

Diversity as an Opportunity for Emotional Competence Development
Loma K. Flowers, MD

When physicians think of diversity in medicine, we often think first of cultural and ethnic diversity, then religious, and sexual, etc., but a broader view of diversity is a much richer concept. For instance, our colleagues, teams or patients may come from anywhere on the spectrum from privilege or persecution. They may speak a number of languages or only one. They may be native San Franciscans or international nomads with a third grade education or seven degrees. Each variation of people's experience shapes their personalities, and we cannot possibly be familiar with them all. However, we certainly can master the appropriate skills to manage both our own feelings and the feelings that arise in our interactions with others.

These skills are known as emotional competence, and I see cultural competence as one of its subspecialties. Interestingly, the birth of cultural competence training actually required a fundamental development in the emotional competence of medical educators. We relinquished the attitude that patients alone should bear the burden of understanding their physicians, and we required physicians to understand their patients and make themselves intelligible and interpersonally accessible. This mutuality of responsibility is a basic principle of successful relationships, and an example of interpersonal emotional competence.¹

The development of cultural competence² might serve as a model for a parallel development in emotional competence in medicine. Cultural competence gained momentum when groups of students underrepresented in medicine benefited from the civil rights movement and became physicians in large enough numbers to influence medical culture and thinking. As an intern at San Francisco General in 1968, well before affirmative action reached San Francisco, I remember our training director summoning me to his office to quietly berate me about a long list of incomplete charts. When I protested that I had been punctilious about my charts, he pointedly disclosed that the program had taken a chance to accept me, an African American woman, as an intern. As the only black intern in three successive classes of over sixty interns, I was not surprised to hear that I had surmounted a pattern of racial exclusion. However, the timing and implications of his disclosure incensed me. Nonetheless, having been raised in England, my emotional control skills were up to the task. I asked to see the list for myself and one glance confirmed that he had mistaken another intern's incomplete charts for mine. Our names were the same except for our first initials. Needless to say, I brought this to his attention. Had the director and I been trained in sophisticated emotional competence skills, we could have used that encounter as an opportunity for an open discussion of the issues rather than a mutual stand off. Such a conversation could have benefited both of us and the program.

True emotional competence is a repertoire of skills that allows individuals to adapt constructively and fluidly to innumerable situations with unique, creative strategies and authenticity. This is in contrast to a strict rules approach, which can lead to very inappropriate and insincere responses. The politically correct rules, which are the butt of

the current “pc” jokes, are a good example of this. Fluid emotional competence is best achieved through a clear understanding of the fundamental principles involved. These principles are grounded in the emotional dynamics that occur in the vast range of socially acceptable, ordinary adult responses to everyday events, including the interpersonal transactions of our daily lives. “Psychonormality” is my shorthand for these dynamics and their development.

Psychonormality includes both content and process, and involves both internal and external reactions. Our internal reactions include feelings, thinking, and judgment and their development throughout our lives. Our external reactions include actions or behavior, such as observations, communications, e.g. with patients, colleagues, students and teams, and other activities that are generated by internal reactions. Although medical schools teach thinking, judgment and certain actions extremely well, they pay far less attention to the essential fourth element, feelings. Yet I have found that students can systematically build understanding of the development of psychonormality through mastering five basic tasks: self-awareness, including feeling management, self-development, relationship dynamics, self-responsibility, and reflection.

Relationship dynamics include a combination of internal and external reactions and managing relationships requires the continual differentiation of motivation and impact. These two internal forces strongly influenced the training director’s and my interaction. He was provoked by my denial of responsibility, because he presumed it was untrue. His motivation for the disclosure was to shame me into compliance and it could have been influenced by a sense of betrayal, if he had advocated for my admission to the program, or a self righteous sense of validation if he had opposed it. The impact of his angry disclosure was that I felt gratuitously slammed by the same unjust racist judgments that drove me to protect myself with punctilious vigilance about keeping my charts up to date. These issues between us were never emotionally resolved.

Forty years ago it was perfectly acceptable to approximate emotional competence by controlling the direct expression of your feelings professionally - most of the time. Occasional tantrums by physicians, especially senior ones, were generally overlooked, or forgiven after some sort of an apology, because of the universally acknowledged dedication and pressure of a physician’s life. In addition, we assumed that everyone would apply the social rules and customs of the majority culture to interpersonal situations. This obviated the need to understand either the colleague or the patient with whom you were dealing or to learn the principles underlying the rules. It was a short cut that for the most part worked pretty well, especially in a basically uniform culture.

I remember at least two personal physicians who, in different ways, demonstrated this style of emotional competence at its best, even with our ethnic differences. In both their practices, there was adequate time to compensate for less sophisticated emotional competence – theirs and mine. Dr. Louis O’Gara, my sons’ first pediatrician, made home visits for their acute illnesses until his retirement in the 1980’s. Each time he came, I felt a profound relief at not having to drag a listless toddler out into the rain to his office. With the humanist (Case) Western Reserve University Medical School in common and

his extraordinary outreach, he bridged all other issues. Similarly, Dr. Eugene Shafton, who relocated to Hawaii in 2005, has a versatility and genuine compassion that over 32 years of care allowed us to develop the kind of doctor-patient relationship presently found more in textbooks than in urban practices. I now have four new doctor-patient relationships to replace his care.

