

**Exemplifying Clinical Empathy: An Analysis of Physicians'  
Narratives About Empathetic Practices in 21<sup>st</sup> Century Healthcare**

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## **Introduction**

Twentieth century America witnessed dramatic gains from what medicine had to offer. Advancements in scientific technology, pharmaceutical products, and improved nutritional intake resulted in increased life expectancies increased and decreased mortality rates (Furst 2003). However, as medicine—both the understanding and practice of it—became more precise and technical, healthcare began to experience a complex array of social problems; in particular, one foundational aspect of clinical care began to decline: the doctor-patient patient relationship. While interest in the relationship between doctors and patients is as old as the practice of medicine, there has been a growing emphasis to—even the need to—preserve the essence of the doctor-patient relationship.

An effective physician-patient relationship is necessary to achieve successful treatment outcomes in any clinical encounter. Medical professionals acknowledge that a therapeutic relationship, when also paired with proper knowledge and practical skills, is an integral part of providing effective medical care. While previous research has heavily investigated how the patient's perceptions affect the provider-relationship, recent efforts are directed towards studying how physicians and their behaviors impact the relationship and therapeutic outcomes (JF Ha 2010). Scholarly inquiry into the doctor-patient dyad has come to a general consensus that physicians who display a warm, friendly, and reassuring manner with their patients are not only more effective but also report better patient adherence to adhere to treatment plans (Martin et al. 2005).

To accentuate the humanistic elements within the doctor-patient relationship, clinical professionals are emphasizing the need for the conscious practice of empathetic care. While topic of empathy in medical education and practice have been heavily research and published over the

last decade, the discussion has evolved beyond simplistic definitions and general speculations and transitioned into a multifaceted exploration of what it means to practice empathy in medicine. This concept is labelled by the term *clinical empathy*, which is classically defined as the clinician's ability to identify a patient's perspectives and experiences and then to reciprocate this understanding back to the patient (Halpern 2003). Clinical empathy encourages provider compassion towards the patients and has been linked to patient empowerment and their ability to cope with illness (Mercer et al. 2002). As one popular medical blog puts it: "Expressing patient empathy indeed advances humanism in healthcare – as a matter of fact — expressing empathy in healthcare is THE KEY INGREDIENT to enhancing the patient experience and patient encounter (Medical GPS)."

Countless studies have demonstrated the benefits of clinical empathy in medical practice—improved patient satisfaction and adherence to treatment recommendations and plans, more accurate diagnoses, reduced distress, fewer medical malpractice claims, increased patient autonomy and agency, and better health and treatment outcomes (Hojat 2007; Haskard et al. 2009; Rakel et al, 2011). Research has even shown that clinicians themselves also benefit from empathetic care, as it results in increased reports of individual well-being, meaningful work, sense of coherence, and overall job satisfaction (Sequist et al. 2008; Street et al. 2009). However, many patients are reporting that they do not experience empathetic responses from their physicians in their clinical encounters. A survey of 800 hospitalized patients found that only 53% felt that their doctors were empathic towards to them (Lown 2011). Another study reported that physicians often overlooked or dismissed signs of distress presented by patients and only provided empathic responses 22% percent of the time (Polluck 2007).

With patients becoming more informed about their rights and their rising expectations of the quality of care they receive at institutions, there is an increasing need for research to

investigate why the demand for empathetic care does not always translate to its dedicated practice. In particular, the majority of the responsibility to enact and carry out these requests fall upon clinicians who are tasked to pursue outstanding levels of performance in terms of quality, efficiency, and appropriateness when already faced with limited resources, increased administrative tasks, and financial demands (Gabutti et al. 2017). Furthermore, physicians have always struggled to find a balance between making connections with their patients and maintaining distance. According to physician David Jeffrey, doctors can either choose to “employ a narrow, technical approach based on their competence or a broader humanistic approach that is more ambiguous and less reductionist” in the clinical encounter with the patient and their style of approach is often educational experience and training (Jeffrey 2016).

Since an empathetic approach to patient-centered care has the potential to improve the quality of the doctor-patient relationship and treatment effectiveness, it is important to understand how the translation of the research is interpreted and implemented by clinicians. The way physicians approach and practice compassionate care is based largely on their perspectives regarding empathy—and clinician’s perspectives are shaped by their experiences, training, contextual knowledge. While some physician might state that empathetic care is already naturally ingrained into their clinical practice, other physicians might feel that practicing empathetic care is a form of emotional labor that they exercise as needed.

The purpose of this pilot study is to analyze and engage with physician’s narratives regarding the ways empathy is embodied in modern medical practice. By interviewing a sample of physicians to collect their narratives, I examine four key areas: 1) physicians’ definitions of empathy and what it means to be a “good doctor”, 2) methods and techniques of practicing empathetic care, 3) for whom and when empathy is used in the clinical encounter, and 4) challenges that prevent fully practicing compassionate care. Narrative collection via interviews

allows for analysis of the linguistic context and categories, which often times plays a crucial role in the interpersonal transmission of information, knowledge, and stereotypes in communication (Lázlo 2013). Furthermore, from a sociosemiotic perspective, language is a tool necessary for the individual's representation of knowledge as "language is the essential condition of knowing, the process by which experience becomes knowledge (Halliday 1993; Seah et al. 2013)."<sup>1</sup> I found through qualitative analysis of the interviews that while empathetic care is acknowledged as a foundational aspect of medicine, it is also not a dichotomous practice—that is, empathetic care is practiced on a continuous scale depending on the clinical and social context of the patient's case. Thus, understanding clinicians' perspectives via analysis of their narratives allows future research to investigate better ways of implementing interventions for empathetic practices.

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<sup>1</sup> The field of social semiotics examines signifying and symbolic practices in specific social and cultural situations. It was originally defined by Ferdinand de Saussure as the "the science of the life of signs in society." It investigates the implications of the fact that "codes" of "language and communication are formed by social processes. As such, the meanings and semiotic systems are often shaped by relations of power and that as power and autonomy shifts in society (or within a system), the languages and meanings can and do change too.

