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# The limits of empathy: problems in medical education and practice

Anna Smajdor, Andrea Stöckl, Charlotte Salter

School of Medicine, Health Policy and Practice, University of East Anglia, Norwich, UK

**Correspondence to**
Anna Smajdor, School of Medicine, Health Policy and Practice, University of East Anglia, Norwich NR4 7TJ, UK; a.smajdor@uea.ac.uk

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## ABSTRACT

Empathy is commonly regarded as an essential attribute for doctors and there is a conviction that empathy must be taught to medical students. Yet it is not clear exactly what empathy is, from a philosophical or sociological point of view, or whether it can be taught. The meaning, role and relevance of empathy in medical education have tended to be unquestioningly assumed; there is a need to examine and contextualise these assumptions. This paper opens up that debate, arguing that 'empathy', as it is commonly understood, is neither necessary nor sufficient to guarantee good medical or ethical practice.

## INTRODUCTION: PERCEPTIONS OF MEDICAL PROGRESS AND EMPATHY

Empathy is commonly regarded as an essential attribute for doctors.[1 2] A paper published in 2006 argued that medical schools need students who are '… more capable of understanding the patient and his point of view and thereby providing better treatment'.[3] General Medical Council (GMC) guidance includes numerous references to empathy and describes empathy as being one of the qualities that make a good doctor.[4–6] In recent years this prevailing assumption has led to a conviction that empathy must be taught to medical students. Yet it is not clear exactly what empathy is, from a philosophical or sociological point of view, or whether it can be taught.[7 8] The meaning, role and relevance of empathy in medical education have tended to be unquestioningly assumed. We suggest that there is a need to examine and contextualise these assumptions. This paper opens up that debate, arguing that 'empathy', as it is commonly understood, is neither necessary nor sufficient to guarantee good medical or ethical practice.

In the mid 19th century, with the rise of the upper middle classes, the social position of doctors began to change.[9] This, in conjunction with scientific developments, led to a growing divergence between doctors' and patients' world views.[10] According to historian Edward Shorter, it was during this period that empathy was gradually edged out of mainstream medical practice.[11] Since then, medicine has aligned itself with the sciences rather than the humanities, taking a clear stance in the polarisation that C P Snow famously termed the 'two cultures'.[12]

Now, however, the doctor–patient relationship is undergoing another transformation. The humanities are making a reappearance in medical training. There are two distinct lines of argument behind this. One view is that medical education was previously too focused on science; doctors need to re-develop empathy through training in humanities and 'soft' skills. Chris Cowley, for example, states that 'medical schools have come a long way towards improving the curriculum by increasing the content of humanities subjects and communication skills in the past decades'.[13]

The other interpretation is that doctors previously maintained the capacity for empathy despite the science-focused nature of their training, but recent changes in the practice of medicine have undermined this. Howard Spiro, for example, laments that 'empathy must joust with equanimity now that physicians are being turned into clerks and mechanics by a bureaucracy that regards "healthcare workers" as interchangeable modules'.[14] John Spencer makes a similar point, linking empathy with idealism and arguing that, as junior doctors get involved in the everyday business of medical practice, both their empathy and their idealism dwindle.[15]

In response to these concerns, there have been moves to rehabilitate empathy in medicine through teaching humanities and 'soft skills'. Spiro has been highly influential in introducing empathy into the medical curriculum in the USA, largely through a focus on literature and humanities. In the UK, empathy has also become embedded in medical education. It appears in various guises throughout the curriculum, in communication skills, ethics and professionalism.[16] Yet it is still unclear exactly what empathy is, whether a greater focus on humanities and soft skills is likely to enhance it and, indeed, whether such an enhancement would be beneficial.[17] We will now consider what constitutes the teaching of empathy at present in most British medical schools.

## TEACHING EMPATHY THROUGH CONSULTATION SKILLS

Much of the guidance published by the GMC and the Royal Colleges on the GMC's website emphasises the importance of empathy. Empathy is described as a key skill to be demonstrated across the spectrum of medical practice.[4–6] Empathy has also been an area of research over the last 25 years. Stewart *et al* in their treatise on patient-centred medicine describe how, in order to be patient-centred, doctors can no longer be detached and dispassionate observers but should heal through empathetic understanding. Compassion, empathy and caring are seen as central to the doctor–patient relationship.[18]

In 1993 *Tomorrow's Doctors* emphasised the importance of effective communication for doctors,[19] and empathy has come to form a key focus of training and assessment of communication skills.[19–23] Commonly considered the modern day

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gurus of communication skills teaching in medicine, Silverman, Kurtz and Draper[21] developed a model that is adopted in well over half of all UK medical schools. Of the 20 medical schools which use a formal model for teaching purposes, 18 have adopted the Calgary-Cambridge approach.[24] Empathy is a core skill in this teaching model and students are assessed specifically on their ability to show 'empathy and support'.[24]

