The art of medicine

Medicine's uncanny valley: the problem of standardising empathy

A month after my father died of heart failure in a cardiac intensive-care unit in my hometown, I flew back to Baltimore to finish my final year of medical school. Although I was apprehensive about returning to the hospital, I knew that the full schedule would be a welcome distraction. Still, I was surprised how easily I fell back into the old routine of attending morning rounds, admitting patients, writing progress notes, and presenting cases to the head physician.

My second rotation back was internal medicine, where we saw many patients with chronic and acute heart failure. Almost every morning I listened to patients' lungs for the crackles of pulmonary oedema, checked for pitting in their feet and legs, and asked them to lean back and turn their heads to the left while I searched with my penlight for the elusive biphasic flutter of the internal jugular vein. It was not so much seeing the disease itself that, from time to time, transported me back to the days I spent with my father in the intensive-care unit. Rather, it was moments that often seemed fairly mundane and nondescript: a doctor's gesture, a nurse's expression, a worried relative's tone of voice.

A few weeks into the rotation, I attended a lecture on breaking bad news and having goals-of-care discussions with families in the critical care setting. The presentation was like many I had seen before: strategies for conveying empathy and assessing comprehension were offered, together with an acronym or mnemonic device to remind us when to speak, listen, and offer some gesture of understanding or solidarity, such as an empathic statement or verbal identification of observed emotion. I remember one slide in particular that showed a pie chart of the optimum speaking to listening ratio; the listening section, as the presenter pointed out, was larger. When I first arrived at medical school, this kind of formulaic approach to patient communication seemed somewhat misguided, but I was also aware that, at that point, I had never had to be on the receiving end.

The doctor on duty during the week my father spent in the cardiac intensive-care unit was young, focused, and energetic. In the few brief conversations we had she used many phrases that I recognised from medical school. But her approach couldn't hide the fact that she would have rather been looking at the screen of her smart phone than talking to me or my mother; if anything, the rote phrases she used emphasised it. At one point she awkwardly nudged a box of tissues in our direction, although neither one of us was crying.

My father's nurse was awkward as well, but in a different way. Older and reticent, he, too, was more comfortable doing things than making conversation, but when he did speak his words seemed unrehearsed. At one point, my mother and I were sitting in my father's room, where he lay sedated and intubated, while the nurse and physician conferred by the door about some medication changes. I caught only fragments of the conversation, but one of them was the nurse's observation that, "he has a crappy heart". I hoped my mother had not heard this remark, and felt angry towards the nurse for his callous words. But then, despite my anger, I realised that his transgression also felt human and forgivable, unlike the doctor's prepackaged expressions and superficial manner which seemed to preclude any meaningful connection and left me feeling far worse.

Looking back, I wondered why that might be. The physician had, after all, followed her training and used appropriate language to have a difficult conversation with a critically ill patient's family. The language, per se, was not the problem. But there seemed to be an absence of genuine feeling behind the words. Her approach was more problematic, I would argue, than the nurse's insensitive remark.

As I thought about this subtle but powerful disconnection between the doctor's words and her manner, I recalled the hypothesis in animation and robotics known as the uncanny valley, which proposes that as non-human figures reach a certain point of human likeness we begin to feel revulsion towards them rather than affinity. To me, this idea makes sense. What else could one possibly feel towards something whose form suggests the promise of reciprocal human interaction, but which we simultaneously sense is not real? The same seems to go for empathy: the only thing worse than not having it is being insincere about it.

Communicating with patients is not about using or not using a particular phrase or style of conversation, it's about finding a way to connect with another person in the midst of this frightening universal business of living and dying. It is no coincidence that it was William Carlos Williams, a physician, who wrote: "it is difficult / to get the news from poems / yet men die miserably every day / for lack / of what is found there".

There are certainly words and actions that express empathy better than others. By all means, let's promote them in medical training. But the connection must be there first, and for better or worse, we are all well attuned to the ineffable signs of its presence or absence. Empathic statements are powerful ways to communicate with patients and they should be taught as such; they can greatly aid the expression of compassion

and solidarity. But as anyone who has spoken to a script-reciting customer service agent knows, they cannot convincingly take the place of those emotions. Evaluating a medical student's empathy with a checklist can make it easier to grade a test or plot a graph, but real people suffer miserably every day for lack of what cannot be found there. Real damage is done, to both providers and patients, when medical training inadvertently facilitates the substitution of scripted empathy for the real thing.

Cultivating real empathy, while also balancing personal feelings with the necessary clinical objectivity, is neither easy nor straightforward. It is a topic of much discussion, and during my time in medical school I have heard all kinds of ideas, ranging from classes in medical humanities, to visits to art museums, to early acceptance programmes that allow pre-med students to pursue a broader undergraduate curriculum. Ultimately, the only thing that seems clear is that there is no single way to go about it. In fact, beyond the important basics of general support and encouragement of individual interests and wellbeing, I wonder how much any standardised programme can do for a process as personal and varied as the development of empathy, compassion, and a sense of one's relation to, and responsibilities towards, other people.

My father's cardiologist came to see him the day after he was admitted to hospital. He introduced himself to the nurse, who handed him the chart, which he paged through slowly, reading the story told by hourly recordings of medication levels and vital signs. Then, wordlessly, he took the stethoscope from around his neck and walked to the bed. He leaned over, breathed in, and, holding the firm blue tubing like the needle of record player, he placed the instrument on my father's bare chest, closing his eyes for a few respiratory cycles, the room silent except for the rhythmic bursts of the ventilator and muffled monitor alarms filtering in from the hall. It is the only time I remember seeing a physician touch my father from the moment I arrived at the hospital to the day he died.

The afternoon my father's supportive care was to be withdrawn, I found an empty conference room on the unit and called the same cardiologist who was away for the weekend. I understood the situation, I said, but I wanted him to explain it to me one last time. He told me, instead, to explain it to him, and he listened as I struggled to make sense of things. When I finished, he told me about the first time he met my father and how much he had grown to admire and care about him over the years, and finally how he knew that what was happening was the best thing for his patient and his friend. As he spoke, unhurried and affectionately, I realised what it means to be a good doctor.

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***Wall of Light Stone* (2000) by Sean Scully**

Caregiving, it has been said, is a moral act with unique power to enrich and give meaning to the lives of both giver and receiver. In the end, time is short and the stakes are high with every word and every gesture. What health-care providers say (and how we say it) and what we do (and how we do it) matters, and this should be a source of inspiration for our profession. The worst thing we can do is try to circumvent the recognisable, yet unquantifiable, struggle for real human connection and steer medicine further in the direction of becoming a massive customer service agency.

When I returned to medical school after my father's death, I taped four lines from T S Eliot's poem "Little Gidding" to the otherwise bare wall of my apartment:

> "Every phrase and every sentence is an end and a beginning,
> Every poem an epitaph. And any action
> Is a step to the block, to the fire, down the sea's throat
> Or to an illegible stone: and that is where we start."

At the time, I thought I saw a kind of comforting stoicism in the words. But now, thinking back, I suspect that what they really gave me was more active: a reminder that it is often out of confusion, uncertainty, and sometimes loss, that our clearest thoughts and most meaningful experiences arise.

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Further reading

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Kleinman A. Caregiving as moral experience. *Lancet* 2012; **380:** 1550–51

Williams WC. Asphodel, that greeny flower and other love poems. New York: New Directions, 1938