Patient Education and Counseling 98 (2015) 1248–1254

Contents lists available at ScienceDirect

Patient Education and Counseling

journal homepage: www.elsevier.com/locate/pateducou

Clinicians' recognition and management of emotions during difficult healthcare conversations

Elliott B. Martin Jr.[a,b,c,*], Natalia M. Mazzola[a,b,c], Jessica Brandano[a,b,c], Donna Luff[a,b,c], David Zurakowski[a,b,c], Elaine C. Meyer[a,b,c]

[a] The Institute for Professionalism and Ethical Practice, Boston Children's Hospital at Waltham, 9 Hope Avenue, Waltham, MA 02453, United States
[b] Boston Children's Hospital, 300 Longwood Avenue, Boston, MA 02115, United States
[c] Harvard Medical School, 25 Shattuck Street, Boston, MA 02115, United States

ARTICLE INFO

Article history:
Received 25 January 2015
Received in revised form 29 July 2015
Accepted 31 July 2015

Keywords:
Difficult conversations
Emotions
Interprofessional
Education
Simulation

ABSTRACT

Objective: To examine the most commonly reported emotions encountered among healthcare practitioners when holding difficult conversations, including frequency and impact on care delivery.
Methods: Interprofessional learners from a range of experience levels and specialties completed self-report questionnaires prior to simulation-based communication workshops. Clinicians were asked to describe up to three emotions they experienced when having difficult healthcare conversations; subsequent questions used Likert-scales to measure frequency of each emotion, and whether care was affected.
Results: 152 participants completed questionnaires, including physicians, nurses, and psychosocial professionals. Most commonly reported emotions were anxiety, sadness, empathy, frustration, and insecurity. There were significant differences in how clinicians perceived these different emotions affecting care. Empathy and anxiety were emotions perceived to influence care more than sadness, frustration, and insecurity.
Conclusions: Most clinicians, regardless of clinical experience and discipline, find their emotional state influences the quality of their care delivery. Most clinicians rate themselves as somewhat to quite capable of recognizing and managing their emotions, acknowledging significant room to grow.
Practice implications: Further education designed to increase clinicians' recognition of, reflection on, and management of emotion would likely prove helpful in improving their ability to navigate difficult healthcare conversations. Interventions aimed at anxiety management are particularly needed.

1. Introduction

It remains easier to classify 'difficult healthcare conversations' than to define them [1–8]. One may communicate difficult news, may unwittingly 'open a can of worms', may 'say too much', or one may provide conflicting information to a patient or family. Difficult conversations may be planned or unplanned, and they may involve any number of providers or family members. They may be influenced by cultural perceptions or misperceptions; they may be welcome or unwelcome [9]. They may occur spontaneously—even the seemingly most benign conversation may unexpectedly turn, leaving the clinician scrambling for the right words [10–12]. Patients and families generally do not recall specifics of these conversations, but their perception of how information was communicated by healthcare providers has been shown to impact their evaluation of the quality of care received, their ability to cope with the communicated 'bad news', and even their subsequent ability to bereave [13–17].

A difficult conversation is a conversation with considerable emotional and values-system investment. In narrative terms, a difficult conversation is one in which the clinician must deliver potentially unwelcome news with subsequent follow-up to the patient's or patient's loved ones' responses. Historically, through the mid-twentieth century, difficult conversations were more the rule than the exception [18]. That is, before disease was curable, clinicians—more expert in prognosis and the natural course of disease—most often found themselves delivering bad news,

* Corresponding author at. Present address: Department of Psychiatry, Newton-Wellesley Hospital, 2014 Washington Street, Newton, MA 02462, United States.
E-mail addresses: emartin9@partners.org (E.B. Martin), natalia.mazzola@googlemail.com (N.M. Mazzola), jessmarieb.2010@gmail.com (J. Brandano), donna.luff@childrens.harvard.edu (D. Luff), david.zurakowski@childrens.harvard.edu (D. Zurakowski), elaine.meyer@childrens.harvard.edu (E.C. Meyer).

http://dx.doi.org/10.1016/j.pec.2015.07.031
0738-3991/

withholding bad news, or couching bad news in metaphorical terms, frequently with the tacit consent of the patient [14,15].

