Emotions and Medical Decision-Making

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Abstract
Sociologists have written surprisingly little about the role emotions play in medical decision-making, largely ceding this terrain to psychologists who conceptualize emotional influences on decision-making in primarily cognitive and individualistic terms. In this article, I use ethnographic data gathered from parents and physicians caring for children with life-threatening conditions to illustrate how emotions enter the medical decision-making process in fundamentally interactional ways. Because families and physicians alike often defined emotions as useful information to guide the decision-making process, both parties could leverage them in health care interactions by eliciting or demonstrating emotional investment, strategically deploying emotionally charged symbols, and using emotions as tiebreakers to help themselves and one another make choices in the midst of uncertainty. Constructing emotions as valuable in the decision-making process and effectively marshalling them in these ways offered a number of advantages. It could make decisions easier to arrive at, help people feel more confident in the decisions they made, and reduce interpersonal conflict. By connecting the dynamic role emotions can play in the interactive process through which medical decisions are made to the social advantages they can produce, I point to an underappreciated avenue through which inequalities in health care are perpetuated.

Keywords
doctor-patient interactions, emotions, ethnography, health care inequality, medical decision-making

Of the myriad decisions we make over the course of our lives, medical decisions can carry some of the highest stakes. Major shifts in the organization and culture of health care have led patients and caregivers to play a more agentic and influential role in their medical care than ever before (Boyer and Lutfey 2010), and responsibility for decision-making is increasingly “shared” between patients, families, and health care providers (Charles, Gafni, and Whelan 1997). Yet sociologists who are uniquely positioned to theorize how emotions enter into these decision-making processes in deeply interactional ways—and explicate their social consequences—have left the topic of emotion and decision-making primarily to psychologists (for reviews, see Lerner et al. 2015; Phelps, Lempert, and Sokol-Hessner 2014). These analyses are almost

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exclusively cognitive, physiological, and individualistic in nature. While medical sociologists historically paid substantial attention to emotions in the medical arena writ large (e.g., Fox 1988; Smith and Kleinman 1989), Underman and Hirshfield (2016) found in a recent review that this arena of study has surprisingly languished in recent years.1

At the same time, the medical field itself has increasingly recognized the importance of emotion in medical practice and taken small but deliberate steps toward training and assessing practitioners on this basis. Underman and Hirshfield (2016:99) propose, therefore, that the “time is ripe” for sociologists to renew the study of emotion in medical spaces. Here, I heed this call by showing how emotions can be constructed as valuable information in the decision-making process and are thus strategically employed by patients, caregivers, and physicians in the interactions through which they are made.

Because medicine as a scientific field is often predicated on notions of objectivity and “affective neutrality” (Parsons 1951), emotions being leveraged quite deliberately in the medical decision-making process is striking. The dominant paradigm of evidence-based medicine might, in fact, be expected to push emotions further out of the decision-making process or at the very least render them suspect.2 Yet my data show that emotions are often highly valued and regularly brought in to the health care interactions through which decisions are made. Whether or not these strategies generate medical advantages, they can produce real social benefits. Here then, I advance our understanding of how emotions are mobilized in health care encounters and propose that examining the consequences of these strategies can move us toward a fuller accounting of the social mechanisms through which inequality in health care is reproduced.

BACKGROUND

Emotions loom large in shaping social life, and sociologists have long understood emotions to be shaped by culture, social contexts, and interpersonal interactions (for reviews, see Thoits 1989; Turner and Stets 2006). Hochschild’s (1983) classic work on emotion management and emotional labor has been foundational in driving sociological theorizing about the fundamentally interactional nature of emotional experience and the malleable nature of emotion in response to social conditions. Building on this work, sociologists have shown how emotion work is often quite “functional” (Lively and Weed 2014), as people work to spark emotional responses to accomplish their goals in any number of settings.

People work to activate emotions in others, for example, to encourage them to buy products (Schweingruber and Berns 2005), join social movements (Gould 2009; Schrock, Holden, and Reid 2004), or issue a death penalty verdict (Berns 2009). People also deliberately work to activate their own emotions to sustain difficult endeavors—by, for instance, imagining their future feelings of regret if they fail to persevere (Lois 2013) or focusing themselves on the good feelings and community respect they can derive from engaging in them (Kolb

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1Notable exceptions include Clare Stacey’s (2011) work on the emotional labor of home health aides and Rebecca Olson’s (2016) analysis of the emotion work involved in caring for a partner with cancer. Emotional dynamics are also quite obviously present, if not foregrounded, in prior sociological analyses of medical decision-making between patients/families and practitioners (see e.g., Anspach’s classic 1993 ethnography of a neonatal intensive care unit).

In tight-knit social group settings, collective efforts to elicit particular emotions from one’s peers and perform the emotions expected by them can serve to foster and deepen group solidarity (Schwalbe 1996; Thoits 1996).

More generally, it is through routine interpersonal interactions that emotions of all kinds are amplified or diminished (Hallett 2003). Small inklings of emotions, Hallett illustrates, can rapidly escalate when fueled by responses from interactional partners. Conversely, these same dynamics can allow especially intense, burning emotions to be relatively quickly cooled (Hallett 2003). Even imagined interactions with others can have such effects (e.g., Sharp 2010).

Although little sociological work has examined the role interactively produced emotions play in decision-making, Lauren Rivera’s (2015) analysis of employment decisions is an important and promising exception. Rivera found that job candidates’ abilities to generate feelings of excitement in interviewers gave them a significant leg-up in the hiring process and that interviewers’ emotional responses to candidates could trump other factors in the final employment decision. Rivera acknowledges that emotional dynamics like these do not invalidate other social factors that influence hiring or discredit other models that can help explain employment decisions. But she suggests that to ignore emotions is to miss a major component of the process.

Alison Pugh (2013) has similarly argued on a broader scale that emotions play a largely underestimated role in driving behavior. Pugh engages Vaisey’s (2009) proposal that cultural beliefs may motivate action largely at a “snap judgment” level—using, by way of example, the case of teens who explain their choices around deviant behavior in terms of intuition or just “knowing” what is right or wrong. Pugh suggests that emotions are a “missing vector” in models like these that deserve more nuanced attention by researchers seeking to explain why people do what they do.

