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The art of medicine

The caregiver's dilemma: in search of sustainable medical empathy

In 2015, our daughter Alma was delivered by emergency caesarean section at a local children's hospital. I listened for her cries, but she was silent. The medical team, too, was eerily quiet, gripped with concern. Alma struggled to live. We learned later that during her birth she had suffered a stroke. In those first moments as a parent, I realised two things. First, I wanted to protect my daughter more than anything I'd ever wanted. Second, I had already failed.

Alma was whisked to the intensive care nursery (ICN), where the staff treated us with heroic kindness. Physicians, social workers, and nurses took time to answer all our questions, welcomed our emotion, and even cried with us. Alma is thriving now, but those first weeks could have been much worse.

As a research psychologist and neuroscientist, I have spent my career studying empathy—people's ability to share, understand, and care about each other's emotions. But I have never needed empathy from strangers, or received it from them, the way I did after Alma's birth. In some ways, the ICN staff members were closer to us than anyone else during our hardest moments. Their compassion helped us get through an agonising time.

Our family is not alone. Once viewed as a fuzzy soft skill, empathy is now regarded as a key element in effective medical treatment. Patients of empathic, versus less empathic, physicians are generally more satisfied with their care and more likely to heed medical recommendations. Receiving empathic care also seems to improve some patients' outcomes.

This does not mean empathy is easy, especially for clinicians. As my family's haze of worry cleared in Alma's early days, I began to wonder about the people caring for her. A few feet to her right and her left were other struggling babies; hovering over their incubators, other anguished families. The ICN specialises in treating very premature babies, many of whom die. If suffering were light, the ICN would be visible

from space. How could these nurses and doctors witness so much pain, go home to their families, and then return the next day to do it again? For how long? And at what cost?

Many months after Alma's birth, these questions remained with me. I had begun work on a book, *The War for Kindness*, which focuses on how individuals can learn to empathise more effectively. As background research, I shadowed people in the "trenches" of empathy, including teachers, actors, police trainers, and the ICN staff.

My return to the ICN was eerie. The intense emotions I had felt as a parent were gone, but many other things were familiar. The pastel-coloured flower murals and uncomfortable vinyl chairs rang bells. I recognised some staff members, but only vaguely, like they were characters from a dream. My phone remembered the unit's Wi-Fi.

Just like before, the ICN nurses' and physicians' compassion shone through in all their interactions with patients and families. But this time I also realised how deeply many of them struggled. In interviews, one nurse remembered a patient she had worried about constantly, even outside of work. A physician recounted a time he had avoided delivering bad news clearly, for fear of causing further pain. Other staff members reported symptoms of anxiety and depression related to difficult cases and patient deaths. I asked one staff member how he dealt with the emotion of his job, and he responded, "I just push it down until it becomes a health problem."

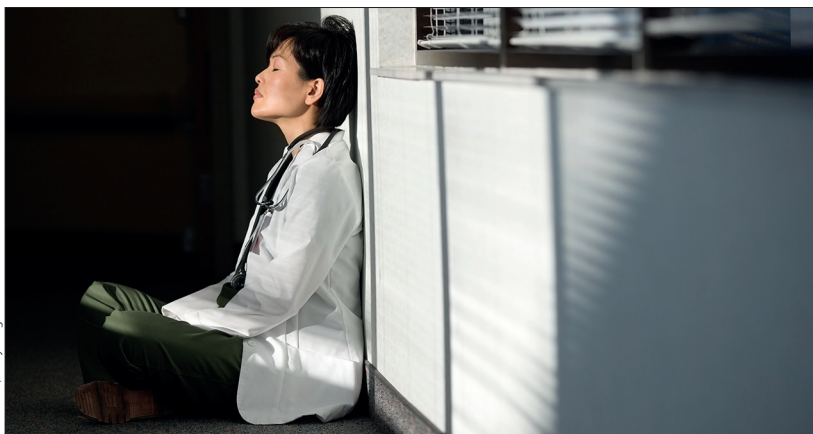
These are examples of caregivers' psychological struggles, which include secondary trauma—PTSD-like symptoms associated with witnessing others' suffering—compassion fatigue—emotional numbing in the face of that suffering—and burnout—general exhaustion and loss of meaning. Research has shown that burnout, the most studied of these phenomena, is more prevalent among physicians in the USA than in the general working population.

It's tempting to view trauma, fatigue, and burnout as empathy's repetitive strain injuries. In my conversations at the ICN and beyond, health-care professionals voiced this concern so often I have come to think of it as the caregiver's dilemma—the notion that chronic, full contact caring can contribute to burnout in health-care workers. Medical professionals who believe in the caregiver's dilemma might see themselves as trapped by a double bind. Do they keep connecting with their patients but wear down in the process, or preserve themselves by turning their empathy off?

