Tuyen Pham

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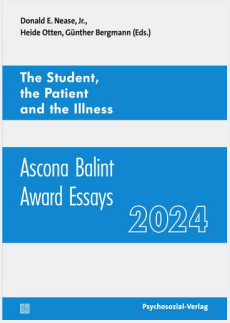

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On the Inconvenience of Empathy

Tuyen Pham

There's a phrase that you may be familiar with if you've ever loitered in a hospital hallway and eavesdropped on the conversations happening between the doctors and the medical students.

"Good signs".

A patient has a "good sign" if they have a clinically discernible finding of their disease that a nervous and inexperienced young student can appreciate. Of course this is quite silly when you think about it because having any signs at all does not bode well for the patients. For medical students, however, "good signs" is music to the ears. You hear a consultant utter the words "bed 24 has good signs" and you're already halfway there, reaching reflexively towards your neck for the stethoscope looped around it. Your fingers are hot and ready on the trigger, eager to plant your stethoscope on that patient's frail chest like it's a flag.

On this particular afternoon I was once again embarking on the eternal hunt for patients with "good signs". I wandered through the maze of hallways like a rudderless boat, each nurse station an island in a sea of floating, faceless patients. They proved as elusive as ever, but as a fresh-faced third-year medical student my search was fuelled by coffee, naivete and an impressive zest for the concrete jungle of hospital life.

Predictably, desperation soon began to erode my enthusiasm. Potential patients turned down my requests for histories one after the other, with many shooting me blank stares or telling me outright that they were sick of students. It was nearing 4 o'clock. The lingering effects of Covid hung over the wards like a muffling blanket, casting weary fatigue into the faces of all the staff members. The next tram home was beckoning me, but I was determined not to leave without having seen a patient.

In a last-ditch effort I decided to finally brave the dementia ward, a floor of the hospital that had felt too intimidating to venture into until now. The first nurse I came across pointed out a cardiac patient nearby with a clear murmur. Jackpot. I set off to find them with a bounce in my step, already thinking through differentials in my head.

I never made it.

Five doors from the patient's room a horrifying, blood-curdling scream stopped me in my tracks. I almost tripped over the carpet in shock. In the room I was passing an elderly woman was stretched out on a mattress, her skeletal hand trembling in the air between us. Pale blue eyes looked straight at me as she cried out.

"Help! Please help!"

I scrambled through the door towards her. My heart was pounding so hard it felt like it would ricochet out of my chest. I was only three weeks into my first ever clinical placement. Was this an emergency? Were there any nurses around? Where was that button?

It didn't take long for me to realise that there was no actual crisis. Not a physiological one, anyway. As I knelt down next to the makeshift bed on the floor and exchanged my first words with the frail woman before me, it became clear that she was only distraught by the staff's ignorance to her cries. She simply wanted someone to acknowledge her for who she was; long-suffering geriatric. Classic dementia case. Dressmaker from Athens. Human crushed alive by the weight of one hundred years.

Woman by the name of Helen.

"What's your name?" she asked, her breath wheezy and shallow.

"My name's Tuyen. It's nice to meet you."

"Tuyen ..."

"That's right."

"I want my daughter." Her hands balled into fists and she slammed them down on the bed with all the force she possessed. "Where is my daughter? She was just here to visit me. I want my daughter back!"

"She'll come to visit you soon. It's okay. She'll be back."

"She will?"

"Yes. She'll be back as soon as she can."

She settled back into her pillow, satisfied for the moment. "Are you a student?"

"Yes. I'm a medical student."

"A medical student." She leaned forward and beckoned me closer. "What's your name?"

"My name?"

"Yes. What's your name?"

"My name's Tuyen."

"Tuyen. That's a nice name," she said. A sudden equanimity passed over her as she looked serenely up at the ceiling. Then she shot upwards.

"I want my daughter!" she screams. "Where is my daughter?"

"She's coming back as soon as she can. She visited you today, didn't she?"

"Yes. She came today. I want her now! Please!"

"I'm sorry, she can't come right now. But she'll be back as soon as she can."

