Yale Journal of Health Policy, Law, and Ethics

Volume 2
Issue 2 *Yale Journal of Health Policy, Law, and Ethics*

Article 8

2002

Making a Place for Emotions in Medicine

Nancy R. Angoff

BOOK REVIEW

Making a Place for Emotions in Medicine

Nancy R. Angoff, M.D., M.P.H., M.Ed.*

From Detached Concern to Empathy: Humanizing Medical Practice. By Jodi Halpern. *Oxford: Oxford University Press,* 2001. Pp. 188.

The practice of medicine is fraught with emotion. For patients, illness with its accompanying losses engenders fears, anxiety, anger, and suspicion. For physicians, there are many sources of emotion. Certainly the emergency room seethes with intensity with each trauma case, and in the operating room, tempers may flare or despair may reign if all does not go well. But even in the patient's room, physicians may find anger, hostility, sadness, or withdrawal. Yet physicians are taught to remain detached from participating in these emotions in order to maintain the objectivity thought to be crucial to accurate clinical decision-making.

In their often quoted essay entitled, *Training for 'Detached Concern' in Medical Students,* Renee Fox and Harold Lief discuss the successful acculturation and professional development of medical students as a journey to achieve what has been termed detached concern. It is a journey that exposes them to "emotion-laden" experiences, such as cutting into a cadaver for the first time. The student learns through objectifying and intellectualizing these experiences to distance himself from his initial pangs of anxiety and fear. This distancing, or detachment, when balanced with the appropriate amount of concern for the patient, has long been considered a recipe for empathy in the patient-physician relationship. As Fox and Lief note: "The empathic physician is sufficiently detached or objective in his attitude toward the patient to exercise sound medical judgment and keep his equanimity, yet he also has enough concern for the patient to give him sensitive, understanding care."[1]

In her new book, *From Detached Concern to Empathy: Humanizing Medical Practice,*[2] Jodi Halpern presents a well-reasoned and philosophically grounded argument that moves us from comfortable acceptance of the ideal of clinical detachment towards an understanding of the therapeutic good of the use of emotions in medical practice to establish empathetic

* Nancy R. Angoff is Assistant Professor of Internal Medicine and Associate Dean for Student Affairs at the Yale University School of Medicine.

and healing clinical relationships. As Halpern points out, emotions are already present in the patient-physician relationship. We cannot deny that they are there even though physicians may be unaware of, or out of touch with, their emotions. But we can learn to recognize them and use them constructively in the service of empathy.

Halpern's concept of empathy is central to the development of her thesis. It is different from the dictionary definition or from what is frequently taught in medical schools. It is not a projection of one's personality onto another—it is not imagining oneself in another's shoes.[3] Nor is it an intellectualized stance, or the opposite, sympathy, an over-identification with another's problems.[4] Her view of clinical empathy is a process that requires the physician's awareness of her own affect, openness to being moved, curiosity about the patient's state, and ability to imagine how it feels for the patient to experience something. In achieving clinical empathy, the physician's own emotions are put to work. Halpern believes that:

> [E]xperiencing emotion guides what one imagines about another's experience, and thus provides a direction and context for learning. ...[E]motions are not necessarily pre-programmed and static, but, rather, involve making new linkages. Here is where empathy depends upon specific properties of emotional reasoning—associative linking and moods that provide an organizing context.[5]

In Halpern's view, critical clinical decision-making and diagnosis depend not on emotional distance, but on emotional engagement that allows the physician to gain deeper understanding of, and insight into, the patient's experience of illness. In fact, clinical reasoning, the process whereby a physician applies medical evidence to the questions raised by the illness of a patient, depends as much on emotional reasoning utilizing empathy as on detached reasoning. As Halpern writes:

> Empathy involves discerning aspects of a patient's emotional experiences that might otherwise go unrecognized. Empathic communication enables patients to talk about stigmatized issues that relate to their health that might otherwise never be disclosed, thus leading to a fuller understanding of patients' illness experiences, health habits, psychological needs, and social situations.[6]

Halpern received her medical and doctoral degrees from Yale University in 1989 and then completed training in psychiatry. Her dissertation in philosophy was entitled, *Beyond "Detached Concern": The Cognitive and Ethical Function of Emotions in Medical Practice.* In 1993 she

extended her thinking in an essay entitled, *Empathy: Using Resonance Emotions in the Service of Curiosity.*[7] Her new book draws on these previous two works and expands her thesis.

