

# Last Lecture 2016 Frankel

[0:04:00]

Richard: And so here we go. So I want to make a disclosure to begin with and that is that I have no financial conflicts of interest to declare, but reports of my death or retirement have been greatly exaggerated. So I'm going to start here with a photograph that is iconic that was taken by Dorothea Lange during the Farm Security Administration in 1936. And I start here because as you look at this photograph, it likely is bringing forth some feelings. If you look, for example, at the mom touching her lip, the crinkle in her eyes, the set of her mouth, the two children who are somewhat unkempt turned away from the camera, it's a touching photograph. One might say that it brings forth a feeling of empathy -- a feeling of empathy.

So I want to read to you a story that was told for the first time after 25 years by a very senior physician. He said: I was a third year student in the emergency room when a family, a grandmother, uncle and a 10-year-old girl came in badly burned. The girl was in arrest and despite all our efforts died. The smell of charred flesh was overpowering. I was sent to ask the mother for an autopsy. Instead of beginning with the news of her death, I began with "Sorry to bother you with a time like this but we'd like to do an autopsy on your daughter." The mother screamed, collapsed, hitting her head on the floor. As the tears began to stream down this physician's face he said, "I was aghast, guilty, stunned, felt inadequate to make any appropriate response. I still feel terrible about it to this day."

So I'd like you to consider three questions. What are the first two or three words that describe your reaction to this story? What words come to mind? And the second question, what feelings does the narrator describe and what emotions did he express when the mother collapsed? And finally, for someone telling a story 25 years later, what psychological conditions are associated with unexpressed emotion?

Here's the story again. Many people when they listen to this story ask, how could a third year student be asked to do this? What educational principle would put a third year student in this position? What feelings did this now senior physician have 25 years earlier? He was aghast, guilty, stunned, felt inadequate, still feels terrible about it today. But emotions did he express? And the answer is we don't really know but he doesn't describe any emotion. He doesn't say what I said to the parent, what I was expressing at that moment. I'm going to want to make a distinction between feelings and emotions based on this.

So that's a scientific introduction. The personal introduction is what I call Black Thursday. It was November 15th, 1979 and I'm sitting in my office at Wayne State University, a new faculty member. I've been there since August. And the phone rings and it's my dad and in a voice barely above a whisper he says, "It's your mom." And I said, "What about my mom?" And he said, "She is dead." Well, she had been in the hospital for eight days for a three-routine test which could have been done in an out-patient clinic in an afternoon. In the end, once the test came back, all negative. Her physician waited 48 hours to give her the news that her test results were normal. She was still experiencing symptoms. And so the news was her test results are normal. There's nothing wrong with you. It's all in your head. Go home.

**[0:05:39]**

So my who was a university professor took her home and lived in their apartment outside of New York City, asked the neighbors to look in on her. He was gone for about an hour and a half. When he came home, he found that there was a utility truck outside of their apartment and they had broken into the apartment because she had had access to barbiturates, had taken an overdose of barbiturates, taped the doors and windows of the kitchen and turned on the gas and was dead on the floor.

It seemed to me at that moment that the medical profession had failed my mom, that instead of listening to her complaints and her fears, her physician, who was an immigrant from Nazi Germany and certainly knew about suffering, simply didn't get the import and the meaning that her symptoms had for her. So that's part one of my personal story.

So let's come back to empathy. In 1964, Potter Stewart, who was a justice in the Supreme Court was trying to define obscenity and he said, "I shall not today attempt further to define the kinds of material I understand to be embraced in obscenity but I know it when I see it." Like the blind man and the elephant, the same applies to empathy. When I started studying empathy and went to the dictionary, I found no fewer than 17 different definitions of empathy. So I thought it was really very interesting. But as a researcher, it made it very difficult.

I was surprised to discover that empathy is actually a 20th century word. It derives from the ancient Greek, *empathia*, which means physical affection, passion, partiality and that in turn derives from *pathos* or passion or suffering. It was translated in 1909 by Edward Titchener who was a psychologist, British-born but he did his work at Cornell University. Actually, its first usage was in 1874 in a PhD dissertation on architecture. So you have a word that is devoted to the study of architecture being translated imperfectly from German into English into

a theory of introspection and no wonder there are 17 different definitions because there are 17 different ways to define empathy.

