

Beyond the feeling of empathy. The need for professional behavior

'It is thus plain from what has been said, that in no case do we strive for, wish for, long for, or desire anything, because we deem it to be good, but on the other hand we deem a thing to be good, because we strive for it, wish for it, long for it, or desire it.'

BARUCH SPINOZA

(Ethics Demonstrated in Geometric Order)

INTRODUCTION

Much has been said and is still being said about the physicians' need to express their compassionate and empathy feelings to their patients. Some new study programs intend to cover those attitudes through the reading of medically relevant Great Books, and through the writing of thoughts on disruptive emotional situations or the discussion of conflicting relationships.

The new physicians would be encouraged to be more mature and humanitarian. However, it would be surprising that these brief and isolated activities allowed budding physicians to obtain and practise compassion, and to take hold of those desirable values in our profession. It seems hard to modify the attitudes, the character, or even the individual perspective in a few recitation classes. These activities may not be of great help either for those students who already enter the school of medicine with some sort of possession of those qualities.

It is still difficult to teach and learn the curiosity and the compassionate and empathy feelings; it is much easier to teach and learn the explicit actions in the relationship with the patient, which imply a professional behavior that translates into the patient's feeling of being well treated. These actions may consist of shaking hands with the patient, sitting by his side while talking, looking into his eyes, and paying attention to him. These and other actions are the necessary –or maybe always sufficient– ground for the patient to have a positive experience.

Posed the problem as it is, many could believe it is just a question of leaving aside a feeling such as the empathy, which would require an elaborated and perhaps deep psychology, even at the physician's unconscious level, for a simple list of good manners.

However, such sharp division in fact does not exist; a philosopher like Spinoza claims, as transcribed above (appendix of the proposition IX in Part III of the *Ethics Demonstrated in Geometrical Order*), that (1) *'It is thus plain from what has been said, that in no case do we strive for, wish for, long for, or desire anything, because we deem it to be good, but on the other hand we deem a thing to be good, because we strive for it, wish for it, long for it, or desire it.'*

Perhaps what Spinoza is trying to show us is that if we strive for, wish for, long for, and desire explicit actions of professional behavior, then we can judge what is good, and not the inverted reason that starts with the concept of what is good.

Based on Spinoza's concepts, we will try to prove that the proper professional behavior in the relationship with our patients is highly useful and generates compassionate and empathic feelings, and that these 'rituals' or 'language games' are an intrinsic part of our medical profession.

LANGUAGE GAMES IN THE MEDICAL INTERVIEW

Up to later than the 20th century, the logic considered language as based almost exclusively on its informative or denotative function. However, there are other statements, other 'language games' as called by Ludwig Wittgenstein, with different rules, that are not the ones from Frege's logic. While it is true that scientific discourse language is informative; there are also other languages used to insult, declare, promise, ask, order, etc.

During the course of an interview, when the physician tells his/her patient 'take off your clothes because we're going to check you up', this statement is neither true nor false, neither insults nor declares, or promises, or asks, or argues. When pronouncing it, the sender, in this case the physician, produces an effect on the receiver: he turns that man or that woman into a patient. The physician's statement or 'speech act' can be compared to a game that, as any game, follows very precise rules.

This game could be seen as a theatre play, in which the sender, in this case the physician, should be recognized by the recipients of the message, in this case the patient, and his/her family or the individuals who accompany him/her. Because to be a physician is not a personal quality but a role played in certain circumstances or scenarios, in which the importance of the institutional frame (hospital, office, etc.) emerges. If that same physician (sender) tells a woman (receiver) walking in the street: 'take your clothes off because I'm going to check you up', he will probably be considered a pervert or a madman, even when he is indeed a doctor within the hospital.

In order that a statement of this kind, called 'performative statement' by Austen, be valid, it is necessary that all participants agree on playing or acting, and therefore accept the stated rules of the game; there should be a contract or 'social link', explicit or not, among participants. These rules are observed in the society, even when it is very difficult for participants to explicit them. (2)

On the other hand, as in every game, there are rules that state which moves can be done and which ones are forbidden. If a physician explained the patient the *modus tollens* logic, he would also be considered a madman, since the logic statements belong to a different language game. It would not be unusual that the person in charge of playing the role of the physician in this medical meeting 'game' were a professor of epistemology; in such situation, when he explains the logic to his students, he is playing another 'game', with different rules, in a different institutional framework. Even if one of his students were the very same patient in the medical meeting, the sender's (not a physician now but a professor) and the receiver's role (not a patient now, but a student) would have changed completely; now they play a different role.

To put it in a nutshell, the different language games are autonomous in themselves and heterogeneous with respect to the other, since each of them has its own rules. The physician cannot convince his/her patient with logical arguments to undress; his/her acceptance depends on a tacit agreement on the particular language game between doctor and patient. Nor can the physician validate a logic scientific or denotative proposal with his students, just because he is a doctor.

