Cultivating emergency physician behavioral empathy to improve emergency department care for pain and prescription opioid misuse

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Abstract
Clinical empathy is the ability to understand the patient's experience, communicate that understanding, and act on it. There is evidence that patient and physician benefits are associated with more empathic communications. These include higher patient and physician satisfaction, improved quality of life, and decreased professional burnout for physicians, as well as increased patient compliance with care plans. Empathy appears to decline during medical school, residency training, and early professional emergency medicine practice; however, brief training has the potential to improve behavioral measures of empathy. Improvements in emergency department physician empathy seems especially important in managing patients at elevated risk for opioid-related harm.

We describe our conceptual approach to identifying and designing a practice improvement curriculum aimed to cultivate and improve behavioral empathy among practicing emergency physicians. Emergent themes from our preliminary study of interviews, focus groups, and workshops were identified and analyzed for feasibility, sensitivity to change, and potential impact. A conceptual intervention will address the following key categories: patient stigmatization, identification of problematic pain-subtypes, empathetic communication skills, interactions with family and friends, and techniques to manage inappropriate patient requests. The primary outcomes will be the changes in behavioral empathy associated with training. An assessment battery was chosen to measure physician psychosocial beliefs, attitudes and behavior, communication skills, and burnout magnitude. Additional outcomes will include opioid prescribing practice, naloxone prescribing, and referrals to addiction treatment. A pilot study will allow an
1 | INTRODUCTION

Pain is among the most common complaint presenting to the emergency department (ED) where emergency physicians serve on the frontlines of care for those with both acute and chronic pain conditions. This has always been difficult: patients often report dissatisfaction with the lack of attention to their informational and psychosocial needs, whereas physicians are often dissatisfied by the mismatch between their professional competencies and patient needs, including expectations for pain relief. In the current epidemic of prescription opioid-related harm, physicians face additional challenges: in addition to relieving distress associated with painful conditions, they also must limit opioid-related harm. In this challenging context, patients are at risk for stigmatization, as well as over- and under-treatment. High-quality ED pain management is more likely when patient–physician interactions are characterized by empathy, trust, and patient-centered communication. The purpose of this article is to describe our concept for empathic approaches to pain patients. In addition, we propose a web-based practice improvement intervention to enhance the tools and techniques necessary to identify and respond to empathic opportunities in caring for this patient population.

Despite evidence of benefits to training, scant data are available for emergency physicians, although several studies examining ED patient communications have emerged in the past few years. This literature explores opioid prescription practices for ED super-users, pain clinic referral patterns for patients at risk for opioid-related harm, and protocols mandating the use of prescription drug monitoring program. There is evidence for significant reduction in ED visits and prescription of opioids associated with implementation of a prescription drug monitoring program. In another study of the impact of family and friends presence, patients with a high school education or less benefited from the presence of a close friend or family member, with a concomitant positive influence on clinician–patient communications. However, efforts to enhance emergency physician empathic communication among pain patients has received little study.

To promote physician–patient empathic interactions, and enhance patient-centered communication in the ED, we present and describe a curriculum to enhance behavioral, observable measures of empathy, the Emergency Medicine Physician Advances in The Healing of Patients (EMPATH) project. It is an extension of a recent educational curriculum, EMPainline, the first practice improvement activity addressing ED opioid prescribing practice to be approved by the American Board of Emergency Medicine (ABEM) in satisfaction of ABEM recertification requirements. EMPATH also is patterned on the Studying Communication in Oncologist-Patient Encounters (SCOPE) trial, which demonstrated that a 1-hour program to foster oncologists’ empathy-related skills improved both physician empathy and patient trust.

A core EMPATH principle is that empathy is not just a stable trait that a physician brings to the experience of caregiving, but that it is constituted of elements that can be specifically targeted and enhanced. Empathy has 3 elements: affective, behavioral, and cognitive. Affect refers to the ability to sense a patient’s emotional state, behavior refers to the ability to communicate, and cognitive refers to the ability to see the world from the patient’s point of view. Although we will be measuring cognitive and affective elements of physician empathy, our primary goal is to influence the behavioral and/or communicative components of empathy. In operationalizing the concept of behavioral empathy, we concentrate on ways to approach the clinical encounter so as to reduce the likelihood of stigmatization, on sensitizing the physician to common dysfunctional responses to pain, and on behavioral indicators of empathic engagement, including patient-centered communications, verbal statements of patient support, as well as nonverbal cues (eye contact, body posture, gestures).

