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3 **Therapeutic empathy: what it is and what it isn't?**

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13 **Abstract**

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16 In October 2017, a group of clinicians, empathy researchers, health care managers, philoso-

17 phers and patient representatives from around the world gathered in Oxford for a colloquium

18 to address some of the uncertainties surrounding therapeutic empathy. Research on this sub-

19 ject is blossoming with an increasing number of trials demonstrating its benefit on patient

20 outcomes. Yet the blossoming enthusiasm for empathy in healthcare has been mixed with

21 scepticism about its very possibility, and whether it is helpful. This editorial summarises our

22 colloquium discussions on what therapeutic empathy is and isn't with a view to clearing up

23 myths and misconceptions on the subject.

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34 **Introduction**

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37 Research on empathy in healthcare has blossomed, with the number of PubMed citations con-

38 taining the word 'empathy' in the title increasing tenfold (from 34 to 354) in the last 20 years.

39 <sup>1</sup> The references include several randomised trials showing that empathic care can improve

40 patient outcomes. <sup>2-4</sup> It is thus unsurprising that the General Medical Council considers empa-

41 thy to be an essential component of good communication. <sup>5</sup>As a testament to its importance in

42 healthcare, there are now training courses on the subject in the United States, <sup>6</sup> United King-

43 dom, <sup>7</sup> and South Africa. <sup>8</sup>

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49 Yet this enthusiasm for empathy in healthcare has been mixed with some negative reactions.

50 Sceptics have raised doubts about the possibility of empathy, <sup>9</sup> while others claim it is harm-

51 ful. <sup>10</sup> In October 2017 a group of clinicians, empathy researchers, health care managers, phi-

52 losophers and patient representatives from seven countries gathered in Oxford to discuss what

53 *therapeutic empathy* is, and how it might be attained. The discussions during the course of the

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meeting—some of which will be explored later this year in the empathy series within the *Journal of the Royal Society of Medicine*—included:

- The definition, phenomenology, and application of therapeutic empathy
- How technology enhances (or detracts from) therapeutic empathy
- Patient perspectives of therapeutic empathy
- Therapeutic empathy as a whole body and everybody experience
- How understanding transference can move us from empathy and patient centered medicine, towards compassion, self-compassion and a collaborative model of care.

In anticipation of these further thoughts, here we will review and attempt to clear up some of the confusions surrounding therapeutic empathy that arose at the colloquium.

### Seven myths about therapeutic empathy

**Myth #1. Therapeutic empathy cannot be defined.** The term ‘empathy’ (in English) dates back to 1873,<sup>11</sup> and its roots can be traced back to Ancient Greece.<sup>12</sup> As used in recent trials which have demonstrated its benefits, therapeutic empathic has been defined<sup>13</sup> and involves understanding the patient, communicating that understanding, and acting on that shared understanding in a helpful (therapeutic) way.<sup>13</sup> Each of these features is required. Understanding what a disease means to a patient is required for accurate diagnosis, prognosis, and shared decision making. Communicating that understanding is required to alleviate patient anxiety and doubts about whether they have been understood. Acting is required to maximise the therapeutic benefit of shared understanding. A range of ‘actions’ is acceptable in this context, ranging from prescription or referral to constructively dealing with emotional distress. This description of what empathy-based medicine is helps us clarify what it is not.

**Myth #2. Therapeutic empathy cannot be achieved.** There are two kinds of empathy: affective and cognitive. Affective empathy is achieved when we mirror the emotions of another person,<sup>14</sup> so that we actually experience those emotions. Complete affective empathy is probably impossible to achieve, since we will never know *exactly* what it means to be in another’s emotional state. At the same time, it is possible to achieve some degree of affective empathy. Few people do not experience any vertigo when watching someone walk a tightrope across the Grand Canyon. And because pain—in some form or other—is a near-universal human experience, we can all emphasize, to some degree, with another’s pain. More importantly, experiencing the emotions of another is not required for empathy. It suffices to *understand*—or at least try to understand—what it might be like to be in another’s shoes (‘cognitive’ empa-

