ORIGINAL ARTICLE

PERCEPTION OF DOCTORS, PATIENTS AND FAMILY MEMBERS ABOUT THE ROLE OF CLINICAL EMPATHY IN PROMOTING PATIENT RIGHTS IN THE CONTEXT OF DISCLOSURE

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Highlights: (1) The importance of developing the empathetic capacity of healthcare professionals in the context of health disclosure is understood. (2) Clinical empathy was considered a factor of respect and engagement, facilitating understanding and acceptance by patients and family members. (3) The relationship between clinical empathy and patient rights was verified, especially in the context of disclosure, emphasizing the need to incorporate empathy into the care process, especially in challenging situations such as adverse events.

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PERCEPTION OF DOCTORS, PATIENTS AND FAMILY MEMBERS ABOUT THE ROLE OF CLINICAL EMPATHY IN PROMOTING PATIENT RIGHTS IN THE CONTEXT OF DISCLOSURE

ABSTRACT

The present article aims to analyze the existing connections between clinical empathy and patient rights, proposing foundations to build a theoretical basis for the branch of Clinical Bioethics that is based on patient rights and clinical empathy. To this end, a descriptive-exploratory research was conducted with a qualitative approach, involving 4 doctors who deal with the topic of disclosure and 5 patients and family members who experienced an adverse event in the context of health care.All participants are adults and legally capable. Disclosure is a complex and multifaceted approach, encompassing a communicational process and an apology. In the event of an adverse occurrence, disclosure must be adopted by the health organization. Thus, from its beginning to the end, it is a process permeated by emotions, given that some harm has been caused to the patient and their families, and, in certain situations, it has also affected the professional directly involved in the event. Therefore, it is important to investigate the role of empathy in the disclosure process, especially regarding the fact that the empathy of health professionals is subject to a choice process, in being empathetic or not in the disclosure process, in empathetic communication, and in the apology, which can directly affect all those involved.

Keywords: Empathy; Disclosure; Patient Rights; Patient; Adverse Event.

INTRODUCTION

When a patient is in a healthcare relationship, their expectation is that it will be performed with quality and safety. However, adverse events associated with healthcare do occur, which can be a traumatic situation for those involved1.In this regard, it is essential that the patient and family members are informed, in a transparent and empathetic manner, about the adverse event and that their needs are taken into account[1].

According to data from the World Health Organization (WHO)[2], it is estimated that 134 million adverse events occur annually in low and middle-income countries, making it one of the top 10 causes of death and disability in the world. In high-income countries, up to 10% of hospital admissions result in harm to patients, and most is avoidable[3].

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After an adverse event occurs, research indicates that patients want and expect someone to inform them about what happened, apologize, and implement actions to ensure that the event does not recur [4]. However, the prevalence of disclosure and its perception varies worldwide, in Europe, Asian countries, and the United States, ranging from 39% to 97%[5]. Likewise, the needs of patients and families are generally not prioritized, as in some situations, their perspectives are not even heard by healthcare professionals, who do not develop and utilize their listening and empathy skills, and by healthcare organizations, which do not adopt a patient safety culture based on learning and full reparation to the victim of harm[6].

As can be seen, patients and families affected by adverse events need direct interaction with health professionals and organizations, which results in the duty of health systems to prepare to meet the needs of patients, especially those that translate into their rights. Consequently, priority must be given to the right to information and complete redress following the occurrence of an adverse event.

In this sense, it is noted that, in the event of an adverse occurrence, disclosure must be adopted by the health organization, which consists of an open dialogical process, where there is room for listening for all those involved in order to seek the adoption of measures to repair the damage caused to the patient[1]. It is recorded that disclosure can contribute to improving the relationship between the health professional and the patient, increasing society's trust in professionals and in the health organization[3], thus contributing to the reduction of lawsuits against such professionals and organizations, as well as related costs. Likewise, according to Albuquerque[1], it constitutes a means of implementing the principles of prioritizing patient-centered care and restorative conflict resolution, as well as the rights to information and full reparation.

