ABSTRACT

Background

Despite a plethora of research on empathy and its associated constructs, there is little evidence exploring clinicians’ perceptions of their empathy and its impact on service level outcomes.

Methods

The aim of this single centre mixed methods study was to investigate nurses’ and therapists’ empathy levels and explore their views regarding its impact on clinical decision making at a national specialist orthopaedic centre. Data were collected from 126 respondents using an online validated empathy scale (Jefferson scale) supplemented by interviews with a convenience sample of 20 respondents. Questionnaire data were analysed using descriptive and inferential statistics. Qualitative interview data were subjected to a standard process of inductive thematic analysis prior to seeking relationships between the two datasets.

Results

There was a statistically significant difference in empathy levels between nurses and therapists (*p*=0.031), with nurses scoring lower than therapists. Interview findings identified four key themes; displaying empathy, therapeutic use of self, influences and impacts, and learning. Differences between empathy scores and participants’ subjective accounts of empathy were apparent.

Conclusion

Empathy is an important construct built upon personal and professional experiences. Previous research reports empathy as a positive tool, however, our data suggest that its inappropriate use might also have a negative impact on service delivery and health outcomes.

INTRODUCTION

Empathy is a complex concept that can be defined as “*a predominantly cognitive (rather than emotional) attribute that involves an understanding (rather than feeling) of experiences, concerns and perspectives of the patient, combined with a capacity to communicate this understanding*” (Hojat, 2007; Hojat, 2016). Although there is overlap with compassion, empathy is a broader concept that is seen as more relevant and useful for clinical practice (Jeffrey, 2016).

Sternke et al. (2016) argue that empathic interactions help create a respectful, trusting relationship that enable healthcare staff to see the world from a patient's point of view and that facilitate shared decision making. However, kindness motivated by empathy may also have negative effects (Bloom 2016). Focus group discussions conducted during a local service evaluation support this view, finding empathy to have unintended negative impacts on discharge decisions i.e. granting patients’ wishes to remain in hospital longer than necessary to please and appear more caring. This paper aims to further our understanding of clinicians’ perceptions of empathy and its impacts and provide new insights to support improved healthcare delivery outcomes and patient experience.

BACKGROUND

A large number of primary research studies and systematic reviews have investigated the impact of empathy on patients’ experience and health outcomes from the patients’ perspective (for example, Beck et al., 2002; Derkson et al., 2013; Harun et al., 2017; Howick et al., 2018; Lelorain et al., 2012; Smith et al., 2016; Steinhausen et al.,2014). Patients view empathy as a positive construct and report that a clinician's ability understand them and to express this understanding is key to a successful therapeutic relationship (Shattell et al., 2007). A systematic review by Beck et al. (2002) found that empathy, reassurance and support were positively associated with improved patient reported health outcomes and Smith et al. (2016) demonstrated that clinician empathy during discharge reduced potential litigation. A systematic review and meta-analysis (*n*=28 trials) by Howick et al. (2018) concluded that greater practitioner empathy has small patient benefits for a range of clinical conditions, especially pain and anxiety.

Self-reported empathy levels have been assessed in a range of undergraduate health care students, including nurses, doctors, physiotherapists and occupational therapists around the world (Brown et al., 2010; Petrucci et al., 2016; Sulzer et al., 2016; Yucel and Acar, 2016; Ferreira-Valente et al., 2017). There are, however, few studies reporting qualified health care professionals’ empathy levels, or their perceptions of its impacts on them as individuals or on their patients. Brady et al. (2015) did assess self-reported empathy in doctors working in Ireland, with findings suggesting that participants had a high degree of empathy. However, the impact of empathy levels on clinical decisions and actions was not explored.

Studies to date predominantly focus on the impact of empathy from a patient perspective. Whilst this is important, outside of its recognised negative effects on caregivers, such as burnout and fatigue (Duarte & Pinto-Gouveia, 2017; Wilkinson et al., 2017; Williams et al., 2017), little attention has been given to the perspectives of qualified healthcare staff.

The aim of this single centre mixed methods study was to investigate nurses’ and therapists’ empathy levels and explore their views regarding its impact on clinical decision making. Objectives were to:

* *Assess self-reported levels of empathy*
* *Explore clinicians’ views of how empathy is actioned during healthcare delivery*
* *Identify and explore differences between healthcare professionals*

METHODS

Data were collected at a national specialist orthopaedic hospital. Based in London, England, this is the largest orthopaedic NHS trust in the United Kingdom (UK) providing a comprehensive range of neuro-musculoskeletal health care for both adults and children across two sites. The study received approval from the NHS Health Research Authority (ref 249452) and the hospital’s research and development department.

