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Communication study

How does a physician's accurate understanding of a cancer patient's unmet needs contribute to patient perception of physician empathy?

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ABSTRACT

Objective: Unmet supportive care needs of patients decrease patient perception of physician empathy (PE). We explored whether the accurate physician understanding of a given patient's unmet needs (AU), could buffer the adverse effect of these unmet needs on PE.
Methods: In a cross-sectional design, 28 physicians and 201 metastatic cancer patients independently assessed the unmet supportive care needs of patients. AU was calculated as the sum of items for which physicians correctly rated the level of patient needs. PE and covariates were assessed using self-reported questionnaires. Multilevel analyses were carried out.
Results: AU did not directly affect PE but acted as a moderator. When patients were highly expressive and when physicians perceived poor rapport with the patient, a high AU moderated the adverse effect of patient unmet needs on PE.
Conclusion: Physician AU has the power to protect the doctor–patient relationship in spite of high patient unmet needs, but only in certain conditions.
Practice implications: Physicians should be encouraged toward AU but warned that high rapport and patient low emotional expression may impede an accurate reading of patients. In this latter case, they should request a formal assessment of their patients' needs.

1. Introduction

Patient perception of physician empathy (PE) is an important factor in cancer care, often associated with positive patient outcomes [1], such as a better quality of life [2] or adherence to treatment [3]. In spite of its various definitions [4], empathy in a medical setting is often defined as the clinician's cognitive ability to understand accurately their patient's needs and concerns [5], which we will refer to as accurate understanding (AU) in this article[1]. Strikingly, few empirical studies have tested whether AU really matters for PE. In fact, the sparse data available in oncology do not reveal any link between physician AU and concepts close to PE, such as patient trust in the physician [6] or satisfaction with the consultation [7].

Thus, on one hand, it could be that the physician's accurate perception of patients is not so important for PE. A good bedside manner without an accurate perception of the patient, but with

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[1] In the present study, we will use 'accurate understanding' (AU) to describe the accuracy with which a physician perceives the needs and concerns of a specific patient.

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active listening and warmth [8,9], as well as sufficient time devoted to the patient [10–14], seems sufficient for patient satisfaction. Consistent with this idea, in a vignette study responded to by analogue patients, Blanch-Hartigan found that 'patients' were satisfied with 'physicians' who were able to detect the occurrence of patient emotions, even if they were wrong at determining the *nature* of the detected emotions [15]. Thus, as some authors argue, accuracy may not be as functionally important as might *a priori* be thought [16].

On the other hand, an accurate perception of patient needs should be necessary for clinicians to address these needs and thus be perceived as empathic. Findings that patients' unmet information needs are strongly related to low PE [17–19] support this line of reasoning.

We reasoned that previous studies have failed to demonstrate the association of AU with PE [6,7] because of the two following methodological drawbacks.

First, rather than influencing PE directly, AU could moderate the link between patient unmet needs and PE. As previously stated, there is a strong link between patient unmet needs and low PE [17–19]. However, somewhat surprisingly, PE depends on elements that go beyond the action scope of physicians, such as the hospital's organization of care [20–22]. Dysfunctional hospital organization could create patient unmet supportive care needs, for which physicians are not responsible, but which do still impact PE. However, it could be expected that, although physicians are not responsible for and perhaps unable to meet these patient needs, their accurate awareness of these concerns could at least lessen the strong negative impact of unmet needs on PE. We thus expected a moderating effect of AU on the link between patient unmet needs and PE. Although there is no empirical study to date to support this hypothesis, from a theoretical point of view, it is conceivable that AU, as an acknowledgement of patient suffering, could buffer the negative impact of unmet needs on PE. Nevertheless, as developed in the following two paragraphs, the moderating effect could be possible only under certain conditions.

