Expanding Clinical Empathy: An Activist Perspective

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BACKGROUND: Discussions of empathy in health care offer important ways of enabling communication and interpersonal connection that are therapeutic for the patient and satisfying for the physician. While the best of these discussions offer valuable insights into the patient-physician relationship, many of them lack an action component for alleviating the patient's suffering and emphasize the physician's experience of empathy rather than the patient's experience of illness.

METHODS: By examining educational methods, such as reflective writing exercises and the study of literary texts, and by analyzing theoretical approaches to empathy and suggestions for clinical practice, this article considers how to mindfully keep the focus on what the patient is going through.

CONCLUSION: Clinical empathy can be improved by strategies that address (1) the patient's authority in providing first-person accounts of illness and disability, (2) expanding the concept of empathy to include an action component geared toward relieving patients' suffering, and (3) the potential value of extending empathy to include the social context of illness.

KEY WORDS: communication skills; doctor-patient relationships; medical education—attitudes and psychosocial; patient-centered care; medical humanities.
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Much has been published on empathy in health-care education and practice. Over the decades the discussion has evolved beyond simplistic dictionary definitions and general speculations to a sophisticated understanding of empathy as it is practiced in medicine, usually described as *clinical empathy*.[1] The challenge for those writing about clinical empathy is to make clear recommendations for medical practice and education. Many authors suggest that impediments to clinicians' empathy stem from aspects of medical education that overwhelm and humiliate students, leading to a "tough emotional crust and marked disidentification with patients."[2,3] Others focus on medical school, targeting case presentations,[4] role-playing exercises with students in the role of patients[5,6] or with simulated patients[7,8] as ideal opportunities for teaching empathy. Still others recommend using literary texts and reflective writing exercises as ways of helping medical students and health-care practitioners to become empathically attuned to patients' experiences of suffering.

This paper considers a range of approaches, those geared toward educating medical students and more theoretical discussions directed toward academics and practicing clinicians. My purpose is to examine how among even the best of these approaches—particularly Jodi Halpern's arguments[1,9] and educational methods involving reflective writing—theories and practices of empathy have the potential to obscure rather than illuminate what a patient is going through and the social factors that influence their experience of illness and health.[10] Theories of empathy that depend on physicians representing patients' experiences from a "first-person" point of view can lead to mistaken assumptions and a focus on physicians rather than patients. These assumptions have the potential to create barriers, rather than avenues, to encouraging the patient to play an active role in treatment, to learning more about the patient, and to understanding the social and cultural context of the patient. This paper offers strategies for keeping the focus on the patient, the social context of illness, and, not only *feeling* empathy, but also *acting* to alleviate the patient's suffering.

There are significant challenges to discussions of empathy in health care. Although widely accepted as important,[11] empathy is not consistently defined, discussed, taught, or practiced in medical school or the clinic. In fact, the "hidden curriculum"[12] or actual clinical practice often undercuts classroom discussions of the importance of empathy.[2] The biomedical approach to medicine all too often overrides concern about patients' psychological and social experiences of illness.[13] Nonetheless, health-care practitioners and educators continue to stress its importance in the patient-physician relationship, responding in part to studies that suggest that, rather than inculcating empathy, medical training in fact suppresses it.[14–16] Authors have identified aspects of medical education that may contribute to a harmful objectification of the patient: cadaver dissection, an exclusive emphasis on basic science, and a reliance on medical technology at the expense of listening to the patient's story.[17]

Factors that create obstacles to empathic encounters with patients likely include extended work hours and resulting sleep deprivation,[18,19] and a culture that often neglects physicians' personal identity and physical experience.[20] Increasingly "caught in a web of pressures," physicians struggle with burnout[21] and other stresses that interfere with empathic care, particularly the limited time allotted to building relationships with patients.[22] Physicians who engage empathically with patients increase the patient's sense of "satisfaction," adherence with therapeutic regimens, and increased physiological

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well-being.[23–25] Some argue that empathy plays a key role in physician satisfaction as well, reducing burnout by opening physicians up to moving encounters with patients.[9]

