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Iete Schrooten & Menno D. T. de Jong

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If You Could Read My Mind: The Role of Healthcare Providers’ Empathic and Communicative Competencies in Clients’ Satisfaction with Consultations

Iete Schrooten and Menno D. T. de Jong

Department of Communication Science, University of Twente

ABSTRACT
This article investigates the relationship between healthcare providers’ empathic and communicative competencies and clients’ overall satisfaction with consultations. Two aspects of empathy were included: empathic attitude (sensitivity to the clients’ perspective) and empathic skills (ability to estimate clients’ evaluations). Communicative competencies were narrowed down to the clarity of the information provided. In the context of work disability examinations, 90 healthcare providers (44% physicians, 56% vocational experts) participated. For each provider, up to 20 dyads with clients were investigated. Within every dyad, clients rated their experiences and healthcare providers estimated clients’ scores. The results show that both aspects of empathy and clarity of information significantly contribute to clients’ overall satisfaction and as such confirm the importance of empathy and communication in medical consultations. Specifically, healthcare providers’ empathic dispositions, in addition to their overt communicative behavior, appear to contribute to clients’ overall satisfaction. Of the two aspects of empathy, only empathic attitude is significantly related to the clarity of information.

Introduction
The importance of empathy and communication in medical consultations is virtually undisputed. Ever since the rise of the concept of patient-centered care, it has become clear that a good relationship between healthcare providers and patients plays a critical role in the quality of care (Mead & Bower, 2000). As a result, empathy and communication have gained considerable attention, both in the academic literature and in education and training programs. In this article, we describe a study into the effects of healthcare providers’ empathic and communicative competencies on clients’ satisfaction with consultations. Empathic competencies comprised empathy as an attitude and empathy as a skill, which boil down to the willingness and ability to empathize. Communicative competencies involved the clarity of information. Theoretically a relationship between both empathic competencies and clarity of information may be assumed.

Empathy in Medical Consultations
Research into patient preferences shows that empathy is a core competence of healthcare providers (Bensing et al., 2011). Several studies demonstrated that providers’ empathy is positively related to patient satisfaction (Blatt, LeLacheur, Galinsky, Simmens, & Greenberg, 2010; Kim, Kaplowitz, & Johnston, 2004; Pollak et al., 2011) and agreement between providers and patients about the course of action (Parkin, De Looy, & Farrand, 2014). There is even growing evidence that providers’ empathy may contribute to patient compliance, patient enablement, and clinical outcomes (Del Canale et al., 2012; Hojat et al., 2011; Kim et al., 2004; Lelorain, Brédart, Dolbeault, & Sultan, 2012; Mercer, Bhautesh, Maxwell, Wong, & Watt, 2012; Price, Mercer, & MacPherson, 2006). Support for the importance of empathy can be found in emotional and sensitive contexts such as those involving end-of-life decisions and cancer care (Lelorain et al., 2012; Selph, Shiang, Engelberg, Curtis, & White, 2008), but also in the treatment of common colds (Rakel et al., 2011). The relevance of empathy is not restricted to “high touch” medical disciplines; the beneficial effects of empathy have also been shown among “high tech” surgeons (Weng et al., 2011). Empathy may contribute to the success of medical consultations and interventions in two ways: (1) via a cognitive/informational route: empathic healthcare providers may collect richer, more truthful, and more complete information from patients, and (2) via an affective/motivational route: patients of empathic healthcare providers feel understood and valued as a person and may therefore be more motivated to actively work on their health (Neumann et al., 2009; Squier, 1990).