## **Background and Literature Review**

Through an interdisciplinary approach, in this literature review, I present and describe historical and sociological developments in medicine that led to the movement for practicing empathetic care. I present pertinent background information required to understand how changes in the historical and sociological landscape of medicine has inflicted changes in the dynamics and demands of the clinical-patient relationship. First, I briefly outline the major historical developments in medical education and emphasize the idea that educational reformations were in response to the then-societal critical discourses and perceptions regarding the medical field. Then, shifting to a sociological perspective, I analyze how the rise of institutional power and scientific knowledge not only make medicine a privileged practice but also completely changed the workings of the physician-patient relationship. I then present the introduction the discussion of compassionate care in medicine and discuss how the paradigm shifted from training detached concern to clinical empathy. Lastly, I present the topic of a “structurally competent” physician in 21<sup>st</sup> century medicine, providing necessary background information for specific results found from the study.

### *Training Physicians to be Scientists*

The creation of the modern medical educational system was a long and arduous process. In the 19<sup>th</sup> century, the medical profession was generally weak, divided, insecure in its status and its income. Agencies and organizations, such as the American Medical Association (AMA) and the Association of American Medical Colleges (AAMC), were established in the late 19<sup>th</sup> century to oversee the accreditation and curriculum overhauls of medical schools, implement and codify state licensing laws, and regulate admission requirements in an effort to elevate the status



of medicine. However, these organizations alone did little to standardize American medical education, which sought to be on par with their European counterparts.

Rigorous medical reforms in part were initiated by the release of Abraham Flexner's 1910 *Carnegie Foundation Bulletin Number Four*, better known as the Flexner Report, which accessed the then-current state of medical educational affairs; Flexner's recommendations echoed pedagogical concerns that had developed earlier in medical institutions during the 1870s and the 1880s by this report by criticizing American medical schools for focusing on profit rather than quality in care and rebuked the profession for its remarkably low standards that resulted in the over-production of uneducated and ill trained medical practitioners (Flexner 1910; 10). More importantly, his report catalyzed the public's interest—and consequently their stakes—in the developments of the medical world. The public became increasingly attentive to the fact that, as highlighted in the report, the then-clinical method of practice did not accurately reflect the state of scientific medical knowledge of the time.

In response to the public's observance, medical institutions' top priority was to transform and improve the quality of education that students received in the 20<sup>th</sup> century. Sociologist Paul Starr states the transformation of the core of clinical education training gave professionals the opportunity to consolidate power for the overall medical profession: "Social structure is the outcome of historical processes. To understand a given structural arrangement, like professional sovereignty, one has to identify the ways in which people acted, pursuing their interests and ideals under definite conditions, to bring that structure into existence (Starr 1982; 8)." By aligning medicine directly with the practice of applied science, the medical field began to appeal to a more selective, affluent group of students, thus elevating the newfound societal profile of doctors. This was a sharp contrast with the rag-tag image that the proprietary schools had

created, where any “causal strollers from the highway” could attempt to become a practicing physician (Flexner 1910; 22).

However, not only did medicine become a powerful and prestigious profession, but these institutions also succeeded in shaping the basic organization and financial structure of American healthcare that would carry for years to come. According to medical historian Roy Porter, the bid for institutional power was the foundation of the start of the medical-industrial complex:

Modern medicine has been able to root, spread, and propagate itself in this way in part because it changed its objectives. Traditionally the physician patched up the sick individual; but [modern] medicine gradually asserted a more central role in the ordering of society... The more medicine seemed scientific and effective, the more the public became beguiled by the allure of the medical beneficence, regarding the healing arts as a therapeutic cornucopia showering benefits on all, or like a fairy godmother, potentially grating everybody's wishes (Porter 1997; 629-630).

Flexner's views on restructuring medical teaching institutions overlapped with the public's increasing faith in utilizing scientific solutions to societal problems and that medical students needed to be “trained to regard the body as an infinitely complex machine (Flexner 1910; 63).” However, the report set in motion a clinical culture that was primarily focused on knowledge acquisition and disease diagnosis. As we shall see, there a host of unintended social consequences resulted from the specialization of medicine, as it ignored how a key component of medicine would also be affected—the doctor-patient relationship.

### *Reexamining the Physician-Patient Relationship*

At the turn of the 19<sup>th</sup> century, doctors became better equipped to pinpoint the origins of the pathology and properly treat it. Medicine witnessed the emergence of new scientific fields (i.e. histology, pathology, and microbiology) and the elucidation of the germ theory. A biochemical-based understanding of physiology guided diagnoses of ailments. New effective

drugs, such as antibiotics, were introduced to the mainstream market. Surgical techniques became more humane and refined. Physicians, who were previously stymied by the lack of cures, now gained a sense of understanding—and consequently control—of the treatment as a major epistemological shift occurred as experimental methods of science could be applied to the study of disease and therapeutics, not just the condition.

The progression of scientific-based clinical practice was a sharp contrast from the narrative-based, guesswork nature of medicine in the 18<sup>th</sup> century. As literary historian Lilian Furst describes:

Lacking both sound knowledge and tools for probing examination, medical men had to rely solely on their senses by observing their patients and listening to the recital of their complaints. They would scrutinize their patients' appearance, looking at skin color, and paying attention to signs of wasting or bloating; they would feel the pulse to assess its rate and strength, and they would closely inspect the urine. Yet even the evaluation of this visible specimen would be largely guesswork, stemming at best from comparison with previous similar cases (Furst 2003; 3).

Doctors served as active listeners and observers while patients recited their symptoms—including feelings and thoughts—to them, which served as crucial pieces of the diagnostic puzzle. However, the inventions of medical instruments helped physicians to gather data that humans could not provide. For example, the stethoscope, invented by René Laennec in 1816), was the first major instrument that allowed clinicians to hear rhythmic sounds from the heart and lungs, enabling them to observe and collect various patterns of the heart's rate and pace and to draw distinctions between different sounds without the need for a patient's testimony (Furst 2003; 8). With a better conceptualization of ailments, specifically that concerned the *disordered function* of diseases, physicians performed their assessments at more refined levels.

While the medicine reaped from the successes of better scientific knowledge, another aspect of the clinical encounter experiences also consequential change—the physician-patient

relationship. In order to categorize the shifting dynamics between the clinician and patient, sociologists Thomas Szasz and Marc Hollender created useful terms for defining the various models of the physician-patient interactions: activity-passivity, guidance-cooperation, and mutual participation.<sup>2</sup> Most physician-patient relationships historically have followed the relatively egalitarian guidance-cooperation model, in which the physician recommends a treatment plan and the patient cooperates accordingly. Starr details how such clinical relationships are considered necessary for the healing process:

The sick are ordinarily not the best judge of their own needs, nor are those who are emotionally close to them. Quite aside from specialized knowledge, professionals possess an advantage in judgement... Professionals are ideally suited for this role because they refuse to indulge such tendencies in patients without threatening their relationships with them. And so professional authority facilitates cooperation in recovery besides compensating for the often impaired and inadequate judgment of the sick (Starr 1982; 5).

