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Original Article

Empathy In Practice: Comparing Physicians' Self-Assessment and Patient Perceptions Using the Jefferson Scales

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Abstract

Background: Empathy is essential for effective patient care, improving communication, satisfaction, and compliance. This study was done to assess empathy levels in a tertiary care center in South India. **Methods:** A cross-sectional study among 40 physicians from various specialties assessed physician empathy using the Jefferson Scale of Physician Empathy–Health Professionals version (JSE-HP) and patient perceptions using the Jefferson Scale of Patient Perceptions of Physician Empathy (JSPPPE). Five patients per physician participated. Data were collected from January to June 2024, and was analyzed by a t-paired and ANOVA tests and a multilevel linear mixed-effects model. **Results:** A total of 200 patient–physician encounters were analyzed. Most physicians were under 50 years (90%), and patients were aged 19–85 years. Mean physician self-empathy (JSE) was 74.5 ± 8.6, and mean patient-perceived empathy (JSPPPE) was 31.0 ± 4.6. No correlation was observed between self- and patient-rated empathy ($\rho = -0.06$, $p = 0.71$). In multilevel analysis, self-empathy was not associated with patient-perceived empathy ($\beta = -0.05$, 95% CI [−0.15, 0.06], $p = 0.37$). Physician age, gender, and specialty were not significant predictors. The intraclass correlation coefficient (ICC = 0.066) indicated 7% of variance in patient empathy scores was due to physician-level differences. **Conclusion:** A disparity exists between physicians' self-perceived and patient-rated empathy. Experienced physicians and those in patient-centered specialties are rated higher. Regular empathy training and feedback can align self-perceptions with patient expectations, improving communication and care quality.

Introduction

Empathy is the ability to recognize, understand, and respond to others by cognitively perceiving their feelings and physical state. It is the ability to gain understanding into others' physical and emotional experiences either by interpreting their behavioral cues or by mentally recreating those experiences and moving through them as if they were one's own.[1]

Empathy can be classified into cognitive, affective, behavioral, social and ecological elements, though the predominance of one or the other differs amongst scholars.[2–6] Empathy has to be distinguished from the similar concept of sympathy, which is the recognition of another's affective experience without re-experiencing it, either through interpretation or mental simulation.

With regards to patient care, empathy is believed to be a cognitive skill that helps to develop a relationship between health professionals and their healthcare users which reinforces their cooperation towards a tailor-made therapeutic plan, enhancing the patient's satisfaction from the therapeutic process. This way, quality of care is enhanced, errors are eliminated, and an increased percentage of health care recipients positively experience therapy with better compliance.[7] Such an approach might enhance the sense of usefulness among healthcare providers, ensuring better job satisfaction and preventing burnout.[8]

Various studies have shown that empathy varies depending on the country, gender of the healthcare worker, the specialty, the evaluation instrument used and the evaluator.[9–12] Literature supports the need of incorporating empathy during the training and practice years of practitioners.[13]

Owing to the critical role of empathy in physician–patient relation and clinical outcomes, the purpose of this study is to evaluate empathy status in physicians and correlation of empathy scores by patients, with demographic features in a tertiary care center in South India.

Methods

Study design and setting

This is a cross-sectional study conducted at a tertiary care teaching hospital with outpatient and inpatient capacity.

Participants

In order to obtain a widespread idea of empathy among physicians, data was collected from physicians from the

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departments of Medicine, Surgery, Ophthalmology, ENT, Obstetrics and Gynecology, Orthopedics, Dermatology and Medical Gastroenterology of the institute. Physicians were selected as per convenience and these specific departments were chosen due to their varying levels of patient complexity.[14]

Sample Size and Study Period

A total of 40 physicians and their respective patients (200) were assessed. The research data was collected on a weekly basis per department from January 2024 to June 2024.

Data Collection and Study Tool

Physicians were asked to analyze their empathy using the questionnaire 'The Jefferson Scale of Empathy (JSE)-HP version'. Patients treated by the same primary physician and his/her team on an inpatient or outpatient basis at PSGIMS&R were asked to give their perception of their treating physicians' empathy by using questionnaire 'Jefferson Scale of Patient Perceptions of Physician Empathy (JSPPPE)'. Informed consent was obtained from each individual physician and patient.