There is no short road to learning empathic competencies. Research shows that healthcare providers’ empathy may be related to their personality (agreeableness, openness to experience) (Magalhães, Costa, & Costa, 2012), their well-being or distress (Neumann et al., 2007; Passalacqua & Segrin, 2012; Shanafelt et al., 2005), their specialty (“high tech” vs. “high touch”) (Dehning et al., 2014; Newton et al., 2000), context and circumstances (private vs. statutory health insurance) (Neumann et al., 2011), and patient characteristics (e.g.,
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substance abuse or marital status) (Pollak et al., 2010; Williams et al., 2012). Several studies found a gender difference regarding empathy: Female providers are generally more empathic than their male colleagues (Nunes, Williams, Sa, & Stevenson, 2011; Williams et al., 2012). Research shows that medical students may lose their empathic competencies in the course of their educational program ("the devil is in the third year") (Hojat et al., 2009; Nunes et al., 2011), although this phenomenon was not always confirmed in other studies (Colliver, Conlee, Verhulst, & Dorsey, 2010; Magalhães, Salgueira, Costa, & Costa, 2011).

This overview of antecedents suggests that the manifestation of empathy in the daily work of healthcare providers partly depends on personal characteristics, and partly on situational factors. However, research suggests that training can also play a beneficial role (e.g., Bonvicini et al., 2009; García et al., 2013). Several approaches have been proposed and used, including creative and imaginative approaches (narratives, writing, or drama), communicative and interpersonal skills training, exposure to the feelings of patients (interviews, observation, feedback), experiential learning (role reversal), and reflection (Batt-Rawden, Chisolm, Anton, & Flickinger, 2013; Stepen & Baernstein, 2006). In most cases, positive effects of such approaches were reported.

As important as empathic competencies are for healthcare providers, the concept of empathy seems to be broad, complex, and multifaceted (Pedersen, 2009). This is illustrated by the definition of clinical empathy by Mercer and Reynolds (2002): "Clinical empathy involves an ability to: (a) understand the patient’s situation, perspective, and feelings (and their attached meanings); (b) to communicate that understanding and check its accuracy; and (c) to act on that understanding with the patient in a helpful (therapeutic) way" (p. 59). This definition highlights that empathy has receptive (understanding patients) and expressive aspects (communicating that understanding). Furthermore, a distinction is often made between affective and cognitive empathy. Affective empathy involves the ability to imagine emotional experiences, whereas cognitive empathy involves the ability to take the mental perspective of others (Cox et al., 2012; Duan, 2000; Irving & Dickson, 2004; Kim et al., 2004). In medical practice, the distinction between both types of empathy is not always clear, as interpretations and emotions may be closely connected.

So far, the literature on healthcare providers’ empathy does not fully recognize the potentially multifaceted nature of the concept of empathy. Even an influential and reportedly multidimensional instrument as the Jefferson Scale of Empathy (e.g., Hojat & LaNoue, 2014) seems far from satisfactory in this respect. The three factors in the questionnaire are assumed to reflect perspective-taking, compassionate care, and standing in the patient’s shoes, which may be hard to differentiate. However, based on the specific items, the factors appear to represent the even more coarse-grained distinction between perceived importance of empathy (e.g., “Patients value a physician’s understanding of their feelings which is therapeutic in its own right”), compatibility of empathy and medical treatments (e.g., “I believe that emotion has no place in the treatment of medical illness”), and perceived difficulty of empathizing with patients (e.g., “It is difficult for a physician to view things from patients’ perspectives”). In most studies, empathy is operationalized into one single construct that cannot cover all aspects of empathy—for instance, the communicative behavior of healthcare providers (Bylund & Makoul, 2002, 2005). An exception is a study by Kim et al. (2004), which distinguished between cognitive and affective empathy, and showed that both aspects had differential routes toward patients’ satisfaction and compliance.