So I want to differentiate empathy from empathic communication because I think there is our two fairly different concepts. So empathy may be a feeling that arises in us but empathic communication is the expression of that feeling in some form of emotion. So empathic communication is a response to suffering. It can be verbal. It can be visual. It can be nonverbal. As compared with sympathy, empathy is yet again a different concept. If I have a sympathetic reaction to something that my wife Michelle says and she's crying and I start crying, I'm having a sympathetic reaction. If I turn to her and I say, "This must be really difficult you," that's an empathic response. So they're two very different ways of thinking about how we are **[0:09:36] [Indiscernible]**.

Empathic communication really has three constituents. There's recognizing emotion and microemotions. There's sorting out. So I see a tear beginning to form, what does that mean? What can I infer from that? And how does that make me feel internally? And then there's responding, selecting from among different ways of responding to the emotion. You know that you've been accurate in empathy when the other person agrees with your assessment. I'll show you what that means in just a moment.

**[0:10:16]**

In short, empathy arises from feelings or content of awareness and it's expressed in emotions. And still to this day, this comes from Darwin's expression of emotion in man and animals which was published in 1872. It was actually the first book to use photographs of emotion. It's really quite a stunning book. So here, let me try to make the point. One of these two players is holding four aces. Which one is it? Is it this guy or is it this guy? Hard to tell, isn't it? So whatever that person is holding the four aces might be feeling the inside, you have no clue as to what they are actually feeling by reading their emotion. We have the ability to mask our emotions. So let me give you an example of the expression of emotions in healthcare.

[Video Playing]

So I think it's fair to say that these are emotions which haven't been edited in any way but they are being expressed direct. Let me contrast that with a videotape. You are going to hear the actual air traffic control conversation between Flight 1549. This is the US Airplane that went into the Hudson four or five years ago piloted by Captain Sullenberger and air traffic control in LaGuardia and in New Jersey. What I'd like you to think about is put yourself in the left-hand seat or the right-hand seat of aircraft. You are the pilot or first officer or

you're air traffic control, what would you be feeling? So US Air Flight 1549 takes off, two minutes later, it's struck by birds.

[Video Playing]

So put yourself in Captain Sullenberger's shoes, air traffic to your borough, air traffic LaGuardia. What words would describe how you would be feeling at this point? And given the time that we have, I'll tell you what people have said. I'd be scared shitless, terrified, wouldn't know what to do. What are they expressing emotionally? None of that. There is no emotion as you compare it with what you have heard the physicians saying and expressing the emotion. Here when you hear the emotion being masked. In fact, when you listen to the two air traffic controllers, they can be organizing a picnic.

**[0:15:29]**

So what's the difference? Is it that doctors are bad people and scream at one another and airline pilots are good people and don't scream at one another? It comes from training. Captain Sullenberger was a safety expert. He had gone through multiple, multiple, multiple simulations and so he felt confident and comfortable in what to do, and he was able to overcome one emotion he might be feeling. The same thing is true for the alternative controllers. These guys have multiple planes that are flying around New York City as they're dealing with these emerging situation and given the way in which they handled it, Sullenberger was able to land on the Hudson. There was no loss of life, no casualties.

So part two in my own story, it's November 15th, 1989 exactly to the day ten years after my mother's suicide. I'm in Toronto, Canada facilitating a daylong communication skills workshop with about 60 Canadian family physicians who are the equivalent of primary care physicians, interns here in the United States. We get to the last session of the day which is the session on empathy and I asked people in groups of six at round tables to talk about a meaningful experience that they have. And the group's task was to come up with an empathic response.

So there were about 10 groups and I was sitting outside with one of these groups so that I can be available if I was needed. A youngish family practitioner from a small town in Northern Ontario started to speak and he said, "About ten years ago, I was treating a couple and I knew that the man in the couple was depressed but I didn't know how depressed he was and I didn't know much about depression. And after two weeks of seeing both of them in care, I got a call from the wife telling me that her husband had hung himself in the basement of their family home," and the tears started to come.

And he said, "In ten years, I have never told this story." And he went on to say that, "I wish that I knew then what I know now and there are some days that I wish that it was me and not him." And there was a silence with about 15 seconds as he was living with the import of having shared that story. And a colleague of mine happened to be in this group and she said to him, "So whatever happened to the wife?" And this youngish physician said, "Well, she came to see me as her physician for the next 10 or 11 months and then she moved off to another town and I never heard from her again."