Thus, disclosure, from the perspective of the needs of victims resulting from the damages suffered, is an approach that lacks studies in Brazil. This research is based on the studies developed by the Research Group of the Patient Rights Observatory of the Graduate Program in Bioethics at the University of Brasilia, It aims to develop theoretical contributions for the deepening of disclosure, specifically based on the approaches of clinical empathy and patient rights. Thus, this study addresses the perception of doctors, patients, and family members of patients who are victims of adverse events, regarding the role of clinical empathy in promoting patient rights in the context of disclosure.

Clinical empathy involves the professional's ability to understand the patient's perspective and their health condition, and to participate in decision-making based on that understanding[7]. Particularly, clinical empathy can help healthcare professionals develop behaviors in favor of patients' rights, especially by taking the patient's perspective and resonating with their emotions, as well as by understanding their will, preferences, and needs in the context following the occurrence of harm[8]. Disclosure is a complex and multifaceted approach that encompasses a communication process and an apology. For a deeper study of disclosure, it is essential to recognize that, from its beginning to its end, it is a process permeated by emotions, given that some harm was inflicted on the patient and their families, and in certain situations, also on the professional directly involved in the event. Moreover, it is emphasized that a quick, empathetic, and open response from healthcare professionals can prevent the escalation of unnecessary legal conflicts[9]. Thereby, it is not possible to understand disclosure adequately without shedding light on the emotions that permeate it, recognizing them, and learning to manage them. Furthermore, it is added that disclosure should not be a mere formality for healthcare organizations or the fulfillment of protocols, but should be guided by the perspective of patients and families, aiming to meet their needs. Research indicates that key elements of disclosure for patients and families are rarely considered central by the professionals involved in disclosure, such as the apology, the explanation, and the commitment to prevent its recurrence[10].In this regard, even when disclosure is made, the conversations that accompany it rarely meet the needs of patients and families[11]. Aiming to contribute to changing this situation, it is crucial to investigate the role of empathy in the disclosure process, particularly regarding the fact that the empathy of healthcare professionals is subject to a choice process – to be empathetic or not – in the disclosure process, empathetic communication, and the apology.

Thus, the present research aims to analyze the role of clinical empathy in promoting patient rights in the context of disclosure. Therefore, it focuses on the perception of the role of clinical empathy in promoting patient rights, especially concerning the right to information and the right to full reparation, considering the perspective of doctors, patients, and relatives of victims of adverse events in healthcare.

METHOD

Ethical aspects related to research participants

The present study was approved by the Research Ethics Committee of the University Center of Brasília (Opinion No. 6.105.042, CAAE 69559923.1.0000.0023). Prior to conducting the interviews, the researchers explained the content of the Informed Consent Form, which was signed by the participants in two copies. The anonymity of the participants is ensured through their designation adopted in this research, namely: doctor 1, doctor 2... and patient/family member 1, patient/family member 2 up to patient/family member 5.

Type of research

This is a descriptive-exploratory type of research, with a qualitative approach. The research was conducted and structured according to the Standards for Reporting Qualitative Research instrument, which consists of 21 items for reporting qualitative research, preserving its characteristic of flexibility to accommodate various paradigms, approaches, and methods[12].

This study is part of the research developed by the Clinical Empathy Research Group of the Patient Rights Observatory of the Graduate Program in Bioethics at the University of Brasília.