Viewed from the competencies required of empathic healthcare providers, the overall concept of empathy may be divided into three basic competencies: (1) willingness to see things from the patient’s perspective, (2) ability to see things from the patient’s perspective, and (3) ability to communicate empathically (De Jong & Lentz, 2007; Berkens, Bensing, & Lagro-Janssen, 2013; Irving & Dickson, 2004; Norfolk, Birdi, & Walsh, 2007). This boils down to a distinction between empathy as an attitude, as a skill, and as communicative behavior. The need to distinguish between the three is supported by general models predicting people’s behaviors or performance (Ajzen, 1991; Mitchell, 1982). It is generally accepted that ability and attitude are distinct predictors of behavior. Healthcare providers who are willing to empathize with patients may lack the ability to do so effectively. Providers who have the ability to empathize may not always be willing to do so. Willingness and ability to empathize do not necessarily mean that empathy will be communicated. Research into human behavior invariably shows gaps between attitudes and skills as predictors and intentions and behaviors as outcomes (cf. Ajzen, 1991). Actual behavior may also depend on, for instance, healthcare providers’ communicative style. On the other hand, earlier studies stress the communicative aspects of empathy, suggesting that showing empathy to patients may be learnable by focusing on do’s and don’ts in behavior and communication (Benbassat & Baumal, 2004; Bonvicini et al., 2009; Bylund & Makoul, 2002, 2005; Coulehan et al., 2001; Harres, 1998). With their main focus on communicative processes, they suggest the possibility of shortcuts toward empathic behavior, which do not seem to require empathy as an internal process.

A limitation of earlier research is that empathy is measured using self-reports by healthcare providers, impressions of patients, or behavioral observations. Providers’ self-reports have the disadvantages of social desirability and a focus on general attitudes. Impressions of patients and behavioral observations obscure the difference between internal representations of empathy (attitude and skill) and empathy as communicative behavior. In this study, we focus on the effects of empathy as an attitude and empathy as a skill by using a dyadic approach, in which healthcare providers estimate the experiences of clients.

Clarity of Information in Medical Consultations

Research into physician–patient communication comprises many different aspects (Stewart, 1995; Wouda & Van De Wiel, 2012). Concepts such as patient-centered communication emphasize that healthcare provider–patient
communication is multifaceted and plays a central role in patients’ satisfaction with medical care (Finney Rutten et al., 2015; Wanzer, Booth-Butterfield, & Gruber, 2004). Finney Rutten et al. (2015), for instance, mention building and maintaining healing relationships, two-way communication, responding to emotions, managing uncertainty, decision-making, and enabling self-management. Wanzer et al. (2004) mention introductions, clarity, empathy, immediacy, listening, and humor. Many of those aspects are intricately bound up with empathy as communicative behavior (showing empathy).

An important aspect of the communication between healthcare providers and patients is clarity of information. Several studies in different areas of the healthcare system suggest that providers do not always manage to communicate clearly with patients (Bagley, Hunter, & Bacarese-Hamilton, 2011; Chappuy et al., 2012; Debaty et al., 2015; Howard, Jacobson, & Kripalani, 2013; Weatherspoon, Horowitz, Kleinman, & Wang, 2015). Some studies draw attention to complicating factors: Healthcare providers overestimate their communicative skills (Howard et al., 2013; Wolf, Baker, & Makoul, 2007), see their communicative performance from a different perspective than patients (Kenny et al., 2010), and doubt the usefulness of effective communication techniques (Weatherspoon et al., 2015).

The concepts of empathy and clarity of information are theoretically related. The literature on creating usable and understandable discourse shows a development from a word- and sentence-level orientation (e.g., avoiding jargon, using simple sentences), via a focus on the organization of information (e.g., providing a clear structure), to a focus on connecting information to the prior knowledge, needs, and perspectives of the other party (e.g., De Jong & Lentz, 2007; Schriver, 1997). Empathy is necessary to make the right estimations and can thus be seen as a factor that potentially affects the clarity of information. In the CARE (Consultation and Relational Empathy) instrument for measuring “consultation and relational empathy” (Mercer, Maxwell, Heaney, & Watt, 2004, p. 700), “explaining things clearly” is even one of the ten items used to measure the construct of empathy.

This Study

Our research focuses on the prevalence and effects of empathy as an attitude, empathy as a skill, and clarity of information in work disability examinations. Three questions are addressed. The first is to what extent healthcare providers dispose of the two aspects of empathy and communicate clearly (RQ1). The second question is to what extent the two aspects of empathy and clarity of information contribute to clients’ overall satisfaction (RQ2). On the basis of the literature about the impact of empathy and good communication practices we hypothesized that empathy and clarity of information have positive effects on clients’ satisfaction, and that these effects complement each other. The third research question (RQ3) is to what extent the two aspects of empathy contribute to the clarity of information. On the basis of the literature on discourse quality we hypothesized that both aspects of empathy are related to the clarity of information.

