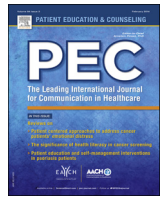




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Let's talk about empathy!

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ABSTRACT

Background: Research faces a challenge to find a shared, adequate and scientific definition of empathy. **Objective:** Our work aimed to analyze what clinical empathy is in the specific context of cancer care and to identify the effect of empathy in it.

Method: This study gives voice to physicians with extensive experience in cancer care. This original research combines qualitative data collection and quantitative data analysis. Semi-structured individual interviews were conducted with 25 physicians. The content of the interviews was analyzed according to the Content Analysis Technique.

Results: Empathy is described according to six dimensions that give a strong role to interpersonal and cognitive skills. This description integrates previous and various conceptualizations of clinical empathy. Physicians detail the beneficial effects of clinical empathy on patients' outcomes and well-being as well as physicians' practices. Physician interviews also revealed the relationship between empathic concerns and physicians' emotional difficulties.

Conclusion: Empathy in cancer care is a complex process and a multicomponent competence.

Practice implications: This operational description of clinical empathy has three main implications: to draw up a training program for physicians, to detail recommendations for physicians' work-related quality of life and to develop new tools to measure empathy.

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1. Introduction

The concept of clinical empathy has existed since the 1960s and yet systematic and scientific studies on the subject appeared in the last decade [1–4]. These have identified the many advantages of empathy in medical practice: quality of care, therapeutic results, quality of life and satisfaction (see details below).

Although we all have a concept of empathy in daily life, research struggles to find a general agreement about an adequate and scientific definition [5]. For example, Bayne [6] considers that this difficulty could come from the place given to emotion in the definition of empathy: could “empathy consist of recognizing the emotion of a patient, or experiencing it, or both?” In the medical

context, empathy is mainly considered a cognitive quality involving an understanding of the patient, his/her experiences, concerns and point of view, associated with the ability to communicate this understanding and check its accuracy in order to provide therapy [7]. However, rather than the perception or the understanding of others, Eisenberg [8] places emotional feeling at the core of his definition of empathy. He thus considers empathy an effective response to the emotions of others. There are also descriptions of empathy based on these two components: one cognitive and one affective [6,9]. Lastly, there is debate about the addition or not of a behavioral component in the definition of empathy [7,8].

Benefits of empathy on patients are regularly studied and many are identified [10,11]. Concerning cancer care, Lelorain and colleagues [1] highlight the direct benefits for the patient: greater satisfaction with their care, a better psychosocial adaptation, less psychological distress and less need for information. Clinical empathy increases patients' compliance to treatment [12] and health outcomes also seem more favorable with it [13]. Physicians

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who adopt empathic concern are more effective than those who stay formal and show no emotional care [14]. In addition, clinical empathy has positive and direct effects on physicians. Some research has demonstrated the protective factors of empathy against professional dissatisfaction and burnout [15] as well as it being a potential factor of well-being [13]. Empathy is strongly associated with personal accomplishment and job satisfaction for physicians because it enables them to find pleasure and satisfaction in their work [9,16,17]. However, we need to be vigilant, developing empathic skills with patients can also represent some risks for physicians [18]: emotional exhaustion [19], emotional distress [17], even empathy may create burnout [4,20].

Despite the increasing data concerning clinical empathy, previous researches may present some limitations [21]. Thus for example, results from quantitative cross-sectional studies do not allow the clear identification of the determinants and components of empathy. Observational studies may help to distinguish the causality effects of empathy on health outcomes [10], especially if they generate hypotheses that could be tested thanks to longitudinal cohort or randomized controlled trial (RCT) studies. Those kinds of design would offer the possibility to assess the effectiveness of empathy, and to strongly define statistically the size and the significance of those effects. Recently, a *meta*-analysis of 13 randomized controlled trials indicated that the patient-physician relationship has a small but statistically significant effect on clinical outcomes [22]. Some limitations of current studies may be due to empathy measurement tools used, which may present some restrictions: (1) most of it are self evaluation which may present social desirability bias [23]; and (2) are not psychometrically robust and do not cover all the domains of empathy [24]. Thus if recent quantitative studies may help to infer what could be the components of this empathy, knowing better intra- and interindividual components and determinants of empathy is necessary and will be possible by conducting cross-sectional studies based on observations of physician-patient interactions. Moreover, qualitative studies are helpful to detail their nature, their origins and/or their impact especially when we want to include physicians' experiences, their interpretations, but also the context in which empathy is developed and practiced.

