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Conveying empathy to hospice family caregivers: Team responses to caregiver empathic communication

Elaine Wittenberg-Lyles, PhD*,

Curtis W. and Ann H. Long Department of Family and Community Medicine, University of Missouri, Columbia USA

Debra Parker Oliver, MSW, PhD,

Curtis W. and Ann H. Long Department of Family and Community Medicine, University of Missouri, Columbia USA

George Demiris, PhD,

Biobehavioral Nursing and Health Systems, School of Nursing & Biomedical and Health Informatics, School of Medicine, University of Washington, Seattle USA

Anna Rankin, MA,

Department of Communication, University of Kentucky, Lexington USA

Sara Shaunfield, MS, and

Department of Communication, University of Kentucky, Lexington USA

Robin L. Kruse, PhD

Curtis W. and Ann H. Long Department of Family and Community Medicine, University of Missouri, Columbia USA

Abstract

Objective—The goal of this study was to explore empathic communication opportunities presented by family caregivers and responses from interdisciplinary hospice team members.

Methods—Empathic opportunities and hospice team responses were analyzed from biweekly web-based videoconferences between family caregivers and hospice teams. The authors coded the data using the Empathic Communication Coding System (ECCS) and identified themes within and among the coded data.

Results—Data analysis identified 270 empathic opportunity-team response sequences. Caregivers expressed statements of emotion and decline most frequently. Two-thirds of the hospice team responses were implicit acknowledgments of caregiver statements and only one-third of the team responses were explicit recognitions of caregiver empathic opportunities.

Conclusion—Although hospice team members frequently express emotional concerns with family caregivers during one-on-one visits, there is a need for more empathic communication during team meetings that involve caregivers.

Practice implications—Hospice clinicians should devote more time to discussing emotional issues with patients and their families to enhance patient-centered hospice care. Further consideration should be given to training clinicians to empathize with patients and family caregivers.

*Corresponding author at: University of Kentucky, Markey Cancer Center and Department of Communication, 741 S. Limestone, B357 BBSRB, Lexington, KY 40506-0509 USA, Phone: (859) 323-4118, Fax: (859) 257-6030, Elaine.lyles@uky.edu.

Keywords

empathy; hospice; family caregiver

I. Introduction

Patient-centered communication remains at the forefront of national efforts in the United States for improving and emphasizing health communication in clinical settings [1–3]. One feature of patient-centered care is the provider's ability to express empathy [4–6]. Physician empathy has been defined as an understanding of the patient's situation and feelings, the ability to communicate understanding and check for accuracy, and acting on the understanding to help the patient [7]. Patient reactions to the emotional distress of illness are indirect forms of communication that invite reassurance or support from the care provider, requiring physicians to appropriately respond to patient needs [8, 9]. Communication may be adversely affected if the provider fails to recognize an empathic opportunity, interprets emotion incorrectly, or neglects to respond [10]. The physician's lack of an appropriate empathic expression can result in poor interactions and unmet expectations that increase anxiety for patients [8].

Prior research has found that a physician's expression of empathy positively influences the physician-patient relationship [11, 12]. Physicians who offer empathy, encouragement, praise, and active help increase feelings of acceptance, value, belonging, and validation for the patient and are perceived to be more trustworthy [4, 11]. Acknowledging the patient's emotions can have several benefits for the patient-provider encounter including increased patient self-efficacy and improved patient outcomes such as adherence and satisfaction [4, 12]. For example, among Korean patients empathic communication significantly influenced patient satisfaction and compliance [13]. Responding with empathy can encourage patients to disclose more about their symptoms, resulting in a better understanding of the patient's needs and facilitation of patient-centered care [11, 12].

