The role of empathy in establishing rapport in the consultation: a new model

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CONTEXT Considerable research has been conducted recently into the notion of patient-centred consulting. The primary goal of this approach is to establish a clear understanding of the patient's perspective on his or her problem, and to allow this understanding to inform both the explanation and planning stages of the consultation. The quality of this understanding is largely determined by the empathic accuracy achieved by the doctor; the primary benefit is a therapeutic rapport between doctor and patient.

METHODS To highlight the role of empathy and communication skills in establishing rapport, we initially developed a model which seeks to draw the various motivational and skill elements identified in separate research papers into a comprehensive model of the journey towards shared understanding between doctor and patient. We then conducted an initial validation of the model via qualitative analysis involving general practitioners (GPs) and clinical psychologists.

RESULTS The validation offered encouraging support for the principal elements of the model. Specific suggestions for clarification and extension were then incorporated in a revised model.

CONCLUSIONS The model appears to capture the dynamic process of establishing a therapeutic relationship (rapport) between doctor and patient, defined by the quality of the doctor's understanding of the patient's perspective on his or her problem. Arguably, the most important contribution of the model is to highlight the fact that 'empathy' and consequent 'rapport' are not mystical or exclusive concepts but, rather, involve the use of specific skills accessible at some level by all.

KEYWORDS humans; *patient-centred care; *empathy; communication; physician–patient relations; clinical competence/*standards; motivation.

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INTRODUCTION

The quality of doctor–patient communication remains central to the effectiveness of the medical consultation, both in terms of immediate patient satisfaction and longer-term health outcomes.[1,2] In this context, analysis of effective communication in the consultation has increasingly been focused on the patient-centredness of the encounter, where the patient's perspective is specifically addressed alongside the presented symptoms.[3,4] The central goal here is a professional *rapport* between doctor and patient, a therapeutic alliance based on trust and co-operation[5] and established through a shared understanding of the patient's perspective.

The strength of the rapport between doctor and patient is largely determined by the quality of the empathy at the heart of it, a notion this paper seeks to reinforce. The concept of empathy has been the subject of continuous debate for many years within the medical literature and beyond. The original use of the term referred to the cognitive skill of 'interpersonal imagination',[6] used to establish an accurate understanding of the thoughts or words of the other. Since then, apart from occasional suggestions that it might be an exclusively affective or emotional response to another person,[7] empathy has generally been seen as a multidimensional quality

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Overview

What is already known on this subject

Patient-centred consulting involves establishing a shared understanding of the patient perspective. Empathy plays a key role and encompasses both the desire and the ability to understand.

What this study adds

This study demonstrates a more comprehensive model of the journey towards shared understanding. It identifies the specific interaction between a doctor's empathy and communication skills in developing rapport. It validates the model developed through exposure to experienced practitioners.

Suggestions for further research

Future research might focus on experimental validation of the model in the training environment and analysis of its impact on patient outcomes.

potentially informed by either or both affective and cognitive factors,[8] but also involving a behavioural component (i.e. empathy demonstrated through behaviour).[9]

The primary need for a doctor's perceptions to be accurate, if shared understanding is to be reached, highlights the importance of *cognitive* empathy – which should itself be distinguished from sympathy, as the latter is characterised by a more generalised or globally supportive assessment of another person's problem ('feeling sorry' for someone).[10]

Whether the doctor's empathy has an emotional dimension to it or not, however, the key is to maintain sufficient clarity of mind in search of empathic understanding of the actual thoughts and feelings of the patient.[11,12]

This paper builds on specific recent attempts to develop a more practical understanding of the factors involved in relationship-building. This is epitomised by a recent review of the relevant empirical literature, which generates a summary model of 5 aspects of patient-centredness and 5 factors influencing its development.[13] The review suggested, however, that identification of the 'more complex and contextual dimensions of patient-centredness' required a different approach.[13] We have therefore chosen to direct the focus of this discussion more closely onto the active heart of the model, defined as 'doctor behaviour', looking at the specific motivation and skills required by doctors to establish the therapeutic relationship at the heart of patient-centred medicine.

Other recent approaches have involved looking specifically at verbal 'opportunities' for empathic engagement, which patients offer and doctors either respond to or miss,[14] or to suggest specific verbal triggers that help develop empathic understanding.[15] What this paper argues is that the verbal and non-verbal skills involved in relationship-building are interpersonal *communication* skills rather than empathic skills, because the latter are internal diagnostic skills: the doctor is picking up important signals from the patient and interpreting them, much in the same way as he or she internally assesses the patient's presenting symptoms. This internal empathic journey, taken by the doctor alongside any clinical assessment, is then facilitated and reinforced by the use of communication skills (e.g. open question style, checking patient agreement).

