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Examining Empathy in Medical Encounters: An Observational Study Using the Empathic Communication Coding System

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Educators, researchers, clinicians, and patients often advocate empathy in the physician-patient relationship. However, little research has systematically examined how patients present opportunities for physicians to communicate empathically and how physicians respond to such opportunities. The Empathic Communication Coding System was used to investigate empathic opportunity-response sequences during initial visits in a general internal medicine clinic. This study focuses on 100 visits during which patients created at least 1 explicit empathic opportunity. Overall, patients presented 249 empathic opportunities in these 100 visits; physicians most often responded by acknowledging, pursuing, or confirming the patient's statement. The mean length of empathic opportunity-response sequences was 25.8 sec; sequences tended to be longer in duration when the physician used a more empathic response. Positively valenced empathic opportunities generated a more empathic response than did negatively valenced empathic opportunities. However, there was no relation between the emotional intensity of empathic opportunities and the level of empathy in subsequent physician responses. Further research should examine patient preferences and outcomes associated with varying levels of empathic responses.

Empathy is seen as an essential element of the physician–patient relationship (Bayer-Fetzer Conference on Physician–Patient Communication in Medical Education, 2001). Physicians and medical students are expected to have empathy toward their patients and to learn the skill of empathic communication (Spiro, 1992; Squier, 1990; Winefield & Chur-Hansen, 2000; Zinn, 1993). Research to date suggests a relation between physician empathy and increased patient satisfaction, as well as reduced time and expense (Beckman, Markakis, Suchman, & Frankel, 1994; Bellet & Maloney, 1991; DiMatteo & Hays, 1980; Matthews & Feinstein, 1989). However, we know very little about *how* empathic communication occurs between physician and patient in everyday clinical practice.

At a more fundamental level, there is no general consensus on the meaning of empathy. Some have written of empathy as having a cognitive or “role-taking” dimension (Bellet & Maloney, 1991); others have focused on the affective dimension (Spiro, 1992; Zinn, 1993), sometimes called “emotional contagion” (Stiff, Dillard, Somera, Kim, & Sleight, 1988); and others have focused on the behavioral dimension (Winefield & Chur-Hansen, 2000). Some conceptual definitions of physician empathy encompass all of these dimensions: “a physician’s cognitive capacity to understand a patient’s needs, an affective sensitivity to a patient’s feelings, and a behavioral ability to convey empathy to a patient” (Feighny, Arnold, Monaco, Munro, & Earl, 1998, p. 435). The behavioral ability is particularly relevant to researchers examining physician–patient interaction. In other words, the primary construct of interest is not a physician’s internal empathy, but *how* that empathy is communicated. A physician who feels empathy but does not communicate that to the patient is not likely to appear empathic.

Empathy is not just something that is “given” from physician to patient. Instead, a transactional communication perspective (Miller, 2002) informs us that the physician and patient mutually influence each other during the interaction (Makoul, 1998). Thus, it is important to investigate both physician and patient roles in empathic communication during the medical encounter. For example, some patients provide their physicians with repeated opportunities to provide an empathic response, while others may not provide any such opportunity. Physician responses will be a product of the empathic opportunities created by patients as well as characteristics of the physician and the context of the encounter. The fidelity of any empirically based picture of this phenomenon will be a function of the extent to which measures assess both empathic opportunities and subsequent responses.

Thus, this project had two general purposes: (a) to investigate the empathic opportunities created by patients; and (b) to examine patterns of physician responses to empathic opportunities. This work sets the stage for future research on the outcomes of empathic communication. Our earlier published work on this topic (Bylund & Makoul, 2002) detailed the theory and research behind the design of the Empathic Communication Coding System (ECCS) and initial findings on the relation of physician and patient gender to this phenomenon. This follow-up article

provides a more descriptive picture of empathic communication in everyday clinical practice, and it demonstrates the utility of the ECCS (revised from its initial conceptualization, Bylund & Makoul, 2002).