Method

The research was conducted in the Netherlands in the context of a continuing education training program for healthcare providers on the topic of empathy. The program was developed and given by the first author and accredited by the Landelijke Huisartsen Vereniging (LHV; the Dutch association of general practitioners), the Sociaal-Geneeskundigen Registratie Commissie (SGCR; the registration committee of social physicians), and Hobéon SKO (the certification organization for vocational experts). The program consisted of three phases. In the first phase, the healthcare providers received training in empathic skills, exchanged experiences, and co-developed a questionnaire of aspects they found important to know about experiences of clients during a consultation. In the second phase, the questionnaire was used to collect data in their work setting (see below). In the third phase, the providers received individual feedback about their functioning. The program was offered 13 times, with 1–11 participants.

For each provider, client data were collected for up to 20 consultations. Immediately after each consultation, the first author held a structured interview with each client using the questionnaire. At an identical time, the provider filled out the same questionnaire about the consultation, with the assignment to estimate which answers the client would give.

The research took place in a context of medical examinations regarding work disability. Employees who cannot work due to (partial) disabilities are obliged to periodically take a medical examination, to verify their medical situation and determine the extent to which they are still able to work. The examination is conducted by an independent healthcare provider. In the Netherlands, two types of healthcare providers are active in this area: medically schooled company or insurance physicians, and “vocational experts,” who have completed a higher vocational education program and a specialized follow-up program. Both groups of providers participated in our study.

Due to the embedding in a training program, the questions in the questionnaire varied, in terms of range of topics covered and sometimes in terms of formulation. We selected items that were largely constant in all 13 questionnaires.

Questionnaire

The questionnaire comprised twelve items, which originally were intended to cover four overall topics (Table 1). Six of the questions related to questions in the CARE questionnaire (Mercer et al., 2004). All questions were measured on a five-point scale. We aimed to explain overall satisfaction with the healthcare provider using the other three factors, two of which were empathy and communication related (whether clients felt they were taken seriously, and whether the provider informed them in a clear way), and one involved the agreement between client and provider about the conclusions regarding work disability.

In a principal component factor analysis (with varimax rotation), we found that only two factors could be distinguished: (1) overall client satisfaction and (2) clarity of the information provided. It appeared impossible to statistically
differentiate between feelings of being taken seriously, agreement about the healthcare providers’ conclusions, and overall judgment of the healthcare provider. Three of the four questions about clarity of information formed a separate construct (the item on clear language loaded equally high on the two factors). The two resulting scales had sufficient Cronbach’s alphas: .86 for overall assessment (eight items), and .67 for clarity of the information provided (three items).

**Participants**

In total, 90 healthcare providers participated. The providers were quite evenly distributed over the two educational backgrounds (44% physicians, 56% vocational experts). Male providers were over-represented (80 vs. 20%). The providers’ age ranged from 29 to 63 (M = 46.1, SD = 7.2). All providers participated on a voluntary basis. The total number of participating clients was 1520. Male and female clients were quite evenly represented (54 vs. 46%). The clients’ age ranged from 17 to 65 (M = 41.1, SD = 11.4). The number of dyads per provider ranged from 6 to 20.

**Analyses**

In our analyses, we first examined the prevalence of the two aspects of empathy and the scores of the healthcare providers on the clarity of the information provided (RQ1). To investigate the clarity of information, we analyzed the mean scores given by the clients on the three questions. To investigate empathy as an attitude, we compared the mean scores of clients with the estimations of these scores given by the providers. To investigate empathy as a skill, we analyzed the correlations between clients’ scores and providers’ estimations.

