

Ep #37: Developing Empathy with Dr. David Carsten



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Welcome to *Practicing with the Masters* for dentists with your host, Dr. Allison Watts. Allison believes that there are four pillars for a successful, fulfilling dental practice: clear leadership, sound business principles, well-developed communication skills, and clinical excellence. Allison enjoys helping dentists and teams excel in all of these areas. Each episode she brings you an inspiring conversation with another leading expert. If you desire to learn and grow and in the process take your practice to the next level, then this is the show for you. Now, here's your host, Dr. Allison Watts.

Allison: Welcome to *Practicing with the Masters* podcast. I'm your host, Allison Watts, and I'm dedicated to bringing you masters in the field of dentistry, leadership, and practice management to help you have a more fulfilling and successful practice and life.

Tonight we have Dr. Dave Carsten. He holds a BS in biochemistry from Washington State University, a DDS from the University of Washington, and a certificate in anesthesia from Lutheran Medical Center in New York City. He was recognized with the Award of Distinction in Continuing Education from the Academy of Dentistry International in 2005. He taught at OHSU School of Dentistry from 1995 to 2008.

He lectures and writes on many topics. His particular interests are in the science and psychology of empathy, nutrition, pharmacology, and perception. He serves patients in the Spiritual Care Department at Salmon Creek Legacy Hospital in Vancouver, Washington and maintains a private mobile anesthesia practice.

Dr. Carsten is not a Buddhist. I think that's so funny. Dr. Carsten does however lecture with a Buddhist monk which I find very interesting and I'm sure we will come to that as part of your story here when we get started.

David: That's been in a lot of fun. You know, it's terrific to be here. I'm so pleased and honored that you invited me. I'm happy to share

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information. I like to hear myself talk but I like to talk to people and get questions and respond. It's just a lot of fun.

Allison: Great. I wanted to start off by asking you to talk a little bit—what I find so fun about you and intriguing and really interesting is the way that you come to this conversation both about empathy and nutrition. You're really a scientist at heart. I hear empathy talked about and I hear nutrition talked about, but a lot of people don't bring the science to it.

David: Yeah. In the last few years, there's been so much information coming out on empathy and in fact our medical colleagues have really had to notice it because it was so compelling. I definitely want to talk about that. But why don't you keep going, Allison?

Allison: That's what I was actually going to ask you to start with. I wanted you to share with us this, when we were talking I found that so interesting that they have—tell us about the MCAT.

David: Well, that's one of the really fascinating things that's happening in medicine right now is they're changing their training programs. Where this came from, as we all know, or we're probably aware, that for many, many years, dating back to 1900 roughly, physicians were taught that detachment was the way to go. That the physician should be the person that could be standing out in the field with death and mayhem around and being perfect cool and calm. Which kind of sounds like sociopathy, of not really caring.

With the idea that they wouldn't be involved in a patient's emotions and they wouldn't suffer from empathic distress themselves. They'd be able to make better decisions. But what began to be noted was that this wasn't leading to good outcomes. Patients oftentimes would feel very not cared about and that they would feel like the physician just wasn't in their best interests.

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In fact, some of this started with the work done by Jane Goodall where she started talking about empathy in a scientific context. She was severely criticized about that back in the 70s and 80s but then people started to take noticed that it had a real relevance. Research started being done on the topic of empathy and especially what institutions like Mayo Clinic, Jefferson Medical College, Cleveland Clinic, and Massachusetts General Hospital all came out with lots of information saying that an empathic healthcare provider would lead to better patient outcomes.

The one in particular, Jefferson Medical College, a guy by the name of Mohammadreza Hojat, came up with a way where you could actually measure empathy. What he was noting was that in training programs, both dentists and physicians would decrease in empathy as their training progressed. They would be the most empathetic as first-year students. They would become less and less and less and less until they finally came out as a practitioner and they would have the least empathy of their lives.

Combining that with the problem with poor outcomes has led the people in the medical community to want to change the MCAT. So in 2015, 50 percent of the questions are changing with the idea that they're going to look for doctors that are going to be more empathetic and more caring and more concerned about patients. So many of the residency programs that are having to go through the throes of how do we train these new people and how do we try to improve their empathy rather than decrease it?

Allison: Yeah. What about the DAT, has there been any conversation about the dental exam changing?

David: I have not noted anything. One of the reasons why I want to talk about this is because I think our dentistry, we think of ourselves

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as friendly and more gregarious. Yet, when we look at it in a scientific context, we're not really that much more empathetic, at least by measurement than the physicians are. Maybe they're in a little bit different circumstance than we are.

So the physicians are trying to address it and I'm hoping dentistry will as well. I think people like Sandy Roth and Mary Osborne and some of our different practice management people have been trying to address it for many years, but gosh, what percentage of people are listening and really taking that to heart? Because empathy has everything to do with how do you interact with patients, how do you create relationships? And how will you make long-term relationships with patients? How can you do a treatment plan and enlist the patient so that they want to follow through?

But how can you also know, what does that patient want as an outcome unless you can be empathetic? So maybe I should define empathy. That's one of the things that people oftentimes get confused about is what is empathy versus say sympathy. One of the things I always like to try to define is that you can even see this in the brain in the fMRI studies that empathy has to do with our mirror neurons and our ability to try to understand what's going on to somebody or an animal in front of us. So we're trying to understand. It doesn't really involve our emotions.

Sympathy on the other hand, is a different set of neurons. Sympathy has to do with how we feel about that. Not so much are we trying to get into how they're feeling and we feel it ourselves but we're thinking of our own stuff. So if you're living in empathy, you're thinking about that person or patient in front of you. If you're in sympathy, it's about you.

If you look at what do the best practitioners, or who we would recognize as the most understanding people do, is they spend

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most of their time in that empathy part of trying to understand. Because what does the patient really want? They want you to understand them. Then they'll drift over into the sympathy part of, gosh, you know, if I were in that situation, I'd feel X. But they get right back to the empathy part. So they only spend a little bit of time there.

These sets of cells are inhibitory. If you're in empathy, you're not in sympathy. If you're in sympathy, you're not in empathy. The real question is, who is it about when you're in a patient relationship? Is it about you? Or is about them?

Allison: Wow. That's a nice distinction. Yeah, is it about you or is it about them? Exactly. How does that work, how can we get better at empathy?

