What To Do with Emotions in Medicine?

Slide 1: Medicine is full of emotion

Patients have emotions, so do doctors, residents, and medical students

Emotions result from our emotional connections with others

We don't yell at our cars

Positive emotions

Gratitude, happiness, pride, relief

Negative emotions

Anxiety, fear, vulnerability, guilt, sadness, dislike, frustration, anger, shame

Slide 2: Medicine is full of emotion, but…

Emotions are often complicated, unruly, unpredictable, confusing, and distressing

We do not do a very good job of preparing learners to deal with the emotions that arise in difficult, stressful, tense clinical situations

Therefore medical students often conclude that emotional connection is the problem, and emotional detachment is the solution

Video clip: This lesson about the problematic nature of emotion sometimes plays out as follows in this dialogue between a medical student and her resident.

Slide 3: In my work, I make some assumptions about emotions in the clinical setting. These are assumptions with which you may well disagree, and we can certainly talk about them at the end of this talk

Being aware of and able to modulate/manage emotions in self and others is essential to good patient care and good medical teamwork

In any clinical context, the physician or student–physician (and/or supervisor, or colleague) should be able to recognize when experiencing and/or expressing a particular emotion

(1) does not advance patient-centered goals and/or

(2) is distressing for the patient (or the physician)

This awareness should trigger a process of working with or modulating the emotion to ensure that patient care (and physician well-being) do not suffer…

All the while maintaining an emotional connection with the pt

Slide 4: This approach raises the question of whether I am de facto suggesting the formation of a kind of emotions police

Am I trying to "make" students feel a certain way?

No, not at all, and I am also not suggesting that we need to "teach" students certain emotions, a position which students rightfully find a patronizing if not insulting attitude

My goal is less teaching, and more facilitating the identification, understanding, and exploration of feelings

It is not about telling students or doctors *what* to feel, but to encourage them to think about what they should *do* with their feelings

Slide 5: Do emotions matter in medicine? Of course

They affect both doctors and patients in terms of decision-making, information-processing, and the doctor-patient relationship
Patient emotions are related to clinical outcomes, clinical symptoms, decreased adherence, decreased trust, and poorer follow-up

Slide 6: Medical students/residents of course have emotions too
Emotional distress is common among medical students and residents
Early on, students feel
Helplessness, uncertainty
Anxiety, confusion
Later, students experience positive emotions, but also…
Anxiety, guilt, sadness, anger, shame
Moral confusion and distress
Can feel dislike/aggression
Can feel all these things not just toward pts, but toward residents/attendings/nurses

Slide 7: Medical students are certainly afraid of becoming emotionally deadened as a result of their training.
But they are even more afraid of becoming emotionally overwhelmed by their patients, in effect being emotionally swept away by their patients' suffering.
Many of the emotional strategies they adopt are self-protective in nature - what would be good for them, not necessarily what would be good for the patients)

Slide 8: Physicians can be poor role models for how to manage emotions
Students look to their residents/attendings to understand how to process their own and patients' emotions, but…
Physicians often deal with anxiety by distancing from their own emotions
They rely on cognitive/behavioral strategies when interacting with patients (do they cognitively apprehend their diagnosis?; outlining the behavioral lifestyle changes they must implement)
They tend to ignore negative emotions (sadness, anger) – crying study
Physicians are not very good judges of reading pts' emotions; or acknowledging pts' emotions
When do acknowledge, tend to offer only minimal empathy
Engage in "blocking behaviors" that discourage further emotional disclosure (breaking eye contact, introducing a new topic)

Slide 9: Detachment – implicit professional ideal?
Messiness of emotions leads to viewing emotional detachment as an implicit 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."
Scholars point out that clinical detachment was descriptive not prescriptive, based on sociological observations of dr/pt interactions
No research exists documenting the efficacy of detachment in either

Reducing physician stress or improving physician coping
Improving patient care

Slide 10: House M.D. the epitome of this position
Although no one would publicly hold up Gregory House as the ideal physician to emulate, in fact he embodies that belief that science (and therefore the objectivity/detachment of the scientist) are predictable, reliable, and safe, whereas emotions are unruly, chaotic, and dangerous

Slide 11: The example of empathy [can OMIT]
In medical education, empathy is often presented in purely cognitive/behavioral terms
Cognitive apprehension of pt perspective
Verbal/nonverbal behaviors
Yet many scholars contend that empathy must have an element of emotional resonance as well as cognition and behavior
Sometimes empathy arises naturally
When it does not, it is in part because of underlying feelings of fear, dislike, vulnerability, judgment
These cannot be counteracted purely by cognitive injunctions or behavioral strategies, but require the capacity to, if only for a moment, step into the patient's shoes

Slide 12: So how can we help learners develop greater understanding and skill in working with their own and patients' emotions?
Goal is not…
to "make" learners feel a certain way
Goal is….
to help learners be aware of and understand their emotions and those of their patients…
to help them recognize when their own emotions and/or the patient's are interfering with good patient care…
and to develop the skills to work with these emotions in a constructive, beneficial way
…so that they can retain a positive emotional connection, an open-heartedness, toward patients, supervisors, and colleagues

I don't think we have clear answers as yet
The most we can do is begin to more systematically investigate available bodies of knowledge.
Some that are intriguing and that may have relevance for clinical practice are

Slide 13: Relevant conceptual models
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
Cultivation of positive emotional responses
Finding a response between hypo- and hyperarousal, primarily through cognitive reappraisal (changing how we think in order to change how we respond emotionally)

Slide 14: Other Theoretical Constructs of Relevance to Emotions [can OMIT]
Clinical empathy (Halpern)
Detailed experiential as well as cognitive understanding of what pt 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)
How to avoid emotional collapse in emotionally challenging situations
Emotional equilibrium (Coulehan)
Steadiness and tenderness

Slide 15: Pedagogical Tools to Develop Capacity to Work with Emotions
Mindfulness/meditation
Self-awareness – through small group discussion, interactions with preceptors, reflective writing
Narrative medicine – listening to patients' stories to become more skillful in terms of empathizing with other perspectives and points of view

Slide 16: Final thought – Anatole Broyard
How can we help students learn to plunge into their patients without drowning and without becoming broken?

Slide 17: From the theoretical to the practical: Translational applications
In the context of already busy learning environments, how do we begin to offer guidance about emotions?
Ask learner about emotions
What do you think this pt might be feeling?
How did this pt. make you feel?
How do you think these feelings might affect your care of the pt?
Catch it, check it, change it
Disclose own emotions and compensatory strategies
Your turn!
Spend 10 minutes talking about how you acknowledge emotions in clinical care
Choose the most interesting ideas to share with large group