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Notes on Empathy and Trust as Key Notions in English Medical Discourse

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ABSTRACT

The paper offers partial results of a long-term project aimed at the inquiry into the field of medical interviewing. More specifically, it deals with the meaning and value of empathy and trust in general practice consultations. Firstly, it introduces both terms, with the main focus given to empathy. Secondly, it examines the interrelation between empathy, trust, and outcome-based research, stressing the importance of patient's satisfaction and his/her compliance with the advice given by the doctor. Thirdly, it offers a list of selected discourse strategies capable of conveying empathy a trust during the medical interview. Finally, the attention is given to the role of non-verbal communication.

Key words: Medical consulting, empathy, trust, outcome-based research, discourse strategies, nonverbal communication.

1. INTRODUCTION

The paper deals with the meaning and value of empathy and trust in medical consulting. In order to provide information support for what should be considered key notions of doctor–patient interaction and its research, I will introduce the essential terminology via a variety of definitions and examples. Firstly, I will present both terms, with the main focus given to empathy. Secondly, I will try to examine the interrelations between empathy, trust, and outcome-based research, stressing the importance of patient's satisfaction and her compliance with the advice given by the doctor. Thirdly, I will offer a list of selected discourse strategies capable of conveying empathy and trust during the medical interview. Finally, I will note some relevant aspects of nonverbal communication.

2. EMPATHY AND TRUST IN DEFINITIONS

Historically speaking, the modern usage of the word empathy appeared in the second half of the 19th century when the German aesthetician Robert Vischer coined the term *Einfühlung* as a method of understanding a particular piece of art through the projection of human feelings (Clark, 2007; Hunsdahl, 1967; Pigman, 1995). Over the course of the following fifty years, the term underwent a conceptual broadening of its meaning, outgrowing the borders of aesthetism and crossing into the realms of interpersonal functioning (cf. Clark, 2007; Jenkins, 1997; Wispé, 1987). At the beginning of the 20th century, the term *Einfühlung* entered the New World, and was translated by Edward Titchener into English as *empathy* (Clark, 2007; Katz, 1963). As is apparent, the English form derives form the Greek *empatheia*, that is: to enter into or share a person's suffering or passion (Clark, 2007; Schmid, 2001).

In the course of the 20th century and during the early years of the new millennium scholars have introduced a number of varied and often ambiguous definitions of empathy. As scientific disciplines have evolved, there have appeared numerous opinions regarding the meaning of empathy. Both theoreticians and practitioners from such fields of institutional interaction as psychotherapy, psychoanalysis, and medicine have competed with each other for who is able to come up with a better explication of the concept of empathy. However, as is already quite clear today, it is by no means possible to produce a definition which would be capable of functioning universally. Nevertheless, we are able to identify at least three modes of empathy: namely (i) *experiential*, (ii) *communicative*, and (iii) *observational* (Clark, 2007, pp. 5–12).

The experiential mode of empathy (or the so called mode of experiencing) was recognized and emphasized by Carl Rogers (1902–1987), the proponent of client-centered therapy and probably the most prolific 'empathy' writer of the 1940s, 1950s, and 1960s. He proposed the so-called *attitudinal* focus of empathy (e.g. Rogers 1949, 1951, 1966), which, in his view, involves a state of being with a client and a strong will to create a supportive climate for consultation. "In order to do this, a practitioner typically expresses empathic responses to the client in order to verify or affirm the experience of the individual. This interactive aspect of understanding emphasizes the experiential quality of empathy" (Clark, 2007, p. 6). Moreover, the practitioner is supposed to identify with his client and imagine what it may be like to be in his/her place (Bachrach, 1976). However, this last aspect of Rogers' approach is sometimes criticized for not being fully aware of the importance of *emotional detachment* (cf. Mearns 2003).

The communicative mode of empathy (or the mode of communication), in accordance with Rogers' therapy, stresses the importance of the practitioner's active resonance to the client's experiencing. However, unlike the experiential mode, which does not state *unequivocally* that the comprehension of the client's inner feelings must be communicated back to the client (Marcia, 1987), the advocates of the communicative mode (e.g. Carkhuff & Berenson, 1977; Jacobs & Williams, 1983) emphasize the communication of empathy. They understand empathy as an interpersonal skill which can be learned, taught, and evaluated through observable criteria of so-called *accurate* communication, and in this way substitute Rogers' sensing from the attitudinal perspective (Hackney, 1978). In other words, "the essence of empathy became transposed from an experiential state involving the client and counselor to an observable interpersonal process" (Clark, 2007, p. 9), with verbal *reflection* being its most distinctive technique. Importantly, this mode of empathy has also been criticized. Concerns have primarily focused on the issue of equating empathic understanding with the ability to utilize 'accurate' communicative techniques (Rogers, 1980).

