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Original Articles

Compassionate Silence in the Patient–Clinician Encounter: A Contemplative Approach

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Abstract

In trying to improve clinician communication skills, we have often heard clinicians at every level admonished to "use silence," as if refraining from talking will improve dialogue. Yet we have also noticed that this "just do it," behavior-focused "use" of silence creates a new, different problem: the clinician looks uncomfortable using silence, and worse, generates a palpable atmosphere of unease that feels burdensome to both the patient and clinician. We think that clinicians are largely responsible for the effect of silence in a clinical encounter, and in this article we discuss what makes silence enriching—enabling a kind of communication between clinician and patient that fosters healing. We describe a typology of silences, and describe a type of compassionate silence, derived from contemplative practice, along with the mental qualities that make this type of silence possible.

Introduction

A 67-year old woman was admitted with nausea and vomiting, and after a work-up the inpatient team had serious news: the patient's colon cancer had spread through the peritoneum. The inpatient attending, picking up the service that morning, agreed to let the resident lead the discussion because he knew from past experience that the resident had reasonable communication skills, had asked to be able to give the news, and had known the patient for the past 2 days. The resident indeed knew something about giving serious news: he confirmed the patient's understanding, and he was straightforward and clear with the news. However, after giving the news, an awkward silence developed. The attending decided to step in and made an empathic comment.

After the visit ended, when they were leaving the room, the attending asked the resident about that moment. "I was trying to use silence," the resident said. "I guess it didn't work."

In trying to improve clinician communication skills, we've often heard clinicians at every level admonished to "use silence,"[1] as if refraining from talking will improve dialogue. We have done it ourselves—we cite empirical data indicating that physicians, for example, typically interrupt patients just 18 seconds into a story.[2,3] Yet we have also noticed that this "just do it," behavior-focused "use" of silence creates a new, different problem: the clinician looks uncomfortable using silence, and worse, generates a palpable atmosphere of unease that feels burdensome to both the patient and clinician.

Silences are filled with texture and feeling, and can have therapeutic, neutral, or destructive effects on the therapeutic relationship.[4–9] While there are silences that feel awkward, indifferent, or even hostile, there are also silences that feel comforting, affirming, and safe. They resonate with the ease of a patient and clinician exchanging feelings and thoughts that do not quite make it into language. What makes these therapeutic silences different?

We think that clinicians are largely responsible for the effect of silence in a clinical encounter, and in this paper we discuss what makes silence enriching—enabling a kind of communication between clinician and patient that fosters healing. We start by offering a typology of silences. A silence with therapeutic effects, we will argue, is not simply a matter of withholding speech. The medical and psychotherapeutic literature discusses silences that result from withholding and silences that invite participation. The clinician in these silences mostly awaits a response from the patient. In our view, derived from our experience teaching contemplative practice to clinicians,[10] there is another kind of silence not previously defined in the medical literature that reflects the quality of mind that the clinician contributes to the encounter; this silence affirms relatedness and understanding, and allows for mutual wisdom to arise.

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A Typology of Silences

The effect of silences on communication has not yet been studied empirically in the context of palliative care. In medical encounters, the proportion of time the clinician speaks has been widely reported as a descriptor of the patient-centeredness of the clinician's behavior,[3,11,12] and these studies generally assume that the more the patient talks, the better. But what happens when no one is talking? We propose the following typology of silences (table) to promote further discussion and research.

Table 1 summarizes existing research on silence and adds a new kind of silence: compassionate. The awkward category describes silences that are generally untherapeutic, described mostly in psychotherapeutic literature based on case histories.[4,13,14] The invitational category describes silences with an intended positive therapeutic effect, drawn from research by psychotherapists.[4,15,16] We have coined the compassionate category to describe a specific kind of silence drawn from contemplative practice that has not yet been described in the psychotherapy or the medical communication literature. We are using the term compassion in a particular way, to denote the active generation of a personal intention for a good outcome (generally to reduce suffering) that is described in contemplative practices in both Buddhist[17–19] and Christian traditions.[20]

Awkward silences

In our experience, silence most often feels like it is dragging on too long when a well-meaning clinician thinks he should be "using silence." We see them trying to experiment with a new unfamiliar skill, and while we endorse this kind of intentional practice, and recognize that new skills have a learning curve before they can be performed smoothly, we also think that the problem with a directive to stop doing something (e.g., talking) is unlikely to produce the quality of silence that is actually therapeutic. The problem with these awkward silences is that the feeling of awkwardness that is transmitted to the patient is likely to interpreted as something else—often judgment, ambivalence, disapproval, or withholding.

