

# Factors affecting empathetic patient care behaviour among medical doctors and nurses: an integrative literature review

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## Abstract

**Background:** Healthcare professionals' empathetic behaviour is an important component of quality health care. Patients' reports suggest that empathy is often lacking. Specific factors that may facilitate or inhibit empathetic behaviour have not been extensively examined. In Qatar, empathy may be affected by a completely multicultural, multilinguistic setting where healthcare professionals and patients interact.

**Aim:** The purpose of this integrative literature review is to provide the latest evidence on factors that influence the demonstration of empathetic behaviour of nurses and physicians toward patients and to draw general conclusions that increase understanding.

**Methods:** A literature search was conducted in CINAHL, Medline (Ovid), PsycINFO, Psychology and Behavioral Sciences Collection, Middle Eastern and Central Asian Studies, Education Research Complete, ERIC, Health Source: Nursing/Academic databases, and Google Scholar to identify relevant studies. A total of 18 quantitative and qualitative studies that satisfied the inclusion criteria were selected to be included in the review.

**Results:** Three high order factors are described: organizational, personal and interpersonal, and demographic factors. Seven subfactors included: burnout, increased workload, lack of organizational support, training workshops, patient behaviour, inappropriate role modelling, and informal, experiential learning.

**Conclusion:** The organizational culture is strongly implicated in inhibiting empathy. Healthcare providers' empathetic responses to patients are linked and connected to a well-resourced, collegial, professional organizational environment that builds empathy towards everyone (not only patients).

Keywords: Compassion, Healthcare Professionals, Communication, Barriers, Facilitators

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## Introduction

This integrative review synthesizes current publications about medical doctors' and nurses' capacity to show empathy. The review was conducted as a preliminary step to explore these health professionals' empathy in the Arabian Gulf Region where empathy has not yet been studied.

It is our view that, internationally, a high degree of empathy toward patients is important for all healthcare professionals. This view is supported by research indicating that empathy is implicated in patients' trust, satisfaction and compliance (1-5). However, research also shows that healthcare professionals often ignore opportunities for acts of empathy (6), and patients are treated with detached functionality rather than empathetically (7).

This review was conducted to respond to the question: what are the inhibiting and facilitating factors that affect the demonstration of empathetic behaviour by medical doctors and nurses toward patients?

## Methods

An integrative review is “a form of research that reviews, critiques, and synthesizes representative literature on a topic in an integrated way such that new frameworks and perspectives on the topic are generated” (8). Our review used Knafli and Whittmore's 5-step process (9): (1) problem identification, (2) literature search, (3) data evaluation, (4) data analysis, and (5) presentation.

### Problem identification

Knowledge about the factors that affect the demonstration of empathetic behaviour by medical doctors and nurses is not well developed.

### Sources

Databases accessed included Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline (Ovid), PsycINFO, Psychology and Behavioral Sciences Collection, Middle Eastern and Central Asian Studies, Education Research Complete, ERIC, Health Source: Nursing/Academic, and Google Scholar. We searched for

publications from 2000 to 2015 using the terms *empath\**, *nurs\**, *therapeutic communicat\**, *communicat\**, *factor\**, *influen\**, *barrier\**, *facilitator\**, *perception\**, *perspective\**, and *points of view*. The initial search generated 1408 articles.

### Preliminary scan for inclusion and exclusion

Following Knafl and Whittemore (9), the topical articles were evaluated for eligibility using titles and abstracts. Delimiters included: (i) written in English; (ii) peer-reviewed; (iii) primary sources; and (iv) addressed facilitators and barriers for empathy. A manual search of article reference lists yielded 18 additional articles. Grey literature was excluded. Ultimately, 24 articles met the inclusion criteria.

### Critical appraisal

The next step included a 10-item Critical Appraisal Skills Programme (10) that was applied to the qualitative research, and Barker's 12-item critical appraisal tool (11) to assess the quantitative studies. Six articles were rated as low-quality studies and excluded. Eighteen articles were included in the final review: 5 qualitative and 13 quantitative (Figure 1).

