Review Paper

A 5 Step Empathetic Model (5-SEM) for Doctor Patient Communication

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ABSTRACT

Although empathy in the physician-patient relationship is often advocated, a theoretically based measurable practical model for doctors has been missing. This paper presents a Five Stage Model for Empathetic Communication (5-SEM) and a measurement scale. The suggested measurement's aim is to assist doctors to evaluate the effectiveness and contribution of the 5-SEM in terms of the levels of patient trust, a patient will for joint decision making, patient motivation to collaborate, and measurement of health outcomes. The 5-SEM is designed to become an integral part of natural communication. In this paper, the 5-SEM model is elaborated both technically and theoretically in order to demonstrate its rationale and its mechanisms in the production of empathetic communication.

Keywords: empathy, empathetic communication, doctor patient relationship, decision making.

Introduction

Communication is considered one of the most important facilitators of all social interactions and the main catalyst for interpersonal relationships. In the medical profession, the ability to establish good interpersonal relationships is of great value. Research shows a strong correlation between positive doctor-patient relationships and the extent to which patients are willing to exchange information and participate in decision-making [1-3]. Effective doctor-patient communication has a major influence on regulating patients' emotions, facilitating comprehension of medical information, and better-identifying patients' needs and perceptions. It can encourage patients to share information, follow advice, and follow prescribed treatment. In addition, patients' agreement with the doctor about the nature of the treatment and the need for follow-up is strongly associated with their recovery [4-11]. The question remains as to what constitutes positive and effective interpersonal communication. This paper will introduce empathy.

Empathy

Empathy is known to profoundly contribute to the construction of positive communication [12-13], yet it is commonly perceived as an obscure and impractical concept, more suited for therapists, educators, or parents. In the medical environment where time is short, patients are many and professional decisions are sometimes difficult to establish, often the formation of meaningful relationships with patients remains a privilege. This can contradict an awareness that some forms of communication such as empathy are correlated with positive health outcomes [14-15]. This paper suggests a 5-Step Empathetic Model (5-SEM) for empathetic communication that can support a doctor's communication requirements, that stem from a unique work environment. 5-SEM can make empathy an effortless and integral part of patient-doctor communication and beyond. This is a highly valuable skill that can become a natural part of

everyday communication, yet at the same time, is a powerful tool with which to construct and sustain any relationship through the establishment of trust, mutuality, and growth.

5-SEM will be discussed later in this paper; first, a few comments about the unique and positive effects of empathetic communication. Empathy is all about having a special moment with someone. A moment that can become a turning point in any form of relationship. Between couples, colleagues, doctors, patients, or professionals and their clients. This moment happens when you feel that another person simply gets you. Although it certainly can be, it does not have to be a very deep moment or some profound inner truth. It can be a word or phrase that describes someone else's subjective needs, feeling moods, or perspectives, whether they are positive or negative or neither.

That moment is constructive for any relationship because of three reasons:

1. It results in the perception of being understood, which is a rare and most desirable moment.
2. It can become a source of insight and growth for the recipient.
3. It is a catalyst for the formation of trust and mutuality, which are the building blocks for the construction of positive relationships.

Rarely do people truly feel that their subjective experience or opinion is understood by another. During an argument, consultation, conversation, or conflict, people make a concerted effort to be understood. Mostly, both participants make this effort simultaneously and often unsuccessfully. On rare occasions, one gives up on trying to be understood and instead tries to listen to understand the other. This act of looking outwards makes it possible to learn something about the subjective truth of another person, without judgment. This is a moment of transformation. In the event of a listener's success, a deep appreciation from the recipient will be the outcome, particularly if this understanding will be articulated for the recipient ("If I understand correctly, you think that…or, your experience is…"). This articulation can sometimes become an insight for the recipient because the articulation of one's subjective truth transforms it into something that can be observed and decided upon.

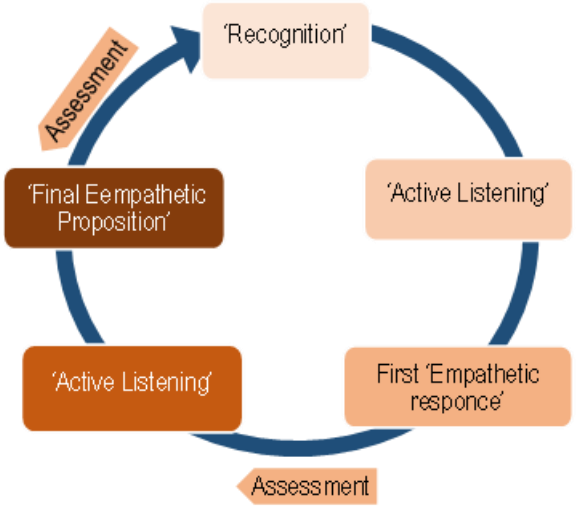
For instance, during a consultation, doctors often encounter perceptual differences, such as a patient's unique belief system about different types of medicine. A different belief system can become a barrier to patients' acceptance of treatment. Such was the case during the Covid-19 pandemic and the resistance to vaccination [16-18], which was very difficult to overcome. One of the characteristics of a belief is that it is not necessarily a part of a rational thought process but rather an integral part of an innate belief system. There are many barriers to mutual understanding, such as personal differences, gender, age, emotional state, or culture. Empathy (understanding another subjective truth) turns differences into opportunities for a positive and constructive dialogue.