However, as these redefined roles came into practice, the physician-patient relationship shifted from guidance-cooperation towards the paternalistic model of activity-passivity. The public prestige paired with the consolidated power and authority that came with practicing medicine resulted in physicians demanding more respect from their colleagues and patients as “the experts with the power to cure or at least to alleviate suffering (Furst 2000; 17). Patients’ roles also shifted, but to more passive responsibilities. Patients believed that doctors had the technical skill

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<sup>2</sup> There are three basic models of the physician-patient relationship proposed and described by sociologists Thomas Szasz and Marc Hollender. The first model is the *activity-passivity*. This relationship is analogous to a parent-infant relationship and is paternalistic in nature. The patient is figured as helpless, in need of the physician’s expertise in order to begin the path to recovery and to regain autonomy. The second model is *guidance-cooperation*, which is similar to the interactions between a parent and child. Unlike the previous relationship, this takes into consideration that the ill patient has feelings and thoughts regarding their condition but is willing to “cooperate” with the physician who is wiser and more knowledgeable about the best course of action for treatment and recovery. The physician, who is still superior in this model, “guides” the patient to good health. The last model outlined is *mutual participation*, which states that both the patient and physician are equal in terms of power, independence, and satisfaction. The patient not only has a greater voice in the relationship, but they also have a greater responsibility to assume in terms of their health outcomes. Thomas Szasz and Marc Hollender, “A Contribution to the Philosophy of Medicine: The Basic Models of the Doctor-Patient Relationship,” *A.M.A. Archives of Internal Medicine* 97, no. 5 (1956): 585-592.

about ability to alleviate them from their pain and suffering; as such, they were more willing to relinquish their autonomy during the clinical examination.

This type of detached behavior exhibited by physicians matched with the “doctor knows best” theory. While physicians attempted to consider the patient’s requests and feelings regarding their illness and treatment, physicians ultimately have the final say as they are deemed to have the utmost knowledge in their field of medicine and healing. Bioethicist Jay Katz states a major reason why doctors dominate the decision-making process:

Physicians’ apprehension of, and resistance to, breaking with their millennia-long tradition of solitary decision making express not only their understandable reluctance to depart from familiar practices but also their concern that joint decision making will bring to the public’s and patients’ attention vexing problems about the state of the art and science of medicine...the idea of sharing the burdens of decisions with patients will create new tensions; it will allow bring to the surface old tensions that solitary decision making has obscured (Katz 1984; 83).

Starr additionally notes that patients may develop a psychological dependence that further creates a differential power dynamic between the expert clinician and lay person seeking curative treatment: “The authority to interpret signs and symptoms, to diagnose health and illness, to name diseases, and to offer prognoses is the foundation of any social authority the physician can assume (Starr 1982; 14).” Clinicians became the ones who constructed—and even sometimes skewed—patients’ narratives regarding their health and illnesses in ways that allowed them to retain power and authority over the patient, thus leaving the patient in a powerless position in regards to their own medical decision making and making them completely become dependent on the physician.

### *Training Physicians to be Empathetic*

Derived from the German term *Einfühlung* (which means to “feel into” or “feel onto”), empathy is conventionally defined as “the ability to understand and share the feelings of another (Oxford Dictionary).” In the clinical context, however, empathy typically carries a different connotation as it is taught and interpreted as a form of detached cognition—a concept that postulates that doctors can remove themselves from their personal emotions while maintaining a professional concern for patients. In the 1960s, sociologists Renée Fox and Howard Leif advocated that this detachment is crucial to successful medical practice as it allows physicians to simultaneously “dissect a cadaver without disgust” and carefully listen to patients without becoming emotionally drained from each clinical encounter (Lief and Fox 1963). Physicians thus believe that detaching themselves emotionally best meets the cognitive and moral demands that distinguish medicine from other service professions, and institutions, such as the Society for General Internal Medicine and the National Institute of Health, defined empathy as “the act of correctly acknowledging the emotional state of another without experiencing the state oneself.”

Researchers in medicine agree that empathy plays an important role in the clinician-patient relationship, the definitions of clinical empathy have been contested as it conceptualized as a human trait, professional state, communication process, attribute of caring, and reciprocal relationship. However, for this thesis utilizes ethicist and physician Jodi Halpern’s definition and understanding of clinical empathy—that is “the physician’s ability to recognize and understand a patient’s perspective and experiences and convey such an understanding back to the patient (Halpern 2003).”

Halpern states that that empathy does require that clinicians need to “vicariously experience and introspect” about their patient’s emotions. However, she emphasizes that “the

function of empathy is not merely to label emotional states, but to recognize what it feels like to experience something.” This is where emotional attunement plays a key role in Halpern’s definition of clinical empathy—she argues that physicians’ emotional attunement greatly serves the cognitive goal of understanding patients’ emotions:

Emotional attunement operates by shaping what one imagines about another person's experience. In trying to imagine what the patient is going through, physicians will sometimes find themselves resonating. This is not an additional activity to imagining, but rather a kind of involuntary backdrop to it. Further, resonance...a part of ordinary communication (Halpern 2003).

Thus, clinical empathy as a professional skill is distinguished by this “subjective, experiential input for specific, cognitive aims” with emotion guiding the timing and tone of the conversations between physicians and patients. A study published in the *Journal of the American Medical Association* found that within the patient-physician interactions, nonverbal attunement led physicians to pause at moments of heightened anxiety, at which times patients disclosed information; if clinicians did not practice this, then patients did not share vulnerable information, despite the physicians asking the patients appropriate and accurate questions (Suchman et al. 1997).