### Compilation and interpretation of data

Analysis was carried out in 3 phases: data reduction, data display and data comparison (9). It involved iterative comparisons seeking higher-order thematic clusters across data sources. During data reduction a categorization structure was developed. Foremost, this was a strategy for managing data from each study. Relevant data were entered into a literature review matrix that was used to facilitate constant comparison, focused on finding patterns, themes, variation, and relationships among the barriers and facilitators. The extracted data were then displayed in a graph and a chart to enhance the visualization of themes and patterns. The data comparison phase involved grouping data together to determine if there were higher- and lower-order themes. Finally, the interpretation and integrated findings were represented in a newly created conceptual model that depicts barriers and facilitators of empathy (Figure 2).

### Results

Three high-order themes that affect empathy emerged: organizational, personal and interpersonal, and

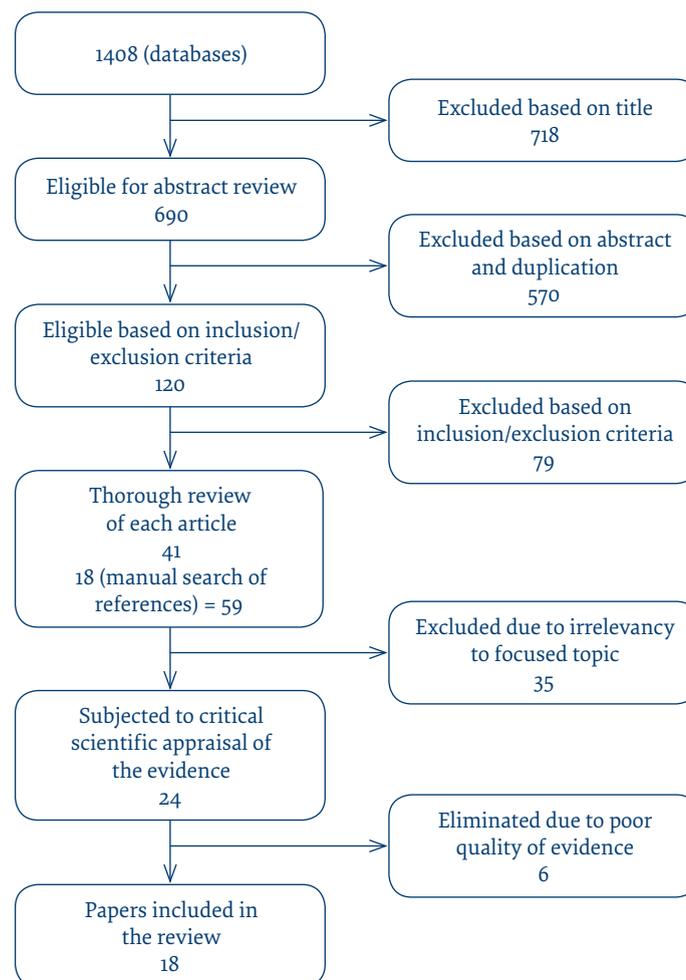


Figure 1. Selection process of studies

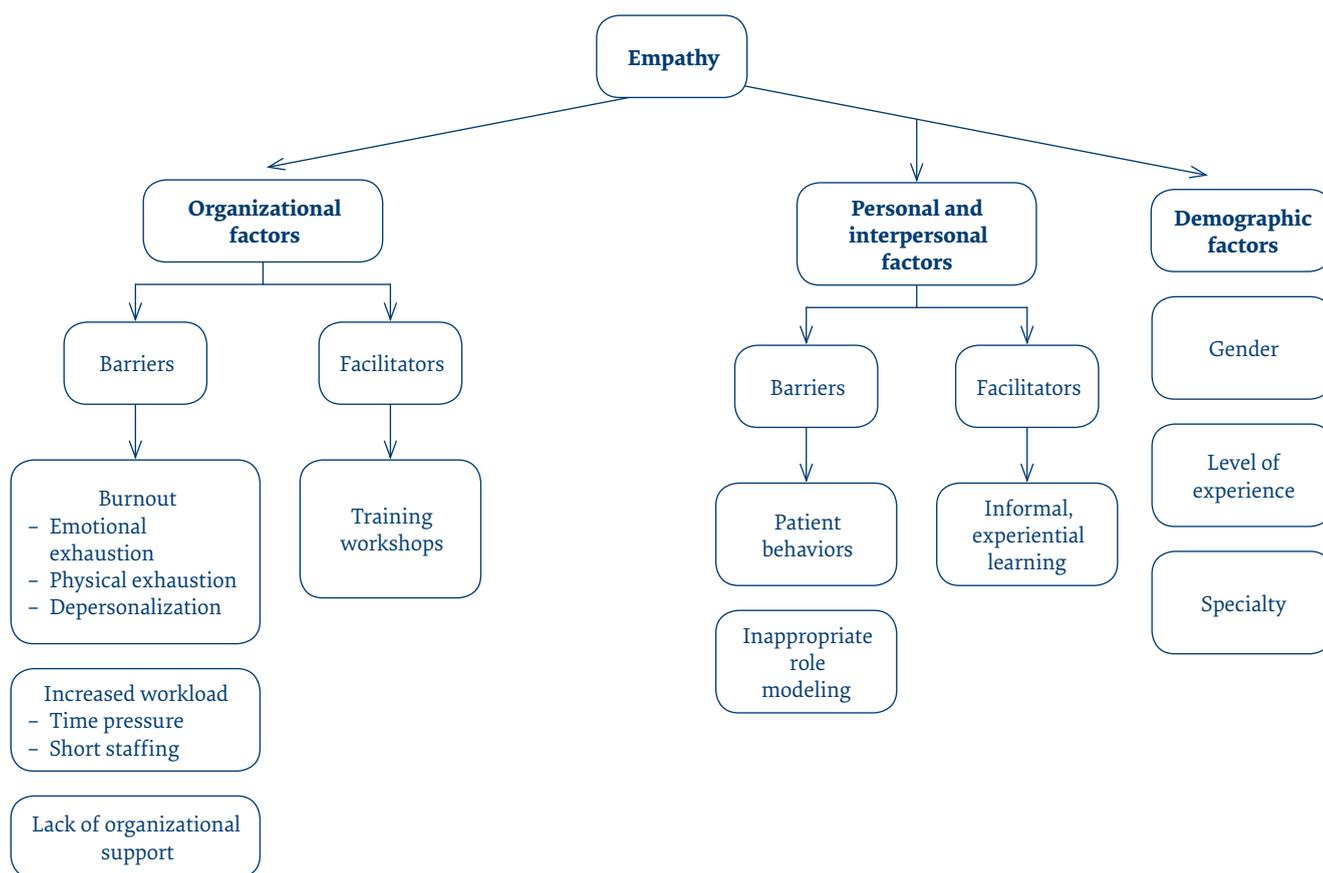


Figure 2. Conceptual framework representing barriers and facilitators of empathy

demographics. These categories, though useful to support an analysis of empathy, are linked and overlapping. The major themes are not mutually exclusive but provide a useful way to conceptually frame the findings.

**Organizational barriers**

The demonstration of empathy is vulnerable to organizational factors that may compromise healthcare professionals’ intentions to provide empathetic care.

**Lack of organizational support**

Healthcare professionals’ ability to demonstrate and practice empathetic behaviour is largely influenced by organizational support. Lack of organizational support may include decreased availability of resources; lack of support from supervisors for empathetic care; and failure to acknowledge bonds between staff and patients. Schell and Kayser-Jones (12) studied the care provided to dying patients and reported that lack of organizational support could be an impediment for healthcare professionals’ empathy during end of life care. Similarly, Bayne et al. (13) reported that physicians who feel unsupported by their administration are more prone to lack empathy.

