Interventional Empathy: Healing Through Feeling

Paul Michael, MD, FSCAI[1]; Youssef Gerguis[2]

[1]Medical Director, Palm Beach Heart & Vascular, Boynton Beach, Florida; Medical Director, JFK Wound Management & Limb Preservation Center, Palm Beach, Florida; [2]Research Fellow, Palm Beach Heart & Vascular, Boynton Beach, Florida

Abstract: Critical limb ischemia (CLI) is a life-altering experience that requires a better understanding of the whole patient. A holistic biopsychosocial model is required to understand the whole patient who is dealing with the traumatic stress of the CLI experience. Negative psychological factors independently increase morbidity and mortality risk, and collaboration is required between the whole patient and the whole caregiver to understand the CLI experience. Interventional empathy is a compassionate approach to integrated CLI therapy that can repair the relationship between CLI patients and healthcare by providing whole care.

VASCULAR DISEASE MANAGEMENT 2021;18(10):E194-E195. Epub 2021 October 15.
Key words: compassion, critical limb ischemia, empathy, healing, holistic care, interventional empathy

Introduction

Critical limb ischemia (CLI) is a life-altering experience that requires an understanding of the whole patient. Modern science, through the reductionism of people by current biomedical healthcare models and vascular guidelines into body parts, does not represent real-world CLI patients, alienating them from healthcare. A holistic biopsychosocial model is required to understand the whole patient who is dealing with the traumatic stress of the CLI experience. Negative psychological factors independently increase morbidity and mortality risk, and collaboration is required between the whole patient and the whole caregiver to understand the CLI experience. Interventional empathy is a compassionate approach to meaningful, integrated CLI therapy to heal the whole patient by engaging, connecting, and nurturing to move from illness to wellness. Interventional empathy can repair the relationship between CLI patients and healthcare by providing whole care.

The Reality of CLI

CLI treatment involves revascularization to minimize tissue loss performed by an interdisciplinary care team to provide comprehensive care and complete wound healing. But we often miss the larger wound in these patients, which is a psychosocial wound. The struggle for these patients is reality; reality is experience; and experience is in relationship to each other. Under modern healthcare practices, CLI patients are hidden from the system. The deeper we can study the reality of CLI, the better we can understand the meaning of CLI therapy. Instead of focusing on the negatives, we need to change our mindset to positive thinking, which allows people to understand the meaning of this disease, which will compel them to do the right thing. When the meaning of CLI therapy is understood, the purpose of prevention and appropriate treatment is actualized.

Illness should be looked at as a continuum. CLI patients start in illness and end there, without an opportunity to physically be in what is considered "health." Unfortunately, our current medical system focuses on a treatment paradigm, which is reactive. But society and culture have been telling us for thousands of years, through Eastern philosophy, that health is not a reactive program to be taken care of; it starts in childhood and should be seen as total wellness. We are starting to come back to this philosophy via holistic care.

Maslow's hierarchy of needs will dictate our understanding of CLI patients. The physical loss, emotional impact, and social challenges they face lead to the loss of self. CLI patients lose their sense of reality, and that is where they break down. We meet with patients to discuss arteries, tissues, catheters, balloons, and stents, but often forget that these are people who lose their sense of self and are disconnected from society. Using interpretive phenomenological analysis can help us understand what these patients are going through and the medical system can begin to understand—but it begins with us listening to our patients. To listen to our patients, we must be able to listen to ourselves in a mindful manner. In palliative care, we use compassionate inquiry, removing our sense of self and freeing ourselves up so patients can fully connect with us as they are completely disrupted from their norm. Patients are in a constant state of emotional shock and high stress, and the disease severity disables them and puts them in a constant pain cycle that triggers a neurohormonal circuit, wreaking havoc on their brain and immune system. They feel anxiety, fear, depression, uselessness, and hopelessness. They are stuck in the Kübler-Ross change curve between denial, frustration, and depression, going back and forth, often with no hope of possible therapy or being able to walk again. The biopsychosocial isolation in the untreated CLI continuum further alienates these patients, who are in desperate need of meaningful connection. Understanding patients' subjective experience requires collaboration to remove the implicit bias that we have the minute we walk into a patient's room. We must be able to engage in a mindful manner to bridge the gap, understand our patients' true experiences, and establish a compassionate connection.

