

## EDITORIAL

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### Empathy: A Timeless Skill for the Pain Medicine Toolbox

The timeless appeal of the image of a kindly physician at the bedside, portraying the special relationship of physician and patient sharing an illness experience, transcends more modern images of medicine, such as the masked doctor in scrub suit gloving for a procedure to fix a medical problem, a symbol of the technical isolation of doctor from patient. This empathic relationship, a principal therapeutic tool of the physician in earlier times, is endangered in today's medical culture, opines Dr. John Banja in our Ethics Forum. He carefully examines the value of empathy in medical care, the causes and effects of the loss of empathic expression in the physician-patient encounter, and its particular relevance to the specialty of pain medicine. We, after all, define our specialty by the very suffering for which empathy may provide the only salve when our more modern medical interventions fail to cure chronic pain. Empathy is not sympathy, he emphasizes, but rather our ability to share therapeutically with patients our understanding of their suffering. By virtue of both our unique knowledge about the nature of pain and suffering and our pre-eminent clinical expertise in helping patients manage pain and suffering, shouldn't our core professional attitude be empathic expression? Shouldn't we be the experts, the teachers of other physicians?

Dr. Banja does not suggest that we retreat to an earlier time when we had few technical tools for treating pain. The value of his treatise lies in its exposition of the benefit of empathic expression for the practice of modern pain medicine. We all struggle to define common ground with our patients, to establish therapeutic goals consistent with their inner values and conscious desires. The growing literature on disparities in health care emphasizes not just equal access to quality treatment but providing choices to our patients based on their personal preferences, which to some extent are culturally determined in our multicultural society. When our treatment clashes with their preferences, a successful outcome of treatment is less likely.

Empathic expression improves our chances of understanding these preferences in each of our patients. By doing this well we avoid the scenario

in which our authority, as an expression of our own needs, rather than the patient's true desires and best interests, determines medical care choices. The medical context determines the range of choices. A life-threatening emergency such as crushing chest pain presents only one choice for a patient for whom survival is the only goal of treatment—perhaps which hospital emergency room to attend. A life-threatening illness such as cancer provides many more choices, so that a patient must parse an incredible amount of information about specific treatments and their potential benefits and toxicities, about doctors, hospitals, and whether and to what extent they will continue occupational roles. Chronic pain presents what seems at times to be an infinity of choice. If we as pain doctors assume the role of primary provider for chronic disease management, if we take responsibility for the quality of life of our patients, which may involve a broad array of biopsychosocial outcomes, our task can be infinitely more complex. There are several assumptions we can make with relative confidence. Patients will not come to a pain doctor unless they have some expectation that their pain will be treated successfully. But the desirability of other outcomes may diverge considerably from our own value system. For example, they may not want to try to resume work, fearing a layoff, loss of disability payments, or inability to care for a sick family member at home. They may fear paralysis from surgery, the pain of an injection, or addiction from opioids because of some negative past personal or family experiences. Their personal expectations of cure may be based on biased or even erroneous information propagated by marketing of one treatment or another. Unless we understand these expectations, and discuss them openly, our treatment may be at odds with their priorities, reducing our likelihood of a successful outcome.

Dr. Banja provides specific examples of barriers in our medical culture to empathic communication. These are our familiar whipping horses—not enough time, poor reimbursement for procedures or cognitive skills, decision-making by non-physicians about access to treatments. His description of personal barriers in the clinician is

more threatening. Physicians are accustomed to being effective and to being right. We had to do well in our classes to get into and through medical school and we had to demonstrate competence to complete our training. Patients with chronic pain challenge us because they often have incurable conditions that may resist our most skillful treatments. Clinicians may feel threatened, even weakened, by a patient's expression of pain and suffering. When pain specialists apply hard-earned knowledge and technical skill to ease the suffering of chronic pain, we and our patients and their families hope to be rewarded with a successful outcome. We can take credit for our skill, fulfilling our personal needs, and may be well paid for our efforts. Empathic communication increases the likelihood that patients and their families can participate effectively in planning and implementing treatment. This shared participation increases our chances of achieving an outcome that satisfies all parties. The outcome may not be a cure, but at worst, the successful implementation of the plan and the accumulation of new knowledge about their chronic pain will improve our chances of choosing an effective approach in the future.

Can we train ourselves in empathic communication? Our professional meetings and workshops

tend to teach technical, mechanical skills—how and where to place a needle or titrate a medication, how to effectively bill for our services for maximal reimbursement. These are important to our survival and progress. Yet Dr. Banja suggests that these are not enough for us to be successful. Our identity as a specialty resides not just in the size and contents of our technical toolbox but in our unique attitude and special sense of professional responsibility towards patients with chronic pain and suffering. Once trained in empathic communication, rather than threatening our objectivity, empathic skills will help us and the patient make treatment choices that are more likely to result in effective treatment trials, and ultimately, more satisfactory pain management for both patient and doctor. We can learn much from our primary care colleagues about empathic communication. They teach these skills in medical schools and in residencies. We should invite them to train us in these core skills for our own toolbox, much as we believe we should teach them about new medications for pain control in primary care.

Sincerely,

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### Palliative Care Section

In 2006, we will be starting a Palliative Care Section of the journal under the leadership of Allen Burton, Steven Richeimer, Gil Fanciullo, and Doug Weschules. The decision to organize the Section arose from the observation that there is a paucity of literature on palliative care in the pain medicine literature even though pain medicine specialists often provide palliative care in their institutions. The goal of the section is to encourage the growth of pain medicine in the practice of palliative care. Today, most pain physicians are anesthesiologists and palliative care physicians are oncologists or primary care physicians. This section is an opportunity to enhance the image of pain physicians as committed to the comprehensive care of their patients.

We hope that you will make this section of *Pain Medicine* a success by submitting articles on pain and palliative care.