In contrast, do you remember, “See one, do one, teach one?” This old maxim of my medical training was no doubt designed to encourage an aggressive approach to learning. However, it also showed a reckless disregard not only for the diversity of learning speeds and styles of medical students and house staff - which in itself was terrifying - but also for the diversity of emotions evoked in doctors and patients by life threatening procedures. When those same inexperienced trainees performed diagnostic and treatment procedures, every emotion from horror to glee was possible. Ignoring those emotions bypassed an opportunity to teach the art of medicine. During those intense moments that we share with patients around procedures, practitioners have a chance to explore existential issues and expand their understanding of the essential diversity of human bodies and minds, from vulnerability to strength. In the past, students who acknowledged such feelings had to cope with them without guidance. Today, perhaps because of the increased number of women in the profession, there is wider recognition of these issues, more training in communications, professionalism, etc. and greater support available.³ Nonetheless, there is still no cohesive curriculum on emotions to facilitate the integration of all this information.

Our aggressive medical teaching has also conditioned us to rise to every challenge without setting realistic limits, indicating an unbalanced sense of self-responsibility. I suspect this has left many physicians vulnerable to unreasonable pressures to automatically increase clinical and research loads, rather than aggressively redefine the issues and propose constructive alternatives. “Publish or perish” is another reflection of this conditioning, and both situations exploit the our skewed self-responsibility skills. Equal opportunities for respected, slower tracks for clinical, research and academic medicine are still in the future.

Beyond historical legacies, the emotional side of medicine is presently complicated by numerous other familiar factors. For one, the rules “everyone” knew have eroded and the diversity of issues that doctors face daily is increasing so rapidly that there is little predictability and less common ground in relationships. Therefore, physicians have to feel their way emotionally through every interaction, which as psychiatrists know, is exhausting. At the same time, we no longer enjoy the status that previously offset much of the burden of our professional responsibilities. Moreover, there is a steady accumulation of negative feelings from the never-ending disruptions in doctor-patient relationships by economic forces. These feelings must be continually faced and processed, not just controlled, for us to retain our productivity and pleasure in work. Finally, even the traditional delegation to a spouse (usually a wife) of the management of the emotional side of a physician’s life seems just a quaint, shadowy memory. Now, most of us have to do that job too.

Judging from my experience in private practice and teaching, these complexities of today's medical practices exact an enormous toll on physicians. I believe this deserves immediate preventive attention. Most modern doctors do not have the luxury of adequate time to carry them over any emotional competence deficiencies they may have. Clinicians have to manage brief, quick snippets of patient contact in large daily numbers. These are the same patients who are frequently blocked from contacting their doctors outside of appointment times. They have to persist through endless telephone trees and voice mails to even reach a staff person, who recognizes neither their voice nor name and who treats this unwelcoming situation as routine. These obstacles invest the actual face to face time between doctors and patients with ambivalence, frustration and enormous expectations, both appropriate and unrealistic. Then add the patients' anxiety about their medical conditions. All these feelings have to be managed in those same few minutes that are available to tell and hear history, make and hear diagnoses, then plan, order and negotiate treatment while keeping a real emotional connection with your patients. Given this complexity, it is obvious why formal integrated teaching of the fundamentals of emotional competence could be helpful.

Incorporating this "missing curriculum"⁴ into premedical and medical training has been reported to mitigate a number of internal emotional problems as well as resolve some interpersonal issues. Students of mine, who have learned about emotional competence early in their premedical or medical education, have the opportunity to establish good emotional habits and both reinforce and develop their skills during their training. I recommend that as a profession, we further develop our self-responsibility skills and give all future physicians this opportunity of mastering emotional competence.

LKF is a clinical professor of psychiatry at UCSF where she mentors and supervises residents in psychotherapy and teaches dream interpretation and emotional competence skills. As a personal and professional development consultant, she lectures and leads workshops internationally. She is a past president of the Northern California Psychiatric Society and recently founded Equilibrium Dynamics, a non profit corporation for emotional competence education and training for youth, particularly those underrepresented in higher education. She can be reached at Loma.Flowers@ucsf.edu

¹ Gardner H. Intelligence Reframed. New York: Basic Books; 1999.

² Brown Flowers LK. Psychotherapy: black and white. J. Nat Med Assoc. 1972;64:19-22.

³ Jerome SB. Resident Support Groups Help Create Balanced Physicians. San Francisco Medicine: J of SF Med Soc. 2005;78:24-25.

⁴ Flowers L. K., "The Missing Curriculum: Experience with Emotional Competence Education and Training for Premedical and Medical Students." Journal of the National Medical Association, 2005; 97: 1280-1287.