Physicians Experiencing Intense Emotions While Seeing Their Patients: What Happens?

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ABSTRACT

Objectives: Physicians often deal with emotions arising from both patients and themselves; however, management of intense emotions when they arise in the presence of patients is overlooked in research. The aim of this study is to inspect physicians' intense emotions in this context, how these emotions are displayed, coping strategies used, adjustment behaviors, and the impact of the emotional reactions on the physician-patient relationship.

Methods: A total of 127 physicians completed a self-report survey, built from a literature review. Participants were recruited in 3 different ways: through a snowball sampling procedure, via institutional e-mails, and in person during service meetings.

Results: Fifty-two physicians (43.0%) reported experiencing intense emotions frequently. Although most physicians (88.6%) tried to control their reactions, several reported not controlling themselves. Coping strategies to deal with the emotion at the moment included behavioral and cognitive approaches. Only the type of reaction (but not the emotion's valence, duration, relative control, or coping strategies used) seemed to affect the physician-patient relationship. Choking-up/crying, touching, smiling, and providing support were significantly associated with an immediate positive impact. Withdrawing from the situation, imposing, and defending oneself were associated with a negative impact. Some reactions also had an extended impact into future interactions.

Conclusion: Experiencing intense emotions in the presence of patients was frequent among physicians, and the type of reaction affected the clinical relationship. Because many physicians reported experiencing long-lasting emotions, these may have important clinical implications for patients visiting physicians while these emotions last. Further studies are needed to clarify these results.

INTRODUCTION

Emotions play a significant role in human interactions, yielding communicative intentions, modeling behavior, promoting attachment, influencing information processing, and even determining choices.[1,2] Physicians' emotions in professional settings, traditionally considered to be unprofessional and a taboo, have increasingly been addressed in medical education as a result of the recognition that physicians often deal with emotions arising from both the patient and themselves.[3,4] Even if feelings of moderate intensity are manageable or unnoticeable in medical encounters, physicians' intense emotions constitute particular challenges that are more difficult to ignore and possibly to manage at the moment. The way physicians react and manage these emotions can affect both the physician and the patient[1,4] and shape the clinical relationship in fundamental ways. What happens when physicians experience strong emotions in the presence of their patients? Although numerous studies have focused on patients' emotions and on how physicians deal with them,[5,6] physicians' own emotions arising when they are seeing their patients have received less attention.

Research on physicians' emotions highlights the importance of physicians' awareness of their emotional states during the medical encounter. Unrecognized emotions may impede the use of patient-centered skills and may be associated with harmful behaviors, such as inappropriately interrupting the patient, changing the subject, avoiding patients' psychological issues, avoiding bonding with patients to prevent suffering, avoiding conducting certain medical procedures again, or avoiding patients altogether.[7-10] One study showed that physicians themselves perceive their emotional states as influencing medical acts such as prescribing, talking to patients, and referring.[11] In addition, lack of recognition of one's emotions and low-level choices, more than clinical knowledge or medical skills, have been proposed to be associated with medical error.[7,8] Along with the effects of emotional unawareness on patient care, research has also examined the impact of physicians' emotions on their own well-being. Unexplored feelings may be associated with distress, poor judgment, loss of privileges, social isolation, increased workload, risk of litigation, burnout, reduced work satisfaction, and an increase in alcohol and other substance use.[12-16]

This research is informative of important systematic and lasting effects of emotions experienced by physicians after the encounter with patients. However, it does not address how physicians manage their intense emotions when these arise in the presence of their patients. How these emotions are displayed to the patient and their impact on the relationship are overlooked. Most previous studies that focus on physicians' emotions deal with the extreme contexts of dying patients, medical errors, safety-related events, and treatment complications.[17-20] Emotions in these contexts include hurt feelings, anger, frustration, remorse, sadness, guilt, and unhappiness,[21] and disturbing emotions can last for years.[19] Coping strategies used in these contexts include obtaining emotional support from others, trying to have a positive perspective over the situation, getting back to work to clear the mind,[22] talking

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to other physicians or family members, doing physical exercise,[20] doing nothing, and talking to the patient.[21]