Despite an evidence base for the benefits of expressing empathy with patients, research shows that physicians do not respond appropriately and consistently to patient emotions during medical encounters. Previous research indicates that less than one-third of patient-initiated actions soliciting empathy were acknowledged with clear empathic responses, and in most cases the physician did not respond to any emotional cues [4, 14, 15]. Instead, physicians tend to respond more frequently to patient informational cues rather than emotional cues and many concerns raised by patients are often dismissed or minimized [4, 14]. Commonly, physicians respond to patient concern by turning the conversation to biomedical information, nonspecific acknowledgment, medical explanation, or reassurance [4].

Thus far the majority of research on empathy has been based in a physician-patient context, yielding important conclusions about physician communication and patient expectations, yet little is known about empathic communication in other clinical settings. We used data from a randomized controlled trial of family caregiver (friends or family of the patient) participation in care planning discussions with hospice interdisciplinary team members to investigate empathic communication between team members and family caregivers. Our aim was to explore empathic communication opportunities presented by family caregivers and corresponding team responses.

1.2 Background on Hospice care

Acknowledging the reciprocal relationship between patients and family caregivers when disease is present, hospice clinicians consider the patient and family together as the unit of care. Through an interdisciplinary team trained in medicine, nursing, chaplaincy, and social work, hospice provides compassionate, comfort care aimed at meeting the medical and psychosocial needs of terminally-ill patients and their families [16]. Shared decision-making among patients, families, and providers is crucial in hospice when an appropriate decision can only be determined by considering the needs and preferences of the family caregiver and patient [17]. Communication with family caregivers becomes instrumental in establishing and promoting quality of life among caregivers and patients and ensuring patient-centered care [18].

To deliver patient-centered care, hospice clinicians must foster a nurturing relationship between caregivers and patients [19]. This is important when patients and their families make the initial transition from curative care to hospice care – the provider's ability to detect and respond to caregiver distress is critical in reducing potential anxiety and depression about death and dying [20, 21]. Decision-making about hospice care requires caregivers to balance the patient's wishes, the quality of life of the patient, and their own burden as a caregiver [22]. Caregivers struggle to make good decisions on behalf of the patient with little knowledge about disease and care processes [23]. Family caregivers report a desire to meet with hospice providers to gain a better understanding of the illness, to ask questions and receive answers, to get reassurance, and to feel a sense of involvement [24]. Given the emotional nature of hospice caregiving, including family caregivers in care planning discussions positions family members as core team members and enables teams to engage in patient-centered care by empathizing with caregivers and providing support and information. To explore empathy in this setting, we utilized an observational measure of caregiver-expressed empathy and team response to empathic opportunities.

2. Methods

2.1. Overview

Data for this study come from a larger, randomized controlled trial aimed at assessing the clinical outcomes from family caregiver participation in hospice interdisciplinary care planning discussions (nr R01NR011472). The study enrolled hospice family caregivers and interdisciplinary team members at two hospice agencies in the Midwestern United States. Family caregiver participation was facilitated via Virtually Interactive Families (www.vifamilies.com), a web-based video-conferencing platform. Family caregivers were invited to participate in bi-weekly meetings for the duration of their loved one's hospice care. During these meetings, family caregivers were asked if they had any questions or concerns to share with the hospice team. A random sample of video-recorded sessions were chosen for analysis. The Health Sciences Institutional Review Board at the University of Missouri approved the study.

2.2. Family caregivers

Caregivers had to be at least 18 years of age and the designated primary caregiver(s) for a hospice patient (as determined by hospice staff). The telemedicine component required a high-speed Internet connection with a computer to participate in the video conference session. However, audio participation was available with any telephone device. After hospice staff gained consent to contact from eligible family caregivers, a member of the research team called the caregiver, visited the caregiver's home, explained the study, obtained informed consent, and provided instruction and assistance with video-conferencing.

2.3 Hospice interdisciplinary team members

Team members from two hospice agencies in two local communities participated. A member of the research team visited the hospice agency, explained the study, and obtained informed consent from hospice staff who participated in weekly meetings. During meetings, a web camera was connected to a computer with high-speed Internet and the family caregiver's screen image was projected onto a large screen for the entire hospice team to view. This connection allowed family members to have a visual image of the team as well as a two-way conversation with them.

