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The feeling physician: educating the emotions in medical training

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Abstract

In this paper, I first address what medical students learn about appropriate (or tolerated) professional attitudes and emotions in the clinical context and how the performance of emotional positions that create distance between doctor and patient and the defining of patients as other is encouraged through the informal and hidden curricula. Next, I examine what we know about medical students' emotions. I then identify particular problematic emotional attitudes that can emerge in medical students toward patients, especially vulnerable patients who are marginalized or stigmatized in the healthcare system. To better understand this phenomenon, I discuss how such emotions emerge in response to both intrapsychic and systemic pressures. The paper then examines alternative models of healthcare that prioritize connection and solidarity with patients, considers how concepts such as emotional intelligence and emotional regulation may be pertinent in the training of future physicians and notes the relevance of such models and concepts to curricular innovation.

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Introduction

Medical education does not typically pay explicit attention to the attitudes and emotions of its trainees. Hafferty's seminal work [1] drew the attention of medical educators to 3 types of curricular experience in medical training: the formal curriculum (sanctioned official, authorized coursework and training experiences); the informal curriculum (the values, attitudes and behaviors highlighted through interpersonal interactions between learners and teachers) and the hidden curriculum (the influences exerted on learners by the larger organizational structure and culture). The formal curriculum rarely considers trainee emotions directly, although it periodically enumerates officially desirable attitudes and values of respect, altruism and caring. The informal curriculum often conveys the message that the appropriate professional relational position *vis-à-vis* the patient is one of emotional distance and detachment [2,3]. At times, the informal curriculum presents examples of outright physician disrespect, annoyance, hostility or intolerance toward patients [4] and thus promotes attitudes of cynicism among trainees, although of course it also offers students counter-examples of caring, compassion and empathy [5]. The hidden curriculum frequently appears to prioritize efficiency of function and productivity over benevolence and kindness.

In one telling ethnographic study, surgeons and intensivists intentionally tried to be unaware of their patients' stories and to reduce their work to technical, biomedical tasks [6].

All these pedagogical encounters, whether of the formal or the informal variety, teach something to their learners about appropriate professional attitudes and emotions. Although the specific content is mixed, there seem to be 2 dominant, albeit somewhat contradictory, messages. The more accepted position is that, on the whole, physician emotions are untrustworthy and problematic and have little or no place in the practice of medicine. They are implicitly viewed as self-indulgent, co-dependent, even at times histrionic. An assumption exists that, if not overruled by cognition, experiencing emotion can lead to burnout and compassion fatigue [7]. The view persists that inadequate emotional control can result in professional failures [8].

Such suspicions apply to both positive and negative emotion. Positive feelings - such as liking and/or feeling affection for a patient - are seen as potentially inhibiting the physician's ability to face either problematic diagnoses or otherwise difficult situations that affect the patient [9], although no actual research supports the idea that caring about patients and establishing an emotional connection with them results in problematic outcomes [10]. Nevertheless, the fear of "caring too much" about patients

and hypothesized consequent emotional exhaustion, is widespread among learners [11]. Problematic emotions such as frustration, helplessness, anger or resentment are rightly also regarded as risky, as they can negatively influence patient care, for example, causing the physician to avoid regular follow-up care of disliked patients [12] or resulting in more automatic, stereotyped physician responses to patient concerns [13].

In consequence of this discomfort with emotion, many physicians believe they should be objective, rational, precise and intellectual in their interactions with patients [14]. Scholars have noted that the dominant cultural norms of medical education likewise promote emotional detachment, affective distance and clinical neutrality [3,15,16]. The overriding principle governing the doctor-patient relationship is one of emotional control [17] with many physicians inferring that they must exert control over their emotions in the work setting [18], (which, as I will discuss later, is different from emotional regulation). Medical students are particularly susceptible to this message, because they are still learning how to successfully imitate a professional demeanor, including the expression or suppression of emotion and pay careful attention to the role modeling around them [19].

