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Qualitative Research

Physicians' empathy levels in a primary care setting: perceptions of patients and their physicians, a qualitative study

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Abstract

Background. The physician–patient relationship is a crucial element in successful medical care. Empathy is the ability to understand an individual's subjective experience yet remain as an observer. It plays a major role in establishing a good physician–patient relationship.
Objective. The aim of this study was to evaluate the perspectives of patients and their corresponding emergency physicians regarding physicians' empathy levels and to extract themes that both patients and their doctors considered as important for an empathic encounter.
Methods. This is a qualitative study conducted at a Middle Eastern tertiary care centre Emergency Department (ED) using in-depth semi-structured interviews administered to each participating patient and his/her corresponding ED physician. Empathy-related themes were identified using inductive thematic analysis.
Results. This study shows that both patients and physicians believe in the importance of empathy in the ED based on four major themes: emotions, interpersonal skills, time and chief complaint. Time and the chief complaint were perceived as barriers by physicians, but not by their patients.
Conclusions. A gap lies in the expressive communication phase of empathy between the two groups. The four major themes retrieved could form the basis of an empathy measure in the medical encounter in Lebanese and similar settings.

Keywords. consultation, doctor–patient relationship, empathy, physician competency, primary care, quality of care

Background

The physician–patient relationship is central to medical care (1), hence the importance of studying empathy, which impacts this relationship. Empathy is the ability to understand an individual's subjective experience by sharing it while remaining an observer (2). Its benefits in the medical setting include: strengthening the physician–patient relationship (3), promoting effective communication (4), achieving better adherence to treatment, improving patient outcomes (5), enhancing patients' enablement (6), supporting professionalism (4), improving diagnostic accuracy (7), increasing patient satisfaction (8) and loyalty (9), and improving physicians' overall job satisfaction (7). In spite of these benefits, physicians face barriers to expressing empathy due to short encounter times, fear of strong emotions, burnout, and lack of training in empathetic communication (3). One way to improve the latter is through involving patients in the assessment and feedback on physician's communication skills and empathy (10). From patients' perspectives, empathetic physicians lead more successful consultations

Key Messages
- Evaluating patient and physician perspectives is key to understand empathy.
- Themes are emotions, interpersonal skills, time, and chief complaint.
- A gap lies in empathy expression between physicians and their patients.

(10). However, empathy entails expression and reception; thus it may be better assessed if both patients and physicians' perspectives are evaluated simultaneously. Nevertheless, a thorough exploration of PubMed, Medline, CINAHL and EMBASE, retrieved only one study done in a Taiwanese Emergency Department (ED) that discussed both physicians and patients' perceptions of empathy (11). Evidence on empathy being culturally sensitive raises the question if those findings may be translated to other settings (12,13). For instance, in Lebanon and the region, the concept of physician empathy is not well studied yet. Furthermore, primary healthcare is underdeveloped due to chronic underinvestment, higher incentives for pursuing specialty training, and lack of gate keeping within the health system (14). Hence, a visit to the lower acuity ED seeking solutions for primary care complaints may be many patients' first encounter with healthcare. International literature shows that expressing empathy in the ED decreases frustration caused by waiting (15), chances of violent behaviours (16), anxiety (17), and malpractice litigation risks (18). Although the Jefferson Scale of Physician Empathy and the Consultation and Relational Empathy measure quantitatively study empathy through patients and physicians' ratings, neither of them has been validated in Arabic yet. Therefore, studying this phenomenon qualitatively becomes even more important for understanding it in the Lebanese context. Given the aforementioned gaps in the literature, the research question arose: in Lebanese primary care settings specifically EDs, what are the perspectives of physicians and their patients regarding physician empathy and is there a difference between those two perspectives? The aim of this study was to answer this research question by soliciting patients and physicians' perspectives in order to identify themes deemed important for empathetic encounters and evaluate for any differences. This was done in the hope of increasing the body of knowledge on empathy in the Lebanese and similar settings in order to bridge any gaps and inform practice based on data from the two pillars of the medical encounter.

Methods

Setting

This study was approved by the institutional review board of the American University of Beirut and conducted at its medical centre in the low acuity ED. AUBMC is a tertiary care centre with over 350 beds (19), one of the busiest EDs in Lebanon and around 48,000 visits annually (20).

Eligibility

Any physician working at the ED was eligible for this study. Patients' inclusion criteria were age between 19 and 65 years, visiting the low acuity ED with an intact level of consciousness and cognition, a pain score of three or less on discharge, able to articulate their experience in Arabic or English and consenting to take part in the study whether they accepted to be audio-taped or not. In case of the latter, extensive notes were taken during the interview.

