



# 4

## Empathy as a Way of Acknowledging Patients' Personhood in Palliative Care Interactions

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### Ageing, Dying, and Palliative Care

Ageing and dying are clearly intertwined issues, albeit ones that have not always been researched alongside each other (Gott and Ingleton 2011). There are also some key parallels and overlapping topics of debate and concern between these two areas. For example, Gott and Ingleton (2011) note that models of “successful ageing” define “‘success’ in terms of the ability to stave off ... death,” meaning that “there is no place for older people who are dying except, perhaps, as cautionary tales of ‘failure.’” This contemporary concern mirrors the “impersonal high-technology” (Miller 1992, p. 227) medical environment of the period after the Second World War, when an inordinate emphasis was placed on curing patients and, conversely, little attention was paid to the palliative aspects of medicine. This state of affairs is reflected in several reports released throughout the 1950s and 1960s (Clark 2007), three of which, in particular, inspired

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the founder of the palliative care movement, Cicely Saunders, to start gathering evidence and, eventually, to open St Christopher's (the "first modern hospice" (Clark 2007, p. 432)) in 1967 (Saunders 2001). As Clark (1999) notes (in language which echoes Gott and Ingleton (2011)), before the palliative care movement, there was "little attention [paid] to medicine's 'failures', to those in their last illness whose time was short" (p. 227).

Just as dying patients were neglected in the post-war era, so too is there the possibility of older, dying patients in the modern era becoming lost amidst the desire to fight off ageing on the one hand and death on the other. As Seymour and Gott (2011) note, "One of the central problems in all clinical decision-making relating to end of life care is the fluctuation and variability not only in personal wishes and preferences, but in individuals' abilities to express these." Concerns along these lines have also been raised by palliative care researchers, who have noted that dying is a highly individualised process and not amenable to one-size-fits-all conceptions. Stringer (2007), for example, shows death to be a "highly individualised concept" (p. 25). Staff and patients may differ in what they consider to be "a good death" (Payne et al. 1996), and concerns have been raised about patients feeling pressured to conform to cultural expectations about what constitutes a good death (Goldsteen et al. 2006; Hart et al. 1998; Macnamara et al. 1994). An illustration of this can be seen in Goldsteen et al.'s (2006) interview study with terminal patients and their family members. Participants acknowledged that they were culturally expected to, for example, accept or communicate openly about death. Participants did not always fit these expectations, however, with some showing a lack of acceptance or an unwillingness to communicate. As Goldsteen et al. (2006) conclude, "what can be considered a good death is something that cannot be defined beforehand ... and is not the same for everyone" (p. 384).

In theory, the palliative care movement avoids these issues, built as it is around a holistic approach which takes into account not only patients' physical pain but their emotional and spiritual pain as well (Baines 2011; Saunders et al. 1995). However, there has been no prior research looking at how doctors actually put such principles into practice. Given the aforementioned possibility that older patients' personhood may be neglected,

however, it is important to get a sense of how experienced palliative care practitioners actually go about treating older patients as persons with their own thoughts, feelings, and experiences. I do so here by analysing a set of interactions between doctors and older patients in palliative care, focusing particularly on how the doctors display an empathic understanding of these patients' emotions. Displaying empathy is, I show, one of the key ways in which palliative care doctors acknowledge older patients' personhood at the end of their lives.

I start by establishing my approach to empathy, which will be not as an internal mental state, but as an interactional phenomenon. I then review some of the prior work on empathy in this interactional tradition before moving on to the analysis itself. This analysis is based around a series of extracts taken from interactions between doctors and older patients in a hospice. Through these extracts, I show how doctors' displays of empathy ensure that the focus remains on older patients as whole persons.

## Empathy as an Interactional Phenomenon

Empathy is a notoriously difficult concept, with several articles devoted simply to trying to define and disentangle it from the related concept of "sympathy" (see Wispé 1986). In their reviews on the subject, Hemmerdinger et al. (2007) and Pedersen (2009) show how empirical research on empathy research in medicine has overwhelmingly fallen into one of two traditions. Medical communication researchers in the first tradition have used scales and questionnaires to "measure" empathy, whether that is by asking patients to rate how empathic their doctor was in a particular interaction (e.g. the Consultation and Relational Empathy (CARE) Measure (Mercer et al. 2004)), or by asking doctors to answer a series of questions with the aim of determining how empathic they are (e.g. the Jefferson Scale of Physician Empathy (Hojat et al. 2001)).