OPERATIONALIZING EMPATHIC COMMUNICATION

Research on empathic communication in physician–patient encounters has employed a variety of measures. One approach has been to apply instruments developed to measure empathy as a trait in the context of psychotherapy research (e.g., Evans, Stanley, & Burrows, 1993; Fine & Therrien, 1977; Robbins et al., 1979). Such an approach presents problems, including low reliability (Robbins et al., 1979) and the fact that physician responses to patients “do not require the depth of empathy necessary in a therapeutic relationship” (Fine & Therrien, 1977, p. 754). More recently, the Jefferson Scale of Physician Empathy (Hojat et al., 2002) has been developed and has demonstrated validity and reliability. This 20-item scale is used specifically with medical students and physicians. Although quite promising, it does not measure empathic communication but, rather, physicians’ and students’ orientations toward empathy.

To measure empathic communication, other researchers have utilized global ratings of nonverbal and verbal physician empathic communication (Colliver, Willis, Robbs, Cohen, & Swartz, 1998; Harrigan & Rosenthal, 1986). Though this method may be useful in capturing raters’ perceptions of empathy, the results can be difficult to interpret because ratings may not correspond to perspectives of the patients involved. Finally, analyzing written responses to hypothetical scenarios (Winefield & Chur-Hansen, 2000) has limited validity because it relies on text-based representations of encounters.

A more promising and productive approach has used observational methods to methodically investigate the nature of patient-created empathic opportunities and subsequent physician responses. Branch and Malik (1993) used the term *window of opportunity* to describe cases wherein patients discussed emotional, personal, or family concerns. Suchman, Markakis, Beckman, and Frankel (1997) built on this foundation, defining *empathic opportunity* as a patient’s explicit statement of emotion, *praise opportunity* as an explicit statement about something praiseworthy (e.g., adopting a health promoting behavior), and *potential empathic opportunity* as a “patient statement from which a clinician might infer an underlying emotion that has not been explicitly expressed” (p. 679). More recently, Levinson, Gorawara-Bhat, and Lamb (2000) invoked the more general term *patient clue* to characterize a “direct or indirect comment that provides information about any aspect of a patient’s life circumstances or feelings” (p. 1021).

Physician responses to patient-created opportunities have also been of interest in this line of observational research. Suchman and colleagues (1997) defined an

empathic response to be “a clinician’s explicitly expressed recognition of a patient’s expressed emotion” (p. 679), and *praise* as “an explicit statement by a clinician in response to a praise opportunity that conveys recognition and positive valuation of the praiseworthy behavior” (p. 681). A *missed empathic opportunity* is one that is not followed by an empathic response, and an *empathic opportunity terminator* changes the subject (Suchman et al., 1997). Levinson and colleagues (2000) provided a categorization scheme that details the types of responses physicians may give to clues: *Positive responses* are those in which a physician acknowledges, praises, reassures, encourages, or shows support; *missed opportunities* occur when a physician gives inadequate acknowledgment, uses inappropriate humor, denies the patient’s concerns, or terminates the discussion of emotions. Although useful and important to our understanding of empathic communication, these methods do not differentiate between levels (i.e., depth) of physician responses. In other words, simple acknowledgment of a patient’s empathic opportunity would be treated the same way as confirmation (i.e., legitimization). To fill the void, this study employs the ECCS to rigorously examine empathic opportunity–response sequences in everyday primary care practice.

RESEARCH QUESTIONS AND HYPOTHESES

Central to the logic of this study is the notion that patients create opportunities for physicians to show empathy (i.e., empathic opportunities). Accordingly, our first research questions focused on patients’ tendencies to create empathic opportunities:

- RQ1: Do encounters that include at least one empathic opportunity differ from those with none, in terms of patient or visit characteristics?
- RQ2: What is the relation between the number of empathic opportunities and patient or visit characteristics?

When using a relatively new coding system, it is often useful to examine the frequency with which the various coding categories are used, which offers a means to describe the variance of responses and to determine if any of the categories should be subdivided:

- RQ3: To what extent are the physician responses outlined by the ECCS evident in this study?