Whether they know it or not, some clinicians seem to make the second choice. Medical students' empathy declines sharply in their third year of training, just when they begin regular patient contact. Physicians may exhibit blunted physiological empathy, and both nurses and

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physicians can underestimate patients' pain and suffering. Some caregivers engage in defensive dehumanisation, whereby they reduce their distress by ignoring or denying patients' emotions. Others might derogate patients or blame them for their suffering. These strategies might protect caregivers in the short term, but can damage the therapeutic alliance, undermine clinicians' ability to treat the whole person, and leave patients feeling alienated.

Yet the caregiver's dilemma is a false choice. Systemic changes, such as reducing administrative burden, efforts to foster positive learning environments, and creation of strong peer support networks, can help. So can individual-level practices such as mindfulness, counselling, and self-care. And crucially, research from psychology and neuroscience offers strategies for sustainable empathy, through which clinicians can emotionally connect with their patients without sacrificing themselves. Two insights are especially worth considering.

First, empathy is more than one thing. Psychologists largely agree it is best considered an umbrella term that describes related but distinct ways people respond to others' emotions. These include emotional empathy—vicariously sharing others' feelings—cognitive empathy—inferring what others feel and why—and empathic concern, also referred to as compassion—a desire for someone else's wellbeing to improve. Although these elements of empathy are related, they can also split apart. For instance, emotional and cognitive empathy develop at different ages, are affected by different psychiatric conditions, and are supported by different systems in the brain. One distinction could be useful for medical practice. Emotional empathy—especially taking on others' distress—is a risk factor for burnout and fatigue among physicians, but empathic concern may help reduce the risk of those same negative outcomes. In other words, caregivers need not choose between their own wellbeing and empathy for their patients. If they can feel for patients and families without feeling as they do, empathy can be both connective and sustainable.

This is especially useful given a second insight: empathy is a skill. People often assume that empathy is a fixed trait, baked into our genes and hard-wired into our brains. In fact, it is more like a skill. Empathic ability is partly genetic, but our experiences also shape how we empathise. Crucially, this means that through the choices we make and habits we adopt, people can purposefully grow, broaden, and fine-tune their capacity for care.

Medical schools have increasingly leveraged this insight. Whereas "bedside manner" was once viewed as a quality professionals simply had or lacked, various training programmes now teach empathy in patient care. These include role playing in which trainees practise delivering bad news, perspective taking exercises through which they simulate patients' experiences, and education around the power of empathy to improve clinical outcomes.

Nursing and medical students could also benefit from an additional strategy: learning to tune their empathy away from sharing others' distress and towards empathic concern. Research suggests that such tuning is possible. Some studies have examined the effects of short-term contemplative practices, such as compassion meditation, aimed at strengthening empathic concern. These practices may increase individuals' generosity and their ability to decipher what others are feeling. They may also reduce personal distress in the face of others' suffering, suggesting that they could be useful in solving the caregiver's dilemma. Compassion training classes may also help caregivers to develop greater connection with patients.

A tenet of compassion training holds that rather than trying to escape suffering, we can recognise that it knits us together through shared struggle. The ICN staff saw my family's suffering; it was an honour for me to witness theirs as well, and to realise that in caring for people like us, they felt emotions not so different from our own.

Medical professionals often try to withdraw their emotions from interactions with patients, so as to maintain professional distance. But we patients and family members always see someone on the other side of those conversations. If that person appears unfeeling, we imagine they do not care. They recede behind a white coat and a degree, and seem fundamentally unlike us. By sharing some of their feelings, and their concern for our feelings, caregivers can cross that divide, reach out, and turn painful moments into opportunities for fellowship, meaning, and healing together.

This is all the more important now, as the COVID-19 pandemic has multiplied these painful moments. In countless tragic cases, physicians and nurses have been the only company for patients with COVID-19 as they take their final breaths. The pandemic has adversely affected mental health of some citizens and also front-line health professionals. Addressing these difficulties will require comprehensive efforts, including broadening access to psychological services and formalising social support networks within health-care settings. I also believe that efforts based on developing sustainable empathy and human connection may be another way to help if we hope to manage the pandemic's long-term psychological impact.

I will forever remember the warmth with which the ICN staff treated my family in our darkest hours. My hope is that my own and others' research on empathy can reciprocate in some small way—by helping medical professionals continue to connect with patients while also maintaining their own wellbeing.

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