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The Art of Medicine:

When praise is worth considering in a difficult conversation

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In one of our recent communication skills workshops, we were helping a physician trainee talk to the wife of a patient with relapsed lymphoma. In this teaching scenario, the patient has become septic and is off stage in the intensive care unit; the physician is talking to the patient's wife, who he knows quite well. The wife has a seemingly bottomless well of questions. The physician, who had wanted to be empathic, was instead struggling to be civil ("I wanted to say", he explained later, "you're missing the big picture"). Although the physician tried answering all the wife's questions, she appeared more and more dissatisfied. The facilitator stopped the scenario to allow for discussion and brainstorming; the physician and the rest of the group were stuck. "I've seen people like this before. They're impossible!" So the facilitator made a suggestion. "It's fine to acknowledge to yourself that you are irritated. But when you respond, what if you address what's good about the wife's actions? What if you say," You have done an amazing job advocating for your husband. I realise that you are trying to make sure that every detail of his care is handled correctly. "The trainee looked sceptical. "Really?"

Physicians tend to overlook praise as part of the communication repertoire. Although we acknowledge that praise has received little attention empirically, we think praise deserves special mention because we find that, if used judiciously, praise is a powerful tool that can help deepen conversation and enable physician and patient to move through difficult conversations.

The facilitator restarted the conversation, and the physician praised the wife's effort. "Of course", said the wife, "this is my husband whose life is on the line". "Well", the physician responded, "I have taken care of a lot of very ill people and not every family makes this kind

of effort. I'm impressed with all that you have done.” “Hmmm”, said the wife, who thought for a minute before speaking again. “Thank you for saying that. Sometimes I worry that the nurses just think I'm nosy. But every time I leave I'm so worried about what could happen. He's hanging on by a thread.” Later in the debriefing, the physician named this moment as the turning point in the conversation. The wife, when asked by the facilitator what she was thinking about at that moment, said “I felt the doctor recognised something of what I was going through, that he could see that I was trying to be the best wife possible.” The physician's praise enabled the wife to articulate the concerns running underneath her questions.

As with other communication skills, praise seems to be intuitive when performed fluently by an expert. Yet communication skills are largely learned, and constitute a distinctive expertise repertoire within doctoring. One speculation about why physicians tend to neglect praise is that they associate praise with feedback on their performance. A common educational practice in the USA is the “feedback sandwich”, in which a piece of negative feedback is “sandwiched” between two pieces of positive feedback, presumably to make the negative feedback more palatable. The upshot is that many American medical trainees have been conditioned to regard positive feedback as an introductory statement for negative feedback. These trainees have learned to brace themselves after the “but” for the real point. Thus, we want to distinguish positive feedback given by educators on a trainee's behaviour from praise given by a clinician to a patient or family member about their intentions or efforts.

We use praise to show a kind of respect for the person, offering our esteem for the way they cope with a scary, complicated, and often lonely situation. In considering the use of praise, it is useful to note that the words exchanged between a family member or patient and physician carry both a cognitive meaning and an emotional meaning. In the workshop example above, the cognitive meaning of the wife's questions about the details of her husband's care often overshadows the emotional meaning of these questions, which is about how a good wife should make sure nothing is missed. When the physician recognised the wife's effort, he recognised the wife as the kind of person who is trying her best. The physician found something in the wife that he could genuinely respect.

Praise applied indiscriminately can backfire, however. Praising family members and patients will make things worse if the praise seems inauthentic or patronising. One helpful guideline is that the opportunity for praise is often easier to see in a patient's (or family's) effort or intention than in their actual behaviour. When a patient brings in folders of internet printouts, for example, a physician might be irritated by the printouts but still able to respect the effort the patient is putting in to learning about his or her illness. To put it another way, finding an opportunity to praise requires that the physician start to see a story in the patient's or relative's behaviour that puts them in a favourable light. Often the story is about a person who is trying to do their best, yet finds their actions motivated by worry, frustration, anxiety, or anger to be interpreted by clinicians as unhelpful or hostile. What the physician sees in the moment may reflect worry or frustration—but in using praise he or she responds to the person's deeper motivation.