Physician response to empathic opportunities (i.e., empathic communication) may be related to characteristics of the physician–patient relationship and context of the encounter. Our next research questions focused on potential correlates of empathic communication:

- RQ4: Is the level of empathy evident in the physician responses related to the familiarity of physicians and patients?
- RQ5: Is the level of empathy evident in physician responses related to the length of the empathic opportunity–response sequences?

Because communication is a transactional process (Makoul, 1998; Miller, 2002), one may reasonably assume that characteristics of the empathic opportunities themselves will affect the physician responses. As empathic communication might well involve a response to the emotional content of empathic opportunities, the patient's nonverbal and verbal display of emotion is of interest. Specifically, physicians might detect and reflect the emotional intensity evident in the empathic opportunities created by patients:

- H1: There will be a positive relation between the emotional intensity of empathic opportunities and the level of empathy in the physician responses.

In addition, research has shown that most responses to distressed others are insensitive (Burlison, 1990). Burlison proposes that this might be due to the fact that, in general, people are unskilled in providing emotional support. Moreover, physicians are often uncomfortable talking with patients about nonmedical problems (Waitzkin, 1991). Thus, we expect that physicians might use more empathic communication when responding to something positive that the patient is sharing as opposed to something negative:

- H2: Physician responses to positively valenced empathic opportunities will reflect a higher level of empathy than will responses to negatively valenced empathic opportunities.

METHODS

Participants

Videotaped encounters between general internists and adult patients were randomly selected from a sample of 500 videotapes (20 physicians with an average of 25 patients each) collected as part of ongoing research conducted by the Program in Communication & Medicine at Northwestern University's Feinberg School of Medicine. We screened 168 of the randomly selected encounters to obtain a purposive sample of 100 encounters (i.e., 5 patients with each of the 20 physicians) in which the patient created at least one explicit empathic opportunity. Patients' ages ranged from 24 years to 89 years ($M = 52.3$, $SD = 16.6$), and 57 percent of the patients were female. Half of the encounters were with physicians practicing in Chi-

icago, Illinois, and the other half were collected in Burlington, Vermont. Physicians' ages ranged from 30 years to 48 years ($M = 37.7$, $SD = 5.3$). Four of the 20 physicians (20%) were women.

Measures

The ECCS. Using the ECCS involves two steps: (a) identifying patient-created empathic opportunities; and (b) coding physician responses to those opportunities. Empathic opportunities are defined as patient statements that include an explicit (i.e., clear and direct) statement of emotion, progress, or challenge by the patient (Bylund & Makoul, 2002; Makoul, 2001). This operationalization combines Suchman and colleagues' (1997) notion of empathic opportunities and praise opportunities, also including statements of challenge. It is, however, a conservative definition of empathic opportunities in that it excludes potential empathic opportunities (Suchman et al., 1997), indirect clues (Levinson et al., 2000), and statements focused only on physical symptoms (e.g., "The pain is really bad.") The rationale for adopting a conservative definition is straightforward: If patients' explicit statements of emotion, progress, or challenge do not elicit responses from physicians, it is unlikely that more subtle empathic opportunities will yield responses. The ECCS unitizes communication in medical encounters based on the occurrence of these opportunities: Empathic opportunities begin when a patient initiates a statement of emotion, progress, or challenge, and they end when the patient finishes talking about that particular topic during his or her conversational turn.

In addition, the ECCS is used to systematically and hierarchically categorize physician responses to the empathic opportunities. As illustrated in Table 1, responses are placed into one of seven distinct categories, ranging from Level 0 (i.e., denying or disconfirming the patient's perspective) to Level 6 (i.e., communicating shared feelings or experiences). To provide a basic structure for this coding system, we initially looked to Burleson's (1984) three conceptual, hierarchical divisions of comforting communication: explicit recognition, implicit recognition, and denial of the other's perspective. The final ECCS, however, is quite distinct from Burleson's coding system. For example, comforting communication is defined as "communicative attempts to alleviate the emotional distress of another" (Burleson & Goldsmith 1998, p. 246). This is a very specific focus. Empathic communication may not always alleviate stress, although it may result in the patient feeling more understood. An example from our data helps to illustrate this point. In one interaction a patient says, "I'm just really depressed about the fact that I'm not losing this weight. And I'm not trying to. That's bothering me more than anything." The physician goes on to agree with the patient's concern about lack of desire to lose weight, especially because she previously had the desire and was successfully losing weight. Although more discussion follows about the patient's possible clinical

