THE VALUE OF EMPATHY IN THE
PATIENT-CLINICIAN RELATIONSHIP

Introduction
Empathy is considered fundamental to successful patient engagement and healthcare outcomes. An empathic clinician can affect a patient’s levels of anxiety and stress, patient satisfaction and adherence, and patient enablement. Within a health team, empathic treatment enhances information exchange between health team members, diagnosis and treatment outcomes. Specifically, there is a significant correlation between the empathic clinician and patient responsiveness to treatment.

The Role of Empathy
Empathy is a component of the clinical and therapeutic relationship and is key to quality healthcare. Researchers have written about empathy in the context of psychotherapy and about the role it plays in clinician-patient communication. Empathy has a major impact on lowering anxiety and distress in patients and results in better clinical outcomes.

Neuroscientific researchers have most recently studied the science of empathy. It is a new field of research with clinical implications. They have reported on a neurobiological basis for empathy following discovery of the mirror neuron system (MNS) that affects an individual’s ability to be empathetic. The mirror neuron system provides a neural mechanism whereby individuals can understand the actions of others.74-76
Recent studies using functional magnetic resonance imaging (fMRI) experiments clinicians have looked at mirror neurons in the ventral premotor cortex and parietal area of the brain. Neurons in the somatosensory areas and in limbic and paralimbic structures are also seen. The insula, located deep inside the lateral sulcus, within the cerebral cortex of the brain, plays a role in connecting these regions. The fMRI experiments show that people who score higher in a questionnaire measuring a tendency to relate to the experiences of others activate the MNS region more strongly when listening to other’s express their emotions. The neurobiological studies, however, do not provide information about clinical outcomes.

**Definition of Empathy in Healthcare**

To assess the value of empathy in clinical practice, its definition must first be understood. There is no standard definition of empathy but certain elements can be identified. Empathy in healthcare is generally viewed as the competence of a health clinician to understand the situation of a patient including the patient’s perspective and feelings. It is also the ability to communicate and to act on that understanding in a therapeutic way.¹⁻⁵

Empathy can be defined as an attitude, competency, and behavior. Attitude reflects in the respectfulness one shows toward another person. It also reflects in the interest, impartial and receptive treatment one carries toward others. Empathy is considered the basis of good clinician-patient communication. It has an impact on patient satisfaction, adherence, anxiety and stress, and on clinical diagnostics and outcomes.

Clinician competence can include empathic skill, communication skill, and the skill to build a patient relationship based on mutual trust. Empathic skill refers to how a health clinician can engage a patient by drawing close to
their inner world. By recognizing a patient’s health needs, a clinician can gain the patient’s trust and thereby obtain needed health information from the patient. With effective communication skills, a clinician is able to check, clarify, support, understand, reconstruct, and reflect on the perception of the thoughts and feelings of a patient. When a clinician-patient relationship based on mutual trust is developed this reflects the ability of a clinician to emotionally resonate with a patient.1-5

A clinician’s behavior indicates how well the clinician recognizes a patient’s feelings and identifies with him or her. Behavior includes verbal and nonverbal skills whereby the clinician shows recognition of the emotional state of a patient in their situation, such as a change of environment, or of suffering from anger, grief, and disappointment. The empathic clinician reflects on and communicates an understanding of the patient’s circumstance to the patient. Empathy is considered by both patients and clinicians as patient-centered and humane. A majority of patients would recommend an emphatic clinician to someone else.77

**Barriers to Empathy**

Barriers to empathy have been identified as including an increase in technology and emphasis on productivity in medical practice, which influences aspects of patient care. A decrease in effective communication and a low level of empathy in clinician-patient relationships has been correlated to the rise of medical technology and productivity in everyday practice.

Various authors have reported on a greater interest by clinicians in technological and biomedical aspects of care. Some express concern that an emphasis on technology means less interest in empathy. Recipients of
healthcare may not feel clinicians are able to understand their situation and then become dissatisfied with their care. The improvement of patient satisfaction and adherence was addressed by Hojat, et al., who found a correlation between patient satisfaction and perception of physician empathic engagement.\textsuperscript{77,78} It was also found that the response of anxious patients correlated with the response of their health clinician, and patients tended to report lower levels of anxiety when under the care of an empathic clinician.

Varied research studies confirmed data findings of patient satisfaction and adherence. The data found links between health clinician empathy and patient satisfaction in various clinical settings. Researchers reported that empathy directly correlated with increased satisfaction, trust, and adherence; and patients who were more satisfied with their care also showed better adherence to treatment regimens. The same was found to be true for Lelorain, et al.\textsuperscript{79} It was showed that a patient’s view of quality of medical consultation related to health clinician competence and empathy.

