Moral distress amongst physician trainees: reflections on the emotional sanitization of medicine

Charlotte A. M. Paddison, PhD

Department of Psychology, Anglia Ruskin University, Cambridge, England, UK.

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To the editors:

The experience of serious illness is rarely an emotionally neutral event. Many people who are ill or dying understandably become distressed. For the most part, we recognise this. But it's not just patients who may be distressed by suffering, as was so eloquently described by Dzeng and colleagues in their recent paper.[1]

For physicians, witnessing suffering in others—particularly when it appears unnecessary—can be deeply distressing. Some become less empathetic, not more, as they struggle to articulate the unthinkable: 'we torture them before they die'.[1]

Reflecting on these issues from a psychological point of view, I am struck by the emotional sanitization of care—and its consequences for the delivery of compassionate care.

Compassionate care is fundamental to the practice of medicine. In the UK, the Francis report[2] asked probing questions about the provision of compassionate care within the National Health System. Delivering on the promise of compassionate care requires that both doctors and patients are emotionally present. Patients need to be able to express their feelings of vulnerability or distress. Physicians need to be able to recognise such emotions in their patients, and to respond with humanity and compassion.

However, some patients report being discouraged by clinical staff from expressing their feelings of vulnerability.[3] Similarly, doctors may be encouraged to adopt a dispassionate or 'objective' viewpoint and to value emotional distance. Perhaps this helps to explain why some trainee physicians develop detached and dehumanising attitudes as a coping strategy when experiencing moral distress.[1]

Where the emotional sanitization of medicine leaves little space for doctors or their patients to acknowledge suffering and distress, and privileges emotional distance over a need to be emotionally present, compassionate care is surely compromised.

Yet it doesn't have to be this way. If the organizational culture promotes open discussion and normalization of emotional issues—for example, the interestingly named 'death rounds' described by Dzeng's participants[1]—this seems to offer much benefit.

Such environments are the exception rather than the norm. Should they be? Is it time, now, to embrace a discourse between psychology and medicine that acknowledges the importance of emotional distress[1] and organisational culture[4] in health care, and in doing so, to restore compassionate care to its rightful place at the heart of internal medicine?

Corresponding Author: *Charlotte A. M. Paddison, PhD; Department of Psychology Anglia Ruskin University, East Road, Cambridge CB1 1PT, England, UK (e-mail: charlotte.paddison@anglia.ac.uk).*

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