Invitational silences

The difference between an invitational silence and an awkward one is the clinician's intention. The clinician deliberately creates a silence meant to convey empathy, allow a patient time to think or feel, or to invite the patient into the conversation in some way. Therapists generally think of themselves as actively creating this kind of silence. While we recognize that these silences are tremendously valuable, we also note that these silences are often described as a kind of holding,[21] which has a stage-setting, expectant quality.

In contemplative traditions, a counterpart to the quality of attention deployed in an invitational silence is seen in mindfulness practices, where a person who wishes to remain open to bodily sensations and to experience them without expectation or judgment attempts to notice sensations and perceptions without judging them or being carried away in further thoughts about them. As recent research demonstrates, an invitational silence based on a mindfulness practice could be useful to a clinician aiming to increase awareness of what is happening in the clinician–patient encounter,[22] because it could enable increased awareness of data about the patient (such as microexpressions in the face[23] or barely perceptible changes in voice tone[24]) that may influence how the clinician responds.

Table 1. Existing Research on Silence

Type of silence	*Clinician's intention*
Awkward	Often without clear intention (uncertainty), but also may reflect distractedness or hostility, often masked by the clinician.
Invitational	Wanting to give the patient a moment (or longer) to think about or feel what is happening, often after an empathic response.
Compassionate	Recognizing a spontaneous moment (or longer) of silence that has emerged in the conversation, often when the clinician and patient share a feeling or the clinician is actively generating a sense of compassion for the patient.

Compassionate silences

While the typical use of silence recommended by many communication teachers would fall into the category of invitational silences just discussed, there is another type of silence that has received little attention in medicine, although it is highly prized in contemplative traditions: the compassionate silence. Compassion in contemplative traditions is transmitted through a quality of mind and requires active intentional mental processes—it is the opposite of passive, receptive activity. These compassionate silences arise spontaneously from the clinician who has developed the mental capacities of stable attention, emotional balance, along with prosocial mental qualities, such as naturally arising empathy and compassion.[17,19,25]

Defining the Mental Qualities Essential for Compassionate Silence

From a contemplative perspective, silence is not a tool to be used with a specific set of indications and meanings. Instead, silence is seen as a quality of mind that the clinician brings to the encounter, which becomes manifest as a spontaneous consequence of the clinician's presence. In compassionate silences, clinicians can find that the silence has a moment-by-moment character that patients can experience as a profound kind of being with, standing with, and contact in a difficult moment. This kind of silence can nurture a mutual sense of understanding and caring.

Contemplative traditions generally recommend that one cultivates specific mental abilities related to attention, focus, and clarity as habits of mind, watches for silences to emerge, and treats the silence respectfully. Typically, the contemplative perspective focuses on cultivating one's intentions and abilities, rather like virtue ethics, and tends to place less emphasis on measuring success by examining the outcome of a specific action. The effect of cultivating these mental abilities on clinical practice has not been measured directly in contemplative traditions and may be amenable to empirical research. Contemplative traditions emphasize three mental qualities:

1. ***The clinician's ability to give attention*** for the purpose of understanding that person is, in our experience, a prerequisite for enabling moments of therapeutic silence. This ability to give attention is related to the clinician's intention, motivation, or what some educators might call attitude. We prefer the term intention because it signals the active orientation of the clinician to their pivotal role as healers aiming to reduce suffering. Clinicians can use their intention, which includes their aspirations and values, as a first step in giving attention. This intention, in contemplative traditions, encompasses a philosophy that care—including medical care—should address the whole person, that the person has within themselves an important role in healing, that the clinical encounter is the space in which some of this healing can occur, and that clinicians genuinely aspire to reduce suffering. The second determinant of the clinician's ability to give attention is related to their mental ability to notice relevant data about the patient in the moment, such as verbal cues, facial expressions, or changes in tone of voice. Some of these abilities (microexpressions) can be improved by specific types of training,[26] and in particular mindfulness training seems to improve attention to unexpected cues.[27]
2. ***The clinician's ability to maintain a stable focus*** is critical because attention (especially untrained) is typically unstable and evanescent. Maintaining focus implies not only an ability to select an important focus but to set aside distractions common in clinical settings that may include: the patient bringing up something different; another clinician asking a question; a page from a colleague; one's own sadness, or hunger. Obviously a clinician who seized a single focus and never released it would not be effective; but the problem we see is that there are so many distractions in a typical patient-clinician encounter that the clinician shifts her/his attention so that often the conversation does not gather enough depth to make silence even possible.
3. ***The clinician's clarity of perception*** requires explanation because it seems, at first glance, so obvious. By clarity, we mean that the clinician can perceive the clinical issues in a way that is free from distortion or bias. In the clinical setting, there is a history of personal accounts by physicians and nurses describing how they have come to understand their own biases. We and others have also written about the effect of the clinician's inner life and personal emotions can have on patient care.[28,29] While we acknowledge that it is probably impossible for clinicians to act in completely unbiased ways, we also have seen how expert clinicians who acknowledge their biases are able to find ways to minimize the effect of these biases. For example, a clinician who experiences sadness when a patient triggers memories of the clinician's own mother can remember to acknowledge inwardly this extra sadness and consider the possibility that extra debriefing is needed.