My colleague, Yvonne, said, "Well, did you have any interpretation of that?" And he said, "No. I just thought I was kind of curious." And so she said, "Well, did it ever occur to you that the wife had forgiven you for your mistake and the evidence was that she trusted you enough to continue seeing you as her physician." And again the tears started to roll down his face. I would say in my career I have seen true healing take place, maybe the number of **[0:19:40]** **[Indiscernible]**.

**[0:19:42]**

You could see this youngish physician see the possibility of forgiving himself for the first time in ten years. And I was sitting there on the 10th anniversary of my mom's death thinking to myself, oh, my goodness, I have always thought of the bad guy as being her physician. It never occurred to me that there are at least two victims when somebody commits suicide, that the physician is as much a victim as the person who has taken their own life.

So I went up to this youngish physician and I said, "Thank you. Thank you for sharing. It's given me an insight that I really never had about how important it is to understand both sides." And we both got a little teary-eyed and we hugged and went our separate ways. It's now 1990 on the 11th anniversary to the day of my mom's suicide and I was doing a workshop on adult life development with the feminist physician friend of mine and in walks this youngish physician, sits down, goes through that workshop. Afterwards, he comes over to me and he says, "You probably don't remember who I am," and I said, "Oh, no, I remember you."

And he said, "I wasn't really that interested in adult life development but I did want to come and tell you what a good year it's been and how much I have been able to forgive myself." I say this was a training point because it gave me the opportunity to help someone else deal with a difficult issue. I have done in many workshops on suicides. It's one of the few things in medicine that we don't talk very much about from the physician's perspective but I would say that there's not a physician who has lost a patient to suicide who doesn't carry heavy on his or her heart.

All right. Let's talk about researching empathy. So using Potter Stewart's model of knowing when we see it and having 17 different definitions of empathy out there, my colleagues and I, we were at the University of Rochester at the time, picked 100 videotapes at random looking for examples of empathy saying, "We'll know when we see it." And surprisingly out of a hundred examples, we found only one that we thought was empathy. And so we asked, is there something else that might be going on before you get to empathy that might explain? And so this is what we studied and it also led to a publication in general.

So let me give you one example about their talking to a patient who is coming back having had cancer. He says, "You seemed a little upset. You seemed a little teary-eyed." "Yeah, well, it gets to you, you know." This is the first time we've had a little session like this where you're really talking to somebody about it. "I think I'm blessed because I had a very dear friend who passed but she waited too long and she had to have chemotherapy. I haven't had to and I should be thankful and I am. I guess that's why I'm crying." And the doctor says, "That's right. It's brightening." It is. There is the agreement that he's used accurate empathy in this because you hear so much about everything but I say if I don't have to endure so much pain, I mean but I imagine when the time comes for any pain to endure that you can go through that. So that was the one example we found.

What we did find was something that we call the potential empathic opportunity. This is where a patient makes a statement that might have emotion but it doesn't on its face. So the doc said it was touch and go. And the physician says, yeah. So we called that a potential empathic opportunity. And one of two things can happen; that potential empathic opportunity can take the next step toward empathy or it can be terminated. So here is a terminated. I'm in the process of retiring. I am not in the process of retiring. "You are?" says the physician. "Yeah, I'll be 66 in February." "Do you have a Medicare?" So there is the termination of what might be an emotion-laden conversation.

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Here is an empathic opportunity. "How do you feel about the cancer" -- this is from that same videotape -- "about the possibility of it becoming bad?" " Well, it bothers me, it bothers as an emotion would but I don't dwell on it. I'm not as cheerful" -- another emotion word about it -- "when I first had -- I just had very good feelings" -- another emotion word -- "that everything was going to be all right but now I dread another operation." So there is a real empathic opportunity that you saw taken in the first example. He says, "You seemed a little bit teary-eyed. You seemed a little upset. You seemed a little teary-eyed talking about it."

But here is missed empathetic opportunity. Does anybody in your family have breast cancer? No. No, I just stopped and we couldn't hear much what she said. After I had my hysterectomy, I was taking estrogen, right? My doctor says, "Yeah." You know how your breast got really hard on everything, you know how you got sort of scared? It was the emotion work? How long were you on estrogen? So once again, what we see is lots of hints, lots of potential empathic opportunities, lots of empathic opportunities, few of which are actually taken. So in this first study, what we found was that of a hundred tapes where there were opportunities for empathy, only one was taken. Great opportunity for improvement.

