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Research Article

Empathy (part I): contributions to a person-centered approach

Empatia (parte I): contribuições para a abordagem centrada na pessoa

Empatía (parte I): contribuciones a un enfoque centrado en la persona

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Abstract

Introduction: This article explores the theme of empathy in the doctor-patient relationship. **Objective:** To contribute to the improvement of clinical communication skills by reviewing the understanding and application of empathy in clinical practice. **Methods:** A non-systematic review of the main books used in clinical communication on the topic of empathy. The methodological approach consisted in the following steps: (1) An intentional sample of the literature; (2) Data collection and reading, i.e., extracting fragments from texts; (3) Content analysis, focusing on definition, importance and instrumentalization for practical application; (4) Selection and synthesis to facilitate understanding and contextualization on the topic; and (5) Comparison and ponderance of the selected content. **Results:** The scope within which empathy was worked on in the selected literature resulted in three levels of empathic density: low, moderate, and high. Thus, low empathic density was limited to definition and importance; moderate density incorporated some examples of how to apply empathy in a fragmented way; high empathic density addressed the topic more fully, facilitating instrumentation in clinical practice. There is agreement in the literature analyzed that the practice of empathy reflects on the improvement of medical care. However, its exercise remains in the rational field. By exemplifying the practical application of empathy, the authors suggest that the physician adopt a non-judgmental posture, while proposing an imaginative exercise of guessing the patient's feelings/emotions. Although high-density empathy authors understand the importance of emotions and name them in the process, there is a need for an unfolding and deepening from this point on. **Conclusions:** Empathy is a complex subject with several nuances and is approached in different ways in the selected literature. This evidences its richness and originality, at the same time that it presents gaps for the application of empathy in clinical practice.

Keywords: Empathy; Family practice; Physician-patient relations; Education, medical; Nonviolent communication.

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Resumo

Introdução: Este artigo explora o tema da empatia na relação médico-paciente. **Objetivo:** Contribuir para o aperfeiçoamento das habilidades de comunicação clínica ao revisar o entendimento e a aplicação da empatia na prática clínica. **Métodos:** Trata-se de uma revisão não sistemática dos principais livros utilizados na comunicação clínica sobre o tema da empatia. O recorte metodológico compreendeu as seguintes etapas: (1) amostra intencional da literatura; (2) coleta e leitura de dados – i.e., extração de fragmentos dos textos; (3) análise do conteúdo, com o foco na definição, importância e instrumentalização para a aplicação prática; (4) seleção e síntese, para facilitar a compreensão e a contextualização sobre o tema; e (5) comparação e ponderação do conteúdo selecionado. **Resultados:** A abrangência com que a empatia foi trabalhada na literatura selecionada resultou em três níveis de densidade empática: baixa, moderada e alta. Assim, a baixa densidade empática limitou-se mais à definição e importância do tema; a densidade moderada incorporou algum exemplo de como aplicar a empatia, porém de forma fragmentada; e a alta densidade empática abordou o tema de modo mais completo, facilitando a instrumentalização na prática clínica. Há concordância na literatura analisada de que a prática da empatia reflete-se na melhoria do cuidado médico, entretanto seu exercício permanece no campo racional. Ao exemplificar a aplicação prática da empatia, os autores sugerem que o médico adote uma postura isenta de julgamentos, ao mesmo tempo que propõem um exercício imaginativo, de adivinhação dos sentimentos/emoções do paciente. Apesar de os autores de alta densidade empática compreenderem a importância das emoções e nomeá-las no processo, percebe-se a necessidade de um desdobramento e aprofundamento a partir desse ponto. **Conclusões:** Por se tratar de um assunto complexo, com vários matizes, a empatia é abordada de diferentes formas na literatura selecionada. Isso evidencia sua riqueza e originalidade, ao mesmo tempo que apresenta lacunas para sua aplicação na prática clínica.

Palavras-chave: Empatia; Medicina de família e comunidade; Relações médico-paciente; Educação médica; Comunicação não violenta.