We used regression analysis to investigate the contribution of empathy and clarity of information to clients’ overall satisfaction (RQ2). The dependent variable was the clients’ mean score on the eight items of factor 1. The three independent variables were

1. Clarity of the information provided: the clients’ mean score on the three items of factor 2 (clarity of the information).
2. Overall sensitivity to the clients’ perspective (empathy as an attitude): the summation of all (positive and negative) differences between the clients’ scores and the providers’ scores in each dyad (on all 12 items). An underestimation of the clients’ satisfaction reflects a self-critical and client-oriented overall attitude among the providers. Healthcare providers received points when they underestimated the satisfaction scores of clients, and points were deducted when they overestimated their scores.
3. Ability to estimate clients’ evaluations (empathy as a skill): the summation of all absolute differences between the clients’ scores and the providers’ scores in each dyad (on all 12 items). The closer providers’ estimations approached the evaluations of clients, the better their empathic skills are developed. Providers received penalty points for every deviation (either positive or negative) from the scores of the clients.

We used a correlation analysis to investigate the relationship between both aspects of empathy and clarity of information.

**Ethical Aspects**

At the time of data collection, the first author worked as an independent consultant and was not affiliated to a university. As a result, she had no access to an institutional review board. All healthcare providers participated on a voluntary basis and had a clear personal interest: training their empathic skills, and earning obligatory yearly refresher course credits. They had the opportunity to opt out at every stage of the research, and confidentiality and anonymity were guaranteed. Clients participated on a voluntary basis as well. Before their consultation, they were informed about the purpose of the research, both orally and on paper, and were asked to participate. If they consented, they were asked again after the consultation. The interview did not focus on their personal medical situation, and confidentiality and anonymity were guaranteed. The program, including the data collection, was approved by the LHV (the Dutch association of general practitioners), the SGCR (the registration committee of social physicians), and Hobéon SKO (the certification organization for vocational experts).

**Results**

**Prevalence of Empathy and Clear Information among Healthcare Providers**

RQ1 focuses on the prevalence of both aspects of empathy and clear information in the consultations. Table 2 presents the descriptive results and the correlations between clients evaluations and providers’ corresponding estimations. In these analyses, the dyads between clients and providers formed the units and the 12 separate questions were used. Only complete dyads were included.

Both the scores on overall satisfaction and the scores on clarity of information appeared to be high. All average scores

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**Table 1. Items included in the research.**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topic 1: The client is taken seriously (6 items)</td>
<td>The provider took his/her time to talk to the client. The client felt that he/she was taken seriously by the provider. The client felt at ease during the consultation. The provider offered the client the chance to ask his/her questions. The most important aspects of the clients’ complaints have been discussed. Everything that is important to the clients has been addressed in the consultation.</td>
</tr>
<tr>
<td>Topic 2: The client is well-informed (4 items)</td>
<td>The provider used clear language. The provider drew clear conclusions. The provider gave clear information about his/her health assessment. The provider gave clear information about the follow-up after the consultation.</td>
</tr>
<tr>
<td>Topic 3: The client agrees with the healthcare provider’s conclusions (1 item)</td>
<td>The client agrees with the healthcare provider’s conclusions.</td>
</tr>
<tr>
<td>Topic 4: The client has a positive overall judgment about the provider (1 item)</td>
<td>The client has an overall positive judgment about the provider.</td>
</tr>
</tbody>
</table>
Regression analysis for overall client satisfaction.

Table 2. Relationship between clients’ evaluations and providers’ estimations.

