

The Doctor-Patient Relationship: How a Physician Navigates Clinical Empathy and Patient  
Death

by  
Hannah Smith

A THESIS

submitted to

Oregon State University

University Honors College

in partial fulfillment of  
the requirements for the  
degree of

Honors Baccalaureate of Science in Biology  
(Honors Associate)

Presented May 17, 2019  
Commencement June 2019



## AN ABSTRACT OF THE THESIS OF

Hannah Smith for the degree of Honors Baccalaureate of Science in Biology presented on May 17, 2019. Title: The Doctor-Patient Relationship: How a Physician Navigates Clinical Empathy and Patient Death

Abstract approved:

---

Courtney Campbell

As the importance of empathy in medicine has become more understood the dynamic of the patient-doctor relationship has changed. However, how to properly incorporate empathy into a healthcare relationship has not been thoroughly investigated. There is also continued disagreement on how to appropriately define empathy in a healthcare setting. The objectives of this research paper are to discuss these topics in further detail. In addition, there has been limited research regarding the impact on grief and coping with patient death when physicians form empathetic relationships with their patients. This research paper seeks to analyze this in further depth to investigate whether the empathetic model of patient care causes more emotional distress for physicians in the face of patient death. In order to answer these questions, an in-depth review of the literature on this subject was performed. Then one-on-one interviews with eight physicians were conducted to gain a first-hand account of these topics and further the understanding of the literature review. The findings of this study emphasized the components of emotional attunement, engaged curiosity, and skillful cognition by the physician in defining clinical empathy. The practice of clinical empathy relies on effective communication skills, the establishment of mutual trust, and the building of appropriate boundaries through shared decision-making between the doctor and the patient. The literature review and physician interviews had a mix of answers regarding whether forming empathetic relationships with patients made coping with their death or poor clinical outcomes more difficult. The conclusion was that regardless of whether it made it more challenging, forming empathetic relationships with patients was still worthwhile and adds richness to the medical profession.

Key Words: patient-doctor relationship, clinical empathy, shared decision-making, grief, patient death

©Copyright by Hannah Smith  
May 17, 2019  
All Rights Reserved

The Doctor-Patient Relationship: How a Physician Navigates Clinical Empathy and Patient  
Death

by  
Hannah Smith

A THESIS

submitted to

Oregon State University

University Honors College

in partial fulfillment of  
the requirements for the  
degree of

Honors Baccalaureate of Science in Biology  
(Honors Associate)

Presented May 17, 2019  
Commencement June 2019

Honors Baccalaureate of Science in Biology project of Hannah Smith presented on May 17, 2019.

APPROVED:

---

Courtney Campbell, Mentor, representing the School of History, Philosophy, and Religion

---

Eric Hill, Committee Member, representing the University Honors College

---

Sarah Sheldrick Committee Member, representing the School of Arts and Communication

---

Toni Doolen, Dean, University Honors College

I understand that my project will become part of the permanent collection of Oregon State University, University Honors College. My signature below authorizes release of my project to any reader upon request.

---

Hannah Smith, Author

## **Chapter 1: Importance of Clinical Empathy**

*“I could see myself in her: immigrant, growing up in the same place, similar goals of living the American dream. But the idea of her cancer could not leave my mind. As she was dreaming, eating, laughing, her cancer was feeding itself, decreasing her chances of seeing her kids grow up with the same dreams. I wanted to ask her how she could be so strong and composed, smiling and making jokes...Afterward I felt guilty for not thinking about her throughout [the procedure]. My scientific interest in patient experience had originally attracted me to the field of medicine, but now, after talking to her I felt guilty looking inside her with a scope. I felt as if I had invaded her, and after having connected to her, I felt almost invaded myself...Was it too dangerous to be emotionally connected to the patient?”*

*Given another chance, I would still have talked to her as I did and probably would have connected just as much. I do not want to become a doctor who does not know her patients. But how do you provide good care when you cannot remain productive and objective? I tried to think of how I would want my doctor to act and which questions I would want to hear 2 hours after my surgery.” (Pories, Jain & Harper, 2006)*

Dr. Yana Pikman, a pediatric hematologist-oncologist for the Boston Children’s Hospital describes an emotional encounter during her medical training in which she had to operate on a young woman with metastatic cervical cancer. Pikman explains the difficulty of separating her emotional connection with her patient from her responsibilities as a physician, though she remarks that the establishment of a personal connection with the patient was valuable. This excerpt from *The Soul of a Doctor: Harvard Medical students face life and death* reveals the strain many doctors experience when attempting to navigate the emotions of a medical career.

These facets of so-called “soft science” within healthcare are instrumental in developing the medical profession.

Most paramount to the profession of medicine is the relationship cultivated between patient and doctor. Physicians must trust the information given by the patient to move forward with a diagnosis, and the patient has to be willing to divulge personal and intimate details about themselves as well as allow physical contact from an otherwise perfect stranger. A study conducted by Dr. John Kelley (2014) from Harvard University found that better patient care was linked to stronger patient-doctor relationships. Patients with empathetic physicians felt more encouraged to communicate details of their health which enabled physicians to make a more accurate diagnosis (Kelley, 2014). Patients that had better relationships with their healthcare providers were also more likely to follow the treatment path and believe that it would work (Kelley, 2014).

The importance of perceived empathy within the patient-doctor relationship cannot be understated and has been long examined in the healthcare field. One medical school professor summed it up by claiming, “We cure with modern medicine, and we heal with our presence and compassion” (Tsang, 2013, p. 79). When patients believed that their physicians cared, more information was exchanged (Kelley, 2014). The use of empathy is beneficial on many levels as it has shown to reduce anxiety in patients, improve the accuracy of diagnosis, increase the likelihood a patient will adhere to the treatment path, and reduce the experience of burnout (Hirsch, 2007, p. 426). Perceived empathy also had the most impact on patient satisfaction reports (Kim, Kaplowitz, & Johnston, 2004). As a result of these findings, the American



Association of Medical Colleges (AAMC) has incorporated teaching strategies aimed at instilling and maintaining empathy within the profession.

Given the significance of empathy within the patient-doctor relationship, I wanted to investigate what the further implications were for doctors that have to cope with patient death and poor clinical outcomes. The goal of this research paper is to take an in-depth look at the emotions within this relationship, how an empathetic relationship is cultivated, and how it is defined. My interest in this topic began with my own loss, and I was curious about how people that experience death routinely could still actively engage and develop new and meaningful relationships with other patients. Further, given the many advantages of empathy within the patient-doctor relationship I wanted to analyze a possible negative consequence of this healthcare model and determine whether it makes coping with patient death more challenging.

## **Methods Section**

The primary objectives of this research study are to procure a more specific definition of clinical empathy within a patient-doctor relationship, to investigate the differences between traditional forms of empathy and clinical empathy, and to discuss how clinical empathy is established. From there, the goal is to identify what the impact is on a physician when a patient they formed an empathetic relationship with dies compared to the emotions experienced by a physician who portrayed the previously widespread “detached concern” model of care.

To address these questions I used a two-sided approach by interviewing physicians as well as analyzing existing literature on the subject to aid my interviews and provide background information regarding patient-doctor relationships. The initial research emphasized the

importance of empathy within healthcare relationships and then built upon that by investigating the emotional world of physicians. Expressions of empathy were often compared to emotional disclosures within the literature. Empathy was considered both a positive and potentially negative aspect of emotions in the patient-doctor relationship, though there are many other complex emotions within the profession. This research study focused primarily on empathy and the emotions following patient death. The literature chosen for the project was used to supplement the questions asked within the interviews and to address other aspects of the research that could not be taken from the in-person discussions. Following IRB approval, eight physicians were asked eleven questions concerning clinical empathy to establish first-hand accounts of this terminology and what it meant to a variety of physicians. The goal of the interview process was to enrich topics brought up within the literature reviews and also allow for the opportunity of a second opinion, to hear what other physicians had to say on these intimate topics. This created a more original interpretation of the data collected in the literature analysis. Each of the doctors were in different specialties and various stages of their profession ranging from surgical specialties and pediatrics to retired and practicing physicians. The purpose of this was to show the ways the emotional connection within a patient-doctor relationship can also be influenced by specialty.

The emotional side of healthcare is largely ignored, though several studies have investigated how empathy and emotional development can both positively and negatively impact the profession and patients. In order for a doctor to give the best quality of care, there needs to be a deeper understanding of clinical empathy and how to appropriately handle the complexities of patient death in the face of these emotional connections the profession is now calling for. This

research also illuminates the emotional side of health care and can provide insight into those interested in the profession or readers hoping to learn what to look for in a caring physician and further understand the dynamics of this field. After all, since patients stand to benefit from improved patient-doctor relationships they have just as much stake in the research as physicians.

In the next chapter, the literature will be summarized by giving a brief history on the dynamics of a patient-doctor relationship, the definition of clinical empathy, and a cursory explanation on the emotional experience of patient death. This will bring up insights that will later be developed in the interview process. The interview portion will be presented in chapter 3 in which general trends from the physician's responses will be discussed and juxtaposed with the literature analysis. Chapter 4 presents the conclusions of this research and why it is essential for physicians, prospective medical students, and patients. It will also address other avenues of research that should be further examined.

## **Chapter 2: Literature Review**

*“The secret of the care of the patient is in caring for the patient.”*

*-Dr. Francis Peabody*

### **History of an Evolving Relationship**

Sir William Osler (1906), the “Father of Modern Medicine”, taught that “the good physician treats the disease; the great physician treats the patient who has the disease”. Osler believed that doctors should operate with compassion; however, he also argued that the leaders in this profession must maintain equanimity and be imperturbable. He described imperturbability as an inherent virtue that physicians should work to maintain so that they appear as “calmness amid storm” (Osler & Camac, 1906). He was not alone in these ideals as early physicians viewed the demonstration of emotion at odds with competence in the profession. Many physicians of this time were unconcerned with establishing empathetic relationships with their patients and instead argued against them (Osler & Camac, 1906). The process of defining how best to practice medicine has been created on a trial and error process, eventually leading to the empathetic and collaborative approach of today.