However, these situations are limited to a few extreme scenarios associated with negative emotions (one study did identify positive daily emotions, including gratitude, happiness, compassion, pride, and relief, but these emerged among medical trainees and were associated with connecting with patients and with colleagues, receiving recognition for one's work, learning, being part of modern medicine, and receiving emotional support).[23] Intense emotions during interactions with patients in less extreme scenarios may present a bigger challenge for physicians. They may impair an ongoing clinical interaction, lessen empathy, or jeopardize the physician-patient relationship. Physicians must make decisions while experiencing powerful feelings, and they need to manage these emotions in front of their patients. The aim of this study is to explore intense emotions physicians experience in their daily practice while with patients, how these emotions are displayed to the patients, the strategies used to manage these emotions at that moment, and the impact the emotional reactions have on the physician-patient relationship.

METHODS

Procedures

In this cross-sectional, retrospective study, participants were recruited through 1) a snowball sampling procedure, 2) institutional e-mails (from the School of Medicine of Oporto University, the Portuguese League against Cancer, and the Oporto Health Campus Ministry), and 3) in-person contact during service meetings at the major central hospital in Oporto and in several primary care centers in that geographic area. Data were collected between June 2012 and February 2013. Physicians were informed about the aim of the study, as well as the confidential, anonymous, and voluntary nature of their participation. Agreement to participate served as informed consent. The hospital ethics committee approved the study.

Instrument

A questionnaire on physicians' emotional experiences was developed for this study after a literature review. The Geneva Appraisal Questionnaire[24] assesses individual appraisal processes in the case of an emotional episode and was close to the goals of this study. Several items from its version 3 were translated and used in their original form or in a modified version. Three additional items were included in the questionnaire to address specific issues in this study (eg, strategies used to control the emotional expression). The questionnaire was then applied to a sample of physicians and medical students who were not participating in the study to check for meaning, accuracy, and completeness. Ambiguous/incomplete items were modified, and the survey was again tested with a different sample of physicians and medical students. This procedure was repeated until the final version of the survey was approved. The final 21-item version combines open-ended and multiple-choice questions (presenting either 4, 5, or 6 options, plus an additional option that can be either "I don't know" or "other—specify").

The questionnaire starts with the following instruction: "In this questionnaire, we ask you to recall moments [in your clinical life] when you experienced an intense emotion, either positive or negative. The events might have been brought about by you, [by a patient], by someone else, or by [other] causes." Next, physicians were asked to recall and briefly describe a situation of their daily clinical practice in which they experienced an intense emotion while they were seeing their patients; to name the emotion experienced; to indicate how long ago they experienced the emotion, how long the emotion lasted, where it took place, and the attitude they had at that moment (options ranging from complete control of the emotion to uncontrolled emotional reaction); to describe the actual reaction (if they had one); to indicate what they did after realizing they reacted openly (eg, returned to their previous posture, apologized); to describe the strategies used to control the emotion; and to describe how the emotional reaction affected their relationship with the patient at that moment and in future encounters. Two final questions were added for a better understanding of the occurrence of strong emotional experiences

Table 1. Sample characteristics of physician survey respondents

Respondent characteristics (N = 124)	Value[a]
Age (years), mean (SD; range)	37.8 (12.8; 25-66)
Professional experience (years), mean (SD; range)	12.0 (12.3; < 1-40)
Sex (n = 122)	
Women	75 (61.5)
Men	47 (38.5)
Professional level (n = 121)	
Attending	56 (46.3)
Resident	65 (53.7)
Currently practicing	124 (100)
Geographic work location (n = 123)	
Urban	115 (93.5)
Nonurban	8 (6.5)
Northern country	118 (95.9)
South (Madeira Island)	5 (4.1)
Medical specialty (n = 119)	
General practice	46 (38.7)
Internal medicine	13 (10.9)
Ophthalmology	11 (9.2)
Psychiatry	6 (5.0)
Infectious diseases	5 (4.2)
Nephrology	5 (4.2)
Legal medicine	4 (3.4)
Endocrinology	4 (3.4)
Cardiology	3 (2.5)
Pediatrics	3 (2.5)
Neurology	2 (1.7)
Gynecology	2 (1.7)
Pathology	2 (1.7)
General surgery	1 (0.8)
Pulmonology	1 (0.8)
N/A (1st-year interns)	11 (9.2)

