Empathy-an essential tool for communication for palliative care doctors

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This article is a discussion on the quality of empathy in palliative care, with sharing of some past studies on this important subject in the context of physician-patient communication and relationship.

What is Empathy?¹

Empathy is the feeling that persons or objects arouse in us, as projections of our feelings and thoughts towards the external persons or objects (in Jung’s terms). It is expressed when ‘I and you’ becomes ‘I am you’, or ‘I might be you’. It requires a certain merging between the viewer and the viewed. It brings a feeling of being at home with the object contemplated, not as a stranger. It is different from sympathy which involves compassion and means, ‘I want to help you’. The concept of empathy was first elaborated from arts, where empathy is what we feel when we see a picture that moves us - the esthetic aspect. For the picture to move us, we have to once feel the picture or something similar. Empathy is more than knowing the facts. It also involves knowing the emotions accompanying the facts. Empathy is an ability which, if you do not use it, you lose it gradually.

Our present medical training and practice may decrease empathy in doctors. During medical education, we teach students science and detachment, to see themselves as experts, to fix what is damaged. They learn equanimity instead out of pride and learn to mask their feelings and even deny them. They do just what they are trained to do, with not much empathy involved. Modern medicine has turned physicians away from themselves and toward the contemplation of technical images e.g. CT scans which only show the body and its various systems and structures and do not show the mind and spirit of the patients. The to-be doctors are selected by victories. We teach medical school by being bright and competitive, hardworking and achieving. Residency often requires long hours of duty, sleep deprivation, facing prolonged human tragedies and the often futile and incomprehensible therapeutic procedures. These experiences quench the little empathy we have for the defeated, the humble, the dying and the sick. Work and study is nearly everything, with little time left for contemplation, and none remains for the humanities. In clinical medicine, we talk about the case, not about the person. The style of medical writing is often objective and impersonal. Artists may discover themselves in their work. They uncover the subject in their drawing and painting by reflection. History taking can be a discovery for the physician too by a more narrative approach, by knowing something of the life of the person besides the disease he has, to obtain the story of persons with disease and what they feel and suffer in their bodies. Conversation with people helps cultivating empathy, sharing experiences and feelings. But medical students have very little time for that. They have limited time for spontaneous collegiality, meeting our colleagues in an unstructured non-hierarchical way. The environment around the physicians is not conducive to develop empathy. This self-awareness is the important first step to recover our empathy.

Empathy can be strengthened through consideration of human life and experience, the reading of stories and novels to enlarging our life experience, and the discussion of narratives, paintings and role models. Subjects of humanities and rhetoric (literature) are beneficial to build character and enhance empathy for the clinicians. When we ask the patient what he or she thinks is wrong, this does not mean the patient can diagnose better than we do. But the patient usually knows the circumstances of his or her illness in greater details than does the physician. We physicians tend to begin by getting a story from the patient, then abstracts the patient. The patient becomes transparent before us after we have extracted the information we like to know. Conversations about life experiences, about doctor-patient relationships and human relationships in general, narrative approach to case history taking, case discussions about patients and their stories, and about ourselves