How Do Clinicians Acquire These Mental Qualities?

The mental qualities we endorse are not due to luck or genetics—they can be cultivated by contemplative practices. By contemplative practices, we mean habits of mind that are acquired through regular, intentional repetition: mindfulness meditation, insight meditation, compassion practices, and centering prayer are some of the practices. Emerging research on contemplative practices—mindfulness has been studied the most extensively—indicates specific regions of the brain and neuroendocrine–immune processes are activated by these practices. For example, compassion meditation done in the Tibetan tradition by practitioners with a great deal of expertise (over 10,000 hours) shows activation of the brain, surprisingly, in the motor region—as if compassion meditation done in this way creates a state of readiness to act.[30] Equally impressive are data demonstrating neural integration as evidenced by high-amplitude gamma-band oscillation in experienced meditation practitioners, suggestive of beneficial effects of contemplative practice on cognitive and affective functioning.[31]

The aspect of contemplative practice that is novel for clinical practice is the focus on moment-to-moment experience, which is what contemplative practices emphasize. There is empirical evidence that moment-to-moment attention activates different regions of the brain than does narrative experience that enables clinicians to understand a patient story, and conduct clinical reasoning such as differential diagnosis.[32] Yet to enable a compassionate moment of silence to emerge, a clinician may have to shift out of a narrative mode of thought and into a moment-to-moment mode that has more empathic or compassionate relational immediacy with a patient.

Clinicians who have participated in contemplative training seem to acquire the mental pliancy to be able to shift spontaneously into moment-to-moment awareness. For example, a clinician who completed the Being with Dying program[10] said in a qualitative research interview[33] that "I feel like my sense of being able to . . . enter into a very nonjudgmental space is different as a result. . . . Now I have the ability to . . . mentally create a space of receptivity, knowing that what they're angry about isn't me but about the existential crisis." Another clinician compared the development of mental qualities to practicing a musical instrument: "You need to both develop the capacity to play . . . and then you need to keep doing it or else it kind of disappears . . . it doesn't totally disappear, but you're just not as facile. . . . Thinking about my quality of mind in that way was a real revelation." The silence that results feels different to these clinicians—one described the emergence of such a silence with a patient's family this way: 'before going in and trying to data dump . . . I first try to create some kind of communion or bond . . . [and for this family] it was clear this was just a time they needed, it wasn't awkward, it was a reverence."

Anchoring Silence in the Breath

We appreciate that without some kind of contemplative instruction (which tends to be largely experiential), the discussion above may seem abstract. In order to try out this approach, we suggest anchoring silence in your breath. Pick a moment in the conversation when a deeper look would serve both you and your patient. Shift out of your narrative, story-constructing mode of thinking and into giving attention to each moment. Anchor your attention in your breath. This pause for breathing may be evident to your patient, who may mirror your pause, and a silence may emerge. Enabling the silence by anchoring your attention to your breath, you may notice as well how your body is responding: is there energy, is it tense, what are the sensations? Simply notice these

sensations and allow new data to arise in your awareness. This might include your own experience and what you are perceiving through your sense fields of your patient's experience. Your moment-to-moment attention may uncover something you have not noticed previously—a facial expression, a hand gesture, or a phrase from earlier in the conversation that you skipped over. Or personal feelings that will need to be addressed later. See where these new data lead you in the encounter.

Notable is that in this approach we direct the clinician's focus more inwardly than outwardly. We are emphasizing the clinician's use of the body and breath as an anchor; and then using silence as the ground for deeper perceiving, followed by insight. This is a different approach to communication that we think is complementary to other approaches.[34]

Viewing silence as something that arises spontaneously from the clinician's quality of mind—rather than using it in an instrumental fashion—is one area in which contemplative practice could have an important contribution to clinical practice. Of note, what we have covered here represents only a small section of contemplative practice that might be relevant.

Conclusion

Many communication training approaches use behavioral techniques, which have lead to the use of silence. An alternative approach, derived from contemplative practices, is to ask clinicians instead to cultivate an ability to give attention, maintain focus, and perceive clinical situations clearly—and then to watch for silences to emerge from a ground of compassion, insight, and mutuality. The ability to actualize mindful, compassionate silence, although requiring training to use most effectively and consistently, can enable a clinician to shift from using silence, to making space for silence to emerge as a way to affirm mutual respect and understanding.

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