In the other tradition, medical communication researchers have observed actual doctor-patient interactions to identify and rank empathic moments. A major body of work has, for example, been built up around the concept of "empathic opportunities" (Suchman et al. 1997), which

are moments where patients say something which could, potentially, allow for an empathic response from the doctor. Researchers have developed scales to identify empathic opportunities, often with the aim of ranking the empathic quality of the doctor's response. The Empathic Communication Coding System (Bylund Makoul 2002), for example, rates doctors' responses on a six-point scale, ranging from zero (the physician's denial of the empathic opportunity) through to five (the physician shares in the empathic opportunity, offering an experience of their own analogous to the patient's).

This chapter is more closely aligned with the latter tradition than the former, inasmuch as it also uses actual doctor-patient interactions as data. However, as various critiques have pointed out (Sandvik et al. 2002; Stone et al. 2012), coding systems for empathy can be problematic because they are attempting to neatly encapsulate something that may be done in subtle ways that go beyond the boundaries of pre-established codes. Rather than identifying and ranking empathic moments, therefore, I approach empathy as something which exists within the interaction between doctor and patient. My chosen method in doing so is conversation analysis (CA), which treats interaction as an orderly phenomenon amenable to structural analysis (Sacks 1995; Psathas 1995). See Chap. 2, this volume, for discussion of other forms of discourse analysis.

## The Conversation Analytic Approach to Empathy and Emotion

Conversation analysts Hepburn and Potter (2007) suggest that empathy can be approached in two ways in interaction. The first approach, similar to the one outlined earlier, would involve developing a definition of empathy and then looking for examples of that definition in interactions. The second approach (the one that they, and I, adopt), meanwhile, involves using "interaction analysis to critically explore and perhaps respecify" (p. 99) notions of empathy. In other words, rather than treating empathy as an object that *manifests* in talk, this approach sees empathy as something that is intrinsically interactional and *part of* talk.

A similar approach is outlined by Silverman and Peräkylä (1990). They note that classic accounts of empathic communication treat it as a mental process that gets communicated through talk. However, as they go on to argue, such accounts are treating public behaviours as indicators of inaccessible mental processes. The approach that they advocate is thus to set the mental processes aside and focus instead on the “logic of public actions only” (p. 313). As Ruusuvuori (2005) notes, this means seeing empathy “as [a] sequential [process] in talk-in-interaction” consisting “of turns of talk rather than a sequence of experiences” (p. 206).

The approaches advocated by Hepburn and Potter (2007), Silverman and Peräkylä (1990), and Ruusuvuori (2005) find precedent in the so-called discursive turn in psychology (see Edwards and Potter (1992) and Harré (2001)). This turn has seen classic psychological topics approached as part of naturally occurring discourse, rather than as mental states. It thus differs from traditional cognitive psychological approaches, which do indeed research internal mental processes, and use non-naturally occurring experiments to do so. It also, in its strict focus on interaction and how psychological concepts are employed within it, differs from other forms of discourse analysis (particularly critical discourse analysis) which link language to wider social structures or processes.

To give one example of such research, particularly relevant to this chapter, Edwards (1999) analyses emotion discourse, showing how emotional concepts are employed in interactions between a married couple (Connie and Jimmy) and a marriage counsellor. He shows how Connie ascribes the psychological concept of “jealousy” to Jimmy as an enduring trait and how Jimmy resists this ascription by establishing that his “anger” was a circumstantial response to provocation on Connie’s part. Psychological concepts, rather than being approached simply as mental objects, are thus treated in Edwards’s (1999) analysis as performing discursive actions in interaction (see also Harré and Gillet 1994).

This is in line with other “interactionist” (Hochschild 1979, 2003) work on emotion, particularly by CA researchers, which has focused less on “individuals and their emotional messages” and more on “the ways in which emotional displays are put to use and treated in the process of interaction” (Ruusuvuori 2013, pp. 332–333). This has included work on how emotions are displayed in relation to other speakers’ talk (Selting

2010; Wilkinson and Kitzinger 2006), research on how emotional displays (e.g. laughter and crying) can be used to perform delicate interactional tasks (Jefferson 1985), and research on how such emotional displays are responded to (Hepburn and Potter 2007, 2012; Moore 2009; Weatherall 2015; Weatherall and Stubbe 2015). (See Peräkylä and Sorjonen (2012) for a collection of CA work in this area.)

## Prior Conversation Analytic Research on Empathy

So far, I have established that my approach is grounded in a discursive understanding of empathy and emotion, which treats these classic psychological topics not as internalised states but as interactional phenomena. I now review some of the empirical findings that have emerged from prior work in this tradition. Such work can, broadly, be divided into that which has examined empathy in everyday interaction and that which has researched empathy in institutional environments (including, as is the case in this chapter, medical interaction).