David: Part of it is inherent. You have to have some of that wiring to start with. There's a certain percentage of our population that does not. Right now we're estimating that it's maybe between one and four percent are what we would call sociopaths. Now those are people that don't have that emotional component. With that, the rest of us either can have functional, trainable empathy. We might just be inherently empathetic.

Some people just seem to be naturally gregarious and understand people and are able to work with them and there are people that have difficulty with that. So one of the reasons why I even got interested in empathy is I was having difficulty hiring really great employees in my dental practice. So I was recommended to go up and talk to a doctor named Bud Sipko up in Vancouver, B.C.

He worked with Selection Research which is involved with creating instruments to try to find people. In other words, psychological questionnaires developed by the University of Nebraska. What they did is he would ask people and you would look for certain answers to certain kinds of questions.

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Bud told me that the big thing for him was asking the questions that dealt with empathy. I came to realize, gosh, you know, that's exactly what I'm looking for and realized that if I found people that fit that profile, it was a lot better. Also what he told me is that unless people came out with a decent level of empathy, it would be difficult to train them. So either you wanted somebody that was inherently empathetic or at least trainable.

So how do you train empathy? That's one of the big questions that medicine has been going through, how do you train that? A lot of it has to do with a word that maybe we've heard a bit associated with Buddhism, is mindfulness. It's this ability to focus. So can you focus on that person in front of you and not allow that internal conversation to run? Are you there to listen or are you sitting there with the thought that I'm coming up with a reply?

Allison: Right.

David: If you can get into that mindfulness mode of simply listening and not letting your brain run and coming up with all kinds of solutions but listen to what they're saying, that's one issue with it. How do you train that? Well, a lot of it has to do with paying attention.

For instance, University of Virginia did a study where they hypothesized that, what if we had people do a play? So they did this Shakespearean stuff and they trained them to do a play and act. They found that because they had to pay attention to each other and because they had to pay attention to the response of the audience, they actually got better on their empathy.

So a lot of it has to do with training to pay attention. In medicine, one of the things we've found, there have been many studies done on this in the last few years, that mindfulness

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training, it can actually rewire your brain. In one study, they were showing that a full day of mindfulness training could cause physicians to have permanent changes in their brains where they could become less empathically distressed. They could segregate that idea of not involving themselves so much but being in empathy. So they could perform in a more compassionate way without taxing themselves.

I think that's where a lot of the research is headed in that direction of mindfulness or just this idea of training yourself to pay attention and keeping in mind, who is this relationship about? If this person is sitting here as a patient, I need to pay attention to them and not think about my own stuff. Not just think about my next reply but simply pay attention.

The thing is is the patient is going to tell you all kinds of things. They're going to tell you about symptoms, concerns, and you want to keep them talking. You know what? Most of us have a good enough memory, we can put it together at the end rather than trying to kick along and have this internal conversation and maybe not really pay attention.

Allison: I just had a thought. I just thought this is kind of cool because mindfulness in a way is part of I'd say more of an Eastern thinking and our medicine is so—it just seems like more and more I would love to see the Eastern stuff and the alternative things come more into our medical system. It seems like this in a way could be a little window into those other things, those other alternative things.

We know about the placebo effect, that that works. That our beliefs and our perception, I know you like to talk about perception too. We really didn't talk about that in preparing for this call but it just feels like this mindfulness coming into our whole medical system could be a really good thing in terms of opening up the window for all kinds of things.

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David: Absolutely. In fact, the hospital here where I'm part of the Spiritual Care Department, I asked a Buddhist monk to come with me and we talk about mindfulness each month. We get to take over the chapel for an hour and people come in, they're mostly staff people, and we tell them about mindfulness. I talk about it from kind of the Western scientific point of view, which basically is that we validated these things that the Buddhist monks have been saying for the last couple thousand years about mind training.

Really the Buddhists, when they talk about this mind training, it's apart from their own spirituality. It's about how to train your mind so that you don't suffer and that you can be more compassionate. It was without scientific instruments or fMRIs or anything of that stuff that they came to this conclusion but it was by studying and reflection and trying things. So kind of trial and error.

Allison: I was going to say we're talking about meditating basically, right?

David: Well kind of except that what really is meditation? That's one of the things I've learned in working with Geshi Tashi is that if you really think about what meditation is, it's repeating over and over something that you want to wire into your brain. What he would say is that you could have a negative meditation, you could have a neutral, or you can have a positive. Repeating something over and over like "I hate that patient Mrs. Smith. I hate that patient Mrs. Smith." It's not a good thing.

Allison: That's true, yeah.

David: So maybe you would want to rethink that. So he says, "A meditation can be waking up in the morning and saying 'I'm grateful to wake up. It's a wonderful day.'" Just do that as a ritual every morning. That's a mediation.

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Allison: Okay.

David: Or having a prayer life. That can be a meditation too as a part of your ritual. A meditation really, it can be many things. In fact, Geshe Tashi is writing a book on it right now, although it's going to be in Tibetan so I don't know if we'll ever read it in English.

Allison: We'll have to get it translated.

David: It can be a lot of different things but his primary meditation that he's required as being a monk of the Dalai Lama is that he meditate on compassion for all sentient beings. That would be anything that can suffer. Anything that can realize suffering. That would be a lot of critters, including people.

Allison: Interesting.

David: So anyway, a lot of fun and it's given me some insights in working with somebody like Tashi, he's a fascinating guy. He's got an equivalent of a PhD in Buddhist philosophy, which was granted to him by the Dalai Lama. Used to be the Dalai Lama's ambassador to Mongolia and he's taught all over the world. But his English is a little bit weak so I have a friend that's a Tibetan also who translates. So it's just been fun.

We've done some programs at schools and different areas. Talking about mindfulness and empathy and the import of how you can make your life better by paying attention, by exercising your empathy, involving your own feelings, which turns you to compassion. And what is compassion? Compassion is the wish to relieve the suffering of others. Simple as that. But you don't get there unless you have empathy working.

Allison: Right. Yeah, so this helps every area of our lives. Every area of our patient's lives. Our teams. Our personal life, everything.

David: One of the interesting things I've found is that in Christianity, it's kind of interesting as a major religion because not only do we

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have empathy, we have empathy for God and God has empathy for us because of Jesus. Just a tidbit. That's not why we're here today to discuss that, but it's an empathy in two ways.

Allison: Right.