## WHAT IS EMPATHY AND WHY DO DOCTORS NEED IT?

There is no universally-accepted definition of empathy.[25] Nevertheless, it is useful to note some common assumptions. Empathy is commonly regarded as being distinct from sympathy. Sympathy is 'concern for the welfare of the other'[26] while empathy is the ability to appreciate the emotions and feelings of others. In healthcare, empathy is often viewed as an attribute that enables doctors to understand the inner experiences of the patients, to communicate this understanding and to respond in a therapeutic way. According to Spencer, this is a complex human skill that involves more than just 'putting oneself in another's shoes'.[15] Martin Buber's highly influential account connects empathy with the 'I/thou' relationship' rather than the more formal 'I/you relationship'.[27] The latter is constrained by the boundaries associated with a predefined role which Buber believes is incompatible with the development of a truly intimate relationship.

Havi Carel in her treatise on *Illness, The Cry of Flesh* observes '[t]here are many terrible things about illness; the lack of empathy hurts the most'.[28] Carel draws on Buber's approach, calling for an intimate ethically-demanding encounter between doctors and patients, one that acknowledges the humanity of both people involved. Empathy as feeling—as a recognition and response to another person's uniqueness and subjectivity—is a central concern for those who favour the teaching of empathy. But this is where it starts to become problematic. Cowley asserts that there:

> … has to be room for the uniqueness of each human being, a uniqueness that is more than a unique combination of generalisable traits. A sensitivity to such uniqueness calls for a different way of engaging with the patient: not as an object of study (and diagnosis and treatment) but as another subjective point of view on the world. Such engagement is much more than the simplistic notion of empathy that psychologists like to measure, and much more than the simplistic respect for autonomy that many ethicists go on about.[3]

## EMPATHY, OBJECTIVITY AND THE GOOD DOCTOR

The kind of relationship described above is intense and demanding on many levels. Cowley requires that doctors should be skilled technicians, be fluently conversant with art and literature and able to respond to every individual patient on a profound subjective human level.[3] The GMC's *Tomorrow's Doctors* 2009 seems to endorse this demanding view, stating that doctors must be professionals, scientists and scholars.[19] Spiro asks: 'Is a doctor a scientist, a detective, a parent, or just an expert called in to be a "fixer"?'[14] The implication is that the doctor should be all these things, and perhaps even more. Certainly, mere 'fixing' is not enough.

Can we teach doctors to develop all the attributes that Cowley and Spiro demand and still ensure that they are able to function as 'fixers'? If empathy and 'soft skills' are brought into the curriculum, something else may have to be jettisoned to make way for them. This should make us ask precisely what attributes are crucial for doctors and which, though perhaps appealing, are not essential. Spiro and Cowley take the view that objectivity—that traditional bastion of professionalism—is inherently incompatible with empathy. Objectivity is thus to make way for subjectivity, allowing proper space for empathy to flourish. This raises two questions. First, is it true that empathy and objectivity cannot co-exist? Second, if we had to choose only one of these two attributes for our doctors to cultivate, should we opt for empathy?

The cultivation of either objectivity or empathy does not necessarily cancel out all possibility of switching modes, as it were. Indeed, this switching of modes is surely something that we do all the time. Much of the work involved in non-medical caring requires a degree of objectivity: noticing that a bath or shower is needed, ascertaining whether the person is hot or cold, seeing if they are wearing clothes that are comfortable and that suit them. These are evaluations that are carried out using a different set of criteria from those involved directly in 'feeling', but they do not preclude empathy. Spencer echoes this fact when he suggests that 'a more sustained nurturing of self-awareness and broadening of vision would seem the key'.[15]

Even if objectivity were incompatible with empathy, it is not obvious that empathy should be the preferred attribute for doctors. Developing objectivity helps doctors to do extraordinary things—not least, cutting into living flesh. The case of Dr Rogozov, who removed his own appendix during an Antarctic expedition, is an extreme example of this. Rogozov's non-medical colleagues on the expedition struggled to overcome their feelings of horror while assisting during the operation. In contrast, Rogozov's doggedly objective approach (even referring to himself as 'the patient') enabled him to carry out the procedure successfully.[29]

To replace clinical objectivity with empathy is counterproductive in medicine. A doctor who flinches as he makes an incision will be a worse surgeon—even if a better human being—than one who effectively dissociates himself from the feeling that he is cutting human flesh. William Branch describes with approval a student who 'recoiled when he inflicted pain on a patient during a pelvic exam'. However, '… on reflection, he was glad he had not become insensitive'.[30] Perhaps the patient would have preferred a painless examination carried out with less empathy. Branch does not tell us if the pain was caused by incompetence, nor does he say whether the student's empathetic recoil added to the patient's discomfort. Either way, even if this event shows the student's essential humanity, it does not show that he will be a good doctor.

