

# Empathy: What's the big deal?

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Approximately a year ago I was asked by a family member to join her for moral support at a hospital appointment where she was due to receive the results of a biopsy from a lump she had found in her breast. The experiences led me to reflect on aspects of the curriculum at my medical school and share my experiences.

At medical school, there is a large emphasis placed on concepts such as the biopsychosocial model, patient perspective and communication skills, to name a few, under the title of Health, Culture and Society which aims to broaden students' cultural and social awareness. However, the non-medical science aspects of the course are often overlooked by many students and often thought of as less significant aspects of learning, especially in preclinical years where most students allocate their time to the medical sciences. I don't think anybody would argue that communication isn't important and I'm sure most understand why we have communication skills workshops and why we are asked to read about patient perspectives, but I personally feel it is quite far removed learning about coping mechanisms and dealing with a diagnosis when you are reading it in a book or in an online article. A similar article written by a newly qualified doctor reflecting on his time at medical school admitted he initially found it difficult to appreciate the importance of these sessions and also found other students ". . . *not taking the curriculum seriously*.", with it being viewed as a "*waste of time that could be better spent*".<sup>1</sup> During our clinical time we are given logbooks with long lists of cases we need to clerk and examinations that need signing off, which often leads to a logbook focused approach. I often hear "Have you seen the guy on the stroke ward? I've just examined him, he's got great upper motor neuron signs" or "Have you seen the lady on Ward 39 with PKD? You should do an abdo exam she has huge kidneys, you can feel them in her iliac fossa's", which everybody rushes to examine for the experience.

Last year, after being with my family member whilst she was diagnosed with breast cancer, made me realise the significance of these subjects within our curriculum and why there is such an emphasis on some of them. It brought to my attention, more than ever, that we aren't just dealing with dysfunctional machines or medical mysteries for us to learn from, but with human beings who have emotions and a social setting.

As we entered the consultation room, we hadn't even sat down before the doctor started the consultation, making it difficult to hear as chairs were being moved to accommodate us. We asked him to repeat himself, which he did very impatiently and rolling his eyes. He continued and informed us that he didn't have the appropriate notes, so we left for another short spell in the waiting room. We were called back through where again after little introduction, pulled his chair up to my family member and abruptly said, "You have cancer, we're going to have to perform a mastectomy". That was it, that was all the information we were given. I looked over to my family member and she had tears in her eyes. I was seriously shocked. Both at the diagnosis and how the news was delivered. I can't describe what it feels like to be on the

receiving end of that news, even as a relative. Your stomach hits the floor and you just feel a wave of, I guess, panic come over you. He sat back in his chair and told us the nurse would take us next door.

This brings me to how I believe an empathic approach and models, such as the biopsychosocial model aren't always considered. The biological aspect, she had breast cancer and it needed to be removed. However, that family member has suffered from severe mental health problems in the past, meaning she now becomes very anxious and overwhelmed by, what appears to us a family, very insignificant things. I suspect nobody would take that diagnosis well but having it delivered so bluntly was not a great experience even sitting on the side-lines. She spent days afterwards crying and didn't leave the house – I'm sure this is a normal reaction but I had never really considered how people might react after they leave the hospital with such news. Of course I'd always thought it wouldn't be pleasant, very difficult and I imagine upsetting but the reality is far worse than that – it's devastating.

It is widely recognised that communication is a core competency and the BMA states that "*good communication skills are an essential component of the doctor-patient relationship*".<sup>2</sup> Empathy often confused with sympathy, can be described as a process of understanding an individual's subjective experiences by sharing that experience while maintaining an observant stance.<sup>3</sup> It has thus been argued that when breaking bad news in a sensitive and caring manner, morale can be maintained which eases the process of coming to terms with illness.<sup>4</sup> It is also well understood how doctors communicate with patients directly affects that patient's perception of that doctor.<sup>5</sup> Increasing evidence suggests that patients value concern as much as technical competence, suggesting that empathic insight has a therapeutic impact, by directly reducing patient anxiety.<sup>3, 6</sup> When patients were asked why they thought it was important for doctors to listen to their patients, responses included, "It builds up a relationship. Otherwise the patient feels unimportant" and "doctors can learn more by listening than by prodding you".<sup>7</sup> I feel the above reiterates the need for an empathic approach and active listening, going beyond detached concern, where one just attaches a label of an 'emotional state' to someone, but the doctor actually recognises what it's like to experience something.