This paper therefore takes the research forward in 3 distinct ways:

1. the proposed model (Fig. 1) sets out to integrate past research and models looking at the nature and power of empathic accuracy in helping to ensure that a patient's experience of his or her illness is sufficiently explored;[8,14]
2. the paper seeks to clarify the specific roles played by the doctor's empathic motivation and skills, alongside verbal and non-verbal communication skills, in ensuring empathic understanding – and hence therapeutic rapport – and
3. the model is then tested, via applied research with relevant practitioners.

The specific objective of generating the model was to better inform the development of the relevant skills among practitioners.

Development of new model

The main components of the model emerged from a variety of sources – in part from the wider psychology literature and a body of related medical research (as indicated above), but also from more recent validated

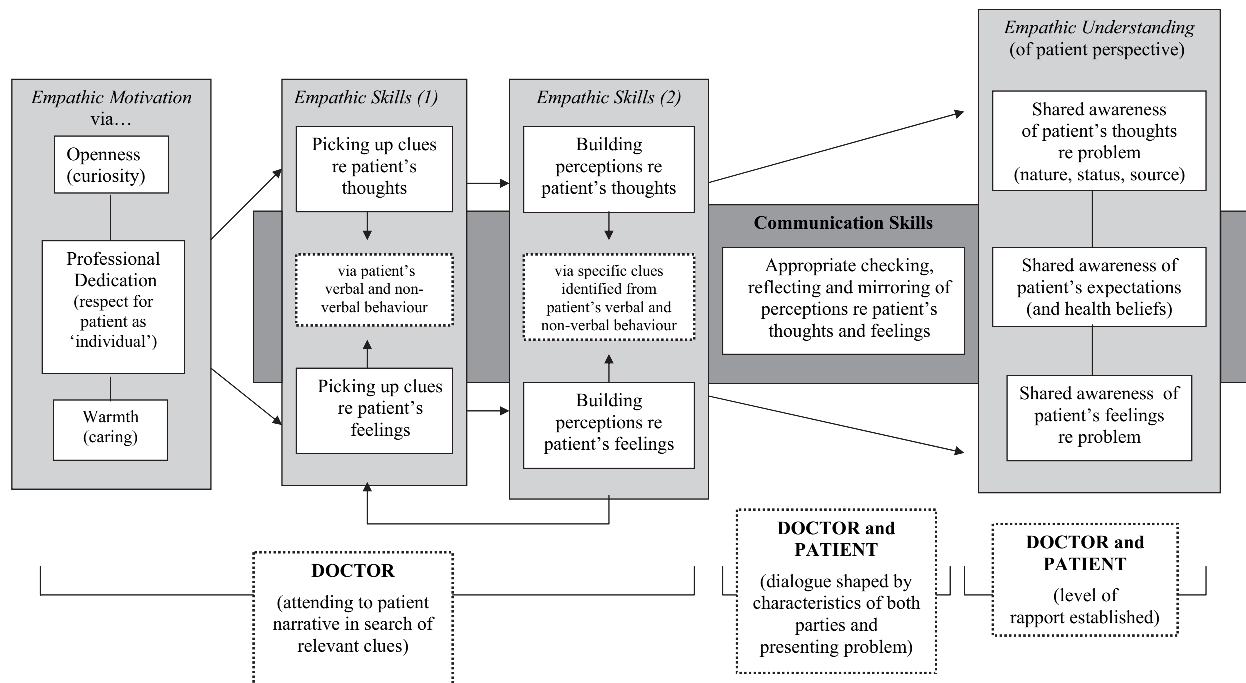

Figure 1 Developing therapeutic rapport in the consultation (via empathic understanding of the patient's underlying ideas, concerns and expectations)

research into the competencies determining effective consulting in general practice.[16] This highlighted the important distinction between empathy (as an internal process) and communication skills (as used in open expression between individuals).

Briefly, the model suggests that the essential therapeutic rapport between doctor and patient is derived from a particular interaction between the doctor's empathic motivation, empathic skills and communication skills, potentially constrained by a range of other specific factors.