**Workload**

Lack of empathy is partly attributed to increased workload. An overly demanding pace of work is exhausting and health professionals simply do not have the emotional energy to demonstrate empathy (13). Bayne

et al. examined 21 healthcare professionals’ viewpoints of the practicalities of empathy in clinical practice (13). Under the theme external barriers, the authors found that shortened consultation times led to reduced empathy. Likewise, under the theme obstacles to improving communication, Klitzman found that time pressure was an obstacle for physicians’ empathy (14). Students balancing heavy course loads and mastering clinical skills find it difficult to express empathy in their interactions with patients (13,15). Hojat et al., using the Jefferson Scale of Physician Empathy found a decline in medical students’ mean empathy scores from programme entry to completion (15). The research linked time pressures to students’ reduced levels of empathy. Similarly Ward et al. noted a significant reduction in mean empathy score from admission to the end of the programme in a group of undergraduate nursing students (16).

**Burnout**

Burnout is closely linked to the daily pressures and pace of work faced by health professionals. Shanafelt et al. (17) cited Maslach, Jackson and Leiter (1996) when they stated: “Burnout is a syndrome of depersonalization, emotional exhaustion, and a sense of low personal accomplishment that leads to decreased effectiveness at work” (p. 358). Empathetic behaviour toward patients is reduced as a result of healthcare professionals’ emotional exhaustion, burnout, lack of sleep, workload and physical exhaustion (13,15,18,19). Thomas et al. studied

the relationship between decreased levels of empathy and burnout among 545 medical students, using the Interpersonal Reactivity Index to measure dimensions of empathy and the Maslach Burnout Inventory to measure depersonalization, emotional exhaustion and personal accomplishment (19). The authors found a significant reduction in empathy with increased depersonalization ( $P < 0.02$ ). Similarly, Brazeau et al. surveyed 90 medical students and showed that a high level of burnout was correlated with a decreased level of empathy (18). Hojat et al. found that lack of sleep, and heavy workload, resulted in a loss of empathy among medical students (15). Those healthcare professionals who were assessed as not suffering from burnout adopted strategies to guard themselves against potential sources of emotional tension (13).

### Organizational facilitators

Despite the different organizational factors that exert a negative influence on empathy, evidence suggests that strategies implemented by organizations can enhance empathetic behaviour of healthcare professionals.

### Training workshops

Training can improve empathetic skills. Razavi et al. found significant enhancement of effective empathy 3–6 months after 105 hours of an empathy training programme that used videotapes of simulated interviews to evaluate the ability of 115 oncology nurses to use emotional words (20). They found that nurses who had empathetic training used fewer neutral expressions than untrained nurses, particularly 3 months after training ( $P = 0.055$ ). Furthermore, the level and depth of emotional expression was significantly increased in nurses who did the training in comparison to untrained nurses ( $P = 0.023$  and  $0.016$ , respectively). Chism and Magnan studied 223 nurses and found that empathy training was significantly more effective for people who identified themselves as spiritual ( $P < 0.01$ ) (21). Similar positive results from an organizational intervention were reported by DiLalla et al. who examined 1181 medical students' self-rating of empathy after attending wellness sessions (22). The wellness training resulted in greater empathy ( $P < 0.01$ ).

Dow et al. designed an intervention study whereby professors from the drama/theatre department acted emotionally with 14 internal medicine residents in a controlled environment to assess whether empathy could be learned using theatre techniques (23). Evaluation before, and 4 months after the intervention, relied on observed interactions between practitioners and patients in clinical visits. The intervention group showed a significant improvement in listening, nonverbal communication, respect for dignity, and overall impression ( $P < 0.01$ ) but no significant improvement in verbal communication ( $P = 0.058$ ).

### Personal and interpersonal barriers

Empathy is a human interaction that is relational and is influenced reciprocally by the behaviour and responses of the other person.

