



# Routine, empathic and compassionate patient care: definitions, development, obstacles, education and beneficiaries

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## Abstract

**Rationale** We believe that this study represents an innovative approach to clarifying the definitions of routine, empathic and compassionate health care, as well as of sympathy. We emphasize the importance of affective empathy and its intensification in the context of patient suffering (compassion), without abandoning the ideal of clinical equanimity.

**Methods** We develop a pedagogical model for clinicians and trainees who are weaker in their empathic skills that includes four levels of growth. We clarify representative obstacles to empathic and compassionate care in education and clinical practice. We summarize the four beneficiaries of empathic and compassionate care (clinicians, patients, trainees, institutions). We suggest areas for future research, including the development of a compassion scale and conclude with a statement on how the conceptual and professional confusion we address adversely impacts patients and trainees. The article represents the consensus work of a group of health care professionals and students at Stony Brook University Hospital and School of Medicine who have been engaged in this project for several years through the Center for Medical Humanities, Compassionate Care, and Bioethics, established in August of 2008.

**Conclusions** We discern a shift away from concepts of clinical empathy and compassionate care that deny a significant place for an affective component and that idealize 'detachment'.

## Introduction

In the confused discussion about empathic and compassionate care, there comes a time for clarification. In this article we distinguish routine, empathic and compassionate health care. We highlight the importance of affective empathy in addition to cognitive empathy; we define sympathy in terms of agreed perspectives rather than the presence of emotion; we discuss compassionate

care as an intensification of affective empathy in the context of suffering. Although we by no means abandon the ideal of clinical equanimity, we suggest that it can be over-idealized and interfere with appropriate affective engagement with patients. Our pedagogical focus is on clinicians and trainees who are weaker in their empathic skills. We emphasize the importance of role modelling in the experiential learning of empathy and compassion, and of allowing students to sort through their observations of good and

bad role models. The four beneficiaries of empathic and compassionate care are enunciated (clinicians, patients, trainees, institutions), along with areas for future research.

## Definitions of routine, empathic and compassionate care

'Empathy' at its fullest is the ability to understand or imagine the depth of another person's feelings, and to resonate emotionally with that feeling to some degree. The word is a translation of the German term *Einführung*, meaning 'to feel one with'. Empathy by definition is a feeling state as well as a cognitive state.

Empathy is *not* sympathy. Sympathy implies conceptual agreement with the interpretation that anchors the underlying distressful emotions of another (e.g. 'I was treated unfairly' or 'I was not responsible in the least'). Clinicians should be unconditionally empathic with patients, but they need not accept their patients' interpretive perspectives. Unlike sympathy, empathy does not involve any determination of fairness. We can empathize with another person but not feel fully sorry for them because we deem them to be responsible for their plight. When we empathize with a patient we step outside of ourselves and engage them in their experience of illness, but we may not accept their perspective as our own.

*Einführung* has been classically described in the philosophical literature as including a cognitive dimension of *Verstehen*, meaning 'understanding', as well as an affective or emotional dimension in which the agent genuinely feels what the other feels. These dimensions are intertwined, and it is frankly odd to think of anyone manifesting empathy while placing their entire affective apparatus on the shelf in some effort to maintain strict emotional detachment. However, the idealization of emotional detachment has a considerable history in mid-20th century medical writings, where empathy has been defined by some in purely cognitive terms and anything affective is exiled to the forbidden wastebasket of 'sympathy' – that is, anything affective is walled off from empathy [1]. This tendency had roots in Dr William Osler's celebrated essay *Aequanimitas* [2], although it is unfair to think that as great a physician as Osler did not find time for some affective connection with needful patients.

Empathy, however, as Dr Jodi Halpern emphasizes, has a soft side [3–5]. As the Yale clinician and humanist Dr Howard M. Spiro argues conclusively 'Without feeling there is no empathy' (p. 3) [6]. This softer side is nicely expressed in modern medicine by Dr Francis W. Peabody [7], who clearly recognized a place for affect in 'the secret of the care of the patient'. In clinical practice, degrees of detachment and equanimity are essential if the clinician is not to be overwhelmed by the feeling state of the patient. However, when detachment and equanimity eliminate all affective presence, the clinician can be perceived as cold, scripted or unsupportive, and may even be unwelcome by patients who in their suffering desire at least a small iota of the doctor's heart accompanying his or her intellect [8]. No patient should ever have to choose between a technically competent and an empathic clinician. Human dignity itself requires that the clinician be competent both technically and empathically [9–11]. In the ideal clinician both are present.

Some clinicians may be good listeners, able to understand their patient's emotional state at a rational level and accurately reflect

this understanding back to the patient as an affirmation [12]. Patients will typically be grateful for this acknowledgment of their illness experience. But when patients are deeply suffering with major illness and looming loss, they hope for a response that is more than just cognitive. This does not mean that patients want their clinicians to lose the objectivity needed to carry forward with competent treatments, but they will be greatly benefitted by a quiet moment of solace and even the occasional shared tear. Emotion is constitutive of *Einführung*, so its complete absence violates empathy at its core. No trainee wants to emulate the 'empathy' devices that are now available as applications on cell phones, which reflect back understanding devoid of affect.