2.4 Measure

The Empathic Communication Coding System (ECCS) was used to code caregiver empathic opportunities and team responses to empathic opportunities from video-recorded team meetings with consenting family caregivers [25, 26]. The ECCS has been validated, showing acceptable reliability among intercoders (Cohen's Kappa = .73 – .81) and analysis at both the patient level and empathic-opportunity level yielded a statistical power of at least .85 in the original research [25, 26].

2.4.1 Identification of empathic opportunities—The ECCS classifies empathic opportunities into statements of emotion, progress, or challenge. To adapt the ECCS for the hospice setting, the following adjustments were made. Statements of emotion, originally defined as the patient's feeling of emotion, was extended to the caregiver's statements about their feelings of emotion (fear, hope, desire), burden, their own physical condition related to caregiving tasks, and compliments to hospice staff. The ECCS instrument identified statements of progress as the patient's description of positive developments in physical, quality of life, or life-changing events. In contrast, we identified statements of decline and included caregiver's talk about the patient's decline, disease progression, improved caregiver quality of life and performance of caregiving, turning points in care, and stories of competence. Finally, statements of challenge, originally identified as negative physical or quality of life effects or devastating, life-changing events, were adjusted to include the caregiver's description of a negative physical or psychosocial problem with the patient, the caregiver's explicit interruption of the team, and when the caregiver introduced a new topic to discuss.

2.4.2 Coding empathic responses—Team responses to an empathic opportunity were identified and coded using six levels of empathy ranging from zero to five. Levels three through five documented explicit recognition of the caregiver's perspective through acknowledgement (level three), confirmation (level four), and statement of shared feeling or experience (level five). In contrast, lower level responses included implicit recognition of the caregiver's perspective (level two), automatic or script-type responses that reflected perfunctory recognition (level one), and ignoring or denying the caregiver's perspective (level zero).

2.4.3 Coding process—The ECCS was used by three members of the research team to code video-recordings of family caregivers and hospice teams. Two training sessions were held to develop inter-coder reliability. In the first training session ECCS materials were reviewed and four videos were collectively coded. This highlighted a need to develop coding rules for identifying empathic opportunities in the hospice context. Coders then independently watched five additional videos to clarify coding rules and a second training session was held to discuss and review videos.

After this training period, two members of the research team watched the videos together and jointly identified empathic opportunities and team responses using half of the data set.

Once caregiver empathic opportunities and team responses were identified and transcribed, coders independently applied the ECCS. A reliability check was conducted for the two-part coding system (empathic opportunities and responses) and inter-coder reliability was acceptable (Cohen's kappa = .94 on empathic opportunities, with 100% agreement reached for team response levels 1, 2, 3, and 6, and Cohen's kappa at .96 and .92 for levels 4 and 5 respectively). Coders met to discuss and resolve coding disagreements. With inter-coder reliability established, the remaining data set was divided evenly among the two coders for coding the remaining data.

2.5 Analysis

Frequency counts for coding categories were calculated using SPSS [27]. To further understand hospice caregivers' empathic communication we applied traditional grounded theory methods to consider emerging themes within statements of emotion, decline, and challenge [28]. Two members of the research team engaged in descriptive coding of the empathic opportunities identified through the ECCS. Detailed labels were applied to segments of the data based upon their content and/or meaning. Themes were compared both within and among all coded entries for each empathic opportunity (emotion, decline, challenge), leading to generated themes that provide a more in-depth view of caregiver needs during hospice care. Finally, a Kruskal-Wallis H-Test was performed to assess for differences between median team response level for each of the three types of empathic opportunities.

3. Results

A total of 82 meetings between family caregivers and hospice interdisciplinary team members were reviewed for empathic opportunities. From this data set a total of 270 empathic opportunity-team response sequences were identified in 68 discussions, an average of 4 empathic opportunities per discussion.