Empathy in medicine may remind us that doctors are people and that the doctor–patient interaction is a shared human experience. But, as suggested above, doctors do not necessarily benefit patients by entering their world view and feeling their pain or embarrassment.[31] Looking at the question from another perspective, when we allow doctors to see and act on our bodies, we may take comfort in the idea that they are unable to feel with us in the 'usual' human way. Medical practice relies partly on doctors' ability to distance themselves from the subjective world of the patient. It is by this means that both doctor and patient can protect themselves.

## EMPATHY AS A VIRTUE

Objectivity has a useful function in medicine as a protective framework within which certain social taboos can be safely broken. But there may be areas in which subjectivity and empathy have a more valuable role to play—particularly, perhaps, in general practice where longer term relationships can be developed. We would not dispute this. However, it is

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important to consider exactly what we expect of empathy and why it is important.

Empathy often seems to be understood as a virtue: a necessary part of what it is to be a 'good' person. It appears to follow from this that a good doctor must be empathetic. But this logic is flawed on two counts. First, the virtues of a 'good person' are not necessarily identical to those of a 'good doctor'. Second, being empathetic is not sufficient to make one 'good'. These problems relate back to one of the challenges debated in Plato's Protagoras: what is virtue and can it be taught? Protagoras himself asserts that virtue can be taught—and that he does teach it. Socrates rejects the possibility of teaching virtue, since wisdom is the source of all virtues and wisdom cannot be taught.[32] This is a question that has never satisfactorily been answered. But in the context of medical teaching, empathy has been invested with a similar status to that of wisdom in the Protagoras. Empathy is assumed to be the source of virtue in doctors, and it is assumed that it can be taught.

If empathy is a virtue, it may be classed with other virtues such as honesty or courage. But it is misguided to suppose that, in isolation, any of these are a guarantee of 'goodness'. This is precisely why Socrates argues that wisdom is the source of virtue; none of the other virtues is sufficient. A truthful person may deliberately hurt or offend. Courage can be used in the pursuit of evil ends. Likewise, empathy cleverly deployed can be used to gratify one's own pleasures or to further one's own interests. Doctors who can enter into patients' distress, pain or embarrassment might take pleasure from this ability. As Bernard Williams has said:

> If it is a mark of a man to have a conceptualised and fully conscious awareness of himself as one among others, aware that others have feelings like himself, this is a precondition not only of benevolence but (as Nietzsche pointed out) of cruelty as well.[33]

A similar point is made by Ken Binmore who observes that '… a gunfighter may use his empathetic powers to predict an opponent's next move without losing the urge to kill him'.[34] To be a good hunter, one must enter into the world of one's prey as fully as possible; empathy is a crucial weapon in this context.[35 36] Harold Shipman had a good rapport with many of his patients who felt that he understood and had time for them. This enabled him to gain their trust and ultimately take their lives.[37] This seems to have been overlooked by those who assume that the development of empathy must necessarily yield 'good' doctors. Even if we could effectively teach empathy (which is questionable), those who are by nature cruel or manipulative may use it as an additional tool with which to pursue their ends.

Empathy alone is not enough. What we want is something prior to empathy—that is, good people who will empathise in ways that we deem morally appropriate. The essence of the arguments put forward by Spiro, Cowley and others seems to be that doctors should be good *people*. What does this really mean, though? Surely *all* people should be good—not just doctors! To say that people in general should be good is an empty tautologous statement. What is actually being suggested here by Spiro, Cowley and others is that doctors have special moral obligations. It is more important for doctors to be good than it is for plumbers, lawyers, teachers or musicians. In short, doctors ought to be better than other people.

## EMPATHY, PATERNALISM AND THE GOOD DOCTOR

Since the division of 'professional' doctors from other healers, doctors have come from the powerful social classes. Their elevated social status in conjunction with their scientific knowledge created an exaggerated power imbalance in which paternalism flourished. But recent trends in medical ethics and education repudiate paternalism. Respect for patient autonomy entails a greater expectation of equality between doctors and patients. The view that doctors should have and exercise all the human virtues as well as technical skills and scientific knowledge seems incompatible with the idea that doctors are essentially no better or worse than the rest of us.