In relation to medical history taking and the patient interview, emotional attunement directs the doctor’s attention to some aspects of the patient’s histories over other portions of the interview. Halpern refers to the works of neuroscientist Antonio Damasio and philosopher Ronald de Sousa, in which they “describe this focusing and riveting of attention as necessary because human beings are so cognitively complex that events in daily life involve too many possible things to pay attention to (Halpern 2003).” Applying this to the cognitive tasks that physicians must complete, Halpern states that logic alone cannot determine which matters are most important for doctors to pay attention to and as such attunement automatically directs their

attention to matters that have a level of emotional significance to the patient. This is not to say that doctors must race through the medical exam, not paying attention to other clinical clues—but rather, attunement and the resulting resonance offers clinicians opportunities to check-in with non-clinical “symptoms.”

Multiple scholars state that empathy is a clinical skill that physicians need in order to respond to patients’ thoughts and feelings in order to make a stronger clinical diagnosis. Studies have highlighted the far-reaching benefits of compassionate care for both physicians and patients (i.e. such as better ability to diagnose and treatment outcomes): patients who perceive and rate their physicians to be more empathetic, caring, and/or compassionate recover from a cold quicker and present signs of a stronger immune system and doctors who self-report showing caring behaviors towards their patients significantly feel more satisfied with their jobs and experience less burnout (Rakel et al. 2011; Lampert and Glasser 2018). Physicians also experience an increased diagnostic accuracy and find their patients to be more compliant; for patients, this results in greater satisfaction, less emotional distress, and increased quality of life and treatment outcomes (Neumann et al. 2011).



## Methods

This qualitative, descriptive study analyzed clinician’s perspectives about clinical empathy and their practices involving empathetic care. Data for this study came from semi-structured, open-ended interviews that were evaluated using conventional content (inductive) analysis. Interview questions were broad, open-ended to capture a breadth of responses. An interview guide included the following domains: (1) professional background, (2) personal definition about clinical empathy, (3) notions about a “good clinician” vs “bad clinician”, (4) practice and integration of empathy in the clinical encounter, and (5) interpretations of patient-centered care. The study was approved by the Institutional Review Board at Vanderbilt University.

Residents (n=4) and physicians (n=11) from emergency medicine, cardiology, and internal medicine were interviewed. These specialties involve different patient populations and health needs and, as such, offer varying perspectives on the situations and levels of empathetic care integrated within the clinical

Category		Participants (n=15)
<b>Age</b>	Mean	39
	Low	28
	High	58
<b>Sex</b>	Male	8
	Female	7
<b>Specialty</b>	Emergency Medicine	11
	Internal Medicine	3
	Cardiology	1
<b>Years in Practice</b>	Mean	13
	Low	1
	High	32

*Table 1. Participant Demographic Information*

encounter. Interviews were conducted over an eight-week period from January to March 2019 in Nashville, Tennessee. Interviewees were recruited via an opportunistic, snowball sampling approach, resulting in a convenience sample. Potential participants were identified using online searches to generate a list of physicians. Individuals were invited to participate via email. Residents were recruited via departmental listserv and emailed the principal investigator

expressing interest and availability for an interview. Interviews were conducted in person at the participant's preference, such as a medical office or café, or via phone when a common in-person arrangement could not be coordinated. Participants were provided written informed consent at the start of the interview. Interviews were recorded using digital audio-recorders with consent. All participants agreed to be recorded. Interviews lasted between 12 to 35 minutes. Participants were not provided compensation.

A semi-structured interview guide was developed using a structure with introductory, flow, key, and final questions (Krueger and Casey 2009). The introductory questions were designed to make the participants speak about their experiences on a more general level and make them comfortable and free to discuss their experiences in the first phase of the focus groups. The flow questions meant to create a smooth transition to the key questions the researchers wanted to explore. The final questions were used to summarize and finish the interview and make sure that the participants did not have further comments. The interview guide was tested and revised with the principal investigator's advisor. After each interview, the principal investigator wrote reflectional notes regarding the interviews as best practices in qualitative research (Watt 2007). These reflections assisted with code development and enhance data analysis.

<b>Introductory questions</b>	<b>Follow questions</b>	<b>Key questions</b>	<b>Final questions</b>
What inspired you to pursue medicine as a career?	How do you define empathy?	Is empathy beneficial to your practice? Why or why not?	What does the future of empathy look like in medicine?
What do you envision are the characteristics of a good clinician?	What does empathy look like in your own clinical behaviors?	Are there situations when you cannot employ empathetic practices? If so, can you describe a situation?	Is empathy a sustainable practice for the future?
		How was empathy taught to you in medical school? How is it being taught to you in the hospital setting?	Would you like to add anything else not mentioned in the interview?
		Is there anything preventing you from practicing empathetic care? If so, can you explain more.	
		Which groups of patient populations do you think tend to receive empathetic care?	

*Table 2. Interview Guide*

Data analysis was completed between April to May 2019. Interview recordings were transcribed verbatim and deidentified. Transcripts were read by the principle investigator to identify emergent themes used for coding. Themes were broadly defined to capture depth and variation across participations experiences. These were organized into a structured coding dictionary that included definitions for the codes. Using NVivo 11 Software (QSR International), codes were qualitatively assigned to interview text that matched the corresponding code definition. The principle investigator coded the transcriptions. For data analysis, codes that appeared at least in 5 out of the 15 transcriptions were considered for thematic analysis for the results. Themes were generated from meaningful groupings of the codes and represent some level of patterned response or meaning within the data set.

## Results

This exploratory study interviewed a key sample of n=15 physicians who are based in Nashville, Tennessee. While a total of 16 participants consented to take part in the study, one participant was not available during the scheduled timeframe for interviews. A set of predetermined interview questions were used to learn more about their experiences and perspectives about their personal practices regarding empathetic care and their opinions about the benefits, limitations, and sustainability of empathetic care. Through qualitative data analysis, emergent themes and trends were found and are presented below with representative interview quotes.

