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## Empathy in general practice—the gap between wishes and reality: comparing the views of patients and physicians

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### ABSTRACT

**Background:** Empathy is regarded by patients and general practitioners (GPs) as fundamental in patient–GP communication. Patients do not always experience empathy and GPs encounter circumstances which hamper applying it.

**Objective:** To explore why receiving and offering empathy during the encounter in general practice does not always meet the wishes of both patients and GPs.

**Method:** A qualitative research method, based on focus group interviews with patients and in-depth interviews with GPs, was carried out. Within the research process, iterative data collection and analysis were applied.

**Results:** Both patients and GPs perceive a gap between what they wish for with regard to empathy, and what they actually encounter in general practice. Patients report on circumstances which hamper receiving empathy and GPs on circumstances offering it. Various obstacles were mentioned: (i) circumstances related to practice organization, (ii) circumstances related to patient–GP communication or connectedness, (iii) differences between the patient's and the GP's expectations, (iv) time pressure and its causes and (v) the GP's individual capability to offer empathy.

**Conclusion:** When patients do not receive empathy from their GP or practice staff, they feel frustrated. This causes a gap between their expectations on the one hand and their actual experiences on the other. GPs generally want to incorporate empathy; the GP's private, professional and psychological well-being appears to be an important contributing factor in practicing empathy in

daily practice. But they encounter various obstacles to offer this. It is up to GPs to take responsibility for showing practice members the importance of an appropriate empathical behaviour towards patients.

## INTRODUCTION

Both patients and general practitioners (GPs) generally regard empathy to be an important, useful and effective part of consultations in primary care (1–3). Patients report that consultations in which empathy is applied are more satisfactory and make them feel understood and respected. Empathy also helps them to talk freely about their worries and concerns, relieves their anxiety (4) and decreases emotional and physical stress during consultations (5). When patients experience a lack of empathy, they feel disappointed and sometimes even stop visiting their GP (6). There is more and more evidence that empathy on the part of the physician is an important part of patient–physician communication, in general practice and elsewhere (5). GPs particularly underline that applying empathy results in them acquiring more varied important information about the patient’s context. Besides, they find that empathy is indispensable in building a patient–GP relationship which is based on partnership, and that empathy helps them cope with emotional moments during the consultation (7). Patients expect their GP to show empathic behaviour to make them feel they are being taken seriously and are being supported. They want a GP to radiate humanity, equality, trust and safety. Regarding the GP’s empathic skills, they want their GP to make direct eye contact and have a listening posture, and they want their GP to reflect upon earlier situations (6). GPs generally have similar expectations of empathy in daily practice. Both patients and GPs are convinced that empathy has a positive effect on clinical outcomes (6,7). Even though patients and GPs have similar wishes and expectations with regard to empathy in daily practice, there seems to be a gap between these wishes and the reality of many consultations (6,8). Patients often experience a lack of empathy, resulting in stressful consultations and in them feeling upset and overwhelmed (6). GPs experience barriers in showing empathy during clinical encounters (8). So far, little research has been done into which circumstances in daily general practice create this gap between what patients and GPs want and what actually happens with regard to empathy. This qualitative comparative study combines the results of two studies, one of patients and one of GPs, and explores how and why the wishes of both patients and GPs with regard to empathy in patient–GP communication, are not always met.

## METHOD

### Study design

We used data from a focus group study with patients and an in-depth interview study with GPs regarding their experiences with empathy in daily general practice (6–8). Both studies were carried out in the Netherlands. Five semi-structured focus group interviews, with six to seven participants each, were carried out in 2015 (6). Thirty in-depth interviews were conducted with GPs between June 2012 and January 2013 (7). Participants of the focus group interviews were recruited from the general population using a press report published in free local newspapers (including their websites) in four Dutch regions. Diversity in sex, age and level of education of

