, 2016). When defined from a patient perspective, empathy is a cognitive attribute that involves an ability possessed by the physician to understand the patient's inner experiences and perspective and a capability to communicate this understanding (Weiner & Auster. 2007).

It should be understood that empathy is not just a one-way street. Empathy not only means understating someone else's feeling, but also one's own. The more a person is aware of his/her own feelings and experiences, the easier he/she can show empathy for another's feelings and experiences, because it is easier to identify potential similarities. Once you acknowledge and accept your own feelings, you can empathize with another person (Friedman, 2016).

As previously noted, one of the biggest mistakes physicians and patients can make regarding empathy in the healthcare setting is confusing it for sympathy. Empathy is not similar to sympathy; it is different on many different levels. Empathy is an advanced, effortful, intellectual, and trainable attribute that involves cognition more than emotions and contributes to professional satisfaction, whereas sympathy is a primitive and effortless reaction. However in all media forms, the words empathy and sympathy are used interchangeably. Therefore awareness about the context of using these two words should be taken in to consideration to avoid confusions (Mudiyanse, 2016).

The definitions of empathy in a healthcare setting usually have a cognitive focus, but many definitions also include the affective side of empathy. Affective empathy is the emotional resonance people feel for another person's pain or situation. The reason this definition is not usually used in healthcare is because it is akin to sympathy. When people question if you can show too much empathy, the answer is yes - there can be too much affective or emotional empathy. This may lead to misguided decisions. The role of empathy in a physician is to give them the ability to "get under the patient's skin" and see the world from their point of view, but also to get back out so that physicians can be objective and make the best rational decision (Weiner & Auster, 2007).

Research Question Two: How do physicians' empathy skills impact health outcomes of patients?

The main focus of all research regarding empathy is to understand its importance to health and healing by identifying benefits of empathy for the patients

and the physician health outcomes may be improved. Empathy matters for several reasons. First, empathy is good for patients. Empathy helps to build trust (Drummond, 2015). This trust helps to increase patient satisfaction and compliance. When patients perceive that they connect on common ground with the physician and have established a bond, they have better recovery rates. Second, empathy helps physicians do their job well, and even buffer against physician burnout. Burnout is directly linked to a number of undesirable consequences such as lower patient satisfaction and care quality, higher medical error rates and malpractice risk, higher physician and staff turnover, physician alcohol and drug abuse and addiction, and physician suicide (Drummond, 2015). Stress management and burnout prevention are not things usually in medical school or residency training, but should be (Drummond, 2015). So it should be stressed again, empathy is not only beneficial for patients but also for physicians.

Much of the research conducted on the benefits of empathy focuses on communication. Communication is a skill that has the potential to promote person-centered care. Although this may sound straightforward, effective communication about health issues is anything but simple. Physicians must be good at explaining and on the flip side, be engaged listeners (English, 2016).

There has been some research on the relationship between health literacy and empathy. Much of it has been centered on opening up the lines of communication between physicians and patients, so that patients understand what they are being told. Empathetic communication helps the doctors avoid jargon. It also helps to clarify the pros and cons of treatment options and engage individuals in the decision

process (Krupat, Bell, Kravitz, Thom & Azari, 2001). This type of communication helps to create an atmosphere in which a patient feels their questions are welcome and never feel rushed. This type of communication is also part of patient-centered care (Krupat, et al., 2001).

It is important to realize that communication is not just between the patient and the physician. Person- centered care is a group effort, which may include a primary physician but also nurses, nutrition experts, social workers, and other professionals. Physicians should communicate effectively with the whole care team, including the patient. Physicians should place a priority on collaboration, sharing of information, and recognizing the challenges that patients may face in the their care plan. Teamwork is a way to promote health and wellness rather than passively waiting for problems to arise and then providing treatment (English, 2016).

Empathy plays a part in patient-centered care by helping the patient feel important and honoring the patients' individuality (English, 2016). The doctor may have a certain way of doing things. But people vary enormously in their values and priorities. They have different goals, different thresholds of pain, different anxieties, different needs for support, different backgrounds, and different resources to draw on. Individuals should feel empowered, aware of their choices, and connected to their health care providers through meaningful communication and understanding. They deserve to feel that their personal dignity and their wishes are a top priority (English, 2016).

Patient-centered care values patient participation. Patient participation aids in the individualization of care. Participation helps patients to be more active in

consultations. This changes centuries of physician-dominated dialogues to those that engage patients as active participants. Training physicians to be more mindful, informative, and empathic transforms their role from one characterized by authority to one that has the goals of partnership, solidarity, empathy, and collaboration (Epstein & Street, 2011).

Research Question Three: How can empathy be implemented back into the healthcare setting?

