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# Empathy

## From Bench to Bedside

**edited by Jean Decety**



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# 13 Clinical Empathy in Medical Care

Jodi Halpern

Medical practice is a particularly important yet challenging setting for empathy. Empathy is necessary because patients may be reluctant to discuss, or may not be able to identify, their most concerning problems, so that discerning their needs requires excellent listening skills. Empathy is also crucial because the biggest obstacle to effective medical care is patients not adhering to treatment recommendations, and the biggest determinant of adherence is trust in the physician. Empathy plays a crucial role in establishing that trust.

Empathy is challenging, however, because doctors are dealing with the most emotionally distressing of situations—illness, dying, suffering in every form. These situations would normally make an empathic person anxious, perhaps too anxious to be helpful. As Decety and others have shown, when initial empathy is coupled with too much self-related anxiety, a person may in fact employ a variety of psychological processes that interfere with perspective-taking and other aspects of empathy (Jackson, Meltzoff, and Decety 2005; Decety and Ickes 2009).

Empathy is also challenging because physicians are expected to provide equally reliable services to everyone, and yet people ordinarily empathize more with some people than others. Furthermore, doctors are particularly at risk of phases of "compassion fatigue" in which it is hard for them to muster much empathy for anyone at all.

For all these reasons, the question we are asking is a difficult one: What kind of empathy, if any at all, should we expect doctors to provide for their patients?

## Clinical Empathy as "Detached Concern"

Until very recently, doctors thought that they had solved this problem. They wanted a version of empathy that they could deploy reliably even in difficult situations such as the following:

Mr. Smith, a fifty-eight-year-old businessman, suddenly paralyzed from the neck down with (potentially reversible) Guillain-Barré syndrome, is refusing necessary

care. He will not speak further with the doctors and nurses, saying their care is "useless, a waste." The whole medical team is fed up with him, and his wife is panicked.

Ron, a nineteen-year-old star college athlete is refusing life-saving colon surgery because, he says, he cannot live with a colostomy because it would keep him from "being active." His medical team tries in vain to reassure him that he can play many sports with a colostomy. They feel extremely frustrated, label him "irrational," and call psychiatry.

In these cases physicians' feelings of frustration, helplessness, and anger decreased their clinical effectiveness. Doctors view such cases as professional disasters. Thus, it is perhaps not surprising that physicians have developed their own emotion-free conception of professional empathy—one of detached concern. Note that this conception is quite radical, not like ordinary cognitive empathy or Zen mindfulness. Rather, the ideal of detached concern is that the physician needs to first overcome basic human responses such as fear and disgust in order to cut into human bodies and face death. This utter neutralization of emotion then enables special objective insight into patients' suffering. Thus, the term "detached concern" was coined, denoting a pathway to empathy *through* detachment.

Medical graduations to this day continue to honor Sir William Osler, father of medical residency training, and quote his essay "*Aequanimitas,*" written in 1904, as an inspiration to new physicians. He writes that the doctor should be so emotionally neutral that "his blood vessels don't constrict and his heart rate remains steady when he sees terrible sights." This neutrality in witnessing human suffering gives him a special glimpse into the "inner life" of patients (Osler 1963). Fast-forwarding two generations to 1963, Rene Fox and Howard Lief write their classic essay "Training for Detached Concern." They describe how medical students equate the detachment required to dissect a cadaver to the stance they need to listen empathically without becoming emotionally involved (Fox and Lief 1963). The seeming inconsistency —in which it is detachment from all human emotion that makes one especially skilled at empathy—hints at the unconscious, wishful thinking motivating the ideal of detached concern.

Yet physicians have developed increasingly sophisticated, less problematic versions of detached concern over the past forty years. They rightfully distinguish empathy, which aims for understanding the patient, from sympathy and show how trying to "share" the patient's feelings in sympathy invites errors of projection and overidentification (Aring 1958; Blumgart 1964; Coulehan 1995; Halpern 2001). These concerns have motivated some to define clinical empathy as strictly cognitive empathy. Consider for example, the Society for General Internal Medicine's statement that: "Empathy is the act of correctly acknowledging the emotional state of another *without* experiencing that state oneself" (Markakis et al. 1999).



