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Cover Page Footnote

I am grateful to all of the patients I have visited, who have welcomed me into their rooms and shared their stories. I would like to thank Hartley Jafine for his continuous support, encouragement, and enthusiasm.

Self and Other: Creative Writing to Develop Empathy Across the Asymmetries of Healthcare

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“Would you like some hand cream?” she asks with a voice that is louder and kinder than before. What an idea! My hands don’t have a diagnosis; they have been neglected by the nurses. Now they are dry and in need of attention. Within these walls, only sickness gets attention. What about me? What about my hands?

She takes the unscented lotion from the shelf and fills her naked palms. I reach over to give her my left hand, and the tube in my arm pulls once more. Her hands are soft and slow; how different from the gloved hurry that handles me every day. No stranger has done so much as shake my hand without wearing gloves, and here is this girl rubbing lotion into both of our skins. We are connected: we are absorbing together and we are absorbing each other.

A nurse walks in, holding a blood sugar device and a small swab. She sees our hand cream ceremony and stops. ... Our hands remain still, holding the air between our palms with cautious awareness. (Coret 3)

To introduce her seminal essay *Illness as Metaphor*, Susan Sontag describes two kingdoms of which we are all citizens: the kingdom of the healthy and the kingdom of the sick (Sontag 3). Ingrained in this metaphor is a divide, despite each citizen having a passport to each kingdom. A certain border is established; a fragile passport control is in place. Indeed, the experience of sickness is alienating, isolating its victims in their own suffering, uncertainties, and mortality.

No matter how well-intending, kind, and knowledgeable a healthcare provider might be, there is an inherent and inevitable asymmetry between their own experience and that of their patients. This

asymmetry, to contextualize it in Sontag's metaphor, is the bricks in the wall of the border, the very wire of the fence. The experience of a patient in a hospital contrasts to that of their provider in several ways. For the patient, this illness could be a monumental life event, filled with fear, pain, and transformations of identity. The illness could be a peak of meaning, an unwanted stay in the kingdom of the sick, a mountain in its landscape. The patient, moreover, often lacks a comprehensive understanding of the physiology of the disease and its biological functions, and may contextualize the illness within their life narrative rather than a biological cause. They might have little to no comparison to other patients with this disease to see how they are coping. This experience differs from that of the physician, whose daily job involves taking care of numerous other patients with similar problems. They are likely stressed with the workload and the focused desire to cure the biological. The physician enters this relationship with a knowledge of disease mechanisms, which can feel like control (over the disease or over the patient?). As such, the relationship between patient and physician is inherently unbalanced and asymmetrical, communicated across the border of the two kingdoms. But this divide is penetrable, permeable, filled with room for emotion and meaning to leak through, if you let it. This is done most powerfully through narrative.

Stories, written and oral, are the ambassadors of these kingdoms, moving freely across the border. They bring unification, humanity, and care into medicine. This idea is not new. Rita Charon writes that "the narrative features of medicine 'answer,' broadly speaking, the divides we find within healthcare" (xi). This essay will emphasize why these divides are important to notice, and how creative writing can help healthcare providers become more aware of these asymmetries in order to develop their own empathy. Empathy, in turn, can mitigate the risks of burnout among physicians, resulting in better patient care (Thirioux et al. 8).

Empathy, in contrast to sympathy, is an essential component of the patient-physician relationship. The term "empathy" has been used in various ways since it was first introduced by Robert Vischer in 1873 and more formally by the German philosopher Theodor Lipps in 1913 (Montag et al. 1261). Lipps used the term *einfihlung* which translates to "feeling into" from *ein* [into] and *fühlen* [to feel] (Montag et al. 1261; Thirioux et al.

4). This is distinguished from sympathy, or *mitfühlen*, which means “to feel with” or “to join the feelings of another person” (Thirioux et al 4; Hojat et al. 27).

Empathy, then, is the ability to understand what someone else experiences, including their emotions, thoughts, pain, and fears, rather than feel it along with them. Psychiatrist Harry A. Wilmer defines an empathetic relationship as one where “we use ourselves as the instrument for understanding, but by the same token we keep our own identity clearly separate” (Wilmer 245). Moreover, we must know ourselves and our own biases in order to understand clearly and deeply what someone else is communicating to us. The ethicist Petra Gelhaus writes in her trilogy of papers on the desired moral attitude of physicians that in empathy, in contrast to sympathy, “you are aware that you are outside and have to reach *inside* the other [person]” (105, emphasis is original). A prerequisite for empathy is, in other words, an awareness of the difference between self and other. Sympathy, on the other hand, has been shown to merge identities and blur the distinction between self and other, and as such, it is not the aim in a patient-physician relationship (Thirioux et al. 4-5; Gelhaus 105). There is an alterity, a distinction, between the physician’s experience and that of the patient, which must first be recognized in order to be bridged.

There is a gap in experience between the newness and potency of suffering for the patient and the corresponding lacklustre of routine for the observing care-provider. I do not expect nor recommend that the experiences of patients and providers be symmetrical – that is unrealistic and impossible; asymmetry of experience is inevitable and necessary. It allows providers to focus on treating disease and not be overcome by suffering. The indelible asymmetries in all dimensions of life add beauty and meaning to our layered existence, revealing different ways of being, knowing, and aching. The differences we observe between ourselves and the rest of the world – across the Self-Other distinction, whether it is illusory or not – strengthen and shape our own identities and challenge us to care for others despite the divides. But what happens when we lose sight of the different perspectives people hold, and we get too comfortable in our own ways of seeing? Might, then, the unnoticed asymmetry cause

suffering, as we implicitly assume that others perceive this event in the same way that we do?