This is just a motto that we came up with showing that if you start with a potential empathic opportunity and it's followed up, it goes to empathic opportunity which then goes to -- well, I'm sorry. I'm determining it goes to an empathic response at which point the patient feels understood.

I'm going to say just a word about non-verbal behavior. We know that empathy would not be the exact appropriate term to use for this but in the gray wolf, male gray wolves are aggressive toward one another. In many animal species, they will fight to the death. In the gray wolf, what happens is that the vanquished will make its most vulnerable part which is its neck available to the victor. No fighting takes place then both move off.

Nonverbal behavior in humans. So we know that there is a particular behavior when two animal species face one another without head tilting, that's a sign of aggression and if it doesn't change, it will lead to aggression, head tilting in human beings is a sign of empathy. It's a sign of sensitivity and it's not by chance that the male in this picture has his head looking forward and the female has her head bowed because females are much more likely to engage in this nonverbal behavior than the males.

All right, so what does that look like? Some of you may have seen this movie starring Emma Thompson. It's called Wit. If you haven't seen the movie, let me recommend it to. If you can see and hear what empathy looks like.

[Video Playing]

**[0:29:47]**

All right, here is the audience participation part of my talk. I want you to find a partner, take one minute to share with your partner, a meaningful experience or stepping stone in your life. If you are the partner, I want you to make an empathic statement in response and then I want you to reverse roles. You're

going to have three minutes to do this. So find a partner, talk about a meaningful experience.

[Group Discussion]

Thank you. I'm sorry to limit it so much. But standing here, listening to you, there was so much emotion in the room. The buzz was so beautiful to hear and I hope that you had some positive feelings that came from being listened to and heard, being responded to. I heard laughter. I don't think I saw any tears but there might have been some.

All right, I'm going to rush through this just to say that the role of empathy has really changed since the turn of the 20th century when a kind of objectivism really helps. Patients were more or less like specimens under the microscope and physicians were taught really there is this idea of detached concern, not to get involved for patients emotionally because it would be overwhelming and it would preclude making good diagnostic decisions.

Well, it turns out that in 2016, there is pretty robust evidence to show that physicians who can use their emotions and engage with patients and use empathy rather than sympathy actually produce more positive outcomes. So Tait Shanafelt at the Mayo has shown that burnout is reduced when physicians have the capacity to use their emotions in working with patients.

Patient concerns and adherence have been shown. There's an old **[0:34:08]** **[Indiscernible]** study that I'll go through in just a moment. Recent study on diabetes show that physicians with higher empathy scores actually had patients with better outcomes in diabetes and then in paper that will be published in the Journal of General Internal Medicine shortly. Investigators of the Cleveland Clinic showed that teaching physicians communication skills resulted in higher patient satisfaction or patient experience score, higher empathy scores because empathy was taught as a skill and lower burnout scores.

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This is actually a study that Dr. Inui was part of and this was the one of the first outcome-based communication studies. It was done in 1984 and the investigators were looking at different forms of emotional support. They looked at encouragement, reassurance and empathy. As you can see, reassurance was used most frequently followed by encouragement reassurances. You are doing a great job. Encouragement is "You're doing a great job." Reassurance, "Don't worry, everything is going to be okay. This must be really difficult for you." Reassurance most, encouragement second, empathy not used very much.

Nonetheless, what the investigators found was that empathy was the only behavior that had an effect on outcome and it increased satisfaction with the visit and reduced maternal concern. So the thing that we do most which is to try to reassure our patients actually has no impact on outcome. The thing that we do least, which is to use empathy, has the greatest thing happened on outcome, again a great opportunity for improvement.

So Hojat study, the 891 patients treated by 29 MDs. I'm going to rush through this. What he showed was that for hemoglobin A1c, the high empathy, there was a 15% gap medium and low. So the more empathy, the better, the hemoglobin A1c, the same thing for LDL cholesterol. And then finally I have already told you about this study coming out in the Journal of General Internal Medicine. Why so little empathy? And I think there are three reasons. One is that the recognition of emotion is sometimes difficult, cultural differences and medical education.