In sifting through all the justifications for avoiding emotional empathy, three strong, if empirically unvalidated, arguments emerge. The first is that emotions interfere with the cognitive assessment of the patient—that a physician needs a fully objective mindset to obtain a thorough history and make an accurate diagnosis. Second, emotions undermine the ability to provide effective care during difficult circumstances. Third, they increase the risk of burnout (Coulehan 1995; Roter et al. 1997b). In this chapter we challenge each of these claims and argue that a richer clinical empathy, involving emotional and cognitive empathy, makes for more effective medical care.

## Finding a New Norm for Clinical Empathy

There has been an upsurge of research on clinical empathy in recent years, but this research has had several problems. First, most of the studies include little or no precise definition of "empathy," and the term seems to be used to describe very different things, ranging from sympathy to self-related concern. Second, the most frequent quantitative method is self-report, which is especially problematic when empathy is not clearly defined. Third, most of the studies involve questionnaires in which the questions are about general tendencies, rather than anchored in concrete circumstances. Fourth, real patients are rarely asked to evaluate physician empathy, although in a few recent studies simulated or standardized patients evaluate physicians. Overall, looking at the 206 studies done over the past ten years, none probe for "concrete details about what the patient or physician understood/misunderstood" (Pedersen 2009).

Simply doing more research without clearly defining and operationalizing empathy is unlikely to be helpful. Rather, to make empirical progress we first need to put forward a clear conception of clinical empathy, which can then be tested and refined empirically. My goal in this chapter is to lay the groundwork for such a conception. To do this, I go to the roots of each of the basic arguments used to rationalize detachment and consider what, if any, kind of empathic stance best meets the goals of medical care.

Let us state that the purpose of clinical empathy is to understand the patient's emotions well enough to help her address her medical problem therapeutically. This is already a complex goal, involving both understanding and addressing the patient's concerns. This dual purpose conception of empathy has been described in other settings as well. As Daniel Batson points out, there are two distinct, if related, tasks of empathy in our personal relationships: understanding how another person is feeling and having an appropriately caring response (Batson 2009). In the case of physicians the second aim is not just to have a caring response but to have a therapeutic response. I say more about this below.

Given this definition, we can break down our inquiry into the conception of clinical empathy into four precise questions we need to address:

1. What (if any) is the cognitive role of empathy in clinical care?
2. What (if any) other ways does empathy contribute to medical care?
3. How can doctors avoid errors of empathy, such as projection and overidentification?
4. How can doctors provide "reliable" empathy? How can they deal with situations that evoke negative emotions? How does empathy relate to burnout?

Note that these questions are not merely descriptive: they are also normative. They ask: what forms of engagement are *good* for medical care? The normative goes beyond describing what *is* to describe how things *might be*. Of course this normative conception needs to be realistic; so empirical findings form the building blocks of this account. However, unlike a simple descriptive project, empirical findings are used here to address questions about the goals that we think empathy *ought* to serve when things are going well.

## What (if Any) Is the Cognitive Role of Empathy in Clinical Care?

Many research studies and medical educators presume that the cognitive aim of clinical empathy is to help the physician label the patient's emotion type correctly—recognizing for example, when a patient is angry or worried. However, I would argue that this labeling is only a very beginning step. It is often fairly obvious that a patient is angry or sad, but what needs to be understood is what, in particular, his anger or sadness *is about*.

Emotions are characteristically *about* something in the way that thought is about something. Sometimes an emotion contains a full-fledged belief, and sometimes it involves a less-focused point of view that shapes a person's other beliefs. Thus if I am angry at you, I believe you have wronged me. If I am feeling happy, I may not have one specific belief, but my view of the world as pleasurable and good shapes how I interpret and form many other beliefs (Schwarz 1983).