Given the teachings of Osler and other prominent figures, it is unsurprising that the goal of establishing empathetic relationships with patients was not always part of Western medicine’s design. The history of Western medicine has been broken down into four central “ages” by Dr. Mark Siegler (2011), a respected physician known internationally for his research in the field of medical ethics. Dr. Siegler incorporated the works of Pedro Laín Entralgo, a Spanish historian of medicine, into his analysis. The primary period was termed the “age of the doctor” or the “age of paternalism” (Siegler & Entralgo, 2011, p. 12). In this period, physicians were viewed as

authoritarians and patients were told their responsibility to their health. This period lasted the longest with some estimates tracing it back to 500 B.C. and dominating into the 1960s (Siegler & Entralgo, 2011, p. 12). The goal of the physician was to provide the prognosis and symptomatic relief, not emotional support; the patient was exempt from the decision-making process, and complete trust had to be placed in the physician's technical skill and knowledge (Siegler & Entralgo, 2011, p. 13). This traditional role, though it had its limitations, did function to serve the basic needs of patients for a sufficient passage of time. However, paternalism had apparent shortcomings. Patients could not communicate their health goals with their physicians, and their concerns could not be adequately addressed. This model of medicine is still practiced, though it has taken a backseat to some of the other types of patient-doctor relationships.

The next era was characterized by improved patient control, so it is referred to as the "age of the patient" or the "period of autonomy" (Siegler & Entralgo, 2011, p. 14). This healthcare model was first practiced after World War II and lasted until the early 2000s. During this time there were significant advances in medicine and the understanding of illness. This shifted treatment focus from alleviating symptoms to addressing the source of the disease. While this provided many opportunities for patients, it was also costly, especially since preventative medicine was lagging behind (Siegler & Entralgo, 2011, p. 14). In the United States, the cost of care was typically covered by third parties and not by the patients' themselves. Perhaps the most transformative feature of this period was the establishment of informed consent as a legal concept (Siegler & Entralgo, 2011, p. 14). This provided a shift of power in favor of the patient and quickly became a central characteristic to modern medicine. While this period offered many benefits to the patient, the model was later determined to be inefficient because of rising

healthcare costs and relatively inadequate treatment compared to the paternalistic model (Siegler & Entralgo, 2011, p.14). However, the value of patients retaining power and control in their healthcare is maintained in the current medical model. Patient autonomy is also an essential component of empathy-driven relationships between doctors and patients which makes it a primary feature in the shared decision-making model that is practiced today.

The third age, which began only recently (within the last few decades), is known as the “age of bureaucracy” (Siegler & Entralgo, 2011, p. 15). In this period public powers, like the government, came to be seen as responsible for covering the price of healthcare. The dynamic of medicine shifted because the cost to society became a consideration in healthcare decisions (Siegler & Entralgo, 2011, p. 15). The government became a third party into what was previously only a patient and doctor relationship. Now, the quality of care had to be balanced with the monetary burden of treatment for the population. This period contrasts with the other two in that the patient’s best medical interests are no longer the only concern. Instead, the good of the patient must be in balance with the good of society. For obvious reasons, this was frustrating for both patients and physicians. It was abruptly replaced with the final age of medicine.

The fourth and present age of healthcare demonstrates why the development of empathy within the patient-doctor relationship is so vital to modern medicine. Power is meant to be equally vested in both parties as the patient and physician take a collaborative approach to the patient’s healthcare needs (Siegler & Entralgo, 2011, p. 16). Since both parties are working towards a common goal, it is emphasized that they work together in this period. Doctors and patients alike have clear expectations for one another when following the treatment path. The

benefits of this model include improved trust and confidence in doctors (Siegler & Entralgo, 2011, p. 17). The previous model of paternalism and the model of patient autonomy created adversarial tension between the patient and doctor that limited the quality of care (Siegler & Entralgo, 2011, p. 13). Healthcare decisions are also more fiscally realistic for the patient in this dynamic as they can discuss various treatment options and their costs with the physician (Siegler & Entralgo, 2011, p. 17). In addition, there is better cooperation with treatment plans, patient satisfaction has increased, and medical outcomes on chronic illnesses have improved (Siegler & Entralgo, 2011, p. 17). All of these benefits are accessed when a physician is able to cultivate empathy within the patient-doctor relationship. This approach combines the most salient characteristics of each period in order to balance the power of both the patient and the physician in addition to maintaining consideration for the cost of medical care.

Though it was not a practiced model until the late 1980s in the United States, shared decision-making in medicine is not a new concept (Siegler & Entralgo, 2011, p. 16). Plato (1967) initially described the idea in Book IV of *The Laws* in which he stated weak patient-doctor relationships and paternalistic models of medicine were akin to “slave medicine.” He wrote (1967):

The physician never gives the slave an account of his problems nor asks for any. He gives some empiric treatment with an air of knowledge in the brusque fashion of a dictator and then rushes off in haste to attend to the next ailing slave.

Plato described a healthy patient-doctor relationship as one in which the physician explains to the patient what the treatment options are and the patient cooperates with the treatment only when they trust the physician and their recommendations. In this way, if a patient chooses not to follow

the treatment path it is the fault of the doctor for not creating a trusting, empathetic relationship with the patient. It took many centuries for these ideals to be practiced, but they have proven to be a useful model of treatment with a multitude of benefits.

### **Detached Concern**

The roots of medicine, in the “era of paternalism”, created the image of a physician as expressionless and emotionally removed. Even as the importance of empathy became more understood, the image of the physician did not change. This is reflected in popular culture with television doctors like Dr. House and Ben Casey and in shows that portrayed physicians as satirical and emotionally distant such as in *M\*A\*S\*H* or *Scrubs*. Instead, Osler’s illustration of “equanimity” in physicians was replaced with the almost synonymous terminology of “detached concern”. Under this model, healthcare professionals were still unable to tap into the numerous benefits of the empathetic and collaborative relationship. So while physicians were discussing the possible improvements in medicine through expressing empathy, they lacked an understanding of what that truly meant.

Knowing the advantages of an empathetic relationship and learning how to establish one are a little different, and with a shortage of time, it becomes essential to learn how to make every second count. Empathy is defined as: “the ability to understand and share the feelings of another” (Merriam-Webster's collegiate dictionary, 1999). In the context of a medical relationship, this definition becomes more specific, but the way to accurately described it has proven elusive. Dr. Danielle Ofri (2013), author of *What Doctors Feel: How Emotions Affect the Practice of*



*Medicine*, wrote “Empathy is one of those odd concepts that is so central to human interaction, so obviously a requirement in medicine...yet so difficult for many to precisely define” (p. 10).

A study conducted by Jodi Halpern (2003), a professor of bioethics and medical humanities, sought to measure clinical empathy in more precise terminology. Halpern juxtaposes clinical empathy with traditional forms of empathy by explaining that outside of the walls of hospitals, empathy primarily involves emotional resonance, while physicians have been taught to display empathy as a “form of detached cognition” (Halpern, 2003, p. 670). The Society for General Internal Medicine defines the term as “the act of correctly acknowledging the emotional state of another without experiencing that state oneself” (Markakis, Frankel, Beckman, & Suchman, 1999). Instead of emotional resonance, empathy becomes a cognitive understanding; experiencing the emotion by oneself is superfluous for the construction of clinical empathy (Halpern, 2003, p. 674). A physician cannot always completely understand the breadth of emotions a patient may have and a sympathetic physician may over-identify with patients, which is thought to cloud their judgment (Aring, 1958). In these ways, emotions have always been seen as needless or inhibiting, even in discussions of clinical empathy.

The replacement of the emotionless doctor for so-called “empathy” initially fell short in definitions and in practice. In the 1960s empathy in healthcare was described as “neutral empathy” which was defined by the importance of detached reasoning with only an observation of a patient’s emotions (Blumgart, 1964). Halpern illustrates this model of care through the story of an obstetrician trying to approach an anxious patient (Halpern, 2003, p. 672). This type of empathy relies on emotional labeling followed by an explanation from the physician for why the patient may be showing a certain emotional response. The obstetrician understands that

childbirth can cause some patients to exhibit signs of nervousness. When confronted with a troubled patient he began to discuss pain management options and the steps of a labor and delivery procedure without pausing to check in with the patient (Halpern, 2003, p. 672). In this practice, emotions are assumed and rarely discussed. He noted that the patient was still anxious and asked if she had any other concerns (Halpern, 2003, p. 673). The patient reassured him that she had no hesitations but promptly switched obstetricians. When questioned about her decision she claimed that she felt the physician expressed sincere concern, but that she felt her fear was not appropriately addressed (Halpern, 2003, p. 673). As a rape victim, the patient was concerned about feeling violated during the procedure, and his assumption of pain management made her feel stifled (Halpern, 2003, p. 673). Halpern explains that incorrect emotional assumptions are not uncommon for this model because it does not allow for the dynamics of interpersonal interaction and limits the physician to their own cognition of the patient's circumstances. She reasons that emotional attunement is a necessary part of the definition of clinical empathy because of these shortcomings. Halpern (2003) clarifies this point further:

The skeptic might ask, can't a detached but thorough physician notice the patient's gaze? The answer is yes, of course. However, it would be difficult for even the most thorough but non-intuitive physician to consciously observe and attend to the dozens of signals that have emotional import in each patient interview. Emotional attunement spontaneously directs attention to some aspects of patient's histories over others (p. 672).

Logic by itself is not enough for a physician to understand and express clinical empathy. There has to be an emotional component to enhance patient interactions (Halpern, 2003, p. 674).

“Neutral empathy” therefore has minor improvements from the “detached concern” model but it is still inefficient at addressing the myriad of emotions within a healthcare relationship.

However, traditional definitions of empathy cannot encompass the professional use of it as she describes. Imagining how another may feel or putting oneself in another’s shoes is analogous to daydreaming, which a physician does not have time to do (Halpern, 2003, p. 671). Though clinical empathy is still an emotional experience like traditional empathy, it must be a skillful one. Physicians have multiple patient interactions in a day, and the discussions must fall in a short time frame. Understanding emotional nuances is a necessity, but it has to be done in a timely fashion (Halpern, 2003, p. 671). The obstetrician addressing the common anxieties of childbirth with the patient is skipping an emotional evaluation to save time but ends up wasting a portion of the appointment attempting to calm a fear that never existed. By emotionally attuning to the patient the doctor must be an active and careful listener (Halpern, 2003, p. 671). Brief moments spent uncovering a patient’s genuine concerns and giving them a chance to speak can prevent unnecessary explanations and improve the quality of the relationship. Having competent emotional resonance capabilities allows for valuable shortcuts in patient-doctor interactions.