In the everyday interaction tradition, Gail Jefferson (1988) suggests that speakers can respond empathically when another speaker is relating a troublesome experience. This might include, for example, saying “How awful” when the other speaker reaches a particularly strong emotional point in their story. John Heritage (2011) goes further by outlining a spectrum of responses that speakers use when responding to other speakers’ troubling experiences. These range from unempathic responses like asking an “ancillary question” about a side issue only tentatively related to the experience that has been described (e.g. a listener asking about a speaker’s tan when the speaker has been talking about a fun holiday experience), through to highly empathic “response cries” whereby the listener simulates the response that they imagine that the speaker would issue in the situation that they have described (e.g. “Ohhh go: (d)”). Kupetz (2014), meanwhile, suggests that listeners use “response cries” and other such “fleeting” empathic responses in the early stages of a speaker’s story, before moving to more substantial empathic displays as the story develops. She gives a specific example of a speaker telling her friend about the death of her grandfather. In the early stages of this story,

the friend displays empathy nonverbally using facial expressions (raising her eyebrows and dropping the corners of her mouth). The friend's empathic displays become more verbal and substantial as the story goes on, however, reaching a point where, after the speaker has finished, her friend shows her understanding by talking about the death of her own grandfather.

CA research on empathy in institutional interactions, meanwhile, has been far more extensive and diverse, covering a range of environments from psychotherapy (Muntigl and Hovarth 2014; Muntigl et al. 2014; Voutilainen 2012; Weiste and Peräkylä 2014; Wynn and Wynn 2006), helpline calls (Hepburn and Potter 2007; Kitzinger 2011; Moore 2009; Pudlinski 2005), general doctor-patient interactions (Ruusuvuori 2005, 2007), HIV/AIDS counselling (Silverman and Peräkylä 1990), to disaster relief (Kuroshima and Iwata 2016) and health visitor interactions (Heritage and Lindström 2012). While a full overview of this research goes beyond the scope of this chapter, a few recurring themes from it are particularly relevant to the analysis later, and are thus worth covering.

First of all, researchers on institutional interactions have, like researchers on everyday interactions, attempted to delineate empathic conversational practices. One such practice is that of a professional "formulating" (i.e. reworking in some way) the talk of a client. Formulations are typically divided into gist and upshot formulations, with the former referring to one speaker summarising what another has said and the latter referring to drawing out the implications of what another speaker has said (Heritage and Watson 1979). The empathic potential of such formulations is that they can display an understanding of the emotional resonance of what a client has just said. While formulations are perhaps the most commonly identified way for professionals to display empathy for clients, they are by no means the only empathic practice found in the CA literature. Alternative practices include relating a similar experience (Heritage and Lindström 2012; Kuroshima and Iwata 2016; Ruusuvuori 2005; Wynn and Wynn, 2006), naming the client's feelings (Muntigl and Hovarth 2014; Hepburn and Potter 2007; Pudlinski 2005; Wynn and Wynn 2006), and assessing the client's experience (Pudlinski 2005). CA researchers have also focused on non-semantic ways for professionals to

display empathy for a client's experiences, including embodied actions (such as a psychotherapist placing a hand on her client's shoulder) (Wynn and Wynn 2006), intonation (Weiste and Peräkylä 2014), and response cries (Kitzinger 2011).

CA researchers on empathy in institutional interactions have also focused on how empathy interacts with the functions that these institutions perform. Ruusuvuori (2005, 2007), for example, shows how doctors can use empathic statements in response to a patient's description of their problems to both reassure the patient and to move the interaction forward to the prescribing of a treatment. In telephone helplines, meanwhile, researchers have shown how call takers can avoid displaying empathy in direct response to callers being upset, instead leaving their empathic responses to the end of the call so as not to disrupt the flow of the institutional task (Kitzinger 2011; Weatherall and Stubbe 2015).

In this section, I outline my interactional approach to empathy. This approach involves studying empathy not as an internalised trait or process (as has traditionally been the case in empathy research in medicine) but as an interactional phenomenon. Having situated my approach within the "discursive turn" in psychology, I then outline some of the prior interactional research done on empathy, establishing a precedent for my analysis by showing how it has yielded valuable findings in the past. With all of this established, I now show how I have put this approach into practice in my analysis of doctors displaying empathy when interacting with older patients in palliative care.

## Research Example: Ways of Doing Empathy with Older Patients

In the previous section, we saw multiple different definitions and conceptualisations of empathy. For the purposes of this analysis, empathy is defined as *the doctor's expressed understanding of the patient's emotional experience*. This definition was, in line with Hepburn and Potter's (2007) suggested approach, developed in tandem with data analysis rather than prior to it.



