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When doctors experience their vulnerability as beneficial for the patients

A focus-group study from general practice

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Abstract

Objective. To describe events where doctors have experienced that their own sense of vulnerability might have been beneficial for the patient. *Design.* Qualitative focus group study with data drawn from two group sessions. Analysis was conducted with systematic text condensation. *Subjects.* A total of 12 GPs (five men and seven women) aged 30–68 participated. Their clinical experience ranged from one to 39 years. *Main outcome measures.* Analysis presented different aspects of participants' experiences of vulnerability experienced as beneficial. *Results.* The participants generously shared stories about personal and professional vulnerability which they had perceived and sometimes disclosed to the patient. One cluster of stories dealt with situations where the doctors in some way or other had identified with the patient and his or her problem. They felt that their awareness and capacity for interpretation, creative solutions, and compassion had been enhanced through recognition. Another cluster of stories covered events where uncomfortable feelings due to uncertainty or inconsiderate behaviour sharpened the doctors' reflexivity towards their own roles in the interaction. Presenting an excuse or sharing the doubt could break the ice and make a difference. *Implications.* Vulnerability may bring strength, but must be used with caution. Our study opens towards further awareness of the vulnerability of the doctor and how it can benefit the patient in some situations.

Key Words: *Family practice, focus groups, identification (psychology), physicians role, physician–patient relationship, qualitative research, risk-taking*

The doctor is expected to behave according to biomedical ideals regarding objectivity, neutrality, and omnipotence [1,2]. However, patients also want a doctor who is compassionate and empathetic [3,4]. Zinn called attention to the emotional components of clinical practice, emphasizing the potential of improving quality through personal awareness [5]. Malterud and Hollnagel argued that a better balance between emotions and rationality can prevent humiliations in the consultation [6]. A previous study indicated that doctors' disclosure, sharing personal experiences and feelings, could be appreciated by the patients [7]. However, this study also revealed questions about conditions in which and when exposure of vulnerability would be professionally useful and responsible.

Sharing the experiences of being vulnerable in clinical encounters, we held the preconception that vulnerability was not necessarily negative, but might also function as strength [8]. We decided to pursue the question about conditions for beneficial disclosure of doctors' vulnerability, challenging the existing literature dealing with negative aspects of the issue. We set up a study to describe events where general practitioners have experienced that their own sense of vulnerability might have been beneficial for the patient. The aim was neither to find out whether vulnerability could be positive, nor to evaluate negative experiences of disclosing vulnerability.

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The doctor is expected to be detached and omnipotent, yet compassionate and empathetic. Attention is usually drawn to the negative aspects of doctors' vulnerability and emotionality related to burnout or misconduct.

- Focusing on the potential benefits of vulnerability in the doctor, we find that it may bring strength, but must be used with caution.
- Vulnerability may be experienced as positive in situations where the commonalities of human life trigger off a sense of identification, enhancing the doctor's ability to understand the patient.
- Events implying professional or personal uncertainty may have improved the doctor's reflexivity and awareness of sensitive matters of interaction.

Material and methods

Data were drawn from two focus-group interviews [9] with 12 general practitioners. The study was approved by the regional committee for medical research ethics and The Norwegian Data Inspectorate. We established a purposive sample with variation regarding gender and age. Five men and seven women aged 30–68 accepted the invitation. Participants' experience from clinical practice ranged from one to 39 years.

We conducted two group sessions (90 minutes) where participants were respectively below 40 years and over 40 years. A moderator (KM) called for stories about situations where being vulnerable in front of patients had been experienced as beneficial for the patient by the doctor. A formal interview guide was not used. Two observers (LF and MG) made notes during the interviews and evaluated the atmosphere and interaction.

The interviews were recorded on audio-files, transcribed, and then analyzed by systematic text condensation [10], developing descriptions and concepts concerning experiences of potentially positive vulnerability. We emphasized descriptive accounts of events ("when"), but participants often added explanatory comments that validated their assumption of beneficial effects ("why").

Results

The participants generously shared stories about personal and professional vulnerability which they had perceived and sometimes disclosed to the patient. One cluster of stories dealt with situations where the doctors in some way or other had identified with the patient and his or her problem. They felt that their awareness and capacity for interpretation, creative solutions, and compassion had been enhanced through recognition. Another cluster of stories covered events where uncomfortable feelings due to uncertainty or inconsiderate behaviour sharpened the doctors' reflexivity towards their own roles in the interaction. Presenting an excuse or sharing the doubt could break the ice and make a difference. Below, we elaborate these findings.

In the same boat

Recognizing similarities between their own life and the patient's story, the doctors said that they would identify more closely with the patient's perception of the problem and increase their capacity to search for solutions.

The participants gave different examples of how their life experiences would shape their interpretation of the patient's story, yet realizing that the patient's perception and solutions might be different. Drawing on their own experiences, they could more easily understand what was going on. Specific examples were childhood neglect, abuse, divorce, or weight problems. Their insider information, either personal or from family members, made them listen more attentively. A young doctor who had some experiences with eating disorders said:

> *Then I feel I have a special understanding for how it is being a relative for this group of patients. (Anna – Group 1)*

The participants also spoke of vulnerability which had been aroused by more general existential matters, sharing the human condition of for example being pregnant, a parent, a child, or mortal. One of the more experienced participants had organized a ceremony in the home of a patient who had died. Together with the family, she said goodbye to the deceased. Later on, the patient's daughter remarked that seeing the doctor crying had had a great impact on the family.