Compassionate care is an intensification of the affective dimension of empathy in the context of significant suffering, coupled with effective interventions to alleviate that suffering [11]. Empathy is more generic than compassion because it can occur in a range of positive affective states such as mirth, joy and awe.

Not every clinician will be equal in the art of compassionate care. For example, clinicians who work in palliative care and hospice must be compassionate at an affective level in order to be optimally successful with patients and their families [10]. Yet there is a place for compassionate care in every specialty as demanded by human dignity [9].

In the everyday clinical reality of competent and technologically sophisticated care, clinicians and trainees are faced with a major challenge in simply avoiding diagnostic and treatment errors. They are confronted with time pressures that are new to contemporary health care [13], and often must struggle to simply try to provide treatment with temporal efficiency. Competent care is, optimally, evidence based and applied with the right external skill sets so as to be safe, avoid mistakes and optimize successful outcomes. We refer to this basic level of competent care as *routine care*.

We propose the distinctions (explained in the next section) indicated below in Fig. 1 as levels of development:



Figure 1 Educational steps.

Importantly, we do *not* propose that this particular set of distinctions proceeds in some clear progressive pattern for those students who are, by nature or nurture, better prepared for compassionate care long before they arrive in medical school or training for the allied health professions. They are compassionate and emotionally empathic from the start of their education, and generally their peers and mentors can discern this quality in them from early on. But for those students who are not empathically developed, this progressive pattern provides a plausible four-level educational model that is worth considering. For these trainees moving beyond routine care to detached empathy as a cognitive exercise is certainly a major and worthwhile advance, as patients will believe that they are of somewhat more interest than would be a biological specimen.

## A developmental model of empathy and compassionate care for those with weak empathic skills

Whatever the source may be, some students reveal themselves as empathically gifted in interactions with peers and with patients [14]. With training they can improve cognitive skill sets in communicating empathically with patients and team members, but in general they take to this dimension of the art of medicine like a duck takes to water. Their ability to translate these empathic talents into clinical settings benefits from practice, feedback and experience, and such students are typically very pleased to engage in such activities as well as to reflect on them. They are already reflexively empathic at the affective level, and simply need to be self-aware of maintaining appropriate balance, and of the possibility of being too emotionally connected with patients, which can detract from objectivity. This is a welcome problem in that it does not require building empathy, but using it wisely.

The more deeply empathic students can struggle with adjustment to those clinical clerkships where the behaviours of clinical role models may fall short of empathic with regard to the treatment of patients and team members. These trainees may be more sensitive and easily demoralized by some of the abrupt and callous role models they encounter. Anecdotally, these students may at first ask themselves if they really want to continue in medical or nursing school.

But as stated, our focus in this paper is with students, residents and others who either do not accept empathic and compassionate care as clinical values, or who accept them but are weak in their ability to exhibit them. There is no certainty that such students will ever rise above detached empathy, but they can be taught interview techniques that ask patients how they are coping and offer a brief reflective statement of formal empathic comment like, 'Yes, it sounds like you are having a very hard time with this'. This relatively minor movement beyond the biological is beneficial to patients, and such cognitive techniques indeed can be taught to even the less empathically developed. Moreover, some students who have not developed very far empathically over the course of their lives will, in the process of learning detached empathy, experience the unsought discovery of a deeper self and begin to light up emotionally.

For the care providers and trainees who are weaker in their empathic skills, and yet who want to achieve more, we will suggest an educational pathway based on the distinctions of care that we previously laid out in Fig. 1 in order to enhance their skills.

### Level one: routine care

A plausible developmental model might begin with *routine care* and simply asking the trainee to reflect on how the disease or injury impacts the patient. Routine care should minimally engage the student in a respectful dialogue with patients that begins to recognize the interpersonal characteristics of the interview process, the importance of being centred on the patient rather than distracted, the questioning needed to elicit diagnostically relevant information from the patient, and the significance of patient comfort during the evaluation. Negative behaviours such as rudeness, abruptness and interruption are to be discouraged. Routine care does not involve an active or focused training in the commu-

nicative techniques associated with cognitive empathy. As we define it, routine care is the skilful practice of evidence-based medicine so as to be safe and avoid mistakes.

Once the trainee has developed a facility with routine care, he or she can be encouraged to take steps towards empathic care.

### Level two: detached empathy

As the trainee in this subset understands, develops and experiences the basic construct of routine medical care, he or she is better prepared to move to the next stage, which we label *detached empathy*. This form of empathy in detachment, with its roots in Freud and perhaps a misreading of William Osler, has been emphasized in medical education, and we endorse it at this early stage in the development of empathic skills. Coulehan points out the value of empathy that is emotionally detached from physician to patient. This 'detachment may act as a protection for the physician, a shield from being overwhelmed and paralyzed by pain and suffering' (p. 592) [15]. He asserts that detachment protects the patient in that medical decisions are not influenced by feelings and biases. This stage of empathy focuses specifically on learning how to effectively communicate care and concern for the patient and family at a cognitive level. The communication of care and concern, while not emphasized in what we termed 'routine care', are embedded within this step in a deliberate attempt to behave in a manner consistent with an empathic professional during the learning phase.

A patient interview will go beyond symptoms and medical history to ask questions about how the patient is handling this illness and what it means to them. Although the trainee may not have an affective response to the patient's answers, he or she can accurately summarize the patient's experience and reflect it back.

