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Communication Study

A comprehensive model for optimizing empathy in person-centered care

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ABSTRACT

Objective: This study examined perspectives regarding the use of empathy within medicine and developed a model to demonstrate the components of empathy in a medical setting.
Methods: Grounded theory guided the methodology and final theory formation. Participants included 21 medical professionals representing multiple specialty areas and employed in a teaching hospital, private practice, or clinical setting in Eastern Virginia. Processes for transcription analysis and coding preserved participant perspectives and contributed to a final model.
Results: Participant interviews revealed a seven-tier model that displays the facilitative conditions and potential barriers that may impact the full expression of empathy within the medical setting. Interviews also delineated between levels of empathy and described the benefits of providing empathic care, all of which are included in the final model.
Conclusion: This new model of empathy describes a complex and dynamic process and conceptualizes ideal conditions for empathic treatment. The model presents concepts that may be useful in medical education, and creates new directions for empathy research.
Practice implications: Physicians can assess themselves along each level of the model and can use it to identify barriers as well as ensure optimal conditions for empathic treatment. This new conceptualization of empathy also has implications for medical training and directions for future research.

1. Introduction

The quality of the relationship among physicians and patients can significantly impact treatment outcomes through increased compliance, lower malpractice claims, more accurate diagnosis, and higher patient satisfaction [1–5]. One component of this relationship, empathy, has been identified as a determining factor of relationship strength and satisfaction [6,7]. These findings have led to a renewed focus on how to facilitate empathy in medical training and resulted in the establishment of empathy as an essential component of instruction by the American Association of Medical Colleges (AAMC) [5,8]. Although research has illuminated the benefits of using empathy within the medical setting, inconsistent definitions and various training modalities make it difficult to assume a clear conceptualization of what empathy might look like within the context of patient care [2,5–7,9–13].

Regardless of how it is defined, recent literature has acknowledged that empathy is attributed to establishing a relationship of trust as well as identifying the factors that impact illness [9,14]. Though often seen as an additive component of a medical interview, empathy can have profound effects on the experiences of both the patient and the physician, leading to greater satisfaction and better treatment outcomes [4,5]. Furthermore, Levasseur and Vance [15] warn that lack of attention to empathy, or focusing solely on physical symptoms rather than acknowledging the impact of disease and treatment on a patient's wellbeing, can actually cause a patient harm by delivering treatment that is not sensitive to the totality of the patient's needs.

The study of empathy in medicine in recent years has added to an understanding of the importance of empathic connection, but has also encountered several limitations that merit a new approach. A review of the past several years of research on empathy in medicine reveals that 171 out of the 206 studies employed quantitative methodology [11]. Although this research has illustrated where further training may be needed and has been pivotal in making a case for the inclusion of empathy in physician training and practice, it does not provide a clear operational definition of empathy from the physician's perspective [11]. In fact,

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Pederson [11] found that many quantitative studies on empathy in medicine did not provide an operational definition. Furthermore, construct validity of instruments claiming to measure the same or similar constructs is weak, suggesting that identified components of empathy may not be fully valid [9,12,13].

In addition, instrumentation such as the Jefferson Scale for Physician Empathy (JSPE) and the Consultation and Relational Empathy Scale (CARE) have been widely used to measure empathy in the medical setting [16–18], but they are necessarily limited due to their emphasis on only certain constructs of empathy. In an effort to clarify the process of empathy in the medical field the rich descriptive data that characterize qualitative research can be useful to further develop theory and explain inconsistencies resulting from quantitative methodology [19,20]. The authors therefore chose grounded theory, a qualitative approach that identifies themes through continuous data collection and interpretation [19–21], to explore how empathy is applied in the medical setting.

2. Methods

The purpose of this study was to conceptualize how empathy is utilized in the medical setting through grounded theory methods. The authors aimed to utilize rich description from participant interviews to gain a broader understanding of the phenomenon of empathy in medicine, while also exploring elements not currently present in the literature that could provide direction for further testing and analysis [19–21].