When the doctor in some way or other felt a similarity with the patient, he or she might offer more extensive support than usual. One of the oldest participants admitted that he himself was a person who had often been ignored. He therefore had a weak spot for patients who did not have such strong resources, exemplified by the story about a mentally retarded patient whom he had personally walked through the social welfare offices:

> *I figured he wouldn't reach anywhere in any system. (Steven – Group 2)*

The vulnerability following identification would not always be presented explicitly. One participant said that, in a case of sexual abuse, she could ask the patient the "right" questions because of her own experiences, somehow sending signals about being in the same boat:

> *I knew out from my own experiences how she reacted. Then I could use my own experiences in the consultation and ask. . . . And she probably had the understanding that I knew it. (Amy – Group 2)*

Considering the adequate level of revealing their vulnerability in front of the patient was among the reflections presented during the interviews. A female participant described a consultation with a patient who was troubled by her ongoing divorce. The doctor had met with similar problems in her own divorce, and finally decided that coming out with some of the positive experiences of coping might help the patient. However, the participants – especially the youngest of them – more often held back rather than coming out with their own experiences. A female doctor said:

> *I often wonder about using own experiences in the consultations, but in the end I usually don't. I often consider if it's wise or not, but I mostly I feel it's not wise. (Sarah – Group 1)*

Sometimes, however, it was neither possible nor necessary to escape an explicit mutual identification. In a small local community, everyone would for instance know that the doctor was also a parent of small children who would know something about never having an uninterrupted night's sleep. The credibility of the doctor's advice might then be stronger.

On thin ice

Several stories dealt with events where a feeling of uncertainty had revealed their vulnerability. Sometimes, such situations would take a fortunate course, where the patient more or less explicitly remarked on his/her contentment. We also heard stories where the doctor's perception of a positive outcome had been validated by patients commenting positively on the specific event to one of the other participants in the focus group.

Especially among the young doctors, uncertainty was linked with situations where they had made a wrong decision, such as overlooking a serious infection in a patient who was later hospitalized, or ignoring complaints when complications developed after a shoulder fracture. A positive turn had been reached when the doctors contacted the patients, explained the situation, apologized for their mistakes and offered careful follow-up. One of the participants talked about how she had pushed the subsequent investigations:

> *She said that she felt incredible gratitude when I had called her and presented the swift appointments which I had arranged for her. Her mother had had a postoperative thrombosis which led to her death. Nobody had ever apologized for this, although she was not on anticoagulation medication. . . . But the patient said that it was actually very good for her that her own case had been solved in this way. (Betty, Group 1)*

The perceived benefit of vulnerability might come to a different patient than the one who triggered off the doctor's feeling of insecurity. A couple of participants spoke of serious incidents where their mistakes had led to the death of a patient. After a hard time of grief, sorrow, and self-reproach, they found themselves ruminating on what could be learnt from such a hard lesson. An experienced middle-aged woman explained:

> *There were, after all, some positive consequences of this experience for my professional coping in situations where people die. Some of it came from the mother of the child who died – she called me and asked for a talk. We had a long conversation which inspired me to establish the routine that I always contact the family if any of my patients die – irrespective of my responsibility regarding the mortal outcome. I force myself to call, because this will give them an opportunity to ask questions or even blame me. . . . A lot of them have thanked me for just making myself available for them. (Carla, Group 2)*

Other stories described incidents where the doctor realized that he or she had behaved rudely or insensitively towards a patient. Such situations would most often develop in such a way that the doctor became aware of the blunder when it had just happened. One of them described a consultation where he lost his patience with a yelling child, where he roared back and scared the boy. Another participant practically made a patient cry by making a thoughtless joke on his way from the waiting room. Such experiences could lead to a positive short-term outcome when the doctor could present an unreserved and immediate apology that was acknowledged by the patient. In other cases, the benefit developed in the long run, by motivating the doctor to change attitude or procedures:

> *I stopped being careless. (Steven Group 2)*

Uncertainty would often appear in the doctor when trying to find out what was wrong with the patient. Usually, this feeling would remain within the doctor's thoughts, but sometimes the participants said they would share their ambiguity with the patient. Yet, admitting their professional insecurity could be experienced as painful for the doctor, exposing their professional vulnerability. A young woman said:

> *It feels dangerous – you fear the risk of losing esteem from the patient. . . . It is also somehow taking a chance – the patient might use it against you, or misunderstand it, or spread it around. (Anna, Group 1)*

Another participant added that a certain level of experience was needed to dare to admit any crack in the surface. In the first years after graduation, she said, she was absolutely certain about everything. An experience reported across the groups was that as long as the doctor retained the leadership, referring patients for further examinations when they expressed their lack of diagnostic conclusions, the patients responded with understanding and gratitude:

