Cardiology in the Young

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The role of the virtues in CHD

Joseph Burns[1], Shipra Rai[1], Marin Gillis[2] and Amy Basken[3]

[1]Cohen Children's Medical Center, Queens, NY, USA; [2]College of Medicine, Roseman University of Health Sciences, Henderson, NV, USA and [3]Conquering CHD, Madison, WI, USA

Editorial

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Author for correspondence:
Dr A. Basken, Conquering CHD, Madison, WI, USA. E-mail: abasken@conqueringchd.org

Congenital heart care offers a unique lens to evaluate the importance of the practice of empathy understood as respectful compassion. Beginning in utero, providers can interact with patients across the lifespan and at different stages in the experience of CHD. These multiple opportunities to connect with patients from diagnosis to correction and recovery allow the clinician to build rapport and trust of tremendous therapeutic and interpersonal value. Taking time to get to know the values, preferences, experiences, and stories of the patient and families and continuity of care are essential elements.

The movement towards teaching virtue or character ethics in medicine came forward with the medical professionalism movement. There was an acknowledgment that as one entered medical school, one's identity transitioned towards a professional identity. A road one travelled to become a good doctor included the development of characteristics that good doctors have, including patience, compassion, trustworthiness, honour, duty, excellence, perceptiveness, humility, and accountability, for example. Often on the list of virtues is empathy, and indeed, empathy has become the pinnacle of virtues and the virtue that most caring, humanistic clinicians were said to hold.[1]

While empathy is often touted as one of the primary virtues that should be instilled in medical professionals, attempts at a standard definition of empathy and how to tell if it is instilled or not bring forward a legion of challenges. Empathy has many definitions, from moral imagination (Aristotle) to emotional intelligence (Goleman). Empathy is commonly described as the ability to understand or share the feelings and experiences of others and a capacity to perceive another's experience.[2–4] Interestingly, neurologic evaluation has found similarity in excitation of brain areas related to observing another's emotions based on facial expression and when the observer experiences the same emotion through what are referred to as "mirror neurons."[4] However, feeling what a patient feels may not necessarily be what is needed to be a virtuous physician. First, there is an ethical issue regardless of the conceptual and empirical issues surrounding the claim that we can experience the same state as another. It seems to be less than humble to assert that one can indeed be in a position, especially over short durations of time, to honestly know what another is going through and what their experiences mean to them. Second, a mirror state is unnecessary for the kind of humanistic engagement that we believe is important for patients, families, and clinicians. That is not to say that emotion or shared understanding is unnecessary to realise or, worse, detrimental to the goals of medicine in the clinical encounter. As Osler reminds us, it is vital for clinicians to be composed for the sake of patients and to manage one's emotional states to be as transparent as possible in one's clinical judgment.[5]

Yet the dictum to manage one's outward and inward emotional responses with patients and families is not the same as a moratorium on emotions. If we regard emotions as being a central part of the human experience, in advocating for humanism in medicine, we must acknowledge the emotional life of patients, families, and clinicians. Perhaps the definition we seek is that empathy is respectful compassion.

To respect patients fully as human beings is to acknowledge and provide some space for their emotional life. For example, they may well be scared, hopeful, or angry in the face of a diagnosis. The ability of physicians to perceive such states and communicate in some way that they perceive them makes a positive impact on the clinical interaction because it helps build rapport. Through rapport, trust may be developed, and arguably, a necessary condition of any therapeutic relationship is trust. Marshaling one's ability to perceive the emotions of others, and to know how much space in the clinical encounter to give them, is therefore warranted as it is a means to the best possible outcomes. And it is also valuable because it is a way to respect patients as human beings, as having an inherent dignity.

Educational interventions meant to develop empathy in medical students have attempted to realize humanism in medicine. But it is unclear what has been effective, not unsurprisingly, because it is difficult to determine what one can measure to see if empathy has waxed or waned, and indeed, what we mean definitionally by empathy is blurry: it is a tricky subject to teach and assess. Do we mean feeling what another feels? If so, what makes this state better for the goals of medicine than understanding that someone has specific emotional responses and that we ought to acknowledge this in some caring way?

Interestingly, pediatricians, internists, and family medicine physicians scored among the highest relative to other subspecialties using a validated scale to assess physician empathy,

although those asked believed empathy was unclear and likely varied.[6] But it is worth looking at what these clinicians do differently so that we can determine and therefore be able to train students and other clinicians to do it too.

