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# Can Clinical Empathy Survive? *Distress, Burnout, and Malignant Duty in the Age of Covid-19*

by ADRIAN ANZALDUA and JODI HALPERN

In an article for the *New York Times Magazine*, Helen Ouyang, an emergency room doctor in New York City, illustrated her experience caring for an elderly man dying from Covid-19 when the city’s case count was skyrocketing:

I want to spend time with him, but more patients, much younger patients, keep arriving, struggling to breathe. I have to tend to them instead. The disease has won against him; the new patients have a chance. I don’t want to think that way, but it is the dismal truth of our new situation. I hope the morphine is enough to blur the reality that he’s all alone. I move on, forcing myself not to think about him again. Too concerned about the new patients, I never take the time to check on him again. Too exhausted at the end of my shift, I don’t say goodbye to him either. He dies later that night.<sup>1</sup>

Distancing herself from the harsh realities of treating Covid-19 patients, and emotionally and physically exhausted, Ouyang appears to be in a state of sympathetic distress and showing signs of burnout, a serious psychological syndrome brought on by bad workplace conditions.

Ouyang’s account appeared on April 14, 2020, just as health care workers in New York and surrounding areas were shouldering their way through the peak of the deadliest coronavirus surge the country had faced. Mental health data collected on New York City health care workers during that surge proves that Ouyang’s experience was far from isolated. One study of 657 of the workers showed that 57 percent manifested symptoms of acute stress (which could lead to post-traumatic stress disorder), 48 percent experienced depression, and 33 percent showed signs of generalized anxiety.<sup>2</sup>

While these data represent mental health impacts during one of the most devastating regional outbreaks on record, such outbreaks are recurring now, during January 2021. The national Covid landscape has turned into a mosaic of

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*The virtuous nature of medical professionalism becomes a force that traps workers in clinical environments that undermine their ethical goals, exposes them to psychological injury, and precludes them from striking or protesting.*

multiple hotspots around the country, and things are getting worse as winter wears on. Now, a year since the first U.S. cases were identified, conservative estimates from Johns Hopkins University show at least 450,000 people killed and nearly twenty-seven million confirmed cases.<sup>3</sup> The trends in stress, depression, and anxiety among American health care workers brought on by the pandemic surely anticipate a similar rise in burnout.

Burnout is a psychiatric syndrome that stems from prolonged exposure to a deleterious work environment. It manifests with symptoms of emotional and physical exhaustion, feelings of professional inefficacy, and depersonalization, a sense of lost identity marked by feeling disconnected from one's own thoughts and feelings.<sup>4</sup> These symptoms have profound impacts on both the individual sufferer and the health care system. Data published in 2010 from an international study of 53,846 nurses across six countries showed a negative correlation between burnout and nurse-rated quality of care.<sup>5</sup> Data from a smaller retrospective study assessing the relationship between physician burnout and independent quality of care indices (such as medical errors and patient satisfaction) showed similar correlations.<sup>6</sup> The picture is clear: as burnout increases, quality of care decreases.

Increases in burnout are also linked to the loss of clinical empathy.<sup>7</sup> This is not surprising given that two of the three core features of burnout—emotional exhaustion and depersonalization—undermine, respectively, the emotional reserve and sense of self required for the practice of clinical empathy. Clinical empathy is a health care worker's capacity to listen in a way that integrates cognitive and emotional empathy.<sup>8</sup> It improves clinicians' collection of patients' medical history,<sup>9</sup> patient adherence to treatment,<sup>10</sup> patients' capacity to cope with bad news,<sup>11</sup> and clinicians' ability to resolve difficult conflicts with patients.<sup>12</sup> Research indicates that, as clinical empathy goes up, physician-reported error rates go down, and vice versa.<sup>13</sup>

The poor American handling of the pandemic has created novel, intolerable pressures on the health care system and on health care workers' mental health and personal safety. Optimists may believe that the pandemic's additional injury to health care workers' mental health and capacity for clinical empathy will quickly correct itself once the pandemic ends, without longer-term impacts. And perhaps this would be realistic if not for the high baseline rate of mental health issues among health care workers before Covid-19. Pre-pandemic burnout rates approached 50 percent for phy-

sicians;<sup>14</sup> for nurses, the prevalence was approximately 35 percent.<sup>15</sup> Given the compounding of preexisting mental health concerns with current, novel burdens, we are concerned not only that an entire cohort of health care workers are too burned out to provide empathic care but also that those injuries may result in permanent psychological injury.

Why have health care workers tolerated such injurious workplace conditions for so long? And why, after more than thirty-three hundred health care workers' deaths to date from Covid,<sup>16</sup> do they continue to tolerate deterioration of their work environment? The answer is undoubtedly multifaceted. With burdensome debt so common among medical trainees,<sup>17</sup> many health care workers have little choice but to keep working. Others might be the sole earners for their families. It's also possible that fear of retaliation is keeping some health care workers from making their concerns known.

