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.

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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, Levassuer 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,
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 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 |
|---------------------|---------------------|---------------------|---------------------|
| **Gender** | **Age** | **Race** | **Years in practice** | **Specialty** | **Avg. visit time (min)** | **Avg. no. of patients/day** | **Setting** |
| 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 | DB | 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, OB/GYN; 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.
although saturation of the overall themes occurred at interview 12 [21–23], and the additional cases confirmed the initial findings. Though interview questions were adjusted to search for new information, the themes were consistent across participants.

2.2. Data analysis

Participant interviews were analyzed using open coding to identify primary data points in transcribed interviews. Codes were then further collapsed into categories and themes using axial and focused coding. These coding procedures serve to preserve participant perspectives by gathering data directly from participant statements, thus guarding against researcher bias and lending credibility of the results [22–24]. Two additional research team members, a medical student and a doctoral counseling student, coded interviews and consolidated codebooks to ensure consensus in data analysis. The research team also recorded memos of significant themes and patterns, which were later used to structure the final model. Each interview transcript was read and coded by at least two research team members.

The final model was determined based upon common themes within the interviews, and structured by patterns that emerged in analysis. Research team members completed a final round of critiques and indicated their consensus with the levels and subcategories of the model. Copies of the model were also sent to interview participants to provide input, and changes were made to incorporate the feedback of the two participants who responded.

3. Results

Participant interviews revealed that empathy in medicine is a complex and multi-level process encompassing several factors (Fig. 1). The model is centered on the healthcare professional’s role in facilitating empathic care and is based exclusively on the quotations of the participants. The following sections provide a brief explanation of each component of the model through discussion of categories and subcategories at each level. Participant quotes are referenced throughout (Table 2). The model is structured as a sequential process due to participant descriptions of empathy as being grounded first within physician qualities, continuing through avoidance of potential barriers that may limit empathic opportunities, leading to differing levels of empathic communication, and concluding with consideration of patients and outcomes. Future research could explore whether this is indeed a sequential process, and how each level may function independent of or in conjunction with another.

3.1. Physician qualities

This first level concerns the characteristics of the physician that can potentially impact empathic care. These characteristics are seen as more intrinsic and difficult to change, therefore they represent the first necessary step of empathic care (P21, 346). Physicians may have inherent personal qualities, such as compassion or interpersonal ease, which make them by nature more likely to include empathy in their practice. A motivation to connect with patients, or a feeling of investment in the person of the patient, also adds to the likelihood of an empathic physician (P24, 197).

Competency can also play a role in a physician’s ability to be empathic. As physicians reach levels of expertise they are more likely to have the time and energy to improve empathy and other communication skills with patients. Medical students, residents, and new physicians may be primarily focused on improving knowledge and medical techniques and may therefore have little awareness or desire to practice empathic care (P12, 232).

The way a physician conceptualizes empathy and its role in medicine also may impact how he or she utilizes it with patients. If a physician believes that empathy is primarily a sense of caring or compassion for a patient, he or she may also attempt to limit

![Fig. 1. Conditions for empathy in medicine.](image-url)
Table 2
Selected participant quotes.

**Physician qualities**
I think it’s something that’s innate in people. Some people can get connected with a patient like that (snaps fingers). For some people, it’s a little bit different. P21, 346
So, yes, there are things that are technical, like how you ask things. But a lot of it, I think, is the desire to develop that relationship. P04, 197
They [physicians] may need to learn a little bit about themselves and mature in their field in order to continue to develop and be able to have that rapport with their patients. P12, 232

Then you gotta stop and put yourself in their position and say, you know, their husband is out of work, the poor guy is getting unemployment, you know they can’t afford their medicine, what would I feel like? What would I be like in that position? And you have to kind of understand their situation to be able to go forward and treat them. P18, 207

You know, you’re taught early on in medical school that it’s Mrs. Jones in Room Two. It’s not … It’s not a heart attack in Room Two because Mrs. Jones who is ninety and having a heart attack is totally different than Mrs. Jones who is forty-eight and having a heart attack. You know? You’ve gotta do different things; you’ve gotta think differently because it’s always the disease in the context of the patient. P10, 397