Key stages in the new model

Empathic motivation

The journey towards empathic understanding initially involves volition, the conscious or spontaneous commitment to engage fully with the patient's individual experience.[12,17] Having the initial desire to understand the patient's perspective, in other words, is fundamental to achieving the goal.[18]

There appear to be both innate (spontaneous) and consciously chosen (deliberate) sources of this motivation to listen or attend fully to a patient. Two particular personal attributes seem to trigger more *spontaneous* attention to the patient as a unique individual: innate interest or curiosity (i.e. being open to new possibilities)[19] and innate warmth (i.e. being inclined to care for others).[20] The curiosity about people is an intellectual trigger, linked to cognitive empathy;[8] the warmth towards people is an emotional trigger, linked to affective empathy.[21] Alternatively, if or when a doctor has low levels of both spontaneous triggers to this motivation (i.e. intellectual curiosity and affective warmth), a more conscious or deliberate focus on the patient can be generated. This is in effect drawn from established values rather than personality – representing a professional commitment to the patient – and is specifically intended to reach a sufficient understanding of the patient's experience of his or her illness.

Empathic skills

The second element in the journey to empathic understanding highlights the important distinction between the *desire* to understand and the *ability* to understand.[22] Motivation has no necessary association with ability: the former reflects an attitude of mind; the latter reflects skill, and the specific skills are *internal* diagnostic skills running parallel to those used to assess the patient's clinical presentation, which allow a doctor to first identify significant clues to the patient's thoughts and feelings,[9] and then make constructive sense of what has been identified

(Fig. 1, Empathic Skills 1 and 2). These clues may be verbal, non-verbal or both.[9,23]

Communication skills

A doctor might have strong empathic motivation and skills but, unless the patient can see or sense this, the consultation might in theory be no less dysfunctional than a meeting conducted by a doctor with little or no interest or skill in identifying the patient's perspective.[24] This is self-evidently because if the doctor is without the communication skills to articulate or demonstrate either empathic interest or, later, empathic skill, the patient has no reason to believe that the doctor wants either to listen or understand. This fundamental link has been recognised since Rogers' early formulation of the empathic process,[25] yet the clear distinction between empathy and communication skills is seldom made in either consultation models or assessment tools.

Communication skills perform two specific roles in helping establish a therapeutic relationship in the consultation. Firstly, they act as eliciting skills, encouraging patient disclosure. This involves both verbal skills (e.g. appropriate use of open questions, reflecting or echoing patient words, clarifying and summarising) and non-verbal skills (e.g. warmth of voice, appropriate use of silence, smiling, nodding, mirroring of posture).[25,26] Secondly, these skills will determine the doctor's empathic accuracy through testing or checking how well he has read the patient's verbal and non-verbal behaviour in terms of the clues it offers to the patient's thoughts and feelings.[12,14]

Empathic understanding (and its impact on establishing rapport)

This defines the effectiveness of the empathic journey, or the degree to which the doctor has managed to accurately identify the patient's perspective. The greater the level of understanding reached, the stronger the rapport between doctor and patient. The degree of empathic understanding achieved will be related to the doctor's use of specific skills in search of that understanding.[21,23] Empathy and associated communication skills are in this sense being employed or activated in pursuit of a deliberate professional goal, providing a sufficient sensitivity to the 'moment' in an individual consultation that allows for the establishing of a therapeutic alliance or *rapport* between doctor and patient.

It is important to recognise that the rapport established between doctor and patient is not a static moment or outcome, but rather a dynamic, iterative process in which the doctor attempts to reach an increasingly accurate understanding of the patient's thoughts, feelings and expectations.[27] The strength of the rapport can therefore fluctuate, and the pace at which it develops will often vary between patients.

Possible constraints on the development of therapeutic rapport

There are clearly various factors that will potentially influence the rapport established between doctor and patient. Outlined above are specific motivational and skill factors central to the process itself, but the quality of every interpersonal encounter is in part determined by momentary or stable characteristics of both the individuals involved and the particular environment in which they meet.[28]

Doctor factors would potentially include, among other things, other personality characteristics (in addition to previously mentioned levels of innate curiosity and warmth), professional confidence, self-awareness, present mood and the impact of past experiences – both professional and personal.

Patient factors would potentially include, among other things, personality characteristics, self-awareness, health beliefs, present mood, communication skills and the level of complexity attached to the presented problem (which might, for instance, refer to an openly acknowledged complexity in the presented problem, or complex psychological elements in the patient's perception of the problem).

Environmental factors would potentially include, among other things, stable aspects of the practice setting (e.g. waiting room and consulting room size, lay-out and lighting), available resources, time of day or week and number of patients waiting.

Content validation

To assess the conceptual or 'content' validity of the model, and in particular the role of empathy in the development of rapport, the researchers (occupational psychologists) needed to measure theory against the realities of a practice environment. They therefore conducted a separate piece of qualitative research across two populations for whom the therapeutic relationship is of primary practical importance: general practice and clinical psychology practitioners. The aim was to test the model, the appropriateness of its components and the

relationships between them, and then to revise the model accordingly.