EMPATHY AND ACTION

While the medical literature lacks consistency and clarity about what empathy is and how it works, the most conceptually and ethically rigorous definitions draw on psychological studies of empathy.[9,26–28] These studies describe empathy as involving emotion, reason, and a desire to help a person in distress. Some authors view the objective of empathy as "recognizing and explicitly acknowledging the patient's emotion."[29] Others insist on greater input from the patient and clearer action from the physician. For example, Coulehan et al. use a definition of empathy derived from psychological models of therapy (which influenced nursing education and practice beginning in the 1950s).[27,30] They contend that empathy is a collaboration with the patient that involves an "action component": physicians must "check back" with patients to confirm or to correct their shared understanding ("Do I have this right?").[25] Benbassat and Baumal similarly argue that clinical empathy is incomplete when it does not lead to an attempt to help, and ethically empathic physicians move beyond psychological engagement to material aid.[28]

A physician's concern about a patient's distress should be the foundation of an active response rather than an end in itself. Many authors underscore how critical it is for physicians to communicate empathy to patients, to appreciate, understand, and accept.[31,32] While these advocates of clinical empathy do not make explicit the relationship between empathy and action, they imply it in related discussions of supporting patients and actively involving them in shaping treatment methods and goals.[31,32]

The biopsychosocial model of clinical practice recommends an emotional "attunement" with patients, which involves mindfully eliciting patients' perspectives and feedback to avoid "confus[ing] empathy with thephysician's] projection of his or her needs onto the patient."[33,34] The relationship-centered care model urges physicians to "view patients as experts" and learn about their values and backgrounds and to empathize as a means of helping patients to "experience and express their emotions."[35] This model extends physicians' responsibilities beyond empathy to establishing relationships to the broader community (by learning about community perceptions of health-care and local community dynamics and environments and by participating in policy-making and implementing community health strategies).[35]

Recognizing, understanding, and accepting patients' suffering can be a starting point for acting with patients to alleviate it. Empathy with action can mobilize the physician to actively seek out knowledge of their patients' individual experiences of illness and health and the broader contexts that influence experience and then act to relieve their patients' distress. This extension of empathy to integrate action and activist components from biopsychosocial and relationship-centered care models and include acting with patients and learning from them about their social context is an emerging definition articulated here. Subsequent analysis is needed to determine whether this approach offers greater benefit to the patient and is feasible given physicians' current clinical burden.

LEARNING EMPATHY THROUGH LITERATURE AND REFLECTIVE WRITING

In the extended model of empathy, one key question for medical educators and practicing physicians is whether empathy can be learned and put into practice. Halpern suggests that practitioners develop clinical empathy through self-education and self-awareness;[9] others review approaches for teaching empathy to medical students.[26] Lipkin recommends replacing the term *diagnosis* with *assessment*,[36] and Lowenstein uses the case presentation to extend the scope of patient care from disease to the patient's experience of illness,[4] although Burack et al. suggest that attending physicians need further training in teaching empathy.[37]

Many physicians and medical educators advocate training students and practitioners in empathy through the study of literary texts and narrative techniques.[20,38–41] This approach stems from the assertion that narrative, metaphor, and other modes of literary study are crucial to understanding the social and ethical aspects of health care, as well as shaping medical knowledge and interpretation.[42,43] Advocates of this method see reflective writing as a means of understanding patients' experiences. While some writing exercises involve students and practitioners reflecting on their role in medicine, the suffering they encounter, or even their own experiences of illness,[20] others invite students to imagine themselves as patients and to write narratives in the first person, substituting "I" for "he" or "she." In some schools, first-year medical students interview a patient and then write a medical history from the patient's perspective in order to know "where a patient is coming from."[44] Another exercise involves students of gross anatomy writing imagined narratives of the cadaver's perspective of dissection and "autobiographical" sketches of the lives the cadavers might have lived.[40] In another exercise, students interview and then write autobiographical accounts in the voice of patients with AIDS.[45]

The articles that discuss these reflective writing exercises assume a correlation between reflective writing and empathy but do not necessarily provide evidence for this assertion. As Stepien and Baerstein have discussed in their thorough review of empathy education, studies with small groups of students who have used writing and literary study to develop empathy have reported improvements in emotive and cognitive aspects of empathy. The authors note that small sample sizes and reliance on self-reporting limit the generalizability of the findings.[26] Few studies have used randomized samples of students whose performance in medical interviews was analyzed by outside reviewers, in addition to self-reported data.[46,47] These studies and Stepien and Baernstein's recommendations offer models for future studies of the effectiveness of writing exercises and literature in developing empathy.

In addition to gathering empirical data, further theoretical analysis of the relationship between empathy and writing first-person accounts of another's illness will ensure that such writing encourages students to better attend to patients' accounts of illness. Incorporating the action component (checking back, acting to relieve distress) and relationship-centered care's emphasis on the physician's responsibility to social concerns and the community may also help students use empathic understanding to better understand and act on behalf of the patient's needs.

