Debates

Should family physicians be empathetic?

YES

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When we answer the question "Should family physicians be empathetic?" in the affirmative, we are saying yes to empathy as it is defined by Hojat et al,[1] who state that the concept of empathy must be limited to its cognitive and behavioural dimensions. They define it as "a cognitive attribute that involves the ability to understand the patient's inner experiences and perspective and a capability to communicate this understanding."

A powerful tool

Empathy is a powerful tool that health professionals can use to deliver care that is adapted to an individual's emotional, cognitive, and biological needs. Empathy also enables a patient to feel that he or she has been heard and understood. This helps to strengthen the therapeutic relationship and increases the patient's trust in his or her physician.

A physician's empathy helps a patient to manage what are sometimes intense emotions, and makes it easier for the patient to begin the therapeutic process. For example, when a patient reports emotions such as distress, sadness, shame, powerlessness, or discouragement, empathy enables a professional to communicate his or her understanding of these emotions, maintain the professional distance required to remain objective, and keep his or her own emotional balance intact.

If empathy is such a powerful tool for communication, why is it the subject of a debate here? In our opinion, over the years, notions that are related to, yet different from, empathy, such as sympathy, humanism, compassion, and caring have unfortunately been misused and confused. The terms *empathy* and *empathetic* can be found in the official documents of accrediting bodies and medical associations.[2-4] Even in these contexts, however, they are often used incorrectly to mean "altruism" or "unconditional acceptance" of the patient, with no regard for the context in which the patient is being seen or for the nature of the medical problem being addressed.[5] Spiro's article[6] is a good example of this shift in usage. In his commentary, published recently in *Academic Medicine,* he states that empathy is a human "emotion" and not a cognitive attribute. Empathy, in his view, spontaneously arises in the physician who then has an "I am you" or an "I could be you" experience, replacing the "me and you." This use of the term *empathy* confuses metaphor and reality; as human beings, we are eternally separate from one another. We can only imagine it to be otherwise. Given Spiro's definition, it is hardly surprising that many physicians perceive this task to be impossible and exhausting.

A key distinction between empathy and sympathy

Let's go back to the definition provided by Hojat et al,[1] which states that the cognitive aspect of empathy refers to a care provider's ability to understand an experience or emotion reported by a patient or his or her family. This understanding cannot be observed directly; it is an intrapsychic phenomenon arising in the physician. The behavioural aspect is observable; it refers to a care provider's ability to clearly reflect his or her understanding of an emotion or experience back to the patient or the family. This observable behaviour demonstrated by the physician is what creates in the patient a sense of being understood.

Unlike empathy, sympathy refers to an individual's ability to share an emotion being experienced by another and to feel his or her emotions stirred by another's emotions. Sympathy is a form of "emotional resonance" between physician and patient. For example, a physician is described as being sympathetic to a patient's sadness, hopelessness, or concern when he or she is saddened by the patient's sadness, feels hopeless because of the patient's hopelessness, or is concerned by the patient's concern. In these instances, the physician feels and (up to a point) shares an emotion analogous to the emotion experienced by the patient.

While a relationship does exist between the notions of empathy and sympathy,[1,7] sympathy, particularly when excessive, is clearly inappropriate in the context of delivering care because of the risk that it will cloud the care provider's clinical judgment and place the care provider at risk of burnout. One of the reasons for not becoming involved in delivering care to a member of our own family is precisely because our emotional involvement with our family could interfere with our ability to

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make a diagnosis or suggest appropriate treatment. In a nutshell, sympathy can adversely affect care.

Lastly, we should note that empathy is not an innate clinical practice. It requires rigorous training that is not currently included in medical training. Hence, the risk of slipping into a practice of sympathy, rather than empathy. We believe that empathy, as defined here, must be included in the curriculum. It is a powerful communication tool that enables a clinician to clearly express his or her understanding of another's suffering while protecting his or her own psychological integrity.

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Competing interests
None declared

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References

1. Hojat M, Gonnella JS, Nasca TJ, Mangione S, Vergare M, Magee M. Physician empathy: definition, components, measurement, and relationship to gender and specialty. *Am J Psychiatry* 2002;159:1563-9.
2. Royal College of Physicians and Surgeons of Canada. *CanMEDS 2005 physician competency framework. Better standards, better physicians, better care*. Ottawa, ON: Royal College of Physicians and Surgeons of Canada; 2005. Available from: **http://rcpsc.medical.org/canmeds/CanMEDS2005/index.php**. Accessed 2010 Jun 10.
3. College of Family Physicians of Canada. *Four principles of family medicine*. Mississauga, ON: College of Family Physicians of Canada; 2006. Available from: **www.cfpc.ca/English/cfpc/about%20us/principles/default.asp?s=1**. Accessed 2010 Jun 10.
4. Working Group on Curriculum Review, Section of Teachers of Family Medicine. *CanMEDS—Family medicine roles*. Mississauga, ON: College of Family Physicians of Canada; 2009. Available from: **www.cfpc.ca/English/cfpc/education/canMEDS/default.asp?s.** Accessed 2010 Jun 10.
5. Lussier MT, Richard C. Because one shoe doesn't fit all. A repertoire of doctor-patient relationships. *Can Fam Physician* 2008;54:1089-92(Eng), 1096-9 (Fr).
6. Spiro H. Commentary: the practice of empathy. *Acad Med* 2009;84(9):1177-9.
7. Lussier MT, Richard C. Feeling understood. Expression of empathy in medical consultations. *Can Fam Physician* 2007;53:640-1.

CLOSING ARGUMENTS

- The medical establishment must clarify the definition of empathy to put an end to the confusion between this term and similar terms.
- Empathy, as a cognitive attribute that involves the ability to understand a patient's experience and to communicate it clearly, represents a powerful communication tool for supporting patients who are dealing with difficult emotions.
- Defined in this manner, empathy can be taught and practised without placing a physician's psychological integrity at risk.