**Internal barriers**
And I suppose sometimes that’s what physicians do, you know, just come in and say you have cancer and walk out and you don’t have to deal with your own emotions. And so it may not be … that they’re not empathetic, they just don’t want to be too vulnerable. You know, cause as soon as you open yourself up you start … becoming too involved with the patients. P08, 364
… A lot of it has to do with timing. When are people coming in? Is it the right time of the day? Is it the right time of the week? How many people have I seen before them? How tired am I? How is my life going outside of work? How focused am I on work at this time? P20, 229

There’s a certain empathy level where people tend to go down with age and time, where people get hardened and bitter with what they’re doing, or bored with medicine, or bored with people, or tired of phone calls, or tired encountering patients. P05, 537
It’s hard to define. But I just feel like empathy is the reflection of the feeling you have whereas sympathy is a shared connection, rather than just a reflection. P17, 78

**External barriers**
I think unfortunately what medicine’s turned to nowadays is it’s less about what the patient’s feeling and more about what is the insurance company telling me I have to do, what I gotta give, and how I’m getting out of here by such and such an hour. P18, 95
But no matter at that point how much you empathize, you still have to get the body back to some sort of livable, physiological state. You can’t have someone with a very, very low blood pressure and empathize. You have to treat them medically, too. So I think empathy maybe takes a back seat – it’s not as important to my job when they have such an acute illness that’s not compatible with life. P17, 206
Especially for primary care, where they are narrowing it down to 15 and 20 minute visits, and you have to do … I mean, there are actual problems, their med lists, and their preventive care … And what, you are going to do this all in fifteen minutes, and you’re going to be caring? P02, 300
Admissions committees are too concerned with grades and research and all that stuff, which doesn’t mean anything because those are going to be the doctors that sit down and have monotone voice and don’t really listen to patients. P06, 231

**Initial empathy**
I think you can certainly teach behaviors that can emulate it [empathy]. It may not be pure empathy, but you can … Behaviors are things that are taught that people can do. You can teach people to go in, sit down, and look them in the eyes. You can teach people to speak, um … to speak plainly in laymen’s language and not use medicalese. P21, 348

We can be attentive to their comfort, you know “is it too cold in here for you?” you know, “how was your parking?” That sort of … just starting to relate as humans. P01, 126
Learned empathy is probably … you know, sooner or later the patient will call you on it. Um, so you have to be genuine about it, P08, 337
But you certainly can learn, I think, those skills to some extent. You can fake it. P03, 363

**Genuine empathy**
I think you gotta stop there and put yourself in their position and say “if I were that patient, where am I? What’s happening to me, what’s going on?” I think you find a whole different picture, you realize that oftentimes when people aren’t doing what you ask them to do or can’t comply, cause they’re struggling, they’re struggling emotionally, physically, financially. P18, 214

You have to care, because if you don’t care you don’t listen. And if you don’t listen you don’t know. You know, you have to listen to the patient who is trying to tell you the diagnosis. P16, 172

At the end of the day we didn’t do too much, you know changing what the medication this person’s on, but it’s the interaction and things like that they value. You know, and myself as a physician they call it, it … itself is a therapeutic intervention. You know, it’s not the medicine, it’s just us as physicians. P08, 148
I think what has happened is you get the ability to relate to these people in more than the disease entity, but rather as people, as patients, as friends, and not as customers. P16, 60

**Patient role**
You tend to lose your empathy – I do, to a degree – for people who wait until the last minute … It’s kind of hard to feel sorry for that person, you know? I think when there is no effort put forth on the part of the patient to help themselves, and their expectations are unrealistic – like I can’t do everything for them. P07, 173–179
A lot of this medical stuff, it’s another language, and some physicians don’t speak English; they speak in ‘medicalese,’ which patients will just say, ‘Okay, Yup. Mm hmm. I understand,’ and really not. P21, 101
I think probably subconsciously, there is probably a certain selfishness to this. When they [physicians] see someone that they identify with, I think in some way it’s almost like they’re treating themselves. And if it’s somebody they can really identify with, I think it’s easier to empathize with them, and you say, “Wow. This could be me.” P20, 243
Yeah. Some people just aren’t very nice. You know? Some people who come in, they’re kind of endearing … And some people are just horribly mean. And they were mean to start with, and now you put them in a bad situation – they just become downright brutal. And there are just some people you don’t want to go and deal with, and your interactions are just very, very short because you don’t feel like taking their abuse. P14, 333