2 | RATIONALE

Patients with pain usually express their emotions (typically negative) with statements that allow the physician an opportunity to respond with empathy. These negative emotions may be expressed directly and spontaneously; however, the discerning physician needs to be aware and sensitive to clues indicating these underlying emotions. Physicians with inadequate communication skills may allow these clues and even direct expression of emotions to pass without acknowledgment, potentially depriving them of important clinical information. Negative stereotypes and stigma often are triggered when patient with chronic or recurring pain present to the ED with one of the common features that led to ED visit (ie, high levels of severity, lack of convincing medical evidence, comorbid psychological distress). Empathic responses to patients are less likely when patients are stigmatized. Under those conditions, physicians (especially those that are less empathic) are more likely to blame patients for coping poorly with their clinical conditions and may be less likely to partner with them. Hence, it is important for physicians to prepare for a clinical encounter in a
manner that reduces the likelihood of negative stereotyping, while also sensitizing them to common dysfunctional patterns.

Another important aspect of empathy is effective communication to specific pain–patient subtypes that may be perceived by physicians as particularly challenging. These subtypes include patients with high fear-avoidance beliefs, catastrophizing ideation, mood disorders, and those presenting with evidence of chemical coping and opioid-related aberrant behaviors.23 Such communication skill sets to be used in these challenging patient–physician encounters are seen as situation-specific indicators of empathy and deserve special attention in the context of an ED encounter.24

More generally, a good quality improvement training in behavioral empathy would provide techniques to enhance physician skills in recognizing and acknowledging patients’ underlying emotional states and promoting empathic responses. When physicians communicate an understanding of emotions and respond effectively to them, they can increase patients’ perceptions of physician empathy and enhance trust.2,3 In our proposed EMPATH curriculum, encompassed scenarios encourage emergency physicians take advantage of empathic opportunities by recognizing cues indicative of negative emotions, such as fear, anger, grief, and disappointment, and responding to them using scripted statements. The NURSE acronym (Name the emotion, Understand the emotion, Respect the patient, Support the patient, and Explore the emotion) was used to categorize these responses.21 Examples of such cases are illustrated through physician-patient encounter scenarios, allowing learners to practice identifying and responding to challenging patients with guidance provided by content experts (Table 1). In recognizing and responding to these opportunities, physicians can make the patient feel heard and understood, resulting in a more satisfying clinical experience for both patient and physician. Ideally, improvements in empathic patient interactions also will positively contribute to a potential decrease in stress and burnout measures in emergency physicians.

3 | CONCEPTUAL INTERVENTION

When dealing with pain patients in the ED, our preliminary study identified unmet needs through the series of focus groups of emergency physicians, nurses, patients, and an online survey among American Chronic Pain Association members. Themes and subthemes identified through the series of focus groups, and are illustrated in Figure 1. Those themes were selected for emphasis in a proposed educational curriculum, they include “empathy,” “stigmatization,” “burden of care,” shared decision making,” “communication skills,” “physician expectations,” “coping skills,” and “family and friends.” Curriculum methods and assessment measures were further revised through pilot educational workshops and feedback from practicing physicians who reported their views of curriculum feasibility and acceptability.

Based on previous empathy studies, experts’ and colleagues’ feedback, it was found that a 1.5-hour curriculum with videos and content of vignettes illustrating behavioral empathy and responses to empathic opportunities will enhance behavioral empathy among emergency physicians when dealing with pain patients. Five different modules are planned national dissemination. These modules include adequate mental preparation for patients encounters to avoid stigmatization, recognition of pathological pain subtypes (eg, catastrophizing, chemical coping, depression), verbal and non-verbal communication skills (eg, body posture, eye contact, standing vs sitting), dealing with family and friends, and techniques for managing inappropriate patient requests for opioids (Table 1). Pre- and post-intervention assessment instruments have been selected to evaluate the impact of the curriculum among physician participants. Previously validated instruments will be used to assess a wide range of behavioral changes and outcomes in participating physicians (Table 2). In combination with the educational materials, an evidence-based curriculum will be advanced.