The Jefferson Scale of Empathy

The Jefferson Scale of Empathy (JSE) is a validated instrument to measure clinical empathy in physicians and practicing health professionals (HP-version), medical students (S-version), and health professions students other than medical students (HPS-version).[15] These versions have been developed with minor alterations in them to make them relevant for each target population.[16] It is a 20-item answered on 7 point Likert-type scale (1- Strongly Disagree, 7- Strongly Agree) which takes up to 5 minutes to fill.17 A global score is calculated with higher scores (ranging from 20 to 140 for the total scale) reflecting a higher empathetic approach.

The JSE-HP is a tool used by health professionals to assess their own level of empathy in patient care.

The Jefferson Scale of Patient Perceptions of Physician Empathy (JSPPPE) is a brief, 5 item survey developed for measuring patient perceptions of their physician's empathy. Each item of the survey is answered on a 7-point Likert scale (1-Strongly Disagree, 7-Strongly Agree).

Satisfactory evidence of the Jefferson Scales, in support of its validity and reliability properties, amongst various healthcare workers has been reported.

JSE-HP, JSE-S, and JSE-HPS focus on self-assessment of empathy. JSPPPE shifts the perspective to patients evaluating their physician's empathy.Using both JSE-HP and JSPPPE together, as in this study, helps identify gaps between physician self-perception and patient experience.

Ethics Statement

The study was approved by the institutional human ethics committee (IHEC Project 23/266) in accordance with the institutional guidelines and regulations.

Inclusion and Exclusion Criteria

40 physicians in total, from four (n=19) 'people-oriented' and four (n=21)'technology-oriented', specialties were included (Internal Medicine, Medical Gastroenterology and Obstetrics & Gynecology and Dermatology, Surgery, Orthopedics, Ophthalmology and Otolaryngology, respectively) The selection of participants was by convenience sampling.

Adult patients coming to outpatient clinics or inpatient care of the respective departments during the study period were included. Consenting patients were added in a consecutive manner till required sample size was attained. The departments of Psychiatry and Pediatrics and their patients were excluded as it was felt that a level of discrepancy may arise. The department of emergency medicine was excluded due to the nature of urgent care.

Procedure

Physicians completed the questionnaires before approval was obtained to include their patients. Outpatients received questionnaires immediately after their consultation, while inpatients were approached on the second day of admission. English was the primary medium of communication in this private tertiary care hospital; any language barriers were addressed by bilingual volunteers. Non–English-speaking participants, primarily Tamil- or Malayalam-speaking, received verbal translations from a bilingual interviewer, as validated translated versions were unavailable. To ensure double blinding, patient responses were anonymized, and no identifying information was collected.

Sample Size

Enrollment was capped at five consecutive patients per physician as both physician and patient interviews added approximately 25 minutes to each clinic session. With 40 consenting physicians across eight departments, this produced a patient sample (n) of 200. An effective sample size (neff) was calculated to ensure whether 200 patients were a representative sample. As 5 patients were nested within physicians (m=5) and observations could be co-related, a design effect (DE) was calculated to understand the effect of clustering on variance on precision.

$$neff = n/DE$$
$$DE=1 + ICC(m - 1)$$

The effective sample size under clustering is n = 200 / 1.60 ≈ 125; assuming ICC = 0.15 from comparable outpatient empathy scores.[18, 19] With SD of mean JSPPPE (σ) ≈ 8 points,15 the 95% confidence interval (CI) for JSPPPE mean scores.

$$95\%\ CI = 1.96 \times \sigma/(n_{eff})^{1/2}$$
$$= 1.96\times 8/(125)^{1/2}$$
$$= +1.4$$

This proved that the design would achieve a +1.4 precision around previously reported mean JSPPPE scores while staying within practical extensions of clinic and physician times.

Data Analysis

Data were analyzed using the Statistical Package for the Social Sciences (SPSS) version 23 (SPSS Inc., Chicago, IL, USA) and RStudio version 2025.05.01 +513 (R Foundation for Statistical Computing, Vienna, Austria). Descriptive statistics (mean, standard deviation, and range) were computed for physicians' self-rated empathy scores on the JSE-HP (range 20–140) and patients' perceived empathy on the JSPPPE (range 5–35). Independent t-tests were used to compare means between pairs of groups, and one-way ANOVA was applied when comparing more than two groups.

