Exploring the Role of Empathy in Academic Detailing

RxFiles Academic Detailing

Saskatchewan, Canada

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Marlys LeBras BSP, ACPR, PharmD

Disclosure Statement

- All speakers have no conflicts of interest to disclose or relevant financial/nonfinancial relationships
- Artificial Intelligence (Copilot and ChatGPT) was used to generate the images seen in the presentation

Learning Objectives

By the end of the presentation learners will be able to:

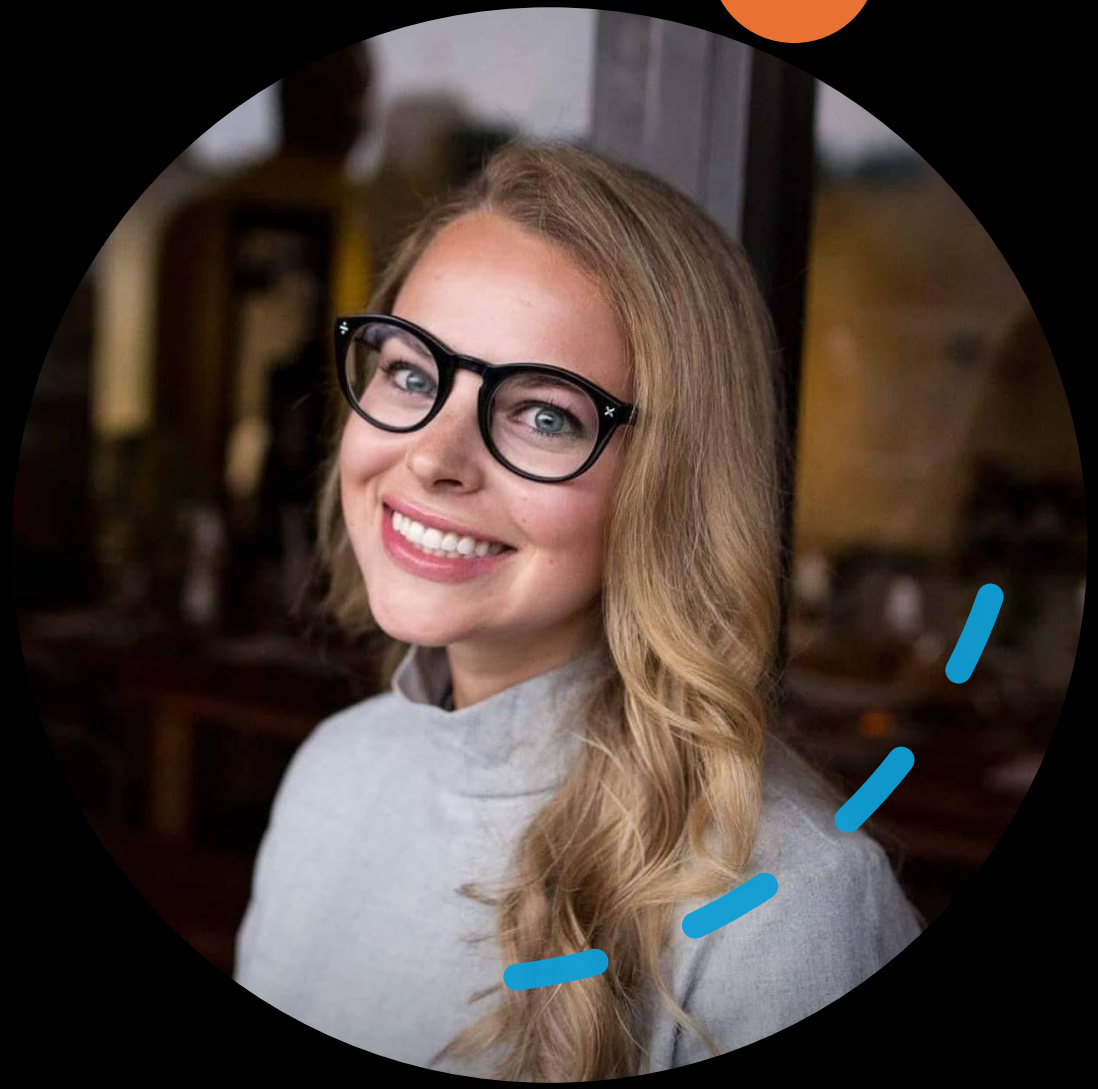
- Discuss the impact of burnout on healthcare providers, patients, and the healthcare system.
- Discuss the role of empathy in academic detailing.
- Practice using empathy to develop relationships as part of an academic detailing introduction and needs assessment.