TABLE 1
Empathic Communication Coding System Levels

<i>Level</i>	<i>Name</i>	<i>Description</i>
6	Shared feeling or experience	Physician self-discloses, making an explicit statement that he or she either shares the patient's emotion or has had a similar experience, challenge, or progress.
5	Confirmation	Physician conveys to the patient that the expressed emotion, progress, or challenge is legitimate.
4	Pursuit	Physician explicitly acknowledges the central issue in the empathic opportunity and pursues the topic with the patient by asking the patient a question, offering advice or support, or elaborating on a point the patient has raised.
3	Acknowledgment	Physician explicitly acknowledges the central issue in the empathic opportunity but does not pursue the topic.
2	Implicit recognition	Physician does not explicitly recognize the central issue in the empathic opportunity but focuses on a peripheral aspect of the statement and changes the topic.
1	Perfunctory recognition	Physician gives an automatic, scripted-type response, giving the empathic opportunity minimal recognition
0	Denial/disconfirmation	Physician either ignores the patient's empathic opportunity or makes a disconfirming statement.

depression, the important distinction is that this response would not be considered comforting, as the doctor did not try to alleviate the patient's stress. Rather, the physician confirmed that the concern was valid. Moreover, although comforting communication is focused on lessening emotional distress, empathic communication can occur whether patients present positively valenced or negatively valenced empathic opportunities.

The original structure of the ECCS was revised for this study to distinguish between two different types of acknowledgment, resulting in an acknowledgment category and a pursuit category. Although the ECCS categories articulate different levels of empathy, they are not hierarchical in a normative sense (Bylund & Makoul, 2002). For instance, the ECCS does not hold that Level 6 (shared feeling or experience) is "better" than Level 5 (confirmation) and so forth, only that it is conceptually and practically different. Although the literature and our scale development work (Bylund & Makoul, 2002) suggest that communicating a shared feeling or experience may convey more empathy than would a statement of confirma-

tion, there is no evidence of a difference in patient preferences or outcomes associated with different types of response.

Patient questionnaire and medical record review. We also relied on information obtained via a questionnaire given to the patients in the study sample immediately after their visits and a focused review of their medical records, both of which were approved by the institutional review boards at our two research sites. Questionnaire items most relevant to this study included an item designed to assess perceived familiarity between doctor and patient (6-point scale) and demographic questions (e.g., educational attainment). The medical record review provided data on two additional variables that serve as proxies for physician-patient familiarity (i.e., length of time since the patient's first visit, number of times the patient had seen the doctor in the past 2 years) and basic demographic information, such as age.

Procedure

Identifying empathic opportunities. To determine reliability of the unitizing process, the first author and a research assistant worked to identify empathic opportunities in the encounters (Guetzkow's $U = 0.13$, with 0 = perfect agreement). The first author then analyzed the videotaped encounters for each of the 20 study physicians to identify five encounters per physician that contained at least one empathic opportunity.

Rating the emotional intensity of empathic opportunities. To gain a measure of emotional intensity, 18 undergraduate students in a health communication course at Northwestern University rated the emotional intensity of the empathic opportunities. On viewing an empathic opportunity, the students rated the intensity of emotion expressed using a 5-point scale, from 1 (*low*), to 3 (*medium*), to 5 (*high*). They were given the following instructions for each empathic opportunity: "How would you rate the *emotional intensity* of this patient statement?" "Think about *what was said* and *how it was said*." Three groups of six students each rated 83 empathic opportunities (one third of the 249 total). The average measure intraclass correlation (representing consistency of values within cases) was 0.82 for Group 1, 0.74 for Group 2, and 0.85 for Group 3. Mean ratings (i.e., the average of six scores across each empathic opportunity) were used as an index of emotional intensity for each empathic opportunity, offering a more valid and stable rating than would individual ratings.