"Alright. Alright. Thank you."

"You're welcome, Helen."

For one hour I sat by her side, holding her veined hands as she oscillated between states of delirium and lucidity. In one breath she would scream out for her daughter; in the next she would cry with gratitude purely because I had taken the time to speak to her. Whenever she slid into that brief penumbra that her condition would occasionally allow her, she would turn to me and ask for my name. Then the pendulum would swing and she would again lapse into confusion. I must have introduced myself a dozen times in that hour.

As I learned how to reassure Helen, I also learned her uncanny quirks. When lucid she was a remarkably funny woman. She hated compliments about how well she looked for her age ("I'm old! I don't want to hear that I'm not old. I don't want the compliment.") and had a great eye for fashion ("This skirt, is it vintage?"). She could name the fabrics my clothes were spun from better than I could.

"Is this silk?" Helen asked me one time, gesturing to my shirt.

I shrugged. "You're the dressmaker. You tell me!"

She rubbed my sleeve between her fingers and wrinkled her nose, almost in disdain at the telltale texture of modern polyester. "It's a blend."

Suddenly Helen lurched upwards with a surprising burst of strength and gripped my wrist. "Be careful of the bad people out there," she told me fiercely. She gestured out the door with a vigorous jerk of her head. Only when I nodded did she settle back into her pillows, a deathly calm settling over her again.

I wondered if she meant to speak of the world in general or if she was referring to those outside her room. From her perspective we were the enemy, faceless strangers who refused to look her way or even acknowledge her existence. But as healthcare workers on the other side of the curtain, we know that there's a different story at play. In an overflowing dementia ward, the clamour of screaming patients was the established hospital soundtrack. The staff were run into the ground, burnt out, stressed and overworked. Every other patient was making un-

reasonable demands, abusing staff or screaming for attention, and at the end of the day it's simply inconvenient to care. Compassion was a finite resource exhausted eons ago, a fossil fuel deemed unsustainable to keep reaching for.

But as I watched nurses shake their heads and roll their eyes to Helen's face, as they stood outside for twenty minutes with their back to her while she pleaded for them to turn around, it occurred to me how scared these dementia patients must feel. Many like Helen only wanted their existence to be acknowledged. Instead they were met with retreating backs. Helen told me that I was the only person who had responded to her in days. No wonder she'd taken to screaming. I was overcome by sadness not only for the patients, but for these people who had been so worked to the bone that they struggled to acknowledge another person in need.

After over an hour I bid Helen goodbye and told her that I would return to visit her soon. In the hallway I discussed the encounter with one of my superiors. His response surprised me.

"Don't enter the room when patients act out like that."

"What? Why?"

"Don't go into the rooms. There's nothing you can do for them."

But had I not experienced the exact opposite? To this day I wonder if I was making a rookie mistake. These patients were unlikely to survive or even remember me. Many would say that I was setting myself up to be hurt. Perhaps sensitivity was a skin that I would shed as I underwent my metamorphosis into a doctor. Perhaps in years I would look back and smile ruefully at my innocence, glad that I aged out of the blissful ignorance of youth.

But perhaps that's just another spoonful of sugar to help the medicine go down. We see enough of that already. You talk to peers about how you feel and they throw thought-ending cliches at you like it's a defensive play. "It is how it is". "That's just the job, isn't it?". This is the way things roll around here. Studies have shown this and studies have shown that. But have studies shown the smile of a 100-year-old woman as she offers you the flowers in her room? Have studies shown the look on her face when you tell her you'll visit again, even though nobody else will?

What studies have in fact shown is that the more we see, the more our empathy reduces. Maybe once you've exited the revolving hospital doors enough times part of your soul gets snagged on the way out. You grow resistant to it the further into the waters you wade. Pulsus paradoxus, not only in the flesh but in the mind.

Around me it was already happening. I could sense the detachment on the lined faces of the other doctors, the way they walked around looking like a beaten

edge. But as a medical student I still inhabited that interstitial space before true responsibility set in where I could spend hours with patients and bask in my own warm-bloodedness. I was determined to remain there for as long as I could.

