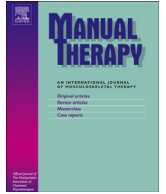




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Professional issue

## The role of clinician emotion in clinical reasoning: Balancing the analytical process

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## ARTICLE INFO

## Article history:

Received 7 July 2014

Received in revised form

26 May 2015

Accepted 12 June 2015

## Keywords:

Memory

Emotion

Physiotherapy

Reasoning

## ABSTRACT

**Introduction:** This review paper identifies and describes the role of clinicians' memory, emotions and physical responses in clinical reasoning processes. Clinical reasoning is complex and multi-factorial and key models of clinical reasoning within musculoskeletal physiotherapy are discussed, highlighting the omission of emotion and subsequent physical responses and how these can impact upon a clinician when making a decision.

**Discussion:** It is proposed that clinicians should consider the emotions associated with decision-making, especially when there is concern surrounding a presentation. Reflecting on practice in the clinical environment and subsequently applying this to a patient presentation should involve some acknowledgement of clinicians' physical responses, emotions and how they may play a part in any decision made. Presenting intuition and gut-feeling as separate reasoning methods and how these processes co-exist with other more accepted reasoning such as hypothetico-deductive is also discussed.

**Conclusion:** Musculoskeletal physiotherapy should consider the elements of feelings, emotions and physical responses when applying reflective practice principles. Furthermore, clinicians dealing with difficult and challenging presentations should look at the emotional as well as the analytical experience when justifying decisions and learning from practice.

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### 1. Introduction

Clinical reasoning is defined in many ways and lacks any single developed framework or model from which musculoskeletal clinicians are able to enhance their practice or use as a reflective tool in their professional development (Case et al., 2000; Edwards et al., 2004). The process of clinical reasoning is multifarious and clinicians of all levels of ability and experience look to develop the cognitive elements of decision-making to enhance practice and improve patient-care (Benner, 1984; Higgs, 1992; Neistadt, 1996). This synthesising process involves considering many facets of patient data, clinician experience, clinician knowledge, and the literature (Higgs and Jones, 2008; Simmons, 2010). This interactive process then further evidences the clinical decision (Orme and Maggs, 1993; Noll et al., 2001; Doody and McAttee, 2002; Childs et al., 2003; Curran et al., 2006). Musculoskeletal physiotherapy research has seen common reference to models such as hypothetico-deductive, pattern-recognition, narrative reasoning

and clinical prediction (Mattingly and Fleming, 1994; Jensen et al., 2000; Childs et al., 2004; Jones et al., 2008). Models such as these and others have described the components of the process of reasoning and explained temporal sequencing, however they take little account of the role of emotion and physical responses that the clinician may experience when reasoning through a patient presentation.

This theoretical paper makes a case for reconsidering the processes involved in reasoning within musculoskeletal physiotherapy which traditionally has employed more analytical models. It is proposed that if musculoskeletal physiotherapists do not consider how their own emotions and subsequent physical responses influence their clinical reasoning and the cognitive system that constructs the diagnosis, then they may be limiting their own reasoning acumen. It is also proposed that these emotions and physical responses that may influence reasoning are an important adjunct to the process of reflective practice.

#### 1.1. Methods of reasoning

Physiotherapy research has conceptualised clinical reasoning in a number of different ways. Evaluative work surrounding expertise

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and novice practice shows similarities between professions, especially in common decision-making skills (Mattingly, 1991; Curran et al., 2006; Hoben et al., 2007). Expert practice in physiotherapy has been proposed to involve a combination of knowledge, clinical reasoning, movement and virtues (Jensen et al., 2000), whilst “master” or expert practice when compared to novice has been shown to be separated by the ability to use time, develop frameworks, communicate, teach, and predict clinical outcomes (Jensen et al., 1992). The musculoskeletal physiotherapy literature surrounding therapists and reasoning suggests that clinicians commonly may generate initial hypotheses and subsequently test them via questioning or physical examination procedures (hypothetico-deductive) in a deductive way from a general presentation resulting to one that is more specific (Jones, 1995, 1997; Loftus and Smith, 2008). They attempt to recognise clinical patterns that have been experienced before (pattern-recognition) (Patel et al., 1997), clinicians may create an understanding of the patient story (narrative reasoning) (Mattingly, 1991; Mattingly and Fleming, 1994) or identify a number of clinical variables that when presented together suggest a treatment plan (clinical prediction) (Childs et al., 2004). In addition to these commonly cited musculoskeletal models there are other less familiar methods of reasoning identified such as ethical and procedural: Ethical reasoning requires the knowledge of ethical principles, codes of conduct and professional standards and applies these when confronted by a clinical dilemma (Barnitt and Partridge, 1997; Edwards and Delany, 2008). Ethical reasoning is also associated with issues such as confidentiality, whistleblowing or clinical decisions surrounding the most appropriate intervention to choose (Clawson, 1994). Procedural reasoning explores how therapists assess the physical performance of patients' (such as climbing stairs) and then subsequently links this to the integration of home adaptation/equipment into the diagnosis and plan (Fleming, 1991). The models above suggest that musculoskeletal physiotherapy reasoning is commonly a rational analytical process with a lack of emphasis on clinician emotion and its possible effects on cognition.