participants was aimed at (Table 1). When it turned out that women with a higher education were clearly overrepresented among the respondents, a second press report was issued, specifically inviting men and people with lower education backgrounds to take part, to try and ensure more variation within the group. This was only partly successful. Adults who had visited their GP at least once in the previous year were included. Persons who had been involved in a formal complaint procedure with a GP were excluded. One mixed-gender group, three groups with female participants and one group with male participants were composed; one focus group consisting solely of participants with a healthcare background (as caregivers) was formed. Each focus group session was moderated by an experienced female moderator with a GP background (LV) and audio recordings were made. The sessions lasted 90–110 min. More detailed information on the methodology of this focus group study can be found elsewhere (6). The recruitment of GP-participants was performed by a systematic random sampling from the Netherlands Institute for Health Services Research (NIVEL) GP register (which includes all practising Dutch GPs). A maximum variation sample with characteristics such as age (<45, 45–55, >55), gender, practice type (solo, duo or group) and grade of urbanization was reached (Table 2). More details such as participants flow (Fig. 1), further recruitment methods and GPs' characteristics can be found elsewhere (7,8). The interviews were held face to face at the GPs' own practices and lasted between 45 and 70 min. All interviews were conducted by a male experienced interviewer with a GP background (researcher FD) who also made audio recordings and transcribed the interviews. The focus group interviews and the in-depth interviews were based on a topic guide which was progressively adapted during the course of the interviewing process.

[TABLE 1] [TABLE 2] [FIGURE 1.]

### Data analysis

Data analysis was done using a qualitative research software package, ATLAS-ti (version 7). First, two researchers (FD, ToH) selected all quotes regarding experiences of frictions or difficulties in applying empathy in patient–GP communication. The first author (FD), together with the second researcher (ToH), a male practising GP with 10 years' experience in general practice and with expertise in qualitative research methods, categorized all quotations based on their content. During several meetings with the research team (FD, ToH, AL, JB) verbatim transcripts of the GP interviews and the patient's focus group interviews were read, analyzed and discussed. The categories were grouped into themes representing important and relevant aspects of difficult circumstances to empathy as experienced by patients and GPs during the clinical consultation. These emerging categories were discussed with the research team. Quotes which illustrate the main results were translated from Dutch into English by a near-native speaker of English and are presented here. The consolidated criteria for reporting qualitative studies (COREQ) were applied (9).

### Results

The study was based on five focus group discussions with a total of 28 participants, and 30 interviews with GPs. Most of the participants of the focus group discussions were highly educated and female. An overview of the background characteristics of

the participants is presented in Table 1 (6). The GPs' demographics show variability concerning gender, age, degree of urbanization and practice type as shown in Table 2 (8). We identified a number of circumstances in which patients perceived a gap between their expectations of receiving empathy and the reality of it. The participating GPs reported similar obstacles to offering empathy in the way they wanted.

### **Circumstances related to practice organization**

Both patients and GPs indicated that the way a general practice is organized, whether on a practical level or in communication, can be an obstacle to receiving or giving empathy in the individual consultation. However, patients mentioned different issues regarding the influence of practice organization as GPs did. To patients, the main issues in this regard were how they often felt treated defensively and negatively by practice assistants when calling for an appointment or how they felt unduly interrogated by them. To GPs, the most important obstacle to showing empathy in this regard was formed by unpredictable circumstances disturbing consultations, such as emergencies or incoming telephone calls.

#### **Patients**

“It's the organization surrounding the GP that forms the obstacle; I think that generally the practice assistants tend to act much more defensively than the GPs themselves.” (FG 6-11-2015, female patient, 50–65)

*“When you phone, they immediately ask you why you want to visit the GP. That always gets to me, when the practice assistant asks me that... what's it to her? In a way, I guess I understand why they ask, but it does irritate me.”* (FG 24-11-2015, female patient, 50–65)

*“Is it so difficult for an assistant on the phone to say ‘OK, I do think the doctor should take a look at this, in spite of protocol?’* (FG 23-11-2015, male patient, < 50)