David: So I think that's kind of a fascinating piece of it. This is not just Buddhists. This is very much a Christian thing too, and a central part.

Allison: When you're speaking at the hospital in Vancouver?

David: Yes.

Allison: Is that the same thing you were just talking about where you go in and you do those classes? You're talking to physicians, right?

David: Well I'm talking to physicians and nurses and technicians and also sometimes patients come too.

Allison: Oh, I was curious about that.

David: So sometimes we'll have people that have been suffering psychological problems, depression, or they have a long-term illness or a terminal illness or whatever. People will come and we talk about mindfulness and we talk about empathy and compassion and how this all works and how they can clear their minds and suffer less, everybody. How can you suffer less?

Allison: We're going to have another call and you're going to teach us that. Can you teach us that in an hour?

David: I'd be happy to do that. That should be a lot of fun.

Allison: I do want, I mean, Kate Dahl is the one that recommended you of course and I know one of the things she loves to hear you talk about and you can make the transition as smoothly as you'd like to, but I don't want to leave out nutrition tonight

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because I know it's one of your passions and I know that's one of the things she wanted to hear you talk about. Do you have a direct correlation that you can bring empathy—I know we talked a little bit about some of the people that are overweight.

David: Some of the people that the medical system has the least compassion for and the least empathy for are people that are obese. In fact, it influences how well the physician works with them, or the dentist. And it influences the attitude and the outcome of those people that are obese.

As you probably well know, as a nation, even as a world, we're getting fatter and fatter. In fact, it's interesting just a few months ago there was a study that came out. I think it was out of the University of Virginia that was talking about how the NHISs, this is the one where we track how fat we are and a bunch of other things too, national health survey.

One of the things that it said, and we've know this for years, that it was grossly underestimating how heavy people actually are and how much they're actually eating. And why? It's because they were collecting the information exactly as we're doing right now, talking on the phone, and asking Mrs. Jones, "What did you eat? How much do you weigh?" Mrs. Jones wouldn't want to say even though it's supposed to be anonymous. Can you imagine not wanting to say, "Well I actually ate a whole cake" or whatever it is?

Allison: Or just no remembering because I've tried, you know, you do that and then you keep a food journal and you're like, "Oh my gosh, I hate four cookies today."

David: Sure. Both the men and women were grossly underestimating how many calories they were eating and they would grossly underestimate how much they actually weighed. The more they weighed, the more they underestimated. So anyway, we know it's invalid in that we're a lot worse off than we thought.

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In fact, what it's showing if you look at some of the statistics, if we factor that in, even without factoring that in, more than 80 percent—if you push this to 2030, more than 80 percent of people in some places in the southeastern part of the United States are going to be overweight. Many of them are going to be very overweight.

If we keep pushing this out, if we keep going in the same direction we're going, well, all of that overweightness has a huge effect on how much inflammation there is and a huge effect on how much diabetes and heart disease there is for some very good chemical, scientific, physiologic reasons.

But I think the more basic question is, why? Why are we so much heavier than we were say in 1955? Are we really that much different? So what has changed? One of the things that's changed is that we eat an enormous amount of omega-6 fatty acid compared to what we did 50 or 100 years ago. So why is that?

Allison: Can you tell us what has omega-6 in it? What are the things that have that?

David: Vegetable oils, like sunflower, safflower, peanut, pretty much everything you see on the corn oil, everything, all those vegetable oils that you see at Safeway or wherever have largely omega-6. So why does it have mostly omega-6? Well part of it's historic. We discovered omega-6 first and we realized that it was an essential fatty acid. That was discovered like back in the 1930s. We didn't discover omega-3 and there's a good reason for that too. It's because it was very fragile. It breaks down quickly.

So we knew that omega-6 was required and one of the important things about omega-6 is that it's pretty robust. It doesn't break down quickly. So things that contain a lot of

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omega-6 don't go rancid very fast. In fact, that's one of the reasons why it was so useful to saturate fats.

A guy got the Nobel Prize for fat saturation way back almost 100 years ago because it was great, they could saturate fat and with that saturation, it would have a long shelf life because you're getting rid of those darn double bonds and you were getting rid of that pesky omega-3 that would break down. Except they didn't know that the omega-3 was there.

So what does omega-6 do? Omega-6 is the feedstock for inflammatory compounds, interleukins. Interleukins that create inflammation. You know, we've heard about interleukins from studying periodontitis, right? Periodontitis has a big inflammatory component, that's a big part of it. Well guess what? Almost all disease involves inflammation. Of the top ten killers of people, how many do think involve inflammation?

Allison: I know the answer because I told you all of them. But you said that's not correct.

David: I said, well, one of them maybe not, that was like accidental death.

Allison: Yeah, like trauma or something.

David: Yeah, well people being in car accidents. That probably doesn't involve inflammation.

Allison: Although... if you autopsy them.

David: Well maybe.

Allison: 9 out of 10.

David: Yeah, 9 out of 10. So that means that inflammation is either an initiator or an exacerbator of 9 of the 10 top causes of death. So wow. So omega-6 is the feedstock. Okay, so, there's a yin and yang between omega-3 and omega-6. Omega-3 goes to a

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whole different set of compounds called, and get this name, resolvins. Somebody must have enjoyed naming that. But they call them resolvins. What they do is they resolve inflammation.

The way it's supposed to work is that when you get some kind of insult, an injury, a cut, your body's response is going to send those interleukins so that your immune system kicks on and you protect the integument, the skin, or wherever that thing happened. So you want to get all those inflammatory compounds there and get the white blood cells that come and attack. As soon as that's done, which doesn't take very long, then it should be shut off by the omega-3s, those omega-3 resolvins.

That should happen quickly but what if you hardly have any omega-3 available? And what if your omega-6 is very, very available? This goes back to why do we think about paleo diets? What's different about a paleo diet versus what we eat now? One of the things that's different is that paleo people ate an omega-6 to an omega-3 ratio of maybe 2 to 1, 1 to 1, something like that. Well, North Americans eat a much different ratio.

Many of us, if we're kind of health conscious, we probably eat a 20 to 1 ratio. If we're not so health conscious, maybe a 40 to 1. Or if we're a junk food junkie, maybe a 60 to 1. So why is that significant? It's significant because omega-3 and omega-6 are competitive in your system. So when they're metabolized to the actual resolvins and those interleukins, they have to go through this enzyme system and they compete with each other. So if you've got 40 times more omega-6 than maybe your body was designed to handle, would even see that omega-3?