Participants of the research and invitation strategy

The present research was conducted involving 4 doctors who deal with the topic of disclosure and 5 patients who have experienced some adverse event in the context of health care, or family members of those patients. All participants are adults and legally competent. The Doctors and patients/family members participating in the research were invited from the snowball sampling method, which is understood as: "The type of sampling referred to as snowball is a form of non-probabilistic sampling that uses referral chains. In other words, from this specific type of sampling, it is not possible to determine the selection probability of each participant in the research, but it becomes useful for studying certain groups that are difficult to access[13]." In this way, key participants are used, referred to as seeds, in order to locate other participants with the necessary 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 start their contacts and to probe the group to be researched”[13]

Conducting and analyzing the interviews

The technique of semi-structured interviews was employed. Regarding semi-structured interviews, they are understood as an enunciative device, that is, "the interview is not merely a tool for appropriating knowledge; rather, it represents a device for producing/capturing texts, that is, a device that allows revisiting/summarizing various situations of enunciation that occurred at earlier moments[15]." The interviews aim to access content that the participants have already formulated in previous interactions, especially since they are doctors and patients, or family members of these patients, "but which would be extremely difficult for the researcher to access, as they would need to follow the referred actor in all their interactions over a more or less extended period, waiting for the intended topic to be addressed, etc."[15]

Thus, the choice of doctors and patients, or family members of these patients, is justified because the theme of the interviews is familiar to them, given that it deals with the healthcare of patients and the empathy of the doctor in such a context. In this sense, it is noted that "only those who already 'know' something about a certain topic are interviewed (that is, those who are capable – or who have been capable – of producing text(s) about what they wish to know)." Specifically, regarding the choice of doctor participants, this occurs because interactions between patients and doctors are more common compared to those of other stakeholders nursing professionals. Thus, in order to facilitate access to the previous formulations of the patient participants, or their family members, the choice was made to include only physician participants. However, it is understood that the reflections drawn from the interviews can be applied to other health professionals, considering their specificities.

The semi-structured interview was conducted through pre-formulated questions about the definition of an empathetic doctor, the importance of the doctor's empathy in achieving more positive outcomes in healthcare, and how the doctor's empathy helps the patient to: better understand their own treatment and what actually happened during the adverse event, as well as to understand the needs of patients and families after the occurrence of harm in the context of healthcare. The questions were similar for both groups of participants, as the aim is to provide reflection on the same research subject, which is the interface between clinical empathy and patient rights.

Research Environment

The interviews were conducted via the Zoom Platform by the principal researchers, between the months of July, August, and September 2023, after a prior contract was established and a convenient time was scheduled for the participant.

Analysis of the interviews

The interviews were analyzed based on Minayo's theoretical formulation of thematic analysis, which is grounded in the following stages: pre-analysis; exploration of the material and treatment of the results obtained and their interpretation[15]. Indeed, thematic analysis involves the articulation of the theme that is linked to a statement about a given content, encompassing a bundle of relationships that can be graphically expressed in a word, phrase, or summary15. In this way, firstly, the reading of the transcribed interviews was carried out to become familiar with their content. Subsequently, the following steps concerning the transcribed interviews were adopted: (a) identification of the core meanings of each question, aiming to guide the exploration of the material to detect excerpts from which contents close to the mentioned cores would emerge; (b) analysis of these excerpts and their core meanings; (c) establishment of correlations between the core meanings that emerged from the excerpts of the material and those identified in the questions; (d) analysis of the core meanings of the material, aiming at the construction of broad themes; (e) reconfiguration of the excerpts of the data related to the core meanings based on the identified themes; (f) unfolding of the themes into contents, with a view to enabling their articulation with the theoretical formulations that underpin their analysis.

Thus, based on the steps of the thematic analysis explained, four thematic categories emerged, namely: (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 full reparation.

The results were analyzed in light of the theoretical foundation of clinical empathy, based on the concept of clinical empathy adopted in this project; the formulations of Howick[16] and Halpern[17] were chosen because both adopt multidimensional conceptions of clinical empathy, which include its emotional component. Regarding the interfaces with patient rights, it is noted that there are few studies on the subject, particularly when it comes to the context of disclosure, which leads to the exploratory nature of this research.

