‘A Crisis in Caring’ – A Place for Empathy & Compassion in Today’s Medicine

Introduction

His name was Mr ‘Malignant Melanoma Fractured Right Shoulder’.

Often, during a busy ward round, names are lost and the underlying disease or pathology replaces their identity. Sir William Osler (frequently described as ‘The Father of Modern Medicine’) was the first physician to pry medical students away from a curriculum of medical textbooks and lecture theatres to the then-revolutionary bedside clinical teaching.\(^1\)\(^-\)\(^3\) The modern medical curriculum strongly implements Osler’s educational concept with daily teaching ward rounds.\(^4\) He famously quoted that ‘it is more important to know what patient has a disease, than what disease the patient has’.\(^2\) Osler placed the utmost importance in the holistic care of the patient and treating the individual rather than a disease process.\(^1\)\(^-\)\(^3\) Similarly, Maimonides, one of the most prolific and influential Torah scholars and physicians of the 12th century, said, ‘May I never see in the patient anything but a fellow creature in pain. May I never consider him merely a vessel of disease.’\(^5\) Too often today, it appears that the concern for the patient is being replaced by a preoccupation with disease management.\(^1\)\(^-\)\(^3\)\(^6\)
It is with this in mind that I realised my most formative experience in medicine had occurred entirely accidentally on my first rotation as a Foundation Year 1 (FY1) trainee with Mr RA.

Case Study and Discussion

Mr RA was a kindly 70-year gentleman. Despite the devastating diagnosis of superficial spreading extensive malignant melanoma with widespread bony metastases, he refused sympathy. One day, he pleaded with me to postpone the blood transfusion he was due to have. He had friends visiting whom he hadn’t seen in 20 years. He wanted them to see him ‘at his best’. He had asked his wife to bring him his finest suit and his favourite Old Spice aftershave. He was preparing to celebrate his last birthday with the people he loved dearest. I empathised and reorganised his blood transfusion session as requested. As physicians, we must constantly strive to preserve personal dignity for patients, especially when their identities are threatened by the strange and often dispassionate hospital environment. On this occasion, I was humbled by Mr RA’s request and did my best to empower him whilst understanding and accounting for his medical needs.

Mr RA had been relatively stable in the 3 weeks he was with us. We treated him for recurrent pleural effusions with therapeutic pleural taps and talc pleurodesis. On the day he was due to be discharged, he told me he was very pleased that he would be able to fulfil his deepest desire; to return home to his warm bed in his quiet village and to be nestled within its comforting silence.
He wanted to have his wife’s hand within his as he ‘departed’. Sadly, shortly after that conversation, Mr RA suddenly went into cardiac arrest. This was my first time dealing with a cardiac arrest and I was very taken aback by the blasé approach my senior team members had regarding the situation.

Mutterings about ‘malignant melanoma, metastases’ floated about in heated discussions in the room regarding his resuscitation status. The outcome was to continue resuscitation but if successful; a ‘Do Not Attempt Cardiopulmonary Resuscitation’ (DNACPR) order should be actioned. Within 1 cycle of cardiac compressions, Mr RA came around. The crowd of doctors dissipated away silently, leaving me alone with Mr RA and a signed DNACPR by his bedside.

The next day, Mr RA appeared forlorn and defeated. He realised the reality that he was dying with the end point due swiftly. There was very little that I could say to help him, but I felt his anguish. He needed a dressing change that day. On this occasion, I made it a point to do it myself – cleaning every sore wound thoroughly and applying clean dressings – all in complete silence. I felt he understood my actions; that I cannot change the inevitable, but I can do my best to keep him as comfortable as I can. On completing this, Mr RA tried very hard to lift his fractured arm; predictably unsuccessfully. Then, unfazed and maintaining a dignified poise, he lifted his uninjured left hand and reached out for mine. He shook my hand firmly and held it there for a long moment. He whispered through glazed eyes, "I am very glad to have had the opportunity to meet you in my lifetime."

