

# Clinical Empathy as Emotional Labor in the Patient-Physician Relationship

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INTEREST IN THE RELATIONSHIP BETWEEN physicians and patients is as old as the practice of medicine. Over the past 20 years, scholarly interest has increased as educators and practicing professionals have realized that a therapeutic relationship, along with integration of knowledge and skills, content of care, information management, teamwork, and health systems<sup>1-3</sup> is an integral part of healing and effective medical care.<sup>4,5</sup> The *context effect*, better known as the placebo effect, addresses in greatest detail the impact of the patient-physician relationship on a patient's recovery.<sup>6</sup>

The published literature suggests that physicians who display a warm, friendly, and reassuring manner with their patients are more effective.<sup>7</sup> In addition, Halpern<sup>8</sup> wrote that empathy (1) makes patients more forthcoming about their symptoms and concerns, thus, facilitating medical information gathering, which, in turn, yields more accurate diagnosis and better care; (2) helps patients regain autonomy and participate in their therapy by increasing their self-efficacy; and (3) leads to therapeutic interactions that directly affect patient recovery.<sup>8</sup> In sum, "making connections"<sup>9</sup> and developing empathy are fundamental to caring and enhance the therapeutic potential of patient-clinician relationships.<sup>10,11</sup>

Given the need for empathy as part of effective treatment, physicians have to learn to empathize with their patients. To cultivate an acute ability to empathize with others, one needs patience, curiosity, and willingness to sub-

ject one's mind to the patient's world.<sup>8</sup> However, there are many obstacles that contemporary physicians face as they aspire to develop empathy. These include a demanding work environment with heavy workloads,<sup>12</sup> little importance attached to empathy,<sup>13</sup> and cynicism.<sup>14</sup> In addition, research indicates insufficient training and education in compassion and emotional aspects of health care for various health professionals.<sup>15,16</sup> We believe that better understanding of empathy—and more importantly, framing the psychological and behavioral activities in this process as acting methods used in emo-

Empathy should characterize all health care professions. Despite advancement in medical technology, the healing relationship between physicians and patients remains essential to quality care. We propose that physicians consider empathy as emotional labor (ie, management of experienced and displayed emotions to present a certain image). Since the publication of Hochschild's *The Managed Heart* in 1983, researchers in management and organization behavior have been studying emotional labor by service workers, such as flight attendants and bill collectors. In this article, we focus on physicians as professionals who are expected to be empathic caregivers. They engage in such emotional labor through deep acting (ie, generating empathy-consistent emotional and cognitive reactions before and during empathic interactions with the patient, similar to the method-acting tradition used by some stage and screen actors), surface acting (ie, forging empathic behaviors toward the patient, absent of consistent emotional and cognitive reactions), or both. Although deep acting is preferred, physicians may rely on surface acting when immediate emotional and cognitive understanding of patients is impossible. Overall, we contend that physicians are more effective healers—and enjoy more professional satisfaction—when they engage in the process of empathy. We urge physicians first to recognize that their work has an element of emotional labor and, second, to consciously practice deep and surface acting to empathize with their patients. Medical students and residents can benefit from long-term regular training that includes conscious efforts to develop their empathic abilities. This will be valuable for both physicians and patients facing the increasingly fragmented and technological world of modern medicine.

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tional labor—would help physicians successfully incorporate empathy in their daily practice.

Although the concept of emotional labor, the “act of expressing organizationally desired emotions during service transactions,”<sup>17</sup> is well-known in organizational management, it is not widely appreciated in medicine. In this article, we explore the parallel between the psychological processes of empathy and emotional labor. Because our goal is to articulate the physician’s mental processes and behaviors, we adopt a psychological approach in considering clinical empathy that occurs on the physician’s part, emphasizing the patient-physician relationship.

The FIGURE, taken from Davis’ Theory,<sup>18</sup> summarizes the process of empathy and outcomes that patients and physicians are likely to experience. We suggest treating the process of empathy as that of emotional labor, and we propose the use of acting methods in training physicians about empathy. We believe that adopting such a framework will help physicians better grasp and use empathy in their practice.

We first present a model of clinical empathy and describe the mechanisms involved. Then we review the research on emotional labor and acting methods. We also discuss the value of learning about emotional labor and acting methods in creating an empathic treatment relationship. Last, we discuss future research and implications for the medical community.

