ism as a disease. My lived experiences situate me directly in the frame of addiction, leaving me entangled by contradictory and complicated feelings. While the scientific knowledge from my pre-medical education provides me with logic and research that outline alcoholism as an innate mental and chemical imbalance, I still find it difficult to diagnose my lived experiences in terms of something so matter-of-fact. At times, it seemed like this identification excused my father's actions, took away the traumatic narrative of my childhood and invalidated my ongoing struggle with its repercussions. It is in these moments that I feel the tension and resentment toward my father and alcohol most. I am left to grapple with a dichotomous feeling that waded in the shadows of my sheltered youth, and conversely, bombards me daily in my adult life: How much weight should the context of my childhood have on my father's medical diagnosis as an alcoholic? At what point should the choices he made, the symptoms he portrayed and their downstream effects on my family outweigh his classification as a victim of a disease?

***

As I plan for my own career in medicine, I find myself contextualizing all of my thoughts and actions around my father's relationship with addiction. Despite the ways in which he has tainted my childhood, I grew up admiring the idea of my father––a person I had only heard about, and seldom met––allowing me to idealize how he could have been, instead of what he lacked. As a coping mechanism, I clutched onto memories of him that were revealed to me through anecdotes from the past––the doting physician that I read about in stories from thank you cards that patients mailed to my house, or the adventurous and bright teenager that my grandparents described who joined the Peace Corps to teach high school science in Kenya, or even the loving husband who knew he would marry my mother on their first date. During the worst times, this man sounded like a stranger who went missing during crucial moments of my childhood. I would only meet this beloved person after my father went through extensive in-patient treatment, where he was reminded to mend his relationships with those he hurt, and fill in the blanks for that which he missed. Yet, I still find myself unsatisfied. Although it is almost three years since the resurrection of my thoughtful, curious and dedicated father, I continue to boil over with intense resentment, and I find myself fantasizing about what could or should have been. In these moments, I am caught in the crossfire of ambivalent emotions towards two completely different people: my father (the alcoholic), and my father (the recovered alcoholic).

As I continue to uncover new and old emotional scars, I accept that my lived experience with the duality of addiction affects my interactions, motivation, memories, and relationships. Instead of giving into the pressure to pick from the two father figures, I choose to love and hate, acknowledge and ignore, and forget and remember each simultaneously. Rather than focusing on one way to interact with alcohol, I choose to see the paths to both overbearing intoxication and complete abstinence, removing the veil that clouded many of my previous decisions, and making my own route down the middle. And most importantly, I choose to allow my longstanding relationship with alcoholism to shape a healthy way for its incorporation in my life.

***

Yet, even with these conclusions, I still find myself lingering on the question: How can I still want to be a doctor like my father? There is no simple answer to this question. I cannot deny that the collisions, broken memories and distorted relationships I have with alcohol, addiction and my father influence (and sometimes cloud) my perspective on the world. Nevertheless, they simultaneously compel me to challenge the overwhelming amount of hypocrisy I feel when I socially interact with alcohol, and reform its frame to include the context of my childhood. My father shaped, for better or for worse, who I am. His disease encouraged me to love medicine despite its flaws and its failure to rid him of his addiction, and allowed me to understand that a disease cannot be simply understood by its biology––a lesson I will carry with me as I pursue a degree in science and healthcare. In turn, I find ways to appreciate the stories of his compassion and ambition––true character traits that were veiled for many years underneath the cloud of his disease. Consciously, I choose to welcome the uncomfortable notion of remaining emotionally torn. With the odds stacked against me, I intend to become a doctor for reasons that I have fought for––ones that incorporate the lessons I have learned from my father, and most importantly, those that commend, exemplify and unravel my tenacious, ever-curious pursuit of understanding a disease that I never asked for, but cannot seem to get away from. .



# Sympathy, Empathy, and Compassion

Rose Mahoney

Empathy, sympathy, and compassion are often enveloped in conceptual and semantic confusion. The three are frequently used interchangeably in literature and conversation, conflated and boiled down to a bare-bones definition of "feeling bad" for someone. Recent studies suggest that a patient's perception of their healthcare provider as empathetic correlates with better outcomes. These studies have serious implications for clinical practice, medical education, and research., Physician education has shifted to emphasize the importance of empathy, particularly in instances of palliative care. This transition towards medicine rooted in empathy is made difficult by the lack of a clear practical and conceptual definition of empathy.