### *Defining Empathy*

Participants individually defined empathy in their own words. While one participant was not able to and had to search the term online before continuing with the rest of the interview, another nine participants used the phrase “putting yourself in somebody else’s shoes” to explain empathy:

*I think it’s being able to put yourself in somebody else’s shoes or being able to kind of have some understanding of what somebody else is going through. Having kind of some compassion for what they may be experiencing. (ID 2)*

The majority participants also words such as “understanding” and “recognizing” in referring to the key components of empathy. Empathy was often equated and interchangeably used with “compassion” but was contrasted against “sympathy”:

*...you would need to have had at some point some sort of similar experience in some way to be able to be truly empathetic versus sympathetic. (ID 4)*

Participants also contrasted their definitions of empathy with how they distinguish empathy in medicine, without directly referring to their subset definitions as “clinical empathy”:

*I think almost as a doctor you have to be able to understand what people are feeling but not put yourself in their shoes. Cause you won't get through a day. (ID 6)*

*Especially in medicine, I think it's the ability to imagine yourself in that patient or that family's situation. And really think like, how would I want, this is for my mother or father or sister or grandfather, what would I want their care to look like, and what would I want their providers to be doing for them. (ID 13)*

### *Characterizing the “Good Clinician”*

Participants described key characteristics that a “good clinician” must personify in order to be successful and effective in the doctor-patient relationship and clinical encounter. Most participants stated the following traits: proper medical knowledge and scientific competency, efficient communication skills, a desire to be curious, the ability to participate in integrative team work, knowing one’s own limitations, and being compassionate. A few participants also stated that while a physician might be very competent in scientific knowledge, if lacking the proper verbal and non-verbal communicating and “people person skills”, doctors may not be as effective in interacting with patients and their ability to understand the diagnosis and respond to treatment plans.

*...also recognize every time you walk into a room you're stepping on a stage. [You] have good awareness and control of your body language, your skills...your body language is a part of somebody's healing process. (ID 6)*

*It's a unique combination so I think you need to be a curious person, curiosity is important, you are interested in learning how things work, why they work they work the way they do, because really that curiosity is what drives change in medicine and how we get better in medicine. (ID 7)*

*I think probably one of the most important characteristics that probably a good clinician needs to have is humility. Being able to recognize what they know and don't know, and humility. The consequences of humility are very good. Comes with an attitude of wanting*

*to constantly learn, develops an attitude of service to others over yourself. So I think with humility kind of breeds some honesty. (ID 7)*

*I think that a good clinician needs to have a strong medical background, absolutely, but then a lot of medicine is actually what we talk about as the art of medicine in addition to the science of medicine, which I think is really being able to interact with your patients and your colleagues in a way that's effective. Being able to do a history and physical and really get down to the bottom of what's going on with a patient. Whether that's just listening or being able to ask the patient the right questions to help figure out what's going on with them, I think is really important. (ID 8)*

*The best clinicians aren't necessarily the ones who have all the book knowledge and who always have the right answer but are the ones who try to figure out what the answer is when they don't know...and who are kind of open with patients about what they don't know but ways they're going to figure it out. (ID 13)*

### *Practicing Clinical Empathy*

Participants were asked to reflect upon their own practices and behaviors involving empathetic care in the clinical encounter. The level of empathetic behavior embodied was based on the participant's engagement and understanding of empathy—that is, physicians who had more nuanced understandings of empathy described and explained their personal behaviors in greater depth. All participants agreed that communication was key in having a successful doctor-patient interaction; particularly, listening to the patient and giving them the opportunity to narrate what brought them to the hospital. Participants believed that allowing patients to take the lead in beginning the communication is key to making them feel valued and a part of clinical decision-making process. Non-verbal language (i.e. body position and movement) was another important element highlighted; many participants said that they preferred to sit next to the patient's bedside or make sure that they were in proximity to the patient, facing their direction without any distractions (i.e. technology use, note taking). Many participants dictated that their empathetic behavior—and the corresponding “tricks”, “shortcuts”, and “mechanical behavior” used to

achieve this—was based off the notion that they wanted patients to *perceive* empathy coming from their physicians (“placebo effect”).

Multiple participants stated that empathy takes work and effort. Participants mainly used empathetic communication for when they had to break bad news to patients and their caregivers or when they had to explain and reason through situations that seemed uncertain from the patient’s perspective. Participants felt that palliative care and internal medicine were the two main subspecialties that employed empathetic care in their everyday practices while emergency medicine employs empathic care if there is time and if the situation allows for it (i.e. not an emergent case, patient is not looking for secondary gains in the visit). Furthermore, participants also agreed that it is easier to be empathetic and understanding toward patients that shared similar characteristics and experiences and who have been kind and well-behaved during the clinical visit. However, it was also widely agreed upon that participants need to maintain boundaries and objectivity in their interactions, that they should not and cannot be emotionally consumed by the patient’s feelings that would then affect the participant’s decision making and treatment protocols.

*I try to remember that going into every room, that this is somebody whose life was interrupted and they're here for help, and they didn't schedule it, they didn't plan on this, people do. But really the idea [is] when I walk into a room I'm a part of the solution to a problem that scares them. (ID 6)*

*Whereas some of the people who are not very sick are scared about things that are not emergent to me...They need that anxiolytic empathy connection so they can really understand that you were there for them. (ID 6)*

*I think the delivering of bad news, it is so important to be empathetic because that's how people are gonna feel, they're gonna remember that's how you made them feel when you delivered that terrible...and if people sense that you really do have compassion as you're saying these...that's what they really remember and they'll remember you as a good physician just for that reason. (ID 7)*

*So that's about the only way to really practice empathy I guess, is to be able to let patients tell you how they feel about things. I do think it helps a bit in decision making. Maybe not necessarily medical decision, but on some social level I trust it helps the patients feel they're being clearly heard as best as possible within time limits. That those caring for them have genuine concern. Sometimes it's hard, it takes a lot of work to generate empathy. (ID 8)*

*I think that being really empathetic in those situations and just thinking about how they feel blindsided in a sense where it's not really what they expected to be hearing when they come to the emergency department. I think for me, those situations where I just take a second outside of the room and collect my thoughts and think about what I'm going to say and how it might go. Then just really making sure that I take the time to sit down and explain what we're seeing and name what we're most concerned about. (ID 9)*

*And I found in general that people respond to me better when I show them that I care. And I show them that I have done everything in my power to prove to them, that they are not going to die. (ID 10)*

*Just letting the patient know they have your full and outright attention which sounds like common sense but given all the distractions these days. (ID 11)*

*Well I can tell you very mechanically what I do...maneuvers, the sitting, and the touching, and introduction, and listening. (ID 15)*

*I think as a human it's much easier to be a little more empathetic to someone who has been kind to you, but as a physician as well we're also trained and [took] an oath to treat all patients. (ID 4)*

*My general point is doctors can more easily or naturally or instinctively empathize with patients who are like them. For every doctor that's a different group of people. (ID 11)*

