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Empathy – can it be taught?

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ABSTRACT There is now a societal and cultural expectation that doctors and nurses should feel, and display, empathy for their patients. Many commentators argue that medical and nursing students should be taught empathy. Empathy, however, is difficult to define: it is not the same as kindness, as it implies a degree of psychological insight into what the patient is thinking or feeling. Empathy is seen by some as a form of emotional intelligence that can be systematically developed through teaching and positive role models. Here we debate the meaning of empathy, and whether it is truly a quality, or attribute, that can be taught.

KEYWORDS empathy, medical education

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EDUCATION

Can we really teach empathy?

D Jeffrey

> Yes we can
> *Barack Obama, 2008 US Presidential Election slogan*

Complexity

Empathy is a multifaceted concept which has been described as feeling what another person feels, imagining oneself in another's situation or imagining being the other person in their situation. Empathy has also been thought of as a capacity to understand the content of other people's minds and as the moral foundation of care.[1] Empathy is also conceptualised as a personal attribute and as a relational construct.[2] Empathy is needed not just to understand a patient's illness or emotions but to understand enough of their context, concerns and expectations to diagnose and treat them appropriately.[3] Despite its importance there have been recent distressing reports describing a lack of empathy in patient care.[4–6] A paradox exists in medicine between a theoretical commitment to empathy yet valuing detachment and objectivity in practice.[7] The empathy deficit in clinical care is mirrored by quantitative studies suggesting that medical students' empathy declines during their training.[8,9] Two recent systematic reviews conclude that it is possible to teach empathy.[10,11] This paper explores the challenges of teaching empathy by interrogating various facets of the construct.

Yes we can: clarify the concept of empathy

Doctors have always struggled to balance connection and detachment in their relationship with patients. Medical education and practice have promoted a narrow approach to empathy, emphasising its cognitive and behavioural dimensions and leading to 'detached concern' as a model for medical professionalism.[12] A more appropriate broad view of empathy adds affective and moral dimensions.[11,13] This broad concept of empathy embraces a sharing of emotions with the patient and acknowledges that empathy is a driving force for acts of altruism.[12,14]

'Broad' empathy can be regarded as a relational process which involves cognitive, behavioural, affective and moral dimensions working together, but varying according to the clinical context and needs of the individual patient; each dimension will now be explored.[2,15]

Yes we can: teach perspective taking, curiosity and reflection (cognitive dimensions)

Understanding the patient's view, the meaning of their disease, their concerns and expectations, depends on imaginative perspective-taking. The perspective is other-orientated, outward looking and concerned with trying to view the world from the patient's point of view. A curiosity to discover the patient's views is in contrast to taking a self-orientated perspective in which the student imagines 'how would I feel in this situation?' Such a self-orientated perspective can lead to personal distress or an urge to abandon the patient to escape the suffering. Students and doctors need time for reflection to increase their self-awareness and to develop their sense of clinical curiosity. Other-orientated perspective taking has been successfully taught by using role play, experiential teaching and the medical humanities.[3,10]

Yes we can: teach sharing feelings (affective dimensions)

To enhance affective (emotional) empathy we need to address students' fears that sharing emotions will cloud clinical judgement or lead inevitably to burnout.[12] There is a difference between experiencing empathic concern, which forms a bond of shared humanity, and personal distress which can lead to burnout. Neuroscience research shows that different pathways in the brain are involved in personal distress and empathic concern.[16]

Experiential learning[17] and role models have been used to enhance emotional empathy and learn emotional regulation.[18] Students can learn the importance of retaining self-other differentiation since although empathy should involve deep engagement with the patient , this does not mean the student loses sight of where the self ends and the other begins.[2] In empathy the student is emotionally engaged with the patient and at the same time is able to reflect on these emotions, knowing that they originate in the other person.[12] Mentoring offers an opportunity to reflect on emotional regulation.[19]

Mindfulness training,[20] narrative medicine,[21] medical humanities,[22] and reflective writing[23] are training initiatives that can help students to learn a broad form of empathy. Neuroscience research shows that brief interventions using meditation techniques induced brain responses and promoted pro-social behaviours in response to the suffering of others.[24–26] These changes suggest increased resilience and a greater capacity to attend to the suffering of others. So fears of the harms of 'too much' empathy may not be justified, acquisition of empathic skills could increase rather than decrease the emotional stability of the doctor.[24–26] Furthermore, it appears it is the suppression of emotions, rather than emotional connection, which leads to the doctor's detachment and eventually to burnout.[27,28]

