"Let Me See If I Have This Right . . . ": Words That Help Build Empathy

Consider these two physician–patient dialogues:

1. Patient: You know, when you discover a lump in your breast, you kind of feel—well, kind of— *(her speech tapers off; she looks down; tears form in her eyes)*.

Dr. A: When did you actually discover the lump?

Patient: *(absently)* I don't know. It's been a while.

2. Patient: (same as above)

Dr. B: That sounds frightening.

Patient: Well, yeah, sort of.

Dr. B: Sort of frightening?

Patient: Yeah . . . and I guess I'm feeling like my life is over.

Dr. B: I see. Worried and sad too.

Patient: That's it, Doctor.

Dr. A's patient may well go home feeling unheard and misunderstood. Dr. B's patient, while equally distressed about the possibility of having breast cancer, may leave the office believing that her doctor understands her.

One of the most widespread and persistent complaints of patients today is that their physicians don't listen. For their part, physicians complain that they no longer have sufficient time to spend with patients, and they often blame economic pressures imposed by managed care (1, 2). Nonetheless, they acknowledge that personal encounters with patients constitute the most satisfying aspect of their professional lives. They recognize that empathy, the ability to "connect" with patients—in a deep sense, to listen, to pay attention—lies at the heart of medical practice (1, 3, 4).

In clinical medicine, *empathy* is the ability to understand the patient's situation, perspective, and feelings and to communicate that understanding to the patient. The effective use of empathy promotes diagnostic accuracy, therapeutic adherence, and patient satisfaction, while remaining time-efficient (5–11). Empathy also enhances physician satisfaction (12). As with any other tool, clinical empathy requires systematic practice to achieve mastery (13, 14). Certain well-timed words and sentences facilitate empathy during the clinical encounter. These "words that work" are the subject of this paper.

Empathy in Theory

Tichener coined the term "empathy" in 1909 from two Greek roots, *em* and *pathos* (feeling into) (15). For some 50 years thereafter, empathy was discussed in the psychological and psychoanalytic literature as a type of vicarious emotional response (16–23). For example, Katz (24) wrote "when we experience empathy, [it is] as if we were experiencing someone else's feelings as our own. We see, we feel, we respond, and we understand as if we were, in fact, the other person." Lief and Fox (25) diluted this strong sense of identification when they used the word to designate the vector for detached concern. They wrote that empathy involves "an emotional understanding of the patient," while maintaining sufficient separation "so that expert medical skills can be rationally applied to the patient's problem" (25). In practice, "emotional understanding" has to be tested by checking back with the patient, and its accuracy is enhanced through iteration.

The concept of empathy has three important implications. First, empathy has a cognitive focus. The clinician "enters into" the perspective and experience of the other person by using verbal and nonverbal cues, but she neither loses her own perspective nor collapses clinical distance. Second, empathy also has an affective or emotional focus. The clinician's ability to put herself in the patient's place—or walk a mile in his moccasins—requires the experience of surrogate or "resonant" feelings (26). Finally, the definition requires that clinical empathy have an action component. One cannot know without feedback. The practitioner communicates understanding by checking back with the patient, using, for example, statements such as "Let me see if I have this right" or "I want to be sure I understand what you mean." This gives the patient opportunities to correct or modulate the physician's formulation. At the same time it expresses the physician's desire to listen deeply, thereby reinforcing a bond or connection between clinician and patient.

Empathy is sometimes confused with sympathy, or emotional identification with the patient's plight. Sympathetic responses include a physician's feeling sad and becoming teary eyed when his patient starts crying, or a physician's experiencing righteous anger when her pa-

tient recounts an injustice. Sympathy also applies to feelings of loss that people experience in response to another's loss. When present, sympathy often contributes to the physician–patient relationship, yet physicians may not always exhibit sympathy because some patients are disagreeable, culpable, or unlikable. Empathy, by contrast, does not depend on having congruent feelings and thus may be more versatile. A physician can be empathic even when he or she cannot be sympathetic (27, 28).