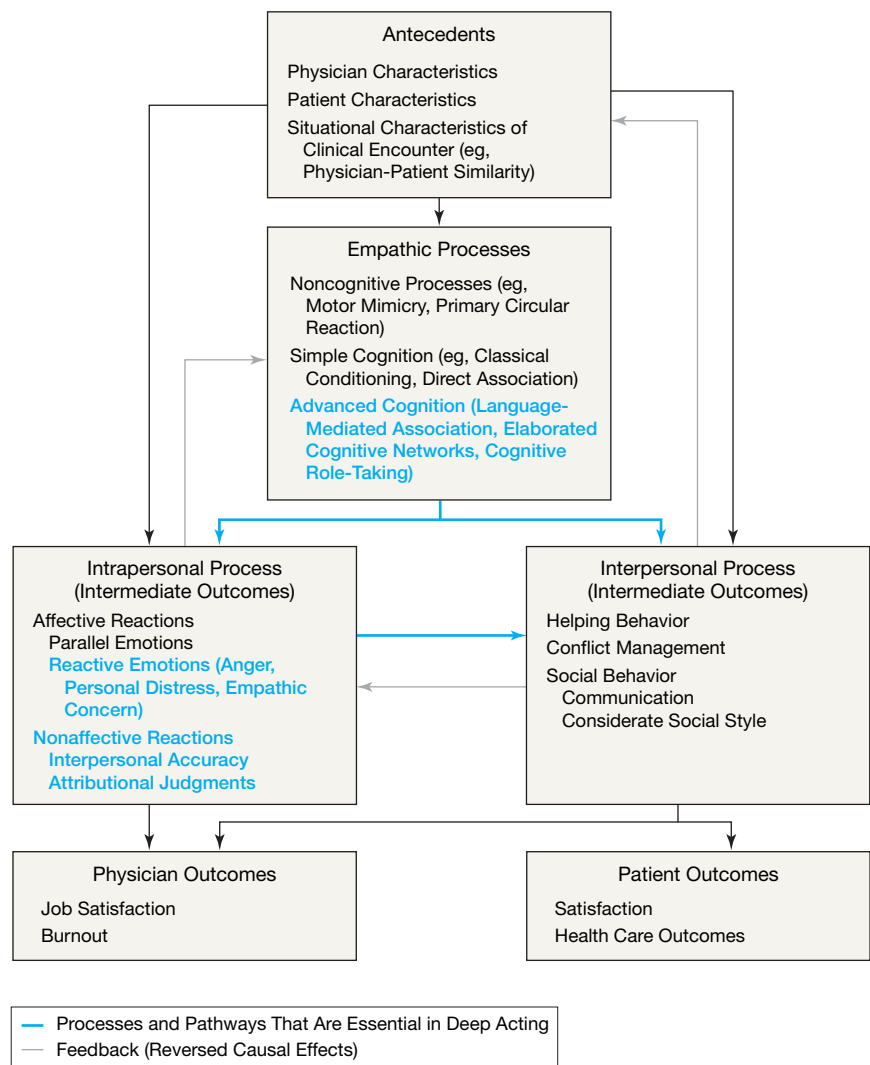
### Clinical Empathy and Its Consequences

The word empathy is routinely used in discussions of patient-physician relationships. Irving and Dickson<sup>19</sup> recently proposed treating empathy as an attitude. They pointed out that there should be a skill (behavioral) dimension to empathy in addition to the cognitive and affective dimensions. They further pointed out that the skill dimension reflects the interpersonal process that happens between people in the expression of empathy while the cogni-

tive and affective dimensions are part of an intrapersonal process that happens within a single person who is experiencing empathy for another. Although such conceptualization echoes the writing of other researchers,<sup>8,20</sup> empathy is not just an attitude. Rather, empathy is a process that encompasses affective, cognitive, and behavioral activities. A dictionary defines *empathy* as “the action of understanding, being aware of,

being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another . . . without having the feelings, thoughts, and experience fully communicated in an objectively explicit manner.” According to Rogers,<sup>21</sup> empathy involves “being sensitive, moment-to-moment, to the changing felt meanings which flow in this other person.” This description indicates that empathy is an unfolding

**Figure.** A Process Model of Clinical Empathy



Empathic processes and intrapersonal outcomes (blue, boldface) and paths linking them (blue, thick lines) play an essential role in deep acting. They tend to be weaker or distorted when surface acting is the dominant method used to meet the requirements of display rules. Advanced cognition, increased reactive emotions, such as empathic concern and distress, greater interpersonal accuracy and better attributional judgments about patients as well as the paths they travel through to affect interpersonal outcomes are all defining aspects of deep acting. The Figure is based on an organizational model proposed by Davis.<sup>18</sup>

process in response to the changing target and situation.

