Research Article
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Clinical empathy and patients' rights in geriatric care: analysis of the perception of physicians and elderly patients

Abstract

The research object of this study is to analyze articulations between clinical empathy and patients' rights and to propose a set of supporting foundations to build a theoretical basis for the formulation of an aspect of Clinical Bioethics, based on clinical empathy and patients' rights. The research was carried out involving 5 geriatricians and 4 elderly patients. Geriatric care is permeated by a series of challenges related to the biopsychosocial process of aging, which causes cognitive, emotional, and physical vulnerabilities in elderly patients, which is combined with problematic issues concerning ageism. Thus, elderly patients, in addition to the weaknesses experienced by patients in general, have specificities that make them fear placing themselves in an equal relationship with the physician, by asking questions, inquiring about risks, and bringing their perspective into the decision-making process.

Keywords: clinical empathy, patients' rights, elderly care, elderly patients

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Aline Albuquerque, Nelma Melgaço, Isis Cunha

Research Group on Clinical Empathy of the Observatory of Patients' Rights of the Postgraduate Program in Bioethics at the University of Brasília, Brazil

Correspondence: Nelma Melgaço, Research Group on Clinical Empathy of the Observatory of Patients' Rights of the Postgraduate Program in Bioethics at the University of Brasília, Brazil, Tel 619321-7819, Email nelmamomelgac@gmail.com

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Introduction

World population aging has been accelerating[1] since life expectancy has been increasing over the last few years. Therefore, as a demographic process, aging has impacts in several areas and, among them, unimaginable challenges for health systems. According to data from the World Health Organization (WHO), by 2050, 80% of older people will be in middle- and low-income countries, and, between 2015 and 2050, the proportion of the world population over 60 will increase from 12% to 22%.[1] Despite data and evidence that population aging will require new distributional and social arrangements, geriatric care still is not a priority in many countries. Therefore, a significant number of elderly patients do not have specific public policies that guarantee dignity, integrity, and self-determination in the context of their care. The health conditions of the elderly are mainly related to the aging process, and these include hearing loss, cataracts, neck and back pain, chronic obstructive pulmonary disease, diabetes, osteoarthritis, depression, and dementia, among other diseases. As you age, it is likelier that more than one of these conditions will occur simultaneously, that is, multimorbidity is part of the aging process. Thus, the emergence of complex health conditions becomes more common. These conditions are called geriatric syndromes and are associated with multiple underlying factors, including urinary incontinence, falls, delirium, frailty, and pressure ulcers[1]. In addition, the elderly tend to have a prevalence of chronic diseases, physical disabilities, mental disorders, and other comorbidities.[2]

As can be seen, older people need more intense interaction with health services due to their conditions, and this creates a significant connection with health professionals. Thus, health systems must prepare to meet the specific needs of elderly patients and ensure their rights. For this reason, new institutional designs need to be drawn, and beliefs and values must be revised to build care centered on elderly patients, which is today one of the most urgent priorities of health systems.[3] This process requires ethical reflections on geriatric care since this reconfiguration of health systems involves not only managerial issues but, notably, changes in the behaviors of health professionals about elderly patients. Research shows that elderly patients are associated with deterioration of mental functions, which negatively affects their relationship with health professionals and their participation in the decision-making process about their care. Commonly, elderly patients are considered ineligible to receive information, even without an assessment of their decision-making capacity, and family members are depositaries of this information. In the sphere of health care, research shows that ageism manifests itself in poor quality treatments, lack of attention and even restricted access to resources.[4]

As pointed out, ethical issues related to the care of elderly patients are part of the theoretical arsenal yet to be systematized to think about a new configuration of geriatric care. Clinical Bioethics, as a field of knowledge that deals with the ethical issues that emerge from health care, is one of the contributions to be applied in such a context, "and should be incorporated into geriatric care to develop high-quality care".[5] In fact, Clinical Bioethics presents a series of theoretical aspects, and it has its hegemonic line called Principialism Theory. This study, in the wake of the research developed by Albuquerque within the scope of the Patients' Rights Observatory of the Graduate Program in Bioethics of the University of Brasília,[6] focuses on the development of theoretical contributions to the elaboration of an aspect of Clinical Bioethics based on clinical empathy and patients' rights. Specifically, regarding the rights of elderly patients, it should be noted that Cunha, and Paranhos, a researcher at the Observatory,[7] developed research on the subject,[8] which was used by the research team to formulate the reflections that motivated this study.

