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"Isn't There Anything More You Can Do?": When Empathic Statements Work, and When They Don't

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Abstract

The query, "Isn't there anything more you can do?" represents a classic informational question with an emotional subtext. In our previous work we have emphasized the value of noticing the emotional cue implicit in this question, and responding with an empathic statement. Yet responding explicitly to patients' emotions is not the best initial communication strategy for all patients. In this paper we discuss four different opening communication strategies—verbalize empathy, exchange information, contain chaos, respect searching—for patients who ask, "Isn't there anything more you can do?"

Case

Your inpatient palliative care team was consulted to discuss goals of care with a 45-year-old patient with metastatic colon cancer. The patient was hospitalized for a pain crisis yesterday, and a CT shows substantial progression on 3rd line chemotherapy. The medicine team resident tells you that the patient's functional status has dropped precipitously in two weeks, so that the patient has been mostly on the couch at home. After you introduce yourself, the patient asks: "Isn't there anything more you can do?" The resident accompanying you says, "There is always something more we can do." The patient frowns and says, "No, I don't mean more pain medicine. I mean something you can really do—to stop my cancer."

Introduction

The query, "Isn't there anything more you can do?" represents a classic informational question with an emotional subtext. Many clinicians would respond to this question at face value by describing further treatments of limited efficacy. In our previous work we have emphasized the value of noticing the emotional cue implicit in this question, and responding with an empathic statement that responds explicitly to the emotion.[1,2] We distinguish empathic statements that are explicit and verbal from other kinds of empathic responses, such as a nonverbal touch[3] or a comfortable silence.[4] While patients and experts agree that a clinician's ability to see a situation through the perspective of another person is important,[5,6] there are critics who challenge the importance of verbal empathic statements. Empathic statements, in this view, are not wanted or needed by all patients.[7,8] For example, one study reported more patient interest in technical biomedical information or in evidence of physician competence;[9] anecdotally, occasionally patients respond to empathy with anger or sarcasm.

How can a palliative care clinician—or any clinician facing a patient with a life-threatening illness—know when verbal empathic statements will facilitate a difficult conversation, know to avoid them when they might be counterproductive, know when to delay addressing emotion until later? In our experience, verbal empathic statements usually make difficult conversations flow better. But there are a few situations in which verbal empathic statements don't help in the initial phases. In this paper we provide illustrations of cases when verbal empathic statements were useful and not useful, using the query, "Isn't there anything more you can do?" as an example.

Scenario 1: Verbal Empathy Creates a Moment of Insight

Suppose the patient is a male human resources manager, who makes a living by matching people with jobs that match their talents and aptitudes. When he said, "Isn't there anything more you can do," the clinician recognized the emotional cue, and responded with a verbal empathic statement: "I can see this isn't what you were hoping for." The patient said, with urgency in his voice, "You bet this isn't what I was hoping for—I thought I would have more time." The clinician paused to allow him to continue 'thinking out loud.' The patient's eyes filled with tears, he looked down, and said, in a

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more reflective tone, "Maybe this ***is*** it." In this case, the clinician's empathic response, and pause, created a moment of self-reflection for the patient that opened the door for the clinician to ask, "So if you don't have quite as much time as you hoped for, what's important for you to be doing now?"

What has happened in this moment of self-reflection is a paradigmatic example of how verbal empathy can create the environment for a patient to touch more deeply into their own lived experience, and to use that as the basis for sound medical decision making. The clinician recognized an emotional cue, responded by verbally acknowledging the emotion, and paused while the patient reached a new level of self-understanding.[10] Note that the clinician did not need to confront the patient to reach the self-understanding; the patient did a great deal of the work himself, in a 'reflective space' created by a skilled clinician—work that the patient probably could not have done on his own.

Scenario 2: Exchanging Information Takes Priority

Suppose the patient is an aerospace engineer, who is responsible for the lives of people who fly in the airplanes she helps build through the structural data analyses she conducts. When she says to the clinician, "Isn't there anything else you can do?" the clinician says (again), "I can see this isn't what you hoped for." She says, "No of course not. But I want to know, What's the data about 4th line chemo for my kind of cancer?" In this case, the clinician takes a different tack, and says, "Here's what your oncologist told me—that the 4th line regimens have response rates of less than 10%, and have not been shown to improve survival." The patient looks down, her eyes fill with tears, and she says, "Ok, that's what I read too. I just wanted to have someone confirm it." The clinician says, "That must have been hard to read." She replies, "Well, the data is the data—that's what we say in my business. So now what do I do?"

