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SHORT COMMUNICATION

Empathies" Rather than "Empathy" in The Clinical Context Of General Medicine: Acute Or Chronic Diseases, Physical Or Mental Health Problems and Types Of Doctor-Patient Relationships

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Abstract

Empathy has been a widely discussed topic in practice, education, and research. Understanding and recognizing this concept is considered fundamental to medical practice. Thus, it has acquired the status of "ideal" in modern medicine. But, in reality it is a complex and heterogeneous phenomenon. Furthermore, the idealization of empathy has made it difficult to reach a consensus on a definition and the effects of its different components. Thus, it is important to reflect on several aspects: 1. Empathic tendencies can be "risky strengths." Excessive empathy can also be dangerous for the patient. A high level of empathy without a corresponding high level of assertiveness can harm the patient as the doctor forgets her / his professional tasks. Empathy and assertiveness are two axes of the same plane: a high level of empathy must be associated with a high level of assertiveness. There is a certain point where the doctor should no longer adjust to the patient; 2. Empathy must be conceptualized within a broader biopsychosocial approach that includes (in addition to assertiveness) other psychological phenomena that occur in the consultation, and that are interconnected, such as doctor-patient relationship, transference and countertransference and the placebo effect; 3. The empathy-assertiveness of the doctor depends on multiple conditions, some related to the doctor, others to the patient, as such or as people, others to the disease, others to the context. Thus, this empathy-assertiveness can be different in different pathologies, modes of doctor-patient relationship, and in acute disease or chronic disease; 4. Empathy must be rebalanced by a "doctor-centered empathy."

Keywords: *Empathy; Physician-Patient Relations; Psychotherapeutic Processes; Transference (Psychology); Countertransference (Psychology); Placebo Effect; Communication Skills*

Empathy can be defined, tentatively, to begin to reflect on it, as the ability to share and/or understand the emotional state of others without confusion between oneself and others, and it is considered a central characteristic of the doctor-patient relationship (1). Physician empathy is considered essential for good clinical care. The potential benefit of clinical empathy may go far beyond patient satisfaction and extend to improved clinical assessment, therapeutic alliance, and compliance, and therefore better clinical outcomes (2, 3).

A commonly shown example is that described in the book of John Berger "A Fortunate Man: The Story of a Country Doctor" and Illustrated with Photographs by Jean Mohr, which was published almost 50 years ago (but has recently been republished). Berger describes the work of Dr John Sassall, a rural GP in the Forest of Dean, in the county of Gloucestershire, England (4). Studying this book provides insight into the empathy process. There is agreement that we need more empathy in healthcare, although conflicting evidence suggests that medical students experience decreased levels of empathy during training (5).

Also, the words empathy, sympathy, and compassion are not interchangeable. Empathy means that one

feels what another person feels; sympathy means that one understands what the person feels; compassion is the willingness to alleviate the suffering of another person. One can be empathic without being compassionate. With compassion, we take a step away from the emotion of empathy and ask ourselves “how can we help?” Because the empathy joins in the suffering of others, but takes no action to resolve the problem, such empathy can become a reflection on the problem. In fact, people prone to an empathic response are also more likely to experience depressive symptoms(6). Similarly, many good doctors are compassionate without being particularly empathetic; patients tend to value other qualities more, such as competence, honesty and respect (7).

Empirical evidence shows that empathy is correlated with better patient satisfaction, compliance, and clinical outcomes. However, these data have been criticized for their lack of consistency and reliability. The definition of empathy and its application in the medical field are the subject of extensive debate among scholars (8). It has been argued that these problems stem in part from the widespread idealization of empathy: it is wrongly assumed that physician empathy always contributes to good care; but, empathy may be of little benefit to the patient and could harm the physician (9). Empathic tendencies can be "risky strengths" (10).

In this way, several aspects of empathy are very interesting, and it does not seem that they have been the frequent object of reflection or research. Especially the hypothesis that excessive empathy can be dangerous for the doctor, as exemplified by the sad ending of the empathetic Doctor Sassall; John Berger linked Sassall's regular bouts of depression directly to his over-identification with his patients' distress: "he becomes increasingly susceptible to the suffering of others." This depression eventually led to Sassall's suicide in 1982. “The suffering that certain physicians witness,” Berger wrote, “may be tenser than is generally admitted (4).

The truth is that despite this, the enthusiasm for empathy has grown to the point where it has acquired the status of "ideal" in modern medicine. We need to pause and examine this ideal before proceeding. Taking empathy as an ideal blurs the distinction between the multiple goals that empathy seeks to achieve. While these goals may work together, they also separate, leading to different recommendations for the type of behavior clinicians should cultivate in a given situation (11).