Although they may not have the affective attunement to address every clinical encounter, practitioners of detached empathy can recognize that a more substantive empathic engagement is appropriate. They can consider referral to clinical pastoral care, medical social workers or mental health professionals who have a more developed affective presence with patients. This referral may be as much as some students, residents and clinicians can do, and it is an advance over a narrow focus on routine care techniques. Referral affords the patient potential resources for fuller emotional support.

In reference to Fig. 1, detached empathy requires a cognitive skill set, and the effort to direct it towards the patient's experience in addition to his or her physiological well-being. Certain body languages are appropriate as well, such as nodding the head in acknowledgment of the patient, attentive facial expression, appropriate eye contact and the like. The cognitive characteristics involve understanding the inner experiences and perspectives of the patient, and reflecting this back to the patient to check for accuracy and to communicate this understanding to the patient [16]. In detached empathy, listening attentively, accurately identifying patient emotions and being reflective of patient's statements are key [12]. Reflecting back might include a question such as 'So, it sounds like this ordeal is really difficult for you, especially when you think about the financial pressures that your family will face for a while, yes?' Detached empathy includes responsiveness, building rapport and appropriate bedside manner. The reflective

techniques involved can be very easily taught and practiced, identifying the patient's emotions without establishing affective resonance with them.

A medical trainee can be taught cognitive empathic skills through active learning, a process by which the trainee engages in doing, discussing, observing role models, practicing and reflecting. Role models that demonstrate the integration of these skills in their practice of medicine are not just helpful but essential to the development of detached empathy [17,18]. Students learn from what they see modelled in front of them in all its details. Didactics and exhortations are useful, but this behaviour is mostly transmitted by role models who pass the torch.

In the case of diseases, disorders and treatments that cause discomfort or may have poor outcomes, patients and families prefer a fuller emotional presence.

### Level three: affective empathy

For some or even many students who are not empathically developed, the learning of cognitive empathic techniques may lead to another level of what we, following Halpern, refer to as *affective (or emotional) empathy*. Affective empathy describes the professional's ability to both understand what the patient is going through (cognitive empathy) and experience a non-verbal resonance with the patient emotionally [3]. At some point, as the empathically weaker students engage in a relatively detached practice of cognitive empathy, they may experience an affective quickening [4]. Psychologists do speak of emotions following activities, as captured in the famous James–Lange theory that physiological arousal instigates the experience of a specific emotion. Hence the popular phrase, 'Smile even if you are not happy, and your feelings can catch up'. Detached empathy is generally something expected, required and at some level testable by observations and simulated patient feedback. But our third step, affective empathy, involves an evolution beyond extrinsic actions and cognitive empathy to something more.

Halpern describes empathy as 'an experiential way of grasping another's emotional states' (p. 673) [3]. Halpern also describes empathy as a perceptual activity that operates alongside logical inquiry. So as long as physicians continue to exercise their skills of objective reasoning to investigate their empathic intuitions, empathy should enhance medical diagnosis rather than detract from it [3].

In Halpern's assessment, emotional attunement is an attribute a physician can utilize to sharpen responses to patients through an emotional facet. By understanding the affective dimension of a patient's experience, one may be able to set the tone of a clinical scenario through a specific emotion or mood to which the patient may relate. By emotionally grasping a patient at an existential level, the physician may further appreciate the personal meanings of patients' words and concerns. Where the practitioner of detached empathy accurately summarizes and reflects back the patients illness experience, the practitioner of affective empathy will be able to synthesize this experience and respond to it with a true emotional presence, almost as if he or she had experienced it. Importantly, empathy at this sophisticated level appears to facilitate trust and disclosure, probably making patients more comfortable to answer sensitive questions.

### Level four: compassionate care

Lastly, we posit a most sophisticated level in the ability to achieve a complex emotional attitude towards patients who are suffering, that of *compassionate care*. Compassionate care is a deep response to suffering at the affective level and appropriate action to relieve it. Compassionate care is appropriate only in the context of true suffering, and expressions of compassionate care in the absence of suffering may be seen as unwelcome or patronizing. It is worth noting, in this respect, that different patients will experience suffering in different situations. Compassionate care is just as called for in the case of a sore throat in the student expecting to sing at an upcoming talent show as it is inappropriate for someone excited for the promise of improved mobility offered by a knee replacement and who understands and accepts the long and painful recovery.

The practice of compassionate care is hopefully a direction for every trainee, but it is not a destination to which all will arrive. Some trainees will tend to feel discomfort around patients who are suffering, and they may seek to avoid them. This can be ameliorated, but not entirely for everyone. Yet for some, this development will occur as they discover a capacity within themselves, find gratification in its expression [19], or therapeutic value in its employment.

Perhaps some trainees and clinicians undergo an illness experience themselves or in a loved one that deepens their appreciation for the suffering of others, as in the tradition of the 'wounded healer'. For example, a psychiatrist who treated patients with depression felt that he never really connected with his patients on a deeper level until he himself experienced a serious episode of depression, which allowed him to better understand his patients and break through to a new level clinically [20,21]. Sometimes health care professionals only realize the importance of healing relationships when they become ill themselves, and are suddenly wearing the shoes of a patient. The psychoanalyst Carl Jung referred to the 'wounded healer' who, through his or her own illness experience, is able to heal others through increased empathy [21]. The ancient Roman philosopher Seneca wrote, 'The wounded doctor heals best' [21]. Falling ill can be transformative for the health care provider.

