

# Exploring Empathy in the Face of Patient Anonymity and Professional Challenges and Barriers

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## ABSTRACT

This article defines *empathy* as the conveyed expression of awareness, understanding, and sensitivity to the experiences, feelings, and emotions of a patient with a medical condition. This article is a reflective short story addressing empathy through the eyes of Maria (a fictitious patient), who is confronted with the challenges of negotiating her first encounter at a medical facility, and through the actions of Dr Jones (a fictitious physician) who, at a critical juncture, fails to engage empathically with her patient donning the ubiquitous hospital gown. The gown is instructive in this context because it compounds the deidentification of an already nondescript person. Maria's story is a collage of multiple clerkship experiences of a fourth-year medical student, and of shared anecdotal accounts from patients and medical practitioners.

In this article, I explore the following: 1) the insecurities and anxieties experienced by individuals with medical ailments, 2) the critical role that empathy can play in reassuring and comforting patients in pain, 3) the belief held by some individuals that empathy erodes with the practice of medicine, 4) the ongoing threats and barriers to empathy in the medical profession, and 5) the vigilance and diligence required of medical practitioners to ensure maintenance of this essential human quality. Additionally, I describe the challenges of identifying who is responsible for screening for empathy in aspiring medical school applicants, incorporating empathy training in the classroom and in clinical apprenticeships, and monitoring and ensuring empathy maintenance among physicians in training and physicians in practice.

## INTRODUCTION

*Empathy* in health care is the conveyed expression of awareness, understanding, and sensitivity to the experiences, feelings, and emotions of a patient with a medical condition. This article is a reflective short story addressing empathy through a fictitious case.

## CASE VIGNETTE

Maria, a young recent immigrant, carefully folds her work clothes, which identify her as a waitress, as she prepares to change into a hospital gown that will cover her now anonymous body: Shielding her slender frame from what she perceives as an indifferent and, perhaps, insensitive external world. She ponders quietly and nervously about her symptoms, as she obsesses over her vulnerable logistical predicament. *How will I pay for the medical expenses? I am*

*a single mom struggling to survive! What if I have cancer? A knock on the door wrenches her attention from her introspective concerns; "Hi," an aloof voice greets her. Maria extends a hand to the physician, but the physician does not react to the gesture as she proceeds to her computer and begins typing. This is Maria's first visit to a physician's office in the US. Maybe the doctor did not see my extended hand, she wonders. Maybe it's disrespectful in this country to greet a physician, a person of status, with a handshake. How crude of me to think that this busy and important professional would want to engage in trivial pleasantries with a simple immigrant peasant like me. She sits quietly, embarrassed by her presumed inappropriateness, intimidated by the sterile examination room, isolated in her concerns about her physical condition, and alarmed at the prospects of what*

might happen to her young child if the prognosis is serious and the outcome is fatal.

Resigned to her fate, Maria whispers an appeal to God in her native Russian language. *Dear Lord, help me! Do I have cancer? Will I survive my illness, or will I go through prolonged agony and pain and then die? Please take care of my baby if something happens to me.* Dr Jones, an American descendant of Russian-born parents, recognizes the foreign dialect and is reminded that, like Maria, she too has a deep concern for her dependent Russian parents and children. Pushing aside her exhaustion from a long day at the clinic, Dr Jones inquires, "What part of Russia are you from, Maria?" as she makes eye contact for the first time. "I'm a descendant of parents from St Petersburg. How about you? My maiden name is Ivanov, but I married an American, and now my last name is Jones," the physician explains.

Maria's fatalistic deportment immediately and visibly changes. Her perplexed facial gestures, catastrophic bewilderment, and manifestly strained body language morphs into a perceptible beacon of light, illuminating the sterile inanimate room with a sense of humanity. "My family is from a small farming community south of Moscow," Maria enthusiastically replies. "My Russian name is Masha, but everyone calls me Maria. How long has your family lived in the US, Dr Jones?" Maria and Dr Jones exchange stories about the motherland throughout the entire medical consultation. Finally, the examination is completed, and the diagnosis is severe gastroenteritis. Maria is sent home with prescriptions to ease her discomforts and expedite her recovery. She is advised to

monitor her progress and return to the clinic if her symptoms do not subside.

## DISCUSSION

Maria's initial obsessions with her health and anxieties about going to a medical facility are not uncommon.<sup>1</sup> The yearning to be understood and comforted, the trepidations with the unknown, the sense of fear and concerns about the worst possible outcomes, the preoccupations with treatment costs, and the inevitable thoughts of mortality are among the tsunami of affect that (even if unfounded or unjustifiably exaggerated) can consume patients in Maria's predicament.<sup>1</sup> Moreover, as cortisol levels rise in response to the anxiety of being ill and in a medical facility, blood pressure and glucose levels spike, sleep and appetite diminish, and many other somatic manifestations of stress respond to the perceived medical crisis and to the impending hospital encounter.<sup>2-4</sup> These emotional sequelae are unfortunate artifacts of getting ill. What should not be a side effect of illness, however, is the dispassionate conduct on the part of a healer (even if unwitting and momentary) that can catalyze an already difficult situation. Maria's reaction to Dr Jones' initial behavior illustrates how quickly a patient can misperceive a physician's demeanor and how the misperception can aggravate a patient's precarious emotional state, influence what she is willing to disclose about her medical condition, and even discourage future physician visits.<sup>5</sup>