3.1 Description of the study population

Table 1 provides an overview of demographics for caregivers who participated in team meeting discussions analyzed for this study. Team discussions with 29 caregivers were included in the data set, with most caregivers participating more than once. The majority of caregivers were female (72%) or Caucasian (96.5%). Caregiver relationship to the patient was predominantly adult child (72%) followed by spouses (10%). Most caregivers did not live with the patient (83%) and were providing oversight for patients in nursing homes (68%) or patients still living in their own home (32%).

Hospice teams were composed of professionals who were involved in direct patient care. Hospice Team 1 ($n = 25$) included 20 women and 5 men and Hospice Team 2 ($n = 47$) consisted of 36 women and 11 men. Clinicians included medical directors, nurses, case managers and social workers, chaplains and bereavement counselors, patient, team and volunteer coordinators, and other healthcare professionals. Multiple clinicians were present during meetings with caregivers.

3.2 Family caregiver empathic opportunities

The 270 family caregiver empathic opportunities represented all three types of empathic opportunities identified by the ECCS. Caregivers expressed statements of emotion (42%) and statements of decline (38%) most frequently. Approximately 20% of the empathic opportunities were statements of challenge. Table 2 provides an overview of caregiver empathic opportunities, definitions of the coding category, and examples. To further discern

caregiver empathic communication during meetings, we provide the following themes within each empathic opportunity type.

3.2.1 Statements of Emotion—The majority of empathic opportunities emerged from caregivers who talked about the emotional toll of caregiving. Statements of emotion were characterized by feelings of stress and anxiety about the caregiving role and responsibilities. Emotional statements revealed uncertainty over the delivery of hospice care as well as unfamiliarity with the caregiving role. Caregivers conveyed a sense of helplessness that had little to do with caregiving performance and more to do with the supportive role of the caregiver during the patient's dying process.

Caregivers also shared emotional concerns alongside logistical parameters for patient care decisions, especially as related to patient safety. Safety concerns were a prevalent theme when it came to decision-making. Finally, caregivers frequently made a point to thank team members for their good work and often became emotional when conveying appreciation.

3.2.2 Statements of Decline—Statements of decline emerged as empathic opportunities when caregivers described role mastery, changes in patient quality of life, and patient adjustment to a new living environment. Caregivers highlighted their role in the provision of care and described challenges to patient care and the actions they took to overcome them. Updates about patients allowed caregivers to highlight their role in patient care with pride and satisfaction, giving the team a chance to acknowledge their role.

Similarly, caregivers emphasized positive changes to the patient's quality of life. The effectiveness of medication for both the patient and the caregiver were touted as a benefit of hospice care. Statements of decline also detailed disease progression leading to decreased quality of life for the patient. These reports were often somber in tone, excluded requests for additional assistance or discussion, and facilitated indirect sharing of the psychosocial impact of caregiving for a dying loved one.

As part of the transition to hospice care, many patients had been moved to a new care environment such as a nursing home or another family member's home. Central to this theme was the adjustment of the patient, mainly as it pertained to depression and mood. Despite receiving adequate care, caregivers realized that this sometimes did not change the demeanor of patients who were often "overwhelmingly depressed."

3.2.3 Statements of Challenge—Statements of challenge were used less frequently than statements of emotion and decline, but they were largely very direct attempts at soliciting empathy. Statements of challenge referred to concerns about the coordination of pain management or medication, care coordination, or clarification of information. Caregivers often directly requested more information or needed the team to repeat information. Discipline-specific jargon was used regularly among team members and some caregivers asked for a definition and explanation of medical terms. Finally, statements of challenge often emerged from frustration and the team meeting discussions were a venue for sharing dissatisfaction and complaints.

