What To Do About Feelings in Medicine?: Emotions in the Context of Medical Professionalism

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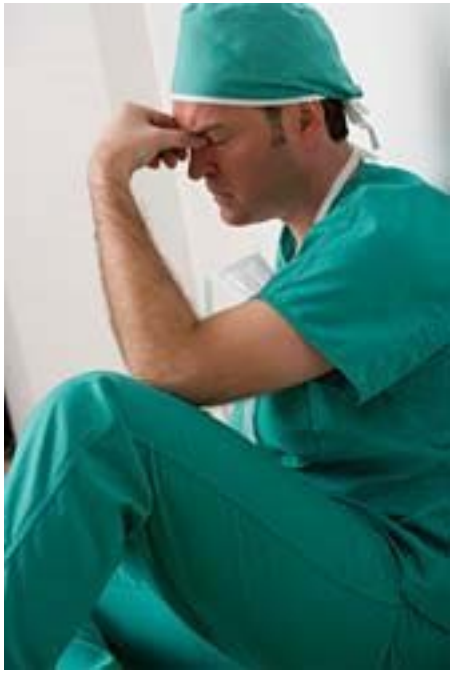
Is crying unprofessional?

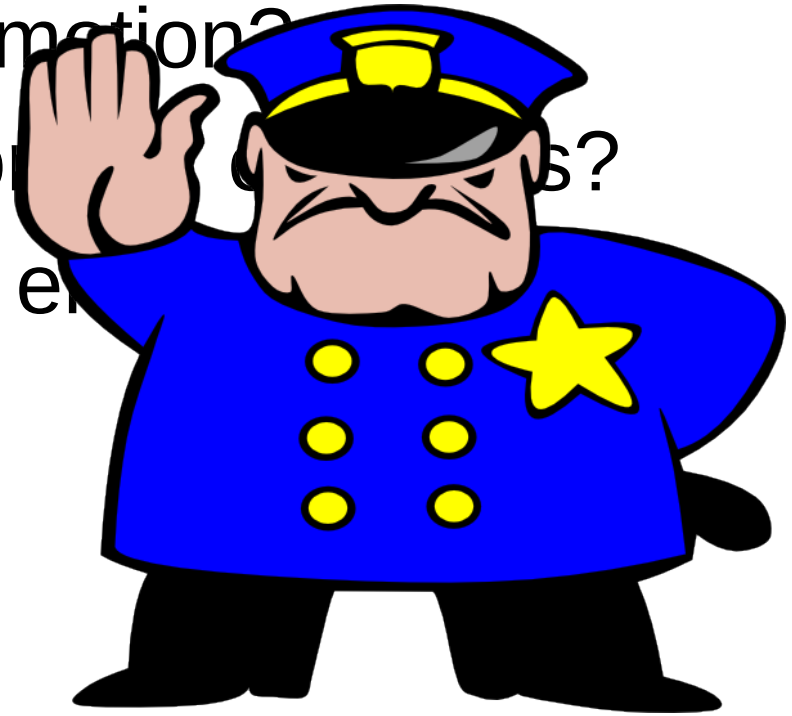


My Assumptions about Emotions in the Clinical Context

- Being aware of and able to modulate and manage emotions in self and others is essential in good patient care
- A competent physician must be able not only to diagnose biological disease but also to distinguish/cope with the patient's (and his/her own) feelings about that disease in the context of the patient's life
- Terms such as "positive" or "negative" in referring to emotions not meant to imply judgment of the emotion per se
- In any clinical context, physician or student–physician (and/or supervisor, or colleague) can make the discernment that experiencing and/or expressing a particular emotion
  - (1) does not advance patient-centered goals and/or
  - (2) is distressing for the patient, the physician, or both
- This awareness should then trigger a process of working with or modulating the emotion to ensure that patient care (and physician well-being does not suffer

The Emotions Police

- “Teach” emotion?
- Teach “co s?
- Discipline e



The Example of Empathy

- Does empathy even require feeling? Can we just keep it at the level of cognition?
- Rhetoric of professionalism consistently urges learners toward empathy
- In medicine, empathy has a positive valence
- So why is it hard to achieve?
- Underlying feelings of fear, dislike, vulnerability, judgment compromise empathy

Do emotions matter in medicine?