Somewhat contradictory to this official view supporting the value of an objective, emotion-free attitude toward patients, is a competing and more self-justifying attitude toward negative emotions. In this perspective, rarely stated but not infrequently enacted, it is acceptable to express annoyance, anger or even ridicule about certain patients, for example, in the hospital corridors during rounds [20,21]. Sometimes, especially non-verbally through tone of voice or gestures, such emotional reactions are communicated even in the presence of patients who, in the judgment of the physician, "deserve" such treatment because of their stigmatized status as "causing" their own illness, being demanding, "not caring" about their own health or being difficult or non-compliant. Because feelings are rarely addressed in the curriculum, this competing emotional reality receives little attention or acknowledgment, resulting in trainee disillusionment and cynicism.

Trainee emotions and attitudes toward patients

It is well-documented that medical learners have a range of intense emotional reactions to patients, many of them confusing or shameful. Emotional distress is common among medical students and residents [22] as is moral distress, defined as the negative feelings that arise when one knows the morally correct response to a situation, but is afraid to act because of institutional and power factors [23]. Students struggle to reconcile "the essential fractured nature of ourselves and our hearts" [24], the existential reality that for physicians personal selfishness and humane care must exist side by side. It has been pointed out that young physicians have no special emotional preparation

for dealing with the issues of sickness, disability and death that will confront them on a daily basis [25].

In one study of students' first patient encounters, students reported feelings of helplessness and uncertainty when faced with serious illness and death and they described their initial attempts at physical examination as anxiety-provoking and confusing [26]. Another study found that while students in the third year of training experienced positive emotions such as gratitude, happiness, compassion, pride and relief, they also experienced anxiety, guilt, sadness, anger and shame [27]. A pedagogic exercise to teach personal awareness revealed multiple fears and anxieties in students, as well as unrecognized anger, disdain and withdrawal [28]. A recent study using paintings of patients as prompts found that while some students reported feelings of empathy and compassion, others admitted less noble reactions of sarcasm, resentment, helplessness, pity, anxiety and judgment [29]. Students even engage in derogatory humor about patients as an outlet for unacceptable emotions [20]. One study concluded that students tended to rationalize or justify these negative feelings as appropriate because of patient behavior or characteristics [30].

The complicated emotions evoked in patient care are often particularly intense in clinical situations involving vulnerable populations. No single definition of such marginalized and stigmatized populations exists, but can include the poor, patients who are chronically ill or disabled [31], patients who are racially or culturally different from the physician [32], as well as the aged, persons who are institutionalized (i.e., prisoners or the mentally ill), drug or alcohol users or persons with HIV/AIDS or other stigmatizing diseases or conditions perceived to be under the control of the patient [33] (lung cancer associated with tobacco use; obesity associated with overeating [34]). With such patients, learners may experience the heightened temptation to see these patients as threatening and alien others.

Vulnerable patients can trigger feelings in student physicians of fear of loss and awareness of the randomness and chaos inherent in life as they observe the effects of specific circumstances and conditions on these patients. Confronted with these fears, students may be asking less "Who are you?" in relation to the patient and more, albeit unconsciously, "How might you harm me?" [35]. Like other privileged groups, medical students have deeply entrenched habits of repression and objectification, which makes it difficult for them to fully respond to and become implicated in the suffering of others [36]. Below, I discuss some particular problematic emotional responses in learners based on numerous discussion groups and classes with students in their clinical years.

Emotional pitfalls

Initially, vulnerable patients can evoke fear, revulsion and pity in medical students [37] because they are metaphorical sources of contamination and defilement [38]. Further, because learners typically enter medicine to "help" patients and "fix" problems, they may feel overwhelmed by the extent and number of problems vulnerable patients present.

This realization adds a sense of helplessness in learners as well, because they perceive that they and their medical team often lack control to transform these patients' situations [39]. Filled with feelings of shame and discomfort, some students may simply avoid these patients or withdraw emotionally out of a desire to avoid these complicated feelings.

