

# The importance of empathy in the enablement of patients attending the Glasgow Homoeopathic Hospital

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## SUMMARY

**Background:** Patient enablement in general practice is known to be limited by consultation length. However, the processes within the consultation that lead to enablement are not well understood.

**Aims:** To investigate patient enablement in a setting where time is less of a constraint than in primary care, in order to determine the importance of other factors in enablement.

**Design of study:** Exploratory questionnaire-based study.

**Setting:** Two hundred consecutive outpatients attending four doctors at the Glasgow Homoeopathic Hospital, an NHS-funded integrated complementary and orthodox medicine unit.

**Method:** Information was collected on enablement and a range of other factors, including the patient's expectations, their perception of the doctor's empathy, and the doctor's own confidence in the doctor-patient relationship.

**Results:** Although there were many factors that correlated with enablement, multi-regression analysis showed patient's expectation, doctor's empathy (as perceived by the patient), and doctor's own confidence in the therapeutic relationship to be the three key factors. Together they accounted for 41% of the variation in enablement, with empathy being the single most important factor (66% of the explained variation in enablement).

**Conclusion:** Patient enablement at the Glasgow Homoeopathic Hospital is mainly related to the patient's perception of the doctor's empathy.

**Keywords:** patient enablement; empathy; patient expectations; therapeutic relationship.

## Introduction

THE consultation is the core activity of clinical medicine and has been extensively researched, particularly in the general practice setting. However, much remains to be learned and attention is increasingly being paid to patients' views.<sup>1,2</sup> A recent advance in research on the consultation has been the development of an outcome scale, termed the Patient Enablement Instrument (PEI), which measures aspects of the consultation related to, but distinct from, patient satisfaction.<sup>3,4</sup> Work on its use in general practice has highlighted the importance of length of consultation and continuity of care.<sup>5,6</sup> However, given the importance of a holistic approach in good consulting behaviour<sup>7</sup> and the proposed use of the PEI as a quality measure,<sup>3,6</sup> there is a need to understand the processes within the consultation that lead to enablement.<sup>8</sup>

Recent calls to integrate complementary therapies with conventional medicine also seem to relate to holism,<sup>9-13</sup> although there is a paucity of research on this topic.<sup>14,15</sup> The Glasgow Homoeopathic Hospital (GHH) is an NHS facility that integrates complementary and orthodox approaches in a secondary care setting, where length of consultation is substantially longer than in general practice. Patients attending the GHH report high levels of satisfaction and apparently good clinical outcomes across a range of chronic diseases.<sup>10,11,16,17</sup> The GHH therefore represents an interesting setting to investigate the factors that influence patient enablement when time is less of a constraint than is currently the case in primary care.

## Method

We studied consecutive outpatients attending the GHH aged 16 years or over. They were asked on arrival to fill in the first part of an anonymous questionnaire, which asked about previous attendance at GHH, change in main complaint and well-being since first attendance, and current health status in terms of quality of life. The Glasgow Homoeopathic Hospital Outcome Scale (GHHOS)<sup>10,11</sup> — a simple (though as yet unvalidated) outcome scale that relates outcome to impact on daily life — was used to assess changes (in follow-up patients) in presenting complaint and general well-being since first attending the GHH. The Euroqol E5 (a widely used and well-validated generic measure) was used to measure current health status.<sup>18</sup> Patient expectation was measured on a single-item, ten-point scale: 'How confident are you that the treatment offered by the Glasgow Homoeopathic Hospital can alleviate your complaint(s)?'.

Consultation length was recorded by the four participating

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**HOW THIS FITS IN***What do we know?*

Patient enablement in primary care is hindered by shorter consultations and enhanced by knowing the doctor well.

*What does this paper add?*

In a clinical setting, which is less time-constrained than primary care, the patient's perception of the doctor's empathy is the key explanatory factor in enablement. The doctor's own confidence in the therapeutic alliance with the patient is also important, with patient expectation before the consultation playing a much smaller role in enablement.



doctors (two consultants, an associate specialist, and a senior clinical assistant, all with dual training and accreditation in conventional and homoeopathic medicine) who also recorded their own confidence that a therapeutic alliance had been formed with the patient by the end of the consultation and their confidence in the homoeopathic remedy given, if prescribed (both on a ten-point scale).

