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Consequences of the presence and absence of empathy during consultations in primary care: A focus group study with patients

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ABSTRACT

Objective: There is general consensus that explicit expression of empathy in patient-GP communication is highly valued. Yet, little is known so far about patients' personal experiences with and expectations of empathy. Insight into these experiences and expectations can help to achieve more person-centeredness in GP practice care.
Methods: Participants were recruited by a press report in local newspapers. Inclusion criteria: adults, a visit to the GP in the previous year. Exclusion criterion: a formal complaint procedure. Five focus groups were conducted. The discussions were analyzed using constant comparative analysis.
Results: In total 28 participants took part in the focus group interviews. Three themes were identified: (1) Personalized care and enablement when empathy is present; (2) Frustrations when empathy is absent; (3) Potential pitfalls of empathy. Participants indicated that empathy helps build a more personal relationship and makes them feel welcome and at ease. Furthermore, empathy makes them feel supported and enabled. A lack of empathy can result in avoiding a visit to the GP.
Conclusion: Empathy is perceived as an important attribute of patient-GP communication. Its presence results in feelings of satisfaction, relief and trust. Furthermore, it supports patients, resulting in new coping strategies. A lack of empathy causes feelings of frustration and disappointment and can lead to patients avoiding visiting their GP.
Practice implications: More explicit attention should be given to empathy during medical education in general and during vocational GP-training.

1. Introduction

Explicit expression of empathy on the GP's part is highly valued by the general public and patients alike [1–3]. Patients consulting GPs (General Practitioners) with psychological problems in particular regard empathy and the use of empathic statements by GPs as important aspects of a caring attitude [4,5]. Patients consider empathy to be so important, that recommending a GP to others is strongly associated with the empathic characteristics of that GP [6]. Mercer et al., studying patients' views of the quality of GP consultations, found that the doctor's empathic concern was regarded as one of the core elements of consultations in GP practice [7]. These experiences are all the more interesting because of the mounting evidence that empathy is closely associated with outcomes measures such as lower levels of HbA1c and LDL-cholesterol in diabetic patients and less severe and shorter lasting common cold symptoms [8,9]. While this literature shows that, a GP's empathy is a core value and major satisfier for patients, not much is known so far about patients' personal experiences with empathy, whether it be positive, or negative ones.

In addition, several developments in current GP practice, which possibly influence the above-mentioned aspects, should be taken into account. GPs increasingly have to deal with IT- and administrative requirements. Furthermore, primary care work has increasingly become teamwork, as GPs have to work closely together with other healthcare professionals [10]. These developments require more organizational arrangements and protocols [11,12]. To many GPs this protocol-driven care is an important obstacle to showing empathic behaviour [13].

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Patients consider GPs to be responsible for the effectiveness of the medical consultation [2,14]. It is worth mentioning that, in contrast to patients' opinions about the value of empathy, the GP's focus seems to have shifted to a more task-oriented approach, an emphasis on biomedical factors rather than the patient's emotional aspects, and to productivity and efficiency [15–17].

The concept of empathy can be regarded to be a catch-all one; some scientists and theorists think of empathy as either emerging from more cognitive mechanisms or as an affective process, while others see the emotional and cognitive aspects as overlapping rather than separate [18–21]. Some have made a distinction between 'trait' empathy (parent-infant dyad) versus 'situational' empathy [18,20,22]. To make matters even more confusing, the concepts of empathy, sympathy and compassion are often used interchangeably in today's healthcare literature [23].

Although Macnaughton (medical humanities) has questioned whether a physician can ever really "stand in the patient's shoes" [24], patients, as was stated earlier, on their part highly value empathy. A better understanding of patients' personal experiences with, expectations of and opinions on a GP's empathic behaviour could be instructive for the GP and GP practice at large and may result in more adequate GP practice consultations. However, patients' personal experiences during GP practice consultations and their consequences have so far not been studied thoroughly. Therefore, this qualitative focus group study aims to explore patients' experiences of and opinions on empathy in the encounter In GP practice.