Second, according to some authors' point of view [16,23], perspective-taking (i.e. adopting another's perspective) could be one way, among others, to achieve AU. Therefore, it might be that previous studies did not assess the AU stemming from physician perspective-taking [24,25], which recalls the *distinctive* accuracy of social psychology [26,27], but rather a *normative* or *stereotype* accuracy resulting from physician heuristics to obtain an idea of the patient's situation rapidly and effortlessly. These heuristics are typically stereotypes (e.g. 'All advanced cancer patients must have a lot of unmet needs') or egocentric perspectives (e.g. 'If, as a physician, I have done all that can be done for a patient, (s)he should not have unmet needs') [16,23,25]. If, for example, a physician then assumes that cancer patients always have numerous unmet needs, (s)he will be accurate with all patients that do have many unmet needs. However, although this *stereotype* AU can be high, since it is not based on a sound knowledge of a specific patient by taking his/her perspective, it should not be related to PE. We therefore propose that AU could have the speculated moderating effect (i.e. AU moderating the negative impact of unmet needs on PE) but only for a *distinctive* AU.

Because of physician external constraints [8], such as lack of time, and since perspective-taking is an energy-consuming and demanding task, it can be assumed that, by default, physicians do not take patient perspectives but use heuristics instead. A distinctive AU ought to occur if physicians have a good reason to engage actively in the interaction with patients and take their perspectives [28]. Among other motivations, perspective-taking is triggered in difficult situations to cope with relationship threats [29] or lack of personal control [30]. This may explain why medical students elicit more patient perspectives in the case of an unclear diagnosis, which can be challenging for the doctor–patient relationship, compared to a clear diagnosis [31]. Therefore, although it may not seem intuitive, we assumed that distinctive AU would be more likely with patients for whom physicians perceive *poor* rapport rather than with 'easy' patients. Moreover, distinctive AU can only occur with patients who disclose information/cues on which physicians can draw in order to understand them accurately [32–34]. Without clear available information, physicians have no other choice but to use heuristics.

To summarize, our primary goal was to investigate the unresolved issue of how AU could contribute to PE. Clarifying this issue is vital to demonstrate the importance of AU in the doctor–patient relationship. Based on a theoretical reasoning, we hypothesized that AU would buffer the negative impact of unmet patient needs on PE, but only for an assumed *distinctive* AU, which, in this study, is either with expressive patients providing diagnostic information about their needs or when physicians have poor rapport with a patient. High patient expressiveness and poor rapport will be used as 'proxies' for an assumed distinctive AU, as our study does not allow distinctive AU to be empirically disentangled from stereotype AU.

A subsidiary goal was to explore whether classical covariates of PE, i.e. physician self-reported empathy [14,35,36], length of consultations [10,11,22,37], and physician experience in oncology in a reverse sense [35,38,39], would also correlate with PE in the context of advanced cancer care.

Advanced metastatic cancer patients were chosen to reach those likely to report unmet supportive care needs and because the doctor–patient relationship was deemed particularly important in this phase of the disease trajectory.

2. Methods

Full details of the study may be found in another report [32] so only the main information is given here.

2.1. Procedure

Eligible physicians from four French hospitals were invited to participate in the study. Upon acceptance, they completed a questionnaire assessing their self-reported empathy and providing their socio-professional characteristics. They then had to include 10 consecutive patients meeting the inclusion criteria. At the end of a consultation with the physician, patients were given a detailed written study description, a written consent form and the questionnaires to fill in. Within one day of each inclusion, physicians had to fill in a short questionnaire assessing their understanding of the patient's unmet supportive care needs (i.e. the AU task, see Section 2.3).

2.2. Participants

The sample was composed of 28 clinicians, mostly medical oncologists with 19 years of experience in oncology on average (SD = 8.4), and 201 adult advanced metastatic cancer patients. Most patients were female and lived with someone, their mean age was 62 years and the primary cancer sites were breast, colorectal and lung cancers. In all cases, patients had already consulted the physician at least 3 times before joining the study so that they already had a minimal knowledge of each other.

2.3. Measures

Patient perception of physician empathy (PE) was measured using the Consultation And Relational Empathy measure (CARE), a 10-item 5-point Likert scale providing an overall score of PE [40,41],