Allison: No.

David: Not very much.

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Allison: So we're over here taking fish oil or krill oil or whatever.

David: So if you take fish oil maybe that would have some good effect. Except, that the omega-6 is still going to compete so perhaps what you're doing, and in fact there were some studies about how taking fish oil, large amounts of it, seemed to enhance certain cancers. So that confused people.

Let's think about it. If you're just taking excess omega-3 and not decreasing your omega-6, you're pumping a whole bunch of fats into your system that have lots of double bonds that can break down and if they're not used, guess what's going to happen to them? They're going to go to reactive oxygen species which can cause problems.

So it's not a matter of simply taking more omega-3. It's a matter of trying to get it into balance where we're not eating excessively on the omega-6. I would tell people, "You know what? Probably the real answer is eat a whole lot less omega-6." Maybe you could consider getting some omega-3, but gosh, probably the best place to do it is by eating wild salmon or something like that. If you don't have that available, well maybe a supplement is not a bad idea.

Then think about too, if you're getting it in fish, remember I said that omega-3 is fragile. Well guess what happens when you cook it?

Allison: Oh, yeah.

David: You break it down. That also suggests to me, gosh, and in fact, it made sense, geez, maybe we should cook these more gently because I don't want to break down all the omega-3 that I'm trying to take advantage of. So that was one of the things that I started to look into and I got into this thing about how does temperature affect food?

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One of the things I discovered is this whole chemistry about the Maillard reactions, what that is is the browning on food. You get these Maillard reactions and you get that nice brown crusty stuff that you like. Well what that really is is that's a reaction of amino acids and sugar.

It creates these things called advanced glycation endproducts. Guess what they do? They create reactive oxygen species, they're hard on your cardiovascular system. In fact, we've been warned. I think it's been in the media that you cook on the barbie and you'll get these things that cause heart disease. Turns out the chemistry says exactly that. So I thought, that's interesting. Then it's more than that. It's more than just those AGEs.

If you go a little bit farther on that, back in 2002, a Swedish scientific group, I kind of picture them as Sven and Ole. They're sitting at the lab bench and Sven asks Ole, "Hey, what's that brown stuff on your gingerbread?" Ole says, "Well, you know, I don't know, let's find out." They found out it was acrylamide which comes from a reaction of the amino acid asparagine and a reducing sugar like fructose or glucose.

When you get that, it has to be at a specific temperature, 247 degrees Fahrenheit. You get that whenever you cook anything that has asparagine and a reducing sugar. That means that the brown stuff on bread has acrylamide. In fact, the brown stuff on any kind of vegetable product has acrylamide.

Allison: Wow.

David: That's a potent neurotoxin and carcinogen. The funny thing is, back to the empathy part, is the Swedish group, when they published that, pretty much the whole country in Sweden stopped eating bread for about four days and then they went back. I think it was just because it got blurted out and they knew that the acrylamide was bad for people but they hadn't done

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studies on humans, obviously. You know, people had eaten that stuff their whole lives and it was almost in the whole food supply, so why are they going to pay any attention to it?

Allison: Right.

David: Yet, as a biochemist, I know that we use polyacrylamide gels and we were also warned how dangerous it was to deal with that stuff and I found out it's in all our food.

Allison: Wow.

David: Okay, so we knew from industry that there was a threshold of tolerance, but golly, when the Swedes first looked at that, they realized that for the threshold that we had used in industry one serving in McDonalds french fries would have 900 times what we thought was safe to eat in a day.

So if you look at the Food and Drug Administration's website and you look at the Center for Disease Control website, you'll find that they have information on how to reduce acrylamides in your food supply but I don't think it's very much in the awareness of the public.

Allison: I don't either.

David: So what we're you going to ask, Allison?

Allison: I was going to ask, so the bread thing. There's a lot of people reacting to gluten and all these things with bread and wheat is bad and everything. So is it just the crust? I mean obviously there's still gluten in the bread but I mean you're saying...

David: Well I'm just using the acrylamide as one example but if you want to talk about wheat and bread. Wheat is interesting in itself. You could look at the whole history of wheat and how it's developed. Okay, so, yes, there are some people that have celiac disease. Those are people that have a very high reaction

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to either gluten or glutenin. There's several proteins in wheat that they can react to.

If you go back historically, wheat didn't use to be what it is today. So if you go all the way back to original wheat, einkorn wheat, it had fourteen chromosomes. It wasn't that toxic. I mean it had a version of gluten but it wasn't that toxic. But then about 14,000 years ago or so, it got hybridized against something called goat grass. It doubled its number of chromosomes. Then along the way, it got hybridized again into like the emmer kind of wheats. That was the wheat that Jesus, for instance, ate. Then it had 42 chromosomes.

It's remained at 42 chromosomes but it's been hybridized many other times until we finally hybridized it back in the early 60s and created dwarf wheat which seems to be much more toxic than it ever was before. So one of the interesting things about that is that there were some studies done by Chinese and other people trying to figure out why are Americans getting so fat. They tried to look at well is it because they ate too much fat? Is it because they ate too meat? Is it because that ate too much carbohydrates? What they came up with is that we ate too much grains and wheat.

Mostly where that took off was right in the mid-60s where the obesity epidemic started to explode. So there are other things about wheat too. Wheat is high in phytic acid. You might ask, what is phytic acid? Phytic acid is the way plants store ions, divalent cations, like calcium, magnesium, manganese, stuff like that. Well, they store it in their seeds. And it's mostly in the outer coat of the seed, the phytate.

What will happen is when the seed sprouts the phytate breaks down, it releases those minerals and the plant can use it to grow. Incidentally, omega-6 is the storage compound for fats for plants—not for people—for plants. So plants have phytase to

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break down the phytate. They also have an enzyme that will turn omega-6 fatty acid into omega-3 for the plant to grow because omega-6s are in seeds, omega-3 are in leaves. In fact, that's why fish have high omega-3 is because they eat leaves or they eat animals that eat leaves, like kelp and algae and stuff like that.

Anyway, the phytic acid, what it does in a mammal is it latches on to all these ions. So if you eat a high phytic acid meal, you might lose half the minerals that you were going to get. Interesting, and in fact, if you look in third-world countries where they get food stressed, you can see that people actually can have specific deficiencies. So food stress meaning maybe they only have to depend on just eating wheat or barley or something like that that has a lot of phytic acid, they'll end up having zinc and iron deficiencies. The woman will all be anemic and the men will be sterile. The kids won't grow.