METHODS

Twelve experienced practitioners, identified through opportunity sampling, took part in the study: 6 GPs (with an average of 16 years in practice) and 6 clinical psychologists (with an average of 19 years in practice). The client bases of both were comparable in that neither set of practitioners dealt solely with patients or clients with chronic problems.

Rather than start with direct analysis of the model and the role of empathy in generating rapport, each practitioner first took part in a 90-minute semi-structured interview based on the critical incident technique,[29] in which he or she was initially asked to recall and describe separate specific patient sessions in which the development of rapport had:

1 gone well, and
2 proved difficult.

Practitioners were then asked to define and describe the concept of 'rapport', and the relationship between empathy and rapport. Finally, they were asked for their professional opinions on the validity of the model. (Inviting general reflection on the establishing of rapport allowed researchers to identify spontaneously the perceived role played by empathy *before* more specific prompting about its role.)

An average of 4 patient sessions were discussed with each participant, resulting in a total of 48 analysed sessions, which were audiotaped with full consent and later transcribed.

Analysis

Qualitative data for each section of the interviews were initially integrated for the purposes of analysis. Given that an existing conceptual rapport framework was being addressed and a significant amount of qualitative data had been collected, template analysis was chosen as a suitably systematic method of analysis.[30] This defines and codes a priori a number of themes reflecting key components of the research topic. Five themes salient to the model were identified and used for coding transcripts: empathic motivation; empathic skills; communication skills; empathic understanding, and model specifics (sequencing and terminology).

RESULTS

Empathic motivation

Motivation was implicit in all participants' descriptions of rapport-building. Its inclusion in the model as a discrete concept was viewed as a useful distinction by the GPs. More specifically, the idea that it was important to be aware of one's natural motivational sources (and responses to this) throughout the session, whether driven primarily by curiosity or warmth, was found to be helpful by the GPs. The role of 'professional dedication' as a motivational source was seen by both groups as comprising many factors, including respect and integrity.

The influence of expectations and role clarity became apparent in the experiences of both groups, particularly those of the psychologists. 'Expectations' in this sense are what each individual brings to the interview: the client's expectations, for instance, are based on previous experience of similar interviews, and beliefs about his or her health and the role that he or she plays in shaping it; the practitioner's expectations are often based on previous experience of patient groups (e.g. related to age, gender or other demographics) or patterns of clinical presentations.

The individual's particular expectations, whether client or practitioner, were seen to shape the motivation and initial dialogue in terms of information provided and how this was subsequently dealt with. It was felt therefore that reference to 'expectations' should be included in the model.

Empathic skills

Two levels of empathic skill emerged from the data, related to picking up clues and building perceptions from these clues, respectively. These were very much intertwined in practitioner descriptions of the development of rapport, but it was felt to be useful – certainly for training purposes – to distinguish clearly between them so that each step could be identified and modified where necessary.

All participants made reference to the notion of 'attending', either explicitly or implicitly. This was seen as being distinct from empathic skills. It did not involve picking up clues, but rather referred to the concentration on and interest shown in the patient or client, and served as encouragement to the patient to share his or her story. It was suggested that this be more explicitly recognised in the model.

Communication skills

The purpose and content of communication skills within the model were accepted as valid by all participants. Checking the accuracy of empathic perceptions was significantly apparent across both groups. The majority suggested that despite regularly using such empathic and communication skills, they had not previously been able to conceptualise them with such clarity themselves.

Empathic understanding (and therapeutic rapport)

Therapeutic rapport was defined by both psychologists and GPs as a shared understanding or connection between practitioner and patient or client, much in line with the model. Empathy was viewed as a key aspect in the development of rapport by all participants.

Model specifics

Sequencing

Overall the sequencing of the behaviours was felt to be appropriate, provided the iterative process of developing rapport was highlighted via more feedback loops, particularly from empathic understanding to empathic skill, so that some level of mutual understanding would then facilitate the gathering of further or more in-depth information.

Terminology

All the psychologists were very familiar with the language used. The majority of GPs initially found the terminology slightly unnatural but, once familiar with it, found it represented clear and useful language in the context of training and practice purposes.

DISCUSSION

There was strong evidence for the content validity of the model across and within both populations. All concepts contained in the model were thought to be valid and relevant, and its value as a potential training tool was commended. Few amendments or additions were suggested, and the majority of these related to issues of terminology or the expansion of existing concepts. Despite some specific differences in perception between the GPs and psychologists, findings suggested the model had a high degree of potential for generalisability as a model of medical relationship-building.

