Invisible work

Valuing emotional labour in family medicine

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My last patient today was a woman who had just lost her husband. There wasn’t a reason for her visit listed in my schedule, but when I asked what I could do for her, she told me about how she and her husband had met, how sad she felt without him, and how surreal it had been to attend his funeral. She cried, and I held her hand. Eventually she left, and I wrote my note. As I clicked through my electronic medical record to complete the visit, I realized, for the thousandth time, I had no idea how to fit the visit into health authority-approved definitions of medical care.

What I have learned over the years is that my most important therapeutic tool is being deeply present with patients. Health care, when it’s done right, involves no demands in the relationship. It is about collaborating with people to make them well. We employ all the resources at our disposal in the hope that our patients get what they need to function and thrive. In the end, being with a person—being present—is the best kind of healing work that we can do. But it’s hard to name, and therefore remains invisible.

Invisible work in family medicine

The ugly truth is that our health care system prioritizes values responding to discrete demands. It’s much harder to focus on hazy notions of health and well-being. Physicians are judged by administrators on how many patients we see, how many procedures we do, and how quickly we flow patients through hospital or clinic services. I work in a number of settings and I never seem to be able to escape the push to see more patients, see them faster, and get them out sooner. The assumption is that this will enable me to better meet patient and system demands. The reality is none of this encourages taking their loved ones. But again, there is no way to name what we do. This is no accident, as our work is tallied with no demands in the relationship. It is about collaborating with people to make them well. We employ all the resources at our disposal in the hope that our patients get what they need to function and thrive. In the end, being with a person—being present—is the best kind of healing work that we can do. But it’s hard to name, and therefore remains invisible.

This focus on numbers of patients seen doesn’t necessarily translate to better medical care. As early as 1994, a study from New Brunswick showed that the number of prescriptions written per patient increased with the number of patients seen in a day.1 If we’re honest with ourselves, we have probably all had the experience of weighing simply refilling a medication versus having a long, difficult conversation with a patient to determine if it’s still required.

Those difficult conversations are work. The time we spend listening to and sitting with patients (and sometimes crying ourselves) is known as emotional labour. It’s the effort we expend to make relationships work, helping to manage feelings with and for others. It gets at the roots of demands, which enables us to meet patients’ needs more effectively. Make no mistake, it is real work, but it remains invisible to almost everyone. For a long time, it was invisible to me, even though I performed it daily. I couldn’t articulate what I did in the course of a day and I couldn’t explain why my work felt so exhausting.

Despite the fact that it remains hidden in a system that has no way of assessing our efforts other than assigning monetary value, emotional labour remains integral to good family medicine. Given the nebulous nature of this work (part bearing witness, part counseling, part finesse), it’s no wonder that no billing codes exist for it. Certainly the expectation that family doctors will perform it might be a new phenomenon, caught up in the movement toward patient-centred medicine.

Relational care extends beyond the singular clinical encounter. We know that context and community are critical to health. In hospital, for example, I spend hours explaining death and dying to patients’ families, wading through their feelings as they care for and grieve with their loved ones. But again, there is no way to name what I do. This is no accident, as our work is tallied based on discrete clinical encounters with individuals, leaving aside their social context.

In divorcing care of the patient from attending to and supporting their community dynamic, the government and society at large send a powerful message about the definition of medicine and what has value. For family doctors, trained to see individuals in their social context, picking away at discrete issues inevitably fails to address the emotional care foundational to our practice. Unsurprisingly then, many physicians often follow their acknowledgment of the difficulty of our job with the admission that they couldn’t ever imagine family practice for themselves.
Value of being present

A 2008 report from the College of Family Physicians of Canada identified being “present” with patients as a fundamental part of family medicine. It was, in fact, one of the things that set us apart from other specialties. The report argued that these types of skills should be taught by generalist family doctors in medical school and that family medicine should occupy more clerkship training hours. But in practice, as part of an effort to “get the right care by the right people,” we are actually encouraged to refer patients to allied health professionals when they require emotional labour. Of course, family physicians have no monopoly on this work and there are absolutely limits on what our training allows us to do. But any family doctor in practice can tell you how awkward and corroding it can be to the central relationship of physician and patient to refer away a patient who wants to talk to you. It makes it less, not more, likely that patient needs will be met.

To further complicate the issue, we know that simply spending more time with patients isn’t a panacea—we need to ask good questions and listen carefully to the answers. Sometimes this alone can be enough to constitute great care. And sometimes it is irrelevant how much time you spend with patients or which questions you ask. What they really need is just you—a supportive figure in their lives. Learning to navigate these waters is the skill of “presence.” If it sounds messy and contradictory and full of nuance, that’s because it is. Likewise, creating new fee codes will not itself solve the problem of valuing these skills. We have a culture of medicine that must grapple with how we define health itself, and where family medicine fits.

But back to my patient. Today wasn’t her first or last visit with me. She’s working through her grief. Sometimes she comes with a pretense of a discrete issue: a cold or a blood pressure check. Mostly she just shows up and I hold her hand while she remembers the love of her life. There’s no real way to quantify this work for the government, but I am fairly certain it represents the very foundation of good care.

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Competing interests
None declared

References

Photographer: Jon Nicholls, Bedford, NS. The photo subject is not the patient referred to in this article.

In this 2-part series, Dr Dhara first explores the hidden toll that emotional labour can take in family practice. In next month’s issue, she will highlight challenges unique to women in family medicine. Stay tuned.