Sample and recruitment

We invited all qualified nurses (*n*=373) and therapists (*n*=115) employed by the organisation to complete a questionnaire. To further explore participants’ views, all questionnaire respondents were also offered an invite to be interviewed. Twenty people (10 nurses and 10 therapists) volunteered to take part in an interview. All but three therapists were female, but no other demographic details were collected specifically from the sample of interviewees.

Following formal approvals, all potential participants were sent an internal email containing a study information sheet, a link to an online questionnaire and an invite to additionally take part in an interview. Return of a completed questionnaire was taken as consent, with further written consent obtained from all those who agreed to be interviewed.

Data collection

We used an online version of the Jefferson Scale of Empathy (Physician/Health Professions (HP - version) (Hojat et al., 2001) questionnaire to collect empathy data. The Jefferson scale is a validated tool designed to assess qualified health professionals self-reported perceptions of empathy (Hojat et al., 2001). Each of the 20 questions is scored from 1 (strongly disagree) to 7 (strongly agree). Thus, total scores can range between 20 and 140, with higher scores reflecting a greater level of empathy.

To qualitatively explore clinicians’ perceptions of empathy and its impact on their clinical activities, face-to-face semi-structured interviews lasting 30-60 minutes took place. Interviews with the therapists were conducted by the nursing members of the research team and vice versa. All interviews were audio recorded and took place on hospital premises within working hours using an agreed question format. Questions focused on interviewees’ views about what empathy is, what influences it and its impacts on clinical care.

Data analysis

We analysed the questionnaire data using descriptive and inferential statistics. We compared categorical datasets using chi square and interval level data using an independent sample t- test and Pearson’s correlation. Statistical significance was set at *p*< 0.05. Qualitative interview data were subjected to a standard process of inductive thematic analysis (Braun & Clarke, 2006), selecting representative quotes from the nurses (N) and therapists (T). In a final step, we sought relationships between the two datasets.

RESULTS

One hundred and twenty six staff completed the questionnaire (see Table 1), 61 (48%) nurses, 44 (35%) physiotherapists and 21 (17%) occupational therapists (OTs). The majority of respondents were female (*n*=110, 87%), reflecting the local and national workforce. Most respondents were under 50 years (n=99, 79%), however the nursing sample were older than the therapists (Figure 1).

**Figure 1: Age groups of respondents**

Whilst 26 (21%) of the sample had less than five years clinical experience, the majority (*n*= 52, 41%) had been qualified for more than 15 years, particularly those from the nursing profession (Figure 2).

**Figure 2: Clinical experience of respondents**

Respondents worked across a range of adult and paediatric specialities including spinal cord injury, rehabilitation and pain management, critical care, joint and spinal surgery, inpatients, outpatients and pre-admission, oncology, theatre and recovery, private patients, research, infection prevention and control, tissue viability, rheumatology, foot, ankle, amputation and shoulder services.

Empathy scores

Total Jefferson scores for individual respondents ranged from 73-137 (mean 113.8). There was a statistically significant difference between nurses and therapists scores (*p*=0.031) with nurses scoring lower (73-137, mean 111.8) than therapists (97-130, mean 115.9). There were also statistically significant differences between nurses and therapists in a number of individual domains of the Jefferson scale (Table 1). With the exception of question 9, “*I try to imagine myself in my patients' shoes when providing care to them*”, therapists scored higher than nurses in all these domains.

**Table 1: Statistically significant differences in responses between nurses and therapists**

Increasing age was associated with a lower empathy score in the nurse sample, whereas the opposite was true for therapists. However, these differences were not statistically significantly different and based on low numbers for some groups (*n*=6 nurses vs *n*=21 therapists aged 20-30 years; *n*= 4 therapists aged over 50 years vs *n*=20 nurses).

In terms of personal ill health experience, of 123 respondents, the mean rating was 3 (range 1-10). Sixty two respondents (49%) agreed that personal experience impacted the degree of empathy they display to their patients and free text responses, predominantly provided by OTs, further support this view (Figure 3). Most described this impact positively; however, as explained by one OT participant:  *“My personal experiences do not relate in any way to that of what my patients experience so I'm not sure how much my levels of empathy is affected by that”*.

**Figure 3: The impact of personal ill health on degree of empathy towards patients**

Despite a suggested association between personal ill health experience and empathy, no statistically significant differences between those with and without personal ill health experience, either for the whole sample or by subgroup was identified. Furthermore, there were no statistically significant associations for any other demographic variable.