*To proactively recognize that this is a person maybe with a different belief than me, but I need to put that aside, and I need to make an extra effort to be empathetic with him. (ID 15)*

*...it could be a hindrance...if you start looking within [yourself] so intensely that you start recalling your own emotions in a similar experience, or start focusing on that experience, rather than the experience of the patient that's at hand at the time. (ID 4)*

*...there's some things that we're trained to be able to give sound advice about. We've gone through years and years of school and education in order to be able to say, "Hey,*



*my advice is X.” I thinking communicating that advice to patients is important and obviously, ultimately, if a patient has decisional capacity, then they choose their path. (ID 4)*

*But, I think there's also situations where if you are overly empathetic where you want to be caring and kind above all else, I guess that could conceivably or potentially get in the way of doing the right thing or the best thing. (ID 11)*

### *Examining the Doctor-Patient Relationship*

When discussing examples from clinical practice, participants alluded to power dynamics shifts in the doctor-patient relationship depending on the severity of the clinical case and how active of a participant the patient wanted to be. Many participants discussed the integral importance of the relationship and its impact on both the level of information doctors can gather from patient and treatment adherence for patients. Most of the judgement and level of interaction within role dynamics in the doctor-patient relationship is based on the individual participant's judgement and preference regarding the clinical encounter.

*...there's like this formalized notion of a patient-doctor relationship and I think sometimes that may prevent people from talking to a patient like they would [to] anyone else. So, I always perceive any clinical interaction...as just like a regular interaction. (ID 2)*

*It's really powerful and healing to both develop a relationship to get all the data you need from a person to help them, but also to help them feel like regardless of how the day goes or the outcome of their medical situation that it'll be okay. (ID 6)*

*...as a physician, you do have a position of authority, because you know you have the medical background and knowledge to make these types of decisions. At the same time, you have to convey this message in a way that's relatable to the patient. And not so much I'm talking to you as a doctor, I'm talking to you more as a peer. (ID 10)*

*I will say that there's times of empathy may not impact. It may not make a difference. Sometimes I feel like you're better off just being the authoritative doctor, and just telling the patient like it is. (ID 10)*

*In general, [patients] feel like they've been heard which is an important therapeutic part of what we do clinically because if a patient feels like they haven't been heard, even if the physician is making the right diagnosis and providing the treatment, the patient may not be aware of that. (ID 12)*

*...while it is important to remember that patients are human and empathetic and they should absolutely play a role in the decisions that occur, they should not be made to feel like they need to bear the weight of the world on their shoulders. (ID 12)*

### *Using Clinical Empathy to Understand Structural Health Factors*

Six participants presented explanations of personal situations when they had patients who had presented to the emergency department with severe health complications and issues. In these narratives, the participants highlight that through empathy-driven conversations and behaviors, they were better able to understand the reasons why the patients came to the emergency department and more about their life histories. It was then that the participants understood the patients' barriers and inability to access health care earlier (i.e. social determinants of health). Furthermore, one participant also stated that more vulnerable groups are more deserving of empathy because of the impediments they face when trying to access proper, safe healthcare.

*...step back and think about maybe some of the circumstances that led them to come to the ER instead of going somewhere else or waiting, whether it be like insurance issue, or access to care, or just like timing they couldn't get off work during business hours. (ID 4)*

*I would say more vulnerable groups are more deserving of empathy...I would say people who have been marginalized their life. People who don't necessarily have a say or don't often voice their opinions. People who are, sort of like, people who are poor, who don't have good access to healthcare. People with extenuating social circumstances, who may not have the social resources, or the resources in general, to have a better outcome. I think they need more care. (ID 14)*

For example, one participant presented a poignant example of an undocumented immigrant who was experiencing blurry, painful vision could not see out of one eye. The participant recalled how excited she was as a resident to see her first cause of iritis, but then also

realizing that the patient was scared and sought medical attention when his symptoms were as severe as possible:

*He didn't have any money, he'd come to the emergency department, knew he couldn't see so he couldn't work, and if he couldn't work he wasn't going to be able to make the money that he needed to send home to his family. And realizing that, that was what he was carrying with him coming to the emergency department. I needed to hear his concerns... chatting with him to get that information, and then relaying it to my attending saying, "Hey, I don't think this guy is gonna follow up." Cause he needed to get steroids and see ophthalmology. These were just more medical visits. I said, "I don't think this guy's gonna be able to follow to ophthalmology. I think we need to consult him in the emergency department." (ID 6)*

Working with her attending, the participant was able to get his costs covered by medical charity funds. However, this participant alluded to her ability to connect with the patient and understand the situation that the patient was coming from was key in shaping and developing her treatment objectives for and clinical interaction with the patient:

*I think I connected with this guy because my family also were immigrants so I understood how deep that fear can be. I also recognize it made him more likely to follow through on the medical treatment because he felt like were on his side and he didn't need to fight against a system that was going to try and charge him more than he could afford. (ID 6)*

### *Understanding Barriers to Practicing Empathy*

Participants were asked about what they felt were “barriers” they faced when practicing empathetic care. Barriers were interpreted by participants as any factor that could potentially hinder physicians from developing bonds with patients and developing close relationships with patients. Limited time and resources, administrative paperwork and documentation, payment and reimbursements procedures were the main factors that participants cited. Many participants felt that even though they want to practice empathetic, compassionate care, they are not being paid to do so, nor do they have the amount of time that would allow for a meaningful clinical encounter.