Personal considerations undoubtedly reinforce tolerating psychologically injurious workplace environments that undermine the conditions for clinical empathy, but problematic structural and cultural forces also bear responsibility. In this essay, we'll consider how health care workers motivate themselves under alienating conditions, which is through a sense of obligation or duty<sup>18</sup> to provide care no matter the circumstance. Acting from duty is seldom necessary when workplace conditions permit the practice of clinical empathy, which provides professional motivation, meaning, and psychological protection. When clinical conditions do not permit the practice of clinical empathy, health care workers turn to their sense of obligation or duty to not abandon patients. Submitting to professional duty can protect some from psychological injury, for at least a while, but the chronic suppression of authentic reactions of outrage, fear, and grief that accompany submission to duty can further contribute to distress and burnout.

The American experience of Covid has been a traumatic shock to an already burdened health care system. The remainder of this essay explores the interplay between burnout, clinical empathy, and medical ethics revealed by the heightened stresses of the current moment. While the relationships between these phenomena are complex, we might summarize the thesis as follows: burnout begets burnout. The clinical behaviors commonly available to prevent burnout often cannot be deployed due to poor clinical conditions (in the case of clinical empathy); other behaviors, like

submission to professional duty, lessen burnout in the short term while worsening it in the long term.

To support this thesis, we'll first develop an understanding of the phenomenon of clinical empathy, showing that, at its core, clinical empathy is based on genuine emotional engagement, which requires the mental freedom to process difficult emotions. The injurious clinical conditions leading to burnout (such as the battlefield-type conditions seen in hospitals throughout the pandemic) undermine the mental freedom clinicians need to think, feel, and connect. This inevitably undermines clinical empathy and further contributes to burnout.

Loss of the conditions required for clinical empathy forces health care workers to fall back on internalized duties to motivate themselves, especially in the setting of heightened physical and mental health risks. Different clinical situations elicit different professional duties; for example, Covid-19 has called upon and tested the duty of nonabandonment.<sup>19</sup> While the substitution of duties for clinical empathy may be beneficial in the short term, we'll show how relying on duty without clinical empathy for extended periods undermines mental freedom, further fomenting burnout and distress.

Finally, we'll argue that health care workers are particularly susceptible to remaining bound to injurious workplace conditions because they tend to identify personally with their professional roles. They are, in this regard, virtuous—they practice health care according to their values: they live their values in their work. However, acting on values from a sense of obligation or duty alone is unsustainable when at odds with one's emotions and sources of meaning. Thus, during prolonged exposure to overwhelmed clinical environments such as those seen during Covid-19, health care workers risk deep moral and psychological injury. The conditions health care workers are contending with during Covid-19 might be fatally damaging the virtuous ethical center of medical professionalism. If this is true, medicine will be forced to reexamine not only its professional ethics but also how those ethics interact with other interests present in today's complex medical industry.

### The Dynamics of Clinical Empathy

Clinical empathy, a specific form of empathy that has therapeutic impact in the medical setting and is professionally sustainable, was first conceptualized by one of us, Jodi Halpern, as emotionally engaged curiosity.<sup>20</sup> Her work challenged the expectation that physicians should limit themselves to detached cognitive empathy, showing how affective resonance, when redirected into curiosity about the patient, is essential for therapeutic impact. Halpern's interactive model of affective and cognitive empathy has been supported by empirical research, including findings regarding improved diagnosis, treatment adherence, and coping as well as studies of specific diseases (for example, about improved diabetes outcomes<sup>21</sup>), though more research is needed to precisely identify the specific ways that affective

resonance and cognitive curiosity contribute to meeting specific clinical needs.<sup>22</sup> This model is also supported by neuroscientific findings showing how affective attunement improves cognitive empathy.<sup>23</sup>

Models of compassion in medical care add valuable practices of mindfulness but do not emphasize an individualized appreciation of each patient's predicament. We thus work with Halpern's model, which emphasizes using emotional resonance to inform imagining the world from each patient's perspective. Halpern defines the cognitive aim of imagining each patient's perspective as "curiosity" because the practice of clinical empathy as engaged curiosity is founded on the recognition that each patient brings their own distinct world, with a unique set of values and needs that the physician cannot presume to know. This is a subtle but vital point. As often as clinicians feel compelled to say to a patient, "I know how you feel," these words cover up a profound fact: one can never truly know the lived experience of another. Rather, it is when health care workers realize that they cannot fully know, yet still need to know, what matters to the patient that they become curious to learn more about the patient's particular lived experience. This is clinical empathy as engaged curiosity, and a departure from responding to patients with detached scientific curiosity or a generic "detached concern"—viewpoints that obfuscate the patient's individuality and so create the conditions for ethical and clinical failures.<sup>24</sup>