Students also sometimes attempt to cope with unpleasant feelings of distress by adopting a stance of "triumphalism", that is, constructing a narrative of triumph over adversity regarding the patient [40]. This reaction seems to occur primarily toward subsets of vulnerable patients perceived by learners as innocent or "deserving", for example, children with AIDS, persons with disabilities, "virtuous" (i.e., hardworking) poor, *etc*. This counter-reaction to emotional distress acknowledges patients' strengths and substitutes a more positive response of approbation and amazement. Yet excessive admiration of vulnerable patients can restrict their full humanity as much as denigration and avoidance. This response may exaggerate the patient's capacity for positive coping and may limit their expression of fear and suffering. Disability studies identify overcoming or inspirational narratives as ableist and impeding the idea of understanding disability as a social construction [41].

The opposite reaction to triumphalism is blame. Attempting to sort out a "why" that will restore boundaries and order, learners may develop a narrative that holds vulnerable patients personally accountable for their difficult circumstances [42]. Again, this attitude tends to be applied to only a subset of vulnerable patients who present a counter-narrative to those generating a triumphalist response: that is, patients who abuse drugs, are labeled as disability-seeking or "non-compliant," are perceived as "not caring" about their medical conditions (often patients from other cultures who hold different health beliefs or expectations for medical care) or whose diseases are perceived to be self-inflicted. Although personal responsibility is a relevant factor in some clinical circumstances, typically "blame" is assigned not after careful investigation of a particular situation, but rather as a reflexive emotional default position based on superficial and stereotypic perceptions. Its intention is not to serve the specific patient, but to ameliorate the distressing feelings of the learner.

Other students may engage in reaction-formation by adopting the comforting emotional stance that vulnerable patients are "just the same" as themselves, whereas in fact, at a deeper unconscious level, the students may be experiencing fear of the essential alterity or difference of the patient [43]. Because unresolveable distinction is frightening, the student prefers to think that differences do not exist or can be transcended. This position denies the student the opportunity to confront and become comfortable with the idea of inalienable divergence among individuals by requiring a fundamental similarity of all people. It also enables students to avoid feelings of fear and dread that may be triggered in the presence of vulnerable others - the fallout from confrontation with fallibility, suffering and alterity that inevitably threatens their sense of perfection and safety [44]. Lack of pity was

an important corrective to historically socially acceptable responses of seeing vulnerable persons as "less-than" and "feeling sorry for" their perceived lacunae, gaps and deficiencies [45]. However, the banner of "no pity" has created the perhaps unintended consequence of "not noticing" difference, particularly in naïve learners.

In all these situations, a more desirable critical stance might authentically confront problematic emotions that arise in encounters with vulnerable others, discuss how these are encouraged and reinforced by the societal and cultural norms operating within medicine and open themselves to solidarity and connection with patients in a way that embraces (or at least does not turn away from) difference. Yet attaining such self-positioning for the learner is complicated by medical education's support for attitudes of detachment and otherness.

Systemic reinforcement of certain attitudes and emotions

As we have seen, on an individual, psychological level, the performance of emotional objectivity creates a sense of safety and invulnerability that insulates the "non-vulnerable" medical student from the fragility and helplessness that their patients might otherwise engender [46]. On a group level, otherness serves as a construct of exclusivity, one that neutralizes and makes safe the existential threat patients pose by negatively "fixing" them into rigid categories [47]. By maintaining an emotional position of otherness, especially toward vulnerable patients, medical students can foster a sense of homogeneity with desirable, powerful individuals (their physician supervisors and teachers) and conform to standards of belongingness with the medical team. Emotions are contagious, in that we tend to mirror the expressed feelings of those around us, especially admired and powerful superiors [48]. Thus, if attending physicians and residents are dismissive, judgmental, impatient, frustrated or sarcastic regarding vulnerable patients, learners will swiftly incorporate these emotional performances into their own behavioral repertoire, to the detriment of patient care and the perpetuation of stereotypes that negatively label categories of people.

How emotional responses are valued, constructed and performed within medical culture is not merely a private matter then, but heavily affected by normative group processes intimately tied to issues of membership, belonging, success and advancement. Which emotions are allowed and which suppressed – the regulation of permissible and "professional" emotions – may stem less from individual predilections and values and more from the expectations and requirements of the profession. Tender emotions in learners, for instance, especially tears, are often seen as evidence of lack of professionalism [49]. While judgmental negative emotions are disallowed by the formal curriculum, they are in fact pervasive in the "informal" and "hidden" curricula. As a result, students often conclude that emotions are dangerous and best avoided [50].

