

Empathy: A Miracle or Nothing at All?

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Friday night at the hospital, Mr. Asucar refused his evening insulin dose. His nurse tried to contact Mr. Asucar's physician and found that Dr. Xylom was on call. Dr. Xylom, who had never met Mr. Asucar, asked about the difficulty.

Doctor: *Why doesn't he want to take it?*

Nurse: *I don't know. He's always difficult. I think maybe he's in denial.*

Doctor: *I see. What have his sugars been?*

Nurse: *Not too bad. Tonight he was 120 and this morning 100.*

Doctor: *OK. Let's not give him any insulin tonight, and I'll talk with him in the morning.*

Nurse: *Sounds good, but I doubt you'll be able to convince him.*

On Saturday morning, Dr. Xylom went to see Mr. Asucar. He found the patient in bed, with a woman seated by the bedside.

Doctor: *Hello, I'm Dr. Xylom. You must be Mr. Asucar. Is this Mrs. Asucar?*

Mr. Asucar: *Yes, Doctor. This is my wife.*

Mrs. Asucar: *You're probably mad at us.*

Doctor: *I don't think so. What should I be mad about?*

Mr. Asucar: *I didn't want to take the insulin last night.*

Mrs. Asucar: *He's had so many reactions.*

Mr. Asucar: *When they happen at night, they're especially bad. I've had it happen several times, and I don't want any more.*

Doctor: *I see. Above all, you want to avoid nighttime hypoglycemia. I can understand that.*

Mr. Asucar: *That's it.*

Doctor: *So, avoiding hypoglycemia in the middle of the night is really important to you.*

Mr. Asucar: *It's awful. You wake up sweaty and confused.*

Doctor: *I see.*

Mr. Asucar: *Maybe not wake up at all.*

Doctor: *Pretty scary.*

Mr. Asucar: *You got it, Doc.*

(Pause)

Mrs. Asucar: *What do you think we should do?*

Doctor: *Well, how about trying a lesser dose of insulin and checking your blood sugar during the night?*

Mr. Asucar: *OK, sounds good.*

An intern and a nurse had accompanied Dr. Xylom into the patient's room. When the trio moved out to the hallway, Dr. Xylom asked them what they thought had happened. The intern said, "Nothing at all. Apparently he had changed his mind before you came in." The nurse disagreed. "It was a miracle," he said. "Ten minutes ago he was set against any evening insulin."

What is Empathy?

The responses from the intern and nurse are typical of observers of effective empathic communication. But what is empathy? We like the definition offered by Coulehan and Block [1]:

Empathy is a type of understanding. It is not an emotional state of feeling sympathetic or sorry for someone. Nor is it the same as the virtue of compassion. Although compassion may well be your motivation for developing empathy with patients, empathy is not compassion. . . . In medical interviewing, being empathic means listening to the total communication—words, feelings, and gestures—and letting the patient know that you are really hearing what he or she is saying. The empathic physician is also the scientific physician because understanding is at the core of objectivity.

Participants in any conversation want to be heard and understood [2]. We may also want agreement, advice, reassurance, or a laugh, but above all, we want evidence that we have been heard and understood. If we are the listener, our task is threefold: to listen, to try to understand, and to give clear evidence of that understanding to the patient. Consider these examples:

Patient: *I've had this pain since last Christmas. It isn't there all the time but maybe a dozen or so times in the last 6 months. It lasts about half an hour, maybe even an hour. It sits right here under my ribs on*

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the right. And, you know, the funny thing is that I usually feel better if I walk around while the pain's there. It's worse if I sit or lie down.

Doctor: *Any other symptoms? Nausea? Vomiting? Cough?*

This physician listened without interrupting until the patient seemed to be running down. Then the physician logically proceeded to fill in some of the blanks. Sensible? Sure. But the patient had no clear evidence that he had been understood. Maybe the physician misheard the location of the pain or didn't hear the report that movement helped. To confirm that she heard accurately and to show she understands, the physician needs to tell the patient what she thinks she heard:

Patient: *(as above)*

Doctor: *Let me see if I heard you right. You've been having separate pain episodes under your rib cage on the right maybe a dozen times in the past 6 months, lasting 30 to 60 minutes, and you feel better if you move about.*

Patient: *That's right, Doctor.*

This sort of response is called reflective listening. It is an understanding response. Reflective listening often includes a framing statement at the beginning, such as "Let me see if I got this right" or "Sounds like you're telling me. . . ." The framing statement tells the patient that it is your turn to talk and his turn to listen and enlists him to confirm or correct your understanding. When you have finished your understanding response, you know you've done the job right when you get the patient's acknowledgment. According to Barrett-Lennard [3], communication is not finished until the person being understood realizes that he has been comprehended and closes the circle with something akin to, "You got it, Doc".