We can look at that as an extreme example but then we can look at our own food supply and think, "What is this doing to us if we eat a lot of grains?" Hmm. So other thing that you'll find in wheat is that it contains a lot of lectins. So there's one in particular, glutenin, which means it will agglutinate red blood cells. But it does other things too. So one of the concerns is is that the lectin in wheat will cause gut permeability and in fact, it will exacerbate allergies.

So interesting, within my own patients, people have told me that when they—some of them have been celiac disease or they've been gluten sensitive. Celiac is usually one or two percent of the population most of us think. Then gluten sensitive is perhaps ten percent, five to ten percent, something like that.

When they stopped eating wheat, several people have told me this, their other allergies went away over time. I thought, "Well, interesting, obviously not a scientific study, but interesting." I've

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noted that. So in my own life, when my son, he was three or four, he started to get some reactions on his lips. We knew another child that had a wheat sensitivity that had a similar kind of reaction.

We just thought, well why don't we try just cutting down on the wheat and he seemed to get better. Then we thought, well maybe it's gluten. So we decided to cut it down even more. But of course, me, I'd always eaten my Wheaties and I wasn't going to cut it out for myself entirely. But at a point we decided how hard could it be? Let's try 100 percent. When we cut it all out, everything that had gluten or wheat and pretty much all the grain, I lost 20 pounds in six weeks without trying. That got my attention.

So I started reading about it more and I thought, "Huh, so what could this be?" Well, part of the wheat thing is that wheat is largely carbohydrate. You know that white flour stuff, it's between 60 and 85 percent glucose. Which I didn't really realize. I figured there was some there but it's between 60 and 85 percent glucose in the form of amylopectin which is glucose times 300,000. So it's a big molecule but easily broken down. In fact, whole wheat is more glycemic than sucrose. You'll get more of an insulin reaction to whole wheat than you will to sucrose.

Allison: Wow.

David: How funny, how funny. It's not something I'm making up. I mean, you could just read in literature. So some of those things really got my attention. My wife really got me on this thing about, "Dave, you know these health food stores are talking about inflammation and an anti-inflammatory diet." You know, I kind of pooh-poohed it a little bit but then I decided, okay, I'll read the literature. I realized, huh, interesting, there is something to this.

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Allison: I was going to ask you, now I'm really wanting for you to make us a "eat, don't eat." Or how do you eat? This is one of those, everybody I'm sure on the line, can't imagine somebody on here that hasn't seen all the different things that we're not supposed to eat and not supposed to have. Then you kind of end with this attitude which I think a lot of us either get overwhelmed and confused and you don't even know so you don't even try.

David: Right.

Allison: Or I can't eat anything.

David: Like the acrylamide thing, right? Where everything has got acrylamides so golly, I can't eat anything.

Allison: Yeah, so I'm just going to eat it anyway.

David: Or I can't eat my barbecue anymore.

Allison: Right.

David: Yeah, I get that. We don't have any problem finding things to eat and I think part of it is a willingness to realize that—so for instance, we want to reduce the overall inflammatory potential of our food. So we simply stopped buying all of those vegetable oils that are so high in omega-6 fatty acids. We just cut that out. Now I also realize that if I go to a restaurant, I can't really say anything about that but the thing is you need some. But if we cut it out at home, that will have a big impact.

Also, we tend to use more butter but I like to use pasture-fed butter more than I ever did before. If you want to use a high temperature oil, what you can do is you can clarify butter, make it into ghee. In other words, you get rid of the milk proteins, you can take it up to 500 degrees and it won't break down, or not very much.

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As far as olive oil, olive oil doesn't really have much omega-3 or a little bit of omega-6, it has mostly omega-9, but it has a lot of polyphenols that are good for you. If you heat it very much, it damages it. So we tend to put olive oil on food but we don't cook with olive oil.

Avocado oil is more heat tolerant so we tend to cook with that more. It doesn't have a significant omega-6 load because what I realized is that really a lot of what I was looking at to try to reduce the inflammatory-ness of our diet was looking at the omega-6 load of a lot of these foods. So why would you want to eat grass-fed beef for instance? Well, the fact is is that if they eat grass, as I said, where do you find the omega-3s? In leaves. Where do find the omega-6s? In seeds.

So if they're grain fed, guess what they're full of? Omega-6. So that's one of the primary reasons that you would rather have grass fed. So we opt to have grass fed meat. Yeah, sometimes it cost a little more but we pay attention and if it's on sale, we'll buy a bunch. So on the same token, we prefer wild salmon. Why? Well the farm salmon, in fact, the Norwegian farm salmon, they feed them omega-6 fatty acids. How crazy.

Allison: Wow.

David: But the wild salmon has plenty of omega-6s and if we cook it gently you're not going to break them down. The farm salmon, yeah, they feed them omega-6 but you know if you look at the statistics, they have more omega-3, many of them, have more omega-3 than the wild but it's that level of omega-6 that's very very, very high that throws it out of proportion. That's why I would opt to not eat the farm salmon and would prefer the wild because of the omega-6 load that the farm is going to put on me.

As far as the lectin issue, I tend to prefer to stay away from things that have a lot of lectins because they affect your

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allergenicity, the likelihood of you having problems with your gut. So what has the most lectins? Well, legumes have the most lectins. After that, mostly it's seeds. Scientists have suggested that maybe one of the big reasons for these lectins is that they prevent critters from eating too much of that plant because if you eat a certain amount it will be kind of toxic. So maybe it prevents the animals, that's what some people think.

But you know, lectins are interesting. What they are is they're glycoproteins. They're sugars connected to proteins and plants use them like neurotransmitters. They use them for communication. They can use to communicate with bacteria in the soil. They can use them to communicate with parts of themselves. Well, some of them are toxic to humans.

So soy, for instance, has lots and lots of lectins. In our household, we tend to mostly avoid legumes. But green leafy? Gosh, we eat those. We eat lots and lots of vegetables. So with fruit for instance, one of the big issues with fruit is that it's got so much sugar but if it's very fibrous, say with berries where you have lots of skin and seed and all that kind of stuff, pretty much they don't have a whole lot of glycemic reaction in your body but they have tons and tons of phytochemicals that are good for you, antioxidants, like black berries and blueberries.

