Point of view – Ethics

Perceived physician empathy – a societal view*

Corea Viran[1]

Journal of the Ceylon College of Physicians, 2015, **46**, 48-52

The concept of empathy

Central to the topic of my brief address, is a concept, which therefore I must deal with at the very outset – the notion of 'empathy'. What is 'empathy'? Reaching for a dictionary as a layman, I find the Oxford Dictionary defining the term as "the ability to *understand* and *share* the feelings of another".

This address relates to the notion of empathy in the context of the physician-patient relationship. Therefore, 'physician empathy' for the purpose of the matters dealt with in this address, may be defined as "the ability of a physician, to *understand* and *share* the feelings of a patient and his/her family". In the context of the fact that the role of a doctor is viewed from the perspective of involving the business of caring for one's patient, there is no gainsaying the obvious importance of 'physician empathy'. Suffice it to say that having undertaken a bit of "searching" in view of this address, I find it is viewed as so important in developed healthcare system discourse, that there now exist several tests designed to empirically measure the levels of doctors' empathy for the benefit of the healthcare system and the person it aims to ultimately serve – the patient.

The definition, makes it clear that there are two facets of 'physician empathy' – the ability to (1) understand; and (2) share what is felt by the patient and to some extent, his/her family. These may be described as two elements, components or domains of 'empathy'. The first element of empathy (understanding), or as it is sometimes called – the 'cognitive domain', involves a capability of a physician to view things from the *other* person's (patient's) perspective. It requires the ability to properly appreciate a patient's inner experiences and feelings. This is not always easy for a physician, for reasons I shall proceed to consider shortly.

The second element of empathy (sharing feelings), is the 'affective' (or 'emotional') domain', which involves the capacity to enter into or join the experiences and feelings, of a patient. What exactly this is will also be considered, particularly in the context of the notion of 'sympathy' and the need to distinguish ineffective sympathy from effective empathy in the doctor-patient setting.

I would seek to deal first, with the first identified domain of physician empathy, 'the cognitive domain' (or understanding feelings), which involves several challenges. It is a fact that different patients understand their health conditions and issues at different levels and process information in different ways, depending on contributory factors as background, education, past experiences and even temperament. This poses a challenge to the physician, who must adopt the ability to step out of his/her own personal high levels of knowledge and awareness, to be able to fully appreciate how the facts seem from the patient's own and family perspective. What is crystal clear to any physician and some patients may be unclear and frightening to other patients. Therefore, the feelings that a patient holds in a given health issue scenario can only be understood by a physician, by properly understanding how that issue is actually understood in the cognitive sense (rightly or wrongly, whether correctly or incorrectly), by the patient whom the physician seeks to serve. It is imperative from a patient (or societal) perspective, for a physician to properly understand how a patient perceives his/her predicament. It is only then, that the physician would be equipped to enable the patient to better embrace actual reality and secure the right patient attitudes, expectations and conduct.

I would now focus attention on the second element of empathy – the 'affective (or emotional) domain', which involves the capacity to enter into or join the experiences and feelings of a patient (and his/her family). This element requires careful consideration, with the notion of 'sympathy' that becomes relevant in its consideration.

Although the concepts of empathy and sympathy are often mistakenly used interchangeably, it is important to distinguish between the two, in patient-care situations. They both involve sharing and it is possible to argue that without a degree of sympathy, one cannot be said to possess empathy, in the sense

[1] *Attorney at Law, Colombo.*

* *Guest Lecture delivered at the Annual Sessions of CCP 2015*

E-mail: virancorea@yahoo.com

of sharing in the emotional domain. However, an important distinction requires to be drawn where physicians are concerned, which is suggestive of the fact that 'effective patient empathy' is different to 'sympathy' *per se*. This difference was well captured by a definition of empathy by famous psychologist, Carl Rogers, which has become one of the most useful and widely used definitions of the word today. He defined 'empathy' as – the ability to perceive the internal framework of reference of another with accuracy *as if* one were the other person, but without ever losing the 'as if' condition.

In order to do so, it becomes necessary to keep sympathy at a reasonable distance, to maintain emotional balance and ensure the required level of 'objectivity' for proper diagnosis and treatment that over-emotion can impede. Furthermore, it is discernible that constant high levels of negative emotion would be harmful to the wellbeing of the doctor, his/her personal relationships, and ultimately the patients too. No member of society is entitled to make such an unfair demand of any physician. So what then, would I, as a member of society consider an indication of a 'good balance'?