The explosion of therapeutic modalities, however, in more recent years—aided in no small part by extensive media coverage of 'medical breakthroughs', and unbridled mass advertising—has brought with it the expectation of cure, and this has arguably made the difficult conversation that much more so [15]. Clinicians generally set out to cure their patients, or at least to diagnose them with a degree of certainty, and patients and their families expect to be cured. When uncertainty arises, or death is inevitable, those who are used to healing their patients may find themselves nearly as helpless as their patients [21,22].

Given that medicine has historically relied on artful conversation [23], it is perhaps surprising that there is sparse literature on how well clinicians recognize and manage their emotions during difficult healthcare conversations, and even less literature on educational models to enhance awareness and strategic utilization of these emotions [1,19–22]. The paternalistic model tends to renounce emotion, perhaps necessarily so in an era when one's patients were expected to die [24–26].

There is of course rationale for the insistence among many clinicians that emotions remain submerged. The underlying etiology of much of psychopathology, after all, is the inability to separate thought from emotion [27]. Healthcare professionals generally perform their duties in a logical, evidence-based fashion. They collect their thoughts and proceed. Emotions interfere with logic. Definitions of emotion remain diverse, but as opposed to cognitive and volitional processes, emotions tend to be spontaneous, have physiological factors associated with them, and quite frequently facial and/or vocal expressions as well [1,28–30]. When healthcare professionals have difficulty recognizing, managing, and reflecting on their emotions, they can find themselves at the mercy of these emotions [1,31,32]. In conversations with considerable emotional and values-system investment, healthcare professionals ideally attend to their own emotional states through recognition, management, and reflection. How well they do this may affect their ability to navigate difficult conversations [1,32].

Our goal in this initial study was to examine the most commonly reported emotions encountered among healthcare practitioners when having difficult conversations, including frequency and perceived impact on care delivery.

2. Methods

2.1. Design

Data were collected during the course of the academic year September 2013–May 2014 from healthcare providers representing a range of specialties and experience levels who attended the Program to Enhance Relational and Communicational Skills (PERCS) workshops offered by the Institute for Professionalism and Ethical Practice (IPEP) at Boston Children's Hospital (BCH) [32]. Participants included physicians, nurses, medical interpreters, social workers, and other psychosocial professionals. Participants were provided self-report questionnaires by an administrative associate prior to the start of each workshop, who then collected them after the workshop. Each participant was provided a research number to assure confidentiality. As these were workshops designed for all healthcare providers it was felt that all participants should be included in our survey, rather than restrict our design to one or two professions.

Please describe the most common emotions you experience when having difficult healthcare conversations with patients and families.

	How frequently do you experience this emotion?	Do you think this emotion affects the care you provide?	If yes, how do you think this emotion affects the care you provide?
a)	1 – Minimally 2 – Somewhat 3 – Quite 4 – Very	a) Yes b) No	
b)	1 – Minimally 2 – Somewhat 3 – Quite 4 – Very	a) Yes b) No	
c)	1 – Minimally 2 – Somewhat 3 – Quite 4 – Very	a) Yes b) No	

How well do you think you recognize your own emotions relative to having difficult healthcare conversations?

1	2	3	4	5
Not at all	Minimally	Somewhat	Quite	Very

How often do you reflect on your own emotions relative to having difficult healthcare conversations?

1	2	3	4	5
Not at all	Minimally	Somewhat	Quite	Very

How well do you think you manage your own emotions relative to having difficult healthcare conversations?

1	2	3	4	5
Not at all	Minimally	Somewhat	Quite	Very

Fig. 1. Questionnaire assessing the most common emotions, frequency, effect on care delivery, and assessment of abilities to recognize, reflect on, and manage own emotions. This is the standardized questionnaire to which study participants responded.