**The Importance of empathy in healthcare**

In 2013, a group of researchers in the Netherlands screened 964 original clinical studies available on PubMed, EMBASE and PsychINFO published in English between 1995 and 2011. The studies were evaluated based on their empirical data about patient experience and General Practitioners' empathy. Researchers defined empathy as "the competence of a physician to understand the patient's situation, perspective, and feelings; to communicate that understanding and check its accuracy; and to act on that understanding in a helpful and therapeutic way." The study found a "good correlation between physician empathy and patient satisfaction… [and] direct positive relationship with strengthening patient enablement." The study concluded that in most cases, a physician's expression of empathy was found to "lower patients' anxiety and distress and deliver significantly better clinical outcomes." In their conclusion, the authors warned about a systematic movement away from good patient-physician communication and towards the technological aspects of care and productivity in general practice. They suggested that in the future, efforts should be made to draw the attention of policy makers and health insurers to these aspects of empathy.

A 2012 study of almost 900 diabetic patients and their primary care physicians in Parma, Italy found that physicians with high empathy scores had patients develop acute metabolic complications at a significantly lower rate. The physicians' empathy scores were determined using the Jefferson Scale of Empathy, a validated instrument developed at the Center for Research in Medical Education and Health Care at Jefferson Medical College which measures empathy based on "understanding of experiences, concerns, and perspectives of the patient, combined with a capacity to communicate this understanding with the intention to help." Patient outcome was measured as a function of acute metabolic complications, which are common among diabetic patients, including diabetic ketoacidosis, hyperosmolar state, and coma. For patients with high empathy scores, the rate of acute metabolic complications per 1,000 patients was 4.0, differing significantly from the 6.8 patients per 1000 for physicians from the moderate and low empathy score category. The report concludes empathy plays an immense role in a trust-based physician-patient relationship, which leads to optimal clinical outcomes through mechanisms of better communication and greater compliance with treatment plans.

**The difference between sympathy, empathy, and compassion**

In June of 2018, a report was published in the Journal of Palliative Care in which 53 advanced cancer patients in large urban hospitals were interviewed on their experiences with physician sympathy, empathy, and compassion. Upon coding and analyzing patient responses to questions such as, "In your experience are compassion and sympathy related, are compassion and empathy related?" the following table was constructed.

| | Sympathy | Empathy | Compassion |
|---|---|---|---|
| **Definition** | A pity-based response to a distressing situation that is characterized by a lack of relational understanding and the self-preservation of the observer. | An affective response that acknowledges and attempts to understand an individual's suffering through emotional resonance. | A virtuous response that seeks to address the suffering and needs of a person through relational understanding and action. |
| **Response to Suffering** | Acknowledgement | Acknowledgement, understanding, and emotional understanding | Acknowledgment, understanding, and emotional resonance linked with action aimed at understanding the person and the amelioration of suffering |
| **Patient-reported Outcomes** | Demoralized<br>Patronized<br>Overwhelmed<br>Compounded suffering | Heard<br>Understood<br>Validated | Relief of suffering<br>Enhanced sense of well-being<br>Enhanced quality of caregiving |
| **Examples** | "I'm so sorry"<br>"This must be awful"<br>"I can't imagine what it must be like" | "Help me to understand your situation"<br>"I get the sense that you are feeling …"<br>"I feel your sadness" | "I know you are suffering, but there are things I can do to help it be better?"<br>"What can I do to improve your situation?" |

While patients spoke to the many similarities between compassion and empathy, they were quick to identify sympathy as distinctly unhelpful and superficial, rooted in a pity and perceived as a coping mechanism used by healthcare professionals in situations that they feel unable to address. Empathy and compassion rooted in acknowledgment of, understanding of, and emotional resonation with a suffering person, were valued by interviewed patients. Some of their responses are recorded below.

*"Sympathy, I think is you're feeling sorry for that person. I don't Want somebody to feel sorry for me, I want you to help me." – Patient 48*

*"That's because empathy is, for me, empathy is that personal conection…whereas sympathy doesn't have to be personalized, it can just be, you know it's just all those comments, my thoughts are with you, blah, blah blah." – Patient 49*

*"When you empathize with people you, you've crawled. Right into their moccasins." – Patient 44*

In differentiating between empathy and compassion, patients emphasized the importance and effectiveness of response rooted in action. While both empathy and compassion acknowledge and attempt to understand another's suffering, compassion adds an active response.