#### **General practitioners**

“If surgery is interrupted by an emergency, it does get more difficult, I'm aware that I'm distracted then. When the next patient comes in with a difficult problem, I can find it hard to focus on that and handle it well; I often cannot do it.” (GP, A029, male, >55)

*“Yes (sighing), it's more difficult in the mornings than in the afternoons, because there is still so much to do, and I suddenly see that the assistant has added appointments to the schedule, because she finds it hard to say no. The result is that I'm completely overburdened. My schedule is filled with appointments and then there are all the telephone calls. It makes me feel tense and tired, and yes, it gets in the way of how I want to behave.”* (GP, B073, female, 45–55)

### **CIRCUMSTANCES RELATED TO PATIENT–GP COMMUNICATION OR CONNECTEDNESS**

Both patients and GPs reported that empathic communication can be hampered when there is no feeling of connectedness or solidarity. From the patients' point of view, it is hard to feel connected and therefore to experience empathy, when a GP acts arrogantly, shows no real attention or authentic interest or concern, or acts irritably towards the patient. Furthermore, many patients emphasized the importance of a GPs' non-verbal communication; when, for instance, there is little eye contact because the GP is mainly focused on the computer screen, they find it hard to experience empathy during the consultation. A number of GPs indicated that offering

empathy in patient–GP consultations can be hampered by an absence of a personal ‘click’, a lack of reciprocal interaction, or a lack of trust and openness (caused by, for instance, liability issues). They also find it hard to act with empathy towards patients who show unpleasant or amoral behaviour. Some GPs described that they are aware of the fact that prejudice can result in less empathic behaviour.

### **Patients**

“I really experienced arrogance then. I have an education background, so I know how it should be done; I really felt treated like a child.” (FG 24-11-2015, female patient, 50–65)

*“I am brain-damaged, my memory doesn’t work that well, and that caused the friction. She felt that I kept repeating myself, but I simply wasn’t aware that I had told her this before. I could really feel her irritation.” (FG 10-11-2015, female patient, 50–65)*

*“He’ll be sitting there behind his computer. There’s no eye contact, you can’t see how he feels about what you’re telling him.” (FG 6-11-2015, male patient, <50)*

*“The first thing that springs to mind is listening with interest. To me, listening is of the utmost importance, and especially that you feel that it’s genuine. That the other person really wants to know how you are. Not some professional attitude, but authentic interest.” (FG 10-11-2015, female patient, <50)*

### **General practitioners**

“That can really make me lose my empathic capabilities, when people are very aggressive or distrustful, like ‘the GP will just try and get rid of me by giving me some paracetamol’. When I perceive an attitude like that, it can really influence my behaviour.” (GP, B057, female, >55)

*“If there is a legal undertone, or when someone is just very angry, it makes it hard for me to act with empathy. It can certainly make me hold back.” (GP, B071, female, 45–55)*

*“It’s quite clear to me: if I really dislike someone, it is very difficult for me to be empathic. On the other hand, when you really do like someone, there’s a risk of getting too involved, of doing too much. There is a possibility that you don’t do enough for someone that you have a difficult relationship with, and I don’t want that. And those you do like, you may spend too much time and energy on them, at the cost of the others.” (GP, A 007, male, >55)*

### **DIFFERENCES BETWEEN THE PATIENT’S AND THE GP’S EXPECTATIONS**

Patients and GPs, when speaking about consultations in which a lack of empathy is perceived (by one or both parties), described how differing expectations of the consultation can play a part. Patients expect their GP to pay attention to the patient’s environment, opinions and expectations; to create an atmosphere where the patient can speak freely, to create common ground and to try to involve the patient in making decisions. When these expectations are not met, patients feel let down and a lack of trust can be the result. Some of the GPs in this study indicated that they experienced difficulties in meeting the patients’ expectations because of the influence of protocols and checklists. Furthermore, some GPs also mentioned that personal preconceptions play a role in not fulfilling patients’ expectations.