This analysis is structured around five extracts from palliative care consultations.<sup>1</sup> These extracts are all drawn from wider collections of the phenomena that they illustrate. There were two key criteria when selecting extracts for this chapter. The first was age—where possible, given the choice between examples, I tried to select the example featuring the older patient. It was also important, though, that the extracts be strong examples of the phenomena that they were selected to illustrate, and could also fit reasonably within the confines of this chapter (many examples would require extensive contextualisation). The selection process was, as such, a balance between these two factors.

In the first two extracts, I show how palliative care creates a space for patients to tell stories that, strictly speaking, go beyond the biomedical remit. I also demonstrate how doctors can empathise with the emotions touched off by such stories. The next extract, meanwhile, highlights how doctors can empathise with patients in the course of discussing their biomedical symptoms. The final two extracts then demonstrate how doctors can display empathy with patients' emotions when those emotions clash with the care that is being offered. The focus throughout is on how doctors' empathic displays are used to show an understanding of older patients as persons, rather than objects to be treated. This idea is developed in detail throughout the analysis.

## Patients Telling Stories

Extract 4.1 comes from a consultation in which the (female) patient's friend—labelled “Com” for “Companion”—is telling the (female) doctor a story about how she found the patient struggling to breathe (the patient herself is aged 64). This was the first occasion on which

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<sup>1</sup> The data for this chapter are taken from 37 recordings of doctor-patient hospice consultations, which were collected as part of the “Video-based communication research and training in decision-making, empathy, and pain management in supportive and palliative care” (VERDIS) Project (see <https://tinyurl.com/ybk8t3mz>). Researchers on this project obtained full consent from participants for the use of their recordings in research as long as the recordings were appropriately anonymised. With this in mind, pseudonyms are used in place of the patients' real names in this chapter. It should also be noted that, while the overwhelming majority of patients in the data were indeed older, this was not true in every case.

they became aware of the patient's illness, and this led to the patient's initial hospitalisation.

**Extract 4.1 Oh gosh [P43/F: 9.23 – 9.53]<sup>2</sup>**

- 1 Com: She just managed to eat a tiny little  
sandwich.=And then she  
2 said she wanted to go toilet. .hhh So I says,  
'Okay.' I've  
3 got a chairlift anyway.=She went toilet. (0.4)  
And she was  
4 up there for some ti::me. (1.0) An::d uh::  
(0.3) I says,  
5 'Blythe.' (0.4) 'Blythe.' (0.4) 'Blythe.' (0.6)  
Eventually I  
6 went up. (0.7) She was sitting on the  
loo.=Lea::nin' (.)  
7 over the s:ink. (0.3) And she was going blue.  
8 Pat: Mm-hm.  
9 **Doc: Oh gosh.**  
10 Pat: ((Coughs))  
11 Com: Y:[ou know uh: ]  
12 Doc: **[Must have been fright]ening.**  
13 Com: It was really scary. She couldn't breathe.

A traditional approach to empathy might focus on what the doctor is “feeling” at this point in the interaction. This might involve, for example, giving the doctor a questionnaire after the consultation and asking what they were thinking about when they displayed empathy. It could also involve giving such a questionnaire to the patient and asking whether they felt empathised with at this moment. (See, again, Hemmerdinger et al. (2007) and Pedersen (2009) for reviews of such measures.)

By contrast, this analysis is grounded in an understanding of what role the doctor's empathic turns at lines 9 and 12 actually play in the interaction. In other words, *why* does the doctor display empathy at this stage

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<sup>2</sup>Extracts are presented using the conventions laid out by Jefferson (2004). These conventions were developed specifically for the transcription of talk-in-interaction, and thus render not only *what* was said, but *how* it was said (intonation, breathiness, etc.), where it was said (e.g. when two speakers talk in overlap), and any pauses or gaps within the talk. A glossary of the symbols used in this chapter can be seen in the appendix. (See, also, Hepburn and Bolden (2017) for a more detailed discussion.)

and what effect does it have on the unfolding interaction? To answer this, we can turn to the story that the patient's friend has been telling up to this point. We can see from lines 1–6 how the patient's friend has been building up to the point where she discovered the patient in the bathroom. She ultimately reaches this point at lines 6–7 where she describes how she found her friend “Lea::nin' (.) over the s:ink ... going blue.” This is clearly, then, a shocking emotional moment in the context of the story that she is telling. The doctor empathically recognises this emotional impact by both doing a response cry (“Oh gosh”) simulating the shock that one must feel at finding a close friend in that situation (Heritage 2011), and in her use of the adjective “frightening” to suggest how the situation “Must have been.”

Aside from the doctor showing an understanding of the emotional impact of the events of the story itself, there is a broader point here about the patient's friend telling this story to begin with. It is worth pointing out that, medically speaking, it is not strictly necessary for the doctor to hear this story. As noted above, the events within it happened at the beginning of the patient's illness, leading to her initial hospitalisation. Any relevant medical information from the story (about the patient's condition etc.) could thus be gleaned from the patient's medical records.