It has been observed that the systematic use of the proposal of clinical empathy significantly affects geriatric care. Clinical empathy consists of health professionals being able to understand the elderly patient's mental state, needs, and situation. Particularly in the case of Nursing, empathy is a key factor in high-quality geriatric care.[9] A study has shown that the empathy of nurses is a vital ingredient in the provision of quality care for hospitalized people with dementia.[9] Another study showed that strategies to increase the empathy and moral sensitivity of nurses, and education focused on geriatric nursing care, help improve attitudes related to care for elderly patients.[10] Another study has pointed out that educational programs to increase empathy towards elderly patients, who are in long-term

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care in hospitals, should be adopted to improve nursing practices in this context.[11] Similarly, research has shown that nursing empathy can improve the rehabilitation and adherence to treatment of patients who have suffered a cerebral infarction.[12]

Empathy is an essential part of quality care for elderly patients.[13] Indeed, according to Smith, empathy is integral to communication with the elderly, since it is an essential factor for patient-centered care, as it implies the health professionals' effort to understand the elderly's perspective and emotions and, at the same time, communicate this understanding to them.[14] The elderly value the health professional's attentive listening, which includes moments of uninterrupted listening and guidance offering.[15] Thus, empathy in the context of geriatric care is an important ethical aspect that contributes to the quality of nursing practice.[16] Endorsing this assertion, the literature on the subject states that health professionals who have a higher level of empathy in their interaction with elderly patients achieve better quality of care and greater patient satisfaction.[17] Another aspect to be considered concerns the relationship between ageism and empathy. This is considered an important component in coping with this prejudice since empathy is negatively associated with ageism, that is, the more empathy, the less propensity to adopt behaviors that express ageism.[13]

The research object of this study is to analyze articulations between clinical empathy and patients' rights and to propose a set of supporting foundations to build a theoretical basis for the formulation of an aspect of Clinical Bioethics, based on clinical empathy and patients' rights. These foundations would be sourced not only from existing studies, but also from the perception of doctors and patients about the role of clinical empathy in promoting patients' rights, particularly the right to informed consent, the right to be informed, and the right to participate in decision-making. Thus, we seek to contribute to the insertion of clinical empathy as an ethical dimension of Clinical Bioethics. Interviews with this audience were studied to analyze the perception of geriatricians and elderly patients regarding the role of clinical empathy in the realization of patients' rights. The formulations presented below focus on theoretical contributions that give consistency to a new aspect of Clinical Bioethics, as already pointed out, based on clinical empathy and the rights of elderly patients.

Methods

Ethical aspects related to research participants. This study was approved by the Research Ethics Committee of the University Centre of Brasília. Before the interviews, the researchers explained the content of the Informed Consent Form, which was signed by the participants. The anonymity of the participants is assured, and they are referred to as Doctor 1, Doctor 2, etc., and Patient 1, Patient 2 to Patient 4. The inclusion criteria for the research were: to be a legally capable adult; the physicians, to be geriatricians or experienced in geriatric care; and the patients, to be over 60 years of age. The interviews with the physicians were conducted on the days and times as follows: August 21 (8:32 am); August 28 (6:20 pm); August 31 (10 am); August 28 (5 pm); and September 14 (11 am). The interviews with the patients were conducted on the days and times as follows: August 27 (4:21 pm); August 25 (9:49 am); and August 24 (9 pm).

Research type

This research is descriptive-exploratory, with a qualitative approach. It was conducted and structured according to the Standards for Reporting Qualitative Research, which consists of 21 items to report qualitative research, preserving its flexibility to accommodate various paradigms, approaches, and methods.[18] This study is part of the research developed by the Research Group on Clinical Empathy of the Patients' Rights Observatory of the Graduate Program in Bioethics of the University of Brasília.

Survey participants and invitation strategy

The research was carried out involving 5 geriatricians and 4 elderly patients. The physicians and patients participating in the study were invited to the snowball sampling, understood as: "The type of sampling named as snowball is a non-probabilistic sample form, which uses reference chains. That is, from this specific type of sampling it is not possible to determine the probability of selection of each participant in the research, but it is useful to study certain groups that are difficult to access."[19] Thus, to start, key participants, named as seeds, are used to locate other participants with the required profile for the research, within the general population. "This happens because an initial probabilistic sample is impossible or impractical, and thus the seeds help the researcher to initiate their contacts and to approach the group to be researched".[19]

