

## MEDICAL HUMANITIES

# Doctors do cry

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### Abstract

*Physicians have tried to understand whether crying for a patient is a raw emotion that demonstrates their lack of control over themselves and the situation, or whether it is a sign of humanity and concern for one's fellow beings. Studies on medical students and doctors' narrations of times when they have shed tears over a patient's suffering or death have established beyond doubt that medical students and physicians are not immune to their patients' suffering and may cry when overwhelmed by stress and emotions. Even though humanity is the cornerstone of medicine, depersonalisation has somehow crept into the physician-patient relationship and crying is considered incompatible with the image of a good physician, who is supposed to be strong, confident and fully in charge. Thus, crying has been equated to weakness and at times, incompetence. This could be attributed to the fact that our medical curriculum has ingrained in us the belief that emotion clouds rationality and prevents us from being objective while making decisions regarding a patient's clinical progress. Our curriculum fails to teach us how to handle emotional situations, witness the dying process, communicate bad news, interact with the bereaved during the period of grief immediately following death, and reduce the professional stress involved in working with newly bereaved persons. Our training focuses on cure, amelioration of disease and the restoration of good health, with little emphasis on death, which is an absolute reality. It is crucial that medical educators take note of these lacunae in the curriculum. Physicians and teachers must recognise and accept the emotions that medical students experience in these situations, and teach them to offer their patients a sound blend of rationality and compassion with an attitude of humility.*

*Heaven knows we need never be ashamed of our tears, for they are rain upon the blinding dust of earth, overlying our hard hearts. I was better after I had cried than before – more sorry, more aware of my own ingratitude, more gentle.*

Charles Dickens, *Great Expectations*

A middle-aged man with primary pulmonary hypertension was advised immediate hospitalisation after a right heart catheterisation revealed that his pulmonary artery pressure was 125 mm Hg. The man did not understand the sudden need for admission when he felt just fine, albeit a bit short of breath. I was a final year medical student then and on my part, could not comprehend the reason why everyone in the team

looked mournful every time this patient was discussed. As this was a rare case, I was given the opportunity to take his history and do the basic work-up. He was my first patient during my internal medicine internship and I took an instant liking to the pleasant gentleman. After her review of the records, the nurse practitioner told me, "The last patient who I saw with such high pressures didn't last a week. He is going the same way." The man and his family were unaware of the prognosis and even after four-and-a-half years of medical training, I did not know how to tell them that he was on the road to death. For the next few days, I watched his condition deteriorate. Every time I entered his room, he would smile brightly through his laboured breathing and remark, "I know I am going to be fine because you are with me." I did not know how to respond. I felt a surge of guilt and helplessness every time I left his room. I wished against the best of my medical judgement that some divine power would intervene and this man would recover. True to the nurse practitioner's prediction, he expired a week later. The resident-on-call tried to offer words of comfort to the grieving family and I tried to keep the tears that were flooding my eyes from streaming down my cheeks. After we had communicated the news to the family, I rushed out of his room and into the staircase alley, where I stood sobbing. I could not get over it for days. This made me question my own stability and sanity, and then I realised that the curriculum had prepared me to treat patients, but had made me believe that crying was a sign of being weak and had not prepared me to deal with death. It made me wonder – was I a weakling or do doctors cry too?

### Discussion

Expressing emotional empathy in the medical context has always been a matter of debate. Physicians have tried to understand whether crying is a raw emotion that speaks of lack of control over oneself and the situation or whether it is simply a sign of humanity and concern for one's fellow beings. The views on the display of emotions range from enthusiastic advocacy or guarded acceptance to outright rejection or vehement condemnation. The conflict on this issue is not new in the field of medicine.

### Do doctors cry?

Studies on medical students and doctors' narrations of situations in which they have cried over a patient's suffering or death have established beyond doubt that medical students

and physicians are not immune to their patients' suffering and might well cry when overwhelmed by stress and emotions (1).

Wagner et al reported that 57% doctors, 76% nurses and 31% medical students had cried at work at least once, and women cried significantly more often than men (2). Sung et al found that 69% students and 74% interns cried for reasons related to medicine (3). Whitehead reported that physicians had very strong and lasting emotional reactions to the deaths of some patients, and also, that this could give rise to intense thoughts related to their professional competence and sense of responsibility (4).

Vejlgaard and Addington-Hall found that physicians' attitudes to the process of dying were generally negative. They observed that when the physicians had a patient with terminal illness, they withdrew emotionally or physically, became curt or perfunctory, abandoned their bedside manner and left the care of the dying patient to others (5). Linklater reported that 61% of the Scottish respondents in his study had found the most unforgettable death in their experience with patients emotionally distressing and 26% had felt personally bereaved recently due to a patient's death (6).