<table>
<thead>
<tr>
<th></th>
<th>Clients’ evaluations</th>
<th>Providers’ estimations</th>
<th>Paired t-test results</th>
<th>Correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall satisfaction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time to talk</td>
<td>4.32 (.62)</td>
<td>3.98 (.53)</td>
<td>t = 18.285*, df = 1490</td>
<td>.19*</td>
</tr>
<tr>
<td>Taken seriously</td>
<td>4.30 (.74)</td>
<td>4.02 (.59)</td>
<td>t = 13.238*, df = 1485</td>
<td>.28*</td>
</tr>
<tr>
<td>Felt at ease</td>
<td>4.16 (.82)</td>
<td>3.80 (.66)</td>
<td>t = 15.041*, df = 1484</td>
<td>.22*</td>
</tr>
<tr>
<td>Asking questions</td>
<td>4.34 (.64)</td>
<td>3.99 (.52)</td>
<td>t = 17.828*, df = 1478</td>
<td>.15*</td>
</tr>
<tr>
<td>Complaints discussed</td>
<td>4.16 (.74)</td>
<td>3.91 (.57)</td>
<td>t = 11.950*, df = 1458</td>
<td>.28*</td>
</tr>
<tr>
<td>Everything addressed</td>
<td>4.14 (.77)</td>
<td>3.89 (.53)</td>
<td>t = 11.705*, df = 1475</td>
<td>.21*</td>
</tr>
<tr>
<td>Agree with assessment</td>
<td>3.84 (1.10)</td>
<td>3.71 (.83)</td>
<td>t = 4.524*, df = 1172</td>
<td>.51*</td>
</tr>
<tr>
<td>Overall judgment</td>
<td>4.26 (.68)</td>
<td>3.88 (.50)</td>
<td>t = 19.779*, df = 1471</td>
<td>.25*</td>
</tr>
<tr>
<td>Clarity of information</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear language</td>
<td>4.25 (.64)</td>
<td>3.86 (.58)</td>
<td>t = 18.968*, df = 1490</td>
<td>.15*</td>
</tr>
<tr>
<td>Clear conclusions</td>
<td>4.25 (.62)</td>
<td>4.00 (.54)</td>
<td>t = 11.963*, df = 1401</td>
<td>.12*</td>
</tr>
<tr>
<td>Clear health assessment</td>
<td>4.18 (.73)</td>
<td>3.76 (.64)</td>
<td>t = 15.550*, df = 1117</td>
<td>.13*</td>
</tr>
<tr>
<td>Clear follow-up</td>
<td>4.26 (.59)</td>
<td>4.02 (.54)</td>
<td>t = 12.030*, df = 1325</td>
<td>.14*</td>
</tr>
</tbody>
</table>

Measured on a five-point scale, 1 = negative, 5 = positive. * Significant p < .001.

Table 3. Regression analysis for overall client satisfaction.

<table>
<thead>
<tr>
<th>Predictors</th>
<th>Beta</th>
<th>t</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>−0.081</td>
<td>−0.843</td>
<td>p = .402</td>
</tr>
<tr>
<td>Age</td>
<td>−0.112</td>
<td>−1.146</td>
<td>p = .256</td>
</tr>
<tr>
<td>Educational background</td>
<td>−0.203</td>
<td>−2.282</td>
<td>p = .025</td>
</tr>
<tr>
<td>Empathy as an attitude</td>
<td>0.338</td>
<td>3.297</td>
<td>p = .002</td>
</tr>
<tr>
<td>Empathy as a skill</td>
<td>−0.205</td>
<td>−2.123</td>
<td>p = .037</td>
</tr>
<tr>
<td>Clarity of information</td>
<td>0.537</td>
<td>5.806</td>
<td>p = .000</td>
</tr>
</tbody>
</table>

Adjusted R² = .43, F (6,78) = 10.836, p < .001.

The regression analysis resulted in a model with a good fit, which explained 43% of the variance of the clients’ overall satisfaction with the consultations. Of the three background variables, only the educational background had a significant relation with overall satisfaction: Physicians received better scores than vocational experts. Gender and age appeared to be non-related. The three variables of interest all had a significant relationship with clients’ overall satisfaction. The strongest predictor was clarity of the information provided. If healthcare providers, according to the clients, were better able to give information that was clear to them, the clients’ overall satisfaction tended to be higher. But also the two empathic competencies had a significant relationship with clients’ overall satisfaction. If providers were more critical of their behaviors toward the clients, and thus showed more sensitivity to the clients’ perspective (empathy as an attitude), the clients’ overall satisfaction tended to be higher. And the same applied to the providers’ ability to estimate the clients’ experiences (empathy as a skill): If they were better able to estimate individual clients’ evaluations of the consultations, the clients’ overall satisfaction tended to be higher.