### Patients' behaviour

Evidence suggests that the response of healthcare professionals varies according to the type of emotion that is expressed by patients (6,24,25). Sheldon et al. reported on a study with 74 nurses to explore their empathetic responses to patients' emotion (24). Nurses had a significant increase in affective response to sadness versus anger. Kennifer et al. recruited 48 oncologists and audiotaped their responses to patients (25). A subset of 44 recordings in which patients expressed at least 1 negative emotion were analysed. The oncologists scored higher in responding to sadness than to fear. Likewise, Hsu et al. found that patients' expressions of grief and family strain are more likely to induce an empathetic response than the response generated by patients who are angry or distrustful of their doctors (6). Hojat et al. found that medical students had reduced empathy for patients whose behaviour was judged as demanding, difficult, hostile, insulting, unappreciative and/or malingering (15). Bayne et al. supported these findings, adding drug seeking to the list of patients unlikely to receive empathy (13).

### Inappropriate role modelling

Role modelling is one of the ways that healthcare professionals learn how to interact empathetically with patients (14,15,18). Brazeau et al. used a questionnaire to study the relationship between medical students' empathy and the general climate of professionalism, which was defined within characteristics such as altruism, accountability, duty, excellence and service (18). Based on the results of 90 responses they found that the level of empathy was positively related to the professional climate.

### Personal and interpersonal facilitators

#### Experiential, informal learning

Bayne et al. used grounded theory to develop a model of empathy that highlighted 2 types of empathy: initial and genuine (13). Initial empathy is a primary level empathy that is superficial and can be taught. Genuine empathy is a deeper level of empathy that rests in the capacity to imagine and to "walk in a patient's shoes". Klitzman interviewed 50 doctors who had experienced serious illness and identified that this experience served as a catalyst that enabled them to connect with their patients at a deeper level, showing more genuine empathy (14).

#### Demographic factors

Significant variance in healthcare professionals' empathy has been attributed to personal demographic differences related to gender, experience and area of practice (16,22, 24,26).

Evidence suggesting that female healthcare professionals are more empathetic to patients than men was consistent across studies (15,19,22,27-29). DiLalla et al. evaluated self-ratings of empathy by 1181 medical students and healthcare practitioners to investigate variations according to gender, experience and age (22). They found that women had significantly

higher empathy scores ( $P < 0.001$ ). Ward et al. found that among undergraduate nursing students empathy was significantly higher in women (29). Quince et al. found the same gender related difference in empathy among medical students (28).

Healthcare professionals' level of experience is another factor influencing the demonstration of empathy. Bayne et al. found that physicians with more experience demonstrated more empathetic behaviour (13). A similar finding was reported in the study of Ward et al. of nursing students in which mean empathy scores were higher among nursing students with the most clinical experience (29). In contrast, a subsequent study by Ward et al. found a decline in empathy measured at the beginning and end of 1 academic year (16).

There is evidence that the level of health professionals' empathy differs among specialty areas (15,26,27). In a study of 456 medical students, Hojat et al. found that those who pursued their residency training in psychiatry had the highest mean empathy scores (127.0), while anaesthesiology had the lowest (116.1) (15). Kataoka et al. used the Jefferson Scale of Empathy (JSE) with 285 female physicians (26). The results showed that physicians in people-oriented specialties, such as general internal medicine and psychiatry, showed significantly higher empathy scores than physicians in technology-oriented specialties, such as anaesthesiology and surgery ( $P < 0.001$ ).

## Discussion and implications

Despite that there has been no research conducted in the Arabic Gulf Region, implications can be drawn from this integrative review. The health workforce in Qatar is dominated by multinational professionals who likely differ, both from one another, and with patients in their cultural approaches to communication and interactions. The patients for whom they provide care also differ in their nationalities and cultures. One of the routine challenges facing healthcare workers in Qatar is a language barrier between themselves and their patients. The initial findings for this review identified the importance of educational programmes to increase and maintain professionals' empathetic awareness and practice. In Qatar, the emphasis of health professionals' empathy training needs to focus on nonverbal communication that respects the cultural diversity of patients in Qatar. This includes lessons in culturally sensitive physical gestures and the appropriate and inappropriate use of physical touch. This literature review reinforces the need for health professionals in Qatar to learn optimal ways to manage and care for patients who do not speak the same language as the caregiver. The language barriers and social hierarchies that manifest in Qatar generate tensions and frustrations that demand that healthcare professionals learn how to respond with empathy to angry or hostile patients (and with one another). Such training sessions need to be offered on a regular basis, as a way to check the level of burnout and to foster and maintain empathetic skills.