Medicine seen as a 'language game' places the accepted behavior rules above the feelings. It would give importance to the practice and the capacity of a professional behavior rather than to the development of the character only.

We should place the physician's professionalism and the patient's satisfaction in the core of the clinical meeting, and we should bring back some of the ritual elements that have always been an important part of the healing professions. Moreover, it is well known that medical training is more effective when it deals with learning at the patient's bedside, as in a trade, than in a post-graduate school. The trainee will probably learn more by observing their colleagues' compassionate, attentive and emphatic behavior than by listening to their class discussions on how to do it.

Even when we continue making efforts to develop curious, compassionate and humane doctors, we should not overlook the probably more immediate benefit of emphasizing the 'game' of good professional behavior.

FEELING OF EMPATHY, UNEMOTIONAL?

To our everyday language, feelings and emotions have very blurred boundaries; we even believe feelings are primary and emotions are secondary. When we are sad, for instance, it makes us feel emotional and cry. Sometimes we may have sad feelings, but the circumstances prevent us from showing our grief; then it seems evident that *feelings* are related to our mind and are private; whereas *emotions* are related to our body and are public.

If we look up the term '*feeling*' in the Spanish language dictionary, we will find it means 'the affective mood generated by highly impressive reasons'.

Antonio Damasio clearly expresses that '*emotions play out in the theater of the body. Feelings play out in the theater of the mind... We tend to believe that what is hidden is the origin of what is expressed. Moreover, we know that, as regards the mind, the feeling is what really counts... Our suffering or delightment is based on real feelings. Strictly speaking, emotions are exteriorizations... The core position of feelings confuses the issue of how feelings arise and favors the view that, in a way, they occur first and then are expressed in the emotions. This idea is incorrect...*' (3)

Why, in Damasio's words, the sequence 'feeling precedes emotion' is incorrect? Simply because, in the biological evolution, emotions, which are formed on the basis of simple reactions that may easily promote the survival of an organism (many lives have been saved by the 'fear' or the 'anger' in the adequate circumstances), were selected first and could continue evolving easily in that way.

It is as if nature had decided life was very beautiful and precarious at the same time, even before intelligence and brain existed, and so only the clever beings were able to survive.

If the feeling arises later in the evolution, it is due to the fact that it is necessary that neural networks appear in a clever brain. So, when a 'sad emotion' appears, it is immediately followed by 'sad feelings' and next the brain itself generates cognitive thoughts that normally trigger the sad emotion and the sad feelings. But the process does not end there: the associative learning has linked the ongoing process of the emotions and the cognitive levels (thoughts) in a rich two-way network, where the emotions 'represented' in the brain and not motivated by external sensations have also the power to generate feelings and the type of thoughts learned as suitable to those emotional expressions.

Consequently, certain thoughts evoke certain emotions, the same as certain emotions evoked certain thoughts before.

It is a well-known fact in popular wisdom that emotions generate feelings or thoughts, and it is re-

flected in the saying 'laughter is contagious'; other's laughter makes ourselves laugh and feel happy; when I was a child, my wise father used to make me whistle a gay melody to dispel my fear of walking along a dark corridor during the night, and this turned my fear into confidence. However, feelings or thoughts also generate emotions both in the actors who 'play out' the emotions and in the simulators who, by cheating people, end up cheating themselves.

Damasio claims that: *'My hypothesis, then, presented as a provisional definition, is that a feeling is the perception of a certain state of the body along with the perception of a certain mode of thinking and of thoughts with certain themes.'*

The phrase 'I think I am happy' is an illegitimate proposition, because to be correct it should be 'I feel happy'. Happiness is a feeling of a pleasant body state that we find 'positive and good' in the normative framework of life, and if we do not experience it we have no reason to consider phrases like 'the pleasure of thinking' or 'the intellectual joy' as legitimate.

Clearly, the body is the origin of the perceptions that constitute the core of the feeling, and many of its parts are being continuously mapped in several brain structures, so that the immediate *substrates* of the feelings are the mappings of countless aspects of the body states in the sensory regions designed to receive the signals from the body.

We feel some of these body signals in the form of unpleasant specific pains, when we have a painful bowel contraction or we perceive changes in our heart rate. Also when we experience changes in behavior, called 'appetites' by Spinoza, such as hunger or thirst.

To have a feeling or a sensation such as happiness or pleasure is to perceive the body is in a certain way, and to perceive the body in one way or another requires sensorial maps where neural patterns are exemplified, and from which mental images can be triggered.