Relationship between Empathy and Clarity of Information

RQ3 involved a correlation analysis regarding both aspects of empathy and clarity of communication. Empathy as an attitude and empathy as a skill had a moderate correlation (.44), which indicates that they are related but different aspects. A moderate correlation was also found between empathy as an attitude and clarity of the information (.35). This confirms that empathy as an attitude may play a role in healthcare providers’ performance in giving clear information. However, the percentage of explained variance was rather low (12%). Contrary to our expectations, no significant correlation was found between empathy as a skill and clarity of information (.21).

Discussion

Main Findings of This Study

This study aimed at investigating the role of empathy and clarity of information in the context of work disability examinations. The results regarding RQ1 show that the healthcare providers in our study scored high on clarity of information and empathic attitude. They performed well in the eyes of the clients and empathic attitude. They performed well in the eyes of the clients who scored high on clarity of information. However, the percentage of explained variance was rather low (12%). Contrary to our expectations, no significant correlation was found between empathy as a skill and clarity of information (.21).
clients, and were generally more critical of their own performance than clients were. These high scores may be attributed to the specific context in which our research took place: as a follow-up of healthcare providers workshops focusing on empathy, which may have raised the attention to and awareness of clients’ experiences among the participating providers. Effects may be ascribed to self-selection of the healthcare providers and to a priming of the importance of empathy. However, the empathic skills appeared to be less developed: The correlations between the clients’ evaluations and the providers’ estimations were low. Empathy as a skill was not part of the training program prior to the data collection reported here. It may have been improved in the follow-up to the data collection (the third phase of the training program), when the healthcare providers were confronted with the fits and misfits in their estimations of client’s experiences, but this is beyond the scope of our study.

The results regarding RQ2 confirm that both aspects of empathy and clarity of information affect clients’ satisfaction with a consultation, and that empathic attitude, empathic skills, and clarity of information complement each other in their effects. In our study, we were able to focus on the internal representations of empathy by using a dyadic approach in which providers estimated the experiences of clients. As a consequence, we were able to measure healthcare providers’ empathy as an attitude and as a skill, apart from their competencies of communicating empathically. Our results show that these internal representations of empathy matter. It appears to be worthwhile to go beyond the shortcut of tips and tricks of communicating empathically, and invest in empathic attitudes and skills. Of course, this does not necessarily disqualify interventions primarily aimed at providers’ empathic communication behavior, such as those described by Benbassat and Baumal (2004), Bonvicini et al. (2009), Bylund and Makoul (2002, 2005), Coulehan et al. (2001), and Harres (1998). These interventions approach empathy as a learnable communicative skill, not focusing on the receptiveness of providers but on the way they express empathy. Benbassat and Baumal (2004), Coulehan et al. (2001), and Harres (1998), for instance, provide many shortcuts to enhance empathic communication with patients, ranging from general behaviors to the use of very specific sentences. Bylund and Makoul (2002, 2005) approach empathy as the matching of “empathic opportunities” with specific types of communicative behaviors in medical encounters. Bonvicini et al. (2009) describe the design of a communication training program, in which they predominantly focused on actively communicating empathy. Our results show that a focus on the development of empathic attitudes and skills may be a fruitful strategy as well, and raise the question which of the two strategies (learning to express empathy vs. learning to understand the client) will be most effective.

The results regarding RQ3 show that providing clear information to clients does not straightforwardly follow from an empathic attitude and empathic skills. A weak relation between empathy and clarity of information was found, only involving empathic attitude. This is not in line with insights about effective discourse, which suggest that empathizing with people helps to gear information to their specific needs (De Jong & Lentz, 2007; Schriver, 1997). A possible explanation involves the distinction between affective and cognitive empathy (Cox et al., 2012; Duan, 2000; Irving & Dickson, 2004; Kim et al., 2004). Providing clear information requires cognitive empathy, whereas estimating clients’ experiences may be more connected to affective empathy.