Good listeners do not use reflective techniques with every message, but, when a misunderstanding can have serious results, reflection helps to avoid errors. To see this technique in use in an abbreviated fashion, you need only listen to conversations between airline pilots and air traffic controllers. All important data are repeated.

Pilot: *Denver control, this is United 123.*

Air traffic controller: *United 123.*

Pilot: *I have information delta and have just passed intersection orange.*

Air traffic controller: *United 123, switch to 234.5.*

Pilot: *234.5. Good day, sir.*

The Power of Empathy in Medicine

Interactions in which the physician responds empathically are impressive. They demonstrate the immense power of the physician's understanding of his patient's concerns, values, or fears (eg, Mr. Asucar's concern with nocturnal hypoglycemia and his fear of dying during such an episode).

Although we may fail to provide this sort of response because of our own fears or uncertainties, an empathic connection is probably the most therapeutic of our conversational tools [4-6]. Use of empathic communication seems to be one of the few panaceas in medicine: it yields improved patient and physician satisfaction, better patient adherence to therapy, improved clinical outcomes, and fewer malpractice suits [7-11]. Unfortunately, many opportunities for empathic communication are not obvious because the patient does not name his feelings and may not even express them clearly. Moreover, physicians often miss these oblique opportunities to identify and respond to the values or feelings implied. Consider this example from Suchman et al [12]:

Patient: *You know how your breast gets real hard and everything? You know how you get sort of scared?*

Doctor: *How long were you on the estrogen?*

The physician interviewing this patient missed this empathic opportunity. The response would have been more powerful had the physician recognized the patient's hint of being frightened and responded with some understanding.

Patient: *(as above)*

Doctor: *It does sound scary.*

With this response, it is likely that the patient would have felt heard, understood, accepted, and ready to go on with her story.

Obstacles to Empathy

Physicians introduced to the concept of empathic communication often raise one of four concerns.

1. *There are some people you just can't empathize with.*

Empathy does not necessarily entail liking someone. Theoretically, you could empathize with a violent felon if you were able to understand how he saw things. In fact, the effort to understand someone else's perspective is the key step to empathy. Olson [13] studied nurses' attempts to empathize with patients and found that their efforts were hampered by "not liking" a patient or blaming him for his condition. Some study participants found it difficult to empathize when they thought a patient was responsible for his own illness (eg, a smoker with lung disease). Nonetheless, true empathy is not concerned with liking or forgiving. An in-depth understanding of the situation may lead to some form of liking or forgiving, but it does not start with these states.

Some physicians assume that, because they have not had the patient's particular experience, they cannot empathize. For example, a male physician may claim that he cannot empathize with a pregnant patient because he's never been

pregnant himself. But a male physician can imagine changing shape, adding weight, and regarding such changes in his body as foreign. A fortunate physician will not have suffered the loss of a child, and, indeed, a grieving parent may ask, "How can you understand? You have never lost a child, have you?" However, most physicians could respond, "It is true that I have never lost a child. I have had losses, though, and can understand what a terrible loss this must be for you. This is probably the worst loss a person can ever experience, and I can understand your grief and your anger."

Some patients may reject our efforts to understand their feelings or motivation. These patients may find it hard to recognize their own feelings, or they may feel frightened by the intimate quality of an empathic comment. With such patients, perhaps the most comforting remark is something like, "Lots of people in your shoes would feel angry (or sad, or fearful). I hear you telling me that you don't have any of those feelings, but I think that if I were you, I'd be pretty upset" [14].

2. What do I do AFTER an empathic reflection?

The answer is "Probably nothing." We recommend remaining silent after an empathic remark, perhaps counting slowly to 10 before saying anything else. The pause allows the patient to absorb the experience of feeling understood and allows you to consider how it would be to feel or think what the patient is feeling or thinking. We often have a strong urge to rush on—to fix the situation or to reassure the patient. But consider Jacob Weisberg's remark, "There is no advice for a feeling" [2]. After we remark that we can understand how frightening it must have been to hear the diagnosis of cancer, we are often in a great hurry to add "but we have some terrific chemotherapy for this sort of tumor." It is usually better to hold the "but" and wait a few seconds before continuing. Often we have nothing to offer except our presence. This too should be offered, but only after the necessary pause.

3. Wouldn't an empathic response just open the floodgates of emotional disclosure?

Are the patient's emotional floodgates opened by the physician's display of understanding? Only in the sense that the patient's trust increases, and, with trust, the physician may be granted access to other and deeper feelings, values, and ideas. After empathic remarks, patients seldom pour out inchoate emotion or a litany of complaints; in fact, the opposite is usually true. If we fail to give evidence of understanding, the patient tries again and again to reach us, often with an escalation in the number and force of his emotional issues. Rather than the patient erupting with an outpouring of emotions after an empathic communication, we believe it is more often the physician's own feelings that surface and disturb the process. As Novack et al [15] note, "Unrecognized feelings and attitudes can adversely affect physician-patient

communication; they may interfere with physicians' abilities to experience and convey accurate empathy. . . ."

