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Clinicians' strategies for managing their emotions during difficult healthcare conversations

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ABSTRACT

Objectives: To examine strategies employed by clinicians from different disciplines to manage their emotions during difficult healthcare conversations.
Methods: Self-report questionnaires were collected prior to simulation-based Program to Enhance Relational and Communication Skills (PERCS) workshops for professionals representing a range of experience and specialties at a tertiary pediatric hospital. In response to an open-ended prompt, clinicians qualitatively described their own strategies for managing their emotions during difficult healthcare conversations.
Results: 126 respondents reported emotion management strategies. Respondents included physicians (42%), nurses (29%), medical interpreters (16%), psychosocial professionals (9%), and other (4%). Respondents identified 1–4 strategies. Five strategy categories were identified: Self-Care (51%), Preparatory and Relational Skills, (29%), Empathic Presence (28%), Team Approach (26%), and Professional Identity (20%).
Conclusions: Across disciplines and experience levels, clinicians have developed strategies to manage their emotions when holding difficult healthcare conversations. These strategies support clinicians before, during and after difficult conversations.
Practice implications: Understanding what strategies clinicians already employ to manage their emotions when holding difficult conversations has implications for educational planning and implementation. This study has potential to inform the development of education to support clinicians' awareness of their emotions and to enhance the range and effectiveness of emotion management during difficult healthcare conversations.

1. Introduction

Conversations are the most commonly performed 'procedures' in healthcare [1]. Information is transmitted directly through conversation; patients learn of diagnoses, of prognoses, of treatment options. They receive orientation to, or alienation from, an often unknown and intimidating world of medicine [2]. And like any procedure, a conversation may go smoothly or there may be complications. The clinician may perceive that (s)he has performed well when in fact the patient and family are left distraught and overwhelmed; or the clinician may perceive that (s)he has performed poorly when in fact the patient and family are immensely grateful [3–10]. Patient and family perception of how clinicians communicate information, regardless of the news that is shared, has clearly been demonstrated to affect their satisfaction, understanding, and ability to adjust to the clinical situation [11–15]. How these conversations are remembered has

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been shown to affect patients' and families' appraisal of the quality of healthcare received [16–18].

Challenging healthcare conversations also impact clinicians. A recent study demonstrated that clinicians experience significant emotion distress before communicating difficult news [19]. In a commentary article, clinicians recounted their emotions including: the need to rescue the patient, a sense of failure and frustration when the illness progresses, feelings of powerlessness against illness, fears of becoming ill oneself, and/or desire to separate from and avoid patients to escape these distressing feelings [20]. Given that nearly all clinicians must regularly engage in difficult conversations, it is surprising that there is little standardized training for healthcare professionals to learn how to better attend to their emotions. In this context we hypothesized that practicing clinicians, regardless of discipline and level of experience, will have developed their own strategies for managing their emotions during difficult healthcare conversations.

So why do clinicians have a difficult time with emotions during healthcare conversations? Buckman [9] discusses anxieties and fears that doctors have when it comes to breaking bad news, including fear of being blamed or fear of not knowing all the answers. Clinicians are typically confronted with and forced to come to terms with many of their own emotions and/or values during challenging healthcare conversations [15,21–25]. However, clinician emotions have received relatively little attention, and providers may have little training related to recognizing, identifying, and attending to their own emotions [26,27]. When it comes to dealing with their own emotions, in the hospital and clinic environment healthcare providers find themselves learning to be objective and even detached from emotions [28]. However, there is wide empirical evidence suggesting that being detached from one's own emotions can have negative consequences on health and psychological well-being [29]. Bakker and Heuven [30] found for policemen and nurses, that emotionally demanding interactions can affect performance and even lead to job burnout. Moreover, emotional detachment may have downstream negative consequences on patients and families, particularly when emotional detachment leads to empathy degradation [31].