A multilevel linear mixed-effects model was employed to account for clustering of patients within physicians. The primary outcome was patient-perceived empathy (JSPPPE), and the primary predictor was physician self-empathy (JSE-HP). Physician age group, specialty, and gender were included as covariates. The model was specified as: JSPPPEij= β 0+ β 1(JSE-HPc)+ β 2(Age)+ β 3(Specialty)+ β 4(Gender)+u0j+ ε ijwhere i represents individual patients, j represents physicians, u_{0j} is the random intercept for physician, and ε ij is the patient-level residual error. A random intercept was included to account for between-physician variance. The JSE-HP was grand-mean centered for interpretability. Model parameters were estimated using restricted maximum likelihood (REML), and p-values were derived using Satterthwaite's degrees of freedom approximation.

Effect sizes are reported as unstandardized regression coefficients (β) with 95% confidence intervals (CI). The intraclass correlation coefficient (ICC) was calculated to quantify the proportion of total variance in patient-perceived empathy attributable to physician-level differences. Additionally, an unadjusted Spearman rank correlation was performed between mean physician JSE-HP and mean patient JSPPPE scores aggregated per physician. All statistical tests were two-tailed, with a significance threshold of α = 0.05.

Results

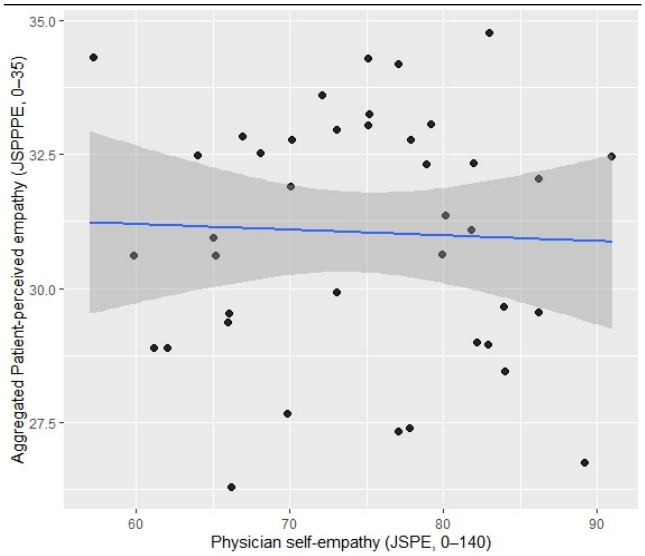
The analysis included 200 patient–physician encounters involving 40 physicians. Of these, 18 (45%) were aged <35 years, 18 (45%) were between 35 and 50 years, and 4 (10%) were older than 50 years. Patient ages ranged from 19 to 85 years. The mean (SD) score for physicians' self-rated empathy (JSE-HP) was 74.5 ± 8.6, while the mean (SD) for patients' perceived empathy (JSPPPE) was 31.0 ± 4.6.

At the physician level, there was no significant correlation between self- and patient-rated empathy (Spearman's ρ = –0.06, p = 0.71). In pairwise comparisons, male physicians had marginally higher but statistically insignificant JSE-HP scores than female physicians (p > 0.05).

Physician self-empathy was not significantly associated with patient-perceived empathy (β = –0.05, SE = 0.05, 95% CI = –0.15 to 0.06, p = 0.37; ***Figure 1***). After standardization (mean = 0, SD = 1), this relationship remained non-significant (β = –0.08, SE = 0.10, 95% CI = –0.28 to 0.11, p = 0.37).

Physicians aged 35–50 years reported the highest self-empathy scores [mean = 76.2 (SD = 7.3); 95% CI = 74.6–77.7], followed by those <35 years [mean = 73.8 (SD = 9.5); 95% CI = 71.7–75.7], and physicians >50 years [mean = 70.5 (SD = 7.8); 95% CI = 66.8–74.2]. Interestingly, patients rated physicians aged >50 years significantly higher on empathy [mean = 32.1 (SD = 2.8); p = 0.033]. This is depicted in ***Figure 1.***

Figure 1. Relationship Between Physician Self-Empathy (JSPE) and Patient-Perceived Empathy (JSPPPE).



Legend: Scatterplot showing the relationship between physicians' self-rated empathy (JSE-HP, 0–140) and aggregated patient-perceived empathy (JSPPPE, 0–35) for each physician (N = 40). Each point represents one physician and their corresponding aggregated patient-score. The blue line represents the fitted linear regression line, and gray-shaded band indicates the 95% confidence interval. The relationship between JSE-HP and JSPPP was not significant (Spearman's ρ = –0.06, p = 0.71).