[a] Data are no. (%) of physician survey respondents unless otherwise indicated.
SD = standard deviation.

in clinical practice throughout physicians' careers: to indicate (as many as applicable) intense emotions experienced when seeing patients in situations other than the one already described (the list included 24 emotional reactions; eg, deep sadness, depression, enthusiasm, intense fear, total relief, intense joy, and deep shock); and to indicate how frequently intense emotions were experienced in the presence of patients. Participants additionally answered questions on demographic and professional characteristics (eg, sex, birth date, level of medical training, medical specialty, years of medical experience, and current professional status, whether practicing or not).

Participants

A total of 127 participants completed the questionnaire. Three were excluded (2 men who reported never experiencing intense emotions while interacting with patients and 1 woman who described a situation outside of the study's goals). The final sample (depicted in Table 1) comprised 124 actively practicing physicians working mostly in the north of the country (95.9%) and in urban areas (93.5%). Because of missing values and nonapplicability of some items to subgroups of respondents, the total number of participants included in each analysis varied between 53 and 124.

Analyses

A content analysis was applied to the description of the episode, with both authors independently coding the situations. Observations were compared, with Cohen's K = 1 in 12 categories, plus K = 0.91, K = 0.92, and K = 0.96 in the 3 remaining categories, respectively. The shorter-answer, open-ended questions were also independently coded, with final categories reached through

Table 2. Fifteen types of situations eliciting intense emotions in daily practice from 122 physician survey respondents[a]

Categories of situations	n (%)	Indicators
Health deterioration/death	35 (28.7)	I watched a patient die before the medical team's powerlessness and anguish. The patient was conscious and we could tell by his facial expression that he could understand what was going on. He tried to tell us something but it was not perceptible.
Physical or psychosocial suffering	14 (11.5)	I followed-up with a patient in the intensive care unit. She was young and suffered from severe systemic lupus. She had a tracheostomy and was ventilated but conscious. In one of the medical visits she asked me for a paper and wrote, "Help me." She was in very bad shape and eventually died.
End-of-life patients	13 (10.7)	She was a terminal patient receiving comfort measures in the intensive care unit. For four years I could never get her to accept her illness and start treatment. I felt frustrated watching her die and could not do anything. Then, she grabbed my hand and looked at me in a way I will never forget, and smiled. I felt that her look meant, "It was my fault, you did everything you could. I am in peace."
Aggressive patients	11 (9.0)	During a consultation a patient pointed a gun at himself. In the ER the family of a patient invaded my office and threatened me because I was taking too long to see her …. I felt very vulnerable around them all. They were threatening to destroy everything, using inappropriate language, hitting the wall, and dropping material that was over the desk.
Communicating bad news	11 (9.0)	Having to tell a young patient that her husband and children died.
Solving the patient's problem	8 (6.6)	The first time I alone diagnosed and successfully treated a patient in the ER. A patient who was amazed about the surgery that restored his sight.
Patients' rudeness	7 (5.7)	While I was with a patient, his wife spent the entire time reading the newspaper. I felt disrespected.
Unexpected disabling condition	7 (5.7)	A young patient entered the emergency room in cardiac arrest. She was alone at that moment without any family members who could provide any information. After two cycles of advanced life support, she recovered. When we could collect a clinical history, we found out that she had terminal brain cancer.
Accusations of malpractice	7 (5.7)	During a consultation, a patient confronted me with the desire to have a routine examination check for everything, and about my obligation to do it. He said, "I have paid taxes for many years and now I have the right to have the exams I want. Nowadays, doctors study medicine for money. In the old days, we had good doctors that did the exams we wanted." A family member of a patient I had seen the day before came to tell me that the patient died on her way home. He criticized me for not sending her to the emergency room instead.
Disagreeing about the proposed treatment	4 (3.3)	The team told a patient's family that he would die and that the situation was inevitable. I believed that a bigger effort on our part could still save him.
Patient telling disturbing information	1 (0.8)	I felt repulsed after a patient mentioned that during an impulsive episode she killed her pets.
Making harmful decisions	1 (0.8)	A patient asked me for a compulsory detention of her mother, who took care of a bedridden brother. This brother would be abandoned for lack of social and family support.
Stress at work	1 (0.8)	Stress in the operating room.
Demanding patients	1 (0.8)	Following-up a patient with a personality disorder. She questioned every medical intervention, saying nothing was working. She had multiple complaints and was very demanding. Dealing with her husband's pressure ("You have to make her better").
Patients' gratitude	1 (0.8)	A patient's widow offered me a reminder of her husband, who had died three months earlier. I never met him, only supervised some aspects for his well-being during his palliative phase.