Recruitment process and consent

Both researchers met with the ED nurses and physicians to introduce the study. Physicians' informed consents were obtained prior to the initiation of the study. Only one physician rejected audiotaping, so extensive notes were taken during his interviews. Nurses were introduced to the study and informed about the patient inclusion criteria as they were the ones to screen their patients for eligibility. Recruitment took place between June and September 2015. After the end of medical treatment, nurses asked eligible patients if they would like to enrol in the study. For those who accepted, one of the researchers (KA) briefed them about the study and discussed the informed consent. At most, two eligible patients were selected from the same emergency physician's shift using random sampling. All participants were reassured about the confidentiality of their data.

Data collection

One of the researchers (KA) conducted in-depth semi-structured interviews with both patients and their physicians in a closed conference room for up to 50 min depending on the participants' willingness to talk. Patient and physician interview guides are described in Tables 2 and 3, respectively. Patients were interviewed first followed by their respective physicians until saturation of themes was reached (21). If a physician was unable to be interviewed on the same day, an appointment was taken the second day and he was asked to keep notes to remember the encounter. All physician interviews and most of the patients' interviews were conducted in English and transcribed verbatim by one of the researchers (KA). Arabic interviews were first translated into English by the researchers who are fluent in both languages.

Analysis

This study used an inductive thematic analysis approach (22). 'Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data' in an attempt to describe the data set and answer the research question (22). Both researchers analysed all the data separately then met to compare their findings. They read and re-read the transcripts until they were familiar with the concepts discussed. Then they used the data to generate initial codes rather than trying to fit the data into pre-determined themes. The researchers searched for themes by combining different codes. This process was repeated multiple times with each revision of themes until each of the researchers was able to define and name overarching themes. The researchers then met to compare results and discuss areas of disagreement until consensus on the final themes was reached.

Results

Fourteen patients were interviewed. The low acuity ED has nine physicians. We excluded the only female among the group, as reference to gender would disclose her identity. One physician refused to participate so we ended up with seven physician participants; five of whom were interviewed twice, one was interviewed three times, and one physician was interviewed once due to the frequency of their ED

shifts. This amounted to fourteen interviews. Only one physician was unable to be interviewed the same day and hence the interview was scheduled the following day to decrease recall bias. Table 1 shows the characteristics and chief complaints of the patients interviewed. When comparing the perception of empathy between patients and their physicians' four major themes were identified: emotions, interpersonal skills, time, and the chief complaint.

Acknowledging patients' emotions and expressing physicians' caring emotions

Even though patients neither verbalized their emotions nor their real concerns, they still wanted them to be addressed. One patient explained: 'I wish that he could have asked why you are so depressed about this … unless they ask, you will not say anything'. Patients expected physicians to notice their emotional cues and deal with them. A patient confessed: 'I was coming in crying and sobbing; maybe he understood on his own that I always take things more negatively'. They also wanted physicians to express emotions through verbal remarks, facial expressions, and body language. One patient remarked: 'I know that there won't be emotions involved, but he had a permanent poker face'. Interestingly, physicians thought they 'do not express emotions to the patient', but they show care by asking 'what is hurting them and give them something for the pain'. When one of the physicians was asked if he understood and addressed the patient's concerns, he replied: 'indirectly; well I examined her…We gave her an injection for the pain, so she felt that we were taking care of her medically'. A common justification was that if the 'patient was sicker; I would have interacted with her differently'.

Interpersonal skills are necessary for an empathetic encounter

When asked whether physicians understood their patients' concerns, patients began noting medical aspects of the encounter. One patient said: 'He asked me questions related to the pain, so I can easily say that he was aware of my situation and had definitely seen many other patients with cases similar to mine. But, me as a person? I don't know'. Later during the interview, patients began focusing on non-medical attributes that led to a satisfying encounter: good communication and interpersonal skills. Eye contact was crucial. They wanted to be 'looked at', as though they wanted their individuality to be validated. One patient clarified: 'Doctors with all the people and catastrophes they see at the end of the day, the patient becomes a piece of meat or whatever. It is better for them to depersonalize the patient which is not what happened here; the guy looked me in the eye'. Moreover, all the patients stressed the importance of physicians being friendly: they wanted to be told a few comforting words to feel the empathic touch. One patient said: 'He was very friendly. He came in and said how are you Adam?' Another patient emphasized that physicians need to practice their humility. He explained: 'He is a human being, he is not God. He is, on some level, just like me'. Perceived haughtiness negatively affected the encounter. This was not only judged by physicians' verbal communication, but also through their body language. One patient expressed that 'the body language … the way the doctor came into the room was like he was the president' affected his perception of the physician's empathy.