### **Patients/participants**

“He will be standing next to his desk, and it’s obviously over, so I’ll just go. He does address the problem, but he will never just ask how I am, not even when I haven’t seen him for a long time.” (FG 10-11-2015, female patient, 50–65)

*“To me, not being involved by a GP in decisions that are taken, decisions that affect the client, that’s the most serious lack of empathy. To me, that’s shocking.” (FG 6-11-2015, male patient, <50)*

### **General practitioners**

With diabetes-sufferers, for instance, we have to record about 73 items in a list as part of integrated care, and I thoroughly dislike that, because you’re spending most of your time looking at the computer screen instead of at the patient. What you really want is spend time on the problem that patient is actually there for. (GP, A004, male, <45)

*In my experience, the more you’re doing your own thing, the less you really listen. That way you run the risk of missing things in a patient and later you think, if I had just kept quiet for a moment and listened, if I had just taken a little bit more time, I would have picked up on things that would have changed the situation and the patient would have been more satisfied. (GP, A 007, male, >55)*

### **TIME PRESSURE AND ITS CAUSES**

Many patients stressed how essential it is to them for a GP to give them time and space in order to be able to experience empathy. In reality however, they often experience a lack of these aspects during or around the consultation. Many of GPs addressed time pressure as an important hampering factor in offering empathy. Examples of this they mentioned were overloaded work schedules, full waiting rooms and red tape (excessive administrative processes or rules).

### **Patients/participants**

There are GPs who, the moment you say you have some psychological issues, get flustered and start looking at their watches; they obviously find it difficult to listen. (FG 23-11-2015, male patient, <50)

*A GP consultation, those 10 minutes are over before you know it. It feels like they listen to you, but don’t really step into your shoes. Time is certainly an issue. (FG 6-11-2015, male patient, 50–65)*

*You want to feel like there is enough time, that there is room for you. Also, that there is enough time for some open questions at the end of the consultation; that the GP can ask you whether you have any questions, for instance. (FG 10-11-2015, male patient, <50)*

### **General practitioners**

Time. Bringing up a whole new set of issues, while you simply don’t have the time, and the waiting room is full, I feel no shame in saying that I simply don’t want to do that; I must get on. (GP, A010, male, >55)

*Sometimes it’s just a matter of racing on. And when you are with a palliative patient, and there are all these other things you have to do, it can be very difficult to actually take the time to act empathically. (GP, A051, female, 45–55)*

### **THE GP'S INDIVIDUAL CAPABILITY TO OFFER EMPATHY**

Some GPs indicated that applying empathy during the consultation is difficult for them when their personal capability to offer empathy is limited. This can occur when their physical condition is not good (feeling ill or exhausted) or when they are distracted by private issues. One or two participants of the focus group interviews mentioned how patients' expectations of the GP's capacity to offer empathy at any moment may at times be too high: *"I think that at times we expect too much, and maybe our demands are too high. They're only human (FG 24-11- 2015, female patient, >65)"*.

#### **General practitioners**

I was definitely less empathic then, because I was so tired, and I was in a bad mood and snappy; I was simply exhausted and that absolutely affects the way I work with my patients. (GP, B003, male, <45)

*Having a stressful morning, having to take my daughter to the sitter, being late, not having enough time to take care of myself, brushing my teeth in an hurry, and the washing-up is still in the sink, yes, they are all factors that do not have a positive impact on empathy. (GP, B057, female, <45)*

*I'm about to go on holiday, and last week I really decided to I have to put the brake on things until then, like from now up to Friday, things just have to go to plan, some things just have to get done, people have to be left behind well. But that can only happen when I don't have to deal with an additional 5 major issues every day. There are limits. So I have to limit my empathy a bit. There is no endless source of empathy inside me that can keep on being tapped. (GP, B071, female, 45–55)*