Resumen

Introducción: Este artículo explora el tema de la empatía en la relación médico-paciente. **Objetivo:** contribuir a la mejora de las habilidades de comunicación clínica mediante la revisión de la comprensión y aplicación de la empatía en la práctica clínica. **Método:** se trata de una revisión no sistemática de los principales libros utilizados en comunicación clínica sobre el tema de la empatía. El enfoque metodológico comprendió los siguientes pasos: (1) Una muestra intencional de la literatura; (2) Recopilación y lectura de datos, es decir, extracción de fragmentos de textos; (3) Análisis de contenido, centrándose en definición, importancia e instrumentalización para la aplicación práctica; (4) Selección y síntesis para facilitar la comprensión y contextualización sobre el tema; y (5) Comparación y ponderación del contenido seleccionado. **Resultados:** el alcance con el que se trabajó la empatía en la literatura seleccionada tuvo como resultado tres niveles de densidad empática: baja, moderada y alta. Así, la baja densidad empática se limitaba más a la definición y la importancia; densidad moderada, incorporó algún ejemplo de cómo aplicar la empatía, pero de manera fragmentada; alta densidad empática se acercó del tema de manera más completa, facilitando la instrumentación en la práctica clínica. Existe acuerdo en la literatura analizada en que la práctica de la empatía se refleja en la mejora de la atención médica. Sin embargo, su ejercicio queda en el campo racional. Al ejemplificar la aplicación práctica de la empatía, los autores sugieren que el médico adopte una postura no crítica, al tiempo que propone un ejercicio imaginativo de adivinar los sentimientos/emociones del paciente. Si bien los autores de alta densidad empática entienden la importancia de las emociones y las nombran en el proceso, existe la necesidad de un desdoblamiento y profundización a partir de este punto. **Conclusiones:** Por tratarse de un tema complejo y con varios matices, la empatía es abordada de diferentes maneras en la literatura seleccionada. Esto evidencia su riqueza y originalidad, al mismo tiempo que presenta vacíos para la aplicación de la empatía en la práctica clínica.

Palabras clave: Empatía; Medicina familiar y comunitaria; Relaciones médico-paciente; Educación médica; Comunicación no violenta.

INTRODUCTION

Family and community medicine (FCM) has as one of its main bases the doctor-patient relationship and its direct therapeutic action.[1] For this relationship to develop, it is essential that communication is effective. More than just an exchange of information, effective clinical communication is understood as an interaction, in which individual characteristics of both (doctor and patient) are relevant and the relationship between them enables acceptance, dialogue and mutual understanding.[2] The aim is, thus, a collaborative partnership between equals, favoring the active participation of the patient in their health care.[3]

Medical training still understands communication skills as secondary factors or characteristics of the doctor's personality, so much so that during medical graduation they are still little explored.[4] In this way, there is a risk of reproducing an ineffective model of medicine, in which doctor and patient adopt defensive

postures and create a relationship of distrust, moving away from the desired therapeutic relationship. According to Mahendran,[5] the communication skills of medical students who have not had specific training worsen as they progress through the course.

Many of the problems in medical practice can originate from miscommunication. For example, McWhinney (p. 38)[6] highlights that many errors in medicine are due to "carelessness, insensitivity, failure to listen [...] and failures in communication". Some consequences of the lack of these skills can result in unnecessary interventions, poor adherence to treatment, patient dissatisfaction and lawsuits against doctors[7,8] For example, a survey carried out in 2017 in the United Kingdom, which included more than 2,000 adults, revealed that 82% would probably not complain if their family doctor communicated openly and with empathy, and three of the top five reasons for making a complaint about their family doctor were related to poor communication and behavioral factors.[8] Therefore, valuing and improving clinical communication is an initiative to reduce such undesirable consequences.

The doctor-patient relationship was studied and analyzed in the 1950s by Michael Balint, a Hungarian doctor and psychoanalyst, who proposed a biographical approach or model of consultation.[9,10] To him, this relationship has a fundamental therapeutic function, by presenting the role of the doctor as a "drug".[11] In this process, the word has a main function that can lead to both beneficial and unfavorable effects.[12] At the heart of this approach is empathy, a fundamental element for the therapeutic process, as "*a sufferer is not healed by a person who keeps his distance*" (p. 115, authors' emphasis).[6]

This article explores the topic of empathy in clinical communication. First, a review of the topic was carried out in the main books used in FCM training in clinical communication. Subsequently, a synthesis of the results was constructed, which allowed an analysis of how empathy has been addressed in the selected references. Finally, a reflection is presented on how different authors have approached empathy in the doctor-patient relationship. In this way, we intend to contribute to the improvement of clinical communication skills by studying and reviewing the topic of empathy and its application in clinical practice.