This emphasis on curiosity may make clinical empathy sound like a mostly cognitive process, whereas our everyday idea of clinical empathy is one of emotional resonance, of fellow feeling. However, this affective component is crucial for the model of emotionally engaged curiosity, insofar as it is emotional resonance that helps guide what the listening clinician imagines and it is also nonverbal resonance that conveys to the patient that the clinician is attuned. When emotional resonance develops between health care worker and patient, the benefits of clinical empathy are richest for both.<sup>25</sup>

As essential as clinical empathy is to effective care (and to preserving physician wellness), clinical empathy as engaged curiosity does not happen automatically in all contexts. Engaged curiosity is an energy-intensive process requiring specific conditions for safe deployment. In addition to having sufficient physical and emotional energy to engage curiously with another's lived experience, a medical provider requires a degree of mental freedom to have the capacity for engaged curiosity. Experiencing emotional resonance with suffering patients when lacking the freedom to therapeutically channel it into engaged curiosity can lead to sympathetic distress.<sup>26</sup> Even before the pandemic, medicine's trajectory favored the conditions of worsening burnout and sympathetic distress due to overwhelming administrative tasks, heavy caseloads, and insufficient time with individual patients, undoubtedly contributing to increasing rates of physician dissatisfaction.<sup>27</sup>

National failures during the pandemic have left the health care workforce sick and struggling. Those who have

been able to avoid contracting Covid-19 amidst shortages of personal protective equipment and overflowing emergency rooms now work extra hours to cover for those less fortunate and for those who chose to retire early rather than continue on in health care. Many who did contract Covid-19 continue to work despite ongoing fatigue and respiratory issues. Increased workload pressures have risen in concert with rescue pressures, the moral injury of losing patients due to insufficient resources, and the need for additional vigilance to ensure health care workers maintain their families' physical safety.<sup>28</sup> This collapses the space for mental freedom, undermining both the health care worker's sense of their professional self and clinical empathy as engaged curiosity. The depersonalization that comes with collapsed mental freedom, coupled with the loss of psychological protection afforded by clinical empathy as engaged curiosity, starts the health care worker well on their way to burning out.

### **Duty to Provide Care as a Substitute for Clinical Empathy**

Of course, it is perfectly reasonable that the conditions for clinical empathy would be greatly curtailed, if not altogether absent, during a crisis. It is in such situations that health care workers rely instead on their personal and professional sense of duty. For this sense of duty to safely and effectively motivate them to continue taking personal risks during difficult times (and for long periods), it is critical that this duty emanates from a person's character. When duties are internalized, they can be relied upon to motivate and sustain health care workers in the face of personal hardship and oppressive conditions. The expression of an authentic, internalized sense of duty toward patients and fellow practitioners is not dissimilar from the sense of duty we see among soldiers, which helps us understand the outpouring of respect and even love we have seen among health care workers. Duties, when they authentically spring from within, are powerful drivers of group cohesion and social good.

Duty-motivated behavior can be protective for some, for some amount of time, but it is incredibly energy intensive. Moreover, acting strictly from duty further collapses the space for mental freedom, worsening the individual's ability to engage with authentic reactions of outrage, fear, and grief. This encourages a process of depersonalization. A depersonalized sense of duty can be tolerated only for a short period without the risk of further loss of clinical empathy and burnout. Prolonged reliance on a strict sense of duty encourages a prolonged experience of exhaustion and depersonalization, raising the prospect for chronic burnout and other mental health issues. If the mental health burdens wrought by the American experience of Covid-19 undermine clinical empathy and ask too much, for too long, of workers' sense of duty, then health care workers may begin associating professional duty with mental health issues like burnout. If leaders of the American health care system allow this association to take hold, they risk undermining the

duty itself. If duties lose their inspirational power, what will be left to provide professional meaning and motivation in the strained everyday practice of health care in America, let alone to motivate meaningful work during the next public health crisis?

### **The Rise of Malignant Virtue**

What animates the health care workers' sense of duty? The basis for medical professional duties, we argue, is not merely that health care workers make an external promise, like taking an oath; rather, internalized, virtue-based ethical practices are what ground and animate medical professional duties.<sup>29</sup>

Virtue ethics views the person acting in the role of health care worker as largely indistinguishable from who that person is in private.<sup>30</sup> Whether medicine selects for individuals with virtue-based ethical practices or the profession develops these practices in its trainees, medical duties are deeply personal commitments. This is why countless Covid-era op-eds and purpose statements have tried to rally health care worker morale with phrases like "This is who we are"<sup>31</sup> and "we run toward a fire."<sup>32</sup> The virtuous center of medical professionalism is what animates and informs the everyday sacrifices we've come to expect from health care workers, as well as the exceptional sacrifices we've seen from them throughout the Covid-19 pandemic.