**Diagnosis and Clinical Outcomes**

Better diagnostics and clinical outcomes were confirmed through the research on empathy, indicating that communication between health clinicians and patients is associated with underlying clinician attitudes. Health clinicians with a positive attitude when addressing patient psychosocial issues tended to show more concern and empathy. Improved patient satisfaction and clinical outcomes correlated with patient appreciation of empathy shown to them.\textsuperscript{3-5} An attitude of genuine empathy and concern by the clinician, as well as an ongoing relationship with the clinician, was highly valued by patients.
Patients under the care of empathic health clinicians offered up more personal information about social and psychological issues affecting their health. Patients indicated how a clinician’s attitude hindered or helped them when discussing their health problems. Patients also indicated how a clinician helped them resolve or understand problems as well as supported their efforts to change.

Hojat, et al., elaborated on a correlation with regard to health clinician empathy and patients’ clinical outcomes. Patients with laboratory diabetes testing who had been checked for their glycosylated hemoglobin (A1c) and low density lipoprotein (LDL) were found to have better test results when under the care of a clinician showing empathy. Empathy in the clinician-patient relationship enhanced mutual understanding, trust and honesty between both parties. It also provided good alignment of patient needs with treatment plans, resulting in a more accurate diagnosis and improved treatment adherence.\textsuperscript{77,78}

Researchers have shown that when clinicians communicate with empathy this can lead to better diagnostic and clinical outcomes. Patients talk more about their symptoms and concerns, which enables clinicians to collect more detailed personal health information, and to arrive at an accurate medical and psychosocial evaluation, diagnosis, and treatment regimen. For a patient group with higher health clinician empathy a duration of 5.89 days versus 7 days of hospital stay occurred.\textsuperscript{3-9}

There have been reports that even the common cold may be less severe in cases where empathy exists in the health clinician-patient relationship. More evidence is needed about the effectiveness of empathy in the daily practice of health clinicians.
**Patient Enablement**

A higher level of patient enablement has been reported where health clinician empathy exists. There is also a positive relationship between enablement and changes in wellbeing and patient complaints. Patient enablement may be measured through use of the *Patient Enablement Instrument* (PEI). Questions in this test cover the ability of the patient to cope with illness and life in general, as well as patient confidence about health and the ability to remain independent.

Research studies have focused on the relationship between patient health outcomes and clinician empathy. The use of empathy in communication was raised as a *soft element*. Empirical evidence also exists relative to the positive impact of clinician-patient interaction, including aspects of empathy and patient satisfaction, adherence to treatment (during periods of patient anxiety and distress), strengthening of patient enablement, and clinical outcomes.  

**Measuring Levels of Empathy**

Researchers use various tests to measure levels of empathy, including those outlined below.  

- **Jefferson Scale of Patient Perceptions of Physician Empathy (JSPPPE):**  
  a self-report measuring scale for cognitive and attitude factors.
- **Consultation and Relational Empathy (CARE):**  
  a patient rating system that measures clinician communication skills and attitudes.
- **Roter Interaction Analysis System (RIAS):**  
  an observer-rating system that measures empathy skills.
- **Tape Assisted Recall (TAR):**
measures the development of a long-working relationship.

A health clinician can be trained on ways to improve empathy and be tested for empathy level and communication style. As mentioned earlier, empathetic communication in the clinical encounter impacts the overall satisfaction with healthcare service for a patient, adherence to regimens, comprehension, and perception of a good relationship are related to the interpersonal communication between a clinician and the patient. This is particularly related to the clinician’s empathy. A warm communication style can lead to a positive effect on patient anxiety and engagement.

The higher focus on research related to empathy in clinical practice has emerged in the health literature. For example, in 2008 the World Health Organization (WHO) raised the importance of primary healthcare in a report *Primary Health Care Now More Than Ever* with the logo and key challenge to clinicians to *put people first, since good care is about people*. Several qualitative studies have shown that health clinicians link empathy to fidelity, moral thinking, pro social behavior, good communication, patient and professional satisfaction, good therapeutic relationships, fewer damage claims, and good clinical outcomes. Ideality, the medical clinician can communicate with patients, understand them, know the families, and regard the patient as more than “a case.”

In a study on how primary care clinicians try to convey empathy to medical students, basic principles of clinician empathy are raised. This includes moral development in the clinician, a basic willingness to help, and a genuine interest in the feelings of others. Limiting factors during clinical consultation are time pressures, heavy workloads, a lack of skill, and a cynical view on the effectiveness of empathy. Patients also tend to notice time pressures on
a medical clinician as a barrier. While empathy is generally viewed as part of
good clinician-patient communication, barriers exist for implementing this in
general practice.80

Empathy in medical school has been specifically studied. Several reports
showed that empathy appeared to increase during the first year of medical
school, and it decreased after the third year. Empathy remained low in the
final year of medical school, as measured using the Jefferson Scale of
Physician Empathy – Student Version. Additional studies had suggested that
the degree of empathy shown by medical students declined over the course
of their training.81 Hojat, et al., had previously noted that there were no
gender differences in empathy levels for medical clinicians. Quince, et al.,
recognized that among male medical students their affective empathy
decreased slightly but cognitive empathy did not change. For females,
affective and cognitive empathy did not change.82

According to Treadway and Chatterjee, when a medical student finally
begins clinical practice after medical school, the student may begin to lose
empathy. Possible explanations of the decline in empathy were identified as
a lack of good role models, changes in culture, and ethical views on health
and illness.83

The evidence of a positive impact between empathy and clinical outcomes
needs to be emphasized more among health clinicians, especially in light of
current education trends focused on technological changes and systems
approaches within healthcare. The heightened emphasis on technology could
influence the clinician-patient engagement in a negative way and to
potentially undermine clinician empathy. On the other hand, there are some
who express the belief that clinician empathy will improve if it is stressed more during education and training of all health clinicians.