Numerous investigators have demonstrated the importance of empathy in the medical encounter. Empathy allows the patient to feel understood, respected, and validated. This promotes patient satisfaction, enhances the quantity and quality of clinical data, improves adherence, and generates a more therapeutic physician–patient relationship (5–11, 29–31). To achieve these goals, medical educators conceptualized empathy as a set of teachable and learnable skills and developed a new focus on communication skills in the medical curriculum (13, 14, 32–36). More recently, some educators have explored the roles of narrative and literature in teaching clinical empathy (37–39), and others have emphasized the importance of reflection and self-awareness in maintaining one's empathic skills (40–44).

EMPATHY IN PRACTICE

Clinical empathy can be visualized as a positive feedback loop, or a neurologic track with afferent and efferent components (45, 46). The afferent arm includes verbal and nonverbal cues that lead to the practitioner's initial appraisal or understanding of the patient's message. The efferent arm includes the practitioner's responses—queries such as "Tell me more" or statements such as "I can imagine how difficult it is." Such responses elicit additional information. While it is impossible for the clinician to understand exactly how the patient feels, in clinical empathy successive cycles may lead to a clearer, more accurate "fix" on the patient's perspective and feelings. Thus, empathic communication includes the following components.

Active Listening

This requires nonverbal and paralanguage skills, such as appropriate position and posture; good eye contact; mirroring of facial expression; and facilitative responses, such as nodding and minimal expressions (for example, "Hmmm . . ." and "Uh-huh"). It also demands that the physician remain silent and focus her attention on the patient's story (47, 48).

Framing or Sign Posting

Clinicians often initiate an empathic response when they "pick up" a suggestion or indication that the patient is experiencing concern, conflict, or emotion. Because accurate understanding is not commonly attempted in ordinary conversation, patients may be unaccustomed to empathic responses. Clinicians may need to disclose their intent, providing a frame or signpost for the patient (35). Lengthy warning may be inefficient and exhausting, so we usually abbreviate it in these ways:

Let's see if I have this right.

Sounds like what you're telling me is . . .

Or simply *Sounds like. . .*

Reflecting the Content

An empathic response accurately identifies the factual content of the patient's statement, as well as the *nature* and *intensity* of the patient's feelings, concerns, or quandaries. A reflection of content (symptoms or ideas) might sound like the following:

So you were fine until this morning when you woke up with pain in your belly, and it's been growing more severe ever since.

Sounds like you think that you have appendicitis and that you might need to go into the hospital.

The physician may also mirror the patient's interests and values:

So, if I'm hearing you right, what you really enjoy is going out at night with your friends and having a few drinks.

Identifying and Calibrating the Emotion

Clinical empathy often entails responding to the patients' expressed (or suggested) feelings. This means identifying the emotion and calibrating its intensity. Sometimes emotional content is evident, but the nature of the emotion is unclear. In such cases the patient will often reveal the feeling, if given an opportunity.

Tell me how you're feeling about this.

I have the sense that you feel strongly, but I'm not sure I understand exactly what the feeling is. Can you tell me?

The following are examples of empathic responses to patient statements that express sadness, fear, anger, distrust, and ambivalence.

Sadness: *That must have been a pretty painful experience for you, you sound like it was very sad.*

Fear: *Sounds like you were really frightened when you discovered that lump.*

Anger: *That situation really got to you, didn't it? I can imagine how angry I'd feel if that happened to me.*

Distrust: *It seems you're not sure whether you should trust me further after I didn't get that test result back to you last week.*

Ambivalence: *It seems to me that you're caught in a bind about whether to stop smoking or not.*

Feelings vary markedly in intensity; often, clinicians tend to sanitize or dilute them. Consider this example:

Patient: Most days the pain is so terrible that I just want to stay in bed. I just stare at the ceiling . . . what's the point of it all?

Doctor: So you're frustrated about the pain?