We have previously demonstrated a range of emotions identified by clinicians as impacting their care delivery during difficult conversations [32]. Across disciplines and experience levels, clinicians identified five predominant emotions in these clinical scenarios: anxiety, sadness, empathy, frustration, and insecurity. These emotions subjectively influenced the quality of care delivered; empathy and anxiety more so than the others. We also noted sparse literature on clinicians' ability to recognize and manage emotions during difficult healthcare conversations, and that there is even less available research on heightening awareness or the benefit of educating clinicians on how to recognize and attend to their emotions when interacting with patients and their families.

In an effort to inform development of educational materials to enhance effective clinician emotion recognition and management, the Program to Enhance Relational and Communication Skills (PERCS) through the Institute for Professionalism and Ethical Practice (IPEP) at Boston Children's Hospital (BCH), a tertiary care pediatric hospital, conducted a study to assess the frequency and impact of clinicians' emotions during difficult healthcare conversations, to ask clinicians across disciplines and experience levels to reflect through personal narratives on how these emotions affect care delivery, and to qualitatively examine clinicians' strategies for managing emotions during difficult conversations. Here we report specifically on the strategies that clinicians from a range of disciplines have developed to manage their emotions during these challenging conversations.

2. Methods

Data were collected from healthcare providers representing a range of specialties and experience levels who voluntarily attended 13 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) from September 2013 through May 2014. PERCS is a well-validated, simulation-based educational approach designed for interprofessional participants to improve their confidence and skills when conducting difficult conversations with patients and their families [33–35]. The workshops include realistic enactments with professional actors as patients and family members [36,37] and provide a safe and interprofessional learning environment that enables and encourages participants to reflect on and practice difficult conversations.

Workshop participants included physicians, nurses, medical interpreters, social workers, and other psychosocial professionals. Participants were given self-report pre- and post-questionnaires by an administrative associate who also collected both surveys after the workshop. Each participant was provided a research number to assure confidentiality. The self-report pre-questionnaire contained demographic items (discipline, years of experience, and socio-demographic characteristics) and open-ended questions asking participants to describe their most commonly experienced emotions during difficult healthcare conversations with patients and families. Participants applied their own definition of difficult healthcare conversations. The pre-questionnaire also asked participants to rate how frequently they experienced reported emotions and their perception of the impact of each particular emotion on care delivery. Full details of the questionnaire and responses to these items have previously been reported in this journal [32]. Subsequently we undertook further analysis of the data to focus on clinician management of emotions, which we report here.

We analyzed participants' responses to the following open-ended question: "Please share what strategies/approaches/advice you use, if any, to help manage your own emotions when having difficult healthcare conversations." Using qualitative content analysis [38,39] we determined the primary types of strategies employed during difficult conversations. First, the responses were read by three researchers (DL, ECM and KM) who each noted emergent coding categories. The team met to compare categories and agreed upon an initial coding framework. The responses were then all coded by one researcher (KM) using this initial framework. The team met again to review the coding and to refine the categories, providing a definitional statement for each one. All three researchers reviewed each response again to ensure that the response fit the definition of the emerging category. Once the team agreed upon the final categories and their definitions, one researcher (KM) did a final round of checking for saturation of the categories, and that all the coded data fit into the emergent categories. Finally, the three primary researchers (DL, ECM, and KM) met to choose illustrative responses to report for each category.

3. Results

In total 152 participants from a range of specialties, including Cardiovascular and Critical Care, Neonatal Intensive Care, Neurology, Palliative Care, Psychiatry, and Radiology returned completed pre-questionnaires. Among these 126 (83%) interprofessional participants responded to the open-ended question on strategies/approaches/advice, comprising our study cohort. Among this study group of 126 respondents, 83 (66%) were females, 40 (32%) were males, and 3 (2%) did not specify gender. Respondents' self-

reported race/ethnicities were as follows: 87 (69%) White, 19 (15%) Hispanic, 9 (7%) Asian, 1 (1%) African-American, and, 7 (6%) Other, 3 (2%) Not Specified. Respondents' disciplines and work experience are described in Table 1.

Respondents each identified 1–4 strategies that they employed for managing their emotions when holding difficult conversations, most reported two different strategies. By analysis of all strategies described, we found that clinicians across disciplines employ five primary types of strategies to manage their own emotions which we categorized as: Self-Care; Preparatory and Relational Skills; Empathic Presence; Team Approach; and Professional Identity.