Currently, a small empirically based examination explains the benefits of empathy. There are some high-quality studies that show promising results on evidence-based grounds but more research is needed. Neumann, et al., also highlighted the need for an examination of the cost-effectiveness of empathy in light of the recent focus by policy makers and health insurers on health systems and the efficiency of healthcare delivery. Raising awareness on empathy in healthcare with policy makers to show it is an effective and efficient way of managing patient outcomes has been pursued over the past decade. Researchers have reported that empathy should improve the clinician-patient relationship, and that more patients reported they want an empathetic clinician.

A concern has existed that empirical studies on clinician empathy are relatively scarce. However, the existing literature until now has clearly revealed that empathy is an important factor in patient satisfaction and adherence. It also helps decrease patient anxiety and distress and allows for better diagnostic and clinical outcomes. Clinician empathy also strengthens patient enablement and seems to improve physical and psychosocial health outcomes. Importantly, empathy should result in satisfaction not just for the patient but for the clinician because they will experience less compassion fatigue or burnout. While more research is needed, clinicians need to learn more about the practical use of empathy in healthcare settings, and focus more on the effects of empathy in the clinician-patient relationship.

The above discussion highlights the measurement of empathy as an important part of the current research and quality outcomes in healthcare.
delivery. It is often based on subjective self-reports. Other remote, objective findings identifying concrete feelings, experiences, and interpretations in clinical practice from the perspective of the clinician-patient encounter have improved the evidence on the value of empathy in healthcare. Patient perceived empathy is related to patient outcomes; a patient perceived empathy scale to measure the empathy of a clinician has been implemented in some healthcare settings to identify gaps in patient-centered care within an organizational culture.\textsuperscript{85}

Many patients look for empathy from their health clinicians. Outside of the medical setting, empathy means a human understanding that involves emotional resonance. Medical education has increasingly recognized this need.

**Detached Cognition In The Health Clinician**

The concept of detached cognition relates to the way educators in the medical field define empathy with a focus on emotional attunement and understanding of a patient’s emotions. Educational curriculums in healthcare are being evaluated more closely for how they are designed to teach empathy to health clinicians. Medical clinicians have a challenging role in that they try to be detached yet reliably care for all patients regardless of their personal feelings.\textsuperscript{33-37}

Medical educators as well as professional bodies overseeing licensing and continuing education for health clinicians are increasingly recognizing the importance of empathy. They define empathy in a unique way to be consistent with the idea of detachment. As mentioned, outside of medicine, the term empathy means a way of understanding and involves being moved by the experiences of another person. The Society for General Internal
Medicine defines empathy as the act of correctly acknowledging the emotional state of another person without experiencing the state oneself. A medical clinician cannot and should not experience the suffering of each patient. The emphasis on clinician empathy is that it is intellectual and a way of knowing how the other person may feel, but not emotional. The assumption is that experiencing the emotion is not important for understanding what the patient is feeling.\(^3\text{-}^5,33\text{-}^37\)

The current medical literature defines health clinician empathy as cognitive in contrast to sympathy. A clinician who is sympathetic could risk over identifying with a patient.\(^29\) Emotional responses could be seen as a threat to objectivity. In *The New England Journal of Medicine* and the *Journal of the American Medical Association* during the 1950s and 1960s clinical empathy was discussed as necessarily detached reasoning. This meant that the health clinician would do what needed to be done for patient care without feeling grief, regret, or other difficult emotions. The clinician was described as having a primary role to observe the patient to predict a response to illness. This concept of a detached clinician continues to persist throughout the current literature. In a classic 1963 article, *Training for Detached Concern*, Fox and Lief described how a medical student can dissect a cadaver without disgust. This same detachment allows a clinician to listen empathically while not becoming emotionally involved.

**Meanings of Empathy and Detachment**

Medical clinicians are trained to view the emotions of a patient objectively; however, they should recognize that they cannot overcome all emotions. The model of detached concern involves knowing that a person is in a certain emotional state. The clinician does not just label the person’s emotion but tries to recognize what it feels like to experience that emotional state.\(^29\text{-}^31\)
Clinicians guided by empathy can know what emotional descriptor applies to a patient. The following case examples illustrate the concepts of empathy and detachment in clinical practice.