Angoff interviewed 182 medical students and reported that 73.1% had cried and 16.5% had nearly done so on account of an encounter with a patient (7). Compassion for a suffering or dying patient was the most common reason that moved students to tears. The other reported reasons for crying were the identification of the patient with oneself or with one's family, having made a mistake that might have led to the suffering of the patient, insensitive behaviour on the part of a physician towards the patient, and having faced a situation in which the treatment choices were complicated by ethical conflicts (7). In their study covering 65 third-year medical students, Rodess-Kropf et al reported that what evoked the strongest reaction was the finality and suddenness of death (8).

### Why do doctors find it difficult to cry?

Even though humanity is the cornerstone of medicine, the physician-patient relationship somehow became depersonalised and crying came to be viewed as incompatible with the image of a good physician, who is supposed to be strong, confident and in charge of the situation. Over a hundred years ago, in his valedictory address at the University of Pennsylvania, Sir William Osler urged the undergraduates to cultivate imperturbability and suggested that a physician should be relatively "insensible" to the slings and arrows of patients' care. This is also reflected in his essay, "*Aequanimitas*". The concept of a detached physician who should view a patient's clinical progress accurately persisted throughout the twentieth century. In their classic 1963 article, "Training for detached concern," Lief and Fox described how physicians believe that the same detachment which enables medical students to dissect a cadaver without disgust allows them to listen empathically without becoming emotionally involved (9).

The main reason why medical students and doctors have refrained from displaying their emotions is because crying has

been equated with weakness and incompetence (7). This might be due to the fact that our medical curriculum has ingrained in us the belief that one should be detached because emotion clouds rationality and prevents one from being objective while making decisions regarding the clinical progress of patients. Our training makes us believe that emotions debilitate us, and our curriculum fails to teach us how to handle emotional situations, witness the dying process, communicate bad news, and interact with survivors during the period of grief immediately after a death. Further, our training does not equip us to reduce the professional stress involved in working with newly bereaved persons. Our training focuses on cure, the amelioration of disease and restoration of good health, with little emphasis on death, which is an absolute reality. It has been shown that as students progress through medical school and residency, their level of empathy declines (10). It is not only students, but experienced physicians as well who are handicapped in handling emotionally challenging situations (11-13).

### Handling emotions and grief

The tremendous power that we physicians have over our patients is sometimes terrifying. While our training tells us not to let in our patients' feelings and strive for emotional detachment so that rational and reliable decisions can be made, it has been shown that patients often expect empathy from doctors (14).

Krauser has reported that she realised that her patients saw tears as her way of acknowledging the shared vicissitudes of the human condition and the patients were not alone in their sorrow (15). Studies have found that emotional involvement is beneficial both for the patient and the doctor. It leads to better outcomes for patients (16), and doctors who withdraw emotionally have higher rates of burnout (17). Therefore, it is crucial that medical educators take note of these lacunae in the curriculum. Physicians and teachers must recognise and accept the emotions that medical students experience towards their patients instead of ridiculing them. They should help them grow into mature individuals who are capable of handling such situations while at the same time, preserving their capacity to feel compassion and care for their patients. Indeed, Angoff has proposed that medical teachers who fail to listen to their students' stories about having cried may be missing an opportunity to have an impact on their emotional lives and their development as caring physicians (7). It is also important for doctors to be adequately prepared to handle grief. Several methods have been suggested for this over the years. One is the introduction of end-of-life curricula in medical education (18). Another is to hold talks about death, including conversations between physicians and their patients regarding terminal conditions, which are believed to make the dying process more comfortable for both parties (19). The other methods are the provision of support to professionals experiencing grief (20); organising "death rounds" or discussions which provide physicians an opportunity to speak about their terminal cases with their colleagues and gain

their support (21); acknowledging one's feelings; documenting one's feelings in the form of clinical obituaries (22); and using humour to deal with death (23).

Even though our curriculum trains us to remain detached from the misery of our patients, evidence has established the fact that doctors do cry and feel for their patients. However, it has also been established that due to our medical training and the depersonalisation of the doctor-patient relationship, they are unequipped to handle emotionally challenging situations. We, as doctors, are bound to deal with several failures and deaths in our careers and will never have all the answers. In the light of this, it is essential that students and physicians be given proper training to enable them to cope with such situations and to help ease the emotional demands of the profession. At the same time, they should be trained to approach their profession with rationality, compassion and humility.

### Competing interests

The authors have no competing interests to declare.

### Declaration of funding source

No funding was received for this study.

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