The anthocyanins in blueberries are great antioxidants. In fact, there's another effect of those anthocyanins in blueberries is they lower your intraocular pressure. Good for people that have glaucoma for instance. You would probably say that we're kind of paleo except that I don't really follow on to any particular person's paleo approach, especially if they recommend people eating a lot of nuts. I've noticed that a lot of paleo diets tend to include nuts, a lot. They're full, well, they're seeds. So they're full of omega-6.

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So I'm concerned about the omega-6 load. So actually, when you start looking at these things, what would be kind of a neutral grain? Well, white rice is pretty neutral. It doesn't have a lot of lectins. It doesn't have a lot of bad things in it so we do eat a certain amount of white rice. In fact, we find ourselves eating kind of Asian-y. Like more of a Japanese diet.

Allison: Do you do the raw fish thing and all that too?

David: You know, there's issues with parasites but the fact is that you're not going to have a lot of the bad things if you don't go over 247 degrees. So boiling water is 212, so if you boil things or steam them, you're not going to have that issue. On the other hand, if I really want to put something on the barbie, I'm going to make darn sure it's really good and it's worth it. But I'm not going to do it typically.

Allison: Right. So you are an anesthesiologist, do you have any opportunities to talk to patients about this stuff? Or is it just kind of your personal thing?

David: Usually when you're doing anesthesia you don't get to spend a lot of time advising patients on how to eat. So a lot of this was research that I did but I mean I've been interested in nutrition all the way back into the early 80s, shortly after I got out of dental school. My wife asked questions and I wanted to see what the literature said and it's been things I've encountered, patients that I've bumped into.

So as I accumulated this information, I realized a lot of times this is very much at odds with what people think. Just in our family, it's made quite a difference. In fact, people that I've spoken to, even some of the docs in my area where I can think of one guy who was diagnosed as having diabetes. I just spent a few hours chatting with him about what he could do to change it and he lost weight. His HbA1c went from like in the 8s down

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into the 5s. You know, those kinds of things have gotten my attention.

But in an anesthesia practice, generally you don't get to spend a lot of time with a patient so that's not been part of it. So my involvement in the local study club, they invited me to come and talk about nutrition. I want to speak to them about nutrition from the literature, not from some opinion or just because I stopped eating wheat and I lost weight or something like that. Yes, that's part of my story and that's why it got my attention. But that's not why I want to share it with other people. But I would encourage them to read. Now I understand most people are—I don't watch TV, I read scientific literature for entertainment.

Allison: I love to read but not scientific literature.

David: Yeah, well most people would not do that. So why not share it? I can cherry pick the literature of things that I think are especially interesting. On the coorsdentist.org website, I've put up some of the literature that I've gleaned out so that people can read it and think about it. You know, if they want to write me and they want some of these guidelines, I'd be happy to share some of this information.

Allison: Okay.

David: I'm perfectly fine with that. So they can write me at sleepyteeth, you know, dentist/anesthesiologist, sleepyteeth@gmail.com. I can send them some info.

Allison: Thank you.

David: Make things easier.

Allison: Yeah. I know we're at the end of time. It went by really fast. Does anybody want to raise their hand...

David: It breezed...

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Allison: What were you going to say?

David: It just really breezed by.

Allison: It did.

David: There's so many things I didn't get a chance to talk about.

Allison: I know, you have a lot of knowledge. It's really wonderful, I appreciate it.

Matt: Yeah, I really enjoyed what you were talking about tonight. I mean, you're right down my alley. I love this. When I was at Hippocrates, it's very interesting, because I really didn't know what to expect there and they're totally raw vegan. So for four days I did a raw vegan diet. I mean, they cook nothing over 115 degrees.

There's no dairy. There's no meat. There's no chicken. There's no fish. There's no wheat. Almost everything they do is sprouted. So everything comes from the sea. They believe the most energy is in the seed. And it was a very, very interesting diet for four days.

I mean, it was good. You have to adapt to it. I mean, my diet is really good anyway, it's pretty paleo. But I'm not to the extreme that they were. Every morning you start with wheatgrass juice and then you have a different—so it was a very, very interesting experience. They take a lot of patients there that are stage 3 and stage 4 cancer patients that have been discarded by physicians because they can't do any more with them.

They put them on this meditation, tai chi, relaxation, and the nutritional diet. It's amazing. I interviewed a bunch of people there. It is amazing how many people were given a month to live or two months to live and they've been there a year and they're thriving now.

David: Yeah.

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Matt: Just by changing their total lifestyle and their diet.

David: Interesting thing about that approach is that they're tremendously decreasing the omega-6s usually. They're increasing their omega-3 because they're doing it so much with colorful plants, they're greatly increasing the antioxidants. Some of the concerns though I have about going with a raw diet long term is that you're going to tend to get more lectins and sometimes there's a concern about the phytates over time. So as long as they're sprouting them, it makes sense.

I think it depends upon how scientific you're taking it when you're doing more of a raw diet. Some people won't adapt well to it but I think as a therapeutic measure especially for people that are ill and making a dramatic change like that, I think it can have a real positive effect.

Matt: It's amazing. They have sprout houses there. I was take through. I was a guest there. I mean, it's amazing. I've never seen so many sprouts in my life. I felt that if I stayed too long they'd be sprouting me.

[Laughter]

David: See when you sprout these things, you're taking them from an unhealthy to eat state, where it's mostly omega-6 and it's bound phytate. When you sprout them, all that stuff is released and you're making it much healthier.

Matt: They do beet sprouts, they do radish sprouts, I mean, it's amazing the things they're sprouting there. They're delicious. They're really good.

David: Yeah.

Matt: I mean it's much more advanced than that. You know, it's funny, I was dying for a tortilla. I was dying for something to put some of this stuff on and so one of the people there said, "Oh I

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can get you something, don't worry. I'll get you something." So she brings me this thing out. It's an algae tortilla, it's made from sea algae.

Allison: Oh my gosh.

Matt: So I tried rolling it, it cracked. It cracked into a million pieces.

[Laughter]

It was so funny. I thought, man, I'd hit the jackpot. Somebody had snuck me in something here. I was wrong.

Allison: Next time take some nori rolls with you, Matt.

Matt: I will.

David: Funny thing about the seaweed is that usually when you buy seaweed you would imagine it would be high in omega-3 but you know what they put on it? The oil that they put on it to keep it from sticking together?

