GUEST EDITORIAL

To feel or not to feel? - that is the question

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In this issue of PCCM a junior doctor working on PICU reflects on the emotional impact of her work and specifically, after an especially gruelling shift, the loss of her capacity to feel empathy or anything else for that matter1. She further reports that the numbness she felt was - to her alarm - fleetingly associated with thoughts of ending her life. The issue of the elevated risk of suicide in doctors in general, and anaesthesiologists in particular, is a serious one which is not acknowledged often enough2.

But this piece also touches on a conundrum regularly experienced by those working in the caring professions over the course of their careers; namely the challenge of maintaining empathy for the human beings whose suffering they are trying to alleviate, whilst preserving enough professional distance to do their job properly. Or, to put it another way, how do we hold on to the capacity to feel but also to retain the ability to turn this capacity down a bit, when there is a risk of being overwhelmed, without losing ‘it’ altogether?

Interestingly, given the prevailing emphasis on the importance of demonstrating empathy in interactions with patients and their families, there is some evidence there may be some personal benefits to having a degree of detachment. A prospective study of burnout in n=1668 medical students found that higher depersonalisation scores were actually protective against work-related emotional exhaustion 12 years later3. And recent guidance for trauma therapists4 outlines a number of distancing self-care practices, including resisting the inclination to visualise traumatic events as the patient is relating them and deliberately not mirroring their body language. These techniques are recommended as ways for therapists to protect themselves, if they feel they are at risk of over-identifying with the people they are trying to treat.

Gerada5 has also recently referred to the value of psychological defences in medical practice. Humour is an example of one such mature, healthy defence. So too is ‘suppression’ which is defined as ‘the conscious decision to delay paying attention to a thought, emotion or need in order to cope with the present reality: making it possible later to access uncomfortable or distressing emotions whilst accepting them’6. It can be a protective strategy, as long as it is not overused to the point where it becomes a habit (which then can start to invade home life as well as work life) and provided that that there is sufficient time and space7 available to reflect on experiences and feelings later.

On an individual level, it can be therapeutic to process feelings by writing them down8, as Lissman1 describes. Formal debriefing sessions and discussions with a superior have also both been found to be associated with lower rates of burnout in ICU staff9 and attendance at regular unit meetings has recently been shown to be linked with lower rates of moral distress10 in this group.

Obviously the extent of autonomy and responsibility at work and the pressures of life outside work, are different at different stages in a career, so coping strategies may need to be adapted over time to reflect this. The recent interesting breakdown of burnout and coping by generation, provided in a national US survey11 is revealing in relation to this point. ‘Generation X’ physicians (aged 40-55y), who reported the highest levels of burnout in the survey, apparently cope with work stress by exercising, whereas the younger ‘Millennials’ are more likely to get some extra sleep and talk to their friends and the older ‘Baby Boomers’ are most likely to isolate themselves from others to cope. It remains to be seen whether these strategies will continue to be characteristic of these different generational cohorts or rather reflect the particular work-related pressures experienced at different stages in their working lives.

But it is a fact that Intensive Care is still relatively young as a specialty, which means that very few people have to date spent a whole career as an intensivist. It may be that the cut and thrust of the early job is not best suited to physicians nearing the end of their careers. The experience and knowledge of Rissman’s ‘older haggard’ colleagues might be put to better use – and their stamina increased - in roles involving reduced clinical hours, more teaching and mentoring. Recent guidance drawn up by the Royal College of Physicians12 in the UK, in response to a growing awareness of impending staff shortages as more experienced practitioners opt for early retirement, offers a number of creative suggestions along these lines.

Finally, other strategies which have been found to be associated with lower burnout and greater job satisfaction are taking the time to *recharge* as well as to recover, and *‘job crafting*’13. The latter refers to the practice of taking proactive steps to develop a work role such that it better aligns with a person’s strengths, interests and values, enabling them to find greater meaning in their work. It may be unrealistic to expect to achieve the perfect balance between home and work, or between feeling and not feeling, but with more open discussion of the challenges and satisfactions this work setting affords, it is to be hoped that a greater number of PICU health professionals can find their own way to survive and thrive in this important field14.

881 words

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