In Jodi Halpern’s (2011) book *From Detached Concern to Empathy: Humanizing Medical Practice*, she details a case in which a patient refused dialysis treatments despite the knowledge that she would die without the treatment intervention. She was in her mid-fifties and had multiple amputations because of her diabetes mellitus, her husband had just left her, and she did not see any point in living (Halpern, 2011, p. 4). In this patient’s case, modern medicine had the capacity to treat her, but the medical professionals did not. The issue, Halpern claims, was that the medical team was focused on the tangible facts of the patient’s case to justify her choice

to die (Halpern, 2011, p. 6). “As if ticking off items on a checklist: Was she cognitively impaired? Did she have the legal right to refuse treatment? Have attempts been made to establish a therapeutic alliance?” (Halpern, 2011, p. 4). However, the target problem was that the patient, whom she refers to as Ms. G, was operating under irrational emotional reactions. This is expected under circumstances like illness and personal strife, but her distress encouraged her to seek control through a damaging and permanent decision.

Instead of viewing her decision to die as a “strategic psychological response” to her misery, the doctors confirmed her appraisal of hopelessness and allowed her to move forward with the choice to end her life (Halpern, 2011, p. 6). Since patient autonomy is a primary consideration in the new wave of medicine, nothing else could have been done to assist the patient. However, Halpern (2011) describes how forming an empathetic relationship with the patient would have encouraged Ms.G to take her dialysis treatment. Empathetic relationships can be used as a tool to help patients that may be opting out of or having difficulty complying with the treatment path. Since people make irrational decisions that compromise their health every day, the role of the doctor has to expand beyond the reach of medical facts to encourage the patient. As Halpern explains, the way to do this is to invest in the relationship emotionally and maintain “engaged curiosity” with the patient. “Engaged curiosity” is her shorthand definition for clinical empathy (Halpern, 2011, p. 113).

When she reflected on her exchange with Ms. G, she noted that the medical team, herself included, had responded with “detached concern” (Halpern, 2011, p. 25). They were mirroring the patient’s perspective of hopelessness and playing into it by allowing her to shut them out and by agreeing that her future was doomed (Halpern, 2011, p. 4). They spoke to the patient in soft

voices and apologized to her repeatedly for her circumstances (Halpern, 2011, p. 18). One of Ms. G's doctors told Halpern that he would make the same choice as the patient if he was in her position (Halpern, 2011, p. 5). Of course, this made it easier to handle a situation in which the physicians saw a woman in pain who was not permitting them to help her, but it did not change the situation or solve the patient's problems. This is where "engaged curiosity" is intended to come in and where the line of clinical empathy is drawn in the patient-doctor relationship. The healthcare providers put themselves in the patient's shoes and saw her misfortune, but in doing so, they orchestrated a theater that validated the patient's emotions while simultaneously confirming her decision to die. This method of care is parallel to traditional definitions of empathy, but it does not operate well in a healthcare interaction. Instead, the doctors should have let the patient know that she was making a permanent decision while she was stuck in a very narrow and temporary state of mind by using the phrase "right now" when addressing the patient's circumstances (Halpern, 2011, p. 72). Using "right now" while discussing a dilemma to the patient reaffirms the notion that the current state of turmoil is a temporary one. This is where traditional forms of empathy must be separated from the definition of clinical empathy. While it is fine to see things from the patient's perspective, it is crucial to maintain cognition and emotional control. In these moments, Halpern recommends affirming the recognition of the patient's emotional state while at the same time reminding them that the feelings they may be having at the moment will pass.

According to the research on defining clinical empathy, it is part emotional attunement and part recognizing a patient's emotions on a cognitive level. Ofri (2013) echoes a similar perspective to Halpern's description of empathy in a clinical interaction by claiming it "requires

being attuned to the patient's perspective and understanding how the illness is woven into this particular person's life. Last-and this is where doctors often stumble-empathy requires being able to communicate all of this to patient" (p. 10). The empathetic physician is engaged with the patient, actively listening to them, and noticing nonverbal communication. They are aware of their emotional expressions or how their wording impacts patients (Halpern, 2003, p. 673). Clinical empathy is considerate while maintaining an intellectual assessment of the patient's best interest.

### **Grief in Medical Practice**

Emotional awareness in a medical setting has come a long way into creating the dynamic of empathy that is used in modern healthcare relationships. There is no way of removing emotions from the healthcare profession, and the previous method of suppression has enabled more problems that it has helped. Jerome Groopman (2008), author of *How Doctors Think* wrote, "Cognition and emotion are inseparable...the two mix in every encounter with every patient" (p. 39). This calls the accepted form of clinical empathy, that of "detached concern", into question. Clinical empathy is an emotional aspect of the patient-doctor relationship, but there are many other intense emotions within the profession, both to the benefit and detriment of the patient. That makes the development of these emotional subtexts an incredible tool in the patient-doctor relationship for understanding and improving clinical empathy.

Physicians that routinely experience patient death face a plethora of complex emotions, and medical schools still do not teach students how to approach this issue. Ofri (2013) explains, "Grief is an overwhelming emotion for anyone who faces tragedy, so it is surprising how little

attention it receives in medicine” ( p. 107). Some physicians and researchers have taken a look into this aspect of medical care, and grief counseling is now widespread in healthcare settings. However, with the rise of empathetic relationships, surely this must make experiencing patient death that much more unsettling. The “detached concern” model of care not only created an air of professionalism for the physician but a space between the physician and patient as well. Though many doctors have discussed the hardships of losing patients, there is limited research surrounding the difference in the experiences of patient loss and whether the empathy model is preferred over the “detached concern” model in the face of patient death. “Grief is one of the most commanding of human emotions, and it does not tread lightly” (Ofri, 2013, p. 98). It evokes an interesting dilemma then, of whether long term practice of clinical empathy causes more distress and burnout for physicians. This topic will be explored further in chapter three.

In her book *How Doctors Feel*, Ofri (2013) articulates the experience of patient death from both her perspective and other doctors. She follows the profession of a pediatric intern who must deliver a baby girl with Potter syndrome that would live only minutes after birth (Ofri, 2013, p. 98). The young parents did not want to look at or touch the baby, and with a limited amount of space, she had to lay the child on a metal cart in a supply closet and wait for the umbilical cord to stop pulsing to record the time of death (Ofri, 2013, p. 100). Alone in the cramped closet, she debated holding the child but did not want to be reprimanded for not getting the accurate time of death. After staring at the cold, dying child, she felt the need to cradle her and whispered, “I love you, baby,” as she rocked her (Ofri, 2013, p. 102). Within fifteen minutes the baby fell still. She stiffly wandered out of the closet and was dryly reminded to fill out the paperwork, call the morgue, and continue with her rounds (Ofri, 2013, p. 103). There was no

moment for her to pause and process her grief. Ofri (2013) concludes that this was a moment for Eva, the pediatric intern, to grow her armor, as many physicians do when they experience their first death (p. 104). Ofri (2013) claims, "...armor could be destructive, as it does not actually prevent grief from entering; it only channels it into an awkward holding area...all of this eventually burrows within us, powerfully affecting how we take care of our future patients" (p. 98).

Ofri (2013) follows the intern as she progresses through her medical training to demonstrate how the growth of this "armor" has many negative consequences, including burnout. At the very end of her residency her team received a young boy who was a victim of drowning (Ofri, 2013, p. 104). They were able to resuscitate him but his body remained in a comatose state as his brain had been deprived of oxygen for too long. Eva describes feeling emotionless as she went through the monotonous routine of maintaining the child's vitals and relaying the unfortunate news to his family (Ofri, 2013, p. 104). She switched to psychiatry but realized she had lost the ability to care for her patients and no longer had any desire to pursue medicine. In the middle of her hiatus she had an emotional breakdown when she saw a movie in which a child fell into water (Ofri, 2013, p. 105). Her residency in pediatrics had plagued her with PTSD and failed to equip her with the tools she needed to advance in her career.

However, how to appropriately process grief in a healthcare setting is still unclear. Ofri (2013) writes, "What matters is how the sadness is navigated, something that is influenced by both the individual personality of the doctor and our surrounding environment" (p. 98). In a study of oncologists, physicians who routinely experience patient death, the conclusion was clear, "grief was pervasive in their lives" (Granek, Krzyzanowska, Tozer & Mazzotta, 2012).



The doctors discussed their strategy of compartmentalizing the patient deaths yet the findings from this study show how apparent it was that this coping technique did not work (Granek, Krzyzanowska, Tozer & Mazzotta, 2012). Many of the oncologists in this study confessed how hard it was to come into work knowing they may have to interact with someone they knew was going to die. Their patients remarked on the emotional withdrawal of their physicians, and the doctors themselves admitted to trying to detach from their patients to handle the emotional toll (Granek, Krzyzanowska, Tozer & Mazzotta, 2012). The oncologists claimed they felt like “failures” in their career; the research showed that these physicians were more likely to pursue overaggressive treatment paths for their other patients once one of their other patients had died (Granek, Krzyzanowska, Tozer & Mazzotta, 2012). On the other hand, if they felt their patient had suffered unnecessarily before dying, they recommended a far less aggressive treatment approach for the next patients, even if the path was warranted (Granek, Krzyzanowska, Tozer & Mazzotta, 2012).

There is no perfect algorithm for approaching grief from a patient loss, but it is clear that neglecting to process it has damaging consequences. In the best case scenario, physicians become withdrawn, and the patient-doctor relationship suffers. The physician may experience burnout and have difficulty going through the motions of their job (Granek, Krzyzanowska, Tozer & Mazzotta, 2012). At its worst, it impacts the physician’s decision-making process and deteriorates their treatment approach. This has devastating consequences for future patients either way.

The oncologist research study also uncovered a striking conclusion about what made coping with a patient’s death more troubling. The doctors claimed that the death was harder to

process in circumstances where they felt close to the patient and their family, if they identified with them, or if they had spent a great deal of time with them (Granek, Krzyzanowska, Tozer & Mazzotta, 2012). Other challenging cases involved patients that were relatively young or when the death was not expected (Granek, Krzyzanowska, Tozer & Mazzotta, 2012). The obvious conclusion then is that grief increases when physicians form stronger relationships with their patients.