**Example 1: Spinal Cord Injury Case**

A 33-year old male patient has been paralyzed from the neck down following a motor vehicle accident and becomes depressed and refuses treatment. During a clinical encounter, the patient is immobile and struggles to whisper through a tracheotomy tube to the clinician. The clinician responds to the patient’s attempts to speak by speaking in a quiet and gentle way. Despite the clinician’s gentle and non-threatening approach, the patient remains withdrawn in his response to the clinician.

The clinician may feel shame and retreat, which is a reflection of what the patient feels. Conversely, the clinician may recognize that continuing to communicate to the patient in a quiet and gentle way might not be effective because the patient is not engaging in treatment. The clinician may try asking the patient what is bothering him in a more assertive manner, risking an angry response from the patient to avoid sharing his true feelings. The patient may even express feeling disrespected by such an approach to engage. In such a scenario, the clinician and patient have engaged albeit there may be emotional anger communication by the patient, and now the clinician may begin an effective therapeutic approach.

**Example 2: Pregnancy Case**

A 20-year old pregnant patient meets with her obstetrician on what to expect during her first labor and delivery. The young woman appears anxious as the physician explains to her the options for pain relief. After he
explained in detail about the patient’s options she still appeared anxious and became more withdrawn. The obstetrician asked the patient what was making her anxious, however she did not answer. When the patient did not respond, the obstetrician continued to explain in more depth the options for pain, and attempted to cheer and reassure the patient that all would be fine. Shortly after that encounter, the patient moved her care to a new physician.

In this case, the patient’s unresolved anxiety included an element of panic as the obstetrician tried to reassure her about pain relief. She may have imagined being tied to an intravenous (IV) line as he explained the process of IV analgesia during delivery. She may have feared being restrained and losing control. In the patient’s medical history questionnaire, she had reported a past experience of sexual abuse as a rape victim, which triggered fear of being confined to an IV line. When the obstetrician explained options to the patient, not taking into account her history of sexual abuse, she likely felt that her fear was not being recognized. She may have felt that the obstetrician appeared unconcerned about her past experience of trauma, as he did not pause to listen or use nonverbal observation skills to cue the patient that he was paying attention and understood her trauma was the basis of her fears.

*On Reflection: Case Summary*

With each of the two above case examples, the medical clinicians are genuinely concerned. They both asked the same questions related to what was making the patient feel anxious. In the first case, emotional attunement guided the timing and tone of the clinical encounter. In the second case, that appeared to not occur where the obstetrician observed the fear however did not pause when observing the patient become more frightened.
**Nonverbal Attunement**

In clinician-patient interactions *nonverbal attunement* allows the clinician to pause at moments of observing a patient’s heightened anxiety. With nonverbal attunement, the patient is able to disclose information. When clinicians do not pause to allow nonverbal attunement, patients do not share vulnerable information even when the clinician asks an appropriate and accurate question.

The key point to remember is that people rarely give a full and useful response when asked a direct question. Clinicians need to rely on emotional cues and shifts in the emotions of patients to understand the basis of their anxiety, and to pause to allow the patient to reveal more information and for engagement to occur.

**The Empathic Clinician And Emotional Attunement**

In this section, the concept of emotional attunement is discussed in more detail as it relates to the empathic clinician. The prior section discussed detached concern, which some may confuse as being the same as emotional attunement, however they are not the same. Emotional attunement shapes what a person imagines about the experience of another person.\(^{94}\)

A health clinician may imagine and resonate with what a patient is feeling. Resonance is part of ordinary communication; it can be subtle and involve a nonverbal sense of what another person is feeling. It does not always involve resonating with a strong feeling and verbalization. Empathy does not require that a health clinician fully experience the emotions of a patient. The focus should not be on the introspective response of the clinician but rather on the patient.\(^{93,94}\)
In clinical practice, the challenge is to use skillful attunement in multiple, rapid, and ordinary interactions. An example is if a patient reports stopping prescribed medication and appears angry about the potential side effects. The patient could also feel hopeless about having a certain diagnosis. Addressing the patient appropriately depends on being attuned to the emotions of the patient. In this case, the clinician’s best approach may be to discover why the patient stopped taking medication, and to reflect on how to respond empathically while deciding on other treatment options for the patient.6,34-36

There are several ways a clinician can use their emotional response to enhance patient care. First, they can use emotional attunement to appreciate the meaning of the words of a patient. Second, their emotions should focus and hold their attention on what is making a patient anxious. Third, empathy can facilitate patient trust and disclosure. Empathy can enhance a clinician’s individual practice and interactions with patients to be more meaningful. In general, empathy is a way for the clinician to grasp the emotional state of the patient.