Conducting and analyzing interviews

The semi-structured interview technique was used. About semi-structured interviews, these are understood as an enunciative device, that is, "the interview is not a mere tool for appropriating knowledge, but rather represents a device for producing/capturing texts, that is, a device that allows resuming/condensing various situations of enunciation that occurred in previous moments."[20] The purpose of the interviews is to access content that the participants have already formulated in previous interactions, even because they are doctors and patients, "but whose access by the researcher would be extremely difficult, since they would need to accompany the referred actor in all their interactions, for a more or less extensive period, waiting for the desired topic to be addressed at some point, etc."[20]

Thus, the choice of doctors and patients is justified because the subject matter of the interviews is familiar to them, given that it deals with the health care of patients and the doctor's empathy in such a context. In this sense, it is pointed out that "only those who already 'know' something about a given topic are interviewed (that is, who is able – or who has been able – to produce text(s) about what they want to know)."[20] Specifically, about the choices of doctor participants, this is because interactions between patients and physicians are more common when compared to nurses and patients. Thus, to facilitate access to the previous formulations of the patient participants, only doctor participants were chosen. However, it is understood that the reflections extracted from the interviews can be applied to other health professionals, keeping their specificities.

The semi-structured interview was conducted through previously formulated questions about the definition of an empathetic physician, the importance of physician empathy to achieve more positive results in health care, how physician empathy helps the patient to a) better understand their treatment; b) be involved in decisions about their care; and c) decide whether to consent to a certain treatment or procedure. The questions were similar for both groups of participants since the intention was to reflect on the same research object, which is the interface between clinical empathy and patients' rights. The environment in which the research was carried out. The interviews were carried out using the Zoom Platform by the main researchers, between July and August 2023, after a prior contract and scheduling of convenient time for the participants.

Analysis of interviews

The interviews were analyzed based on Minayo's theoretical formulation of thematic analysis, which is based on the following steps: pre-analysis; material exploration, and result treatment and interpretation.[21] Thematic analysis implies the articulation of the theme that is linked to a statement about a certain content, encompassing a bundle of relationships that can be expressed graphically in a word, phrase, or abstract 21. Thus, first, the transcribed interviews were read to become familiar with their content. Then, the following steps were adopted regarding the transcribed interviews: (a) identification of the nuclei of meaning of each question to guide the exploration of the material to detect excerpts from which contents would emerge close to said nuclei; (b) analysis of these excerpts and their nuclei of meaning; (c) establishment of correlations between the nuclei of meaning that emerged from the excerpts of the material and those identified in the questions; (d) analysis of the nuclei of meaning of the material to build comprehensive themes; (e) reconfiguration of data excerpts referring to the nuclei of meaning based on the identified themes; (f) unfolding of the themes into contents to enable their articulation with the theoretical formulations that underlie their analysis.

Thus, based on the steps above, five thematic categories emerged, namely: (a) definition of clinical empathy; (b) benefits of clinical empathy for the patient; (b) clinical empathy and the right to information; (c) clinical empathy and the right to participate in decision-making; and (d) clinical empathy and the right to informed consent. The results were analyzed in the light of the clinical empathy theoretical foundation. According to the concept of clinical empathy adopted in this project, we opted for the formulations of Howick[23] and Halpern[22] because both adopt multidimensional conceptions of clinical empathy, which include its emotional component. As for the interfaces with patients' rights, there are few studies on the subject, especially when it comes to the context of geriatric care, which leads to the exploratory character of this research. About the concept of clinical empathy, it should be noted that Mercer and Reynolds[24] proposed its definition as a form of professional interaction that encompasses skills and competencies. Howick and Rees[25] structure the concept of clinical empathy based on three components: (a) understanding the patient's situation, feelings, and perspectives, recognizing the difficulties of putting oneself in the patient's shoes; (b) communicating this understanding, checking its accuracy; (c) acting according to this understanding to help the patient. To this end, studies on the subject indicate that health professionals must have the following behaviors as guides of empathic care: (a) adopt sufficient time to understand the patient's story; (b) talk about general issues; (c) offer encouragement; (d) give verbal signals that the patient is being understood (hmm, ah, etc.); (e) be physically engaged (by adopting certain postures, gestures, eye contact, appropriate touch and others); (f) be welcoming throughout the entire consultation.[25] Therefore, there is a consensus in the specialized literature on the theme that clinical empathy consists of three components: (a) understanding; (b) demonstration of this understanding; and (c) therapeutic action based on understanding after verifying its accuracy.[26] The professional's understanding goes back to the social, physical, and mental needs of the patient, as well as their perspective, especially regarding the patient's worldview. The demonstration of understanding implies the professional's ability to share with the patient what they have learned. A professional who understands what is happening to the patient, but does not communicate it, is seen as non-empathic.