My heart filled with a confusion of heartbreaking warmth and despair.
It was in that tender moment that I felt with full force the realisation of the original reason I had chosen a career in medicine; the simple desire to help others. I had always admired the altruism and nobility of medicine and wanted this to embody my personage. However, it seemed that the elements I had cherished most – the humanity, empathy and compassion of medicine - was fast becoming secondary to the technical and cognitive abilities.\textsuperscript{6,9,11,16,17,32}

There is an obsessive preoccupation with biomedical medicine that does not only diminish the attention given to the bio-psychosocial aspects of medicine, but denigrates it as irrelevant.\textsuperscript{6,7}

\textit{The Benefits of Clinical Empathy and Compassion in Medicine}

Various studies have researched the role of clinical empathy in the medical profession.\textsuperscript{10-5,18,22,25,28,29,31,33-5,37-51,55-6} As illustrated in Chart 1, the Medline search for ‘physician empathy’ and ‘physician compassion’ revealed 798 articles published in the past 5 years and a fifth having been published as recently as in the past 12 months.
Clinical empathy and compassion have been associated with improved patient satisfaction, increased adherence to treatment, fewer malpractice complaints, improved physician health & wellbeing and professional satisfaction.\textsuperscript{13, 18, 23 – 27, 32, 34 – 36, 41}

\textit{Differentiating Empathy, Sympathy and Compassion}

Some studies suggest that there are important differences between the concepts of empathy, compassion and sympathy.\textsuperscript{36,43} Empathy is defined as the ability to understand the patient’s situation, perspective, and feelings and to communicate back that understanding.\textsuperscript{19} An empathic response always includes disentangling one’s own emotions from those of the other person.\textsuperscript{43} However sympathy does not entail an emotional separation from the other person’s emotional state and is therefore thought to interfere with clinical
In contrast, compassion is defined as a sympathetic consciousness of others' distress with a desire to alleviate it.\textsuperscript{36,43} Thus empathy lacks an internal motive to do something and is instead a technical ability.\textsuperscript{43} With reference to Mr RA, I provided empathy when lending a listening ear and demonstrated my understanding of his circumstances, however the actions of reorganising his blood transfusion and cleaning his wounds myself were in the interest of alleviating his distress, and thus acts of compassion.

There has been a recent change in the focus of communication skills in medical school training.\textsuperscript{54} A ‘patient-centred approach’ is favoured over a ‘doctor-centred approach’. Communications skills are now a separate category for assessment in OSCEs, which is mandatory for medical students to pass. The empathetic techniques taught are indeed very effective in satisfying a patient’s emotional needs\textsuperscript{34-4, 42}. However, as argued by Fan et al (2013), one does not necessarily need to be engaged with the patient to employ these techniques; and they can be used as an effective ‘mask’.\textsuperscript{42} This is likened to the model of ‘detached concern’ described by Halpern.\textsuperscript{30} It has been suggested that only physicians who attempt to genuinely understand what their patient is feeling and communicate their concern will achieve the aforementioned benefits of clinical empathy. Therefore it is only effective if the physician practices clinical empathy with compassion.
Effect of Medical Experience on Clinical Empathy & Compassion

At some point during medical training, a desensitisation process takes place for a majority of medical professionals. Some studies have identified that the degree of empathy shown by medical students decline over their course of training, most markedly during their final clinical years. It is ironic that the closer a medical student is to becoming a doctor, the less empathy they have left for the patients they will soon treat. Lown stated that 'Caring without science is well-intentioned kindness, but not medicine. On the other hand, science without caring empties medicine of healing and negates the great potential of an ancient profession. The two complement and are essential to the art of doctoring.' Chekhov was a bit more extreme in his views of caring and believed that medical students should spend half their time learning what it feels like to be ill. Both Chekhov and Lown emphasised the essential nature of empathy and compassion in medicine. It is crucial to be able to identify with the patient's feelings, fears and apprehensions so that the medical knowledge acquired can be applied meaningfully in the context of the patient's needs.