Physicians from technically oriented specialties (Dermatology, Otolaryngology, Surgery, Ophthalmology, and Orthopaedics) had lower mean JSPPPE scores [mean = 30.9 (SD = 4.0)] than those from person-oriented specialties (General Medicine, Obstetrics and Gynecology, and Medical Gastroenterology) [mean = 31.0 (SD = 5.0)].

In the multilevel model, none of the covariates (physician age group, specialty, or gender) were significantly associated with patient-perceived empathy (all p > 0.05). The variance of the physician-level intercept was 1.42 (SD = 1.19), and the patient-level variance was 20.08 (SD = 4.48). Approximately 7% of the variance in patient empathy scores was attributable to between-physician differences (ICC = 0.066).

Discussion

Empathy, compassion, and communication skills are strongly linked to physician traits that have been demonstrated to enhance patient-centered outcomes. This study was undertaken to identify the current perception of empathy amongst the clinicians and their respective patients.

Our hospital-based cross-sectional study involving 200 patients and 40 physicians found a negative correlation between physicians' self-assessed empathy and patients' perceptions of physician empathy during clinical encounters.

Previous studies using various scales, such as the Consultation and Relational Empathy (CARE) questionnaire, have similarly reported a lack of correlation between physician and patient ratings of empathy.[20,21] Although most physicians considered themselves empathetic, there was an insignificant inverse correlation between their self-rated and patient-rated empathy scores (ρ = –0.06, p = 0.71). This finding indicates that higher self-assessed empathy does not necessarily translate into higher empathy ratings from patients. One possible explanation is that physicians may possess an inherent sense of empathy but fail to address patients' unmet emotional or supportive needs during consultations.

Interestingly, patients rated physicians aged >50 years higher for empathy, despite these physicians assigning themselves lower self-empathy scores. Effective communication with patients is an art refined through years of experience and practice. Older physicians may have established longer relationships with their patients and developed greater skill in managing clinical workloads efficiently. Prior studies have shown that older, more experienced physicians tend to rate themselves higher in empathy than younger physicians.[22,23] Over time, clinical experience and exposure to diverse patient populations may enable a more holistic approach to care, with seasoned clinicians focusing more on the human aspects of medicine.

Our study population comprised individuals from similar ethnic and linguistic backgrounds, which may explain the absence of significant associations between patient–physician demographic factors and empathy ratings.

In this study, physicians' self-rated empathy (JSE-HP) did not correlate with patient-perceived empathy (JSPPPE), even after adjusting for physician age, gender, and specialty in a multilevel model. The intraclass correlation coefficient (ICC) indicated that approximately 90% of the variability in empathy perception lay at the patient–encounter level. This discrepancy suggests that physicians' self-perceptions of empathy may not accurately reflect the empathic behaviors perceived by patients during real clinical interactions. The absence of significant effects for physician age, gender, or specialty further implies that empathy, as perceived by patients, is likely more situational and relational than trait-based.

Contrary to earlier reports, our study found no significant association between physician gender or specialty and patient-perceived empathy.[24,25] However, specialties requiring greater patient interaction and communication (e.g., general medicine, obstetrics and gynecology) showed slightly higher empathy scores in the preliminary analysis compared to more technique-oriented fields (e.g., surgery, dermatology, orthopedics). This may be because physicians in patient-centered specialties spend more time on history taking and discussion, allowing for richer empathic communication, whereas procedural specialists may focus more on technical skills, leading to briefer and less emotionally engaged interactions.

This study contributes to the existing literature by providing a regionally grounded perspective from the Indian healthcare context, where physician–patient interactions often reflect unique cultural expectations and communication styles.

Conclusion

This study suggests a disparity between physicians' self-assessed empathy and patients' perceptions of their empathy, as measured by the Jefferson Scales. There are lacunae globally, in the medical curricula, typically lacking substantial emphasis on empathy training. Empathy plays a significant role in successful clinical encounter, patient satisfaction and treatment outcomes.

Experienced physicians, particularly those over the age of 50, tend to receive higher empathy scores from patients, despite giving themselves lower self-assessment scores. This may indicate that while self-perception of empathy may diminish with age and experience, patients may appreciate the depth of care and communication skills developed over years of practice. Conversely, younger physicians may rate themselves higher, possibly reflecting an idealized view of their empathetic capabilities that does not always align with patient feedback. This variation could also be influenced by individual differences in attitudes toward humility. We also observed that specialties demanding greater patient interaction and communication scored higher on empathy compared to more technique-focused specialties. This suggests that the nature of the specialty has an influence on the practice and perception of empathy, with specialties that prioritize patient communication and relational skills inherently fostering higher empathy. However, there cannot be a 'one size fits all' approach, and definitely the patients' needs and demands differ according to the specialty they are consulting.

