A Sentimental Patient

JOHN PORTMANN

Today's *Zeitgeist* dictates that physicians not only care for their patients, but also care deeply about them. According to a recent article in a prominent journal, "patients who are given good medical treatment are often upset or angry when they feel that their doctors do not care about them personally."[1] It may well be that the *Zeitgeist* says more about how we feel as potential patients than what we actually expect of physicians. Nonetheless, this *Zeitgeist* poses an important problem for the physician who cares for a sentimental patient. "Sentimental" here describes a contrived exaggeration of the emotional availability of physicians. Despite the impossibility of articulating precisely how much emotional engagement clinical encounters demand, sentimental patients expect too much of their caregivers.

Sentimental patients are not hateful, although they present the same underlying difficulties James Groves described in "Taking Care of the Hateful Patient." Groves's insightful essay in the *New England Journal of Medicine* focused on a collision of "the ideal of the perfect physician" with "the quotidian realities of caring for sick and troubled patients." Groves argued that a physician's negative reactions to his patient constitute "important clinical data that should facilitate better understanding and more appropriate psychological management for each."[2]

Groves's remarks are as timely today as they were in 1978. In the two decades since the essay appeared, the "ethic of care" has transformed clinical ethics, at least in the United States. My enthusiasm for the ethic of care prompts my concern about abuses of it, specifically, that enthusiasm for caring physicians may incline us to choose and evaluate physicians on the basis of their apparent emotional availability. We should beware of pushing physicians into starring roles in our minds.

Sentimentality

Emotional needs, especially if unchecked, can arouse self-deception. Various philosophers have pondered the question of how self-deception is possible. This is not the place to rehearse the logic of their explanations. Suffice it to say that philosophers and nonphilosophers alike concur that we can and do deceive ourselves regularly (about, for example, our beauty, intelligence, integrity, or what we are due from others). Sentimentality qualifies as a type of self-deception. Philosophical disapproval of sentimentality in this century follows centuries of popular approval. French, German, and English novels of the

Virginia Germino offered generous suggestions for improving this paper.

Cambridge Quarterly of Healthcare Ethics (2000), **9**, 17–22. Printed in the USA.
Copyright © 2000 Cambridge University Press 0963-1801/00 $12.50

https://doi.org/10.1017/S0963180100901038 Published online by Cambridge University Press

eighteenth and nineteenth centuries offer approving examples of lofty emotional expectations and lavish appeals to the heart.

Why the modern disapproval of sentimentality? We no longer think of sentimentality in terms of a robust capacity to feel; we tend to think of it in terms of emotional falseness. In the last few decades philosophers have also come to focus on the rationality of emotions, and this focus has not helped sentimentality's reputation, for sentimentality thwarts rationality. Mary Midgely has argued that sentimentality involves "misrepresenting the world in order to indulge our feelings."[3] For Midgely sentimentality amounts to an emotional indulgence that depends on a distortion of the way things are. The moral objection peculiar to sentimentality arises from the special character of the fiction that sentimentality employs, in this case a fiction of caring. To maintain the fiction one has fabricated about a favored person, it is often necessary to construct other, dangerous fictions about the world that person interacts with. The corresponding, dangerous fiction in this case happens to be the imputed callousness of other physicians who do not or cannot care enough for a patient.

In daydreams and fantasies we seek comfort inside our own minds; in sentimentality, however, we seek it in the real world. We achieve this consolation through misrepresentation. Insofar as this misrepresentation stems from a conscious decision, the sentimental emotion results from choice. Sentimentality involves attachment to a distorted series of beliefs; this attachment is not something that simply happens. Emotional responses to the world are determined by how we see the world. The world does not impose views on us; we do that to the world. To the extent that emotion is a product of belief, we are responsible for our sentimentality. The choice we can exercise over our beliefs and emotions should employ truth-orienting reflection; sentimentality eschews them.