Respectful compassion in CHD

Teaching compassion remains a challenge, especially in medicine. Generally, patients report appreciation of a holistic approach to care, including understanding the psychosocial difficulties of diagnosing CHD and understanding the importance of space and time alone to digest this information with loved ones.[7] For these reasons, it is imperative to invest in evaluating and developing these tenets in medical trainees.

A significant, measurable, and teachable way that such respectful compassion is operationalised is through communication. Deliberate language choices may improve patient and family perceptions of how they feel that they are being cared for and respected. For example, among families advised that a child's CHD is "rare," 25% understood this to mean less than one in one million births, and 27% interpreted this word to mean that few or no patients with the condition are alive.[8] Factors reported by such families include feeling pressured to terminate, a lack of optimism about life expectancy, being advised that death was "somewhat" or "very" likely, and description of the child's lesion as "rare."[8] In addition, abandoning terms with microaggressive connotations improves patient relationships and understanding of their disease processes,[9] and it reveals respect for patients and families as persons with inherent dignity. Patient and family perceptions of being respectfully cared for are also associated with the likelihood of seeking a second opinion.[8] This again supports deliberate word choice when discussing CHD and assuring that expectations and definitions are understood. Ensuring clear expectations for surgical timing, course, and the possibility of future re-intervention allows for transparent conversations and improvement of family understanding of the expected course and lifelong experience with CHD and is empowering.

Patient and family feelings of being informed, understood, and cared for have consequences in older patients. Among adolescent patients transitioning to adult congenital care and providers, the companionship and continuity associated with cardiac care were identified as critical interpersonal needs in the transition process.[10] The importance of such humanistic practices is relevant to providers and the larger CHD community. Families frequently report joining support groups and online communities to express and receive validation.[11]

Steps to develop respectful compassion

We offer that perhaps lumping all humanistic aspects of healthcare under the concept of empathy may be less than salutary. Indeed, measuring empathy is exceptionally challenging if its definition is not agreed upon. Looking at encounters where patients feel they are being treated empathetically towards discrete skills has shown promise. Measures include sharing affect, self-awareness, and regulation of overwhelming emotions, among others.[12] Recent research has focused on optimising self-reporting tools to validate observation and neural activity on imaging.[12] This is to say, introspection and honest self-evaluation are paramount in understanding one's tendencies in the context of caring encounters to identify both strengths and areas of improvement. Despite the challenges in assessing empathy, several techniques have been identified to improve humanistic medicine with respect and compassion.

One method is narrative medicine.[13] Narrative medicine involves deliberate storytelling and reflection through discussion and writing of various materials.[13] The reflection can cover diagnosis, illness, and recovery and permits physicians to understand better the biological, social, and psychological determinants of disease.[13] In addition, encouraging reflection by both providers and patients allows for developing this skill and recognising moments to allow for this manner of discourse.[13] According to Charon, narrative medicine has three moments.[13] First, through techniques to promote active listening, physicians can realize the patient's story, which will reveal preferences and values relevant to the therapeutic relationship. Second, through iterative, collaborative techniques, physicians can become habituated to adequately represent the patient's illness narrative. And one and two combined lead to the third moment, which is an affiliation between the patient and the provider where the provider can become a good advocate for the patient.

Active listening and proper representation of patients and their illness narratives in language can be developed and measured like any other clinical skill. Engagement with literature has also demonstrated value in cultivating empathy when empathy is understood as moral imagination, including improving patient perspectives and coping with stress among medical students.[14] Additionally, engagement in artmaking also develops understanding and relevant skills, including greater self-awareness.[15] Patient-centered medicine curricula in medical school address history and physical exam skills and help students develop humanistic communication skills, especially with standardised patients.[16]

The take-home point in this section is not to discard the teaching of humanism in medicine because, for example, virtues are hard to measure. We must discern what actions or practices are associated with patients feeling that they have experienced clinician empathy and develop, teach, and assess those.

Conclusion

All patients desire a meaningful, empathetic relationship with their providers. Though the study and cultivation of these principles are sometimes challenging, it is essential to leverage every patient interaction to build a respectful, meaningful relationship. Physicians should be mindful of these needs from patients and work to improve their comfort with expressing what we have called respectful compassion. The skills needed to develop this virtue can be taught, whether starting early in medical school or as a seasoned cardiologist or cardiothoracic surgeon, and will positively impact the relationships cultivated with patients as they are cared for across the lifespa

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