METHODS

This is a non-systematic review that explores the theoretical bases and practical application of empathy. The literary sample was intentionally selected to contain the main books used to deepen clinical communication skills in FCM training programs. The titles and authors are described in the three tables in the results section. Books in digital format were used, as they enable a quick search for terms and definitions throughout the texts. The book "*Comunicação Clínica: aperfeiçoando os encontros em saúde*" (Clinical Communication: perfecting health encounters) is a recent publication in Portuguese, and its digitized version is not easily available.[2] Therefore, it was decided to use the index and the highlighted chapters on empathy as a search strategy for the theme in this book.

The methodological strategy developed was to use the root of the word empathy ("empat") through the quick search tool for digitized books, as it covers terms in both English and Portuguese. They are: *empathetic*, *empathically*, *empathize*, *empathy*, *empathic* and *empathizing*. This allowed us to explore how the authors of the selected books approached the topic. The first stage of the process involved reading and collecting data (i.e., extracting fragments from the texts). In the second stage, content analysis was carried out, based on three thematic axes: definition, importance and instrumentalization for practical application. The third stage consisted of reducing (selection and synthesis) the information

analyzed, to facilitate understanding and contextualization of the topic. The constant comparison and weighting of each selected content were part of the classification process carried out by the three researchers. The empirical material was classified into three categories of empathy density: low, moderate and high. The term "empathy density" was metaphorically coined by the authors with the purpose of conveying the scope and depth with which the topic was worked on in the selected literature in the three thematic axes: definition, importance and practical instrumentalization. Thus, low-density empathy was more limited to definition and importance; moderate-density empathy incorporated some examples of how to apply empathy, but in a loose way, not systematizing its instrumentalization. In high-density empathy, the three axes were presented more completely to better instrumentalize their application in clinical practice.

RESULTS

Low-density empathy

In this category, the authors conceptually mention empathy regarding its definition and importance in clinical practice, but without going deeper or demonstrating how to apply it in consultation. Ramos,[13] McWhinney and Freeman[6] bring definitions that are similar in an attempt to put oneself in the other's shoes. Stewart et al.,[4] in addition to understanding the other person's situation, add two factors to the definition: communicating such understanding and acting in that situation in a way that can help the person. Herrera Ornelas and Pico da Cruz[14] present empathy in three aspects, including moral, that is, the individual motivations of the professional to be empathetic towards others (Table 1).

Moderate-density empathy

References that deepen the definition/importance of empathy conceptually and provide some examples of how to apply it, although still superficially, were considered to be of moderate empathy density.

Carrió[15] is closer to the authors classified as low density in terms of the definition of the term and adds the view of empathy as an emotional state of the interviewer that allows detecting the emotions of the other. He states that through empathy it is possible to feel the pain of others, more through reason than through the heart. He highlights the importance of the professional maintaining a therapeutic distance from the patient that allows for more analytical and moderate decisions, such as, arguing a "no". The author demonstrates empathy through empathetic phrases exemplified in dialogues throughout the work (Table 2).

Neighbour[16] is also like previous authors regarding the definition of empathy and highlights its power, both in the doctor-patient relationship and in the consultation as a whole. For him, empathy is fundamental to achieving "connection", which he calls "the first 'checkpoint' of the consultation". The practical application of empathy involves what he calls "matching" with the patient (Table 2). He emphasizes the importance of noticing the patient's non-verbal cues to be able to perceive the "unsaid", since initially the patient is more vulnerable and may have greater difficulty exposing themselves. He suggests adjusting the doctor's behavior to resemble that of the patient, since the process of trying to achieve "matching" through this willingness to go towards the patient's way of thinking favors empathy to occur.

High-density empathy

References that deepen the definition and importance of empathy and present more concrete proposals for practical application were included in the high-density empathy category.

Table 1. Low-density empathy.