The asymmetries of healthcare will always exist, and we must continuously be aware of how we approach them. When a physician lacks the awareness of the differing perspectives of their patients, there is potential for reduced empathy from overlooking the patient's experiences, beliefs, worries, values, and expectations, which might contrast to those of the physician. A desensitization to patients' stories, as occurs in burnout, would further this divide and isolate both physician and patient. Both kingdoms are bare and painful without narrative to weave a web of meaning into their landscapes. How can one claim true empathy – the ability to understand someone else's perspective – without being aware of your differences? How do you bridge a gap if you do not know what it looks like?

Creative writing, in all its forms, cultivates an awareness of asymmetry by teaching you how to listen and how to imagine. Listening like a writer involves an attention to detail and an ability to hear the unsaid and the unspoken. Entering a patient's room as a writer, in addition to a doctor or nurse or physiotherapist, means caring for the patient's story, too. You are there to receive it, to observe it, and to honour it. Writing about hospital experiences is an active process of refocusing our attention onto the emotional sphere of the patient, and our own spheres in relation to theirs. It is an act of attention re-allocation. It sharpens our ability to notice what we are not noticing; to notice *that* we are not noticing. A healthcare provider who engages with creative writing to reflect on their clinical experiences grows to notice and value the stories they receive from their patients.

Creative writing also strengthens our capacity for imagination. Writing poems to reflect on clinical experiences with patients requires a process of imagining how they might be thinking about their illness, what they know, and what they might be expecting, fearing, or hoping. Creative writing can develop the imaginative capacity that philosopher Gregory Pence describes is necessary for compassion in medicine:

A richer, more powerful imagination is needed to understand and feel the suffering of people of different backgrounds, values, and

needs. Because of this *gap* between people, obtaining the imaginative understanding of suffering can at times be a *worthy achievement* like other medical achievements. (189, emphasis is original)

The value in the poem or short story is not in its truth or realism, but rather in the process of its creation: the writing process necessitates an openness to alterity and an imagination of different experiences. We are aiming for a perspective shift, rather than an accurate documentation of the other's emotions. We can never fully know what someone else is experiencing, but we can try. The excerpt from the beginning of this essay is an example from my own creative writing, where I imagine a patient's perspective, without claiming that the descriptions are necessarily True or factual about her life. Writing is an experimentation of reaching out into other lives and narratives much different from our own, while remembering the entire time that we are not them, and that we are limited in how much we can really know about someone else. This maps onto Carl Rogers' definition of empathy as an ability "to perceive the internal frame of reference of another with accuracy as if one were the other person but without ever losing the 'as if' condition" (210-211).

To understand the divides between you and another person, not only must you strive to understand them, but also strive to understand yourself. Reflective creative writing can reveal inner parts of ourselves we might not have been conscious of, and depict them in new and relevant ways. This can lead to greater self-knowledge and comprehension. Through writing about our experiences in the hospital, we become more familiar with both the kingdom of the sick and the kingdom of the well. The kingdom of the sick is understood better through listening and imagining, as described above. The kingdom of the well is understood through its contrasts to the other, in its familiarity magnified and recognized. Creative writing gives words to thoughts you might not have known you had. The asymmetry has two sides across the border: you must know yourself to see what is different in the other. Clarity with yourself and your own experiences, as achieved through reflective writing, leads to greater clarity and understanding of others.

An additional outcome of creative writing, both in and out of healthcare, is its potential to help the writer cope with difficult life experiences. If the writer happens to also be a healthcare provider, this coping is especially relevant to their empathy skills in clinical encounters. A physician who has reflected on a challenging or stressful case and expressed their feelings through writing – and perhaps even shared it with someone else – is going to be more open and able to receive new stories and empathically witness new suffering, for they have recognized and dealt with the past, to a certain extent.

Creative writing fosters the capacities to listen to others and to imagine their perspectives, as well as the practices of self-learning and coping. These four skills – listening, imagining, self-learning, and coping – integrate to develop one’s ability to “feel into” someone (empathize) to understand their inner state. Such empathy has no need for limitation, as Mohammadreza Hojat explains that “sympathy must be restrained to facilitate clinical neutrality, but empathy has no restraining boundary because an abundance of its core ingredient — understanding — is always beneficial and never harmful in patient care” (27-28).

An acceptance of our diverse perspectives is an acceptance of our subjectivity; acknowledging that our experiences differ in silent, invisible ways. Writing can highlight these alternate perspectives, for finding the words is another step in learning to see. Empathy is fostered by allowing the physician to extend beyond their own perspectives to see more clearly the perspectives of their patients. Indeed, the act of representation (that is, writing) illuminates and defines that which is being represented. Articulation of the observed helps to enhance the observation. And isn’t that the goal, to observe the world around us keenly, openly, and fully? To understand the people around us as deeply as we can? To care for the patients around us with empathy, humility, and humanity?

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