My data bolster this proposition. I analyze how families and health care providers make sense of the role emotions can play in the decision-making process and show how these conceptualizations permeate health care interactions and guide medical decisions. My analysis is a fundamentally symbolic interactionist one. As Blumer (1969:2) articulated, this perspective takes care to consider how “human beings act towards things on the basis of the meanings that the things have for them” and that “the meanings of such things derives from, or arises out of social interaction.” If we substitute the word emotions for things here, we find ourselves with an excellent framework for analyzing the social nature of emotional experience.

I do not attempt here to arbitrate between what should or should not “count” as emotion—for instance, whether what one calls a “gut feeling” is an actual emotion or a masked cognitive process rendered as one. In my assessment, terms like gut feeling tended to be invoked when there was reason to be worried or afraid, and I would speculate that what many termed gut feelings was something of a heady brew of anxiety and uncertainty mixed together with hope and the prospect of relief. Whether this judgment is correct in all cases, I ultimately treat as emotion that which was defined, framed, or taken for granted as emotion by those in my study. That the families and physicians I interviewed chose to highlight this component of the decision-making process in their accounting of how they decided or steered others to decide underscores the value emotions were deemed to have in pointing people toward or away from good and bad decisions.
I also do not intend to imply that decisions were made on purely or even primarily emotional grounds. There is no question that cognitive strategies and more “objective” information were often equally or more central to determining which path to follow. The point here is that emotions were deemed important to “listen to,” and thus grounding decision in emotion to some degree helped facilitate the decision-making process.

A huge expanse of sociological research has examined the vast landscape of doctor-patient interactions across multiple social dimensions, including how the conversational structure of these interactions influences care delivery and patient satisfaction (e.g., Heritage and Maynard 2006; Roter and Hall 2006), how consensus around medical decisions is (or is not) achieved (e.g., Spencer 2018), and how social identities across race, class, gender, sexuality, and other differences impact doctor-patient relationships (e.g., Johnson et al. 2004; van Ryn et al. 2011). Scholars have increasingly analyzed the complex role these interactions, as situated within broader contexts of inequality, play in producing health disparities (e.g., Lutfey and Freese 2005; Shim 2010) and highlight the active and agentic efforts among patients to influence care provision. Examples of such patient agency include resisting medication recommendations (Koenig 2011), refusing hospital discharge (Oh 2017), and engaging in regular medical advocacy throughout the treatment process (Gage-Bouchard 2017; Gengler 2014).

How emotions shape the practice of medicine and doctor-patient interactions has also received both scholarly and popular attention (e.g., Halpern 2001; Ofri 2013), albeit largely outside of sociology. One potential indication of a nascent renewal in the sociological analysis of emotions in the medical arena is the work of Wong and colleagues (2018), who found that oncologists often viewed helping their patients manage difficult emotions as an important and rewarding part of their job. Adopting this approach to their work allowed them to enact valued professional identities, but they drew important lines around how far this emotional engagement should be taken, in part to protect themselves. Physicians who are especially empathic with patients and perform more emotional labor can have both higher levels of job satisfaction and higher levels of burnout (Larson and Yao 2005). This research points to important questions about what savvy emotion work can accomplish in health care encounters. While the work of being an emotive and empathetic health care provider extends well beyond the realm of decision-making alone, a clearer understanding of what can be achieved when emotions are strategically engaged in this central component of health care delivery can help us better understand the value and impact of this work.

Previous research has generally found that emotions can present obstacles between those providing and those receiving help in a crisis. The call-takers in Whalen and Zimmerman’s (1998) study of a 9-1-1 emergency call center, for instance, deemed callers “hysterical” when they expressed strong emotions the call-taker feared might interfere with their ability to do their work: namely, to obtain useful information (e.g., an address) and provide instructions for delivering aid until help arrived. Similarly, the wilderness rescuers in Lois’s (2001) study worked hard to keep the emotions of victims and their family members in check so that they could do their search and rescue work most efficiently. As Hochschild (1983:214) pointed out while establishing her own theoretical approach to studying emotion, “we tend to associate the idea of emotion
more with irrational or unwise action than with rational or wise actions’ despite the fact that many rational actions (like expressing affection to one you love) are prompted by emotion. The dominance of evidence-based medicine in recent decades would seem to largely rest on the former assumption, implying that the wisest course of action is best determined by minimizing the influence of emotion on medical decisions. Ironically, Timmermans and Angell (2001) found that the pediatric residents who most embraced evidence-based medicine actually felt much more stressed and uncertain as result of constantly scouring and scrutinizing the findings and methods of countless, potentially conflicting medical studies.

My findings suggest that rather than working to shut down or shut out emotions, patients, families, and physicians may lean on them as a resource in the process through which they make and encourage one another to make health care decisions. Here, I show how emotions can be engaged in this regard and what these emotionally rooted decision-making strategies can accomplish. I argue that it is essential to consider the implications of these dynamics for inequalities in health care delivery. How people think and feel about medical risk and health outcomes is colored by their (unequal) previous life experiences and social contexts. Cottingham and Fisher (2016), for instance, found that among the healthy clinical trial volunteers they studied, whether potential subjects deemed participation in a study to be too fearsome or risky was relative to the alternatives—for example, hyper-policed neighborhoods or economic desperation—and previous hardships they had faced. Such findings point to important links between social inequalities writ large and the emotional landscape of health care. Among those managing serious, chronic, or life-threatening conditions, similar and perhaps even greater emotional divides are likely to exist. To the extent that the strategies I outline in the following can have positive outcomes—whether minor or significant, medical or primarily social—suggests that those best positioned to utilize them may be at an advantage over those less well positioned or less inclined to do so.