Importantly, emotional beliefs and views have different properties from detached beliefs. They can arise on less evidence—which makes them crucial shortcuts for sensing danger, and so forth. For example, I may feel suspicious toward someone for reasons that I do not yet recognize, and this could prove to be self-protective. However, the fact that emotional views are less evidence-based can also create problems. It can be difficult to get someone to shift his emotional view by logic alone. For example, if a patient is afraid that he will have a rare complication from an important medical intervention, telling him that his objective risk is quite low, even anchoring this in understandable data (lower than having a car accident on your way to work) might



not be helpful enough. Finding out that he is afraid of what happened to his friend, who had a bad outcome from a similar treatment, would be crucial for addressing his concerns.

Further, when doctors themselves are involved in conflicts with patients, as in the difficult situations described at the beginning of this chapter, labeling the patient's emotion is likely to exacerbate the conflict, whereas understanding what in particular the patient is upset about is likely to help (Halpern 2007). For example, in Mr. Smith's case, it was quite obvious that he was feeling terribly depressed about his condition, and his doctors telling him sympathetically that they recognized that he felt hopeless only made things worse.

I was called to take care of him. When I first entered his hospital room I noticed a flicker of interest in his eyes as he saw me. He did try to say something to me but when he tried to speak through his tracheotomy tube, his voice was too feeble to hear. I suddenly felt terribly sorry for this man, and also ashamed at imposing on him, and I spoke very gently to him. Almost immediately, this turned him off; I felt his withdrawal from me. His wife, sitting at the bedside, looked very uncomfortable, and I left his room.

On reflection, awareness of his initial interest and then his withdrawal when I showed sympathy made me realize that feeling sorry for him was the worst thing I could do. Further, I began to wonder why I felt such overwhelming hopelessness about him when he had at least a 50 percent chance of full recovery and another 20 to 30 percent chance of significant recovery, much better odds than most of my ICU patients faced. But his full recovery depended on his participating in physical therapy, which he was rejecting along with all of his other treatment.

This realization led me to reenter his room with a different tone. I asked him directly and assertively what he meant by saying that treatment was "useless, a waste"? My tone was business-like, trying to find his bottom line so that we could negotiate. He immediately responded, looking right into my eyes. He gave a long, angry tirade (whispered but audible) about how disrespected he felt, his body essentially splayed on the bed in front of his wife, his nurses and doctors and therapists entering his room at all hours without permission or notice, and all for what? As I listened, I found myself imagining going from being a virile leader of my family, a titan of industry, to being so helpless that I couldn't even protect my wife. This felt so enraging that I understood his global rejection of all of us and our treatment. Thus began an effective therapeutic alliance.

In Mr. Smith's case, the cognitive challenge was to shift from labeling his emotion from a third-person perspective to imagining how he experienced feelings from an insider perspective. The crucial mental process for shifting in this way was curiosity—wondering about both his responses and my own. Curiosity helped me avoid the error of taking my immediate sympathetic response to him at face value. Rather than seeing

him as a man in despair who needed to be treated with kid gloves, I came to see how such treatment actually felt to him. Although the fact that he felt unhappy with his medical care was obvious, what I needed to learn was that he specifically hated the way all of us on his medical team were speaking softly and gently to him. He hated our obvious sympathy; it exacerbated his feelings of shame. We needed to understand this to treat him effectively. This case illustrates how *an important cognitive aim for clinical empathy is to understand what, in particular, a patient is concerned about.*

The cognitive aims of medical care are, of course, much broader than understanding how a patient feels. The overarching cognitive aims include making an accurate diagnosis, and not missing important needs that can be addressed to help the patient. The pathway to meeting these goals is to take a "good" history—a history that tracks important needs and leads to correct diagnosis. It turns out that listening in a nonverbally attuned way, which is another aspect of clinical empathy, plays a crucial role in taking a good history.

Direct observational research shows that patients wait to sense that a physician is nonverbally attuned before they disclose their most concerning symptoms. Careful videotaped studies show that when expert physicians ask all the right questions but lack such attunement, patients refrain from bringing up their anxiety-provoking symptoms. In contrast when doctors ask good questions and their body language and gestures show emotional attunement, patients give fuller histories (Suchman et al. 1997; Finset 2010).