Regarding the concept of clinical empathy, it is worth noting that Mercer and Reynolds7 proposed the definition of clinical empathy as a form of professional interaction that encompasses skills and competencies. Howick and Rees[18] structure the concept of clinical empathy based on three components: (a) understanding the patient's situation, their feelings, and perspectives, recognizing the difficulties of putting oneself in the patient's place; (b) communicating that understanding, checking its accuracy; (c) acting according to that understanding in a way that helps the patient. To that end, studies on the subject point out that healthcare professionals should have the following behaviors as guiding principles of empathetic care: (a) taking enough time to understand the patient's story; (b) discussing general topics; (c) offering encouragement; (d) giving verbal cues that the patient is being understood (hmm, ahh, etc.); (e) to be physically engaged (through the adoption of certain postures, gestures, eye contact, appropriate touch, and others); (f) to be welcoming during the consultation, from its beginning to the end. Therefore, there is consensus in the specialized literature on the subject that clinical empathy consists of three components: (a) understanding; (b) demonstration of that understanding;(c) therapeutic action based on understanding, after verifying its accuracy[19]. The professional's understanding focuses on the social, physical, and mental needs of the patient, as well as their perspective, particularly regarding the patient's worldview. Demonstrating understanding implies the professional's ability to share with the patient what they have grasped. A professional who understands what is happening with the patient but does not communicate it is seen as lacking empathy.

Regarding the interface between clinical empathy and patient rights, only a few studies on empathy and human rights have been found. The formulations of Rorty[20], Hunt[21], Von Harbou[22], and Phongpetra[23] stand out on the subject. Although it is not the focus of this project, it is worth noting that traditional theories of human rights have ignored the role of emotions, altruism, and human nature[22]. On the other hand, others have argued that empathy would be sufficient, making rights unnecessary. However, as Hunt[21] argues, the issue is not to replace claims for rights with claims for empathy; the central question is how to make demands for rights meaningful in societies where they were absent, that is, how to change hearts and minds.

Specifically regarding patient rights and their connection to clinical empathy, it is important to highlight that empathy is a human trait that is conditioned by various personal and environmental obstacles. Thus, respect for patient rights, which constitute the ethical minimum in health care, cannot be entirely subject to the empathy of the professional. Furthermore, empathy, as an individual capacity, does not hold the same ethical function as patient rights, which consist of a set of rules resulting from socially constructed agreements on how patients should be treated. Therefore, patient rights are an indispensable tool so that clinical empathy does not merely serve a utilitarian ethical role in enhancing the well-being of both the patient and the professional, but can also predict appropriate ethical behaviors from the patient's perspective. Regarding the rights of patients who have suffered any adverse event in the context of health care, addressed in this research, two rights were chosen: the right to information and the right to full reparation[24]. These rights served as a starting point to investigate the connections between clinical empathy and patient rights, based on the theoretical formulation that clinical empathy, beyond the mentioned benefits and its role in specific approaches in health care, plays a role in advocating for the realization of patients' rights in the daily practice of clinical work. Studies on the correlations between clinical empathy and patients' rights are scarce. This scarcity can be attributed to the fact that the theoretical framework around such rights is still in its early stages and that clinical empathy is a topic unfamiliar to researchers in the field of Law. However, some research is noteworthy, such as that which claims that empathy, spiritual intelligence, and nursing responsibility can improve attitudes in favor of patients' rights[25].

RESULTS

Four thematic categories were identified and classified that emerged from the material obtained from interviews conducted with research participants. The categories are: (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 full reparation.

In addition to the presentation about each of the categories, excerpts from the participants' speeches will also be presented to exemplify the indicated categories. The speeches from participants will be presented separately, that is, medical participants and patient and family participants, given that their analysis was conducted separately and, later, in comparison of both.

Category 1 - Definition of clinical empathy

Category 1 deals with the components of the concept of clinical empathy, understanding it as a multidimensional capacity of health professionals, which has three components: understanding, through which the professional comprehends what is happening with the patient/family; communication, in which the professional verifies the accuracy of their understanding; and finally, their action, which aims to adopt a supportive and caring behavior.