**DATA AND METHODS**

Data for this article are drawn from a larger study examining the paths families of critically ill children followed through the health care system (Gengler 2020). I began conducting fieldwork at the Ronald McDonald House (RMH) associated with Kelly-Reed University Hospital (a pseudonym, as are all names used throughout) in late 2011. The RMH provides housing to families of seriously ill children under the age of 21 who travel to receive care at Kelly-Reed, a top-ranked university research hospital. As a guest services volunteer, I generally worked once or twice per week for three- to six-hour shifts. Fieldwork at the RMH allowed me to immerse myself in the social worlds of families of critically ill children, refine my research interests, and recruit families to the study.

Case-study families were recruited using a strategic case selection strategy. In this approach (Small 2009), the researcher deliberately selects cases that offer the greatest analytic leverage on their research questions and help them to deepen their analyses through the

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3This Ronald McDonald House was one of many operating under the Ronald McDonald House Charities umbrella—a multinational non-profit organization that relies on donations to provide services. It is separate from the McDonald’s Corporation, although they are its largest corporate donor. Families who stay there are not required to pay but can make a suggested donation on a voluntary basis.
inclusion of negative cases (Becker 1998) that seem contrary to or shed further light on initial findings. Because my aim was to uncover broadly generic processes in managing serious childhood illness that are not particular to a specific type of disease, regional culture, or social position, I selected cases that reflected a variety of serious childhood illnesses and treatments and recruited families from across geographic, educational, racial, and socioeconomic backgrounds. During a year and a half of fieldwork at the RMH, 18 case-study families were recruited to the study.

Of these families, seven were white, six were black, two were biracial, two were Latinx, and one was South Asian. Three traveled to Kelly-Reed from outside the continental United States (Canada, Puerto Rico, and Argentina). Eleven of the parents were married or partnered with their child’s other parent. In two additional families, parents were divorced but continued to co-parent. Three parents were single mothers, and two were custodial grandmothers (one single, one married). Eight families came to Kelly-Reed so that their children (N = 9) could undergo bone marrow, peripheral blood, or umbilical cord blood derived stem cell transplantation. These children generally spent months being cared for on what families and physicians colloquially referred to as “Unit 27” at the hospital. Four children received different novel medical technologies, including enzyme replacement therapies, a unique organ-tissue transplant (at the time, available nowhere else in the world for children with a particular rare chromosomal deletion syndrome), or cancer vaccine immunotherapy trials. Six children underwent surgery to correct congenital defects, had standard organ transplants or cancer treatments, or received primarily life-sustaining intensive care. Nine families had at least one parent with a college degree and at least one parent in a professional or managerial job. Nine remaining families held hourly wage working-class jobs, had quit working-class jobs to care for ill children, were retired from working-class jobs, or were already unemployed or receiving SSI before the child’s illness.

Initial interviews averaged two hours but ranged in length from 90 minutes to over three hours. If one parent or guardian were present at Kelly-Reed with their child, initial interviews included only the available parent. If both parents were present, parents were interviewed together—allowing them to add details to one another’s responses and share similar and differing perspectives on the experience. Often, I was able to conduct a second interview with a nonpresent parent at a later date or informally during future observations. All interviews were recorded and transcribed verbatim.

After initial interviews, I asked to accompany families on hospital visits or medical appointments so that I could observe their interactions with their child’s health care providers. Observations included attending follow-up clinic visits (at which children were usually seen by a nurse, nurse practitioner, and one or more doctors); occupational, physical, and speech therapy sessions; patient-education sessions prior to clinical trial entry; stem cell transplantation; MRIs; lumbar punctures; and observing life-supporting care in the pediatric intensive care unit. I was able to conduct medical observations with all except five families, who were observed only at the RMH because their treatment was nearing completion when I began formal interviewing. Many families were observed more than once across different clinical settings. During these observations, I was able to gather direct empirical data on families’ interactions with health care providers and observe how parents and
physicians negotiated medical decisions in the moment. Observations also facilitated opportunities for informal follow-up interviews, and ongoing fieldwork at the RMH similarly gave me the chance to check in with families whose treatments were sustained over a lengthy period of time. Getting to know families and spending time with many of them in a variety of medical and nonmedical contexts allowed me to develop some degree of intimacy and deepen trust with the families I studied, increasing the validity of my data.

Following a grounded theory approach (Glaser and Strauss 1967), interview transcripts and field notes were coded for emerging themes early in the process so that developing analyses could inform follow-up interview questions, case selection, and observations. Coding continued throughout the project and was followed by early and regular memo writing (Emerson, Fretz, and Shaw 1995) on emerging themes in the data. Approximately one year after I completed the family case-study portion of this project, I returned to the field to interview six physicians who worked closely with many of the families in the study. Five of these physicians oversaw the care of the children undergoing stem cell transplantation on Unit 27 at Kelly Reed, and the sixth physician cared for children receiving the breakthrough life-saving treatment she had developed for children with a rare chromosomal deletion syndrome (received by one of the case-study children and several others I met at the RMH during my fieldwork). Interviews with physicians provided an important window into their perspectives on families’ illness management and decision-making strategies and invaluable insight into their own strategies for steering families through this process.

Here, I zero in on the process through which families and physicians made difficult medical decisions during the course of caring for or treating critically ill children. Early in the project, I noticed that emotions were referenced as useful in resolving indecision and that this was often described as a collaborative endeavor. As the project progressed, these dynamics also surfaced in my observations. In the following, I illustrate how medical decisions—both large and small—could turn on the ways those involved marshalled emotions in the making of them. I begin by establishing how emotions were conceptualized as valuable in the decision-making process.

### ELEVATING EMOTION IN MEDICAL DECISION-MAKING

The families in my study paid close attention to how emotions bubbled up as they navigated the fraught waters of caring for a critically ill child and interpreted these emotions as important clues, or signs, that guided them toward or away from a particular path forward. By constructing their feelings as a form of wisdom, they could more comfortably and confidently make medical decisions. Jeanetta Moore, a black, working-class mother of three in her forties, was able to arrive at a final decision about whether to proceed with a high-risk treatment for her infant daughter’s rare, fatal chromosomal deletion syndrome (received by one of the case-study children and several others I met at the RMH during my fieldwork). Interviews with physicians provided an important window into their perspectives on families’ illness management and decision-making.