Reference	Definition	Importance	Practical application
Manual de Medicina de Família e Comunidade (McWhinney and Freeman)[6]	"Empathy is the capacity to enter into another person's experience. For the physician, it is the capacity to sense what it is like to be the patient to experience illness, disability, depression, and so on". (p. 143)	"To understand the illness at the higher psychological and social levels, the physician has to identify with the patient and loved ones through qualities of empathy and compassion". (p. 85) "Empathy is usually understood as the professional route for the understanding of emotions, he observes that bodily processes play a part in the transfer of emotions from person to person." (p. 143)	*Does not specify empathy in practice.*
Medicina centrada na pessoa: transformando o método clínico (Stewart et al.)[4]	"Empathy] has recently been defined cognitively and behaviorally as understanding a person's situation, communicating that understanding and acting on that situation in a way that helps the person". (p. 132)	For doctors, [empathic identification] is important because it favors an integrated understanding of the person. (p. 132-133; Figure 7.1)	*Does not specify empathy in practice.*
A Consulta em 7 Passos: execução e análise crítica de consultas em medicina geral e familiar (Ramos)[13]	"Imagine yourself in 'another's shoes'". (p. 20) "Empathy is the result of a tension between personal involvement and professional distance". (p. 24) "Show the patient how we try to understand what they feel." (p. 77)	"[Empathy], together with knowing how to smile, makes others feel welcome and shows us as available [doctors]". (p. 24)	*Does not specify empathy in practice.*
Comunicação clínica: aperfeiçoando os encontros em saúde Chapter 2 – Construção da relação (Herrera Ornelas and Pico da Cruz)[14]	"Cognitive possibility (the intellectual ability to understand the feelings of others), moral possibility (individual motivations of the professional) and emotional possibility (imagining emotions and feelings). Furthermore, as a genuine interest in understanding who the person is, what feelings are involved in that encounter and recognizing the needs of the other integrated as components of a therapeutic process". (p. 22)	"[brings] a behavioral component of the professional that [enables] both verbal and non-verbal communication about this empathetic construction of the relationship". (p. 22)	*Does not specify empathy in practice.*

Source: elaborated by the authors (2022).

Grosseman and Dohms[17] address empathy in more depth, citing definitions from various authors, but they are mainly based on the thinking of Carl Rogers. Regarding the practical application of empathy, they instrumentalize it more objectively, suggest reflections for the professional and present examples to assist in this process. They propose a basis for applying the empathic response (Table 3) and present,

Table 2. Moderate-density empathy.

Reference	Definition	Importance	Practical application
Entrevista Clínica: habilidades de comunicação para profissionais de saúde (Carrió)[15]	"Knowing how to put yourself in someone else's shoes". (p. 33) "Tunes into their patients' *deep emotions* as they surface". (p. 34) "*Empathy* is, first of all, an emotional state of the interviewer that allows them to detect emotions in their interlocutor". (p. 67)	[Through empathy, it is possible to demonstrate a] *personalized concern* for the patient. [...] doing this honestly is an important step towards building trust". (p. 54) "Empathy helps establish therapeutic alliance". (p. 194)	Brings the following examples in dialogues: "I understand how you feel". (p. 68; Table 2.6) "I understand", "That's very good", "I see you suffer", "I understand". (p. 85-86) "It's understandable that you have this fear". (p. 150) "I understand your situation". (p. 169) "The truth is that I understand you, it's really not pleasant…" (p. 173) "I suppose this situation is not comfortable for you, nor for me". (p. 178) "I understand your anxiety". (p. 190) "I put myself in your place". (p. 232)
The Inner Consultation: how to develop an effective and intuitive consulting style (Neighbour)[16]	"to enter briefly but completely into the patient's world; to imagine her pain, to sense the extent of her distress, to understand just what it is that frightens, bewilders and saddens her — in a word empathy". (p. 147)	"When you communicate as closely as that with a patient, the rapport that develops has a richness which fertilises the remainder of the consultation". (p. 82)	"Matching": adjust your own behavior to resemble that of the patient. Trying to talk, look or sound like the patient, motivated by a genuine concern to calm the patient. How to achieve "match"? Initially just be quiet, listen and watch, with as much attention as you can muster […] don't try to interpret […] When you get the chance, say one or two things that the patient will agree with. one or two things that the patient agrees with […] Listen for any speech predicates, imagery and metaphors in the patient's speech. Likewise, try and notice some of the patient's eye movement accessing cues […] patient's non-verbal minimal cues, nonjudgmentally […] looking at the eyes and facial expression, then at the rest of the body for the kinaesthetic cues, then listening to anything that strikes you about the patient's tone of voice. (p. 136-137) The act of trying to achieve a "match", of being willing to move towards the patient's way of thinking, has an effect on the doctor's own attitude that makes empathy and understanding easier to access.

Source: elaborated by the authors (2022).

separately, how to be empathetic in specific emotional situations, for example, those involving anger, fear and sadness.

Moulton[18] is similar to the authors analyzed so far in her definition of empathy and presents the importance of first recognizing the other's feelings and, subsequently, communicating them verbally and/or non-verbally. Regarding the practice of empathic response, the author systematizes it in three steps (Table 3) and demonstrates it with examples. Like Neighbour,[16] she highlights the importance of observing the patient's non-verbal language the doctor needs to be in tune with, as it strengthens the bond and makes communication more understandable.