A sentimental patient dislikes some important feature of his healthcare. A sentimental patient seeks to satisfy some desire that would otherwise probably remain frustrated. The object of this desire may be either to feel better about himself or to feel better about the world. And the desire to feel better about the one or the other is likely to be felt, or felt especially strongly, if the patient lacks the ground for satisfying it. Thus a sentimental patient confronted with the prospect of pain, illness, or death may choose to view his relationship with a physician in a way that allows him to feel better about his plight.

The falsification at the heart of sentimental beliefs eliminates unpleasantness. The sentimental patient idealizes his physician in order to accommodate his own feelings, instead of adjusting his feelings to the demands of the healthcare setting. The sentimental patient resists thinking that investing emotionally in each of her patients might exhaust the physician and raise far-reaching questions about her sincerity. The sentimental patient may try to ignore the fact that he pays for the services of his physician (insurance coverage from an employer may facilitate this ignoring). A sentimental patient will assert that most physicians choose their profession because of a need to care for others, and not for the considerable financial compensation involved. Sentimental patients choose not to focus on the fact that they pay for any expressions of sympathy they might receive from physicians. Of course, the physician's concern may be heartfelt, but the economic context of the physician–patient relationship draws into question the motivational purity of sympathy in the clinical setting.

Sentimental patients may exacerbate the vulnerability of physicians who are expected to care in many different directions. As an example of sentimentality

https://doi.org/10.1017/S0963180100901038 Published online by Cambridge University Press

distorting reasonable expectations, Midgely takes up one of Dickens's syrupy creations, Little Nell of *The Old Curiosity Shop*. To be overly moved by Little Nell, Midgely says, is to risk inability to deal "with the real world, and particularly with real girls." If we do allow ourselves to wallow in our sympathies for Little Nell, we may cease to be alive to the genuinely pitiable. If this occurs, then most probably it happens in virtue of there being what Mark Jefferson has aptly referred to as an "emotional economy."[4] Jefferson suspects that most of us recognize limits to our emotional expenditure. We cannot afford to be emotionally spendthrift—to squander too much energy on the likes of Little Nell. Jefferson may be correct that there is barely enough of the sympathetic in us to allow for such wastage. Some physicians may well be equipped to enjoy countless caring partnerships without deadening themselves to other patients who happen to be worse off medically, but such physicians must surely be rare creatures. Most physicians always have to worry about overdrawing their emotional reserves.

This, then, describes briefly a sentimental patient. No doubt it may seem heartless to caution physicians about the emotional needs of any patient. Taking issue with a well-founded commitment to caring can be a very tricky matter. John Kekes, from whom I borrow substantially here, points out that what makes this sort of falsification so insidious and recalcitrant to criticism is that it always contains an element of truth, for the feature of the situation it concentrates on is indeed there.[5] Sentimental patients genuinely need medical attention (unlike hypochondriacs). It is just that their emotional expectations make it difficult to deliver excellent healthcare. It is indeed of great importance that a physician treat a patient sympathetically, as the professional integrity of the physician dictates. At the same time, a patient may ask too much of his physician.

The imbalance between expectations and the constraints of the workaday world, as well as commitments to sincerity and authenticity, are bound to place limits on the caring capacities of physicians. Given that patients in some important sense employ their physicians, it is important to ensure that patients respect their physicians, who are in the reigning *Zeitgeist* particularly vulnerable to accusations of callousness. It may not be enough for physicians to treat patients with the warmth and courtesy that professional integrity demands. Physicians may be expected to care in a way that strikes them as excessive. A sentimental patient may not accept anything less than what he deems an adequate level of emotional commitment. The reason a sentimental patient may be unwilling to correct a falsification is that he would be brought back to the frustration he was trying to avoid through the falsification. He does not want to feel bad about himself or about the world, so he is strongly motivated not to see that his beliefs are false.

Belief in the caring generosity of physicians falsifies what we know about them by emphasizing their virtues and underplaying their other commitments and motivations. This falsification fuels false hope. False hope is not merely a harmless solace that people in difficult circumstances may cultivate and enjoy. False hope is harmful because it jeopardizes physicians. It deceives us into believing that time is not so formidable an obstacle to an exemplary physician–patient relationship as it actually is. And the harm that comes from that belief is that it instills guilt in physicians, who are led to feel inadequate and unresponsive. Sentimentality about physicians could conceivably affect the volume of a

https://doi.org/10.1017/S0963180100901038 Published online by Cambridge University Press

physician's practice and even the chances that a good-hearted but ostensibly stolid candidate would not be admitted to medical school at all.