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4“Thick” descriptions of these interactions were recorded in detailed field notes as soon as possible following each observation (Emerson, Fretz, and Shaw 1995).
depressed and morbid” while trying to decide whether to pursue this treatment but had an unambiguous change of heart after nearly hitting a mother bear and her two cubs while driving down a rural road. She viewed this event and the feelings it sparked as a “sign” to proceed with the treatment. She explained:

I stopped, and I said “Look at that!” The momma [bear] was taking care of her children. I was thinking to myself, “You know what? You gonna be alright Kaelyn. You gonna be alright.” And I just got real emotional at that time. I said, “You gonna be fine. You gonna make it girl.”

For Jeanetta, this sign—which she believed may have come from God—shifted her perspective on Kaelyn’s chances for survival and helped tip the emotional scales clearly toward pursuing treatment.

Because parents often granted strong emotional reactions like these significant weight in making medical decisions, what some referred to as gut reactions could encourage them to refuse physician recommendations as well. Simone Brady-Fischer, a white, middle-class, 40-year-old, Canadian mother of five, told me that she and her husband had balked when a physician suggested prescribing synthetic marijuana to her 10-year-old son, Max. Max was born with a congenital malformation that caused severe headaches and seizures and interfered with the flow of cerebral spinal fluid around his spine. Although Max took many other psychotropic medications, the Brady-Fischers found the proposition that their child take this particular medication to be inappropriate and dismissed it out of hand based on their feelings about the meanings attached to such a medication (see Conrad 1985). Simone expressed significant confidence in relying on gut feelings like these when she made medical decisions for her son: “When I have a gut feeling about my kids I’m almost always right. . . . So I think I go a lot with my gut, like the whole ‘put your kid on pot’ [thing]. Like, that’s just common sense to me. Why would you do that? It’s stupid.”

Simone did extensive research on her son’s condition, the medications and treatments that might help them more effectively manage it, and experts and treatment options outside of their home province in Canada that might provide more help. Yet she ultimately explained her decision to travel to the United States to obtain care from the particular physician at Kelly-Reed who was able to more effectively treat her son as one guided as much by emotion as by research. She explained that she had listened to:

Hours and hours of doctoral lectures, like from specialists [in this rare condition] online, and then after I listened to [Dr. J’s] lecture, I knew he was the right doctor, ’cause Max’s symptoms all fit what he specialized in, so I knew he was just the right one—so [it was a] mama-gut-feeling.

Describing decisions rooted in significant research and evidence as fundamentally driven by embodied feelings as opposed to the substantial information-gathering efforts many parents undertook elevated the place of emotion in medical decision-making and presented emotion itself as an authoritative form of wisdom to be followed. Framing her decision as an emotional one underlined Simone’s confidence in it.

Deirdre Klein, a white, middle-class mother of five in her late forties, similarly imbued strong gut feelings with significant import, granting them a lofty place in her decision-making. Deirdre’s 10-year-old son, Jackson, underwent bone marrow transplantation at Kelly Reed
for a recurrence of leukemia. Because Jackson was immune-compromised, she routinely had to decide what level of germ-exposure risk she was willing to take while also trying to allow him to maintain some degree of a normal childhood—for instance, playing with friends or going to movies. Deirdre viewed her gut reactions to potentially risky situations as critical signposts in making these determinations:

I think there are times it just, it does hit you in the gut. “No way, I’m just not comfortable with that.” And if I’m not comfortable with it, I personally feel—because I am a very religious person—that God’s saying, that’s God sort of using my intuition, motherly or womanly intuition, to keep us from a situation.

For Deirdre, gut-level feelings about which everyday risks were acceptable and which were a bridge too far were divinely inspired. By closely examining her feelings and assigning them a (literal) higher power, Deirdre was able to feel confident in her decision to let Jackson play outside with a neighborhood friend but chose not to let him attend a movie at a public theatre.

In the absence of other more clear-cut grounds for decision-making, assigning emotions real value in the decision-making process could help families more swiftly and confidently move toward a course of action rather than remain stuck in uncertainty. As a result, both families and physicians at times deliberately mobilized their own or others’ emotions during health care interactions to facilitate the decision-making process.

**LEVERAGING EMOTION IN DECISION-MAKING INTERACTIONS**

Because emotions could be so esteemed in the decision-making process, they were regularly marshalled in the social interactions through which these decisions are often made. In this section, I show how families and physicians did so by (1) working to elicit and exhibit emotional investment to facilitate “better,” more confident, and perhaps swifter decisions; (2) deploying and managing emotionally resonant symbols with the same ends in mind; and (3) using emotions as tie-breakers between physicians and parents or between two parents or multiple physicians to reduce conflict and protect interpersonal relationships when uncertainty ran particularly high. Whether the decisions these strategies resulted in actually are better is of course largely unknowable and potentially subjective. Believing that a decision is the best one possible, however, might be construed as beneficial in its own right. Either way, each strategy offered social advantages apart from any potential medical advantage (or disadvantage) the decision itself may have produced. After outlining these dynamics in the following, I will more fully consider the implications of this active role emotions can play in the medical decision-making process.

“What Would You Do If It Was Your Kid?”: Eliciting and Exhibiting Emotional Investment

Parents caring for critically ill children wanted to encourage physicians to make the best possible medical decisions for their child, and physicians wanted to encourage parents to do the same. One way each party attempted to accomplish this goal was to deliberately extract emotional responses from the other. Parents encouraged physicians to imagine their child as the physician’s own to elicit greater emotional investment in their child. Physicians worked to demonstrate emotional investment to create trust and gain compliance from parents while
facilitating smoother interactions and decision-making processes for all involved.