The five primary types of strategies are described below, in order from most to least commonly reported. Illustrative responses from the written narratives are presented for each strategy.

3.1. Self-care

More than half, 51%, of respondents reported at least one self-care strategy to manage emotions related to difficult healthcare conversations. These strategies were employed before, during and after the conversation. Some clinicians recognized the value of self-reflection in advance of the conversation:

I try to first acknowledge my feelings about the situation. (physician)

Others described practical techniques to calm themselves before and during the difficult conversation:

Deep breaths, lipstick and courage! (nurse)

Taking a moment before having a difficult conversation. (physician)

Self-care strategies after the conversation included taking time to process the experience:

Find an outlet to vent with others. Find destressors afterwards: exercise, writing, yoga. (social worker)

I go to the gym after a difficult conversation. I cry and acknowledge my limitations. (medical interpreter)

Table 1
Demographic characteristics of participants (n = 126).

Discipline, n%	
Physicians	53 (42)
Nurses	36 (29)
Medical Interpreters	20 (16)
Psychosocial	12 (9)
Other	5 (4)
Valid N	126
Gender, *n%*	
Female	83 (66)
Male	40 (32)
Not Specified	3 (2)
Valid N	126
Ethnicity, *n%*	
Caucasian	87 (69)
Hispanic	19 (15)
Asian	9 (7)
African	1 (1)
Other	7 (6)
Not Specified	3 (2)
Valid N	126
Age	
Mean (SD)	38 (10.6)
Range	22–67
Work Experience	
Range	0.5–36
Interquartile Range	7

3.2. Preparatory and relational skills

Respondents reported several ways in which they prepared themselves for difficult conversations and adopted specific relational skills as the conversation unfolded. These strategies were employed before and during a difficult conversation. 29% described at least one preparatory or relational skills strategy, including: reviewing the chart, anticipating the family's needs, or rehearsing conversations beforehand.

I prepare myself to talk to families by asking myself what they need to hear from me and how one might prefer to hear it. (physician)

Respondents also considered their relational skills during the conversations:

Speaking as slowly and calmly as possible; gauging the situation to see what the best approach would be. (medical interpreter)

Several respondents commented on the value of pauses during the conversation itself:

Allowing silence (physician)

I have learned to use silence as I feel the emotions are running high. (nurse)

3.3. Empathic presence

28% of respondents reported the importance of remaining empathic to manage their emotions by keeping the focus on the family and their needs during these conversations. Empathy was described in several ways:

Try to have a good understanding of the family's experience thus far in their healthcare journey. (nurse)

Put yourself in their shoes. (physician)

Not necessarily thinking about me but about what they are going through. (physician)

Just remember you're there for the patient and family. (nurse)

3.4. Team approach

Clinicians also utilized colleagues as a source of support and forum to process these challenging situations. Among respondents 26% identified at least one team approach strategy.

Give news with team of people available to answer questions. (physician)

They also sought team advice before or after a difficult conversation:

Talk with other HCPs [health care professionals]/mentors. (physician)

Talk with charge RN or other staff about various situations. Talk about various ways to approach the conversation and how it could have gone better. (nurse)

3.5. Professional identity

For some participants (20%), invoking and remaining mindful of their professional role, standards, and responsibilities, including the values and limitations of their professions, was helpful.

Being true to who I am as a nurse. Allowing them to see my compassion may help connect during a difficult time. (nurse)

This strategy enabled clinicians to separate their professional-self from their personal-self and, therefore, permitted them to better maintain their emotional equilibrium during and after these challenging healthcare conversations.

Remind myself of my role; separate emotion from responsibility. (physician)

I try to calm down and perform my duties with precision and care. (medical interpreter)
Leave my work problems at work. (nurse)

4. Discussion and conclusion

Our study of practicing clinicians from a range of disciplines revealed five primary types of strategies for coping with their emotions during challenging clinical conversations. The most common strategy in our study, used by half of respondents, was self-care. The implication is that self-care is critical for the emotional well-being of the healthcare provider and that, by extension, self-care may be critical in the effort to successfully take care of others.