In this case, the physician identified an emotion (frustration) but failed to capture the patient's profound sense of helplessness. Weak affective words such as "bother," "annoy," "upset," "uneasy," and "apprehensive" are sometimes appropriate. At other times, red-blooded adjectives such as "infuriated," "enraged," "tormented," "overwhelmed," and "terrified" are more in order. This patient feels so depressed and helpless that he asks, "What's the point of it all?" By hearing only annoyance or frustration in the statement, the physician missed a diagnostic cue and perhaps a useful path of inquiry and has distanced herself from the patient. An alternative answer could be, *It sounds to me like you're completely overwhelmed . . . you must feel helpless.*

Finally, patients are often unaware of, or out of touch with, their feelings. Sensitive inquiry by the physician may provide opportunities for them to acknowledge this situation and "tune into" their feelings ("Well, yes, I hadn't thought of it that way, but now that you mention it, I am angry.") Alternatively, such patients may continue to reject, deny, or disguise their emotional responses ("Angry? No way. I'm just stating the facts."). This is often true in situations involving somatization or compensation, where social and cultural factors militate against emotional disclosure.

Requesting and Accepting Correction

Respectful acceptance of the patient's correction is a powerful way of communicating the desire to understand.

Did I miss anything? Anything I left out?

Then, when corrected, the physician incorporates the new data into a second (or third) cycle of listening, reflecting, and responding. The process continues until the patient confirms the clinician's understanding: "You got it, Doc," or "That's it, Doc."

When and Where

Empathy belongs with every patient and throughout every encounter (49, 50). However, much of the time empathy is invisible (one does it unconsciously) because the patient's needs are relatively transparent and the physician's responses automatic. Clinicians often initiate an empathic response when they "pick up" an indication that the patient is experiencing concern, conflict, or emotion. What are these indications? In some cases the patient presents a frank expression of suffering or emotion; in others, a more subtle affective comment is casually "dropped" to test the water's temperature. More commonly, the physician might realize that her patient's strong feelings are embedded in quasi-factual statements or inquiries. Alternatively, the observant clinician might notice discordant messages between verbal expressions and aspects of nonverbal communication, such as eye contact, movements, and autonomic responses. Suchman and coworkers (37) referred to these moments as potential empathic opportunities. They found that physicians frequently rejected these opportunities by changing the topic. In their study of experienced practitioners, Branch and Malik (51) noted that most physicians bypassed such opportunities for getting to the heart of their patients' problems.

Don't Just Do Something, Stand There

Having established an empathic connection, physicians are often anxious about what to do next. Some launch into immediate efforts to reassure. It is effective to delay that effort, allowing a pause of several seconds. A good rule might be "don't just do something, stand there." During the pause, the patient is experiencing being understood, which in itself has therapeutic value. At the same time, the physician can be considering more deeply just what this patient has been going through. Sometimes the introspection leads to further powerful communication. One of us recently reported visiting with a "difficult patient":

> I kept reminding myself that I needed to be empathic with this patient despite the fact that I was not having much sympathy for her. I have to admit the task was taxing and difficult. What seemed to work with my patient was honesty. I told her, "You know, I want to understand and to help you, but sometimes I feel like you are driving me crazy. I don't want to feel that way, but I do." Then I went on to say, "Sometimes, when doctors feel their patients are driving them crazy it is because the patients experience their own lives as crazy and chaotic." She looked at me with disbelief and started crying and then told me that she felt she was losing control and how difficult it was to live with this pain. She said, "I feel that I am driving myself crazy as well as all the people that are around me."

Physicians hear so many difficult and distressing stories, it is no wonder that they often rush to reassure their patients: *It can't be as bad as that. Everything will be all right. Don't worry, most of the time it's a false positive*. In a profession that values decisiveness and action, it is difficult not to do *something* to defuse patient distress when it occurs. Reassurance springs to the lips. Such statements are usually made in good faith and sometimes are probabilistically true: that is, it is likely that everything *will* be all right. Nonetheless, such reassurance often fails if the physician does not also communicate an awareness of the patient's deepest fears or concerns.