[a] In this particular question only 122 physicians answered; 2 participants reported the emotion but not the situation that elicited it.
ER = emergency room.

consensus. Chi-squared tests and independent-sample *t*-tests were conducted in PASW, version 20 (IBM, Armonk, NY).

RESULTS

Physicians indicated experiencing many and varied strong emotions in the presence of their patients throughout their careers (median = 6.00; interquartile range = 4; range, 1-16 emotions per physician). The emotional spectrum includes both positive and negative feelings, and though most emotions in the list we provided were negative, several positive emotions appeared at the top of the list as frequently experienced (enthusiasm was the most signaled emotion in the list). Forty-eight participants (39.7% of the 121 who answered this question) reported experiencing strong emotions only a few times per year while interacting with patients. But 18 (14.9%) mentioned monthly occurrences, and 34 (28.1%) reported weekly and daily experiences of intense emotions in the presence of patients. Frequency was independent from physicians' gender and geographic work location. However, physicians reporting frequent strong emotions had fewer years of medical practice (mean ± standard deviation [SD], 8.40 ± 11.03) than those reporting more sporadic experiences of strong emotional reactions (mean ± SD, 15.43 ± 12.73), $t(109) = 3.12$, $p = 0.002$.

Regarding the specific emotional event described in the questionnaire, most physicians reported situations that occurred long ago: years ago in 48 cases (38.7%) and months or weeks ago in 59 cases (47.6%) of all 124 physicians. Only 17 (13.7%) recalled an event that occurred days or hours ago. These situations included several extreme events (the most frequently mentioned was, "Dealing with patients' health deterioration or death"), but also less extreme scenarios (eg, "A patient did not want to greet me with a handshake"). Additionally, some situations were positive experiences ("A patient was amazed about the surgery that restored his sight"; Table 2).

Physicians' emotions associated with these situations are depicted in Table 3 according to their positive, negative, or mixed (comprising compassion and surprise) valence. Mostly, physicians reported negative emotions (139 instances, or 85.8% of all 162 reported emotions). For 47 participants (39.8% of the 118 who answered this question), these emotions lasted longer than a few minutes or hours: more than 1 day for 34 physicians (28.8%) and more than 1 week for 13 participants (11.0%), and 2 participants offered that the emotion is still retrieved upon recalling the situation.

Most physicians (109 of the 123 who answered this question [88.6%]) at least tried to control their emotions, and 33 (26.8%) reported they completely controlled themselves. Only 14 participants (11.4%) reported they did not control their emotional reaction. Only participants experiencing negative emotions reported controlling them completely in the presence of their patients ($\chi^2(1) = 9.379$, $p = 0.001$). The difference from physicians experiencing positive and mixed emotions was statistically significant ($\chi^2(1) = 9.379$, $p = 0.001$), though some of the latter also attempted to control themselves.

Table 4 depicts physicians' actual reactions. Physicians were more likely to touch the patient when experiencing positive emotions than when experiencing negative emotions ($\chi^2(1) = 6.563$, $p = 0.022$), and only smiled when experiencing positive emotions ($\chi^2(1) = 39.375$, $p < 0.001$). All other reactions occurred only during negative and mixed emotional experiences.

Several participants who reported not completely controlling their emotional reactions adjusted their behaviors after they reacted (n = 58). Of these, 16 (27.6%) said they tried to return to their previous posture, 3 (5.2%) apologized for their reaction, 1 (1.7%) allowed room for the patient to apologize. Thirty-eight (65.5%) felt that their reactions were expected and that no further action was necessary. No significant differences were observed between physicians who attempted to adjust their behavior afterwards and physicians who did not, regarding the different types of reactions.