Patients completed the rest of the questionnaire immediately after the consultation. This included the PEI,<sup>5</sup> perception of the doctor's empathy,<sup>19</sup> if they were seeing the same doctor as usual, and how well they felt they knew the doctor (as a proxy measure of continuity of care).<sup>5</sup> The empathy scale — developed, validated and used in psychotherapy in the United States, where it has been shown to predict recovery from depression<sup>19</sup> — was slightly modified by changing the wording from 'therapist' to 'doctor', and from 'session' to 'consultation', by adding an extra option to extend the response scale from four to five options ('completely' in addition to 'a lot', 'moderately', 'somewhat' and 'not at all') and by omitting one of the original five positive items ('My therapist felt I was worthwhile') and one of the five negative items ('My therapist pretended to like me more than he or she really did'), as we felt these questions were less appropriate to general medical patients. The modified scale was thus composed of the following items:

1. I felt I could trust the doctor during today's consultation.
2. The doctor was friendly and warm towards me.
3. The doctor really understood what I said during today's consultation.
4. The doctor was sympathetic and concerned about me.
5. Sometimes the doctor did not seem to be completely genuine.
6. The doctor did not always seem to care about me.
7. The doctor did not always understand the way I felt inside.
8. The doctor acted condescendingly and talked down to me.

Permission to use the scale (which is under copyright) in this format was obtained from the original author for this study only. The internal reliability of the scale as used in the present study was found to be high (Cronbach's  $\alpha = 0.872$ ).

Demographic and descriptive data were also collected. Social class was calculated from current or previous occu-

pation, according to the Registrar General's system. The questionnaires were then collected in a sealed box in the waiting area.

Statistical analysis was done using SPSS software. Spearman's correlation was used to assess the strength of associations between variables. Stepwise multiple linear regression analysis was performed as an exploratory model-building technique. Independent variables that showed marked skew were transformed before being entered into the analysis.<sup>20</sup>

**Results**

Two hundred questionnaires (50 for each doctor) were obtained from 237 consecutive patients (response rate = 87%); 26 (13%) of these were new patients at first appointment, the other 174 (87%) having attended the GHH for an average of five appointments. Seventy per cent of follow-up patients had been attending the GHH for under three years. Eighty per cent of patients had been referred by their GP; the remaining 20% having been referred through a conventional care hospital specialist. Over three-quarters of referrals were patient-led — 55% at the direct suggestion of the patient and 21% as a joint decision with their doctor. The remaining 24% were referred at the suggestion of the doctor.

The mean patient age was 41 (range = 16 to 86) with four times as many women as men (Table 1). The socioeconomic indicators showed a range of circumstances but with a preponderance of educated, middle-class patients (Table 1). All but one participant spoke English as their first language. As found previously,<sup>10,11,16,17</sup> a wide range of chronic diseases were represented, but some 60% to 70% had painful conditions (results not shown). Over two-thirds of patients had problems in performing usual activities, with higher percentages reporting pain, anxiety, and depression (Table 2).

The mean enablement score of the 200 consultations was 4.7 (95% confidence interval [CI] = 4.1 to 5.3). Enablement scores of new patients were slightly lower, though not significantly so, from those of follow-up patients (mean = 4.2,  $n = 26$  for new patients versus mean = 4.8,  $n = 174$  for follow-up patients;  $P = 0.44$  by independent  $t$ -test, 95% CI of the difference = -2.01 to 0.90). The pattern of referral (GP or specialist, patient or doctor-led) had no effect on enablement scores (results not shown).

No significant links were found between enablement and personal income, educational level, or social class (Table 1). There was, however, a significant association between age and enablement, and between marital status and enablement, with single patients having significantly lower mean enablement scores than married patients (Table 1). However, controlling for the effect of age (the single patients were younger) reduced this to just below statistical significance ( $P = 0.069$  by analysis of covariance [ANCOVA]). Low enablement was also associated with severe pain or discomfort (Table 2).

One doctor had a mean enablement score significantly below the other three (3.4 versus 5.3, 5.1, and 4.9,  $P < 0.05$  by analysis of variance [ANOVA]); this doctor also had significantly shorter consultations for follow-up patients, lower confidence in the therapeutic relationship, and lower patient expectation and empathy scores ( $P < 0.05$ , results not

Table 1. Enablement (mean PEI score) and demographic and socioeconomic characteristics of patients attending the Glasgow Homoeopathic Hospital.