However, grief on its own is not necessarily bad. Grief is an expectation of the profession and Ofri (2013) explains that for many physicians it adds an element of appreciation for the depth of their work (p. 108). From the oncologist study, improving the patient-doctor relationship through empathy proved to complicate grief; but that does not mean forming connections with patients should be avoided. The issue is when that grief is mismanaged, like when physicians withdraw or maintain a detached composure (Granek, Krzyzanowska, Tozer & Mazzotta, 2012). The conclusion of this study is limited though, given that only one specialty is represented. There are plenty of other specialties that experience frequent patient loss that have different types of relationships and encounters with their patients.

There is some hope for improvements in dealing with grief in the medical universe. For instance, the University of Rochester medical center started hosting a mandatory support group for the oncology staff and it is open to anyone who assists with the cancer department (Ofri, 2013, p. 107). The group discusses treatment strategies aimed at prioritizing self care amongst healthcare workers. Ofri remarks that Eva may have had a much different experience in residency had these resources been available to her as well. She wrote, “If the program had offered its trainees space to acknowledge the intense emotions precipitated by these situations,

Eva might not have experienced the explosion of PTSD” (Ofri, 2013, p. 109). More effective means for alleviating the negative consequences of grief need to be explored to reduce burnout in other physicians, but the establishment of support groups is a step in the right direction. Many hospitals have followed this strategy, but physician burnout and suicide rates are still on the rise. This indicates that there needs to be further conversation on grief management in the healthcare profession.

### **Chapter 3**

*“He cures most in whom most are confident.”*

*-Galen*

My literature research provided definitions of clinical empathy, understandings of the meaning of patient-doctor relationships to the physicians that form them, and views on how patient death can impact these relationships. This chapter will explore and extend these concepts further through interviews with experienced physicians. Eight physicians were interviewed in total, including an emergency room doctor (referred to in this chapter as Dr. L), a doctor specializing in geriatric medicine and palliative care (Dr. H), a resident in internal medicine (Dr. M), a cardiologist (Dr. T), a family medicine specialist (Dr. G), a retired pediatrician (Dr. N), a bariatric surgeon (Dr. D), and a retiring physician in internal medicine (Dr. A). The names of the physicians were omitted to protect their privacy. Any patterns in responses were used to shape the sections of this chapter. The responses that highlighted ideas in the literature review are also discussed in further detail.

The interview process lasted roughly forty-five minutes to an hour with each physician, and each question was designed to be open-ended to encourage more personal and detailed responses (The complete set of questions can be found in Appendix A). The study participants were either retired or practicing physicians from the Corvallis area that had previous contact with the principal investigator of this research project. Those that expressed interest in being part of the study were then contacted separately to determine availability for the interview process. The

participants were briefed on the consent form at the beginning of each interview and reminded again that they could decline to answer any of the questions asked during the meeting. The participants were also asked at the start of each interview whether it was permissible for their responses to be audio recorded. The responses were then transcribed after the interview process was completed and stored following IRB guidelines.

## **Building and Maintaining Empathetic Relationships**

### **Trust**

The American Medical Association (1980) states: “A physician shall . . . be honest in all professional interactions,” but this stipulation did not become a requirement until the 1980s. The modern relationship between the patient and the physician is formed with the understanding that the doctor is obligated to be trustworthy. It is no wonder then that overwhelmingly, the responses from my physician-interviewees emphasized the elements of trust that made it necessary for the patient-doctor relationship to function. Dr. A mentioned that patients “tell their doctor things they do not tell anyone else” and in many cases, this extended beyond the scope of just physical ailments. He reported that patients would ask him questions about finances or disclose issues they were experiencing in their personal lives. Many of the physicians described encounters with patients in which the patient divulged intimate details to the doctor beyond the scope of their health, but that they felt honored the patient would trust them to that extent. Dr. G echoed this: “I have always considered it a privilege... to come into this room and have people open up their lives to me.”

Dr. Carlos Pellegrini (2016), a retired chief of surgery for University of Washington Medical Center, envisions the physician-patient relationship as an arch, where each respective party represents an individual pillar and trust embodies the top of the arch, “the so-called keystone on which the stability and the integrity of the arch are dependent”. However, trust is built over numerous interactions and requires the patient to perceive the physician’s competency and intent. Dr. G emphasized that to accomplish this “you have to put your ego aside so you can understand what they need.” Although the physician is the medical expert, the patient is the one most knowledgeable about their body and their healthcare goals.

Dr. M used the term “collaborative” while explaining his view of the relationship and stressed the importance of allowing the patient to communicate their goals effectively and, as a physician, being receptive of those goals. He claimed, “Modern medicine has been pretty good at coming up with solutions to most problems, but often those solutions are not exactly what the patient needs or wants.” Instead, he described that the objective is to see the relationship as being on the “same team” and letting the patient know, “I’ll meet you where you are at.” To create trust, the physician should present information to the patient and help them come to a decision that they feel comfortable with.

Yet, while all of the physicians agreed on the benefits of shared decision-making care within a patient-doctor relationship, many of them mentioned that the paternalistic model had value still as well. The paternalistic definition of this relationship casts the patient as a child incapable of understanding medical information and lacking the capacity to make choices in their best interest. The doctor takes on the role of the parent, who makes judgment calls on behalf of the patient and expects that they will follow through, much like a child would. They are exempt

from any choices in the decision-making process and are instead supposed to rely on the knowledge of the physician. Dr. H claimed, “There’s a role for paternalistic care,” as she works with many older patients. She explained, “That’s what they are used to...some people that’s what they want out of their relationship.” Again, the component of trust is still essential for this type of patient-doctor relationship as the patient must depend entirely upon the expertise of the physician.

However, relationships are a two-way street. When Dr. M was discussing his patient interactions, he stated that the physician should make themselves vulnerable as well since the patient is opening up their lives and may be forced to divulge otherwise sensitive information. Dr. M said, “You need to reciprocate on some level to make yourself a person. I like to talk about my family or what I like to do... I don’t make it too personal because I’m still maintaining a professional relationship.” Many of the other physicians maintained that the physician should contribute some level of reciprocity, at least what was considered professionally appropriate. Obviously revealing equal or more information than the patient would be unprofessional, but small amounts of self-disclosure can yield many benefits. According to a study in 2007, the advantages to physicians divulging appropriate personal information can yield improved patient support, foster a sense of closeness with the patient, reinforce patient motivation to follow the treatment path, and introduce mutual trust into the relationship (Lussier & Richard, 2007, p. 422). Physicians should then be willing to take a moment with each patient and explore a personal conversation in which the patient has the opportunity to learn about the person providing their care.

Since the patients are typically viewed as the more vulnerable party, it is not surprising that most conversations regarding trust are directed towards making the physician seem honest in the eyes of the patient. While it is crucial for the patient to trust the doctor, with the transition from paternalistic care to shared decision-making care, there is a greater concern that the physician must be able to trust the patient as well. Within the initial interaction, the patient gives an account of their symptoms, which the physician must believe to move forward with an accurate diagnosis. The doctor then must rely on the patient to follow the treatment path. Mutual trust improves cooperation for both parties and helps, as Dr. Y explains, “give something back” to the physicians by boosting the sense of professional satisfaction. An interpersonal trust also reduces the compulsion for monitoring and increases the likelihood that the patient will trust the doctor in return (Thom et al., 2011; Cook et al., 2004). The psychosocial understanding of this interaction is that “successful and sustainable cooperation must be built on a foundation of trust and reciprocity” (Walker, 2009, p. 124). Essentially, viewing the patient as trustworthy acts as moral support by allowing the patient the chance to satisfy the requirements set by the doctor.

Further, mutual trust in the patient-doctor relationship provides a baseline for respect for patient autonomy. Dr. Wendy Rogers (2002), a psychology professor at Georgia Institute of Technology, explains that “we cannot respect autonomy if we do not even recognize the other as a moral agent, capable of making choices and bearing responsibility for those choices” (p. 78). In her research on the subject, she concluded that trust also “enriches the medical understanding of beneficence,” and if the physician is incapable of trusting the patient, the burden falls on the patient, not the doctor (Rogers, 2002, p. 79). Patients are already at a power disadvantage within the patient-doctor relationship and distrust shifts even more power away from the patient. When



they feel disempowered about following a treatment path or making a recommended lifestyle change, they are less likely to adhere to the plan (Rogers, 2002, p. 79). Not only then is it essential for the physician to be honest, but there is a moral duty for the patient to be trusted as well.

Trust has a plethora of positive impacts within the relationship, and one that lacks it demonstrates a diversity of shortcomings. One study investigating the importance of trust found a modest improvement in patient symptoms after only two weeks following their appointment when they reported a firm trust in their doctor (Thom et al., 2002). Another benefit uncovered from the same researcher in 1999, David Thom, a physician in family medicine and PhD-trained epidemiologist, found that patient adherence to treatment recommendations is often correlated to the level of trust within the patient-doctor relationship. He found that two-thirds of patients that reported high levels of trust for their doctor continued to take their prescribed medication compared to only 14 percent of those that claimed low levels of trust in their doctor (Thom, 1999). Lack of confidence can also predict continuity amongst patients and physicians; a quarter of those in the lowest quartile of trust from the same study ended up transitioning to a new doctor, compared to only three percent of those belonging to the highest quartile of trust. This also leads to an increase in emergency room visits for patients that are continually changing doctors which can have many poor consequences for the healthcare industry and the patient (Gill, Mainous, & Nsereko, 2000, p. 338).

Many problems associated with the absence of trust within a healthcare relationship have devastating repercussions. Researchers theorize that when patients do not trust physicians, mistrust increases healthcare costs associated with verifying a doctor's recommendations through

superfluous referrals or diagnostic tests as well (Thom, Hall, & Pawlson, 2004). Worse than that, some experts believe that the lower levels of confidence in their doctors expressed by people of color may explain why minority populations have lower rates of care seeking and use of preventive services when compared with the Caucasian population (LaViest et al., 2000). This may explain why minority races tend to exhibit higher percentages of chronic illnesses and shorter life spans compared to the Caucasian population in America (LaViest et al., 2000). Mistrust is also a primary culprit behind patients that choose to skip vaccines which has a broader implication on the health of the general public (Thom, Hall, & Pawlson, 2004). Trust is then an essential component of the patient-doctor relationship that improves patient symptoms, lowers health care costs, and promotes public health.