Table 3. High-density empathy.

Reference	Definition	Importance	Practical application
Comunicação Clínica: aperfeiçoando os encontros em saúde Chapter 9 Comunicação com emoções fortes: resposta empática à raiva, ao medo e à tristeza no cuidado em saúde (Grosseman and Dohms)[17]	"A process, a way of being with another person, understanding them, entering their private perceptual world, 'being completely comfortable with it'. According to [Rogers], this involves 'being sensitive to the meanings of the feelings that flow through the other person, moment by moment, from fear and anger to tenderness and confusion'". (p. 103)	"An empathetic relationship tends to strengthen the bond and partnership with the patient and has therapeutic potential." (p. 101) "It contributes to personal and professional growth." (p. 101) "It enables [the person] to explore the meanings of their attitudes, constructively rescuing their internal resources for self-realization." (p. 103) "Conducive conditions are created for [the person] to listen to their own flow of internal experiences with more precision and [...] [enables] a reframing of concepts about themselves and their attitudes [...] they develop greater self-knowledge, which gives them greater confidence and ability to transform themselves in a constructive way. [...] [It promotes] greater freedom and autonomy to be the total person that they are internally, being able to express all the complexity of their being and, consequently, becoming more effective in promoting their own growth." (p. 104)	(p. 103-104) According to Rogers, it lists three essential elements: - authenticity: transparency of the professional as a person, open to feelings-attitudes; - acceptance: care-valuing the person as they are, legitimizing the patient's feelings, without judging; - empathic understanding: requires "active listening" to understand the patient's feelings and communicate this understanding. (p. 112) "Identify the emotions, name them for the patient, [or when the emotion is not clearly expressed, ask the patient. For example]": (p. 105) - "You seem to be (worried — or sad — or nervous)." - "Could you tell me how you are feeling emotionally right now?" (p. 112) Listen to them in a qualified way, legitimize the emotion expressed, without barriers or value judgments, apologize, thank them for sharing, support the patient, ask about their concerns, as well as demonstrating interest, respect and partnership. (p. 106-107) They present the acronym in English, PEARLS (Partnership, EMPATHY, Apology, Respect, Legitimization, Support) with the example: - Empathy: "you seem to be feeling…" "Non-verbal communication must be in tune with verbal communication, including eye contact, facial expression that demonstrates interest in the patient, soft tone of voice, pauses and calm rhythm of speech." (p. 112)

Continue...

Table 3. Continuation.

Reference	Definition	Importance	Practical application
The Naked Consultation: a practical guide to primary care consultation skills (Moulton)[18]	"Being able to identify where the feeling has come from; in other words, what has happened to the patient to have caused it". (p. 60) "Empathy is about recognising: a patient's feelings and acknowledging these with words or non-verbally or both". (p. 60) "Empathy: being in tune with the patient; stepping into their shoes and feeling what it's like for them". (p. 198)	"Empathy helps the patient to know that you have understood how they felt and why". (p. 58)	(p. 60-65) Three stages of empathic response: (1) Recognize and identify the emotion the patient is feeling: It may be clear in the behavior corresponding to the feeling (e.g., tearful); in the content of the speech ('- you don't know how afraid I've been'); non-verbal signs (facial expression, hesitation in speech due to 'ums' and 'ers', slowing down of speech). For feelings to appear in the consultation, some patients need permission, for example: - recognize the perceived feeling 'I can see how upset you are about this'; - report a similar case that happened to a supposed friend; - suggest possible feelings; - explicit permission ('it's okay to feel sad'); - softeners ('I wonder if you're feeling…'); - occasionally, the doctor shares their own feelings-experiences related to the case. (2) Be able to identify the origin of this feeling, what happened to the patient to have caused it. (3) Bring the two factors together and respond to the patient so they know you made that connection - Respond verbally and non-verbally and sometimes use silence, lean towards the patient, nod, touch the arm, smile. Examples of emphatic sentences: - "I can understand that this must be difficult for you" (p. 67); - "Like you, I'm self-employed and I know it can be hard to take time off to rest. But if you look after yourself next week, you will get better more quickly." (p. 95).
Skills for Communicating with Patients (Silverman et al.)[3]	(p. 137-138) Empathy: the essential building block for compassion [,,,with] three interdepende 1.	"Uses empathy to communicate understanding and appreciation of the patient's feelings or predicament; overtly acknowledges patient's views and feelings. [Important to develop rapport]". (p. 23)	"A first step in empathy is the internal motivation and commitment to understanding the patient's perspective". (p. 138) (p. 138-140) Empathy is a two-stage process: (1) the sensitive understanding and appreciation of another person's predicament or feelings; (2) the communication of that understanding back to the patient in a supportive way: - non-verbal empathetic communication: facial expression, touch, tone of voice, silence;

Continue...