Julia Bareham

- Full-time with RxFiles Academic Detailing at the University of Saskatchewan
- Pharmacist with Shoppers Drug Mart - casual
- Committee member of the Drugs and Therapeutics Advisory Committee for Non-Insured Health Benefits (NIHB) of Indigenous Services Canada
- Canada’s Drug Agency’s Appropriate Use Advisory Committee

Marlys LeBras

- RxFiles Academic Detailing at the University of Saskatchewan
- Primary Care Pharmacist
  - Sanctum (HIV hospice)
  - Community Clinic, Westside
- Committee member of the Canadian Academic Detailing Collaboration (CADC)



Zack Dumont

- Manager of Pharmacy Practice (Regina) for the Saskatchewan Health Authority

- Clinical Pharmacist with RxFiles Academic Detailing Service (University of Saskatchewan)

Breakout #1

Groups of 3

Detailer
Clinician
Observer

15 minutes

5 minutes for each role/ scenario

Detailer

You have never met this clinician before

Detailing topic (choose your adventure):

- Your own AD topic – past, present, future
- CFL is superior to the NFL
- Ketchup chips are the best flavo(u)r of potato chips

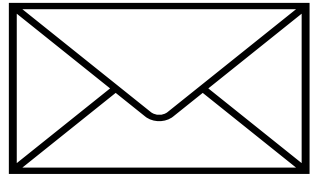
Focus on your introduction and needs assessment

Clinician

Read your envelope and do your best to play the role outlined for you

Observer

Watch for key questions / phrases / techniques the detailer used



Breakout #1 – Debrief (~10 minutes)

- Was a relationship established?
- Detailers – how would describe the clinician?
- Clinicians – did you feel a connection with the detailer?
- What made it hard to connect?
- What enabled a connection or relationship to be established?

Workshop Outline

- A case for burnout
- Empathy explained
- Empathy and academic detailing converge
- Breakout #2
- Wrap-up


BURNOUT

BURNOUT

- **Chronic stress** associated with emotionally intense work demands for which resources are inadequate

- Work-related syndrome involving **emotional exhaustion, depersonalization & a sense of ↓ personal accomplishment**

- How do burned out physicians feel?
  - "Used up" at the end of a workday & have nothing left to offer patients from an emotional standpoint
  - Like they have depersonalized their patients - feelings of treating them as objects rather than human beings & becoming more callous toward them
  - Ineffective in helping patients with their problems

West, C P et al. "Physician burnout: contributors, consequences and solutions." *Journal of internal medicine* vol. 283,6 (2018): 516-529. https://hbswk.hbs.edu/item/the-economic-cost-of-physician-burnout

BURNOUT

"ESSENTIALLY IT'S THIS FEELING OF BEING OVERWHELMED. YOU DON'T FEEL LIKE WHAT YOU ARE DOING IS MEANINGFUL ANYMORE."

West, C P et al. "Physician burnout: contributors, consequences and solutions." *Journal of internal medicine* vol. 283,6 (2018): 516-529. https://hbswk.hbs.edu/item/the-economic-cost-of-physician-burnout

Physician Burnout in Canada & US

CANADA[1]

MDs reporting burnout:

- 2017: 31%
- 2021: 53% (~50% reported emotional exhaustion)

4,121 respondents

USA[2]

MDs ≥1 symptom of burnout:

- 2021: 62.8%
- 2022: 53%
- 2024: 48.2%

12,400 respondents

31 states, 81 health systems

What Drives Burnout?