In response to the findings of the content validation study, a revised model was generated (Fig. 2),

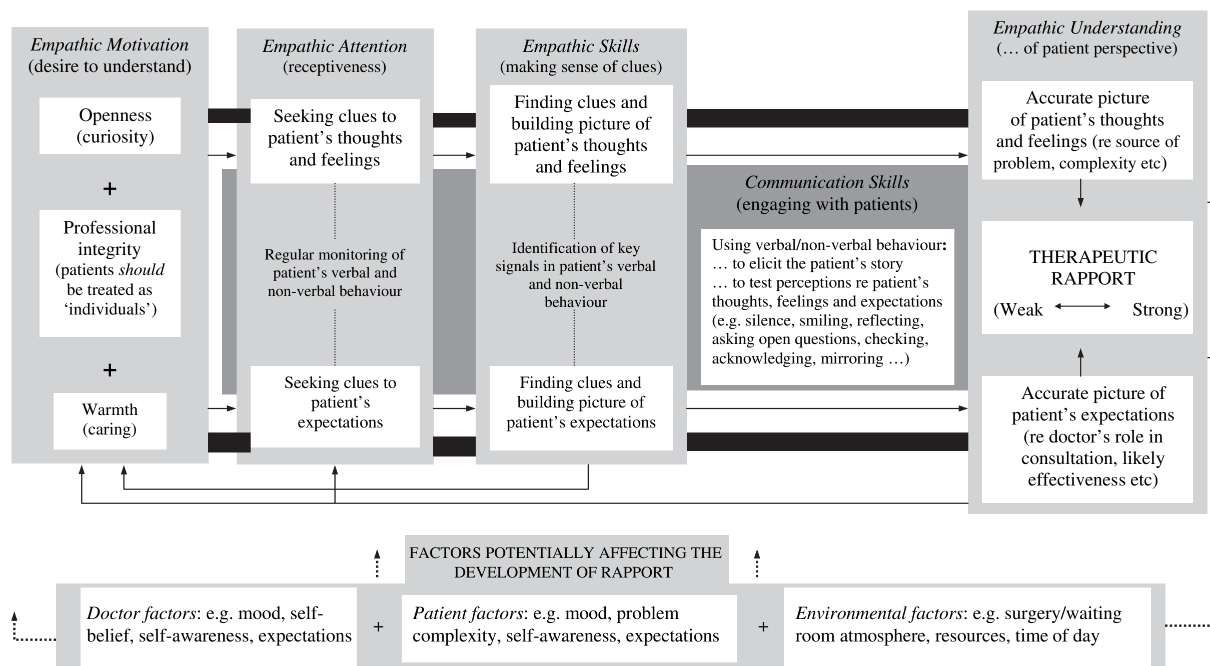

Figure 2 Developing therapeutic rapport in the consultation (via an empathic search for understanding of the patient's dominant thoughts, feelings and expectations)

involving a number of clarifications to the initial model and the introduction of an additional stage to the process of developing therapeutic rapport (Empathic Attention).

Limitations

Reference should be made to certain limitations of this study. Firstly, most of the GPs had some knowledge of the model prior to the interview because of their role in previous training activities that had either referred to or incorporated competencies used in the model. However, the only GP who was entirely unfamiliar with the competencies underpinning the model described the concepts and sequencing of the model very closely in reports of her experiences.

Further, no data were collected from the patient or client perspective as the content validity of the model was evaluated from the practitioner perspective alone. Inclusion of the patient or client perspective might have generated different conclusions.

CONCLUSIONS

We believe the revised model presents an accurate and transferable summary of the empathic journey towards therapeutic rapport. As the initial validation suggests, the model has immediate and ongoing practical relevance for selection and training in many areas of medicine, whether for GPs or other related practitioners (e.g. clinical psychologists, counsellors and nurses). The relationship-building skills at the heart of the model are certainly those targeted early in medical training and assessment and, because the emphasis is on demonstrating specific skills rather than achieving specific tasks, the model has obvious potential as a formative instrument that may help trainers and trainees to concentrate on developing specific core skills as well as measuring or ticking off the achievement of a list of tasks.

The authors have subsequently been involved in using the new model in training related to the development of rapport; the model certainly now requires a more rigorous experimental validation. Further research might look at the role and impact of the new model, both on other elements of the consultation (e.g. negotiation to establish a management plan) and on patient outcomes (e.g. satisfaction and adherence to treatment plans). The model's generic potential might also be validated through the assessment of its impact on the performance of other related professional groups, such as nurses.

Contributors: TN conceived and designed the model. DW organised the acquisition and analysis of data. All authors contributed to interpretation of data, and the revision of the article. All authors approved the final manuscript.

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