

Opinion

Compassion in Medicine – A Psychiatric Physician’s View

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Sympathy: *A general kinship with another's feelings, no matter of what kind.*
(www.dictionary.com)

Empathy: *The power of understanding and imaginatively entering into another person's feelings.* (www.thefreedictionary.com)

Compassion: *Sympathetic consciousness of others' distress together with a desire to alleviate it.* (www.merriam-webster.com)

There are several definitions of sympathy, empathy, and compassion on the internet. I have chosen the above definitions to emphasize their salient differences, for the following reason: In medical school, in the early 1960s, we were taught not to sympathize with patients, but to empathize: By empathizing, one can retain some professional objectivity toward the patient, in order to be of some help. To sympathize, on the other hand, was to immerse oneself in the patient's suffering and



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lose one's professional perspective. This worked, insofar as the insulation afforded by the empathic approach allowed one to consider therapeutic approaches reasonably objectively.

Nevertheless, there always has been a range of clinicians' responses to patients, from inability to distinguish sympathy from empathy to full distancing from one's patients. A vivid example of inability to distinguish sympathy from empathy was the young nursing student on an inpatient psychiatric unit for which I was the head psychiatrist, who identified and became romantically involved with a young, male, sociopathic, drug-addicted patient. After multiple counseling sessions, the student gained no insight into her behavior and was ultimately discharged from nursing school. At the other extreme, an example of full distancing from one's patients was the oncologist with whom I worked several decades ago, who wanted to know all the pathological details about his patients' cancers, but he did not want to know anything personal about his patients as people, for fear of compromising his objectivity toward planning their complex chemotherapeutic regimens. He had nurses and social workers deal with his patients' understanding of their situations, their fears and hopes, and their reactions to the courses of treatment he prescribed. This split approach may have met the oncologist's needs, but it fell far short of his patients' needs, who wanted a closer relationship with their physician, the person "calling the shots." More broadly, regarding medical specialties, extreme examples would be emergency room physicians at one end, who in the press of time often consider their patients as "cases", and psychiatrists at the other end, whose expression of empathy is a *sine qua non* of their specialty.

As a psychiatric resident at the UCLA Neuropsychiatric Institute, 1962-1965, I was taught that splitting a patient's care between a psychiatrist (who often primarily prescribes medication for mental disorders) and a psychotherapist (who deals with the psychosocial aspects of the patient's life) was not the best care. The rationale was that the ultimate goal of treatment was for the individual to manage all aspects of his or her life in an adult way, whereas we were demonstrating that it took two professionals to manage this person's life, which was quite a contradiction. Unfortunately, this duality of mental health care continues in a number of organizations, related to insurance coverage and the costs of care.

Even with a number of external constraints, compassion in health care continues to be promoted in various ways. When demonstrated in mental health care or in any other medical arena, compassionate care has well-proven its worth in health outcomes and patient satisfaction. Another example will underscore this: In my residency I had the good fortune of meeting Dr. George Engel, an internist and psychiatrist who was a pioneer in psychosomatic medicine. He provided care to many ulcerative colitis patients, who often suffered debilitating symptoms, with unpredictable bowel activity and pain. Their considerable anxiety about their illness led to frequent phone calls to Dr. Engel. He realized that their anxiety exacerbated when he was not immediately reachable by phone, resulting in frequent calls from patients trying to find him. He then instituted the practice of giving his patients his home phone number, and when he was traveling, he informed them of where he was staying, and how to reach him by phone at those locations. He encouraged them to call him at any time, and with any concern. With that security, his patients contacted him far less often – an apparent paradox, but understandable from the perspective of Masserman's Ur-defenses of man:

In 1953, Jules Masserman [1], a psychoanalytically trained psychiatrist, asked his students, “Consider puny man, blessed with almost boundless imagery, but cursed...with an intelligence that perceives about him a vast, chaotic, infinitely threatening universe ready at any moment to harm or destroy him. What basic defenses ... must he evolve, else suffer from anxiety so deep and pervasive that life would be intolerable?” Answers were that at least three basic processes were essential to man’s psychic economy – Masserman’s so-called Ur-defenses of man. He emphasized that “each of the three is contrary to the bitter evidence of our senses, ... may therefore be called ‘delusional’ – and yet each is an article of faith so universal as to approach all that man can know of truth ...” These are the delusion of invulnerability and immortality, the delusion of the omnipotent servant (I always can be rescued by another), and man’s kindness to man. It is immediately apparent how powerful and vulnerable these are in the doctor-patient relationship: Doctor, I am very sick; please don’t let me die. I know you can help me. Treat me with compassion! As Jimmie Holland, MD, a pioneer in understanding the psychosocial aspects of cancer, pointed out, “One of the things that I’ve learned in 40 years is that our emotions are exactly the same. They haven’t changed one iota over millennia. It’s fear. It’s worry. It’s what’s going to happen to me and what’s going to happen to my family. All of those fears are there. What the patient has always wanted and still wants is to know that this doctor cares about me.” [2]