Grounded theory is a method in which a researcher "derives a general, abstract theory of a process, action, or interaction grounded in the views of the participants" ([22], p. 13). This method of theory development requires constant comparison, a circular process of gathering and interpreting data in search of commonalities and divergent themes. The use of multiple researchers increases trustworthiness of the findings through assistance with coding and analysis, generating different perspectives, and allowing for discussions to guard against bias.

The primary research question for this study was "How do physicians conceptualize the practice of empathy in the medical interview?" Sub-questions included (1) "What influences empathic communication in the medical setting?" and (2) "How does the conceptualization of empathy influence medical training?" Theoretical sampling was utilized to select participants by first reviewing current literature on empathy in medicine [4,5] and then identifying components that seemed common to the conceptualization of an empathic physician. Because current research suggests that empathy results in higher patient satisfaction, initial participants were selected by obtaining a list of the top-scoring physicians within a teaching hospital in Eastern Virginia based on compiled patient satisfaction ratings. Participants then identified colleagues who they considered to be highly empathic, operating on the belief that highly empathic physicians are able to recognize empathy in others. A total of 21 interviews were conducted, with participants representing a wide range of specialties. All participants were employed in Eastern Virginia and represented both urban and suburban settings. The following table displays participant profile information (Table 1). Participants primarily identified as male (57%) and White (90%), with a mean age of 50 (25–73) and a mean of 21 years in practice (0–39).

2.1. Interviews

Primary interview questions were constructed based upon the literature review and research questions. As common for grounded theory research, questions were revised as the study progressed in order to fully explore new concepts. This method allowed for identification of themes driven by the data, rather than restricted by the researcher. Interviews were semi-structured to allow for elaboration and new directions, with an interview protocol consisting of questions including "how, if at all, do you facilitate a relationship with your patients;" "how would you define empathy as it relates to medicine;" "what barriers exist in using empathy in medicine;" "what parts of what you do are not related to empathy;" "how, if at all, did you learn to be empathic in medicine;" with the freedom to adjust the interview to follow up on participant statements or new directions.

The authors followed the guidelines of Creswell [23], who states that 20–30 participants are sufficient for assuming saturation and variety of perspectives, thus guarding against concluding a study prematurely. In this study, a total of 21 interviews were conducted,

Table 1
Participant group profile.

Gender	Age	Race[a]	Years in practice	Specialty[b]	Avg. visit time (min)	Avg. no. of patients/day	Setting[c]
F	59	C	29.5	FM	20	10	MS
M	61	C	35	ID	–	20	MS
F	56	C	30	MM	10	40	MS
F	45	C	10	OB	30–60	30–40	MS
M	73	–	38	PS	10–20	5–35	MS
M	25	C	0	MS	30–60	6–9	MS
M	46	C	15	ID	30–60	12	MS
M	59	A	30	FM	15–20	11	MS
F	53	C	20	MM	15–60	28–38	MS
M	44	C	16	FM	20–30	14	PP
F	61	C	39	GC	60	1–7	PP
F	61	C	38	NP	30	12	CL
F	34	C	3	NP	30	25	MS
M	40	C	9	GS	5–30	15–20	MS
M	55	C	26	FM	20	11–12	MS
F	54	C	23	PN	–	35–50	MS
M	35	C	5	NE	30	15–20	MS
M	67	C	37	FM	15–30	25	PP
M	63	C	31	PD	15	22	PP
M	33	C	2	PSY	30	10–20	MS
F	38	FA	14	GE	10–60	5–10	MS

[a] *Abbreviations*: C, Caucasian; AA, African American; A, Asian American; FA, Filipino American.
[b] *Abbreviations*: FM, Family Medicine; ID, Infectious Disease; MM, Maternal Fetal Medicine; OB, OBGYN; PS, Plastic Surgery; MS, Medical Student; GC, Grief Counselor; NP, Nurse Practitioner; GS, General Surgery; PN, Pathology/Neuropathology; NE, Nephrology; PD, Pediatrics; PSY, Psychiatry; GE, Geriatrics.
[c] *Abbreviations*: MS, Medical School; PP, Private Practice/Outpatient Office; CL, Clinic.