What happened in this moment was fundamentally an information exchange. The clinician started by noticing the emotional cue implicit in "Isn't there anything you can do," made the same verbal empathic statement as in the previous case ("I can see this isn't what you hoped for")—but the patient reacted in an entirely different way: She made another information request. So the clinician follows the patient's lead and responds to the request for information rather than making another verbal empathic statement.[11] Notably, the clinician provides data without applying it to the patient's situation, knowing that this data-savvy patient will want to do that for herself. Thus the clinician creates a reflective space with information. She put the empathy in the background because the patient is ready to be engaged through information ("That must have been hard to read" implies that both the patient and clinician would have found the information sad).

Scenario 3: Containing Emotional Chaos Takes Priority

Suppose the patient is an unemployed woman with a long addiction to cocaine and many primary care notes describing nonadherence to medical plans. She fired her first oncologist for suggesting that she enter rehab. This patient also says, "Isn't there anything else you can do?" When the clinician responds with. "I can see this isn't what you hoped for" she says, "If these doctors could only see how much I deal with!" Pointing at the clinician, eyes blazing, she says, "I thought you would be different but you're no better than the rest. You are giving up on me because I can't pay. I ***know*** there is something better you can do!" The clinician tries again to be empathic and says, "I wish there was something I could do." In response, the patient becomes ***more*** agitated, retorting, "I'm going to go somewhere else where they can really help me!" Then she bursts into tears, throws the blankets and pillows off the bed, and yells, "Get away from me!" The clinician realizes that more verbal empathy will be counterproductive—so picks up the pillow off the floor and says, "Let's take a deep breath, and talk about where we really are. I am on your side and we can get through this. How about this—I will come back later today and we can talk again. I will help you figure out the best thing to do."

What happened in this encounter is that the clinician encountered a patient who has some awareness of her situation—set within maladaptive coping skills, chaotic emotions, low trust in medical clinicians, and high impulsivity. When the patient asked, "Isn't there anything more you can do?" the clinician responded with an empathic statement—and got a firestorm of anger and accusation. To the clinician, the anger is data that verbal empathy actually increased her emotional intensity. So the clinician switched to a containment strategy as an initial step—a series of statements demonstrating her willingness to work with the patient, outlining a process for making decisions—and if needed, delineating boundaries for reasonable behavior. The containment strategy in this scenario is aimed at maintaining engagement with a patient whose emotional volatility, once started, tends to spiral out of control. Realizing this, the clinician still draws on her ability to see the patient's perspective, but does not make verbal empathic statements that highlight the role of emotion. Defusing the volatility is a necessary step for further work to proceed.

Scenario 4: Respecting the Search Comes First

Finally, suppose that the patient is a writer who is prized for his intellectual prowess, who has been seeing both an oncologist at your medical center and another in New York City. He's well connected and knowledgeable. When he says, "Isn't there anything else you can do?" and the clinician responds with, "I can see this isn't what you hoped for," he says, "Thank you so much. I've got lots of support. Where I need your experience is thinking about what else I might consider to treat my cancer. I know about the NCI's Phase 1 trials, FDA, and their approval process for new drugs. But I'm willing to think out of the box. It's my life, after all." The clinician says, "You want something out of the box for a tough situation." The patient says, "That's right. I've been talking to people in Germany. Perhaps you know them?" The clinician replies, "What if there isn't the solution you're looking for?" The patient says, "I'm not at that point." The clinician says, "If you are thinking seriously about going to Germany, and there is a clinician who wants to communicate with me, I'd be happy to talk to them by phone or email."

What happened here is an encounter between the clinician and a patient who tends to intellectualize. After the clinician's initial verbal empathic statement, "This isn't what you hoped for," the patient responded with his agenda. His agenda is that he thinks that there must be something else ('out of the box') that would slow his cancer, and is willing to conduct an exhaustive, worldwide search. This searching behavior,

combined with an unwillingness to talk about his current situation, represents a kind of rigidity in his coping. In our experience, this is perhaps the most difficult situation—not only because these patients can be resolute in their determination to keep searching, but also because their intellectual curiosity, and our admiration for their curiosity and accomplishment, draws us in. The problem becomes apparent when it becomes evident that intellectualization is the patient's only way of coping (because many patients do some of this). In our experience hyper-intellectual coping is most often a way of avoiding a reality that is messy and disappointing. Thus, the clinician might initially engage in discussions about the search, but later would intentionally move the conversation towards more relevant and more emotionally charged topics.