We adapted the conceptualization of empathy suggested by Davis<sup>22,23</sup> to define empathy as a psychological process that encompasses a collection of affective, cognitive, and behavioral mechanisms and outcomes in reaction to the observed experiences of another. The Figure shows mechanisms that are most relevant to the clinical situation. It also indicates that intrapersonal and interpersonal outcomes have immediate and longitudinal effects on patient and physician outcomes.

The core of the process model is the empathic processes and their intrapersonal and interpersonal outcomes. The empathic process includes different psychological activities that take place within a person. The Figure illustrates that empathic processes lead to cognitive, affective, and behavioral changes. Antecedent factors such as characteristics of the physician, the patient, and the clinical setting affect the physician's internal and external activities directly and indirectly. Because empathy usually involves ongoing interpretation, interpersonal outcomes (social behavior) will in turn affect intrapersonal outcomes and antecedents, and intrapersonal outcomes can change the empathic processes (indicated by gray in the Figure).

### Empathic Processes

In a naturally occurring situation (eg, witnessing the struggles of a patient), the observer first engages in empathic processes. Empathic processes can be grouped according to cognitive complexity involved. At the most basic level, noncognitive processes such as motor mimicry and primary circular reaction are responsible in generating similar affective outcomes.<sup>24</sup> For example, profoundly depressed patients may elicit a reflex depressed feeling in physicians. The next level of empathic processes involves rudimentary cognition. Classical conditioning and direct association are both based on the idea that the observer has in the past experienced similar affect, which is regenerated at cues

found on the target person or in the situation. For example, the patient may show facial expressions that remind the physician of similar emotions he or she experienced in the past. The more advanced level of empathic processes include language-mediated association,<sup>24</sup> elaborated cognitive networks, and role taking.<sup>24</sup> The first 2 processes are said to be functioning as the observer responds empathically and forms inferences from verbal cues. For example, the physician can understand a patient better if the patient expresses more about his or her situation. Role taking is the most advanced process in which the observer actively imagines the target's perspective and responds accordingly. Cognitive role taking involves inferring about thoughts, motives, or intentions; affective role taking involves inference about emotions.<sup>23</sup> For example, the physician imagines being in the patient's situation or imagines what the patient feels or thinks.

**Intrapersonal and Interpersonal Outcomes.** Empathic processes affect how the physician (observer) thinks, feels (intrapersonal outcomes), and behaves (interpersonal outcomes) with the patient (target). The intrapersonal outcomes can be affective or nonaffective. Affective outcomes include parallel and reactive emotions. Parallel emotions are usually reproductions of a patient's affect. Reactive emotions, on the other hand, are the observer's responses and are not usually experienced by the target. For example, anxiety in the physician at the sight of an anxious patient is a parallel emotion. On the other hand, a physician's anger when observing a patient unfairly treated is a reactive emotion. Personal distress and empathic concern (a feeling of compassion for others) are 2 other common reactive emotions.<sup>23</sup> In general, the generation of reactive emotions requires more advanced cognitive processing (eg, role taking). Non-affective outcomes are forms of judgment, evaluation, or belief about other people. In a clinical setting, nonaffective outcomes are typically physicians' estimation of patients' thoughts,

feelings, and characteristics as well as attributions about patients' behaviors and decisions.

Interpersonal outcomes exemplify the behavioral aspect of empathy, including helping behaviors, aggression, and social behaviors. In the patient-physician relationship, social behaviors such as communication and a considerate social style (eg, warmth, sensitivity, positive outlook, and even temper) are the main concern.<sup>23</sup> Empathic processes and intrapersonal outcomes increase helping behavior and reduce aggressive behavior, encourage conflict avoidance and improve conflict management, promote good communication and a considerate social style. In addition, empathic processes can affect interpersonal outcomes directly such that understanding a patient's situation (eg, through role taking) leads to habitual helping behaviors.

**Antecedents and Feedback Loops.** Antecedent factors include characteristics of the person and the situation that increase or decrease the likelihood that certain empathic processes and outcomes will occur. For example, physicians' dispositional empathy or personal history determines how easy it is for them to engage in role taking, or how likely they react with certain emotions and make certain attributions. Most people find it easier to be empathic to persons who are like themselves. Sometimes a situation can be so powerful that such individual characteristics do not matter.

