independence" to states gaining control of other's political machinations. Intervention solely to stop a crime against humanity infringes on neither of these, so it does not fall within the Charter's force prohibition. Furthermore, humanitarian intervention is within the principles of the UN, because the Charter's dual purposes are preserving peace and promoting human rights.[12]

Additionally, international law requires the existence of grave violations of human rights, an exhaustion of non-forcible responses, and the unavailability of UN-sanctioned action. The response must be proportionate—no more than necessary to achieve humanitarian ends—and it must not interfere unnecessarily with a country's self-determination. Finally, the interveners must disengage upon securing fundamental rights and report their actions to the Security Council.[13]

Nations should be justifiably cautious about using or threatening intervention to stop crimes against humanity. Policy makers must carefully consider risks to relief workers, civilians, and troops, as well as the danger of complicating future health-promotion activities. Forced intervention is a complex policy question, but blanket rejection may condemn innocent civilians and prevent deterrence of crimes against humanity. Where leaders engage in intentional acts of cruelty toward their populations, wealthy nations should be prepared to intervene beyond their borders to safeguard health and human rights.

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How doctors feel: affective issues in patients' safety

Two books have directed attention to the underpinnings of doctors' thinking.[1,2] Thinking (cognitive) failures abound in clinical decision making, especially in diagnostic formulation, and taxonomies of common cognitive errors have been developed.[3] Diagnostic failure has been identified as a major threat to patients' safety[4] and, this year, the *American Journal of Medicine* published a supplement on the problem[5] to coincide with the first symposium on diagnostic error.[6] Despite the tardiness of this focus on how doctors think, we welcome the advance in evolution of patients' care and safety. The more difficult next step is to recognise that how doctors feel would also be a complementary and worthy topic for investigation, especially for any effects on clinical decision making and patients' safety.

Historically, the prevailing view in medicine is that clinical decisions should be objective and free from contextual affective issues: one could not be objective and rational if emotion entered the reasoning process. Indeed, many of us would consider it a professional virtue to be able to rise above the emotional pull of clinical situations, to deliver cool, clear, analytical judgments. However, despite what we might believe, our feelings (affect) intrude into almost every decision that we make. Our daily interactions with others are influenced by conscious or unconscious social transference phenomena[7] which are affectively polarised in ways that range from subtle to substantial. Similarly, specific clinical situations provoke lesser or greater degrees of affective valence. In fact, our first response to anything is an affective one

Panel: Taxonomy of affective dispositions to respond

- *Transitory affective states:* environmental factors, sleep deprivation, sleep debt, irritability, stress, fatigue
- *Clinical situation induced:* specific affective biases (eg, fundamental attribution error, counter-transference)
- *Endogenous disorders:* circadian, infradian, or seasonal mood variation, mood disorders, anxiety disorders, emotional avoidance

that governs the future direction of our relations[8]—we tend to trust our first impressions and stick with them. To then understand the role that affective state has in clinical decision making seems important.

A consensus is emerging that decision making occurs through one or a combination of two modes: the first (system 1) is intuitive, fast, automatic, often involves an affective component, and uses few resources, and the second (system 2) is analytical, slow, deliberate, affect free, and resource intensive.[9] Importantly, most errors of judgment occur in system 1 in which affect predominates. In system 1 heuristics (mental short-cuts, maxims, rules of thumb) and biases also occur. The powerful affect heuristic[10] might substantially influence judgment. For example, some patients will elicit affective responses from their health-care providers. Sometimes these responses are positive, but they could also be negative and lead to labelling,[11] patients being referred to as complainers, difficult, high maintenance, or worse. Labelling not only influences a clinician's thinking but also that of other health-care providers—eg, in borderline personality disorder, visceral reactions elicited by the patient in their provider might be the basis for making the diagnosis.[12] Affective valence towards patients, positive or negative, can compromise decision making. The best evidence might be degraded when it is unconsciously passed through an affective filter.

The idea of affective influence on decision making will be unfamiliar to many clinicians. Efforts should be made to raise awareness of how affect influences clinical performance, and to describe its many forms. The panel provides a preliminary taxonomy that groups affective dispositions to respond towards patients into three main categories. The first are affective states in the caregiver that might be induced by the immediate environment or work conditions—eg, irritability induced by high levels of ambient noise or negative affective states associated with sleep deprivation. The second are affective biases that are specific to the context or patient. One of the most powerful is counter-transference, in which the caregiver feels positively or negatively towards the patient because of experience with previous exemplars. Another example here is fundamental attribution error, in which patients can be judged on the basis of dispositional qualities rather than circumstantial ones—eg, blaming patients for their obesity rather than underlying socioeconomic factors that might have led to their condition. The third are endogenous affective states within the clinician: some depend on various temporal factors, others on mood disorders, or emotional avoidance leading to mistreatment or neglect of patients.

In summary, increasing evidence exists, mostly from the field of psychology, that affective factors could influence physicians in the diagnostic process, medical decision making, and interactions with patients. There is a growing imperative for medical educators to understand and incorporate this knowledge into clinical training.

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