Trying: On Teaching Empathy

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A tall doctor I had never met before came into the exam room, did not introduce himself, silently performed an ultrasound, and said "there is no pregnancy in the uterus." When I put my face into my hands he said, "I'll get the nurse" and left. After years of trying and failing to have a baby, through residency, fellowship, and as an attending, this was the farthest I had ever made it. That morning I had been pregnant enough to vomit in the trash can under my office desk and scroll through maternity jeans online before rounds.

I took a cab home and gathered the things I had squirreled away in the closet, a tiny blue polka dot dress, a children's book about a mouse in winter. I went to the hallway and shoved them down the trash chute.

I was in the third year of my internal medicine residency training the first time I remember someone trying to teach me a way to respond to patients' emotions. I rolled my eyes along with everybody else. *This is ridiculous*, I remember thinking. *I don't need to memorize a bunch of corny phrases to say to patients having a hard time*. The attending drew the word NURSE in big letters on the white board and led us through the acronym. Name the emotion, he encouraged us. Express Understanding! Respect what you admire in the patient! Support! Explore! He made us practice sentences on each other from a photocopy: "You seem frustrated." "I can't imagine what it's like to hear this news." As a resident, my plan for dealing with hard situations was to use authentic emotions and respond like a human. My co-residents and rotation evaluations assured me that I was good with people.

My skepticism about the need to teach empathy started to crumble when I became the patient and craved a bare minimum of understanding. I spent early mornings and covert lunch breaks at the fertility clinic. The waiting room walls were covered in giant photographs of flowers in fertile bloom as if they would wear off on us. Orchestral versions of pop songs played calmly over the speakers. Struggling to have a baby in your mid-30s as a physician is an unoriginal story. The clinic reflected this, full of familiar people from the hospital, a GI fellow who was rude on the phone the week before, a radiologist I knew as an intern. We all stared at our phones instead of making eye contact.

There are many variations on the specific bad news that comes with trying to get pregnant with science, and many ways to deliver it, but the punchline is always the same: no baby. There was the nurse who called with my first ever positive pregnancy test after so much trying, but at a level so barely positive that any stranger in the waiting room could tell you it meant imminent failure. "There's still a chance!" she said, so chipper, before hanging up. There was the phlebotomist drawing blood to confirm yet another failed attempt who asked why I was crying while she tightened her tourniquet. When I said that I was probably miscarrying again, she said, "Don't talk like that, the baby will hear you!" Then there was the doctor who visibly avoided eye contact in the hallway moments after sharing the news that the latest embryo had implanted, but in a location probably incompatible with life.

In between visits to the clinic, I was learning to teach communication. In palliative care this is serious business, taught systematically, like learning the steps of a sterile procedure. We spent whole days in small groups, teaching the fellows to notice when a patient has an emotional response that will hijack their ability to process information. We reviewed NURSE and other communication acronyms, drawing them in bright colors on gigantic Post-It notes and sticking them on the walls. The fellows I was training practiced with actors who shouted about hopes for a miracle or begged for more chemotherapy. We scribbled notes and scrutinized missed emotion cues. We refined and perfected their language.

Before rounds many mornings, I left the house at dawn to line up with the other infertile women behind a metal gate, rushing to be first to sign in when the receptionist turned on the lights. On rounds I wrote down the words the fellow used to share information with the patients. In the same back hallway of the oncology unit where I took my own bad news phone calls from the fertility clinic, we went line by line through notes from family meetings. "I like how you started with a warning statement," I would say, "and then you told the news so clearly and explained what it meant."

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NURSE made it possible to function at work with a serum estrogen level 100 times the upper limit of normal, crying randomly without provocation, and hoping no one would notice. "This must be so frustrating," I could say to an angry daughter in the ICU, a little robotic but without needing to think too hard. "I can't imagine what that's like" to the fellow upset in my office about her surprise pregnancy, who hopefully did not notice the envy behind my rehearsed phrase. I tweaked the language my learners used with patients and was tempted to do the same at the fertility clinic.

When the tall doctor at the clinic who did not introduce himself offered to get a nurse to console me rather than try it on his own, I wished I could feed him a line. Can you think of a way to respond when the patient in front of you is devastated after hearing bad news, I could have asked him: How about "you seem upset"? Or "this must be difficult"? Or "I wish I had better news"? Do you want me to write some options on a giant Post-It note and stick it to the wall for next time?

Not everyone from the clinic needed a remedial course in communication. I secretly referred to my favorite reproductive endocrinologist as Dr. Fingernails because of her wild multicolored manicure that probably violated the hospital's guidelines. When it was her voice on the other end of the phone in the hallway, she didn't need any hints. "The results are not what we had hoped for," she said as I paused rounds with my team. Nice warning statement, I wanted to tell her, standing feet away from my fellow who had just used a similar phrase. "This must be so disappointing." The terrible news felt slightly less terrible, and my pounding heart slowed back to normal. We were on the same team.

Now I teach the students and fellows who rotate with me all of the phrases that once made me cringe, and I make them practice on me. This will come in handy sometime, I promise them. Maybe during a long rotation in winter when you haven't seen sunlight for days. Maybe after months of a pandemic when you are exhausted. I think of the people who took care of me, who meant well and didn't mean to be cruel. They just didn't know what to say.

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