3 forces drive burnout:

- Pressure to care for too many patients in too little time & with too few resources
- Expectations to engage in activities felt to be rote, irrelevant, or counterproductive
- An inability to meet the medical or social needs of patients

Khullar D. Burnout, Professionalism, and the Quality of US Health Care. *JAMA Health Forum*. 2023;4(3):e230024. doi:10.1001/jamahealthforum.2023.0024

Cost of Burnout in Canada & US

CANADA[1]

$213.1 million

- $185.2 million due to early retirement
- $27.9 million due to reduced clinical hours
  - Family physicians - 58.8%
  - Surgeons - 24.6%
  - Other specialists - 16.6%

USA[2,3]

$4.6 billion a year

- For every MD who leaves due to burnout, the related cost to the organization is $500,000 to $1 million or more depending on the specialty.
- Turnover costs > costs of reduced productivity
- Costs are greater in primary care physicians <55 years

1. Dewa CS, Jacobs P, Thanh NX, Loong D. An estimate of the cost of burnout on early retirement and reduction in clinical hours of practicing physicians in Canada. BMC Health Serv Res. 2014 Jun 13;14:254. doi: 10.1186/1472-6963-14-254. PMID: 24927847; PMCID: PMC4062768.
2. Physician burnout rate drops below 50% for first time in 4 years (2024) 3. Shasha Han, Tait D. Shanafelt, Christine A. Sinsky, et al. Estimating the Attributable Cost of Physician Burnout in the United States. Ann Intern Med.2019;170:784-790. [Epub 28 May 2019]. doi:10.7326/M18-1422

Consequences of Burnout

Threat to health care quality, patient outcomes, & the vitality of the medical workforce

Patient Care	Physician Health	Health Care System
Lower quality care	Substance use	↓ physician productivity
Medical errors	Depression/suicidal ideation	↑ physician turnover
Longer recovery times	Poor self-care	Less patient access
Lower pt satisfaction	Motor vehicle crashes	↑ cost

West CP, Dyrbye LN, Shanafelt TD. Physician burnout: contributors, consequences and solutions. *J Intern Med*. 2018;283(6):516-529. doi:10.1111/joim.12752

Healthcare Professionals, Burnout, & Empathy

- Negative association between burnout and reduced empathy among healthcare professionals
  - As burnout increases, empathy decreases
- In addition, healthcare professionals are at the greatest risk of overdosing on empathy
  - "Empathy" or "Compassion" fatigue

Wilkinson H, Whittington R, Perry L, Eames C. Examining the relationship between burnout and empathy in healthcare professionals: A systematic review. Burn Res. 2017 Sep;6:18-29.
Jamil Zaki. The war for kindness: Building empathy in a fractured world"

What does empathy mean to you?

