FROM THE INSIDE

Empathy: some thoughtful reflections among a favorable attitude

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My advanced ‘career’ has been from an experienced ICU doctor to an oncology patient. With the diagnosis of a multiple myeloma, a rapid change in my perspective occurred. Thirty years of daily intensive care practice, numerous discussions with the staff, and communications with relatives of critically ill or dying patients, teaching the young physicians, clinical science, ‘flying’ from one congress to the other, to the next symposium, etc., while following the diagnosis, I was grounded from one day to the next. I found myself sitting in the oncology ambulance for hours and hours instead of doing my interdisciplinary rounds in my large operative ICU; lying in a prone position and expecting six bone marrow biopsies instead of putting ARDS patients in a prone position; and receiving a central venous catheter (malposition of jugular vein catheter in the subclavian vein required correction) instead of inserting ECMO cannulae.

During numerous infusion sessions in the onco-ambulance and during a 19-day treatment in the bone marrow transplantation ward (high-dose chemotherapy and autologous stem cell transplantation)—oscillating between depression, hope, and self-composure—I learned to accept my new role as a patient. And I began to observe, to feel, and to work up my emotions: How do nurses, doctors and other members of the staff communicate with me? Do they sense and support my conflicting emotions? What is it about empathy? Do I want to be treated with empathy or with ‘practicality’? With frequent blood samplings, I came to know two characters of nurses (both named Maria): *Maria 1*—very empathic, with an open face, ‘motherly’, but she required two or three (painful) attempts to hit the vein; and *Maria 2*—very business-like, unemotional, and factual, but she was brilliant at a pain-free venous puncture. I learned to

be happy when *Maria 2* fetched me in an unemotional manner from the waiting zone and I began to think about empathy and what it is, and what it could really mean in medicine.

Empathy can be defined as “the ability to understand and share another person’s feelings and perspectives, and using that understanding to guide future action”. The German term *Einfühlung* (=feeling into) was the psychological inspiration to create and investigate the term ‘empathy’ at the beginning of the nineteenth century. Subsequent studies on empathy were complex in terms of its evolutionary origin, its development, neurobiological bases, social context, and interpersonal relationships, using various scientific domains (psychology, neuroscience, medicine, brain mapping, behavioural sciences). Current medical ethics encourage empathy as a single specific duty—together with compassion and care—to embody the physician as a responsible and moral personality. The empathic doctor (and the empathic nurse, in a specific way) is characterized by the ability to adequately understand the inner processes of the patient’s health-related problems, wishes and perspectives. But, for me, as a patient—and for some other ethicists and philosophers—the practice of empathy comprises some inconsistencies: on the one hand, the capacity of empathy as “feeling inside the other” is strongly postulated as a virtue for all kind of healthcare workers, while on the other hand, (much) empathy per se does not make a good doctor or nurse with a high moral attitude. Doctors always need to reach a balance between connection and distance in their relationships to patients. The basis of empathy is the fundamental acceptance of the existence of the ‘Other’. Such a learning of acceptance develops with maturation, and, in people with autism, a lack of empathy is assumed. Without doubt, perception of the ‘Other’ (the patient!) embedded in empathy is a necessary precondition for a successful physician–patient interaction, aimed at understanding (a cognitive

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dimension), resonating and attuning to the mood (an emotional dimension) of the patient or the relatives. Empathy is not necessarily followed by an action, and actions derived from empathy are not automatically of a high moral 'quality'. What is the adequate level of empathy? How is empathy linked to a 'good' action? Can too much empathy be harmful? Does empathy stand in opposition to objectivity?. Are *empathy*, *sympathy*, *altruism*, and *compassion* the same?

Empathy is often confused with sympathy or compassion. *Sympathy* is defined in the literature as an emotional reaction of pity in situations of misfortune of the 'Other', especially when they are perceived as unfair. *Compassion* means an awareness of suffering of the 'Other' coupled with the wish to help. In contrast, *altruism* equals feelings and behavior that show a desire to help the 'Other' even if it results in a disadvantage for oneself. *Appropriate empathy*—while maintaining a clear 'self-other' differentiation—linked with respect and competence will result in an adequate action, and might be a valuable ethical 'equipment' for a good physician, while sympathy, compassion or altruism are not the most important attitudes for him.

During my 'oncologic career', in the past 15 months, I tried to observe and reflect on the patient's role and interactions in a system of ambulances, intensive care, and normal wards, or intervention institutions like bone marrow biopsy, and I made a (preliminary) conclusion for me: Empathy—whatever it is: Might it be a complex construct? Might it be the simple ability to slip into the patient's shoes?—is a *conditio sine qua non* for a moralistic medical care, but an 'overdose' of empathy will not further benefit the patient's wellbeing. In other words: *Sympathy* alone does not a good healthcare worker make. I personally could be a fan of a well-defined (and educated) empathy, combined with competence and respect as ingrained in a self-confident (but not arrogant!) physician or nurse.

Compliance with ethical standards

Conflicts of interest

The author declares that there are no conflicts of interest.

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