Yes we can: teach empathic behaviour (behavioural dimension)

Viewing empathy as a behaviour has generally been taught by a range of communication skills courses which have demonstrated increases in empathy.[11] Students can learn appropriate body language, phrases and open questions which suggest empathy but do not necessarily lead to 'genuine' empathy.[29] OSCE exams may not increase 'genuine' empathy since in these situations students are often inward looking rather than adopting the outward perspective integral to empathy.[30,31] If empathy is viewed simply as a performance rather than as a deeply held commitment there is a risk that it may become limited to patients similar to oneself rather than to all patients.[29]

Yes we can: teach ethics (moral dimension)

We share a basic human need to be valued and recognised by others; a need for empathy.[32] Empathy forms the cornerstone of care ethics and drives altruism.[33,34] Empathy involves capacities of moral sensitivity, both of opening oneself to the subjective experience of others and getting judgements about their experience right.[33] Hilfiker suggests that the fundamental goal of teaching medical ethics is to enhance empathy.[35]

Yes we can: explore the limits of empathy

Macnaughton argues that empathy may be dangerous, but conflates the construct with identification.[36] Although we cannot know exactly what it feels like to be another person an empathic doctor strives for empathic accuracy. Macnaughton suggests saying 'I know how you feel' shows empathy, but such a self-orientated view is characteristic of sympathy rather than empathy.[36] Downie describes a narrow cognitive view of empathy and calls instead for 'engaged attention', which is really a part of broad empathy.[37]

Yes we can: support and empathise with students and doctors

Student and physician wellbeing is related to their empathy and depends on the opportunity to reflect on one's feelings and vulnerabilities. All students and doctors need time to discuss these issues with their colleagues and mentors. We need to interrogate biomedical paradigms to appreciate that any observation and understanding in medicine is already interpreted and situated.[3]

Medical schools must create a learning environment that respects the integrity and authenticity of their students and nurtures them as professionals and as people.[28] How can we expect students to be empathic if they are not treated with empathy from their medical school?

Yes we can: change the medical culture

Medicine has adopted a positivist view that prioritises technology, hierarchy and evidence-based interventions which risks viewing patients as objects of intellectual interest.[38] The medical culture does not acknowledge a need for a doctor to share and process their feelings.[28,39] Empathy should be seen as essential, not something 'nice' but irrelevant to 'real' medicine. The medical culture has more influence in teaching empathy than the efforts of a single positive role model.[29] To respond to Francis' call for a culture change, a change is needed in attitudes to recognise the importance of working with emotions in the doctor–patient relationship.[5,29]

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Culture change also requires removing the barriers to empathy in the formal and hidden curriculum.[3] Competition, harassment, bullying and hierarchies can threaten empathy development.[40,41] The balance between the scientific biomedical parts of the curriculum and the psychosocial elements needs to be redressed.[3] The strong emphasis on the biomedical has a distorting effect which creates a gap between the doctor's and patient's way of understanding.[3] Pedersen suggests that this could be addressed by looking at situations where the biomedical paradigm is clearly insufficient in patient care, e.g. end of life care.[3] Medical teachers also need to have time to teach and for their efforts to be recognised and valued by the administration.[3]

Yes we can: teach empathy

Medical schools have a responsibility to educate their students in a humane empathic way.[28,43] Students can learn that their wellbeing is critical for their empathy and so for their education.[28] Empathy requires practice and there is no substitute for patient contact from an early stage in the course.[44,45] Students want to empathise with patients and their teachers need to build on their willingness.[46] Although the current literature on teaching empathy is hampered by conceptual confusion and methodological weakness, a review of ten rigorous studies supports the notion that empathy can be enhanced by teaching.[47] Students and doctors can learn that empathy is neither detachment nor immersion but an iterative relational process of emotional resonance, reciprocity and curiosity about the meaning of the clinical situation for the patient.[29]

Although the current literature on teaching empathy is hampered by conceptual confusion and methodological weakness, a review of ten rigorous studies supports the notion that empathy can be enhanced by teaching.[47] Students and doctors can learn that empathy is neither detachment nor immersion but an iterative relational process of emotional resonance, reciprocity and curiosity about the meaning of the clinical situation for the patient.[29]