And so each afternoon I mounted the stairwell to the dementia ward in my best outfit, emotionally bracing for Helen to have forgotten me. To my surprise, although she continued to ask my name, her face would reliably light up in recognition each time I rounded the corner. I would sit cross-legged by her bed as she shared stories, commented on the colour of my earrings and cried for her dead husband. Often we sat in pure silence. In the relentless din of the hospital, we had found a brief window of peace.

Through this I am reminded of the archaic practice of bloodletting; withdrawing blood from our veins in manageable doses for therapeutic benefit. In school we're encouraged to break in our organs. Let them feel something. Haemorrhage those emotions. But medicine dictates that there is a point where the proof of concept intersects with the economics of real life. You see your first few deaths, get a taste of the job and now it's time for the heart to shut up shop. Anything more and it's just an impracticality, an obstacle to vault over by yourself in the shadows of bathroom cubicles and hospital carparks. I'm told it becomes a practised motion after a while.

All this to say, do we really feel as much as we think we do? I watch how humans pass by each other, each of us encased in our own mutinous bag of flesh. So many numbed to the senses, afraid to expose ourselves to the cold bite of life. Conservative management, all the way through. But I scored just past the middle of the bell curve and ended up here by a centenarian's bedside, listening to disjointed tales of Athens and hushing her cries. I'm no medic, but what I know is that people die. They die of disease, of heartache, of pure dumb luck, but also of time. I wonder how long you can lay there on the floor, crying out for the people in front of you to look your way before you start to look away too.

I remember when Helen asked me to meet her daughter, the only child she had not outlived. The next afternoon I slipped away from my ward round early and climbed the stairs to her room, hoping that I'd finally catch her family during visiting hours. Instead of her familiar smile, I was greeted by someone soaping down the blow-up mattress on the floor. The flowers that Helen had offered me were gone from the corner of the room. There was not a trace of her left.

A panicked interrogation of a nearby nurse revealed that she hadn't died but had been discharged early. Although I was grateful for Helen's health, I felt a melancholy pang at having never said goodbye. I wondered if I would ever see her again. If she died, I wondered if I would even know.

Patient death was an idea that I hadn't had to grapple head-on just yet. The closest I'd come was during mandatory dissections in medical school. It was there where I learned the difference between a cadaver and a body donor. A cadaver was a corpse, sourced through various means and not necessarily with the consent of the deceased. A body donor had explicitly and voluntarily donated their body to science. We were told strictly not to refer to the bodies as cadavers. That was not what they were. They were donors who had made a sacrifice to further our learning and they were to be treated as such; with utmost respect.

The cohort was in a buzz before the first dissections began. Many relished the opportunity to prematurely wield scalpels and surgical tools and fulfill their childhood dreams of becoming a surgeon. I, on the other hand, was terrified. I'd never seen a dead body before. I'd never even had somebody close to me pass away. Now not only was I expected to see dozens of dead bodies every other week, I was also expected to cut into one on the first time.

I remember clutching my arms as we walked into that frigid underground laboratory for the first time. Rows of bodies were laid out on their slabs – their beds, as I liked to call them. There was a collective exhale of relief from the group when we realised that the faces of the donors were covered by a sheet. We would be alright today. We'd see their insides, yes. We'd take them apart layer by layer, inspect the texture of their skin, the colour of their blood vessels, but we would not have to look them in the eye. There was a difference there. Interesting how dissecting a body was, well, just that. Looking into someone's face? That was somehow too much. Now there was a curtain to separate us and we basked in the mercy of that detachment.

Starting with the arm, we dissected upwards and moved to the clavicle and the heart. Week by week the sessions slowly evolved from a nerve-wracking, sweat-inducing affair to that other class that we had after lunch on Thursdays. Even I was becoming desensitised to the sight and stench of a dead body in front of me. In my mind the head was not attached to the body. This delusion was what made it achievable.

After a few months the schedules for the upcoming block of dissections were released. We looked through them while we went through handwashing procedures and retrieved our lab coats from the lockers. Lungs next. After that we would move on to the abdomen. That would be unpleasant. Then it was head and neck, and then ... wait, head and neck?