2.2. Measures

A questionnaire was designed specifically for this study. Demographic items included age, gender, ethnicity, occupation, and years of experience. As Fig. 1 depicts, participants were asked to describe, in free text, up to three common emotions they had experienced when having difficult healthcare conversations. Participants were allowed to apply their own definition of difficult healthcare conversations. Participants rated the frequency of each emotion listed on a 4-point Likert scale (1 = minimally, 4 = very). The impact of each particular emotion on care delivery was also measured by a single yes/no item: "Do you think this emotion affects the care you provide?" Five-point Likert-scale items (1 = not at all, 5 = very) also assessed each participant's subjective awareness of, reflection on, and management of his or her own self-reported emotions.

The third column collected qualitative data based on responses to the first two columns, asking participants to elaborate specifically on how they thought their particular emotions affected their care. This data will be analyzed and presented in a future publication.

2.3. Data analysis

Statistical analyses were completed in SPSS and Excel. The reported emotions were grouped into main categories. Agreement about which category to which a particular emotion was assigned was reached through a process of study team discussion. First, the reported emotions were carefully read and grouped into initial categories by two authors independently. In a next step, both authors went through the list of emotions together, compared the initial categories they found, and discussed their results until agreement was reached as to emotions belonged together and to the title/name/label of categories. In the final step, the categories were discussed with two other authors to achieve consensus on the final categories. Participants' responses to open-ended questions were entered into a computerized document for subsequent qualitative analyses, to be reported separately. Association between frequency of reporting of the common emotions and the percentage of participants indicating that the emotion affects care were assessed by the Pearson chi-square test. The *z*-test was used to compare proportions between males and females to determine if experienced emotions and their impact differ according to gender. Logistic regression analysis was applied to determine odds ratios and 95% confidence intervals (CI). Two-tailed values of $p < 0.05$ were considered statistically significant.

3. Results

3.1. Participants

A total of 152 participants from a range of specialties, including Cardiovascular and Critical Care, Neonatal Intensive Care, Neurology, Palliative Care, Psychiatry, and Radiology returned completed questionnaires. Participants were predominantly female (66%), Caucasian (68%) and included physicians (47%), nurses (29%), medical interpreters (13%) and psychosocial professionals (7%) with a wide range of clinical experience (see Table 1).

Table 1
Demographic characteristics of participants.

Characteristic	Total
Discipline, *n* (%)	
Physician	71 (47)
Nurse	44 (29)
Medical interpreter	20 (13)
Psychosocial professional	11 (7)
Other[a]	6 (4)
Valid N	152
Gender, *n* (%)	
Female	101 (66)
Male	49 (32)
Not specified	2 (1)
Valid N	152
Ethnicity, *n* (%)	
Caucasian	104 (68)
Hispanic	22 (14)
Asian	13 (9)
African	2 (1)
Other	8 (5)
Not specified	3 (2)
Valid N	152
Age	
Mean (SD)	37 *(9.9)*
Range	22–67
Years of experience	
Range	0.5–36
Interquartile Range	12

[a] Includes technician (5), occupational therapist (1).

3.2. Outcomes

3.2.1. Most common emotions

Participants were asked to describe up to three emotions that they commonly experienced when having difficult conversations with patients and families; 24 participants reported one emotion, 50 reported two, and 78 participants reported three emotions, a total of 358 reported emotions. The five commonest emotions identified were: anxiety, sadness, empathy, frustration, insecurity/inadequacy (Table 2). No quantitative emphasis was given to the response order. Responses that did not fall into either of these categories were declared either uncodable or classified as one-of-a-kind. In some cases, participants reported two or three emotions which fell into the same category (e.g. "stress" and "nervousness" falling into the category anxiety-related emotions).

As illustrated in Table 2, 101 of 152 participants (66%) reported experiencing anxiety-related emotions; 80 participants (53%) indicated sadness-related emotions; 60 participants (39%) reported empathy-related emotions when having difficult conversations with patients. Anxiety-related emotions were not only the most commonly reported, but they also tended to be the first emotion to be reported by 67 of 152 participants (44%). Regarding the Reported% as a comparison between the most commonly experienced emotions (chi-square test = 124.39 on 4 d.f., $p < 0.001$). Thus, among these 5 emotions, the frequency is significantly higher for anxiety and sadness, lowest for frustration and insecurity, and in the middle (40%) for empathy.