A virtue-based medical professional ethics can be beneficial save for one notable weakness: internalized virtue cannot be silenced or shed at the end of the day. This means that clinical conditions that violate medical ethical principles directly threaten the health care worker's sense of self. When this happens, virtue morphs into a malignant force.

In the modern American medical system, the clinical conditions favoring this malignant transformation are not only commonplace; they result from fundamental structures on which modern medicine relies. For example, miserly and arbitrary insurance formularies can turn a provider's beneficent prescription into an onerous economic hardship, transforming the physician's moral good into a moral liability. Similarly, health care workers who are forced by circumstance to discharge homeless patients in delicate medical conditions back to the streets must either detach themselves from their ethical values or experience moral injury.<sup>33</sup> The capacity or incapacity to address patients' social needs has been shown to affect primary care physician burnout.<sup>34</sup>

Workers in other fields might protest the corruption of their profession's ethical standards by outside forces, but the virtue animating medical ethics precludes many forms of resistance. In this way, the virtuous nature of medical professionalism becomes a force that traps health care workers in clinical environments that undermine their ethical goals, exposes them to psychological injury, and precludes them from deploying methods like strikes or protests to fight for change.

Any chance of returning to clinical conditions that don't predispose health care workers to these types of malignant ethical transformations seems far-fetched in this current moment. In fact, it is worse than that: Covid might be the tipping point that existentially threatens the sense of virtue-informed duty for which clinicians are known. Like any precious but fragile element of professionalism, medicine's ethical center must be protected. It requires adequate hospitals and affordable medications, housing on discharge, decent caseloads so patients can get empathic attention, and more, and these measures in turn depend on the right combination of social structures, including responsive local, state, and ultimately federal governance.

Covid-19 has done more than exacerbate the weaknesses in the social structures that undergird the virtue-driven ethical center of medicine; it has also summoned new phenomena that chip away at its foundation. American health care workers have witnessed a dangerous conception of personal liberty drive a backlash against commonsense preventive health measures. A certain percentage of Americans have fallen prey to the delusion that the pandemic is a hoax perpetrated to justify restricting individual rights. Federal leadership has not only been absent but has, in many cases, worked against medical health care workers, as evidenced by the former president imploring the public to not "be afraid of Covid" despite his recent hospitalization.<sup>35</sup>

Health care workers have long understood, perhaps implicitly, that the virtue informing their professional ethics puts them at outsized risk for burnout, sympathetic distress, physical exhaustion, and mental health issues. The pandemic has supercharged these risks in a new way, a development that health care workers are starting to notice and acknowledge. Take Erik Andrews, a nurse at Riverside Community Hospital in one of Southern California's hardest hit counties, who openly lamented to the *Los Angeles Times* in June about what he perceived to be a pattern of deliberate understaffing in the middle of a Covid surge: "Our professionalism is being exploited."<sup>36</sup> Whether medical ethics and professionalism as we know it survive the pandemic remains to be seen.

### Changing the System

Covid-19 has exacerbated a number of systemic and cultural issues long present in medicine. But the difficulties are also opportunities. The crisis may catalyze a necessary restructuring of our medical system, a restructuring centered on securing and maintaining the clinical conditions required to provide genuinely empathic care. Accomplishing this goal will undoubtedly proceed from the inside out, beginning with individual health care workers who, driven by the devastation of the pandemic, will demand more benevolent clinical environments for themselves and their patients. Already there have been work stoppages around the world aimed at securing better personal protective equipment.<sup>37</sup> Unfortunately, these actions, though disruptive, will be necessary to force industry and government to provide the

physical and emotional safety that clinicians need to provide empathic and effective medical care.

Finally, the health care professions must develop new models of professionalism in which individual and collective action undertaken to protect health care workers' well-being and clinical empathy will be seen not only as defensible but as an expression of foundational professional duties. This new professionalism will undoubtedly benefit students in health professional schools who experience burnout at alarming rates.<sup>38</sup> Inculcation of a new professionalism could mean that future medical professionals would be better positioned to demand concessions from insurance companies, pharmaceutical companies, and state and federal governments to better serve patients.

Such aspirations might have seemed far-fetched even a year ago, but Covid-19 has softened the grout holding together our patchwork health care system. A new medical professionalism built upon the twin pillars of clinical empathy and provider well-being could reorient the complex American health care system to finally meet the needs of clinicians and patients alike. Health care workers have the opportunity to create lasting, systematic change now. The only question is whether they can overcome their collective trauma, burnout, and exhaustion enough to do so.

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