### 1.2. Cognition and emotional markers

It is recognised that the process of decision-making at a cognitive level has been purported to involve stimuli, interpretation, reaction, and evaluation of outcome, whilst acknowledging the role of personal experience (Ullsperger and von Cramon, 2006; Sailer et al., 2007; Croskerry, 2009; Ellamil et al., 2012). Furthermore, this cognitive process is reported to be assisted by emotion-related signals, known as emotional/somatic markers (Velasquez, 1998). Emotional/somatic markers can be described a homeostatic changes that occur in different levels of the brain and body in given situations, and link the body to the emotional response (Dunn et al., 2006). When making decisions an emotional reaction to an option is generated and is suggested to create what is known as an emotional/somatic marker which includes sensations from the viscera, skeletal and smooth muscles. These markers are suggested to serve as an indicator of the value of what is represented, and are linked to the emotional areas of the brain thus creating a marker which has physical and emotional components (Damasio et al., 1996; Bechara and Damasio, 2005).

This process is in contrast to economic theory which suggests decisions are devoid of emotion and are led by a rule-based approach assessed over a period of time (Kim and Lee, 2011). Rule-based decision-making requires conscious weighing of the options available, whilst taking a slower, reasoned approach towards alternatives (Bunge, 2004), whereas the emotional/somatic marker theory suggests emotions can rapidly guide or bias our

decisions and may have a supportive role in faster decision-making (Damasio et al., 1996; Bechara and Damasio, 2005).

Some health-related decisions appear stressful and happen quickly, yet these still require confidence in an outcome, based on the rapid interpretation of the clinical scenario. For example, in an emergency situation, a deliberate rule-based approach may not be appropriate as a quick decision is needed as length of time could have a detrimental effect on outcome, unlike a decision involved in long-term condition management which can be considered over a protracted time period. An example in the musculoskeletal literature of a fast decision system are clinical prediction rules which enable the identification of common variables to support a decision yet this rule-based system fails to acknowledge clinicians beliefs and experiences upon the decision made. Decision-making, whether fast or slow, requires interpretation of the information, and the clinician reaction to the consequence of this decision may be psychological, emotional, physical, or perhaps all (Krawczyk, 2002).

The emotional component that inter-links with the cognitive element of the clinical examination is generated by the clinicians' empathy and the ability to interpret and appreciate the patient experience enhancing the patients' sense of being listened to and understood (Mattingly, 1991; Orme and Maggs, 1993). This clinician and patient relationship has been described as intuitive practice (English, 1993; Smith et al., 2004; Gore and Sadler-Smith, 2011) and is well documented in nursing literature. A qualitative study that explored the opinions and beliefs of nurses' intuition, suggested that it is an interaction of attributes including: expertise; knowledge; personality; and the environment (McCutcheon and Pincombe, 2001).

Within musculoskeletal physiotherapy there is a lack of reference towards the role of intuition and “gut feeling” which have been noted with greater reference in the nursing and medical literature. Intuition has been described as emotional awareness (Strick and Dijksterhuis, 2011), and “intuitive knowing” (Smith et al., 2004), whilst gut-feeling has been highlighted as a mechanism for describing unease, and a signal to be more deliberate in decision-making for assessing patient cases (Woolley and Kostopoulou, 2013). This gap in the literature suggests that the cognition required to make a decision may involve clinicians' emotions and subsequent physical reactions such as a stress response, which has been demonstrated in other forms of decision-making, as yet this is to be acknowledged in musculoskeletal physiotherapy.

Intuitive thought is suggested to be a sub-conscious decision process that is difficult to conceptualise but linked to emotion (Hammond, 1996), whilst remaining largely invisible when attempting to articulate it (Standing, 2008). Strick and Dijksterhuis (2011) suggest that intuition uses senses, feelings and thoughts to provide a depth of understanding that is linked to emotions. A study that explored this further asked 63 participants to analyse information regarding the choice of selecting an apartment under different circumstances. One apartment was “loaded” to be the more attractive option based on its facilities suggesting this would lead to a feeling of that particular apartment being the right choice. The decision accuracy was reported to be 36% in the group with time to make a decision, 47% in the group without time, yet 59% in the group with time and who were also distracted (Dijksterhuis, 2004). This result was explained as stemming from a weighting principle that gives less conscious thought the ability to link the importance of various attributes in a decision and create a sense of confidence that supports a successful outcome.

The use of emotion has classically differentiated analytical and less rational systems of decision-making (Damasio et al., 1996), yet there is evidence that emotion and decision-making are inter-

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