Table 2
Most commonly experienced emotions according to frequency and effect on delivery of care ($N = 152$).

Emotion	Reported		Frequency				Affects care	
	(*n*)	(%)	Minimally	Somewhat	Quite	Very	(*n*)	(%)
Anxiety	101	66%	4	52	34	11	62	61%
Sadness	80	53%	2	30	32	16	42	53%
Empathy	60	39%	1	7	24	28	46	77%
Frustration	29	19%	8	14	5	2	17	59%
Insecurity	22	15%	1	16	4	1	8	36%

Percentages for affects care are based on those who reported each emotion.

Also of note, based on the *z*-test for comparing independent proportions, sadness was reported in a significantly higher percentage of females than males (62% vs. 35%, $p = 0.05$). No gender differences were found regarding anxiety ($p = 0.73$), empathy ($p = 0.33$), frustration ($p = 0.65$), or insecurity ($p = 0.87$). There were no significant differences between disciplines ($p = 0.41$) or experience levels ($p = 0.23$).

3.2.2. Frequency of most experienced emotions

With respect to how frequently clinicians experience any particular emotion, Fig. 2 breaks down the number of participants who reported experiencing the emotion in that row via the frequency indicated in that column. For example, of the 80 participants who experience sadness, 48 (60%) experience this emotion quite to very frequently; 52 out of 60 participants (87%) reported experiencing empathy quite to very frequently; 22 out of 29 (76%) and 17 out of 22 (78%) experience frustration and insecurity/inadequacy, respectively, only minimally to somewhat frequently. In comparing the list of five most common emotions, we see that there is a highly significant difference in high frequency (quite or very) between the emotions (chi-square = 49.59 on 4 d.f., $p < 0.001$). One can see in looking at the horizontal bars that empathy (87%) and sadness (60%) are experienced more frequently than anxiety (45%), frustration (24%) and insecurity (23%).

3.2.3. Do emotions affect health care delivery?

Most participants indicated that their emotional states do indeed affect the health care they provide. For example (Fig. 3), in response to the "yes/no" question, 62 out of 101 participants (61%) believe that the anxiety-related emotions they experience during difficult conversations with patients and families affect the care they provide, and 46 out of 60 (77%) feel the same way about empathy. Of the five main categories of reported emotional states, all but one (insecurity/inadequacy) were reported as affecting health care delivery more than 50% of the time they are experienced.

Clearly there are significant differences among clinicians in how they perceive these different emotions affecting the care they provide (chi-square = 14.04, $p = 0.007$). This confirms that empathy (77%) and anxiety (61%) are emotions that are perceived to influence care more than sadness (53%), frustration (59%) and insecurity (36%).

3.2.4. Clinicians' ability to recognize, reflect on, and manage their own emotions

Participants were asked to assess their ability to recognize their emotional states, how often they reflected on them, and how well they felt they were able to manage their own emotions. Overall, clinicians rated themselves as somewhat to quite capable of recognizing (mean = 2.74, S.D. = 0.83), reflecting on (mean = 2.54, S.D. = 1.02), and managing (mean = 2.7, S.D. = 0.78) their emotions relative to having difficult conversations with patients and families; *t*-tests revealed no significant gender differences in regards to these scores. Further analyses (ANOVA) were conducted to identify significant differences across disciplines, and these differences were not found to be significant. Older participants tend to rate their ability to recognize their own emotions higher than do younger participants ($r = .21$, $p < 0.05$), while more experienced clinicians showed a tendency to reflect on their emotions more often ($r = .20$, $p < 0.05$) than do less experienced participants.