**Results of empathy in medicine**
Empathy encourages an activated patient. And that’s the best we can do. If you have a … a consistently nonjudgmental physician, who’s oriented toward patient-centered medicine, and you have a patient that’s activated, they are interested in their health, they’re informed, they’re willing to contribute, and they feel power in the relationship, that’s the best we can do. P01, 212
We may write a lot of prescriptions, but what really counts is how do patients feel about things? What’s going to get them better? And I think a lot of what goes [toward that] is empathy in [helping] build relationships and trust, and I’m sure it improves compliance with therapy. P15, 206
I think that can actually play an impact in the legal side of things where, ‘Well, that doctor was mean, and he doesn’t care about me, and he this bad thing happened, so I’m going to sue him.’ Versus, ‘This terrible thing happened, she called me in the hospital, she’s so sad, too, it wasn’t really their fault.’ I think it can have small, everyday flow of office impact. But I think it can have a huge, overall impact, as well. P13, 148
I mean, I think that’s one thing that makes the job rewarding: to have those relationships. To understand – you’ll never understand what someone is going through – but to have some insight into what their thoughts are, what their feelings are doing usually a very difficult time in their life. P21, 362
empathic connections so as not to become emotionally exhausted by personal investment in patient issues. Physicians who view empathy as understanding the patient’s perspective may not feel this need for emotional distancing and will likely be more concerned with cognitive processes and accurate reflections (P18, 207).

Finally, empathic physicians value flexibility in assessment and treatment of patients based on individual and situational factors (P10, 397). These physicians pay attention to subtle cues from patients, or recognize biopsychosocial factors that enable unique treatment plans for each patient.

3.2. Internal barriers

Physicians may possess some or all of the personal qualities that can contribute to empathy, yet experience temporary internal barriers that impede empathic treatment. For instance, physicians may impose professional boundaries or emotionally distance themselves from their patients out of fear of over identifying or becoming enmeshed (P08, 364). Others may view themselves as authority figures, which can result in not listening to the patient or failing to elicit patient perspectives regarding their condition. Still others may be fearful of criticism or an error in judgment and be unwilling to listen to the patient and demonstrate empathy toward them. Also, physicians who are sick, exhausted, or discouraged by the medical system may not have the energy to demonstrate empathy (P05, 537). In addition, physicians who confuse empathy with sympathy can become burnt out as they become unnecessarily burdened by their patients’ situations (P17, 78).

3.3. External barriers

Similar to internal barriers, external barriers can prevent empathic physicians from achieving optimal empathy. Participants identified managed care and the business focus of the medical system as significant external barriers to providing empathic care (P18, 95). Restrictions on reimbursements and prescriptions, paperwork requirements, and standardized treatment serve to de-emphasize the physician/patient relationship. High-pressure scenarios and life-threatening medical conditions also serve to move empathy to the back burner as physicians attend to more immediate needs (P17, 206). Furthermore, a high volume of patients and short patient visits leave little time for anything beyond checklists and quick goal-setting (P02, 360). Additionally, many participants indicated that current medical students are ill prepared to provide empathic treatment due to medical school admissions emphasizing measures of intelligence over compassion, and curriculum favoring clinical knowledge over patient communication skills (P06, 231).

3.4. Initial empathy

Provided that the physician possesses some or all of the personal characteristics identified as facilitating empathy, and internal or external barriers do not limit his/her ability to be empathic, a primary level of empathy may be achieved. Although not “genuine empathy,” this initial level may include such items as attention to the patient’s level of comfort, practicing timeliness with visits, or sitting down with patients rather than standing (P21, 348; P01, 126). These actions are likely well received and may be sufficient for patient satisfaction, though patients may also perceive the physician to be mechanical or disingenuous (P08, 337). Initial empathy also includes important communication skills such as active listening and the use of open-ended questions. Also referred to as microskills or communication skills, these skills can be easily taught to most people and can be employed even if a healthcare provider does not have a deeper, genuine, empathic connection (P03, 363). The physician's primary focus in this stage remains on treating the disease.