Interview findings

Qualitative data analysis revealed four key themes; displaying empathy, therapeutic use of self, influences and impacts, and learning (Table 2).

**Table 2: Themes and their associated codes**

Displaying empathy

There was a collective view that empathy is about understanding an experience and that it is different from sympathy. For example, one participant said *“if you can empathise with the patient, you can understand what they are going through…But I think with sympathy that’s where you feel sorry for them”* (N2). Participants described examples of displaying empathy saying “*it’s important to go and speak to patients and you know…sometimes it’s just a, a different cup of coffee… or, you know, allowing the dog to come in and say hello when you have been in hospital for 6 months you know, all, it’s just little things*” (N8). People also used empathetic phrases, often combined with non-verbal body language, for example, one participant said, *“I might nod and I might say something like ‘that sounds really difficult, that sounds really challenging”* (T2).Many also used phrases such as “*putting yourself in another person’s shoes”* and “*being able to imagine yourself in someone else’s situation*” (N3). Participants also discussed how empathy meant developing an understanding of the whole person, physically, mentally and emotionally. As one participant explained *“nobody is just a knee are they?*” (T5).

Many participants saw displaying empathy as part of their job, saying for example, *“I see it as a really routine part of my job, I don’t see empathy as something separate”* (T2). However, the sincerity of empathy was also questioned. For example, one nurse participant said *“… you don’t always feel that they [doctors] mean it… empathy is not just empty words”* (N6). Another also questioned the sincerity of some colleagues saying, *“I guess that it can be a smile, it can be a good morning, but if that doesn’t fall natural to you, then, you know, do we say that that person is less empathetic?”* (N8).

Therapeutic use of self

Participants discussed how they used empathy to facilitate a therapeutic relationship. As one nurse participant said “*I would say a consultation has gone well when I’ve been empathetic…consultations that have gone badly, I know it’s because I haven’t shown empathy*” (N3). This therapeutic use of self was illustrated by one participant who said “*we’re dealing with all walks of life… so you have to be a slightly different person for your patient… therapeutic use of self, to, to get the most for your patient*” (T9). Participants described how building a rapport enabled a therapeutic relationship that made patients “*more likely to trust the advice that you’re giving them and… that therapeutic relationship… that can often help them to open up”* (T1). Participants pointed out that those who lacked empathy “*might struggle to have the same rapport with a patient in comparison to someone who is very empathetic*” (T10) and that this might affect their ability to provide optimal care. Another described using empathy to avoid escalation of a situation: *“…I didn’t do anything I just listened and we sat and chatted about things…*” (N5).

Participants explained that practitioners’ use of empathy differed, depending on the situation. For example, one participant noted that “*the longer stay patients umm, who I know are having bigger operations, wrongly or rightly, are the ones I’m going to build more of a rapport with*” (T7). Another suggested that it was particularly important “*with the more emotive patients, for example the children with sarcoma*” (T4). The need to adapt empathy was illustrated by one participant who said “*everybody is different...I think everyone… should have the same quality of service, but it’s not THE same service. It can’t be the same...patients require different levels of empathy and I suppose as healthcare professionals we need to try adapt to that as best as possible*” (T9).

Participants also described a tension between too much versus not enough empathy and the impact that this can have on clinical care. Participants suggested that some patients actually want a more directive approach. One participant suggested that “*maybe it’s not that important to look at those things, for someone who has come out of a total knee replacement, you know...sometimes we’re too caring and understanding*” (T5). Another participant described the pros and cons of empathy saying “*Being too empathetic sometimes doesn’t help the individual. Being too firm doesn’t help. But actually, it’s this perpetual continuum between the two and trying to find the right pitch at the right time. Umm, it’s a dance isn’t it?*” (T9).

Influences and impacts

A wide range of factors were described as influencing empathy. Many participants felt that personal experience of ill health helped and described how sharing their own experiences could be beneficial. For example, one participant said “*I can say things about depression, which comes from a place of, you know, personal experience and I don’t feel that’s fake, I feel that’s you know, that’s real*” (T6). In contrast, participants described difficulties empathising with people who had conditions they had not experienced. As one participant explained “*I certainly struggle with patients with mental health because maybe that hasn’t actually been something that I’ve been though*” (T5).