But the brain is able to go a step beyond: it may block the way of nociceptive signals (the sensations generated internally by the body, different from the exteroceptive signals coming from the outside), and may determine a 'false' brain mapping (between inverted commas) or, on the other hand, simulate certain emotional body states internally, 'create' (between inverted commas) a brain mapping, as it happens during the process of turning a friendly emotion into an emphatic feeling.

An example of 'false' brain mapping occurs when the brain eliminates the central body maps that permit to experience pain. For instance, in trying to escape from danger, it is of great help for the victim not to feel the pain caused by wounds from a predator's bite or from the obstacles interfering the escape.

The periaqueductal gray substance in the brainstem sends messages that interfere the nervous routes that would normally send injury signals in the

tissues and generate pain, and as a result of this filtering we obtain a 'false' body map. In fact, what we feel is not exactly what we would feel without the wise interference of the brain.

This interference is equal to being injected with morphine, with the characteristic that the brain does it naturally for us. Precisely, one of the varieties of this interference uses morphine analogs, such as endorphines, generated in the body.

Without this interesting trait of our brain, which allowed for the evolution, maybe this same evolution would have suspended the delivery in favor of a less painful form of reproduction.

The brain mapping simulation that turns the friendly emotion process into an emphatic feeling is a mechanism of a variety Damasio has called '*as-if* body loop' system. It entails an internal brain simulation consisting of a quick modification of the current body maps, obtained when the prefrontal cortex directly indicates the brain areas sensible to the body.

These neurons can represent the movements that an individual's brain perceives in other individuals, and can actually perform them. They are present in the prefrontal cortex of monkeys and human beings and they are called 'mirror neurons'.

In both filtering or signal simulation, the brain creates a group of possible body maps that do *not* correspond exactly to the body reality at a certain moment. What is felt, then, is based on that 'false' construction and not in the 'real' body state.

Other studies reinforce this interpretation, such as the ones in normal individuals who subtly and immediately activate the muscle groups in their own faces when seeing photographs about emotions, 'mirroring' the emotional expressions in the photographs.

As Antonio Damasio summarizes, *'the sensitive areas of the body constitute a sort of theater where not only can 'real' body states be 'played out', but also different 'false' body states can be performed, for instance, 'as-if' states, filtered body states, etc. According to recent studies on mirror neurons in both animals and humans, the orders to generate 'as-if' states may come from different prefrontal cortexes.'*

RULES ARE NECESSARY FOR REALITY TO EXIST. BETWEEN THE ANYTHING GOES AND THE NOTHING GOES

One law of Nature involves at least one restriction; in order that the world around us look diverse, creative, and changeable to us, there should be restrictions. The margin of uncertainty, contingency, or chance Nature has the right to has two limits: the *anything goes* and the *nothing goes*.

The reality with no laws is the one in which *anything goes* and everything is chance; it is a reality in which we have weakened the restrictions in such a way that now there are none left. The objects in this

reality would not even be influenced by the neighboring objects; the events do not even depend on their own history.

But the world is not so; if it were, it would have a different appearance, it would be uniform and equiprobable, and it would not be intelligible; nothing and nobody able to ask themselves a single question could exist in it. But since science has already been able to discover many regularities, restrictions and laws that anticipate the uncertainty, we already know it is false to stick to this idea.

When we play a chess game, pieces have allowed or forbidden moves, so these moves have restrictions; thus, it seems to us that there are boundless possible games and that they would belong to the *anything goes* category. However, even though the number of possible games to be played is astronomic, even higher than the number of atoms present in the whole universe, it is a finite number. Each move the player makes sets a new course of the game – many of the moves will not be used – and trillions of possible games are discarded; once the player gets to last but one move of a game, the situation turns into a ‘forced move’, it is the limit situation of checkmate (defeat) or of stalemate (draw), which means that the following move is totally impossible, all moves are forbidden, *nothing goes*, the player loses the game because he cannot maintain himself in the reality of this world.

When everything is restriction, when *nothing goes*, it is possible that one object stays without the minimum chance necessary for its existence. But as reality exists, and the first great hypothesis in science is the hypothesis of the real world, the *nothing goes* is not part of the reality of our world.

Once the *anything goes* and the *nothing goes* are discarded, there remains two possibilities of reality: a reality with restrictions and with a certain amount of chance, in which everything is permitted by law, or a limit-reality, in which everything is law, there is no dose of chance, and behavior is unique.

In this latter case, restrictions are so strong that there is margin for only one thing. There is no margin for choosing or selecting. These laws and principles, which imply a perfect determination, have been highly considered in Physics. Among the countless lines available, only one takes place in reality.

The reality in which what has to occur simply occurs is a reality with determinist laws, where there is no choice or room for chance, in which thinkers such as Einstein, Spinoza or Dostoevsky found comfort. Everything is written somewhere, as Einstein argued in his famous phrase: ‘*I want to know God’s thoughts, the rest are details*’, since he himself claimed that: ‘*God does not play dice*’.