Table 3. Continuation.

Reference	Definition	Importance	Practical application
	Cognitive empathy: "which is the capacity to understand others' perspectives, to see how others think about things and to know cognitively how they are feeling". 2. Emotional empathy: "which is the capacity to sense how the other person is reacting to feel with the other, to have an emotional connection". 3. Empathic concern: "This is the capacity not only to understand the other's predicament and to feel with them but also to spontaneously want to take action to help them". [Authors' emphasis]	"Empathy is a fundamental determinant of quality in medical care, enabling the clinician to fulfil key medical tasks more accurately and thereby leading to enhanced health outcomes". (p. 137) "Demonstrating empathy in this way overcomes the isolation of the individual in their illness and is strongly therapeutic in its own right. It also acts as a strong facilitative opening, enabling the patient to divulge more of their thoughts and concerns". (p. 138) "Providers may build stronger therapeutic relationships and achieve better health outcomes for their patients in moments of vulnerability". (p. 142)	- empathic statements: "Empathic statements are supportive comments that specifically link the 'I' of the doctor and the 'you' of the patient. They both name and appreciate the patient's affect or predicament". (p. 140) Examples: - "I can see that your husband's memory loss has been very difficult for you to cope with". - "I can appreciate how difficult it is for you to talk about this". - "I can sense how angry you have been feeling about your illness". - "I can see that you have been very upset by her behaviour". - "I can understand that it must be frightening for you to know the pain might keep coming back".

Source: elaborated by the authors (2022).

Silverman et al.[3] define empathy in three interdependent varieties: cognitive, emotional empathy and empathic concern. The authors synthesize and unify the previous definitions. Just as Stewart et al.,[4] they state that action to help others is part of the concept of empathy. Silverman et al.[3] present several studies to highlight the importance of empathy in clinical practice and conclude that it constitutes a fundamental determinant of the quality of medical care, influencing better health outcomes. They highlight that empathy, more than just a quality typical of an individual's personality, is a skill that can be developed and improved during medical training. In practical application, the authors organize it into two stages and exemplify it (Table 3).

DISCUSSION

Definition

Etymologically, the word empathy derives from Greek (*em* [in] + *pathos* [feelings]).[19] It can be deduced that it is an internal movement of connection with feelings in which there is an attunement with one's own shared humanity. In 2021, Tan et al.,[20] through a qualitative approach from *Grounded Theory*,

constructed the concept of empathy in its application to health professionals, medical/nursing students and patients. According to these authors, empathy involves an internal dimension (imaginative, affective and cognitive) associated with behavior that conveys genuine concern for others. Therefore, it requires good communication skills that promote a sense of connection, trust and relationships with others. In the present study we found similar reflections. For example, for some authors empathy remains more in the rational field or understanding what is happening to the other, as exemplified by Stewart et al.[4] Herrera Ornelas and Pico da Cruz[14] include a "moral" and/or motivation of the person to be empathetic. However, other authors suggest that the doctor adopt a non-judgmental stance, while at the same time proposing an imaginative exercise, of guessing the patient's feelings/emotions. For example, Moulton[18] suggests "recognizing the perceived feeling: '— I can understand that this must be difficult for you'" (p. 67). This stance can detract from the patient's protagonism in the consultation, since the naming of the feeling is made as a statement by the doctor, often with little or no space for the patient's confirmation/reflection. There are some lines of "understanding" that may even sound insensitive and superficial, as in the excerpt: "Like you, I'm self-employed and I know that it can be hard to take time off to rest" (p. 95).[18] Controversy too is seen in Carrió[15] who, at the same time as he highlights the importance of honesty in the exercise of empathy, says that "the small hypocrisy, or 'theatre', of declaring that we 'feel' someone else's pain when in fact we hardly feel it" (p. 68). However, most authors understand that empathy requires authenticity and/or lack of judgment in the relationship with the patient. For example, McWhinney and Freeman[6] see empathy as the ability to experience the feelings of another. Likewise, Grosseman and Dohms,[17] based on Carl Rogers, describe it as a dynamic process: "being sensitive to the meanings of the feelings that flow in the other person, moment by moment" (p. 103). In other words, empathy is essentially relational and fluid and allows the sharing of feelings experienced in the present moment. Therefore, expressions such as "knowing how to put yourself in someone else's shoes", "tuning in with emotions" and "entering briefly but completely into the patient's world" can be found in the authors studied. This corroborates findings by Tan et al.,[20] who question the common definition of clinical empathy as a cognitive process with emotional distance. Accordingly, Kerasidou et al.[21] clarify that, for an empathetic approach, a distinction must be established, not distance, between myself and the other, so as not to confuse the patient's feelings with those of the professional when sharing the other person's affections and perspectives.