REFERENCES

1 Coplan A, Goldie P. *Empathy Philosophical and Psychological Perspectives*. Oxford: Oxford University Press; 2011.
2 Jeffrey D. Clarifying empathy:the first step to more humane clinical care. *Br J Gen Prac* 2016; 66: 101–2. http://www.dx.doi.org/10.3399/bjgp16X683761
3 Pedersen R. Empathy development in medical education – a critical review. *Med Teach* 2010; 32: 593–600. http://www.dx.doi.org/10.3109/01421590903544702
4 Derksen F, Bensing J, Lagro-Janssen A. Effectiveness of empathy in general practice: a systematic review. *Br J Gen Prac* 2013; 63: e76¬–84. http://www.dx.doi.org/10.3399/bjgp13X660814
5 Francis R. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary*. London: The Stationery Office; 2013. http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/report (accessed 9/5/16).
6 Health Service Ombudsman. *Care and Compassion? A Report of the Health Services Ombudsman on Ten Investigations into NHS Care for Older People*. 2011. http://www.ombudsman.org.uk/care-and-compassion/home (accessed 9/5/16).
7 Coulehan J, Williams PC. Vanquishing virtue: The impact of medical education. *Acad Med* 2001; 76: 598–605.
8 Neumann M, Edelhauser F, Tauschel D et al. Empathy decline and its reasons: a systematic review of studies with medical students and residents. *Acad Med* 2011; 86: 996–1009. http://www.dx.doi.org/10.1097/ACM.0b013e318221e615
9 Hojat M, Vergare MJ, Maxwell K et al. The devil is in the third year: a longitudinal study of erosion of empathy in medical school. *Acad Med* 2009; 84: 1182–91. http://www.dx.doi.org/10.1097/ACM.0b013e3181b17e55
10 Batt-Rawden SA, Chisolm MS, Anton B et al. Teaching empathy to medical students: an updated, systematic review. *Acad Med* 2013; 88: 1171–7. http://www.dx.doi.org/10.1097/ACM.0b013e318299f3e3
11 Stepien KA, Baernstein A. Educating for empathy. A review. *J Gen Intern Med* 2006; 21: 524–30.
12 Halpern J. *From Detached Concern to Empathy: Humanizing Medical Practice*. New York: Oxford University Press; 2001.
13 Morse JM, Anderson G, Bottorff JL, et al. Exploring empathy: a conceptual fit for nursing practice? *Image Journal Nurs Sch* 1992; 24: 273–80.
14 Batson CD, Ahmad N, Lishner DA. Empathy and altruism. In: Snyder CR, Lopez SJ, editors. *The Oxford Handbook of Positive Psychology*. New York: Oxford University Press; 2002: p.485–98.
15 Sulzer SH, Feinstein NW, Wendland CL. Assessing empathy development in medical education: a systematic review. *Med Educ* 2016; 50: 300–10. http://www.dx.doi.org/10.1111/medu.12806
16 Decety J, Ickes W. *The Social Neuroscience of Empathy*. London: MIT Press; 2011.
17 Wilkes M, Milgrom E, Hoffman JR. Towards more empathic medical students: A medical student hospitalization experience. *Med Educ* 2002; 36: 528–33.
18 Winseman J, Malik A, Morison J,et al. Students' views on factors affecting empathy in medical education. *Acad Psychiatry* 2009; 33: 484–91. http://www.dx.doi.org/10.1176/appi.ap.33.6.484
19 Jeffrey D. *Medical Mentoring: Supporting Students, Doctors in Training and General Practitioners*. London: Royal College of General Practitioners; 2014.
20 Krasner MS, Epstein RM, Beckman H et al. Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. *JAMA* 2009; 302: 1284–93. http://www.dx.doi.org/10.1001/jama.2009.1384
21 Charon R. Narrative medicine - A model for empathy, reflection, profession, and trust. *JAMA* 2001; 286: 1897–902.
22 Shapiro J. Walking a mile in their patients' shoes: Empathy and othering in medical students' education. *Philos Ethics Humanit Med* 2008; 3: 10–21. http://www.dx.doi.org/10.1186/1747-5341-3-10
23 McDonald P, Ashton K, Barratt R et al. Clinical realism: a new literary genre and a potential tool for encouraging empathy in medical students. *BMC Med Educ* 2015; 15: 112. http://www.dx.doi.org/10.1186/s12909-015-0372-8
24 Preusche I, Lamm C. Reflections on empathy in medical education: What can we learn from social neurosciences? *Adv Health Sci Educ Theory Pract* 2016; 21: 235–49. http://www.dx.doi.org/10.1007/s10459-015-9581-5