Assigning a valence to empathic opportunities. The groups of students also rated the same videotaped empathic opportunities as being about something positive, neutral, or negative in the patient's life. For the three groups raw agree-

ment percentages were 85%, 92%, and 76%, respectively. Correction for chance agreement using Cohen's kappa resulted in reliabilities of .78, .88, and .64, respectively. The assigned valence for each empathic opportunity corresponds to the valence invoked by the majority of raters, increasing the stability and validity summary of observations. There was no majority rating for 18 of the empathic opportunities (i.e., the valence was unclear). In these cases, the first author reviewed the tapes and made the final determination.

Coding physician responses. The first author and a research assistant coded physician responses to the 249 empathic opportunities using the ECCS. After a training period on 20% of the data, they reviewed all 249 empathic opportunity-physician response sequences, assigning ECCS codes independently. Periodic reliability checks were conducted, and intercoder reliability was acceptable (Cohen's kappa = .74). The two coders discussed all disagreements, a process resulting in agreement on 239 (96.0%) of the sequences. To ensure coding quality, the second author reviewed the coding for all sequences; discussions with the two coders yielded 100% agreement.

Data were analyzed at both the patient level ($N = 100$) and the empathic-opportunity level ($N = 249$), yielding statistical power of at least .85 for detecting medium effects at $p = .05$ (Cohen, 1988). Hereafter, we refer to each occurrence of a patient's empathic opportunity and a physician's response as an *empathic opportunity-response sequence*. We timed each of these sequences for analysis.

RESULTS

Empathic Opportunities

Of the 100 encounters with at least one empathic opportunity, the mean number of empathic opportunities per encounter was 2.49 ($SD = 1.6$). These 249 empathic opportunities had a mean emotional intensity rating of 3.30 ($SD = .72$), a point very near the middle of the 5-point intensity scale. Emotional intensity ratings were not associated with any of the familiarity variables. In terms of valence, 22% of the empathic opportunities were coded as positive, 6% as neutral, and 72% as negative.

Creation of empathic opportunities. The first research question focused on differences in patient and visit characteristics for encounters that included at least one empathic opportunity versus those that did not. The 100 patients who created at least one empathic opportunity were not significantly different from the 68 patients who did not create any empathic opportunities in terms of their age, social class, education level, perceived physician-patient familiarity, number of previous physician visits in the past 2 years, or length of time since their first visit with the

doctor. Neither the sex of the physician nor the sex of the patient predicted a patient's creation of an empathic opportunity.

The samples did differ significantly, however, in terms of encounter length: On average, encounters with at least one empathic opportunity were 35% longer than those with no empathic opportunities ($M = 25$ min 20 sec vs. $M = 18$ min 47 sec), $t(159.58) = 3.28, p < .01$. However, the empathic opportunity–response sequences do not account for this time differential because the mean sequence length was 25.8 sec ($SD = 30.39$). Given the mean number of 2.49 empathic opportunity–response sequences per encounter, this adds an average of 64.1 sec, or only about 16% of the time differential. Interestingly, and perhaps more closely related to the issue of time, encounters with at least one empathic opportunity included an average of one more visit agenda item than did those with no empathic opportunities ($M = 6.33$ vs. $M = 5.20$), $t(133.6) = 2.2, p < .05$.¹

Number of empathic opportunities. The second research question focused on the relation between the number of empathic opportunities that a patient creates and the patient and visit characteristics. Only encounter length had a significant association with the number of empathic opportunities created by patients: $r = .33, p < .01$.

Empathic Communication

The third research question focused on the extent to which the ECCS codes are used by physicians. As summarized in Table 2, the physicians in this sample most often responded by acknowledging (30.3%), pursuing (28.2%), or confirming (26.5%) the patient's statement. Few responses were coded as indicating a shared feeling or experience. In addition, a small number of responses were coded as falling into the three lowest levels (i.e., denial, perfunctory recognition, implicit recognition).