Empathy in the clinical encounter involves perceptual activity however it also operates alongside logical inquiry. If a clinician exercises the skill of logical, objective reasoning as they reflect upon their empathic intuitions, this enhances patient communication, and, as mentioned already, improves the medical diagnosis and treatment options. A problem can arise if empathy is viewed as dependent on emotional responses, which are outside of a person’s immediate control.6,34-36

**Listening to the Patient’s Story**
Health clinicians can reliably and reasonably empathize with a patient even when experiencing a negative emotion. Emotional resonance can flow easily at times however a busy and overworked clinician could find being responsive to patients challenging or even impossible. One way to train clinicians on empathic responses is to encourage them to keep a natural curiosity about the lives of their patients. Encouraging clinicians to be curious about patients involves training them on concepts of listening to the patient’s story and then retelling the story as the patient shared their illness and personal circumstance.

Training clinicians to write narrative histories helps them to more carefully listen to the words of the patient. An example would be a patient who became paralyzed and expressed that treatments were useless and a waste of time. If a clinician focuses on the narrative, it can be useful to elicit feedback from other health team members or peers on how to engage the patient by repeating back the narrative during another clinical session when the patient feels more prepared to explore treatment options. The goal of repeating the patient’s story would be to help the patient consider and agree to treatment options rather than continuing to feel as though life after a traumatic injury or major illness was useless and a waste of time.

**Barriers to Empathy**

Barriers to empathy are important to understand, and at times multiple barriers can exist. Barriers can be due to both the patient and clinician responses. For example, patients could experience anxiety or other emotions that interfere with empathic responses; or the clinician could be pressured by the lack of time to listen. A significant barrier to empathy is when clinicians do not see the emotional needs of the patient as an important part
of care and illness. Research shows that clinicians communicate better if they regularly include psychosocial dimensions of care in their practice.

An additional barrier to empathy concerns how negative emotions can arise when tension exists between a clinician and patient. A clinician can feel angry with a patient for not cooperating with treatment and this leads to barriers to understand the perspective of the patient. Clinicians can be educated to show tolerance and to be mindful of their own negative feelings, such as when a psychiatry clinician learns to pay attention to countertransference, which is redirection of the clinician’s feelings toward the patient. Both empirical and theoretical work is needed to address these barriers and to help provide steps for clinicians to include empathy into everyday practice.

Clinician Education

Education curriculum has already been raised as a way to address barriers to empathy in the clinician-patient relationship. Specifically, clinicians can be trained to focus on the beginning of a patient interview, giving the patient time to speak without interruption. This helps set the tone for patient disclosure and trust to develop. Education can also focus on how the clinician perceives the psychosocial needs of the patient as important and integral to good diagnostic outcomes.

Clinicians also need to be educated to focus on their own self-care, and potential anxiety as they often function within overworked and short-staffed health teams. They need to be educated to acknowledge and seek interventions for their own emotional needs.

Neural Basis Of Empathy
Empathy is fundamental to the emotional and social lives of people and is defined in general as the ability to share the feelings of others. As mentioned, human imaging studies have been used to determine how empathy consistently showed activation in regions of the brain that involve experiencing pain. This suggests that empathy is based at least in part on shared representations of firsthand and imagined experiences. These emphatic responses are not static. They can be modulated by the characteristics of a person such as the degree of alexithymia, which is the subclinical inability to identify and describe emotions within oneself. This is a marked dysfunction in emotional awareness, interpersonal relationships, and social attachment.

Empathy-related insular and cingulate activity (with the cingulate cortex part of the brain situated in the medial aspect of the cerebral cortex) can reflect a domain general computation, representing and predicting feeling states in oneself and others, and believed to guide responses and goal-directed behavior in dynamic social contexts. Empathic neuronal activation can also be modulated by contextual appraisal that includes perceived fairness or group membership with others. Empathy
can involve co-activation in further networks that are associated with social cognition. This depends on the specific situation and the information available in an environment.

**Empathic Negotiation And Confrontation**

Avoiding confrontations is often considered the best approach to handling a difficult patient. However, a closer look at the topic of confrontation with patients is needed to identify concepts and methods for coping strategies. Kontos, Querques, and Freudenreich provided insights into the rationale and responsibilities in patient confrontation. They identified that all clinicians can find themselves challenged with patients who are behaviorally inflexible, demanding, and temperamentally difficult.87

Being prepared through education on the empathic approach when dealing with patients is the ideal in order to carry forward empathetic negotiation and persuasion. There can be a natural reluctance to confront patients if they are unresponsive to these approaches, and at times the confrontation can be mishandled. Confrontation is defined as a clinical interaction that is interpersonal, face-to-face, and has the potential for an emotional clash, forcing a comparison of two points of view on medical care. Confrontation can also be a communication tool for a clinician to use when attempting to make decisions in a patient’s best interest. It can also be a patient-centered approach and relies on shared responsibility.