4. Discussion and conclusion

4.1. Discussion

When clinicians enter into emotionally charged conversations with patients and families they enter into privileged worlds, sacred spaces, places formerly not their own. Clinicians thereby become woven into the patient's, the family's world, their memories. Whenever that patient's family recalls 'the moment we heard such and such', it will be the clinician who conveyed the news, for better or for worse, who will be conjured. The exact words will likely be forgotten, but the memory will be re-constructed based on how well, or poorly, that clinician conducted that conversation, or series of conversations.

There is sparse literature looking at the emotional states of healthcare givers under any circumstances, and these are mostly narrative case reports. Our goal was to quantify the most common emotions experienced by healthcare givers during difficult conversations, and to examine whether clinicians believe the care they provide is influenced by their emotions during these conversations.

The order of questions on our questionnaire was carefully designed. Clinicians were first asked to list, in their own words, the most common emotions they experienced, how frequently they experienced each of those emotions, and whether, in their estimation, those emotions affected care. Clinicians were then specifically asked first how well they recognize their emotions in order to provide themselves with a baseline in order to assess the subsequent questions on reflection and management of emotions.

The majority of study participants were physicians and nurses from a major academic children's hospital, clinicians who frequently engage in difficult healthcare conversations not only with patients, but with their parents and other supports. The most frequently reported emotions during difficult conversations were, in order of frequency: anxiety, sadness, empathy, frustration, insecurity, and inadequacy, with anxiety far and away most common.

101 of 152 clinicians reported anxiety-related emotions (66%) and among those who experience this emotion, 62 (61%) indicated that it affects the care they provided. Focusing on 'Affects Care' (Table 2), and applying logistic regression analysis, when empathy

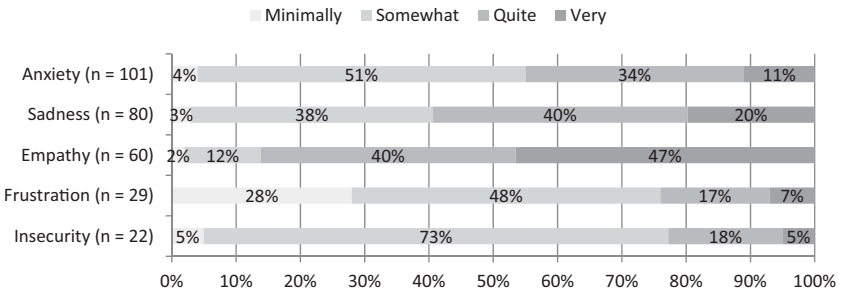

Fig. 2. Frequency of most commonly experienced emotions.

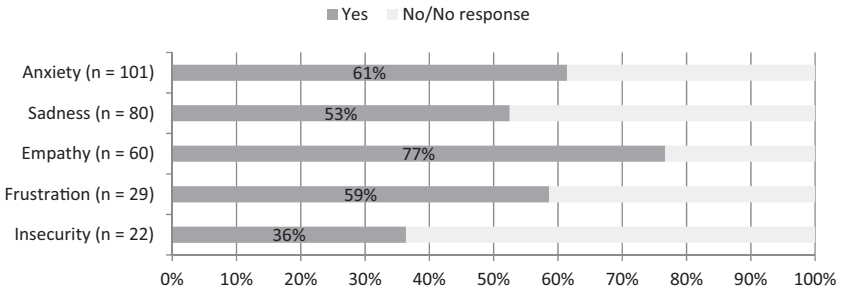

Fig. 3. Perception of emotions affecting care.

is experienced a significantly higher percentage of clinicians indicate that it affects care compared to when anxiety is experienced (77% vs. 61%, $p = 0.009$; odds ratio: 2.1, 95% confidence interval: 1.2–4.3). However, among clinicians who experience anxiety-related emotions, a higher percentage of them perceive that it affects the care they provide as compared to when insecurity is experienced (61% vs. 36%, $p = 0.018$; odds ratio: 2.6, 95% confidence interval: 1.6–6.8). Similarly, when clinicians experience empathy, a higher percentage indicate that this emotion affects care than when insecurity is experienced (77% vs. 36%, $p = 0.002$; odds ratio: 5.3, 95% confidence interval: 1.8–15.5) or when sadness is experienced (77% vs. 60%, $p = 0.04$; odds ratio: 2.6, 95% confidence interval: 1.2–6.8) or when frustration is experienced (77% vs. 59%, $p = 0.04$; odds ratio: 2.3, 95% confidence interval: 1.1–6.0).