Physicians agreed on the importance of portraying empathy to patients, but felt it was enough to express it through taking care of them medically without engaging in non-medical communication or body language. They emphasized the importance of not neglecting patients and providing quality medical care by treating symptoms and alleviating pain. When a physician was asked to describe how he addressed his patient's complaints, he answered: 'I explained about his pain and his differential diagnosis'. Another physician noted that an appropriate sense of humour often reassures a patient, but that no blanket formula applies to everyone. He shared an experience with a patient of his by narrating: 'When I went in again, I tried to dismiss it (the patient"s concern that she has colon cancer) with a laugh to try to reassure her, "cancer? This is not cancer"- to kind of establish a rapport with her'. On asking for the patient's feedback, she stated that this empathetic approach calmed her down and reassured her, so she stopped asking for further cancer screening.

Physicians overestimated the time needed to express empathy

Physicians believed that more time was needed to express empathy. One physician explained: 'I was empathetic to the degree that my job allows me to do, I'm sure I can do a way better job had I been given the luxury of time. … Usually in the ED the rapport is not majorly established with the patients because it cannot. I do not have an hour of my time and I need to see very sick patients; I need to prioritize'. Their alternative way of expressing empathy was through a timely response to the patients' concerns. However, one physician believed that if one is serious about helping patients, he could always devote a few minutes. 'Sometimes it only takes 30 seconds if you do it right, so there is always time'. Yet he still referred to the time spent counselling the patient as 'lost time'. Although physicians apologetically mentioned how they only have a short amount of time to spend with their patients, patients did not expect them to stay longer. They were convinced that effective empathetic communication needs just a few minutes: 'Any patient who comes in does not want to chat with the doctor. Instead, he only needs a couple of words from him regarding what is wrong, how long the treatment is going to take, and simply put, if he's going to be okay'. In addition, patients associated shorter waiting times with greater empathy. To them, only physicians who are empathetic enough to sense that waiting increased their anxiety would hasten 'to relieve the patient's fear'.

Table 1. The age, gender and chief complaints of 14 patients visiting a low acuity Emergency Department in Lebanon for primary care complaints and interviewed by the researcher regarding their corresponding physicians' empathy levels (n = 14, 2015, Beirut, Lebanon)

Patient number	Age	Gender	Chief complaint
1	43	Female	Finger injury
2	22	Male	Headache
3	19	Male	Fever and abdominal pain
4	22	Male	Cough and vomiting
5	29	Female	Diarrhoea
6	53	Female	Knee and wrist pain after a fall
7	24	Female	Abdominal pain and diarrhoea
8	65	Female	Leg trauma
9	21	Male	Leg trauma after a motor vehicle accident
10	20	Female	Vomiting
11	32	Male	Forearm fracture
12	53	Female	Epigastric pain and acid reflux
13	56	Male	Bloating
14	27	Female	Diarrhoea

Table 2. Interview guide for 14 patients visiting a low acuity Emergency Department in Beirut for primary care services regarding their perspectives on their corresponding physicians' empathy levels (n = 14, 2015, Beirut, Lebanon)

Open-ended questions	Probing questions
How did the emergency physician communicate his/her understanding of your concerns?	Did the physician tell you that he/she understands your concerns? Were there certain verbal or non-verbal communications used to portray the understanding of the actual concern?
Did you feel that the physician empathized with you? Why? How?	Was the physician able to see the patient beyond the chief complaint?
Did you give any feedback to the physician about how well they understood your concerns/ emotions/ thoughts? How? What would you improve on the communication at both the patient and the physician level if the encounter were repeated?	Did you tell the physician that this is exactly what you are concerned about or if it is something else that he/she may have missed? Would you ask different questions or say more or less that what you have said? Would you have wished to be asked something more? What would make a better encounter in your opinion?

Table 3. Interview guide for seven Lebanese physicians providing primary care services at a low acuity Emergency Department in Beirut regarding their empathy levels during the encounter with their interviewed patients (n = 14 interviews with seven physicians, 2015, Beirut, Lebanon)

Open-ended Questions	Probing Questions
After you listened to the patient's concerns, what thoughts and feelings did they raise in you?	Could you understand why the patient was concerned or why he/she came to the ED? Could you feel the patient's worries? Did they emotionally affect you?
How did you communicate to the patient your understanding of his/her concerns?	Did you tell the patient that you understand his/her concerns? Were there certain verbal or non-verbal communications that you used to portray your understanding of the actual concerns?
Did you empathize with the patient? Why? How? What would you improve on the communication at both the patient and the physician level if the encounter were repeated?	Were you able to see the patient beyond the chief complaint? Would you ask different questions or say more or less that what you have said? Do you think it is important to show the patients that you empathized with them? What would make a better encounter in your opinion?