In the case of Mr RA, if one were to view him as a disease process; placing a DNACPR order was entirely appropriate considering the very poor prognosis of his diagnosis. However, if this had been discussed with Mr RA, would he have agreed with this decision? If not, would it be the responsibility of his caring medical team to aid him in achieving the outcome he desires (i.e. dying
at home)? Using informal survey, I had questioned this matter amongst senior and junior staff in the hospital I worked at. Senior staff were more inclined to agree that the DNACPR was the correct decision considering the extent of the disease, whereas FY1s were the most inclined to favour resuscitation for Mr RA. Interestingly, these differences in views between junior and senior staff have been researched in several studies.\textsuperscript{18, 25, 37} The different approaches in thought, empathy and compassion are related to the magnitude of medical experience one has. Studies have found that less experienced physicians perceive the pain of others more intensely than more experienced doctors.\textsuperscript{10, 52-3} However, pain-induced emotional distress was similar irrespective of professional experience. Surprisingly, practicing medicine for a longer time did not give doctors a direct advantage on learning how to down-regulate the detrimental effects of practicing empathy. Instead recent findings suggest that professional experience simply desensitises a doctor against the pain of others. Thus with seniority, there is a reduction in empathy but no reduction in personal or professional distress. Bill Ross, former head of family practice at the University of Texas, made an adept observation, "Why does it seem that the more we learn, the less we care. Does this mean that knowledge breeds contempt?".\textsuperscript{6} Whilst contempt is unlikely to be the prevailing thought of senior clinicians, it is more likely that with time, one unknowingly applies less empathy or compassion in the care for the patient, especially when caught up with other aspects of the patient’s management and work commitments.
Causes of Declining Clinical Empathy & Compassion

Various factors have been attributed to the depletion of clinical empathy and compassion in medicine. Some suggest that prolonged exposure to the pain of others alone may potentially decrease empathy levels. Other articles more critical of the physician allege that doctors generally lack the cognitive and emotional resources to engage in empathic processing. Most studies however credit the physician and recognise that empathy is an effortful exercise that requires cognitive flexibility and high levels of self-regulation. Empirical studies have shown that people have a limited capacity for self-regulation and that depletion of cognitive resources reduces clinical empathy. These cognitive resources may be particularly restricted in physicians owing to a demanding and stressful work pattern. This theory is supported by a study by Decety et al (2009) that has demonstrated that doctors who experience very low compassion satisfaction but high compassion fatigue were those who worked the highest numbers of ‘on-call’ shifts. They also had higher incidences of illness and sick leave. These results support the contention that overly demanding clinical duties can cumulatively deplete a physician’s cognitive resources, and thus inevitably affect their ability to engage in empathic processes.

It has been postulated that physicians who are most vulnerable to professional distress are those who have difficulties in regulating the negative emotions elicited by perceiving their patient’s distress. A recent
meta-analysis by Purvanova et al reviewed 183 studies and found that women in medicine were more prone to be emotionally exhausted than men.\textsuperscript{38} This may imply that women are at higher risk of burnout compared to their male counterparts.\textsuperscript{38-40} Another study shows that the highest scores of empathy exist among physicians at the front line of primary care, but that there is also a very high rate burnout in these physician cohorts.\textsuperscript{55}

One cannot deny that maintaining appropriate levels of clinical empathy is challenging because medical practitioners routinely deal with the most emotionally distressing situations—illness, dying and suffering in every form. However the majority of medical professionals do agree that clinical empathy is undeniably an integral component of effective medical care\textsuperscript{1-42, 55-59}. The challenge at present is not just to cultivate a culture of clinical empathy and compassion but to also equip the physician with techniques to down-regulate the detrimental effects of compassion fatigue and avoid burnout.

\textit{Techniques to Optimise Practice of Clinical Empathy & Compassion}

There has been growing research in the implementation of clinical empathy and compassion in medical practice, which include a variety of effective methods to aid the physician.\textsuperscript{24, 26, 35, 41-2, 56-59}

As the main agent for compassion, the doctor sensibly should be the first target for intervention.\textsuperscript{60} Educating the doctor, patient and families about the importance of clinical empathy and compassion including its benefits, would
help physicians to understand that it is central to their ability to understand patients and effectively conduct their clinical duties, leading to more satisfying outcomes.\textsuperscript{41,42} There is a tendency, especially in time-pressured environments, for the physician to justify to themselves and others that there is a ‘trade off’ between clinical tasks and ‘the soft bits’ of medicine.\textsuperscript{60} Providing physicians with knowledge of their their innate promoters and inhibitors of compassion can encourage better self-management (e.g. self-awareness of when a physician is being uncompassionate)\textsuperscript{60}. Training doctors on how to manage their expectations of patient behaviour, the diversity of disease course outcomes and learning to tolerate clinical ambiguity and uncertainty would greatly reduce emotional exhaustion \textsuperscript{41,42,60}. Physicians can reap the benefits of empathy and compassion and down-regulate the costs associated with the practice.\textsuperscript{26}