3.3 Team responses

Team responses represented the six response categories identified in the ECCS and are detailed in Table 3. The majority of responses were implicit recognitions of the caregiver's perspective (34%). Responses that implied recognition addressed the empathic opportunity, but remained focused on biomedical or procedural information. Medical information was routinely highlighted as part of the response to caregiver concerns.

Commonly, team responses relied heavily on perfunctory language (21%) and overt denial (13%) of the caregiver's empathic statement. Obligatory, scripted responses often discouraged caregivers from further elaboration of their feelings. Denial responses often occurred toward the end of the meeting when it was clear the team wanted to end the conversation. Team members ignored empathic opportunities by discussing the patients among themselves, remaining silent, or verbally ending the conversation. Lower level responses of the ECCS (levels 0–2) accounted for two-thirds of all team responses.

Team responses illustrating explicit acknowledgements (21%) and confirmation (11%) were less frequent. These responses focused on recognizing the enormity of the caregiving role, conveying tangible support, and clear recognition of the caregiver's concern.

Only a handful of hospice team responses provided confirmation to caregivers. Confirming statements legitimized the caregiver's perspective and offered positive remarks about the caregiver's role in the patient's care. Finally, only two hospice team responses reflected shared experience between the caregiver and team.

Overall, the most frequent team response was an implicit recognition of caregivers' empathic communication. Furthermore, the Kruskal-Wallis H-Test revealed significant differences between the median team response for each of the three empathic opportunity types [$H(2)=8.245$, $P=0.016$]. Typically, statements of emotion received the highest scores on the ECCS team response scale of 0 (denial of empathic opportunity) to 5 (shared experience), followed by statements of decline and statements of challenge. Table 4 provides an overview of the distribution of team responses by type of empathic opportunity.

4. Discussion

This study examined empathic communication opportunities presented by family caregivers during care planning discussions with hospice team members. It also examined the topic of caregiver empathic communication and the resulting team responses. To our knowledge, no study has examined empathic communication in the hospice clinical setting by focusing on team communication with family caregivers. The study fills an important gap in extending empathic communication research beyond physician-patient interaction.

4.1 Hospice family caregiver need for empathy

Statements of emotion emerged as the primary empathic communication opportunity, providing further evidence that family caregivers experience reciprocal suffering during the hospice experience [29, 30]. As in other family caregiving research, emotional concerns were largely driven by uncertainty about the situation and decision-making [31, 32]. While the effectiveness of caregiver discussions about psychosocial issues with staff has not yet been established [33], this study confirms that it is a salient issue for caregivers, who are responsible for helping staff implement patient-centered care. Prior research has found that caregivers tend to express more emotional distress when their loved one is not present [34].

In addition to sharing their emotional strain, caregivers frequently discussed patient decline. This is consistent with other clinical settings where the topic and goal of the discussion are to provide updated information on patient care. Interestingly, empathic communication opportunities were embedded in these reports as caregivers highlighted challenges in patient care and subsequent role mastery. When caregivers talked about changes in patient quality of life, staff had the opportunity to further educate about the dying process to help caregivers understand the normalcy of the hospice experience. While caregivers do routinely provide reports to clinical staff, findings from this study suggest that these interactions provide opportunities for therapeutic counseling and psychoeducational interventions [35].

Whereas caregivers expressed emotion and appreciation for staff, they also felt comfortable reporting dissatisfaction with the patient's plan of care. However, complaints about care were predominantly about nursing home staff. When care is long-term, prior research has found that family caregivers prioritized interpersonal relationships with long-term care providers to feel that their situation was important and understood [24]. This study's findings are contradictory to the idea that family caregivers would be more closely aligned with long-term care staff. Future research is needed to learn more about the triadic communication that takes place among caregivers, hospice providers, and nursing home staff. Importantly, complaints are opportunities that should be appropriately addressed by staff. Since family caregivers share in the disease experience of their loved one, it is essential that clinicians recognize and communicate with family caregivers about their experience [36]. Improved communication can enable individualized patient care and reduce the burden of decision-making for caregivers [32].