Kontos, Querques, and Freudenreich made the case for effective use of confrontation in patient care. Other interpersonal and social interventions were raised. The goal was to discuss an approach that could improve therapy, reduce clinician frustration, and minimize misallocation of
resources. The authors noted that medical literature and training can neglect guiding a clinician in managing poor patient behavior and attitudes.\textsuperscript{88}

Confrontation with patients can seem inconsistent with medical best practices. But there is an argument that confrontation and healing are not mutually exclusive. Some have argued that clinician assertiveness has therapeutic value with hesitant or oppositional patients. There needs to be a balanced focus on patient care outcomes and clinician duty to confront a situation. A poor confrontation with a patient can give a clinician a sense of powerlessness with respect to the clinician’s concerns and judgment on safe and appropriate patient care. Confrontation that is poorly executed can be counter-therapeutic and sever the clinician-patient relationship.

The authors proposed three questions to help clinicians decide if confrontation can be in the best interest of patients. The first question is: \textit{Does my patient prioritize health?} The second question is: \textit{Is Confrontation of My Patient Ethically Permissible?} The third question is: \textit{What If Confronting My Patient Is Emotionally Gratifying?} The authors recommended that the clinician does not want to subdue the patient as an opponent. Rather, the clinician wants to turn the patient into an ally to fight for their own better health.

The most important question to ask in choosing if patient confrontation is an option relates to whether the patient prioritizes health.\textsuperscript{89} The business of the clinician includes patient attitudes and behaviors that negatively impact clinical progress. If proper patient care cannot proceed, confrontation could be justified. The proposal could be a \textit{negotiated} change. If a patient does not prioritize health, the clinician should explore and try to work with the priorities of the patient. The clinician can try to influence the patient but
cannot impose on the patient to minimize disease burden except in special circumstances.

Problems can arise if a patient makes demands and does not highly prioritize health. Take for example a 55-year-old patient with type 2 diabetes mellitus and long standing poor glycemic control due to nonadherence who attends appointments sporadically, refuses nutritional guidance, and has comorbid heart disease. In this case, confrontation could be justified. In such a case, the patient seeking care needs to improve cooperation with the diabetes care being provided. Cooperation does not mean passivity. A responsible patient should engage actively in their pursuit of health and in medical decision-making. If there is clinical inefficacy due to a defect in the clinician-patient relationship, this should be considered in the decision concerning patient confrontation.

Ineffective clinical care can be due to an imbalance between the health clinician’s and the patient’s responsibility. Confrontation could be justified to bring these two components into a productive balance. For example, a psychiatric illness could cause a failing clinician-patient relationship, such as with a sociopathic patient who is angry and hateful. Challenging such a patient, who may also have comorbid conditions related to the mental illness, such as an addiction disorder, personality disorder, or other psychopathology, is challenging however it is important for the clinician to identify if a barrier to health is resolvable, and if the patient is invested in his/her own health.

Avoiding conflict might not be the best option. Patients sincerely tending to their health would likely inform the clinician of their needs and hope for a remedy to their ailment. However, after identifying, adjusting to, and
reducing barriers to care, if the patient is not invested in his/her own health then confrontation could be an option to potentially correct the imbalance in the clinician-patient relationship and ineffective clinical outcomes.

Confrontation and Ethics

Confrontation could be considered a violation of patient autonomy and concerns medical ethics. Patient autonomy is a cornerstone of current healthcare, but simply respecting a patient’s decision could be a dangerous oversimplification. For example, consider the case of a 55-year old patient with coronary artery disease who presents repeatedly to an emergency department with worsening symptoms of shortness of breath and chest pain. Each time the patient leaves the emergency department against medical advice after receiving nitroglycerin and morphine. Confrontation by the clinician might be the only way such a patient would stop with decisions that are not helping his/her health.

In the clinician-patient relationship it is assumed that patients can do no wrong. However, a clinician can use their expertise and authority to make medical decisions and request patient accountability. In an ideal situation, the clinician-patient relationship is between two autonomous parties with a mutual goal, and where the clinician can have legitimate expectations of the patient. The relationship should ideally include truthfulness, respect, and adhering to a plan for care that is negotiated. In an honest relationship, respectful confrontation can occur when one person bears a burden in a failing direction. Because the clinician is considered a caring stakeholder in a patient’s health, if the health of a patient is deteriorating due to patient action or inaction and other avenues of intervention are exhausted, the clinician should care (and be justified) to confront.
The main point in this section is that confrontation can become an option. When the patient’s health is deteriorating, harm can occur through passivity and a superficially inoffensive relationship between the clinician and patient. Once the clinician has thought through in advance about whether a patient has enough opportunity to control certain variables, the clinician should hold the patient accountable.

Clinicians are also considered stewards of healthcare resources and if the patient is unfairly and unjustifiably using finite resources, this should be confronted as well. The issue of confronting a patient is a challenging issue that some clinicians may prefer to avoid, but it is an increasing topic in the health literature relative to clinician-patient engagement and a topic that clinicians are recommended to focus on in terms of professional development and competency.

**Confrontation and Emotional Gratification**

At times a clinician can feel frustration or anger with a patient and feel compelled to step back. This frustration or anger can be due to *countertransference* or simple human emotion. A good approach is not to simply act on a positive or negative response, but to evaluate responses in context of the clinician’s relationship with the patient.