A Clinical Problem: Emotional Detachment

Two decades ago Marcus Welby endeared himself to television viewers who liked the idea of emotional engagement in the clinical setting. Marcus Welby, a fictional physician, really cared about his patients. That patients seem not to be getting what they want from physicians in the real world today is reflected in the popularity of "alternative" treatments. More and more Americans make use of "unconventional practitioners" such as acupuncturists, herbalists, and chiropractors. Numerous studies estimate that in recent years Americans have spent on unconventional healers nearly as much as they pay in out-of-pocket hospital bills (over $11 billion in 1997). The two top ailments for which alternative help is sought are anxiety and depression, with back pain a very close third. Many of us bring emotional expectations into the doctor's office, however, not just those who suffer from depression or anxiety disorders.

His fictional patients never thought about replacing Marcus Welby in the television series. Viewers learned what the characters on the show already knew: you just couldn't do better than Dr. Welby. Today, however, people change doctors all the time, and they look for alternatives to traditional physicians. It is unlikely that physicians could solve this problem just by becoming more emotionally involved with their patients. Nonetheless, an attitude resembling emotional detachment can throw into question a physician's competence.

A Clinical Problem: Emotional Attachment

Groves's objections to the "hateful" patient pertain centrally to the problem I identify with sentimentality. Groves wrote that, "When the patient creates in the doctor feelings that are disowned or denied, errors in diagnosis and treatment are more likely to occur."[6] Inflated emotional expectations from a sentimental patient may contribute to these errors. The sentimental patient is not a hypochondriac, but this condition may provoke the same reaction in a physician. Harvard psychiatrist George Vaillant has written, "The kindest physician learns to hate the hypochondriac. The hypochondriac never understands why. The invisible answer is that the unacceptable subterranean rage of the hypochondriac now becomes the conscious burden of the caregiver."[7] Groves and Vaillant share the concern for physicians' psychic welfare that I have.

Instead of teasing out conclusions and generalizations from cases here, I want to focus on a recent article in order to ask whether the literature of medicine might itself encourage patients to expect too much of the clinical encounter. In "Nonabandonment: A Central Obligation for Physicians," Drs. Timothy Quill and Christine Cassel take issue with several prominent biomedical ethicists for having generally neglected the issue of "nonabandonment." What they call "nonabandonment" amounts to another way of discussing the principle of beneficence.[8] Quill and Cassel seek to root "the physician's open-ended, long-term, caring commitment to joint problem solving at the core of medical ethics and clinical medicine."[9] Consequently, theirs is not a modest task: they aim to reorient the very way we look at relationships between patients and physicians and to illuminate both "the underlying essence of

https://doi.org/10.1017/S0963180100901038 Published online by Cambridge University Press

being a physician" and "core physician obligations." In the course of outlining this reorientation, Drs. Quill and Cassel suggest themselves as sentimental patients.

"Nonabandonment reflects a continuous caring partnership between physician and patient," Drs. Quill and Cassel tell us.[10] Their idea of nonabandonment appears to be fairly straightforward: physicians should not desert the patients who rely upon them. Although other scholars have used the word "abandon" in the context of physician–patient relationships, Drs. Quill and Cassel have chosen to speak of "nonabandonment" instead of, say, a failure of beneficence, and have elevated the concept to the status of a "central obligation."

Quill and Cassel's choice of words both reflects and determines attitudes and expectations about medical care. Their description of the ideal physician–patient relationship encourages readers to expect a great deal of emotional attention from physicians. Especially in this age of heterosexual and homosexual cohabitation, their frequently used term "caring partnership" bespeaks affective ties. (Numerous other writers in the field have referred to this relationship simply as a "partnership.") Furthermore, the pivotal sentence, "The relationship may begin in health or in sickness, last through potential recovery or adjustment to chronic illness, and often continue to the patient's death,"[11] evokes the conclusion of many a Hollywood wedding script: "in sickness and in health, until death do us part."