Todd and Savannah Marin, white middle-class parents in their early thirties whose infant son, Jacob, was diagnosed with Tay-Sachs—a fatal genetic degenerative neurological condition—were especially involved in decision-making about almost every aspect of their son’s care. These efforts were instrumental from the very beginning of their son’s illness, when they sought out an experimental stem cell transplant rather than accepting the palliative hospice care originally offered to them. At one point during the months-long hospitalization that follows transplantation, Jacob declined dramatically and was transferred to the pediatric intensive care unit (PICU). At this grave juncture, Todd and Savannah had to decide whether to allow Jacob to be intubated and placed on mechanical ventilation, a form of life support. They were hesitant to do so, they told me, because they understood that children who went “on the vent” rarely “got off of it”—prolonging the dying phase for children who did not recover. The Marins also worried that Jacob had “a particularly delicate airway,” making intubation even harder on him. In their struggle to decide whether to consent to intubation, they intentionally worked to extract an emotionally informed response from those whose advice they sought. Savannah explained that instead of asking doctors what they should do in Jacob’s situation, they specifically asked: “Well, what would you do? What would you do if this was your kid? You know? Because those are two different answers.” Parenthood is a deeply salient identity, one described by Ara Francis (2012) as a “social psychological lynchpin.” By asking physicians to stand in their parental shoes—and thus to take on an emotional investment in their child akin to the investment physicians would have in their own child—parents believed they could obtain more thorough and thoughtful advice that would help them make the right call at a critical juncture. Savannah’s assertion that asking the question “What would you do if this was your kid?” would garner a different response than the one initially offered implies that a physician’s first recommendation may be limited (perhaps by hospital policy, liability concerns, availability of local resources, or the routinization of crisis in the health care arena), but pushing physicians to think outside these bounds might expand the advice they provided. If physicians assured her that their initial recommendation was precisely the choice they would make for their own child in the same situation, this could allow Savannah to feel a greater sense of comfort and confidence moving forward.

Other parents also reported that a question like “What would you do if this was your kid?” was a valuable tool to get deeper insight from physicians when making a difficult decision. During my interviews with physicians, I asked how they responded to this strategy. All of the physicians I interviewed reported that they received this question regularly and found it to be equally useful in their own efforts to shape parental decisions. Dr. Coleman, a white man in his fifties, stated plainly:

I welcome that question. I welcome that question. And a lot of times I’ve drawn it out of parents. Because I felt that if they heard that, if they asked me that question and I could respond, you know, I’d be able to help them with the struggle that they were facing.

Dr. Coleman found this especially important when helping parents make exceptionally difficult decisions in the context
of great ambiguity, as when deciding whether to proceed with a second transplant after an initial transplantation attempt failed (a second transplant carries an even lower likelihood of success) or to stop treatment.

I often will say [when they ask what I would do if it was my child], “depends which child.” You know? I have one daughter who had problems with strabismus, crossed eyes. Had four surgeries before she was 12, on her eyes, and you know, medical stuff doesn’t freak her out. If she relapsed after a transplant, yeah I’d put her through a second transplant because she’d want to go down with her guns blazing. . . . The other two? They hate doctors, they hate the hospital. So no, I’d probably just take them home. I wouldn’t go through a second transplant with them. So I don’t usually answer the family’s question, but I will try to get across to them: you have to put it in the context of your family, of your child.

Here, Dr. Coleman proposes that when he has the opportunity to stand in the role of “parent” when guiding his patients’ parents through difficult medical decisions, he can more effectively help them consider more factors that might help them arrive at the best one for their child—here, shifting their focus to the child’s perspective and desires. More generally, by deploying their own emotionally symbolic identities as parents, physicians could foster solidarity with fearful families, soothe parents’ anxieties, and nudge them toward a decision.

I observed this dynamic directly during an outpatient surgical procedure I attended with Simone Brady-Fischer and her son, Max. Simone had arrived at the hospital with the impression that Max would receive general anesthesia (full sedation) prior to his lumbar puncture, or LP—a procedure that involved the insertion of a needle directly into his spine to remove a sample of his cerebrospinal fluid and measure his intracranial pressure. After we arrived, however, a nurse explained that Max was scheduled only for “moderate sedation.” Simone was very concerned about proceeding without full sedation, fearing that the medications would not be strong enough to keep Max from experiencing the pain of the LP or moving during the procedure. The attending physician who came to speak with us offered Simone the option of rescheduling but reassured her that LPs can be safely performed even on “uncooperative” patients. He gently offered detailed descriptions of each of the medications they would administer along with their benefits and potential side effects. As he did so, he outlined the side effects of the intravenous drug ketamine, including the potential for the patient to stop breathing:

I’ve given tons and tons of kids ketamine, and I’ve never seen it, but it has been reported, so I always mention it. And I will say that when my own son had to get stitches next to his eye, they gave him ketamine, so it’s something I’m comfortable giving my own son.

By deliberately stepping into the emotional position of parent, this physician effectively and efficiently underscored his comfort with this medication to put Simone at ease, preempt resistance, and encourage her to consent to proceed with the planned procedure without further negotiation.

Dr. Oliver, a white woman in her early sixties who had developed an innovative treatment for infants with a rare and otherwise fatal chromosomal deletion disorder, told me it was vital to demonstrate emotional investment in the children in her care to pave the way for whatever
lay ahead. Dr. Oliver explained that she worked to demonstrably express heartfelt commitment to her patients and their families from the day she met them.

It starts with the very first meeting of the baby. What have you done to make the parents feel you love that baby? . . . A quarter of my patients are going to die. I do not want the parents to think that I'm just trying to free up a bed with what I'm doing. I want the parents to feel that I love that baby. And for me, it's easy, because I do.

Dr. Oliver explained that she took care to consciously perform (Goffman 1959) this love for parents. "You can do certain things that make the parents feel you love their baby," she told me, describing how she “fussed” over babies by gushing over how beautiful they were and remarking enthusiastically on small developmental advancements, like the ability to lift their head. She explained that this laid important groundwork for future decision-making interactions because: “The family watches me with their baby and they know I really care about their baby. And so whatever I'm doing, they feel it's with the baby’s best interest at heart.” By demonstrating an emotional investment in their patients, whether through actions designed to communicate devotion or symbolically invoking their own identities as parents and the choices they would make for those in whom they are most deeply emotionally invested, physicians could more effectively and efficiently influence parents’ decision-making processes and encourage them to trust their recommendations.

