



Art of Family Medicine

What's sewn in

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*I went to the circus and I was not awed;
at the acrobats' daring I calmly smiled,
an understanding acknowledgement:
that's what they do, being them.
At the vistas, at the plains, at the birds of paradise
I only observed, an appropriate acceptance.
At the compost bin not maintained properly,
when the snake slithered away,
when the house left open infested with mice
I dealt with it as it, less than it: absented odours and
symbolism.
At the sadness no sadness, at the newborns no fear no joy;
I was not afraid at the dusk of an endless night, just
after lunch.*

*All day this life placed these stones in hidden
pockets it sews into me:*

*I went home, said the day was fine,
another one, had dinner with my wife and son.*

Doctors deal with the profound, strange, sad, joyful, and tragic of human life—of individual human lives. A medical education prepares doctors mostly to deal with the nature of physical illness and, in recent decades, to attempt to understand and heal the whole person as well. Formal medical education for the most part does not help doctors prepare for the personal effects of this new life. Doctors in training encounter novel stressors. As there are different sorts of medical trainees, there are different sorts of responses to these stressors. Some doctors are better prepared for the life of the clinic because they have doctors in their families who have in some way cultivated them; some are better prepared based on their personalities; and some are particularly susceptible. Regardless, trainees tend to deal with the emotions doctoring generates on their own and with trusted peers. The apparent lack of emotional responses to patients on their teachers' parts might seem in some ways an ideal but also a barrier to communication. Trainees might admire more experienced doctors' capacity to remain in control in difficult situations, but this might make their teachers harder to relate to, suggesting to trainees that their teachers are callous and would not understand their emotions.

Norms

People learning to be doctors see quickly that most of their emotional responses to their patients and their patients' situations cannot be expressed. This is conveyed based

on the norms of the clinic, the behaviour their teachers model, and the patients' own expectations. While we have tried to teach doctors to be more "patient-centred," more "person-centred," more empathetic, there remains a fairly small range of emotions that is acceptable for doctors to show patients. This relates to the role of the physician as the detached scientist of Western medicine, and it relates to beneficence as well: the doctor-patient encounter is about the patient's emotions, not the doctor's. Doctors can and do establish human relationships with their patients, but the nature of these is circumscribed by the profession's norms and the professional colleges' rules.

Move on

But the normative demands of the profession do not change the presence of emotions for doctors who are inclined to feel them. They just complicate them: emotions have to go somewhere, and so can be delivered or end up, actively or passively, in compartments within a doctor's psyche. This is how doctors continue calmly and stoically interacting with patients they care about, whom they have just delivered bad news to. And this is how doctors open the next door and deal appropriately with the next patient when they have just finished absorbing a patient's anger boiling over.

This is crucial: "The ability to move on is an essential trait for a physician."¹ But perhaps the compartmentalization of emotions contributes to the rash of patients' comments on RateMDs about how their doctors do not really care and all the variations on that theme. While a structured approach to asking about patients' lived experiences of their illnesses can help (eg, asking "How do you feel about that?" or "What are your ideas about that?"), rote inquiries cannot replace the awareness that another person hears you, gets it; this is along the lines of empathy, of course. Teaching this to people who are not inclined to act this way is an uncertain endeavour, and different than ensuring medical students ask the FIFE (feelings, ideas, functioning, and expectations) questions on their objective structured clinical examinations. But then, really experiencing life with another person generates its own reflected existence in a doctor's life.

Ideally, doctors would have a moderate emotional response, the appropriate emotional response; they would experience it and move on, unencumbered. This happens. But in some cases it seems the only alternative to some amount of compartmentalizing is not having the emotional responses at all. This might happen for

some doctors based on their own natures, or for doctors who are more inclined to perceive or understand their role specifically as work and their patients as cases and not complex human beings. But these scenarios should be less likely, as medical schools have tried to ensure acceptance of well-balanced “real” people. But this might not work in the long run, either: doctors who do understand and experience their patients as complex beings can have their compartments fill and threaten to spill messily, and can then retreat.

Evolution

And there is a maturation of the emotional responses that happens to doctors over time. Or at least, there is an evolution. Over time, there is a definite loss of the intensity of doctors’ emotional responses. This is a probably inevitable “getting used to”; these doctors need to remind themselves

that although they have seen a scenario many times and it has lost its punch for them, it is a new lived reality for the patient. The emotional responses that are not dulled, and are not experienced and dispelled, continue to be compartmentalized throughout doctors’ lives—probably working their way out of their compartments over time, seeping into the doctors’ being, changing them. The goal, I suppose, is feeling the “right” amount for our patients, learning what that amount is over time, being aware of what we are feeling, and letting it go: so we can help our patients in their biology and in their selves, but also remain essentially integrated ourselves. 

Dr Sullivan is a family physician practising in Kanata, Ont.

Competing interests

None declared

Reference

1. Cameron I. Nothing to do but wait. A home delivery in 1892. *Can Fam Physician* 2009;55:626-7.

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