I FEEL, THEREFORE I AM

CLINICAL EMPATHY

Jennifer Mundell, MD

OBJECTIVES

• How we got here
• Why we need to change
• How do we change

MY EMPATHETIC JOURNEY

Before I can teach, I first must understand my own empathy development

MY MD ROLE MODELS

Scrubs MASH

WHAT MADE MASH MEMORABLE

They could empathize with the characters
**MASH: OUT OF SIGHT, OUT OF MIND**

Hawkeye was "going through something" he didn't expect

**SCRUBS**

Loosely based on Doris' experiences during his IM residency at Brown Medical

Dr. John Doris

**JILL TRACY**

Several episodes dedicated to her admissions for:
- stress
- nausea
- pesticide poisoning/suicide attempt
- unresponsive and passes away

Organs transplanted to 3 patients
All 3 died with encephalitis
Later discovered that she had rabies

**MY JILL TRACY**

54yo morbidly obese lady

- Lived w/ "old man" in deplorable conditions
- He was "a lazy alcoholic"
- Dropped out of school at age 16
- Couldn’t read
- God fearing woman

**AUGUST 2013**

- ER end of July 2013: left foot ulcer but left AMA
- Week later, returned after fiancé refused to take care of her
- My 2nd month as an intern
NOT HER ACTUAL FOOT

GANGRENE

AUGUST 2013

- GBS + wound culture
- Fiancé was putting shoes on backwards X 4 wks
- Specialists recommended amputation
- She refused
- DC’ed home w/ HHC on po Clinda and Cipro for 6 wks

AUGUST 2013

Medical history:

- Uncontrolled T2DM – hgba1c 12
- 2DD HFpEF
- HTN
- CKD, stage III
- Cataracts

DID SHE GO TO HER PCP

She did...

- Just 2 patients on my schedule
- Time spent on counseling, wound care, and addressing social issues

ONE WK AFTER DISCHARGE

- Brother talked her into having amputation
- She came back to ER
- Successful L foot 4th/5th metatarsal amputation
- Refused SNF
- DC’ed home w/ HHC and continued po abx
- Had f/u apt with her PCP in a week

DID SHE GO TO HER PCP?

She did...

- Taking meds
- Struggled w/ checking BS 2/2 cataracts
- Would get wkly phone calls from HHC nurse about horrible living situation, HTN, etc
**NOVEMBER 2013**

- She came to every clinic apt every week
- She went to every wound care clinic apt
- She went for cataract surgery and felt amazing

**NOVEMBER 2013**

A week after cataract surgery
- Presented to ER w/ anasarca
- 2/2 suspected HFpEF exacerbation
- Worsening cellulitis at amputation site

New dx of cirrhosis 2/2 chronic Hepatitis C

**NOVEMBER 2013**

- Renal – IV diuresis
- GI - not candidate for tx
- Podiatry - more I&D
- ID - more po abx

- Refused SNF again
- Went home w/ HHC and f/u apt with PCP

**DID SHE GO TO HER PCP?**

Through Dec:

1. Continue oral diuresis
2. BMPs every third day
3. Weekly f/u appts
4. HHC wound care f/u

**FEBRUARY 2014**

Took sabbatical from SNF life to have dinner at home with fiancé

**JANUARY 2014**

- AKI
- Profound anasarca
- Nephrotic range proteinuria
- Renal on board for IV Lasix gtt

Finally DC to SNF
FEBRUARY 2014

- Brother in Washington State updated
- Pushed for full code despite septic shock/MSOF
- On 4 pressors, ventilated, CVVHD
- He decided no escalation of care

HER OBITUARY


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MY REACTION

ANGRY
FRUSTRATED
ANNOYED

HER REALITY

AFRAID

I failed her as her physician …

Clinical Empathy

WHAT IS EMPATHY

Knowing
Imagining
Adopting
Feeling
Projecting
To Kill a Mockingbird – Harper Lee

“you never really understand a person until you consider things from his point of view ... until you climb into his skin and walk around in it”

MISUNDERSTANDINGS

WHEN DID EMPATHY = CLINICAL DETACHMENT

1912: Sir William Osler

Neutralizing one’s emotions to the point that you feel nothing in response to suffering

DETACHED REASONING

All emotional responses seen as threats to objectivity

“neutrally empathetic” physician is one who will do what needs to be done without feeling grief, regret, or other difficult emotions

CLINICAL DETACHMENT

1963 - Training for Detached Concern
Fox and Lief, et al.

“The same detachment that enables medical students to dissect cadavers without disgust allows them to listen empathetically without becoming emotionally involved”

THIRST FOR KNOWLEDGE

• HOM (almost 200 yrs) occupied search for increasing scientific objectivity
• Focus intensified in recent decades by advancement of understanding medical pathophysiology
CLINICAL DETACHMENT = COMPETENCY

- Favor the tech skillful, rational, and emotionally detached physician
- Training teaches: “technical skills are [considered] fundamental, whereas interactive skills (if encouraged at all) are secondary”

WHEN EMPATHY = WEAKNESS

1. Over-identify with patients = over-treat without considering side-effects
2. Unable to stay composed when faced with emotionally difficult situations, and become unable to guide and support the patient through it

“THE GOOD PHYSICIAN”

1. Deny
2. Feel the emotion and internalize
3. Detach themselves

CREATING MORE “GOOD” PHYSICIANS

Empathy Decline begins in 3rd yr of medical school
- Emphasis on emotional detachment and clinical neutrality
- Overreliance on technology
- Lack of role models
- Inappropriate treatment during training

CHANGING TIDES

TRANSFORM

- Patients WANT us TO CONNECT with them
- Attuning to patients = subtle nonverbal sense of where another person is emotionally
WHY IS IT IMPORTANT

- Increased patient satisfaction
- Improved adherence to therapy
- Decreased medical errors
- Fewer malpractice claims
- Better outcomes
- Facilitating trust and disclosure
- Increasing job satisfaction/decreasing burnout

BALANCING ACT

Technical skill

Emotionally engaged

BARRIERS TO EMPATHY

- Census
- Time
- Patient attitudes
- Physician attitudes
- Lack of training

Out-dated attitudes about empathy

EMPATHY EDUCATION

EMPATHETIC GROWTH CHART

ROLE-PLAY

- Physicians who practice "deep acting" technique may, over time, learn to be genuinely empathic

- Teaching acting empathetic speed up learner’s journey

- Self-reflective writing
CULTURAL AWARENESS

• Without understanding the cultural basis of the patient's emotional state, it is difficult for MD to generate an empathic response
• MD may feel confused 2/2 does not understand the basis of the patient's feeling

IMPROVE COMMUNICATION

Patient wants to be:

1. Treated as a person, not an illness
2. Reassured that we heard concerns
3. Addressed nonmedical aspects of condition

EMPATHY DEVELOPMENT

Demonstrate
Validate
Teach
Promote

FORMAL EDUCATION

• Workshops that promote empathy, role-playing, cultural awareness, and humanism
• Having faculty mentors/champions that lead group discussions and encourage self reflection

IN SUMMARY

• Understand the war raging in us between clinical detachment and clinical empathy
• Lots of barriers to developing and utilizing clinical empathy
• Patients want us to have it, lawyers want us to have it, insurances want us to have it
• Clinical empathy can be a learned skill with role-play, cultural awareness, and communication workshops

QUESTIONS

Jennifer.Mundell@ascension.org
Mangione, Kane et al. 'Assessment of empathy in different years of internal medicine training." 2002. Medical Teacher. Vol. 24, No. 4, pg 370-373