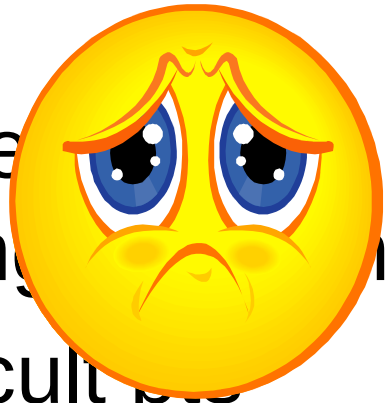
- Emotions influence both doctors and patients in critical areas such as
  - Decision-making
  - Information processing
  - Doctor-patient relationship
- Patient emotions have a relationship to clinical outcomes (diabetes, MI)
- Physician role models
  - Have trouble acknowledging their own emotions
  - Have trouble accurately identifying/responding to patient emotions

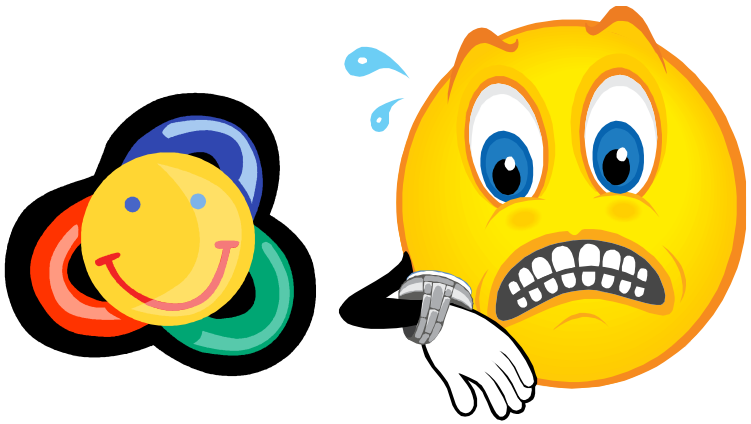
Patients have emotions

- Patient (negative) emotions are associated with
  - Increased clinical sxs (e.g., pain)
  - Decreased adherence to medical regimen
  - Decreased trust
  - Poorer follow-up
  - Poorer clinical outcomes
  - Poorer breaking bad news, addressing sensitive clinical issues
- Students may perceive negative patient emotions as a barrier to care

Medical students have emoti

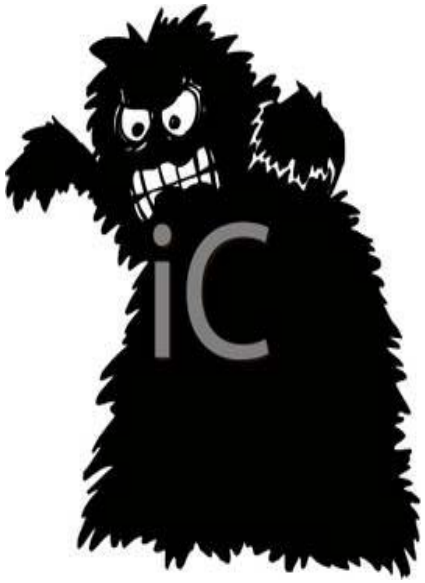
- Positive emotions – gratitude, happiness, pride,
- Negative emotions - Anxiety, fe
  vulnerability, guilt, sadness, an e
- Aggression/dislike toward difficult pts





Students' Fears

- Big fear – will become detached from emotions picture scary monster
- BIGGER fear – w[illegible]me overwhelmed by emotions
  - Swept away
  - Self-protective
  - Picture bigger scary monster



Physicians are (sometimes) terrible role models of emotions

- physicians typically deal with anxiety by distancing themselves from their emotions
- they rely on cognitive and behavioral strategies to help them respond to patients
- Physicians tend to ignore negative emotions (sadness, anger)
- Physicians not very good judges of reading their pt's emotions; or acknowledging pts' emotions
  - When do acknowledge, tend to offer only minimal empathy
  - Engage in "blocking behaviors" that discourage further emotional disclosure

Detachment – Just how did this become the professional ideal?

- “North American medical education favors an *explicit* commitment to traditional values of doctoring—empathy, compassion, and altruism among them—and a *tacit* commitment to behaviors grounded in an ethic of detachment, self-interest, and objectivity.”
  - J. Coulehan, P. Williams
- Scholars point out that clinical detachment was descriptive *not* prescriptive, based on sociological observations of dr/pt interactions
  - J. Halpern