The patient's friend being given the opportunity to tell this story is thus, in itself, representative of the underlying philosophy of palliative care. In this environment, patients and their companions can tell stories that, within a stricter biomedical framework, would be deemed unnecessary. Furthermore, doctors, rather than cutting off or ignoring such “life-world” stories (as has traditionally been seen as the case in other medical environments—see, for example, Mishler (1984)), engage and empathise with them. This gives an initial illustration, therefore, of what is meant about empathy being a way for doctors to acknowledge patients' personhood in palliative care.

A further illustration of this point can be seen in Extract 4.2. This extract comes from a consultation in which the (male) patient (aged 57) is telling the (female) doctor about various stresses that he has been experiencing as a result of his illness. One such source of stress, and the focus of his story, has been the various problems that he has had getting the necessary adjustments made to accommodate his wheelchair. As with the

previous case, the extract begins just as the patient is bringing his story to a particularly emotional point.

**Extract 4.2 That's adding quite a bit of stress, is it? [P02/A: 20.48 – 21.48]**

- 1 Pat: S:o anyw↓ay (0.5) shih they're coming back u::m  
(1.7) on
- 2 (the eleventh I think.= Needs) to rip all that  
down and redo it.
- 3 (0.3)
- 4 Doc: **Oh de:a:r.**
- 5 Pat: U::m (0.5) (now) Nick has taken (the) day  
off.=She's gonna be  
6 there.  
7 (0.4)
- 8 Doc: Mm.
- 9 Pat: Because they're supposed to cover the bed  
up.=Because  
10 obviously the door was shut.=So I d- I didn't  
see what was going  
11 on.  
12 (0.9)
- 13 Pat: And when Nick came home in the evening (0.8)  
u::m (0.3) I tried  
14 to sweep up the bits (). shih And Nick  
come back.=  
15 I did see what was on the b↑ed.  
16 (0.5)
- 17 Pat: (There/It) was all (like) u::m metal filings all  
over the bed  
18 and that.  
19 (0.8)
- 20 Pat: So: Nick went mad about that.=NOT (.) not at me,
- 21 Doc: Mm.
- 22 Pat: You know.= (But/At-) at them.=They (uh) they  
should have done it.  
23 shih  
24 (1.7)
- 25 Pat: pt. So she's (taken/taking) the day off to u::m  
(0.3) make sure  
26 she's there,  
27 (0.7)
- 28 Pat: And that.

- 29 (1.0)  
 30 Pat: To make sure it's done properly this time.  
 31 (1.5)  
 32 Pat: [ (A:nd- ) ]  
 33 Doc: **[And that's adding quite a bit of: s::tre:ss is it.**  
 34 Pat: Yea:::h.=  
 35 Doc: =(Yeah./Mm.)

The structure of this extract is similar to Extract 4.1. From lines 1–2, the patient brings his story to a dramatic peak, revealing that the workers are going to have to come back again in the future to “rip all that down and redo it.” Given that this work has been stressful for him before, the workers having to come back and do it again is clearly, in the context of his story, a highly negative development. The doctor displays understanding of this negative impact on the patient with her empathic turn at line 4: “Oh de:ar.”

In response to this first empathic display, the patient adds further details to his story, noting that his wife (Nick) will have to take the day off work the next time the workers come because, last time, the workers made a mess. After the patient has added these further details, the doctor displays her understanding again at line 33, noting that these events have “[added] quite a bit of: s::tre:ss” to the patient’s situation.

As with Extract 4.1, the story that the patient is telling in this extract is not strictly necessary for the doctor to hear. It is not, after all, as though the doctor will be able to do anything to resolve or otherwise directly affect the situation that the patient is describing, this being a bureaucratic problem with the local authorities more than anything else. The patient’s problem is not, in other words, “doctorable” (Heritage and Robinson 2006), and the conversation that he is having with the doctor is much closer to a “natural [conversation] between friends” (Barry et al. 2001, p. 497).

It is precisely this lack of doctorability, though, that makes this extract another strong example of a palliative care doctor engaging with a patient in a way that goes beyond what would be expected or needed within a traditional biomedical framework. By listening to and empathising with the patient’s story, this doctor is, like the doctor in Extract 4.1, showing an appreciation of the patient as a person with his own unique experiences and emotions. Towards the end of the consultation, the patient

does, in fact, show his appreciation at having been given the opportunity to tell his story, as can be seen in Extract 4.3.

**Extract 4.3 Sometimes it's nice to just chat**  
[P02/A: 56.05 – 56.22]

- 1 Doc: And we'll met again next wee:k [yeah.]  
 2 Pat: [Yea:]:h.  
       (But) sometimes  
 3 it's nice to: (0.6) (to just) chat to an individual.  
 4 Doc: Mm.  
 5 Pat: You know.