“Just Don’t Go to Taco Bell:” Deploying Emotionally Charged Symbols

Because physicians recognized that emotions could powerfully influence parents’ decisions regarding their children’s health and well-being, they sometimes capitalized on this dynamic by deploying emotionally charged symbols to push parents toward (or away) from the kinds of decisions they viewed as most reasonable. For immune-compromised children, for instance, exposure to common germs, viruses, and bacteria can lead to life-threatening complications. For children undergoing transplantation on Unit 27, these risks were minimized with positive-pressure HEPA filtration and other precautionary measures. Children were not discharged until they were believed to have stronger immune systems (a determination based on both time and laboratory findings), but were told to wear paper nose and mouth masks in public spaces (including on hospital clinic visits), and generally instructed not to return to school or other high-traffic spaces (grocery stores or shopping malls) for a longer period of time. The physicians I interviewed told me that some parents did not take these risks seriously enough, while others became so fearful that they were hesitant to let anyone visit or allow their children to participate in what physicians considered reasonably low-risk situations that were important to allow children to continue leading meaningful lives.

For instance, Dr. Newell, a white woman in her late thirties who oversaw the care of children undergoing stem cell transplantation, explained, “We didn’t go through all that [the grueling process of transplantation] and their family didn’t go through all this and the child didn’t go through all this to live in a bubble.” But she also was surprised at times to run into families in places she considered to be high risk (e.g., a large department store) too soon after discharge. To help parents make good decisions, Dr. Newell gave families examples that she hoped would invoke symbolic danger. For instance, she recalled telling an anxious family that “it’s okay
now to go out to a restaurant... just don’t go to Taco Bell.” By raising the specter of a fast-food restaurant that had recently been in the news for questionable food quality standards, Dr. Newell encouraged families to use emotional (and in this case, also class-based) associations about what restaurants “feel” more or less risky to help them balance these choices. Dr. Newell assumed that Taco Bell functioned as an obviously unsettling symbol of the kind of place to avoid while setting what she assumed was a relatively low bar to minimize parents’ reluctance to resume normal life and help them comfortably make what she deemed acceptable choices.

Dr. Coleman also enlisted emotionally resonant symbols in his efforts to guide parents toward decisions. He recounted one instance during which a family was reluctant to remove life support from a child who had lingered on mechanical ventilation for quite some time and whom he viewed as having no chance of recovery. Dr. Coleman encouraged the child's parents to withdraw life-supporting care by suggesting they do so on his upcoming birthday:

I said, you know, “Maybe what’s supposed to happen is that we close the circle on his birthday.” I think, you know, “my recommendation would be to take him off the ventilator on his birthday.” His birthday was on a weekend. I wasn’t on call that weekend. He wasn’t there on Monday. They had listened.

By using the symbolic meanings attached to an emotionally significant date in this family’s lives, Dr. Coleman was able to help them attach comforting feelings and meanings to the extraordinarily painful decision he encouraged them to make.

At other times, physicians worked to circumnavigate symbols that might spark a strong emotional reaction and deter parents from making a decision they deemed appropriate. Lakira Harris, a black single mother in her early thirties, and her eight-year-old son, Jayden Lacoste, had traveled to Kelly Reed for a cord-blood derived stem cell transplant in the hopes of curing Jayden’s sickle cell disease. Jayden was undergoing his pretransplant “work-up”—the process of ensuring that he was in the best possible physical shape to begin transplantation—when a scan revealed an abnormal structure in his sinuses. Because it is critical that patients have no active infections entering into transplant, they were referred to an ENT specialist who was asked to review the scan. I attended this appointment with Lakira and Jayden, observing as the physician walked her through a series of dark shadowy images in which this particular spot did not stand out and was difficult to see. From my field notes:

Dr. Q slowly moved through the images, describing structures (“here’s his nose, his nostrils, his upper jaw, septum, teeth”) to situate this vague “spot,” and explained, “the area that they are noticing is different is this part here, where it’s a little bit of a darker color than this tissue.” As she scrolled through the images, she described the growth as a heman-gioma, or “a ball of blood vessels,” and explained that such structures are almost always benign. She then answered Lakira’s questions about whether this was a clot related to red blood cell sickling. She reassured Lakira again that the transplant team had just wanted to make sure that “nothing else was going on,” but she had double checked with the radiologist and “they’re really comfortable” that’s all it is.

Lakira absorbed this information and the scan images with little reaction,
nodded, and voiced no concerns. The doctor then nonchalantly added, “I'll show you what it looks like on the MRI scan too, because it's a little easier to see.” She clicked up the new image and Lakira immediately exclaimed “Oh!!”—in response to the glaring spot in question. Dr. Q said, “See how that lights up there? It's kind of bright.” Lakira exclaimed, “Now that’s pretty big!” The doctor then mentioned that it was “close to the eye” and Lakira asked if this could be why Jayden had some trouble seeing out of that eye. Dr. Q conceded this was possible, but noted that it was not near the nerve.

In this encounter, the physician buried an emotionally charged symbol (a very clearly identifiable image of the vascular malformation in Jayden’s sinuses) to minimize Lakira’s potential alarm. By first spending a great deal of time showing her opaque images while articulating all the reasons to remain unconcerned and expressing her own confidence that it was fine for Jayden to proceed to transplant, she was able to get ahead of the emotional response generated by the very striking image. Becoming alarmed at the beginning of the discussion might have derailed Lakira’s willingness to proceed to transplant or simply caused more general distress (and thus greater need for reassurance) about the hemangioma itself than the physician deemed necessary. At the end of the appointment, as Jayden got a bit antsy, the doctor summed up by reiterating that they were not worried about this and would do a follow-up scan in six months to ensure there was no change and the structure remained at what she believed was already its “stable size.” Lakira thanked her cheerfully and turned her attention to Jayden.