3.5. Genuine empathy

This level is an extension of the previous level in that it utilizes microskills while also involving a compassionate connection between physician and patient. Physicians at this level care for their patients as individuals and are concerned with understanding the patient’s perspective. They are aware of nonmedical factors and sensitive to how these factors might impact treatment (P18, 214). In addition to understanding the patient, physicians at this level are able to communicate their understanding back to patients through accurate reflections of patient statements and acknowledgment of emotions. Additionally, in this stage physicians are concerned with treating the whole person, rather than just the disease. Several participants remarked that the empathic connection itself can be healing for patients, and can inspire physicians to focus on patient concerns beyond what is necessary for a diagnosis or treatment plan (P08, 148; P18, 60).

3.6. Patient role in physician empathy

Although this model focuses on the physician’s perspective of empathy in medicine, patient receptivity to the physician’s attempts at empathic communication influences whether physicians are able to provide empathic treatment. Patients who are angry or who have other intentions, such as drug seeking or malingering behaviors, will likely prevent an empathic connection (P07, 173).

Patients must have faith that their physician is acting in their best interest, and should also be able to understand their treatment plans. Patients who have intellectual disabilities, language differences, or who are unfamiliar with medical terminology may lack full understanding of treatment options (P21, 101). If physicians are not sensitive to barriers in patient comprehension, or if patients do not disclose lack of understanding, both empathy and successful treatment will likely be compromised.

Finally, certain patients may be easier to connect with than others, thus influencing the extent of physician motivation and ability to respond empathically. For instance, physicians may find it easier to connect with patients who are similar to themselves or their family members (P20, 243). Also, patients who are vulnerable, whether by terminal condition, age, or disability, may trigger responses that result in more comprehensive or sensitive care (P14, 333).

3.7. Results of empathy

Provided that empathy has been at least minimally facilitated in each preceding level, it is likely that physicians and their patients will experience some of the outcomes of empathic treatment. These outcomes, identified by participants as unique to empathic care, enhance medical treatment through increased patient engagement in the medical process, willingness to provide information and seek clarification, and interest in acting as collaborators in their own treatment (P01, 212). Empathic physicians are able to provide more individual patient care that is sensitive to patient realities, which increases compliance and treatment efficacy as patients are more likely to follow through with taking medication, appearing for follow-up appointments, and making lifestyle changes (P15, 206). Participants reported that the quality of the physician/patient relationship also improves as a result of empathic treatment, which they felt was also correlated with lower incidence of malpractice claims (P21, 362).
4. Discussion and conclusion

4.1. Discussion

This model demonstrates the dynamic and complex nature of empathy in the medical setting. Participant interviews revealed potential barriers that may limit the application of empathic treatment and highlighted physician characteristics and considerations for facilitating empathic practice. The use of qualitative methods captured the nature of empathy through the experiences and perspectives of healthcare professionals, resulting in a model that is both thorough and based on practical examples.

Though the final model was determined through participant accounts, its content aligns in many ways with existing literature. Within the theme of physician characteristics, participants identified motivation to connect as a key determinant of empathy, which seems to support the concept of moral empathy in medicine [5]. There were also several behavioral elements that were seen as indicative of empathy in the medical interview, ranging from communication skills to demonstration of deeper understanding [5,16,17]. Participants echoed many of the findings from previous studies regarding the benefits of empathic treatment, such as adherence to treatment and relationship satisfaction [1-7]. Participants had mixed opinions on the question of whether empathy is an intrinsic quality or whether it can be nurtured through training, which is also consistent with current perspectives in the literature [8,9,17]. Future research will be needed to test this model and determine the degree to which it clarifies, contradicts, or enhances an understanding of the practice of empathy in medicine.