Other thinkers, like Darwin, Boltzman, or even Borges, have felt more comfortable with a reality with certain right to contingency, a reality full of diverging paths, where you can and should choose.

As Jorge Wagensberg points out, (4) ‘*In a few words, the set of basic laws of Nature are halfway point between the two extremes: the ‘nothing goes’ and the ‘everything goes’.* Both extremes are unique cases with intermediate infinities... We have been going around the following question: ‘*Is chance the result of our ignorance or an inherent right of nature? ...and we have already arrived at one of the answers. It is not a question of believing in it or not. Let’s say we accept it as a working hypothesis... Working hypotheses are not true or false; they are reasonable or unreasonable, they work or they do not work. If we accept that a law is a restriction to access or stay in reality, and that law does not cover everything, then there will always be a domain in which speaking about an important concept makes sense: the selection.*’

If we accept these premises, it means there are restrictions in our reality of professional behavior that enables us to be intelligible, but within them we can and must choose the path we want to walk along, and that implies exercising responsibility.

SOME RESTRICTIONS IN THE MEETING BETWEEN THE PHYSICIAN AND THE PATIENT

While it is true that, ideally, we would all deserve a doctor who helped us keep healthy as a result of his professional quality, and his attentive, compassionate and emphatic attitude throughout our life, in fact, most of patients’ complaints refer to inappropriate behavior or to lack of professionalism.

They usually say: ‘he pays no attention to what I say, when I speak, he fixes his gaze on his computer screen and does not look at me’; ‘he does not pay attention to me; he never remembers what I told him’; ‘he does not inspire confidence in me, he is so formal and serious... he never smiles’; ‘he does not remember I already told him several times I have two children’.

Recently, Michael W. Kahn, a psychiatrist from Harvard Medical School, has explained how, during his recent hospitalization, found out that his European surgeon’s Old World-like manners were faultless, such were his clothes, body language, and visual contact; he immediately said to himself ‘what a professional!’, and even ‘what a gentleman!’ He narrates that, no matter what real feelings his physician had had at that moment, his respectful behavior, very attentive and calm, had generated in him a comforting feeling of confidence. (5)

That experience confirmed his belief that medical education and postgraduate training should emphasize these aspects of the physician-patient relationship, which he would call ‘medicine based on the etiquette’, since, as far as he knows, no medical school teaches good manners systematically.

To address the problem of the patients’ satisfaction, he proposes to develop a verification list of the medical ‘etiquette’ for the clinical meeting.

As a variant out of the many variants available, for the first meeting with a hospitalized patient we could use a verification list such as follows:

1. Ask for permission to enter the room and wait for the answer.
2. Introduce yourself, tell your name and last name, and confirm the patient's name and last name ('You are Ricardo Gómez, aren't you?').
3. Always shake hands, even if it is necessary to wear gloves.
4. Get close to the bedside, sit down if possible, and smile if it is appropriate.
5. Briefly explain your role within the team.
6. Ask the patient how he/she feels to be in hospital.
7. Before dealing with the specific problem, try and get in touch with some details of the patient's personal history (name's origin or meaning, favorite activity, number of grandchildren, etc.).

This and other similar verification lists have the great advantage that the items to be followed and proved are concrete and so efficient to teach and evaluate, and also easy to be practised by trainees whose skills at bedside need improvement. It does not refer to how the doctor feels, but just to how he behaves; it is simply a guideline for trainees.

Of course, this list is only an example; it can be modified by the medical teachers in this situation or in a great variety of other clinical situations: behaving at the office, explaining the steps of a study plan, preparing for discharge, telling bad news, and many other situations that may arise from the doctor-patient meeting.

Although these suggestions may sound superficial, think of how a professional pianist is trained. When he starts his career, he does not attend courses about the feeling of the artistic sensibility or the theory of musicality, but instead he learns how to place his hands on the keyboard, which posture is the best, and

how to play and practise the scales. The emotion and the feeling of artistic joy the great pianists express and transmit is expected to be developed during their study and practice periods.

CONCLUSIONS

Medicine based on appropriate professional behavior should first prioritize behaving over feeling, since following the ways to behave generated by the emotions, the compassionate and emphatic feelings will arise by extension. It will give importance to the development of practice, skills, and professional behavior, to allow for the later emergence of character.

It is time that professionalism and patient satisfaction be placed at the core of the clinical meeting and, consequently, bring back those elements from the medical ritual that are an important part of professions like ours, and help heal the suffering disease generates in an individual's personality, who is our patient.

It would be a key contribution along with our effort to educate sensitive, compassionate physicians, able to develop emphatic feelings.

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