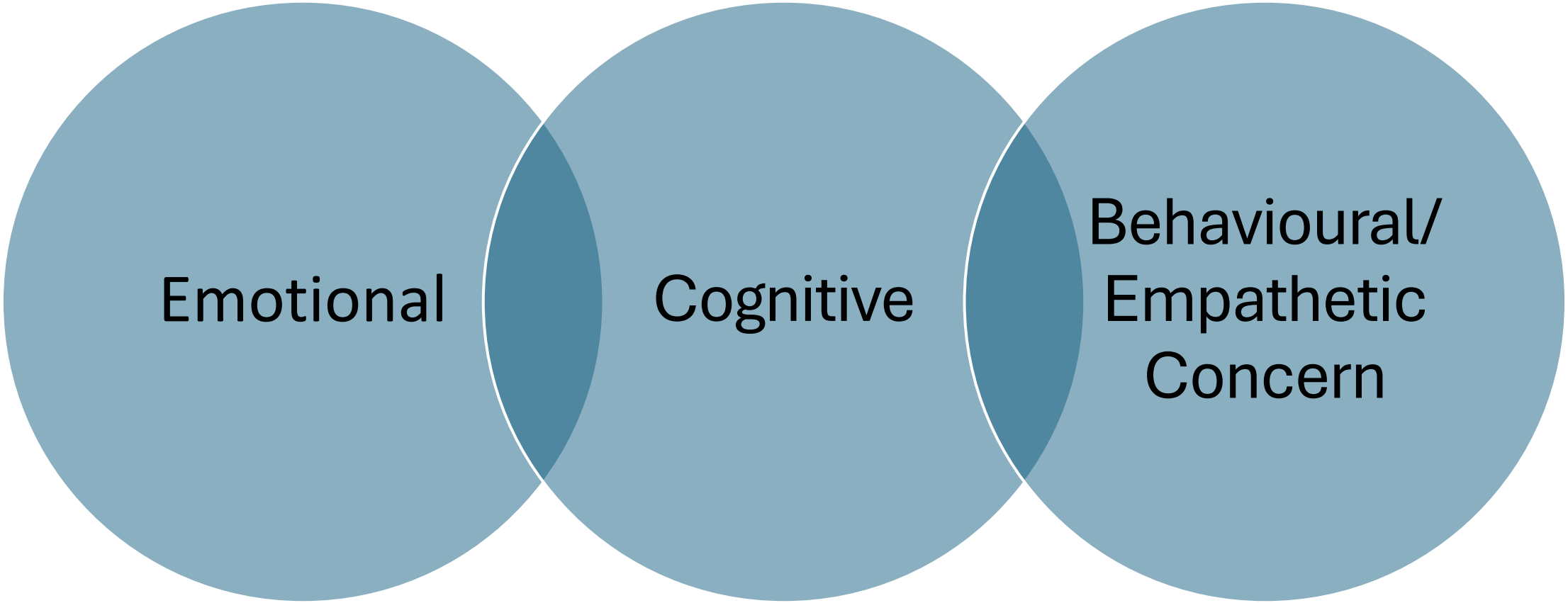
What is Empathy?

Traditionally thought of as “just put yourself in someone else’s shoes”

Now, may be thought of as "understanding the motivations and emotions of others to build relationships"

What is empathy? Daniel Goleman. Emotional Intelligence Empathy. Harvard Business Review Press. 2017.

What is Empathy?



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Empathy vs Sympathy

- Empathy – understanding and sharing someone's feeling
- Sympathy – feeling sorry or pity for someone

Wispé, L. (1986). The distinction between sympathy and empathy: To call forth a concept, a word is needed. *Journal of Personality and Social Psychology, 50*(2), 314–321.

The Difference Between Empathy vs. Sympathy

Empathy vs Compassion

- Empathy – mindset
- Compassion – empathy in action
  - Kindness to another person
  - Compassionate action

Jamil Zaki. The war for kindness: Building empathy in a fractured world"

Why is Empathy Important?

- Building relationships
  - Personal and work-related relationships
  - Healthcare professional and patient relationships
- Improving business outcomes
  - Customer loyalty
  - Innovation
  - Market growth and profits

Maria Ross. The Empathy Edge: Harnessing the Value of Compassion as an Engine for Success. 2019.

Can We Improve Our Ability to Empathize?

- Through practice, we can grow our empathy
  - Empathy is not a fixed trait but rather a skill we can hone
  - Data suggests we can change one's empathy on purpose