The use of empathy by physicians has been on the decline for years now. Empathy was gradually edged out of mainstream medical education and practice and the focus has turned to the sciences rather than the humanities (Smajdor, Stockl, & Salter, 2011). This decline has not gone unnoticed, though, and interest in the humanities and more specifically empathy has increased as educators and practicing professionals have realized that a therapeutic relationship, along with knowledge and skills, teamwork, and health systems is an fundamental part of healing and effective medical care (Smajdor & et al., 2011).

A good question to start with is why, given the desire to care and nurture and all the benefits that can come from this type of relationship, do so many physicians find caring and empathy so difficult. It is suspected it is because caring leads to engagement, and engagement is frightening. Engagement means intimacy, and intimacy involves risk on a human level, risk of rejection, risk of commitment, and acceptance of loss of control (Weiner & Auster, 2007). If empathy is made a norm from the beginning of a physician's career, the issue with physicians' lacking empathy will hopefully fade away.

To better incorporate empathy into healthcare practice, there is not just the task of integrating it into the medical education curriculum but also the task of re-developing it in currently practicing physicians. Some physicians will need to re-develop empathy from the bottom up, while other probably still have this trait, but need to be taught how to properly use it. It can take time, but empathy can be re-developed through training in humanities and other skills (Hojat, 2009).

Future physicians are one of the best places to focus on first. Today, medical education often neglects or negates empathy. There has been a loss of empathy at all years of medical education. If there were one place to focus within medical education, it would be the third year. The third year is the year where there is a significant drop in empathy (Hojat, Vergare, Maxwell, Brainard, Herrine, Isenberg, ... Gonnella, 2009). This may be due to a few different reasons such as lack of role models, high volume of material to learn, time pressure, and environmental factors. The third year of medical education could be the first focus and be the year to change it from sole focus on studies but incorporate the human interaction piece. The study also found that those with lower empathy scores at the beginning of medical school lost more empathy during medical school than others with relatively higher empathy scores. This could suggest that some medical students are “at risk” or more vulnerable to losing their sense of empathy than others. (Hojat, et al., 2009).

There have been many different suggestions on how to improve empathy in medical education, Hojat (2009) came up with a list of 10 possible approaches. The first is improving interpersonal skills. Interpersonal skills development is

considered as an essential prerequisite to demonstrate empathic behavior. This training focuses on capturing the empathic opportunities that provide the caregiver with "windows of opportunities" and avoiding pitfalls in missing or terminating these opportunities (Hojat, 2009).

Another suggestion is audio- or videotaping of encounter with patients. Medical students review and analyze audio- or video-taping of patient encounters with physicians, nurses, hospital and office administrators to identify positive and negative interviewing factors. This can be a valuable learning experience for enhancing empathic engagement. Students can watch these conversations between patients and physicians to help them learn to identify the empathic opportunities and physicians' positive responses, as well as see missed opportunities, or cases in which the concern-related part of the conversation was terminated (Hojat, 2009).

One of the concerns that students had in their third year of medical school was not have inadequate exposure to role models (Hojat, 2009). Having someone to look to as an example can be very beneficial for the students. The fifth idea was that of role-playing, specifically to demonstrate how to interact with an elderly patient. Role-playing aids in the development of awareness and an increased understanding of all patients. This understanding is the key ingredient as it leads to an enhancement of empathy. The sixth suggestion for students is to shadow a patient. This involves requiring first-year medical students "shadowing" a patient (with the patient's permission) during visits to a healthcare setting to observe the patient throughout treatment with the intention of improving or developing their empathy. The intention is that they learn to see patients as people, not as numbers or diseases

(Hojat, 2009). Another suggestion was having the students experience hospitalization. Sharing common experiences can influence an empathic understanding of the patients they would be treating in the future. Because this can be such a powerful experience, there have been suggestions to include this type of experience as a criteria component for medical school admission (Hojat, 2009).

Another idea was to include more literature and art classes in the medical school curriculum. Medical school is very science-based and this is proving to be more harmful than helpful (Hojat, 2009). Some researchers have proposed that reading literature, stories, novels, poetry; watching movies and theater plays, viewing photographs, paintings, sculptures; and listening to music and songs expose medical students and physicians to a rich source of knowledge and insights about human emotions, pain and suffering, and perspectives of other human beings helps to improve the capacity for forming empathic connections. Improving narrative skills has also been suggested as improving physician's empathy. This helps them not only communicate health plans with patients but also helps to understand the patient's explanation of their health conditions and concerns (Hojat, 2009).

One of the final suggestions was integrating the Balint method into medical education. Michael Balint at the Tavistock Institute in London developed the Balint training program for general practitioners (Salinsky, 2013). The training mentioned is based on the notion that medical student often spend their entire training in the laboratory, class or the hospital without sufficient opportunity to develop skills in interpersonal aspects of patient care. This program provides opportunities to enhance understanding of patients' experiences and concerns. Some of the activities

in this program included one to two hours of unstructured, open, and supportive small group meetings every one to three weeks, for one to three years. The primary focus in these meetings was on behavioral, cognitive, and emotional issues related to communication between patients, physicians, and other personnel. The discussions focused on the patient as person rather than his or her disease as a case, and on difficulties experienced in patient-resident encounters. In addition to patient-physician communication, participants were also encouraged to discuss issues related to inter professional collaboration and hospital administration (Hojat, 2009).