4.2. Conclusion

Certain limitations and delimitations inherent both in the nature of qualitative research as well as the specific details of this study warrant discussion and should be considered when applying results. Although every attempt was made to ensure that the results of this study accurately portrayed the opinions and experiences of participants, the limitations may impact the degree of universality of the model. Therefore, future research should examine the model and claims made by this research to add credibility and applicability to participant accounts and theoretical interpretations.

One potential limitation of this study concerns any researcher biases that may have impacted data gathering and interpretation. Researcher bias is frequently cited within qualitative research, as research design requires connections and assumptions that may inadvertently involve drawing upon previous thoughts [21,22]. However, attempts at controlling bias can at least minimize this effect and hold researchers accountable for efforts to maintain objectivity. In this study a research team was formed to provide alternate interpretations of data, ensure through consensus coding that data was not being manipulated away from the intent of participant accounts, and review the final model for fit and accuracy. The model was also sent to participants for review in an attempt to highlight potential misinterpretations or inaccuracies and the minimal responses were used for further clarification of larger themes.

One clear researcher bias is that empathy is important in medical care. Some degree of control over this limitation was attempted by including questions in interview protocol that presented opportunities for participants to discuss empathy’s limitations or disown it as an applicable strategy. The final model thus captures some instances when empathy may not be essential in medicine and also acknowledges that a more superficial level of empathy could be sufficient in most settings.

An additional limitation common to qualitative research is the issue of participant selection. Most initial participants were identified through a list of top-scoring physicians within the teaching hospital system at a local medical school. Later in the research process participants in specialty areas underrepresented in the initial samples, such as pediatrics and psychiatry, were contacted to ensure broad representation. Participants consisted mostly of professionals within the medical school/teaching hospital and community private practice settings. It is unclear how participants of this study might compare to professionals in unexamined settings or communities. Participants varied in age, gender, race, and ethnicity, though the majority was male and Caucasian. Therefore, though efforts were made to find a variety of perspectives, participants of this study may be different from professionals in other settings, and any application of the model developed as a result of this study should take this limitation into account.

4.3. Practice implications

Initial findings for this model suggest several implications for medical practice and training. First, the model contains seven levels, which could each be assessed to determine whether optimal conditions for empathy exist. Furthermore, the model could be utilized in future research or clinical practice to determine how interventions could facilitate empathy at each level or subcategory. The internal and external barriers in particular may be important to consider, as removing or alleviating barriers might be more time-effective than interventions at other levels of the model. Hospitals or practitioners who wish to facilitate more empathic patient care could thus refer to this model to assess current strengths in providing empathy as well as to identify areas for improvement.

The model also has implications for physician training and development. First, the consensus among participants that empathy is intrinsic and difficult to enhance without some sort of previous disposition, whether genetic or learned, suggests that medical schools seeking to train highly empathic physicians should assess for these qualities in admissions. This model may not have fully captured all of the required criteria to measure empathy levels in an individual, but such assessments could be instrumental in selecting students.

Regarding training, this model suggests that teaching communication skills and techniques to relate to patients may indeed facilitate a minimal level of empathy. Though genuine empathy may be difficult for some individuals to achieve, based on personality or situational barriers, at minimum a level of initial empathy could enhance patient and physician satisfaction. Therefore, training programs should continue to provide students with the “tools” of empathy. However, this model does indicate that much of this training, while helpful, cannot fully develop the conditions necessary for genuine empathy to occur. Training programs should thus keep in mind the goals of training and develop assessments of student progress accordingly.

On a systemic level, themes from participant interviews revealed a need for renewed focus on empathy and patient-centered care in medicine. Participants expressed concern over the limitations imposed by managed care and seemed to view the situation as a trend that was both unfortunate and largely irreversible, unless a restructuring of the current medical system occurred. This concern suggests the need for future research on how to blend empathic treatment within a system structured by competing values.
Disclosure

I confirm all patient/personal identifiers have been removed or disguised so the patient/person(s) described are not identifiable and cannot be identified through the details of the story.

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Ethical approval

This study was approved by the Old Dominion University Institutional Review Board for human subjects research.

Disclaimers

The primary author conducted this study to fulfill requirements for dissertation research. The additional authors are members of the dissertation committee and provided guidance throughout the design, implementation, and writing of the study.

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