4.2 Team responses to empathy

Our analysis revealed a consistent pattern of responses to caregiver empathic opportunities across the two hospice teams. While implicit recognition occurred most frequently, concentrated attention on biomedical care topics prohibited further discussion of the caregiver or patient's psychosocial issues. It has been surmised that providers working in hospice develop "intricate defense mechanisms" to enable coping with the demanding role for excessive empathy, and an explicit focus on biomedical management may be a defense mechanism that facilitates coping for staff [37]. However, lack of education about effective communication techniques may also contribute to this finding.

The discrepancy between caregiver empathic opportunities and team responses may be best explained by the context of the care planning discussion. In hospice care, family caregivers do not typically join in team meetings [38]. Consequently, hospice staff set the agenda for the meeting by providing caregivers with a patient update and then prompting caregivers for questions. The format and structure of the meeting was largely biomedical and task-driven by the team's time demands. Since psychosocial issues are less likely to be discussed in team meetings [39], findings from this study suggest that hospice staff were unable to manage both content and relational goals of the interaction.

Consistent with initial work with the ECCS instrument, "shared feeling" was rarely used as a response to caregiver empathic opportunities [25, 26]. Research on empathy in clinical examinations found that acknowledging and confirming were predominant physician responses to patient empathy [25, 26]. This study found the same conclusions in a hospice setting. While it has been surmised that acknowledging and confirming responses to empathic opportunities meet patient expectations, more research is necessary to determine caregiver expectations for empathy, especially in a hospice setting [25, 26]. For example, patient perceptions regarding nurses suggests that empathy is often lacking [40]. While previous research has found that healthcare professionals typically miss about two-thirds of empathic opportunities, findings from this study suggest that the inherent nature of the hospice context, which predicates comfort and compassion, increase the likelihood that staff will respond to empathic opportunities.

4.3 Conclusion

Overall, results from this study demonstrate that hospice team members did not effectively handle caregiver statements of emotion with direct, empathic communication. Default perfunctory responses were likely and may have prohibited further discussion and the development of patient-centered care plans. When caregivers provided an empathic opportunity by talking about caregiver burden, staff were not able to communicate

understanding back to the caregiver, which is an essential part of practicing empathic communication [40]. These findings highlight the need for hospice clinicians' training in recognizing opportunities and conveying empathy in their interactions with family caregivers and patients.

Several limitations to this study should be noted. Generalizability is limited by a lack of diversity within the study sample and because most caregivers oversaw care for patients in institutionalized settings. In the United States, 68% of hospice care is provided in the patient's home and thus our study sample is atypical of the general hospice demographic [41]. Findings may be different among caregivers providing care at home. We also did not account for team responses specific to disciplines represented on the hospice team and this could have provided further in-depth understanding to the role of healthcare teams in general. Still, this is the first study to actually assess team-based empathy with family caregivers during care planning discussions.

4.4 Practice implications

To summarize, the results from this study show a need for better empathic communication between caregivers and team members during discussions about care planning. Better communication about psychosocial issues, emotional losses, and frustrations over the care process between caregivers and hospice clinicians should lead to better, more holistic, patient-centered care for hospice patients and their families. Hospice clinicians need to address and discuss the caregiver's experience during hospice care in order to better educate and support caregivers. Clinician education is essential to ensure that effective communication with family caregivers results in appropriate interventions and that team-based conversations and meetings allow for empathic communication between the team and caregiver. Clinical encounters that are team-based with patients and families should not exclude but rather recognize the emotional nature of the hospice experience.