The last idea presented by Hojat (2009) was to incorporate “acting” into medical education. Because physicians worry about becoming too empathetic, there has been some research on alternative ways on how to incorporate empathy into the healing process without risking the physician becoming too attached. “Acting” is an option for some. It is the process of empathy as that of “emotional labor”. Emotional labor is the process of regulating experienced and displayed emotions to present a professionally desired image during interpersonal transactions at work. For physicians this means the use of psychological resources to produce personal cognitive and affective changes to project an empathic image for the patient (Hojat, 2009). Physicians engage in such emotional labor through deep acting (that is, generating empathy-consistent emotional and cognitive reactions before and during empathic interactions with the patient, similar to the method-acting tradition used by some stage and screen actors), surface acting (specifically, forging empathic behaviors toward the patient, absent of consistent emotional and cognitive

reactions), or both (Larson & Yao, 2005). This method is not highly recommended but the intent of this method is that physicians who practice this “deep acting” technique may, over time, learn to be genuinely empathic; thus, teaching acting may be a method of teaching empathy (Hirsch, 2007).

In addition to these suggestion, a few others from other researchers include enhancing observation skills, which would make it easier to detect a patient’s emotional state, while improving communication skills that would help a physician convey his/her feelings to the patient (Hirsch, 2007). Also, exercises such as self-reflective writing, which helps an individual become more aware of his/her own emotions and subsequently improve ability to be empathetic towards another. There is also a need for cultural education and a wide range of interests should give physicians a greater frame of reference with which to understand and relate to a patient, thus making an empathic response more likely (Hirsch, 2007).

Chapter Four: Conclusions and Recommendations

The purpose of this paper was to demonstrate the relationship of patient empathy and health outcomes and to show the need for empathy to be incorporated into healthcare practice. This chapter includes conclusions and recommendations for medical education and further research.

Conclusion

Though the definition of empathy is still unclear, it still has the same basic principles no matter the setting and it has been proven to have so many benefits to both the patient and the physician. Whether empathy becomes apart of curriculum or physicians are taught how to “act” empathetic, empathy is still something that needs to be apart of a physicians skill set. Of all the benefits it has, it have been proven to be more beneficial in communicating with patients, which is so important in a healthcare setting.

Recommendations for Medical Education

One of the more pertinent recommendations is to incorporate empathy assessments into medical education, medical school admission, and job interviews. It is important to assess the empathy level of physicians, throughout their career. Beginning with medical school, medical students should first be tested at admission to get a baseline and gauge possibly areas of improvement. They should then be tested throughout their education to make sure there are only positive changes in their empathy levels and not negative ones. Physicians should also be tested at their job interviews by an empathy assessment tools or scales that workplace deems appropriate. Empathy would be a great way to see if the physician would fit in their

healthcare setting and also be able to assess the possibility of physician burnout throughout their career.

A second recommendation is for medical students to have more patient interaction and have learning be more face-to-face than computer-based. Many studies reviewed have proven the usefulness of face-to-face time with not only patients but also professors and role models. Some possible recommendations for implementing this would be incorporating role-playing or simulated patient scenarios, a patient-interviewing course, group meetings and discussions.

A third suggestion is to incorporate a cultural competency component into medical education. Regardless of where physicians work, they are going to interact with patients from a different cultural background than theirs. Physicians need to be taught how to overcome these cultural obstacles and barriers so that the patients get the best outcomes possible. This recommendation will also help tackle patients' health literacy more efficiently.

Recommendations for Further Research

The first recommendation is to develop a more universal and efficient ways to measure empathy. Because there are so many different types of ways to measure, it would be beneficial to develop one tool so that all future research can be compared.

The second recommendation is to look at the short and long-term effects of incorporating empathy into medical education. This problem of a lack of empathy has only recently been discovered and work has just started on incorporating it into medical education. It would be beneficial to see the short and long term effects it has on physicians' and their career and overall healthcare in general.

A third recommendation is to come up with more efficient ways to incorporate empathy into existing physician practices. It is simpler to teach empathy to medical students since they are just starting their career, but there are many physicians already practicing who lack empathy and need to be educated. There needs to be new methods created that focus on this group of physicians.

The fourth recommendation is to research what makes someone more “at risk” to having a decline in empathy and what are some protective factors that can slow or stop this decline. From the review of the literature, there has been some, but not a lot, of research done that shows some people are more predisposed to a decline in their empathy than other (Hojat & et al., 2009). It would be beneficial to identify what causes this and how can it be prevented.

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