While the experiential and communicative modes of empathy share common ground, at least as far as the verbal (or nonverbal) affirmation and verification of the client's experience by the practitioner is concerned, the observational mode of empathy (or the so called mode of observation) appears to stand on its own. Unlike the experiential and communicative modes, which concentrate on the *immediate* interaction between the person/client/patient and the therapist/practitioner/doctor, observational empathy frequently involves a *prolonged* view of an individual's life (Ornstein, 1979). The supporters of this mode (Kahn, 1985; Kohut, 1991; Poland, 1984; etc.) understand observational empathy as an effective method for acquiring psychological data with respect to the individual and her life context. They divide the related

process into two parts: the acquisition of knowledge, and the interpretation of the acquired information to the client. This strategy enables the practitioner to reach a deeper understanding of the client, and allows him to transpose his increased understanding back to the client in a more empathic form. What might be a problem is the fact that the mode of observation seems to imply that it is not possible to behave empathically any time the practitioner would like to, for example during the first contact with the client – which, in my opinion, cannot be taken for granted.

My plan in this paper is not, of course, to argue in favor of any of the modes of empathy outlined above, and thus to contribute to and develop a theoretical understanding of the concept of empathy. What *is*, however, important for the purposes of this study is the fact that all three modes agree that empathy has something to do with communication. To put it differently: empathy must be communicated, or: there is no empathy without communication. In this respect, I understand empathy as an "emotional experience between an observer and a subject in which the observer, based on visual and auditory cues, identifies and transiently experiences the subject's emotional state. In order to be perceived as empathic, the observer must convey this understanding to the subject" (Hirsch, 2009).

Having introduced my personal conception of empathy on a general level let me now continue this terminological sketch with three expressions that are frequently confused with empathy: (i) *sympathy*, (ii) *identification*, and (iii) *projection*. The comparison between these three terms is, in my opinion, of certain importance because it can reveal more delicate aspects of the meaning and value of the concept of empathy as such.

Although semantically empathy and sympathy are related to each other, these two concepts are not interchangeable. As described by Black (2004) and Halpern (1993), the purpose of empathy is to arrive at a point at which a practitioner understands a client and her problems, which subsequently enables him to help the client handle those problems. Sympathy, by contrast, focuses on the well-being of the client; the practitioner's understanding of her condition is not a prerequisite. According to Clark (2007, p. 14), "empathy typically engenders therapeutic advance, whereas sympathy may more often be a hindrance". While empathy assumes a sense of emotional detachment, separateness and objectivity, except for time-limited periods of harmonizing with the client (Wispé, 1986), with sympathy, there is a danger of merging the practitioner's and client's psychological perspectives (Kalisch, 1973), which may result in erroneous therapeutic decisions and ineffective processes of treatment.

As regards empathy in comparison with identification and projection, it should be mentioned that both notions overlap with empathy in the sense that they enhance a practitioner's understanding of a client. Identification is an operation through which the practitioner tries to identify with the client's experiences. Projection, by contrast, is an operation through which the practitioner attributes his personal experiencing to that of his client. In both instances, it is important to find an optimal level for their integration into the process of interaction (Olinick, 1969). If the practitioner is not successful in doing so, it can interfere with his intention to make accurate judgments (Shapiro, 1974; Strunk, 1957).

The last term which needs to be explained at this point – because of its importance – is trust. As will be shown in the following section, this is one of the key words characterizing effective doctor–patient relationships. In very simple terms, trust can be defined as a relationship of reliance (Bachmann & Zaheer, 2006). The atmosphere of trust goes hand in

hand with an atmosphere of safety, closeness, intimacy, warmth, and acceptance (Vymětal, 2003, p. 130). Clearly, the concepts of empathy and trust are interrelated. "Empathic understanding often reduces psychological threat through the development of trust and increased communication" (Clark 2007, p. 27). Nevertheless, unlike the atmosphere of empathy within the medical interview, which is a result of rather one-sided activity by the doctor, the aura of trust can be reached only through the mutual effort of both participants: the doctor and the patient.

3. EMPATHY, TRUST, AND OUTCOME-BASED RESEARCH

One of the main issues which are dealt with within the scope of the present study is the dissatisfaction of the participants of the medical consultation with the communicative practices of the opposite party, and with the outcomes that arise as a consequence of such circumstances. Doctors, for example, complain that patients do not comply with the advice given, and do not follow the suggested treatment (Ley, 1983; McManus, 1992; Pendleton & Hasle, 1983). Patients, on the other hand, criticize doctors for not being attentive enough to the information presented by the patient, and for not being able to conduct a medical interview in such a way that the doctor's findings are interpreted (Frankel, 1983; Raffler-Engel, 1989; Allen, 1979).