Extracts 4.1 and 4.2 have both given a sense of how palliative care doctors can create the space for older patients to tell stories that are not strictly biomedical in nature. We have also seen how doctors can empathically engage with those stories. Despite having a wider scope than traditional biomedicine, though, palliative care is still grounded in biomedical conditions—the patients in Extracts 4.1 and 4.2 would not be in the hospice in the first place, after all, if they were not seriously physically ill. We now see how doctors go about engaging with patients' personhood while simultaneously addressing their physical conditions.

## Acknowledging the Person Behind the Symptoms

Extract 4.4 comes as the (female) doctor is asking the (male) patient (aged 64) about his breathing. As the extract begins, the patient is talking about how he monitors his oxygen levels using an oximeter and how these levels can drop when he is engaged in physical activity.

**Extract 4.4 That's scary, isn't it? [P23/F: 10.03 – 10.22]**

- 1 Pat: It doesn't matter what (0.4) what the oxygen's on,  
 2 (0.4)  
 3 Doc: Yeah.=

- 4 Pat: =As soon as I start to do any wa::lkin',  
everything just  
5 goes straight do:wn.=
- 6 Doc: =Okay.
- 7 Pat: (And) it goes down (.) right into (th-) .hhh hhh
- 8 Com: Low six[ties.]
- 9 Pat: [Low- ] low s- low seventies, s:ixties,
- 10 Doc: Okhay.
- 11 (0.3)
- 12 Pat: I mean I've had it d- right down as low as fifties.
- 13 Doc: °Gosh.° That's scary isn't [it].
- 14 Pat: [And that- that's with: .hh with  
15 the oxygen as wh- well.
- 16 Doc: Okay.
- 17 (0.7)
- 18 Doc: °Okay.°=
- 19 Pat: =But uh\_\_
- 20 (1.1)
- 21 Doc: Okay. .hh So I'm hearing that you fee:l (0.3)  
probably a bit  
22 frustrated really that the oxygen is- is the way  
that it i:s,
- 23 Pat: Yeah.
- 24 Doc: Have you- have you talked to Doctor Fairclough.=Have  
you talked to the oxygen tea:m about that.

In some senses, Extract 4.4 is similar to Extracts 4.1 and 4.2. It does, after all, feature the patient telling a story (between lines 1 and 12) and the doctor, at a particular point in that story (line 13), doing an empathic display (“Gosh. That’s scary isn’t it.”) that acknowledges the emotional impact that the events of it have had on the patient. The crucial difference lies in the motivations behind those stories. In Extracts 4.1 and 4.2, as suggested earlier, patients told stories for reasons that would be superfluous in a strictly biomedical framework—doctors did not need to hear them to address their conditions.

In Extract 4.4, on the other hand, it is necessary for the patient to be telling his story because it is through that story that the doctor will be able to understand her condition and offer appropriate medical help. In this sense, the issue of the patient’s personhood is even more relevant in Extract 4.4 because, as Mishler (1984) has noted, there is the possibility of a patient’s symptoms being “stripped” of their context, becoming mere

biomedical objects rather than events with potentially strong emotional consequences for those who are experiencing them. By showing her understanding of how the patient's oxygen levels dropping would be "scary" for him, the doctor ensures that the focus remains on him rather than on his symptoms. Again, then, we can see how empathy is a way of acknowledging the patient's personhood in palliative care.

However, this does not mean that the interaction then becomes *about* the patient's emotions. Rather, as we can see in the extract, after the doctor has displayed her empathic understanding of how "scary" the patient's symptoms are, she goes on to ask him whether he has spoken to "Doctor Fairclough" and "the oxygen tea:m" at line 24. This is because the patient's emotions here have a biomedical cause and are thus potentially amenable to biomedical remedy (rather than being psychosocial and beyond the realm of biomedicine, like in Extracts 4.1 and 4.2). The doctor here is thus acknowledging the patient's personhood while *simultaneously* addressing his biomedical symptoms.

## Older Patients' Emotions and the Medical Agenda

To recap, we have now analysed three extracts. In the first two of these extracts, doctors gave older patients the space to tell stories that were not strictly "necessary" from a biomedical perspective, engaging and empathising with the details of them. In Extract 4.4, meanwhile, we saw how the doctor could show her understanding of a patient's personhood as he was describing emotionally charged physical symptoms, thus avoiding the "context-stripping approach" described by Mishler (1984, p. 164).