It is clear to me, that some element of 'sympathy' is inherent in the notion of genuine care. One cannot be completely emotionally unmoved, and yet be said to 'care'. It has been suggested that where the two ('sympathy' and 'empathy') coincide in optimum measure, one finds 'compassion'. However, I would venture to suggest, that what society is entitled to expect, is a degree of 'compassionate detachment'.

How society views medical doctors and 'power distance'

I have just set out that in my view as a member of the public, a physician requires to demonstrate empathy (both cognitive and emotional), in a manner that allows 'compassionate detachment' but undertakes genuine, conscious engagement of a patient's feelings, considering the context of each patient.

Typically and generally, doctors are highly respected by the public. It is a source of pride anywhere in the world, if your son or daughter is selected to enter medical college. However, in countries like Sri Lanka, there exists additionally, what one would call a 'power distance' between professionals (such as doctors, lawyers and so on) and particularly less affluent members of society. In a developing country like ours, the proportion of such less affluent people is significantly higher than those who would engage you 'eye to eye'. I find that this power distance, is sometimes an obstacle to empathy in a number of ways.

I have had occasion to be present when domestic servants, whom I have taken to very competent and genuinely top class doctors from time to time. The patient, for no other reason but simply being in awe of the doctor, clams up and starts fumbling and miscommunicating the symptoms – which were perfectly well communicated beforehand to me. For the purpose of understanding the effect of this phenomenon, I will categorise the doctor-types involved (without names), adding only that all of them are top-class medical professionals, whose knowledge of their areas of medicine were and remain to my mind, quite unimpeachable.

The first category (Category 1):

These very capable doctors, want the patient to be crisp, clear and precise about their symptoms. They are busy and time is precious. Therefore, they get impatient, with the result that the patient gets even more nervous and ends up giving a wrong description of the symptoms, or a partial narration that is naturally misleading. Often times, with such doctors, I end up having to intervene, to make sure that the doctor gets all the symptoms. Naturally, I am reluctant to send such a worker to see such a doctor unaccompanied by myself or some other person of my social class who could make that intervention if required. I note that the difficulty of extracting all relevant symptoms, is entrenched and deepened by the inability of such a physician to understand through empathy, what the experience of having to 'talk to the dosthara-mahaththaya' means, to the patient. I will now proceed to unpack what I see as the attendant practical problems of this scenario from a societal perspective, despite the fact that (I reiterate here), there is no doubting the medical knowledge and skill of this type of physician.

To begin with, such a physician is challenged in his/her ability to execute the critical first step of proper full extraction of symptoms and relevant patient behaviours/habits, for good diagnosis. What could this mean from a societal perspective? To the patient – more tests, unnecessary tests, wrong tests, and sometimes even wrong or ineffective treatment. Also higher levels of testing are motivated by hospital-given targets or inducements, especially in the private sector, that the physician is more interested in seeing more patients in a shorter period of time, than in discharging the venerated role of 'healer'. In the state-sector, patient discontent takes the form that the doctor is more interested in rushing off to a private practice than in servicing those who rely on state-sector services. Much of this perception leads to misunderstandings of the doctor's role, lowers the esteem of the particular physicians concerned in the eyes of the patients and eventually damages the overall respect for the medical profession.

Just as much as doctors must see the side of patients, it is also important for society to try and properly appreciate the position of doctors. That I will endeavour to do now, in relation to the doctor-type that I have just described. Some of them (being close enough for me to privately chat openly and frankly with them), have told me things to the following effect: ''Look. We deal with hundreds of patients a day. We don't have the time to be mollycoddling patients. Patients must know, when they come to a doctor, they must be prepared and forthcoming with all their symptoms. That's not too much to ask is it?''

This attitude in my view, is often genuine, well-intentioned and not necessarily a reflection of deliberate neglect, greed or cause for the type of high disapproval or bad rap that such doctors tend to attract from patients over time. However, I question whether the lack of empathy retards both efficiency and effectiveness and thereby reduces their overall ability to actually deliver as they otherwise could.

It is inevitable, that society consists of different types of people, with different levels of ability to efficiently interact with their doctors. The role of the physician, is the engagement of physiological suffering with a view to healing – through diligent treatment and medical care, which varies not (depending for example), whether the patient is a policeman or a robber. Embedded at the centre of this fact, is an expectation that an equality of human worth would be attached by a physician, to every patient. Such equality of value would, in my view, demand that a physician exercises sufficient empathy with a less articulate (or backward) patient to be able to elicit the required information for diagnosis and treatment. A commitment towards a 'soft touch' through empathetic interaction where required, seems very necessary. I find many members of society share the view that it would be desirable to find ways of infusing higher levels of empathy skills in physicians of this first category.