As physicians, we are reminded of our responsibility to endeavor to facilitate our initial patient encounters with reassuring sensitivity. As Hardee<sup>5</sup> asserts in his 2003 article on empathy: "Of all the elements involved in effective communication, empathy seems to be the component that is most powerful yet is easily overlooked . . ." Empirical research also informs us that excellence in diagnostic skills is not sufficient; that empathy is an important copartner in patient satisfaction, patient compliance, and health outcomes.<sup>6,7</sup> As Hardee<sup>5</sup> states: "some commentators have asserted that in medical practice the importance of empathy cannot be overemphasized."

From a patient perspective, Maria's hospital gown is also instructive because it is symbolic of an anonymous person, any person, drenched in emotion and uncertainty; a person who enters a physician's office, the office of a healer who is also dressed in a gown, but it is a gown of identity and perceived authority and distinction. Maria's story is instrumental

of lectures from medical school professors, role-reversal accounts shared by practicing physicians who have been hospital patients, personal experiences receiving medical care, clinical observations in clerkships, and anecdotal stories from patients and family members: All anonymous souls in ubiquitous hospital gowns. This medley of experiences has

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in elucidating that beyond the ubiquitous hospital gown that she dons, there is a concerned heart that beats distressingly about her medical condition. She is not just another patient. Furthermore, the reference to the physician's gown is also instructive because it showcases the perceived role that authority figures (in uniforms or gowns of distinction) play in the lives of some individuals, particularly in linguistically and culturally diverse communities.<sup>8-10</sup>

Maria's story reminds us of the many critical connections between empathy and treatment, of our professional obligation to not exacerbate a patient's tenuous psychological state by neglecting (even if just momentarily) our responsibility to be compassionate and sensitive to human affect, of making immediate and continued eye contact with our patients,<sup>11,12</sup> of being aware of facial gestures and body language (ours and our patients'), of being mindful of the plethora of insecurities that accompany pain and discomfort,<sup>1</sup> and of our professional duty to not become dispassionate body mechanics and lose our humanity. We are prompted to be attentive to the kaleidoscopic threats to empathy: To the potential barriers and factors that erode compassion; to the omnipresent patient hospital gowns; to fatigue; and to the various demographic characteristics such as sex, culture, language, religion, age, and socioeconomic status that can compromise our sensitivities for others.

Maria's account is a reflective collage of my experiences as a medical student. This story encompasses an amalgamation

compelled me to put a face on empathy and chronicle the importance of compassion in the practice of healing. Maria's narrative reminds me that among physicians, proficiency is not enough; skills and empathy must coexist and work in tandem to establish a caring therapeutic environment where a seemingly anonymous gown-draped person becomes a patient (our patient) with feelings and with a yearning to be understood and cared for as a dignified and appreciated human being.

As I complete my fourth-year clinical apprenticeships, it appears that considerable variations in empathy exist among my peers, residents, and attending physicians. These variations prompt me to ponder several questions about empathy and its role in medical training and practice. Who is responsible for screening and monitoring for empathy in physicians: Medical schools, medical facilities? Shouldn't medical schools screen for empathy in aspiring physicians? Shouldn't empathy be a part of the medical school curriculum? Does empathy erode with the practice of medicine (as suggested by some authors<sup>13-16</sup>)? And, if it does, shouldn't health facilities (hospitals, clinics, community centers) institute or, perhaps, even mandate periodic professional workshops to ensure maintenance of empathy? These are difficult questions for our profession to confront, and the solutions are not immediately apparent, but until we shed light on and bring these challenges to the forefront, we cannot begin to address them. Moreover, until we begin to

acknowledge and address these fundamental matters, including through empirical investigation, we cannot expect to garner the confidence and cooperation of our patients whom we admonish to actively participate in preventive prescreening and early detection measures, and whom we implore to not wait until their asymptomatic medical conditions or mildly discomforting ailments develop into major life-threatening crises. In this environment, empathy, prevention, early detection, compliance with physician-prescribed treatments, and physician-patient partnerships are symbiotic: Relying on each other to synergistically achieve the same goal—*healing*. ❖

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The author(s) have no conflicts of interest to disclose.

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#### How to Cite this Article

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## Nothing Human is Strange or Repulsive

The patient is no mere collection of symptoms, signs, disordered functions, damaged organs, and disturbed emotions. He is human, fearful, and hopeful, seeking relief, help, and reassurance. To the physician, as to the anthropologist, nothing human is strange or repulsive.

—Tinsley R Harrison, 1900-1978, American physician and editor of the first five editions of *Harrison's Principles of Internal Medicine*