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**Student  
Member  
Spotlight**

# President's Page

## How Emotions Can Affect Your Practice

by Todd Pollock, MD



I hate complications! I assume this is true for all physicians. Fortunately, as a plastic surgeon, my patients typically are healthy and complications are uncommon. But no matter how careful we are, complications eventually will occur.

Rachel (a pseudonym) was a healthy woman in her mid-40s with two kids and an active lifestyle. She fit squarely into the statistical norm of my patient demographic. Her abdomen showed the typical physical sequelae of having two kids and included a C-section scar. Rachel and her husband were pleasant, upbeat people who worked full-time jobs, exercised regularly and chased their young kids around. I felt an instant rapport with them. She underwent an uncomplicated abdominoplasty and spent one night in the hospital. The next day and at the one-week follow-up, the surgical site looked great from both a postsurgical and an aesthetic standpoint.

About three weeks out from surgery, Rachel called my office complaining of a severe headache, malaise and a fever of 102° F. I saw her immediately. Despite knowing that I had done the procedure appropriately and that this was an unusual timeframe for

a postoperative infection, feelings of fear and guilt settled in my stomach as I took her chart from the door of the patient room. Rachel looked ill, but her surgical site looked appropriate for three weeks post-op and she showed no signs of a surgical site infection. An instant feeling of relief coursed through me. I did sympathize with her and how ill she was, and considered what might be the cause. This occurred near the peak of flu season, and her symptoms fit that bill. I contacted her primary care physician, who agreed. After seeing her, he called and told me that, despite a negative rapid flu test, he believed the symptoms were so classic that he started her on Tamiflu® empirically. Again, I felt relief and a little pride in making the medical diagnosis.

### Complications

My boosted spirit was short-lived. The next morning, Rachel showed up at my office looking similarly ill, but her abdomen was markedly swollen, fluctuant and bright red from pubis to umbilicus. My feelings of fear and guilt from the previous day returned; I felt as if I'd been punched in the gut. Ever-so-briefly, my head fogged and my expression showed my shock. Luckily, she didn't notice, as she was recumbent and staring blankly at the ceiling in a febrile haze. I recovered quickly and got her to the operating room. Upon opening the incision, I was met with a sea of foul-smelling pus, a cavernous wound and the terrifying degree of devitalized tissue. My feelings overwhelmed me and my head swam. I paused briefly to collect myself and forced down my emotions as I had been trained.

After two returns to the OR for further debridement, the better part of a week in the hospital for twice-a-day painful dressing changes, two months of very close follow-

up, and a revision of the scar, I can tell you that the end result was positive. Surprisingly, the final result was aesthetically as if the infection had never happened. Isn't Mother Nature amazing? Possibly even more surprising, I had a happy patient singing my praises and an abundance of lessons learned. Most of these lessons were not regarding medical care (despite reviewing every detail in my head hundreds of times), but were about my emotions and how they affected my delivery of that care.

The feelings of physicians as they journey through their careers, from medical student to seasoned physician, was the subject of the 28th annual Conference of the Professions held in May and hosted by DCMS. This annual conference brings together members of the area's medical, legal and theological professions to explore shared challenges. The host rotates among the professions; other groups participating were UT Southwestern Medical School, Dallas Bar Association, SMU Dedman School of Law, SMU Maguire Center for Public Responsibility, and SMU Perkins School of Theology.

This year's topic, "Agony and Ecstasy: How Your Emotions Affect Practice," was presented by Danielle Ofri, MD, PhD, an internist at NYU by day and a prolific author by night. Her area of interest is the emotions of physicians, which she analyzes and covers extensively in her most recent book, "What Doctors Feel; How Emotions Affect the Practice of Medicine." This book is an excellent read and I highly recommend it to all practicing physicians. It opened my eyes to the complex backdrop of emotions that engulfs us through our medical practices, and helped explain the myriad of feelings, experiences and issues we physicians share.