To cope with their intense emotions at the moment, physicians resorted to several types of strategies (Table 5). These strategies were reported especially by physicians who considered they controlled or attempted to control their emotions (73 [96.1%] of the 76 participants who reported using these strategies, $\chi^2[1] = 10.900$, $p = 0.001$). The difference from physicians who did not control their emotions (n = 3 [3.95%)] was statistically significant ($\chi^2[1] = 10.900$, $p = 0.001$). Though most physicians resorting to coping strategies reported intense negative feelings (63 [84.00%], comparing with 12 reporting positive and mixed feelings), using coping strategies was not significantly associated with negative emotions, and the same types of strategies were generally used to deal with negative and with mixed emotions. Using coping strategies was reported in association with positive emotions in 3 cases: breathing, refocusing attention, and a combination of these 2 to deal, respectively, with intense relief (1 case) and with happiness (2 cases).

Of the 89 physicians who considered that a relationship with the patient existed, most (47 [52.8%]) considered that their emotional reactions had no impact in the relationships with their

Table 3. Physician respondents' intense emotions experienced in the presence of patients

Emotions experienced	No. (%)[a]
Negative	
Sadness	41 (25.3)
Fear/anxiety (nervousness, fright, panic, apprehension)	34 (21.0)
Frustration (powerlessness, incapacity)	32 (19.8)
Anger (revolt, indignation)	24 (14.8)
Disappointment	3 (1.9)
Repulsion (contempt)	2 (1.2)
Guilt	2 (1.2)
Shame	1 (0.6)
Positive	
Happiness (joy, self-fulfillment)	7 (4.3)
Relief	2 (1.2)
Mixed	
Compassion (empathy, tenderness, solidarity)	12 (7.4)
Surprise/confusion	2 (1.2)

[a] N = 162 reported emotions. Some survey respondents reported more than one emotion.

patients; 33 (37.1%) considered a positive impact; and only a few (9 [10.1%]) reported negative consequences at the moment. Additionally, 23 participants (43.4% of the 53 who answered this question) reported that the impact of the episode in their relationship with the patient extended beyond the immediate moment into future interactions. For 17 (73.9%) of these 23 participants, the result was positive, whereas for 6 participants (26.1%), it was negative. Positive consequences included sense of relief, ability to clarify the situation, awareness of one's fallibility, increased understanding of the patient's reality, attitudes, increased admiration and interest for the patient, increased attention to the patient's needs, increased empathy, increased relationship strength, closeness, mutual consideration and trust, and increased adequacy of the patient's behavior. Negative consequences included increased defensiveness, avoidance of the patient, loss of empathy and of trust in the patient, and relationship termination.

The (immediate or extended) impact of the emotional reaction on the physician-patient relationship was not significantly associated with valence, duration, relative control of the emotion, or coping strategies used. However, specific reactions had a significant impact in physician-patient relationships. Touching, smiling, providing support, and choking up/crying did not yield a negative impact in physician-patient relationships at the moment ($\chi^2(1) = 7.814$, $p = 0.009$) or in future interactions ($\chi^2(1) = 5.181$, $p = 0.038$). On the other hand, withdrawing from the situation, imposing oneself and defending oneself were significantly associated with an immediate negative impact in the physician-patient relation ($\chi^2(1) = 16.774$, $p < 0.001$). These reactions tended to result in negative consequences for physicians who considered that their reactions required no subsequent adjustment and in positive consequences for physicians who tried to subsequently adjust their behavior and repair the situation. These tendencies were statistically nonsignificant, though. Withdrawing from the situation, imposing oneself, and engaging in medical procedures were further associated with a negative impact in future physician-patient interactions ($\chi^2(1) = 8.727$, $p = 0.009$). Defending oneself was associated with a positive impact in future interactions for the 1 physician who attempted to go back to his previous posture. Additionally, the physician who withdrew from the situation but allowed room for the patient to eventually apologize reported a positive impact in future interactions with that patient. However, these tendencies referred to small numbers of physicians and were statistically nonsignificant.