> *It is almost always positive to signalize that you are uncertain as long as the patient feels that she/he is taken care of. (Anna, Group 1)*

A young doctor told of a consultation where the patient came up with the right diagnostic answer when he himself had said he was in doubt. It was as if the patient rescued him, and both of them were able to appreciate the interaction. Another, from the group of more experienced colleagues, spoke of his embarrassment, finally mixed with relief, when he reluctantly accepted the patient's persuasion regarding thyroid tests. During these negotiations, the story about two brothers came to the doctor's mind. The first brother had been diagnosed with leukaemia, and then the second brother asked for a blood cell count. The tests actually showed that he also had leukaemia. Memorizing this story, the doctor gave in and accepted the patient's wish for a thyroid test which he judged to be unnecessary. However, when the test actually confirmed her hypothyroidism, the doctor wrote to her:

> *Your intuition was better than my knowledge! (Steven, Group 2)*

Later on, the doctor–patient relationship was stronger than ever.

Discussion

Our data present descriptive accounts suggesting that susceptibility through identification can enhance the doctor's ability to understand the patient, and that feelings of uncertainty can improve the doctor's awareness of sensitive matters. However, the interpretation of these conclusions must be considered according to strengths and weaknesses of the study, as well as the findings from similar studies.

Did we really hear the "true" stories about vulnerability?

Our sample covered a broad range of experience backgrounds, from graduation to retirement. The participants had been practitioners in rural and urban contexts all over Norway. The older group was more open-hearted than the younger one, while we noticed no striking differences between men and women. The majority of participants were ethnic Norwegian. A sample including a broader range of ethnic backgrounds could have provided more nuances.

A focus-group setting can enhance or obstruct mediation of sensitive experiences, depending on the interaction of the group [9]. While an individual interview may provide more confidentiality, a focus group has the advantage of sharing the "load". Several of the participants expressed that it was a relief to focus on the bright side of vulnerability. During the interviews, they mainly adhered to the invitation to relate the "positive effect stories". We concluded that there was no strong urge to balance the discussion with stories about negative effects of vulnerability.

A crucial point in our interpretation concerns the doctor's evaluation of the patient having had a positive experience. Recall bias and performance bias can distort the stories, as well as the doctor's need to construct a positive understanding of him- or herself. A few of the stories made us wonder whether the doctor had had a better impression of what happened than the patient might have had. Nevertheless, in the majority of stories, participants made spontaneous remarks about themselves which not could be considered flattering.

Previous knowledge emphasizes risks – our study provides examples of beneficial vulnerability

Previous studies have emphasized risks rather than benefits associated with doctors' emotions. Prolonged stress or frustration may lead to burnout in doctors, and early identification of emotional slippage is recommended to prevent this [11]. The question of what to share with the patient and what to not share may be a difficult balance [12], with

burnout as a negative consequence for those who lose control of professional integrity.

Our study adds to existing knowledge by specifically exploring the positive potentials of vulnerability. The participants' accounts include not only events, but also contextual preconditions and assumptions about explanatory factors. Yet, theoretical perspectives are required to explore the questions of not only when but also why the doctor's vulnerability may benefit the patient.

Awareness of counter-transference is a vital element for psychodynamically oriented psychiatrists [13]. In general practice too, reflexivity is fundamental for rational use of emotional responses. Balint groups, where doctors share experiences of demanding relationships, can provide a safe framework for elaborating complex experiences [14]. Compared with our previous study [7], we have extended the field from disclosure to the specific issues of the existential foundations of being human, and also the challenges of clinical uncertainty. Our findings indicate subject matters that can serve as potentials for development of clinical strategies.

While Beach and co-workers identified different kinds of disclosures indicating that the doctor had the same experience as the patient [15], our findings point to more fundamental commonalities of human life than just having done the same thing ("I've used quite a bit of that medicine myself"). However, there are different opinions about where the lines should be drawn, and what kind of intimacy can be recommended [16,17]. Disclosure is perceived differently by different patients, and the doctor must carefully assess what benefits the individual patient. Lack of limitations can lead to transformation of the doctor–patient relationship into a personal, love relationship, perhaps including a sexual relationship, which is obviously beyond the ethical boundary. There is already extensive literature discussing these aspects. None of our participants spoke of episodes where their identification went out of control and would be considered as over-involvement.

Clinical practice inevitably involves problems that are uncertain and complex [18]. Hewson and coworkers write about "strategic medical management", based on tacit knowledge, which GPs use for management of uncertain and complex medical problems [19]. Some of the examples mentioned by our participants refer to situations of misconduct. Previous studies show that patients prefer explicit apologies when medical errors have been made [20], indicating a paradigm change in medicine regarding disclosure and revealing uncertainty in front of patients [21]. According to our findings, behaving explicitly honestly in such situations, the doctor may even contribute valuable elements to a difficult interaction.

Implications

Vulnerability gives strength, but must be used with caution. Used adequately, it can help build trust and the patient can feel more taken care of. However, when the doctor's emotions are exposed primarily in the service of the doctor, it can give the patient a feeling of not being taken care of. Our study calls for further exploration of how and when the doctor's vulnerability can benefit the patient in some situations.

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