Participants-doctors:

Thus, clinical empathy is present when the doctor "has the ability to connect with the patient, looks at the patient from the patient's perspective" (doctor 4) and when the professional "tries to understand the universe in which the other is involved" (doctor 3). It is emphasized that "empathy is not an attribute, in fact, that is limited to putting yourself in someone else's shoes" (doctor 3). Thus, clinical empathy involves "how much he is able to make himself understood by the patient and how much he is able to understand the needs of the patient, what the patient expects, the doubts, the anxieties" (doctor 3).

Finally, the empathetic doctor is also 'the one who listens to the patient. He listens to their complaints, he listens to their doubts' (doctor 3) and is 'someone who has the perception to dedicate part of their time to listening to the patient, to hear their complaints, to actually pay attention to what they bring' (doctor 2).

Participants-patients and family members:

The empathetic professional 'welcomes and seeks dialogue, seeks to listen to the patient and gives space for the patient to express their sensations, their feelings also in that situation they are experiencing' (patient/family member 1).

Category 2 - Benefits and importance of clinical empathy for the patient

Category 2 identifies the benefits and importance of clinical empathy for patients.

Physician participants: Thus, for the physician participants, clinical empathy contributes to the patient's trust in the relationship with the healthcare professional and adherence to treatment, for example: "you need to connect and open up with your patient so that they trust that they are being heard in an appropriate way, (...) you improve the quality of their care, (...) you listen and even the subtleties that are the biggest modifiers of outcomes" (physician 1).

Participants-patients and families:

Regarding the statements of patients and family members, the benefits also correspond to adherence to treatment and trust in the entire team of healthcare professionals: "the patient feels welcomed, feels received, and begins to have trust in the doctor and the team (...). This improves adherence to treatment, improves dialogue, trust (...)" (patient/family 1).

Furthermore, they highlight the relationship between clinical empathy and the treatment of the patient as a subject of rights and not an object of care: "they all have to listen to the patient, feel the patient, because the patient is a person, he is not simply an object that you go there, look at and see an exam and give the diagnosis (...)"I have even gone through the experience of having a wrong diagnosis because the doctor didn't want to listen to the patient" (patient/family member 2) and "so, if you seek a medical professional and they treat you with empathy, with respect, right, listening and treating the person as truly a human being, their care would be in agreement with what we expect" (patient/family member 5).

It is noted that disclosure can contribute to improving the relationship between the health professional and the patient/family, increasing society's trust in professionals and in the health institution[3].

Category 3 - Clinical empathy and the right to information

The third category identifies the relationship between clinical empathy and the patient's right to be informed. It is essential to point out that this right is not limited to the right to receive accessible information based on scientific evidence about diagnosis, treatment, exams, and procedures but also includes the right to receive information about adverse events and the measures to be taken by the healthcare organization to prevent similar occurrences in the future.

Participants-doctors:

Doctor 4 emphasizes that "it is important to welcome the person in their needs," thus highlighting the importance of considering the specific needs of each patient or family member: "the same adverse event, exactly the same, happening to different people and in different circumstances, is interpreted in different ways and we need to respect this interpretation."

Participants-patients and family members:

From the perspective of patients and their families, considering their own experiences related to the occurrence of harm in health care, it was reported that the lack of clinical empathy hindered their understanding of what happened to the patient. For example: 'It affected me a lot because, from the very beginning of the situation, when I had my first surgery, I, as a patient, had no right to know anything about what was really going on. (...) So, when I asked about something, any doubts about what was being done, what would be done, they would just change the subject or speak harshly to create that distance (...)' (patient/family 4). Furthermore, they reported that the professionals lacked empathy after the occurrence of the adverse event, for example: "there was a lack of empathy and, after the event, it got worse. There was no sensitivity from either the doctor or the nurses regarding the situation we were experiencing" (patient/family 1) and "(...) they did not want to listen, they did not have the empathy to stop and listen to the patient or, in this case, the patient's parents (...) it got worse and we only found out 38 days after the incident" (patient/family 2).