Because much research has been carried out in order to discover which factors have a decisive impact on either the satisfaction or dissatisfaction of doctors and patients with the process and outcomes of the medical encounter, let me now summarize the most important information related to outcome-based research. Attention will be paid both to verbal and nonverbal aspects of doctor–patient communication. To stay within the confines of this study, particular attention will be given to those attributes of the medical interview that are related to the concepts of empathy and trust.

The outcomes from medical consultations are frequently classified into three main categories: (i) immediate, (ii) intermediate, (iii) long-term. "Immediate outcomes from the consultation, so far as the patient is concerned, would include the patient's satisfaction with the consultation, his memory for the doctor's explanations and instructions and changes in the patient's concern about his problem" (Pendleton, 1983, p. 9). As regards intermediate outcomes, they are usually assessed through the doctor's perspective, and include the patient's compliance with the doctor's instructions. The long-term outcomes include particularly improvements in the health status of the patient.

As has been clearly demonstrated by studies relating the patient's satisfaction (i.e. the immediate outcome) to the process of the medical interview (see Pendleton, 1983, pp. 38–39), patients are satisfied when their doctors behave in a warm and friendly manner. The satisfaction of patients is also associated with rather talkative doctors, who volunteer information, tending to discuss not only the patient's problem, but also the causes of the problem. What patients also find positive is the doctor's effort and ability to integrate social issues into the interview. Furthermore, the patient's satisfaction correlates with the use of empathic questions and with non-verbal expressiveness on the part of the doctor. Naturally, patients appreciate being able to understand the doctor's instructions. By contrast, patient dissatisfaction is often associated with doctors who ask many closed questions, and who are not willing to reassure their patients.

Regarding the research findings relating the patient's compliance (i.e. the intermediate outcome) to the process of the medical consultation (see Pendleton, 1983, p. 44), it seems that patients are more likely to comply when their doctors are able to relieve the tension that may arise during the interview, and when they explain things in terms which are lucid to the patient. Moreover, the patient's compliance correlates with the number of questions patients ask their doctors. A significant correlation can also be found between the patient's compliance on the one hand and the patient's satisfaction on the other hand. In addition, patients comply with doctors' instructions when their expectations are fulfilled.

As far as long-term outcomes are concerned, it is understandable that patients whose health state improves are happy and fully satisfied (cf. Woolley et al., 1978). What *is*, however, worthy of attention is the finding that when patients decide to change their doctors, it is not because they are dissatisfied with the doctor's medical competence, but because they consider their doctor to lack empathic understanding, and they consider an atmosphere of trust, care, interest, and motivation to be lacking (cf. Mechanic, 1964). There is also a certain relationship between the improvement in the patient's condition and the doctor's awareness of the patient's problems, both medical and psychosocial (cf. Romm et al., 1976).

What do these findings indicate? It is evident that the quality of the interaction between the doctor and the patient can have an extreme influence on the patient's outcomes and that the patient's expectations might be more important than specific treatment. Therefore, in order to diminish the dissatisfaction of both participating parties, doctors – and it must be them because they are in charge of the medical interview – should direct their attention to the patient as a human being, not as a medical issue. As Hirsch puts it: "Each patient wants to be treated as a person, not as an illness, and wants to be reassured that the doctor understands the nonmedical aspects of her condition" (2009). This, of course, does not mean that the doctor will renounce all standard medical procedures. The point is that it is definitely worth attempting to complement medical care with cognitive and emotional care. The patient's satisfaction will thereby be increased, her compliance with the doctor's advice strengthened, and, consequently, the positive health outcomes will be enhanced.

The above-outlined information implies that it is the client-centered approach (also person-centered, patient-centered) that should be integrated into the process of the medical interview. Hopefully everybody agrees that the main goal of medicine is to treat the patient, not merely to cure the disease (cf. Hippocrates). As Balint (1955) adds, what matters is not only the medicine or the pills, but the way in which the doctor gives them to the patient, in fact the whole atmosphere in which the drug is prescribed. In further reference to this, Raskin argues that "in the theory and practice of client-centred therapy, there is no concept more important than empathy" (2001, p. 1). According to Halpern (2003), empathy is directly therapeutic as far as the reduction of the patient's anxiety is concerned.

In Adler's (1997) view, the patient who trusts the doctor, and is convinced of doctor's understanding of her condition is more willing to share her life stories, which can entail positive treatment results. It is even more important as "patients often do not explicitly state their psychosocial concerns, which may manifest as physical illnesses … and can only be diagnosed by a physician who is carefully attuned to the patient" (Hirsch, 2007). On top of all that, as Anfosi & Numico (2004) maintain, empathic doctors seem to be less susceptible to experiencing burnout syndrome.