The previous examples illustrate some of the ways physicians strategically invoked and managed emotionally charged symbols in an effort to gently direct the decision-making process. Doing so could help them steer patients toward or away from making what they considered necessary or unnecessary decisions. In the previous scenarios, uncertainty—at least on the part of the physician—was relatively low. When uncertainty was higher, emotions could play an even more useful and perhaps determinative role.

“Don’t Make It a Battle”: Using Emotions as Conflict-Reducing Tiebreakers

When medical uncertainty ran particularly high, emotions could enter the equation as “tiebreakers” between multiple invested parties (e.g., between co-parents, between parents and physicians, or among physicians themselves). In the context of my study, this sometimes occurred when children were not doing well or responding to treatment as expected or hoped for. Parents and physicians could both find themselves wishing for but lacking a “crystal ball” at these moments. Yet, as Dr. Fadian, a white man in his fifties, put it, “you've always got to come up with a decision, period.”

At these junctures, leaning into the conceptualization of emotions as a form of wisdom could help both tip the scales, and more practically, reduce interpersonal conflict. Dr. Fadian offered the example of a time when he was unsure of the best course of action for a child who was not doing well, so he sought the advice of several of his colleagues. After these consultations, he explained, “I knew what I wanted to do . . . I wanted to give a bigger dose of cells, but I agreed to give a lower dose because that’s what most people felt comfortable doing.”

Here, Dr. Fadian settled on a decision by constructing the general feeling of his
colleagues (as opposed to any particular evidence offered by them) as meaningful and perhaps because after seeking their advice he did not wish to irritate them by ignoring it. Often such decisions might be small or a matter of degree: as Dr. Fadian noted regarding this particular decision, “it wasn’t questioned [that] the child needs cells . . . [there was] no doubt we’re gonna do it.” But lingering uncertainty was resolved by letting what allowed more people to feel more comfortable cement the final decision.

The Marins were even more frank about their use of emotions as tiebreakers in the instances when the two of them disagreed about how to proceed regarding some aspect of their son’s treatment. Savannah told me that it was “rare” that she and Todd weren’t on the same page when making medical decisions for Jacob, but that if disagreements occurred, they operated on the principle that “if you don’t agree, the person who feels stronger, we go with.” She elaborated:

Like, generally Todd will cede to whatever I [as a nurse] suggest, if he’s like, he doesn’t know about it or whatever. But . . . there’s been once or twice [that there was] something with [Jacob’s] medical care in the hospital or something that he felt strongly about, and so I said, “Okay, we’ll go with that.” You know, like even if I didn’t agree with it, but he feels strongly about it? Fine.

By letting “strong feelings” settle decisions that were generating conflict, the Marins both arrived at a decision and protected their relationship from further discord. Savannah also suggested that her gut feelings about advice she received from physicians could help her arrive at a decision when multiple opinions or factors muddied the water. During the scenario described previously, when the Marins were hemming and hawing about whether Jacob should be intubated in the PICU, they eventually spoke with Jacob’s primary physician by phone—who was not present at the hospital at that time to directly assess his condition. His recommendation was that they consent to intubation and mechanical ventilation because “his organ systems were [otherwise] good.” Savannah explained that she decided to follow his recommendation over others and over their own prior reservations because:

What Dr. S was saying made sense in my gut, and okay, it’s still a super scary situation, but I trust him, and I trust that it will be okay. So it’s a combination of doing your own research and listening and asking—asking more questions, asking more questions—until the answers you get make sense and resonate with you deep inside [italics added].

While Savannah did not linguistically erase her research, information gathering, and advice seeking entirely under the rubric of emotion-based decision-making as we saw in Simone Brady-Fischer’s earlier account, Savannah believed feelings could help her evaluate information, mediate between conflicting opinions, and point her toward a final decision she could feel good about making.

Physicians also gave parents’ feelings significant weight as tiebreakers when they themselves didn’t know what would have the best medical outcome and saw no reason to get embroiled in conflict. Dr. Vogel, a white woman in her sixties, assured me that she had no problem “sitting down with a family and saying, you know, I know where you’re coming from and I know why you’re worried, but this isn’t the right decision and I’m not going to let you make us do that” when she believed that a parent’s input on treatment decisions put a child’s health at
risk. But often, she explained, the situation was murkier, and "many times there's not a single right answer . . . sometimes nobody knows [what's best]." In these cases, she weighed parents' feelings more heavily: "What's the difference? Don't make it a battle, you know."

Dr. Vogel's approach reveals that prioritizing emotions in medical decision-making can help solve interactional problems in health care encounters. In the context of significant medical uncertainty, as was often the case, physicians might choose to put the quality of their interactions and relationships with families first and constructed families' abilities to feel good about the path forward as an important objective in and of itself. For instance, Dr. Ravipati, an Indian man in his fifties, explained frankly, "Their perception about certain things [does] make us do things differently. But a lot of times it is more to help them cope with it and us finding that, 'Okay, if we do this it's not going to hurt.'" Dr. Newell told me similarly:

If it's a decision that truthfully you could choose one medicine or the cousin, you know, [for example] Advil or Tylenol. It totally doesn't matter. Those are just decisions that are fine to make, and are fine to give to the parents, or at least let them, listen to them strongly sometimes [because] that could be helpful for families.

By giving emotions a trump card when decisions otherwise seemed to be something of a coin toss, conflicts could be reduced or avoided, and equivocation could be shut down.

When fostering good feelings and decreasing conflict entered the equation as positive outcomes in and of themselves, emotions could doubly influence medical decisions as a form of wisdom and as worthy goals to strive for.