Familiarity. Our fourth research question investigated the relation between physician–patient familiarity and the presence of empathy in a physician response. Familiarity was operationalized in three different ways: (a) patient self-report; (b) number of days since the patient first started seeing the physician; (c) number of times the patient had seen the physician in the past 2 years. None of these variables

¹Visit agendas are the set of problems, issues, concerns, or procedures raised by physicians or patients during a visit (Makoul, 2002). The primary types of agenda items are physical/physiological, psychological/emotional, social (e.g., retirement, divorce), health promotion (e.g., screening, risk discussions), and administrative (e.g., forms, paperwork).

TABLE 2
Physician Responses to Patients' Empathic Opportunities

<i>ECCS Response Category</i>	<i>Responses</i>	<i>%</i>	<i>M Time (sec)</i>
Shared feeling or experience	5	2.1	94.40
Confirmation	63	26.5	31.54
Pursuit	67	28.2	31.54
Acknowledgment	72	30.3	18.69
Implicit recognition	12	5.0	10.08
Perfunctory recognition	11	4.6	15.82
Denial/disconfirmation	8	3.4	8.50
Unintelligible ^a	3		
Patient did not allow time for a response ^b	8		

Note. ECCS = Empathic Communication Coding System.

^aThese three responses were not coded because either the physician or patient had unintelligible communication during the empathic opportunity response sequence that may have affected the coding.

^bThese eight responses were not coded because following the empathic opportunity, the patient changed the topic or otherwise did not allow the physician to respond.

were found to be correlated with the physician's level of empathic communication in an empathic opportunity-response sequence.

Sequence length. To address the fifth research question, we examined the length of time associated with the various levels of empathic response. There was a modest, positive correlation between the level of empathic response and the length of the empathic opportunity-response sequence, $r = .30, p < .0001$. Table 2 shows the mean time in seconds of the empathic opportunity-response sequence categorized by the physicians' response to the empathic opportunity.

Empathic opportunity intensity. In H1, we predicted a positive relationship between an empathic opportunity's intensity and the level of empathic response. There was no support for this hypothesis; the level of intensity of the empathic opportunity did not correlate with the physician's level of response, $r = -.02$, nonsignificant.

Empathic opportunity valence. We also expected positive empathic opportunities to receive higher levels of empathic response, and we used a one-tailed *t*-test to compare physician responses to positive and negative empathic opportunities ($n = 234$, because empathic opportunities coded as neutral were excluded). This analysis indicated that responses to positive empathic opportunities did reflect a higher level of empathy than did responses to negative empathic opportunities ($M = 4.02$ vs. $M = 3.52$), $t(79.92) = 2.42, p < .01$, thus supporting H2.

DISCUSSION

This article provides results from a large-scale application of the ECCS to primary care encounters. Two general questions guided this project. First, what can we learn about patients' creation of empathic opportunities? Second, what can we learn about physicians' responses to those empathic opportunities? The observational nature of this study yields a focused picture of empathic communication in the medical encounter and lays the foundation for future research.

Empathic Opportunities

Findings from this research indicate that most patients do give physicians opportunities to be empathic (see also Branch & Malik, 1993; Levinson et al., 2000; Suchman et al., 1997). Although the identification of empathic opportunities was restricted by a conservative definition, roughly 3 in 5 observed physician-patient interactions included at least one empathic opportunity. These opportunities are predominantly negative in terms of valence and have moderate emotional intensity.

The presence of an empathic opportunity had a marked association with encounter length: Those encounters with at least one empathic opportunity were more than 6 min longer than those without. In addition, the number of empathic opportunities present also was associated with encounter length. However, the data indicate the time differences are not a simple function of the empathic opportunity-empathic response sequence. A more likely explanation stems from the finding that patients who created at least one empathic opportunity had more agenda items than patients who did not create any empathic opportunities.