Yet the nature and scope of the attributes that the GMC, for example, demands of doctors are so extensive as to make one feel that doctors must indeed be far superior to 'ordinary' people.[19] These exalted expectations of doctors reinforce the idea that patients should be awed, subdued and grateful for their treatment. The presence or absence of gratitude plays a significant part in Spiro's anthology of empathy in medicine. Surgeon George Bascom describes a patient who had suffered complications after abdominal surgery: 'her ingratitude was uncompromising …'.[38] Of another patient who threatened to sue after having been in hospital for 4 days without being seen by the doctor, Bascom writes 'I resented the ingratitude'. In contrast, another patient was appropriately 'appreciative' and her husband was 'grateful'.[38]

If doctors are better than ordinary people, perhaps it is inevitable that patients should show gratitude. But this is not necessarily a positive thing. It implies that patients are supplicants. When they seek medical help, by implication, they seek more than they are entitled to. Every act of the doctor is, on some level, a supererogatory performance. Of course gratitude may sometimes arise spontaneously in any situation, but the expectation of it in medicine seems strangely to imply that doctors always and necessarily exceed the requirements of duty.

The expectation of gratitude does not harmonise well with the principle of respect for patient autonomy. In the modern approach to medicine we no longer expect patients to be treated as quasi children but as autonomous adults with responsibilities. Shared decision-making is at the core of the UK's new health policy. The public are becoming more involved not just in treatment decisions but in health policy at every level.[39] With patients as interested and active participants and decision-makers rather than passive recipients of medical interventions, the relevance of doctors' special moral status becomes questionable. A significant power imbalance necessitates careful moral constraints. In an equal relationship the need for caution is diminished.

Medicine is no longer a domain of arcane and mysterious rites. Everything is rational and explicable. This fundamentally alters the relationship and involves a certain loss of status for doctors, which is exacerbated by scientific developments. 'Technological triumphs have made many doctors feel so much like mere conduits of power that they no longer think of themselves as healing agents'.[14] Empathy may be all that is left to suggest that doctors are more than mere 'fixers'. However, the doctor who diagnoses, refers or operates the technology is not necessarily the 'healing agent'. The role of the doctor is moving towards that of service and information provider. The idea that the provider of information and services must feel and empathise with the consumer/patient seems excessive and incongruous. This is not to say that all interpersonal skills are redundant. But the skills required by modern doctors are not broadly different from those required by pharmacists or other providers of goods or services. If doctors can perform their tasks with the requisite skill and a modicum of courtesy, perhaps this should be enough.

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## EMPATHY OR ETIQUETTE?

As we suggested earlier, the literature on medical education is hazy as to what empathy is, and assumptions about how to teach it are open to question. Yet it is clear that doctors who can communicate effectively with patients will be more effective in many ways: keeping consultations to time without offending patients; persuading patients to comply with medication; encouraging them to give up smoking or take exercise. Patients value clear and courteous communication; unsurprisingly, it makes them feel better.[40] Teaching doctors these skills is thus a valuable enterprise, but is it really empathy that is required in order to achieve this? If so, it is a much 'thinner' version of empathy than that advocated by Cowley and Spiro. Empathy so thin might be more accurately termed 'etiquette'.

Etiquette is formal and generalisable. It is not based in the intimate 'I/thou' relationship that Buber proposes nor in the response to the unique subjectivity of patients that Cowley advocates. Etiquette enables people who are not in intimate relationships to interact without having to enter into each others' subjective experiences, desires or values. Being polite may seem a very minimal requirement but, in fact, it is specifically with basic courtesy that doctors frequently struggle. In Spiro's anthology, a number of cases are presented as examples of failure of empathy: doctors do not meet the patient's eye. They talk over and around the patient who feels that he has been badly treated.[41] These people are being treated with a lack of courtesy that would be astonishing in any other circumstances.

In medicine, politeness is not just of ethical importance but is also pragmatically and financially significant. It is well-known that, when patients sue hospitals, it is often because mistakes have been compounded by a failure in courtesy.[42 43] There is nothing mystical about this. It is not about what doctors are feeling but about their adherence to basic social conventions. We might better equip doctors to avoid these problems by focusing on etiquette rather than on empathy per se. Etiquette for doctors needs to be carefully structured precisely because the things that doctors have to do (discussing your sex life, cutting you, giving you drugs) are socially taboo. Trying to deal with these taboos on a daily basis and formulating a unique way of relating to and feeling with each individual is impossible.

What students can learn in their 'soft skills' training is perhaps more akin to the McDonalds style 'You have a nice day now' than to the rich nuanced and individualised conception of empathy that Spiro and Cowley advocate. But this is no bad thing—as long as we are able to recognise that this is the case and ensure that our doctors have at least this basic ability. As Jodi Halpern writes: '… physicians today are increasingly caring for strangers in bureaucracies'.[44] In these circumstances we lack the resources to be truly empathetic. Doctors must navigate the social complexities of the doctor–patient encounter within very limited time constraints. They need to develop and practise skills that will enable them to do so. But we need to make far more moderate claims about what is being taught, and how and why.

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