Let’s not get Emotional: A Neuroethical Perspective on Clinical Empathy

Eugenia Stefanello (University of Padua)

Since the middle of the last century, medical technologies have allowed us to obtain increasingly precise and objective measurements. This led physicians to consider the information provided by the patients too subjective. Hence, the doctor-patient dialogue has progressively lost its centrality (Reiser et al. 1984). It is often claimed that the solution to this problem is clinical empathy (Spiro 2009; Halpern 2001). Thanks to emotional resonance, clinical empathy achieves two goals: on one hand, it allows the doctor to build an engaged dialogue with the patient, on the other, it enhances - and does not compromise - the reliability of the diagnostic process.

However, I will argue that clinical empathy is not the proper tool to solve the issues that technology poses to the doctor-patient relationship. First, I will show that affective resonance involved in clinical empathy can lead to cognitive and moral distortions: as several neuroscientific studies demonstrate, the empathetic subject is affected by a similarity bias, i.e. the tendency to empathize deeper not only with those who resemble us but also with those who are near and dear (Gutsell et al. 2010; Xu et al. 2009). Second, it has been proven that clinical empathy often leads healthcare providers to negative psychological states such as burn-out and compassion fatigue (Lamothe et al. 2014; Gleichgerrcht et al. 2013).

I will conclude that compassion is a better choice than clinical empathy. According to recent insights, compassion is not only conceptually distinct from empathy, but also involves and activates different brain areas (Singer et al. 2014; Klimecki et al. 2013). Compassion does not require emotional resonance but allows both to establish a fruitful dialogue with the patient and to recognize her emotional state. Furthermore, compassion appears to be a stronger moral motive than empathy and protects physicians from empathetic distress. (Bloom 2016).

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