Clinicians in this study typically utilized more than one type of strategy, suggesting a repertoire of response to emotion management in difficult healthcare conversations. If most clinicians already carry some form of 'toolbox' for these situations (see Table 2), there may be an existing foundation upon which to build educational interventions. We also observed some chronologic trends about when different types of strategies were used by clinicians, specifically before, during, or after difficult conversations (Fig. 1). This is interesting area for further study, and may help clinicians "organize" strategies across a temporal arc of emotional coping.

Understanding the strategies that clinicians naturally use to manage their emotions and sharing common strategies are important first steps in developing support for clinicians' emotional management during difficult conversations. Such interventions may send a strong message to health care providers about normalizing and creating space for clinician emotions. Opening discussions about clinician emotions and actively supporting clinicians through such challenges may prove important drivers of well-being. With unprecedented proportions of clinicians reporting burnout [40,41], it is not difficult to imagine that more effective ways to manage emotion may offset emotional exhaustion and depersonalization, key features of burnout.

Many procedures in medicine have standardized preparation, such as checklists and algorithms to assure against errors [42].

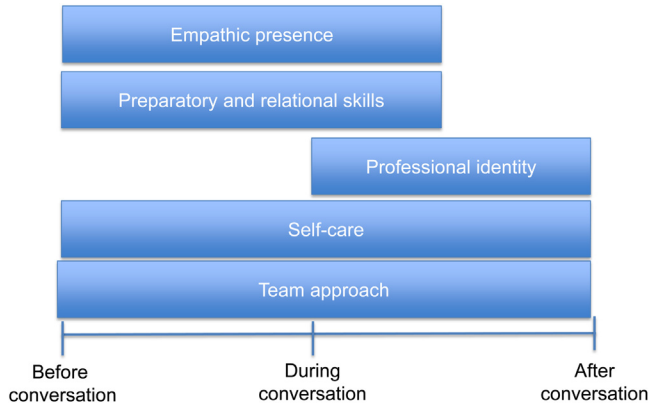

Fig. 1. Temporal relationships of common clinician strategies for managing their own emotions in difficult healthcare conversations.

There is no such standard checklist to prepare clinicians emotionally for the difficult conversations. Our data suggest that clinicians create their own repertoire of personal strategies to manage challenging conversations and the attendant emotions that may arise. Overall, the strategies reported by clinicians in our study map broadly to those previously reported for doctors breaking bad news to patients, where coping responses were categorized as problem-focused, emotion-focused, or meaning-finding [19]. Where the studies differ most is in the realm of meaning-finding. We were surprised that participants in this study did not commonly discuss attempts to find meaning as part of their emotion coping before, during, or after challenging conversations; instead they seemed more focused on strategies to "get through" the difficult task and recover after. Our findings add nuance to these broader domains of problem and emotion-focused strategies, with specific detailed examples that can be readily adopted by other healthcare providers, and are amenable to educational intervention.

Historically, clinicians' ability, or inability, to manage their emotions has been under-represented in medical curricula [26,27]. This may be changing now, particularly in relation to clinicians'

Table 2
Clinicians' "Toolbox" of Strategies for Managing their Emotions.

Category	Strategies
Self-care	Identify personal emotions before conversation Breathe deeply Take breaks or use self-calming techniques Find an outlet to decompress (exercise, writing) Talk about experience with others Acknowledge individual and system-level limitations
Preparatory and relational skills	Anticipate family's needs Consider how patient/family would most prefer to hear the news Rehearse conversations ahead of time Speak slowly; allow silence Adapt approach based on patient/family responses/emotional cues
Empathic presence	Put yourself in patient's/family's shoes Imagine the context of the patient/family health care journey Remember primary role to support patient/family
Team approach	Include other team members in conversation to broaden expertise offered to patient/family Consult with more experienced peers and mentors before conversation Debrief with other team members after conversation
Professional identity	Lead with compassion Separate emotion from responsibility Leave professional problems at the workplace

emotional response to medical errors, where the idea of clinicians as "second victims" has gained widespread attention [43]. For example, the importance of peer support is gaining much interest [44,45], but there are still limited studies in the medical literature that have addressed the mechanisms of clinician coping [46]. It is also notable that many respondents in our study identified strategies that drew on colleague support to help them cope with emotions, talking with team members for example. This suggests that further work on the collective, rather than just individual, management of emotions within healthcare may be fruitful.