Culture and Empathy

In our diverse society, physicians encounter patients from different ethnic and cultural groups, some of whom have a poor command of the language spoken by the practitioner. These patients may experience added distress because traditional support systems or health care arrangements are unavailable in their new communities (52). Is it possible to express empathy for patients whose background and life experience are totally different from your own?

There is a popular belief that one has to experience something oneself in order to understand "what it's like" for another person. Indeed, it would be wrong to minimize the difficulties of cross-cultural, interracial, or even transgender understanding. However, if clinical empathy is understood as a feedback loop, one can see how successive cycles may lead to improved understanding. If nothing else, the clinician's honest attempt to understand should facilitate trust. Empathy involves drawing on our own range of feelings and experiences and then taking an imaginative leap—"Aha! Her feeling is like. . . . " This leap may involve metaphor, where one uses a striking shared characteristic to describe an unknown concept or feeling in terms of something known. For example, a physician might say to a patient who seems angry and disappointed, *You must feel like you rushed to the platform, only to find that your train had already left*.

In essence, the imaginative leap is a hypothesis. The practitioner may not be able to guess her patient's feelings or values on the first try, but clinical empathy as we have described it is a hypothesis-testing feedback loop that allows the physician to move closer to understanding. Here are some examples of empathic statements a clinician might make in a cross-cultural encounter:

Seems like it would be difficult for you not to feel 100% understood.

I imagine it's stressful to find that treatments in the United States are different than in your country.

It has to be very difficult to take pills instead of the herbs that you are accustomed to.

It must be terrifying to have your child so sick, and then have to bring him in to see a doctor you're not accustomed to.

Even when a patient speaks the practitioner's language relatively well, language may still be a barrier to discussing complex medical topics or to talking about personal feelings, beliefs, and values. Often it is unclear whether language itself is the barrier or, alternatively, cultural practices that prohibit airing certain topics or revealing certain information. **Table 1** presents several guidelines to assist in empathic understanding across ethnic and cultural barriers. The next step is to ascertain

Table 1. **Guidelines for Clinical Empathy in the Cross-Cultural Setting**

Understand your own cultural values and biases
Develop a familiarity with the cultural values, health beliefs, and illness behaviors of ethnic, cultural, and religious groups served in your practice
Ask how the patient prefers to be addressed
Determine the patient's level of fluency in English and arrange for a translator, if needed
Assure the patient of confidentiality; rumors, jealousy, privacy, and reputation are crucial issues in close-knit traditional communities
Use a speech rate, tone, and style that promote understanding and show respect for the patient
Check back frequently to determine patient understanding and acceptance

Table 2. **Words That Work: Statements That Facilitate Empathy**

Queries
"Would you (or could you) tell me a little more about that?"
"What has this been like for you?"
"Is there anything else?"
"Are you OK with that?"
"Hmmmm"
Clarifications
"Let me see if I have this right."
"I want to make sure I really understand what you're telling me. I am hearing that . . ."
"I don't want us to go further until I'm sure I've gotten it right."
"When I'm done, if I've gone astray, I'd appreciate it if you would correct me. OK?"
Responses
"That sounds very difficult."
"Sounds like . . ."
"That's great! I bet you're feeling pretty good about that."
"I can imagine that this might feel . . ."
"Anyone in your situation would feel that way . . ."
"I can see that you are . . ."

the patient's beliefs about the nature of the illness and what needs to be done about it (53) and to learn more about the patient's life experience (54), while maintaining a sensitive and respectful demeanor.

SUMMARY: FROM GOOD LINES TO GOOD ENCOUNTERS

Table 2 presents words, phrases, and sentences that are useful in practicing clinical empathy. Empathy might also be visualized as a fastener or lock that enables the physician and patient to "click" together. On the physician's side, the critical step occurs when he or she says something like

Let me see if I've gotten this right.

Sounds like. . . .

I want to make sure that I understood what you're telling me.

I can imagine that this might feel. . . .

On the patient's side, the crucial step occurs when he or she says:

"You got it, Doc."

"Exactly."

"That's how I feel."

If you don't get such a confirmation, you aren't done.

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