Head and neck?

Head?

And neck?

Until now that ghostly veil hanging over the donor's face was the only thing that was keeping me from spiralling. I was treating them as a body instead of a person. But what would happen when I was finally confronted with their ears, their lips, their eyelashes? This was someone's father, someone's son, and now I had to pull apart their face and swallow the fact that they were dead in front of me?

Immediately I started formulating excuses to skip that session, but there ended up being no need to. In the week before it, forearm-deep in the donor's abdomen, a member of my dissection group accidentally nudged the top half of the body. I was resolutely writing dissection lesson objectives on the whiteboard and trying not to look at the spillage of intestines behind me. My back was turned. Then I heard a scream.

"Tuyen, don't look!"

But it was too late. I'd already spun around and my eyes had fallen on the face of the person whose body I had seen turned inside-out over the past few months. The covering had fallen off, now on the floor, and my classmates recoiled at the sight. To this day the image of those pale, cracked lips and lifeless eyes are burned into my mind. Even writing this now goosebumps run up my arms. I didn't know it in the moment, but I'd started to cry. It wouldn't stop. Somewhere inside me something was writhing, turning and screaming and saying get out. Just get it all out!

I dropped my tools and raced out of the lab, wiping furiously at my eyes to stem the flow of tears. Behind the handwashing station and in between the lockers I broke down.

In my arrogance I'd assumed that if I too were cold, I could safely weather the storm of the dissections. I created neat walls of resistance around me, a veil of my own to view the world through. But now the frost was melting away and creating new places for the light to touch. It was my veil that was coming down too. I could never become truly "detached", I realised. The psyche must be heard. It must have an out. And here it was. Here it was all coming out of me, dripping from my eyelashes in one terrifying and torrential onslaught of grief for this man I had both known and never known. There was no use trying to stop the bleeding now.

How strange was it that I knew the size of his heart, the state of his lungs and his kidneys, the layers of his fascia, but didn't know his name?

As much as I wished it, the world didn't stop because I'd had a panic attack in the dissection lab. I spent a week grappling with my emotions and bracing myself for head and neck week. Even that did not prepare me for the sight of a dozen ghostly faces laid out in rows in the lab.

At first I could hardly look. Every time I did my eyes would fill and my breathing would quicken. But as the minutes ticked over, I managed to look for longer snatches of time. The tears dried on my cheeks, leaving behind only a chemical residue. I confronted this man and who he was. I pulled back the layers of skin on his cheek where they were light and paper-thin. I tried to do him honour by knowing him, by not shying away from what was in front of me. I tried to let his body serve me as he wanted it to.

My donor taught me not only the inner workings of the body, but also that everything we witnessed would come back to us eventually. The universe was symmetrical like that. It was only a matter of when. When would it *out* the way it rushed out of me in the lab? If I bottled up everything that I saw, blew it off as the workings of a short-staffed hospital or just another sad case in an endless line of faceless patients, when would I be able to face it? When would it all come to pass?

In my naivety I'd assumed that we pursued medicine so that we could help hurt people and hopefully not end up hurt ourselves. I quickly realised that this was no one's reality. It reminded me of the process of entering medical school. After defeating the multiple grueling examinations and scoring in the top percentile during high school, we all arrived at the final boss; the interview. In a frenzy students would hire tutors and attend interview coaching courses, desperate to learn the secret to the perfect interview answer. Inevitably the age-old medical interview question would come up in our discussions.

"Why do you want to study medicine?"

I remember trawling through an interview coaching website and coming across a "model answer". It went something like this:

"I'm an eager problem solver. Since I was a precocious young child, I've always been fascinated by puzzles and mathematical problems. I wanted to find the x and the y. In pursuit of this I've joined multiple computing, algorithmics and maths clubs, placing nationally in competitions. I love problem-solving and that's essentially what the medical profession boils down to. It's crucial to the discipline. What is the patient's diagnosis? What is their history? What factors do we need to consider in selecting the most appropriate treatment? Everything is a puzzle. This is why I would make a perfect doctor. Medicine appeals to my naturally logical and pragmatic nature."