The type of emotion and its relative control were not significantly associated with physicians' gender or number of years of medical experience. However, a greater percentage of physicians

Table 4. Physician respondents' reactions while experiencing strong emotions in the presence of patients

Categories of reactions	Indicators	No. (%)[a]
Touching the patient	Touching/holding the patient's hand; hugging; shaking hands	13 (18.6)
Performing medical procedures	Writing a prescription; starting life support	10 (14.3)
Withdrawing from the situation	Leaving the room; avoiding the patient (eg, telling him to switch physicians, passing the telephone to another physician); refusing to see the patient	9 (12.9)
Providing support	Maintaining silence, respect, presence; comforting, attempting to understand or to communicate empathically; offering material help (money, goods)	8 (11.4)
Choking up/crying	Showing grief; feeling moved; unable to speak; crying	8 (11.4)
Imposing oneself	Speaking with authority; raising tone of voice; shouting; gesticulating; shaking one's head; getting up; walking back and forth	7 (10.0)
Smiling		5 (7.1)
Defending oneself	Explicitly legitimizing one's perspective	4 (5.7)
Explaining	Providing clarification, including one physician who looked at the patient's eyes and assumed responsibility for what happened	4 (5.7)
Expelling the patient	Standing up and ending the consultation, expelling the patient	2 (2.9)

[a] N = 70 respondents reported reactions.

Table 5. Reported coping strategies to deal with emotional reactions in the presence of patients

Categories of coping strategies	Indicators	No. (%)[a]
Breathing	Breathing; taking a deep breath; holding one's breath	34 (44.7)
Keeping the emotion away/focusing on something else	Ignoring; keeping emotional distance from the situation; continuing the encounter as if nothing was happening; focusing on the (next) task, on the patient, on one's posture; thinking as a professional; thinking of a solution; mentally counting	21 (27.6)
Talking/listening to the patient	Speaking calmly, gradually, with openness; maintaining silence; empathy; understanding; letting the patient express himself; keeping eye contact	7 (9.2)
Breaking eye contact	Gaining time; organizing thoughts	6 (7.9)
Reframing	Thinking of/providing an optimistic, hopeful perspective; rationalizing; accepting	5 (6.6)
Withholding the emotion	Blocking the feelings; not crying	3 (3.9)

[a] N = 76 strategies.

working in rural areas (37.5%) reported compassion, compared with physicians working in urban areas (8.1%, $\chi^2[1] = 7.110$, $p = 0.033$), and physicians from the South (ie, Madeira Island) reported controlling their reactions more than physicians from the North part of Portugal ($\chi^2[1] = 14.061$, $p = 0.001$). However, the interpretation of these results needs caution because very few physicians in the study were from southern Portugal or from nonurban centers. Physicians' specific reactions were not significantly associated with number of years of medical experience or geographic work location. But explaining the situation and expelling the patient were exclusive to male physicians in this sample ($\chi^2[1] = 9.488$, $p = 0.005$). Physicians of both genders used the various coping strategies described, but women tended to resort to breathing more than men ($\chi^2[1] = 5.250$, $p = 0.022$). Breaking eye contact was significantly associated with fewer years of medical experience ($t[22] = 2.115$, $p = 0.046$). Finally, the duration of the emotion, the type of behavioral adjustment attempted after the emotional reaction, and the (immediate or extended) impact of the emotional reaction on the physician-patient relationship were statistically unrelated with gender, geographic work location, and years of medical experience.

DISCUSSION

Results indicate that experiencing negative and positive intense emotions in the presence of patients is frequent among physicians. The fact that experiencing intense emotions was more frequent among those with fewer years of clinical practice suggests that repeated exposure to these situations or increased clinical experience may contribute to attenuating the emotional response, as previous studies indicate.[25]

Previous research on physicians' emotions has specifically focused on extreme scenarios associated with negative strong emotional reactions.[18,19] Such scenarios and associated intense negative feelings were frequent also in this study. However, other contexts emerged as well, including less extreme scenarios (eg, dealing with patients' rudeness) and situations triggering intense positive emotions (the most frequent being resolving the patient's problem). The fact that most situations described here elicited negative feelings may suggest that negative emotions are more strongly felt by physicians, or that these may be recalled more easily than positive experiences.[26] An interesting finding is that, as in previous studies,[19] many physicians reported experiencing longlasting emotions. This may have important clinical implications for patients visiting physicians while these emotions last, namely regarding decision processes.[11]