Category 4 - Clinical empathy and the right to full reparation

This category deals with the full reparation after the occurrence of an adverse event in the context of healthcare. Reparation includes, in addition to possible monetary compensation, an apology, social and psychological support, the provision of healthcare if necessary, financial reparation, and the involvement of the patient/family in the construction of preventive measures for adverse events, if they wish.

Regarding the apology request, in the context of disclosure, this request is understood as an important measure to demonstrate respect and empathy towards the patient and family members, victims of harm in healthcare.

Participants-doctors:

From the perspective of the healthcare professional, clinical empathy was presented as fundamental in disclosure and in the apology: "I think empathy plays a fundamental role in this sense. The apology is part of the disclosure, it is mandatory, but it's not enough for me to just come and say to this person that I'm sorry (...) it's not just the word, right (...) from the moment I have the ability to empathize with the patient, I think it becomes easier for me to define, together with this person" (doctor 4); "if the doctor is empathetic with the patient, then, at the moment of communicating an adverse event, this is certainly fundamental for the patient to have a better understanding and a better acceptance, and this is reinforced by the empathy from the entire multiprofessional team" (doctor 3); "when you have an empathetic bond between the personas, you can humbly admit your mistakes (...) admitting that we have this vulnerability is part of it and that this request is genuine" (doctor 2).

It is important to emphasize that, from the perspective of a doctor (doctor 1), there was disagreement about the apology request, "because there are no guilty parties when we talk about adverse events (...), if an apology is to be made, it must be made on behalf of the institution, never on behalf of the professional." However, it is essential to highlight that the apology request is one of the essential elements of disclosure and has a positive impact on trust, directly contributing to the reconciliation between the healthcare professional and the patient[26].

Participants - patients and family members:

Regarding clinical empathy and the apology, the patients and family members emphasize that, in their experiences, the professionals involved in the event did not apologize, for example: "an apology is something I think you will rarely see, right? (...) when something goes wrong, some sequelae or something that will harm and completely change this patient's life, the apology that this person should give is: 'How can I help you? How can I try to fix what I did? No one wants to make a mistake'" (patient/family member 3). In the same vein: "so, like, I never received an apology. On the contrary, they... they laughed at us, they called us crazy (...)" (patient/family member 5). It is highlighted that the patient expects an apology when there is an adverse event: "We expect them to acknowledge the mistake and apologize. If only to have that feeling of no, they admit it, they are apologizing, but unfortunately, nothing" (patient/family member 4).

Regarding the correlation between clinical empathy and the right to full reparation, specifically in terms of identifying and addressing the needs of patients and their families, it is important to highlight that, in addition to an apology, other needs should be met. Reparation will be guided by empathy and must take into account the perspective of the patient and their family. The needs of patients and families are generally not prioritized, as in some situations, their perspectives are not even heard by health professionals, who do not develop and utilize their listening and empathy skills, and by health organizations, which do not adopt a patient safety culture based on learning and full reparation to the victim of harm[6].

Participants-doctors:

Likewise, this understanding is verified from the perspective of the doctors, for example: "when you work with empathy, (...) you make it clear that the team is there to support you throughout your entire journey" (doctor 3).

Participants-patients and families:

In this sense, patients and families understand that empathy can contribute to meeting the needs of patients and families, for example: “if they show empathy, they will try to do everything possible to fix what they did wrong, whatever the reason (...) the longer it takes for the team to try to repair the damage, the worse the case gets (...) it is extremely important not only to fix the case, to try to correct the mistake, but also, psychologically for the family” (patient/family 2); "Exactly that, if the person realizes they made a mistake and they, with all the power, all the knowledge they have in Medicine, try to remedy this sequela or reduce this sequela, it will contribute a lot to the family and to the life of that patient. Now, what cannot happen is for these people to be thrown to the wind as they are being." (patient/family member 3).