All these emotions significantly affect the care provided, with anxiety and empathy most commonly so, and empathy more so than anxiety.

It is especially interesting that anxiety and empathy emerged as the predominant driving emotions in our study, as these are arguably the most value-neutral of the emotions reported (Table 3). Although anxiety is certainly a negative emotion at times, in our context the positive consequences of anxiety were also described. These include the genuine desire to succeed in relaying information appropriately, attention to details, and overall conscientiousness.

Empathy was generally described as a positive emotion since it grounds the clinician and enables the experience of other emotions. A clinician may, for example, empathize with a patient's or family's anger, frustration, or despair. A clinician may empathize with a patient's or family's distress, with their inadequacy, with the absurdity of a given situation. In the context of difficult healthcare conversations, our data support empathy as an emotion with both positive and negative aspects, as a likely necessary conduit to more fully understanding the patient's perspective. It may be that empathy is positive to a great extent, but yet can reach a tipping point whereby it can be experienced as negative as when it contributes to over-identification. Given that there were no significant differences based on discipline or work experience, empathy may reflect a personality trait of those drawn to work in the healthcare field in general.

Sadness was reported in a significantly higher percentage of females than males (62% vs. 35%, $p = 0.05$). No gender differences were found regarding anxiety ($p = 0.73$), empathy ($p = 0.33$), frustration ($p = 0.65$), or insecurity ($p = 0.87$). But the percentage of clinicians who indicated that emotions affect the care they provide was not significantly different between those experiencing anxiety compared to sadness (61% vs. 60%), $p = 0.63$), or anxiety compared to frustration (61% vs. 59%, $p = 0.68$). The reported sadness is consistent with gender-reported differences of depression in the general population. However, frustration, insecurity, and anxiety, also common symptoms of depression, showed no significant differences between genders.

Our data also suggests that nearly all participants reported some form of emotional distress during difficult conversations. The open-ended question about how emotions affected care was designed to collective narratives to shed light on how reported emotions are perceived to impact care provided. The qualitative analysis of these collected narratives will be reported separately.

4.2. Limitations

There were several limitations that must be acknowledged. The data was collected through self-report questionnaires and, thus, subject to the limitations of such. Some participants may have felt uncomfortable or unfamiliar with reporting on their own

Table 3
Reported emotions as included in referenced categories.

Anxiety	Sadness	Empathy	Frustration	Insecurity
Anticipation	Disappointment	Compassion	Anger	Confusion
Anxiety	Feel like crying with the parents	Concern	Conflict	Feeling like a failure
Apprehension	Sadness	Connected	Frustration	Feeling unprepared
Awkwardness	Sorrow	Empathy	Irritation	Helplessness
Concern		It could be me/us	Not understanding families reasons for some stances	Inability to make it better
Discomfort		Sympathy		Inadequacy
Fear		Understanding		Lack of clear proper words
Feeling like being attacked				Lack of confidence
Hesitation				Little confidence
Loss of words				Powerlessness
Nervousness				Pressure to do it right
Stress				Uncertainty
Tension				
Trepidation				
Uncomfortableness				
Worry				

emotions. Participation in the workshops was largely volunteer and may reflect a selection bias towards those participants who more highly value communication and relational skills. Similarly, participants were largely drawn from a single tertiary care pediatric institution in an urban northeast location. Our sample was also heterogeneous. We included a broad array of professionals, including medical interpreters and psychosocial providers, who may have less medical expertise but more communication expertise. We included physicians and nurses, who may have greater medical expertise, but less so in communication. There was some accounting for this in the demographic breakdown, but there is no escaping the possible impact of professional diversity. What was striking, however, was the consistency of responses across demographic variables, though a larger study might find more prominent differences across professions.