We define compassionate care as cognitive and emotional empathy in the context of a significant active response to suffering. Suffering is the experience of distress or disharmony caused by loss, or threatened loss, of what we most cherish. The vocation of physicians is to relieve suffering caused by illness, trauma and bodily degeneration. However, to relieve suffering physicians cannot rely solely on knowledge and skills that address physiological dysfunction.

Our association of compassionate care with the specific context of patient suffering is consistent with the views of Sulmasy [22], who argues that an explicitly 'compassionate' physician engages patient suffering on three levels: (1) objectively by recognizing suffering; (2) subjectively by responding to suffering; and (3) operatively by performing concrete healing therapy or action.

Compassionate care is a complex attribute that certainly requires both experience and insight. It is likely attainable by those highly motivated to achieve this rather challenging humanistic characteristic of health care delivery, and perhaps not attainable by those less motivated to get there. It is difficult for people to see

patients suffer and for some physicians it may be easier to separate themselves from the pain of others. An emotional resistance may exist, especially in caring for patients in hospice or palliative care, such as cancer patients who have refractory and extensive disease despite aggressive medical and surgical intervention in the context of the best practices currently known. Richardson argues that those in palliative care must learn the experiences of patient's hopes in order to support patients with life limiting illnesses [23]. Physicians and other health care providers who ultimately learn how to connect emotionally with patients in pain or suffering are optimally functioning at this most sophisticated level of clinical empathy, compassionate care. A critical element of compassionate care is a careful balance between maintaining objectivity and yet connecting emotionally. The objective elements include one's knowledge and skills in medical science, hypothesis testing and decision making, and the elements of compassion take the physician beyond those to sharing in the patient's hopes, fears and suffering.

### **Obstacles to developing empathic and compassionate care**

In pedagogy for developing empathy and compassionate care, it is important to discuss some of the obstacles that prevent students and physicians from demonstrating clinical empathy or reaching towards what we posit as the 'most developed' cluster of attributes – compassionate care.

From a social learning theory perspective, one potent obstacle is the absence of consistent, effective and inspiring role models; from a social-emotional context, there are emotional pressures, such as stressors in the work environment, or a hospital culture that discourages emotional expression. From a practical perspective, issues of time, workload, limited privacy and technological dominance might dampen even budding attempts to engage with patients and families at deeper levels of empathy. Below we offer a very partial list of obstacles in brief without any pretence of systematic analysis.

#### **Poor role modelling**

Modelling has long been understood as a potent source of learning. Social learning theory tells us that several model characteristics of a highly salient role model can be imitated by the observer [17]. The learner may be influenced by the status of the model, the power or control the model holds or the response topography utilized by the model [24]. Medical training includes role modelling, which may be recognized especially during the clinical training in clerkships, electives and acting internships. As represented in our empathy and compassionate care model, role modelling is an important learning tool utilized in both the detached empathy stage and in the affective empathy stage. More specifically, in the detached empathy stage, attentive listening may be learned through observation of interactions with more senior physicians. Direct observation of communication skills with patients and their families may help to develop attributes such as rapport building or bedside manner. In turn, role modelling may also be used in the emotional empathy stage where a medical trainee may observe an attending set the emotional tone in conversation and engage in clinical decision making with the patient's feelings or anxieties in

mind. Role modelling is an important tool towards the development of empathic skill sets of medical trainees [17].

Teaching by example is a powerful method, and unfortunately the negative role model holds the same power as positive role models in this respect. Furthermore, the examples set by medical professionals that are higher on the educational ladder and supervisory to the trainee should not be underestimated in their influence. Clinical clerks work very closely with interns, senior residents, allied health trainees and professionals, and attending physicians. Upon entry into the clinical world, trainees experience cognitive and affective dissonance between what was taught as ethical and compassionate care and what they observe and experience in the harried patient care settings.

Branch suggests a student may have learned to ask about patients' emotions in a communications course during their first years in medical school. If the student later observes that none of their supervising residents ask patients about their feelings, or report patient feelings in their presentations, the student may quickly learn to diminish the value of such activities or the value of that part of the curriculum [25].

In order to address the difficulty of negative role modelling, our curriculum at the Stony Brook School of Medicine requires that all students write up cases of good and bad role modelling with empathy in mind, and present their cases in small groups of 8–10 peers in intersessions between clerkships where they can express themselves without fear of adversely effecting grades. These case write-ups have brought up some unpleasant circumstances in small groups, allowing students to support one another in navigating the uneven quality of role models that they encounter. It also gives them a 'safe space' to express and discuss the cognitive and affective dissonance they experience in the wards. Allowing trainees to reflect on their experiences with poor and good role models of empathic and compassionate care enables them to mentally process their own future behaviours and practice styles.

#### **Training against empathy**

Spiro took the position in the early 1990s that empathy requires experiential training [6]. He found that the emphasis in medical training placed on decisiveness or authority obscured the essential role of empathy in patient care. Thus, even physicians in training may endeavour to see themselves as 'experts' and believe that they should behave with certitude of knowledge to fix what is damaged.

