A recent Emergency Medical Journal article[1] examined the relationship between empathy and litigation. The authors enrolled two groups of patients into a randomized, double-blind controlled trial. The subjects watched simulated discharge discussions between physicians and standardized patients; half of the videos differed only by the inclusion of two brief empathy statements. These verbalizations included: 1) a reflection on the patients' concerns about their symptoms, and 2) a reflection on their health awareness.

After watching the video, subjects were asked to score, (on a five-point Likert scale), their thoughts regarding suing the physician in the event of a missed outcome leading to lost work, (primary outcome), and four measures of satisfaction with the physician encounter (secondary outcomes). The empathy group had significantly fewer thoughts around litigation. In addition, the measures of satisfaction with the encounter were significantly better in this group.

In this context, empathy is defined as “the capacity to understand or feel what the patient is experiencing from within the patient’s frame of reference.” Empathy also involves being able to communicate that understanding back to the patient and the ability to be respectful of the patient’s worries or concerns. How you respond to the patient throughout the course of an interaction will determine not only how much information you will obtain, but will also form the core of your ongoing working relationship with the patient. You will often have an opportunity to treat the patient with empathy; a key component of building rapport. Without empathy, the patient will struggle with developing any trust that you understand and sympathize with his or her situation.
This area has been evaluated before by Wendy Levinson, MD, et al., in a 1997 JAMA article[2]. In that landmark study, primary care and surgical specialists were divided into “claims” and “no claims” groups. Significant differences in communication behaviors of the two groups were identified in primary care physicians, but not in surgeons. Compared to the claims primary care physicians, the no-claims primary care physicians used more statements of orientation, educating patients about what to expect and the flow of a visit.

No-claims physicians laughed and used humor more, and tended to use more facilitation, soliciting patients’ opinions, checking understanding, and encouraging patients to talk. They also spent longer in routine visits than claims primary care physicians, (18 versus 15 minutes), and the length of the visit had an independent effect in predicting claims status. The study concluded that routine physician-patient communication differs in primary care physicians with claims versus without prior claims. The study identifies specific and teachable communication behaviors associated with fewer malpractice claims for primary care physicians.

Despite some overlap with other compassionate responses, particularly sympathy, empathy is a distinct emotion. Clinical empathy is an essential medical skill that can be taught and improved, thereby producing changes in physician behavior and patient outcomes. The traditional paradigm for good bedside manner, “detached concern,” is probably too detached. Patients want more trust and connectedness. Most physicians are empathic, and that’s often why they go into medicine. The question is whether patients know that their doctors are feeling that empathy, and whether doctors are able to express that to a patient in such a way that the patient feels supported. The behavioral aspects of empathy and the empathic response can be assessed, and should be integrated into medical school training.

The skills that build empathy are active and reflective listening:

- **Active listening** involves looking and acting interested in the speaker, using good body language, leaning in, nodding understanding, and trying not to interrupt the speaker. This is a skill that takes practice and will allow you to gain more information, understand viewpoints, and build a therapeutic relationship.
- **Reflective listening** is the next level of communication and is what the Emergency Medical Journal study was referring to. It is borrowed from therapy techniques and it involves starting with active listening, then seeking to understand what the speaker said, and then offering that back to them. You literally try to understand what the patient is thinking and feeling and then restate that back to them. Often you can use the patient’s own words. Special attention is paid to emotional feelings and not just content.

Is it all a matter of saying the right words and being sure to repeat the patient’s expressed ideas, values, and feelings? Not by a long shot. More than what you say, what counts even more is how you say it and what your non-verbal messages are. We know that our non-verbal messages count more than our verbal ones and that if there is a discrepancy between the two, the non-verbal will be believed. So it is important for your listening to be accompanied by listening behavior—open to hearing and understanding posture and visage. If we attend to our phone messages or our pager while we are making a pretense of listening to the patient, no one will be fooled. We must establish an open, forward leaning posture, eliminate distractions, use appropriate eye contact, and communicate through our appearance that we are interested.

Studies show that a good bedside manner, along with empathy, has many benefits: it can sharpen your diagnostic skills, improve adherence, HCAP scores, job satisfaction, reduce your risk for burnout, and make it less likely that you’ll be sued for malpractice. These benefits are true for all medical specialties.


2 *The Journal of the American Medical Association*. 1997;277(7):553-559
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