Characteristic	n (%)	Mean PEI score
Age in years (n = 161)		
<20	8 (5.0)	2.3
20–29	26 (16.1)	3.5
30–39	38 (23.6)	4.7
40–49	41 (25.5)	4.6
50–59	32 (19.9)	6.2
60+	16 (9.9)	4.7
		P<0.01 ANOVA
Sex (n = 195)		
Male	41 (21.0)	4.0
Female	154 (79.0)	4.8
Marital status (n = 190)		
Single	63 (33.2)	3.4
Married	92 (48.4)	5.5
Widowed	6 (3.2)	3.8
Divorced	17 (8.9)	5.6
Cohabiting	12 (6.3)	4.0
		P<0.01 ANOVA
Educational status (n = 167)		
Degree or equivalent	67 (40.1)	5.1
Higher Grade or equivalent	47 (28.1)	3.5
Standard Grade or equivalent	29 (17.4)	3.4
None of the above	24 (14.4)	5.6
Social class (n = 135)		
I	16 (11.9)	5.6
II	50 (37.0)	4.3
IIIN	60 (44.4)	5.0
IIIM	2 (1.5)	3.0
IV	5 (3.7)	5.6
V	2 (1.5)	7.0
Income (personal) (n = 165)		
>£30 000	18 (10.9)	4.9
£20 000–30 000	31 (18.8)	4.3
£10 – 19 000	46 (27.9)	4.8
<£10 000	70 (42.4)	4.7

shown).

Mean consultation length was 54.7 minutes (range = 29 to 70, 95% CI = 45.6 to 63.8) for new patients and 21.7 minutes (range = 4 to 70, 95% CI = 19.3 to 24.0) for follow-up patients (independent *t*-test,  $P < 0.001$ ). Enablement was not significantly correlated with length of consultation overall. However, the correlation of enablement with time for new patients was noted to be higher than for follow-up patients (Spearman's  $\rho = 0.389$ ,  $P = 0.06$ , and  $\rho = 0.025$ ,  $P = 0.751$ , respectively).

The statistically significant correlates of enablement overall (all patients) are shown in Table 3. The highest correlations with enablement were with the patients' expectation before the consultation, the improvement in main complaint and general well-being since first attending (GHHOS), the patient's perception of the doctor's empathy, and the doctor's own perception of the therapeutic relationship with the patient. Patient's expectation and the doctor's confidence in the therapeutic relationship tended to be lower in new patients than in follow-up patients, though this trend did not reach statistical significance (results not shown). Mean empathy scores for new patients versus follow-up were virtually identical (mean values = 8.20 and 8.19, respectively).

Table 2. Enablement (mean PEI score) and health status of outpatients attending the Glasgow Homoeopathic hospital as measured by the Euroqol 5D.

Domains of health	n (%)	Mean PEI score
Mobility (n = 182)		
No problems	117 (64)	4.6
Some problems	63 (35)	4.7
Confined to bed	2 (1)	6.0
Self-care (n = 186)		
No problems	151 (80)	4.8
Some problems	33 (19)	4.1
Unable	2 (1)	6.0
Usual activities (n = 189)		
No problems	78 (40)	4.8
Some problems	98 (53)	4.6
Unable	13 (7)	3.7
Pain/discomfort (n = 187)		
None	54 (28)	5.7
Moderate	99 (52)	4.5
Severe	34 (20)	2.9
		( $P < 0.05$ ANOVA)
Anxiety/depression (n = 188)		
None	70 (35)	4.9
Moderate	94 (51)	4.8
Extreme	24 (14)	2.9
Overall current health state (health state today, scale of 0–100) mean = 63.6		

As some of the correlates with enablement were also inter-related (i.e. correlated with each other), multiple linear regression analysis was performed, to clarify which correlates were independently associated with enablement. Three significant and independent factors in enablement were identified by stepwise multiple linear regression analysis: the patient's perception of the doctor's empathy; the doctor's own confidence in the therapeutic relationship; and patient expectation before the consultation (Table 4). Empathy explained the largest part of enablement (27%, Model 1), followed by the doctor's confidence in the therapeutic relationship (a further 11%, Model 2). Patient expectation accounted for only another 3% of enablement (Model 3). The three factors together explained 41% of the variation in enablement scores (Model 3).

## Discussion

### Empathy and enablement

The PEI purports to measure 'themes of patient centredness and empowerment, and of patients' ability to understand and cope with their health and illness'.<sup>4</sup> It is, however, an outcome measure and gives no direct indication of the processes involved in achieving enablement. The present study demonstrates the importance of empathy in enablement in the sample studied. Empathy accounted for 66% of the explained variation in enablement — almost two-and-a-half times the importance of the doctor's own perception of the relationship and nine times more important than the patient's expectations before seeing the doctor.

Although there is evidence that empathy may be lacking

Table 3. Statistically significant correlates of patient enablement at the Glasgow Homoeopathic Hospital.