As peoples’ life expectancy increases, owing to advances in medicine, a compassionate approach to quality of life in the elderly and infirm is especially being recognized as essential. In his book, *Being Mortal*, Gawande [3] states, “You don’t have to spend much time with the elderly or those with terminal illness to see how often medicine fails the people it is supposed to help...Lacking a coherent view of how people might live successfully all the way to their very end, we have allowed our fates to be controlled by...medicine, technology, and strangers.” Gawande gives several examples of how patients’ views of the remainder of their lives differ from the views of their caretakers and even their closest families. Citing the relatively new specialty of palliative care and the hospice movement, Gawande lauds their patient-centeredness: “What is your understanding of the situation and its potential outcomes? What are your fears and what are your hopes? What are the trade-offs you are willing to make and not willing to make? And what is the course of action that best serves this understanding?” As well, practitioners are becoming more enlightened about the fundamental importance of their roles in health care; *e.g.*, a professor of palliative medicine recently commented on “...‘ethical erosion,’ a loss of empathy reported to occur during the process of medical education. It’s troubling to think that empathy would diminish precisely during the years when it is most needed.” She asked, “Do we need to fear that development of clinical skills inevitably results in numbing and emotional detachment?” [4].

As Gawande [3] emphasized, the end of life is a most important time for compassion from clinicians and caretakers. From 2005 to 2013, I was Chief of Psychiatry in the Los Angeles Veterans Affairs Healthcare System. One of their volunteer programs is The Twilight Brigade. This is one of several programs in which volunteer veterans help other veterans. In The Twilight Brigade, veterans are trained to spend time at the bedside of other veterans who are facing terminal illness and in hospice care. This is compassion at its purest; two persons with a shared background of military service forming bonds of friendship, wherein one provides companionship that combats the despair

of the other, who otherwise must face his or her remaining days in an impersonal, clinical environment without the support of relatives or other close persons. In contrast, the veteran volunteers bring warmth and understanding to their lonely, dying comrades-in-arms. Sergeant-Major Louis Roundtree (deceased), the most highly decorated Marine of all time (three Purple Hearts, three Silver Stars, four Bronze Stars) said, "From the bottom of my heart, thank you very much. Your visits made all the difference in the world." Lieutenant Walter Foreman (also deceased) said, "The hardest thing about dying is being left alone. I felt betrayed and abandoned. You made me feel appreciated and proud. God bless you." (<http://thetwilightbrigade.com/testimonials>)

The art and science of maximizing quality of life continue to mature in many healing professions, but with some fits and starts, as might be expected. When I was Chief of Psychiatry at the Los Angeles Veterans Affairs Healthcare System, the concept of Patient-Centered Care was thrust upon us with a special reverence: It was considered to be an important departure from the way clinical care was being offered. Principles of Patient-Centered Care include the following: 1. The health care system's mission, vision, values, leadership, and quality-improvement drivers are aligned to patient-centered goals. 2. Care is collaborative, coordinated, and accessible; the right care is provided at the right time and the right place. 3. Care focuses on physical comfort as well as emotional well-being. 4. Patient and family preferences, values, cultural traditions, and socioeconomic conditions are respected. 5. Patients and their families are an expected part of the care team and play a role in decisions at the patient and system level. 6. The presence of family members in the care setting is encouraged and facilitated. 7. Information is shared fully and in a timely manner so that patients and their family members can make informed decisions. (<https://catalyst.nejm.org/what-is-patient-centered-care/>) Multiple benefits of practicing Patient-Centered Care include improved satisfaction scores among patients and their families, enhanced reputation of providers among health care consumers, better morale and productivity among clinicians and ancillary staff, improved resource allocation, and reduced expenses and increased financial margins throughout the continuum of care.

No one reading the above can argue with either the principles or the improvements afforded by Patient-Centered Care; everything espoused under the rubric is good, positive, and worthy. In my view, however, the concept of Patient-Centered Care begs the question: What have health-care practitioners been doing up to now? Providing care centered on what? Clinicians' convenience? Clinicians' income? Competent clinicians trained in the ethics of medicine have been practicing patient-centered care since the time of Hippocrates, and deviations from this concept; e.g., attempts at excessive cost-containment that imperil medical advances, are quickly called out [5]. Nevertheless, periodic reminders of the importance of care focused on the patient, against the background of distracting influences, are useful. For example, Rush and Thase [6], having been involved in the extremely costly National Institute of Mental Health-supported study, Sequenced Treatment Alternatives to Relieve Depression (STAR*D), indicated that, after initial evaluation, 10-15% of depressed patients did not return for treatment; an additional 20-25% did not complete the first phase of treatment; and another 20-50% did not complete six months of treatment. And, among those who did stay in treatment, 50% showed poor treatment adherence. Staying in treatment and adherence to treatment are, of course, concerns in every medical practice and specialty. Rush and Thase proposed using psychoeducational, behavioral, cognitive, interpersonal, and psychodynamic

models and methods to ensure patients' adherence to treatment, a comprehensive approach they termed "patient-centered medical management." Key elements echoed the precepts of Patient-Centered Care, including prioritizing the patient's treatment goals and preferences; shared decision-making in formulating a treatment plan; aligning expectations as to treatment duration, decision points, and side-effect management; patient engagement not only in monitoring level of function, symptoms, and side effects, but also in healthy activities concomitant with treatment; and patients' maintenance of their general health. These precepts are, obviously, not limited to psychiatric/psychosocial treatments, but are applicable in every area of medicine and health recovery.