Quill and Cassel depict the physician–patient relationship as "a covenantal relationship grounded in mutual respect and caring." Although Drs. Quill and Cassel are not the first to describe the physician–patient relationship in terms of a covenant, they raise the stakes by invoking "caring, fidelity, altruism, and devotion," and endorsing "the particular importance of long-term, engaged presence" and "the promise to face the future together," all of which may reasonably encourage patients and potential patients to expect a great deal of the emotional resources of physicians. Not surprisingly, Drs. Quill and Cassel assert that most physicians choose their profession because of a need to care for others, and not for the considerable financial compensation involved. Yet it is entirely conceivable that a caring person might choose to become a physician in part because of the financial rewards involved in the profession.

The Quill and Cassel piece can be taken as an overly zealous response to a trend Drs. Ezekiel and Linda Emanuel had observed two years earlier, "Patients seem to expect their physician to have a caring approach; they deem a technically proficient but detached physician as deficient, and properly condemned."[12] Patients can condemn their physicians in an economic sense not only by choosing another physician but also by complaining to hospital administrators about their original physician's character. Drs. Quill and Cassel reinforce emotional expectations that may be unrealistic and perhaps even dangerous. They encourage sentimentality in the healthcare setting.

Conclusion

Ultimately, nothing can permanently secure us against sentimentality. We are all apt to feel sentimental sometimes. Be that as it may, we should be all the more sensitive to emotional appropriateness in the clinical setting. We should think carefully about what we can reasonably expect from medical care.

https://doi.org/10.1017/S0963180100901038 Published online by Cambridge University Press

We like to think of ourselves as now living in a time of enlightened enthusiasm for caring. Caring for and about others presents certain timeless problems. Shakespeare's Cordelia asks us to question her frank avowal of the limits of her capacity to care. Why couldn't she simply tell Lear what he wanted to hear? Her sentimental father disinherited and banished her, only later to learn the extraordinary value of his daughter's sincerity and emotional economy. Lear's other two daughters should trouble us with the emptiness of their respective, gushing professions of emotional involvement. This is not to characterize recent writing about physician–patient relationships as empty, only misleading. Seemingly cold at the outset, Cordelia teaches her father the complexity of caring.

In the current *Zeitgeist* Cordelia would likely fail as a physician. The sentimental patient would reject Cordelia, who took the idea of a "caring partnership" very seriously indeed. The sentimental patient may be all too ready to impute callousness to his physician. We should not empower the sentimental patient by romanticizing patient–physician relationships. We should not obscure the contractual dimension of even the best physician–patient interactions, nor should we overlook the limitations of human capacities for caring. The sentimental patient needs to learn what Cordelia knew.

Notes

1. Rhodes R. Love thy patient: justice, caring, and the doctor–patient relationship. *Cambridge Quarterly of Healthcare Ethics* 1995;4:434–7, 441.
2. Groves J. Taking care of the hateful patient. *New England Journal of Medicine* 1978;298:883–7.
3. Midgely M. Brutality and sentimentality. *Philosophy* 1979;54:385–9, 385.
4. Jefferson M. What is wrong with sentimentality? *Mind* 1983;92:519–29.
5. Kekes J. *Facing Evil*. Princeton: Princeton University Press, 1990:218–20.
6. See note 2, Groves 1978:887.
7. Vaillant GE. *The Wisdom of the Ego*. Cambridge, Mass.: Harvard University Press, 1993:49.
8. Quill T, Cassel C. Nonabandonment: a central obligation for physicians. *Annals of Internal Medicine* 1995;122:368–74.
9. See note 8, Quill, Cassel 1995.
10. See note 8, Quill, Cassel 1995.
11. See note 8, Quill, Cassel 1995.
12. Emanuel EJ, Emanuel LL. Four models of the physician–patient relationship. *JAMA* 1992;267: 2221–2226.

https://doi.org/10.1017/S0963180100901038 Published online by Cambridge University Press