Among the emotional responses a physician might have to a patient's feelings, impatience can be a major obstruction to effective empathy. It takes considerable patience to listen to another person's story, to reflect what was heard, and to allow the necessary pause for conscious digestion of the material being reflected. Patience, like empathy, is a procedure that requires practice. Unfortunately, it is a procedure seldom taught to physicians.

4. I can work with most patients, but I have trouble with a really angry patient.

The emotion that is most difficult for physicians to respond to is anger. If the patient's anger is directed at someone else, some physicians fear empathizing because they imagine that the patient will be reinforced in her plans to seek revenge, perhaps through litigation. Yet, communicating our understanding does not imply agreement with the patient's complaints. And it tends to lessen the intensity of the anger, not increase it.

Patient: *I was so angry with that doctor 4 years ago that I could have torn him apart. If I hadn't been hooked up to all those wires and tubes, I would have pounded him into the floor.*

Doctor: *Sounds like you were really very angry with him.*

Patient: *That's right, Doc. I'm glad you understand.*

What if the patient is angry with you? Does communicating your understanding imply that you are guilty of some failure? Not necessarily. Consider a conversation between a patient and a physician that did not occur but probably should have:

Patient: *I couldn't get hold of you when I was home and hurting.*

Doctor: *I see.*

Patient: *I don't know if you do see, Doctor! You had promised that you'd be there if I needed you and I needed you and you weren't there.*

Doctor: *So you were home with the pain and it was frightening and you couldn't get me on the phone.*

Patient: *Yeah. . .*

Doctor: *And you felt alone and abandoned and angry with me.*

Patient: *That's about the size of it.*

Doctor: *I can imagine.*

Patient: *I know that phones are busy sometimes, but I really needed you.*

Doctor: *And you couldn't find me.*

Patient: *That's it, Doctor. I guess it doesn't do me any good to get angry with you, though. I know you're concerned about my welfare.*

Doctor: *Thanks for saying that. Maybe we can figure out another way for you to get help if you need it in the future and can't reach me.*

Patient: *OK.*

Relief of Isolation

A major goal of doctoring is to comfort our patients and reduce their suffering. One form of suffering that we all experience is isolation. Being understood decreases isolation and comforts us. If we omit empathic understanding, the patient feels alone with his illness and his fears.

Consider the dialogue that did occur when the patient above came into the hospital and told his story to a medical house officer. The conversation was painful to the patient, to the interviewing physician, and to the observing physician supervisor.

Patient: *I was home alone when I got the chest pain. It just kept increasing and increasing. I got weak and sweaty and I took a couple of nitros and tried to call my doctor but his line was busy. I felt awful. I thought I was dying. I sat there and I felt as if my pores had opened up and my soul was seeping out. My wife was out shopping and she called me; she's worried about me, you know. I didn't want to worry her so I said I was all right but the pain just kept on. I took a third nitro. I know I'm not supposed to take more than two but I couldn't figure out what to do. I tried to call my doctor again and the line was still busy.*

Doctor: *How long did the chest pain last?*

Patient: *All together? Maybe 3 hours; I don't know.*

Later, when asked why he did not remark on the emotional content of this patient's soliloquy, the physician said, "I thought he didn't want to talk about it." Perhaps a projection of the physician's own discomfort, this hesitation to comment on the patient's emotional distress led the patient to feel more isolated and not understood. How much better it would have been had the dialogue gone something like this:

Patient: *(as above)*

Doctor: *That sounds really frightening.*

Patient: *It was. I was scared out of my wits.*

Doctor: *And it sounds like you couldn't get help. Your doctor's line was busy.*

Patient: *I know. I felt kind of abandoned. I was scared and all alone.*

Doctor: *Scared and all alone.*

Patient: *Yeah, that's it, Doc. You can see how it was.*

Doctor: *Anything I'm missing about how it felt?*

Patient: *No, that's it. You've got it.*

A dialogue like this would have led the physician to understand the patient's entire experience, not just the duration of his pain. The patient would have felt more connected to the physician, his isolation lessened and his confidence increased.

Epilogue

Some physicians may think they do not have time to spend on empathic communication, especially in the era of managed care. Fortunately, as the examples above make clear, empathic communication costs very little time and, in the end, saves enormous amounts of time—time the patient spends telling her story over and over until finally a perceptive physician hears and understands. Besides, even if empathic communication did not lead to increased efficiency, how could we afford not to use this technique? How could we leave our patients feeling not understood and alone with their suffering?

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