Professional background was considered to have an impact on empathy. Participants described how “*we certainly implement different levels of empathy…and that’s possibly you know, clearly down our own umm, development through our profession and sort of personal values…we all clearly have a very different approach*” (T8). In addition, as one participant explained*“…life experience helps so much, especially within a caring environment”* (N10). However, others pointed out that after you see pain and disability for a number of years, you can become accustomed to it and one participant said, *“I don’t feel empathetic so much anymore… now it takes a lot more for me to actually feel emotionally empathetic”* (T2).

Personal characteristics, culture and religion (of both practitioners and patients) were perceived to influence peoples’ expression of empathy. One participant said “*I have worked with colleagues…they can come across as a little bit blunt, or…uncaring*” (N6). Personality clashes were also described, for example, one participant said if a patient is *“not getting what they want…you might come across a bit of a clash of personalities and then it’s hard to empathise”* (N3). A therapy participant also noted that “*…some people you can relate to more than others and your empathy can change”* (T9), whilst a nurse participant further explained that “*some people seem to be able to have empathy straight away”* (N5).

Participants revealed feelings of burnout, linked to working life and stresses, which hindered their ability to empathise with patients. One participant explained *“it can be tricky on the ward when you know you are working full time, shift after shift to always engage those feelings*” (N4). Another participant highlighted the impact of outside stressors and feelings that day on empathy levels and the delivery of care to patients, saying *“they might come into work, they might be physically present, but they don’t always have capacity to show empathy to their patients because they might be overwhelmed themselves”* (T6). Participants also described the need for self-preservation saying, “*you have to sometimes learn when to take a step back and say, be at a professional distance…leave it behind rather than taking it with you and getting upset about the situation*” (N2).

A lack of time was by far the biggest expressed barrier to empathy. One participant illustrated the point saying: *“it’s very hard to think about being empathetic and understanding to people… we are all rushing around trying to do obs or whatever it may be for that particular task and we get bogged down with that, rather than taking the minute to just think about, think about it”* (T9). Time constraints were related to multiple factors, including the working environment and staffing. One participant noted that *“…I think with the pressures at the minute I think probably levels of empathy…levels probably have dropped because of the staffing pressures, financial pressures and the workload”* (N6). This view was supported by therapy participants who said: *“I can see how busy and stressed the nurses are on the wards, just like nation-wide there is that big staff shortages now”* (T3). Processes such as paperwork also impacted on the time to listen. For example, one participant said *“where I know that my expectation is that I’ve got to discharge them in half an hour and do their notes and potentially do a referral. So at that time then empathy might then not be my top priority”* (T7).

The final influencing factors identified by participants were uniform and technology. Participants explained that “*patients can be different, treat me differently because of my uniform (navy blue) than they might maybe a junior staff nurse*” (N4), which subsequently affects empathy. Participants also highlighted that technology can negatively impact empathy because: *“you can’t look the person in the face”* (N8).

Learning

Participants expressed a view that empathy is *“not something you can learn from a book,”* (N10) describing it as a *“sort of a character trait almost”* (T10). Participants suggested that more empathetic people naturally go into healthcare professions and that upbringing also contributes, as expressed by one participant who said, *“my dad’s a doctor and my mum’s a physio, and I think growing up around them, they would, I think kind of almost instilled in me the fact that I am kind of, wanting to be empathetic towards patients and people”* (T3).

In contrast, some participants discussed the importance of teaching others how to deliver empathy, pointing out that it does not necessarily come naturally. Participants identified the need for training both at university and in practice. As one participant pointed out it *“would be nice to have the outcome of how everybody else perceives it [empathy]. But also how it can be implemented within the Trust…Especially for the junior staff, new members that come to us, letting them know… that it’s still important to have that empathy”* (N10).

Team working was deemed vital to displaying collective empathy. The use of reflection as a form of self-development was also suggested. For example, one participant said *“I think it’s being aware of your own feelings… so you can become a better therapist”* (T6). Participants also described the role of the department in role modelling empathy. As pointed out by one participant *“the environment that you are, your colleagues, your team…if it’s positive, it actually makes you even look at things in a very positive and want to do more for people”* (N9). One participant highlighted, however, that departmental influences can also be negative saying: *“I think it probably was the empathy that was missing...the patient calls in the middle of the night, wants something, and they’re met with a sharp/cold response”* (N3). Participants further discussed how empathy can be learnt from other professionals saying, “*Working with psychology, working with occupational therapists here, has erm has 100% changed what I thought empathy was*” (T5). Another participant said *“I will speak to a colleague about a patient and they will bring up something I didn’t know. And then that will change my view on a particular patient or their situation and how I work”* (N2).