There are even more subtle ways that emotional engagement contributes to understanding a patient's history that have yet to be adequately studied. A patient's specific words and anecdotes trigger images and associations for an empathic listener. For example, Mr. Smith's words that treatment was "useless, a waste" guided me to imagine how he now saw his own body as useless, a waste. And attuning to another's shifts in mood provides a kind of stage lighting for imagining what it is like to be in the patient's world. Attuning to mood works in synergy with the capacity to associate to another's images to help one follow the narrative flow of another person's subjective experiences. A patient of mine was describing her insomnia, which began when she started staying up too late at night. She had recently lost her husband and moved into her daughter's home, sleeping in an attic bedroom. As she told me about her life, I found myself picturing her staying up late, watching television in the living room just to hear voices and avoid the lonely walk up to the attic by herself. This understanding led to an empowering conversation, which resulted in her getting music to listen to upstairs, going to sleep on time, and sleeping well.

Following another's experiences narratively can contribute to making a correct diagnosis, since what is often needed is not just a list of symptoms but a temporal unfolding. Even in taking a simple history of a new patient who says that she feels as



though she cannot get out of bed, and who appears sad and demoralized, it would be premature to label her as depressed. What is needed is to imagine how her feelings unfold in real time. Does she first feel hopeless or highly anxious about what the day might bring, or does she first feel weak or as if her limbs are too heavy to move, and then feel discouraged? These distinctions are crucial for distinguishing possible depression from anemia or hypothyroidism or neuromuscular problems.

There are thus multiple empathic processes serving multiple cognitive aims in providing ordinary medical care. These processes include curiosity about what in particular the patient is concerned about and related cognitive empathy; nonverbal attunement, including attuning to mood; and associating to another's associations to imagine the other's experiences. These processes contribute to multiple aspects of healthcare: patients give fuller medical histories to attuned listeners, attunement working in synergy with curiosity and imagination contributes to a narrative understanding of the medical history, and all of these processes together lead to a more individualized understanding of the patient's concerns.

## Empathy Improves Therapeutic Effectiveness

Beyond helping with the cognitive aspects of medical care, empathic relating improves therapeutic effectiveness directly. "Evidence supports the physiological benefits of empathic relationships, including better immune function, shorter post-surgery hospital stays, fewer asthma attacks, stronger placebo response, and shorter duration of colds" (Reiss 2010). Perhaps the most well-understood pathway through which empathy improves health outcomes is the relation between patient perception of physician concern and trust.

In a large meta-analysis of all the factors that predict treatment adherence, the dominant factor was trust in the physician. And the largest predictor of trust was whether the patient felt that the physician seemed genuinely worried about the patient when discussing serious matters (Roter et al. 1997a). Note that in the same meta-analysis, friendliness was not a predictor of trust. Given that the largest single factor in treatment failure is nonadherence to treatment (approximately 50 percent of prescribed medications are not taken as prescribed), empathic concern is very important for effective medical care (Sabate 2003).

Additionally, research in oncology shows that physicians' emotional engagement reduces patients' anxiety when receiving cancer diagnoses and even influences whether the patient is able to take early steps to get into treatment. Physicians delivering bad news in an emotionally detached fashion impacts both the patient's self-reports of feeling confused and overwhelmed afterward and the patient's readiness to seek treatment options, attend support groups, and otherwise becomes agential regarding his or her cancer (Ptacek and Ptacek 2001).