The patients' chief complaint gauged physicians' empathy

When the physicians were asked if they would change anything in their encounters, none of them said yes because the main problem revolved around 'the chief complaint and not the patient'. One physician noted: 'My patient was not in agony; he was ok. I did not associate with him emotionally because it was not a big trauma. It was just a small fracture that could be repaired easily. I had numerous other patients who were also admitted to the hospital. … They had more serious trauma, which allowed me to empathize with them more, and give them more of my time'. On asking this patient for feedback on his physicians' empathy, he expressed disappointment for not receiving any empathy for an injury that affected his life. It appeared that physicians were comparing their patients based on the severity of diseases. For example, when asked about the difference in the level of empathy provided to a stroke patient and a patient with a minor leg trauma, one physician replied: 'as a human being you have the bias from within'.

Discussion

This study revealed that both physicians and patients believed in the importance of empathy in the ED setting. Patients emphasized the need for good medical knowledge coupled with good interpersonal and communication skills. They wanted physicians to address their emotions and were conscious of body language and facial expressions. The main gap was in the expressive communication phase as physicians thought that they communicated empathy by medically addressing the complaints while patients expected to be appreciated as multi-dimensional human beings—physiology being only one of those dimensions. Time and the chief complaint were the main barriers for physicians but not their patients who were convinced that little time was needed for an empathic discussion.

Our findings were in line with the Taiwanese study that looked into the differences between emergency patients and their doctors' perceptions of physician empathy by interviewing both groups. In both studies, patients wanted physicians to ask about their emotions and address their psychological concerns but physicians rarely did (11). Time was considered a barrier (3,11). This was also noted in a study done in the ED of a tertiary care centre in the Middle East where the busy emergency setting was seen as a challenge to achieving empathy (23). However, time was not only an issue in the ED. Other literature shows that general practitioners also called for longer consultation sessions to establish empathic bonds especially with new patients (7). A published study on time and consultation sessions showed a significant correlation between a patient's demand for more time and their dissatisfaction with the 'emotional content' of the encounter (24). This suggests that rather than arguing against empathy due to the shortage of time, physicians should empathize precisely *because* time is limited. Another concern was un-bottling strong emotions which may lead to burnout (3). Since being confronted with emotionally demanding

situations is an 'occupational risk', previous literature advocates for equipping physicians with the necessary tools that could help them overcome emotional distress (25) without encouraging insensitivity (26). A study on general practitioners found that empathy increased job satisfaction and prevented burnout by bringing physicians closer to their patients. It showed that physicians who were in good physical and emotional states and were working in 'organized environments' without the pressure of time were more likely to be empathetic (7).

When comparing themes that patients of this study listed to those of the Consultation and Relational Empathy measure, a 10-item 'consultation process measure' of empathy, the researchers found similarities in all areas except the last two items on empowerment and informed decisions (27). This may be due to the cultural differences between Lebanon and the UK in relation to the roles of physicians and patients.

Strengths and limitations

This study is important because it is the first of its kind in the region. It investigates the concept of empathy from the perspective of physicians and their patients. It was conducted in the challenging ED setting—specifically the low acuity section—where research showed that residents and students had negative emotions towards patients because they took away from their limited time that could have been devoted to more critical patients (23). Yet and because the ED is considered as being 'an appropriate site of service for a non-urgent presentation or complaint if there are no other available sites to provide timely care to the patient', promoting empathy is of paramount importance (28). Given the constraints of the setting, studying empathy from the side of the communicator and the receiver helped gain insight into both parties' perspectives.

A limitation of this study is that all recruited physician were males because there was only one female physician. This prevented comparison of gender effects on empathy. The setting is another limitation. The study took place at a tertiary care centre ED where the sample population may have been slightly different from that found at other hospitals. Replicating this study at other centres would shed light on the issue.

Conclusions

This study revealed the existence of a difference in the perspectives of patients and their physicians regarding the communicative and interpersonal aspects of empathy. It identified four major themes which could form the basis of an empathy measure for medical encounters in Lebanese and similar settings.

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Conflict of interest: none.

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