EDITORIAL

EMPATHY DECLINE: WHY THE HEARTS GET HARDENED?

Empathy in medicine can be defined as the ability to feel to understand and respond appropriately keeping in mind goals of doctor patient interaction. It facilitates patient's trust and disclosure helping the doctor reaching the correct diagnosis and better management[1]. There is a growing body of evidence that empathy leads to better patient satisfaction, good compliance to treatment and better outcome[2]. Moreover empathy directly enhances therapeutic efficacy. Engaged communication has been linked to decreasing patient anxiety, and, for a variety of illnesses, decreasing anxiety has been linked to physiologic effects and improved outcomes[3]. It is observed that patients cope better in the long term if their doctors are empathic in delivering them the bad news. Hence physician empathy is empirically critical to patient health. However research indicates that there is a decline in students' empathy with patients as they enter into 3rd year and start their clinical rotations[4]. It continues to decline throughout medical school and is lower than ideal among physicians. There is, therefore, a dire need to understand reasons behind this decline. It is also important to identify the obstacles and to design interventions to cultivate empathy in physicians.

Empathy is now considered to comprise of two components: cognitive and emotional. In twentieth century doctors saw all emotional responses as threats to objectivity. They defined a special professional empathy as purely cognitive, contrasting it with sympathy and over identifying with the patient. Sir William Osler in his 1927 book, "Aequanimitas," argues that by neutralizing their emotions to the point that they feel nothing in response to suffering, physicians can "see into" and hence "study" the patient's "inner life." with objectivity to serve the patient better[5]. This visual metaphor of projecting the patient's "inner life" before the physician's mind lead to the model of 'Detached Concern'; where viewers stand apart from what they observe. It was believed that the "neutrally empathetic" physician will do what needs to be done without feeling grief, regret, or other difficult emotions. This contrasts markedly with the ordinary meaning of empathy as "feeling into" or being moved by another's suffering. This, nevertheless, bring to the fore the long-standing tension in the physician's role and the patient's expectation. On the one hand, doctors strive for detachment to reliably care for all patients regardless of their personal feelings, whereas patients desire genuine empathy from doctors.

Understandably, it is too demanding to expect doctors to go through patient's experiences vicariously and introspect about patients' emotions. The doctors opine that they don't have time to focus on emotions while attending the heavy outpatient department or when performing sensitive surgeries. While it is true that work load of the doctors has increased many fold lately with little acknowledgement from authorities, making it more difficult to be empathic; we should know that detaching from the patients emotionally would neither serve good to the physicians nor to the patients. The case load with time pressure ensuing stress on the doctors can be addressed in part by imparting the skills known to reduce the burn out along with communicating empathy. For instance, practice of effective communication skills can demonstrate to the physicians that listening can make care more efficient; it usually takes less than ninety seconds for a patient to speak without interruption at the beginning of an interview, and this helps set the tone for trust and disclosure[6].

Many physicians still do not see patients' emotional needs as a core aspect of illness and care. Research, however shows that doctors who regularly include the psychosocial dimensions of care communicate better overall[7]. More generally, to address the anxieties that accompany doctoring, the culture of detachment needs to

shift, encouraging physicians to acknowledge and seek support for their own emotional needs. Another barrier to empathy comes from the negative emotions that arise when there are tensions between patients and physicians. Physicians who feel angry with patients and yet find such feelings unacceptable face barriers to thinking about the patient's perspective. All physicians could be taught to tolerate and learn from their own negative feelings in the way psychiatry residents are taught to pay attention to counter-transference. We need both theoretical and empirical work to address such barriers and to help elucidate the intermediary steps that physicians can take to practice medicine with genuine empathy.

It is important to note here that values of idealism, enthusiasm, and humanity are present in students at the beginning of medical school, but these may diminish as trainees are confronted with clinical reality (characterized by illness, human suffering, and death) and their focus shifts to technique and objectivity rather than the humanistic aspects of medicine. Entrance into a medical school and pursuing medical education is itself a challenge and may result into burnout, low sense of well-being, reduced quality of life and even depression. It seems, therefore, that distress is one of the major factors of empathy decline in medical students. The students hence, need support dealing with their own feelings and attitudes to help them establishing therapeutic relationships with patients.

The lesson learnt from research on medical ethics is that 'if it can decay, it can also be flourished'. The medical educators have to work hard and be mindful of including such an important component of medical education into the regular curriculum and assessment at undergraduate as well as at postgraduate level of all fields of medicine.

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