Note that empathic concern is quite distinct from the other two empathic processes already mentioned—engaged listening seeking to understand what in particular is troubling the patient and nonverbal attunement. We might ask skeptically why patients actually need their physicians to feel emotional concern for them. Why is it not enough for their doctors to be committed to helping them but not be emotionally invested? Daniel Batson emphasizes a central role for protective feelings of concern in empathy (Batson et al. 2007). And there are obvious reasons for valuing such concern as the basis for empathy in intimate relationships—such concern is crucial for survival of the young, and may help cement commitment between spouses over time. Patient-provider interactions, though, are rarely long-lasting enough to require such a foundation. My hypothesis (which needs testing) is that patients understand this and care less about having their doctors feel deep personal affection for them and more about receiving attentive care. That is, my guess is that patients want their doctors to show actual concern because this shows them that their doctor has an emotional reason to believe that their suffering is real and therefore take their needs to be important. Outside of medicine, we do know that people recovering from psychological trauma during war and other catastrophes describe how an emotionally neutral listener makes them feel insignificant, even unreal (Halpern 2001).

In any case, emotions contribute to clinical empathy in a variety of ways. Both curiosity and nonverbal attunement serve cognitive aims, and feelings of concern influence patient trust. Thus clinical empathy is not one simple psychological process, but a complicated one, which may involve different types of emotional engagement to meet different clinical needs.

### Seeking Empathic Accuracy

How can doctors become more accurate in their understanding of patients and, in particular, avoid errors of projection and over-identification? Importantly, although affective attunement and associating to another's associations are, in my view, important contributors to empathic understanding, these mental processes may not be sufficiently focused, nor are they self-correcting enough to lead to an accurate understanding of a patient. Rather, what is also needed is to be genuinely curious to learn more about what the patient is experiencing. Curiosity is a crucial metacognitive organizing theme for clinical empathy (Halpern 2001).

Curiosity is, in my view, crucial for increasing empathic accuracy. At the very least clinicians need to be on the lookout for instances in which we *think* we already understand what a patient is upset about when we do not yet grasp the patient's concerns . . . Consider the case of Ron, the college athlete who was not reassured by his doctors telling him that he could still be physically active. One clinician finally listened more carefully to him—and empathically recognized that what Ron was most



concerned about was *sexual* activity (Ron felt too embarrassed to raise this concern directly). This realization quickly led to a referral to a nurse who had herself adjusted well to living with a colostomy. After she and Ron had a private conversation about his sexual future, he accepted the surgery.

We need to be equally cautious about situations in which we experience emotional empathy for a patient going through a similar medical problem or personal loss to something that we ourselves have experienced. In such situations it can be tempting for the doctor to imagine *herself* in a patient's shoes and think that she knows how the patient feels because of how *she* (the doctor) would feel. Given that each person has a different personal history and personality and is likely to be affected by similar medical diseases in very different emotional ways, this is usually a clinical mistake. Curiosity about how another person with an entirely distinct life is experiencing his or her illness is a crucial corrective to over-identification. I always recommend that physicians avoid saying to patients "I know how you feel," and rather that they learn to say "tell me what I'm missing" (Coulehan and Williams 2003).

Curiosity also protects us from being naively sympathetic and taking our initial resonance at face value or from projecting our concerns onto patients. The team treating Mr. Smith felt so helpless witnessing his predicament that we saw his situation as overwhelming and lost sight of his very realistic chance of significant recovery. We might instead have been curious about how his sense of the future was collapsed at the present moment and helped him become aware that this was the case (Halpern 2010).

Finally, patients seem to appreciate their physician's curiosity even when the physician is having a hard time fully understanding the patient. My psychotherapy patients have referred to instances in which I misunderstood them, but stayed interested as they corrected and guided me, as especially therapeutic. Despite older authoritarian norms of the omniscient physician, or perhaps because patients now find it hard to trust this stance, inviting the patient to let you know what you are missing or getting wrong is a very important way to build trust and a therapeutic alliance (Halpern 2007).

At this point let me summarize and suggest that we conceptualize clinical empathy as, first and foremost, *engaged curiosity*. This involves a real interest in going beyond surface emotions and easy sympathetic identifications—seeking to invite and understand a patient's whole range of emotions.

### "Reliable" Empathizing and Emotional Engagement

How can doctors empathize "reliably" even when they face conflicts with patients? How does emotional engagement affect burnout and compassion fatigue?