So here is another audience participation. Peace. I want you -- when you see the faces that you are going to see in just a moment -- to call out the emotion that you see. For the women in the audience, I'm sure it's obvious to you what these differences are. It maybe not so obvious to the guys. All right, here we go.

Participant: Sadness.

Richard: Sadness.

Participant: Disgust.

Richard: You're not so sure. It's disgust.

Participant: Disappointment.

Richard: That's a neutral face, folks.

Participant: Surprised.

Richard: Surprised. Always. Okay, and that happens to be a picture of my son Matt who is... Sad to say it was probably gasp. What's this?

Participant: Pressured. Annoyed.

Richard: Yeah, only 67% of Americans can correctly identify an angry face whereas in the many different cultures, it's 90% to 95%. So we have difficulty recognizing anger. For things like surprise, happiness and disgust, there are cultural differences but I want to focus on the anger component and the fact that we can only identify two out of three angry faces because -- this was a study of 1,500 physicians who

said the most difficult patient to deal with is the patient who is angry or hostile. If we don't recognize anger, don't be surprised that it's the most difficult emotion to deal with.

Paul Ekman, who is the world's foremost authority on facial expression, also talks about micro emotions so that you can pick up science of anger fairly early on. Personally speaking, I'd much rather be able to detect that Mike Weiner is -- well, it's a bad example because he never gets angry. Mary Ann -- I'd much rather know that Mary Ann is starting to get angry early than deal with her screaming in my things. So I think that part of this issue of why there is so little empathy is that we don't often or we are not adept at recognizing emotion.

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There are cultural differences. So this was a Pakistani resident who said, "The patient is supposed to start chemotherapy this morning. She was crying. I didn't know how to show my support for her. Being from another culture where there are big differences between males and females, we can't get too close. So there was a hesitance to how I could hold her, how I could give her comfort." Again, it comes back to the difference between feelings and emotions. Some people have argued that international medical graduates lack empathic skills. That's not the case at all. They may lack the ability to rapidly translate from Urdu into English back into Urdu but they are not in any way, shape or form unfeeling or unimpacted. And then finally medical education, 68% of those who were surveyed said, "Medical never trained me in how to be empathic." I think that's quite telling.

All right, so here is the postscript. It's spring of 1999. I don't remember the exact day and my dad is 89 years old. At this point, I'm calling him every evening just to check in and see how he's doing. He says to me, "Rick, " that's what they call me, "Rick, you will never guess who called me?" And I said, "Dad, you're right. I won't guess." He said, "Your mom's doctor called me out of the blue." I knew why he had called but I said to my dad -- I don't think psychological insight was his strong suit as a biologist -- I said, "Why did he call?" And he said, "He called just to check in and see how I was doing." But that's not why he called. He called because my mom is dead in a suicide and it's still on his mind. And I guess if you wait long enough, the universe comes around.

So I'm going end with three things that I've learned. Number one, sometimes a tragedy is a gift in disguise. If my mom hadn't ended her life so abruptly, I will never have had the chance to be standing in front of you today. I would never have had the chance to study empathy and role of emotions. Hopefully, we'll feel fuller in some way or form professionally. This is such a hard one and it seems so trite and simple. The two stories that I read to you earlier, one was a story that

was told for the first time after 25 years, the other after 10 years. Think about that, that it takes 25 years to come face to face with a distressing story.

I think what I have learned is that by having trusted friends and colleagues like Dr. Inui and his wife Nancy who helped me through a really difficult period in my life and in my family and being able to tell the story, fighting tears in front of you today to tell this story. I honestly think that I wouldn't be the same person that I am today. So I think there is something powerful and true and trusting the process in greatest good for the greatest number.

And then I think the third thing is to find and follow your bliss. There are so many distractions that we face in this world from cell phones to political **[0:44:29]** **[Indiscernible]**. I promised myself I wouldn't make any political statements but you are fired. No, I was pointing to him. I think -- and this is a gift that Tom Inui really gave to me as well -- all we have is the present moment. All we have is to be together here now in this present moment and we should take advantage of it and celebrate it for what it is.

And the final thing is that it's **[0:45:24]** **[Indiscernible]** a day and thank goodness, my wife and family, that they are so healthy and they keep me healthy too. So empathy may not cure disease but it can alleviate suffering on both sides of the stethoscope. Thank you.

**[0:45:53]**      **End of Audio**