As with healthcare organizations around the world, in Qatar, cost-effectiveness has become a prevailing driver and health professionals are being tasked with increasing workloads. In light of the findings of this integrative review, it rests on healthcare leaders and managers to monitor the increasing veracity of healthcare professionals' work to ensure that duty shifts, assigned workload and working conditions are reasonable and not too taxing. Managerial/leadership focus on empathy should support the development of the professional environment, which has been shown to support empathy. Health professionals who experience their work within collegial, empathetic working relationships are key to building a culture of empathy.

Training and organizational support are insufficient without appropriate role modelling (14). In Qatar, there are many highly committed experienced practitioners who contribute an important resource to develop empathetic behaviour. Brazeau et al. stressed the importance of enhancing role models' awareness of their responsibility to model explicitly empathetic care that can be constantly developed and refined for each instance of practice (18). This refined modelling of empathy is important with patients who have been characterized as difficult or those expressing anger (30).

Finally, an implication from this integrative review is the significant research finding that female healthcare professionals are more empathetic to patients than men are. This finding can be utilized in a highly selective way. Quince et al. indicated that there might be a natural empathetic difference between genders that would have implications in job selection (28). Appointing women to jobs in which patients need a lot of empathetic care is one of the ways to utilize women's empathetic advantage.

## Conclusion

This review adds to the limited body of literature about facilitators and barriers to health professionals' empathetic behaviour toward patients. The evidence shows how these factors are inter-related and may work together to affect empathetic behaviour. The review revealed a dearth of research being conducted in the Arabian Gulf within the unique context of health care that has developed here. From our perspective, it is important to begin to generate knowledge from this region.

Overall, the results identified that some of the inhibiting factors for empathy are related to organizational issues. We suggest that this integrative review and the future research it generates are an important contribution to the work of healthcare administrators. The findings indicate that empathy is more than a personal characteristic that is promoted within each individual's practice. The capacity for healthcare providers to demonstrate empathy is linked and connected to a well-resourced, collegial, professional organizational environment that builds empathy (not only towards patients) as the cultural norm. Administrative strategies to support individual empathetic behaviour include periodic empathy training; careful monitoring of overwork and

fatigue; and identification of key role models whose experience provides a way for them to embrace and embody empathy. Ultimately, this integrative review suggests that strategies to address factors that impede or facilitate empathy should be made an important

focus of contemporary healthcare providers. It is an ongoing, dynamic, organizational and interpersonal issue that every member of the healthcare complex must take seriously.

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## Facteurs influant sur le comportement empathique dans les soins prodigués aux patients par les médecins et les infirmières : analyse documentaire intégrative

### Résumé

**Contexte :** Le comportement empathique des professionnels des soins de santé est une composante importante d'une prise en charge de qualité. Selon les dires des patients, il semble que l'empathie soit souvent manquante. Les facteurs spécifiques qui facilitent ou inhibent le comportement empathique n'ont pas été largement étudiés. Au Qatar, l'empathie peut être affectée par un environnement complètement multiculturel et plurilingue au sein duquel les professionnels des soins de santé et les patients ont des interactions.

**Objectif :** L'objet de la présente analyse documentaire intégrative est de fournir les derniers éléments d'information sur les facteurs qui influencent l'expression du comportement empathique des personnels infirmiers et des médecins vis-à-vis des patients et permettent de tirer des conclusions générales qui augmentent la compréhension.