It is important to note variables that were not associated with a patient's likelihood of creating an empathic opportunity. Of particular interest is the finding that patients created empathic opportunities with physicians regardless of how long they had been seeing the physician, how many times they had seen the physician in the past 2 years, or perceived familiarity with the physician. Makoul and Strauss (2003) had a similar finding in their study of first-time visits between physicians and patients. In this study, which focused on health-related empathic opportunities raised during the history of present illness (HPI), there was no relation between level of empathic response and perceived familiarity with the physician. Patients seem to feel comfortable creating empathic opportunities, at varying levels of intensity, with physicians regardless of familiarity. In other interpersonal relationships, familiarity, sometimes called relational intimacy, is an important correlate of the level of self-disclosure (Littlejohn, 1992). The fact that our data did not support such a relation highlights the unique nature of the physician-patient relationship.

Empathic Communication

This research also allows us to make some general statements about physicians' level of empathic responses to patients' empathic opportunities. First, physicians most often respond by acknowledging, pursuing, or confirming patients' empathic opportunities. The levels of *acknowledgment* and *pursuit* are defined in the ECCS as explicitly responding to the central issue in the empathic opportunity, which could be demonstrated by a range of physician behaviors. These include repeating what the patient has said, asking questions, giving advice, offering help, or providing clear nonverbal cues such as "mm-hmm" or nodding while looking at the patient. In other words, acknowledgment, either with or without pursuit, is primarily an indication that the physician paid close attention to what the patient was saying, which can be appropriately considered a minimum requirement for empathic communication. Our finding mirrors Levinson and colleagues' (2000) observation that acknowledgment was the most frequent positive response that physicians had to clues. Although Levinson's group reported that physicians most often missed opportunities to respond to clues, their definition of *clue* included indirect statements; our definition of *empathic opportunity* was much more conservative.

Confirmation goes to the next level, by legitimizing or validating the feelings or experiences expressed by patients (e.g., "That must have been scary for you" or "I can see why you are so frustrated"). Makoul and Strauss (2003), in the study focusing on health-related empathic opportunities present in the HPI, found that 81% of physician responses fell into the acknowledgment, pursuit, or confirmation categories. These three categories accounted for 85% of the responses in our study, suggesting that these responses may not be context specific. Thus, in a general sense, the physicians in our study tended to use person-centered communication, meaning they adapted to the needs of the patient by recognizing the patient's perspective (Miller, 2002).

Physician responses were infrequently coded into the bottom three levels of the ECCS. We expect that the lack of physician responses that fall into the bottom three levels may be a function of the sample we were using (i.e., academic primary-care physicians). Future research, perhaps examining physicians with low patient satisfaction ratings, might result in a wider variation of use of the levels. At the other end of the scale, physician responses conforming to the commonly used definition of empathy as a shared feeling or experience were rarely seen in this study or in the Levinson et al. (2000) study. There are a number of potential explanations for this finding. Of course, this could be due to physicians and patients lacking a similar set of experiences. It is also possible that physicians are not comfortable with this level of empathic communication or do not feel it is appropriate, or that they may be choosing a perspective-taking form of empathic communication. Qualitative study designs may be able to address these issues.

The second key finding is that physician responses were not related to familiarity, which parallels our observation that creation of empathic opportunities did not depend on familiarity and reinforces the distinctive nature of the physician–patient relationship. The third important finding of this study was that the time of an empathic opportunity–response sequence increased along with the level of empathy in the physician’s response. Although we cannot establish the causality of this relation, it is reasonable to expect a physician’s pursuit or confirmation of a patient’s empathic opportunity to take longer than simple acknowledgment. Similarly, it is logical that physician responses that communicate explicit recognition of the patient perspective (i.e., levels 3–6) would take longer than responses associated with little or no empathy (i.e., levels 0–2). Still, the mean time for the most frequently observed physician responses was on the order of 30 sec. A limitation is that the timing was of the total empathic opportunity–response sequence, not just the length of the physician’s response. Measuring only the physician’s response would be problematic, in part because the ECCS codes certain types of nonverbal communication as a response, and such nonverbal communication could be done continuously while a patient was presenting an empathic opportunity.

