

## **Training Future Physicians: An Emphasis on Empathy**

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This is my last article until September. I hope the next few months prove relaxing and satisfying for you. I also hope that you will find this article as well as the other articles I have written this past year helpful as you reflect upon those activities that bring satisfaction and meaning to your life and to the lives of family and friends. I wish to thank the many readers who have taken the time to send me e-mails in response to my articles. The feedback is always appreciated.

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More than 25 years ago I had the pleasure of co-authoring the book *A Pediatric Approach to Learning Disorders* with two physicians at Children's Hospital in Boston, Drs. Mel Levine and Jack Shonkoff. In the book we quoted an article by Barbara Korsch and Vida Francis Negrete published in *Scientific American* titled "Doctor-Patient Communication." Korsch and Negrete examined factors that either enhanced or compromised effective communication between physicians and their patients. Knowledge of these factors is important for medical practice since an effective dialogue between these parties is associated with a greater likelihood of patients following through with a doctor's recommendations.

Korsch and Negrete offered some important observations. They noted, "The failure to establish empathy with patients can be a serious bar to communication and patient response. . . . A question that invariably comes to mind with regard to a doctor-patient interview is the influence of the length of the session. It is commonly supposed that the more time the doctor can spend with the patient, the more satisfactory the results will be. No doubt part of the dissatisfaction with present medical care is attributable to the limited time hurried physicians can give their patient. Surprisingly, however, the results of our study indicated that time was not necessarily of the essence. The 800 visits (mainly with the child's mother at a walk-in clinic of a Children's Hospital) we examined varied in length from two minutes to 45 minutes, and we found no significant correlation between the length of the session and (1) the patient's satisfaction or (2) the clarity of the diagnosis of the child's illness."

Korsch and Negrete identified factors that interfered with effective communication. Not surprisingly, they found that if the physician's choice of words was too technical and filled with jargon, a barrier was created between doctor and patient. For example, when pediatricians used such phrases as "lumbar puncture" or "incubation period" without stopping to explain to parents what these words meant, a disconnection resulted. Interestingly, satisfaction or dissatisfaction with the physician's communication was not significantly different whether parents were college educated or not.

While the use of technical terms played a noticeable role in compromising the communication between doctor and patient, other factors were also prominent. One significant variable that caused distress in parents was the pediatrician's failure to attend to their specific worries. Korsch and Negrete reported a mother who repeatedly attempted to interest the physician in the fact that her child had been vomiting. "He ignored her remarks and persisted in asking her about other symptoms, which, as she did not realize, related to the same basic problem—dehydration of the child. . . . Among the 800 parents, 26 percent told interviewers after the session with the doctor that they had not mentioned their greatest concern to the physician because they did not have an opportunity or were not encouraged to do so." While some may contend that parents must be more assertive in voicing their questions, a contention with which I would agree, it is also critical for the physician to create an atmosphere which invites parents to do so.

A number of parents voiced concern that the physician had not clarified the nature of their child's problem. They did not receive an explanation of the child's diagnosis, the probable cause of the problem, and what course of treatment to assume. This lack of clarity significantly impacted on whether parents adhered to the physician's recommendations. As Korsch and Negrete discovered, "We found a substantial correlation between the mother's expressed satisfaction with the doctor's behavior in the visit and the compliance with his instructions."

Korsch and Negrete also highlighted those patterns of empathy and communication displayed by the physician that resulted in patient satisfaction and the greater likelihood of parents following through on a doctor's recommendations. One significant variable was the parents' experience that the doctor was genuinely concerned about them and their child. Of importance was the thought-provoking finding that while

most of the physicians believed they had been friendly, fewer than half of the patients experienced this friendliness.

Korsch and Negrete concluded, “Patient rapport and cooperation thrived on specific instructions, expressions of trust in the mother’s caretaking ability and offers of continued interest such as ‘Call me anytime’ or ‘We’ll check Johnny again tomorrow.’”

The Korsch and Negrete article—advocating the need to improve empathy and communication skills for enhancing patient satisfaction and compliance with medical recommendations—was published in 1972, 34 years ago. After *A Pediatric Approach to Learning Disorders* was released in 1980, several physicians told me that they felt that systematic training to enhance these skills in the medical community was still lacking. I have heard similar assessments since 1980.

My attention was drawn back to the Korsch and Negrete research and my earlier writings by recent articles that appeared in *Time* magazine by Nathan Thornburgh and *The Boston Globe* by Liz Kowalczyk about the first substantial changes in 20 years in the curriculum at Harvard Medical School. The changes involve training medical students to gain a more thorough understanding of illness from the patient’s perspective. One of the ways to accomplish this task is for medical students to shadow patients to their different appointments, actually spending time with them in waiting rooms, and chatting about nonmedical issues.

