Empathy in the Time of Burnout
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I want to be a doctor so that I can see more patients per hour with higher patient satisfaction scores than any of my peers, said no medical school applicant ever. Yet, these are 2 of the more common metrics used to assess (and incentivize) physicians. Go faster. Be nicer. Unfortunately, American physicians are burning out en masse. Must the beatings continue until morale improves?

It is hard for burnt-out physicians to be empathic. Unfortunately, burnout rates are climbing; more than 50% of American physicians report burnout symptoms, up 10% from 2011 to 2014. These 3 years were characterized by unprecedented change: declining reimbursements, increased productivity expectations, large-scale electronic health record adoption, new delivery models, fluctuating reimbursement, and consolidation of many practices. To remain afloat in this tumultuous time, administrative burdens (measurements) have increased while physicians have been exhorted to provide higher quality, more efficient, patient-centered care.

If you can measure it, you can manage it, according to conventional wisdom and recent findings in health care. Measuring hospital readmission rates and hospital-acquired infections is already prompting hospitals to align their resources to improve patient outcomes, thus reducing costs and increasing Medicare reimbursements. Measurement of patient experience also affects Medicare reimbursement: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) was developed using the highest standards for survey development. Hospitals that perform well on this survey also affect patient questions. This ritual provides a foundation for patients to have a satisfying experience by promoting polite physician behavior regardless of physician attitude. After all, behavior can be observed and, therefore, it can be measured. Patients can more reliably answer the HCAHPS question, “How often did doctors listen carefully to you?” than “Did your doctor really care about you as a person?” Therefore, HCAHPS results provide a useful and credible assessment of the quality of customer service rendered based on staff behavior while attending to patients. But, these results characterize the transaction, not the connection—how staff cared for patients not whether staff cared about patients. Empathy is required for staff to genuinely care about their patients.

Derksen et al define empathy as “the competence of a physician to understand the patient’s situation, perspective, and feelings; to communicate that understanding and check its accuracy; and to act on that understanding in a helpful therapeutic way…” Empathy can therefore be defined at three levels: as an attitude (affective), as a competency (cognitive), and as a behavior. Empathy’s affective and cognitive elements are beyond the behavioral components that etiquette checklists encourage and HCAHPS measures. That is to say, etiquette checklists establish a floor, not a ceiling, for empathy and subsequently for...
patient experience. The HCAHPS quantifies courteous and respectful behavior. Etiquette checklists promote behaviors that make patients feel they have been treated with courtesy and respect. If this is what we choose to measure and promote, implicitly we teach that polite and reliable customer service is all that is required to care for patients, and we teach that empathy, that caring about patients, we just hope will follow pari passu. But will proper manners, proper etiquette, lead to genuine empathy? Can we fake it ‘til we make it? Does it actually matter? Hard to know—genuine empathy, caring about patients, is currently unmeasured.

Before we rush to add empathy measurements to HCAHPS, it would be wise to consider that measurement fatigue contributes to burnout. Adding empathy measurements might reduce empathy: a perverse Hawthorne effect. We can imagine burnt-out physicians practicing with good etiquette. It is less likely overworked, frustrated physicians will provide reliably empathic care.

Bodenheimer and Sinsky7 offer an alternative to the vicious cycle of adding managerial burden to ensure better patient care, but then, in turn, burning up more and more clinician time in tasks away from the patient. They recommend expanding our system’s Triple Aim (improving patient experience, population health, and costs) to a Quadruple Aim of also improving the work life of clinicians. They propose that we cannot achieve the first 3 aims without also including the fourth. Surely, physician wellness is a prerequisite to reliable empathy.

The road map for achieving a Quadruple Aim includes offloading, standardizing, and synchronizing workflows with team documentation, expanding roles of other team members, colocating team members, and presist planning and laboratory testing.8 Shanafelt et al1 add that the systemic nature of US physician burnout calls for system-level solutions. By improving the efficiency and support of the practice environment, improving physician engagement, optimizing “career fit,” and fostering an environment with a sense of community and flexibility, systems and organizations could cultivate meaning in work and, in turn, decrease burnout.

Etiquette or empathy? Most want both from their physicians. But, in this time of increasing physician burnout, American health care seems to be focusing on etiquette. Etiquette may suffice; courteous, clean, and dependable goes a long way when “caring for strangers in bureaucracies.”10 Consider how well pizza, donut, and coffee shops do in America: reliably served, if not the best for our health. Genuine, empathic physician-patient relationships may have become more of an ideal, like gourmet cuisine, than routine fare. However, empathy is at the heart of patient care and, without it, physicians cannot meet the expectations of our calling, measured or not. A health care system hoping for more substantial physician-patient relationships must invest more in the well-being of its caregivers.

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Abbreviations and Acronyms: HCAHPS = Hospital Consumer Assessment of Healthcare Providers and Systems

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