25 Klimecki OM, Leiberg S, Lamm C et al. Functional neural plasticity and associated changes in positive affect after compassion training. *Cereb Cortex* 2013; 23: 1552–62. http://www.dx.doi.org/10.1093/cercor/bhs142
26 Leiberg S, Klimecki O, Singer T. Short-term compassion training increases prosocial behavior in a newly developed prosocial game. *PloS One* 2011; 6: e17798. http://www.dx.doi.org/10.1371/journal.pone.0017798
27 Jennings ML. Medical student burnout: Interdisciplinary exploration and analysis. *J Med Humanit* 2009; 30: 253–69. http://www.dx.doi.org/10.1007/s10912-009-9093-5
28 Kearney MK, Weininger RB, Vachon ML et al. Self-care of physicians caring for patients at the end of life: "Being connected...a key to survival". *JAMA* 2009; 301: 1155–64. http://www.dx.doi.org/10.1001/jama.2009.352
29 Shapiro J. The Paradox of Teaching Empathy in Medical Students. In: Decety J, editor. *Empathy: From Bench to Bedside*. New York: MIT Press; 2012. p.275–90.
30 Grosseman S, Novack DH, Duke P et al. Residents' and standardized patients' perspectives on empathy: Issues of agreement. *Patient Educ Counsel* 2014; 96: 22–8. http://www.dx.doi.org/10.1016/j.pec.2014.04.007
31 Case GA, Brauner DJ. Perspective: The doctor as performer: a proposal for change based on a performance studies paradigm. *Acad Med* 2010; 85: 159–63. http://www.dx.doi.org/10.1097/ACM.0b013e3181c427eb
32 Sherman JJ, Cramer A. Measurement of changes in empathy during dental school. *J Dent Educ* 2005; 69: 338–45.
33 Maxwell B. *Professional Ethics Education: Studies in Compassionate Empathy*. New York: Springer; 2008.
34 Noddings N. Caring: *A Feminine Approach to Ethics and Moral Education*. Berkeley, CA.: University of California Press; 1984.
35 Hilfiker D. From the victim's point of view. *J Med Human* 2001; 22: 255–63.
36 Macnaughton J. The dangerous practice of empathy. *Lancet* 2009; 373: 1940–1.
37 Downie R. Paying attention: Hippocratic and Asklepian approaches. *Advances in Psychiatric Treatment* 2012; 18: 363–8. http://www.dx.doi.org/10.1192/apt.bp.111.00930
38 de Zulueta P. Compassion in 21st century medicine: Is it sustainable? *Clin Ethics* 2013; 8: 119–28.
39 Coulehan J. Viewpoint: Today's professionalism: engaging the mind but not the heart. *Acad Med* 2005; 80: 892–8.
40 Musselman LJ MH, Reznick R, Lingard LA. 'You learn better under the gun': intimidation and harassment in surgical education. *Med Educ* 2005; 39: 926–34.
41 Marshall R, Bleakley A. The death of Hector: pity in Homer, empathy in medical education. *Med Humanit* 2009; 35: 7-12. 10.1136/jmh.2008.001081
42 Ross MT, Macrae C, Scott J et al. Core competencies in teaching and training for doctors in Scotland: a review of the literature and stakeholder survey. *Med Teach* 2014; 36: 527–38. http://www.dx.doi.org/10.3109/0142159X.2014.907879
43 Bayne HB. Training medical students in empathic communication. *Journal for Specialists in Group Work* 2011; 36: 316-29. http://www.dx.doi.org/10.1080/01933922.2011.613899
44 Schwartzstein RM. Getting the right medical students—nature versus nurture. *N Engl J Med* 2015; 372: 1586–7. http://www.dx.doi.org/10.1056/NEJMp1501440
45 Ahrweiler F, Scheffer C, Roling G et al. Clinical practice and self-awareness as determinants of empathy in undergraduate education: A qualitative short survey at three medical schools in Germany. *GMS Z Med Ausbild* 2014; 31. http://www.dx.doi.org/10.3205/zma000938
46 Tavakol S, Dennick R, Tavakol M. Medical students' understanding of empathy: a phenomenological study. *Med Educ* 2012; 46: 306–16. http://www.dx.doi.org/10.1111/j.1365-2923.2011.04152.x
47 Kelm Z, Womer J, Walter JK et al. Interventions to cultivate physician empathy: a systematic review. *BMC Med Educ* 2014; 14: 219. http://www.dx.doi.org/10.1186/1472-6920-14-219

EDUCATION

Can empathy be taught?