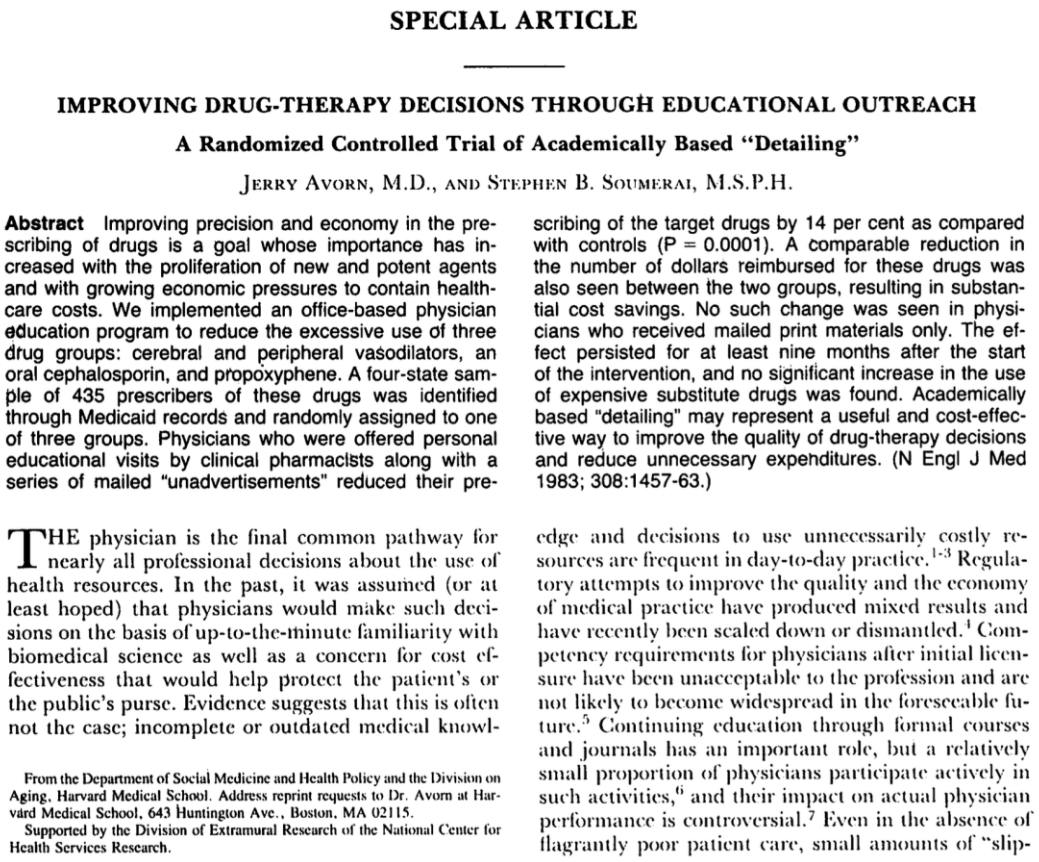
Ariel Knafo, Florina Uzefosky. Variation in Empathy: The Interplay of Genetic and Environmental Factors".

The Six Habits of Highly Empathic People

from: "Empathy: Why It Matters, and How to Get It" by Roman Krznaric

1. **Switching on the Empathy Switch**: Actively deciding to empathize with others.
2. **Curiosity about Strangers**: Developing a genuine curiosity to learn about people’s lives.
3. **Challenging Prejudices**: Recognizing and breaking down personal biases and prejudices.
4. **Living the Experiences of Others**: Immersing oneself in other people's experiences through direct involvement.
5. **Empathic Listening**: Listening to others not just with the intent to respond, but to understand.
6. **Inspiring Mass Empathy**: Using empathy to foster social and systemic change, encouraging wider participation in empathetic actions.

AD Review



SPECIAL ARTICLE

IMPROVING DRUG-THERAPY DECISIONS THROUGH EDUCATIONAL OUTREACH

A Randomized Controlled Trial of Academically Based "Detailing"

JERRY AVORN, M.D., AND STEPHEN B. SOUMERAI, M.S.P.H.