The second category (Category 2):

I now come to the second category of physicians. These are just as medically skilled and experienced as those of the first category, but are more inclined to style and structure the manner of their patient interactions according to the patient's personalities, education levels and differing contextual factors. These doctors in my view, are better equipped to help and to meet the societal expectations of medical practitioners. They are also in my view, more capable of accurate and desired outcomes, than their colleagues in Category 1. They are more adept and capable at serving a poor, less intelligent or educated and less forthcoming patient in a number of ways. To begin with, as I pointed out, they are better able to elicit relevant symptoms and relevant patient behaviours, being relatively unimpeded by the limitations of the patient. This makes the patient more confident of the physician, because after all, a doctor who 'listens', appears more caring and is seen as more likely to leave no stone unturned to ensure the best possible outcome. At the same time, even if the treatment takes time to show results, the patient feels more confident because of the feeling that treatment option decisions were taken, in full consideration of his/her 'problems'.

It may be concluded that from a societal perspective, what is desired is to see greater migration of doctors from Category 1 to Category 2. At the same time, it may only be fair by the physician, to recognise that with long-term exposure to disease stricken scenarios and pressure of heavy workload, it would be quite natural for those in Category 2 to tend to lapse or slide into Category 1. A question worth asking then, is whether it is now time, for regular, scheduled empathy reinforcement methods and conversations to be recognised and implemented, as a definite need for full functionality of a physician.

Physicians viewed as demi-gods – false sense of security

It is a noteworthy facet of patient perception, that medical doctors are (quite unfairly) considered by some, especially from economically marginalised segments of society, to be infallible – almost like demi-gods, with the result that they have a high and unquestioning degree of faith in the practices adopted by doctors. Where such a relationship exists, there is a need for any symptoms/indicators that may require immediate or early revisiting of the strategy adopted by the physician to be spelt out, so that the patient would not unduly delay in seeking the variation or change in regimen that may be required. To leave it to such a patient to detect such a need and revert in a timely manner (which may be well ahead of the next scheduled consultation), would in my view be incompatible with the object of facilitating the 'best and safest medical care', as desired.

In order to reduce the need to function according to such unrealistically high expectations, an empathetic doctor may look to manage and redefine the level of patient expectation to enable the patient to be more realistic in his/her expectations, without losing faith and confidence in the physician. This would require kind emphasis and gentle reinforcement of the fact that a degree of awareness of symptomatic disease progression on the part of the patient, is needed and helpful to the physician, rather than being a matter of 'a questioning of a medical professional's competence'.

Bedside manners – half the treatment

There is the old saying, 'A doctor's bedside manner is half the treatment'. It may originally have been said, based on the belief that psychological comfort by a physician's pleasing bedside manner increases feelings of good health. However, several studies today, point firmly in the direction of definite physiological benefits of good, empathetic bedside manner. For example, in a study of almost 900 diabetic patients, researchers found that patients of physicians with high empathy scores (compared to physicians with low empathy scores) were significantly more likely to have good control of blood sugar.

The terminally or very seriously ill – require more

In my view, treatment of the terminally (or very seriously) ill, involve particular sensitivities and added services that warrant urgent and particular consideration. In the case of the very seriously ill, there are many more needs that kick in, if the dignity and quality of life of a patient are to be duly respected.

In a non-terminal scenario, by and large it is about ascertaining the problem and fixing it through a programme of investigation and treatment. True enough, the exercise of empathy that I have touched upon makes a big difference, but the psychological, social, interpersonal and economic factors coming into play are usually neither as complex nor as intense as in the case of the terminally ill.

In more than the medical sense, the terminally ill require 'life support'. This need kicks in, sometimes long before the need for long-term hospitalisation or being hooked up to machines. It is important to recognise, that when a person is faced with the prospect of an early, disease-induced end to his life, it is often not one, but many lives that face serious challenges. Other things being equal, the patient's family then, becomes an important part of the support structure needed to ensure the wellbeing of the patient. In order to support the patient through his/her last days of earthly life, it becomes necessary for the family also to undertake a difficult process. In many ways, it would mirror the process that the patient himself/herself must undertake. This would involve properly internalising what has happened, informed assessment of all available alternatives, decisions as to what of the available alternatives to choose, accept and close.