Furthermore, a few participants also alluded to professional burnout—often due to the burdens and demands of medicine—as another impediment to practicing empathetic care:

*There's so many pressures on clinicians to check boxes, do paperwork, increase flow, metrics to increase efficiency. We really just kind of have to continuously fight that knowledge that someone is watching our moves, watching our metrics, watching how quickly we're doing things. (ID 4)*

*I would argue that I spend a lot of my time, probably like 30 to 40 percent of my time of documenting...just going through dotting my I's and crossing my T's, and making sure that we are get paid, because the subject for Medicaid. What they have done is really put stringent rules on all we have to document to get paid appropriately, for the level of care we provide. (ID 9)*

*As the healthcare system, we are not paid per the time you spend with a patient. You're paid for the procedures you do. You're paid for the prescriptions you write. You're paid for the laboratory test that you do, but you don't get paid for talking to the patient, and I think that is the biggest impediment to the healthcare system. Is that we're not reimbursed for spending 30 minutes trying to provide empathetic care. (ID 10)*

*I just think that there needs to be a cost attached to it that benefits the provider spending their time doing that...I don't know any colleague of mine who isn't inclined to provide compassionate care. It's just that we're being asked to do a lot with fewer resources and at the end of the day, the primary responsibility is delivering the medical diagnosis and plan...compassion often takes times that does not get paid for. (ID 6)*

*I think that it might just be the nature of the job but it's very easy to get burned out in medicine in the sense that you start to lose the sense of meaning for what you're doing, you feel overworked, you feel tired...I think when someone gets burned out because of whatever system they're working in that can be a real barrier to practicing empathetic care. (ID 7)*

*And I think electronic healthcare records in someway have been helpful in terms of access to information, but I think it has also added a couple of barriers and added time to the way we manage patients as well. (ID 10)*

### *Sustaining Empathetic Practices in 21<sup>st</sup> Century Medicine*

Participants were asked whether they believed empathetic care and the practices associated with it could be sustainable in 21<sup>st</sup> century medicine, especially in a patient-centered care model of care. When asked about giving their thoughts on patient-centered care, two

participants did not know what the term meant while the rest of participants had varying, diverse interpretation of what it meant. A majority of participants agreed that patient-centered care is a core component of integrating empathetic practices in medicine and allows medicine to become more humanized. However, a few participants feel systematic changes must be made in order to make it easier and more feasible to integrate empathetic behaviors in the clinical context—picking physicians who naturally embody the behaviors, formal emphasis and training, paying for the “costs” associated with empathetic practices while allowing for more time in doctor-patient interactions:

*I wonder how much you can do at the system-level as opposed to selecting the right types of people...you get the right environment and culture there in the first place. You select the right people and I think it becomes much more conducive to practicing [patient-centered care]. (ID 5)*

*I think medicine is morphing into more of a ... I should say it's maturing as a business, it's not mature yet. I feel like there's also a culture of not respecting the role of a doctor as a doctor and not a provider. (ID 6)*

*I think the one thing with this is, in order to be able to have something like this that can be something sustainable, I think that trying to identify ways to empathize, in an efficient way, while still being able to meet the constraints of our job and meeting all those demands, is something that's important in this entire thing. (ID 9)*

*Yes, I think it's possible to compassionate care for all patients, but I think you have to prove to the clinicians that it actually saves time when you do it, rather than provide more time. (ID 10)*

*I think [clinical empathy] actually does require a formal emphasis because otherwise given some of the other constraints as far as financial, and seeing more and more patients, without a deliberate focus on it, it could actually be lost. (ID 11)*

## **Discussion**

Through a social semiotics perspective, this study analyzed the narratives of a small and convenient sample of physicians regarding their perspectives regarding clinical empathy in order to better understand what does empathetic care in 21<sup>st</sup> century healthcare look like and what are the opinions of clinicians regarding accessibility and feasibility of practicing empathetic care. Preliminary findings from this research suggest that even though clinical empathy is personalized and contingent on the severity of the clinical case and the patient's willingness to communicate, physicians still learn to adapt and employ comparable methods and face similar barriers when practicing empathetic care.

Within the discipline of Medicine, Health, and Society (MHS), the interviews and their corresponding themes construct a comparative debate between clinical empathy and another emerging key ideology in modern medical practice—structural competency. Before examining the study's data analysis in relation to structural competency, I present a discussion of how this approach came to fruition. I then present the idea of using clinical empathy as a tool in reinvigorating the traditional social history taking process in order for clinicians to address the negative health outcomes imposed by structural and social determinants of health through the perspective of structural vulnerability. By emphasizing clinical empathy's key concepts of focusing attention on the patient and utilizing both verbal and nonverbal attunement mechanisms, patients will be more likely to disclose crucial details. Thus, this would allow clinicians to collect, understand, and engage with the societally imposed risk factors that may exacerbate a patient's health outcomes.

### *Training Physicians to be Structural Competent*

A recent surge and emphasis both in the United States and around the world for health care professionals and social researchers to address what public health calls the “social determinants of health” that is defined as follows:

The social structural forces that affect health outcomes, ranging from individual and national level factors such as socioeconomic status, income inequality, racialized hierarchies and institutional policies (public versus private healthcare, incarceration rates, etc.) to global political and economic factors such as per capita gross national product, international trade relations, and military disruptions or political embargoes (Marmot et al. 2008).

This field of study and inequality has resulted from the United States’ history of discrimination and ineffective care for minority populations; it has generated both medical and social scientific reviews and inquiries into the clinical assessments and examinations made on stereotypes and prejudices regarding race, class, gender, sexuality, or citizenship that results in differentiated—and often detrimental—health outcomes. For example, studies show that African Americans and women receive more infrequent treatment for myocardial infarctions compared to white men, even if they present identical symptoms in the emergency department (Lopez et al. 2010). Much research has documented the ways in which cultural and normative markers and bodily presentations (i.e. accent and personal etiquette) can mix with demographic categories (i.e. race, ethnicity, age, gender, social class) to create responses and judgments that promote social inequality and limit an individual’s opportunities for security and achievement within a given society (Bourdieu 2000). Extending into the clinical domain, these perceptions can influence the type and level of care considered appropriate for an individual or sociocultural group—thus, creating and perpetuating a stigma of differential “health-related deservingness (Willen 2012).”

In response to these challenges and inequalities observed in medical practice, Western health care educators developed and promoted the framework of “cultural competency” in an attempt to eradicate racial and ethnic disparities in health treatment and outcomes (Kripalani 2006). The main objective of cultural competency was to inform and sensitize clinicians, medical students, and health systems to the “needs of diverse individuals and communities whose beliefs, values, and customary practices often differed from those of the medical professionals serving them.” This framework, however, has been criticized for both creating and inadvertently reinforcing cookie-cutter stereotypes of diverse patients (Lopez et al. 2010; Tervalon 1998). Additionally, cultural competency has focused on barriers to health in terms of race, ethnicity, and culture—it neglected the negative health effects of political and economic forces that result in discrimination and inequality (Braveman 2011).