Mutual trust has many added benefits of improved symptomatic relief, lower healthcare costs, and a stronger adherence to the treatment path. By engaging in appropriate levels of self disclosure and placing trust in their patients, doctors can access these benefits. In addition, trust between the patient and physician has incredible impacts on the patient-doctor relationship and its ability to function. Physicians cannot cultivate clinical empathy and form a collaborative relationship with their patient if their patient does not trust them and if they do not trust the patient in return. That makes mutual trust an essential characteristic in establishing the definition of clinical empathy and how it should be practiced.

### **Communication**

The root of any quality patient-doctor relationship is based on effective communication. The physicians involved with this study all made a point of commenting on this facet of the

patient-doctor relationship regarding developing clinical empathy and a robust professional relation. Dr. Y discussed it as a bidirectional component in which developing strong communication skills enables the patient to be more open as well. According to Dr. L, one of the best ways to establish trust and build a foundation for the relationship is to develop a "great rapport" from the beginning.

Dr. Sidney M. Jourard (1968), a humanistic psychologist who studied the impacts of empathetic touch, wrote that dialogue is a necessary prerequisite for helping another person as it allows for "unveiling, where each seeks to be experienced and confirmed by the other". Jourard believed that commitment to helping required the ability to effectively communicate that one was "trustworthy and of good will" (Jourard, 1968). Dr. G expanded upon the notion of quality communication and asserted that "a person may say something with a lot of hidden messages behind it that you have to watch out for." This ties into the concept of emotional attunement, a key component in clinical empathy, in that a physician has to be capable of communicating the diagnosis and the treatment path with the patient and also be able to pick up on any verbal and non-verbal cues a patient may divulge. That makes being an effective communicator a requirement in forming healthy, empathetic relationships with patients.

### Non-Verbal Communication

Communication experts agree a majority of communication is nonverbal, with some estimates as high as 93 percent (Gaughran, 2015). In the United States, the average amount of time most physicians have with each patient is between 17 and 24 minutes (Statista, 2019). The duration of time before a physician interrupts a patient is a measly eleven seconds (Lee, 2018).

Each second with a patient becomes increasingly valuable, and that makes constructing an empathetic relationship incredibly challenging. Dr. G, a primary care physician, emphasizes that “it starts day one” and mentions that paying attention to body language, both the patient’s and yourself, is crucial and can be useful in communicating something to the patient or reading what the patient is trying to convey to the provider. Eye contact was stressed by many of the physicians in this study, and several of those interviewed claimed that the patient could tell when the doctor was not present in the conversation simply by how they were presenting themselves. That makes improving these skills incredibly vital to the patient-doctor relationship and the development of clinical empathy.

All of the doctors claimed that a fast and sure way to develop empathy through nonverbal communication was a simple touch; whether it was something more formal like a handshake or, as Dr. H and Dr. G recommended, making a point to lay a hand on the part of the body that was the source of pain. Touch at the start of the interaction can set a positive tone for the remainder of the appointment. Dr. L said the first thing he did upon entering the room was shake everyone’s hand in the emergency room, no matter how many people were waiting with the patient. Touch affirms both connection and comfort with a patient and their family. Jourard refers to touch as “an action which bridges the gulf many develop between themselves and others” (Jourard, 1968). Many of the physicians stated the necessity of the physical exam despite the advances in medicine that make it obsolete. To the patient, a physical examination confirms that the doctor is caring for them. Dr. Ofri (2010) wrote in the *New York Times*,

Does the physical exam serve any purpose? The laying on of hands sets medical practitioners apart from their counterparts in the business world. Despite the inroads of

evidence-based medicine, M.R.I.s, angiograms and PET scanners, there is clearly something special, perhaps even healing, about touch. There is a warmth of connection that supersedes anything intellectual, and that connection goes both ways in the doctor-patient relationship.

Touch then comprises both the initial greeting of the patient and their family. and the examination. Learning how to touch the patient appropriately is an essential component in the patient-doctor relationship. Dr. H commented that the physician should read the patient to see if touching them would be suitable as some patients may be feeling vulnerable and an unwarranted touch could make them even more uncomfortable. Dr. H advised that if the physician feels unsure about touching the patient, then they should refrain as that could be a clear indication that contact would be unsuitable at that time.

A necessary part of nonverbal communication is the pause in conversation that gives the other person a chance to speak. Dr. L encouraged allowing the patient to speak for a moment longer before they were interrupted and then relaying back what the patient had said to ensure that they felt heard. Dr. T stated, “Time is enough to push them away,” which makes nonverbal communication a helpful tool for displaying empathy within a short time frame. A study from the *Journal of the American Medical Association* noted that patients only shared sensitive information with doctors when they paused at certain nonverbal emotional cues, even if physicians asked the same follow up questions (Suchman, Markakis, Beckman & Frankel, 1997). While doctors and patients operate on a short time frame, taking key moments to pause for the patient can be the most successful way of learning critical information about the patient.

In order to improve nonverbal communication skills, it is important to then practice them. Dr. H touched on the usefulness of having a person observe her interactions with patients so they could describe her body language and what it may have communicated to the patient. In this way, she is able to visualize how the patient is reading the situation and how best to effectively communicate to the patient in turn. Improving upon communication skills and nonverbal cues can be a lifelong lesson, but it is vital to the establishment of clinical empathy and the very foundation of the patient-doctor relationship.

### Humor

The idea that humor is beneficial for human health is not a new concept, and it may be helpful for the physician to cultivate an empathetic relationship with the patient. Dr. M, Dr. Y, and Dr. G touched on the value of humor in the patient-doctor relationship. Dr. L claimed, "Humor is a great way to connect while keeping things light." Though nurses typically employ humor more often than physicians, there's plenty of benefits for doctors to use it as well (Beck, 1997, p. 352). Wender (1996), a family practitioner, studied the use of humor in patient-doctor communication and found that it closes the gap on interpersonal communication, reveals to the patient that they care, and alleviates any anxiety a patient may experience (p. 141). Though the studies associated with humor in medicine have not been exhaustive, related research has shown promising results concerning the use of humor between patients and doctors. One study found that reports of patient satisfaction had a strong positive correlation with the duration of time a doctor spends with the patient as well as the "emotional tone" of the visit (Roter & Katz, 1987). Given the time constraints a physician experiences and taking this research a step further,

another study showed that patients felt like they had more time with their doctors and that their appointment was not rushed when the physician took the time to have a casual conversation with them like discussing the weather or engaging in a joke (Gross et al., 1998). Taking a brief moment to joke with the patient can be effective at strengthening healthcare relationships and create the illusion of more time spent in an appointment.

Not only does humor improve the patient-doctor connection but it also reduces the risk of malpractice. A study conducted in the late 1990's demonstrated that the most common trait among physicians that experienced no claims of malpractice was their use of humor within patient encounters (Levinson et al. 1997). The use of humor in medical relationships can then benefit the physician as well.

Perhaps more significant than the physician using humor in an appointment is the ability of reading when the patient is using humor to signal subtle clues into what they may be feeling. Patients can use humor as a way to reveal hidden frustrations or fears which the doctor can use as a starting point to address any concerns that the patient may have (Bennett, 2003, p. 1261). This fosters a deeper connection with the patient and invites the possibility for the physician to engage in humor as well. Reciprocity of this nature can enhance the patient-doctor relationship and reveal to the patient that the doctor cares and is listening to them.

Humor is often also used as a coping method among healthcare providers. Suzanne Poirier (2009), the author of *Doctors in the Making*, wrote, "Anger and gallows humor are generally accepted forms of expression among undergraduate and graduate medical students... but expressions of serious self-doubt or grief are usually kept private or shared with only a trusted few" (p. 117). Humor then is multifaceted in the ways it can help healthcare professionals

connect with patients, understand where they are coming from, and cope with hardships from the career. Since an important component of expressing clinical empathy with patients is also handling the grief that comes from the profession, humor has the added benefit of helping both the patient and the doctor. It can be used to form a stronger, interpersonal relationship with the patient while also reducing malpractice suits, anxiety in the patient, and assisting with the burden of grief in medicine.

### Discussing Bad News

Being an effective communicator is especially important when the physician has to disclose bad news or explore an intimate topic with the patient. Discussing death can be particularly uncomfortable and learning how to navigate that appropriately is a necessity for many fields within the medical profession. Dr. N mentioned how vital it is to sidestep euphemisms and be direct with the patient, for the patient's sake. Many patients prefer that their physicians be forthright with them, even in the case of bad news (Back & Curtis, 2002). Dr. G repeated this idea: "Using words like 'dying' instead of passing away. It's really important to use language that's honest. With most people, it's better to use frank language. Unless it's a child and they wouldn't get it." Euphemisms may soften information, but they can be misleading for the patient and their family.

The conversation should be simple and direct. Dr. A claimed, "I don't use fancy words they won't understand," for the same reasons that other physicians preferred to be straightforward. Using medical terminology or advanced wording can create a language barrier between the patient and the physician. It can also be confusing for the patient who is trying to



digest weighted information in a vulnerable setting. Dr. M reiterated this point by explaining that technical language can be an effective way of communicating that the doctor is a professional, but it also establishes an emotional distance between the patient and the provider. When trying to build an empathetic relationship, it is necessary to use language that is clear, and the physician should take the time to define any terminology that the patient may not understand.

Research has shown that the most common issue patients report with the delivery of bad news was that the physician did not explain things well (Back & Curtis, 2002). Dr. H said that it was one of the more complicated aspects of the patient-doctor relationship: “I think I’m explaining something but they aren’t understanding.” Demonstrating empathy at this time can be challenging for the physician, but it is one of the most crucial interactions for empathy to be displayed. In these moments, according to Dr. G, the physician should ask the patient to “repeat back” what they understood from the encounter or ask clarifying questions on what they were not sure about when the conversation has finished. He explained that an “empathetic doctor” would be able to recognize when a patient is lost, and this can be a helpful way of making sure they are on the same page.