Spiro's views also suggest that physicians may be trained to mask or even deny their feelings. Physicians in training may be led to believe that work brings all the answers and all the rewards, thus work may be of highest importance in life with less time or priority for emotions. He writes:

We doctors are selected by victories. We reached college because we were bright and competitive in high school, and we reached medical school through competition and hard-edged achievements. We were taught that hard work brings all the answers – and all the rewards. Residencies teach the same tough message. Residency training quenches the embers of empathy. Isolation, long hours of service, chronic lack of sleep, sadness at prolonged human tragedies, and depression at futile and often incomprehensible therapeutic maneuvers turn even the most empathic of our children from caring physicians into tired terminators. No wonder we have little

empathy for the defeated, the humble, the dying, those who have not made it to the top of the heap, and even for the sick. (p. 10) [26]

Trainees are of course well aware that they are selected on the basis of educational success through extensive schooling, competition and hard-earned achievements. This learned competitiveness leads some students to value their academic accomplishments over the humanistic aspects of medicine such as forming meaningful relationships with patients. Competition between pre-med students generally transfers over to medical school where students typically adopt a 'stone cold' approach to their studies, not wanting to let on that they have fears, worries or troubles. Spiro refers to this as 'alexithymia', a failure to recognize feelings in self and/or other (p. 5) [6]. Lack of emotional honesty with student peers might create an environment where empathic caring with patients is viewed as 'weak' and lacking in rigor.

Indeed, in a survey of 800 recently hospitalized patients and 510 physicians, 19% of patients and 23% of physicians agreed that medical skills and scientific knowledge are the sole factors determining patient outcomes, and that empathy and compassion are unimportant [27].

### Technology and the electronic medical record

There is no question that the science of medicine has benefited from enormous technological advances of modernity. With these advances come expense, business opportunities and potent profits. With the presence of technology, patients may develop higher expectations of cure, but perhaps as well, may become progressively less satisfied with the personal aspects of medical care [28].

The electronic health record replaces the jotting of notes by hand in a face-to-face interaction with the patient, with eye-gaze-and-search on a monitor, seeking the right screens, typing or clicking on drop downs. Although this methodology is rapidly becoming the norm, its introduction at the bedside is part of a shifting dynamic for patient, family and physician who each need to acclimate to the entrance of technology into their interactions. The body language aspects of expressing attentiveness, concern and empathy can easily be lost with the presence and use of the monitor in the examination room.

### Stress, burnout and negative emotions

Neuman *et al.* [29] suggest that poor life-work balance and stressors at work may impact trainee maturation. Particularly with respect to the phenomenon known as burnout, development of depression and poor coping skills may impact trainees. These events leave little room for honing one's skills in the development of empathy and compassionate care among trainees. Physician lifestyle may include periodic or frequent sleep deprivation, and the experience of prolonged human tragedies even in the face of incomprehensible therapeutic manoeuvres. These sorts of emotionally charged and perhaps emotionally draining experiences may turn the most empathic or caring individuals into what is described as the 'tired terminators' in Spiro's writing [6]. The intense work environments of training can be and often are challenging contexts in which to enhance the skills in professionalism, communication, empathy and compassionate care [26], but this is by no means insurmountable.

Over the years, physicians have stated that the way to be compassionate without being overwhelmed is to draw certain boundaries: realize that you cannot fix everything; entrust your colleagues; have some sort of 'spiritual' practice [30]; keep in mind the meaning and privilege of being a healer [31]; have a balanced life and claim the time for it [32]; be empathic, but the patient's suffering is not your suffering (let it go).

### Gender issues

Although not well studied to date, female physicians are sometimes viewed as more receptive to learning affect and interpersonal aspects of doctoring [5]. They tend to spend more time and communicate more effectively with their patients. Interestingly, in 2002, Hojat and colleagues applied the Jefferson Scale of Physician Empathy to 704 physicians in the Jefferson Health System to obtain psychometric data and differences by gender and specialty. Women scored consistently higher on the Jefferson Scale of Physician Empathy in areas specifically in the 'perspective taking' aspect of detached empathy [33].

To overcome these and other obstacles to empathic and compassionate care in clinical settings, it is important to underscore the fact that patients, clinicians, students and the institutions themselves benefit from these assets. Indeed, the evidence is so conclusive now that no clinical setting can seriously compete without making a significant place for these behaviours.

### Who benefits from empathic and compassionate care?

It is easier for professional educators to focus on empathic and compassionate care when the four beneficiaries of such care are held in view [34].

*First*, clinicians, nurses, residents and other staff benefit. The human connection that is so uplifting and meaningful for the doctor, and that can help prevent burnout, is denied them unless they make the effort to practice medicine empathically. We know some *hard facts* about how the stifling of compassion harms physician morale: 87% of physicians who report erosion in enthusiasm for medicine (58% of 2608 surveyed nationally in the United States) attribute this loss to the inhibition of empathic care [35]. Clinicians' satisfaction with their relationships with patients can protect against professional stress, burnout, substance abuse and suicide attempts [32]. Burnout is strongly associated with poorer quality of care, patient dissatisfaction, increased medical errors, lawsuits and decreased expressions of empathy [32].