After starting this reflection, I saw a gentleman who had suffered a stroke and lost the use of his left hand. On examination, his right hand functioned well but it slowed as he stared intently at his left hand that was functionless. He became frustrated and looked upset. I can't imagine what it must be like to lose the use of my hand, nor can I imagine what it must be like to be told I have cancer that has metastasized to my spine and I hope I never do experience these things. As medical students and doctors we are exposed to disease so often that, I feel, we can become blunted to the reality of it and it becomes a normal part of our day. It is easy to forget people are three-dimensional and multi-faceted.

I'm not suggesting we should immerse ourselves in behavioural sciences but I do feel the non-medical science

curriculum does help build a basic level of knowledge and understanding to help us relate to patients. This basic understanding of how patients react and feel, in my opinion, will help us show consideration for their feelings. Empathy may not come naturally to some, but I feel, at the very least, we should always aim to be conscious that the news we have to give may be far worse for that person than we personally perceive, and have much further repercussions on their lives than we realise. After all, a doctor's job is to alleviate suffering, not just cure disease.

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# Topic: Better Care Together – Ophthalmology Service Re-design

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## NATIONAL CONTEXT

In March 2015, NHS England and its national partners announced the first of 29 new care model vanguards. There are nine integrated primary and acute care system vanguards which will join up GP, hospital, community and mental health services.

Better Care Together (Morecambe Bay Health Community) is one of the nine vanguards. The partners of this vanguard are all members of the Better Care Together Programme, working on behalf of the population of Morecambe Bay, which has 365,000 residents. They include four NHS trusts: University Hospitals Morecambe Bay NHS Foundation Trust; Cumbria Partnership NHS Foundation Trust; Blackpool Teaching Hospitals NHS Foundation Trust; Lancashire Care NHS Foundation Trust, North West Ambulance Service NHS Trust (NWS) and two clinical commissioning groups: NHS Lancashire North Clinical Commissioning Group and NHS Cumbria Clinical Commissioning Group. Two Local Authorities, Lancashire County Council and Cumbria County Council, are also in the vanguard, together with two GP provider federations, the North Lancashire Medical Group and the South Cumbria Primary Care Collaborative.

The Vanguard will create a system that will take responsibility for the whole health and social care needs of the population within a single budget. 'The Morecambe bay pound'

Ophthalmology BCT pathway was successfully launched on the 6th September 2016. It is designed to make the Hospital Eye Service (HES) more productive, working hand-in-hand with integrated out of hospital services in optical centres and GP practices, and focusing

the HES on the services only it can deliver. The 4 main work streams focus on providing good quality eye care services closer to residents with greater access at times that suit them. The overall goal is to achieve a 20% shift from HES to community care services. These include, Minor Eye Conditions Service – MECS, Paediatric Repeat Refractions – PRR, Glaucoma Referral Refinement – GRR and Post-op Cataract Assessment.

In the first 4 weeks of contract there were 218 contacts with local optometrists, with approximately 50 MECS per week. This is projected to rise to 84 per week or 4,368 planned full shifts from HES into community care per year. The initial review shows that only 20% of MECS are referred to HES. 73% receive advice/treatment at optical centres and discharged. 7% of cases are referred to GP. There was no reported harm or adverse effects. The other work streams have fewer numbers of contacts in the community in the first month but projected to rise steadily in the coming months.

## CONCLUSION

Early indication shows that the launch of the BCT Ophthalmology re-design has been successful. More work is required to increase activities at the community eye care services and obtain feedback from service users.

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