4 | OUTCOME MEASURES

Outcomes of interest in empathic approach to pain patients in the ED are not limited to physicians; benefits to patients and institutional reputation are also considered. Physicians’ empathy in patient care and burnout, opioid prescribing behavior and psychosocial beliefs towards
pain patients, as well as communication skills with patients, are measured. Patients’ perception of empathy and satisfaction with the emergency physician interaction, participation in shared decision making, in addition to their experience with the care they received in the ED, are also measured. An assessment battery of validated measures is implemented to detect changes in these outcomes.

Outcomes anticipated with such intervention including potential decrease in the perceived burden of care that emergency physicians experience in managing pain patients, with resultant improvements in physician quality of life and decreased professional burnout, are measured by the EMPATH curriculum. It is also expected that the patient’s perception of enhanced behavioral empathy on the part of the physician will reduce patient stigmatization, improve satisfaction with care, and enhance compliance with treatment recommendations, including the prescription of non-opioid analgesics, instructions regarding safe opioid storage and disposal, naloxone prescribing, as well as referrals to pain and addiction specialists when appropriate. A number of validated instruments are available to assess patient- and physician-reported aspects of physician empathy and potential changes in important outcomes that may be related to enhancements in empathic skills. General satisfaction with ED care can be measured through the Medicare & Medicaid Services Emergency Department

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**FIGURE 1** Themes and subthemes identified from empathy focus groups

| Major Themes and Subthemes (total mentions) with illustrative quotes: |
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| **Provider Competencies (86)** |
| Patient: “Surprisingly, they were quite understanding and sympathetic.” “I have been made to feel that I am not really in pain, that I am a drug-seeker, and have been shamed for requesting pain relief.” |
| Provider: “I think if you look at kind of how we’re used as a resource where we are experts in difficult conversations.” “The more we can do to help people cope with that and address that in more constructive ways I think would be the bigger solution to this problem.” |
| **Clinical Environment (55)** |
| Patient: “Staff was very professional just overworked.” |
| Provider: “The obvious problem in general is resource - mental health is obviously a resource that is already challenging to get into and then when you add on a sub-specialty of addiction, then all of a sudden your resources become even more than it did. So how do you refer to an already overloaded system? That’s tough.” “The ER is very social. It’s a social gathering place.” |
| **Diagnosis (55)** |
| Patient: “Pain relief is just a band aid. What is causing the pain?” |
| Provider: “A lot of patients come in with expectation that they need some sort of imaging on their back, whether that’s a CT or MRI or something else. As holders of the resources, per say, how do you convey that to them: your concerns, your lack of concern in a meaningful way.” |
| **Treatment (47)** |
| Patient: “Sometimes all you need is a break from ALL pain even for just a little while so you can get your mind ready for the return (of pain).” |
| Provider: “I don’t know that giving patients narcotics drives patient satisfaction rates.” “Probably I don’t do enough of ... things ... like integrative medicine.” |
The idea that cognitive and emotional aspects of empathy may evolve over time in response to training. By fostering superior empathy-related skills and practice patterns (perhaps in a form of muscle memory), physician self-perceptions of empathy may improve, creating a virtuous cycle. Previous research suggests that those constructs are at least important covariates likely to influence learners’ responses to the EMPATH curriculum. If these constructs prove responsive to training, it is likely that empathic behaviors will be resistant to decay.

In the light of opioid epidemic, the concept of cultivating behavioral empathy in emergency physician and enhancing patient-centered communication becomes important to improve the quality of care for patients with chronic pain who are at risk for opioid use harm. Improvement in the care for this patient population has been reported quantitatively. Whereas, the EMPATH curriculum tends to improve the quality of ED decision making, prevent stigmatization of patients, and improve outcomes for those with chronic pain and their caregivers by promoting physician–patient interactions and patient self-efficacy.

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**CONFLICT OF INTEREST**

The authors declare no conflict of interest.

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