### **Setting Boundaries**

Shifting the dynamic from paternalism to the shared decision-making model has created the issue of how best to approach conflicting ideas between the patient and the doctor. In the paternalistic model, the doctor was allowed to choose the treatment path and goal setting for the patient. The advantage with paternalism is that the doctor is the one in the relationship with a wealth of medical knowledge and stopping to explain things to a patient costs time, which is

often something a physician cannot afford. With the shared decision-making model, the patient gets to weigh in on the decisions and in some cases they can be wrong, or they can opt out of the treatment path all together. The physicians interviewed commented on the frustration that accompanies this and how they navigate this issue throughout their career. Dr. L, the ER doctor, said the best method was to be transparent. If there was a test requested by the patient that was unnecessary to run or a medication he did not believe was best to prescribe he would say to the patient, "I'm worried for your health" and would explain why he was hesitant, but be firm about saying no.

Some of the doctors told stories of cases where they had to reject patients from their practice because they would not stick to the treatment plan or refused necessary medical intervention. Dr. D, a bariatric surgeon, routinely has to see obese patients that struggle making necessary lifestyle changes in order to qualify for surgery. In his clinic, he found the best way to treat the patient is to be honest and tell them that if they are not complying with the treatment path that has been set, then he cannot continue to be their doctor. While he said those were challenging conversations to have, they "became the most rewarding experiences later." He claimed that "every single time" the patient would return and would make drastic improvements, even claiming that though he had upset them at the time, it was the push they needed to get better. While turning patients away may seem counterintuitive it has shown positive results within his practice. Dr. D stated, "Sometimes you have to care enough to make somebody mad." Dr. G explained that the feelings of frustration associated with this aspect in medicine is an area that can contribute to burnout. The doctors reported experiences of helplessness and exasperation when patients failed to abide by the treatment path that was agreed upon. Most of the physicians

interviewed claimed that this circumstance was where they experienced some of the strongest emotions. Dr. G stated:

When a patient is not accepting of or responding to healthy suggestions...for example a smoker that keeps getting pneumonia...or a diabetic patient that's not taking their medication. The patient hasn't bought into the plan. Don't try harder than the patient to make them well. You can just beat your head against the wall but if they aren't going to do their part...it makes it hard to be empathetic.

When faced with this challenge he recommended remaining neutral and refraining from using any language that could be construed as shaming. In contradiction to Dr. D, he stated that the "core things to avoid" were statements that made the patient feel angry, afraid, or guilty. He emphasized that a doctor should never make the patient feel bad about what they were going through, regardless of the circumstances.

However, it is worth noting that Dr. D is a bariatric surgeon and Dr. G is a family physician, so while this could be a difference in opinion, it is also likely a difference between specialties. Dr. G would have to maintain lifelong relationships with his patients, and "shaming" them can make the patient feel isolated and incapable of communicating with their primary care doctor. Dr. D, on the other hand, needs to find methods to motivate patients, otherwise he can not move forward with their surgery and treatment path. Given that their roles in medicine are quite diverse it is not surprising that they have their own approaches to patient problems.

These same experiences were mirrored with the other physicians. In Dr. T's case, a woman refused life-saving blood transfusions because of her religious background and her husband insisted that if she was going to die it was God's will. Having just delivered a healthy

baby and recognizing that the baby would need his mom, Dr. T told the patient, "I can't do this. I am going to have another doctor come in." With the threat of losing their physician, the family complied, and the woman's life was saved. At that moment he claimed, "I got very emotional" and mentioned the frustration of not being able to fix a medical issue because of the conflicting desires of the patient. In this case, a relatively simple procedure was all that was needed to save this woman's life, yet her values were not aligned with the physician's.

With the promotion of shared decision-making, it is essential that the doctor learn how to draw boundaries with patients and say no when it goes against the principles of the profession, which are to promote public health and patient welfare. In cases like these, the doctor acts more paternalistic as they are maintaining their own values over the patient's wishes. However, though paternalism is not the preferred medical model, there are moments that call for its use, especially if the physician is experiencing great emotional turmoil over a patient's decision. It is healthier to extend to the patient the option of a new doctor, rather than force the physician to act against their medical beliefs. After all, the concept is "shared" decision-making, so if the doctor is not truly on board with the patient's goals, they should voice their discomfort and know that they have the ability to say no in these circumstances.

Dr. G went on to explain the refusal of vaccines from patients, which causes concern for many physicians. In these moments as well, he recommended the strong-arming technique of warning patients to "find another doctor" if they were going to put themselves and other patients at risk. Dr. L stated that in order to refuse a patient's wishes the physician needed to affirm that they cared about the health of the patient, that they were listening to their concerns, and that the doctor had to explain why they were drawing a boundary in their practice. In doing so, the

physician can feel comfortable that they are upholding the values of medicine and encourage patients to make the right decision in their healthcare without forcing them into it. This reduces the conflicting desires between the physician and the patient and allows the shared decision-making model to function more appropriately. In addition, as many of the doctors commented that this area was one that tested their empathy, feeling comfortable saying no empowers the physician and resists the impact on their capacity to express clinical empathy.

### **Defining Clinical Empathy**

All of the physicians interviewed explained that anyone pursuing a career in medicine needed to have a baseline of empathy from the beginning. Though some believed that emotional training could maintain empathy or improve it slightly, for the most part, the general consensus was that empathic abilities were innate. Dr. Y described empathy on a spectrum and stated that it means the provider is not only kind to the patient, but genuinely cares for them as well. He explained that a nurse or doctor could fall anywhere on the empathy spectrum: from a sociopath, someone incapable of processing other people's emotions, to an empath, a person with an extreme ability to comprehend the mental and emotional state of others. He went further by explaining that most physicians fall closer to the empath side of the scale, but they can be anywhere on it.

I can think of a student of mine who was way on the empathetic side, who couldn't get themselves together to see the next patient. And then we aren't being efficient. So where on the spectrum should we be? I mean, who's the patient, who's the suffering party? On some level, knowing that balance of what's acceptable to show is for the patient's benefit

because everything should be in the interest of the patient. Some empathy is good...too much is not good.

Dr. N viewed empathy in the same fashion and described it as an individual “temperament”. How a physician navigated their relationships with patients was based on who they were as a person, not what was established in medical school and training. Dr. M stated this as well: “Honestly part of it is, you have to go into medicine with some empathy already. Otherwise, you’re going to get burned out. You have to care fundamentally that someone is in pain.” When questioned as to how she evolved throughout her career, Dr. H claimed, “I went in with touchy-feely approach and I’m still a touchy-feely doctor.” All of the doctors agreed, empathy is a characteristic that cannot be taught entirely, but managing emotional competency can be.

When asked how clinical empathy was defined, many of the doctors summarized it by describing the aspects of traditional empathy or in other words, seeing things from another’s perspective and imagining what the patient may be experiencing. Dr. L characterized clinical empathy as: “Trying to have a consideration and acknowledgment of what the patient has been through or is going through. Also, understand every patient is different and they handle illness differently.” He illustrated this point by differentiating two types of patients; both could have the same headache but one may refer to the pain as excruciating while the other may only say they have minor discomfort. The physician should respond appropriately and make sure that they are not stifling the patient's descriptions of their symptoms. Dr. M defined it as “Doing your best to try and experience someone else’s circumstances. But there is a difference within the context of medicine. You don't want to minimize someone else’s pain by saying I know how you feel,

because you really don't." The ultimate conclusion from the interviews was that many of the physicians recognized that traditional empathy did not completely encompass clinical empathy but they did feel that it was strongly related. This suggests a shift in the perception of empathy within the healthcare setting. When the notion of empathy was first accepted into medicine as merely "neutral empathy", the emotions of the patient were purely observed and there was little to no reflection on the part of the healthcare provider. All of the doctors agreed that it was important to stop and consider the viewpoint of the patient and to truly assess how they were feeling.

### **Reducing the Negative Consequences of Emotion in Medicine**

Some of the doctors disagreed with the notion that their emotions affected their decision-making, but perhaps Dr. M summarized it best when he stated, "I'd like to say no, but again we are humans." A study in 1991 seemed to uphold the model of detachment as "emotional involvement and over-identification with patients was linked with a tendency to over-treat without considering the side-effects" (Nightingale, Yarnold, & Greenburg, 1991). However, this oversimplifies the issues of emotion in the workplace. Instead of denying emotions in medicine entirely there needs to be an element of emotional awareness in which the physician can identify this negative component of empathetic connection and work to prevent it.

Dr. L detailed a story in which he continued to regularly treat a patient in the Emergency Room for the same condition, twice a year, because they were someone he knew outside of work and he knew their family. "He was coming in for something that I didn't feel needed any more treatment in the Emergency Room and I think I extended the number of times I treated him more

than I would have if I didn't have a personal connection to him because it was somewhat uncomfortable to say no." In this circumstance, his actions were in conflict with what he believed was the appropriate treatment method. However, the patient was still receiving care for their condition. Eventually, the issue resolved itself regardless, but the negative impact of an emotional connection in this incident was incredibly minor.

Dr. N described a similar situation in which emotions impacted his care. A friend of his had an infant that exhibited symptoms of encephalitis. Upon further investigation, the child had a frontal lobe tumor so Dr. N quickly had him admitted. "I was seeing a patient and it was clear my mind was still with this kid. I'd ask her the same question again and I realized I wasn't paying attention." The patient took notice and commented on his behavior. He explained to the patient why he was distracted and apologized for not being mentally present in their interaction. Once he was aware of the impact his emotional connection had he was able to correct the issue and continue treating the other patient.

Just like the oncology study discussed in the literature review, emotions can, at times, sway healthcare providers. However, if physicians practice emotional management the cost of emotions in medicine is not damaging to the patients. While detachment in medicine would not have these problems, it also would not have the many benefits of emotional engagement. In the cases described by the physicians in this study, recognition of the physician's emotions and their impact was the only solution needed to correct this problem. Dr. L's patient was still receiving quality care and Dr. N was able to adjust his mindset in order to be present with the patient in front of him. Often times, the cost of emotional connections in medicine are simply the ones doctors may not be aware of. In addition, they pale in comparison to the many defects of the



“detached concern” model. In the case of the oncologist study, peer support and discussions of emotional influence was able to ameliorate the problem (Granek, Krzyzanowska, Tozer & Mazzotta, 2012). To lessen the negative consequences of emotional connections in medical practice, physicians should pause to reflect on their decisions and assess whether their emotions may be playing a part in their judgement.