*Second*, medical students experience demoralization and disenchantment when they encounter a clinical environment that is dehumanizing and uncaring towards patients. A cross-sectional survey of all 2682 medical students attending seven US medical schools in the spring of 2009 showed that those students experiencing 'burnout' (about half as assessed by the Maslach Burnout Inventory) had less concern about physician responsibility to society, and were less connected with their initial caring motivations [36].

*Third*, patients benefit. The drive for human connection increases greatly during times of major distress and serious illness, and this is intensified in the depersonalized environment of a

hospital room. The presence of a compassionate clinician is a gift in and of itself that can achieve as much for patients as a great many medicines.

When doctors are compassionate, patients are less anxious [37], and they achieve earlier and more accurate diagnoses because the patient is better able to divulge information when he or she feels emotionally relaxed and safe. Treatment planning and patient adherence are, consequently, more efficient [38,39], especially when patients have chronic conditions [40]. Patient experience of compassionate care correlates positively with both prevention and disease management [41]. Diabetic patients, for example, demonstrate higher self-management skills when they self-report positive relationships with their providers [42]. Diabetic patients who are cared for by doctors with high empathy scores have better glucose and low-density lipoprotein [43]. In a time when as much as 30% of every American dollar spent on health care is related to poor self-care or compliance [44] these are not small benefits.

On a physiological level, considerable research suggests that people who feel compassion are typically more secure and have lower cortisol levels, which is important because high cortisol is associated with slower wound healing [45]. A review of 21 studies related quality of physician–patient communication, major aspects of both detached and affective empathy, with increased physical functioning, emotional health and decreased physical symptoms of pain in patients [46].

*Fourth*, the economic bottom line of health care delivery systems benefits from the practice of compassionate care. Aligned with the Institute of Medicine's six aims for quality health care, which include patient-centred care [47], the new Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) questions ask patients if they have been treated with care and respect, were communicated with well and had things explained to them, and felt responded to adequately by nurses, doctors and other staff. These surveys, which are heavily involved in detached empathy and which touch on affective empathy, are now required for any health care system receiving Medicaid or Medicare reimbursements. Reimbursements are pro-rated based on HCAHPS scores. Moreover, compassionate care is associated with lower malpractice suits [48,49], and it can be assumed that staff will be more loyal to their hospital or health care system if they are able to enjoy an empathic ethos.

## Implications for research

What needs to be investigated and developed in this general area?

First, we do not find anywhere in the literature a scale to measure compassionate care as we define it. What sorts of items might such a scale include? Here we list some representative items:

1 I can't resist reaching out to help when one of my patients seems to be hurting or suffering.

2 I drop everything to care for my patients when they are feeling sad, in pain or lonely.

3 When I believe my patients are having problems I do all I can to help them.

4 When faced with a patient who is suffering I want to avoid them.

5 My attitude towards those who are suffering is non-judgmental.

6 When I am in the presence of a suffering patient, I feel a strong desire to act.

7 I am willing to go out of my way to effectively relieve my patients' suffering.

8 I am more comfortable addressing the physical needs of the patient rather than the emotional needs.

9 When I encounter a suffering patient I fear becoming emotionally involved.

10 I feel the relief of suffering to be central to my professional identity.

It is unclear how much the more complex and nuanced empathic qualities are teachable and learnable. More unknowns are deserving of attention as well:

- What stages of empathy do physicians generally achieve, and what differentiates those who advance further than their peers?

- Are there peaks and troughs during one's training or one's career, in the utilization of empathy at one or another level? That is, is the slope monotonically positive, as described in our proposed model, or is the utilization of one or another level of empathic skills, attitudes and knowledge at any one time also dependent on other influences or contextual events?

- Are there targeted educational activities or curricular inclusions that help develop and sustain physician empathic traits?

- To what extent does the experience of affective empathy on the part of the caregiver (which helps protect against burnout) correlate with the experience of compassion or empathic connection on the side of the patient?

Casting the construct in a developmental perspective provides opportunity to examine its growth, as well as whether and how empathy can be taught to trainees or less experienced professionals in its deeper affective dimensionality.

## Conclusions

A health care environment lacking in empathy and compassion is not optimal for patient outcomes, and constitutes a significant risk. The care of the patient is both a science and an art. It is, on the one hand, the competent application of science; on the other hand, it is the art of being attentively present to the patient in all the complexity and meaning of his or her illness experience. Meta-analysis suggests that being empathically present to the patient in their illness adds to patient well-being, and treatment adherence, especially when their illness is chronic [50]. Because so many patients are suffering in one way or another, compassionate care is at the heart of medicine, adding an element of stronger affective response to empathic care, and deeper awareness of the concrete reality of the patient's 'illness' experience in relation to suffering. No one arrives at compassion perfected, but it is the direction to travel.

It is also important to clarify the meanings of empathy and compassion for clinicians and trainees, who are significantly dissatisfied and confused over strict detachment models of empathy and what they feel a deeper empathy and compassion require. Recently, a qualitative study from the United Kingdom reviewing student reflections after a palliative care experience revealed that students had significant difficulty managing subjective boundaries between emotional detachment and empathy, revealing a conflict between the 'old' professional attributes and newer expectations of professional behaviour among physicians [51]. Allowing more clinician and student small group discussion on this tension as

experienced on the wards in the observation of those role models who idealize detached empathy, and of those who show a softer side as fitting, may be a fruitful endeavour.