Abstract Improving precision and economy in the prescribing of drugs is a goal whose importance has increased with the proliferation of new and potent agents and with growing economic pressures to contain health-care costs. We implemented an office-based physician education program to reduce the excessive use of three drug groups: cerebral and peripheral vasodilators, an oral cephalosporin, and propoxyphene. A four-state sample of 435 prescribers of these drugs was identified through Medicaid records and randomly assigned to one of three groups. Physicians who were offered personal educational visits by clinical pharmacists along with a series of mailed "unadvertisements" reduced their prescribing of the target drugs by 14 per cent as compared with controls (P = 0.0001). A comparable reduction in the number of dollars reimbursed for these drugs was also seen between the two groups, resulting in substantial cost savings. No such change was seen in physicians who received mailed print materials only. The effect persisted for at least nine months after the start of the intervention, and no significant increase in the use of expensive substitute drugs was found. Academically based "detailing" may represent a useful and cost-effective way to improve the quality of drug-therapy decisions and reduce unnecessary expenditures. (N Engl J Med 1983; 308:1457-63.)

THE physician is the final common pathway for nearly all professional decisions about the use of health resources. In the past, it was assumed (or at least hoped) that physicians would make such decisions on the basis of up-to-the-minute familiarity with biomedical science as well as a concern for cost effectiveness that would help protect the patient's or the public's purse. Evidence suggests that this is often not the case; incomplete or outdated medical knowledge and decisions to use unnecessarily costly resources are frequent in day-to-day practice.[1-3] Regulatory attempts to improve the quality and the economy of medical practice have produced mixed results and have recently been scaled down or dismantled.[4] Competency requirements for physicians after initial licensure have been unacceptable to the profession and are not likely to become widespread in the foreseeable future.[5] Continuing education through formal courses and journals has an important role, but a relatively small proportion of physicians participate actively in such activities,[6] and their impact on actual physician performance is controversial.[7] Even in the absence of flagrantly poor patient care, small amounts of "slip-

From the Department of Social Medicine and Health Policy and the Division on Aging, Harvard Medical School. Address reprint requests to Dr. Avorn at Harvard Medical School, 643 Huntington Ave., Boston, MA 02115.

Supported by the Division of Extramural Research of the National Center for Health Services Research.

- "...improve the...appropriateness of...therapeutic decision-making...in a non-coercive, non-regulatory way."

- "...our hypothesis was that sound data on clinical pharmacology and cost issues could be used to improve such decisions if that information was presented in an educational outreach program that was rooted in the established principles of behavio(u)ral science, market research, and communications theory"

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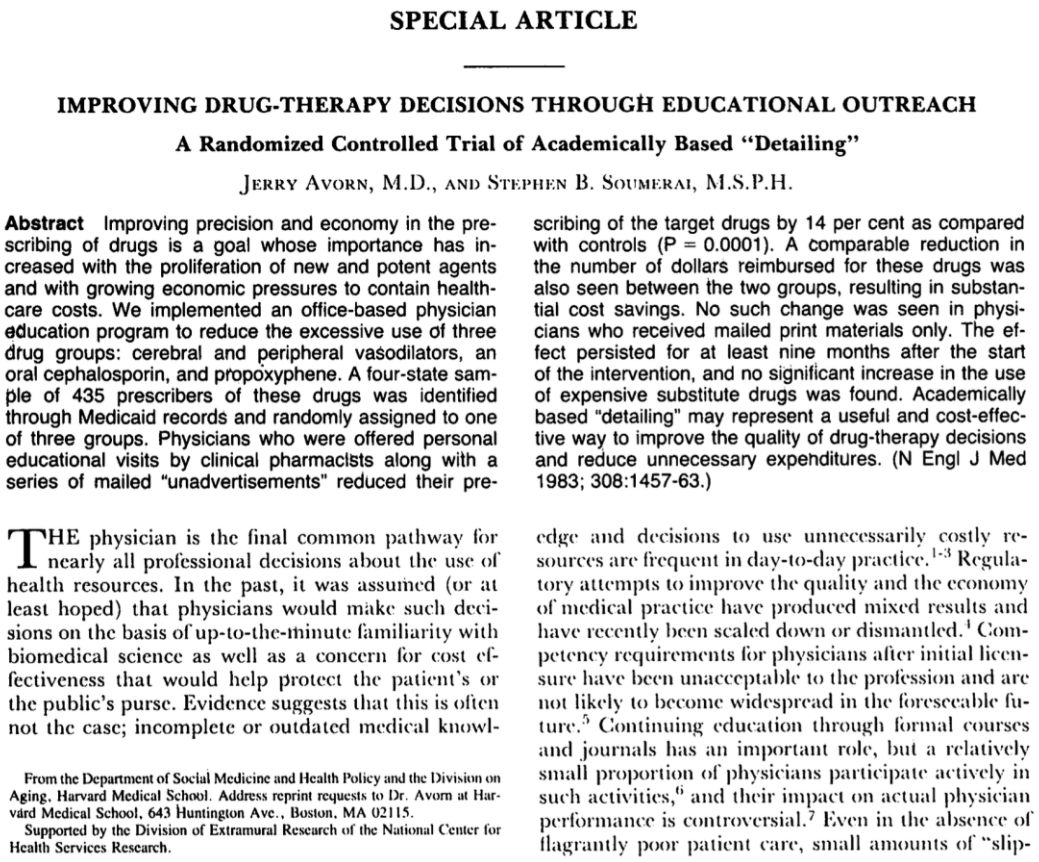
- In other words…
  - …it's always been about empathy