The chronology of emotions during difficult conversations was not examined (whether any particular emotion was more likely before, during, or after the conversation), nor was the intensity of emotion measured quantitatively. Also, the complexity of mixed emotional states was not measured quantitatively in this study. Qualitative data regarding emotional states and impact have been collected, and the hope is to address some of these difficult-to-quantify elements through qualitative analysis.

4.3. Conclusions

Interprofessional clinicians acknowledge a range of emotions that impact their ability to effectively carry on difficult conversations. The most commonly reported emotions include anxiety, sadness, empathy, frustration, and insecurity/ inadequacy.

Clinicians are somewhat attuned to their emotional states at baseline, but our data suggests that there is significant room for growth.

Clinicians acknowledge significant impacts of emotions during difficult healthcare conversations, and most, regardless of clinical experience and discipline, perceive that their emotional state influences the quality of their care delivery.

Further education designed to increase clinician recognition of, reflection on, and management of emotion may be helpful in improving their ability to navigate difficult healthcare conversations.

4.4. Practice implications

Further and continuing education designed to increase clinicians' recognition of, reflection on, and management of emotions may prove helpful in improving their ability to navigate difficult healthcare conversations.

Qualitative data has also been collected regarding clinician attunement to emotional states and their impact on health care delivery, and these may prove most helpful in delineating specific educational strategies; for example, in creating impactful scenarios in simulation-based programs.

Interventions aimed at anxiety management among clinicians are particularly needed. Experiential educational workshops and venues likely offer excellent vehicles for future research, development and trials of educational intervention. Communication and relational skills educational settings may do well to address and incorporate the experience and role of clinicians' emotional experience, and how that may affect communicative encounters with patients and families. By leading the way to help clinicians recognize, reflect on, and better understand and manage their own emotions, we can cultivate clinicians who are less at the mercy of their own emotions, but rather more fully aware and capable of harnessing their own emotions in the service of others.

Role of funding

No financial support was provided for this research and/or preparation of the article.

Conflict of interest

None of the authors had any potential conflicts of interest including any financial, personal or other relationships with other people or organizations within three years of beginning the submitted work that could inappropriately influence, or be perceived to influence, their work.

Acknowledgments

We would like to thank the entire staff at the Institute for Professionalism and Ethical Practice, as well as all the participants in this past year's workshops.