Some of us have waited a long time for this book. Halpern shatters dogma and provides clarity that helps explain our confusion about "how to do" detached concern, a concept that does not ring true to our medical lives. She cites William Osler's influence on physicians in this regard:

> He believed that physicians needed sensitivity to patients' emotional problems, yet he believed that practicing medicine required overarching detachment. His solution to these conflicting demands was to theorize that by neutralizing his own emotions, a physician could achieve special insight, that by not being moved or influenced emotionally by the patient, the physician could more precisely influence the patient therapeutically.[8]

Many medical students and physicians in training and practice today find that they have difficulty "neutralizing" their own emotions, and, in fact, do not wish to do so.[9] This book is written for physicians such as these and for those who would like to learn how to make stronger connections to their patients based on empathy, regardless of whether their patients are well known to them over time or newly encountered.

We have come a long way from the days of William Osler and even from the medical training environment observed and written about by Fox and Lief. One influence on some physicians' awareness of the place for emotion in medicine was the early AIDS epidemic when we could not avoid the reality of feelings of helplessness and despair—our own and that of our patients. As one article described it:

> It was a time in which some patients and their care providers were united in a kind of immediate, naked solidarity. Many clinicians learned or relearned the critical importance of accompanying patients through life-threatening illness, when patients valued above all else from their physicians the commitment not to abandon them to their fate.[10]

Halpern notes:

> The idea that accompanying patients in their suffering can be therapeutic leads to an alternative to the ideal of detached concern for patient-physician interactions. The visual metaphor of the 'objective' doctor standing before the patient and 'seeing through' her irrational emotions ought to be replaced with a paradigm in which the patient 'makes use of' the doctor's nonretaliatory emotional presence to go through the necessarily irrational emotional phases of grieving.[11]

Halpern begins the book with the case of a patient, Ms. G, who wants to be left alone and allowed to die because she sees no useful future for herself.[12] Halpern weaves this case and a few others throughout the book to bring to life the applicability of her hypothesis. The physicians caring for Ms. G. feel that they need to respect her as an autonomous agent with the capacity to understand her medical situation and accede to her wishes to stop dialysis treatment. Ms. G is a double amputee whose husband has left her finding her grotesque and no longer lovable. Ms. G now sees herself in these terms. Her disgust and anger are transmitted to her physicians who acknowledge as objective observers that she has a right to decide not to go on living. As the psychiatrist consulted by Ms. G's medical team to assure her mental capacity to make a decision that would lead to her death, Halpern was bothered by what she realized was perhaps excessive and inappropriate objectivity. The physicians caring for Ms. G were missing out on valuable and material data by sidestepping their emotions about Ms. G's plight as well as about their own plight.

In the first part of her book, Halpern traces the historical pathway that leads to the notion that objectivity on the part of physicians is the ideal, and that the way to achieve objectivity is by neutral emotional observation. This model is of the physician as observer who brings to bear her skills of scrutiny from watching the patient's moods unfold. Obviously this distancing can be problematic. Patients want an emotionally caring and engaged provider. In fact, Halpern points out, "Alleviating suffering occurs through, among other things, emotional communication. People often express their pain in such a way as to have an emotional effect on other people. By refusing to let patients affect them, physicians cut off communication."[13]

Halpern leads the reader to see that Ms. G's physicians have taken a stance of non-interference. Real respect for a person's autonomous decision-making capacity, however, requires that the physician empathize with the patient. She devotes a chapter to the development of this important theme. The weight placed by modern medical ethics on the principle of respect for persons and its attendant acknowledgment of the patient as an autonomous health care decision-maker, does not require the emotional disengagement of the physician. In fact, the physician has a moral duty to try to understand the motivations of his or her patient, motivations that may be steeped in emotion. As Eric Cassell eloquently points out, illness is a state of loss of control and of connectedness to the very sources of our identity.[14] In this state, one has more need than ever for grounding relationships including that of patient-physician:

When one's identity and goals are stable, a person can be resilient and

> emotionally independent and withstand social rejection or neglect without being seriously affected. However, when someone's entire sense of self is disrupted, as occurs with suffering and trauma, the impact of not being empathized with can be very severe.[15]

Through clinical empathy, Ms. G's physicians may have come to know that her view of herself as unlovable may have been shared by them, a factor in their ready acceptance of her decision. On the other hand, by eliciting her emotional story they may have come to know that her view of herself may have been subject to emotional shifts, shifts that may or may not have changed her mind about stopping dialysis. In either case, however, her physicians would have satisfied themselves that they had gone beyond an intellectual and objective understanding of her motivations to include understanding her vitally important emotional motivations. While we have an obligation to engage our patients empathetically, Halpern points out that we must also accept when they decide not to be so engaged.