AD Review



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- AD isn't just about content (and to increase the challenge for everyone involved)
  - "…the person making the consuming decision is different than the payer, who…may also be different from the actual consumer"

- It's about…
  - Decision-making
  - Behaviour
  - Relationships

Behavio(u)r Intervention Continuum

Grol, R., & Wensing, M. (2004). What drives change? Barriers to and incentives for achieving evidence-based practice. *Medical Journal of Australia*, 180(S6), S57-S60.

Empathy in AD… benefits outweigh the risks

- You have 5, 10, maybe 15 mins with a prescriber, AND,
- Months of preparatory work and content
- If you didn’t already have compassion for their burnout…
  - Perhaps you’ll agree that your relationship will be accelerated by taking an empathetic approach, even at the risk of compromising their long-term resilience

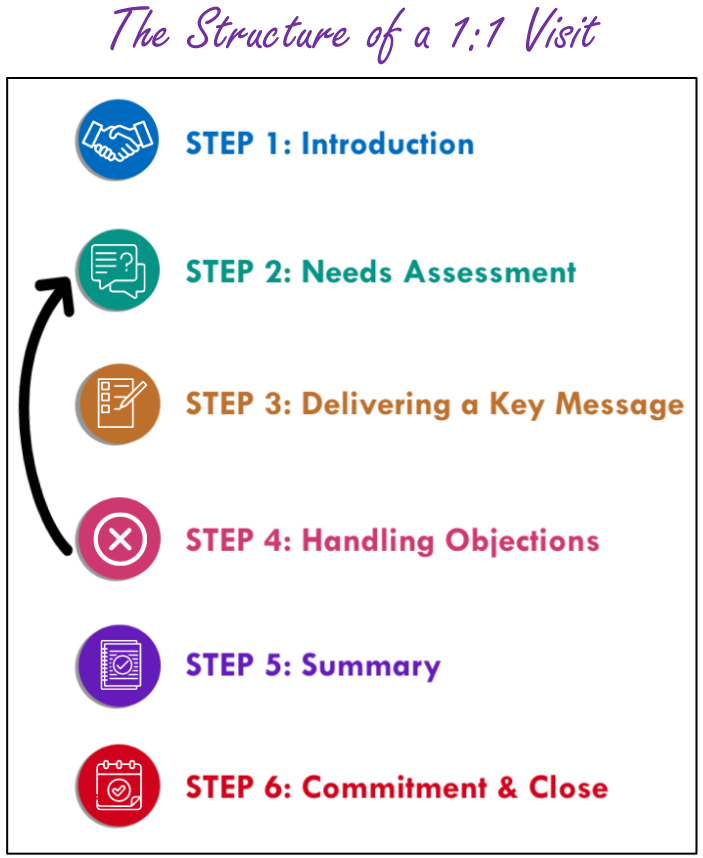
Empathy in AD… benefits outweigh the risks