References

[1] T. Kushnir, J. Kushnir, A. Sarel, A.H. Cohen, Exploring physician perceptions of the impact of emotions on behavior during interactions with patients, Fam. Pract. 28 (2011) 75–81.
[2] M.W. Rabow, S.J. McPhee, Beyond breaking bad news: how to help patients who suffer, West. J. Med. 171 (1999) 260–263.
[3] L. Fallowfield, V. Jenkins, Communicating sad and difficult news in medicine, Lancet 363 (2004) 312–319.
[4] J.K. Rao, L.A. Anderson, T.S. Inui, R.M. Frankel, Communication interventions make a difference in conversations between physicians and patients, Med. Care 45 (2007) 334–340.
[5] G. Lamiani, E.C. Meyer, D. Leone, E. Vegni, D.M. Browning, E.A. Rider, R.D. Truog, E.A. Moja, Cross-cultural adaptation of an innovative approach to learning about difficult conversations in healthcare, Med. Teach. 33 (2011) e57–e64.
[6] P. Brickman, D. Coates, R. Janoff-Bulman, Lottery winners and accident victims: is happiness relative? J. Pers. Soc. Psychol. 3 (1978) 917–927.
[7] R. Buckman, Breaking bad news: why is it still so difficult? Br. Med. J. 288 (1984) 1597–1599.
[8] L. Grassi, L.T. Girali, E.G. Messina, K. Magnani, E. Valle, G. Cartei, Physicians' attitudes to and problems with truth-telling to cancer patients, Support. Care Cancer 8 (2000) 40–45.
[9] J.R. McDonagh, T.B. Elliott, R.A. Engelberg, P.D. Treece, S.E. Shannon, G.D. Rubenfeld, D.L. Patrick, J.R. Curtis, Family satisfaction with family conferences about end-of-life care in the intensive care unit: increased proportion of family speech is associated with increased satisfaction, Crit. Care Med. 32 (2004) 1484–1488.
[10] J.W. Mack, J.M. Hilden, J. Watterson, C. Moore, B. Turner, H.E. Grier, J.C. Weeks, J. Wolfe, Parent and physician perspectives on quality care at the end of life in children with cancer, J. Clin. Oncol. 23 (2005) 9155–9161.
[11] C. Mulry, I have an update, Patient Educ. Couns. 65 (2007) 3–4.
[12] E.C. Meyer, G. Lamiani, M.R. Foer, R.D. Truog, What would you do if this were your child?: practitioners' responses during enacted conversations in the United States, Pediatr. Crit. Care Med. 13 (2012) e372–e376.
[13] T.C. Hoffmann, C. Del Mar, Patients' expectations of the benefits and harms of treatments, screening, and tests, J. Am. Med. Assoc. 175 (2) (2015) 274–286, doi:http://dx.doi.org/10.1001/jamainternmed.2014.6016.
[14] B. McKinstrey, Paternalism and the doctor-patient relationship, J. Gen. Pract. 42 (1992) 340–342.
[15] D.J. Rothman, Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making, Basic Books, New York, 1991.
[16] A. Surbone, Information to cancer patients: ready for new challenges? Support. Care Cancer 16 (2008) 865–868.
[17] W.T. Branch, R. Frankel, C.F. Gracey, P.M. Haidet, P.F. Weissmann, P. Cantey, G.A. Mitchell, T.S. Inui, A good clinician and a caring person: longitudinal faculty development and the enhancement of the human dimensions of care, Acad. Med. 84 (2009) 117–125.
[18] E.B. Martin, How I got schooled in ancient psychiatry, Psych Times 31 (2014) 36–37.
[19] N.R. Angoff, Crying in the curriculum, J. Am. Med. Assoc. 286 (2001) 17–18.
[20] J. Halpern, From Detached Concern to Empathy: Humanizing Medical Practice, Oxford University Press, Oxford, 2001.
[21] F. Borrell-Carrió, R.M. Epstein, Preventing errors in clinical practice: a call for self-awareness, Ann. Fam. Med. 2 (2004) 310–316.
[22] M.S. Krasner, R.M. Epstein, H. Beckman, A.L. Suchman, B. Chapman, C.J. Mooney, T.E. Quill, Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians, J. Am. Med. Assoc. 301 (2009) 1284–1293.
[23] A. Buchanan, Medical paternalism, Philos. Public Aff. 7 (1978) 370–390.
[24] J.F. Childress, Who Should Decide? Paternalism in Healthcare, Oxford University Press, New York, 1982.

[25] S. Yurkiewicz, Our medical education system does not tolerate emotional cracks. KevinMD.com. 5 April 2013, (accessed 10.01.15.) <http://www.kevinmd.com/blog/2013/04/medical-education-system-tolerate-emotional-cracks>.
[26] P. Sloterdijk, Critique of Cynical Reason, University of Minnesota Press, Minneapolis, 1987266–275.
[27] J.S. Beck, Cognitive Behavioral Therapy: Basics and Beyond, 2nd ed., The Guilford Press, New York, 2011.
[28] L.F. Barrett, J.A. Russell, The Psychological Construction of Emotion, Guilford Press, New York, 2015.
[29] J.T. Cacioppo, W.L. Gardner, Emotion, Annu. Rev. Psychol. (1999) 191.
[30] K.R. Scherer, What are emotions? And how can they be measured?, Soc. Sci. Inform. 44 (2005) 693–727.
[31] D. Ofri, What Doctors Feel: How Emotions Affect the Practice of Medicine, Beacon Press, Boston, 2013.
[32] D.M. Browning, E.C. Meyer, R.D. Truog, M.Z. Solomon, Difficult conversations in health care: Cultivating relational learning to address the hidden curriculum, Acad. Med. 82 (2007) 905–913.