

# Alberta Doctors' Digest

## Just like me

The pit of my belly felt stone-heavy. My chest tightened, and the pressure felt suffocating. “I think he’s going into sepsis again. His heart rate is up. He’s delirious. I know he doesn’t have a fever. In the last 14 weeks, he’s never spiked a fever with any of the infections he has had.” I paused to take a few breaths, and my jaw tensed up as I continued, “The ID fellow who rounded today wasn’t aware that Dad has severe CMV colitis.” I sighed.

I braced myself in the seconds of silence that followed. Then she spoke, “My father got sick last year and needed a long ICU admission. He died. I can relate to what you’re going through. It’s so hard.”

It took me a moment to orient to the shift that had just happened. I had gotten so used to the defensive posturing of the medical teams any time they discussed issues relating to Dad with me – the difficult physician daughter. I often wondered if that was how handover began every week in the ICU. Her voice was gentle, “You’re at the bedside day in, day out. I appreciate your input in helping us sort out issues for your father.”

It felt like someone had undone the tight, constricting ropes around my chest. I felt my eyes sting as the tears welled up. “It’s been so hard....” My voice trailed off at the end. I was at a loss for words. There were a few seconds of silence before she spoke again. We discussed his antibiotics, and she addressed the concerns I had. I glanced at my phone after the call ended. The whole conversation had taken just 14 minutes.

Two years later, Dr. O’s voice has stayed with me. I often reflect on what unfolded in the initial moments of that conversation. I wonder how she was able to push aside the need to be defensive, rationalize and fix. Instead, she chose to reach somewhere deep inside her, dipping briefly into the waters of her own suffering. Perhaps the reminder of what it was like for her helped her make space for the suffering behind my words. Evidently, she intimately knew the wound in her own heart and had learned to channel it into compassion for another.

Stories of physicians experiencing the health care system as a patient or caregiver are numerous. While the details are different, the common thread is a transformed awareness of what it is like to be at the receiving end of health care. Many report how disconcerting it is to constantly deal with emotionally distanced medical teams.

Over the last two decades, there have been numerous models in medical literature on how to implement and teach physician empathy. Most involve a cognitive appraisal of the situation and imagining what a patient might need. None of these models highlight the importance of emotional mirroring or processing one’s own emotions. In fact, emotions are described at best as impeding objective decision making and at worst as weak and unprofessional. Yet those of us who have experienced what [Michalec and Hafferty](#) described as “clinically situated emotion-deficient empathy” know how jarring and psychologically traumatizing it can be.

Just like our immune systems have the capacity to recognize self and not turn against it, mirroring of emotions allows us to experience another human being as “just like me.”

This is an essential capacity needed to trigger compassion and connect with the heart of another. We're wired to do this. It's beneficial to us; there is inherent joy in leaning into this part of our humanness.

So why has emotional armour or an emotion-deficient approach become the norm in the physician world? The answers to this question lie in the individual journeys of physicians as well as systemic conditioning by medical culture.

Emotional armour is a conditioned defensive response to unbearable feelings. It's a coping mechanism that is essential to survival and allows physicians to function in situations of high intensity. However, when dealing with patients and their families, it can have a dehumanizing effect that results in judgment, and even contempt, and can impact patient care. Equally concerning, it disconnects us from our own inner landscape.

When shielding from the emotions of others, we protect ourselves from what happens within us when we experience intense emotions. Dissociation and dysregulation in response to unpleasant emotions are both common human responses, especially when the nervous system has been shaped by adversity and trauma during our formative years. Emotions are viewed as threats. Becoming dysregulated impacts our ability to show up to work and carry out the numerous demands of our day. We default to defended, emotionally guarded states.

At a recent workshop I facilitated, one of the participants pointed out, "I wish someone had told me how much trauma I would be exposed to as a physician. I wish we were taught how to navigate challenging emotions and not just suppress them endlessly." Impacted by the stoic culture around them, medical students and residents learn to brace against large emotions they experience as they move through years of training. They learn to focus on providing the best evidence-based medicine there is, so that they can say "We did our best." As physicians, we are conditioned to see the suffering of others as personal failure. Feeling helpless and held back by our human limitations is not welcome and destabilizes us.

[Susan David](#) uses the term "emotional agility" to describe the ability to experience a wide range of human emotion without seeing any of them as inferior or shameful. Part of becoming emotionally agile is learning to process emotions by feeling through our bodies rather than analyzing them or thinking our way out of them. The good news is that emotional agility can be taught and learned. It involves working with our own triggers, becoming intimate with our coping mechanisms, and understanding why they developed.

Being at my father's bedside for five months in an ICU setting has created a wound in my heart that may never completely heal. Through the PFSP program, I accessed professional help to navigate intense emotions and recognize ways I became dysregulated. I realized how emotional distancing had developed as a survival tool at phases in my life where I lacked the skills and the neural wiring to be with intense emotion. I learned to sit with my own grief and to continue to navigate life with gaping holes in my own heart, not by numbing the pain but by leaning into it, small doses at a time.

Leaning into vulnerability requires human connection in the company of those who have sat long enough with their own wounds to not be intimidated by the pain of another. In doing so, we learn to be with the grief of others without the physician saviour complex of needing to rescue or fix. Not resisting the pain and relieved of the burden to fix the

emotions of another, we find that being emotionally present can be healing, and even invigorating, for both physician and patient.

In moments of dealing with patients or colleagues, where I become aware of a default distancing in response to their large or intense emotions, I restore connection by silently saying to myself, "This person is experiencing suffering just like me. They are afraid and grieving just like me." I recognize my own overwhelm at not being able to fix the pain of another and my human limitations in dealing with the enormity of suffering associated with the human condition. I am reminded that I am not called to fix but rather to be with another in their moments of suffering. My heart softens and lets down its guard. For a few brief moments, I am beside them in this journey called life.

In Dr. O's words, there was an unspoken message that made the unbearable a little bit more bearable for me. "You are not alone. I see you. I hear you. How you feel matters." To this day, that message gives my heart solace.

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