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FROM THE INSIDE

"I feel how you feel": reflections about empathy in the relationship between ICU physicians and relatives

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Do you remember when it happened to you for the first time? You were talking to the family, the spouse, the mother, the father, sister, brother or friend of a patient lying in a life-threatening state in the ICU trying to explain the actual status of the patient and you realized that your counterpart tried to follow your words but remained immersed in a sea of fear, pain, doubt, uncertainty—a world of conflicting emotions. You stopped because all of a sudden you realized that some of these emotions had become your own—at least in part you felt what she, he, they felt.

I do. It was during the early phase of my career as an ICU physician when I tried to explain full-blown ARDS in a 16-year-old girl to the family. I felt helpless and failing. While sharing the emotions of the family, I also felt bound to my role as physician and realized that not only was I unable to offer a cure but I did not even see a way to usefully improve her condition. I did the only thing I felt able to do—I remained silent and tried to endure the situation and to share the emotions. Some days later I realized that my relationship with the family had deeply changed. The situation the days before had set up a sense of "he is able to feel what we feel" in the family. From that day on we were able to find the balance between presenting dry medical information and effective explanation of therapeutic steps in such a way as to remain sensitive to emotional response. We simply found the balance between empathy and factual needs. From his own experience, Thomas Bein reported impressively in this journal how important the need is for striking this balance between "unemotional" factual action and empathy for the critically ill patient and relatives.

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There is clear evidence that the ICU stay of a family member has a large impact on the health status of the affected relatives. Spouses having lost their partners on the ICU die earlier and develop more diseases. We know that family members of ICU patients experience depression and anxiety, post-traumatic stress disorders (PTSD) and even mental disorders seemingly unrelated to the episode. We also know that very simple steps might help to reduce the risk of developing such disorders and help the relatives to endure without becoming seriously sick themselves. If "relatives are walking wounded on the ICU" is true, then we have to be aware and respond compassionately—but not act in the role of a therapist. It would be naïve to believe that empathy and feeling what they feel will relieve their burden or solve their problems. But they view the ICU environment as something alien, governed apparently by logic and technical rules where emotions seem to be excluded because they might even endanger "effective" and lifesaving therapy. Some of them might even not be able to say to us: "but it's my wife, husband, father, mother, brother, sister, son, daughter or friend…" because they feel guilt in disturbing this technical wonderland that keeps their loved one alive and tries to ensure survival. That is why so many relatives describe the ICU as technical, sterile and inhuman and that is the point why 'feeling what they feel' becomes so important. With our empathetic awareness, our alien world gets a human face and soul. It is not a cure but does help them to get their feet back on the ground, while allowing them to become a respected and valued part of the process.

Having stated that, what can or should we do to make physicians empathic? Can we simply rely on the 'mirror neurons' of our conscience and instinct, trusting that they will more or less automatically do their job in creating the empathy needed? Independent from the actual

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role of these neurons, which is a matter of an ongoing scientific debate, there is no doubt that they are governed by individual experience and regulated by our brain. Experience is to a large part a matter of age. If you have not experienced the loss of a loved one it is difficult to feel what those engulfed by critical illness feel, and most of our younger caregivers lack this experience. That is why "grey-haired" ICU physicians play such an important role in the ICU team as life-experienced mentors and contact partners for patients, relatives and team members. We have to take care to make the ICU a liveable place for them so as to keep access to their treasure of experience for the sake of everyone. Our brain regulates according to rules that can be trained and taught. In all the discussions about medical education and reformation of training for physicians, we should never forget that medicine remains an empiric science that requires thoughtful training of physiology and pathophysiology but also education in communication and interpersonal relationships. Training and teaching are one important part. But I take the liberty to state that good mentors and bright archetypes play a more important role than any type of modern teaching and training will ever do. Our medical environment must encourage individual archetypes to develop. Unfortunately, current economic pressures, seeming objectivity and so-called evidence might represent obstacles against the development of such personalities.

Finally, feeling what they feel teaches humility. Skills, profound knowledge and the ability to use these aptitudes for therapeutic intervention make a competent physician but, empathy, respect and humility finally distinguish between Mephisto and Faust. In my view the truly good physician lives in balance between thoughtful unemotional actions and honest empathy; both require readiness for life-long learning. That is why feeling what they feel is so important.

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Compliance with ethical standards

Conflicts of interest
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