**Méthodes :** Une recherche documentaire a été menée sur CINAHL, Medline (Ovid), PsycINFO, Psychology and Behavioral Sciences Collection, Middle Eastern and Central Asian Studies, Education Research Complete, ERIC, Health Source : Nursing/Academic databases, et Google Scholar pour identifier les études pertinentes. Au total, 18 études quantitatives et qualitatives qui répondaient aux critères d'inclusion ont été sélectionnées pour être incluses dans l'analyse.

**Résultats :** Trois facteurs d'ordre importants sont décrits : il s'agit des facteurs organisationnels, personnels et interpersonnels, et démographiques. Sept sous-facteurs comprenaient : l'épuisement professionnel, l'augmentation de la charge de travail, les ateliers de formation, le comportement des patients, le manque d'appui organisationnel, les modèles à suivre inappropriés, et l'apprentissage expérientiel informel.

**Conclusion :** La culture organisationnelle est fortement impliquée dans l'inhibition de l'empathie. Les réactions empathiques des prestataires de soins face aux patients sont associées à un environnement organisationnel professionnel collégial, bien doté en ressources, établissant une empathie autour de chacun (et pas seulement des patients).

### العوامل التي تؤثر على السلوك التعاطفي في رعاية المرضى في صفوف الأطباء وأطقم التمريض: استعراض تكاملي للدراسات السابقة

منتهى عليان، جانيت رانكين، محمد الشعراي

#### الخلاصة

الخلاصة: يمثل السلوك التعاطفي للعاملين في مجال الرعاية الصحية مكوناً مهماً لتوفير الرعاية الصحية الجيدة. وتشير تقارير المرضى إلى انعدام التعاطف في كثير من الأحيان. ولم تجر أي دراسة موسّعة من قبل للعوامل المحددة التي يمكن أن تسهل أو تثبط السلوك التعاطفي. وفي قطر، يمكن أن يتأثر التعاطف مع المرضى بالسياق الذي يتفاعل فيه العاملون في مجال الرعاية والصحية والمرضى مع بعضهم البعض والذي يتسم بتعدد الثقافات واللغات بشكل تام.

الهدف: الغرض من هذا الاستعراض التكاملي للدراسات السابقة هو توفير أحدث البراهين عن العوامل التي تؤثر على إبداء أطقم التمريض والأطباء سلوكاً تعاطفياً نحو المرضى، والخروج باستنتاجات عامة لتعزيز الفهم.

طرق البحث: أُجري بحث عن الدراسات السابقة في الفهرس العلمي CINAHL وقاعدتي البيانات Medline (Ovid) و PsycINFO وقواعد بيانات مجموعة علم النفس والعلوم السلوكية، ودراسات الشرق الأوسط وآسيا الوسطى، والبحوث التعليمية الكاملة، ومركز معلومات الموارد التعليمية، وقاعدة بيانات Health Source: فضلاً عن قواعد بيانات التمريض/ قواعد البيانات الأكاديمية، ومحرك بحث «جوجل سكولار» للتعرف على الدراسات ذات الصلة. وجرى اختيار ما مجموعه 18 دراسة كمية وكيفية استوفت معايير إدراجها في الاستعراض.

النتائج: تصف الدراسة ثلاثة عوامل عالية التصنيف، وهي: العوامل التنظيمية، والشخصية والتواصلية، والسكانية. كما تضمنت سبعة عوامل فرعية على النحو التالي: الإنهاك، وزيادة عبء العمل، وانعدام الدعم المؤسسي، والحلقات التدريبية وسلوك المرضى، والافتداء بنماذج غير ملائمة، والتعلم غير الرسمي القائم على التجربة.

الاستنتاج: تشكّل الثقافة المؤسسية عاملاً قوياً في تهيئ التعاطف مع المرضى. فيرتبط التجاوب التعاطفي لمقدمي الرعاية الصحية إزاء المرضى بتوفر بيئة مؤسسية مزودة بالموارد الكافية وقائمة على العمل الجماعي وتتسم بالمهنية، تبني التعاطف مع الجميع (وليس المرضى فحسب).

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