How Verbal Empathy Enables Clinicians To Navigate Rigidity and Chaos

These four examples represent examples of how a clinician uses verbal empathic statements coupled with the conversational data in the patient's responses to create a way to move a conversation about goals of care forward. The first and second cases represent the situations we see most commonly. The human resources manager responded to an empathic statement with self-reflection and a new level of insight. The engineer responded to an empathic statement with a straightforward request for information. The third and fourth cases represent situations we see less commonly. They represent complex situations in which we initially set verbal empathy aside. For the third patient, empathic statements triggered more emotional chaos that responded to containment. For the fourth patient, empathic statements initially seem irrelevant to his all-consuming search. For these patients, clinician empathy is still evident in gestures, pauses, and alignment—and critically important, because these patients don't trust their emotions and with good reason. The third patient's low emotional self-regulation means that she easily pushes herself into emotional chaos. The fourth patient's aversion to emotions leads to a rigid focus on things that don't involve emotion.

We believe that verbal empathy is still the single most useful initial strategy for goals of care conversations because it can perform a lot of conversational work (and we explain this in a forthcoming companion paper)—and how patients respond to verbal empathy provides data that points us to the alternative communication strategies we describe here. These strategies are built around a conceptual framework of adaptation to illness represented by a continuum drawn from interpersonal neurobiology of chaos to rigidity.[12] Our first two cases depict patients who fall towards the middle of the continuum, where they often have substantial personal resources and resilience. Our third and fourth cases depict patients more towards the extremes of chaos and rigidity. Readers familiar with psychological literature will recognize that these concepts derive from a large body of empirical research in attachment that involves children and adults.[13,14] The first and second patients represent secure attachment; the third represents anxious attachment (resulting in chaos), and the fourth avoidant attachment (resulting in rigidity).[15,16]

The Critical Communication Skill: Tracking Responses

Notably, the clinician in all four of these encounters is the same person. Across these four scenarios she has demonstrated an important skill that is not well articulated in the medical literature—the ability to track the flow of the conversation, what she says, and how her patient responds in real time. While she considers verbal empathic statements as her mainstay strategy, she can switch gears if verbal empathy is not leading to more engagement and insight. In scenario 2, for example, she realized that verbal empathy wasn't working, and she switched to information.

Once the clinician recognizes that verbal empathy isn't working, it takes mental energy to switch to a new strategy. One place we often get stuck is in assuming that we just haven't performed verbal empathy skillfully enough; our internal critic says, "Maybe if your verbal empathic statements were better, the patient would hear you and respond." Sometimes this is true. But after a couple of instances in which verbal empathy doesn't move the conversation forward, we also need to be able to say, "I've tried verbal empathy a couple of times, and it isn't working." At this point the clinician's challenge is to switch to a different strategy, which often means that we need to pause and give ourselves a fresh start.

Sometimes the patient will say explicitly when a communication strategy isn't working. In the second scenario, if the clinician had continued to offer empathy in the face of repeated requests for information, the engineer would have likely disengaged from the encounter. "Are you some kind of psychiatrist?" is the kind of comment we have heard—and in this setting, it's not a compliment.

Caveats for Dealing with Chaos and Rigidity

We view containment as an opening strategy for a kind of patient we encounter infrequently—these patients constitute a small fraction of patients on a busy inpatient service. The containment strategy is required for patients with chaotic emotions, low trust, and high impulsivity, and often they have a history of addiction or borderline personality. The containment strategy is valuable—and it requires clinician self-monitoring. If you find yourself using containment more than once or twice in every 20 patients, the following questions might serve as an instructive reality check: Do I work with a patient population where mental health specialists would assess a high incidence of emotional volatility, low self-regulation, and high impulsiveness are common? In addition, opening with containment is a prelude to trust building work—we are not suggesting that containment continues indefinitely.

Similarly, the respecting searching approach to rigidity is something we use rarely. We find the hyper-intellectuals to be the most challenging group we deal with—as Jung pointed out, this group cultivates a "compartment psychology" in which 'one hand doesn't know what the other hand is doing.'[17]

These strategies work best when used with a light, non-judgmental touch.[18,19] When used out of exasperation, clinicians using containment or nonconfrontation risk coming across as punishment or abandonment. The trust building work that follows requires psychosocial expertise. Given time and phased interventions, the chaotic patients can learn to deal with anxiety and some distance; the rigid patients can learn to handle some closeness, but these patterns rise in prominence during times of stress.[20] Even if lengthy psychosocial intervention is not possible in an inpatient palliative

care setting because of the urgency of a rapidly progressing illness, however, the recognition of these issues may enable clinicians to be more compassionate.[21]

Summary

When entering into discussions about beginning a significant focus on palliative care for a patient with serious illness, the clinician's ability to notice emotional cues and respond with verbal empathic statements is a mainstay communication skill. The real masters of communication, however, track how patients respond, and modulate their initial strategies accordingly.

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