Allison: Oh, yeah.

David: Safflower and sunflower, which is high omega-6.

Allison: Of course, oh my gosh.

Matt: You're right on the omega-6. You're right on there. That's true. You get rid of that and it makes a big difference.

David: So anyway, if you're asking my opinion on raw diet. I think it's great as a therapeutic effort. I think a lot of people would have trouble sticking to that for long-term.

Matt: Oh, they do.

David: It's a problem for some people but I think as a therapeutic it might be a really good thing. I personally wouldn't want to eat raw all the time. The way they're doing it where they're

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sprouting everything and they're trying to really pay attention and be scientific, I think that can be healthy.

Matt: Yeah, and it's just used for therapeutic. I don't think anybody could stay on it for a lifetime.

David: No. I think day to day it would be very difficult and it would be hard to stay healthy.

Matt: It would be very boring because there's not much favor. It'd be very boring.

David: Yeah.

Matt: We had one person there, she says, "I think I'm going to live 20 years less but I'm going to enjoy the food." That's the way I think some people feel.

David: Yeah.

Matt: I enjoyed it for the four days that I was there. I'm going back again in January. They want me to do a series on oral systemic health so I'm really excited.

David: That's excellent.

Allison: Matt, are you saying Hippocrates or Appocrates?

Matt: Hippocrates.

Allison: Okay, that's what I thought.

Matt: Just google Hippocrates Health Institute. They have an incredible website. It's really good.

David: Yeah, Hippocrates is a Greek physician.

Allison: Yeah, I remember.

David: He was the guy that talked about...

Allison: Do no harm, right?

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David: Let food be your medicine and medicine be your food.

Allison: That's right.

David: Yeah, so he's a famous physician. 2,500 years ago.

Matt: Yeah, he's still around. Amazing.

David: Yeah.

[Laughter]

Interesting thing is he was one of the people that said we should be mindful. He didn't say it that way but he said you've got to pay attention to the patient. You've got to get inside their heads.

Matt: So much about mindfulness is just being in the moment. Being present in the moment.

David: It is and not letting that internal conversation run in you but pay attention to what they're saying.

Matt: Exactly.

David: Exactly, be in the moment.

Matt: You got it.

David: Right on.

Matt: Well, I enjoyed you. I really enjoyed it tonight. Thank you, Allison.

Allison: Thanks, Matt.

Jill: I appreciated all of the information. It's very intriguing and interesting.

David: Who am I speaking to?

Jill: Jill.

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David: Hi, Jill.

Jill: Hi. Very, very interesting.

David: Well I'm glad you enjoyed it. Gosh, I got to talk about one percent of all this stuff.

Jill: I bet.

David: I hope we get a chance to chat some more some other time, Jill.

Jill: Sure. All right. And thank you, Allison, you do a great job of getting great speakers.

Allison: Thanks, Jill, appreciate it. Good night everybody.

Matt: Thank you both, bye-bye.

David: Thank you, Matt.

Kate: Hey, Dave?

David: Yes.

Kate: I have a question. This is Kate. Regarding empathy.

David: Yes.

Kate: I've run into a couple situations, one with a nanny recently. This is a problem that I'm having because I'm very empathetic and sometimes I'm too sympathetic. But can you enable people? How to prevent yourself from enabling people? Like with too much listening where it feels manipulation? I don't know how to explain it.

David: Well, you know, the thing is that in order to work with somebody you've got to observe them and see how they interact and behave and you see the words that they use. It's difficult if other people are not willing to engage honestly. So if they're trying to

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be manipulative and turn you to their will, then that's really not an honest interaction.

So when you're trying to be empathetic, you're trying to understand their behavior and understand how they feel and partly it's going to be somewhat limited by your own experience. Just like if you're dealing with somebody that's very manipulative and you're not accustomed to it, you may have difficulty predicting their behavior. In other words, truly being empathetic and understanding them.

So empathy is just understanding what the behavior is or how they're going to respond. Then the sympathy part is involving your emotion. So how can you prevent yourself from being manipulated? Is that what you're asking?

Kate: Partly, because I have a knack of, I'm a doer. I can listen but probably after listening to the same thing three times but know they keep causing their own woes, it's really hard to listen to, especially if they have solutions. So it's like I want to remain empathetic but I also want to protect myself from if somebody is not going to change their life, you know what I mean?

David: Right. Empathy is only trying to understand them. If you see them repeating something over and over, you can get the idea that there's some reason why they're repeating this over and over and maybe they don't understand their own behavior. Maybe they don't have the resources or maybe they're unwilling to change. But you know, I'm not sure I have the ideal answer for you, Kate.

Kate: Can you be empathetic but draw a line and not be a bad person? You can still be empathetic?

David: Empathetic is only about understanding, it's not even acting necessarily. You don't have to do anything but simply try to understand. Now you could try to understand and then realize

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you don't want to do anything. And that's okay. You only have a certain capability to help them out. So if you're talking about compassion, so what can you do?

I mean, it's about relieving suffering. So if you're going to move to compassion, if you're going to be moved to compassion, so you want to make some action to relieve their suffering, I guess you have to analyze, are you relieving their suffering or simply enabling them to do something that's destructive to themselves.

Kate: That's pretty much it. I just feel like sometimes like when you care about people it's really hard to remain neutral when you see in great lengths of time after you've been empathetic, and empathetic, and empathetic, that they may not change their circumstances. I mean, it's very complicated.

David: It is, it is. People are funny that way. But empathy is about trying to understand them. It's not necessarily taking action and it's not necessarily involving your feelings. Now if you're moved to take action, that's one thing, but maybe you're going to decide based on your empathy that maybe they just need more information. Or maybe they need some other help other than mine.

Kate: Is there any book I can read about how to be empathetic but without letting crazy people near me? Like honestly?

Allison: Are you kind of asking about like energetic boundaries a little bit?

Kate: Yes, thank you, Allison.

Allison: Okay, that's what I was getting. I've had that issue before but I'm not sure if I can... Can you think of anything, Dave? Like a book or something? I will think about that question and if I can think of something that's helped me, I'll send it to you.

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David: You know, I'm probably thinking of books that are kind of indirect and not really talking about that in a direct way.

Kate: Think about it, you know how to get a hold of me.