Most physicians in this study tried to control the emotion, which may partly explain the lack of perceived impact of their reaction on their relationship with patients. This attempted control suggests that physicians may consider displaying emotional reactions to be inappropriate in the presence of patients, although possibly less so if the emotion is positive. Smiling was associated only with positive emotions, and physicians touched the patient significantly more if they were experiencing positive feelings. On the other hand, only participants experiencing negative emotions reported controlling them completely, probably because they felt that negative emotions were less appropriate during clinical interactions.

… physicians additionally used other strategies in the moment, like breathing deeply, focusing on their posture, thinking about the next action, being empathic, listening to the patient more, and mentally counting.

To deal with these emotions, physicians used both cognitive and behavioral coping strategies. After-the-fact coping strategies reported in previous research appeared in our study as ways of managing emotions at the moment (eg, changing perspectives, keeping emotional distance, or talking to the patient).[10,21,22] In our study, physicians additionally used other strategies in the moment, like breathing deeply, focusing on their posture, thinking about the next action, being empathic, listening to the patient more, and mentally counting.

Whether or not controlled, in most cases physicians' emotional reactions did not affect relationships with patients, at least from physicians' perspectives. The impact was also independent from emotional valence (though no positive emotion had a negative impact on the relationship) and duration, and from the coping strategies used. Some specific reactions, however, did have an impact. Choking up/crying, touching, smiling, and providing support were significantly associated with an immediate positive impact and with no impact. This impact also extended into future interactions. Not surprisingly, withdrawing from the situation, imposing, and defending oneself were associated with a negative immediate impact. The former two reactions plus engaging in medical procedures had a further extended negative impact in future interactions. But the tendency for readjusting the behavior after the reaction to be less associated with a negative impact than when no readjustment existed, though not statistically significant, suggests that the clinical relationship may be shaped by interactions beyond the display of strong negative reactions, and that the reaction does not, per se, necessarily lead to a negative impact on the relationship, as long as interveners have the ability to repair it.

This study took a first step in the inspection of what happens when physicians experience strong emotions while seeing patients, and further research is needed for a better understanding of the results. Specifically, better discrimination of the effects of particular reactions on medical relationships is necessary. Also, the sampling strategy in this study limited our goal of forming a representative sample of physicians in the country, which restricts the generalizability of the results. It is possible that physicians who agreed to participate were particularly interested in the theme, introducing biases (eg, increasing the prevalence of intense emotions in clinical practice). Because we used a self-report, retrospective instrument, recall or report biases may also exist. Finally, the sample size may prevent the analysis and the observation of effects that could be visible with larger numbers of participants per group. Future research needs to consider additional aspects that could affect physician-patient relationships (eg, duration and kind of relationship with the physician) on a larger sample. It is also important to assess patients' perceptions of physicians' emotions and of their impact on the clinical relationship, in addition to

assessing patients' own reactions to the situations. The inclusion of other clinical implications is also crucial, such as the effect of physicians' emotional state in appropriate medical management, as suggested in previous studies.[11]

CONCLUSION

Although the display of emotions in medical encounters may be considered unprofessional, the experience of intense emotions by physicians in the presence of patients seems frequent. Physicians control the display of intense negative emotions more than that of positive reactions. However, relative control of the emotion, coping strategies used, the valence (positive, negative, or mixed), and the duration of the emotion do not affect the clinical relationship. Specific emotional reactions do. Choking up/crying, touching, smiling, and providing support did not affect relationships in negative ways, but leaving the patient, imposing, and defending oneself did. The fact that the impact of these reactions could be different according to physicians' subsequent adjusted behavior suggests that this impact may be modulated by the interlocutors' following actions, namely attempts at repairing the situation. Future studies are needed to clarify these results. ❖

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What Counts

It is the human touch after all that counts for most
in our relation with our patients.

— Robert Tuttle Morris, 1857-1945, American surgeon and author