- We aren’t their teachers
- We aren’t their coaches
- We aren’t their mentors
- We aren’t their bosses

- They already get a lot of “tough love” from others

- We come to them in a service role

Empathy in AD… more than needs assessment



It runs through the entire process

- Why do we do an introduction?
- Why do we congregate around key messages?
- Why do we handle objections?
- Why do we summarize?
- Why do close?

AD… by definition…

- …is empathy in the form of a process

- In other words:
  - We care for carers

Breakout #2

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Observer

15 minutes

5 minutes for each role/ scenario

Detailer

You have never met this clinician before

Detailing topic (choose your adventure):

- Your own AD topic – past, present, future
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Focus on your introduction and needs assessment

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Read your envelope and do your best to play the role outlined for you

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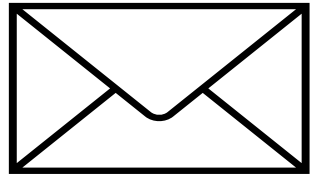
Watch for key questions / phrases / techniques the detailer used



Breakout #2 – Debrief (~15 minutes)

- What did you/your groups members do differently this time?
  - Did it work?
- How did the detailers demonstrate empathy?
- Did you try something new, and it didn’t work?
- What did you learn?
- What will you do differently as a detailer in the future?

How is it relevant to Academic Detailing?

- Strengthen or build relationships
- Anticipate/figure out participant needs or concerns & respond appropriately (with compassion)
- Aid in perspective taking / gathering perspectives
- Influence others
- Suspend judgement
- Help you understand how people are responding to you
- *Empathetic understanding is therefore both an important determinant of how well we communicate with each other as well as a personal characteristic that facilitates our ability to persuade other people to accept an idea, feel a particular way, or pursue a certain course of action*

Faith Valente, 2016. "**Empathy and Communication: A Model of Empathy Development**," Journal of New Media and Mass Communication, Conscientia Beam, vol. 3(1), pages 1-24.

Tips

- **Talk to people. Be curious. Listen more.**
  - Better to ask people about their experiences, what they want, what they think, than imagine how they might be feeling
  - Focus on the individual's current experience, not your own experience

- **Take a moment. Practice presence. Avoid distractions.**
  - Reflect and control your own emotional response allows for a more thoughtful response

- Often, **solve problems with compassion** (e.g. move through the world with the understanding that everyone is struggling and trying their best)

The limits of Empathy. Adam Waytz. Emotional Intelligence Empathy. Harvard Business Review Press. 2017.

Empathy Limitations

- It’s exhausting ➡ compassion fatigue
- It’s zero-sum ➡ empathy is finite for any one person
- It's an "instinct" ➡ narrow focus
- It can erode ethics ➡ altruism to rationalize dishonestly

“Empathy takes time, and efficiency is for things, not people”
– Stephen Covey

The limits of Empathy. Adam Waytz. Emotional Intelligence Empathy. Harvard Business Review Press. 2017.

Strategies to Overcome

- **Prioritize and take breaks**
  - Target specific groups instead of empathizing with everyone
  - It's easier to empathize with one person than many people
  -
- **Make it less of a sacrifice**
  - Look for the win-win
  - Focus on areas where you both agree (find common ground), even if they seem small

- **Contact generally increases empathy** for outsiders

- **We're in control,** in any given moment, we can turn empathy up or down like a volume button on our phone

The limits of Empathy. Adam Waytz. Emotional Intelligence Empathy. Harvard Business Review Press. 2017.

Closing

"Empathy has no script. There is no right way or wrong way to do it. It's simply listening, holding space, withholding judgement, emotionally connecting, and communicating..." - Brene Brown