2. Methods

2.1. Study design

Five focus group sessions were conducted to explore participants' experiences and opinions with regard to empathy in GP practice. Each focus group consisted of six to seven participants recruited from the general population.

Focus group sessions were chosen as a research method, because they rely on group processes, resulting in a deeper exploration and clarification of patients' rationales, expectations and experiences [25]. Furthermore, the size of the individual focus groups allows all participants to express their experiences and opinions [26]. To elicit multiple aspects of empathy, we used a topic guide that was based on literature and expertise of the supervising committee and was tested for appropriateness and usefulness in two pilot focus groups (Appendix A). To progressively focus on the subject of our study, this topic guide was adapted in the course of the first four focus group interviews. The topic guide was further adapted for the fifth focus group (Appendix B).

2.2. Study population and procedures

A press report, in which participants were invited to apply for participation, was published in free public local newspapers (including their websites) in four Dutch regions. To ensure a heterogeneous distribution of the sample, we aimed at diversity in sex, age and level of education of participants. As more women and highly educated people responded to the first press report, a second appeal was issued specifically inviting men and people with lower education backgrounds to take part. Adults who had visited their GP at least once in the previous year were included. Persons who had been involved in a formal complaint procedure with a GP were excluded. Thirty persons agreed to participate and met criteria; two of these participants withdrew before the study started, due to illness.

Participants were given an explanation of the aims of the study and a guarantee of anonymity and confidentiality by mutual e-mail correspondence. They were also informed of the need to sign an informed consent form.

Table 1
Arrangement of the focus groups.

Focus group number	Type, Abbreviation	Gender	Specific characteristics
00	Pilot	Mixed	
0	Pilot	Mixed	
1	MG.FG1	Mixed	
2	C.FG2	Female	Care background
3	M.FG3	Male	
4	F.FG4	Female	
5	F.FG5	Female	

To avoid bias within the group process, the participants within each focus group did not know each other. There was no relationship between researchers and participants prior to study commencement.

Because of the ongoing debate about the usefulness of mixed or homogenously composed groups [27], we decided to compose one mixed-gender group, three groups with only female participants and one group with only male participants. A significant number of participants turned out to be or have been working in care, as for instance nurses or social workers. As we expected them to have specific perspectives as care-receivers and care-givers, we formed one focus group consisting solely of participants with a care background (see Table 1).

The study was approved by the Regional Committee for Medical Research Ethics of the region Arnhem-Nijmegen (letter dd 10-8-2015, file number: 2015-330).

2.3. Data collection

Each focus group session was moderated by an experienced female moderator with a GP-background (LV). The non-participating group observer (FD) took notes and made audio recordings of the sessions. The sessions lasted 90–110 min and were held at the Radboud university medical centre in November 2015 and March 2016. At the end of each session, the moderator summarized the discussion in order to evaluate the contribution of each of the participants and to establish whether participants agreed with the summary. After each session, the moderator and observer exchanged their preliminary impressions of communication between and participation of the group members. All the participants completed and signed informed consent forms. Participants were offered financial compensation for travel expenses and investment of time (a € 50,-voucher per person).

2.4. Data analysis

The observer transcribed the audio recording of each session to obtain a verbatim report. Transcripts of the focus group sessions were imported into qualitative analysis software, Atlas-ti 7. Analysis of the data was performed according to the principles of constant comparative analysis [28]. In order to progressively refine the focus group interview guide to explore the subject in depth, focus group discussions and analysis proceeded iteratively.

The data from the two pilot focus groups were analyzed by the GP-researcher with 35 years' experience in general practice (FD) and a female researcher with expertise in qualitative methods (AP). The data from the other five focus groups were analyzed by the same GP-researcher (FD), a female medical student with expertise in qualitative methods (AvD), and a male practicing GP with 10 years' experience in general practice and with expertise in qualitative and quantitative research methods (ToH). During the analysis of the five focus group discussions, researchers (FD, AvD) familiarized themselves with all data by repeatedly reading all the

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