### **Patient Death**

Emotions within the patient-doctor relationship can be very complex, especially involving the subject of patient death. The next issue to address then is how physicians handle patient death and where empathy plays a part in this. Given the emotionally charged environment of the medical universe, it is not surprising that an emotionally detached doctor was portrayed as competent and professional. The advantage of the "detached concern" model is that it provided doctors an emotional buffer between themselves and their work, or so it was thought. The problem with detachment is that it is merely an expression and may not be a true representation of the emotions that a doctor is experiencing. Often, when a doctor demonstrates detachment, they are suppressing or ignoring their feelings (Kerasidou & Horn, 2016). With the rising percentage of burnout, alcoholism, depression, and suicide in the medical profession, it is clear that the issues of this career path go beyond simple job dissatisfaction. The use of emotional detachment is a burden to both physicians and patients and contributes to these problems (Kerasidou & Horn, 2016). As Dr. D reflects, the advantage of the empathetic relationship is that it allows the benefits of the career path to be "bidirectional" so the physician gets to experience

an emotional reward when the patient does well and the patient can feel confident that their doctor cares about their health and wellbeing.

With this being the case and physicians being prompted to develop deeper connections with their patients, there is a concern that there is more of an emotional burden for the doctor when a patient under their care has died. The physicians unanimously disagreed with this notion. Many also claimed that after a patient under their care had died or was nearing death, their capacity to express empathy only improved or, at the very least, remained the same. In a personal communication, Danielle Ofri explained this idea in further detail:

Being close to a patient makes it more painful when they die. On the other hand, it makes the experience all the fuller even if that “fullness” includes sadness and grief. A stronger human connection is always worthwhile. In fact, one of the most powerful experiences as a doctor is being privileged to help someone through the last stages of their life. Helping someone die on their own terms, helping to minimize suffering and bring comfort at the time of death is one of the biggest honors. It’s still painful, but it’s profoundly meaningful.

Despite the increase in negative emotions when a patient dies, improving empathy within the patient-doctor relationship shows an overall benefit and does not seem to diminish the positive emotions, like an empathetic connection, within the patient-doctor relationship. This demonstrates why the “detached concern” model is obsolete and works against the physicians that employ this strategy.

## **Coping**

The specialties that experienced death more frequently expressed a much more diverse cognition on the subject of death and what it meant to them within their specialty. For instance, Dr. H claimed she went into palliative care when she realized that medicine has many limitations, as indicated in the rise of chronic illness. According to her, many patients do not devote time to preparing for their death, and she found it fulfilling to help people through that part of their life. She viewed death as “just part of our cycle” and was instead disappointed when a patient was “treated” in a sense, but their newfound functional status was not addressed. Dr. H asked the question: “How do you help that person return to their life and what are the patient's goals for the time they have?” In her case, the practice of helping a patient and their family through this stage was what made her grieving process better. Dr. M also reported that spending time with the families and answering any questions they may have was cathartic.

For others, like those in family medicine, death was often viewed almost like losing an acquaintance or friend. Some attended funerals, but they all remarked that it was not the same degree of hardship as a death in their family or in their personal lives. Many claimed that patient death was more difficult to cope with when the death was unexpected as they did not have time to mentally prepare for it. In more extreme cases, the grieving process was impacted by the result of a misdiagnosis that led to a patient death. This led to discussions of guilt and acceptance and learning to recognize that the necessity of this profession is accepting mistakes. Dr. L explained that misdiagnosis happens on occasion. In the event that they do, he recommended sitting down with his team and discussing what they had missed or what led them to the misjudgment. However, Dr. L admitted that misdiagnosis, especially those that led to death, were incredibly

rare. Finding out what had gone wrong was an effective way to cope with the error and move forward in the medical career.

In regard to displays of emotion from the doctor, there was a variety of opinions from the physicians. Dr. A in primary care described a scene he had witnessed in which an oncologist was weeping with the patient and commented:

I think when I lose a patient it's a different relationship than other specialists. I've never cried over a patient, it's just different...you feel bad that they died, but you have to remain professional. You have to keep that separate. I have to go into the next room with a patient who has no idea what I've been through. You get used to leaving it at the door.

However, in regards to crying on the job, Dr. A was actually an outlier. The other seven physicians claimed they had shed a tear or two either with the patient or with the patient's family. They all expressed that the patient and family's reactions were positive. Dr. G stated, "Patients appreciate it and know that you're human and this matters to you too. You're part of a shared medical-decision, and when it goes bad, you care. You should be sincere and honest." Though there has been a bias towards revealing emotions in the workplace with some viewing compassion at odds with competence. Dr. G explains that "When I came out of medical school, I wanted to be, and I thought that being a professional meant you should be standoffish, a little more formal." This is a popular perception in medicine and demonstrates the lingering impact of the original view of what a physician should look like.

All of the physicians mentioned how discussing difficult cases with colleagues helps them move forward in their work. When asked what resources the hospital provided in the event of patient death, Dr. M remarked:

I think this has been something that's been missing in medicine for a long time...taking time to talk about it and get it out in the open is really helpful. Previously the expectation was to move on, but there's been a rash of resident suicides because you can't cope with that emotional stress for a long time without it having consequences. Or becoming a jaded doctor, and nobody wants that.

Dr. G seemed to disagree with this notion: "Most professional organizations have grief support or resources." Many of the doctors commented on the options hospitals provide to them in the event of patient death, but none of the physicians questioned in this study relied on them and instead were far more likely to use peer support. Dr. G continued, "There's lots and lots of resources, but some doctors don't take advantage of them, but they are there."

## **Chapter 4**

*“Wherever the art of Medicine is loved there is also a love of Humanity.”*

*-Hippocrates*

### **Conclusions**

This study was conducted by reviewing modern literature on the subject of patient-doctor relationships, clinical empathy, and emotions in the practice of medicine and then juxtaposing that information with eight one-on-one interviews with experienced physicians in specialties that had exposure to patient death on a routine basis. The most common elements from their responses and answers that incorporated topics from the literature reviews were examined and discussed further. In this way, the information presented could be extrapolated to a more definitive conclusion.

One of the biggest takeaways from this research is how broad the term “doctor” may be and that the definition of clinical empathy has to be general to encompass every specialty. Every specialty had particular “do’s and don’ts” for how to best navigate the patient-doctor relationship and what was most appropriate for them. When searching for trends in responses, the goal was to keep the answers general so that they could apply to every specialty, but even that was at times hard to maneuver. Those in family medicine and palliative care tended to have more extended relationships with their patients, and that made many of their answers involving empathy entirely different than from the responses from specialties like emergency medicine or cardiology. In those cases, first impressions were far more important, as there was much less time for

cultivating long-term relationships with patients. On the other hand, every specialty expressed the importance of empathy within the patient-doctor relationship, and all reported the ways that they choose to demonstrate that to their patients. From this study, though it was a small sample size, there did not seem to be a deficit in empathy in one specialty compared to another.

Disregarding how clinical empathy is defined, the responses from physicians supported the evidence uncovered in the literature analysis. The aspects of communication, trust, and coping with patient loss were similar compared to the literature review. This adds credibility to the conclusions that were drawn, but alarmingly, one of the most prominent questions of this study was then at odds with the initial research. All of the physicians equated empathy in the healthcare setting with traditional definitions of empathy, and that was the main point of Jodi Halpern's research. Halpern (2003) separates these terms by explaining that clinical empathy cannot be simplified to seeing things from the viewpoint of another. This may be a difference in opinion or due in part to the fact that the physicians did not have the same opportunity to examine clinical empathy under the same scrutinizing lens that Halpern did. After all, the physicians were asked the questions on the spot which did not afford them the opportunity to think critically about their responses and may have influenced their answers. On the other hand, it opened the floor to their initial thoughts and reactions.

From this study, the definition of clinical empathy involved the use of engaged curiosity and emotional attunement while maintaining discernment in patient interactions. This is to avoid over-identifying with patients and enabling them to make poor healthcare decisions, like Halpern's patient, Ms. G (2011). The conclusion from the interviews is that clinical empathy is similar to traditional forms of empathy. Constructing clinical empathy in a healthcare

relationship relied on the use of mutual trust, effective communication, and setting appropriate boundaries. Communication skills encompass verbal and non-verbal communication, like the use of humor, touch, and the ability to discuss bad news constructively.

The physicians in this study unanimously agreed that empathy was not a teachable concept. However, because clinical empathy is a skillful tool instead of an innate sense of compassion, it can be taught. Since every specialty had a variety of techniques that they used to communicate empathy to their patients, this component of the profession should be trained during residency. In this way, physicians can learn how to implement clinical empathy within their medical practice and achieve the many benefits provided by empathy within the patient-doctor relationship.

Another conclusion from this study is that improving the emotional connection with a patient through clinical empathy can make it harder when the patient dies. However, grief and emotion in medicine are not entirely negative. They are unavoidable in the healthcare profession, so instead of neglecting them, more efforts need to be taken to manage them.

### **Limitations and Further Areas to Research**

The small sample size had the most limitation on this study because it made it inappropriate to form any concrete conclusions. This is because it invites the possibility of research bias into the study results. Only interviewing eight physicians also meant that plenty of other specialties were left out of this study, and this made it hard to compare the viewpoints with each other. However, it allowed the time to analyze the responses in greater depth than if a more



extensive number of physicians had been interviewed. The information collected then produced more qualitative data.

Instead of interviewing physicians directly, the next time this study is conducted, it would be more appropriate to try anonymous questioning. It seemed like some of the physicians' answers could have been influenced by having an interviewer in the room. In these situations, the doctor was asked to be emotionally candid with a complete stranger, and that can be particularly hard, especially when the questions were based on discussing the complexities of patient death, whether they made a mistake in medicine because of their emotions, and how they coped with these losses. In a more remote setting, it may be easier to admit these things and be willing to divulge information than saying them out loud to someone they do not know. Otherwise, the physicians did give open and long-winded responses (as was hoped), but it would be interesting to see if changing the dynamics of the questioning would have an impact on their answers.