This person was correct; problem-solving is a central component of medicine. What I learned during this first year in the hospital, however, was that to ignore the humanity underpinning each case was to commit a fatal error. Medicine became not so much the study of the human body as the study of humans

themselves. It is not only problem-solving but the art of storytelling, of connecting with a patient on a truly human level, of understanding the underlying psychosocial and economic factors behind someone's presentation. It is the perfect intersection between science, the arts and the humanities.

I was watching a peer of mine take a medical history when this idea of patients as a problem to solve occurred to me again. The patient was presenting with constant chronic diarrhea and admitted to a high alcohol intake and recent unintended weight loss secondary to a dramatic loss of appetite. She possessed almost all the warning signs of cancer. My friend and I exchanged a look of dread before he continued with his line of questioning. Nausea? Constipation? Changes in medications? Any abdominal pain? Where? How long? Any signs of metastasis? Any previous malignancies? He was sorting through the differentials, solving the problem, getting closer and closer to the centre of the maze.

As he progressed through the history I began to notice that the patient displayed an extremely flat affect. Just like signs and symptoms, in medicine we have the mood and its poor substitute for an objective measure of emotion; the affect. It occurred to me as I watched the patient that I had never witnessed a person speak for so long without moving their face. It was as if she were a concrete slab, a blank slate, dutifully opening her mouth to reply but never showing a speck of feeling otherwise.

When we bid her goodbye she watched us leave with those dull, empty eyes, her face again betraying nothing. In the hallway outside we gathered to discuss the case.

"So," the doctor said, "what are our differentials?"

"I'm going to guess a colorectal or a gastric cancer," my friend said.

The doctor turned to me. I shrugged.

"Depression with a side of cancer?"

"Wow," the doctor said, her eyebrows raised. "You actually got it."

"Really?"

"Well, not the cancer bit. That's what we were thinking but thankfully we didn't find any cancer on her. Her diagnosis is depression."

While we were all worried about a malignancy, it turned out that severe depression had caused a lack of appetite, and this paired with her depression-fuelled consumption of two bottles of wine a night was giving her chronic diarrhea.

I learned a fundamental lesson that day. Sometimes you can ask all the right clinical questions and the answer is staring you in the face. Viewing the patient as a puzzle to be solved and fixating on finding a neat biological basis for their symptoms could cause you to forget the fact that they are also a person. We had

to look at the crests on the heart rate monitors but also at the bridges between them too. Those spaces between heartbeats were the stretches where humanity bloomed. You could count the peaks and the troughs, but that undertow of emotion was what formed the fabric of the patient's life. I didn't want to forget to inspect it for holes. Just like Helen, the crisis here was cardiac in the metaphorical instead of the biological sense.

Not long after Helen was discharged I found myself on a slow morning on the wards. That quintessential off-putting hospital smell clung to the air. Around the corner visitors were grumbling about having to take the stairs after the lift had broken down again. Codes and MET calls were being announced over the loudspeaker so often it almost sounded rhythmic.

I was restlessly watching my consultant order lab work when a patient began to scream.

"Water! Please, water!"

I jumped out of my skin. The scream was ear-piercing, but here there was a very clear request. Actionable. Instinctively I started towards the room, but I stopped in my tracks when I noticed that nobody on the ward was moving. Nobody had even looked up. It made sense, of course. These were seasoned professionals who worked to this soundtrack every day. They couldn't care less that a patient was shouting. But I was no seasoned professional. I was new to clinical life and each one of these sounds startled and pained me. I was still a stranger to the depths of human suffering.

The bystander effect describes a phenomenon wherein individuals are less likely to help victims when in the presence of others. We've all heard of the bystander effect, but have you ever *felt* the bystander effect? Have you ever felt the muffling, immobilising static that fills up a room and becomes a solid form, taking up space around your ankles like weights to root them to the ground? Have you ever felt your centre of gravity lurch forward and then dip back, retreating into yourself? I was twenty years old and I couldn't move. It didn't feel like my place to.