## **DISCUSSION**

### **Summary**

Even though both patients and GPs regard empathy as crucial in patient–GP communication, there exists a clear gap between wish and reality. Receiving empathy by patients and offering empathy by GPs is hampered in several ways, from the behaviour of the reception staff, the experience of time pressure or not showing authentic interest and concern, to a lack of eye contact during the consultation (an essential non-verbal empathic skill) or the GP being distracted by organizational or personal issues. Patients emphasized how unfriendly and non-empathic reception staff can make them feel unwelcome. Both patients and GPs see the bureaucratic overload and obligatory checklists that GPs are sometimes faced with as negative influences on GPs' empathic behaviour. All these circumstances stand in the way of the patient's expectations of being given room to speak freely, of creating common ground and of being involved in making decisions. Apart from these more external factors, GPs also mentioned internal ones: they only have a limited amount of empathy to give, and this amount can be affected by personal circumstances. Additionally, both GPs and patients indicate that some kind of personal bond or connectedness is a prerequisite for an empathic patient–GP relationship.

### **Strengths and limitations**

An important characteristic of this qualitative study lies firstly in the comparison of both the experiences of patients and GPs, and secondly in its basis in daily primary care. To the authors' knowledge, this is the first qualitative comparative study focusing on empathy in patient–GP communication specifically. Patients and GPs

were invited to share their stories and opinions and to express themselves freely. This reveals valuable insights into personal elements of the affective side of communication in GP practice. The data of the focus group interviews and of the GP interviews complement each other in many aspects. Tape-recording the GP interviews and focus group interviews, evaluating and checking the participants' contributions at the end of each interview and multiple coding during the analysis add to the rigour of the study. The data collected through the focus group interviews lack narratives of male and lower educated participants. The research team actively tried to redress this imbalance, but did not fully succeed.

It is possible that patients not accessed by the study have a different view of empathy than the slightly older, mostly female, middle class participants who took part. Moreover, it is acknowledged that voluntary participation, both of patients and GPs, may have caused selection bias with participants with little interest in empathy being underrepresented. Furthermore, with the moderator, focus group observer and analyzers all having a GP background, our interpretation of the data from the focus group interviews might be slightly biased. However, this medical background did not discourage criticism of medical behaviour. Moreover, we are convinced that by including a behavioural scientist in the supervising committee (JB), this potential bias has been sufficiently redressed. Qualitative studies are limited in their generalisability. However, compared with quantitative studies, they can provide richer insights. It is possible that, due to the design of the current study, the transferability of the results presented in this study is limited and deserves further investigation; one should be careful to generalize the results.

### **Comparison with existing literature**

The purpose of this study is to explore elements in patient–GP communication in the Netherlands which result in unfulfilled wishes of patients and GPs with regard to empathy. The results provide a more detailed insight into as yet underresearched aspects of how empathy in patient–GP communication is offered and perceived. An important obstacle in experiencing and applying empathy, according to patients as well as GPs, appears to be the daily practice organization. Participants of the focus group interviews particularly mentioned non-empathic behaviour by reception staff—mostly related to their current triage task—as a cause for irritation. This finding is in line with the outcome of a study in primary care in the UK in which the helpfulness of the reception staff turns out to be the second most important factor of patients' overall satisfaction (10). The role of the reception staff has been confirmed by another study in primary care which shows that patients in some Western European countries experience the existing triage system in some countries (UK and the Netherlands) as helpful to the receptionist rather than to the patient (11). When a friendly reception staff exists, patients' coping strategies are enhanced (12). Research in a hospital setting shows that an empathic staff is related to fewer repeat visits and increased satisfaction of patients with received care (13). The GP's private, professional and psychological well-being appears to be an important contributing factor in practicing empathy in daily practice. GPs acknowledge this and some of the focus group participants recognize it and brought it up spontaneously during the discussions. Since it has already been found that many GPs are at risk of burnout (14), it is important for GPs to recognize the power of the emotional and physical challenges they face during practice. However, applying empathy can be an aid in protecting people in caring professions against burnout and being involved can have

positive effects on job satisfaction (15). Anyway participating in regular supportive supervision with colleagues and peer-support can be important preventive measures (14). Participating in inter-collegial counselling (Intervision courses and Balint groups), guided by a behavioural counselor, lessens professional isolation, enhances GPs' morale, increases sensitivity to patients and decreases the incidence of burnout (16).