On a more general level, our research confirms that empathy and clarity of information matter in medical consultations. The large effects of clarity of information on clients’ satisfaction with the consultation call for more attention to this aspect in education and training. Earlier research showed that there are often problems with clarity of information in medical contexts (cf. Bagley et al., 2011; Chappuy et al., 2012; Debaty et al., 2015; Howard et al., 2013; Weatherspoon et al., 2015); our study shows that such problems may have a strong effect on clients’ experiences.

The relationship between healthcare providers’ empathy and clients’ satisfaction with a consultation corroborates results of several earlier studies (e.g., Blatt et al., 2010; Kim et al., 2004; Pollak et al., 2011), but in the different medical context of work disability examinations. In this context the relevance of empathy is not self-evident. The consultations were single and potentially discordant events. It is not realistic to assume that a trust relationship could be built between providers and clients; the healthcare providers were merely supposed to make independent estimations of the clients’ work disabilities. The clients’ threshold for adequate empathic behavior might be lower under such circumstances than in most other medical consultations. Nevertheless, empathy proved to be equally important in this setting.

It is also noteworthy that our results were found in a challenging context. All participating healthcare providers had taken part in a training program, were more than averagely interested in empathy and communication, and knew that their behaviors would be evaluated. Their inclination to empathize with clients might be stronger than in normal medical consultations. It seems reasonable to expect stronger effects of empathy and communication in other medical consultation contexts, with more variance in empathic behaviors among healthcare providers.

Limitations and Future Research

A limitation of our study involves the statistical properties of the questionnaire used. It was impossible to distinguish clients’ feelings of being taken seriously from more general feelings of being taken seriously from more general behaviors to the use of very specific sentences. Bylund and Makoul (2002, 2005) approach empathy as the matching of “empathic opportunities” with specific types of communicative behaviors in medical encounters. Bonvicini et al. (2009) describe the design of a communication training program, in which they predominantly focused on actively communicating empathy. Our results show that a focus on the development of empathic attitudes and skills may be a fruitful strategy as well, and raise the question which of the two strategies (learning to express empathy vs. learning to understand the client) will be most effective.

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Limitations and Future Research

A limitation of our study involves the statistical properties of the questionnaire used. It was impossible to distinguish clients’ feelings of being taken seriously from more general evaluations of the consultation. This underlines the central role of providers’ empathy in clients’ experiences. However, our findings could have been more informative if the distinction in evaluation aspects would have been possible. One way of doing so is by developing a multi-item construct of satisfaction with the consultation, focusing stronger on patient experiences and outcomes instead of their evaluation of the provider.

Another limitation is that only two aspects of empathy and one aspect of communication were included. A more systematic and exhaustive analysis of the concepts of empathy and communication is needed, as well as more empirical research into their differential and possibly complementary effects.
Future research should also focus on the question whether all aspects of empathy indeed originate from the same underlying construct, whether they are learnable to the same degree, and whether the strategies for improving healthcare providers’ empathic competencies, often involving role-reversal, feedback, and confrontation with patients’ experiences, are similar for all aspects.

**Practical Implications**

Our research has several implications for healthcare providers, medical training, and continuing education. The results confirm that empathy is an important aspect to be included in medical school, and that healthcare providers should be trained on their empathic and communicative competencies. They complement earlier research studies by drawing attention to the multifaceted nature of empathy. It appears to be beneficial for clients’ experiences when healthcare providers combine an empathic attitude, empathic skills, and communicative competencies. This requires training focusing on all three aspects.

A general distinction may be made between two routes of improving empathy. The first starts with empathy as communicative behavior: Training programs may focus on the communicative skills to show empathy with patients. The question here is whether such communicative skills eventually will result in more internalized forms of empathy. The second route starts with empathy as a mental predisposition comprising attitude and skills, for instance by role-reversal or exposure to people in the client or patient role. The question here is whether such internalized forms of empathy lead to empathic behaviors that are noticeable for patients and affect their experience. Both routes may lead to an enhanced empathy as experienced by clients or patients, and both routes appear to be important. The results of our study suggest that internalized forms of empathy indeed contribute to clients’ overall satisfaction with a consultation.

**References**