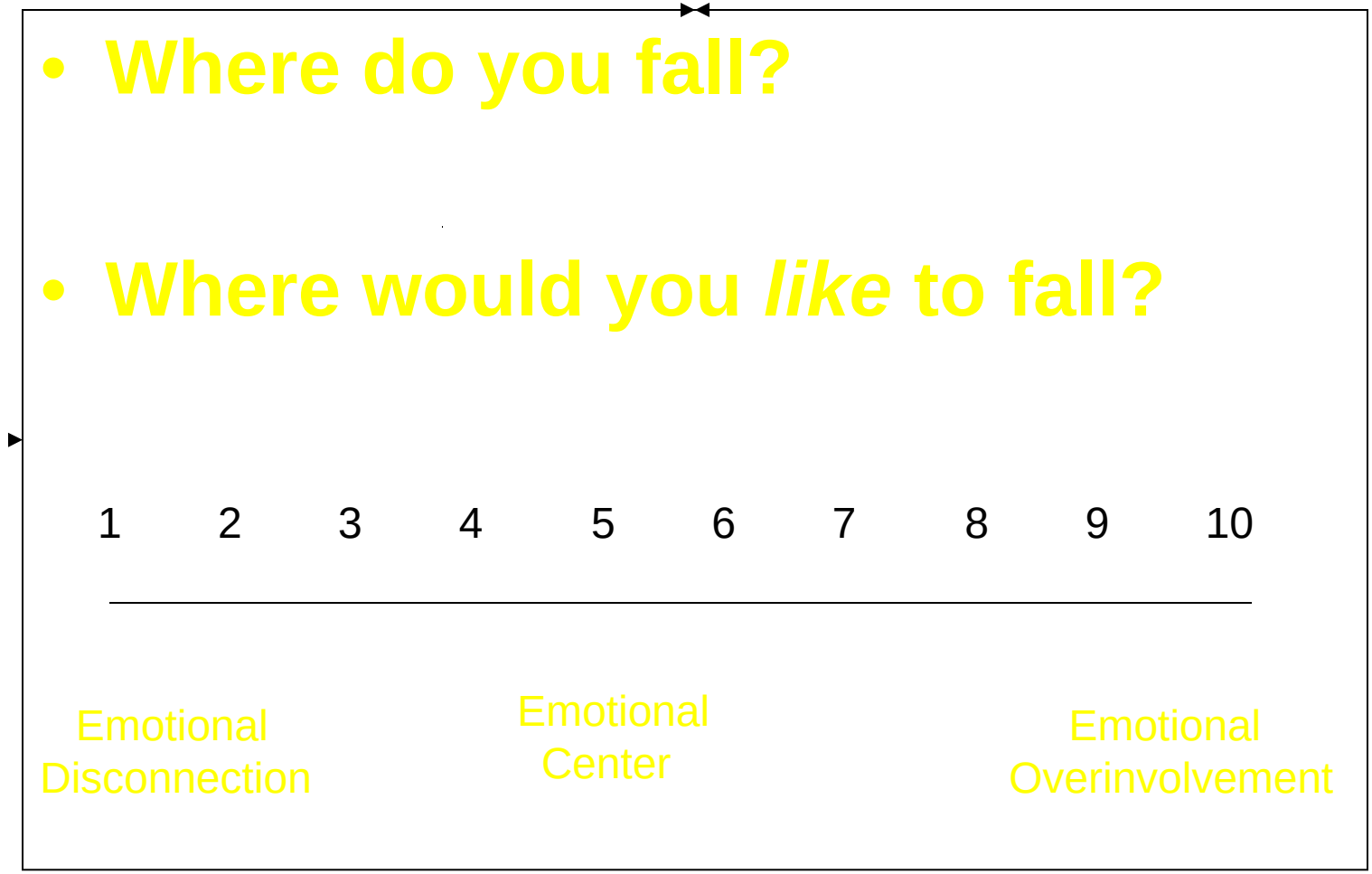
House M.D.

- The epitome of the detached physician
- When he relies on rationality, logic, analysis, he saves his patient
- When he ventures into the emotional realm, it is invariably a catastrophe

- Anatole Broyard quote

Emotional Connection Continuum

- **Where do you fall?**
- **Where would you *like* to fall?**



How can we remain open-hearted toward patients and survive?

- Emotional intelligence
  - Perceiving (awareness of the existence of emotions),
  - Understanding (comprehending the nature of the emotions and being able to discriminate different emotional states),
  - Managing (neither ignoring nor being overwhelmed by the emotions), and
  - Using (being able to experience, acknowledge, and integrate emotions in ways that promote positive rather than negative patient outcomes) one's own and others' emotions
- Emotional regulation
  - Ability to modulate one's emotional experiences and responses
  - Not simply down-regulation (reduction) of negative emotions but rather finding a response between hypo- and hyperarousal, primarily through cognitive reappraisal
    - changing how we think in order to change how we respond emotionally)

Other Theoretical Constructs about Emotions

- Clinical empathy (Halpern)
  - detailed experiential as well as cognitive understanding of what the patient is feeling
  - Capacity to offer patient alternative/complementary frames of experience
- Relationship-centered care (Beach et al)
  - affect and emotion are central to the patient–doctor relationship
- Emotional resilience (Wald et al)
  - not to succumb to emotional collapse in emotionally challenging situations
- Emotional equilibrium (Coulehan)
  - Steadiness and tenderness

Pedagogical Tools

- Mindfulness/mindfulness meditation
- Reflection/self-awareness
- Narrative medicine