The Value of "Heartsink"

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Earlier this year, the press hummed with news that scientists had discovered a new organ that would fundamentally change our understanding of human anatomy—the interstitium. The abstract and nebulous "in-between" space that had long confounded students in anatomy class was finally getting its due. Typically an afterthought, the interstitium was now being touted as a crucial missing piece in understanding a multitude of diseases.

The notion of an "in-between" is helpful when thinking about medical education. Trainees experience a wide range of emotions, from the joy of clinical success to troubling experiences of fear and disappointment. In an effort to characterize such negative emotional experiences among internists, O'Dowd coined the term "heartsink patients," which refers to patients who elicit a downward, negative affective experience in clinicians, characterized by "an overwhelming mixture of exasperation, defeat, and sometimes plain dislike that causes the heart to sink when they consult."[1] Such experiences may be rooted in any combination of clinician fear, anger, anxiety, or shame. With the caveat "all doctors' hearts do not sink for the same reasons," O'Dowd highlighted patient characteristics linked with heartsink, including dissatisfaction with services provided, having many demands, and being "frequent attenders with seemingly endless complaints." Although heartsink may derive in part from certain patient characteristics, it is also inextricably linked to each clinician's personal difficulties with coping.[2]

Heartsink may be the interstitium of medical education. The in-between spaces, which on the surface appear unremarkable, may actually be the crucial connectivity between more typical learning experiences and a "potential space" for truly transformative moments. Perhaps we have been so caught up with the "major organs" of education that we may have missed a linchpin of learning that is so familiar it has become indiscernible.

Untended Negative Emotions

In order to appear confident and capable, trainees may avoid admitting how often they experience negative emotions like discomfort, frustration, and anxiety. Unless they are associated with an overt negative clinical outcome, there often isn't space to acknowledge these experiences. They are subacute and subthreshold, deemed unworthy of analysis or even recognition. These emotions may not overtly affect clinical outcomes, but they are likely to affect the clinician. Untended to, their corrosive effects may lead to pejorative side conversations about patients that may allow the physician to vent for the moment, but are ultimately destructive. This maladaptive coping undercuts any potential opportunity to learn from challenging experiences.

Locus of Control

Negative clinical experiences are partly derived from what the clinician brings to the encounter—elements the clinician may be able to control. The same clinical situation may evoke heartsink in one learner but not in another, or even in a specific learner on one day but not the next. Some factors, however, may be largely beyond a clinician's control: due to lack of time, fatigue, or stress, a challenging encounter that should be an opportunity for growth may become an injuring experience. Recognizing these factors can shift the focus from "difficult patients" at the root of heartsink to "difficult encounters" or circumstances.[3]

Trainees are more likely to experience these aversive influences. Physicians who are younger, work longer hours, and struggle with anxiety and depression tend to have more heartsink.[4,5] In one study, a lack of communication training, lower job satisfaction, lack of training and qualifications, and greater perceived workload accounted for 60% of the variability in heartsink among physicians.[5] Not only are these factors more prevalent during training, but trainees also may have fewer skills to cope with them on the fly. The line between positive, productive stress and toxic stress may be thin.

Myriad Consequences

Training is a time of emotional vulnerability. The stakes are high, the work is hard, and trainees are not sure yet where they stand. When they experience heartsink, they are likely to become self-protective. Rather than seeking to grow through difficult experiences, trainees may be prone to maneuvering around them and avoiding them in the future, thereby

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ceding opportunities to rewrite the narrative. Heartsink may also compound over time. After a difficult experience, trainees may approach the next tentatively or negatively, predisposing them to even greater difficulty. During a time in which trainees are formulating attitudes and perspectives on future pathways in medicine, these negative experiences may be mistaken for warning signs rather than opportunities to learn and strengthen.

It is incumbent on faculty to help learners explore these emotional experiences, determine their roots, and address them so that the care they provide to patients is uncompromised and their learning unhindered. Clinical encounters typically associated with heartsink are ones in which trainees would most benefit from mental clarity, emotional equilibrium, and positive affect. Such emotional experiences are perhaps the most potent learning opportunities because they are so memorable and may provide robust scaffolding for concepts and information learned along the way.

How We Move Forward

Awareness of this issue does not guarantee ready means to mitigate its effects. However, being aware gives the learner a fighting chance to address contributing factors and interpret and understand their clinical experiences with greater nuance and perspective. Awareness may also improve the quality of care provided to the extent that learners may recognize their limitations in a given scenario deriving from not only the bounds of their knowledge and training, but also how they are feeling emotionally at the point of care.

Educators can help learners develop a sincere reverence for those subtle and in-between moments by modeling behavioral patterns of reflection and sharing. Mindful and reflective practice is essential. Trainees should be encouraged to listen to feelings of resentment or frustration, as well as affinity and thankfulness, and understand and address them. A reflection checklist can put these moments into sharp relief and ensure these "potential spaces" of learning and growth are recognized and redeemed routinely. As an example, I have found the rubric "head-heart-and-hands" to be helpful in fully exploring each patient encounter or relationship. When working with a trainee I might ask, "What do you think is going on with the patient clinically? How do you personally feel about the situation or interaction you had? What can we do to make either or both of them better?" Often we go straight from the clinical head to the healing hands without recognizing the value of the affective pit stop in between.

Finally, it is important to recognize negative emotions as valid and reasonable. Humanism in medicine is about recognizing the human core of every clinical encounter. When heartsink isn't acknowledged and addressed, it may lead to faculty and trainees perceiving only surface elements while missing everything that lies underneath. If trainees are not made aware of this gap, they may assume their disquieting feelings are merely due to a lack of knowledge or inexperience. It's always about knowledge and inexperience. Except when it isn't. Sometimes it is the human experiencing heartsink.

References

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