A clinician must not simply indulge in self-gratification. On the other hand, avoiding feelings and reactions could cut off a potentially helpful decision about clinical action and result in harmful decisions. While a clinician can love, hate, or fear a patient, he or she should acknowledge these feelings and examine motives in clinical decision-making affecting patient health. An example would be a 40-year old with systemic lupus erythematosus (SLE) who is inconsistent with keeping medical appointments. Other complicating
factors could be that the patient is verbally abusive, refusing treatment and yet accuses the clinician for not meeting health expectations. If the patient is not cooperative, threatening and showing unacceptable behavior, avoiding and/or disregarding the patient’s displeasure could pose risks for the clinician in the end. If an unfavorable imbalance exists in the clinician-patient relationship, it can lead to the clinician feeling constrained in terms of communicating options to continue versus discontinuing the relationship with the patient. In such cases, while the confrontation could be difficult it may be needed and, in the end, helpful.

A patient can also have a powerful emotion and act in a way that renders a clinician to act on them before the clinician realizes what is happening. This is an unfortunate outcome, and is known as *projective identification*. If the clinician disavows these feelings, a patient can sometimes escalate an already irrational behavior.\(^{87-90}\) Although such circumstances can be challenging, there is still an opportunity to turn the situation toward a more therapeutic encounter. The clinician can choose to either tolerate the unpleasant emotions or examine them from the patient’s perspective. The patient may be helped to identify, understand, and manage their own state. If a clinician responds in a way that is strategic and mature, this can be useful and gratifying to all involved.

Judgment can be clouded by the need for self-gratification. Reactions to a patient and projective identification can involve complex motives and feelings. Clinicians should be aware of these possible outcomes in the patient relationship when considering the need for confrontation. The ideal is that the clinician is reflective and can self-assess their own feelings and responses before, during, and after patient confrontation, and seeks periodic consultation to make sure all factors are weighed responsibly.
In a clinician-patient relationship confrontation can be a legitimate option if that relationship suffers from an imbalance related to a person’s privileges and duties. Kontos, et al., focused more on principles and not on specific techniques of confrontation. Some patients will be confronted and find another health clinician to do what they want. More could be said in the medical literature relative to patient confrontation, such as how to stay consistent with the goals of patient-centered medicine though values of honesty, social responsibility, and mutual accountability.

**Letting Go of Anger**

Letting go of anger is a positive step for both a patient and health clinician. If the clinician holds on to anger, he/she cannot effectively move forward with a solution to problems. If a patient feels anger, they need to be guided as well to let go of it.

Clinicians who feel anger, due to what a patient said or some other reason, cannot effectively act as a health professional. If the clinician or patient are not able to get rid of anger, the price could be high. Not letting go of anger could cause individuals to suffer physically, emotionally, and spiritually; it can lead to bitterness, lack of enjoyment of the present, depression, anxiety, and a lack of connectedness with others. Letting go of anger is a conscious decision, and it opens options for better feelings of understanding, empathy, and compassion. When a person lets go of anger this leads to healthier relationships, greater psychological wellbeing, less anxiety, less hostility, less stress, lower blood pressure, fewer symptoms of depression, a stronger immune system, improved heart health, and higher self-esteem.

**Techniques To Deal With A Difficult Patient**
Insight on the art of handling difficult patients has been offered by Chesanow who notes these patients can be the one many clinicians and staff dread to see walk into a clinic or admitted to hospital. Difficult patients are regarded as those who are angry, disrespectful, rude, demanding of certain drugs or tests even when they are not needed, abusive, and even ask clinicians to submit a fraudulent bill so that insurance will cover the cost of treatment.94

One approach to dealing with the difficult patient is to draw boundaries. Clarify what behavior is allowed and require them to act respectfully. A patient may not be aware that they are being difficult and demanding. If setting such boundaries does not work, the clinician could suggest to the patient that he/she is not the best clinician for the patient. Alternatively, another approach is to overcome the issues encountered with a difficult patient. Trying to determine what the patient is unhappy about in the clinician-patient relationship and being willing to apologize can help even if it is not the fault of the clinician. For example, the patient may have had a long waiting room stay or not happy with a specialist referral. The patient could be forgiving with the clinician if they detect the clinician is genuinely sorry for the patient’s unhappiness.

There is a reported 5 percent of patients that can cause 95 percent of the problems in a clinician’s practice. It may not always be prudent to dismiss the patient from the clinician’s practice; in that case, the clinician must deal effectively with a rude and abusive patient. The clinician and the general office staff need to be prepared to assist in the needs of a difficult patient. The clinician should have staff prepared to deal with, for example, a patient who gets impatient when an appointment wait is long.
In cases of unresolved conflict, the clinician may opt to write the patient a letter or address the patient in the presence of an office manager. An example would be when the clinician needs to calmly inform a patient that a basic ingredient in the relationship needs to be addressed. If the patient’s behavior appears to lack cooperation with the clinician and office staff, this makes it impossible to engage with the patient to promote good health outcomes. Options in such situations are to advise a patient to find another medical clinician, provide a referral to them or ask for a referral from another primary care physician. While the patient is seeking another medical clinician, he/she can be advised that emergency care will be provided for one month from the date of the termination of care letter. Any subsequent behavioral issues should be documented.