Imagining patients' experiences and viewing patients as experts is a critical step in alleviating suffering. While first-

person writing exercises might increase students' empathic awareness of cadavers (and patients) as people with relevant, important life stories, exercises that encourage students to imagine those stories in the *third*-person may invoke a kind of humility about knowing the patient, similar to the concept of "cultural humility" (a development of the notion of "cultural competence" that defines humility as a commitment to self-reflection, self-critique, lifelong learning, and reflective practice).[48]

The study of first-person accounts of illness and disability provides students and practitioners with actual, rather than imagined, perspectives of people with illness. These autobiographical accounts narrate illness within the social contexts that shape them, adding the ethical complications and illuminations of families, hospitals, friendships, and the dynamics of class, gender, and culture.[49–54] Physicians and trainees who read such accounts may mistakenly project them onto patients in the clinic, but reading an account of a person with illness or disability, rather than assuming that one can write it, marks a significant difference between self and other that can be reinforced with cautions about assumptions. Other types of writing exercises that emphasize the importance of action and keep the focus on the patient include physicians writing dual narratives with patients and comparing their perspectives[55] and physicians writing in groups to develop interest and insight into patients' lives.[56] Writing exercises, literary texts, and narratives that contextualize illness and disability can develop physicians' connection to the broader community and concern for the socio-cultural conditions that affect patients' illnesses and health.

HALPERN'S STUDY OF EMPATHY

Theories of clinical empathy would benefit from similar cautions to practitioners about assuming the patient's perspective. Halpern, who defines clinical empathy as "emotional reasoning" that is simultaneously cognitive and emotional, argues that practitioners are unavoidably "sympathetically immersed" when making decisions about patients and must learn to use their emotional responses and their imaginations for therapeutic impact.[9] Halpern's persuasive argument for clinicians' emotional attunement to patients suggests a need for caution. Clinicians should monitor whether the emotions that they experience and the perspectives they imagine are helping them attune to the patient's experience of illness and suffering, rather than just preoccupying them with their own. As with reflective writing exercises in which students and practitioners write the patients' stories *for* them, rather than devoting that time to attending to and empowering the patient, Halpern's formulation makes possible a preoccupation with self that may obscure the other. Because empathy depends on the experiences and imagination of the person who is doing the empathizing, clinical empathy has the potential to obscure or exclude patients and their suffering.

In Halpern's formulation of empathy, the "action component" ends with communicating to the patient the caring and concern that the physician feels. While expressing concern about the patient's suffering can be healing to the patient and the physician, an expanded model of empathy that includes a context-oriented action component may speak more comprehensively to structural issues such as social determinants of health and power relations in the clinic. Discussions of how best to teach and practice this type of empathy should begin to incorporate ways to appreciate patients' concerns about the social and cultural context beyond the clinic.

PROBLEMS WITH EMPATHY: AFFINITY AND PHYSICIAN POWER

Another aspect of empathy that can emphasize the clinician's rather than the patient's experience is *affinity*, the way empathy is more likely to occur when the patient or person who is suffering resembles the practitioner.[57] Recognizing the patient as being like oneself or seeing the patient as unlike or "other" can affect both the emotional and cognitive components of empathy. For example, it may be difficult for a physician to accurately "imagine" the experiences of a patient who is culturally different. The concept of "cultural humility," mentioned above, is one model that encourages physicians to suspend, even if briefly, their role as experts in order to encourage patients to speak for themselves about their experiences of illness and its meanings. Halpern argues that physicians should imagine "how it feels to have a certain illness, disability, or psychological injury" and recommends that physicians use pronouns such as "I" and "he" interchangeably, claiming that empathic understanding is more like the "first-person experiential knowledge of an agent anticipating her own acts than it is like the third-person predictions of an observer."[9] While this may be true, cultural humility can help to ensure that empathy is the product of a reflective practice that is patient-centered.

Future discussions of and exercises in empathy will benefit from emphasizing patients' points of view and the uniqueness of patients' experiences, as well as the community and social context that encompasses physicians and patients. As recommendations for clinical and educational practices of empathy develop, those that address (1) the patient's authority in providing first-person accounts of illness and disability, (2) the importance of an action component geared toward relieving patients' suffering, and (3) the social context of illness in conjunction with the clinical encounter may be more effective as well as ethical and will be important to test in terms of efficacy and effectiveness.

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