These issues are perhaps the most clinically daunting. After all, our emotions are not under our direct control. For a variety of sociological reasons ranging from too

much time pressure to the complexity of treatment options, doctors are increasingly facing conflicts with patients, often leading to frustration and anger on both sides (Halpern 2007). I have just suggested that a new concept for clinical empathy ought to involve genuine concern for the patient. However, basic psychology research suggests that, when we feel concern for another, it can be especially difficult to empathize during a conflict (Steins 2000). Especially relevant here is Decety's recent work suggesting that unreflective emotional resonance with another's pain can lead to self-related anxiety (Jackson, Meltzoff, and Decety 2005; Decety and Ickes 2009; Watson and Greenberg 2009). When a physician feels responsible for a patient who is refusing care, she may feel self-related anxiety, guilt, shame, and so forth. These feelings can decrease the physician's ability to see the patient's perspective.

However long-standing it has been, the medical culture of doctors avoiding their own negative emotions may not be as hard to change as some think. Doctors are people. Basic psychology research suggests that negative emotions (besides rage) tend to make people *more* inquisitive about the basis for their own emotional views (Schwarz 1983, 2000). Although physicians are socialized against self-reflection, early research suggests that they can learn to be mindful of their own negative feelings and, in so doing, improve their clinical care and professional satisfaction (Novack et al. 1997; Shapiro, Schwartz, and Bonner 1998; Epstein 1999; Meier, Back, and Morrison 2001; Gockel 2010).

Still, self-reflection does not automatically lead to curiosity about another's views, especially when that person causes distress. Psychotherapists bridge the two by becoming curious about what clues their own uncomfortable feelings provide about patients' feelings. Psychiatry educators teach residents specific ways to think about their own "negative countertransference" (anxiety or other difficult feelings in response to a patient). Practicing psychiatrists easily recognize subtle negative feelings and use them as important clues to how a patient might affect other important people in the patient's life (Rossberg et al. 2010). By becoming genuinely curious about what their own painful feelings might be showing them about a patient, expert psychiatrists learn to decenter from self-related anxiety to focus on their patient's feelings. This is perhaps why therapists with highly skilled empathy can work in trauma centers and other highly noxious settings and show low rates of burnout (Harrison and Westwood 2009).

Consider the role of curiosity in the following situation: Sam, a nineteen-year-old is blocking the door to his dying mother's room and threatening to shoot the oncology nurses if they give his mother sedating pain medication. The entire team is terrified of him and call psychiatry to admit him involuntarily for "dangerousness to others." How was the situation resolved? First, we asked hospital security to ascertain that Sam had no gun, no way to obtain one at present, and no history of violence (all confirmed). Once the team was reassured that he was not a physical threat, they



shifted to recognizing how sad his situation was. He could not face permanently losing contact with his mother. We met as a team, and each member spoke about what this situation evoked in him or her regarding losing loved ones. Immediately after this reflection, everything changed. No one was angry at the young man anymore; most felt sad for him, and a few began to wonder why his response was so severe, thus developing genuine clinical curiosity coupled with their concern. In this frame of mind, a representative team member met with the young man, showing genuine concern about his grief, and listening to him in an attuned way. Sam responded by trusting her for the first time and telling her that he felt terrible for going away across the country for college the year before, when his mother had already been diagnosed with breast cancer. This confession enabled him to recognize how anxious he was, and he stopped making threats. He then phoned his father, who, despite his grief, was staying home because he could not deal with his son. When the mother died (comfortably medicated), the father held his son in his arms, and they grieved together.

Notably, this was a receptive team of caregivers ready to discuss their own emotions. In many subcultures in medicine it would take much more time to establish this sort of self-awareness. For example, I was asked by a Medical Intensive Care Unit (MICU) team to help them with the following problem: transplant surgeons were selectively ignoring those of their patients who had poor medical outcomes and wound up in the MICU. These were patients whom the surgeons had met with daily during their pre- and posttransplant hospital stay but who now were severely ill and dying because their organs had been rejected. The patients or their families noticed the neglect and were very upset about it. It took several months of ongoing weekly shared rounds with both the medical teams before the transplant team's culture began to shift. As they came to trust the other medical team members, they began to express, often through humor, their feelings that they had "killed" their patients. Gradually they became less avoidant of their dying patients in the MICU.