## Empathy is Central

Classical medical education has emphasized that physicians must remove emotion to avoid clouding their judgment. Renowned medical educator William Osler, MD, in an address to the University of Pennsylvania 1889 medical school graduating class, stressed that “a certain measure of insensibility is not only an advantage but a positive necessity in the exercise of a calm judgment.” Yet, as humans, all of our interactions are encased in a milieu of emotion. Modern-day psychology has shown that we cannot separate cognition from emotion. The quality of the care we deliver can be affected in a positive or negative way based on if and how we choose to understand and process these emotions. I guess even old Osler recognized this as he wrote later in his career that “it is much more important to know what sort of patient has a disease than what sort of disease a patient has.”

The physician’s emotional understanding of the patient’s perception of his or her illness describes empathy, something we all discussed in our med school application essays and display to varying degrees in our practices. Dr. Ofri defines empathy as “recognizing and appreciating a patient’s suffering.” This seems central to the practice of medicine, and yet demonstrations of empathy can vary widely among physicians. The Jefferson Scale of Empathy has shown that a patient’s perception of his doctor’s empathy can have effects beyond their personal relationship. Remarkably, treatment outcomes have been linked to physician empathy. Improved controls of patient blood sugar and cholesterol as well as better oncologic outcomes all have been linked to physicians who have higher degrees of empathy. Empathy is the element that creates the subtle difference between curing and healing a patient. A cookbook algorithm, so common in medicine today, may be able to

cure a patient; only an empathetic physician can heal one. I could have cured my patient’s infection with the proper medical protocol alone, but I suppose that my empathy was what made her a happy patient in the end.

The roller coaster of emotions that we experience in our medical practices affects, consciously or subconsciously, our decision making and treatment choices. My teachers echoed this. The wise Dr. Robert McClelland said that we spend our careers learning through academic sources and base our practices on our last patient. I suppose that is the “art” part of medicine. But that also is our emotions over riding our intellect.

The late and beloved Dr. Gary Purdue said that every rule in the Parkland Burn Unit has a resident’s name and the mistake he or she made attached to it. (I know the rule that has my name attached, but that is for another day.) He was saying that we learn from our

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mistakes, and we make adjustments or rules in our practices based on those mistakes.

A 2000 Institute of Medicine report estimated that each year medical errors result in between 44,000 and 98,000 preventable deaths and 1 million excess injuries. These numbers have been disputed, but it shouldn’t surprise anyone that errors in medicine occur. After all, we are human and, thus, fallible. But it is the emotions that surround these errors and how we handle those emotions that make us better or worse physicians in our future interactions. Studies have shown that doctors retain strong emotions many years after a negative incident. This can surface as behavioral issues (from being generally ill-tempered to disruptive), burnout (leaving practice early), as well as drug and alcohol abuse.

## Overcoming Imperfection

Review of errors is important in our growth as physicians. But, how we review errors can have a greater effect on us than we may realize. The old-school M&M probably did more harm than good. Dr. Ofri says that we experience two inherent and distinct emotions in a poor patient outcome — guilt and shame. Guilt is associated with a particular incident and resolves as the issue resolves. She says that shame, however, is an emotional reaction to the experience of failing to live up to one’s image of oneself. Shame means that we have to accept ourselves as imperfect, and humility is not a common characteristic of the stereotypical doctor. However, if our failings are driven in too hard, we may lose confidence. Although a more temperate intervention and review of an error can reinforce the lesson and

make for a more careful and better physician, harsh treatment can be very destructive. For instance, many excellent physicians never emotionally recover from the harsh insult of a lawsuit, even when absolved of wrongdoing.

Our daily practice of medicine is immersed in a complex web of emotions — empathy, fear, shame, joy. And while animals may act on instinct alone and machines purely on data, humans cannot help but be affected by emotions. This especially is true in the physician-patient relationship where often we are involved in the most intimate parts of our patients’ lives: births, deaths, life-changing diagnoses, and even complications of our own treatments. Understanding the effects, both positive and negative, that our emotions play is important in how we practice, how our patients perceive us, and how they respond to our care. In the simple words of Dr. Francis Peabody, “The secret of the care of the patient is in caring for the patient.” **DMJ**