Concerning issues that potentially can reduce compassion in medicine, an important, recent development is the electronic health record (EHR). For at least two decades, the United States Veterans Health Administration has been using an EHR which, in my experience, continues to be exceptionally useful in linking a veteran's care at multiple hospital and clinic facilities, so that the veteran's complete health record can be viewed during treatment encounters. The EHR has many advantages, including making sure all elements of a given exam are complete, prescription combinations that might lead to unwanted side effects are flagged, etc. It is, however, a double-edged sword, with drawbacks common to all electronic documents. A major drawback is that many times, unless certain fields are completed, one cannot progress in completing a clinical note. These fields may or may not be pertinent to the patient's current problem, and thus can be frustrating to busy clinicians who must waste time on entering irrelevant information for that particular session. And, clinicians' being human, creative ways of time-saving in the EHR are used, including faking an entry to get past a certain field, as well as the more pervasive and dangerous "copy and paste" from earlier notes to later ones. Indeed, I have seen, albeit rarely, clinicians' notes that have been repeated, verbatim, across several visits over a year or more. Surely there was some variance in the patient's presentation, clinical exam, and treatment recommendations over those many months? Not only compassion, but also good medical practice, gets lost in these maneuvers.

In the United States, federal regulations recently mandated that all physicians' practices must convert to EHRs, which has been done slowly and with a steep "learning curve" for those who are not "tech-savvy." The aforementioned frustrations also have been prominent for physicians in the private sector, and an increasing amount of their time is being spent on completing EHRs rather than on direct patient contact. As well, the computer often sits on the desk between the clinician and the patient. A pervasive complaint from patients, including from my own recent experiences as a patient, is that the clinician is looking at and typing into a computer rather than interacting with his or her patient, leading to a cold and compassion-starved encounter.

I do believe, however, which my own experience also supports, that clinicians are becoming more sensitive to the unwanted intrusions of technology into the healing process. As Jimmie Holland's earlier quote summarized so well, "What the patient has always wanted and still wants is to know that this doctor cares about me." And more so than just the physician's completing the EHR while the patient is sitting across from him or her. Even such a fundamental human interaction as eye contact is receiving greater appreciation as important to a satisfactory patient visit.

The future holds the immense promise of "personalized medicine," in which a combination of genetics and precise molecular diagnostics will lead to a treatment approach tailored to that exact

individual. As Greene and Loscalzo [7] commented, “In the 21st century, the framework of biomedical research and clinical practice has begun to shift away from universal models of disease that generalize from close examination of diseased parts (organs, tissues, cells, or molecules) toward an approach that celebrates ‘personalized medicine’ and focuses, at least nominally, on the whole person...Superficially, this transition appears to mark a return to the early modern conception of the patient as ‘sick person,’ whose disease was considered inseparable from his or her complex constitutional inheritance and lived experience. Yet in practice, personalized medicine still tends to reduce the patient to a collection of precise molecular sequences...The task of putting the patient back together again will be complex, arduous, and time consuming, but it promises a new articulation of the biologic and social sciences that are inextricably linked and essential to the advancement of medicine.”

In conclusion, I believe that, even with its ebbs and flows, humanism and compassion in medicine will continue to exist and even to flourish. With the tremendous technical medical advances that have occurred throughout the 20th century and continue apace during this early part of the 21st century, the humanistic needs of our patients remain constant. As well, the humanistic needs of clinicians and other caregivers are important – their compassion is not limitless, and “burnout” for various reasons occurs all too often [8-10]. The needs of both groups must be respected and fully addressed – not only because they are indispensable elements in our patients’ recoveries, but also because we clinicians are made of the exact same stuff, physically and emotionally, as our patients.

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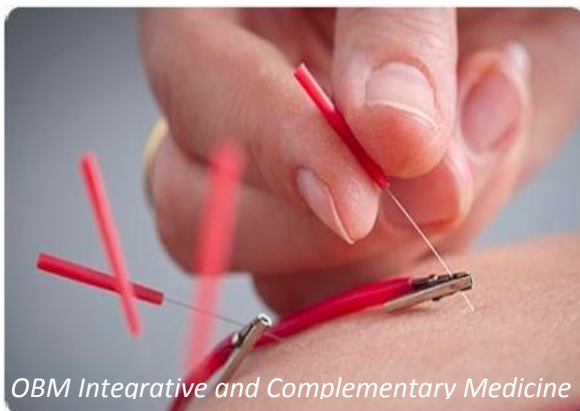
Competing Interests

The author has declared that no competing interests exist.

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