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thy). Cognitive empathy involves imagining, insofar as we can, what it would be like to walk in someone else’s shoes.<sup>15</sup>

**Myth #3. Empathy is harmful.** Bloom has argued that empathy is harmful because it leads us to feel connected to one group and (they argue) more likely to harm another group.<sup>16</sup> Yet even this author acknowledges that empathy, defined as trying to understand what another person is going through, is helpful. A weaker claim is that empathic care leads to fatigue and burnout. There is no evidence to support this claim, and in fact empathy has been shown to reduce practitioner burnout.<sup>17</sup> Insofar as it may induce fatigue, mindfulness practices can mitigate these.<sup>18</sup>

**Myth #4. Doctors already practice empathy.** The extent to which healthcare practitioners express empathy varies widely across medical practitioners and medical specialities, with female practitioners outperforming males.<sup>19</sup> The fact that empathic skills can be learned also suggests that the extent to which therapeutic empathy is practiced is sub-optimal.<sup>20</sup>

**Myth #5. Empathy can be achieved by training practitioners.** Empathy is a relational concept and optimising empathy requires that patients and healthcare managers are involved with facilitating therapeutic empathy. Practitioners operating in an environment burdened by paperwork, where time caring for patients is not valued, and where they are fearful of litigation, cannot optimize how they express empathy. Patients cannot play their potentially important role when there are so few mechanisms by which patients can provide feedback about how they feel about their care. Meanwhile, managers impose targets and guidelines yet arguably display little understanding of what it is like to be a clinician. Empathy training for practitioners has been shown to be effective in some studies, but it will only flourish if all stakeholders involved in healthcare are committed to empathic care. In paediatric care and many other settings, therapeutic empathy will also often require engagement with patients’ family members. Eventually, the horizon of empathy could expand towards a *global culture of* empathic understanding.

**Myth #6. Empathy is the same as compassion and patient-centred care.** There is overlap between the definitions of compassion, empathy, and patient-centred care. And the extent of their differences will depend on how the concepts are defined. Empathy, as defined in clinical trials where it shows a benefit (see above) is the ability to understand others’ feelings, being them positive or negative, convey this understanding, then act on it. By contrast, we take compassion to involve a sympathetic pity and concern for the sufferings or misfortunes of others.<sup>12</sup> Patient-centred care has been defined in numerous ways, and usually requires seeing

things from a patient's perspective.<sup>21-23</sup> As such patient-centred care arguably requires empathy.

**Myth #7. Empathy is opposed to Evidence-Based Medicine / is not cost-effective.** Because evidence-based medicine involves combining best research evidence with patient values and clinical expertise, empathic care is required of rather than opposed to evidence-based medicine. Empathy is useful for making treatment decisions based on the combination of evidence, values, and expertise. Related to this, some fear that empathic care will take too much time. It is true that empathic care will require more time in some cases, and patient representatives attending the colloquium noted the importance of time (where it is required) and continuity of care to achieve therapeutic empathy. However since empathy involves both *caring for* as well as curing, rigorous cost-effectiveness studies are required to confirm the extent to which therapeutic empathy is cost effective. Adding a dose of empathy to a consultation may be cost effective when it improves patient outcomes, and moreover empathic care does not necessarily always require additional time.

Optimising the way in which therapeutic empathy is implemented will require overcoming these myths. It may also need redesigning of healthcare systems with technologies that can free up more time for human interaction. Finally, while empathy is universal in many ways, verbal and physical demonstrations of understanding will differ from culture to culture. Several of the patients in our colloquium, for example, noted that unless the healthcare practitioner touched the patient (in an appropriate way), that the patient would not feel cared for. Relatedly, the expression of empathy is likely to differ slightly from profession to profession. Implementing empathy will have to take these differences into account.

## Conclusion

Empathy between humans has always existed, and the evidence that therapeutic empathy improves patient outcomes is relatively new and growing. The evidence has already reached the stage where it can be—and is being—implemented. Facilitating this implementation requires that therapeutic empathy be clearly elucidated, and we hope to have taken an important step forward in achieving this goal here.

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