Pedagogical revisioning of the emotional relationship between medical students and patients

Models of emotional connection

As the above discussion demonstrates, although students display a spectrum of emotional responses to patients, they are at risk for concluding that emotional distancing, an emotional "pushing away" from the patient, is the strategy most likely to be considered appropriate by their superiors as well as the approach most likely to offer some refuge from being overwhelmed by their emotions. Yet medicine is an increasingly heterogeneous culture and alternative models that advocate for emotional connection with patients exist as well. For example, relationship-centered care [51] acknowledges the central role played in healthcare by the emotions of both physician and patient. The ethicist Jody Halpern talks about the importance of emotional resonance toward patients [52], in which the physician not only intellectually apprehends the perspective of the patient, but is able to connect emotionally with the patient. Halpern also describes clinical empathy as involving not only the capacity to feel the emotions of the patient, but also, when appropriate, to offer the patient alternative and more constructive ways of understanding and feeling about their situation [10].

Jack Coulehan suggests that learners and physicians adopt a position of "compassionate solidarity" with patients in which, motivated by compassion and empathy, they align themselves with the needs and priorities of the patient rather than those of the institution [15]. Howard Brody argues that if physicians take refuge behind objectivity and remain detached from their patients' suffering, that suffering remains without meaning and healing is complicated or impeded [53]. Suzanne Poirier encourages emotional honesty in medical learners, directed both inward toward acknowledging one's feelings and their implications and outward toward the expression of one's feelings and the recognition of the feelings of others [54]. Rita Charon has identified the importance of affiliation with patients and the ability to be moved by patients' suffering [55]. She relishes the reality that "physicians absorb and display the inevitable results of being submerged in pain, unfairness and suffering while being buoyed by the extraordinary courage, resourcefulness, faith and love they behold every day in practice" [56]. Shildrick suggests that recognizing shared vulnerability with those who suffer may be at once a more humane and a more realistic position from which connection with others is possible [57]. Similarly, Spivak calls for a "radical acceptance of vulnerability," in which the enterprise of denying the fragility of existence is abandoned [58]. Nevertheless, although these and other views hold great promise, they have only incompletely made their way into the medical education curriculum and even less so into the culture of healthcare in general.

Emotional intelligence and emotional regulation

Of course, emotional openness and responsiveness involves some risk to patients and physicians. For example, physicians may be less honest about problematic findings out of fear of wounding the patient, resulting in the patient having an imprecise grasp of the clinical situation. Physicians (and students) may undergo the experience of being overwhelmed by difficult-to-tolerate feelings. An unnuanced emphasis on empathy may result in physicians who think they understand their patients' perspectives and feelings, but who in fact are projecting their own voice and imagination, further silencing the patient's opportunity to represent herself [59].

Implied but essential in avoiding the dangers of the above relational models are 2 underlying constructs, *emotional intelligence* and *emotional regulation*. Emotional intelligence is defined as having awareness of the existence of emotions, comprehending the nature of the emotions and being able to discriminate different emotional states, being able to appropriately manage emotions and being able to experience, acknowledge and integrate emotions in ways that promote positive, rather than negative, patient outcomes [60]. The development of emotional intelligence [61], it is asserted, may help physicians to decode emotions expressed by others, recognize and convey their own emotions and be sensitive to the interaction of one's emotions and motivations with cognitive processes. Researchers have conjectured that fostering emotional intelligence in medical education may allow students to develop the kinds of complex, in-depth interpersonal skills that lead to building good relationships [62]. Others have asserted that the components of emotional intelligence might allow medical personnel to experience the emotions involved in close patient relations, while resisting cynicism and burnout [63]. One review article found that higher emotional intelligence contributed to a positive doctor-patient relationship and was associated with increased empathy, teamwork and communication skills, as well as effective stress management, strong organizational commitment and leadership [64].

