EMOTION AND THE CARE ETHIC IN CLINICAL DELIBERATION

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THE PHYSICIAN AND EMOTION

The care perspective urges physicians not only to accept the significance of emotion but to face the challenge to work out "ways of dealing with one's emotions." With a renewed understanding of emotion arising from moral psychology, emotion theory, and the care perspective, physicians and ethicists are able to analyze the clinical situation from some fresh perspectives.

With regard to moral reasoning, the care perspective can occasion a turn to more immediate contextual matters as opposed to more abstract deduction. Alisa Carse forwards a notion of care ethics that is "sometimes principle-guided, rather than always principle-derived." Guidance in moral deliberation in care thought moves in a "virtue-theoretic direction" and is more dependent upon sympathy and compassion as opposed to dispassion. Skills of moral reasoning will be "thicker and richer" in this mode of reasoning as opposed to the type of deductive reasoning seen in the "justice perspective." From this care perspective the clinician is not simply concerned with moral action, rather personal character becomes a "principal focus of moral attention."

From a principles-based perspective, Tom Beauchamp and James Childress recognize the ability of the care ethic to address the moral role of the emotions. Their view reflects the idea that when the care perspective is coupled with the working of the virtues in the experience of emotion, the physician is better able to account for that which "principles and rules cannot fully encompass." The nature of this kind of relationship is one that focuses more on connection and empathic care rather than detachment and objective concern. Beauchamp and Childress admit, furthermore, that often "what counts most in the moral life is not consistent adherence to principles and rules, but reliable character, moral good sense, and emotional responsiveness.”
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In a clinical context emotion can and should lead us to make moral decisions and engage in moral actions that deductive reasoning from principles and rules would not necessarily oblige us to. Beauchamp and Childress go on to argue that “without various traits of character, emotional responses, and ideals that reach beyond principles and rules,” moral deliberation in clinical practice would be “cold and uninspiring.”

The act of engaging and incorporating the emotions in clinical deliberation carries with it certain difficulties. The inclusion of subjective emotion in what is often portrayed as an objective and detached scientific interaction may threaten the necessary rationalism of deliberation. When temperance is practiced as a means of engaging and incorporating the emotions, however, a measure of difficulty is removed. Despite whatever difficulty may remain, inclusion of emotion is not an option to be debated,” since emotion is an ever-present reality in the clinic. Jodi Halpern writes of the “additional burden” that emotion brings to the context of deliberation. Despite this burden, “resonating with the patient emotionally...plays an essential role in informing the physician about the patient’s experience.”

To refuse to engage and include emotion is to refuse our very humanity in a critical relationship within the context of medicine. Current literature focused on the physician’s relation to emotion in the clinic revolves around the notion of detachment. In relation to the emotions of the patient and the physician’s own emotions, detachment is either held up as an ideal or decried as the problem. Some authors encourage detachment, while those who argue against it—to whatever degree—encourage counter notions such as connection, compassion, or empathy. Some authors seek a balance between the two and call for the awkward notion of “detached concern” Authors from across this spectrum attribute conceptions of detachment in clinical practitioners to the work of William Osler. Having now examined Osler’s views on detachment and the engagement of emotion, it is appropriate to question whether equanimity truly amounts to detachment or whether it encourages emotion in clinical practice.

Physicians in training become acutely aware of the presence and force of their emotions on the first day of anatomy lab. Over the course of their entire medical training their experience of emotion undergoes significant changes. Harold Lief and Renée Fox describe this process: “Students are called upon to strike a balance between the attitudes of detachment and concern. For most students, this process seems to be one of acquiring more detachment and less concern.”