Continuous training and self-reflection is pivotal to bridge the gap between physicians' self-assessments and patient perceptions of empathy. Setting up regular feedback systems and improving communication skills training can aid physicians in better understanding and addressing patient expectations, thereby enhancing patient satisfaction and care outcomes. Future research should evaluate the factors behind the discrepancies and propose interventions aimed at aligning physicians' self-perceptions with patient assessment to promote a more empathetic healthcare environment.

Limitations

This study has several limitations. The use of convenience sampling from a single tertiary care hospital and a small, unevenly distributed physician sample limits generalizability and statistical power for subgroup analyses. Validated translations of the

questionnaires were unavailable, necessitating verbal interpretation by bilingual volunteers, which may have affected the reliability of patient responses.

Response bias is possible, as participating physicians may have been more self-aware or confident in their empathy, and patients might have provided favorable ratings due to social desirability. Important confounding factors, including physician workload, patient volume, consultation length, and case complexity, were not controlled for and may have influenced empathy ratings. Cultural factors may also have affected perceptions, as older physicians received higher patient-rated empathy scores, potentially reflecting societal norms rather than true differences in empathic behavior.

Future studies should use larger, representative samples, validated multilingual instruments, objective assessments, and control for workload-related confounders to improve validity and generalizability.

Summary – Accelerating Translation

Title: Empathy in Practice: Comparing Physicians' Self-Assessment and Patient Perceptions Using the Jefferson Scales.

Main problem to solve: Empathy forms the foundation of effective physician–patient relationships and directly influences communication, satisfaction, and therapeutic outcomes. Despite its recognized importance, there remains a gap between how physicians perceive their own empathy and how patients experience it during clinical encounters. Understanding this discrepancy is vital for translating empathy from an internalized professional value into a consistently observable clinical behavior.

Aim: The present study aimed to assess empathy among physicians using the Jefferson Scale of Empathy – Health Professional version (JSE-HP) and compare it with patient perceptions of their physicians' empathy using the Jefferson Scale of Patient Perceptions of Physician Empathy (JSPPPE). The study also explored the association of empathy scores with physician demographic characteristics such as age, gender, and specialty.

Methodology: A cross-sectional study was conducted at a tertiary care teaching hospital in South India between January and June 2024. Forty physicians across eight departments and their respective 200 patients participated. Physicians completed the JSE-HP, while their patients evaluated them using the JSPPPE. Statistical analyses were performed using SPSS and RStudio. Descriptive statistics, independent t-tests, ANOVA, and multilevel linear mixed-effects modeling were used to analyze relationships between self- and patient-rated empathy, accounting for clustering of patients within physicians.

Results: The mean physician self-empathy score (JSE-HP) was 74.5 ± 8.6, and the mean patient-perceived empathy score (JSPPPE) was 31.0 ± 4.6. There was no significant correlation between physicians' self-assessed empathy and patients' perceptions (Spearman's $\rho = -0.06$, $p = 0.71$). Older physicians (>50 years) received higher empathy ratings from patients despite lower self-scores, suggesting that experiential factors and communication style may enhance perceived empathy. No significant associations were found between empathy scores and physician gender or specialty, although person-oriented specialties showed slightly higher mean values. Approximately 7% of the variance in empathy perception was attributable to physician-level differences.

Conclusion: This study reveals a clear disparity between physicians' self-perception of empathy and how patients actually experience it. Self-assessed empathy may not reliably reflect empathic communication in clinical settings. The findings highlight the need for continuous empathy training, reflective practice, and structured patient feedback to bridge this perception gap. Incorporating empathy assessment into medical education and clinical audits can accelerate the translation of empathy from theoretical understanding to measurable, patient-centered practice—enhancing care quality, trust, and therapeutic outcomes..

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Author Contributions

Conceptualization: ET. Data Curation: SS, BM, SSR, RS. Formal Analysis: ET, SS. Investigation: SS, BM, SSR, RS. Methodology: ET, SS. Project Administration: ET, SS, BM, SSR, RS. Resources: ET, SS, BM. Software: SS. Supervision: ET. Validation: ET, SS. Writing - Original Draft: SS, BM. Writing - Review Editing: ET.

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