There is one more implication that can be indirectly deduced from what has been said so far: it is possible to blend outcome-based research with the medical (quantitative) and sociolinguistic (qualitative) approaches (cf. Wynn 1995, p. 115). Outcome-based research is capable of calculating the number of questions, while the latter two approaches can interpret the questions as patient- or doctor-centered, symmetrical or asymmetrical. In the section that follows, I will introduce other variables which contribute to the shifts on the scale between doctor- and patient-centeredness.

4. DISCOURSE STRATEGIES CONVEYING EMPATHY AND TRUST

Right at the start, I would like to state once again that the medical interview is a chief factor in effective health care provision. "Doctor–patient communication is especially important in those numerous cases where there are few if any 'objective' signs of laboratory results, and where the diagnosis and treatment have to be based solely on the information acquired from doctor–patient communication" (Wynn, 1995, p. 9). To conduct the communication in a patient-centered manner, i.e. in such a way that the patient feels that his cognitive and emotional worlds are being acknowledged by the doctor, definitely requires superior communicative skills than if medical issues are the exclusive topic of the interaction. While diseases and their symptoms appear to be always the same, each patient differs. A doctor who wants to be viewed as empathic and whose plan is to build up an atmosphere of trust needs to be able to express his understanding of the patient's psychosocial problems.

Taking into consideration the information shown in Vymětal (2003, p. 148) plus the details related to doctor behavioral styles and categories as introduced by Byrne & Long (1976), Tate (2005), Mishler's (1984) and Cordella's (2004), the doctor's strategies capable of conveying patient-centeredness, empathy, and trust in the medical consultation can be summarized as follows: (i) listen, let the patient be active, do not interrupt her, use silence; (ii) pose rather open-ended questions, use the patient's words and ideas, seek for the patient's ideas; (iii) be friendly, attentive, supportive, and reassuring, (iv) show interest, compassion, and understanding; (v) relieve tension; (vi) inform, explain, reflect, clarify, and interpret; (vii) involve the patient in the decision-making.

The aim of the patient-centered approach is to attain a type of doctor–patient relationship that has been defined by Roter & Hall (1992) as mutuality. In such a relationship the doctor and the patient share similar dominance and control over the interaction, and both participants benefit from the interaction. As can be inferred, this time it is not only the doctor, but also the patient who is supposed to claim a certain amount of power in the medical consultation. According to Ainsworth-Vaughn (1998, p. 180–182), there are seven strategies by means of which the patient can achieve power, though often with the cooperation of the doctor: (i) select topics; (ii) offer candidate diagnosis; (iii) co-construct diagnosis with the doctor; (iv) challenge the doctor's diagnosis; (v) propose treatment; (vi) carry-out potentially face-threatening acts; (vii) frame the medical encounter as friendly and invoke favorable cultural schemas in defining the self.

5. NONVERBAL COMMUNICATION

It is generally known that empathy and trust can also be expressed nonverbally. In English handbooks on doctor–patient interaction (e.g. Pendleton et al., 2003; Silverman et al., 1998), there are large portions of text aimed at various types of nonverbal communication. Attention

is given primarily to *visual-tactile* elements – namely to proxemics, posture, eye contact, facial expressions, gesticulations, and haptics – and their communicative functions in conveying various messages. The above sources of information are based on psychological research carried out during the 1960s, 1970s and 1980s (see Exline, 1974; Frankel, 1983; Kendon, 1967; Mitchum,1989).

Interestingly, it is haptics (the use of touch) that has recently attracted the most significant attention. Not only psychologists and psychotherapists, but also linguists, sociologists, and other behavioral scientists have approached the tactile element of nonverbal communication in an attempt to investigate how it serves as a form of communication in the therapeutic and/or medical process (cf. Durana, 1998).

According to Corey, Corey & Callahan (2003, p. 285), "there are also times when a touch that is given at the right moment can convey far more empathy than words can." It may communicate support, reassurance, warmth, and expresses the doctors' understanding of the patient's psychosocial condition (cf. Horton, 1998). By contrast, "there are potentially damaging experiences where touch represents an empathic failure or a violation of client trust" (Clark 2007, p. 198). The patient may, for instance, feel threatened, or may view the unwanted touch as an invasion into her psychological territory. In particular, when a sexual topic is being discussed during the medical interview, the doctor's touch could be evaluated as unwanted and destructive (Corey et al., 2004). To avoid such misapprehension of haptics, it has been advised that a touch should only last for a few seconds, it should be sincere, spontaneous, non-erotic, restricted to acceptable areas, and appropriate to the needs and readiness of a client (Kertay & Reviere, 1993; Willison & Masson, 1986).

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