It is not easy to internalise and come to terms with the fact of terminal illness. A friend, whose father was terminally ill (and passed away last year), recalls to-date as one of the worst days in the difficult trudge through terminal illness that her family had to face, the day their doctor had told them very bluntly, ''We'll do the best, don't worry. But there's a 70% chance he won't make it.'' There is no doubt that the doctor knew what he was doing, and was right on the facts. But the question is, was there a failure to extend empathetic treatment that would facilitate better acceptance. This failure translated into fear and panic and precipitated an emotional meltdown for the patient's family. The patient thus, came out of anaesthesia into a fearful, insecure emotional support structure. I was able to observe that this unfortunate empathetic (and I emphasize, not medical) misadventure, resulted in a much wider circle of friends and extended family later viewing the 'medical care' itself, as suspect. This is a situation that could well be avoided, if doctors are taught to be empathetic (in both cognitive and emotional senses), at the point of breaking the news of terminal illness. It would make so much difference, if the breaking of the news is preceded by an empathetic explanation of the medical condition, how it can be dealt with, assurance of what best measures would be looked at and implemented in the days ahead, and finally as necessary, a communication of the odds of recovery. Although diagnosis must be clearly communicated, in some ways, the degree of detail disclosed should match the patient expectations (some want all the details, others prefer not to). This matching process requires empathetic sensitivity.

As the son of a terminally ill mother, I have come to learn that the need for empathy does not end where the terminally ill are concerned, with the mere breaking of 'the bad news'. As is often said, 'Hope springs eternal in the human breast'. Where terminal illness is concerned, it is not just the uneducated or illiterate that 'hope against hope'. This means that there will be questions, like – ''What about trying this?'', or ''Could this work?'' and ''What about this new type of treatment I found in my research on the internet?'' My family was fortunate, to have the blessing of several medical professionals, including some close family who did not consider it a waste of time or wanton harassment to field and deal with such a barrage of queries on possibilities. However, I have come across several others, whose experiences have been very different. Many of them were basically told ''Look, we know what can and should be done, so don't worry about it. Leave it to us.'' Again, I am not questioning the truth of that statement. However, by an unwillingness to engage the desperation of the family in a constructive, reassuring way, the result was far greater trauma for the patients concerned and the family. A niggling fear that the doctor is not open to even looking at anything new that may work, was processed and translated into 'are we unable to secure the best care', a fear that was invariably transmitted unwittingly also to the terminally ill patient from the family support structure, through various cues.

Faced with terminal illness, there are difficult decisions to be made. It is important to realise and

respect that some of those decisions must be made by the patient, often in consultation with his/her family. For example, does one opt for a longer length of days that is more painful and/or undignified, or for a course that would entail shorter lifespan but greater comfort and relatively pain free, dignified exit. In these situations, patients require guidance (not pre-determination) as to which course to adopt. The experiences of many, indicate that at present, the approach is largely determined by the personal preference of the doctor in charge. I should think that whilst the views of the doctor clearly and empathetically explained is a crucial consideration, such decisions must ultimately reflect a conscious decision of the patient and his/family. In my view, the facilitation of such decision making, control, hastens acceptance and leads to proper and sooner closure.

All this translates into a rather tall order. It appears quite reasonable, for a physician to say, "Look, all of this is humanly impossible for a doctor to deliver." I for one, readily agree. I have observed inability of the healthcare system to adequately deliver on the fronts I just outlined in relation to terminally ill patients, not necessarily because a practitioner lacks empathetic care, but because there appears to be a near absence (or so it seems), of a more multi-disciplinary care strategy that friends in some other countries report is made available to them, by their physician. As a result, our healthcare systems appear by and large to be in need of a system that offers and encourages a combined, collective effort of contextually appropriate teams of not only experts in other relevant specialities, but also social workers, trained counsellors, occupational therapists and the like. Such teams can be mobilised to better profile the 'patient and family dynamic' matrix, more empathetically provide knowledge in the most digestible form, work through scenarios and options, better deal with fears and insecurities and help find acceptance and closure.

So in summary, this morning, I have sought to explore briefly the notion of empathy, identifying both its cognitive and emotional elements as crucial to societal perceptions of physician empathy. I recognized that empathy involves a level of 'compassionate detachment', and then ventured to enumerate many key perceptions in relation to physician empathy, identifying their possible causes and what society would expect or prefer, in each of those respects.

I am deeply grateful to the Ceylon College of Physicians, for the great honour of the invitation extended to me, to address all of you at this plenary session. If anything I said seemed slightly critical, I would implore that the criticism is processed empathetically, because then it would be understood as being well-intentioned, to help draw your attention from a non-medical societal standpoint, to matters of empathy that would in some way aid better appreciation and provide some ideas for further improvement of the great service that physicians do in this country.