All humans have the cognitive ability to easily learn empathetic communication. There is no age limit to acquiring this skill - on the contrary; exposure to empathy can sometimes be sufficient for learning. In that respect, it could be described as a 'contagious' mode of communication, since if one is exposed to empathy, he or she will probably and unnoticeably acquire it as a skill [19]. From an evolutionary perspective, empathy is a valuable social asset that helps achieve social acceptance and social favor and therefore, increases survival. Research demonstrates that people have an inherent cognitive ability to learn how to be empathetic [20]. This type of learning can be materialized from a very early age. Nevertheless, infants and children who are not exposed to empathy often lack this skill. Children who were understood by their primary caregivers can more easily understand others as well as themselves and therefore be more socially and psychologically content. One of the manifestations of this is having emotional stability and a strong capability to overcome hardship [21-22].

The five step model (5-SEM)

Empathy is an act that manifests the intention to be attentive to another. Hence, the first step in taking interest in another person's moment of distress (or any other experience) must depend on the recipient's permission to do so.

1. The first step is 'Recognition' (R) – hence, finding out if a person is interested in empathy. Forcing empathy is simply not empathetic since it does not manifest the recipient's desire but rather the giver's interest or curiosity. If a person is seeking empathy, they will make gestures to show it. For instance, seeking attention or making a subtle sign such as looking at you and waiting for you to notice. In the case of doctor-patient dialogue, empathy is quite inherent to the nature of the situation, since the roles of the interaction are predefined, thus, the patient seeks help while the doctor tries to diagnose.
2. The second step is 'Active Listening' (AL). AL consists of six different acts:
   a) Listen attentively to the story while making your availability apparent. During active listening, one should give full attention to the speaker, make eye contact, and sit or stand opposite the speaker.
   b) The aim is to try to understand what is the underlying experience that the person's story (description) represents. This has to be done (as much as possible) without judgment (for instance, the experience of getting lost, being impatient, feeling alone, etc.). To be able to do this, you need to find within yourself a similar personal experience that resembles that underlying emotional experience. It could be that your story is completely different but the emotion was similar. For instance, if you have never been in a car accident, you might be able to remember experiencing an accident in a different context. Different life experience often evokes similar emotions. In that case, it may be the experience of 'losing control'.
   c) Try to find a word or a short sentence that represents the emotional experience of that person (for example: maybe you feel that you've lost control) but do not say anything at this stage.
   d) Wait and listen until that person pauses.
   e) Offer the word or sentence with reservation (for instance - "You may feel as if you have no control."). Reservation is a crucial component since it allows that person to own it or rather reject it. The basic assumption is that you do not know the inner truth of another but you try to understand it and verbalize it.
3. The third step 'Empathetic Evaluation' (EE): look for the person's reaction to the first attempt at empathetic articulation. If you succeed, the recipient will react enthusiastically (Yeah!!! that's exactly what I feel!), followed by sharing more information.
4. The fourth step is repeating AL.
5. The fifth step is the 'Final Empathetic Evaluation' (FEE) offering a second EE that can be either similar or more accurate. At times, the first empathetic phrase might be enough. This whole process should take 2-4 minutes; nevertheless, in order to master it and make it a natural part of communication one should practice it (This module is inspired by a personal conversation with Prof. Yuval Wolf).



Measurement and evaluation

There are four parameters to evaluate successful empathetic communication:

1. After the EE stage, the person will express an agreement with the empathetic comment.
2. The recipient will add more information
3. The recipient will start contemplating what he or she is going to do to advance themselves (this can take place after EE or FEE). This is because being understood help's the person understand him or herself and can take it further into action.
4. This is because being understood help's the person understand him- or herself and can take it further into action.

Conclusions

In conclusion, empathy is a deliberate act, whose purpose is to make another person feel understood from his or her subjective and personal point of view. Whether that person's experience is reasonable or appears as not reasonable it is nevertheless her or his innate reality. This experienced reality is all that matters at that moment when effective and productive communication is needed. Empathy creates a bridge that reduces the need to resist, be guarded, feel frustrated, or be suspicious. Those feelings are replaced with trust, appreciation, closeness, and security. That is the best possible condition to strengthen relationships and create mutual responsibility. This is why this act of empathy is so beneficial in any relationship and with no doubt in a doctor-patient relationship, where time is scarce and trust is vital. this act creates a win-win situation for the doctor-patient relationship. The patient feels understood and the doctor can gain trust and have more insight into the patient's emotional and physical features. Hence 5-SEM can be an effective contribution to doctors and to the health system for the following reasons: 1. It can reduce the time necessary to create trust and corporation with the patient. 2. It can become effective in contributing to the correct and effective use of medicine by the patient. 3. It can contribute to successful treatment and therefore an effective use of public funds.