Thus, this study develops a specific approach, one that is both qualitative and quantitative. The goal is to explore the physicians' views of empathy with the intent of (a) building a description of empathy in oncology, and (b) identifying how empathy helps or limits them in their clinical practices.

2. Method

According to recent recommendations [21,25] and in the perspective of an exploratory descriptive approach [26–29], we chose to develop a specific approach which combines a qualitative data collection and a quantitative data analysis. This design provides a better understanding by converging broad numeric trends from quantitative research and the detail of qualitative research [26,30].

Faced with a pejorative representation, various tools have been developed to improve quality and to ensure psychometric qualities of qualitative researches. Thus, during the process of research we used Morse's instructions for establishing reliability and validity in qualitative research [31]. Moreover, for the qualitative data collection, we applied the criteria from the COREQ checklist specific to interviews reports [32], which covers necessary and important components of study design.

Concerning the quantitative data analysis, we used a lexicometric approach based on the main standard criteria described in Reinert's method [33], which are: the frequency, the co-occurrences and the proximity (more details are presented in part 2.4.).

2.1. Sample

The inclusion criteria were working as a physician in a hospital and caring for cancer and critically ill patients. The participants have good knowledge and experience of cancer care, what "ensures efficient and effective saturation of categories with optimal quality data and minimum dross" [31].

2.2. Procedure

The participants were recruited in different hospital departments in the Paris region. The physicians were invited to participate in this study by e-mail, in which the study objectives and procedure were briefly presented. Recruitment was conducted using hospital directories, and researchers have contacted a large sample of physicians working in departments where cancer patients are treated. 58 physicians are eligible and 45 ones have accepted to take part in the study (*i.e.* 78% of the contacted physicians). Considering the criteria of data saturation (see details below), we conducted up to 25 interviews. The participant who agreed to take part signed an informed consent form. The first author conducted face-to-face interviews with each participant, in the workplace of the medical professional. The interview varied in length between 42 and 83 min ($M_{duration} = 54.38$; $SD = 10.31$).

2.3. Material

Data were collected through a qualitative methodology: individual and semi-structured interviews [34]. The interview grid was constructed on the basis of a complete review of the literature and professional experience of the researchers [35]. Two central questions, broad and open-ended, explore the central phenomenon of clinical empathy [26]. The first question investigated the representation and definition of empathy and empathic behaviors. Then, the second central question explored the effects perceived by the physicians of developing empathy with their patients. Each central question is followed by sub questions, and each one narrows the focus of the study but leaves it open for questioning. The central questions were the same across participants but researcher adjusted items to seek new information. This data collection allows to understand the process, exploring the existence and meaningfulness of this competence in cancer care [26,28,34].

The quality of qualitative research is partly based on the size of the sample: neither too small to obtain maximal variation nor too large for an in-depth analysis of the data [36]. Sampling in qualitative studies is based on strategy to achieve saturation or informational redundancy [37]. In descriptive studies, five to 25 interviews are sufficient to assume saturation [37–39]. Thus, in this study, a total of 25 interviews were conducted. According to the scope of the study, the nature of the topic, the quality of the data and the design [40,41], data were saturated at interview 19. The additional interviews confirmed the results by making sure that no new topic appeared due to, for example, an order effect [42,43].

2.4. Data analysis

A quantitative content analysis of the interviews was performed to identify the themes most frequently mentioned by the professionals. The analysis was carried out according to the method of Reinert [44], using the software IRaMuTeQ[®] [45]. These lexicometric analyses are statistical analyses based on vocabulary which reorganize data to make a summary of data and to make them meaningful. In concrete terms, two corpuses of texts were constructed based on the original discourses of all the physicians: one for each part of the interviews: (1) description and (2) effects

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