In the Figure gray arrows connecting intrapersonal outcomes and empathic processes indicate that intrapersonal outcomes can subsequently initiate empathic processes.<sup>25</sup> For example, a physician feeling anxious (parallel emotional reaction) about a patient's situation may start affective and cognitive role taking, which, in turn, would enhance his or her understanding (interpersonal accuracy). Interpersonal outcomes also affect intrapersonal outcomes and the antecedents (as shown by the feedback loop in the Figure). For example, good communication that calms a patient also helps

physicians reduce their own distress (ie, reactive emotions) and changes the situation (ie, patient is not as worried).

**Patient and Physician Outcomes.** Davis and colleagues<sup>26-28</sup> proposed that specific social behaviors have an impact on both the observer and the target's social outcomes (eg, loneliness, anxiety) through perception. Similarly, in our model, a physician's communication skills and social style have a direct impact on patient satisfaction and health outcomes. This is consistent with the findings that empathy results in enhanced treatment outcomes.<sup>6</sup>

Social behavior also affects how physicians feel about their job. Suchman and Matthews<sup>29</sup> pointed out in their discussion of the "connexional" dimension of care that patients are not the only ones who benefit from a meaningful therapeutic relationship; physicians also benefit from such relationships. This is because physicians, like other humans, seek meaning and purpose in life, which can be found in spiritual connections made with patients. In addition, physicians often bear the emotional burden of life and death that needs to be released. Some seek to be needed and seek the attention and authority that people grant them,<sup>29</sup> both of which can be met in *transpersonal* relationships with patients. This clearly indicates the positive influence empathic social behaviors can have on physicians' satisfaction. However, engaging in the process of empathy has perils: the emotional reactions, particularly personal distress, as well as effort in controlling communication can contribute to burnout.

The effects of intrapersonal and interpersonal outcomes on patient-physician outcomes are both immediate and cumulative. In other words, for the patient, social behaviors demonstrated by the same physician have effects within and across visits; for physicians, their own behaviors and intrapersonal reactions within and across visits or patients influence their satisfaction and likelihood of burnout.

Research on the influence of dispositional empathy on communication

consistently supports the concept that individuals with a greater cognitive role taking capacity<sup>30</sup> or higher dispositional empathic concern<sup>31-33</sup> can communicate better than those with decreased capacity. Similarly, dispositional empathic concern and perspective taking were found to be positively related to self-reported considerate behaviors<sup>27,28,34</sup> and attribution of positive results to the other person in marriage.<sup>35</sup>

Overall, although more work is needed to validate the model, it provides a platform for discussion of clinical empathy and is consistent with analyses by medical scholars. According to Halpern,<sup>8</sup> empathy between physician and patient is neither just "detached insight" nor only "affective merging." Attribution, perception accuracy, or parallel emotions are not empathy by themselves but are part of the whole process. Empathy is "an emotion-guided activity of imagination, making use of such distinctive emotional processes as associating, resonance, and moods that provide context."<sup>8</sup> This reinforces the effortful nature of the role-taking process.

### Emotional Labor and Acting Methods

**What Is Emotional Labor?** Hochschild<sup>36</sup> coined the expression *emotional labor* in her seminal book, *The Managed Heart: Commercialization of Human Feeling*, detailing the organizational control over service workers' emotional life at work. The rationale behind emotional labor is that, by adopting display rules that dictate the expression of certain emotions accompanying specific situations,<sup>37</sup> organizations are able to direct the process of interpersonal transactions between their workers and customers for effective service and greater profits. Management and organizational research focuses on the service industry for which face-to-face interaction and voice contacts are frequent. For example, Hochschild documented flight attendants' difficulty when asked to show great hospitality to all the passengers and to avoid displaying annoyance at unrealistic requests.<sup>36</sup> Bill collectors, an-

other group engaged in emotional labor, were selected, socialized, and rewarded for their compliance with emotion-display norms.<sup>38</sup>

We take a psychological approach and define emotional labor as the process of regulating experienced and displayed emotions to present a professionally desired image during interpersonal transactions at work.<sup>17,36,39,40</sup> Empathy encompasses both internal and external emotion management. For a physician, emotional labor uses psychological resources to engender personal cognitive and affective changes to project an empathic image for the patient.

The majority of studies on emotional labor investigate emotional labor of service jobs that do not require specialized skills. However, some literature looks at emotional labor by professionals, particularly that of nurses.<sup>41-43</sup> Nurses are expected to be nurturing and tolerant, not so much by their employers, but by professional standards and customer (ie, patient) expectations. Although researchers<sup>44</sup> have documented how nurses cope with stress from emotional labor by distancing themselves<sup>45</sup> and have ascribed shortcomings in the emotional aspects of caring to a lack of training,<sup>41</sup> the researchers' focus seems to be more on caring than on empathy, perhaps due to the nature of nursing: caring rather than curing.