Fourth, the level of intensity apparent in the empathic opportunity did not correlate with the level of physician empathic communication. The physicians may have responded in a relatively neutral way because they perceived less intensity than did the raters, they did not feel the need to respond with more empathy, or they were not comfortable with emotionally intense responses to negative opportunities. A related finding supports the latter possibility: Positive empathic opportunities received higher levels of empathic response than did negative empathic opportunities. Perhaps when faced with a patient’s negative empathic opportunity, physicians feel a duty to remain calm and try to neutralize negative feelings (see Landau, 1993). Alternatively, physicians might not feel adept at dealing with negative feelings expressed by patients (Levinson et al., 2000; Waitzkin, 1991). In sum, physicians may be inclined to communicate more empathically with patients who are creating positive empathic opportunities.

Future Directions

The ECCS is designed to measure only actual communication behaviors. We are not privy to physicians’ or patients’ intentions and interpretations of the communication that transpired. Accordingly, our initial research on empathic communication has focused on developing a sound measure and describing how empathic communication happens in the medical encounter. The next step in this research agenda is to address relevant patient outcomes. We are currently involved in a study that is testing the divergent validity of the ECCS to see if it will predict the presence or absence of malpractice suits. There is also reason to expect some relation between empathic communication and measures of adherence and health out-

comes. Squier (1990) proposed a model of empathic understanding in the physician–patient relationship that describes how cognitive and affective elements of physician empathy ultimately lead to a patient’s adherence to treatment regimens and preventative strategies, and consequently better health outcomes.

For example, in one of our encounters, the physician suggests to the patient that as a preventive measure for heart disease, she should start taking aspirin. The patient replies, “Oh, I’d hate to start doing that.” The physician pursues the topic with the patient, trying to figure out why she said she would hate to do that (using level 4 of the ECCS). The patient discloses that her father takes aspirin and gets splotches on his arms. The physician is then able to reassure the patient that most people do not have that happen to them. “I wouldn’t be worried that that is going to happen to you,” she tells the patient. This pursuit reply may have helped this physician to resolve the patient’s concerns, potentially leading to better patient adherence. However, the patient may have felt that her fears were not totally understood by the physician, but dismissed. Instead, a confirmation strategy could have validated the fact that the patient felt scared (e.g., “I can see why you would be averse to taking the aspirin”), followed by an explanation that what she feared was unlikely. Future research will need to investigate how using such strategies might affect outcomes.

Empathic opportunities in this study included explicit patient statements of emotion, progress, and challenge. Using this definition, patient statements about medical issues only (e.g., “The pain is really bad”) were not included. Examining a broader conceptualization of empathic opportunities may be fruitful in future work.

In addition, there is opportunity for examining patient preferences for the different levels of empathy that the ECCS describes. It is important to find out how patient preferences may differ based on physician and patient characteristics (e.g., familiarity, gender, age), as well as on the type of empathic opportunity (progress, challenge, or emotion). Further, the results presented herein may be generalizable only to the context of primary care visits with physicians in academic medical centers. It would be useful to examine how patients’ preferences differ across medical context and type of visit. For example, do patients expect or want the same level of empathy during an encounter with a primary care physician that they do during a consult with a specialist? Finally, cross-cultural perceptions and expectations of empathy in the medical encounter could be productively addressed by both research and education.

CONCLUSION

Although many advocate encouraging physicians to show empathy, very little attention has been given to explicating empathic communication in medical encounters. Should empathy be defined as the vicarious feeling of another’s emotion, and should it be the foundation for all physician–patient interactions? (Spiro, 1992). Or

might that type of empathy have a harmful effect on physicians by undermining “their ability to function as wise understanding doctors who give of themselves in guiding patients through life’s concerns and illnesses”? (Landau, 1993, p. 108). We argue that the answer lies somewhere in between these two extremes. Although patients say they want empathy, physicians do not generally communicate the “shared feeling” type of empathy advocated by Spiro (1992). Instead, physicians in our study had a clear tendency for acknowledging, pursuing, and confirming patients’ empathic opportunities. Our earlier research suggested that such responses meet patient conceptualizations and expectations regarding empathy (Bylund & Makoul, 2002). Examining expectations and outcomes regarding empathic communication is essential to progress in the interrelated realms of medical education, practical research, and patient care (Makoul, 2003).

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