When it comes to the interface between clinical empathy and patients' rights, few studies on empathy and human rights are found. The formulations of Rorty,[27] Hunt,[28] Von Harbou,[29] and Phongpetra[30] on the subject stand out. Although not the object of this paper, it is emphasized that traditional human rights theories ignored the role of emotions, altruism, and human nature.[29] On the other hand, others argued that empathy would be sufficient, disregarding the rights. However, as advocated by Hunt, it is not about replacing claims with rights with claims for empathy, the central issue is to make the demands for rights make sense in societies in which they did not exist, that is, how to change hearts and minds.

Regarding the rights of patients and their articulation with clinical empathy, it should be noted that empathy is a human trait conditioned to various obstacles, of a personal and environmental nature, so respecting patients' rights, which constitute the ethical minimum in health care, cannot be completely subject to the professionals' empathy. In addition, empathy, as an individual capacity, does not have the same ethical function as patients' rights, which consist of a set of rules, the result of socially constructed consensus on how patients should be treated. Therefore, patients' rights are an indispensable tool so that clinical empathy not only plays a utilitarian ethical role, increasing the well-being of the patient and the professional but can also be a predictor of appropriate ethical behaviors from the patient's perspective.

Regarding the rights of elderly patients addressed in this research, three were chosen: the right to participate in decision-making; the right to informed consent; and the right to information.[31] We started from these rights to investigate the links between clinical empathy and patients' rights, based on the theoretical formulation that clinical empathy, in addition to the benefits and its role in specific approaches in health care, has the role of contributing to the realization of patients' rights in everyday clinical practice. Studies on the correlations between clinical empathy and patients' rights are scarce. This scarcity can be attributed to the fact that the theoretical construction around such rights is still incipient and that clinical empathy is an unknown topic to researchers in Law. However, some research is highlighted, for example, one that states that empathy, spiritual intelligence, and nursing responsibility can improve the nurses' attitudes toward patients' rights.[32]

Results

The participants of this study correspond to a total of 5 geriatricians and 4 elderly patients. About the phase of treatment of the results obtained and their interpretation, five thematic categories that emerged from the material obtained from the interviews with the research participants were surveyed and classified. The categories are as follows: (a) definition of clinical empathy; (b) benefits of clinical empathy for the patient; (c) clinical empathy and the right to information; (d) clinical empathy and the right to participate in decision-making; and(e) clinical empathy and the right to informed consent. Each category will be explained and exemplified by the extracts from the participants' responses. The participants' responses will be presented separately, that is, doctor participants and patient participants, since their analysis took place separately and were compared later.

Category 1 – Definition of clinical empathy

This category deals with the components of the clinical empathy concept, understanding it as the ability of physicians to resonate emotions and to consider the perspective of patients, to understand their needs and their condition, that is, clinical empathy is present when the physician "can listen to and understand the patient. He tries to understand what is going on with the patient, without judgments" (Doctor 4).

Category 2 – Benefits of clinical empathy for the patient

This category addresses the positive healthcare impacts that clinical empathy presents to patients. For example, for doctor participants, clinical empathy has repercussions on treatment adherence: "It's just that when you explain it right. It's what the person needs to do, why they must do it... it's ... there is a good doctor-patient relationship, so the conversation flows, the person opens up...I see that these patients follow the treatment better" (Doctor 3). As for the benefits extracted from patients' responses, it is noteworthy what Patient 3 said: "the importance in the relationship between patient and doctor is the trust that the doctor has to pass on to the patient".

Category 3 – Clinical empathy and the right to information

This category deals with the connections between clinical empathy and the patient's right to be informed, which includes not only the right to receive information about the diagnosis, treatment, exams, and procedures that are accessible and based on scientific evidence but also the right to be heard, the right to ask questions and the right to be guided, promoting the patients' understanding and engagement. In this sense, Doctor 5 pointed out that clinical empathy provokes in the patient a feeling of "freedom to bring about their questions, take away some of that fear, so I think it's the horizontal equity in health care" ... "we will show to the patient that their whole life history is important and not only the clinical condition, the diagnoses they may have"... "so that they feel more comfortable to bring up complaints, to answer questions". Patient 3 pointed out that "because it is not because he is a doctor that he does not have to give information to the patient. Then it becomes a combination of trust between the two parties" ... "the doctor gradually discovers your medical history, and the history facilitates the trust between doctor and patient".