*"Compassion is actions… sympathy are thoughts and Well wishes" – Patient 14*

*"Sympathy are words and you know, "jeez I hope you feel better" and "it's terrible you got this" and compassion is running over and getting a barf bag." – Patient 13*

**Barriers to compassion and empathy in the medical profession**

Many healthcare providers are drawn to the healthcare field because they desire to provide compassionate care; but this can be emotionally taxing in challenging environments where loss and suffering are common and patient throughput is high. A series of one-on-one, semi-structured interviews of healthcare providers including physicians, registered nurses, social workers, hospice psychologists, and palliative care unit employees, were performed in an attempt to pinpoint barriers to compassion and empathy in healthcare. From these interviews the following table was created.

| Challenges to compassion | |
|---|---|
| **Theme** | **SubThemes** |
| **Personal challenges** | Egotistic caregiving<br>Individual differences in HCPs innate virtues |
| **Relational challenges** | Stigmatization and prejudice towards patients<br>Perceived lack of patient and family receptivity to compassion. |
| **Systematic challenges** | Competing system demands<br>Time constraints |
| **Maladaptive responses** | Treating challenges to compassion as excuses for not being compassionate |

Participants described personal internal factors as a major challenge to compassion, particularly focusing on egotistic caregiving in which healthcare providers overemphasize their role and unique ability in caregiving. This egotistic caregiving leads a healthcare provider to place all praise and blame on their own shoulders. It leads to stress, depression and burnout, creating a dangerous environment for the patient.

*"Sometimes we can be barriers ourselves. As nurses sometimes, we think we know best on what to do or how to control symptoms." –Participant 33*

*"[You think] 'I'm the only one who can care for this person because we have such a close relationship', so you're the one who comes riding in on the white horse with the white hat to save the day… And so, I think that muddies the road of compassion… because it becomes less about that person and becomes more 'I feel better because now this person relies on me'." – Participant 7*

Participants also spoke to the challenges that come about in an unsupportive healthcare system and culture of practice that is perceived as lacking compassion. While compassion often arises as a spontaneous response, it can be stifled by restrictive institutional policies, on overly task-oriented approach and an overly biomedical focus to care. Short-staffing, inflexible schedules, and limited resources were also labeled as barriers to compassion.

*"You have all these other obligations and duties and how do you have those moments and still get your job done and all the tasks that you have in front of you for that day. That's a struggle for me." – Participant 4*



**Conclusion**

These studies reveal to us something very intuitive: that a healthcare provider who is empathic is more readily appreciated, accepted, and valued by patients. These positive relationships, rooted in empathy, have been shown to correlate with better patient outcomes and improved healing experience overall. Qualitative studies like these are difficult to perform on such an elusive and ill-defined concept as empathy. Various researchers have taken perspectives of both patients and healthcare providers to create a working definition of clinical empathy as a response that acknowledges and attempts to understand an individual's suffering through emotional resonance, and takes active steps to alleviate pain or suffering. This work provides a scaffolding upon which qualitative data can be collected and used to inform policy, health insurers, healthcare educational facilities and healthcare providers. This research is especially important now as physicians face mounting demands on their time. Increased emphasis on efficiency and administrative requirements for health care delivery encroach on time that could be spent developing a patient-healthcare provider relationship.

References:
Jeffrey, David. "Empathy, Sympathy and Compassion in Healthcare: Is There a Problem? Is There a Difference? Does It Matter?" Journal of the Royal Society of Medicine, vol. 109, no. 12, Dec. 2016, pp. 446–452

Sinclair, Shane et al. "Sympathy, empathy, and compassion: A grounded theory study of palliative care patients' understandings, experiences, and preferences" Palliative medicine vol. 31,5 (2016): 437-447.

Derksen, Frans et al. "Effectiveness of empathy in general practice: a systematic review" British journal of general practice : the journal of the Royal College of General Practitioners vol. 63,606 (2012): e76-84.

Derksen, Frans et al.

Del Canalo, Stefano et al. "'The Relationship Between Physician Empathy and Disease Complications: An Empirical Study of Primary Care Physicians and Their Diabetic Patients in Parma, Italy" Academic Medicine; Journal of the American Medical Colleges vol. 87, no. 9, Sept. 2012, pp. 1243-1249

Sinclair, Shane et al. "Sympathy, empathy, and compassion: A grounded theory study of palliative care patients' understandings, experiences, and preferences" Palliative medicine vol. 31,5 (2016): 437-447.

Sinclair, Shane et al.

Tijdink, Joeri K et al. "Emotional exhaustion and burnout among medical professors; a nationwide survey" BMC medical education vol. 14 183. 4 Sep. 2014, doi:10.1186/1472-6920-14-183

Singh, P et al. "Healthcare providers' perspectives on perceived barriers and facilitators of compassion: Results from a grounded theory study." Journal of Clinical Nursing vol. 27, no. 9, Mar. 2018