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Table 1Summary Demographic Variables for Caregivers ($n = 29$)

Variable	Caregiver (% , n)
Relationship with patient	
Spouse	10% (3)
Adult Child	72% (21)
Sibling	3.5% (1)
In-law	3.5% (1)
Other relative	7% (2)
Non-relative	3.5% (1)
Lives with patient	
Yes	17% (5)
No	83% (24)
Race	
African American/Black	3.5% (1)
Caucasian/White	96.5% (28)
Sex	
Female	72% (21)
Male	28% (8)
Education	
Some high school	7% (2)
High school/GED	31% (9)
Some college/trade school	21% (6)
Undergraduate degree	24% (7)
Graduate/professional degree	17% (5)
Employment status	
Not employed	3.5% (1)
Part time	17% (5)
Full time	24% (7)
Other	14% (4)
Retired	41% (12)
Marital status	
Never married	7% (2)
Married	72% (21)
Separated	3.5% (1)
Divorced	3.5% (1)
Widowed	14% (4)

Table 2

Family Caregiver Empathic Opportunities

Category	Definition ^a	Examples from data	<i>n</i>	%
Statement of Emotion	Caregiver describes feelings of emotion, burden, or appreciation for staff.	<i>I'm very appreciative of everyone in that room. I wish I could take her pain away.</i>	113	42%
Statement of Decline	Caregiver describes disease progression, positive turning points, or mastery of role.	<i>She's getting really frail. She's been having down days a lot since she was sick.</i>	104	38%
Statement of Challenge	Caregiver determines topic by expressing explicit concerns or negative turning points.	<i>I'm a little bit concerned about her basic safety there and I'm wondering what our options are to improve that. My question was, who is responsible for making sure she gets that medication?</i>	53	20%

^aAdapted from the Empathic Communication Coding System (ECCS) (Bylund & Makoul, 2002)

Table 3**Hospice Team Responses to Family Caregiver Empathic Opportunities**

Category	Definition ^a	Examples from data	n	%
Level 0 – Denial	Team is silent or changes topic and denies caregivers empathic opportunity.	Team member reported patient chart. <i>Bye.</i>	34	13%
Level 1 - Perfunctory Response	Team offers an obligatory, scripted response to empathic opportunity	<i>That could be true.</i> <i>Sure. Sure.</i>	57	21%
Level 2 – Implicit Recognition	Team acknowledges empathic opportunity with biomedical or procedural talk.	<i>Okay! Well I'm gonna pass this information on to Mike.</i> <i>What I would suggest you do is call the Alzheimer's Association.</i>	92	34%
Level 3 - Acknowledgement	Team explicitly recognizes or repeats empathic opportunity.	<i>So she wasn't having a very good day when you were out there?</i> <i>Well I'm glad she's sleeping a little bit better for you.</i>	56	21%
Level 4 - Confirmation	Team legitimizes and confirms what caregiver thinks, or offers a congratulatory/positive remark.	<i>Bless your heart that puts you in a real tough spot.</i> <i>It's not any easy decision [turning off defibrillator], but you've got our support. Call us if you need anything from us.</i>	29	11%
Level 5 – Shared Experience	Team reciprocates disclosure and moves beyond biomedical content to address emotional needs.	<i>We understand perfectly. We really do.</i> <i>[I had a] patient [...] just like that. Your situation is the reverse. The quality of life just isn't what it was before. I think it's a good decision.</i>	2	

^a Adapted from the Empathic Communication Coding System (ECCS) (Bylund & Makoul, 2002.)

Table 4Distribution of Team Responses by Type of Caregiver Empathic Opportunity^a

Team Response	Caregiver Empathic Opportunity		
	Statement of Emotion	Statement of Decline	Statement of Challenge
Level 0 – Denial	21.2%	7.7%	3.8%
Level 1 – Perfunctory Response	22.1%	26.9%	7.5%
Level 2 – Implicit Recognition	28.3%	30.8%	52.8%
Level 3 – Acknowledgement	14.2%	26.0%	24.5%
Level 4 – Confirmation	12.4%	8.7%	11.3%
Level 5 – Shared Experience	1.8%	0%	0%

^aThere is a significant difference in team responses [$H(2) = 8.245$, $P = 0.016$]