Importance

All the above-mentioned authors agree that empathy is reflected in the improvement of health care. According to Chen,[22] the sense of humanity, technical competence and patient participation in decision-making are important elements for good health care. Additionally, sensitivity to feelings and the way in which relationships with others are established are as appreciated as scientific knowledge. Howick et al.[23] summarized the topic in the literature, highlighting that consultations with empathy improved patients' pain, anxiety and satisfaction rates. Furthermore, empathy can lead to greater satisfaction, confidence and better adherence to treatment, as well as improved emotional health and resolution of symptoms.[21]

According to McWhinney and Freeman,[6] empathy favors the understanding of illness at higher levels of being in its psychological and social aspects or, as stated by Stewart et al.,[4] an integrated understanding of the person. It also allows for improved verbal and non-verbal communication. Based on Ramos[13] and Silverman et al.,[3] it is possible to be available through empathy, which acts as a facilitating opening for the patient to share more information about themselves; that is, it is an important tool for welcoming the patient.

Most authors highlight the role of empathy as a therapeutic tool in building and strengthening the doctor-patient relationship. Carrió[15] believes that empathy is at the center of individualized care, i.e., in the "personalized concern" that favors the bond in the therapeutic relationship, fertilizing the consultation in Neighbour's view.[13] For Grosseman and Dohms,[17] empathy also contributes to the development of the professional by stimulating personal growth, self-realization and resignification of themselves and their attitudes, and can stimulate self-knowledge and autonomy by making them look at their own feelings and express them openly. Thus, the benefits of an empathetic approach also extend to healthcare professionals by protecting them from distress and burnout and helping them build better communication bonds with patients.[21]

Practical instrumentalization

According to Neighbour,[16] empathy is essential to establish a "connection" with the patient. The suggested technique is "matching" (mirroring): "adjusting your own behavior to resemble that of the patient". To achieve this, it is essential to pay attention to the non-verbal communication expressed by the patient and that carried out by the professional themselves. The author advises adjusting to "the patient's way of thinking" to favor "matching"; however, the book lacks clear examples of how to develop this technique.

For Hashim (p. 32),[24] empathy can be expressed verbally or through non-verbal gestures, such as respectful silence and/or touch, when culturally appropriate. This author suggests five skills: 1. naming ("*It seems like you are feeling...*"); 2. understanding ("*I can understand how that might upset you...*"); 3. respecting ("*I am impressed by how well you handled this...*"); 4. supporting ("*I want to help in any way I can...*"); and 5. exploring ("*Tell me more about what you were feeling when you were sick.*").[24] This author shows close proximity to Grosseman and Dohms[17] since the focus of the empathic approach is on identifying emotions and verbalizing your impression to the patient or asking them by expressing it in the following ways: "You seem to be (worried/sad/nervous)." Or: "Could you tell me how you are feeling emotionally right now?" These authors also rely on the acronym PEARLS (*Partnership*, *Empathy*, *Apology*, *Respect*, *Legitimation*, *Support*), summarized in the following three steps: a. identify emotions; b. name, check and validate emotions; and c. intention to help (valuing the patient, apologies — if necessary — respect, support and partnership). They illustrate the application of the technique in specific emotional situations, which involve, for example, anger, fear and sadness. Grosseman and Dohms[17] walk in the footsteps of Carl Rogers in the identification, emotion naming and checking stages, but they distance themselves from empathy in the third stage, by bringing value judgments (such as apologizing) and by reinforcing emotional images for which third parties are responsible for your emotions/sufferings. The example presented by Grosseman and Dohms (p. 108)[17] illustrates this distance from empathy: in the first stage there is an attempt to point out the emotion — "It seems to me that you are angry", but then the professional places themselves as the source of this emotion: "Did I do something that offended or upset you?" This reinforces an image of the enemy by validating that the feelings originate "externally" to the patient, in this case, provoked by the professional's act, what Rosemberg calls alienating communication.[25] The tendency is for this to stimulate judgmental and prejudiced thinking, based on right and/or wrong, causing disconnection with the present moment.