Overall, research on emotional labor in management has emphasized its sociological and psychological impact on organizations and their members. Organizational researchers uncovered a different form of organizational control, which was previously concealed by traditional forms of labor (mental and manual), and have articulated its positive and negative effects on individuals. Findings from management research provide an informative perspective on the nature of physicians' work.

**Methods of Acting.** Methods of acting are inherent to emotional labor as ways in which individuals perform emotional labor. Individuals can either fake their emotional display by forging facial expressions, voice, or posture or they can try to alter their inter-

nal experience and act on emotions they actually experience.<sup>36</sup> The former is called surface acting and the latter deep acting. Performing emotional labor can engender either one or both of the methods at the same time, but few studies have examined the joint process. Both deep and surface acting require emotion regulation but with a different focus.<sup>46,47</sup> Deep acting focuses on changing one's internal emotional state. When deep acting, individuals try to change their perception of the situation or alter their emotional focus in order to modify their automatic emotional reactions to the situation at hand and their subsequent expressions. In surface acting, people only modify their emotion expressions without changing how they actually feel inside. In deep acting, memory and imagination are used liberally in an effort to renovate the actor's inner world. Surface-acting individuals mainly engage in overriding automatic expressions that are not desired, fabricating expressions that are desired, and enduring the dissonance of the two.

**A Metaphoric Framework of Clinical Empathy.** With growing emphasis on holistic treatment,<sup>2,8</sup> empathy has become a critical component of today's patient-physician relationship. Like service workers, physicians are expected to adopt certain demeanors in interaction with patients. However, treating empathy simply as a deliverable in physician-patient communication is insufficient. To meet the expectation of empathic treatment, physicians need to understand patients' reactions at both the affective and cognitive levels and channel such comprehension in social behaviors with the patient. If we consider empathic processes as emotional labor and treat the patients' expectations of certain social behaviors as display rules, then surface acting is when physicians apply those behaviors indicative of empathy and do so without the corresponding empathic processes or intrapersonal outcomes. Deep acting, on the other hand, is when physicians actively involve themselves in empathic processes and generate relevant intrapersonal outcomes, which then

naturally produces social behaviors that are consistent with patient expectations of an empathic physician (See blue highlights in the Figure). Halpern's idea of "emotional reasoning" is in line with what we call deep acting in empathy: "Work fundamental to empathy is imagining *how* it feels to experience something. . . ."<sup>8</sup>

Physicians today can draw on a large body of literature on communication skills to guide them in their day-to-day interactions with patients. There are excellent articles describing communication skills in the context of clinical decision making,<sup>48,49</sup> delivery of bad news,<sup>12,50-53</sup> and disclosure of medical errors,<sup>11,54</sup> among others. Some articles discuss details, such as appropriate verbal and nonverbal signals (eg, what to say, how to say it, and use of body language), the choice of physical setting for communication, the presence of family members and other professionals, the extent to which information should be disclosed, and the timing of communication. Published literature emphasizes ostensible behaviors, giving less attention to how physicians can transform themselves internally to be empathic. Zoppi and Epstein<sup>55</sup> addressed this issue by calling forth the "mindful being-in-relation" approach, which emphasized "intangible" understanding of patients—the intrapersonal outcomes of the empathic processes. This would suggest a need to promote deep acting to encourage improved empathic care.

Consistent with our model, the literature on emotional labor in nursing and studies from management research identified job satisfaction and burnout as key outcomes of performing emotional labor.<sup>40,56</sup> The cognitive and emotional effort involved in empathy strain the already overextended psychological resource physicians have, contributing to burnout<sup>57</sup> and even causing emotional pain for some. On the other hand, genuine emotional understanding of patients can bring physicians deep satisfaction from their clinical interactions and their relationships with patients.

**Application of Surface and Deep Acting.** The need for empathy that goes beyond mere communication skills, however, does not negate the value of techniques that can be used effectively without achieving affective and cognitive understanding of the patient. Havens<sup>58</sup> acknowledges difficulty in engaging in the empathic processes (especially the role-taking process) and in evoking empathic concerns. He recognized that caretakers' feelings may not change immediately, but over time—just what we would consider deep acting. Havens also believes that he will never truly understand a patient. He prescribes strategies that caretakers can apply to help patients build hope and change perspectives, even without full affective and cognitive understanding on the caretakers' side. He also suggests forming alliances and indirectly evoking hope and validating patients. These are strategies that can be viewed as surface acting, effectively building a common ground between the physician and patient by showing patients that their reactions are reasonable. Havens' recommendations are a good example of using behavioral tactics when no empathic or only weak reactions are available. This idea attests to the value of surface acting for incorporating empathy into treatment.