**DISCUSSION**

Sociological analysis in general, and a symbolic interactionist analysis in particular, has much to contribute toward building a more robust and complete understanding of how emotions shape medical decisions and the interactive processes through which they are informed and made. Yet sociologists have been comparatively absent from discussions on this topic. Decision-making itself is a useful case more generally that can reveal how emotions and their effective deployment can facilitate inequality. Certainly, getting a job (or not) is one arena in life that can compound inequalities, and Rivera’s (2015) work on the centrality of emotions in hiring decisions was an important step toward establishing the fundamentally social role emotions play in that process. My findings reveal an even more active and strategic dimension to how emotions can be intentionally and fruitfully deployed to steer the decision-making process. Because these strategies could be advantageous socially, medically, or both, they represent an important avenue through which disparities in care may be bred.

Here, I have demonstrated how emotions, when imbued with symbolic value and mobilized in the decision-making process, could make decisions easier to arrive at, increase feelings of confidence in decisions made, and stave off interpersonal conflict. Although my data are grounded in the especially high-stakes context of families and physicians caring for critically ill children, it is reasonable to imagine that similar dynamics play out across medical settings and patient age groups and between patients/caregivers and other types of health care providers (nurses, physical and occupational therapists, etc.). Such strategies may also be engaged similarly in any number of other
arenas—education, real estate, or finance, for instance—as people choose among schools, homes, loan programs, and so on. Future research should consider this and examine how different institutional settings and status hierarchies may shift the use and effectiveness of strategies like these.

Subsequent research should also explore how such strategies may be complicated in other cases and settings and among differently positioned actors. Parents have a particularly high degree of authority as decision-making caregivers for pediatric patients, although even in these cases, the division of responsibility between parents and physicians can be contested terrain (Anspach 1993; Heimer and Staffen 1998; Reich 2016). Nonetheless, the relatively high degree of caregiver control in the present case is diminished in the case of spouses/partners, adult children, and others caring for sick patients who retain some or full say over their own treatment plans—and the ability to refuse treatment. Even more complex emotional dynamics and sophisticated interactional strategies may develop in these contexts (see e.g., Karp and Tanarugsachock 2000), resulting in different emotional pushes and pulls that may drive any number of key decisions.

How significantly the strategies I outline here, and the decisions they impact, affect health care outcomes is—and will almost certainly remain—a relatively open question. Emotional strategies exist alongside other decision-making activities (e.g., reviewing medical research or seeking second opinions), which makes it difficult to conclude how determinative they are in any particular decision made. It is also difficult or impossible to know what outcome an alternative choice would have led to. Some decisions that felt harrowing in the moment may have been inconsequential in the long run. Decisions that seem to turn out badly might still have been less disastrous than some alternative, and decisions that seem to turn out quite well might have been possible to improve upon. The outcome of some decisions may in fact be better measured in the emotional experiences they facilitate rather than a seemingly objective measure like “overall survival”—as when a terminally ill patient stops grueling and painful interventions rather than pursuing what might be (perhaps minimally or painfully) life-extending measures.

Smaller and/or less tangible outcome benefits, which I have elsewhere called “microadvantages” (Gengler 2014), can be a bit easier to pin down. For instance, when Simone was persuaded to proceed with her son’s scheduled surgical procedure under moderate sedation rather than the full sedation she had anticipated, the outcome—though relatively minor in the larger course of his illness—is known. Max tolerated both the combination of intravenous drugs used and the procedure without incident. Had Simone and the attending physician not effectively collaborated to generate an emotional context for this decision in which Simone felt comfortable consenting to proceed with the procedure, all parties involved would have at the least experienced the inconvenience of rescheduling. Delaying this diagnostic procedure might have also deprived Max’s primary physician of the information he needed to adjust medications and dosages more effectively in the interim. Rescheduling would certainly have extended the amount of time Simone and Max had to spend thousands of miles away from the rest of their family. That all of these scenarios were avoided represents the small, everyday ways in which advantages in health care can pile up over the course of the illness and treatment process.

The fact that the deft use of emotions in health care interactions could help
families and physicians alike accrue even simply the advantage of being able to make decisions more quickly, with greater confidence, and with less contention suggests that those who are not as well positioned to successfully adopt these strategies might miss out on even just these processual advantages. Not all patients and caregivers are as comfortable as others speaking up and negotiating with health care professionals (Gage-Bouchard 2017; Gengler 2014), and the fit between a patient/caregiver’s interactional style and that of health care providers is critical to the relationship between them (Dubbin, Chang, and Shim 2013). Proficiency in leveraging emotions (one’s own and others’) in the medical decision-making process should thus be recognized as another key component of what Shim (2010) conceptualizes as cultural health capital. It is a valuable, flexible skill not everyone brings equally to the table.

This points to the need for further research along these lines that examines more closely how the social identities of the decision makers involved (across race, class, gender and other dimensions of difference) influence how emotions are activated and elevated in the medical decision-making process. We know that social identities profoundly shape emotional experience and the feeling rules people are expected to follow (see e.g., Froyum 2010; Kang 2003; Wilkins 2012; Wingfield 2010). As a result, interpersonal efforts to manage emotions in line with such social expectations can serve to reproduce and reinforce inequality (see e.g., Ezzell 2012; Lively 2000). Investigating these dynamics in health care arenas should be a top priority for health disparities and emotions researchers alike. More fully interrogating dynamics like those identified by Cottingham and Fisher (2016) in how emotions (in their case, feelings that shape the very meanings assigned to risk and benefit) are differentially experienced and expressed in the medical arena will be essential to fleshing out the context in which the strategies I have identified here operate.

If patients’, caregivers’, and providers’ abilities to effectively deploy emotions in health care encounters are influential in the medical decision-making process and represent another pathway through which inequalities in the illness experience can be produced, it is all the more pressing that sociologists work to continue explicating the mechanisms through which this occurs. A full and nuanced accounting of these dynamics can help bring more light to an understudied dimension of health care encounters and may be of real value in medical education. Illuminating these processes can also help patients and caregivers negotiating serious and chronic illnesses be more clear-eyed about the strategies they and those around them lean on in making important decisions that affect their health and quality of life. Both emotions and decisions are embedded in the rich and knotty fabric of social life. Those who study both emotions and decision-making will be well served to continue examining the points at which these threads intertwine.

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