And so it went on, on and on and on. The woman's screams rose in volume, becoming sharper and more desperate.

"Please! Water! Please!"

The sound gutted me. Still, nobody moved.

A vivid image of Helen's outstretched hands came to mind, the vision so clear that it seemed to spark some sort of kinetic energy within me. The noise was so painful to me that it would have been more painful to continue to listen to it than to do something. I moved towards the sound.

Inside the room an elderly woman was crumpled on a mattress on the floor, the image bearing a surreal similarity to Helen. She held out a shaky hand.

"Water please."

I bent down by her side. "What kind of water would you like?"

"Warm water. Please."

There was already a jug in her room. It was just out of reach on the bedside table and she couldn't move out of the bed to fetch it for herself. I stood up and poured her some water from the jug, making sure that it was warm.

"I've been calling for so long. Nobody hears me ..."

"I'm really sorry about that."

I handed her the water and helped her take a sip.

"Can I get you anything else?"

"Can you help me shower?"

"I can't help you with that unfortunately, but I can ask somebody to come and help you shower as soon as they can."

"Alright. Thank you, my angel."

My consultant was waiting for me in the hallway.

"Did you get her water?" he asked. I nodded.

He looked me up and down, his eyebrows lifted in dubious surprise. This made me frown. Was what I had done genuinely so surprising? In that moment I felt that it was what anybody would have done, but when I recounted the scenario to a friend later that night, I was met with a different response.

"Okay, but she was probably screaming the entire time and annoying everybody."

"I suppose it was annoying, but you could tell that she just wanted some water."

"Yeah, but staff are burned out already. They don't want to deal with someone who's screaming at them."

"Of course, but you could tell that she just wanted water. That's all she was saying."

"The workers had probably just had enough of her. I don't think you should do something like that next time. It's like you're encouraging bad behaviour."

I couldn't help feeling slightly annoyed by my friend's reaction. Had it become radical to believe that our compassion was not a design flaw but in fact an asset? Our syringes come pre-loaded with this stuff called empathy. Perhaps we can pick and choose when to use it, and perhaps as a doctor the ratios will shift, but there were so many who didn't want to push the plunger at all. The layers of bureaucracy and emotional taxation had systematically worn them down. If hospitals were

more dedicated to implementing effective support programs to preserve the well-being of doctors, to replenish their fuel and to nourish that dormant child within them that dreamed of being a doctor only "to help people", they could make room for empathy instead of siphoning it away. I truly believe that patient-centred care could be achieved if only we allowed it to take up space. Encouraging doctors to spend more time with their patients if appropriate without fearing a heavy loss of wages or shunning from their superiors could unlock more emotionally effective care. Medical students could better preserve their mindfulness by being educated on the dangers of burnout and how to fight off the attitudes of apathy that pervade the profession. In university lecture theatres, in outpatient clinics, in the hallways of hospital wards – there is capacity for it.

I've decided through these experiences that my barometer of success as a doctor would not only be a patient's physical outcome but also how I made them feel. Now I'm no medic, yet. But what I've learned is that love for people is the vital artery that links us, the connective tissue that binds us together at the marrow. And when the chemicals corrode us, when our bodies give way to the elements and the eternal march of time, perhaps we'll realise how hollow our hearts really are, and how the blood pushing through them, that proof of life, is only a composite of every interaction we've shared with another person. After all, we have each other's air in our lungs. All we can do is give mouth-to-mouth and exchange those precious words of comfort and reassurance. Look that person in the eye and truly see them. Ask another what their name is. Have them ask my name too.

I don't know if these words will still be true to me in years to come. Perhaps desensitisation is unavoidable, a dead end that every path in the maze leads to. But I truly believe that all I have to give in life is my own time and understanding. That's the real finite resource. And when my stores are depleted down the line, when I'm scraping at the bottom of the barrel for any dregs of feeling that I have left, I hope I'll search within myself for the pockets of compassion that I've kept hidden away for a rainy day. I pray I'll remember to keep mining for it.

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