This experience speaks not only to the importance of self-awareness for clinical empathy but also to the question of how to prevent burnout. We might hypothesize that holding such painful feelings and never expressing them might contribute to burnout. What we do know is that physicians whose long-standing styles emphasize receptivity to psychological needs tend to burn out less and enjoy their jobs more. Over the past thirty years a field of research on patient-physician communication has developed, yielding empirical evidence that, indeed, doctors miss important information and are less effective when they are emotionally detached. Further, there are suggestions that emotional engagement makes medical practice more fulfilling for doctors themselves and actually protects against burnout (Jackson et al. 2008; Morse, Mitcham, and van Der Steen 1998; Shanafelt et al. 2005). Those with especially skilled empathy show less burnout (Kearny et al. 2009; Maguire and Pitceathly 2003; Wear and Bickel 2000). This observation begs the question of whether those with skilled

empathy might have less self-related anxiety. We do have findings that those with less self-related anxiety are better at perspective-taking/cognitive empathy (Morse, Mitcham, and van Der Steen 1998; Shanafelt et al. 2005; Jackson et al. 2008). Thus, a virtuous cycle could be supported through the integration of skillful empathy in medical practice.

Recently, a new term has emerged—"compassion fatigue"—that may shed important light on barriers to sustaining clinical empathy. Whereas burnout refers to a more global loss of interest in doing one's job, "compassion fatigue" is specifically a lack of empathy when one would expect to feel it. We need research on what specifically causes compassion fatigue. Notably, we see a surprising lack of compassion fatigue in some settings in which we might expect it—hospice physicians, pain-management teams (Kearny et al. 2009). In these settings physicians are immersed in a culture that, unlike the usual medical culture, emphasizes that caregiving requires self-care and conscious attention to grieving and supporting each other. This suggests a positive role for self-care and a culture of connectedness and support in preventing compassion fatigue (Coster and Schwebel 1997; Salston and Figley 2003; Perry 2008; Harrison and Westwood 2009).

## A New Model of Clinical Empathy

In conclusion, although empirical research on empathy in medical settings is still at an early stage, we can propose a coherent model for clinical empathy in terms of four basic mutually sustaining aims:

- The first goal is for physicians to *cultivate genuine curiosity* about the complexity of human emotional lives, avoiding too simplistic a view. This curiosity will foster attentive listening and help physicians invite patients to share more complicated feelings.
- The second goal is *nonverbal attentiveness* with the aim of nonverbal attunement. The path to this goal is through practices that instill self-awareness and mindfulness so that physicians can be calm enough to attune to their patients. This attentiveness will support history-taking for accurate and full diagnoses and could improve patient adherence to treatment leading to better clinical outcomes. It can also play a crucial role in giving a patient a sense that she is accompanied when having to face painful issues (Halpern 2001).
- The third goal is maintaining *genuine, proportional concern for one's patients*, so that when something serious is occurring one can convey genuine worry without becoming overly anxious. This skill will promote trust and therapeutic effectiveness, helping patients regain a sense that they truly matter in an often dehumanizing medical system.



- The fourth goal, essential for meeting the third, is instilling a *culture of social support and self-care in clinicians*. Providing support can help doctors and nurses empathize with patients while continuing to enjoy their profession over time.

My hope is that others will take these goals, all of which can be operationalized, and study them empirically. Several important issues need to be examined. These include (1) the pathways through which these processes improve history-taking, diagnosis, and the establishment of effective therapeutic alliances; (2) how feasible it is to engage in such processes in various settings and situations; (3) how patient-physician dyads and group dynamics contribute to the occurrence of empathy; and (4) how any or all of these processes affect health outcomes.