DISCUSSION

The results of this study, based on the analysis of categories grounded by Minayo, revealed four central themes: Definition of Clinical Empathy, Benefits of Clinical Empathy for the Patient, Clinical Empathy and the Right to Information, Clinical Empathy and the Right to Full Reparations, which dialogue with the conceptualization of the multidimensionality of clinical empathy. The theme emerges as a determining factor to strengthen patient trust, improve treatment adherence, and provide dignified, person-centered care, especially in situations experienced by patients and families after an adverse event occurs. In the realm of patient rights, this work reveals the scarcity of research concerning clinical empathy and such rights, especially in the context of disclosure. The analysis highlights two specific rights: the right to information and the right to full reparations.

Regarding the right to information, clinical empathy acts as a catalyst for providing information tailored to the individual needs of patients and families, as introduced by patient/family 1: "the patient feels welcomed, feels received, and begins to have trust in the doctor and the team involved in health care. This improves treatment adherence, enhances dialogue, and builds trust." That is, clinical empathy is directly related to the listening by the doctor.

The ability to truly understand the unique concerns and experiences of a patient and their family requires the application of medical knowledge, but also the creation of space for expressing the pains of this patient and their family, especially after the occurrence of an adverse event. By cultivating a sensitive listening, the doctor not only collects essential information to understand the needs of the patient and family after the adverse event, but also establishes a connection that transcends the technical aspect. The report from the patient/family aligns with this proposition: "when the doctor has empathy and puts himself in the patient's place, he ends up treating them better. He doesn't simply arrive, look at your face, administer the medication, and leave. He has to stop, he has to talk, listen to the patient. Because when he starts to listen to the patient, he even develops empathy, he can discover a lot more than just looking at the patient, holding the exam in hand, because he has to treat the patient and not just perform tests. The empathetic approach, anchored in careful listening, strengthens the doctor-patient relationship and positively influences adherence to treatment and the emotional well-being of the patient, thus reflecting on the overall quality of healthcare provided.

On the other hand, the lack of empathy and active listening can significantly harm the patient's understanding of the diagnosis, adherence to treatment, and adverse events. The patient/family member infers about the correlation of these aspects: 'a person who has no empathy at all simply gives a diagnosis, says, 'look, this treatment is not for me, I’ll give you some medicine to relieve your pain and then you can look for another team member... I went to the doctor's office he mentioned for the next two days, I got tested and it was nothing at that time. If it had been something serious, my treatment would have been correct because I had support, you know. I simply wasn't discarded.'

According to the participants, both doctors and patients and their families, empathy contributes to building trust and mutual understanding. The lack of empathy, especially regarding the right to information after adverse events, was associated with negative experiences and difficulties in the doctor-patient relationship.

In the context of the right to full reparation, clinical empathy can play a role in rebuilding bonds, especially in the act of apologizing. Despite some disagreements, most participants describe the importance of this gesture in maintaining trust and effectively repairing relationships between health professionals and patients/family members. The apology is identified as a component of disclosure, positively contributing to the doctor-patient relationship.

It is observed that full reparation requires, in addition to monetary compensation, an apology, as seen in the case of patient/family 5: 'It's the bare minimum, it's the bare minimum that is expected. Unfortunately, with us, there was NO attempt at all; they didn’t try to make any contact, they didn’t try for any closeness to offer an apology, for anything. It’s sad, but it’s real.'

By recognizing the inherent vulnerability of patients, clinical empathy, alongside welcoming, not only considers the protagonism of the patient in health care, but also reveals itself as a facilitating agent for the realization of the rights analyzed here.

From the perspective of the health professional, the scope of responsibility for the apology is broadened with the institution according to the doctor: 'if the apology is made, it has to be made in the name of the institution, never in the name of the professional... but it is always in the name of the institution.'