Moulton[18] is similar in some ways to Grosseman and Dohms,[17] in recognizing feelings, suggesting possible feelings and/or telling the patient that it is "okay to feel" this or that way; as well as by exploring with the patient the origin of this feeling and providing feedback by communicating understanding of their feelings verbally ("I can understand that this must be difficult for you" — p. 67) and non-verbally (silence,

leaning in direction to the patient, etc.). However, Moulton[18] does not provide examples as practical and illustrative as Grosseman and Dohms.[17]

According to Silverman et al.,[3] empathy requires commitment and motivation to understand another's situation or feeling in a sensitive way, and then communicate your perceptions verbally and non-verbally. However, the authors suggest naming and/or appreciating the patient's affection or situation by speaking in the first-person ("I"), as exemplified as follows: "*I can see that your husband's memory loss has been very difficult for you to cope with*" or "*I can appreciate how difficult it is for you to talk about this*." (p. 140) Thus, Silverman et al.[3] tend to emphasize the professional's opinion ("I") to the detriment of the patient's, distancing themselves from the proposal of Grosseman and Dohms[17] and Moulton,[18] who focus on the feeling of the other (patient) without directly including themselves in the dialogue. The focus must therefore be on the patient, on their emotional experience and on this vital flow that allows reflection on their own feelings. This can generate insights and help in the therapeutic process.

Coulehan et al. (p. 223)[19] emphasize the importance of identifying and calibrating emotions for an effective empathetic approach. They exemplify some feelings: 1. sadness: "*That must have been a very painful experience for you, it sound like it was very sad*"; 2. fear: "*Sounds like you were really frightened when you discovered that lump*"; 3. anger: "*That situation really got to you, didn't it? I can imagine how angry I'd feel if that happened to me*"; 4. distrust: "*It seems like you're not sure if you should trust me further after I didn't get that test result back to you last week*"; 5. ambivalence: "*It seems to me that you're caught in a bind about whether to stop smoking or not*". However, example 4 can alienate the origin of the patient's feelings by reinforcing the professional's role in the genesis of the feeling of distrust, reinforcing the enemy image, as previously explained.[25]

In practice, "emotional understanding" should be tested by checking with the patient's understanding of the situation. This way, your accuracy is improved through iteration, for example: "Let me see if I understand this correctly" or "I want to make sure I understand what you mean." This provides the patient with opportunities to correct or modulate the health care professional's formulation. At the same time, it expresses the health professional's desire to listen deeply, thus reinforcing a bond or connection in the relationship. [19] As Shanmugam states (p. 1):[26]

> *"We can sometimes underestimate the validation and comfort that showing compassion can provide. Clinical medicine has limits and boundaries, whereas empathy and kindness do not. Making a conscious effort to create an occasional pause so that I can understand how a patient is feeling, and to sit with them through those feelings, has often brought me a renewed sense of satisfaction".*

Coulehan et al.,[19] however, warn that once an empathic connection is established, doctors often become anxious about what to do next and launch immediate efforts to reassure. It is effective to slow this effort by allowing a pause of several seconds. A good rule of thumb might be "don't just do something stand there". During the pause with total presence, the patient experiences being understood, which in itself has therapeutic value.

CONCLUSION

The theme of empathy has been worked brilliantly in the FCM literature. There is a general understanding of its importance for greater consultation effectiveness, both in creating bonds and

strengthening the doctor-patient relationship and in improving health outcomes. The authors studied explored various elements of empathy, as well as ways of applying it in a more systematic way. However, patients' experiences and life contexts are sometimes so distant from the health professional's reality that empathy — defined by different authors as an attempt to empathize with or experience the other's feelings — becomes even more complex. Thus, to contribute to the deepening of the topic, we produced a second article based on another theoretical-practical framework to strengthen the empathic approach in the clinical encounter, titled: "Empathy (part II): contributions of non-violent communication for clinical practice".

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CONFLICT OF INTERESTS

Nothing to declare.

AUTHORS' CONTRIBUTIONS

BYU: Conceptualization, Writing – original draft, Data curation, AHN: Conceptualization, Writing – review & editing, Methodology. TAM: Data curation, Writing – review & editing.

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