Category 4 – Clinical empathy and the right to participate in decision-making

This category refers to the implications of clinical empathy on the patient's right to make decisions. The right to participate is combined with the construction of a doctor-patient partnership, which implies the adoption by the professional of behaviors to actively involve the patient in their care. As for doctors, clinical empathy allows them "to leave an open communication channel, right? You… you are there to remove the doubts of the person" (Doctor 3); "you see, where is the lack of understanding, what is the difficulty, suddenly, of this patient to understand what I am talking about? Am I speaking clearly, does he understand it?" (Doctor 4). Regarding patients, this stands out: "this decision is between patient and doctor, everything comes from the self-confidence that he transmits to the patient" (Patient 3).

Category 5 – Clinical empathy and the right to informed consent

This category concerns the role of empathy in the exercise of the patient's right to informed consent, that is, it has effects on the patient's volitional process as to whether to authorize a procedure, treatment, examination, and other measures related to their care. Thus, it is important to note that Patient 2 addressed the issue of their right to consent to it or not: "I will be able to undertake my treatment, it is to take better care of my health, right?" ... "to accept my decisions too, to explain to me why the treatment is necessary, but let me decide whether or not I want that type of treatment".

Discussion

The discussion of the results was structured based on the themes that emerged from the participants' responses. Thus, it is emphasized that the perceptions of physicians and patients are their original reflections on clinical empathy and patients' rights, which were articulated in the literature on empathy in geriatric care. Although it is recognized that the contributions of clinical empathy are important for understanding the connections between clinical empathy and patients´ rights, which is the object of this study, the discussion is based on the themes that emerged from the interviews, according to the methodology adopted. Interfaces between clinical empathy and patients' rights in the context of geriatric care. It can be extracted from the interviews that when the physicians employ their empathic abilities, it impacts the interaction with the patient and there is a greater chance of broadening the patient's perception of the context in which they find themselves, the experience of living with a certain condition and the various factors that determine their health. Thus, for Doctor 2, clinical empathy implies "understanding the patient's needs, desires, weaknesses, fears", and for Doctor 3, "letting the person tell their story". Clinical empathy is associated with the personalized care of elderly patients, which, combined with the support plan, is an essential tool for giving support to people living with long-term physical and mental conditions, helping them to develop knowledge, skills, and confidence to manage their health, care, and well-being. Personalized care means understanding individual health needs within the context of their lives.[33] In this sense, Doctor 2 points out that "Yes, 10 different patients having the same pathology. They have different experiences. The pathology has different impacts that cause degrees of fear, and suffering. And commitment to different functions. Knowing how to identify this is essential to defining the best therapeutic strategy for that"; and Doctor 4 emphasizes the importance of the comprehensiveness of this understanding, which is essential for personalized care: "If we do not understand the whole context in which the patient is inserted, what they think about that treatment, what they understand about their disease, it is very difficult for them to stick with it and, with that, to have a satisfactory result in the treatment of this patient".

Clinical empathy provides a greater understanding from the physician about the elderly patient's needs and situation and fosters active listening without judging the patients. In this regard, a study points out that empathic communication helps elderly patients feel heard.[14] The issue of listening to elderly patients is central, notably because these patients are generally more vulnerable, especially because they have less control over their own lives and health and are exposed to behaviors marked by the ageism of health professionals.[34] In addition, it is emphasized that the communication process becomes more complicated with aging, since the elderly population is more heterogeneous than the youth, and aging usually involves sensory losses, memory decline, slower information processing, loss of power and control over one's life, as well as a certain level of social isolation.[35]

It is noteworthy that for patients, trust is the main component of the relationship with the doctor, which is correlated with empathy, and this can be seen in the following passages: for Patient 1, the doctor is empathic when "he is interested in your treatment", and he stated that clinical empathy "generates more trust in you. You trust that doctor more. Yes, it generates in you a certain confidence, a certain credibility, and you begin to believe more that the treatment will be effective"; for Patient 2, "[the empathic doctor] is the one who assists me with respect and inspires me with confidence. To me, in a