In a hospital setting, among nurses working in different units, "display rules," represented as shared emotional norms, influenced individual-level affect regulation and well-being outcomes, namely job satisfaction and burnout [47]. In addition, individuals' implicit beliefs about their own emotions may predispose them toward emotion regulation strategies that have important consequences for psychological health: for example, believing that one cannot learn to control emotions and that emotions cannot really be changed was associated with decreased well-being, such as reduced self-esteem and satisfaction with life, and increased psychological distress of stress and depression [48]. Taken together, these findings and those from our study, may inform future research on emotions in healthcare: for instance, examining the relationship between clinicians' implicit beliefs about the malleability of their own emotions and their ability to recognize and attend to their emotions. Further research should also aim to identify predictors of shared beliefs, and examine whether these beliefs predict if and how clinicians working in the same unit perceive their emotions to affect care. A better understanding of these mechanisms could set the stage to design unit-based interventions aimed at developing shared beliefs that help clinicians respond to and manage emotions in an effective way. Recognizing and attending to personal emotions, and collectively fostering resilience among teams [49] may help both health care providers and their patients [50].

This study has several limitations. The data were collected through self-report questionnaires. There may be participants who were more or less comfortable reporting on their emotions and strategies to manage them. Participants also may have different interpretations of what constitutes a difficult conversation, although in over a decade of PERCS workshops we find that clinicians consistently struggle with emotion as a common denominator to "challenging conversations." Participation in the workshops was largely voluntary 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. However, participating clinicians came from a range of disciplines and experience levels, and were part of their own discipline's "unit culture," thus reflecting a broader range of practice settings. The data therefore represent a high-level view of interprofessional emotional coping strategies across disciplines, rather than in-depth conclusions about any one professional group, which warrants further study. Our sample size was too small to power meaningful comparisons between different learner demographics but it is possible that the use of each of the five strategies may differ by gender, discipline, or other demographics. Our findings bear further qualitative and quantitative study with larger samples, both within and across professional groups, to explore possible variation among clinicians in the types and frequency of the emotion management strategies they employ. Because it was beyond the scope of this study, inferences about the effectiveness of any of the reported strategies also cannot be made, and further research in this area is warranted. Further research on the relationship between effective emotion management and burnout also merits attention.

4.1. Conclusion

Clinicians across disciplines and experience levels have developed their own strategies to help them manage their emotions during difficult healthcare conversations. Clinicians have developed a personal repertoire of such strategies, and these extend to periods before, during and after difficult conversations.

In this study, five primary categories among the reported strategies of clinicians emerged: self-care; preparatory and relational skills; empathic presence; team approach; and, professional identity. Research on the effectiveness of these existing strategies, as well as education to supplement and further inform strategies, may be helpful in improving clinicians' ability to navigate difficult conversations and perhaps to overall clinician well-being.

4.2. Practice implications

Understanding what clinicians already do, individually and collectively, to manage their emotions during difficult healthcare conversations has implications for understanding what kinds of educational interventions may or may not be helpful. This approach sees clinicians' emotions as an important, and often overlooked, component in the unfolding of difficult conversations in healthcare. The emotions clinicians experience during challenging conversations and their management have important implications for clinical work and self-preservation.

The findings of this study can inform the development of tools and educational offerings designed to support clinicians' awareness of their emotions, with the goal of improving effective emotion management and patient care. With a better understanding of strategies to manage emotions during difficult healthcare conversations, clinicians may be more capable and confident when engaging in these challenging but inevitable conversations with their patients and families. Creating space and shared strategies to recognize and support such feelings may not only enable better care for patients, but also bring healthier clinicians to the practice of medicine.

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.

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