## References

1. Aring, C. D. (1959) Sympathy and empathy. *JAMA: The Journal of the American Medical Association*, 167 (4), 448–452.
2. Osler, W. (1904) Aequanimitas. In *Aequanimitas: With Other Addresses to Medical Students, Nurses and Practitioners of Medicine*, pp. 1–12. Philadelphia, PA: Blakiston's Son & Co.
3. Halpern, J. (2003) What is clinical empathy? *Journal of General Internal Medicine*, 18, 670–674.
4. Halpern, J. (2007) Empathy and patient–physician conflicts. *Journal of General Internal Medicine*, 22, 696–700.
5. Halpern, J. (2010) *From Detached Concern to Empathy: Humanizing Medical Practice*. New York: Oxford University Press.
6. Spiro, H. (1993) Introduction. In *Empathy and the Practice of Medicine* (eds H. Spiro, M. G. McCrea Curnen, E. Peschel & D. St. James), pp. 1–6. New Haven, CT: Yale University Press.
7. Peabody, F. (1927) The care of the patient. *JAMA: The Journal of the American Medical Association*, 88 (12), 877–882.
8. Cousins, N. (1976) Anatomy of an illness (as perceived by the patient). *The New England Journal of Medicine*, 295 (26), 1458–1463.
9. Chochinov, H. M. (2004) Dignity and the eye of the beholder. *Journal of Clinical Oncology*, 22 (7), 1336–1340.
10. Chochinov, H. M., Hack, T., Hassard, T., Kristjanson, L. J., McClement, S. & Harlos, M. (2005) Dignity therapy: a novel psychotherapeutic intervention for patients near the end of life. *Journal of Clinical Oncology*, 23 (24), 5520–5525.
11. Chochinov, H. M., Hassard, T., McClement, S., Hack, T., Kristjanson, L. J., Harlos, M., Sinclair, S. & Murray, A. (2008) The patient dignity inventory: a novel way of measuring dignity related distress in palliative care. *Journal of Pain and Symptom Management*, 36, 559–571.
12. Coulehan, J. L., Platt, F. W., Egner, B., Frankel, R., Lin, C. T., Lown, B. & Salazar, W. H. (2001) 'Let me see if I have this right . . .': words that help build empathy. *Annals of Internal Medicine*, 135 (3), 221–227.
13. Sweet, V. (2012) *God's Hotel: A Doctor, a Hospital, and a Pilgrimage to the Heart of Medicine*. New York: Riverhead Books.
14. Post, S. G., Underwood, L. G., Schloss, J. P. & Hurlbut, W. B. (eds) (2002) *Altruism and Altruistic Love: Science, Philosophy, and Religion in Dialogue*. New York: Oxford University Press.
15. Coulehan, J. K. (2009) Compassionate solidarity: suffering, poetry, and medicine. *Perspectives in Biology and Medicine*, 52 (4), 585–603.
16. Weiner, S. J. & Auster, S. (2007) From empathy to caring: defining the ideal approach to a healing relationship. *Yale Journal of Biology and Medicine*, 80, 123–130.
17. Ria Jochemsen-van der Leeuw, H. G. A., van Dijk, N., van Etten-Jamaludin, F. S. & de Waard, M. W. (2013) The attributes of the clinician trainer as a role models: a systematic review. *Academic Medicine*, 88 (1), 26–34.
18. Hojat, M., Nasca, T. J., Magee, M., Feeney, K., Pascual, R., Urbano, F. & Gonnella, J. S. (1999) A comparison of personality profiles of internal medicine residents, physician role models, and the general population. *Academic Medicine*, 74 (12), 1327–1333.
19. Post, S. G. (ed.) (2007) *Altruism & Health: Perspectives from Empirical Research*. New York: Oxford University Press.
20. Klitzman, R. (2006) Improving medical education on doctor–patient relationships and communication: lessons from doctors who become patients. *Academic Medicine*, 81 (5), 447–453.
21. Klitzman, R. (2008) *When Doctors Become Patients*. New York: Oxford University Press.
22. Sulmasy, D. P. (1977) *The Healer's Calling*. New York: Paulist Press.
23. Richardson, K., MacLeod, R. & Kent, B. (2011) A Steinian approach to an empathic understanding of hope among patients and clinicians in the culture of palliative care. *Journal of Advanced Nursing*, 18, 686–694.
24. Bandura, A., Ross, D. & Ross, S. A. (1961) Transmission of aggression through the imitation of aggressive models. *Journal of Abnormal and Social Psychology*, 63, 575–582.
25. Branch, W. T., Kern, D., Haidet, P., Weissmann, P., Gracey, C. F., Mitchell, G. & Inui, T. (2001) Teaching the human dimension of care in clinical settings. *JAMA: The Journal of the American Medical Association*, 286 (9), 1067–1074.
26. Spiro, H. (1993) What is empathy: can it be taught? In *Empathy and the Practice of Medicine* (eds H. Spiro, M. G. McCrea Curnen, E. Peschel & D. St. James), p. 7–14. New Haven, CT: Yale University Press.
27. Lown, B. A., Rosen, J. & Marttila, J. (2011) An agenda for improving compassionate care: a survey shows about half of patients say such care is missing. *Health Affairs*, 30 (9), 1772–1778.
28. Coulehan, J. L. (2005) Viewpoint: today's professionalism: engaging the mind but not the heart. *Academic Medicine*, 80 (10), 892–898.
29. Neumann, M., Edelhauser, F., Tauschel, D., Fischer, M., Wirtz, M., Woopen, C., Haramati, A. & Scheffer, C. (2011) Empathy decline and its reasons: a systematic review of studies with medical students and residents. *Academic Medicine*, 86 (8), 996–1009.
30. Krasner, M. S., Epstein, R. M., Beckman, H., Suchman, A. L., Chapman, B., Mooney, C. J. & Quill, T. E. (2009) Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. *JAMA: The Journal of the American Medical Association*, 302 (12), 1284–1293.
31. Coulehan, J. L. (2010) On humility. *Annals of Internal Medicine*, 153, 200–201.
32. Shanafelt, T. D. (2009) Enhancing the meaning of work: a prescription for preventing physician burnout and promoting patient-centered care. *JAMA: The Journal of the American Medical Association*, 302, 1338–1340.
33. Hojat, M., Gonnella, J. S., Nasca, T. J., Mangione, S., Veloksi, J. & Magee, M. (2002) The Jefferson Scale of physician empathy: further psychometric data and differences by gender and specialty at item level. *Academic Medicine*, 77 (10), S58–S60.
34. Post, S. G. (2011) Compassionate care enhancement: benefits and outcomes. *The International Journal of Person Centered Medicine*, 1 (4), 808–813.
35. Zuger, A. (2004) Dissatisfaction with medical practice. *New England Journal of Medicine*, 350, 69–75.
36. Dyrbye, L. N. (2010) Relationship between burnout and professional conduct and attitudes among US medical students. *JAMA: The Journal of the American Medical Association*, 304, 1173–1180.
37. Fogarty, L. A., Curbow, B. A., Wingard, J. R., McDonnell, K. & Somerfield, M. R. (1999) Can 40 seconds of compassion reduce patient anxiety? *Journal of Clinical Oncology*, 17 (1), 371–379.
38. DiMatteo, M. R., Sherbourne, C. D. & Hays, R. D. (1993) Physicians' characteristics influence patients' adherence to medical treatment: results from the Medical Outcomes Study. *Health Psychology*, 12, 93–102.
39. DiMatteo, M. R. (1994) Enhancing patient adherence to medical recommendations. *JAMA: The Journal of the American Medical Association*, 271, 79–83.
40. Beach, M. C., Keruly, J. & Moore, R. D. (2006) Is the quality of the patient–provider relationship associated with better adherence and health outcomes for patients with HIV? *Journal of General Internal Medicine*, 21 (6), 661–665.