nutshell, that's it. You have to inspire me with confidence and treat me with respect"; and for Patient 3, "when the patient starts to believe in [the doctor]". Indeed, in several passages, patients have emphasized that an empathic physician can be trusted. And patients transfer this trust in the professional to the treatment, that is, I, as a patient, trust the treatment more, when I trust the doctor. This research data is in line with the specialized literature, which points out that trust in the doctor-patient relationship is an ingredient of high-quality care and that patients' perception of physicians' empathy influences their assessment of the doctor-patient relationship, through the patient's trust in the physician's benevolence. Thus, the patient's belief in the physician's benevolence and empathy are important for building a harmonious and safe connection.[36] Indeed, clinical empathy leads to strong trusting relationships.[37] On the other hand, the patient's lack of trust in the professional and a non-empathic relationship can have a negative impact on the health condition and mental state of the elderly patient. In this sense, Patient 3 stated that "sometimes something is difficult and if you go to a doctor who does not know how to listen to you, no, he does not know how to assist you with dedication. Then you end up coming out of there worse than you came in, maybe. So, empathy is very important for the treatment." This patient participant's perception is in line with the fact that the connotations of illness for the elderly differ from other population groups, as it is markedly accentuated by the concern to lose self-sufficiency, and by the fear of chronicity and disability related to the disease, which intensifies the emotional effects of illness, and its connotations of abandonment, marginalization and poverty.[35]

Regarding the benefits of clinical empathy, from the research, it initially emerges that the professionals' technique or scientific knowledge is not enough for the provision of quality geriatric care. In this sense, a doctor said: "you can have a doctor who is not technically so brilliant, but he listened, he had empathy, he had access to this more subjective area of the patient, and he can achieve better results than a technically better doctor". Clinical empathy allows patients to be perceived beyond their pathology, providing the physician with a very particular understanding of how that disease manifests itself particularly in that patient, as well as their fears, anguish, and the suffering of living with a given health condition. This perception corresponds to what is addressed in the literature as the epistemic function[38] of clinical empathy, which consists of the ability to identify the patient's mental state. Thus, Oxley proposes two functions of empathy, from the epistemic perspective, that of gathering information and that of acquiring knowledge about the patient to understand them better.[39] As seen in the data, by being empathetic, the physician creates a suitable environment for the patient to express themselves and, concomitantly, he understands what is happening with that patient, which translates into the model formulated by Halpern, in the following steps of the process of acquiring knowledge about the patient: (a) comprehending the patient's situation, which involves recreating the patient's perspective of the world, considering that emotional empathy provides a context for understanding the patient's point of view: (b) imagination of the patient's world, based on their perspective, needs, values, experiences and emotions; (c) attribution of beliefs, needs and emotions to the patient.[39]

Right to participate in decision-making

The elderly patients' right to participate in decision-making can be promoted through clinical empathy, which has the role of sharpening the professionals' perception of what matters to the patient, according to Doctor 1, because the empathic physician "can perceive what is most important to that person at that moment, right? I think that in this perception the exchange happens. [...] 'Is that what is more important to you right now? Let's talk this through.' I think that in these decisions, the patient feels more comfortable to discuss, to discuss these decisions. When you realize: 'wow, that was important to me, right?' So, let's talk more about it, let's think more about it." In addition, clinical empathy, which requires a certain degree of mental freedom from the physician to employ their capacity for engaged curiosity,[40] is a predictor of the professional's openness to include the patient in the discussion about the courses of action present in their care and the impact of each action on the patient. The decision-making process in geriatric care is affected in the case of elderly patients with deterioration in their mental functions since this condition has negative repercussions on the relationship with the health professional. This peculiarity of geriatric care accentuates the relevance of clinical empathy in such a context.

This right corresponds to the adoption by the health professional of Shared Decision Making (SDM), which involves a collaborative process in which the patient articulates what matters to them and their preferences, and the physician provides information. Thus, both participants reach mutual agreements on decisions regarding treatment.[41] Doctor 3 mentioned the limitation of technical knowledge, because "its impact on that patient and the perception of what impact that has on that patient, will only be discovered from the patient's view, there is no technical knowledge that guarantees this". Given this, it is emphasized that SDM encompasses not only the professional's technical knowledge but also the patient's perspective, which, according to Doctor 4, provides a safe environment in which "the patient feels safe to share very personal things, intense pains, which will help in the understanding of that pathology and the other components of the psycho-emotional dimensions of that illness". Thus, clinical empathy encompasses the physician's understanding of pain and suffering, combined with their ability to communicate this understanding and their intention to help,[42] which is, in this case, the realization of SDM. Regarding emotional factors, attention is drawn to three studies in which participants felt that these needs were not met by health professionals and were left to deal with their diagnosis alone, so few patients had room to discuss their concerns with health professionals.[43] It is also noteworthy regarding SDM in geriatric care that during the development of the "Dynamic model for SDM in frail older patients", patients emphasized the importance of being engaged in dialogue with the health team.[44]