David: Yeah, but I think part of it is really thinking through, "What does this person want? What is their outcome?" Is their outcome that they want to solve their problem or is their outcome that they want you to do it for them? It's like working with a patient that's trying to come up with a treatment plan. The very most important thing is to try to figure out their outcome and allow them to clarify what is that outcome they're seeking.

If you're going to be working with this person over and over, whoever it is, I think that's what you're trying to sort out. The best thing you could do is help them sort out what their outcome is. You can decide whether to do it or not. I mean if their outcome is to have you do it for them and you don't want to, then I guess that's the thing to tell them.

Kate: It's not me doing it, it's that they just keep, haven't you ever met those people? They cry and complain and cry and complain but then when they have other avenues, they don't take it and they're right back to where they still were.

David: Oh absolutely.

Kate: I get that it's not about me but it's like you can only hear it so long without it—you don't want to be involved anymore.

Allison: Without losing empathy, yeah.

David: Yeah. Okay, let me put this out there that I think sometimes people get in situations and they get in loops where somehow this particular situation works for them or they're used to it.

Allison: Yeah, that's what I was going to say, exactly.

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David: Okay, then we're in agreement, good. They're going to persist in this because somehow they get something from it. So sometimes there are people that have chronic conditions. Like people might have celiac disease but keep eating wheat and for some reason maybe this whatever it is works for them, this thing about not feeling well. Maybe they get a certain amount of sympathy from other people, or you could think of a lot of other circumstances.

Allison: They don't have to be responsible or something, yeah.

David: They don't have to be responsible for themselves or it's just too much torture to not eat the bread or whatever. People get in loops about relationships. They get in loops about all kinds of circumstances and if it works for them in some funny way—that's that empathy is that sometimes we can't always figure it out. But we can try.

We can try to understand and understand too that when people start to persist in these destructive behaviors or not constructive behaviors, sometimes they have some reward that they're getting from it and there's a reason why they're not moving to a resolution where they're wanting other people to help them out. They're getting something from it.

Kate: So what about us as the empathizers? It's draining.

David: Okay. So you don't have to choose to participate necessarily. That's a lot of what we talk about in the mindfulness is segregating understanding from involving your own emotions. So do you mean it's physically draining or do you mean it's emotionally draining?

Kate: I don't know if I can separate the two.

David: That's where I get into this discussion of sympathy and empathy and that's where people get worn out from these kinds of relationships is that it wears on their own emotions. When

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you can more segregate that, and I'm not saying that's an easy thing, but when you can more segregate that and keep yourself to trying to understand more, then maybe you can deal with these situations easier.

Like in spiritual care, a lot of times I'm dealing with death and dying and people in hospitals. I'm with families where somebody just passed away. Here a few weeks ago, somebody moments before I walked into the door they just got a diagnosis that they were going to die within hours. I have to tell myself, "This is about them. I'm here to understand. I'm not here to involve my own stuff."

Just keeping to that, that little mantra, it's kind of a meditation for myself. This is about them. This is about me understanding. This is about me being a compassionate presence. That's helped me. So if people are sucking the energy out of you, well, how much are you getting out of this relationship?

Kate: It's like listening to you; I want to be the most empathetic person I can. I mean, you both I've touched a tiny bit about where Mia and I came off and I'm the first to admit that my inner tank is probably not the fullest. So though I'm empathetic, sometimes too sympathetic, that it kills me to not want to care and I could definitely benefit from the mindfulness because I'm sure I carry a ton of anger.

But at the same time, it's like I feel like I tend to attract people in general where I need to keep practicing like Allison referred to is some kind of boundaries. But it's a really hard balance, Dave. I had no boundaries the way I was raised. I was raised in a Catholic family. Give the shirt off your back. Then I basically met up with sociopath and you both have heard a little bit about.

So it's like I'm trying to learn how to be empathetic but have boundaries just in general. I just didn't know if you could guide

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me when you think about it to some books, even just start with mindfulness, maybe naturally a balance will kick in. But I really want to learn and I don't want to lose the best parts of me and I feel like I am.

David: You're feeling like you're drifting into the detachment thing where you're not caring.

Kate: Yeah.

David: To protect yourself. Yeah, and that's not good place to be.

Kate: I mean I've had death. Death, my brothers died. My mom died. That, I mean, I'm the most sympathetic person to anyone going through any of that. I really am. To me that's real life, but it's like I don't have a lot of patience when people—when their woes are about everyday little things over and over and over but they won't change. So I feel my empathy being lost.

David: You know, Geshi Tashi would say it really requires taking some time and probably work with somebody that can spend time talking with you and working with you on that. I don't know that he would recommend a book necessarily. I could probably come up with some resources if you let me think about it.

Like with me, when I first went into dentistry, or when I was thinking about going into some kind of healthcare, I thought, gosh, maybe it would be awfully tough dealing with death and dying so maybe I don't want to be a physician. But I've found that I do that pretty regularly now working with spiritual care and I don't feel bad about it.

The thing is, I keep having to remind myself that the reason why I'm there is that I'm trying to understand and I'm being a compassionate presence and I can provide resources perhaps but I'm not there to—it's not about me and it's not about my emotions.

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Now, my emotions may move me to do something about it. That's a good thing because I certainly don't feel that I'm sociopathic. I do involve my emotions but I've come to realize that it's a separate part. It's not something that I came to quickly. I'm certainly not saying that I'm perfect on it. I can remember some times where I've identified with situations too much.

I remember one time when I was in New York City and there was a child that came in with a severe head injury. It was really hard for me because my kid was only a couple of years older and this child died. I had a real hard time with that.

Kate: I get that, the heavy I get, Dave. The heavies I get. I can be the most sympathetic, it's about them, in the heavy situations. It's the little ones that I have a hard time being empathetic about.

David: Yeah and those are the harder ones to draw the boundary.

Kate: But you're okay with drawing boundaries, yet being empathetic? You're okay with that?

David: I think you have to draw a certain boundary and that some people are going to suck the energy out. But for a compassionate person, it's incumbent on you to try to understand where they're coming from. You may not want to go there or facilitate it.

Kate: Got it.

David: I think that's okay.

Allison: At the same time, Kate, have grace with yourself. Like somedays you won't be as empathetic as others and sometimes you won't and with some people you won't because there are going to be things. I mean, it's almost like I don't know if you understand when I say projections but I mean some

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people may bring up stuff in your unconsciously that you just can't be around it right now.

Kate: Got it.

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