Evidence from developmental science, affective social neuroscience and neurological lesion studies suggest that empathy and its component processes are underpinned by specific neural systems.\textsuperscript{43–50} Recent findings reveal shared neural representations for own pain and other’s pain.\textsuperscript{52} Brain regions involved in the experience of physical pain including the anterior cingulate cortex, insula, periaqueductal grey, somatosensory cortex, orbitofrontal cortex, and amygdala are also activated by the perception or even the imagination of another individual in pain.\textsuperscript{43-50,60} Some neuroimaging studies have reported that physicians tend to down-regulate their empathic response to the pain of others.\textsuperscript{53} Recent empirical work suggests that with formal instructions in compassion, one can alter their neural responses to
suffering, like compassion cultivation training programmes. 58-9, 61

One landmark study saw primary care physicians undergo an intense 8-week program on mindfulness, meditation, self-awareness, and communication. 62 Another study involved 19 bi-weekly facilitated physician discussion groups incorporating elements of mindfulness, reflection, shared experience, and small-group learning. 63 Both of these programmes improved work satisfaction, reduced depersonalisation and showed sustained improvements 12 months later. 62-3 The CHANGES study by Van Ryn et al reviewed 4732 1st year medical students and found that students varied their attitude towards the value of physician empathy. 64 The student’s prior world-views and beliefs predicted their attitudes toward empathy and significantly influenced their response to curricula promoting empathic care. 64 Thus, training programmes promoting empathic care are more universally effective if students' pre-existing attitudes are taken into account.

It would also be helpful for patients to undergo training to enhance their relationship with their doctor. Potential areas include learning methods to communicate effectively and to have realistic expectations regarding clinical outcomes and a doctor’s ability to execute change in the circumstances. 60 Offering patient-training workshops in a primary care setting could enhance the doctor-patient relationship, reduce criticism and allow the physician to feel less pressured and thus more enabled to respond with empathy and compassion. 60 A revealing study by Grossman et al (2014) demonstrated that there may be a misunderstanding between patient and physician regarding the concept of empathy itself. 65 They found, utilising the Jefferson
Scale of Patient Perceptions of Physician Empathy, that there was poor correlation between doctors' and standardised patients' assessments of doctors' empathy. 65 This suggests that the doctors’ ability to gauge the effectiveness of their empathic communications to their patients is actually inadequate. Thus organising a study group targeting the type of empathy patient’s respond to would be helpful in training doctors to communicate effectively with patients.

Often the medical professionals’ work environment is not conducive for the practice of empathy or compassion. Limiting unnecessary interruptions during the consultation and providing adequate privacy would allow better communication and rapport development between patient and doctor. 60-2 A provision by the doctor’s institution for adequate staffing levels and allocated time for patient and family contact that is protected from administrative, documentary obligations and teaching sessions would greatly reduce strain off the physician; encouraging clinical compassion that is not at the expense of the physician’s other clinical tasks. 60

Conclusion

In 2012, HRH Prince Charles wrote a guest editorial in the Journal of the Royal Society of Medicine declaring a ‘crisis in caring’.66 This was in response to the shocking findings of the Mid-Staffordshire inquiry revealing the sub-standard care afforded to patients and associated increase in mortality rates. 67 This is a real example of the devastating effects of practicing medicine without empathy or compassion. Peabody said, ‘One of the essential qualities
of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient.\textsuperscript{1} Thus, equipped with this knowledge and inspiration, we have a responsibility as doctors to deliver the ‘healing empathy’ that all patients need and deserve.\textsuperscript{66} We should be at the forefront fostering a new culture of change to return to the most basic of lessons that our forefathers in medicine instilled within us – finding a permanent place for empathy, compassion and humanity in today’s medicine.

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