From my own experience the first question that will be asked is not any mentioned above but whether empathic listening takes too much time? Given that empathy improves trust and treatment adherence and helps prevent ruptures in treatment, patient transfers, lawsuits, and burnout, it likely improves the ultimate efficiency as well as the effectiveness of medical care. I have suggested to medical students that, rather than compartmentalizing empathy into an additional task, they think of empathy as an adverb describing *how* they take a history, perform a physical exam, discuss treatment options, resolve conflicts, and so forth. They can listen with curiosity, touch the patient with sensitivity and attunement, and discuss treatment options with respect and concern.

Learning these skills will take time in the physician's education, but does using these skills add time to patient interviews? The only way to answer this question will be through empirical research. Notably, physicians have long assumed that letting patients talk without interruption at the beginning of an office visit would take significantly more time. When this hypothesis was finally tested, it turned out that the median length of time patients spoke for was a mere ninety seconds (Langewitz et al. 2002). Yet this open-ended listening has many benefits. Patients reveal clinically important information and are much more comfortable with their doctor, both of which are likely to make treatment more effective.

In closing, I have laid out a proposal for a *normative* model for clinical empathy that involves engaged curiosity, nonverbal attentiveness, genuine proportional concern for the patient, and self-awareness. By no means should this full or aspirational conception of clinical empathy be used to devalue the variety of empathies that actually occur in clinical practice. It is likely that even the best doctors cannot do all of this well, all of the time. Utilizing some of these skills even in the absence of others—employing cognitive empathy, or attuning nonverbally or feeling appropriate concern—may still be helpful (Larson and Yao, 2005). On the other hand these skills can also work in synergy—often curiosity about another's perspective invites her to tell one details about her life that naturally move one to resonate nonverbally, which

leads one to feeling appropriate concern. When physicians become skillful at empathy they find these processes not only mutually sustaining but centering and meaningful (Halpern 2001; Kearny et al. 2009). A final challenge requiring empirical research is how we can educate more physicians to gain the skill to engage in full clinical empathy, thus enhancing both the effectiveness of their care for patients and their own career fulfillment.

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# 14 The Costs of Empathy among Health Professionals

**Ezequiel Gleichgerrcht and Jean Decety**

When perceiving another person experiencing pain or distress, the scope of the observer's reaction, depending on various interpersonal (e.g., mood, goals, and dispositions) and situational factors, can range from concern for personal safety, including feelings of alarm, fear and avoidance, to concern for the other person, including compassion, sympathy, or even to absolute indifference (Goubert, Craig, and Buysse 2009; Decety 2011a). In the context of care-giving environments, medical practitioners such as physicians, nurses, emergency workers, and therapists have no choice but to interact with people suffering or traumatized as part of their everyday activities. For these practitioners, providing care and helping others is the fundamental aspect of their duties. This painful reality may take its toll on these people and can lead to compassion fatigue, burnout, professional distress and can result in a low sense of accomplishment and severe emotional exhaustion. A better understanding of the neurocognitive mechanisms that underlie interpersonal sensitivity can contribute to preventing such serious health hazards and risks. It also may shed light on the medical profession's longstanding struggle to achieve an appropriate balance between empathy and clinical distance. Such a detachment is often seen as necessary for doctors not only to avoid burning out or fear of losing control but, more importantly, to provide objective medical care. However, as argued by Halpern (2001), physicians' own emotions may help them attune to and empathically understand patients' emotional states and have therapeutic impact. There is growing evidence from psychoneuroimmunology suggesting that care givers who assist in the healing process by truly paying heed to their patients and respecting their integrity enhance rather than hamper their technical skill (Milligan and More 1994).

Central to health care and the patient-physician relationship is the complex construct of *empathy*, which is usually defined as the capacity to understand or appreciate how someone else feels. Unfortunately, this term is applied to various phenomena that cover a broad spectrum, ranging from feelings of concern for other people that create the motivation to help them, to experiencing emotions that match another individual's emotions, knowing what the other is thinking or feeling, to blurring the line