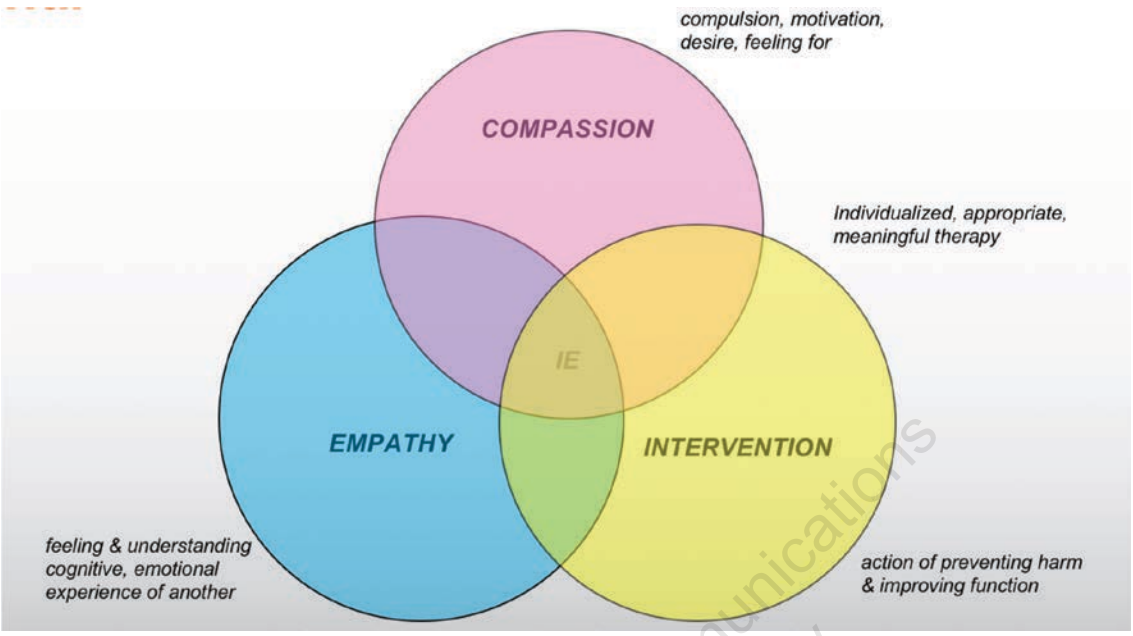

Figure 1. Empathy, compassion, and intervention.

Healing with Empathy and Compassion

Diagnosing and treating is what we are used to, but we need to turn toward our patients' suffering to understand the emotional and social challenges they are going through. We can help them refocus and reclaim their sense of self so they can start to actualize and make decisions, which then gets them motivated to want to do something. If you can bring these patients back to the clinic and develop a relationship, you instill meaning and purpose back into their lives and they are no longer focused on being disabled or feeling useless.

Basically, empathy is feeling for someone, and compassion is feeling with and being moved by someone (**Figure 1**). There is a cognitive and emotional aspect to empathy. There is the logical acknowledgement and understanding mentally of what they are going through (cognitive empathy), and there is the understanding of their feelings as if they were our own (emotional empathy). When empathy turns to compassion, one is being compelled to do something for another—and not just something, but the right thing. There is neurobiological evidence that neuroplasticity allows for rewiring of neural networks in the brain through compassion-based emotion regulation; we can improve our sense of empathy and upregulate experienced positive affect. We can adapt to better understand people's emotions, to be more compassionate, and understand the patient in front of us, which will ultimately lead us to do the right thing. If we do this on an individual level, we can slowly change the healthcare system. To be able to recognize and acknowledge that these people exist, and see what they are actually going through, makes them part of society again. That is treating the whole patient in a psychobiological manner, not just in a medical manner.

By healing the whole patient, not just the hole in the patient, you are able to actualize a new reality for the CLI patient through a better experiential relationship. What they are going through is their experience, and we must acknowledge that. Acknowledging the patient as an individual person begins the shift from health *scare* to health *care*.

Conclusion

CLI is a complex experience of suffering, change, and loss requiring a holistic biopsychosocial approach that addresses the relationship with the patient. Understanding the whole CLI patient acknowledges the true CLI patient we meet in our clinic, who is no longer alone. We need a compassionate understanding and intervention to do the right thing for these patients: saving limbs, saving lives, and healing people with a life worth living through interventional empathy. Finding meaning in CLI therapy achieves the purpose of preventing harm and improving quality of life through mindful connection and appropriate intervention. ■

Disclosure: *The authors have completed and returned the ICMJE Form for Disclosure of Potential Conflicts of Interest. The authors report no conflicts of interest regarding the content herein.*

Manuscript accepted September 17, 2021.

Address for correspondence: Paul Michael, MD, Palm Beach Heart & Vascular, 2609 W. Woolbright Rd., Boynton Beach, FL 33436; Email: drpaulmichael@gmail.com