The display of empathy was seen as a communication skill, which could be improved with practice. For example, one participant said: “*I think you can empathise with them by how you say it…it's how you say it to them*" (N10). The importance of learning to listen to patients’ concerns and stories was particularly important for the nursing participants, one of whom said: *“sometimes just being able to listen, you don’t have to do anything”* (N9).

**Discussion**

The aim of this study was to investigate nurses’ and therapists’ empathy levels and explore their views regarding its impact on clinical decision making.

Our findings provide a somewhat contradictory picture. Whilst our quantitative data suggest that nurses have lower levels of empathy than therapists, our qualitative interview data suggest the opposite, with nurse participants perceiving themselves to be in a better position to develop a rapport*.* Despite differences between professional groups, empathy scores were high for the whole sample, results supported by our qualitative data, highlighting empathy as an important part of being a health professional and a key facilitator of the therapeutic patient relationship necessary to help people achieve their treatment and rehabilitation goals*.*

The reasons for different levels of empathy were multifactorial. Our quantitative results suggest that age and personal ill health experience may both have an impact. Interestingly, younger nurses seem more empathic than older nurses, whereas older therapists seem more empathic than younger ones. Our qualitative data support this contradictory viewpoint, with some participants believing that clinical experience, which comes with age, helps people put themselves in patients’ shoes and others suggesting that you can become accustomed to pain and suffering over time*.* The need for self-preservation was also linked to age and experience, with older professionals often better at not becoming emotionally engulfed in patients’ problems. Our findings further suggest that feelings of burnout, linked to working life and stresses are likely to hinder a healthcare professional’s ability to empathise with patients.

Previous research suggests that empathy helps healthcare staff see the world from a patient’s point of view, to ‘walk in another person’s shoes’ (Sternke et al., 2016). This was echoed in our study. However, what empathic interactions look like according to Sternke et al. (2016) differs to our participants’ descriptions. Our nurses and therapists put more emphasis on the therapeutic use of self and use of empathetic phrases/body language, as opposed to empathic listening and action.

Previous studies using the Jefferson scale to assess self-reported empathy in doctors (Brady et al., 2015) suggest that medical staff have a good degree of empathy, which is greatest in those with personal experience of illness. This outcome was also reflected in our study. However, in contrast to most previous studies, our study focused on the perspectives of clinicians rather than patients. Nevertheless, our findings support the wider literature (Beck et al., 2002; Derkson et al., 2013; Lelorain et al., 2012; Smith et al., 2016; Harun et al., 2017; Steinhausen et al.,2014), which highlights the importance of empathy in facilitating a therapeutic relationship, which in turn likely improves patients’ engagement and outcomes (Howick et al., 2018).

Our findings suggest that there may be times when empathy can be overused. Whilst empathy was generally viewed as a positive concept, our qualitative data suggest that inappropriate use of empathy can have a potentially negative impact on service delivery and health outcomes. For example, tensions between displaying too much versus not enough empathy and the risks of becoming emotionally engulfed in patients’ problems. Whilst these negative effects of empathy have not been uncovered before, Bloom (2016) holds a view that kindness motivated by empathy can have bad effects. In addition, previous research does highlight its link to burnout and fatigue in caregivers (Wilkinson et al., 2017; Williams et al., 2017; Duarte & Pinto-Gouveia., 2017).

Conclusion

This study investigated nurses’ and therapists’ empathy levels and their views regarding its impact on clinical decision making. There were clear differences between practitioners’ subjective descriptions of their empathy and the objective data reported by the Jefferson Scale. Furthermore, whilst empathy is reported in the literature as a positive tool, our qualitative data suggest that its inappropriate use has the potential to negatively impact health outcomes and patient experience.

This single site study only explored empathy from the healthcare professionals’ perspective, thus the views of the service users (i.e. patients) remain unknown. Some of the differences between nurses and therapists may also have been affected by low numbers. Our study is, however, the first to explore the impact of different levels of nurses’ and therapists’ empathy on actual decisions and actions in practice.

Future research should seek to validate our findings and explore the extent to which any professional differences in empathy levels matter within a multidisciplinary working environment. Future studies should also attempt to link the nurses’ and therapists’ perspectives with patients’ views about how clinicians’ empathy levels impact their recovery and clinical outcomes.

Finally, our data highlight the importance of an organisation’s attention to staff well-being, particularly during a time of significant resource strain. They also highlight the role of the clinical team in role modelling the effective use of empathy and the importance of using reflection to learn from self and others.

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