The idealization of empathy has made it difficult to reach a consensus on a definition of empathy and has vented us from gaining a precise understanding of the effects of the different components of empathy. Empathy is a complex and multifaceted construct that has been defined in many different ways. The potential components of empathy (perspective taking, affective empathy, emotional contagion, empathic concern, and empathic distress) can have negative effects depending on how they are exemplified and at what point in the medical interview. This suggests that there is no ideal concept of empathy (12). Furthermore, the usual conceptualizations of empathy are inconsistent and difficult to put into practice (13).

Thus, it is important to reflect on three aspects:

1. Excessive empathy can also be dangerous for the patient: a high level of empathy without a corresponding high level of assertiveness can harm the patient as the doctor forgets her/his professional tasks. Empathy and assertiveness are two axes of the same plane: a high level of empathy must be associated with a high level of assertiveness. The relationship between empathy and assertiveness in the doctor-patient relationship can be exemplified with the kite metaphor: The kite flies because it is tied. If you take a kite and throw yourself into the air, it doesn't fly; On the other hand, if it is tied, the rope allows resistance against the wind and the kite flies. It flies because it is tied (14). The meaning of "caring" in medicine includes empathy, assertiveness, compassion, trust, respect, and listening (15).

Most doctors enter their training with a desire to help people. When a patient asks us for assistance, and what is requested is within our power, we generally say yes. If what they want is not safe or evidence-based—another home detox from alcohol, or a drug that is blacklisted in our formulary—we have good reasons for declining. Where do we draw the line with private referrals for cosmetic procedures or letters to schools about the need for swimming goggles? (16, 17).

The doctor can accommodate the patient's demands, but there are patient expectations that the doctor cannot assume. There is a certain point where the doctor should no longer adjust to the patient. The physician has not only the right but also the ethical duty, to place his own agenda in the care relationship and influence the patient's beliefs. Sometimes he must also assume the courage to raise the psychosocial origin of certain somatizations, breaking cycles of chronic and iatrogenic medicalization (18).

2. Empathy, a central characteristic of the doctor-patient relationship (1), must be conceptualized within a broader biopsychosocial approach (19) that includes (in addition to assertiveness) other psychological phenomena that occur in the consultation, and that are interconnected, such as doctor-patient relationship, transference and countertransference and the placebo effect (20-22).

Two major types of empathy are considered, one referring to the way of thinking (cognitive empathy) involved in anticipating what others are thinking and another, that of feeling (emotional empathy), referring to sharing emotions (23). In a doctor-patient relationship, there is a modality of psychotherapy, where the treatment is based on that relationship, in which the doctor and patient work together to improve psychopathological conditions through the focus on the therapeutic relationship, which brings consequences on thoughts, emotions, and behaviors. The work of a doctor can be understood as a psycho-physiological doctor-patient relationship process through which the doctor and patient can influence the health of the other. Doctor-patient relationship evaluation has to be carried out jointly by both, doctor and patient, on the effect that both are achieving with that relationship (24).

Communication is critical to the treatment of all acute or chronic diseases. Empathy plays a fundamental role in communication, allowing the exchange of people's experiences, concerns and expectations, and provides a link that allows health professionals to perceive the emotions of others and behave in a way that shows they understand. But, this empathy-assertiveness can be different in different pathologies and modes of doctor-patient relationship, for example in rheumatological versus respiratory or infectious or psychiatric or neurological diseases (26, 26).

The empathy-assertiveness of the doctor depends on multiple conditions, some related to the doctor, others to the patient, as such or as people, others to the disease, and others to the situation. The acute disease usually has a more or less rapid onset and a relatively short course, lasting days, weeks or months. The usual thing is that the acute disease presents a clinical picture with frank and obvious manifestations that afflict the patient and easily capture the attention of the doctor. These manifestations are in the form of bodily symptoms, perceived by the patient as sensory or sensitive feelings (pain, dyspnea, asthenia, tremor, pruritus, paralysis, etc.) that are expressed both in their own body and in the narration they make, with great vivacity and acuity, immersed in the situation in manifest emotional affectation. In chronic disease, there is a long development with the appearance of less obvious symptoms, duller, with less clinical sound. On the other hand, the chronically ill person has an experience of illness and a path-biographical content that is different from the experience of illness in the acute patient. Thus, a prudent conclusion is that in acute illness, the empathy that appears in the doctor is emotional empathy, while in chronic illness it is preferably cognitive empathy (27).

3. Empathy must be rebalanced by a "doctor-centered empathy." The doctor must enjoy and develop personally in her office (28). Each consultation must be “meaningful” for the doctor and for the patient (29).

In summary, empathy in medicine must be conceived as encompassing all potential components of empathy and leading to both positive and negative effects on care (12). We must think in terms of “empathies” rather than “empathy” in the physician-patient relationship.

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