Can physicians be taught how to practice clinical empathy and put it to use in emotional reasoning? In her final chapter, Halpern treats it as a skill that can be understood in its component parts and practiced and taught just like other clinical skills. The first step is acknowledging its place in the important goal of reducing suffering. Students come to medical school open to caring, curious about the lives of the people who will become their patients, ready to listen, and aware of their own vulnerability. Rather than training for detachment, medical educators must appreciate their students where they are and praise and reinforce their natural empathic powers. She says:

> Teaching empathy, then, involves not only specific verbal and nonverbal skills, but also, and most importantly, a change in medical culture, from emphasizing premature knowing and certainty toward maintaining curiosity. Physicians who cultivate curiosity about others, sensitivity to their own emotional reactions, and an ongoing capacity to see the patient's situation, motives, and reactions as distinct from their own are likely to develop increasing empathic skills. The accuracy of empathy increases with effort.[16]

Nevertheless, as physicians and educators, we have a long way to go to fully understand our and our students' emotional development. Perhaps attention to the precepts of this book will help us in that regard.

Halpern also addresses the problem of physicians who find themselves, as she puts it, "caught emotionally 'in the morass of the patient's problems'"[17] Rather than feeling overwhelmed, the physician can examine the emotions elicited by the patient's irrationality. The physician should

ask himself: What am I feeling? Why? How is this patient making me feel? What is driving this patient's anger, worry, fear, sadness? Some patients can only feel reassured by a physician who demonstrates sufficient attention to the patient's predicament. For the physician open to recognition of these feelings, Halpern views this experience as an opportunity for positive therapeutic insight and intervention. This view may be easier stated than carried out, but it is worth striving for.

A glaring omission of the book is its lack of attention to residency training. Halpern acknowledges that empathic connections cannot be rushed. Residency is a time when many physicians feel they lose their ability to remain curious, when time and work demands preclude the luxury of deep attention to patients beyond what it takes to get the job done quickly, and often superficially. In fact, it can be protective for residents to detach and not to delve into either their own emotional motivations or that of their patients. Many physicians complain that it is a time that changes them. Real acculturation to the ideal of detached concern may occur not as a student, but as a resident. The particular plight of the resident is mentioned only in the foreword written by John Lantos, a pediatrician.[18] He notes the fulfillment experienced by those residents that he has worked with who allow themselves to enter into the life stories of their patients thereby gaining understanding of themselves and meaning and joy in their work. But how to overcome the pressures and time constraints, and why some residents can engage emotionally and not others, is not addressed. Perhaps what is needed are better role models such as Lantos and Halpern to validate this behavior and lead the way.

The book is beautifully and clearly written. Halpern is a philosopher as well as a physician, so its points are developed by extensive research into the works of Freud, Kant, Descartes, Heidegger, and others. It is only 165 pages, but it is dense and requires thoughtful attention. It is worth working through the book. As a physician who has never been able to reconcile the goals of caring with the concept of detachment, I have found in Halpern a long awaited voice of truth. This book cannot be passed off as some "touchy-feely" appeal. There is a growing core of physicians who not only do not wish to avoid emotions, but who recognize their validity as an important reality, one that we can know and use to help our patients make difficult medical decisions. In this way, we are also helping ourselves be better physicians. As Halpern says, "A physician who allows his patients to move him emotionally will enrich his own experience of doctoring."[19]

References

1. Harold I. Lief & Renee C. Fox, *Training for "Detached Concern" in Medical Students, in* THE PSYCHOLOGICAL BASIS OF MEDICAL PRACTICE 12 (Harold I. Lief et al. eds., 1963).

2. JODI HALPERN, FROM DETACHED CONCERN TO EMPATHY: HUMANIZING MEDICAL PRACTICE (2001).

3. *Id.* at 83.

4. *Id.* at 68.

5. *Id.* at 91.

6. *Id.* at 94.

7. Jodi Halpern, *Empathy: Using Resonance Emotions in the Service of Curiosity, in* EMPATHY AND THE PRACTICE OF MEDICINE 160-73 (Howard Spiro et al. eds., 1993).

8. HALPERN, *supra* note 2, at 25.

9. *See, e.g.*, FRANK H. BOEHM, DOCTORS CRY, TOO 15-17 (2001); Nancy R. Angoff, *Crying in the Curriculum*, 286 JAMA 1017-18 (2001).

10. Peter A. Selwyn & Robert Arnold, *From Fate to Tragedy: The Changing Meanings of Life, Death, and AIDS*, 129 ANNALS INTERNAL MED. 899-902 (1998).

11. HALPERN, *supra* note 2, at 144.

12. *Id.* at 1-10.

13. *Id.* at 123.

14. ERIC J. CASSELL, THE HEALER'S ART: A NEW APPROACH TO THE DOCTOR-PATIENT RELATIONSHIP (1985).

15. HALPERN, *supra* note 2, at 116.

16. *Id.* at 135.

17. *Id.* at 136.

18. John Lantos, *Foreword* to JODI HALPERN, FROM DETACHED CONCERN TO EMPATHY: HUMANIZING MEDICAL PRACTICE, at vii-ix (2001).

19. HALPERN, *supra* note 2, at 145.