Empathetic communication can help the elderly feel valued as partners in health relationships,[14] which is an assumption of SDM, which was mentioned by Doctor 5 when they stated that "I believe that empathy, thus, qualifies the care, yes, even approaches the patient in every way. Thus, I think the patient trusts the team that is empathetic to the patient more, the patient clarifies their doubts better, ... and emerges from that passive posture of 'oh, the doctor should choose, oh, the doctor is the one who studied, the doctor is the one who knows'". Thus, clinical empathy favors the patient's interest and willingness to participate in the decisions about their care, especially by generating a cycle of trust, as introduced by Patient 1: "this empathy helps in your care, because when you have this empathy as a doctor, the doctor with the patient, as they say, it generates this cycle of trust"..." so, as you start to trust the doctor more, you start to believe more that he is telling you the truth, that he is interested in your treatment and at the same time you start to take that treatment seriously". That is, the patient trusts the professional and this promotes the patient's self-confidence regarding the management of their treatment. The self-confidence

transmitted by the professional to the patient is particularly important to overcome the barriers of SDM in geriatric care, as elderly patients commonly feel insecure about their knowledge regarding their illness and despise their knowledge about their situation and experiences.[44]

Right to informed consent

The patient's right to consent or not to a certain treatment or procedure is associated with a relationship in which the patient feels fitter and more comfortable. While the elderly patient has the right to authorize or refuse interventions in their body and their health, Doctor 4 raised the theme of vulnerability: "So, the patient is already feeling fragile when they arrive [at the clinic], right? Often, if they don't understand the proposal of those therapies if there is no relationship of trust, it becomes more difficult because they are even afraid to consent to something that involves fragility, it involves vulnerability" ... "empathy helps in this too, to understand where there is fragility" ... "strengthening this bond so that the patient can feel comfortable making consent for treatments". Indeed, vulnerability can lead the patient to fear making decisions. Thus, clinical empathy, which consists of strengthening the bond with the patient, can provide the understanding of this vulnerability and support the patient, consisting of a clinical empathy element called "result",[42] which implies a movement of help in favor of the patients.

Doctor 5 raised the importance of time to think about the core of consent: "when [the patient] says yes or no or when they ask, 'give me time to think, OK?' 'Let's take the middle path until I can better weigh up these possibilities and make a decision based on what is most appropriate for my values, right?'". Whether consenting or not, the elderly patient often needs time to think. The physician's understanding of this need, while employing their empathic ability, is necessary for them to adopt a pro-patient behavior, ensuring that the patient is supported to make informed choices and increase the management of their condition and their own life, including what type of care they want, who the patient wants to have around and where they choose to be cared for when options exist. Consenting to these choices presupposes taking time to reflect on their wishes and preferences, as well as receiving adequate information.[45]

The patients brought about the correlation between trust in the professional and their consent. For example, Patient 2: "it depends a lot on the trust I have in this doctor. If he gives me confidence, he gives me empathy so that I can trust him, I will trust this treatment, this procedure, because otherwise I won't, right?" Patient 1: "you trust a doctor and... you have that belief in the doctor, it helps that you trust him, that you even allow him... you consent to do that treatment that he proposes, believing that that is the best for you". Elderly patients are more likely to accept medical authority, in terms of attitudes and behaviors, when compared to younger groups.[35] Likewise, some conditions prevalent in the elderly population challenge the proper exercise of the right to informed consent. For example, frailty is present in more than 30% of patients over 65 years of age who undergo anesthesia and surgery, resulting in a range of complex issues in the informed consent process. Certain risks, such as postoperative mortality, complications, and prolonged hospital stay, are generally not considered in conventional risk predictors, which leads to the likelihood that frail, elderly patients are not adequately informed about the true risk of procedures performed in the hospital environment.[46] Accordingly, clinical empathy may be an integral component of senior care that leads the clinician to consider the patient's perspective when informing them about procedures and treatments, understanding that it may be difficult for the elderly patient to raise risks, argue about not mentioned courses of action, and propose alternative treatments and procedures.