	Spearman's rank correlation	Level of significance
Doctor's confidence in therapeutic relationship	0.407	$P < 0.001$
Improvement in general well-being since attending	0.401	$P < 0.001$
Patient expectation (pre-consultation)	0.371	$P < 0.001$
Empathy of doctor (as perceived by patient)	0.370	$P < 0.001$
Improvement in main complaint since attending	0.357	$P < 0.001$
Knowing the doctor well	0.258	$P < 0.001$
Level of pain/discomfort (Euroqol)	0.254	$P < 0.001$
Doctor's confidence in the treatment	0.222	$P < 0.05$
Age	0.183	$P < 0.05$
Current health state (Euroqol)	0.182	$P < 0.05$

Table 4. Key (independent) factors in patient enablement at the Glasgow Homoeopathic Hospital. Stepwise multi-regression analysis with enablement as dependent variable.

Model	R <sup>2</sup>	Adjusted R <sup>2</sup>
Empathy	0.271	0.260
Empathy + doctor's CTR	0.376	0.357
Empathy + doctor's CTR + patient expectation	0.414	0.387

CTR = confidence in the therapeutic relationship; 'empathy' = patient's perception of doctor's empathy; 'patient expectation' = expectation measured before the consultation.

in modern medicine,<sup>21,22</sup> it appears to be a neglected area of research.<sup>23</sup> Most work has been carried out in psychiatry, where empathy and the therapeutic alliance are known to influence health outcomes.<sup>19,24</sup> Because of this we chose an empathy scale that is known to have predictive validity in psychotherapy.<sup>19</sup> However, its suitability for research in a general medical and general practice conventional care context may be limited and work is currently underway on the development of a new measure specifically for this purpose.

Overall, the model developed by the stepwise multi-regression analysis explained 41% of the variation in enablement scores, incorporating the two patient measures (expectation and perception of doctor's empathy) with the doctor's own confidence in the therapeutic relationship with the patient. This interdependence of patients' and doctors' perceptions is consistent with the two-way nature of the therapeutic alliance and highlights the complexity and sensitivity of the clinical encounter. We are currently trying to gain further insight and understanding of this by means of qualitative research on a sample of patients (both new patients and follow-up patients) who participated in the present study.

### Time and enablement

The lack of a direct relationship between enablement and length of consultation differs from previous studies in United Kingdom primary care.<sup>5</sup> It could be that time is the critical, limiting factor in short consultations, but that factors within the consultation itself are more important above a certain duration (e.g. 15 to 20 minutes). However, the trend towards a significant correlation between enablement and time in the new patients in the present study (who had much longer consultations), compared with the extremely low correlation in follow-up patients, would seem to argue against this explanation. It may be that the long initial consultation at the

GHH is important in allowing the patient to tell their story in detail and establishing rapport, and that subsequent consultations are more dependent on the ongoing development and deepening of an empathetic and therapeutic relationship. Alternatively, the lack of a clear association with length of consultation could also simply be a reflection of the study size. A larger, prospective study would help to answer these issues.

### Socioeconomic factors and health status

The fact that there is a skewed socioeconomic distribution (in relation to comparable population data<sup>25</sup>) raises interesting questions about the referral patterns of GPs and conventional care consultants and about the mix of patients who seek and continue with the system of care offered by the GHH. However, enablement was not associated with the socioeconomic indicators that we measured. The apparent relationship observed between marital status and enablement was just over the 5% significance level when adjusted for age. The trend might, however, reflect an effect of social isolation or lack of social support in those with chronic illness who are not living with a partner. Again, a larger study would be required to explore this further. Irrespective of socioeconomic circumstances, it is clear that patients attending the GHH have chronic and complex conditions that impact significantly on their quality of life. This is indicated by the EuroQol-5D results, which are markedly lower (indicating a lower health status) than the average score for the general population,<sup>26</sup> and slightly lower than average scores for patients with rheumatoid or osteoarthritis.<sup>27</sup>

### Limitations of the present study

The present study was cross-sectional and the sample consisted mainly of follow-up patients. As we have no data on patients who stop attending the GHH during the course of treatment, it may be that we are reporting only the views of

those who are satisfied with their care at GHH (and therefore continuing to attend). We have therefore avoided making any claims about the enablement scores (which are higher than in primary care<sup>5</sup>) being causally linked to the approach that the GHH takes. We also cannot be sure that a study of 200 patients attending four doctors is representative of the number of doctors and consultations that take place at GHH. However, the descriptive and demographic mix in the present study is similar to previous studies carried out at the GHH<sup>10,11,16,17</sup> and is likely therefore to be (at least) representative of patients who seek ongoing care at the hospital. The influence of enablement at consultation on longer-term health outcomes was not examined in the present study (and has not as yet been established in the literature) and prospective studies are needed to determine this and the other issues raised above.

## Conclusion

In conclusion, these results suggest that empathy and ongoing therapeutic alliance are key components of patient enablement at the GHH. The relevance of these findings to the primary care setting needs to be established and work on this is currently underway.

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