The last category presents clinical empathy as a means of approaching the needs of patients and families after an adverse event. It tends to enable the conduct of a comprehensive reparative process, based on diagnosing the specifics of each case and promoting actions aimed at the satisfaction and well-being of those involved, as indicated by Doctor 1: "You have to remove all these blockages and all these negative counter-transferences and transfers and really try to feel what the person is feeling, which is empathy."

The development of this research shows how clinical empathy contributes to the implementation of protocols in delicate situations with patients and families, as stated by the doctor 4 “It is important for us to take on the perspective of the other in order to understand that person, because, again, it’s the same adverse event, exactly the same, happening to different people and under different circumstances, interpreted in different ways, and we need to respect that interpretation, and, in fact, try to contemplate and support that person in their needs. I can only know what those needs are if I can establish some degree of empathy with that person”.

By understanding the emotions of the patient and their families in critical moments of high vulnerability, doctors can adapt protocols in a more sensitive and personalized manner. Given the connection established that creates a trusting environment, it provides more comfort to the patient during delicate procedures. In this way, empathy enhances the technical execution of the protocols and significantly contributes to the emotional and relational aspect of interventions after adverse events occur.

It is noted that the present study brought forth a theme that is innovative in itself, as well as providing new reflections on the importance of developing the empathic capacity of health professionals in the context of disclosure in health, and its repercussions on the patient's right to information, which is the central ethical foundation of disclosure, in the act of apologizing and in listening to the patient's perspective.

Limitations

It should be emphasized that this investigation presents some limitations that must be considered from its premise of originality.

This research cannot be generalized to diverse contexts involving adverse events in health care and the interactions between doctors and patients/family members who experienced some adverse event in the context of health care. The population that was investigated also has limitations, as it included only doctors and patients who suffered an adverse event in the context of health care, or family members of these patients, without specific demographic determination. It is also important to highlight the exploratory nature of this research, as, based on the literary investigations conducted, no research was found on the correlation between clinical empathy and patient rights in the context of disclosure.

FINAL CONSIDERATIONS

This study aimed to investigate the relevance of clinical empathy in the context of disclosure and patient rights after adverse events in healthcare, understanding the importance of developing the empathic capacity of healthcare professionals in the field of health disclosure, and its repercussions on the patient's right to information, which is the central ethical foundation of disclosure, in the apology and in listening to the patient's perspective. The thematic analysis highlighted the dimensions of empathy, the benefits perceived by the participants, and the relationship with the right to information and full reparation.

The interviewees indicated in their reports and experiences that empathy contributes to the building of trust, adherence to treatment, and mutual understanding. The lack of empathy, especially regarding the right to information after adverse events, was associated with episodes of difficulties in the doctor-patient relationship and in understanding what had really occurred. Furthermore, patients and families emphasized that they were not heard in various situations, which negatively impacts healthcare. The relationship between clinical empathy and the act of apologizing was described based on the perception of individual experiences from patients/family members, who relate specific actions in the disclosure process. Empathy was considered a factor of respect and engagement, facilitating understanding and acceptance from patients and families. Regarding full reparation, empathy is described as essential for meeting the physical and emotional needs of patients and families. The empathetic understanding of healthcare professionals has been associated with more effective efforts in repairing the damages caused.

Finally, the described results present a scenario of connection between clinical empathy and patient rights, especially in the context of disclosure, highlighting the need to incorporate empathy into the care process, particularly in challenging situations such as adverse events, contributing to a more ethical and patient-centered practice. It is noted that the disclosure of adverse events to patients and families, as well as the attention given to the resulting needs, should be the most patient-centered element of health care; however, the literature indicates that, frequently, the proper importance is not given to this in the practice of professionals. This research represents a milestone in understanding the intersection between clinical empathy and patient rights, providing bibliographic resources for healthcare professionals, researchers, and public policy makers.

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PERCEPTION OF DOCTORS, PATIENTS AND FAMILY MEMBERS ABOUT THE ROLE OF CLINICAL EMPATHY IN PROMOTING PATIENT RIGHTS IN THE CONTEXT OF DISCLOSURE

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