As a counter framework to cultural competency and method to address social determinants of health, structural competency was developed and proposed. There are two key definitions that this paper uses for structural competency, as presented below:

...trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases (e.g., depression, hypertension, obesity, smoking, medication “non-compliance,” trauma, psychosis) also represent the downstream implications of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health (Metzl and Hansen 2014)

The ability for health professionals to recognize and respond with self-reflexive humility and community engagement to the ways negative health outcomes and lifestyle practices are shaped by larger socio-economic, cultural, political, and economic forces (Holmes 2013).

This approach has three fundamental principles for clinicians and medical students to master: 1) understanding patients’ experiences of illness in the context of structural factors, 2) intervening



at institutional levels to address these structural factors, and 3) developing community and structural humility in which leaders work to address the structural change. As clinician-researchers Dr. Jonathan Metzl and Dr. Helena Hansen wrote: “The term *structural* brings into focus institutions and policies that can be altered to promote health equity, while *competency* signals that there are tangible skills clinicians should acquire to address the social structural factors that act as barriers to improved mental health outcomes (Metzl and Hansen 2014).” Thus, since clinicians learn through practice, and with the structural competency framework shifting focus from individuals to institutions, there is a need to also develop and implement the clinical strategies to practice these skills.

#### *Structural Competency via Structural Vulnerability*

Over time, clinicians have become more aware of the detrimental health effects of social, political, and economic forces outside the clinic. However, many clinicians have reported feeling helpless when it comes to addressing these structural factors and consider these to be outside of the range of clinical practice (Gleichgerrcht and Decety 2013). Other physicians think of non-adherence to treatment plans and the inability to pursue and lead a healthy lifestyle to be a reflection of the moral choices of their patients instead of the effects of social structural inequalities (Metzl and Hansen 2013). Resultingly, more clinicians increasingly become frustrated by their patients or are subject to burnout.

As such, I argue that in order for health professionals to understand the bigger picture of what—and more importantly how—structural barriers and inequalities prevent both individuals and populations’ access to good health, clinical empathy can be used as a tool within the doctor-patient interaction as a means to elicit meaningful and pertinent information regarding their

social history and for physicians to understand the impact of the patients' health through structural vulnerability, which is defined as the following:

An individual's or a population groups' condition of being at risk for negative health comes through their interface with socioeconomic political, and cultural/normative hierarchies. Patients are structurally vulnerable when their location in their society's multiple overlapping and mutually reinforcing power hierarchies (i.e. socioeconomic, racial, cultural) and institutional and policy-level statuses (i.e. immigration status, labor force participation) constrain their ability to access health and pursue healthy lifestyles (Bourgios 2017).

Structural vulnerability defines a *positionality* in society—that is an individual's vulnerability is produced by their location in a hierarchical social order and its diverse networks of power and relationships and effects that are often times mediated by the governmental and institutional powers (Bourdieu 2000).

The benefit to understanding structural competency vis-a-vis structural vulnerability is outlined below:

The more neutral term 'vulnerability' may be useful, consequently, to extend the economic, material and political insights of structural violence to encompass more explicitly (and to project to a wider audience) not only politico-economic but also cultural and idiosyncratic sources of physical and psychodynamic distress (Lopez et al. 2010).

This approach limits the concept of agency as it requires an analysis of the forces that constrain decision-making, frame choices, and limit life options; that is certain groups of individuals are constructed as deserving of good health and others are unworthy of having access to health-related resources. For example, Latino migrants are often constructed as an "at-risk population," but a structural vulnerability perspective critiques this label as it connotes an individual behavior stemming from a collective culture that is harmful to their health; "vulnerability is an indicator of inequity and social inequality and demands responses in the sphere of the social and political structure. It is considered that vulnerability determines the differential risks and should,

therefore, be what is acted upon (Bronfman et al. 2011).” Thus, structural vulnerability narrows down the focus to one individual within the framework of structural competency and clinical empathy allows physicians to skillfully guide and facilitate the patient’s medical interview in meaningful ways.

Addressing the challenges related to the social determinants of health requires the development and implementation of resources and ideologies. While structural competency brings a need—and even an urgency—for physicians to not only acknowledge but to also address the systematic influences of health on marginalized populations, structural vulnerability allows the physician to understand one-on-one the risk and impact that an individual within a marginalized group faces through the accumulation of inequalities and discriminations. Thus, it is important in the social history of the medical interview to allow the patient to narrate their stories and experiences with a doctor who is skillful with communicative techniques and the practice of clinical empathy may be apt in achieving this.

### *Understanding the Preliminary Results*

While all the participants in this pilot study acknowledged the importance of empathetic practices and behaviors within the clinical relationship, not all individuals expressed the need for constant empathy in all encounters. Some clinicians described empathy as a method that drove their conversations but others viewed empathy as a tool used in selective situations (i.e. more terminally ill patients, children as patients, etc.). Furthermore, as stated in the “Results” section, many participants felt that it was easier and more natural to be empathetic towards patients with whom they could more easily relate. Additionally, only a few of the interviewees, who practiced emergency medicine, addressed how empathetic conversations with patients allowed for them to

understand not only the structural barriers that impact their health outcomes and decisions but also why affected patients seek medical attention only in the worst-case scenario—when they experience unbearable pain or their condition affects daily living and ability to work.

Through the approach of structural competency, health professionals who employ and practice selective, biased empathetic care may indirectly exacerbate existing health disparities and inequalities—that is, clinicians may serve as gatekeepers to services, resources, and technologies that facilitate or constrain patients' health outcomes and treatment options (Beynon-Jones 2013). However, these practices are not necessarily the result of individual bias or the breakdown of health professionals, but rather the result of the failure of the greater medical institutions and the medicalization of wider social problems (i.e. poverty, racism) that elicits selective empathy towards certain groups of patient populations (Jones 2000; Metzl and Hansen 2014).

Study limitations include (but are not limited to) the following: short interview time slots, sample and convenient sample, interviews conducted via phone calls, and a limited data analysis timeframe. Future research can be directed at recruiting a greater sample sizes from a variety of subspecialties to better understand the practice and perception of empathetic care within subspecialties and directing specific questions about physicians' notions and biases regarding patients' race and socioeconomic status and the resulting level of empathetic care. Findings from this research will assist clinical professionals and educators in reflecting and re-evaluating current models of teaching empathetic care. It will also instruct them in how to construct more effective modules based on the approach of structural competency and structural vulnerability.

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