R Downie

INTRODUCTION

The term 'empathy' is in widespread use both in ordinary conversation and as a technical term in palliative care, social work, psychology and psychiatry. But it is unclear what it means. The term was first introduced in a theory of aesthetics around 1900, but is now taken to mean that after special training doctors and others can be taught to feel what patients are feeling. This is a widespread and dangerous illusion, as is the connected view that the humanities can be used to develop empathy. In fact the attempt to experience the patient's feelings may cloud the doctor's practical judgments.

WHAT IS 'EMPATHY'?

Before we can consider whether empathy can be taught, we must be clear what it is, or indeed whether it is possible. This is not straightforward. 'Empathy' did not exist before about 1900. The word was a foreign import, a translation via Greek of the German 'Einfühlung'. The context for the import was a theory in aesthetics, to the effect that we can appreciate a work of art empathically by projecting our personality or our emotions into it. This is the reverse of what is currently meant by the term. Like other foreign imports, animal and plant, the word has spread widely and colonised more familiar words and ideas. Indeed, it is now commonly used in ordinary and journalistic speech. For example, people say or write, 'I have empathy with your position' and just mean 'I agree with it' or 'I understand where you are coming from'. In other ordinary life contexts, empathy seems to mean much the same as compassion or sympathy. For example, we might be said to empathise with a friend after a bereavement and mean that we convey our sympathy. Now if empathy is just another name for sympathy then there is no need to teach it because we all (psychopaths excepted…) have the capacity to respond to tears and laughter.

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But there is a large literature devoted to developing 'empathy' as a technical term and providing measurement scales. Presumably it is this technical sense of empathy some consider worthwhile to explain and teach in a medical context. But what more precisely is that technical sense? There seems to be no single definition of it. Most definitions involve the point that empathy enables us to feel what someone else is feeling, but others extend the definition to include the idea that we should be able to communicate our empathy to the other person. I shall quote just one definition by writers much respected in palliative medicine. Colin Murray Parkes et al. state that:

> Empathy involves being able to sense accurately and appreciate another's reality and to convey that understanding sensitively.[1]

This definition seems to have two elements: Empathy requires that we can feel what someone else is feeling – we must 'sense accurately'; it also requires us to 'convey that understanding sensitively'. I shall discuss these in reverse order. If empathy requires the sensitive communication of information then no one could object. It is indeed desirable to stress the word 'sensitively', which makes the point that good communication must be more than a mechanical recitation of the risks and possible side-effects of treatments. But the definition seems to be suggesting more than that – it is suggesting that we convey our understanding of the patient's feelings. This leads to the most important point of the definition – empathy requires sensing 'accurately' what someone is feeling. This seems to me to be highly problematic. How can we ever be sure that what we are feeling is similar to what another person is feeling or thinking? Perhaps it is just what we ourselves might feel or think in that situation. As Adam Smith puts it:

> As we have no immediate experience of what other men feel, we can form no idea of the manner in which they are affected, but by conceiving what we ourselves should feel in the like situation.[2]

Or, as Jane Macnaughton puts it:

> It is potentially dangerous and certainly unrealistic to suggest that we can really feel what someone else is feeling […] Any mirroring of feeling will always differ quantitatively and qualitatively from that patient's experience.[3]

Indeed, there is something not a little patronising in the suggestion that during a consultation one's physician can 'sense accurately' what one is feeling. Even one's nearest and dearest can get it wrong!

It seems to me then that empathy is a highly problematic concept. The problem is that the central element in the definition – being able to feel what someone else is feeling – may not be possible or may mislead. Acceptable elements in some definitions of empathy are best expressed in more familiar terms, for example concerning sensitive communication.

DO 'FEELINGS' OR 'EMOTIONS' HAVE A ROLE IN THE CONSULTATION?