Another guideline is that praise requires that the physician has established some level of trust with the patient or family. We are cautious using praise with patients and families who do not seem to trust us, because of the risk that to them, praise could seem insincere, or worse, manipulative. For this reason, we consider praise to be more high-risk than other kinds of empathic responses, and tend to refrain if we are unsure that it would be received well.

Praise is not necessary in the same way that we think responding to emotion is necessary as a fundamental communication skill. Praise goes beyond what is required; that's what makes it memorable, and powerful. The necessary function of empathy is that it allows a physician to construct a conversational space (what Donald Winnicott called a "holding environment") that is, in the language of psychiatrists, "safe". In the context of a life-threatening illness, a neutral conversational space may not be enough to create safety. Praise, in our experience, can enable patients and family members to be more articulate in the moment about their pressing concerns. Perhaps by recognising their strengths, we give them the sense that they are valued in a way that enables them to talk more clearly about what is really on their mind—issues that seemed unbearable might become a little more discussable.

Additionally, using praise allows physicians to practise a kind of magnanimity. Magnanimity was for Aristotle "the crowning virtue"—what physicians do when they refuse to be petty, face life-limiting illnesses with courage and ingenuity, and act nobly. In some sense, we view praise as a practice that recognises virtue in others. But praise goes deeper than respect, in a way that may not be about virtue. Expressing respect is about voicing esteem, or a sense of worth; respect can also express deference to another person's right to hold a point of view. As we are using it here, praise comes from a more personal place than deference; we use it to affirm a sense of the worth of the other person. Perhaps because we most often use it in response to a cumulative series of interactions, praise is more intimate than esteem.

We find that patients and families often respond to praise with surprise. They are not accustomed to having their efforts acknowledged. The surprise may be part of the work that praise can do in communication. Praise, used in the way we describe, can function by creating a small positive experience (a contrast to the negative experiences that many patients and families have with serious illness), and research in other contexts indicates that this kind of positivity can enable people to "broaden and build" their personal resources in facing a difficult situation. Although we do not know of empirical inquiry into the possibility that praise could enable patients and families to build and broaden their resources, our experience is consistent with this hypothesis.

We acknowledge that much remains to be learned about what happens when physicians praise patients and families. Our experience with praise is mostly in working with patients and families experiencing severe, life-threatening illnesses, when the communication is about serious news, risky treatments, the likelihood that treatment failure will soon be followed by death, and allowing death to be more than a biomedical fact. Our experiences represent a particular slice of medicine, and may not be generalisable elsewhere. What we know about praise in other circumstances indicates that it is a complex communication act.

Parents who praise their children globally and indiscriminately may be influencing them to take fewer risks, and try less hard, because they don't want to fail in a way that invalidates their parents' glowing remarks. Psychologists who praise their borderline patients run the risk of reinforcing their patient's sense of inadequacy. What our experience suggests, however, is that praise is worth considering. Praise can perform an important role in the patient-physician relationship, as a communication tool that explicitly recognises the work that patients and family members do to deal with illness. When we can praise a patient's effort in an authentic way, we can move our own attention (and the patient's) above surface issues that might be vexing, and move the conversation to a more meaningful plane. Although not in any way a substitute for more fundamental communication skills like listening carefully, observing emotional cues, or providing medical expertise, what praise can add is a measure of personal engagement by a physician, and a sense of that physician's generous spirit that may otherwise be absent. It is the kind of gesture that enables a physician to practise medicine that feels less like a checklist and more like a personal handicraft.

Further reading

1. Back, A.; Arnold, R.; Tulskey, J. Mastering communication with seriously ill patients: balancing honesty with empathy and hope. Cambridge: Cambridge University Press; 2009.
2. Branson, P.; Merryman, A. NurtureShock: newthinking about children. New York: Twelve Hachette Book Group; 2009.
3. Comte-Sponville, A. A short treatise on the great virtues: the uses of philosophy in everyday life. New York: Vintage; 2003.
4. Frank, A. The renewal of generosity: illness, medicine and how to live. Chicago: The University of Chicago Press; 2004.
5. Slote, M. The ethics of care and empathy. New York: Routledge; 2007.