*The Boston Globe* article noted that Dr. Joseph Martin, the dean at Harvard Medical School, offered the opinion that students observing acutely ill patients only in hospitals “is a very biased way of looking at medicine.” Martin helped initiate the changes in the curriculum. He said he was concerned that students were perceiving patients as cases when “it’s all about patients as people. We want to create a different mindset.”

The *Time* article asked, “Why would the U.S.’s top medical school ask its students to spend valuable time trailing a patient instead of a doctor?” The answer made eminent sense. “At Harvard and other medical schools across the country, educators are beginning to realize that empathy is as valuable to a doctor as any clinical skill. Whether it’s acknowledging that a patient was inconvenienced by having to wait an hour before being seen or listening when someone explains why he didn’t take his meds, doctors who

try to understand their patients may be the best antidote for the widespread dissatisfaction with today's healthcare system.”

As I absorbed these words, I thought about my article from last month that focused on the importance of human connections in lessening the likelihood of the emergence and/or intensification of cardiovascular and other diseases. I also considered that Korsch and Negrete's research and their emphasis on the significance of empathy in medical training occurred almost 35 years ago. Why such a long time to implement changes in the curriculum that research indicates will be beneficial for patient care? The *Time* piece provides some interesting insights.

“As long as medical students are still getting a healthy diet of clinical learning, educators say, there's little downside. Still, centering learning on patients is a fairly radical concept for a medical-education system that is notoriously resistant to change. Medical schools operate largely on principles established in 1910. For most of the intervening century, the third year of medical school has meant total immersion in a series of clerkships in the major fields—six weeks in cardiology, six weeks in intensive care and so on. Students met patients when they were admitted into that section of the hospital, and the relationships ended as soon as the patients were discharged or moved to another ward.”

The article continued, “Dr. Erik Alexander, who directs the new program at Brigham and Women's Hospital in Boston, says the older model prevents students from seeing the larger picture. Every patient is a complex combination of sickness and health across multiple biological systems, and patients are regularly shuttled between various parts of the hospital in the course of their treatment. The best doctors in the future, he says, will make those connections across fields and treat the patient as a whole individual, not a series of symptoms.”

Those responsible for the changes in the Harvard Medical School curriculum are to be applauded. Hopefully, at a time when a “positive psychology” approach is assuming greater importance in the fields of psychology and mental health, and clinicians are increasingly focusing on the resilience and strengths of individuals, the nurturing of empathy, compassion, and satisfying interpersonal relationships will become an integral

part of the medical school curriculum. Both physicians and patients will be the beneficiary of such a shift in curriculum.

As I conclude this article, I want to extend the concept of empathy beyond the medical or mental health professions. As most of my readers are aware, I have been writing about the value of empathy in our lives for more than 25 years. The importance I accord empathy is reflected in the books Dr. Sam Goldstein and I have authored about resilience; also, the first two articles I wrote for my website back in 1999 were about empathy (I believed that empathy would serve as a foundation for the themes I addressed in subsequent articles). Consequently, in my clinical practice, workshops, and writings I have introduced exercises to promote empathy. I believe that if by keeping in mind the following questions, we will become more empathic and caring, enhance our interpersonal relationships, and enrich our emotional and physical well-being (additional exercises may be found in the books about resilience that Sam Goldstein and I have written):

What words do I hope this other person (people) would use to describe me?

What behaviors have I displayed so that this person is likely to use these words?

What words would this person actually use to describe me?

How close are the words I hope this person would use to the words he or she would actually use?

What must I do to bring the descriptions closer together? (This touches on the issue of “personal control” or assuming responsibility for our own behaviors, a topic about which I have written extensively.)

Would I want anyone to say or do to me what I have just said or done to this other person?

Whenever I say or do something to another person what do I hope to accomplish?

Am I saying or doing it in a way in which this other person feels respected and can truly hear what I have to say and respond in a constructive way? (I have learned that many people can articulate what they hope to accomplish, but all-too-often they express themselves in a manner in which other people become defensive, resentful, and angry, thereby losing sight of the key message being conveyed.)

On occasion I have been told that while these are important questions to consider, making changes based on these questions is not easy to implement. I agree, but I always add, “If you think making these changes is challenging and difficult, please keep in mind the likely consequences should you not take the time and energy to engage in this task.” The consequences are evident in the number of people who experience unhappiness and dissatisfaction in both their personal and professional lives. I hope that just as Harvard Medical School has built in experiences to facilitate the process by which medical students become more empathic, that you will build in a few moments each day to consider the questions I have posed above. I also hope this self-reflection will lead to a more satisfying, resilient life.

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