Surface acting and deep acting can be used simultaneously. Physicians may try to take the patient's role while applying communication skills that have been found to be effective in soothing patients and generating positive treatment results. While engaging in both, each acting method can change the dynamics of the situation, thus, reinforcing the use of the other.

Cross-sectional data suggest that surface acting results in lower job satisfaction than deep acting.<sup>56</sup> The long-term effects of applying acting methods in terms of satisfaction and susceptibility to burnout are unknown. We suspect that surface acting can be just as effective and rewarding for some physicians as deep acting, but we think that surface acting without value-guided commitment for care (eg, building hope in patients through alliance) could lead to physi-

cian cynicism and burnout. Regardless of how physicians use these 2 acting methods, the emotional labor of empathy requires effort, dedication, and patience. As Zoppi and Epstein<sup>55</sup> duly commented, “Caring is a charitable act and occurs regardless of liking a patient.”

### Comment

**Benefits of the Emotional Labor and Acting Methods Framework.** Overall, our model serves both health care research and organizational behavior research by connecting emotional labor and clinical empathy. Although the importance of empathy and patient-physician communication has been discussed extensively, the psychological underpinnings of this concept have not been explored. Organizational behavior research, with a few exceptions, rarely investigates professionals’ emotional labor.<sup>55</sup> Introducing the construct of emotional labor and acting methods provides health care researchers with a tool to explore methods that can help improve both patient and physician outcomes, while expanding organizational behavior scholarship.

Finestone and Conter<sup>59</sup> recommended thinking of physician empathy in terms of acting, arguing that it was not unethical for physicians to conceal their emotional reactions when such reactions were not in the direction of empathy. An example would be when showing empathy that may be against one’s own value, belief, or identity. This recommendation is reverberated in management research on service jobs as a matter of “faking in good faith,”—that is, physicians fake empathic behaviors and emotions against their own likes or dislikes because they believe that it’s part of their job.<sup>60</sup> Brown and McMurtry<sup>61</sup> commended such a perspective as a sign of commitment to caring.

The framework of emotional labor and acting methods provides a channel through which physicians can learn skills that activate empathic processes. There are already well-developed techniques in acting training that can be adapted for teaching physicians to empathize. Teaching acting to physicians

also enriches their reservoir of human experience<sup>62</sup> and makes it easier for them to develop perspective, which, ironically, can help them achieve detachment when they become too engaged in a patient’s experience.

Future research should focus on studies in which different parts of the model are tested. For example, we need investigations on the relationship between communication skills, a considerate social style, and physician outcomes—ie, are physicians who are good communicators and who have a considerate social style less likely to experience burnout and have more job satisfaction? Studies are also needed to test the effectiveness of training with a distinctive acting component to enhance physicians’ empathic skills.

**Implications for Training and Selection.** Testerman et al<sup>14</sup> found that medical students developed their cynicism as a coping mechanism to deal with the environment while more experienced and established residents and medical faculty had lower levels of cynicism and higher levels of optimism. On the other hand, entering medical students usually are very idealistic when they begin medical school and may be more in touch with their patients.<sup>63</sup> Both observations indicate a need for training on empathy early in physicians’ career. A set of behavior components exists and could be taught to physicians.<sup>64</sup> However, empathy, considered by many an art, cannot be achieved simply through explicit teaching and mimicking. Rather, it is developed through long-term observation of other physicians and patients and by experiencing moments involving advanced-level empathy through role taking in literature, film, art, and life in general. This is a slow immersion process that can be likened to the maturing of a fine wine. Medical schools and residencies should play an active role in training and development of empathy. Emphasis should be both on designing training programs and creating a culture that values empathy in treatment.

In sum, we hope to establish the idea that empathy is a symbol of the health

care profession. It is not an attribute limited to those who perform direct day-to-day care, such as nurses; it also includes, and in many ways more importantly, those who diagnose and treat. A focus on medicine as a “healing profession” demands attention and effort from everyone: physicians, other health care professionals, the medical community, and even patients. Empathy in healing is more than just deep or surface acting as conceptualized in our model; empathy gives us a fundamental understanding of our physical and mental being.

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