In addition, the resident seemed more willing to discuss the topics at hand compared to a couple of the retired physicians or physicians that had been practicing the longest. It was not clear if this was just a difference in personalities or if there is more difficulty for older physicians to talk about emotions, especially considering that they would have trained and practiced medicine closer to the "era of paternalism", when emotions in the profession were widely discouraged. If this study were repeated, it might be necessary to control for this variable and either only interview doctors in the same stage of their career or use a larger sample size and indicate whether there was a difference in responses between the varying age groups.

There also may be something promising in evaluating clinical empathy and coping with patient loss from specialty to specialty. Though this study did not show a disparity across the

various areas of medicine, it is worth noting that a sample size of only eight makes it hard to draw any concrete conclusions. Sampling a broader population of physicians and comparing answers would show more definitive results. Although it is believed that empathy scores are lower for certain specialties, it would be interesting to adjust how empathy is defined and then compare responses.

Although it was the main feature of this research, more questions should be asked in regard to patient death and how physicians view and cope with this. Many of the physicians mentioned that it was just the innate temperament of the provider that dictated how they handled patient loss, but surely, there is a “right” way to deal with patient death. It would be beneficial to juxtapose physicians that manage the demands of this profession well compared to those that may be struggling or turning to detachment to cope. This would provide more transparent information into maintaining empathy throughout a healthcare career.

## References

- Aring CD. SYMPATHY AND EMPATHY. *JAMA*. 1958;167(4):448–452.  
doi:10.1001/jama.1958.02990210034008
- American Medical Association. Principles of Medical Ethics (1980) 2000 In: Council on Ethical and Judicial Affairs. Code of Medical Ethics –Current Opinions, 2000–2001 Edition, xiv. Chicago: American Medical Association.
- Back, A. L., & Curtis, J. R. (2002). Communicating bad news. *The Western journal of medicine*, 176(3), 177–180.
- Beck CT. Humor in nursing: A phenomenological study. *Int J Nurs Stud* 1997;34:346–352.
- Bennett, H. J. (2003). Humor in Medicine. *Southern Medical Journal*, 96(12), 1257-1261.  
doi:10.1097/01.smj.0000066657.70073.14
- Blumgart, H. (1964). Caring for the Patient. *New England Journal of Medicine*, 270, 449-456.  
doi:10.1056/NEJM196402272700906
- Cook K, Kramer R, Thom D, Stepanikova I, Bailey S, Cooper R. Trust and distrust in patient-physician relationships: perceived determinants of high and low trust relationships in managed care settings. In: Kramer R, Cook KS, eds. *Trust and Distrust in*

- Organizations: Dilemmas and Approaches*. Thousand Oaks, CA: Russell Sage Foundation; 2004:65–98.
- Empathy. (n.d.). Retrieved from <https://www.merriam-webster.com/dictionary/empathy>
- Gaughran, K. (2015, August 27). Body Language: Winning Patient Trust and Better Outcomes. Retrieved January 17, 2019, from <https://www.healthcaresuccess.com/blog/doctor-marketing/26045.html>
- Gill, J. M., Mainous, A., & Nsereko, M. (2000). The effect of continuity of care on emergency department use. *US National Library of Medicine*, 333-338.
- Granek, L., Krzyzanowska, M. K., Tozer, R., & Mazzotta, P. (2012). Difficult Patient Loss and Physician Culture for Oncologists Grieving Patient Loss. *Journal of Palliative Medicine*, 15(11), 1254-1260. doi:10.1089/jpm.2012.0245
- Groopman, J. (2008). *How doctors think*. Boston: Mariner Books.
- Gross DA, Zyzanski SJ, Borawski EA, et al. Patient satisfaction with time spent with their physician. *J Fam Pract* 1998;47:133–137.
- Halpern, J. (2003). What is Clinical Empathy? *Journal of General Internal Medicine*, 18(8), 670-674. doi:10.1046/j.1525-1497.2003.21017.x
- Halpern, J. (2011). *From detached concern to empathy: Humanizing medical practice*. Oxford University Press.
- Hirsch, E., MD. (2007). The Role of Empathy in Medicine: A Medical Students Perspective. *AMA Journal of Ethics*, 9(6), 423-427.
- Jourard, S. M. (1968). *Disclosing man to himself*. New York: Van Nostrand.
- Kerasidou, A., & Horn, R. (2016). Making space for empathy: Supporting doctors in the

emotional labour of clinical care. *BMC Medical Ethics*, 17(8).

doi:<https://doi.org/10.1186/s12910-016-0091-7>

Kelley, J. (2014). Doctor-patient relationship improves your health. *Harvard Health Letter*.

Retrieved February 2, 2019, from

<https://www.health.harvard.edu/staying-healthy/doctor-patient-relationship-improves-your-health>

Kim, S. S., Kaplowitz, S., & Johnston, M. V. (2004). The Effects of Physician Empathy on Patient Satisfaction and Compliance. *Evaluation & the Health Professions*, 27(3), 237-251. doi:10.1177/0163278704267037

King W.D. “Examining African Americans’ Mistrust of the Health Care System: Expanding the Research Question,” *Public Health Reports* 118 , no. 4 ( 2003 ): 366 –367.

LaVeist et al., “Attitudes about Racism, Medical Mistrust, and Satisfaction with Care among African American and White Cardiac Patients,” *Medical Care Research and Review* 57 , supp. 1 ( 2000 ): 146 –161

Lee, B. Y. (2018, July 23). 11 Seconds: How Long Your Doctor Listens Before Interrupting You.

Retrieved January 17, 2019, from

<https://www.forbes.com/sites/brucelee/2018/07/22/how-long-you-can-talk-before-your-doctor-interrupts-you/#2abb282b1443>

Levinson W, Roter DL, Mullooly JP, et al. Physician-patient communication: the relationship with malpractice claims among primary care physicians and surgeons. *JAMA* 1997;277:553–559.

- Lussier, M. T., & Richard, C. (2007). Communication tips. Self-disclosure during medical encounters. *Canadian family physician Medecin de famille canadien*, 53(3), 421–422.  
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1949073/>
- Markakis, K., Frankel, R., Beckman, H., & Suchman, A. (1999). Teaching Empathy: It can be done. *Society of General Internal Medicine*.
- Nightingale SD, Yarnold PR, Greenberg MS. Sympathy, empathy, and physician resource utilization. *J Gen Intern Med*. 1991;6(5):420–3. doi: 10.1007/BF02598163.
- Ofri, Danielle. (2010, August 02). No Longer on the Doctor's Checklist, but Physical Exam Still Matters. Retrieved from  
<https://www.nytimes.com/2010/08/03/health/03case.html?mtrref=www.google.com&gwh=9AC7785ACEF41D285FC85E9F8ABBFDD2&gwt=pay>
- Ofri, Danielle. (2013). *What doctors feel: How emotions affect the practice of medicine*. Boston: Beacon Press.
- Osler, W., & Camac, C. N. (1906). Counsels and ideals from the writings of William Osler. *US National Library of Medicine*. doi:10.5962/bhl.title.16738
- Pelligrini, C. A. (2017). Trust: The keystone of the physician-patient relationship. *American College of Surgeons*.
- Plato. (1967). *The Laws*. Cambridge, Massachusetts: Harvard University Press.
- Poirier, S. (2009). *Doctors in the making: Memoirs and medical education*. Iowa City: University of Iowa Press.
- Pories, S., Jain, S. H., & Harper, G. (2006). *The soul of a doctor: Harvard Medical students face life and death*. Chapel Hill, NC: Algonquin Books of Chapel Hill.

Rogers, W. A. (2002). Is there a moral duty for doctors to trust patients? *Journal of Medical Ethics*, 28(2), 77-80. doi:10.1136/jme.28.2.77

Roter D, Hall J, Katz N. Relations between physicians' behaviors and analogue patients' satisfaction, recall, and impressions. *Med Care* 1987; 25:437-451.

Siegler, M., & Entralgo, P. L. (2011). The Three Ages of Medicine and the Doctor Patient Relationship. *Monographs of the Victor Grifols I Lucas Foundation*, (26), 13-36. Retrieved February 4, 2019.

Suchman AL, Markakis K, Beckman HB, Frankel R. A Model of Empathic Communication in the Medical Interview. *JAMA*. 1997;277(8):678-682. doi:10.1001/jama.1997.03540320082047

Time physicians spent with patient U.S. 2018 | Survey. (2019). Retrieved 2019, from <https://www.statista.com/statistics/250219/us-physicians-opinion-about-their-compensation/>

Thom D.H., "Patient Trust in the Physician: Relation to Patient Requests and Request Fulfillment," *Family Practice* 19 , no. 5 ( 2002 ): 476 -483.

Thom, D. H., Hall, M. A., & Pawlson, L. G. (2004, July/August). Measuring Patients' Trust In Physicians When Assessing Quality Of Care. Retrieved January 17, 2019, from <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.23.4.124>

Thom DH, Wong ST, Guzman D, et al. Physician trust in the patient: Development and validation of a new measure. *Ann Fam Med*. 2011;9(2):148-154.

Tsang, M. (2013). The Importance of Empathy—As I Have Studied and Experienced It. *Hawaii J Med Public Health*, 72, 79-80. Retrieved February 16, 2019.

Walker J, Ostrom E. Trust and reciprocity as foundations for cooperation. In: Cook KS, Levi M, Hardin R, eds. *Who Can We Trust? How Groups, Networks, and Institutions Make Trust Possible*. Thousand Oaks, CA: Russell Sage Foundation; 2009:91–124.

Wender RC. Humor in medicine. *Prim Care* 1996;23:141–154.



## Appendix A

### **Interview Questions**

1. How would you best characterize a patient/doctor relationship?
2. How has your understanding of this relationship evolved throughout your career?
3. How would you define clinical empathy in your own words?
4. What in your experience is the most difficult aspect of expressing empathy within the patient/doctor relationship
5. How do you work to develop clinical empathy within your professional relationships and in your relationships with patients?
6. Have you ever openly expressed grief/strong emotions in front of the patient?  
-if so, what was the impact of this emotional response on your relationship with the patient?
7. Can you relate an experience in which emotional attachment/detachment with a patient influenced your professional decisions?  
-if so, in what way?
8. Can you explain what you do to maintain emotional distance with your patients?
9. What has been the impact on your capacity to express empathy when a patient under your care has died?

10. What methods do you use to cope when a patient under your care passes away?

11. What resources are available to you when a patient under your care dies?