### **Implications for practice, education and further research**

The importance of self-care for physicians has been highlighted (17). In addition, there is an awareness of the advantages of continuous intercollegial counselling with GPs, such as: a valuable opportunity to pay attention to personal and emotional growth; the possibility to increase competency and well-being and a reduction of burnout (18). Primary care institutions should support organizing continuous coaching (intercollegial counselling, supervision, Balint groups) and, for example, mindfulness sessions. Branch has provided a useful practical approach to improving communication skills (19).

Attention to patients' expectations and evaluations of communicative aspects are instructive (20,21), and closely matched beliefs of patients and care-providers produce higher levels of satisfaction and trust (22). We advocate to improve GPs' knowledge and skill, during postgraduate courses, about how to cope with patients' expectations and how to encourage patients' self-disclosure (23,24).

So far, there has been little research focusing on the role of practice assistants. The results of our study would certainly become more instructive when additional data from observational and qualitative studies into the actual behaviour and experiences of reception staff will be available. We strongly recommend paying more attention to empathy in vocational training programmes for practice assistants. However, one should always keep in mind that extra training cannot solve problems that are actually caused by a lack of resources within a practice. We believe that more explicit attention should be paid to empathy in patient–GP communication during GP education (18). Residents' opinions about the position of empathy and their experiences during GP education have not been studied until now. We recommend a tailor-made vocational training programme for GPs and practice assistants and further research into empathy within GP and practice assistants education. It may seem a lot to ask to apply the above-mentioned suggestions in the hectic reality of daily primary care. To help GPs it is necessary for primary care institutions—the GP association and the association of physician assistants—to provide structural support.

### **CONCLUSIONS**

This study shows that within patient–GP communication perceiving a 'click' with someone and experiencing empathy are more or less congruent. Not receiving empathy from a GP or his/her reception staff can be very unpleasant and frustrating for patients and causes a gap between their expectations on the one hand and their actual experiences on the other. GPs notice that a personal limited physical and mental ability to offer empathy influences their behaviour. Furthermore this study indicates that it is up to GPs to take responsibility for showing all practice members the importance of an appropriate and empathical behaviour towards patients. In addition, primary care institutions—the GP association and the association of physician assistants—should provide structural support, within this framework, to workers in GP practice.

## Declaration

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Ethical approval: the study was approved by the Regional Committee for Medical Research Ethics of the region Arnhem-Nijmegen (letter dd 10-8-2015, file number: 2015–330).

Conflict of interest: none.

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## TABLES AND FIGURES

**Table 1.** Characteristics of 28 participants of the study

Characteristics	N (%)
Gender	
Male	9 (32)
Female	19 (68)
Educational level	
Low	0 (0)
Middle (MBO)	8 (28)
High (HBO and Univ.)	20 (72)
Age categories	
<50	3 (10)
50–65	13 (47)
>65	12 (43)
Occupation	
Education	5 (19)
Services	15 (55)
Care	7 (26)

**Table 2.** Characteristics of the participating GPs

Characteristics of the 31 participating GPs	
	N (%)
Sex	
Male	14 (43)
Female	17 (56)
Age	
<45 years	13 (43)
45–55 years	10 (33)
>55 years	8 (22)
Practice type	
Solo	8 (26)
Duo	14 (46)
Group	9 (26)
Urbanization	
Rural area	12 (40)
Urban area	19 (60)
Mean experience as GP, years (range)	16 (2–33)

**Figure 1.** Participants flowchart.