Nevertheless, 5-SEM has to be practiced, simply because empathy is often not an automatic response in spontaneous dialogue. The most effective practice is within a study group, where each participant can bring an example of an empathetic intervention to be explored and learned from. Using the proposed constructed 5-SEM makes the group discussion very fruitful; first since it becomes a common point of reference. Second, this model's success can be easily evaluated. The evaluation can be made in two ways: the patient response as was described earlier, the patient levels of corporation and trust, and a short scale that can be used as a measurement tool at the end of every meeting. It is possible to have a clear indication of the success of an attempt to act empathetically. If you can measure success, you can create a process of learning, which is the purpose of this model, to make empathetic communication a natural part of communication – a second nature.

REFERENCES

1. Bredart A, Bouleuc C, Dolbeault S. Doctor-patient communication and satisfaction with care in oncology. Curr Opin Oncol 2005;17(4):351-4.
2. Duffy FD, Gordon GH, Whelan G, Cole-Kelly K, Frankel R. Assessing competence in communication and interpersonal skills: the Kalamazoo II report. Acad Med 2004;79(6):495-507.
3. Wang Y, Wu Q, Wang Y, Wang P. The Effects of Physicians' Communication and Empathy Ability on Physician-Patient Relationship from Physicians' and Patients' Perspectives. J Clin Psychol Med Settings 2022;1:1-12.
4. Arora NK. Interacting with cancer patients: the significance of physicians' communication behavior. Soc Sci Med 2003;57(5):791-806.
5. Hall JA, Roter DL, Rand CS. Communication of affect between patient and physician. J Health Soc Behav 1981;1:18-30.
6. Harmon G, Lefante J, Krousel-Wood M. Overcoming barriers: the role of providers in improving patient adherence to antihypertensive medications. Curr Opin Cardiol 2006;21(4):310-5.
7. Herndon JH, Pollick KJ. Continuing concerns, new challenges, and next steps in physician-patient communication. JBJS 2002;84(2):309-15.

8. Kindler CH, Szirt L, Sommer D, Häusler R, Langewitz W. A quantitative analysis of anesthetist–patient communication during the pre-operative visit. Anaesthesia 2005;60(1):53-9.
9. Roter DL. Physician/patient communication: transmission of information and patient effects. Maryland State Med J 1983;32(4):260-5.
10. Tongue JR, Epps HR, Forese LL. Communication skills for patient-centered care: research-based, easily learned techniques for medical interviews that benefit orthopedic surgeons and their patients. JBJS 2005;87(3):652-8.
11. Van Erkel FM, Pet MJ, Bossink EH, van de Graaf CF, Hodes MT, van Ogtrop SN, ... & van der Zaag-Loonen HJ. Experiences of patients and health care professionals on the quality of telephone follow-up care during the COVID-19 pandemic: a large qualitative study in a multidisciplinary academic setting. BMJ Open 2022;12(3):e058361.
12. Redmond MV. The functions of empathy (decentering) in human relations. Human Relat 1989;42(7):593-605.
13. Tietbohl CK. Empathic Validation in Physician-Patient Communication: An Approach to Conveying Empathy for Problems with Uncertain Solutions. Qual Health Res 2022;32(3):413-25.
14. Mercer SW, Reynolds WJ. Empathy and quality of care. Br J Gen Pract 2002;52(Suppl):S9-12.
15. Terry C, Cain J. The emerging issue of digital empathy. Am J Pharmaceut Educ 2016;80(4).
16. Saied SM, Saied EM, Kabbash IA, Abdo SAEF. Vaccine hesitancy: Beliefs and barriers associated with COVID-19 vaccination among Egyptian medical students. J Med Virol 2021;93(7):4280-91.
17. Abdul-Mutakabbir JC, Casey S, Jews V, King A, Simmons K, Hogue MD, Veltman J. A three-tiered approach to address barriers to COVID-19 vaccine delivery in the Black community. Lancet Glob Health 2021;9(6):e749-50.
18. Fisk RJ. Barriers to vaccination for coronavirus disease 2019 (COVID-19) control: experience from the United States. Glob Health J 2021;5(1):51-5.
19. Shamay-Tsoory SG. The neural bases for empathy. Neuroscientist 2011;17(1):18-24.
20. Dziobek I, Rogers K, Fleck S, Bahnemann M, Heekeren HR, Wolf OT, Convit A. Dissociation of cognitive and emotional empathy in adults with Asperger syndrome using the Multifaceted Empathy Test (MET). J Autism Dev Disord 2008;38(3):464-73.
21. Walter H. Social cognitive neuroscience of empathy: Concepts, circuits, and genes. Emotion Rev 2012;4(1):9-17.
22. Martingano AJ, Konrath S. How cognitive and emotional empathy relates to rational thinking: empirical evidence and meta-analysis. J Soc Psychol 2022;1:1-18.

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