An important component of emotional intelligence is emotional regulation or the ability to modulate one's emotional experiences and responses in response to changing environmental and interpersonal contingencies [65]. For example, a physician who notices feelings of judgmentalness toward a pregnant adolescent might consider the social circumstances that contributed to this outcome, with a resultant softening of the emotion of blame and a greater feeling of compassion. Individuals who can regulate their emotional states are better able to avoid being overwhelmed by their emotions and therefore can focus on the emotional needs of the other [66,67]. Emotional regulation depends primarily on cognitive reappraisal, that is, changing how we think in order to change how we respond emotionally. Some scholars have proposed a variant, mindful emotion regulation [68] that emphasizes cultivating awareness and non-reactivity in response to troublesome emotions. This approach may

allow individuals to choose more thoughtfully which emotions and thoughts will best advance their personal and professional values as well as their therapeutic commitment to their patients, a task that has been identified as essential in promoting empathy and altruism [69]. In the above example, the physician might first pay attention to, then encourage, even rudimentary feelings of empathy and caring for the patient that may begin to "compete" and eventually replace the original feeling of judgment. One study found that students who are able to express their emotions and address emotions expressed by the patient were most likely to demonstrate flexibility, empathy and patient-centeredness in patient interviews [70], confirming the need to identify and promote emotional awareness and management in future physicians.

Curricular implications

Of course, the goal of any pedagogical intervention is not to *prescribe* certain emotional responses to learners, but rather to examine and critically interrogate them, so that they do not unconsciously drive interactions with patients or medical decision-making. Rather than viewing emotions as only personal and asocial, the assumption here is that willingness to own and express emotion can complicate or challenge normative ways of relating to patients that rely solely on objectivity and distance [71]. Learners must first become aware of and identify their emotional reactions; then they must realize that cultural norms in the profession variously encourage or stifle the expression of emotions and, finally, they must develop the skills to cultivate emotions that support professional attitudes of altruism, empathy, service and connection. Thus, the question is not whether emotional distance or emotional connection is the most "professional" attitude, but how the patient can best be served through an aware, conscious understanding of the role of emotions in healthcare.

Curricular experiences that focus on a non-judgmental consideration of students' and patients' emotional reactions, with an aim toward exploring the ramifications of different forms of emotional expression, fulfill several functions. First, they normalize problematic emotions that students may feel uncomfortable with and therefore tend to ignore, suppress or express in unconscious ways. By discussing their emotions in small groups, for example, students learn that other students (and faculty) experience similar emotions under similar experiences, which further validates their own feelings. Secondly, with practice guided by experienced faculty, students are able to become more skillful at recognizing the emotions of patients and family members in high stress medical situations. In addition, after identifying in a non-judgmental yet clear-sighted manner the various emotional responses available in both themselves and others, students then have an opportunity to consider which emotions will best support their professional obligation to promote the wellbeing and health of their patient [72]. Finally, through the role-modeling of peers and faculty, students can build upon, react against and be inspired by the emotional dimensions represented and practice the differential expression of a

range of emotions that they can then extend to actual clinical interactions.

Conclusion

The current state of medical education is woefully deficient in educating its learners about the role of emotions in healthcare. Despite this formal neglect, informal and hidden curricula communicate various confusing and contradictory messages about the relationship between professionalism and emotion. The result is that students often attempt to stifle or ignore their emotional world and simultaneously feel able to express negative emotions, especially toward vulnerable patients, as ways of protecting self and pairing with powerful others. Alternative educational approaches stressing appropriate emotional connection and shared vulnerability with patients must incorporate emotional intelligence and emotional regulation. Engagement with the complexity of the experiences of vulnerable others presents an opportunity for medical students first to experience and then to critically examine the range of emotions triggered in response to issues of illness and suffering. The development first of emotional awareness and then of skill in negotiating one's own as well as the patient's emotions can, in turn, lead to solidarity with, rather than distancing from, the vulnerable other. As a consequence, medical students may be better able to interrogate both their own problematic emotions and those supported by aspects of their training milieu and better prepared to address emotions in the doctor-patient encounter in ways guided by awareness, integrity, humility and fearlessness.

Conflicts of Interest

The author declares no conflicts of interest.

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