The suggestion that empathy can be taught presupposes that feelings are important in medical practice. Two questions are raised by this presupposition:

1. How important is it for a doctor to have feelings in a professional context?
2. How important is it for a doctor to be able to recognise feelings in a patient?

First, then, doctors will of course have concern for their patients and be aware of signs of distress. But medicine is essentially a practical activity, and the concern will be expressed practically via sensitive discussion and agreed treatment. Feelings require to be damped down or they may get in the way of sound clinical judgment and treatment. In an analogous way a musician may be playing a concerto full of emotion, but the performer's attention must be outward to the music and conductor and not inward to their own emotions - or they might lose the place! The emotion is expressed practically via the fingers. Similarly, the doctor's feelings must be transformed into practical activity or they will get in the way of the consultation. There is a downside to this for the doctor which I shall touch on later.

Second, we can all recognise the body language or facial expressions of many common emotions. This ability can be developed and might be useful in at least some branches of medicine, and other areas such as police interrogation. But this is not a matter of empathy, of feeling what the patient is feeling, but rather of the recognition and interpretation of facial and bodily expressions. Enthusiasm for this alleged skill must of course be tempered by recalling the words of Shakespeare in *Macbeth*:

> Duncan: There's no art
> To find the mind's construction in the face
> …
> [Enter Macbeth][4]

CAN THE ARTS AND HUMANITIES MAKE US MORE EMPATHIC?

It is sometimes said that the arts and humanities can make medical students more humane, and perhaps more empathic. Sir Kenneth Calman and I can take a little credit for promoting the idea of including optional humanities components in the medical curriculum. But we did not think that the humanities make people more

humane, far less empathic. As an unscientific approach to evidence on this, I consider my former colleagues who have obviously spent much time studying the humanities. Are they more humane or empathic than my medical colleagues? I don't think so! What then can the arts and humanities offer?

A great deal can be said on this,[5] but I shall mention just two contributions the humanities can make. First, they can suggest wider perspectives. Medicine is by its very nature narrowly focused and doctors must learn to use their skills in painful and upsetting consultations and treatments. As I suggested above, they should modify any emotions caused by awareness of the distress of the patient because emotions may cloud judgment. But the inhibition of spontaneous emotion can have deleterious effects over a lifetime. An interest outside medicine can help here. This can, but need not, be an interest in the humanities or the creative or performing arts. A doctor once said to me that I worked in an ivory tower while he worked in the dust of the arena. True, but from a tower it is possible to view the world from different perspectives. It is sometimes good to get out of the arena. Secondly, and connectedly, the humanities can offer a critique of medicine, its methods and its concepts. It is good that this journal is allowing a critique of the concept of empathy.

My conclusion then is that empathy cannot be taught. Taken in its technical sense, it is impossible to realise this goal as we can only experience our own feelings and not those of another person. It is undesirable to attempt to teach it, as a concentration on emotions can mislead, blind judgment and lead to bad outcomes. There are acceptable elements sometimes included in the concept of 'empathy' but these are best conveyed by more familiar ideas such as a sympathetic and friendly manner and good communication. To mitigate this negative conclusion I shall finish with a quote from Thurstan Brewin who was a distinguished consultant in palliative medicine:

> The ability of one person to lend strength to another…is a mystery that nobody entirely understands. But, for my money, in medical situations – especially advanced cancer – being natural and friendly has a lot to do with it. Look at the way some hospital cleaners and porters boost the morale of frightened patients. Do they have special understanding, spiritual inspiration, or powers of leadership? Not usually. How many communication and counselling courses have they attended? None. They are just natural and relaxed with friendly good humour and no awkwardness or embarrassment…[6]

And no attempt at empathy!

REFERENCES

1 Parkes CM, Relf M, Couldrick A. *Counselling in Terminal Care and Bereavement*. Leicester: BPS Books, 1996. p. 58.
2 Smith A. *The Theory of Moral Sentiments*. Raphael DD, Macfie AL, editors. Oxford: Clarendon Press, 1976. p. 9.
3 Macnaughton J. The dangerous practice of empathy. *Lancet* 2009; 373: 1940–1.
4 Shakespeare W. Macbeth, Act 1, Scene IV.
5 Downie RS, Macnaughton J. *Bioethics and the Humanities*. Abingdon: Routledge-Cavendish, 2007.
6 Brewin T. *The Friendly Professional*. Eurocommunica Publications: Bognor Regis, 1996. p. 76.

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