Not all clinicians feel comfortable terminating a patient relationship. Some have not been able to identify ever interacting with a difficult patient or consider they have been effective with a difficult patient by listening to their story without interruption. Much depends on the medical specialty and type of clinical practice engaging with patients. A clinician can guide the conversation if it becomes unproductive with unnecessary detail.

If a health clinician feels pressured for time, it may be hard to not show impatience. This can inflame a situation. It is hard to feel compassion for someone who is not cooperating. A clinician can also fear harming a patient by missing a diagnosis or not recognizing a drug interaction, forgetting to check a lab or missing a call back. A problem patient can cut into the time needed for all of this. But a medical clinician can recognize that dealing with a difficult patient is inevitable and requires clear boundaries to be established for both patient and staff.
Frequent Flyers

There are certain patients that arrive at the hospital emergency department as if it was home. Such patients are often on a first name basis with the staff. For example, they could have a history of substance use and addiction, and staff tend to regard them as a regular visitor or frequent flyer.95

The medical frequent flyer generally refers to patients with a number of health needs. Some are rebounding and challenged by alcohol and drug use issues, and others need mental health care. Typically, frequent flyers use the emergency department because they have no health insurance. They usually have no primary care clinician. The frequent flyer may be driven by anxiety and fear, chronic pain, yet feel reluctant to make an appointment to see a primary care clinician.

Some health facilities are considering new ways of taking care of medical frequent flyer patients, and to manage their needs in a more cost effective way. Hospitals, healthcare systems, and academics have been prompted by the urgent need to address the health of medical frequent flyers. The goal is to curtail a problem some believe could become even worse without clear planning and solutions to address it.19-26,95

Insurance companies are also working with hospitals to implement new programs, for example for the frequent flyer with a mental illness or for others with chronic conditions. The attempt is to divert these patients into coordinated care plans that are hospital-sponsored. They also connect with government and community-provided services. Often, case managers are assigned to monitor these medical frequent flyers. The manager follows up after an emergency department visit to prevent a recurring hospital stay. Hospitals are now using electronic medical record programs to flag frequent
flyers for primary care clinicians and community organizations. Hospitals may also assign social workers and nurses to look over records and identify patients who come to the hospital often. They alert these patients that they may need psychological or primary medical care rather than repeated admissions to the emergency department.\textsuperscript{11-13,15-26}

A medical frequent flyer may arrive at an emergency department as many as five times per month. Patients who arrive at the emergency department with such frequency may have drug or alcohol use disorders. Some are also homeless. Often, frequent flyers in the emergency department have complex and severe medical problems. Combined homelessness and addiction issues can complicate the medical picture in the emergency department, for example, the person may be intoxicated and having a myocardial infarction.\textsuperscript{95} They may have fallen and hit their head and sustained a skull fracture. Impaired patients cannot always explain how they are feeling.

Complexities are associated with frequent flyers and their use of emergency departments. The use of an emergency department by a frequent flyer involves a high health cost burden for a hospital. It is also a strain because frequent flyers add to overcrowding in emergency departments, impacting the patient waiting times and delaying emergency, life threatening interventions for those in need. An urgent need exists for policy makers and insurers of healthcare to address the growing needs of homeless and uninsured individuals that become frequent flyers in hospital emergency departments.\textsuperscript{11-13,15-17}

Summary

There is no standard definition of empathy but certain elements can be identified. Empathy in healthcare is generally viewed as the competence of a
clinician to understand the situation of a patient including their perspective and feelings. It is also the ability to communicate and to act on that understanding in a therapeutic way.

Empathy is considered the basis of good clinician-patient communication. It has an impact on patient satisfaction, adherence, decrease of anxiety and stress, better diagnostics and outcomes. Barriers to empathy exist and are important to understand through clinical education and ongoing training. Understanding patient anxiety or other emotions that could potentially interfere with empathic responses is essential, and clinicians need to be aware of their own detachment and emotional attunement to avoid patient perceptions of a lack of time to listen and engage.

Clinicians can be trained on ways to improve empathy and their communication style with patients. Empathetic communication in the clinical encounter impacts the overall patient satisfaction with healthcare service, and patient adherence to regimens, comprehension, and perceptions. A warm communication style by clinicians can lead to a positive effect on patients and lead to improved engagement and health outcomes.
Reference Section

The References below include published works and in-text citations of published works that are intended as helpful material for your further reading. [References are for a multi-part series on THE DIFFICULT PATIENT].


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