41. Sequist, T. D., Schneider, E. C., Anastario, M., Odigie, E. G., Marchall, R. & Rogers, W. H. (2008) Quality monitoring of physicians: linking patients' experiences of care to clinical quality and outcomes. *Journal of General Internal Medicine*, 23 (11), 1784–1790.
42. Greenfield, S., Kaplan, H. S., Ware, J. E., Yano, E. M. & Frank, H. J. (1988) Patients' participation in medical care: effects of blood sugar control and quality of life in diabetes. *Journal of General Internal Medicine*, 3, 448–457.
43. Hojat, M., Louis, D. Z. & Markham, F. W. (2011) Physicians empathy and clinical outcomes for diabetic patients. *Academic Medicine*, 86 (3), 359–364.
44. Levinson, W., Gorowara-Bhat, R. & Lamb, J. (2000) A study of patient clues and physician responses in primary care and surgical settings. *JAMA: The Journal of the American Medical Association*, 284, 1021–1027.
45. Malarkey, W. B., Pearl, D. K., Kiecolt-Glaser, J. K. & Glaser, R. (1995) Influence of academic stress and season on 24-hour mean concentration of ACTH, cortisol, and beta-endorphin. *Psychoneuroimmunology*, 20, 499–508.
46. Stewart, M. (1995) Effective physician–patient communications and health outcomes: a review. *Canadian Medical Association Journal*, 152, 1423–1433.
47. Institute of Medicine (2001) *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century*. Washington, DC: National Academies Press.
48. Hickson, G. B. C., Clayton, E. W. & Entman, S. S. (1999) Obstetricians' prior malpractice experience and patients' satisfaction with care. *JAMA: The Journal of the American Medical Association*, 272, 1583–1587.
49. Fullam, F., Garman, A. N., Johnson, T. J. & Hedberg, E. C. (2009) The use of patient satisfaction surveys and alternate coding procedures to predict malpractice risk. *Medical Care*, 47 (5), 1–7.
50. Kelley, J. M., Kraft-Todd, G., Schapira, L., Kossowsky, J. & Riess, H. (2014) The influence of the patient–clinician relationship on healthcare outcomes: a systematic review and meta-analysis of randomized controlled trials. *PLoS ONE*, 9 (4), 1–7.
51. Borgstrom, E. & Cohn, S. (2010) Professionalism: conflicting values for tomorrow's doctors. *Journal of General Internal Medicine*, 25 (12), 1330–1336.