Right to information

Clinical empathy contributes to the realization of the elderly patient's right to information, as it includes the creation of a safe environment for the elderly patient to ask and answer their questions. This right is only effectively realized when the patient genuinely understands what has been transmitted to them, which must be checked by the doctor asking them, in return, if the elderly patient understood what they need to do, why, and how to do it.[47] It should be noted that Patient 1 pointed out that when the doctor is empathetic "he explains things better, he is interested, he tries to know if you understood everything correctly if you need any more explanation" ... "it helps even when you sometimes talk about your health problems, which sometimes are not even being treated at that moment", and Patient 2 highlighted the explanation about the treatment: "look, it helps you to understand, because if he is a doctor who explains to me, looking me in the eye, and assisting me, right? Looking me in the eye while talking, right? How the treatment would be and how I will respond to this treatment if I follow up, right? Whatever he asks me, right?" ... "The empathic doctor is the one who listens to me very carefully, who has the patience to listen to me". In addition, Doctor 1 brought about the correlation between clinical empathy and medical jargon: "It's a way to overcome that technical and confusing language, right? It's a very common situation in everyday life, in which professionals use technical language". The professional's empathy may be intertwined with the perception that the use of medical jargon will affect the patient's understanding, being a factor that contributes to the physician becoming aware of not using it. In this sense, in the case of elderly patients, it is recommended to use common language and not assume that the patients know the medical terminology.[47] Empathy is an integral aspect of communication with the elderly patient, contributing to increased emotional well-being, increased adherence to treatment plans, reduced pain levels, and improved wound healing.[14]

Another theme that emerged was the elderly patients feeling ashamed. Doctor 2 said: "You make it clear that the patient does not need to be ashamed to say something for fear that it is insignificant, right? I have experienced this a few times, some important details, but the patient does not recognize them as important. Often out of shame" ... "[the patient] feels comfortable saying everything important to them, so if it is not important from a clinical and biological point of view, it will be important from the point of view of the experience they have with the disease. An empathic relationship allows the professional to put the patient at ease, they can feel safe to express everything that bothers them because they know that this discomfort will be welcomed, it will be addressed". The elderly patient may be ashamed to say something and let it show that they did not understand the physician's explanation, even though research shows that most elderly patients want to understand their health condition and learn how to manage it.[47] Clinical empathy, using the professional's openness towards the patient, helps them overcome shame and talk about what matters to them. In the doctor-patient interaction, dialogue is usually conducted by the professional and the patient answers their questions, but, in addition to this traditional interactional model, clinical empathy consists of an emotionally engaged curiosity,[40] which allows the doctor to be curious about what matters to the elderly patient, even if it does not present any medical relevance. This allows the patient to be helped to talk more about themselves, telling their story, which also leads to increased confidence in the doctor. In this sense, Doctor 1 observed that "the patient also feels more comfortable to ask and to question us in a good way."

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The doctor participants stated in several passages that clinical empathy contributes to the elderly patient feeling "more comfortable" so that they share personal issues and the dimensions of the illness, which helps the professional to understand the pathology. Doctor 5 reported: "Thus, I think the patient trusts the team that is empathetic to the patient more, the patient clarifies their doubts better, the patient feels more comfortable to participate in the decisions related to their care actively and leaves that passive posture that 'oh, you should choose, oh the doctor studied, so the doctor is the one who knows'"; and Doctor 2 said: "the patient will feel much more comfortable, including to express his consent" ... "For the consent to be free, enlightened, I have a previous, horizontal relationship. And for me, empathy is essential to achieve this relationship". Therefore, better communication, related to the right to information, which includes the transmission of treatment instructions and the effectiveness of guidelines, contributes to improving the accuracy of the diagnosis.[47]

Limitations

This research cannot be generalized to the diverse contexts of geriatric care and the interactions between physicians and elderly patients. The investigated population is also a limitation, as it included only geriatricians and elderly patients, without specific demographic determination. In addition, it is important to highlight the exploratory nature of this research since, based on the literary investigations carried out, no research was found on the correlation between clinical empathy and the rights of elderly patients, thus revealing an original and pioneering research of a new field of knowledge in the context of Clinical Bioethics.

Conclusion

This study aimed to analyze the perception of geriatricians and elderly patients about the interfaces between clinical empathy and patients' rights. First, it should be noted that geriatric care is permeated by a series of challenges related to the biopsychosocial process of aging, which causes cognitive, emotional, and physical vulnerabilities in elderly patients, which is combined with problematic issues concerning ageism. Thus, elderly patients, in addition to the weaknesses experienced by patients in general, have specificities that make them fear placing themselves in an equal relationship with the physician, by asking questions, inquiring about risks, and bringing their perspective into the decision-making process. This behavior, which is an act of shyness, can be encouraged by the patient's trust in the professional, and the latter's trust in the patient, which can lead to confidence in the treatment. According to this study and the literature on the subject, this trust is associated with the empathy of the professional, who connects with the patients in an emotionally engaged way and activates cognitive functions to understand the patient's situation and communicate with them, adopting behaviors of help and support. Therefore, clinical empathy plays an important role in motivating and encouraging elderly patients to be more active in their care, which correlates with some patients' rights, such as being informed, participating in decision-making, and consenting.

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Conflicts of interest

The author declares no conflicts of interest.

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