We now consider some examples where patients' individual emotions are not simply acknowledged in the course of palliative care, but actively clash with it in some way. To see what is meant by this, consider Extract 4.5. This extract comes from a consultation in which the (male) patient (aged 77) and the (female) doctor have been discussing what the patient would like to happen should he suddenly take a bad turn. The patient has said that he would like to be taken to the hospital only if there was a chance of returning him to his current, stable state. As the extract begins, the doctor is summarising her understanding of the patient's wish.



**Extract 4.5 Not always the easiest thing to chat about [P38/G: 9.06 – 9.31]**

1 Doc: You feel happy (.)  
 2 Pat: Y(h)e[s. ]  
 3 Doc: [To-] to go in ((to the hospital)) if w- if  
 we thou:ght it  
 4 would reverse things.= [If it was a rever]sible  
 cause.  
 5 Pat: [Ye::s. Just- ]  
 6 s'long as it got me back to square one °shorta  
 thhing.°  
 7 Doc: Okay.=  
 8 Pat: =Ye[s. ]  
 9 Doc: [>Okay.<=]That's really helpful.=Thank you  
 10 [for t]alking that through.  
 11 Pat: [Yeah.]  
 12 (.)  
 13 Doc: **I know it's not always the easiest thi:ng [to uh ]**  
 14 Pat: [pt. No.]  
 15 [No.]  
 16 Doc: **[to ] chat about.**  
 17 Pat: No.  
 18 (0.3)  
 19 Doc: (Mm./No.)=  
 20 Pat: =But I can (1.4) all the f- when I- when it is  
 ti:me .hh  
 21 all the family can be with me you see

When older patients enter palliative care, they are often asked to make difficult decisions about the future, and what they would like to happen as their condition continues to deteriorate. Such discussions are an important part of palliative care for older patients (see, e.g. Detering et al. (2010) on advanced care planning, and Seymour and Gott (2011) on end-of-life decision-making), ensuring that the care provided will, where possible, be in accordance with their wishes. For all their medical importance, though, there is the potential for such discussions to be difficult or upsetting for patients, touching as they do upon “dreaded issues” (Peräkylä 1995) such as declining health and, ultimately, death.

In Extract 4.5, we can see how the doctor balances discussion of these issues with recognition of this difficulty. From lines 1–11, the discussion these future planning is wrapping up, with the doctor clarifying the

patient's stance (lines 1 and 3–4), and thanking him for having talked it through with her (lines 9–10). She then, at lines 13 and 16, shows her understanding that these matters are not “always the easiest thi:ng” for patients to “chat about.” From a strict biomedical perspective, of course, whether a topic is “easy” to chat about or not is irrelevant. By showing her recognition of this difficulty at this point in the interaction, then, the doctor is ensuring that the patient's personhood remains in focus, even as she is carrying out a medical task.

An even stronger example of this kind of balancing act can be seen in Extract 4.6. This extract comes from a consultation in which the (female) patient (aged 64) and her (male) partner have been complaining about a doctor at the hospital who advised her to exercise. The patient found this advice offensive because she took it to imply that she must be exaggerating her illness. The problem for the (female) doctor here is that this advice, while perhaps badly delivered by the other doctor, is at its root medically sound. How then can she convey advice that is valid from a *medical* perspective, but would be difficult for the patient, as a person, to follow? Extract 4.6 exemplifies this dilemma; it begins as the doctor is explaining to the patient how exercise can help her condition.

**Extract 4.6 I know that's hard [P35/F: 15.59 – 17.05]**

- 1 Doc: What we (0.3) do kn<sub>o</sub>:w (0.4) .hh (.) i::s that  
 2 try::i::ng t<sub>o</sub>: (0.3) h:el<sub>p</sub> you <m:a:nage> the  
 3 breathlessne::ss: (0.4) so that (0.6) y:ou can be  
 as active >as  
 4 you >><sup>o</sup>chan.<sup>o</sup><<=**Now I know that's ha:rd and [I**  
**know] you've got=**  
 5 Pat: [Mm-hm.]  
 6 Doc: =**lots of other stuff going on as we:ll**, .hhh (0.6)  
 But  
 7 we do:: kn<sub>o</sub>:w (.) that maintaii:ning (.) a little  
 bit of  
 8 activity:: .hh is the thing that's going to keep you  
 9 living (0.3)  
 10 Com: Lon[ger.  
 11 Pat: [Longer.  
 12 Doc: [longer.]

From lines 1–4, the doctor is explaining to the patient the importance of “[managing] the breathelessne::s” so that she can be “as active [as she can] >>°chan.°<<.” Immediately after saying this, however, the doctor at lines 4 and 6 acknowledges that this advice could be “ha:rd” for the patient to follow, given that she has “lots of other stuff going on as we:ll.” She then returns to delivering her advice from lines 6–9 and 12, emphasising that “maintai:ning (.) a little bit of activity::” will keep the patient “living ... longer.”

The doctor in this extract has walked a delicate tightrope. On the one hand, she has reiterated the same advice given to the patient by the doctor at the hospital—the advice that, on that previous occasion, the patient reported herself as having found offensive. As she has done so, however, she has also recognised how “ha:rd” it would be for the patient to follow this advice. The doctor’s empathic recognition of the patient’s personhood is particularly important here, therefore, because the patient has complained about the *lack* of such recognition shown by another doctor.

## Conclusion

In this chapter, we have seen how palliative care doctors can display empathy at various points in their interactions with older patients. In the first section of the analysis, we saw how doctors could give older patients the space to tell stories around their conditions that were not, strictly speaking, necessary to hear in a medical environment. In the second section of the analysis, we saw how doctors could acknowledge the emotional and experiential difficulties caused by older patients’ physical symptoms, whether that was finding it difficult to cough or finding it scary when their levels dropped. Finally, in the third analytic section, we saw how doctors could acknowledge older patients’ emotions at points where those emotions clashed in some way with the medical agenda, whether that was a difficult discussion about planning for the future or a piece of advice that the patient had, on a previous occasion, found offensive.

Researchers have previously raised concerns about an overemphasis on the limited conceptions of “successful” ageing (Gott and Ingleton 2011), and the difficulty of taking into account older dying patients’ individual preferences (Seymour and Gott 2011). This echoes both historical research on the idea of death as a “failure” (Clark 1999) and research showing that the dying process is highly individualistic, with each person bringing their own unique standards, expectations, and experiences (Goldsteen et al. 2006; Hart et al. 1998; Macnamara et al. 1994; Payne et al. 1996; Stringer 2007).

In this chapter, I have shown how empathy is a way for doctors to display an appreciation of older patients’ individual qualities in end-of-life care, be that for its own sake (as in the first section of the analysis) or in the course of carrying out some medical task (as in the second and third sections). In line with palliative care’s underlying philosophy (Baines 2011; Saunders et al. 1995), then, empathy is a key means via which doctors acknowledge older patients’ personhood, ensuring that the care provided for them in the final stages of their lives remains focused on them as human beings rather than their illness as a detached biomedical object.

Aside from this core finding, there are several additional implications of the research outlined in this chapter. The first is that it demonstrates the benefits that close discursive analysis can have for research in the psychology of ageing. It shows, in other words, how an approach rooted in language and interaction can shed new light on matters that have not traditionally been approached in this way. While the discursive turn has had implications across all areas of psychology, there is much to suggest that it could have particular benefits for ageing research. Many issues around ageing are, after all, already rooted in language and communication. Although the specific focus of this chapter, therefore, has been on empathy and emotion, there is no reason why these other issues could not be equally amenable to, and could not equally benefit from, the same approach.

Adopting an approach rooted in actual interactions also means that the findings outlined in this chapter have practical implications for doctors working with older patients at the end of their lives. This is particularly true of the latter part of the analysis, where we saw how doctors could integrate empathy into clinical tasks to ensure that they took into

account older patients' emotions and personhood. While we saw only two examples of this, there is no reason why empathy could not be integrated into a range of clinical tasks. The earlier parts of the analysis, as well, showed how doctors could either create the space for patients to disclose their emotions or empathise with patients' emotions in the course of dealing with other matters. Again, this is a finding with a potential applicability that goes far beyond the few examples of it shown here.

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## Appendix: Glossary of Transcription Symbols

:::	Colons indicate that the immediately preceding sound was elongated, with more colons meaning greater elongation.
—	Underlining indicates that the underlined sound was emphasised.
()	Brackets indicate that the hearing is tenuous or unclear.
=	Equals sign indicates that two pieces of talk are connected.
.,	Indicate different forms of ending intonation. A full stop indicates a fall and a comma indicates a partial rise.
[ ]	Square brackets indicate overlapping talk.
(1.0)	Numbers in brackets indicate pauses, timed to the nearest tenth of a second.
(.)	Indicates a micropause, smaller than 0.2 seconds.
° °	Degree symbols indicate that talk was noticeably quiet.
.hh hh	Standalone h's indicate inbreaths (preceded by full stop) or outbreaths (no full stop).
> <	Inward-facing carets indicate that talk was noticeably fast.
< >	Outward facing carets indicate that talk was noticeably slow.

- (h) H inside brackets within a word indicates laughter.  
*Hhb* Italicised h within a word indicates breathiness.  
**Boldface** Used to draw attention to analytically relevant stretches of talk.  
 ↑↑ Up and down arrows indicate sudden shifts in pitch.  
 .shih Used to denote a sniff, e.g. when the speaker is crying (see Hepburn and Bolden 2017).

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